

Report of the Patient
Management Framework
workshop for the Haematological
tumour stream

Sponsored by the Ministerial Taskforce for
Cancer

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Thanks to the Steering Committee:

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Report on the workshop

Introduction

The Patient Management Framework Workshop for the haematological tumour stream took place at Hilton on the Park, Melbourne, 26 April 2005. This workshop, sponsored by the Victorian Department of Human Services for the Ministerial Task Force in Cancer, follows on from the Patient Management Framework Workshop held in December 2004. The purpose of this workshop was to commence development of the patient management framework for the haematological tumour stream as outlined in *A Cancer Services Framework for Victoria*. (Barton et al, 2003).

The aims of the workshop were:

- To create a Patient Management Framework (PMF) that can be used by Integrated Cancer Services and all cancer service providers in Victoria to guide and optimise cancer patient treatment outcomes
- To provide a road map for clinicians and consumers along the cancer patient's journey
- To allow potential for the PMF to expand and interact with the cancer registry and encourage clinical trial development.

Background to workshop

A Cancer Services Framework for Victoria was launched in November 2003. Two significant directions of this report are the establishment of Integrated Cancer Services in metropolitan and rural/regional Victoria and the development of tumour streams.

Ten tumour streams account for more than 90 per cent of the total cancer incidence in Victoria. *A Cancer Services Framework for Victoria* recommended that organ or system specific tumour streams be adopted to reduce care variation. The concept of tumour streams includes: development of local collaborating tumour groups based on the ten major tumour categories; establishment of statewide reference groups; standards of care; facility standards; clinical and performance indicators; and role designation of services based on specification of the range of services that could be provided at an institutional level. This process is expected to take some years for complete development.

The Ministerial Taskforce for Cancer identified that the first stage in the development of tumour streams should be a clear description of the patient journey across the continuum of care, identifying the critical points along that pathway and the optimal care required. This description will outline a patient management framework for each of the tumour streams. In addition to giving a consistent statewide approach to care management for each tumour stream, these frameworks will provide a basis for mapping of current service provision across the state, and will identify gaps in service provision and priorities for further development.

The completed patient management frameworks are to include the following key elements:

- Identification of the critical points for optimal patient management across the continuum of patient care, from diagnosis to palliation and end-of-life care, if applicable. A critical point is defined as a particular place in the care pathway where decisions and care provided at that time will have a significant impact on the outcome for the patient.
- A brief description of the current state of evidence for practice and, where appropriate, clinical guidelines, care pathways, consensus statements, standards and research that exist to support optimal care at the critical points.
- Consideration of the facility requirements, for example, clinical expertise and skill mix, resourcing and equipment to ensure optimal care at each critical point of the patient pathway.
- Description of the investigations, therapies and supports that need to be available at each critical point.
- Description of performance indicators required to monitor if best practice has occurred.

At the Patient Management Framework Workshop held in December 2004, nine of the ten defined tumour streams were represented, and twelve tumours were considered:

- Breast
- Colorectal (rectal)
- Genito-urinary (prostate, testis)
- Lung
- Skin (melanoma)
- Gynaecological (ovary)
- Upper gastro-intestinal (oesophagogastric, pancreas)
- Head and neck cancers (larynx, pharynx, oral — combined)
- Central nervous system (malignant glioma, cerebral metastasis).

A report from that workshop is available at the Victorian Government Cancer Initiatives web site - <http://www.health.vic.gov.au/cancer/docs/patientmanagementframework.pdf> (Consan Pty Ltd, 2005).

Objectives

The focus of this workshop was on the clinical treatment pathway that includes diagnosis and medical management within the haematological tumour stream. The aim was to determine best clinical treatment practice for the two tumour types discussed, acute myeloid leukaemia and intermediate grade non-Hodgkins's Lymphoma, based on known evidence and clinical expertise/experience.

