

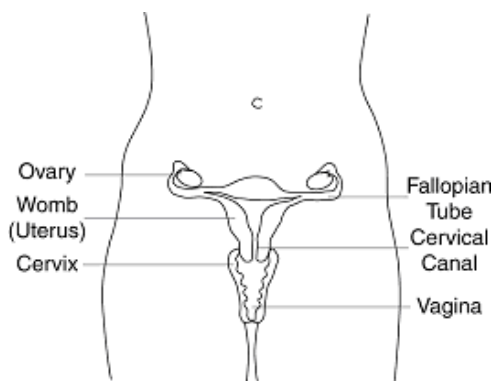
## Macmillan Gynaecology-Oncology Service

### Pelvic Mass

**This information should only be given out by Macmillan Gynaecology-Oncology Nurse Specialists.**

You have recently been diagnosed with a pelvic mass. It is normal at this time, to experience a wide range of emotions. 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. They will listen, answer any questions you may have, and put you in touch with other professionals or support agencies if you wish.

#### What is a pelvic mass?



Pelvic masses may originate from gynaecological organs (ovaries, cervix, uterus or uterine adnexa), bowel (small / large) or bladder. We are concentrating on gynaecological causes for your pelvic mass.

Pelvic masses may simply result from common conditions such as fibroids, endometriosis or benign (non-cancerous) ovarian tumours. However ovarian cancer cannot be ruled out at this stage.



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Pelvic masses can appear as fluid filled sacs or pouches inside or on the surface of the ovaries. They may look simple (just like a balloon filled with fluid) or complex (the cyst may have different compartments and different contents).

**The following information in this booklet is divided into two sections:-**

- 1) Tests and treatment for pelvic mass
- 2) Ovarian Cancer. **(You may not wish to read this information. If you are not sure that you want to know about ovarian cancer at this stage, then skip these pages, you can always read them later if this is appropriate).**

Every woman is different. There may be differences between the information given here and your individual case. The doctors and nurses will talk to you about your surgery. Please do not hesitate to ask any questions. This booklet is not meant to replace any discussion you may want to have with clinical staff.

## Section 1

### Tests and Treatment for Pelvic Mass

Several tests may be used to help diagnose your pelvic mass. These tests will help your gynaecologist decided which treatment is best for your condition.

- **Ultrasound scan** – Sound waves are used to make up a picture of the inside of the abdomen, the liver and the pelvis. You may already have had an internal (vaginal) scan to identify the pelvic mass.
- **CT (CAT) scan** – This is a series of X-rays which build up a three-dimensional picture of the inside of the body. The scan is painless but takes longer than an X-ray (up to 30 minutes). It may be used to determine clearly the size, location and consistency of the mass and disease spread. This is known as CT staging.
- **Blood Test** – A specific blood test known as CA125 may be done if your scan is abnormal. CA125 is a tumour marker for ovarian cancer. It checks whether you have higher than normal levels of CA125 in your blood. If you do have raised levels of CA125 it does not necessarily mean you have ovarian cancer. It can be raised in a variety of benign conditions, for example endometriosis, fibroids, pelvic inflammatory disease or even pregnancy.

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- **Abdominal fluid aspiration** – If there has been a build up of fluid in the abdomen, a sample of the fluid can be taken to check for any cancer cells. The doctor will use a local anaesthetic to numb the area before passing a small needle through the skin.

Some fluid is drawn off into a syringe and examined under a microscope by the pathologist.

- **Surgery** – Often the nature of a pelvic mass cannot be confirmed before an operation is carried out and the tissue removed and sent to the laboratories. It takes up to 6 weeks for the tissue to be examined by a specialist doctor known as a Histopathologist. The Histopathologist will then produce a full report advising of the nature of the pelvic mass i.e. whether it is benign (non-cancerous), borderline (a tumour of low malignant potential), or malignant (cancerous).

## How is the pelvic mass treated?

The treatment you receive will follow agreed guidelines for the treatment of pelvic mass. These guidelines are based on the best research available.

Your gynaecologist will take everything into consideration about your illness and will recommend an individually tailored programme of treatment for you. At each stage they will discuss and explain everything, and obtain your opinion and your consent, to the treatment they recommend.

Your clinical nurse specialist/support nurse (key worker) will explain anything you are concerned about and answer your questions. At appropriate times she will offer you more written information for you to read. If you would like to know anything or would like more information just contact her. Her telephone number is on the useful contact names and telephone numbers at the end of this information.

