University Hospitals Coventry and Warwickshire NHS Trust

Patient Information

Macmillan Gynaecology

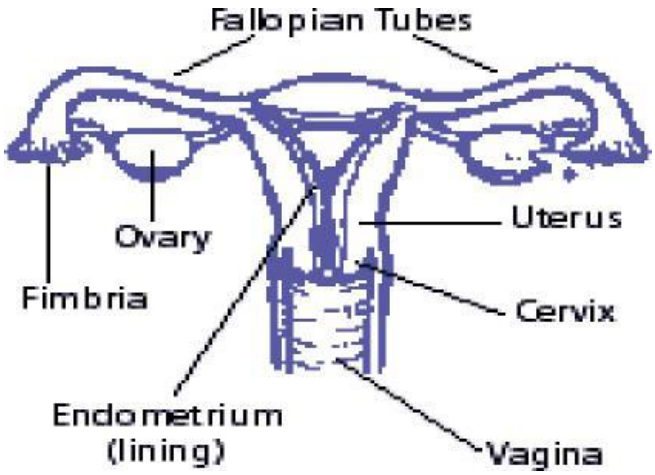
Endometrial Cancer (cancer of the womb)

You have recently been diagnosed with cancer of the lining of the womb (endometrial cancer). It is normal to experience a wide range of emotions. This can be a very frightening and unsettling time. However you may be feeling at present, try talking to 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 endometrium?

The endometrium is the lining of the uterus (womb) – see diagram.

Before the menopause, the endometrium is shed, usually every 28 days – this is known as a woman's 'periods'.



What causes cancer of the endometrium (endometrial cancer)?

We don't know the exact cause of endometrial cancer. It occurs most commonly in women between the ages of 50 and 64. It rarely affects women under the age of 50.

What we do know is:

- Women who are still having periods, and take the contraceptive pill, have a lower risk of endometrial cancer.
- Women who have had their menopause, and take certain types of hormone replacement therapy (H.R.T) for a long time have a slightly increased risk.
- The use of tamoxifen (a hormonal drug sometimes taken to treat breast cancer) over a long period of time, may also slightly increase the risk. However the risk is so slight that the benefits for treating breast cancer are much more important.
- Women with a raised body mass index (BMI) are at an increased risk of developing womb cancer

What are the symptoms of endometrial cancer?

The most usual symptoms are:

- Bleeding in-between periods, or heavier periods than normal.
- Bleeding that starts after the menopause
- Occasional spotting

How is cancer of the endometrium 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 the endometrium.

Generally, endometrial cancer can be divided into four progressive stages:

- **Stage one:** The cancer is contained within the endometrium or the muscle layers of the uterus.
- **Stage two:** The cancer cells have spread to the cervix (the neck of the womb).
- **Stage three:** The cancer cells have spread into nearby tissues such as the supporting membranes in the pelvis, the vagina or nearby tissues.
- **Stage four:** The cancer cells have spread beyond the uterus into the surrounding organs or to other parts of the body. This is known as secondary (or metastatic) endometrial cancer.

Endometrial 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) – these 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.

How is endometrial cancer treated?

The treatment that you receive will follow agreed guidelines for the treatment of endometrial cancer. These guidelines are based on the best research available.

Your gynaecologist and the 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 a member of the team will discuss and explain everything and obtain your opinion and your consent to the treatment recommended.

Your specialist / support nurse (key worker) will try to explain anything you are concerned about and answer your questions. As your treatment progresses, you will be offered written information or details of your personalized treatment plan and how to access it, when and if you wish to do so. This may include more detailed information on radiotherapy and chemotherapy if they are part of your treatment.

In the event of you needing to speak to your nurse specialist, please use the contact numbers given at the end of this leaflet. This booklet is not meant to replace any discussion you may want to have with clinical staff

Possible Treatments

Surgery

Most cancers of the endometrium are discovered at an early stage (when they have not spread beyond the uterus) and are treated by a hysterectomy (surgical removal of the uterus).

Surgery is discussed in more detail later in this leaflet.

