Patient Information

University Hospitals Coventry and Warwickshire NHS Trust

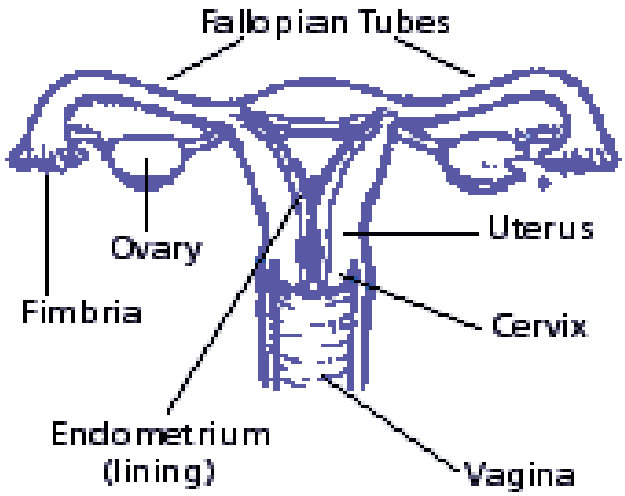
Macmillan Gynae-Oncology Service

Cancer of the Cervix (Cervical Cancer)

You have recently been diagnosed with a cancer of the cervix. It is normal to experience a wide range of emotions. This can be a very frightening and unsettling time. Whatever you may be feeling at present, try talking about it with someone who can help you, such as your GP, consultant or specialist nurse. He/she will listen, answer any questions you may have, and put you in touch with other professionals or support agencies if you wish.

What is the cervix?

The cervix is the lowest part of the uterus (womb). It is also known as the neck of the womb. It extends into the vagina (birth canal) – see diagram. Your doctor can usually see and feel the cervix during a vaginal (internal) examination.



What causes cancer of the cervix?

We do not know exactly what causes cervical cancer. It may be due to a type of papilloma virus. Anyone who has had penetrative sex may be at risk of having cervical cancer.

How does cancer of the cervix develop?

Cancer of the cervix usually takes many years to develop. Early pre-cancerous changes can be identified by cervical smears and treated before they become cancer.

Cancer occurs when cells continuously divide and grow

There are two main types of cancer of the cervix. The most common is called ‘squamous cell carcinoma’ (carcinoma is another word for cancer) and this develops from the flat cells, which cover the outer surface of the cervix.

The other type is called ‘adenocarcinoma’. It develops from the glandular cells, which line the canal (passageway) of the cervix. This type of cancer is less common than squamous cell cancer.

How is cancer of the cervix described?

Knowing the extent of the cancer and the type of cells helps the doctors decide on the most appropriate treatment.

The stage of a cancer is a term used to describe its size and whether it has spread beyond its original site.

Cervical cancer can be divided into four progressive stages.

- **Stage one -** the cancer cells are within the cervix.
- **Stage two –** the tumour has spread into the surrounding areas, such as the upper part of the vagina or nearby tissues.
- **Stage three –** the tumour has spread further into the lower part of the vagina, nearby lymph nodes, the outer layer of the uterus or further within the pelvis.

Sometimes a tumour that has spread to the pelvis may press on one of the ureters (the tubes taking urine from the kidneys to the bladder). This means that urine cannot pass to the bladder and there might be a build up of urine in the kidneys.

- **Stage four –** the tumour has spread beyond the pelvis. This stage includes tumours that have spread to the bladder and the bowel. Cervical cancer can also spread to the lungs, the liver or to bone, although this is not at all common.

Cervical cancer is also graded. Grading refers to the appearance of the cancer cells under the microscope. The grade gives an idea of how quickly the cancer may develop. There are three grades:

- **Grade one:** (low grade) – the cells look very like normal cells. They are usually slow growing and less likely to spread.
- **Grade two:** (moderate grade) – the cells look more abnormal.
- **Grade three:** (high grade) – the cells look very abnormal. They are likely to grow more quickly and are more likely to spread.

What treatment is available for cancer of the cervix?

There are several different ways of treating cancer of the cervix. No one treatment is better than another. Some patients need an operation, some need radiotherapy and chemotherapy, and some need a combination of these treatments. The treatment that you receive will follow agreed guidelines which cancer specialists adhere to. As far as possible these guidelines are based on the best research and knowledge available.

If your cancer is at a very early stage, it may be possible for your specialist surgeon to offer you an alternative operation that will enable you to keep your womb and to try for a family in the future (if you are still of child bearing age and your family is not complete.)

