Somerset, Wiltshire, Avon and Gloucestershire (SWAG) Cancer Services

Haematological Cancer Clinical Advisory Group

Investigational and Clinical Guidelines

June 2023

Revision due: April 2025

VERSION CONTROL

THIS IS A CONTROLLED DOCUMENT. PLEASE DESTROY ALL PREVIOUS VERSIONS ON RECEIPT OF A NEW VERSION.

Please check the SWAG website for the latest version available here.

VERSION	DATE ISSUED	SUMMARY OF CHANGE	OWNER'S NAME
0.1	May 2015	First draft	SWAG Haematology SSG
1.0	30th June 2015	Finalised	S Otton
1.1	30th August 2016	Revision of lymphoma , and leukaemia pathways	H Dunderdale
1.2	31st October 2016	Addition of link to NICE myeloma guidance	H Dunderdale
1.3	April 2017	Biennial review	SWAG Haematology MDT Leads
1.4	22nd June 2017	Revision of clinical guidelines: addition of links to national guidelines and protocols	D Mannari, H Dunderdale
1.5	30th June 2017	Finalised	H Dunderdale
1.6	30th May 2019	Biennial review and rebranding from Site Specific Group to Clinical Advisory Group	H Dunderdale
1.7	June 2022	Biennial review (delayed due to the COVID-19 pandemic)	H Dunderdale
1.8	June 2023	Removal of signature table in line with removal of sign off by the SWAG Cancer Alliance Lead	H Dunderdale

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Haematology CAG Contents

1. Introduction

The following guidelines pertain to the local management of haematology malignancies for the Somerset, Wiltshire, Avon and Gloucestershire (SWAG) Network Haematological Cancer Clinical Advisory Group (CAG).

The CAG refers to the British Society for Haematology (BSH), Guideline Central(GC), the European Society for Medical Oncology (ESMO), and National Institute for Health and Clinical Excellence Guidelines (NICE).

Primary care clinicians should refer to the NICE guidelines *Suspected Cancer: recognition and management of suspected cancer in children, young people and adults* (2015) for information on the signs and symptoms that are relevant when considering referrals to the Haematology Oncology Services.

The guidelines should be reviewed alongside three other key documents for the CAG: the Constitution, Annual Report and the Work Programme. The Haematology CAG Constitution provides an overview of how the CAG operates, outlining the general working processes, patient referral pathways and the guidelines to which the CAG adheres. The Annual Report reflects the period of activity for the CAG from the previous year. It contains a summary of the activity of the Haematology CAG for this period measured against several key performance indicators that have been outlined in the National Quality Surveillance Programme. The Work Programme summarises the key areas for growth, development and improvement of the CAG over the next financial year (and beyond where

appropriate). All four documents should be reviewed together to give a full overview of the CAG, its performance, and future plans.

The CAG is committed to offering all eligible patients entry into clinical trials where available. A list of open trials is available on the SWAG website here.

2. Haematology CAG agreed Investigational Guidelines (NS/Haem/g-17-102)

The Haematology CAG aspires to host a centralised Specialist Integrated Haematology Malignancy Diagnostic Service (SIHMDS) in Severn Laboratory North Bristol Trust, and work is underway to define how laboratories work based on a network model. This preserves local reporting at treatment centres and centralises specialist testing, all of which are planned to be reported on to the HiLIS software system (awaiting implementation in UHBW).

Diagnostic services are available in North Bristol Trust, Gloucestershire Hospitals, Royal United Hospital Bath, Somerset Trust and University Hospitals Bristol and Weston. The CAG agrees to follow the guidelines as recommended by the Royal College of Pathologists (RCP) and the British Society for Haematology(BSH). Local laboratory investigational algorithms that meet the following required criteria are in place:

- Categorisation of suspected disease and relevant clinical / haematological presenting problems
- Multiple investigational modalities are used to confirm a given patient's diagnosis, so that the results of one modality may be used to corroborate those of another
- Allowable options for choices between investigations, specifying how the investigational pathway may be redirected at any point in the process, depending on results up to that point. Choices of investigation and decisions to redirect the pathway will be allowable at the behest of the investigating laboratory alone, as well as that of the referring clinician

North Bristol Trust refers to the investigational guidelines in Table 1. These can be found on the SWAG website here.

