

Streamlining care for women with gestational trophoblastic disease in the local hospital.



Robin Crawford, Sandra Kent, Fay Ronketti, Mercedes Jimenez-Linan, Chris Palmer, Dee Short, Michael Seckl and Peter Baldwin. Addenbrookes Hospital Cambridge, Centre for Applied Medical Statistics, Cambridge and The Trophoblastic Centre Charing Cross Hospital London



Abstract

Streamlining care for women with gestational trophoblastic disease in the local hospital.
Robin Crawford, Sandra Kent, Fay Ronketti, Mercedes Jimenez-Linan^a, Chris Palmer^b, Dee Short^c, Michael Seckl^d and Peter Baldwin. Addenbrookes Hospital Cambridge and The Trophoblastic Centre Charing Cross Hospital London

Abstract:
Following patient dissatisfaction an audit identified that our standard working practices allowed patients with gestational trophoblastic disease to be delayed in or to miss registration for follow up with our regional reference centre. In response to this finding, we have introduced a standardised management protocol to our hospital. The effects of this change on both registration and the patient experience are presented. Up to 29 cases of gestational trophoblastic disease are registered per annum. The performance of this new protocol is compared to other UK hospitals using the same reference centre. There is a wide variation in the registration for GTD which could suggest failures in process rather than differing populations. The process requires little consultant input and is nurse led. There appears to be no negative effect of the change. The benefits of the evolved pathway are better patient care; more rapid registration; improved relationships within the hospital and with our regional service and reducing clinical risk.

Background/ Introduction

Molar pregnancies are rare, occurring at a rate of 0.2-1.5 per 1000 live births. Many consultant gynaecologists will only see one or two cases a year. A centralised approach to the care of women with trophoblastic disease was introduced to the UK in 1973. Prompt registration and follow-up are the cornerstones of this effective system leading to less chemotherapy and intervention. Further attempts at pregnancy are avoided until 6 months follow up has occurred either from evacuation if registered early or from the first normal marker sample. Late registration is associated with more untoward outcomes.

As work patterns and responsibilities within our institution changed it became apparent that the local systems were not completely effective either in consistently achieving early registration or providing those affected with appropriate information and support. Following a patient complaint about a poor experience leading to a longer patient follow up, we undertook an audit of our workload associated with gestational trophoblastic disease in the Cambridge district. We recognised that the workload was best concentrated through a designated pathway. In this poster, we provide details of our audit as well as share the pathway and the responses to the changes that were introduced. In conjunction with our regional centre, we have tried to assess whether the delay in registration is a more widespread problem that may require NHS Trusts who manage molar pregnancies to review their own management pathways.

Materials / Methods

A retrospective audit of molar pregnancy registration over the decade up to 2008 was performed. All patients with a diagnosis of GTD were identified from the local pathology database. The total number was compared to the number registered with the Trophoblastic Disease Centre (TDC) at Charing Cross Hospital, our regional reference centre, during the same time period. The standard chosen was that all cases of GTD should be registered with our regional reference centre. For registered cases, the delay between diagnosis and registration was calculated and cases reviewed in an attempt to identify any adverse events that might be related to this interval.

A standardised protocol for GTD management was produced in 2006 based on RCOG guidelines.

A gynaecology sister (grade 7), with training and cover for leave, identified cases of possible molar pregnancy from all managed early pregnancy failures seen within accident and emergency, the early pregnancy unit and the inpatient gynaecology ward. Where possible histological assessment of products of conception from miscarriages is routinely performed.

To facilitate registration and streamline communication between the hospital and the TDC at Charing Cross, a nominated consultant with an interest in trophoblastic disease agreed to register all the cases under his name. The nurses reported any new or suspected cases to the consultant by hospital email and then registered the patient. The nurses managed the initial contact and consultation with the patient. Standardised patient information was agreed and notification was sent to the GP within 24 hours of the patient registration with the TDC. Registration was deferred until the patient had been informed of the diagnosis and the subsequent management. When required, the nurse was allowed to book a consultant slot for a patient appointment at short notice (within 1 week). In keeping with standard guidelines, the pathology specimen was sent to Charing Cross for verification. Any specimens where there was doubt as to the diagnosis in Cambridge were sent to Charing Cross for a second opinion.

Results

Year	Number of GTD Detected on Histology AH	Number of GTD Registered Charing X	Number of GTD not being registered
1997	17	16	1
1998	12	12	0
1999	7	6	1
2000	10	10	0
2001	18	18	0
2002	19	15	4
2003	21	21	0
2004	15	15	0
2005	13	12	1
2006	20	20	0
2007	29	29	0
2008 (6months)	7	7	0

Year	Mean Number of days from date of diagnosis to Registration with Charing Cross	Median	Quickest registration	Slowest registration
1997	27	30	9	47
1998	31	26.5	8	80
1999	24	18.5	8	37
2000	27	24.5	11	43
2001	37	22	7	76
2002	33	21.5	7	101
2003	40	36	9	48
2004	35	35	4	49
2005	41	30	13	86
2006	40	29	12	95
2007	22	17	10	70
2008 (First 6 months)	15	13	7	39

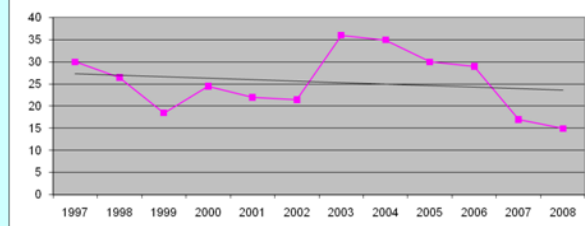


Table and graph showing improvement in registration after introduction of pathway 2007

Centre	Cambridge	1	2	3	4	5
Mean days from miscarriage	23.3	35.2	51.6	37.2	42.6	30.6
Median (days)	20	26	46	28	17	29
Shortest registration	1	7	11	10	10	9
Longest registration	70	110	88	81	272	62
Standard deviation	14.7	25.2	26.6	22.1	62.6	16.1
Treatment required	4	4	0	1	4	1
Total cases	40	50	10	12	21	28

Comparison with other hospitals

Discussion

The audit has shown that in a teaching hospital in the UK up to 21% of cases of GTD may not be registered with the regional centre. Possible explanations include poor record keeping, delay in results reaching a responsible person who might register the patient or lack of understanding by the junior medical staff in relation to the importance of follow up for these women.

Lack of registration and follow up may be detrimental for the patient and increases patient dissatisfaction.

The new GTD pathway provides for enhanced continuity of care and is more patient focussed.

Qualitative assessment has shown that the switch to a nurse led service is very acceptable.

Completion of the audit cycle has reassuringly demonstrated improved satisfaction with the service.

The wide variations in registration times seen in differing hospitals would suggest a lack of process for the management of GTD. These features and the variation in the total number of cases registered raise the possibility that registration may not be complete at all units.

By auditing our department's experience with GTD, we have identified sub-optimal practice and corrected this with a unified patient centred pathway leading to improved registration and greater patient satisfaction.

We suggest that all hospitals managing early pregnancy loss should consider a similar pathway to reduce the late or potential non-registration of patients and to improve the patient experience at what is clearly a stressful time.

The change is cost neutral and provides the additional benefit of improving communication and relationships between patients, primary and secondary care and the regional centre.