Pan-Birmingham NHS
Cancer Network

Coversheet for Network Site Specific Group Agreed Documentation

Document Title	Clinical Management Protocol – Lymphoreticular Malignancies
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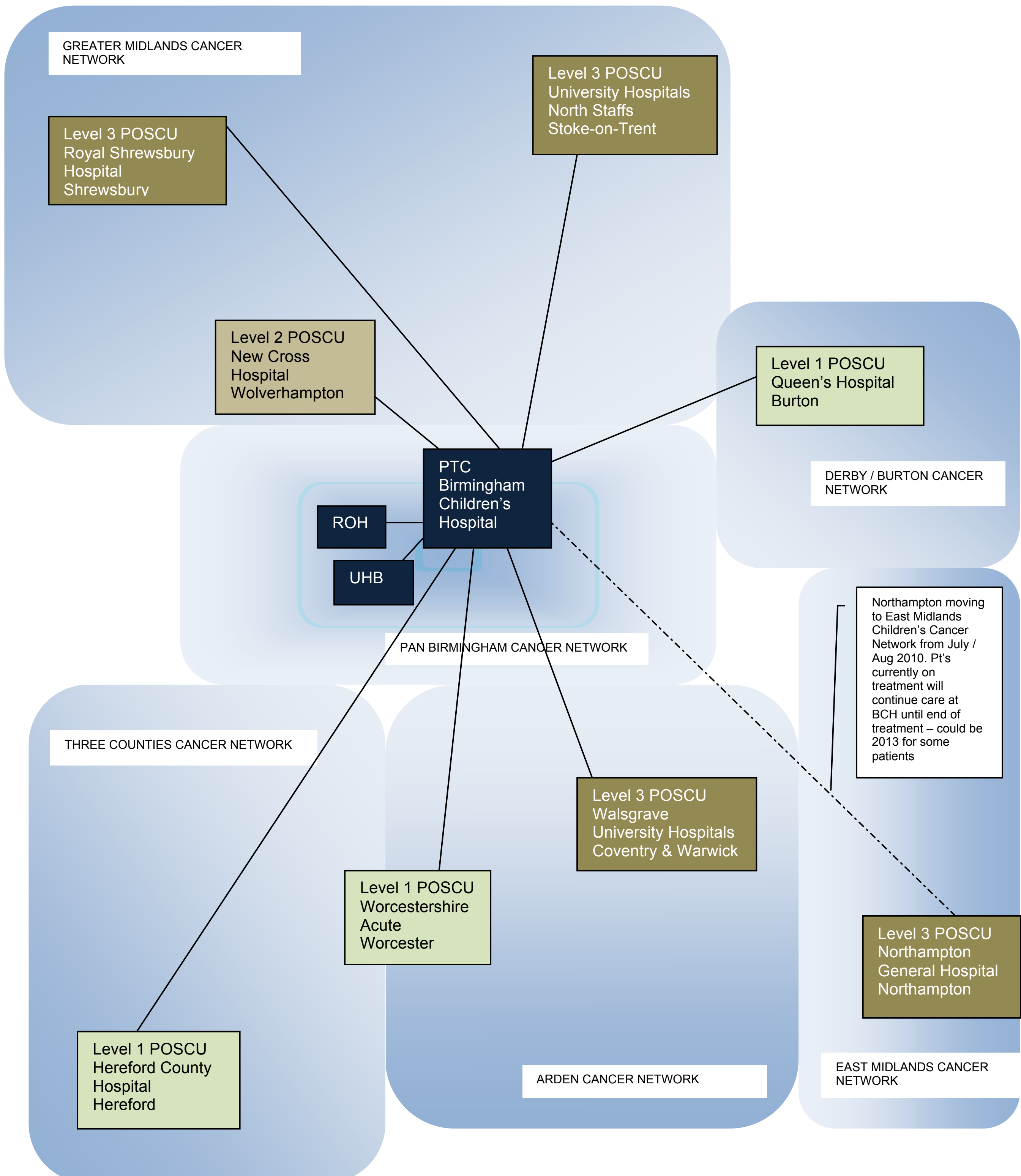
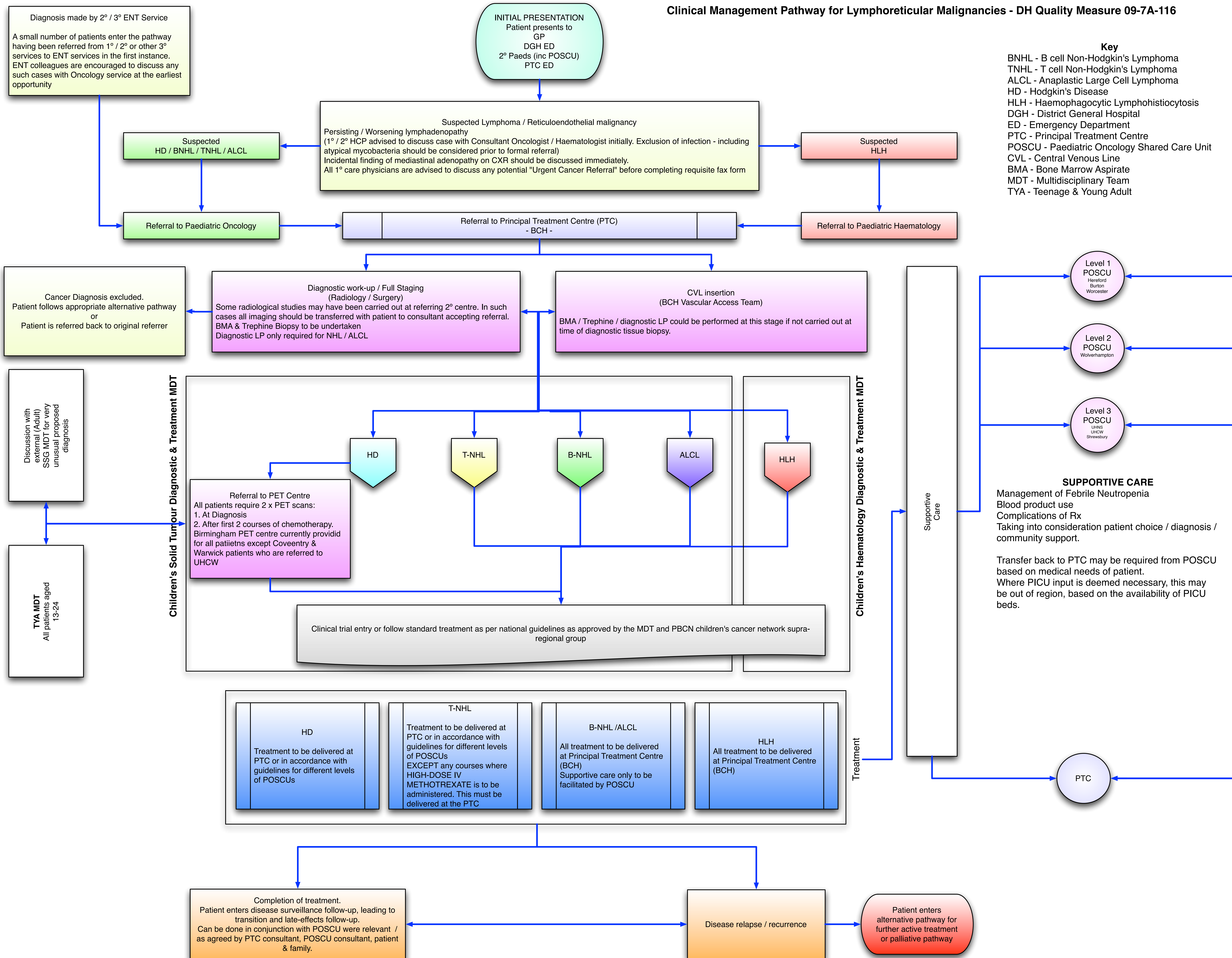
References	1. DH National Cancer Actions Team (2008) National Cancer Peer Review Program Manual for Cancer Services 2008: Children's Cancer Measures 2. National Institute for Health & Clinical Excellence (2005) Referral guidelines for suspected cancer: Section – Cancer in Children & Young People
Consultation Process	Consultation was by the West Midlands Children's' Cancer Network Co-ordinating Group
Review Date	July 2013
Chair of Children's Cancer Network	Gail Fortes-Mayer
Date Agreed by Chair of Children's Cancer Network	05 August 2010

