Optimal care pathway for people with cancer of unknown primary

Quick reference guide

Please note that not all people will follow every step of the pathway:

Support: Assess supportive care needs at every step of the pathway and refer to appropriate health professionals or organisations.

Specific cancer of unknown primary (CUP) subsets have been identified based on histopathological and clinical manifestations. Patients in the specific CUP subset have a favourable prognosis and pattern of disease similar to known cancer types, while the remaining patients are considered within the non-specific subset of CUP.

Step 1

Prevention and early detection

Risk factors: As the primary cancer site is not known for people with CUP, it is difficult to identify risk factors. General cancer risk factors include increasing age, male gender, family history, smoking, alcohol, excess body fat, inadequate physical activity, lower socioeconomic status, Aboriginal and Torres Strait Islander people and infrequent GP consultations.

Prevention: The causes of CUP are not fully understood, and there is currently no clear prevention strategy.

Step 2

Presentation, initial investigations and referral

Early recognition of CUP is important so that specialist assessment and management is not delayed and futile investigations are avoided.

Signs and symptoms: Patients often present to their general or primary medical practitioner with heterogeneous, non-specific symptoms and abnormal test results demonstrating very likely metastatic malignancy but without a clear primary site.

General/primary practitioner investigations:

- a thorough medical history and physical examination
- routine blood tests
- a CT of the chest and abdomen/pelvis
- a biopsy
- additional investigations as indicated based on the specific presentation.

Patients with CUP may present with poorly controlled symptoms. Symptomatic care must be provided in parallel with the investigation process.

Referral: Patients with a disease pattern suggesting a specific CUP subset should be referred to a relevant disease-specific oncology team. Patients with non-specific CUP should be referred to an oncologist with adequate experience in managing acute patients with CUP or a general medical oncology service.

The specialist appointment should take place within two weeks of the initial GP referral.

Communication – lead clinician[1]

- GPs play an important role in coordinating care for patients with CUP, including assisting with side effects and offering support.
- Provide the patient with information that clearly describes their referral details.

Step 3

Diagnosis, staging and treatment planning

Diagnosis: After a thorough medical history and examination, diagnostic workup for patients with metastatic disease should include all of the following investigations to confirm a diagnosis of CUP:

- basic blood and biochemical analyses
- contrast-enhanced CT
- adequate tissue sample from one site of disease for histopathology and immunohistochemistry.

Additional investigations should be carried out for identified CUP subsets.

Investigations should be completed within **two** weeks of specialist review.

Staging: There is no definitive staging classification used for patients with CUP; however, disease can be classified as localised or disseminated disease.

Treatment planning: Patients in the specific-CUP subset should be discussed at the multidisciplinary team meetings of the most closely related tumour stream. Patients in the non-specific CUP subset should be referred to a CUP-specific oncology service or the general medical oncology service.

Research and clinical trials: Consider enrolment where available and appropriate.

Communication

The lead clinician should:

- discuss a timeframe for diagnosis and treatment with the patient/carer
- provide appropriate information or refer to support services as required.

1 Lead clinician – the clinician who is responsible for managing patient care.
The lead clinician may change over time depending on the stage of the care pathway and where care is being provided.

Endorsed by
Australian Government
Cancer Australia
Cancer Council

Support: Assess supportive care needs at every step of the pathway and refer to appropriate health professionals or organisations.

Step 4

Treatment:

Establish intent of treatment:

- curative
- anti-cancer therapy to improve quality of life and/or longevity without expectation of cure
- symptom palliation.

Treatment options: Treatment should be individualised according to the clinico-pathological subset and the suspected primary site.

Patients in the specific-CUP subset who have good-prognosis CUP should be treated the same as patients with equivalent known primary tumours with metastatic disease.

For patients with a non-specific subset of CUP, but who have a favourable prognosis, a two-drug chemotherapy regimen should be considered.

CUP patients identified in the poor-prognosis non-specific group can be considered for treatment with low-toxicity, palliative, chemotherapy regimens and/or best supportive care.

Palliative care: Early referral can improve quality of life and, in some cases, survival. Palliative care interventions should be considered for all patients diagnosed with CUP.

Communication

The lead clinician should discuss:

- treatment options with the patient/carer including the intent of treatment and expected outcomes
- advance care planning where appropriate
- the treatment plan with the patient's GP.

For detailed information see <http://www.esmo.org/Guidelines/Cancers-of-Unknown-Primary-Site/Cancers-of-Unknown-Primary-Site>.

Step 5

Care after initial treatment and recovery

Treatment summary (provide a copy to the patient/carer and their GP) outlining:

- diagnostic tests performed and results
- tumour characteristics
- type and date of treatment(s)
- interventions and treatment plans from other health professionals
- supportive care services provided
- contact information for key care providers.

Follow-up care

There is no evidence that follow-up investigations of asymptomatic patients with non-specific CUP affects the outcome. Patients in the specific-CUP subgroup should be followed up as per disease-specific guidelines. Specific examinations should be undertaken as clinically indicated.

Communication

The lead clinician should ensure regular, timely, two-way communication with the patient's GP because GPs play an important role in coordinating care for patients with CUP.

Step 6

Managing recurrent or progressive disease

With the low rates of curable CUP and the majority of patients palliated, it is likely that their current symptoms will worsen progressively, and this should be managed following discussions with palliative care specialists.

The supportive care needs, palliative care referral, increased support within the community and GP involvement of these patients are particularly important and should be reassessed.

Communication

The lead clinician should explain to the patient/carer the treatment intent, likely outcomes and side effects.

Step 7

End-of-life care

Palliative care: Palliative care interventions should be considered for all patients diagnosed with CUP. Ensure that an advance care plan is in place.

Communication – The lead clinician should:

- be open about the prognosis and discuss palliative care options with the patient/carer
- initiate specialist palliative care during the diagnostic stage
- establish transition plans to ensure the patient's needs and goals are addressed in the appropriate environment.