Pan Birmingham NHS
Cancer Network

Guideline for the Referral of Patients with Suspected Head and Neck Cancer

Version History

Version	Date Issued	Brief Summary of Change
0.1	06.04.11	First draft by Rachel Loveless
0.1	07.04.11	Circulated to Steve Colley at University Hospitals Birmingham NHS Foundation Trust and Lucy Burgess at Birmingham Women's NHS Foundation Trust for comment.
0.2	27.07.11	Box B Updated by Steve Colley
0.3	27.07.11	Additional information added by Lara Barnish
0.4	01.08.11	Reformatted by Rachel Loveless and sent to Steve Colley for approval
0.5	03.08.11	Additional information and change of Sandwell rapid access telephone number changed by Steve Colley
0.6	31.08.11	Reviewed by Lara Barnish for review by the governance sub group
0.7	13.10.11	Additional appendices added by Rachel Loveless and 2, 3.3, 3.4 section 2 added to by Ben Parfitt
0.8	04.11.11	Reviewed and updated by Ben Parfitt in preparation for discussions at Head and Neck Network Site Specific Group on 11.11.11
0.9	11.11.11	Reviewed and updated by Head and Neck Network Site Specific Group
0.10	15.11.11	Reviewed and updated by Network Guidelines Sub Group
1.0	15.11.11	Reviewed and endorsed by Network Guidelines Sub Group

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Date Approved by Network Governance	November 2011

Date for Review	November 2014

1 Scope of the Guideline

This guideline has been produced to support the referral of patients with suspected head and neck Cancer.

2 Guideline Background

Patients with suspected head and neck cancer may be referred to any one of the following designated hospitals with head and neck cancer rapid access facilities:

- City Hospital (part of Sandwell and West Birmingham Hospitals NHS Trust – SWBH)
- Birmingham Dental Hospital
- Good Hope Hospital (part of Heart of England NHS Foundation Trust – HEFT)
- Heartlands Hospital (part of Heart of England NHS Foundation Trust – HEFT)
- Queen Elizabeth Hospital (part of University Hospitals Birmingham NHS Foundation Trust – UHBFT)
- Sandwell Hospital (part of Sandwell and West Birmingham Hospitals NHS Trust – part of SWBH)
- Solihull Hospital (part of Heart of England NHS Foundation Trust – HEFT)
- Walsall Healthcare NHS Trust

Once diagnosed with head and neck cancer, patients should be referred to a head and neck cancer multi disciplinary team (MDT) at either:

- University Hospitals Birmingham NHS Foundation Trust (joint with Sandwell and West Birmingham Hospitals NHS Trust and Heart of England NHS Foundation Trust).
- University Hospitals Coventry and Warwickshire NHS Foundation Trust (UHCW).

Guideline Statements

3 Urgent Referrals

3.1 Patients with any of the following symptoms should be referred by fax (see appendix 1) to the local NHS hospital for assessment by their designated head and neck clinician.

a. hoarseness persisting for more than three weeks .
b. ulceration of oral mucosa persisting for more than three weeks.
c. oral swellings persisting for more than three weeks.
d. all red or white patches of the oral mucosa.

e. dysphagia persisting for more than three weeks.
f. unilateral nasal obstruction, particularly when associated with purulent discharge.
g. unexplained tooth mobility not associated with periodontal disease.
h. unresolving neck masses for more than three weeks.
i. cranial neuropathies.
j. orbital masses.
k. persistent, particularly unilateral discomfort in throat for >4 weeks

3.2 The level of suspicion increases if the patient has had:-

a. previous radiotherapy to the head or neck.
b. is a heavy smoker.
c. a heavy alcohol drinker.
d. unintentional weight loss >3kg in 6 weeks.
e. previous head and neck, lung or oesophageal tumour.

Other forms of tobacco use and/or chewing betel (areca nut), gutkha, or paan should also arouse suspicion.

3.3 GPs should refer patients to the designated diagnostic and assessment team for their host Primary Care Trust as specified in appendix 2.

