Introduction/Background (Encore-but-modified/new-data). Since 2015, BRCA1/2 pathogenic variant (PV) testing is recommended for all epithelial ovarian cancer (EOC) patients in the Netherlands. Recently, recommendations shifted from germline testing to universal tumor testing and subsequent germline testing in those with BRCA1/2 tumor PVs (TPVs). Data on testing rates of these approaches and on characteristics of patients missing out on testing remain scarce. Therefore, we evaluated BRCA1/2 testing rates in EOC patients and compared rates of germline testing (performed from 2015 until mid-2018) versus tumor testing with germline testing only in those with TPVs (implemented mid-2018). Additionally, we delineated characteristics of patients who were less likely to receive BRCA1/2 testing.

Methodology A consecutive series of 250 patients diagnosed with EOC between 2016 and 2019 was included from the OncoLifeS databank of the University Medical Center Groningen. Testing rates were analyzed for the overall study population and by period of diagnosis to evaluate rates of germline testing (period I) and tumor-first testing (period II) separately. Characteristics of tested and untested patients were compared using the appropriate statistical test.

Results Median age was 67.0 years (interquartile range: 59.0–73.0) and 69.2% was diagnosed with high-grade serous carcinoma (HGSC). Overall, 80.4% of all patients had a known germline PV (GPV) status. In period I, 80.1% of all patients had a known GPV status and in period II this was 81.0%. Overall, and in period I and II separately, a significantly greater proportion of patients with HGSC was tested, as compared to those with non-HGSC (74.6% versus 23.9%; P = 0.001).

Conclusion The results show that BRCA1/2 testing rates are suboptimal and suggest that clinicians may not be choosing to test EOC patients with non-HGSC, although guidelines recommend BRCA1/2 testing in all EOC patients. Suboptimal testing rates limit the optimization of care for EOC patients and counseling of potentially affected relatives.

Introduction/Background The UK National Institute for Health and Care of Excellence (NICE) has published guidance for suspected cancer referrals to help Primary Care doctors refer patients for further investigations. The threshold cancer probability for referral is set at 3%. Patients are then seen in rapid access clinics (RAC) in Secondary Care. Unfortunately, many referrals are inappropriate and this creates a burden in secondary care. These referrals also cause unnecessary anxiety to the patients. To improve the efficacy and effectiveness of the RAC, we identify inappropriate referrals and manage these patients in an alternative pathway. We provide timely feedback and education for staff working in Primary Care. Standardised letters have been developed for each type of inappropriate referral, which are sent to both the patient and the referring doctor.

Methodology A retrospective analysis of all suspected cancer referral forms sent to our unit between May 1st 2021 and April 31st 2022 was performed.

Results A total number of 958 suspected cancer referrals were made to our unit within the period of 12 months. These were triaged by a senior gynaecologist and 28% were deemed inappropriate. Of these inappropriate referrals, 15% were for suspicion of endometrial cancer, 7% were for ovarian cancer and 6% were for cervical, vulval and vaginal cancers grouped together. Breakthrough bleeding on Hormone Replacement Therapy (HRT) was the most common inappropriate referral (n = 81). Other common reasons included: obviously benign lesions of the vulva, vagina and cervix, intermenstrual bleeding, postcoital bleeding, non-suspicious ovarian cysts, endometrial thickening, and isolated elevation of CA125. We have identified Primary Care doctors that are outliers and provided targeted education and training.

Conclusion We have identified common reasons for inappropriate referral and created an alternative pathway for these patients. Targeted education has been provided for Primary Care doctors. These measures have enabled the RAC to function more effectively.
Conclusion Cooperation of our patients and techniques provide successful treatment planning and delivery while reducing radiotherapy dose to the organs at risk. This approach significantly reduces the level of anxiety, helps patients trust and cooperate with staff, complete treatment without interruptions and an overall better outcome.

Methodology In this multicentre non-inferiority trial, 316 women from 42 hospitals with FIGO stage IA/B endometrial cancer were randomly allocated to reduced FU (n=160) or usual FU care (n=156). The women completed questionnaires at baseline (after surgery), and after 6, 12 and 36 months. The primary outcome was satisfaction with care (PSQ-III) with a predefined noninferiority margin of 6 points (range 0–100). Mixed linear regressions were used.

Results 299 (95%) women completed the questionnaire at baseline; 291 (92%) at 6-months; 272 (86%) at 12 months and 222 (70%) at 36 months. During three years after treatment, women in the reduced FU group had a median of 3.5 [IQR 3.0–5.0] visits with their specialist/nurse compared to 7.0 [IQR 6.0–9.0] visits for women in the usual FU group. Overall satisfaction with care was similar in the reduced FU (M=82;SD=15) and usual FU (M=82;SD=13) group. At 6, 12 and 36 months, more patients (93/94/90%) in the reduced FU arm were satisfied with their FU schedule than patients in usual FU arm (79/78/82%). Nine women in the reduced FU group and five in the usual FU group developed a recurrence (n.s.).

Conclusion Women receiving reduced follow-up care were just as satisfied with their care as those receiving follow-up care according to Dutch guidelines. Compared to usual care, women in the reduced care group had fewer medical visits and, at the same time, more often reported being satisfied with this reduced frequency.