Table 1:

Investigational Guidelines	Trusts
BHODS Diagnostic Pathways for Haematological Malignancies (2013), Version 3.0	North Bristol Trust
LP-SI-HMDS_BM Processing Overview (2014), Edition 1	University Hospitals Bristol NHS Foundation Trust Weston Area Health Trust
MF-SI-HMDS-VALVERWorkflow (2009), Edition 1	University Hospitals Bristol NHS Foundation Trust

Royal United Hospitals Bath NHS Foundation Trust, Taunton and Somerset NHS Foundation Trust, Yeovil NHS Trust and Gloucestershire Hospitals NHS Foundation Trust broadly agree with the above guidelines, but follow local standard operating procedures.

The Laboratories in the Trusts within the network group handle and transport samples in accordance with the Human Tissue Act (2014). Laboratories have CPA accreditation.

The individual Trusts have local agreements with the clinical commissioning groups (CCGS) that relate to the time limits by which reports are to be produced.

3. Haematology CAG Clinical Guidelines (NS/Haem/g-17-101)

The sub-speciality of Haematology is in the very happy position of having a whole range of respected National and International Clinical Guidelines available and used by the international community. The guidelines are frequently updated in view of the rapid advancement in diagnosis and management. In addition, for certain conditions in the UK, National MRC badged trials offer standardised protocols to follow even if patients are not considered for trial, available here. The Network and individual trusts are expected to follow these guidelines.