Your gynaecologist and multi-disciplinary team will take everything about your illness into account and will recommend an individually tailored programme of treatment for you. At each stage he/she will discuss and explain everything, and obtain your opinion and your consent to the treatment he/she recommends.

No matter what treatment is recommended you will need to be followed up for 5 – 10 years afterwards. Where these follow-up appointments take place, and how often these visits should be, varies from person to person. Your specialist gynaecologist will discuss what is best for you.

Your specialist/support nurse will try and explain anything you are concerned about and answer your questions. At appropriate times she will offer you more written information or will advise you where you can obtain further written information. If you would like to know anything or have further questions, please contact her. Her telephone number is on the **'Useful contact names and telephone numbers'** sheet, at the back of this booklet.

This booklet is not meant to replace and discussion you may want to have with clinical staff.

Possible treatments

Surgery

Surgery for cancer of the cervix often involves a radical hysterectomy (removal of the womb). This is different from a 'simple' hysterectomy because not only are the cervix, uterus and fallopian tubes removed, but also the upper third of the vagina and the tissues around the cervix. Near the cervix are some small lymph nodes, each about the size of a small bean. These nodes make up part of the lymphatic system. This is a network of glands situated throughout the body, which acts as a defence against disease. However, the fluid (lymph) which flows through the network can also spread cancer to other parts of the body. To try and prevent the cancer spreading further, the pelvic lymph glands will also be removed at the time of surgery. The doctor will discuss with you whether it is necessary to remove your ovaries as well.

The uterus and lymph node samples are sent away to the laboratory to be examined under the microscope.

Providing the surgeon can remove the entire tumour, surgery is very effective treatment for cervical cancer. It may be that the operation is all that you need but this can only be confirmed when the pathologist has examined all the tissue samples and lymph nodes under the microscope. Sometimes it becomes obvious during an operation that surgery is not the best treatment. This is because the cancer is in a place where it cannot be removed. In these cases chemotherapy and/or radiotherapy may be more

effective treatments. Your specialist gynaecologist will discuss everything with you.

What happens when I come into hospital?

Prior to your admission to hospital you will need to undergo a MRI (Magnetic Resonance Imaging) scan of your pelvis and abdomen. This imaging helps your specialist gynaecologist and the multi-disciplinary team decide on the most appropriate treatment for your type of disease and stage (position of cancer).

If surgery is decided as the most appropriate form of treatment for your cervical cancer then usually you will come to hospital a couple of weeks before your planned surgery for your pre-admission checks. This appointment takes around two hours. This gives you a chance to meet your clinical nurse specialist/support nurse again and see the lay out of the ward. You will also be briefed again about your planned surgery and what to expect after your surgery whilst you are in hospital. You will also have blood tests, may need swabs, a chest x-ray, ECG (tracing of the hearts rhythm and beat) and any other investigations necessary before your operation.

Unless you have any medical problems, you will come into hospital on the morning of your operation.

Before your operation your consultant, or a doctor from the team working with your consultant in theatre, will visit you. They will again explain the planned operation and ensure that you understand the risks associated with your surgery. Although you will have already signed your consent form at a previous clinic appointment, they will go through the consent form again.

The anaesthetist will come to see you to make sure that you are fit to have a general anaesthetic. He/she will explain what will be involved when you have your anaesthetic and what pain relief you can have after your operation.

Your specialist/support nurse will see you during your stay in hospital; she will give you further information and support. You will also be able to

contact her when you go home. Her details are on the **'Useful contact names and telephone numbers'** sheet.

How is the operation done?

The surgeon will make a straight cut in your abdomen, from just below the umbilicus (tummy button) to just above the pubic bone of your pelvis. Alternatively he/she may make a straight cut along your bikini line.

In some cases with early stage disease, a hysterectomy by vaginal approach/ laparoscopic or robotic, with or without removal of lymph glands may be an option. This will be discussed with you at your clinic appointment.

Are there risks from the operation?

As with all operations there are risks. The main risk for any operation is having a general anaesthetic.

This risk is lessened if you are fit and healthy. The other main risks and the efforts to minimise them are:

- **Bleeding during the operation.** We prepare blood for you which will be ready if you need it. Please advise your team prior to surgery if you have any objections to a blood transfusion.
- **Blood clots (Deep Vein Thrombosis DVT, Pulmonary embolism PE).** You will have a 28 day course of injections to minimise your risk of getting a DVT or PE following your operation. You will be taught how to inject yourself. You will also be fitted with specialist stockings which help prevent clots. These will be worn for 23 hours per day for 6 weeks, they are to be removed for 1 hour a day for washing and inspection of the skin.
- **Bladder infection.** Initially after the operation your urine will be drained away by a urinary catheter. If you develop a bladder infection, you can have antibiotics to treat it. You will be discharged home with your urinary catheter still in place. It will be removed in the hospital 7-10 days later.
- **Voiding (passing urine) dysfunction.** Bladder dysfunction may occur following a radical hysterectomy.