Description of workshop

Selection of participants

There were 22 participants in this workshop. The process for selection of participants began with Professor Robert Thomas presenting at the haemato-oncology committee of the Victorian Cooperative Oncology Group to engage interested clinicians in the process. Some of these clinicians formed the Steering Committee (see Appendix 1) and were encouraged to be the facilitator and co-facilitator/group secretary at the workshop.

The Steering Committee and the Clinical Services Working group members were then invited to nominate participants - clinicians, consumers and allied health professionals who have an interest and expertise in the area of haematological malignancies.

The final selection of participants for the patient management framework workshop was undertaken on the basis of;

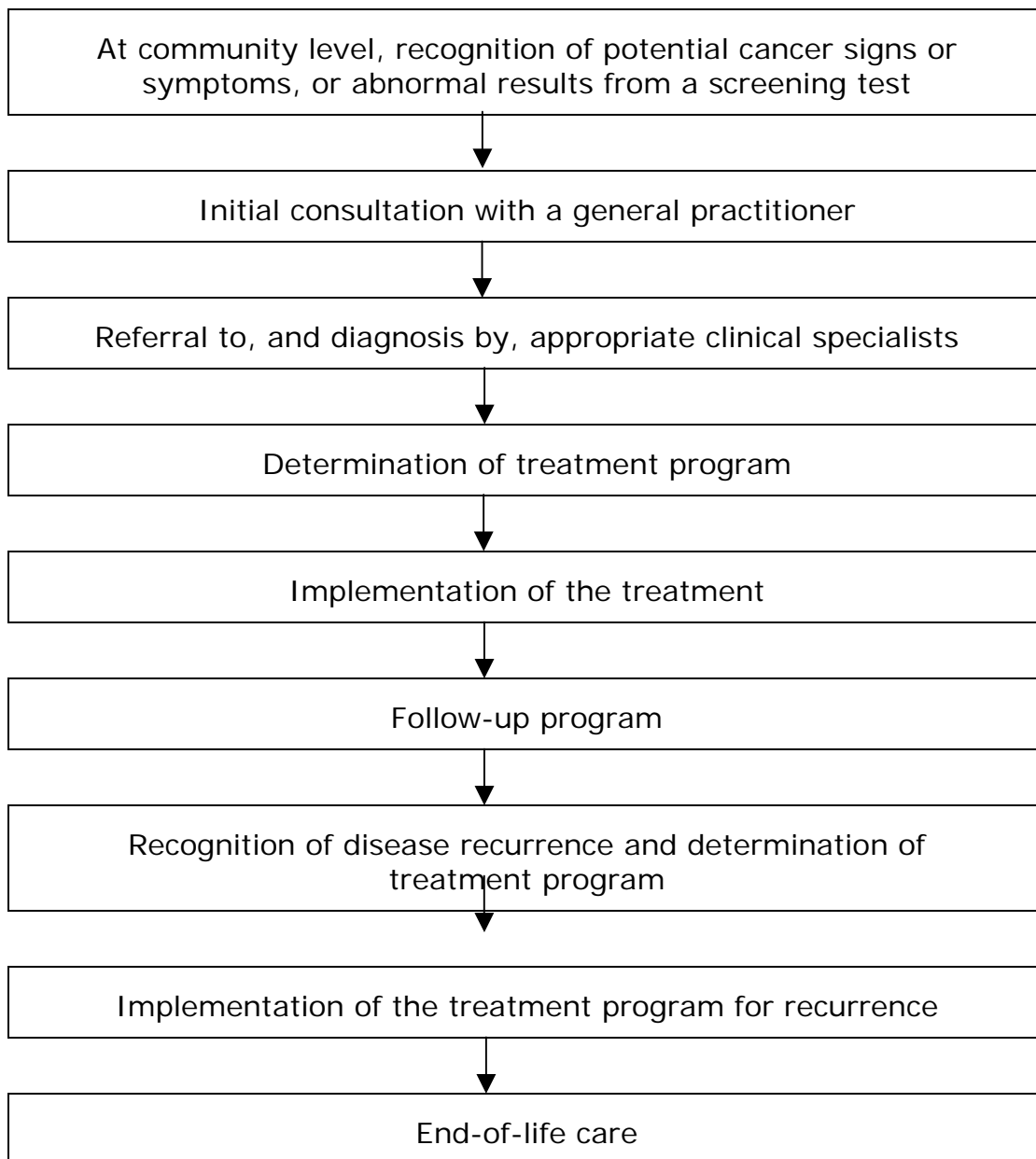
- Fair representation from rural and urban areas
- Representation from varying hospitals or organisations, particularly where there are differences of opinions about aspects of care
- Multidisciplinary representation
- Consumer representation
- GP representation, and
- Availability to attend the workshop.