May 2010 version [6]

- Levels of shared care – Specified on pages 28 to 29 National Cancer Action Team Manual for Cancer Services 2008: Children's cancer Measures 2009
- University Hospitals Birmingham UHB - Radiotherapy and Young Adult Services





Clinical Management Pathway for Lymphoreticular Malignancies - DH Quality Measure 09-7A-116
Key
BNHL - B cell Non-Hodgkin's Lymphoma
TNHL - T cell Non-Hodgkin's Lymphoma
ALCL - Anaplastic Large Cell Lymphoma
HD - Hodgkin's Disease
HLH - Haemophagocytic Lymphohistiocytosis
DGH - District General Hospital
ED - Emergency Department
PTC - Principal Treatment Centre
POSCU - Paediatric Oncology Shared Care Unit
CVL - Central Venous Line
BMA - Bone Marrow Aspirate
MDT - Multidisciplinary Team
TYA - Teenage & Young Adult
Diagnosis made by 2° / 3° ENT Service
A small number of patients enter the pathway having been referred from 1° / 2° or other 3° services to ENT services in the first instance. ENT colleagues are encouraged to discuss any such cases with Oncology service at the earliest opportunity
INITIAL PRESENTATION
Patient presents to
GP
DGH ED
2° Paeds (inc POSCU)
PTC ED
Suspected Lymphoma / Reticuloendothelial malignancy
Persisting / Worsening lymphadenopathy
(1° / 2° HCP advised to discuss case with Consultant Oncologist / Haematologist initially. Exclusion of infection - including atypical mycobacteria should be considered prior to formal referral)
Incidental finding of mediastinal adenopathy on CXR should be discussed immediately.
All 1° care physicians are advised to discuss any potential "Urgent Cancer Referral" before completing requisite fax form
Suspected HD / BNHL / TNHL / ALCL
Suspected HLH
Referral to Paediatric Oncology
Referral to Principal Treatment Centre (PTC) - BCH -
Referral to Paediatric Haematology
Cancer Diagnosis excluded.
Patient follows appropriate alternative pathway
or
Patient is referred back to original referrer
Diagnostic work-up / Full Staging
(Radiology / Surgery)
Some radiological studies may have been carried out at referring 2° centre. In such cases all imaging should be transferred with patient to consultant accepting referral.
BMA & Trephine Biopsy to be undertaken
Diagnostic LP only required for NHL / ALCL
CVL insertion
(BCH Vascular Access Team)
BMA / Trephine / diagnostic LP could be performed at this stage if not carried out at time of diagnostic tissue biopsy.
Level 1 POSCU
Hereford
Burton
Worcester
Level 2 POSCU
Wolverhampton
Level 3 POSCU
UHNS
UHCW
Shrewsbury
Discussion with external (Adult) SSG MDT for very unusual proposed diagnosis
TYA MDT
All patients aged 13-24
Children's Solid Tumour Diagnostic & Treatment MDT
Children's Haematology Diagnostic & Treatment MDT
HD
T-NHL
B-NHL
ALCL
HLH
Referral to PET Centre
All patients require 2 x PET scans:
1. At Diagnosis
2. After first 2 courses of chemotherapy.
Birmingham PET centre currently providid for all patiietns except Coveentry & Warwick patients who are referred to UHCW
Clinical trial entry or follow standard treatment as per national guidelines as approved by the MDT and PBCN children's cancer network supra-regional group
Supportive Care
SUPPORTIVE CARE
Management of Febrile Neutropenia
Blood product use
Complications of Rx
Taking into consideration patient choice / diagnosis / community support.
Transfer back to PTC may be required from POSCU based on medical needs of patient.
Where PICU input is deemed necessary, this may be out of region, based on the availability of PICU beds.
HD
Treatment to be delivered at PTC or in accordance with guidelines for different levels of POSCUs
T-NHL
Treatment to be delivered at PTC or in accordance with guidelines for different levels of POSCUs
EXCEPT any courses where HIGH-DOSE IV METHOTREXATE is to be administered. This must be delivered at the PTC
B-NHL /ALCL
All treatment to be delivered at Principal Treatment Centre (BCH)
Supportive care only to be facilitated by POSCU
HLH
All treatment to be delivered at Principal Treatment Centre (BCH)
Treatment
PTC
Completion of treatment.
Patient enters disease surveillance follow-up, leading to transition and late-effects follow-up.
Can be done in conjunction with POSCU were relevant / as agreed by PTC consultant, POSCU consultant, patient & family.
Disease relapse / recurrence
Patient enters alternative pathway for further active treatment or palliative pathway