Unknown Primary Service for patients at Chesterfield Royal Hospital

David Brooks
Macmillan Consultant in Palliative Medicine

Louise Merriman
GP Cancer Lead

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Context

• Chesterfield Royal Hospital
  – Serves town of about 100,000
  – Rural catchment total 400,000
  – Visiting site specific oncologists most days
  – Some on-site chemo
  – DXT 14 miles away in cancer centre
The unknown primary team

- Palliative care physician – lead and cover
- an oncologist with a special interest (no cover)
  - Peer Review Serious Concern
- Specialist nurses
  - Palliative care specialist nurse
  - Upper GI specialist nurse (cover pending appointment)
- Administrative support and cover
- Radiologist x2
- Histopathologist x2
- *Upper GI and Hepatobiliary surgeons and physicians*
Outline of service model

• Radiology alert
  – Significant unexpected finding of metastases – if no known primary then referral should be made to 2ww clinic – if clinical or biochemical indicators do not suggest primary site for site specific referral then Unknown Primary clinic

• Primary Investigation Out-patient clinic
  – Palliative physician and CNS
  – Parallel to Oncology
    • Opportunities for discussion and same day referral
  – Unknown Primary 2ww on choose and book

• In-patient Primary Investigation service
  – Palliative physician and CNS
  – Advice available from whole MDT outside of meeting times

• MDT meeting separate to but alongside Upper GI
Referral guidance

• Service information says service for:
  – investigation of patients with imaging or pathological evidence of malignancy of undefined primary origin.

• Exclude
  – those with symptoms or signs suggestive of primary
  – those with existing established pathway
    • Neck nodes to Head and Neck
    • Axillary nodes in women to breast
Demographics

• Patient numbers (2015)
  – 106 discussed at MDT
    • 56 Outpatient
    • 35 Inpatient
    • 15 discussed at MDT only

• Age
  – range 45-93 years old
  – mean = 73
  – median = 71
Final Diagnostic Category

- Specific diagnosis, 46
- MUO, 24
- No cancer identified, 23
- CUP, 11
Specific diagnoses

- Lymphoma
- Colorectal
- Prostate
- Neuroendocrine
- Oesophageal
- Renal Cell Carcinoma
- Plasmacytoma
- Gynaecological
- Breast
- Gastric ca
- Lung
- Hepatocellular cancer
- Mesothelioma
- Brain
- Galbladder
- Lung Cancer
## Management

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Number of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Best Supportive Care</td>
<td>43</td>
</tr>
<tr>
<td>No Cancer Identified</td>
<td>23</td>
</tr>
<tr>
<td>Chemotherapy</td>
<td>19</td>
</tr>
<tr>
<td>Hormone Therapy</td>
<td>7</td>
</tr>
<tr>
<td>Radiotherapy</td>
<td>5</td>
</tr>
<tr>
<td>Died prior to treatment commencing</td>
<td>2</td>
</tr>
<tr>
<td>Surgery</td>
<td>3</td>
</tr>
<tr>
<td>Chemotherapy and radiotherapy</td>
<td>1</td>
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<tr>
<td>Chemotherapy and hormone therapy</td>
<td>1</td>
</tr>
<tr>
<td>Entered into a clinical trail</td>
<td>1</td>
</tr>
<tr>
<td>Denosumab therapy</td>
<td>1</td>
</tr>
</tbody>
</table>
Management

• Of the 35 CUP/MUO patients,
  – three had palliative Radiotherapy alone,
  – four chemotherapy alone and
  – one a combination of chemotherapy and radiotherapy.
Challenges

• Referral of uninformed patients
• Referral of patients with vague symptoms who have been under investigated in primary care
• Driving forward referral of in-patients
• MDT referrals in out-patients with inadequate info
• Getting patients home from hospital
When to stop investigations

• Do not offer further investigations to identify the primary site of origin of the malignancy to patients who are unfit for treatment.

• Perform investigations only if:
  – the results are likely to affect a treatment decision
  – the patient understands why the investigations are being carried out
  – the patient understands the potential benefits and risks of investigation and treatment and
  – The patient is prepared to accept treatment.

• Explain to patients and carers if further investigations will not alter treatment options.
  – Provide appropriate emotional and psychological support, information about CUP, treatment options and palliative care.