North Thames TYACNCG Initial Management Pathways: Lymphoma

Principal Treatment Centre: University College London Hospital
TYA Designated Trusts:
- North London: Barts Health (BH), Barking Havering Redbridge University Hospitals (BHRUT), Chelsea & Westminster Hospitals (C&W), Imperial College Healthcare (ICH), Royal Free Hospital (RFH)
- Essex: Colchester University Hospitals (CHUFT) Mid Essex Hospital, Southend
- Mount Vernon: Mount Vernon Cancer Centre/Lister Hospital (MVCC)
- Shared Care only: Basildon Hospital, Whittington Health

TYA Team involvement
Transition as below
- Rapid re-entry to diagnostic MDT for relapse

Diagnostics
- FBC
- ESR
- U+E
- LFTs
- LDH
- BMAT
- Lymph node/mediastinal mass biopsy
- CT/PET
- MRI (teenagers)

1. Site specific MDT
2. Agreed Treatment Plan
   + Fertility assessment
3. Treatment plan discussed and agreed at TYA MDT
4. Allocated Key Worker and other TYA AHPs for holistic care
5. COSD reporting (13-24yrs) by TYA MDT

In treatment
- Treatment plan initiated by named haematologist at one of the following centres:
  - PTC: UCLH
    - Dr S Daw (≤19years)
    - Dr K Ardesna (20-24 years)
  - DH: Barts
    - Dr R Auer
  - DH: BHRUT
    - Dr K Saja
  - DH: C&W
    - HIV-related lymphoma only
    - Prof M Bower
  - DH: ICH
    - Dr S Marks
  - DH: Mid Essex
    - Dr V Chowdhury
  - DH: MVCC
    - Dr J Lambert
  - DH: Southend
    - Dr P Cervi

Post treatment
- End of treatment summary by 12 weeks by named haematologist or keyworker
- No further active treatment available refer to palliative care

Follow-up
- PTC TYA haematology clinic or designated hospital adult haematology clinic
- High Risk LTFU according to late effects pathway (Pathway 2)

Abbreviations Key:
- MDT Multi Disciplinary Team
- NWCCIS North West Cancer Intelligence Service
- LTFU Long Term Follow Up
- CNS Clinical Nurse Specialist
- TYA Teenagers and Young Adults

Note: Patients up to and including the age of 18 years should be treated at UCLH. Patients aged 19-24 years should be offered the choice between UCLH or a TYA designated hospital.
### North Thames TYACNCG Initial Management Pathway: Lymphoma

**Contact Information**

These are the trusts that are designated to treat TYA patients with lymphoma in the North Thames region:

<table>
<thead>
<tr>
<th>Trust</th>
<th>Contact Details</th>
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<tbody>
<tr>
<td>PTC: UCLH</td>
<td>Dr Stephen Daw, switchboard 020 3456 7890, <a href="mailto:Stephen.daw@uclh.nhs.uk">Stephen.daw@uclh.nhs.uk</a>, Dr Kirit Ardeshna, <a href="mailto:Kirit.ardeshna@uclh.ac.uk">Kirit.ardeshna@uclh.ac.uk</a></td>
</tr>
<tr>
<td>DH: Barts</td>
<td>Dr Rebecca Auer, switchboard 020 7377 7000, <a href="mailto:Rebecca.Auer@bartshealth.nhs.uk">Rebecca.Auer@bartshealth.nhs.uk</a></td>
</tr>
<tr>
<td>DH: BHRUT</td>
<td>Dr Khalid Saja, switchboard 01708 435000, <a href="mailto:khalid.saja@bhrhospitals.nhs.uk">khalid.saja@bhrhospitals.nhs.uk</a></td>
</tr>
<tr>
<td>DH: C&amp;GW</td>
<td>Prof Mark Bower, 020 3315 8000, <a href="mailto:Mark.Bower@chelwest.nhs.uk">Mark.Bower@chelwest.nhs.uk</a></td>
</tr>
<tr>
<td>DH: ICH</td>
<td>Dr S Marks, switchboard 020 3311 1234, <a href="mailto:Sasha.Marks@imperial.nhs.uk">Sasha.Marks@imperial.nhs.uk</a></td>
</tr>
<tr>
<td>DH: Mid Essex</td>
<td>Dr V Chowdhury, switchboard 01245 362000, <a href="mailto:Vijoy.chowdhury@meht.nhs.uk">Vijoy.chowdhury@meht.nhs.uk</a></td>
</tr>
<tr>
<td>DH: MVCC</td>
<td>Dr Jonathan Lambert, switchboard 01923 826111, <a href="mailto:jonathan.lambert@uclh.nhs.uk">jonathan.lambert@uclh.nhs.uk</a></td>
</tr>
<tr>
<td>DH: Southend</td>
<td>Dr Paul Cervi, switchboard 01702 43555, <a href="mailto:paul.cervi@southend.nhs.uk">paul.cervi@southend.nhs.uk</a></td>
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**Treatment Planning**