## Surgery for a pelvic mass

The main treatment for a pelvic mass is surgery.

Surgery for a pelvic mass often involves removing the ovaries, fallopian tubes and the womb. This is known as Total Abdominal Hysterectomy and Bilateral (both sides) Salpingo-Oophorectomy, abbreviated to TAH BSO. The surgeon may also remove the fatty membrane lining the abdomen (the omentum) and may take samples from other tissues, such as the lymph glands.

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However if you are still of a childbearing age and wish to preserve your fertility as much as possible, your consultant will talk through the various surgical options that may be applicable to your individual case. A referral to a consultant in the Centre of Reproductive Medicine (CRM) will also be offered before the surgery if this is considered appropriate by you and your consultant.

## Other Treatments

### Biopsy

Major surgery may not be an option for you at this stage (due to the location or spread of disease at the time of your presentation). You may require a biopsy from the pelvic mass to obtain a diagnosis. This can be performed either by USS (scan) guided biopsy, usually under a local anaesthetic or by a laparoscope, under a general anaesthetic. For most patients, both of these tests can be done as a day case.

### Chemotherapy

If cancer is diagnosed following a biopsy, it may be necessary for you to start chemotherapy. However chemotherapy may be followed by surgery to reduce the tumour bulk known as debulking surgery. You may receive a few more cycles of chemotherapy after surgery.

Further information on chemotherapy can be found at the back of this booklet.

### Clinical Trials

You may be asked to take part in a treatment research trial. Cancer research trials are carried out to try to find new and better treatments or treatment regimes for cancer. There can be many benefits in doing this. However you are under no obligation to take part if you do not wish to.

Your Gynae Oncology team will advise you if there are any trials that you may be eligible to take part in.

## What happens when I come into hospital?

If surgery is decided to be the most appropriate form of treatment for you then usually you will be asked to come to hospital a couple of weeks before your planned surgery for your pre-operative assessment. This appointment takes around two hours. This gives you a chance to meet your clinical nurse

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specialist/support nurse again. You will also be informed about your planned surgery and what to expect after your surgery whilst you are in hospital.

Any pre-operative investigations that are needed prior to your operation will be performed at this appointment if they have not already taken place. This includes blood tests, may include swabs, a chest X-ray, ECG (tracing of your heart rhythm and activity).

Your specialist nurse/ pre operative nurse will make an assessment as to whether you need to see an anaesthetist on this day for a pre-operative assessment (this will not be the same anaesthetist you see on the day of your operation, however they will be able to answer any queries that you may have).

Unless you have any medical problems, you will come into hospital on the morning of your operation. **Please follow the starving instructions given to you are pre admission.** However in some cases it may be necessary for you to be admitted the day before for bowel preparation.

The operation may include a lot of handling or surgery to your bowel. To lessen the chance of you having any complications from your surgery, it is important to empty and clean out your bowels as completely as possible – this procedure is known as bowel preparation. If you require bowel preparation your specialist nurse will arrange to admit you the day before your surgery and organise your bowel preparation. This is given in the form of oral medication, which aids your bowel to empty. They will also arrange for the specialist bowel nurses to visit you and site you for a stoma. This involves marking your tummy with a pen, so the surgeon knows where to bring out a portion of bowel (stoma) if needed. Your surgeon and specialist nurse will counsel you about the risk of needing a stoma.

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.

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The anaesthetist will come to see you on the morning of your surgery. They will explain what will be involved when you have your anaesthetic and what pain relief you can have after your operation. You may have already seen an anaesthetist in the pre-operative assessment clinic.

Your clinical nurse specialist/support nurse will see you at least once during your stay in hospital, where she will give you further information and support. Some people may require more than one visit and this will be arranged between yourself and your nurse specialist. You will also be able to contact her when you go home. Her details are on the useful contact names and telephone numbers at the end of this information.

### Are there any risks involved with surgery?

As with all operations there are risks. The main risk for any operation is having a general anaesthetic. The 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 before the surgery if you have any objection to a blood transfusion.
- **Blood clots** (Deep Vein Thrombosis (DVT), Pulmonary Embolism (PE)). You will have a 28 day course of injections (enoxaparin) to lower 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 per day for washing and inspection of skin.
- **Bladder infection.** Initially after the operation your urine will be drained away by a tube (catheter). If you develop a bladder infection, you can have antibiotics to treat it.
- **Damage to adjacent organs** (bladder/bowel). This is usually noted at the time of surgery and repaired as needed during your operation.
- **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. You will be encouraged to perform deep breathing exercises post operatively ( please refer to your physiotherapy leaflet)
- **Wound infection.** Even with the greatest care the wound may not heal as well as expected, this may be due to a wound infection. If you develop a wound infection it will require treatment with antibiotics.

