Multidisciplinary Team Meeting (MDT) Guide

Purpose:

The primary function of these meetings is to discuss the management of women with discordant cytological, colposcopic and histological findings and to discuss other clinical issues.

This guide has been prepared using the relevant CervicalCheck standards and quality requirements CLP/PUB/Q-10 QR4.55 and CLP/PUB/Q-8 Section 3.15.8.

Note: Clinical risk issues should be managed via local hospital risk management processes

Membership:

- All practicing colposcopists
- Cytopathologist representative
- Histopathologist representative
- Virologist as required
- Administrative support
- Trainees and students

A quorum of at least one colposcopist, one cytopathologist and one histopathologist should be present (in person or by audio/video link) at each meeting. Members should attend a minimum of 50% of meetings. The lead colposcopist should act as the meeting chair.

Governance for MDT lies with the lead colposcopist and it is their responsibility to ensure that the process is carried out to best practice and quality assurance standards and the guidelines in this document.

Scheduling a meeting:

- Each colposcopy service must nominate a MDT meeting coordinator who is responsible for scheduling and recording meeting attendance, minutes and actions, collecting the specific cases to be discussed and requesting the necessary materials for discussion. The MDT coordinator is also responsible for collating audit results and the minutes and attendance register for the annual MDT meeting and provided same to the CervicalCheck Colposcopy Coordinator.
- It is the responsibility of the MDT meeting coordinator to organise MDT meetings using approved ICT platforms which are provided and maintained by the local hospital.
- It is the responsibility of the local hospital ICT team to provide support for any ICT issues. These issues should be managed locally and should not prevent regular meetings occurring.
- It is recommended that a schedule of meetings be organised and distributed in advance. Ideally 6 -12 months of meetings should be circulated at a time. Meetings must be scheduled so that the meeting populates participants' calendars.
- Sufficient notice (ideally 10 days) must be provided where there is a change or cancellation to a scheduled MDT meeting
- Meetings must occur at least every two months (more frequently for larger units, i.e. those clinics that receive at least 1500 new referrals per annum).
- A list of the women to be discussed must be circulated in advance (minimum of 10 working days' notice) to allow time for case preparation including review of cytology and histology

cases. Where there are no cases for discussion for a particular laboratory, they should receive an invite to attend, but be made aware that there are no cases for their review on the list.

- There must be facilities for all members to contact the MDT coordinator to add to the list any case where they have concerns they wish to discuss
- For security purposes any files containing women's confidential details must be password encrypted prior to e-mail distribution

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Conducting a meeting:

- An attendance log must be kept, and a record of the attendance records must be available on request of the CervicalCheck Quality Assurance team.
- Slides and images (colposcopy, cytology and histology) may be presented, but this is **not mandatory**. Technical difficulties that prevent images from being presented is not a sufficient reason to cancel a meeting provided a review of the case findings can be provided.
- Minutes must be kept and clinical decisions/management plans recorded in the woman's records and the electronic colposcopy record system.
- Outcomes must be recorded on the colposcopy computer system and laboratory information management systems (LIMS) or other systems. The LIMS should capture any changes made at MDT review and changes should be communicated back to the originating clinically responsible doctor (eg GP or colposcopy clinic) and screening register.
- The supervising colposcopist must be informed of decisions/management plans as should the woman involved and her primary care doctor.
- An annual management meeting of MDT members must take place to monitor the function of the MDT and its meetings. An attendance register and minutes must be recorded for this annual meeting and provided to the CervicalCheck Colposcopy Coordination team.
- Regular audit to monitor the effectiveness of the process is recommended and results of audit should be presented both at this meeting and forwarded to the CervicalCheck Colposcopy Coordinator.

Cases that must be reviewed at MDT:

Note: Cytopathologists should not carry our retrospective reviews outside of the MDT framework for patient management.

- Women who present with a high grade cytological abnormality and who have no colposcopic abnormality identified on a fully visible TZ including biopsy and examination of the vagina must have the screening test reviewed by the Cytopathologist at an MDT meeting.
- Women referred with high grade cytological abnormality and who have CIN 1 or less diagnosed on a biopsy should be managed by a senior colposcopist. If excision is not performed the case should be discussed at MDT.
- Women who present with a high grade cytological abnormality and who have an unsatisfactory colposcopy (Type 3 TZ) should have an excisional treatment performed. If excisional treatment is thought to be inappropriate, then discussion at MDT meeting is required.
- Women treated by excision for suspected high grade disease (CIN 2/3) and who have no significant abnormality on histology must be discussed at the colposcopy MDT meeting before repeat colposcopy including examination of the vagina and consideration of a repeat excision
- Women who have incomplete excision of a primary CGIN or SMILE lesion or where there is doubt about the excision margin must be discussed at MDT and offered further treatment (repeat excision or hysterectomy).

Further management is based on MDT decision

Cases that may be reviewed at MDT

Note: Cytopathologists should not carry our retrospective reviews outside of the MDT framework for patient management

- Conservative management of CIN 2 (the senior colposcopist to decide where MDT discussion is required)
- High grade CIN extending to the deep lateral or endocervical margins of excision (or uncertain margin status) which does not justify routine repeat excision, discussion at MDT should be considered if there is a clinical concern.
- When treating CGIN or SMILE excisional techniques must be used and must consider the anatomical site of the squamo-colmunar junction (SCJ) to ensure complete excision of the lesion. In younger women or women who wish to conserve their fertility, who have colposcopically visible squamocolumnar junction (SCJ), a cylindrically shaped excisional biopsy including the whole transformation zone (TZ) at least 10mm proximal to the SCJ is appropriate. Discussion at MDT is not essential if the colposcopist is satisfied that the above criteria have been met, the excision margins are clear of disease and there are no complicating factors.

Further management is based on MDT decision

Communication of MDT outcomes.

- The responsibility for communication of MDT outcomes lies with the treating consultant under the governance of the lead colposcopist.
- Women should be made aware of, and an explanation of the process should be provided if their case is listed for discussion at MDT.
- The outcome of the MDT including decisions made and next steps should be communicated to the woman and her referring doctor (for information purposes). A copy should also be sent to the woman's GP, with her consent, if they are not the referring doctor.
- Amended results must be recorded on colposcopy and laboratory ICT systems. The amended result must be clearly identified as an MDT review result and should be recorded in addition to the original results. The cervical screening programme must be notified of amended results from MDT discussions.
- Non presentation at a MDT should not delay the treatment and care of a woman where an urgent clinical decision is required. It is the responsibility of the treating doctor to discuss the management of these cases and all relevant documentation with the appropriate MDT colleague to ensure that care is not delayed. The outcome can subsequently be brought to the next MDT meeting to ensure that the appropriate recording of any action taken and communication takes place.

MDT and Invasive cervical cancers

- Cases of invasive cervical cancer are discussed at MDT to clarify diagnosis and determine the management plan.
- Audit of screening history for interval cases of invasive cervical cancer are managed via a separate process. If local investigation of a cervical cancer case is undertaken by hospital risk management a copy of the findings should be forwarded to CervicalCheck