

Treatment Pathways for Patients (age 16 and over) with a Brain Tumour

Version History

Version	Date	Summary of Change/Process
0.1	14.09.12	Produced by Dorinda Palmer (Clinical Nurse Specialist), Hugh Brydon (Consultant Neuro Surgeon)
0.2	19.09.12	Circulated to West Midlands Neuro Oncology Supra Network Group for comment and changes made
0.3	21.09.12	Circulated to Howard Brydon for final review
1.0	05.10.12	Final version circulated to 3 Counties, Arden and Greater Midlands Cancer Networks for local adoption

Date Approved by Network Governance	October 2012
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Date for Review	October 2015
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1. Scope of the guideline

This guideline has been produced describe the pathway patients (over the age of 16) should take once diagnosed with a brain tumour.

2. Guideline background

2.1 Neuroscience MDT's are held and all surgery is performed at one of the three Neurosurgical centres in the West Midlands.

These are:

- University Hospital of North Staffordshire (UHNS)
- University Hospitals Birmingham UHB)
- University Hospitals Coventry and Warwick (UHCW)

Radiotherapy is delivered at the patients local cancer centre and all chemotherapy is dispensed from (if tablets) or delivered at (if intravenous) the patients local cancer centre or unit.

2.2 This guideline links to peer review measure 11-1C-107K

Guideline statements

3. All Patients

3.1 All newly diagnosed patients (other than those who have required emergency surgery) should be discussed at the relevant specialist* MDT, where the treatment planning decision should be made.

3.2 All patients who have undergone emergency surgery at diagnosis should be discussed at the following relevant specialist* MDT.

3.3 All patients should be discussed at the relevant specialist* MDT post operatively.

3.4 All patients should be discussed at the relevant specialist* MDT following a diagnosis of first (and sometimes subsequent) recurrence.

3.5 All patients aged 16-18 at diagnosis should be referred the teenage and young adult (TYA) principle treatment centre (at UHB).

3.6 All young adults aged 19-24 should be offered a choice of treatment either via adult or TYA services.

3.7 All young adults aged 19-24 should be referred to the TYA psychosocial MDT. This should be done by their nurse specialist.

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- 3.8 All new primary brain and spinal tumours patients will be listed for discussion at the Network MDT for supervision of the non-surgical aspects of their care. Cases are re-discussed in the neuro-science MDT and Network MDT at key points in their patient journey e.g. at relapse or if symptoms change. They are listed for re-discussion by their treating clinician, keyworker or AHP.

*the specialist MDT will be either neuroscience, base of skull or pituitary

4. Primary brain or spinal tumours

- 4.1 Following discussion at the relevant specialist* MDT, patients may be managed with neuro-surgery, radiotherapy, chemotherapy, best supportive care or active surveillance.
- 4.2 In the majority of cases, the treating clinician is present in the relevant specialist* MDT and prompt arrangements for clinic or ward review are made. In other cases, onward referral to other teams is arranged as detailed below.

Patients will be seen by the:

- a. Neuro-oncology surgeon if surgery is being offered or active surveillance suggested.
- b. Neuro-oncologist if the patient has already undergone surgery and further treatment with radiotherapy and / or chemotherapy is being recommended, or where patients are not felt to be surgical candidates but there are oncological management options e.g. palliative radiotherapy.
- c. Local Palliative Care Specialist Team if patient is not well enough to come to clinic or is not a candidate for active treatment. It is recommended that best supportive care is delivered via the local teams. Referral to local Palliative Care Team is made by telephone by one of the MDT clinical nurse specialists or a member of the hospital palliative care team who was present at the MDT discussion. The neuro-oncology team remain available for ongoing telephone advice.
- d. Lymphoma MDT – if diagnosis of primary CNS lymphoma has been histologically confirmed, patients will be referred for discussion at the Lymphoma MDT at their local cancer centre. Patients who are potentially suitable for intensive chemotherapy or clinical trial entry should be seen in the Lymphoma new patient clinic. Patients not well enough for chemotherapy should be seen in the neuro-oncology clinic by the neuro-oncology team to discuss radiotherapy or palliative care.