  This can be influenced by the width and extent of the surgical dissection around the pelvic nerves.

This dysfunction may be experienced in a number of ways including a loss of the sense of urgency to pass urine or the inability to initiate passing urine.

This problem can occasionally continue for several months but a full recovery of bladder function is usually made.

There is a small risk that you may need to be taught intermittent self-catherisation if you are unable to empty your bladder properly once your catheter is removed. Intermittent self- catherisation is placing a catheter into your bladder to empty the urine

- **Chest infection.** You will not be as mobile as usual for a few days after your operation. If you develop a chest infection, antibiotics can treat this too. You will be encouraged to perform deep breathing exercises post operatively (please refer to your physiotherapy booklet given to you at your pre-admission appointment.
- **Lymphoedema.** For women who need their lymph nodes removing, there is a small risk of swelling of the legs or lower abdomen (Lymphoedema). If the pelvic lymph nodes are removed during the operation, the lymphatic drainage may be impaired, resulting in a build up of fluid in one or both legs, or in the genital area. The problem can be treated, but you can take preventative measures to reduce the risk of it happening. The nurses or doctors will discuss this with you, or ask to see a leaflet on the subject.
- **Fistula Formation.** A fistula is an abnormal communication channel/hole that can occur between two or more organs.

  There is a small risk that this may occur a few days to a few weeks after your surgery.

  As a direct result of your radical surgery a hole may occur between the bowel and vagina (rectovaginal fistula). This hole would allow faeces to pass through your vagina.

  Alternatively a hole may occur between your ureters (the tubes that carry urine to your bladder) and your vagina (uretovaginal fistula). This hole would allow urine to drain through your vagina.

  Some patients may require further surgery to correct the fistula.

Is there anything I should do to prepare myself for the operation?

Yes. Make sure that all of your questions have been fully answered to your satisfaction and that you fully understand what is going to happen to you.

If you are a smoker, it would benefit you greatly to stop smoking or cut down before you have your operation. This will reduce your risk of chest troubles as smoking makes your lungs sensitive to the anaesthetic.

You should also eat a well balanced diet and if you feel well enough, take some gentle exercise before the operation, as this will also help your recovery afterwards.

Before you come into hospital for your operation, try to organise things ready for when you come home. If you have a freezer, stock it with easy-to-prepare food. Arrange for relatives and friends to do your heavy work (such as changing your bed sheets, vacuuming and gardening) and to look after your children if necessary.

What can I expect after my operation?

You will usually be away from the ward for 3-4 hours. From the recovery room, you will be brought back to the ward. You will find that you are very sleepy for the first 24 hours.

Drips

When you wake up, you will have a plastic tube attached to a needle in a vein in your hand and a container of fluid on a stand.

This is called a drip and it helps to replace fluid lost during or because of your operation. You will have fluids by a drip until you can drink enough to prevent yourself from becoming dehydrated.

Wound

Immediately after your operation you may have a dressing over your wound. This will be taken off 24-48 hours after your operation and the wound exposed. The nurses on the ward will check that your wound is healing properly. Your sutures/stitches may dissolve naturally and will

therefore not need to be removed. Or you may have staples, these are usually removed by the 7th day of your operation.

Drains

There may be one or two tubes from your pelvis (tummy) leading to a drainage bottle (redi-vac). This allows the nurses to check for any bleeding. The drain(s) will be removed once the doctor is happy that there is no bleeding and that any fluid which may have collected inside your tummy, has drained away.

Catheter (tube)

When you wake up after your operation, you will have a small tube leading from your bladder, to a bag. This tube is called a catheter and it drains all your urine away automatically. This will usually be removed 5-7 days after your operation.

As previously discussed after your radical surgery your bladder may not initially work as effectively as you are used to. You may experience reduced sensitivity to your bladder filling and/or an inability to initiate passing urine. Long term bladder dysfunction can be avoided by preventing over-filling of the bladder. So once your catheter has been removed, it is important to empty your bladder regularly.