<table>
<thead>
<tr>
<th>SITE SPECIFIC MDT</th>
<th>TYA MDT</th>
<th>After care monitoring</th>
<th>TYA team input</th>
<th>Transition to TYA</th>
<th>Referral to TYA LTFU</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Discussed at Site Specific MDT or Network Site Specific MDT</td>
<td>Location: UCLH</td>
<td>End of treatment review and clinic with patients haematologist or keyworker</td>
<td>Introduction of service to patient (by post or face to face assessment)</td>
<td>Transition into adult services is planned for and discussed with patients well in advance. Transition at a time of crisis e.g. relapse, intensive chemotherapy will be avoided wherever possible. Transition will be facilitated by the keyworkers</td>
<td>Patients at high risk of late effects or those who develop late effects of therapy will be referred into specific late effects service</td>
</tr>
<tr>
<td>2. The Site Specific consultant haematologist is the person who remains in overall charge of the patients treatment - any other consultant sharing care will be identified in the treatment plan</td>
<td>Time: Wednesdays, 15:00-17:00</td>
<td>End of treatment summary within 12 weeks of completion of therapy by haematologist or keyworker</td>
<td>Discuss at TYA MDT allocate key worker Holistic Needs Assessment (HNA) done within 4 weeks of referral to team</td>
<td>Support from TYA MDT members throughout the patients treatment pathway according to patient wishes</td>
<td></td>
</tr>
<tr>
<td>3. The treatment plan should include those responsible for: Surgical removal of tumours Chemotherapy Radiotherapy Cancer After Care</td>
<td>Lead Clinician: Dr Rachael Hough Coordinator: Alexandra Wood Phone: 07892147785 Email: <a href="mailto:ucl-tr.TYAMDT@nhs.net">ucl-tr.TYAMDT@nhs.net</a></td>
<td>Initial and long-term follow up will be by the named consultant and keyworker in the TYA haematology clinic</td>
<td>Holistic Needs Assessment (HNA) done within 4 weeks of referral to team</td>
<td>Information and support patient and carer (TYA team) supporting age appropriate care</td>
<td></td>
</tr>
<tr>
<td>4. Fertility preservation options discussed as appropriate and recorded in agreed treatment plan</td>
<td>1. All TYA patients will be discussed in the TYA MDT.</td>
<td>Patients entering a palliative phase of treatment, will be referred to the palliative care team, including liaison with local palliative care services as appropriate.</td>
<td>Introduce TYA service to patient (by post or face to face assessment)</td>
<td>Invite to end of treatment group/meet face to face after treatment review</td>
<td></td>
</tr>
<tr>
<td>5. The Keyworker should be identified</td>
<td>2. The TYA MDT will review the treatment plan made by the site specific MDT and promote access to clinical trials wherever possible</td>
<td></td>
<td>Discuss at TYA MDT allocate key worker Holistic Needs Assessment (HNA) done within 4 weeks of referral to team</td>
<td>Family support network</td>
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**IT Systems**

| COSD reporting (13-24yrs) by TYA MDT TYA DATA BASE | Note: Emergency or urgent treatment should not be delayed to allow discussion at the TYA MDT |

**Transition to TYA**

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<tr>
<th>Transition to Adult</th>
<th>Referral to TYA LTFU</th>
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<tr>
<td>1. All TYA patients will be discussed in the TYA MDT.</td>
<td>End of treatment review and clinic with patients haematologist or keyworker</td>
</tr>
<tr>
<td>2. The TYA MDT will review the treatment plan made by the site specific MDT and promote access to clinical trials wherever possible</td>
<td>End of treatment summary within 12 weeks of completion of therapy by haematologist or keyworker</td>
</tr>
<tr>
<td>3. The TYA MDT will review the support network around each individual patient, identify any psychosocial issues and how these will be addressed.</td>
<td>Initial and long-term follow up will be by the named consultant and keyworker in the TYA haematology clinic</td>
</tr>
<tr>
<td>4. The TYA MDT will ensure that a keyworker and other allied health professionals are identified for each patient</td>
<td>Patients entering a palliative phase of treatment, will be referred to the palliative care team, including liaison with local palliative care services as appropriate.</td>
</tr>
<tr>
<td>5. The agreements reached between the site specific MDT and TYA MDT will be documented</td>
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