3.4 All general dental practitioners should refer their patients to Birmingham Dental Hospital.

3.5 Patients referred urgently should be seen within 2 weeks of referral.

3.6 Patients for whom cancer is strongly suspected by the referring clinician:

a. should be referred directly to a head and neck cancer centre MDT
b. may undergo an initial biopsy or fine needle aspiration cytology (FNAC) which is performed by either a head and neck surgeon or radiologist in an outpatient clinic.
c. for those who have FNAC or biopsy, referral should not await the availability of any test result.

3.7 Patients referred urgently should be given the patient information sheet in appendix 1.

4 Head and Neck Genetics Referral Criteria

The following should be referred for genetic assessment:

4.1 Thyroid cancer

a. all medullary thyroid cancer cases.
b. all families with two or more thyroid cancers on the same side of the family.
c. thyroid cancer with a personal or family history of a known familial cancer syndrome (e.g. familial adenomatous polyposis, Cowden syndrome) or strong family history of non-thyroid cancers or family history of rare cancers.

4.2 Parathyroid

Multiple parathyroid adenomas or cancer, or a single tumour with positive family history of hyperparathyroidism or other endocrine tumour.

4.3 Head and neck paragangliomas

a. multiple or early onset head and neck paraganglioma.
b. single paraganglioma with a history of head and neck paraganglioma or phaeochromocytoma.

4.4 Unusual family history with multiple primary tumours of head and neck in one individual or strong family history of cancers at a young age should be considered for referral. Specific familial cancer syndromes may need to be considered with specific tumours e.g. Neurofibromatosis type 2 with vestibular schwannoma and von Hippel-Lindau disease with endolymphatic sac tumours.

4.5 These criteria will not cover all cases of inherited head and neck cancers and many cases that satisfy these criteria may not have an inherited cancer syndrome. However all referrals will be assessed by detailed family history (collected by family history form or direct interview) followed by genetic consultation and testing where appropriate. Low risk cases are not usually seen in the genetics clinics but patient and referring doctor would be provided with written summary.

5 Other Referrals

5.1 Patients who enter the system as a routine patient, but are subsequently thought to have cancer on assessment should be referred to the cancer centre MDT prior to the availability of any test results.

5.2 Patients seen by a non designated clinician with signs or symptoms suggestive of head and neck cancer should be referred to a designated member of the MDT

5.3 Patients found to have cancer as an incidental diagnosis whilst under the care of a non designated head and neck clinician should be referred to the designated member of the MDT.

5.4 Any remaining patients (those without suspicion of cancer) should be referred to the cancer centre MDT within 24 hours of the local unit establishing a histological diagnosis of cancer.

5.5 All patients diagnosed with cancer of the head or neck should be discussed by a head and neck cancer MDT. In Pan Birmingham Cancer Network all treatment is carried out at a cancer centre.

5.6 Summary of management pathways

All City and Sandwell patients are managed jointly by SWBH and **UHBFT**.

Patients seen by the maxillofacial service at Solihull will normally be treated at **UHBFT**.

GHH and Walsall patients are discussed at the HEFT MDT, with patient pathways from HEFT to either **UHBFT or UHCW** for major surgical procedures.

All GHH, Walsall and HEFT patients are discussed at the joint HEFT**UHBFT** MDT. Those patients choosing surgery or radiotherapy at UHCW will be discussed at the **UHCW** Head and Neck MDT.

UHBFT and SWBH patients are discussed at the combined MDT at UHBFT. For these patients surgery is carried out at the **City or UHBFT** sites and all radiotherapy / radioactive iodine treatments **UHBFT**

6 Patient Information and Counselling

6.1 All patients, and with their consent, their partners will be given access to appropriate written information during their investigation and treatment, and on diagnosis will be given the opportunity to discuss their management with a clinical nurse specialist who is a member of the relevant MDT. The patient should have a method of access to the head and neck team at all times.

6.2 Access to psychological support will be available if required. All patients should undergo an holistic needs assessment and onward referral as required.

7 Monitoring of the Guideline

Implementation of the guidance will be considered as a topic for audit by the NSSG in 2012/13

References

1. Department of Health, 2000, *The NHS Cancer Plan: A plan for investment, a plan for reform.* Department of Health, London.
2. NHS Executive, 2001, *Cancer Waiting Times HSC 2001/012*. Department of Health, London. See Also DSCN 22/2002 *National Cancer Waiting Times Monitoring.*
3. NHS Executive, 2000, *Cancer Referral Guidelines HSC 2000/013*. Department of Health, London.
4. Department of Health, 2004, *Manual for Cancer Services 2004.* Department of Health, London.

