Haematology Cancer Clinical Guidelines

Haematology Expert Advisory Group (EAG)
on behalf of Northern Cancer Alliance

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Authors:	Haematology EAG
Circulation List:	
Contact Details:	Mrs C McNeill, Senior Administrator, Cancer Alliance
Telephone:	01138252976

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Endorsed by e-mail to group on 5 December 2018, with formal endorsement at the next meeting.

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CONTENTS

SECTION 1 NEHODS- Northern England Haemato- Diagnostic Service

SECTION 2 Guidelines for Cytogenetic analysis in Haematological Malignancies

SECTION 3 North of England Cancer Network Guidelines and Indications for PETCT

SECTION 4 Guidelines for management of Acute Myeloid Leukaemia (AML)

SECTION 5 Guidelines for Management of Myelodysplastic Syndromes

SECTION 6 Guidelines for Management of Acute Lymphoblastic Leukaemia

SECTION 7 Guidelines for the Management of Chronic Myeloid Leukaemia

SECTION 8
Guidelines for Management of Myeloproliferative Disorders
Polycythaemia Vera (PRV)
Myelofibrosis (MF)

SECTION 9
Guidelines for Management of Chronic Lymphocytic Leukaemia (CLL) and Lymphoproliferative Disorders
Hairy Cell Leukaemia
T-Prolymphocytic Leukaemia
Waldenstrom Macroglobulinaemia

SECTION 10
Guidelines for the Management of Low-grade Non-Hodgkin Lymphoma
Mantle Cell Lymphoma

SECTION 11 Guidelines for the Management of High Grade B Cell Non-Hodgkin Lymphoma (NHL)

SECTION 12 Guidelines for the Management of Classical Hodgkin Lymphoma

SECTION 13 Guidelines for the Management of Mature T-Cell and NK-Cell Neoplasms

SECTION 14 Guidelines for Management of Plasma Cell Myeloma

SECTION 15 Indications for Haemopoietic Stem Cell Transplantation

SECTION 16 Clinical Guideline for the prophylaxis and treatment of tumour lysis syndrome in patients receiving treatment for haematological malignancies

SECTION 17 Blood Transfusion Guidelines

SECTION Appendix
Appendix 1 – Teenage and Young Adult Pathway for initial Management
Appendix 2 – Pathway for follow up on completion of First line treatment
Appendix 3- TYA Designated Hospitals
Appendix 4 – NHS Specialised Services Pathway
Appendix 5 – Local Referral Pathways and Levels of Care
Appendix 6 - Pathways
Appendix 7 – Inter-provider transfers

- Multiple Myeloma
- Non-Hodgkin Lymphoma
- Hodgkin Lymphoma

SECTION 3

NORTH OF ENGLAND CANCER NETWORK GUIDELINES AND INDICATIONS for PETCT

Author:
The principal author of these guidelines is Dr George Petrides with contribution and support from the Network Radiology and Haematology Clinicians and Managers.

Referrals:
Referral for PET CT has to be within the guidelines listed below. If requests are not within the guidelines they must be discussed with an ARSAC holder. ARSAC holders for Newcastle PET-CT scanner are Dr George Petrides and Dr Tamir Ali. ARSAC holders for James Cook PET-CT scanner are Dr Mohamed Shawgi and Dr Ian Minty. The ARSAC holder for Carlisle PET-CT scanner is Jon Berry.

The PET CT request form can be obtained from your local hospital Radiology dept. For Newcastle upon Tyne referrals, requests must be sent to the PET CT secretary at PET-CT.Referrals@nuth.nhs.uk. For all other hospitals, requests should be sent to the local ARSAC holder or delegate, for legal authorisation. These can be identified by contacting your radiology department or one of the ARSAC holders. Radiology will then send the referral on to Alliance.

The Agreement with Alliance is that a patient will be offered an appointment within 5 working days following receipt of a correctly filled in request form. This may be at James Cook, Freeman or Carlisle Hospitals. The report and images should be back on the referring hospitals RIS/PACS 48-72 hours following the day of the scan.

Delays may be due to patient choice or the submission of inadequately completed referral forms (either the clinical or demographic aspects).

NECN PET CT Guidelines:
Below are the current guidelines. The test is funded for patients who fall into the categories below. These are agreed as a basis for referral by The North of England Cancer Network and the ARSAC holder

Please be aware PET CT is to a certain extent non-specific and will often turn up other abnormalities not necessarily related to the malignant process which may need investigating.

Timing of scans:
Both Radiotherapy and Chemotherapy can influence the PET CT result. Therefore the treatment dates of these are important to the reporter. Generally we would like to wait at least 3 months between the end of radiotherapy and end of treatment scanning and 6 weeks following chemotherapy for end of treatment scanning (minimum of 3 weeks). If radiotherapy is planned for bulk disease at the start of treatment, a PET-CT scan can be performed 3 weeks after the end of chemotherapy to ensure any FDG avid disease remaining can be included in the radiotherapy field.

If this 3 week scan is negative, a PET-CT scan at the end of radiotherapy treatment is not required.

In the setting of interim response scans where escalation or de-escalation of treatment may occur as part of a predefined pathway, scanning is performed in between chemotherapy cycles and typically performed 9-13 days following the last dose of chemotherapy.

Specific indications:

Lymphoma
a) Staging of Hodgkin's disease (HD) and aggressive Non-Hodgkin lymphoma (NHL) and as a baseline for comparison with treatment response scan.

b) Staging of patients with early stage follicular lymphoma (FL) considered for radiotherapy treatment.

c) Staging of patients with other forms of NHL where results will alter management.

d) Staging of suspected post-transplant lymphoproliferative disorder (PTLD).

e) To determine extent and identify a suitable biopsy site in patients with low grade lymphomas in whom there is suspected high grade transformation.

f) Interim response assessment in patients with HD as part of a treatment pathway. Interim response in NHL is not commonly performed using PET-CT.

g) End of treatment response assessment of Hodgkin's Disease and aggressive NHL.

h) End of treatment response in other subtypes of non-Hodgkin's lymphoma if the results will alter management.

i) Evaluation of suspected relapse for FDG avid lymphoma in symptomatic patients.

j) Assessment of response to second line treatment and subsequent treatments for FDG avid lymphoma.

k) Prior to bone marrow transplant to assess volume of disease and suitability for transplant.

Myeloma
j) Assessment of patients with apparently solitary plasmocytoma or patients with ambiguous lytic lesions on other imaging.

k) Suspected relapse in patients with non-secretory myeloma or predominantly extra-medullary disease.

References

- The Intercollegiate Standing Committee on Nuclear Medicine 2003
- Yorkshire Cancer Network PET CT guidelines September 2007
- Nuclear Medicine Communications, Volume 28, Number 5, May 2007 for lymphoma.
- Evidence-based indications for the use of PET-CT in the United Kingdom 2013. Royal College of Physicians & Royal college of Radiologists.
- Non Hodgkin's Lymphoma: Diagnosis and management. 2016 NICE guidelines.