Waitematā
District Health Board
Best Care for Everyone

Hospital Services
North Shore Hospital Campus
Shakespeare Road, Takapuna
Private Bag 93-503, Takapuna
Auckland 0740
Telephone: 09 489 0527

27 September 2021

[redacted]

Dear [redacted]

Re: OIA request – Ultrasound waiting times

Thank you for your Official Information Act request received Monday 9 August seeking information from Waitematā District Health Board (DHB) about current wait times for ultrasound scans.

Before responding to your specific questions, it may be useful to provide some context about our services.

Waitematā is the largest and one of the most rapidly growing DHBs in the country, serving a population of around 650,000 across the North Shore, Waitakere and Rodney areas. We are the largest employer in the district, employing around 8,500 people across more than 80 locations.

In addition to providing care to our own resident population, we are the Northern Region provider of forensic mental health services and child rehabilitation services, plus the metro Auckland provider of child community dental services and community alcohol and drug services.

On 10 August, we contacted you to clarify if you were seeking information about the following:

- all transvaginal ultrasound scans or only those regarding possible cancers
- information about scans performed during pregnancy or to rule out an ectopic pregnancy.

That same day, you confirmed that you would like information in instances where there were different referral criteria for each of these.

On 13 August, we contacted you again to seek a further clarification as follows:

Is the wait time you are asking for:

- how long patients on our waiting list have waited for on average (i.e. patients currently waiting for a scan have on average been waiting **x** length of time), or
- are you asking for us to look over (for e.g.) the last six weeks and get the average wait time from referral to examination or report time?

You confirmed that you were seeking information on the second option - how long people, on average, have to wait until they are scanned (rather than how long the current people waiting have waited).

On 27 August, we contacted you to advise that, due to our response in managing the COVID-19 Delta outbreak in the region under Alert Level 4 restrictions, we were unable to provide a response within the standard timeframe and would do so by the end of September.

In response to your request, we are able to provide the following information:

1. **Please provide the current wait time from referral to examination or report time for the past six weeks for an urgent, semi-urgent and routine transvaginal ultrasound (or just ultrasound generally if your data does not make the distinction).**

For gynaecology patients, if there is high clinical suspicion of cancer, all ultrasounds requested should be performed within two weeks of the request – see gynaecological guidelines from the Ministry of Health's *Faster Cancer Treatment: High suspicion of cancer definitions, July 2015* - **Attachment 1**.

Most pregnancy scans are done in the community. Urgent inpatient scans (i.e. possible ruptured ectopic) are done as quickly as possible, usually within hours. If the patient is clinically stable, the ultrasound is done within 24 hours.

If the scan is done via the Early Pregnancy Clinic at North Shore or Waitakere hospitals (monitoring pregnancy progress or possible miscarriage), the scans are done within a week as there are ultrasound scan slots specially reserved for early pregnancy clinic patients.

It should be noted that the information we have provided is for ultrasound female pelvis studies only, not all ultrasound referrals.

You requested transvaginal scans but we are unable to differentiate between female pelvis scans that receive or require a transvaginal scan as part of their study or patients who receive a transabdominal scan. To provide information regarding waiting times for transvaginal ultrasound would require the review of individual clinical records of patients.

Due to the sensitivity of this information, frontline clinical staff would need to review individual clinical files and it would not be appropriate to use a contractor to review the records. This would take the frontline staff away from their clinical work and prejudice our ability to provide core clinical services.

We have considered whether charging or extending the timeframe for responding to this aspect of your request would assist us in managing this work and have concluded it would not. We have, therefore, determined to refuse this element of your request under Section 18(f) of the Official Information Act due to substantial collation and research.

You have the right to seek an investigation and review by the Ombudsman of this decision. Information about how to seek a review is available at www.ombudsman.parliament.nz or freephone 0800 802 602.

However, we have provided waiting times for both female pelvis scans that receive or require a transvaginal scan as part of their study and patients who receive a transabdominal scans as follows:

Waitematā DHB's outpatient waiting times are well within Ministry of Health guidelines. For studies completed in the six weeks between 1 June 2021 and 15 August 2021, average waiting times were as follows:

- urgent referrals: 5 days
- semi-urgent referrals: 12 days
- routine referrals: 44 days.

2. **What is the criteria for evaluating the urgency of a request (general, or ovarian if you have)?**

The criteria for evaluating the urgency of community referrals for pelvic scans is as follows:

- High-acuity outpatient appointments (urgent and semi-urgent referrals) within 1 – 2 weeks. This includes post-menopausal PV bleeding (i.e. abnormal vaginal bleeding) after more than one year amenorrhea or with endometrial cells, if older than 40 years of age and where one of several risk factors is present.
- Routine outpatient appointments within 4 – 6 weeks of referral creation. If the GP has written something concerning, then an intermediate grading is used whereby the priority is "Time critical, within three or four weeks". Pelvic scan requests for abnormal vaginal bleeding are common and are usually graded as routine according to the HealthPathways guideline.

3. What are the current HealthPathways criteria for your DHB for ovarian cancer?

The following information is taken from the Auckland Region Community HealthPathways website:

Ovarian Cancer Symptoms
See also Familial Breast or Ovarian Cancer Syndromes pathway.

This pathway is designed to assist in the diagnosis of women with possible symptoms of ovarian cancer and is consistent with the NICE guideline in clinical resources.
Red Flags

- Genetic risk – strong family history or known HNPCC or BRCA mutation.

