

The Management of Testicular Cancer

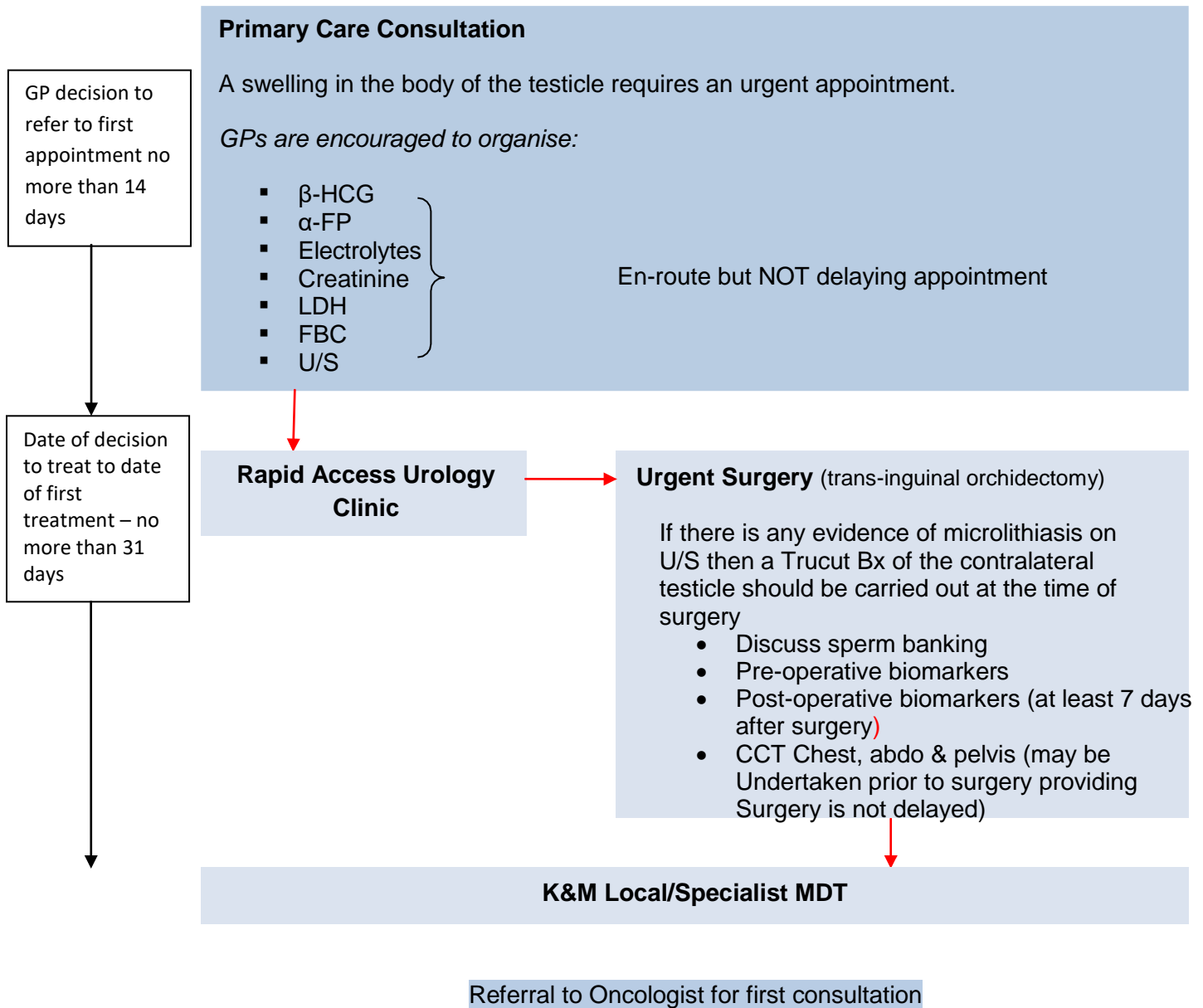
Pathway of Care

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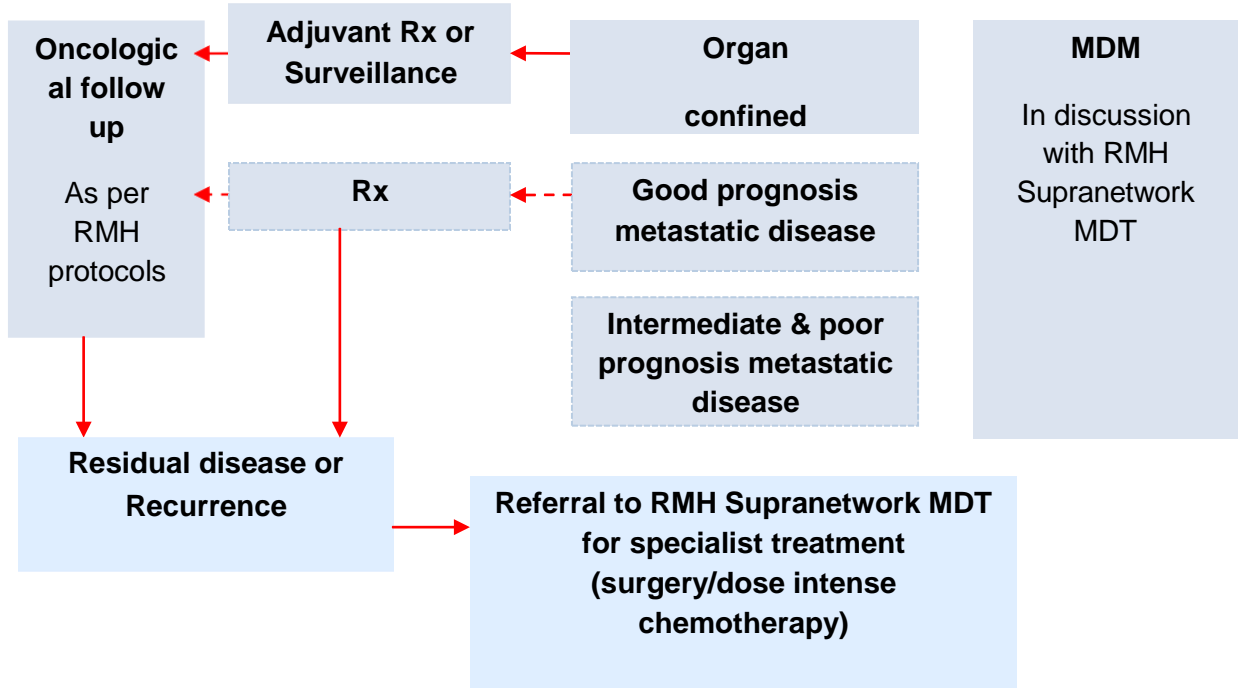
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1.0 Pathway Overview



GP Decision to refer to first treatment no more than 62 days



2.0 Referral Pathway

The Kent & Medway Cancer Collaborative (KMCC) suggested **gold standard** is: Day of surgery: brief alert with demographics and op date e-mailed to oncology. Then Multidisciplinary Meeting (MDM) with review of histology and imaging within 7-10 days and immediate referral to oncology by MDM proforma.

2.1 General Principles

- Patients should be referred according to agreed referral criteria (see below)
- Patients should be assessed in a rapid access clinic, which ideally will be carried out on a one-stop basis
- Patients diagnosed in non-urology clinics should be fast tracked to a urology surgeon if orchidectomy has not been undertaken or a designated oncologist if orchidectomy has been undertaken and the histology confirms the diagnosis
- Patients considered for orchidectomy should be offered sperm banking on an urgent basis
- Regardless to whom the patient initially presents, patients with a diagnosis teratoma should be urgently referred to designated oncologists
- All patients will be discussed with the supranetwork MDT at the Royal Marsden (RMH)
- The following patients will be referred to the Royal Marsden for management:
 - Those with intermediate or poor prognosis metastatic germ cell tumours