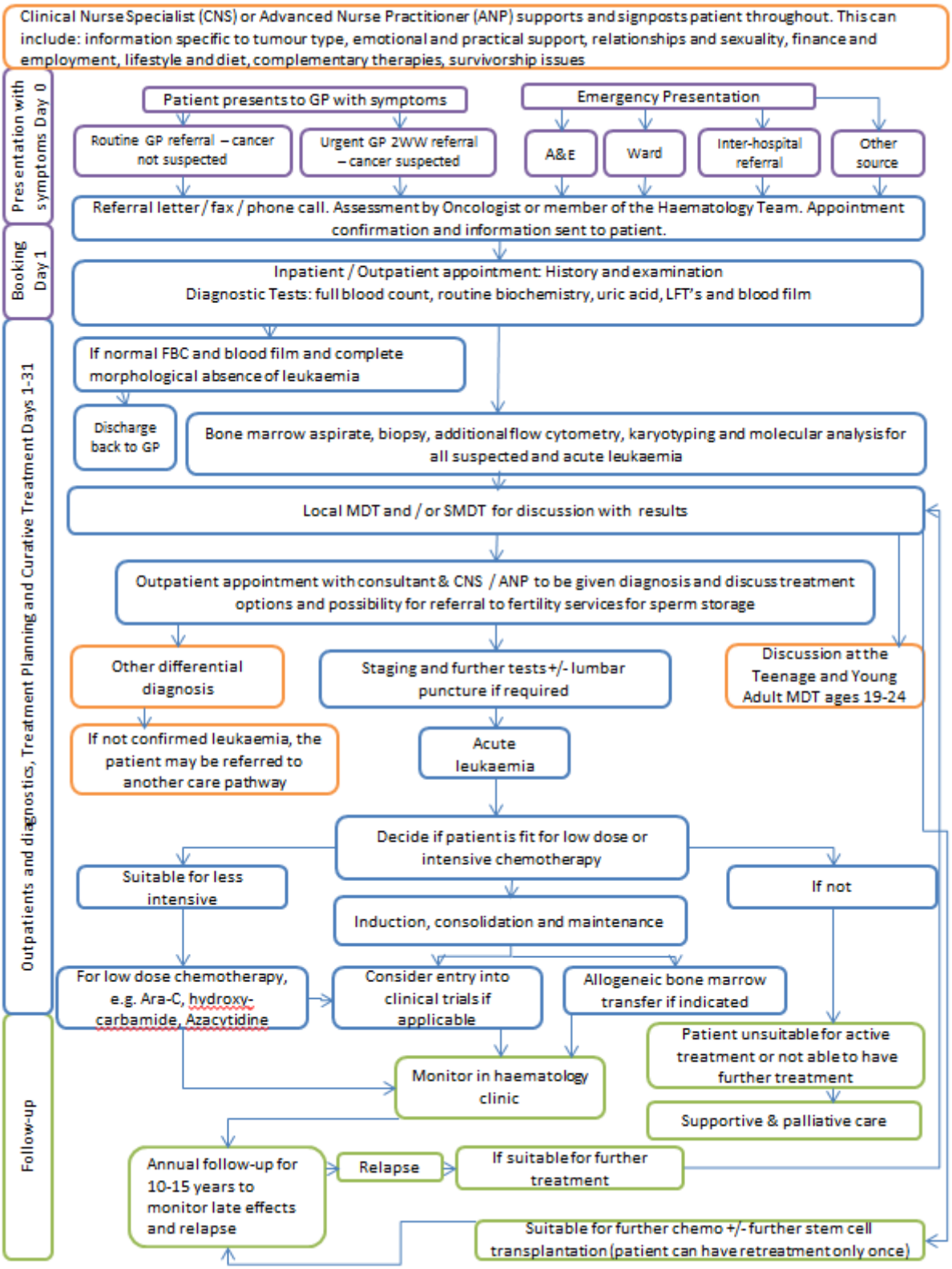
Generic Guidelines	Source	Publication date
Haematological cancers: improving outcomes	**NICE**	**May 2016**
Acute leukaemia and other myeloid disorders	**Source**	**Publication date**
Acute Lymphoblastic Leukaemia Clinical Practice Guidelines UKALL14 & UKALL60+ trials	ESMO	2016
Acute Lymphoblastic Lymphoma: Clinical Practice Guidelines	ESMO	2016
Diagnosis and management of acute myeloid leukaemia in adults AML18 & AML19 & LI-1 trial	BSH	2010
Management of AML in Pregnancy	BSH	2015
Hairy Cell Leukaemia: Clinical Practice Guidelines Diagnosis and Therapy of Hairy Cell Leukaemia	ESMO BSH	2015 2011

Diagnosis and Management of Adult Myelodysplastic Syndromes Iron Chelation Therapy in Myelodysplastic Syndromes (Also refer to the BSH MDS Guidelines)	BSH Advances in Haematology	2013 2010
Upfront Epo-GCSF (EpoG) Combined Therapy in Sideroblastic subtypes of MDS	Blood	2013
Chronic Myeloid Leukaemia: Clinical Practice Guidelines	ESMO	2012
Investigation and Management of Chronic Lymphocytic Leukaemia	BSH	2012
Lymphoid diseases	**Source**	**Publication date**
First Line Management of Classical Hodgkin Lymphoma	BSH	2014
Non-Hodgkin's Lymphoma: diagnosis and management	NICE	2016
Management of Primary Resistant and Relapsed Classical Hodgkin Lymphoma	BSH	2013
Investigation and Management of Nodular Lymphocyte Predominant Hodgkin Lymphoma (LPNHL)	BSH	2015
Investigation and Management of Follicular Lymphoma	BSH	2011
Diffuse Large B-cell Lymphoma (DLBCL)	BSH	2016
Consensus Guidelines – Diffuse Large B-cell Lymphoma, Follicular Lymphoma, Chronic Lymphocytic Lymphoma	ESMO	2013
BSH Guidelines have yet to be published and management of Primary Central Nerve System Lymphoma (PCNSL) is currently controversial. The current standard is for fit patients to be		