Approval Signatures

Pan Birmingham Cancer Network Clinical Governance Committee Chair

Name: Doug Wulff

Signature:  Date: November 2011

Pan Birmingham Cancer Network Manager

Name: Karen Metcalf

Signature:  Date: November 2011

Network Site Specific Group Clinical Chair

Name: Steve Colley

Signature:  Date: November 2011

Appendix 1: referral form

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URGENT

URGENT REFERRAL FOR SUSPECTED HEAD & NECK CANCER

(Version 3.0)

If you wish to include an accompanying letter, please do so. **On completion please FAX to the number below.**

These forms should only be used for suspected cancer and in conjunction with the NICE Referral Guidelines for Suspected Cancer, June 2005

Patient Details	**GP Details (inc Fax Number)**
Surname Forename D.O.B. Gender Address Postcode Telephone NHS No Hospital No Interpreter? Y / N First Language:	**Date of Decision to Refer** **Date of Referral** **GP Signature**

Symptoms: (Check as appropriate)

Hoarseness > 3 weeks	☐	Persistent, particularly unilateral discomfort in throat for >4 weeks	☐
Stridor	☐	Progressive mouth, throat ulceration	☐
Swelling in parotid /submandibular gland	☐	Persistent oral swelling/ulceration >3 weeks	☐
Persistent red and white patches of the oral mucosa (painful/swollen/bleeding)	☐	Unilateral, unexplained pain in head and neck > 4 weeks, associated with otalgia & normal otoscopy	☐
Unexplained tooth mobility > 3 weeks	☐		

Risk Factors:

Smoker	☐	Previous Radiotherapy to Head and Neck	☐
Alcohol	☐	Unintentional weight loss >3kg in 6/52	☐
Previous head & neck, lung or oesophageal tumour	☐	Other :	

Clinical Examination:

Lump in neck, recent, or previously undiagnosed that has changed over a period of 3 to 6 weeks	☐	Thyroid lump with suspicious features	☐
Cranial nerve palsy	☐	Oropharynx ulceration / tumour	☐
Orbital mass / proptosis	☐	Other :	

Cancer Area Suspected:

Larynx	☐	Pharynx	☐
Mouth	☐		☐
Salivary Glands	☐	Neck	☐
Thyroid Gland	☐		

Clinical Details: History\Examination\Investigations (please attach the most recent medial history to this form)

Medication ……

For Hospital Use

Appointment Date Clinic Attending

Was the referral appropriate Yes No (if no please give reason)

HEAD & NECK CLINICS WITH RAPID ACCESS FACILITIES

Hospital	Tel	Fax
City and Sandwell	**0121 507 5805**	**0121 507 5075**
Dental Hospital	**0121 237 2731**	**0121 237 2750**
Good Hope	**0121 424 5000**	**0121 424 8952**
Heart of England	**0121 424 5000**	**0121 424 8952**
Queen Elizabeth (UHB)	**0121 627 2485**	**0121 460 5800**
Solihull Hospital	**0121 424 5000**	**0121 424 8952**
Walsall Manor	**01922 721172 ext 7110 or 7785**	**01922 656773**

Appendix 1 - continued: patient information sheet

Why Have I Been Given a 'Two Week Wait' Hospital Appointment?

What is a 'two week wait' appointment?
The 'two week wait' or 'urgent' appointment was introduced so that a specialist would see any patient with symptoms that ***might*** indicate cancer as quickly as possible. The two week wait appointment has been requested either by your GP or dentist.

Why has my GP referred me?
GPs diagnose and treat many illnesses but sometimes they need to arrange for you to see a specialist hospital doctor. This could be for a number of reasons such as:

- The treatment already given by your GP has not worked.
- Your symptoms need further investigation.
- Investigations arranged by your GP have shown some abnormal results.
- Your GP suspects cancer.

Does this mean I have cancer?
Most of the time, it doesn't. **Even though you are being referred to a specialist, this does not necessarily mean that you have cancer**. More than 70% of patients referred with a 'two week wait' appointment do not have cancer.