 - Those with relapse after initial chemotherapy – this does NOT include patients relapsing on surveillance schedules or after adjuvant treatment with good prognosis disease
 - Those with a second contralateral primary tumour in a solitary testis
 - Those with stromal tumours with metastatic disease or predicted by histological features of high metastatic risk
- Patients who may require emergency treatment (especially patients with rapidly progressive or symptomatic poor prognosis disease should be discussed directly with the supraregional team and should not wait for centre or supraregional MDM
- Whilst patients with testicular cancer will be discussed with RMH, chemotherapy will usually be given locally against RMH/K&M agreed protocols and policies; there may be exceptional circumstances when specialist regimens (very complex clinical trials) may require to be given at the supranetwork centre
- Patients of age between 17 and 24 years old should be referred to the Teenage and Young Adult (TYA) Cancer Service (sarah.trollope@nhs.net) in order to provide specialist, age appropriate care, as well as emotional, psychological, practical and social support.
- In case of concerns regarding infertility or clinical issues related to male hormones a referral to the local endocrinologist with this special interest should be considered. Sperm banking, if not already performed prior to radical orchidectomy, must be considered especially if undergoing chemotherapy.

2.2 Agreed Referral Criteria

Patients with a swelling or mass in the body of the testis should be referred urgently to the local urology MDT.