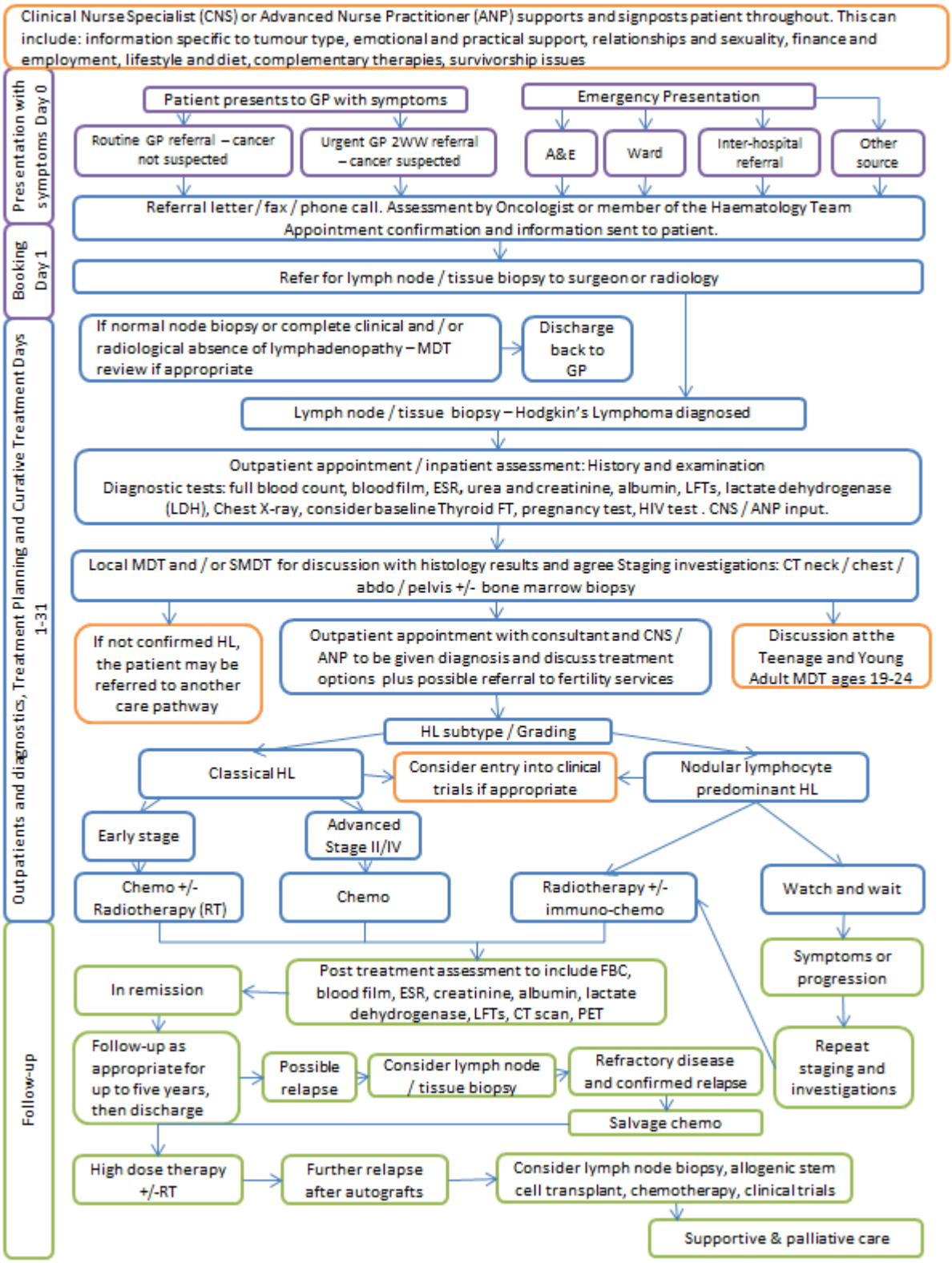
treated with the MATRIX regime, available on the SWCN website here. Primary Central Nervous System Lymphoma (PCNSL)	Belgian Journal of Haematology	2016
Investigation and Management of Mantle Cell Lymphoma	BSH	2012
Waldenstrom's Macroglobulinaemia	BSH	2014
Gastric Marginal Zone Lymphoma of MALT type: Clinical Practice Guidelines	ESMO	2013
Plasma cell malignancies	**Source**	**Publication date**
Multiple Myeloma: Clinical Practice Guidelines http://www.b-s-h.org.uk/guidelines/guidelines/supportive-care-in-multiple-myeloma/ http://www.b-s-h.org.uk/guidelines/guidelines/screening-and-management-of-late-and-long-term-consequences-of-myeloma-and-its-treatment/ http://www.b-s-h.org.uk/guidelines/guidelines/diagnosis-and-investigation-of-al-amyloidosis/ http://www.b-s-h.org.uk/guidelines/guidelines/management-of-al-amyloidosis/ https://www.nice.org.uk/guidance/ng35 Myeloma XII trial	ESMO BSH BSH BSH BSH NICE	2017