Radiotherapy

Radiotherapy is a high energy ray treatment which destroys cancer cells. This may be offered in several situations:

- After surgery, if the multi-disciplinary team feels there would be a chance of the cancer coming back or cancer cells remain.
- Instead of surgery, if the cancer cannot be removed surgically, or if you are not fit enough to have an operation.
- To kill off the cancer cells that have come back (recurred). If this treatment is needed a doctor will discuss it with you.

Hormonal therapy

Treatment with a female hormone, called progesterone, may shrink the endometrial cancer and control symptoms. This treatment is only useful if a hormone drives the development of your endometrial cancer. This treatment is in the form of a tablet. It will not cure the cancer but can help to try and keep the disease stable and reduce the vaginal bleeding

Chemotherapy

Chemotherapy is a drug treatment that is occasionally given. It can be used either on its own or in combination with radiotherapy.

Chemotherapy is planned for each patient's individual needs. Your oncologist will discuss everything with you including possible side effects.

Surgery for cancer of the endometrium

Not all cases of endometrial cancer are suitable for surgery. If surgery has been recommended for you, your specialist surgeon will explain everything to you.

The surgeon will remove your uterus (womb). This operation is called a hysterectomy. The surgeon will also remove both of your ovaries and fallopian tubes too. If necessary lymph nodes close to the womb will be removed. These nodes make up part of the lymphatic system. This is a network of glands situated throughout the body, which act as a defence against disease. However, the lymph fluid which flows through the network can also spread cancer to other parts of the body.

Surgical removal of the lymph-nodes.

For some endometrial cancers, there is a risk that the cancer may have spread to your pelvic glands. Your surgeon will discuss this risk with you at clinic. For some endometrial cancer the surgeon will recommend removal of your lymph glands to see if there has been spread, even if the pre-operation scan shows no abnormalities.

Lymph nodes are small bean-shaped structures located along your lymphatic vessels. They filter your lymphatic fluid, taking bacteria, viruses, cancer cells and other waste products

The standard way of doing this is to perform a pelvic lymphadenectomy. This involves removing the glands in the pelvic sidewall close to the major blood vessels and nerves that supply your pelvis and your legs.

The risks of this surgery include injury to the blood vessels and the nerves which can lead to numbness particularly over your thigh and problems moving your leg post operatively. There is also a risk of lymphedema which causes swelling in your leg and pelvis.

A new technique called sentinel lymph node biopsy may be available to you at UHCW. Indocyanine green (ICG) dye is injected into your cervix at the time of surgery. This helps the surgeon to find sentinel lymph nodes. Sentinel lymph nodes are the first set of lymph nodes to which cancer cells are most likely to spread to from a primary tumor. Only the sentinel lymph nodes are then removed instead of you having a full pelvic lymph node

removal. The benefit to you is significantly reduced risk of complications from the operation and your operation also takes less time.

This technique is being more widely used by surgeons across the world and is being shown to be as good as pelvic lymphadenectomy as long as the sentinel nodes are detected. The sensitivity (SLN + when full lymphadenectomy +) is 98% and the negative predictive value (SLN – when full lymphadenectomy -) is 98%.

In other words, it is a very good alternative to pelvic lymph node dissection with the benefit of reduced risks.

You can discuss having this type of procedure with your surgeon, and if you select to have the standard technique of full pelvic lymphadenectomy, you are able to choose this over having a sentinel node biopsy.

If a sentinel node is only found on one side then a full pelvic node dissection will be performed if this is surgically safe to do.

This extensive surgery should remove as much of the cancer as possible.

Often the surgeon can remove all of the cancer at this stage and no further treatment may be necessary. This can only be confirmed when the pathologist has examined all the tissue samples under the microscope.

If the sentinel gland and/or pelvic lymph glands are negative (no cancer is seen in them when analysed under the microscope), then it is unlikely that you will require pelvic radiotherapy treatment or chemotherapy.

If the sentinel gland is positive then further treatment either by radiotherapy or chemotherapy or sometimes both may be required. This will be discussed at the multi disciplinary teamMDT meeting after the operation, once your histology results are available and you will be informed of the advice that the MDT gives for any next steps in your treatment.