The first few times you pass urine after the removal of your catheter, the nurse may either pass a fine catheter or arrange an ultrasound scan of your bladder to ensure that the residual amount of urine in your bladder is less than 100mls.

If the residual amount of urine in your bladder is more than 100mls on two consecutive occasions, you will be taught how to, intermittently, self-catheterise. This problem can occasionally continue for several months but it is usual for a full recovery of bladder function to be made.

If you are discharged still needing to intermittently self-catheterise, you will be followed up regularly in the gynaecology out patients department to monitor the recovery of your bladder dysfunction.

Monitoring

Your blood pressure, pulse, temperature, oxygen levels, and respirations will be measured at regular intervals. You will wake up from your anaesthetic wearing an oxygen mask, this is perfectly normal, so please do not think there is something wrong. It is a good idea to warn your family about all this so they do not worry unnecessarily when they visit you for the first time.

Pain

This is a big operation, and at first you might have pain. The anaesthetist will make sure that you have pain relief for this. If you are in any discomfort, please do not hesitate to tell the nurses looking after you.

Usually pain relief is given by a special drip into your vein. You can control your pain relief yourself through a special ‘watch’ connected to your drip – this is called Patient Controlled Analgesia (P.C.A.)

Within a couple of days you should be getting up and about, eating and drinking. Then, you can have any pain relief you need as tablets by mouth or suppositories into your back passage.

You will continue to have the injections to prevent blood clots until you are properly up and about, but at least for four or five days after your operation. You will be expected to wear your surgical stockings for your entire stay in hospital.

Bathing

The first day after your surgery a nurse will help you to have a wash (bed bath). The second day after your surgery, if you are well enough a nurse will help you to have a shower. You will be able to have a bath or shower every day. If necessary, a nurse will help you for the first few days, until you feel confident enough to manage on your own.

Moving about

On the day of your operation you will be very sleepy and will remain in bed all day. From the first day after your surgery you will be encouraged to be up and about as early as possible. The nurses will help you in and out of

bed for the first few times, until you are able to manage on your own. Being mobile, as soon as possible after the surgery helps to prevent blood clots, chest infections and any stiffness caused by being in bed. You will be seen by the physiotherapist during your stay in hospital; he/she will teach you some exercises and give you some advice before you go home.

Blood tests

One to two days after your operation we will take a specimen of blood. This is to make sure that your blood count is normal.

Wind

Your tummy may feel upset with wind following your surgery. Getting up and about as quickly as possible often helps ease this discomfort. Some ladies find peppermint cordial in warm water eases the wind (you will need to ask your family to bring this in from home, as we do not stock this at the hospital).

What about going home?

Most women stay in hospital for 3-5 days, however if surgery is performed laparoscopically you may be able to go home after 1-2 days.

If you are discharged home with sutures (stitches) that are not dissolvable, or staples to your wound, we will request that you make an appointment with your practice nurse at your GP's surgery to have them removed. However if you are experiencing mobility problems we can arrange for the district nurses to come to your home to remove them.

It is normal to have a blood stained discharge (from the vagina) for around two weeks, but if you begin to bleed heavily or develop a smelly discharge, please arrange an appointment with your GP.

If you need a medical certificate to cover your length of illness and the post operative recovery period, please ask the ward doctor that discharges you for this.

Recovery from surgery

Getting back to normal varies from person to person. It is a good idea to be as active as possible, but you do need to take it easy for a while. Listen to your body and do what is best for you.

In general, for the first 4 weeks after your operation, we recommend that you restrict your physical activities. In terms of house work you **should not** do any vacuuming, cleaning windows, mowing the lawns etc. You **should not** lift anything heavier than a kettle half full of water. Stick to light house work for the first few weeks; for example dusting.

We advise that personal intimate relations with your partner do not resume for three months after your radical surgery. This is to minimise the chance of infection, but some women feel they need longer before they feel confident and comfortable enough. Take things at your own pace.

We advise you not to drive for at least 4 – 6 weeks after your operation or until you have had your first check up at the hospital. You should contact your car insurer for advice on driving following major abdominal surgery.

Some women return back to work after three months, whereas others take longer before they feel that they are able to resume all their previous activities. Remember – the return to normal life takes time, it is a gradual process and involves a period of readjustment and will be individual to you.

If you have no one at home to take care of you, and no relatives or friends that are able to stay with you for a short time, the social services department can organise a ‘home care package’. Please let the nursing staff know as soon as possible if you would like to be referred to the social services department.

You will probably find that you are tired at first, but this is only natural after a big operation and with the extra worry of having cancer, and you will feel better as time goes on.