4. Pathways

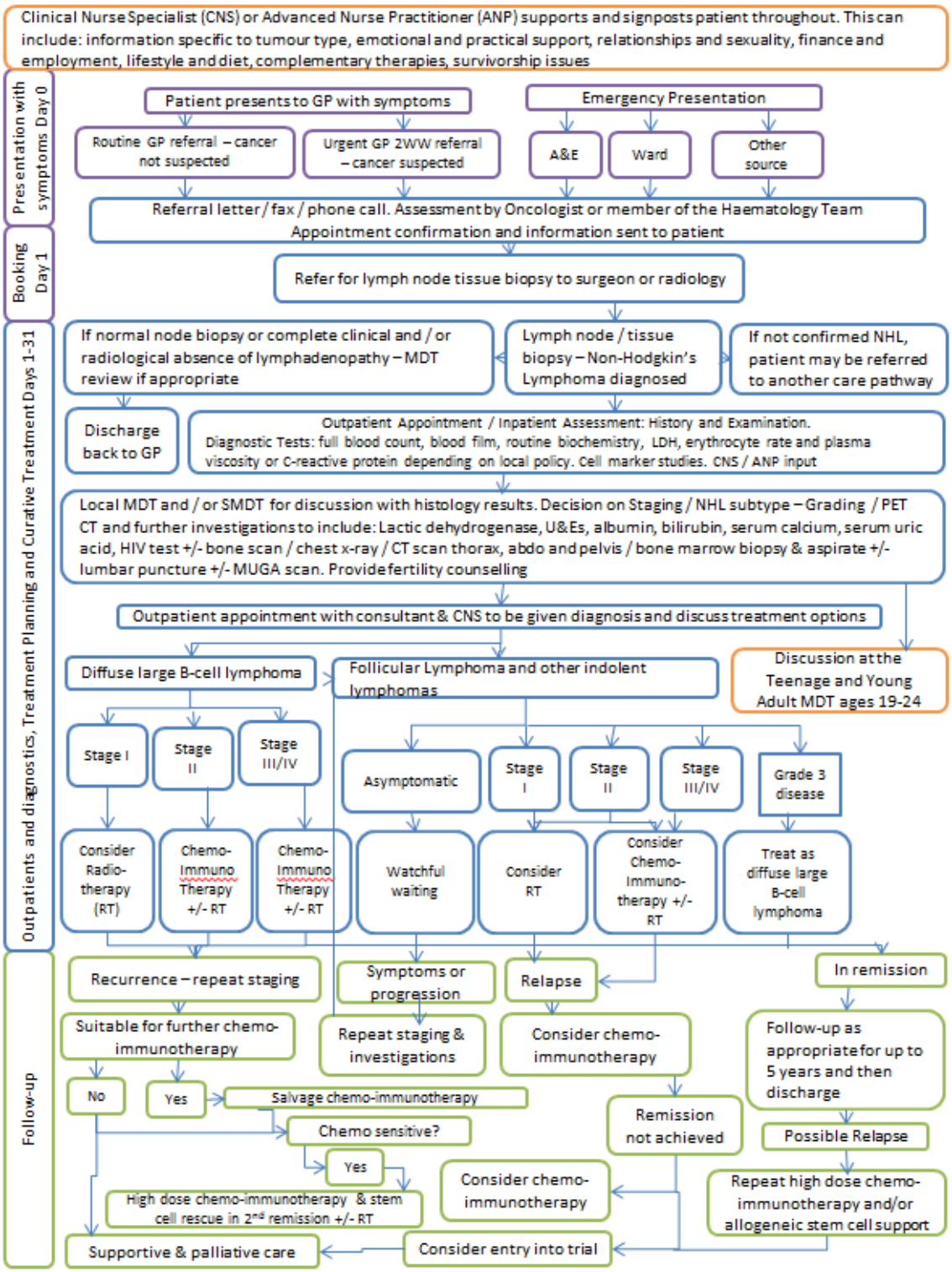
4.1 Best Practice Acute Leukaemia Cancer Care Pathway