What happens when I come into hospital?

Please note there may be slight variations on what happens during your hospital stay, depending on which hospital your treatment takes place at.

Normally you will come to hospital a couple of weeks before your planned surgery for your pre-admission. This appointment takes around two hours. This gives you a chance to meet your clinical nurse specialist / support nurse again and to see the lay out of the ward. You will also be told again about your planned surgery and what to expect after your surgery whilst you are in hospital. You will also have blood tests, and other investigations

necessary before your operation, such as swabs, chest X-ray, ECG (tracing of your heart rhythm and activity)

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

A doctor will visit you on the morning of your operation to explain about your operation and you will need to sign a form agreeing to the operation. If you have already signed a consent form at your clinic appointment, the doctor will just re-cap again and answer any remaining questions you may have)

The anaesthetist will also come to see you on the morning of your operation and will make sure you are still deemed 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 can be found at the end of this leaflet.

How is the operation done?

The surgeon will either make a straight cut along your bikini line or a straight cut in your abdomen, from just below the umbilicus (tummy button) to just above the pubic bone of your pelvis. Some patients may be suitable for laparoscopic or robotic (minimal access/ keyhole) surgery. Your consultant will discuss this with you before your operation.

There is a separate leaflet for robotic operations please refer to this as well.

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 these are:

- **Bleeding during the operation.** As gynaecological structures are rich in blood supply, you may bleed more than usual for an operation. You may need to receive a blood transfusion. We prepare blood for you which will be ready if you need it. Please advise your team before your surgery if you have any objection to a blood transfusion. You may be given iron tablets to take home.

- **Risk of injury to other internal parts of your body.** The gynaecological organs are surrounded by bowel, bladder, ureters (tubes that carry urine from the kidneys to the bladder), blood vessels, nerves. There is a small risk that these may get damaged during the operation. If the surgeon is aware that an injury has occurred it will be repaired whilst you are still asleep. If the injury does not become clear until the post operatively, you may require a second operation to repair the injury.

- **A fistula.** A fistula is a communication channel between either your bladder and vagina or ureters and vagina. It causes urine to leak through the vagina. An operation may be needed to repair it.

- **Blood clots in the legs (deep vein thrombosis or DVT), blood clots in the lungs, pulmonary embolism or PE).** You will have a 28 day course of Enoxaparin 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 knee length surgical stockings which help prevent clots. These stockings will be worn for 23hrs per day for 6 weeks. The stockings are to be removed for 1hour per day for washing and skin inspection. The ward will send you home with two pairs of surgical stockings.

- **Bladder infection.** Initially after the operation your urine will be drained away by a urinary catheter. If you develop a bladder infection, you will be given antibiotics to treat it.

- **Chest infection.** You will not be as mobile as you usually are 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 the physiotherapy leaflet given to you at your pre admission appointment).

- **Wound infection.** Even with the greatest of care the wound(s) may not heal as well as expected, this may be due to a wound infection. If you develop a wound infection you will be given antibiotics to treat it.

- **Pelvic collection/infection.** If this happens you may need antibiotics, the collection to be drained under ultra sound/CT guidance or return to theatre for a second operation to drain it.

- **Risk of lymph fluid draining through the surgical port sites (surgical cuts on your tummy):** Your surgeon may recommend that you have your lymph nodes in your pelvis removed at the time of surgery. This is done in order to help stage your cancer (determine the spread of cancer). In turn this helps the team to decide if you

would benefit from any extra treatment in the form of radiotherapy or chemotherapy after your surgery.

The risk of lymph fluid coming through the surgical ports is approximately 5% (5 in 100). If the lymph fluid is coming through the surgical ports on your tummy, the team will put a surgical bag/stoma bag over the port site in order to collect the fluid and help keep you and your clothes dry. If you do experience lymph fluid coming through the surgical port sites, it usually stops within 2 weeks of surgery.