What symptoms might need a 'two week wait' appointment?

- A lump that does not go away.
- A change in the size, shape or colour of a mole.
- Abnormal bleeding.
- A change in bowel or bladder habits.
- Continuous tiredness and/or unexplained weight loss.
- Other unexplained symptoms.

What should I do if I'm unable to attend an appointment in the next two weeks?
This is an important referral. Let your GP know immediately (or the hospital when they contact you) if you are unable to attend a hospital appointment within the next two weeks.

What do I need to do now?

- Make sure that your GP has your correct address and telephone number, including your mobile phone number.
- The hospital will try to contact you by telephone to arrange an appointment. If they are not able to make telephone contact, an appointment letter will be sent to you by post.
- **Inform your GP surgery if you have not been contacted by the hospital within three working days** of the appointment with your GP.
- You will receive further information about your appointment before you go to the hospital. It is important you read this information and follow the instructions.
- Please feel free to bring someone with you to your appointment at the hospital.

It is important to remember that even though you will receive a 'two week wait' appointment, being referred to a specialist does not necessarily mean that you have cancer. Remember, 7 out of 10 patients referred this way do not have cancer.

Publication date: October 2009
Review date: October 2012
Patient Information adapted from Harrow Primary Care Trust

Appendix 2: current list of designated hospitals for diagnosis and assessment of head and neck cancers

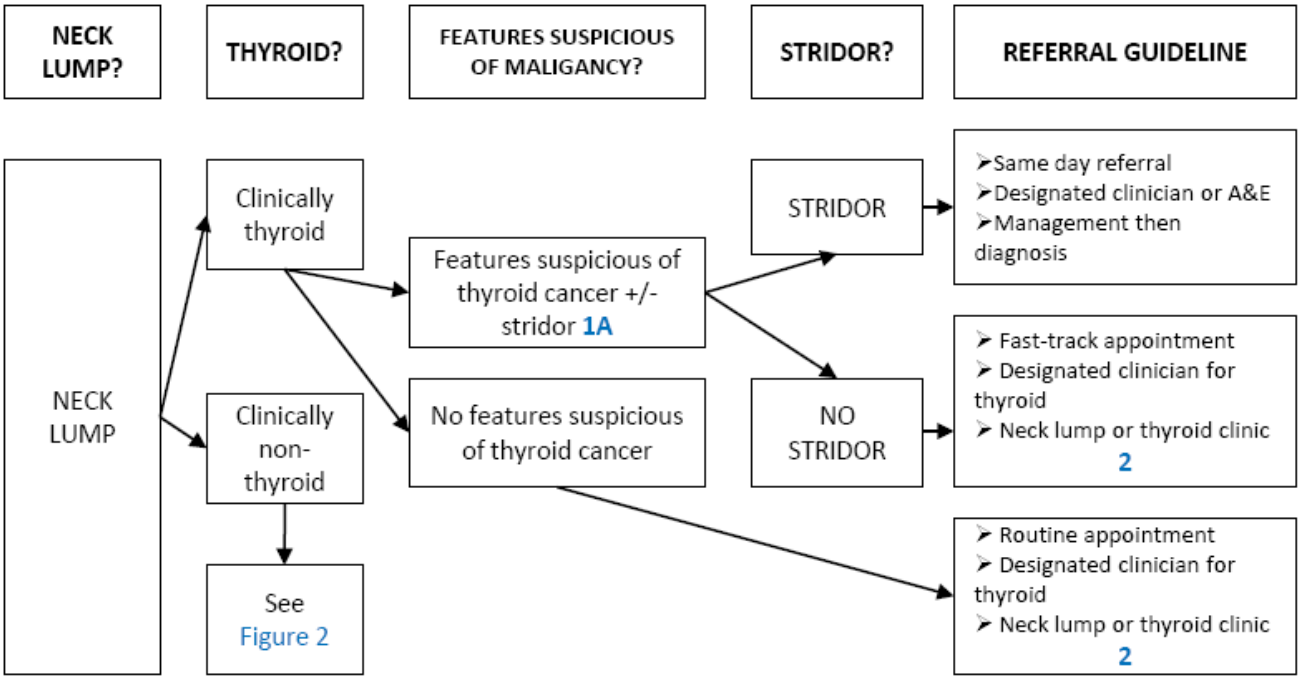
Designated Hospital	Local Support Team?	Neck Lump Clinic?	Specialist Thyroid Clinic?	Named Consultants	Roles	Referring PCTs
Birmingham Dental Hospital*	No	No	No	Dr John Hamburger Dr Andrea Richards	Consultant in Oral Medicine Consultant in Oral Medicine	All Dental Practitioners
City Hospital	Yes	Yes	Yes	Ms Janet O'Connell Mr Jason Rockey	Consultant Head & Neck Surgeon Consultant Head & Neck Surgeon	Heart of Birmingham
Good Hope Hospital	Yes	Yes	No	Mr Ijaz Ahmad Mr Huw Griffiths	Consultant Head & Neck Surgeon Consultant Head & Neck Surgeon	South Staffs (BLT)
Heartlands Hospital	Yes	Yes	Yes	Mr J Campbell Mr Huw Griffiths Mr Hisham Mehanna Mr D Morgan	Consultant Head & Neck Surgeon (thyroid) Consultant Head & Neck Surgeon Consultant Head & Neck Surgeon Consultant Head & Neck Surgeon (skull base)	Birmingham East & North Solihull
Queen Elizabeth Hospital (UHB)	Yes	Yes	Yes	Mr Andrew Brown Mr Chris Jennings Mr Tim Martin Mr Sat Parmar Mr Paul Pracy Mr John Watkinson	Consultant Head & Neck Surgeon Consultant Head & Neck Surgeon Consultant Head & Neck Surgeon Consultant Head & Neck Surgeon Consultant Head & Neck Surgeon Consultant Head & Neck Surgeon (thyroid)	South Birmingham
Sandwell Hospital	Yes	Yes	Yes	Ms Janet O'Connell Mr Jason Rockey	Consultant Head & Neck Surgeon Consultant Head & Neck Surgeon	Sandwell
Solihull Hospital	Yes	Yes	No	Mr Ijaz Ahmad Mr Huw Griffiths	Consultant Head & Neck Surgeon Consultant Head & Neck Surgeon	Solihull
Walsall Hospital	Yes	Yes	Yes	Mr Ijaz Ahmed Mr Huw Griffiths Mr Sat Minhas (ext. member)	Consultant Head & Neck Surgeon Consultant Head & Neck Surgeon Consultant Head & Neck Surgeon	Walsall