Some tips:

- Try to keep the wound clean and dry. Bath/shower daily and pat the wound dry with a clean towel.
- Take the pain relief that have been prescribed for you regularly.
- Do not allow yourself to become constipated. If you have not been to the toilet to open your bowels for more than three days, take some laxatives.
- Try to eat a healthy diet, including fresh fruit, vegetables and fibre.
- It is important to continue doing the exercises shown to you by the physiotherapist for at least six weeks after your operation. Ideally you should carry on doing the pelvic floor exercises for the rest of your life.

What are the long-term side effects of this operation?

- You may have difficulty in passing urine. The possibility of this should have been discussed with you. You will be offered more information on this if necessary.
- There is a very small risk that you may develop a urinary or bowel fistula (as previously mentioned). This is a link between the bladder and vagina or bowel and vagina. Sometimes fistulas heal on their own. If a fistula did happen, your surgeon would discuss with you the best way to treat it.
- You may have an altered bowel pattern and may need to change your diet. You may find that you need to take a laxative to help your bowels move.
- You could have symptoms of the menopause, if your ovaries have been removed. Hormone replacement therapy (HRT) might help. You need to discuss this with your gynaecologist.
- Even if your ovaries have not been removed, you could have menopause symptoms at an earlier age.
- There is a small risk of swelling of the legs or lower abdomen (Lymphoedema). Normally, lymphatic fluids circulate throughout the body, draining through the lymph glands. Where the pelvic lymph glands have been removed to prevent the spread of cancer cells, the lymphatic drainage system may become blocked, resulting in a build up of fluid in one or both legs or in the genital area. The problem can be treated, but preventative measures can be taken to reduce the

risk of it happening at all. You can discuss this further with your specialist nurse or doctor and there is also a leaflet which you can ask for.

- The skin around the wound is usually numb for several months until the small nerves damaged by the incision grow back (this is usually more problematic for those ladies who have a bikini line incision, rather than a vertical incision). Sometimes the numbness may affect the tops of the legs or the inside of the thighs. This nearly always gets better in 6-12 months.

What about losing my fertility?

At any age, having to have your womb and/or ovaries removed can affect the way a woman feels about herself. A hysterectomy will prevent you having any children in the future. The loss of fertility can have a huge impact if you have not yet started or completed your family and you have an operation that takes that choice away. You may want to make sure that you have explored all your options. It is important that you have the opportunity to discuss this and how you feel about it with the gynae-oncology surgeon and gynaecological cancer nurse specialist before your operation. Advice is also available from our specialist fertility team.

Will my ovaries still continue to produce eggs?

Yes, if you still have your ovaries after the operation. As you will have had a hysterectomy, you will not menstruate (have periods) each month and so the eggs will be absorbed harmlessly by your body.

Will I need hormone replacement therapy (HRT)?

You may need HRT if you have both your ovaries removed and have not already been through the menopause. HRT is available in many forms – as an implant, patches (similar to a nicotine replacement patch), tablets, and vaginal creams. There are also alternative ways of managing the potential symptoms. Please discuss the options available to you with the gynaecological oncology team before you are discharged from hospital, or with your GP.

Should I continue to have smear tests?

No, cervical smear tests are usually not necessary after this operation, as your cervix will have been removed. However, it is important to come for regular examinations in the Outpatient clinic.

If you were treated with a ‘simple hysterectomy’ for very early cervical cancer a ’vault smear’ (taken from the top of the vagina where the cervix was removed), may be taken as part of your routine examination.

Follow-up

It may be that the operation is the only treatment you need. This can only be confirmed when the pathologist has examined all the tissue samples, under the microscope and lymph nodes if removed.

It might be 3-4 weeks before the results are available. The specialist nurse/doctor will arrange an appointment for you to receive your results. At this appointment if further treatment is required this will be discussed with you and plans made to refer you on to a specialist doctor called an oncologist. An oncologist is a doctor who treats cancer with either chemotherapy or radiotherapy.

No matter what, if any treatment is recommended you will need to be followed up in clinic for at least 3 years after your surgery. The follow-up will take place at a hospital which is most convenient for you and your consultant. Your follow up appointments may be alternated between the joint gynae-oncology clinic and the colposcopy clinic or the nurse led clinic.