Background
About ovarian cancer diagnosis

- Ovarian cancer is more common in postmenopausal women.
- The mean age of diagnosis is 65 years.
- The lifetime incidence for women is 1.6%
- In premenopausal women, ovarian cancer is uncommon but more likely if there is a strong family history of known HNPCC or BRCA mutations.
- Around 10% of ovarian cancer is caused by hereditary cancer syndromes.
- Non-specific symptoms make diagnosis difficult.
- Examination is important as there may be a mass and clinical evidence of abdominal disease.
- Patients with one first or second degree relative with ovarian cancer occurring when aged > 50 years have a 5% lifetime risk, which is slightly increased from the general female population lifetime risk of 1.6%. Patients with known genetic mutations e.g., BRCA mutation have a much higher risk.
- There is currently no proven role for Ca125 or ultrasound screening in asymptomatic women.[1]

Assessment

1. Assess possible ovarian cancer if new abdominal or pelvic symptoms are present on a persistent or frequent basis – particularly > 12 times per month:
    - Persistent abdominal distension or bloating
    - Early satiety or loss of appetite
    - Pelvic or abdominal pain without another cause
    - Increased urinary urgency or frequency
    - Irritable bowel symptoms, especially if new onset and aged > 50 years
    - Unexplained weight loss or fatigue

    Consider asking the woman to keep a symptom diary.
2. Consider other causes of chronic, vague abdominal symptoms including bowel cancer.
3. Examine the abdomen and pelvis for signs suggesting ovarian cancer, including a pelvic or abdominal mass or ascites.
4. Investigations:
    - Initial blood tests: Ca125, LFT, FBC, CRP, calcium, creatinine, urea, and electrolytes.

- If signs include a pelvic or abdominal mass or ascites, arrange an ultrasound scan within 2 weeks.
- If no signs, manage according to Ca125 result.

Management
Management of investigation results differs depending on whether the woman is premenopausal or postmenopausal.

Request
Request gynaecology assessment:
- if scan is abnormal e.g., shows ascites or complex cyst.
- if Ca125 is elevated, as in Management above, depending on menopausal status.

4. If you are able to grant us permission to access Health Pathways for your area that would be appreciated.

The Auckland Regional HealthPathways site is regionally funded by the three metro Auckland DHBs and seven PHOs. It is not intended for access or use by consumers, patients, or people who are not health professionals.

However, the parts of the site you are wanting to access to can be demonstrated by Auckland Regional HealthPathways programme manager Catherine Turner. Please contact her in the first instance by email: Catherine.Turner@middlemore.co.nz

I trust that this information is helpful.

Waitematā DHB supports the open disclosure of information to assist community understanding of how we are delivering publicly funded healthcare. This includes the proactive publication of anonymised Official Information Act responses on our website from 10 working days after they have been released.

If you consider there are good reasons why this response should not be made publicly available, we will be happy to consider your views.

Yours sincerely

[redacted]

Executive Director Hospital Services
Waitematā District Health Board

3. Gynaecological

GYNAECOLOGICAL CANCER	
If the patient presents ***with one or more*** of the following red flags, then the referral should be triaged as 'High Suspicion of Cancer'.	
Red flags	**YES or NO**
Biopsy-proven or cytology positive gynaecological malignant or premalignant disease[3] or Gestational Trophoblastic Disease	
A visible abnormality suspicious of a vulval, vaginal or cervical cancer (such as an exophytic, ulcerating or irregular pigmented lesion)[4]	
Significant symptoms (including abnormal vaginal bleeding, discharge or pelvic pain) AND Abnormal clinical findings suspicious of gynaecological malignancy (including lymphadenopathy, vaginal nodularity or pelvic induration)[5]	
Post-menopausal bleeding. *(N.B. High suspicion of cancer may be excluded if physical examination, smear and vaginal ultrasound are normal[6])*	
A rapidly growing pelvic mass or genital lump[7]	
Women with a palpable or incidentally-found pelvic mass (including any large complex ovarian mass >8 cm) UNLESS investigations (ultrasound and tumour markers) suggest benign disease[8]	
Women with a documented genetic risk who have a suspicious pelvic abnormality or symptoms[9]	

[3] Please see National Cervical Screening Programme recommendations for colposcopy referral.

[4] Women with an undiagnosed visible genital abnormality which is not highly suspicious of malignancy should be referred for gynaecological or dermatology review or undergo a biopsy.

[5] Women with gynaecological abnormalities or symptoms may also have gynaecological malignancy and the development of triage pathways is encouraged. Specific consideration includes premenopausal women with abnormal uterine bleeding. Those with persistent or deteriorating symptoms should be reviewed by a gynaecologist. A raised CA125 supports the need for further investigation in woman with persistent pelvic or abdominal symptoms.

[6] Early access to vaginal ultrasound will reduce demand on secondary services. Women without post-menopausal bleeding but with a thickened endometrium should undergo gynae review but are not defined as high risk.

[7] Discernible growth within a 3 month period is normally of concern. Undiagnosed external genital lumps with any discernible growth should normally be reviewed by a gynaecologist and/or biopsied.

[8] The development of referral pathways is recommended to ensure rapid assessment of patients with a pelvic mass, early access to pelvic ultrasound is seen as crucial to this process.
N.B. Suspicion of ovarian malignancy is indicated by metastatic disease, ascites or radiologist's impression, a raised CA125 in a post-menopausal woman or germ cell markers in a woman under 25. The risk of malignancy index (RMI) is utilised to triage patients for subspecialty care.

[9] Usually women with strong family history or known hereditary nonpolyposis colorectal cancer (HNPCC) or BRCA mutations.