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- **Stoma.** If the cancer has spread to the bowel, a small piece of bowel may be removed and the two ends joined together. If the two ends cannot be rejoined, the upper end of the bowel will be brought out onto the skin of the abdomen to form a colostomy or ileostomy. The opening of the bowel is known as a stoma. A bag is worn over the stoma to collect stools (bowel motions) Your Consultant or specialist nurse will discuss this with you. The risk of requiring a stoma is approx 3-5%

## What can I expect after my operation?

You will usually be away from the ward anything from two - ten 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 bag of fluid on a stand. This is commonly called a drip or IVI 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.

## Wounds

Immediately after your operation you may have a dressing over your wound. This will be taken off 48hours after your operation and the wound is left exposed if it is clean and dry. The nurses on the ward will check that your wound is healing properly. Your sutures/stitches may dissolve naturally and therefore will not need to be removed. Alternatively you may have staples; these are usually removed within seven - ten days after your surgery.

## Drains

There may be a tube from your pelvis (tummy) leading to a drainage bottle (redi-vac). This allows any fluids to drain out rather than collect in your pelvis. 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.



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### **Naso-gastric tube**

If your surgery involves handling your bowel or bowel surgery, you may have a naso - gastric tube inserted during your surgery. This is a thin flexible tube that goes through your nose and into your stomach. It empties your stomach so your bowels can rest. It may feel slightly uncomfortable to your nose and the back of your throat. As your bowels start to return to normal the tube will be removed.

### **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. This is usually removed 24 - 48 hours after your surgery( depending on the extent of your surgery and your mobility)

### **Monitoring**

Your blood pressure, pulse, temperature, oxygen levels, and respirations (breathing rate per minute) 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 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 tell the nurses looking after you.

Your anaesthetist will advise you if he/she plans to give you an epidural (injection around the spinal cord) for post operative pain relief.

Usually pain relief is given by a self controlled morphine device into your vein. You control your pain relief yourself through a 'watch' connected to your patient controlled analgesia (PCA). Your specialist nurse will give you an information leaflet at your pre-admission appointment discussing your PCA in more detail.



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

Please refer to the leaflet given to you at pre admission ' post operative pain relief' for more information.

### **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 are recommended 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 it's very likely you 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. She/he will teach you some exercises and give you some advice before you go home. Please refer to the physiotherapy leaflet given to you at pre admission. You will be shown how to inject yourself with a blood thinning drug (enoxaparin). You will have these injections for 28 days post operatively. You will be fitted with specialist stockings that help to prevent blood clots in your legs. You will be expected to wear these for 23 hours per day for 6 weeks.

### **Blood tests**

Day one – two after your operation we will take a blood sample. This is routine and is to check how your body is responding after major surgery.

### **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

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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 in hospital).

### **What about going home?**

Most women stay in hospital for three - five days (depending on the extent of your surgery), but you may be able to go home sooner if your condition and circumstances allow. You will be reviewed daily and advised when the team thinks it is safe to discharge you.

If you are discharged home with stitches that are not dissolvable or staples to your wound, we will ask you to 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 nurse to come to your home to remove them.

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

### **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.

Depending on the extent of your surgery, but in general, for the first four 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. As a guidance you should not lift anything heavier than a kettle half full of water. Only undertake light house work for the first few weeks such as dusting.

We advise that you do not resume sexual intercourse for three months after your surgery. This is to minimise the chance of infection and allow the top of the vagina (the vault) to heal but some women feel they need longer before they feel confident and comfortable enough. Take things at your own pace.

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Most women return 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 the results of your operation indicate that further treatment is required, then it is very likely that you will require more than three months off work.

If you have no one at home to take care of you, and no relatives or friends that are able to check in on you or to stay with you for a short time, the social work department can organise 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, you will feel better as time goes on.

## **Will I need Hormone Replacement Therapy (HRT)?**

You may need HRT if you have had both of your ovaries removed and have not already been through the menopause. HRT is available in many forms –

- As an implant,
- Patches,
- Tablets
- Vaginal creams.

Please discuss the options available to you with your consultant before you are discharged from hospital. However your doctor may wish to have all of your histology results back before deciding how suitable HRT is for you as an individual.