4.2 Best Practice Hodgkin Lymphoma Cancer Care Pathway


Clinical Nurse Specialist (CNS) or Advanced Nurse Practitioner (ANP) supports and signposts patient throughout. This can include: information specific to tumour type, emotional and practical support, relationships and sexuality, finance and employment, lifestyle and diet, complementary therapies, survivorship issues
Presentation with symptoms Day 0
Booking Day 1
Outpatients and diagnostics, Treatment Planning and Curative Treatment Days 1-31
Follow-up
Patient presents to GP with symptoms
Emergency Presentation
Routine GP referral – cancer not suspected
Urgent GP 2WW referral – cancer suspected
A&E
Ward
Inter-hospital referral
Other source
Referral letter / fax / phone call. Assessment by Oncologist or member of the Haematology Team Appointment confirmation and information sent to patient.
Refer for lymph node / tissue biopsy to surgeon or radiology
If normal node biopsy or complete clinical and / or radiological absence of lymphadenopathy – MDT review if appropriate
Discharge back to GP
Lymph node / tissue biopsy – Hodgkin's Lymphoma diagnosed
Outpatient appointment / inpatient assessment: History and examination
Diagnostic tests: full blood count, blood film, ESR, urea and creatinine, albumin, LFTs, lactate dehydrogenase (LDH), Chest X-ray, consider baseline Thyroid FT, pregnancy test, HIV test . CNS / ANP input.
Local MDT and / or SMDT for discussion with histology results and agree Staging investigations: CT neck / chest / abdo / pelvis +/- bone marrow biopsy
If not confirmed HL, the patient may be referred to another care pathway
Outpatient appointment with consultant and CNS / ANP to be given diagnosis and discuss treatment options plus possible referral to fertility services
Discussion at the Teenage and Young Adult MDT ages 19-24
HL subtype / Grading
Classical HL
Consider entry into clinical trials if appropriate
Nodular lymphocyte predominant HL
Early stage
Advanced Stage II/IV
Chemo +/- Radiotherapy (RT)
Chemo
Radiotherapy +/- immuno-chemo
Watch and wait
Symptoms or progression
Repeat staging and investigations
In remission
Post treatment assessment to include FBC, blood film, ESR, creatinine, albumin, lactate dehydrogenase, LFTs, CT scan, PET
Follow-up as appropriate for up to five years, then discharge
Possible relapse
Consider lymph node / tissue biopsy
Refractory disease and confirmed relapse
Salvage chemo
High dose therapy +/-RT
Further relapse after autografts
Consider lymph node biopsy, allogenic stem cell transplant, chemotherapy, clinical trials
Supportive & palliative care

4.3 Best Practice Follicular lymphoma and other indolent lymphomas & diffuse large B-cell lymphoma cancer care pathway



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