*The Birmingham Dental Hospital receives referrals from General Dental Practitioners only and all cases of cancer are referred to the MDT at UHB. The Dental Hospital has direct booking to clinic appointments at UHBFT

Appendix 3 - referral schemas

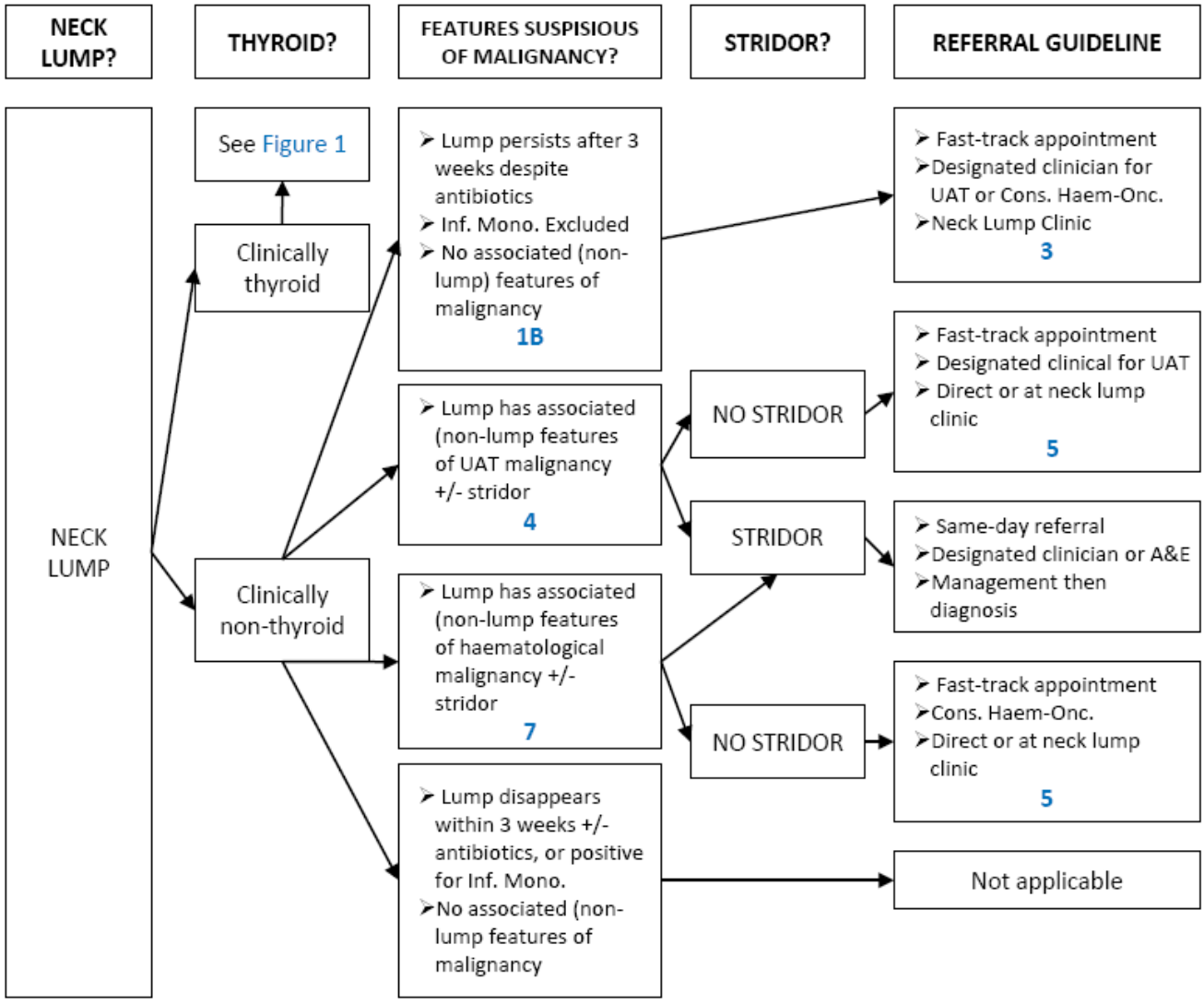