This formed a group larger than any of the groups at the initial Patient Management Framework Workshop. A list of the 22 participants is included at Appendix 2

Structure of the workshop

Participants worked in their small tumour-specific group using questions to guide them in discussing the critical points in a patient's journey. A clinician, nominated to lead and gain consensus among group members, facilitated this discussion. The group also included a co-facilitator / secretary as a recorder of the information discussed and consumers who provided input about consumer expectations at the different critical steps of cancer care.

Figure 1: Critical steps of cancer care



A computer based template was used to guide discussion and to record group decisions. The template was displayed on a screen via a data projector. A copy of the template is included at Appendix 3

A copy of the program is included at Appendix 4

Patient Management Frameworks

Workshop notes

Extensive recommendations and suggestions regarding the delivery of high quality care formed the notes for the two tumour types discussed, acute myeloid leukaemia and intermediate grade non-Hodgkins's lymphoma. Sections of the template that were not completed at the workshop were assigned to individual clinicians to complete. Once completed and compiled, the output was then sent to the facilitator to review and edit for accuracy, completeness and readability. Few modifications were received. The resulting documents are detailed in the next section of this report.

These notes reflect the broad discussion that the workshop stimulated about ideas, issues and opportunities for improvement around patient care. The notes also document the agreements that were reached by the workshop participants. While there is some reference to evidence to support the consensus reached, there is recognition that further evidence will need to be sought.

Key themes

A number of common themes emerged during the day's discussion.

They were:

- The need for care coordinators
- The need to streamline referral patterns and availability of highly specialised facilities for all patients requiring allogeneic stem cell transplantation, and
- Appropriate tertiary facilities for patients requiring curative therapy for acute myeloid leukaemia.

Future development

There was a limited focus on supportive and palliative care at both the Patient Management Framework workshop in December 2004 and the Haemato-oncology workshop. Further development in this area was undertaken at a workshop in May 2005.

The workshop notes will be combined with the supportive and palliative care requirements to form draft Patient Management Frameworks. More importantly, further clinical and consumer consultation will then be required to gain consensus and support for endorsement of the draft Patient Management Frameworks.

Workshop notes

Acute myeloid leukaemia

Step 1: At community level, recognition of potential cancer signs or symptoms, or abnormal results from a screening test

1.1 Signs and symptoms that should lead to consultation with a General Practitioner (GP)

- Fatigue or other symptoms of anaemia
- Unexplained or persistent irritability in paediatric patients
- Pallor
- Unresolving infection or fevers
- Abnormal Bleeding/bruising
- Persistent sore gums/mouth ulceration
- Unexplained bone pain

- Symptoms at presentation are often non-specific

1.2 Timeframe for GP consultation after consumer recognition of signs

- Multiple presenting symptoms require immediate consultation
- Abnormal bleeding/bruising requires immediate consultation

1.3 Those at high risk

- Patients with prior chemotherapy and/or radiation therapy
- Known previous haematologic disorder with a risk of leukaemic transformation
 - Myelodysplastic syndromes
 - Myeloproliferative diseases
- Known predisposing genetic disorders with a risk of leukaemic presentation
 - Down syndrome
 - Neurofibromatosis type I

1.4 Other relevant issues

- Early, rapid diagnosis may have a major impact on survival
- While the majority of patients are over the age of 60 years, this disease can present in any age group and age cannot be used as a discriminator