GPs should be encouraged to organise the following (these should not delay the consultation):

- β -HCG
- α -FP
- Electrolytes
- Creatinine
- LDH
- FBC
- U/S
- CXR

3.0 Local Urology Clinic

If the patient has not undergone the investigations outlined in 2.0 they should be requested in the local clinic.

Other investigations:

- U/S of testis
(If there is evidence of Microlithiasis on U/S a biopsy of the contralateral testicle should be carried out at the time of surgery)
- CT Chest, abdomen & pelvis
(These can be undertaken prior to surgery but should NOT delay it)

Pre-and post-operative biomarkers

4.0 Data Collection

Collection of data at each stage of the pathway is the responsibility of the team looking after the patient at that time. The minimum dataset agreed by the Tumour Site Specific Group (TSSG) will be a combination of those data items that meet national requirements, and additional items as agreed by the TSSG.

National data requirements will include:

- Cancer Waiting Times monitoring, including Going Further on Cancer Waits. The data items required will be as defined in ISB0147 at the time of referral and/or treatment.

Cancer Waiting Times data will be submitted according to the timetable set out in the National Contract for Acute Services.

- The Cancer Outcomes and Services Dataset. The data items will be as defined in ISB1521, and any subsequent versions, at the time of diagnosis and/or treatment. The requirement will include those fields listed in the “Core” section of the dataset, and any additional tumour site specific sections, as applicable.

Details of the COSD are available from:

http://www.ncin.org.uk/collecting_and_using_data/data_collection/cosd.aspx

Cancer Registration and Cancer Outcomes and Services (COSD) data will be submitted according to the timetable set out by the National Cancer Registration Service (NCRS).

- Where applicable, teams will also collect additional data items as defined in any corresponding National Clinical Audit Support Programme (NCASP) audit dataset.

Data for NCASP audits will be submitted, where applicable, according to timetables as agreed by the TSSG, and within the overall submission deadlines for each audit.

Submission of data to meet these national requirements will be the responsibility of each individual Trust.

Note that these standards are subject to variation from time to time, and where these requirements change, the data items required to be collected by the team will also change in line with national requirements.

Local data requirements will include any additional data items as agreed by the TSSG. These must be selected to avoid overlap with any existing data items, and where possible must use standard coding as defined in the NHS Data Dictionary.

Where possible and applicable, InfoFlex will be used for the collection and storage of data.

Additional areas of the Cancer Outcomes and Services Dataset (COSD), relating to pathology, radiotherapy, Systemic Anti-Cancer Therapy (SACT), diagnostic imaging and basic procedure details will feed into the dataset from other nationally mandated sources. It is the responsibility of each team to ensure that the whole of the relevant dataset is collected, and it is acknowledged that this may come from a variety of sources.

5.0 Referrals to Supranetwork team – The Royal Marsden Hospital (RMH)

1. The team making the referral to the Supranetwork MDT is responsible for ensuring that appropriate notes, imaging and pathological slides are sent to the Supranetwork MDT. Local MDTs are expected to have written policies outlining how this works and who the key contacts are set out in their operational policies.
2. The Supranetwork MDT should discuss patients referred from Kent & Medway (K&M) teams at their next meeting following receipt of the referral; the Supranetwork MDT should inform the referring team of when discussions are to take place so that “dial in slot attendance” by K&M team members can be achieved – reasonable notice to referring teams should be given to facilitate this. If timetabling permits, K&M clinicians should strive to attend RMH testicular MDTs on at least 2 occasions during a 12 month period in order to consolidate team working between RMH and K&M.
3. The Supranetwork team is responsible for:
 - a) Returning notes, imaging and pathological slides
 - b) Communicating with the referring MDT (copy to the GP) in a timely manner to outline:
 - MDM decisions
 - Treatment discussions and decisions held with the patient
 - Outcome of surgery
 - Discharge summary
 - c) Communicating with the K&M Specialist MDT
4. The named Supranetwork Team for the population of K&M is the Royal Marsden
5. The named Specialist Team for the population of K&M is Maidstone

6. MDTs in Dartford, East Kent and Medway will liaise with Maidstone and the Royal Marsden on the management of testicular cancers.

6.0 The Management of Testicular Cancer – RMH guidance

Please refer to RMH Guidance which can be found on the London Cancer Alliance Website via the following link and documentation attached:



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idelines_october-201

7.0 Pathology

All K&M reporting pathologists follow The Royal College of Pathologists Histopathology Reporting on Cancers guidelines – a copy of which is available through the KMCC Cancer website:-
<http://kmcc.nhs.uk/tumour-sites/sub-groups-or-cross-cutting-groups/pathology-group/>

8.0 Imaging

KMCC imaging guidelines are located in the KMCC agreed document located on the KMCC website on the following link: <http://kmcc.nhs.uk/tumour-sites/sub-groups-or-cross-cutting-groups/diagnostics-group/>

9.0 Oncology Provision

Please refer to RMH guidance which can be found on the London Cancer Alliance Website via the following link and documentation attached:



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idelines_october-201

10.0 Follow up Protocols

Please refer to RMH guidance which can be found on the London Cancer Alliance Website.