Reference: Manual for Cancer Services – Head and Neck Measures (version 2.0)

FIGURE 1: SCHEMA (Numbers refer to numbered footnotes below)



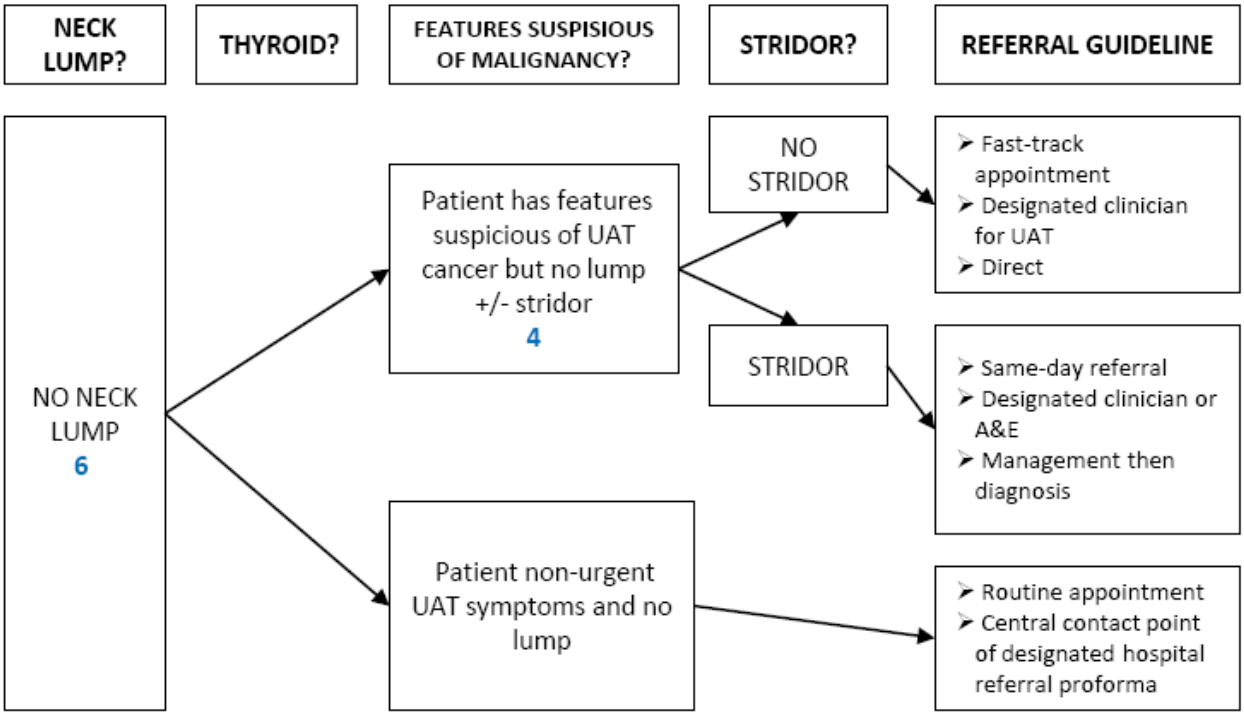
Please see appendix 2 for details on the location of head and neck and thryoid clinicans within the Pan Birmingham Cancer Network

