

# Optimal cancer care pathway for people with Hodgkin and diffuse large B-cell lymphomas

## Quick reference guide



Please note that not all patients will follow every step of this pathway:

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

### Step 1

#### Prevention and early detection

**Risk factors:** The causes of lymphoma are not fully understood. All ages and all demographic groups are at risk for Hodgkin and diffuse large B-cell lymphomas (DLBCL). However, they are most common in middle-aged to older adults. There is an additional 'peak' of incidence in Hodgkin lymphoma in adolescents and young adults. Other risk factors include

- intrinsically immunosuppressed patients or those receiving therapeutic immunosuppression
  - Epstein-Barr virus (EBV) infection with immune deficiency
  - family history
  - any past history of a lymphoproliferative disorder
  - obesity (a modest but modifiable risk factor).
- Early detection:** Individuals at risk of immunodeficiency-associated lymphoma should be made aware of this increased risk.

### Step 2

#### Presentation, initial investigations and referral

#### Signs and symptoms:

The following should be investigated:

- a lump or mass
- lymphadenopathy, particularly persistent lymphadenopathy of up to four weeks
  - or associated with systemic symptoms (below)
  - despite treatment for presumed infection
  - pain in the lymph nodes following alcohol consumption
- one or more of these symptoms even without lymphadenopathy: fever, drenching sweats, unexplained weight loss, persistent severe itch
- undiagnosed back or abdominal pain without palpable lymphadenopathy
- unexplained elevation of lactate dehydrogenase (LDH)
- unexplained cytopenias.

**Moderate or severe symptoms require consultation within two days. Persistent or enlarging lumps without other symptoms should be seen within two weeks.**

#### General/primary practitioner investigations:

If there is a high likelihood of a malignant process, prompt referral to a specialist centre to facilitate a tissue diagnosis is appropriate.

For others, further investigations should be completed within four weeks and may include:

- full blood examination
- imaging (ultrasound for peripheral lesions, chest radiography and computed tomography (CT) scan)
- biopsy
- a period of observation of up to six weeks.

**Referral:** All patients with suspected lymphoma should be evaluated and cared for within a lymphoma-specific multidisciplinary team environment. Healthcare providers should provide clear routes of rapid access to specialist evaluation.

#### Communication – lead clinician to:<sup>1</sup>

- explain to the patient/carer who they are being referred to and why
- support the patient and carer while waiting for specialist appointments.

### Step 3

#### Diagnosis, staging and treatment planning

**Diagnosis:** A tissue diagnosis is required prior to initiating definitive treatment. Excisional node biopsy is the preferred approach. Tissue suitable for anatomical pathology, flow cytometry, cytogenetics and gene mutation testing should be obtained.

**Staging:** The disease stage (Ann Arbor system), including evaluation of bone marrow status, should be determined in all patients. This should include fluorodeoxyglucose (FDG) positron emission tomography (PET) scanning.

**Treatment planning:** Ideally, a multidisciplinary team meeting should be conducted before treatment begins.

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

#### Communication – lead clinician to:

- discuss a timeframe for diagnosis and treatment with the patient/carer
- explain the role of the multidisciplinary team in treatment planning and ongoing care
- provide appropriate information or refer to support services as required.

<sup>1</sup> 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.

## 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:

**Systemic chemotherapy and drug therapy:** Systemic chemotherapy is a key component of treatment. A range of biological and targeted therapies are increasingly being used to treat patients with these lymphomas.

### Stem cell transplant:

High-dose chemotherapy and autologous stem cell transplant may benefit:

- fit patients with recurrent lymphomas that respond to salvage treatment
- some patients with responsive Hodgkin lymphoma who have failed to achieve a complete remission.

**In selected patients, allografting may be considered.**

**Radiation therapy** should be considered for suitable patients with localised disease or those

with more advanced disease with a dominant bulky lesion. This is almost always in the context of combined chemotherapy and radiation.

**Palliative care:** Early referral can improve quality of life and in some cases survival. Referral should be based on need, not prognosis.

### Communication – lead clinician to:

- discuss treatment options with the patient/carer including the intent of treatment as well as risks and benefits
- discuss advance care planning with the patient/carer where appropriate
- discuss the treatment plan with the patient's general practitioner.

More information at <http://www.esmo.org/Guidelines-Practice/Clinical-Practice-Guidelines/Haematologic-Malignancies>

## Step 5

### Care after initial treatment and recovery

Cancer survivors should be provided with the following to guide care after initial treatment.

**Treatment summary** (provide a copy to the patient/carer and general practitioner) 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 plan** (provide a copy to the patient/carer and general practitioner) outlining:

- medical follow-up (tests, ongoing surveillance)

- care plans for managing the late effects of treatment
- a process for rapid re-entry to medical services for suspected recurrence.

Potential late effects of therapy that may require specific screening and monitoring will be determined by the primary treatment used.

### Communication – lead clinician to:

- explain the treatment summary and follow-up care plan to the patient/carer
- inform the patient/carer about secondary prevention and healthy living
- discuss the follow-up care plan with the patient's general practitioner.

## Step 6

### Managing recurrent, residual and metastatic disease

**Detection:** Most cases of recurrent Hodgkin lymphoma or DLBCL are identified through routine follow-up or by the patient presenting with symptoms, or by 'non-specific' systemic tests such as serum LDH.

**Treatment:** Where possible, refer the patient to the original multidisciplinary team. Treatment will

depend on the location, extent of recurrent or residual disease, performance status, previous management and patient preferences.

**Palliative care:** Early referral can improve quality of life and in some cases survival. Referral should be based on need, not prognosis.

**Communication – lead clinician to:** explain the treatment intent, likely outcomes and side effects to the patient/carer.

## Step 7

### End-of-life care

**Palliative care:** Consider referral to palliative care if not already involved. Ensure that an advance care plan is in place.

### Communication – lead clinician to:

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

Visit [www.cancerpathways.org.au](http://www.cancerpathways.org.au) for consumer friendly guides. Visit [www.cancer.org.au/OCP](http://www.cancer.org.au/OCP) for the full clinical version and instructions on how to import these guides into your GP software.