11.0 Supportive & Palliative Care

Patients who have inoperable/recurrent/relapsed testicular cancer should be referred to the specialist supportive & palliative team. The prime aim of the treatment is to alleviate symptoms.

Open and frank discussions with patients should take place with patients at all stages of their journey so that patients are not confused about their prognosis or have unrealistic expectations of any of the forms of treatment offered to them.

Relatives and carers will need to be appropriately supported and given appropriate information. However, in accordance with the recommendations set out in Improving Outcomes Guidance, relatives and carers should not be given information different to that given to the patient.

Palliative care provision should be made for all patients:

- Hospital teams, including the Clinical Nurse Specialists for urology cancer patients
- Primary Health Care Team would provide for palliative care at home
- General Practitioner should be informed within 24 hours of the diagnosis, treatment plan and medication

The management of symptoms, psychological, social and spiritual issues, and the communication of the diagnosis, and any associated problems, should be within the domain of all health care professionals.

Referral to specialist palliative care services should be considered when these issues have not been resolved and in particular for patients with:

- Complex symptom management issues, which are difficult to manage
- Difficulties in adjusting to the diagnosis or disease progression
- Psychological and family issues – such as communication problems within the family
- Spiritual issues – such as the challenging of belief system/faith/cultural values as a result of the cancer

Consideration of specialist palliative care or support should be given throughout the patient pathway, particularly:

- At the Multidisciplinary Team Meeting
- When no active treatment is considered
- After active treatment
- At relapse
- In the terminal stages

12.0 Clinical Trials

Wherever appropriate patients should be considered for entry into clinical trials. The decision to enter a patient into a clinical trial should be recorded in the notes / MDM records.

The reason NOT to enter a patient into a clinical trial should be recorded in the notes / MDM records.

13.0 Children & Young People

Children and Young People (CYP) with Testicular Cancers will be treated in accordance with principles set out in the CYP IOG.

All children and Young People up to the age of 18 must be referred to the CYP Principle Treatment Centre which for K&M is based at the Royal Marsden.

All Young People between 16 and 24 years of age must be offered a referral to the CYP Treatment Centre.

Referral to a CYP Principle Treatment Centre does not necessarily mean that treatment will be undertaken at that centre; shared care management protocols may allow some treatments to be undertaken locally.

14.0 Personnel and Contact Information

A comprehensive, up to date list of MDM contact details can be found on the KMCC website via the following link: <http://kmcc.nhs.uk/tumour-sites/terms-of-reference/>

15.0 Glossary

Acronyms in common usage throughout KMCC documentation

CNB	Cancer Network Board
CYP	Children & Young People (in relation to the IOG)
DCCAG	Diagnostic Cross Cutting Advisory Group
DOG	Disease Orientated Group (NSSG/TSSG/TWG)
DVH	Darent Valley Hospital
EK	East Kent
EKHUFT	East Kent Hospitals University Foundation Trust
HoP	High Level Operational Policy
IOSC	Improving Outcomes: A Strategy for Cancer
K&C	Kent & Canterbury Hospital, Canterbury, (EKHUFT)
KMCC	Kent & Medway Cancer Collaborative
KMCRN	Kent & Medway Cancer Research Network
LSESN	London & South East Sarcoma Network
MFT	Medway Foundation Trust
MTW	Maidstone & Tunbridge Wells NHS Trust
NOG	Non Surgical Oncology Group <i>(Permanent oncologist sub group of the TSSGs with a specific responsibility for chemo/rad pathways and advice to the TSSG, KMCC and geographical locations on new drugs)</i>
PoC	Pathway of Care <i>(KMCC agreed disease site specific clinical guidelines)</i>
QEQM	Queen Elizabeth the Queen Mother Hospital, Margate (EKHUFT)
QoL	Quality of life
RAT	Research and Trial Group <i>(Permanent sub-group of the TSSGs with a specific responsibility for taking forward the clinical trials agenda)</i>
RMH	Royal Marsden Hospital
RNOH	Royal National Orthopaedic Hospital
QVH	Queen Victoria Foundation Trust Hospital East Grinstead
TSSG	Tumour Site Specific Group
UCLH	University College Hospital London
WHH	William Harvey Hospital, Ashford (EKHUFT)
WK	West Kent

16.0 Document Administration

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