5. Cerebral metastases

- 5.1 There are 3 subgroups of brain metastases patients for whom referral to the neuroscience MDT is appropriate.

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- 5.1.1 Good prognosis patients who may benefit from surgical resection or stereotactic radiosurgery. This group is defined as patients with:
- A solitary metastases, or less than 4 cerebral metastases all measuring < 4cm
 - With good performance status (KP > 70 i.e. independent and self-caring
 - AND who have systemically controlled disease
- 5.1.2 Patients with hydrocephalus or critically raised intracranial pressure, particularly from an obstructing cerebellar tumour
- 5.1.3 Patients with cancer of unknown primary site with no disease elsewhere in the body where neuro-surgical biopsy should be considered to obtain a histological diagnosis.
- 5.2 All patients with brain metastases are managed in close collaboration with their treating site-specialised oncologists.
- 5.3 Patients requiring stereotactic radiosurgery are referred to the National Gamma Knife Centre at Sheffield.

6. Base of skull tumour patients

- 6.1 Following discussion at MDT skull base patients should be seen in an out-patient clinic by a core member of the skull base MDT team to discuss their treatment options. These include active surveillance, surgery or radiotherapy.
- 6.2 All treatment and follow-up should be supervised by an MDT core member.
- 6.3 Patients with supportive care or rehabilitation needs should be referred on to the Cancer Network MDT, with liaison via their key worker.

7. Pituitary tumour patients

- 7.1 Patients with pituitary tumours should be seen in a specialist clinic by an endocrinologist or surgeon associated with the pituitary MDT to discuss their treatment options. These include medical or surgical management, or active surveillance.
- 7.2 If radiotherapy is being recommended, they should be referred on to a clinical oncologist associated with the pituitary MDT.
- 7.3 Patients should be referred on to the Cancer Network MDT as required, at the discretion of treating clinicians and clinical nurse specialists.

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8. Staging

- 8.1 Cancer Registries have been set a national target to record an overall TNM stage for 70% of all invasive cancers (excluding non melanoma skin cancer) by December 2012.

This 'registry' stage is produced using data supplied from the trusts in the form of MDT data, imaging data and pathological data. In the mandated Cancer Registration Dataset the three staging components (clinical [pre-treatment], pathological and integrated TNM stage) are present, as they are in the Cancer Outcomes and Services Dataset that becomes mandatory in January 2013.

8.2 All Trusts

- a. The Trust should send electronic extracts from their histopathology system regularly to the WMCIU.
- b. The Trust should send imaging extracts for cancer patients electronically to the WMCIU regularly, unless they have established remote access for the WMCIU to their radiology information system

- 8.3 For cancers diagnosed clinically or those that have not had surgery clinical TNM stage should be recorded on the MDT database

- 8.4 For those with invasive cancer who have had surgery MDTs should record the full cancer registry dataset onto their MDT database at the time of discussion at the MDT meeting and send extracts to the WMCIU on a regular basis

9. Performance status

All patients should have their performance status recorded onto the MDT database at the MDT. This should be done using the WHO classification which will ensure it is in line with the cancer outcomes and services dataset guidance

10. Patient information and counselling

- 10.1 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 Brain/CNS team at all times.
- 10.2 Access to psychological support should be available if required. All patients should undergo a holistic needs assessment and onward referral as required.

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11. Palliative care

Palliative care services will be made available to all patients as deemed appropriate by the MDT.

12. Clinical trials

- 12.1 Wherever possible, patients who are eligible should be offered the opportunity to participate in National Institute for Health Research portfolio clinical trials and other well designed studies.
- 12.2 Where a study is only open at one Trust in the Network, patients should be referred for trial entry. A list of studies available at each Trust is available from the local cancer research network office
- 12.3 Patients who have been recruited into a clinical trial will be followed up as defined in the protocol.

Monitoring of the Guideline

Adherence to the Network guidelines may from time to time be formally monitored.

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