- **Risk of lymph fluid draining through the vaginal vault (top of the vagina):** As previously mentioned your surgeon may recommend that you have your lymph nodes in your pelvis removed at the time of surgery. The risk of lymph fluid coming through the vagina post operatively is approximately 5% (5 in 100 people). If this happens your surgical team will want to hear from you to make sure that the fluid coming through the vagina is definitely lymph fluid and not urine. Urine coming through the vagina could indicate that you have a surgical complication called a fistula. A fistula is a communication channel between the ureters (tubes that carry urine from the kidneys to the bladder) and the vagina or a communication channel between the bladder and vagina.

  Once the surgical team have established it is lymph fluid, you will simply be asked to wear sanitary towels/incontinence pads to keep you dry.

  Once the top of the vagina (the vault) is 'water tight' the fluid will stop leaking through the vagina. This may take a couple of weeks to resolve.

- **Lymphoedema.** For women who need their lymph nodes removing, there is a small risk of swelling of the legs or lower abdomen (Lymphoedema). Removal of lymph nodes can affect the way the lymph fluid normally flows around the body. As it is the lymph nodes in the lower part of your abdomen which may be removed, fluid can build up in one or both legs, or in the genital area. Lymphoedema does not always develop but if it does it can be treated, you can also take preventative measures to reduce the risk of it happening at all. The nurses or doctors will discuss this with you, or ask to see a leaflet on the subject.

- **Lymphocyst.** Collections of lymph fluid in the pelvis. These can be seen on imaging. They most commonly do not cause any symptoms for you as the patient. Rarely they can become infected or cause nerve pain if they press on other structures in the pelvis. Very rarely this will require draining

What can I expect after my operation?

You will usually be away from the ward for 2-3 hours. From the recovery room, you will be brought back to the ward. You will find that you are very sleepy for the day of surgery. If you have minimal access surgery (laparoscopic or robotic) we would aim to send you home within 24hrs of surgery.

Drips

When you wake up, you will have a plastic tube attached to a needle in a vein in your hand and a bag 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

If you have dissolvable sutures or glue (dermabond) to your wound (s), you may not have a dressing on your wound (s). If you have a dressing over your wound, this will be taken off 24-48 hours after your operation and the wound exposed. . 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 7$^{th-10th}$ day of your operation (your nurse will tell you on discharge when to make an appointment with your practice nurse to have them removed).

Drains

There may be a tube from your wound leading to a drainage bottle. This allows the nurses to check for any bleeding. The drain 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.

Tube (Catheter)

As previously mentioned, when you wake up from 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 24 hours after your operation (if you have open surgery). You should then be able to get out of bed and go to the toilet normally.

If you have minimal access surgery, your tube (catheter) will be removed either the evening of surgery or very early the morning after surgery.

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 killers for this. If you are in any discomfort, please do not hesitate to tell the nurses looking after you.

Pain relief may be given intravenously (into your vein), orally (by mouth), by injection, or by a suppository into your back passage

Please refer to the information sheet regarding post-operative pain relief (this information sheet would have been given to you at your pre admission appointment).

If you have minimal access/robotic surgery most patients only require simple post-operative analgesia for three days on average eg. Paracetamol.

We recommend that you purchase some simple analgesia such as paracetamol to have at home ready for your discharge post surgery.

Bathing

The first day after your surgery a nurse will help you to have a wash (bed bath), if you do not feel up to washing yourself. If you have had open surgery (a big cut on your tummy), 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 shower every day.

If you have had minimal access surgery you will be going home either the same evening of your surgery or the next day. Please inspect your surgical wounds daily, wash in plain water and pat dry with a clean towel. Pay particular attention to cleaning and drying the naval (belly button) wound.

Moving about

On the day of your operation you will be very sleepy and are likely to remain in bed for the rest of the day. If you had minimal access surgery/robotic surgery and went to theatre early in the morning, you may be awake and well enough to mobilise around the ward and go home that evening.