## **Some tips**

- Try to keep the wound clean and dry. Bath/shower daily and pat the wound dry with a clean towel. Spend time lying on your bed airing the wound, to ensure it does not become moist or sticky (moist and sticky wounds are a breeding ground for bacteria).
- Take the pain relief that has been prescribed for you regularly.

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- Do not allow yourself to become constipated. If you have not been to the toilet to have your bowels open for three days, take some gentle 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. Pelvic floor exercises should be done life long.

## Follow-up

It may be that the operation is the only treatment you need. This can only be confirmed once the pathologist has examined all the tissue samples removed under the microscope.

It may be 4-6 weeks before the results are available. The specialist nurse/doctor will arrange an appointment for you to receive your results.

This may be a virtual appointment or a face to face appointment. You will be informed of the date and time once your results are available and have been discussed in the specialist Multi Disciplinary Team meeting. At this appointment if further treatment is required this will be discussed with you. You may need to be referred to a specialist doctor called an oncologist (an oncologist is a doctor who specialises in giving cancer treatment in the form of chemotherapy or radiotherapy).

## Section 2

### Ovarian Cancer

#### What is the ovary?

The ovaries are two small, oval shaped organs which are part of the female reproductive system. They are in the lower part of the abdomen, which is also known as the pelvis. Other organs are very close to the ovaries. These include:

- The ureters, which drain urine from the kidney to the bladder
- The bladder
- The lower part of the bowel (the rectum)

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- The omentum (a membrane of fat which supports abdominal structures).
- Groups of pelvic lymph nodes

Each month, in women of childbearing age, one of the ovaries produces an egg. The egg passes down the fallopian tube to the womb (uterus). If the egg is not fertilised by a sperm it passes out of the womb and is shed, along with the lining of the womb, as part of the monthly period. The ovaries also produce the female sex hormones, oestrogen and progesterone. As a woman nears the menopause, the ovaries make less of these hormones and periods gradually stop.

## Ovarian cancer risks and causes

About 5,500 cases of ovarian cancer are diagnosed in the UK every year. This makes it the fourth most common cancer in women after breast, bowel and lung.

The following information is about risk factors for epithelial cancer. Epithelial cancer makes up almost 90% of cases of ovarian cancer. Epithelial means surface layer. So this type of cancer is a cancer of the surface layer covering the ovary. There is more detail on this, on the next page.

If you wish to find out about other less common types of ovarian cancer, this information can be found on the Macmillan and Cancer Research websites, (see useful contacts and telephone numbers).

The cause of ovarian cancer is not exactly known. But there are some things that may increase the risk

- A family history of ovarian, breast or colorectal cancer
- Personal history of breast cancer
- Reproductive history – if you started your periods young or had menopause late, you may have a slight increased risk of developing cancer. Also, never having been pregnant is a slight risk.
- Infertility – stimulation of the ovary by drugs used during infertility treatment can slightly increase the risk of developing ovarian cancer
- Being obese or overweight
- Using HRT (Hormone Replacement Therapy)
- Smoking

### **What are the symptoms of ovarian cancer?**

The symptoms of ovarian cancer can be vague, particularly when the disease is in its early stages.

Many women with early stage cancer of the ovary don't report any symptoms at all (sometimes the pelvic mass is found during other investigations)

Early symptoms can include:

- Pain or discomfort in the lower part of the tummy (abdomen) or side
- Bloating, full feeling in the abdomen

Symptoms of later stage ovarian cancer

Later stage disease can cause symptoms due to the tumour growing in the pelvis. This can cause:

- Lower tummy (abdominal) pain
- Swollen abdomen
- Change of bowel habits
- Back pain
- Irregular vaginal bleeding
- Passing urine more often than usual or difficulty in passing urine.

Below are some of the symptoms that patients **may** experience with advanced ovarian cancer.

Advanced ovarian cancer can cause even more symptoms, if the cancer has spread into the abdomen or elsewhere in the body

- Loss of appetite / indigestion
- Weight loss
- Feeling or being sick
- Constipation
- Tiredness
- Shortness of breath
- Noticeable swelling of the abdomen

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Many of these symptoms are vague and can be difficult to spot. They are all more likely to be caused by less sinister conditions, than ovarian cancer.

### How is cancer of the ovary described?

Most ovarian cancers are a type called epithelial cancer. Epithelial ovarian cancer means the cancer has started in the cells that cover the surface of the ovary. There are several types of epithelial cancers of the ovary.

The most common types are:

- Serous
- Endometrioid.