Useful contacts and telephone numbers:

Arden Network - Gynae-Oncology Service

University Hospitals Coventry & Warwickshire (Walsgrave hospital)

Clinical Nurse Specialists

Macmillan Gynae Oncology Advanced Nurse Practitioner: Vikki Jones

Macmillan Gynae Oncology Clinical Nurse Specialists: Lisa Washington & Rachel Hotchkiss **024 7696 7238** (line to office and answer machine)

Macmillan Gynae Oncology Clinical Nurse Specialists: Sandeep Chahal & Catherine Mathews **024 7696 7465**

Macmillan Gynae Oncology Patient navigator:

Stacey Morris 024 7696 7238

Secretaries

Mr. M Dunderdale **024 7696 7383**
MS. S Shanbhag **024 7696 7400**
Mr. J Twigg **024 7696 7382**
Mr. S Kumar **024 7696 7410**
Dr. M Hocking **024 7696 7485**
Dr. N Walji **024 7696 5500**
Dr. V Sangha **024 7696 7497**
Dr. L McAvan **024 7696 7484**

George Eliot hospital

Clinical Nurse Specialist

Kerry Pearson

All available on 0798 4216109 or **024 7635 1351** and ask for speed dial 1491.

Secretaries

Dr Hocking (Anne-Marie Horton & Kay Gilbert) **024 7686 5371**

Warwick hospital

Clinical Nurse Specialist

Liza Newton **01926 495321** via switchboard extension **8122**

Or bleep via switchboard on 5127 or direct line to office **01926 608077**

Secretaries

Mr Olah (Sandy) **01926 495321** Extension **4526**

Dr Walji (Indira Lal) **01926 495321** Extension **4060**
Patient Liaison Officer (Janet Bosner) **01926 495321** Extension **8120**

Redditch Alexandra hospital

Clinical nurse specialist

Helen Farnhill (based at Redditch) **01527 503030** ask to radio page **01905 733257**
Nicky Plant (based at Worcester) **01905 733257**
Or Radio page via switch **01905 763333**

Secretaries

Dr Irwin (Mrs D Campbell) **01527 512028**
Dr R Panchal (Anne Hyslop) **01527 503030** ext **44078**

Support Services

Droitwich Cancer Support Group Contact:
Joan Summers **01905 773482**
Barbara Wells **01527 577721**

Worcester Cancer Support Contact:
Hannah Thake **01905 355642**
Don Faulkner **01905 423295**
Benefit Advice:
DIAL South Worcestershire **01905 22191**

Where can I obtain further information and support?

National services

Macmillan Cancer Support **0808 808 000**
www.macmillan.org.uk

Jo's Cervical Cancer Trust: Jo's Cervical Cancer trust is the only UK charity dedicated to women and their families affected by cervical cancer and cervical abnormalities.

Helpline: www.jostrust.org.uk **0808 802 8000**

Local services

- **Cancer Information Centre: 024 7696 6052**

  Information and support based at University Hospitals Coventry and Warwickshire This service provides information about all aspects of cancer.

  Service open Monday – Friday 9.00am – 4.00pm.

- **Cancer United:** University Hospitals Coventry & Warwickshire. Support group for all those affected by cancer. Meetings held on the first Wednesday of the month between 10.30am – 12.00am at Coventry Myton Hospice
- **Spiritual and religious support** whilst in hospital. Please ask the nurse looking after you to contact switchboard and they will contact the relevant person according to your faith.
- **Cancer Support Groups**: Supports all cancers including all gynaecological cancers.

  Meets – **2nd & 4th Thursday of the month at 7.30 pm**

  Venue – **SIMTA conference centre** (behind parkway private hospital) Damsonwood Parkway, Solihull.

  Contact: **Patricia Hill 0121 711 1966** or **Shirley Peck 0121 705 1818**

- **Warwick Cancer Support Group**: supports all cancers including all gynaecological cancers.

  Meets – 1st Friday of every month 2.30-4pm

  Venue –The back room of the restaurant. Warwick Hospital.

  Contact – Deborah Smith Macmillan information officer

  01926 495321 EXT 8214

  Lesley Gotschy (Clinical Nurse Specialist) **01926 495321 EXT 8231**

  Refreshments provided. The group is informal – the group is suitable for anyone (including relatives and carers) affected by cancer.

- **Citizens Advice Bureau (CAB) Tel: 024 7625 2050**

  This appointment only service provides free advice regarding benefits etc. To book an appointment please telephone: 024 7625 2050

The Trust has access to interpreting and translation services. If you need this information in another language or format please contact 024 7696 7238 and we will do our best to meet your needs.

The Trust operates a smoke free policy.

To give feedback on this leaflet please email feedback@uhcw.nhs.uk

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