From the first day after your surgery you will be encouraged to be up and about as soon 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. Getting mobile, as soon as possible after the surgery, helps to prevent blood clots, chest infections and any stiffness caused by being in bed. You may be seen by the physiotherapist during your stay in hospital. Please follow the physiotherapy leaflet given to you at your pre admission appointment.

Blood tests

The morning after your operation we will take a specimen of blood. This is to make sure that you are not anaemic (low blood count), there are no signs of infection and that your kidneys are working as well as expected.

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). Sometimes the wind can feel trapped and you may experience pain underneath your rib cage or shoulder tips if you have minimal access/robotic surgery. This usually resolves within 48hrs

What about going home?

Most women stay in hospital for 3 days with open surgery, however if your surgery is performed laparoscopically (key hole surgery)/robotically, you may go home the same evening or only require an overnight stay in hospital.

If you are sent home with sutures that are not dissolvable or staples to your wound, we will request that you make an appointment with your practice nurse at your GP surgery to have them removed. However if you are

experiencing mobility problems we can arrange for the district nurse to come to your home to remove them.

It is normal to have a vaginal blood stained discharge for around two weeks, but if you begin to bleed heavily or develop a smelly/offensive discharge, please arrange an appointment with your GP.

Please purchase some sanitary towels before your surgery and bring them into hospital with you.

If you need a medical certificate to cover your length of illness and the post-operative recovery period, please ask the ward doctor/Advanced nurse practitioner 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 shouldn't do any vacuuming, cleaning windows, mowing the lawns etc.

Stick to light house work for the first few weeks i.e. dusting.

Personal intimate relations (sex) with your partner may resume after twelve weeks, 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 if you had open surgery. If you had minimal access/robotic surgery you may feel confident and comfortable to resume driving before this time period. . You should contact your car insurer for advice on driving following major abdominal surgery.

Most women return back to work within three months of their open surgery, whereas others take longer before they feel that they are able to resume their previous activities. Ladies who have had minimal access surgery may only need a few weeks off work (depending on their job and the level of physical activity it requires)

Remember – the return to 'normal life' takes time, it is a slow 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 or check in on you for a short period of time,

the social work department can assess if you are eligible for a 'home care package'. Please let the nursing staff know as soon as possible if you would like referring to the social work 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. You will feel better as time goes on.

Some tips

- Try to keep the wound clean and dry. Bath or shower daily and pat the wound dry with a clean towel.
- Take the pain killers that have been prescribed for you regularly.
- Do not allow yourself to become constipated. If you have not been to the toilet to have your bowels open 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

Follow-up

It may be that the operation is the only treatment you need. However, this can only be confirmed when the pathologist has examined all the tissue samples and if removed, the lymph nodes, under the microscope. It might be 21 days before the results will be available so don't worry if you go home without knowing the results.

If this happens the specialist nurse / doctor will arrange an appointment for you to receive your results. At this appointment if further treatment is needed 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.

Whether or not you have further treatment, you will need to be followed up in the clinic for at least 3 years after your surgery. The hospital in which this takes place, depends on which is most convenient for you and your consultant.

If your histology results advise that surgery was the only treatment you required, your long term follow up may be in the specialist nurse led clinic.

Useful contacts and telephone numbers:

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 (direct line to office answer machine) 9am – 4pm

Macmillan Gynae Oncology Clinical Nurse Specialists: Sandeep Chahal & Catherine Mathews024 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 Specialists

Patient Information

Kerry Pearson

All available on 07984216109or **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 & Beth Molyneux

01926 495321 via switchboard extension **8122**
or bleep via switchboard on **512** 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 or Barbara Wells 01527 577721

Worcester Cancer Support Contact: Hannah Thake 01905 355642 or 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 0000 www.macmillan.org.uk

Local services

- **Cancer Information & support 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 10.30-12.00 Coventry Myton Hospice Please ring **024 7696 6052 for more details**

- **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

Patient Information

Venue – The back room of the restaurant. Warwick Hospital

Contact – Deborah Smith, Macmillan information officer

01926 495321 EXT 8214 (Warwick).

01926 495321 EXT 5871 (Stratford)

Refreshments provided. The group is informal – and 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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