Emergency Presentations and Ovarian Cancer Treatment

Following the launch of NOCA's Quality Improvement intervention in 2025, we invited all gynaecological cancer systems across England and Wales to share their experiences of managing patients diagnosed with ovarian cancer following an emergency admission. This report presents an anonymised summary and synthesis of the responses received, covering current practices, challenges and limitations as identified by the responding systems. It also highlights a range of best practice examples from centres across the country. These examples can be used as a guide to inform quality improvement interventions aimed at improving the rates of treatment for women diagnosed following an emergency admission.

Why are treatment rates in women diagnosed following an emergency admission an issue in your gynaecological cancer system?

Patient and population factors

- Populations from areas of significant socioeconomic deprivation, where late presentation is more common — including deprived coastal and rural communities with poor primary care access.
- High rates of stage 4 disease at presentation, impacting treatment rates and survival outcomes.
- High proportions of elderly patients with significant comorbidities; average age of 80+ among those not receiving treatment at some centres.
- Some patients, particularly older or very unwell individuals, declining active treatment.
- Where patients are not offered treatment, this often reflects an MDT assessment that treatment is unlikely to provide meaningful clinical benefit, not a failure of service access.

Diagnostic and pathway delays

- Delays in imaging and radiology reporting; lack of image-guided biopsy facilities.
- Limited availability of specialist interventional radiologists, increasing vulnerability to delays particularly during periods of leave.
- Protracted pathology reporting, driven by outsourcing, shortages of laboratory staff, and lack of gynaecological pathologists.
- Delays in MDT discussion pending completed investigations.
- Delays in referral from acute admitting teams to the gynaecological oncology service.
- Poor awareness of ovarian cancer diagnosis and management pathways in non-specialist secondary care and among GPs.
- Emergency admissions presenting at spoke sites with no consultant gynaecological oncology presence, leading to delays in specialist review.

Service and capacity pressures

- Limited access to inpatient chemotherapy: patients often discharged before oncology review; bed capacity constraints; variable clinician comfort initiating chemotherapy for acutely unwell patients.
- Insufficient theatre access for short-notice cancer cases and insufficient gynaecological oncology surgeon numbers.
- Oncology and surgical workforce turnover and vacancies affecting service continuity.

What are the gynaecological cancer systems doing to improve their treatment rates?

MDT and pathway improvements

- Moving MDT lists to shared digital platforms, improving accessibility and enabling advance planning of investigations and appointments.
- Ensuring all investigation results are available before MDT discussion so that a management plan can be confirmed at the first meeting.
- Introduction of one-stop joint gynaecological/medical oncology clinics and formal inpatient referral pathways for early consultant-level treatment decisions.
- Standardised referral communications to all teams admitting patients with suspected ovarian cancer, setting out the expected pathway.
- Regular pathway tracking meetings to identify and resolve delays in radiology, outpatient and theatre capacity, and pathology turnaround.
- Advanced ovarian cancer planner documents tracking surgically suitable patients across multiple hospital sites.

Accelerating diagnostics

- Closer working with interventional radiology to streamline access to rapid image-guided biopsy.
- Biopsy requested by the referring unit as soon as disseminated disease is identified on CT, ahead of MDT discussion.
- CT imaging discussed at MDT before biopsy results are available where primary debulking surgery is a consideration.
- Direct GP access to radiology vetting protocols, enabling earlier access to CT imaging for patients with suspected ovarian cancer.
- Direct communication between admitting teams and oncologists to progress diagnostic tests without waiting for MDT outcomes.

Surgical and treatment capacity

- Reserved slots in the surgical diary for primary cytoreductive surgery.
- Expansion of NHS surgical capacity into the independent sector.
- Development of formal inpatient chemotherapy pathways for emergency admissions, minimising delays to treatment.
- Introduction of laparoscopic interval debulking surgery for stage 4 patients, particularly elderly or comorbid patients who might otherwise decline open surgery.

System-level and support

- Development of managed clinical network models across cancer alliances, engaging cancer clinical directors and primary care.
- Planning of regional workshops involving emergency departments, primary care, acute oncology and gynaecological oncology teams.
- GP and secondary care education programmes on ovarian cancer symptoms, diagnostics and management pathways.
- Prehabilitation services, frailty assessment, acute oncology services across spoke sites, and strong palliative care integration as enablers of performance.
- Application for dedicated ovarian cancer pathway navigator posts to track patients across complex multi-site systems.