Less common types of epithelial ovarian cancer are;

- Mucinous
- Clear cell
- Undifferentiated or unclassifiable.

There are also less common types of ovarian cancer. These include germ cell tumours (ovarian teratomas) and sarcomas. Germ cell tumours tend to affect younger women and behave very differently to other types of ovarian cancer.

### Grading and Staging of Ovarian cancer

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

Ovarian cancer is graded. Grading refers to the appearance of the cancer cells under a microscope. The grade gives an idea of how quickly the cancer may have developed. There are 3 grades:

- **Grade one (low grade)** – the cells look similar to normal cells. They are usually slow growing and are least likely to spread.
- **Grade two (moderate grade)** – the cells look more abnormal than low grade cells.
- **Grade 3 (high grade)** – the cells look very abnormal. They are likely to grow more quickly and are more likely to spread.



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

### **Borderline Tumours of the ovary**

Borderline ovarian tumours make up about 15% of epithelial ovarian tumours. They are also called tumours of low malignant potential. This means they are unlikely to spread and are usually easier to cure, commonly not requiring any further treatment apart from surgery, however if you have not had complete pelvic clearance and still have a remaining ovary you will require regular follow ups and ultrasound scans

#### **Staging of cancer**

- **Stage one** – Cancer is found only in the ovary or ovaries.
- **Stage two** – the cancer has grown outside the ovary or ovaries, but it is inside the pelvis.
- **Stage three** – cancer has spread outside the pelvis into the abdominal cavity. It may also be found in the lymph nodes in the upper abdomen, groin or behind the womb.
- **Stage four** – the cancer has spread into the other body organs such as the liver or lungs.

### **Chemotherapy**

If you have been diagnosed as having ovarian cancer, it is very likely that you will require further treatment in the form of chemotherapy. This will be discussed with you by your specialist nurse and oncologist.

The chemotherapy drugs are given intravenously (into one of your veins) commonly referred to by medical staff as IV, so that they can circulate through your bloodstream. Usually the chemotherapy is given once every three weeks, and this is repeated six times.

The drugs most commonly used are Carboplatin on its own or with Paclitaxel (Taxol).

Further information on the named drugs is available from your specialist nurse or from Macmillan Cancer Support. See list of contacts.

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Once you are referred for oncology treatment, you will be introduced to a new key worker. A clinical nurse specialist who specialises in supporting patients having oncology treatments.

You will be followed up in the Combined Gynaecology / Oncology clinic on a regular basis for at least 5 years.

If you have any further queries or concerns please contact your nurse specialist.

## Useful contacts and telephone numbers

### University Hospitals Coventry & Warwickshire

Arden Network - Gynae-Oncology Service

### 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 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

## Patient Information

### **George Eliot Hospital**

#### **Clinical Nurse Specialist**

Kerry Pearson

Available on **07984216109** 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**

Clementine Stott (based at Redditch)

**01527 503030** ask to radio page **01905 733257**

Helen Farnhill & Nicky Plant (based at Worcester) **01905 733257**

**Or Radio page via switch 01905 763333**

#### **Secretaries**

Dr Irwin (Miranda Powell) **01527 512028**

Dr R Panchal (Anne Hyslop) **01527 503030** ext **44078**

Patient Information

## 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](http://www.macmillan.org.uk)

Ovacome - A nation-wide support group for people affected by ovarian cancer: **0845 3710554**

If you are under 45 you can find out more about Ovacome's young ovarian cancer support network by contacting Ruth Payne on **020 7299 6650**

Ovacome runs a network which can put you in touch with someone in your local area with ovarian cancer, who can talk to you over the phone. You can join Fone Friends Network by ringing **020 7299 6654**. [www.targetovariancancer.org.uk](http://www.targetovariancancer.org.uk)

Target Ovarian Cancer - Target Ovarian Cancer runs a programme of courses to support women living with and beyond ovarian cancer including local day events, support after finishing treatment and training to raise awareness of symptoms.

Telephone **020 7923 5470** for further information.

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### 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.

- Coventry Benefits Advice Line **024 7683 2000** Offers advice and information regarding benefits, over the telephone. Appointments can be made for a face to face consultation to help complete benefit forms.
- 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 – 12.00pm 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 – 2<sup>nd</sup> & 4<sup>th</sup> 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 – 1<sup>st</sup> 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) **024 7625 2050**  
This appointment only service provides free advice regarding benefits etc.

## Patient Information

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](mailto:feedback@uhcw.nhs.uk)

### Document History

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