FIGURE 2: SCHEMA (Numbers Refer to Numbered Footnotes)



Please see appendix 2 for details on the location of head and neck and thryoid clinicans within the Pan Birmingham Cancer Network

FIGURE 3: SCHEMA (Numbers refer to numbered footnotes)



Please see appendix 2 for details on the location of head and neck and thyroid clinicans within the Pan Birmingham Cancer Network

Notes to numbered points on Figures 1-3

1A

Features suspicious of cancer associated with a thyroid lump (reference: guidelines for the management of thyroid cancer in adults, 2002, British Thyroid Association and Royal College of Physicians):

- Solitary nodules increasing in size;
- Patient has history of neck irradiation or family history of thyroid cancer;
- Patient over 65;
- Unexplained hoarseness or voice change associated with a goitre;
- Associated cervical lymphadenopathy.

1B

Features suspicious of cancer associated with the non-thyroid neck lump itself (reference: Department of Health Referral Guidelines for the Diagnosis of Cancer, reviewed 2005):

- Persists for three weeks despite antibiotics;
- Infectious Mononucleosis excluded.

2

Depending on network-agreed local arrangements, designated clinicians for UAT assessment may also be designated for thyroid assessment and the services may be provided in one common, neck lump clinic; or endocrinologists/endocrine surgeons may be designated for assessment of thyroid cancer only and work in a specific thyroid clinic.

3

See measure 11-1D-112 regarding the requirements for common working between designated clinicians for UAT cancer assessment and consultant haemato-oncologists.

4

Features suspicious of UAT cancer which are not features of the lump itself (reference: Department of Health Referral Guidelines for the Diagnosis of Cancer, revised 2005):

- Hoarseness for more than six weeks;
- Oral mucosal ulcer persisting for more than three weeks;
- Oral swelling persisting for more than three weeks;
- Red or red and white patches of the oral mucosa;
- Dysphagia for more than three weeks;
- Unilateral nasal obstruction, especially with purulent discharge;
- Unexplained tooth mobility, not associated with periodontal disease;
- Cranial neuropathies;
- Orbital masses.

5 Referral to a neck lump clinic or direct to a designated clinician is at the discretion of the referrer depending on the nature of the presenting features.

6

- In the absence of a thyroid lump, there are unlikely to be any other head and neck features which would discriminate towards thyroid cancer compared to UAT cancer. Stridor is dealt with independently.
- Features of haematological malignancy, without neck lumps are not relevant to head and neck specific guidelines.
- The very rare cases of UAT and thyroid cancer presenting only with features due to distant metastases are not covered by these guidelines. They are better dealt with as part of guidelines on the diagnosis and management of a separate entity "carcinoma of unknown origin".

7 Features suspicious of haematological malignancy (reference: Department of Health Referral Guidelines for Suspected Cancer).