Step 2: Initial diagnostic consultation with General Practitioner

2.1 Required diagnostic tests

- Patients with clinical features of coagulopathy should be referred to an appropriate facility without necessarily waiting for results of laboratory tests.
- Full blood examination immediately. Results should be actively followed-up and acted upon in the same working day.
 - Patients with a laboratory diagnosis of acute leukaemia should be referred for immediate admission to an appropriate facility.
 - Patients with severe unexplained cytopenias (neutrophils $<0.5 \times 10^9/L$, platelets $<50 \times 10^9/L$), especially if circulating blasts are reported, should be referred to a specialist haematologist immediately
 - Patients with circulating blast cells without cytopenias or with less severe cytopenias should be referred to a specialist haematologist within 24 hours.
 - Acute leukaemia without blasts or severe cytopenias is still possible. Coagulopathy with bleeding may be a feature of acute promyelocytic leukaemia and requires urgent referral.

2.2 Duty of care - optimal referral process

- A new diagnosis of acute leukaemia (confirmed or suspected) requires immediate discussion directly with a haematologist or haematology registrar in order to facilitate rapid specialist assessment.
- Ready availability of an appropriately experienced surgeon, specialist haematologist or medical oncologist for early discussion to guide the referral process, is optimal.
- There is a need to refer patients with persistent symptoms even in the absence of a confirmed diagnosis
- Patients with severe symptoms or major laboratory abnormalities should be regarded as a medical emergency and be referred immediately. Others should be seen within 2 weeks.
- Appropriate pathologic investigations on any biopsy material must be assured
- Appropriate documentation including the results of all prior relevant investigations and imaging should be sent with the patient

2.3 Duty of care - communication to patient and family

- The patient should be informed that a possible diagnosis of acute leukaemia is a medical emergency and requires immediate specialist assessment. A form of words such as "potentially serious blood disorder" may be appropriate.
- The patient should be informed that while this is a serious disorder, effective treatment is available.
- Professional medical interpreters should be made available for non-English speaking patients at all stages

Step 3: Referral to, and diagnosis by, appropriate clinical specialist/s

3.1 To whom should the patient be referred?

- Haematologist with adequate experience in the management of acute leukaemia

3.2 Duty of care - communication from GP to specialist

- As in section 2.2
- Relevant past history
- Current medication/allergies
- Relevant psychosocial aspects

3.3 Duty of care - communication to the patient and family

- A potentially serious diagnosis with the need for a rapid, confirmed diagnosis by a biopsy to ensure accurate prognosis and therapy
- Preferably, carers should be involved at this stage
- Patients may require the services of support groups such as Cancer Council Victoria or Leukaemia Foundation Victoria at this point
- Advice on risks

3.4 Duty of care - optimal referral process

- Clinical haematologist with adequate experience in the management of acute leukaemia and an adequately experienced multidisciplinary team in the institution.
- The responsible clinician and team should be an active participant in multicentre trial groups in the field of acute leukaemia
- Paediatric patients are usually managed by paediatric oncologist in highly specialised centres.

3.5 Other relevant issues

- There may be patients for whom active therapy is inappropriate, but all patients have the right to an early haematological opinion, including pathological confirmation of the diagnosis

Step 4: Determination of treatment program

4.1 Who should be involved in determining the treatment path taken?

- Clinical haematologist with adequate experience in the management of acute leukaemia and an adequately experienced multidisciplinary team in the institution. The centre should be a major tertiary referral hospital with appropriately experienced nursing staff.
- The responsible clinician and team should be an active participant in multicentre trial groups in the field of acute leukaemia
- Paediatric patients are usually managed by paediatric oncologist in highly specialised centres.
- The multidisciplinary treatment plan should commence as soon as possible after the diagnosis is confirmed. Such planning must be reviewed and documented at a team meeting.

4.2 Preferred model to provide multidisciplinary care in different settings

- The multidisciplinary team should include at least haematology nurse coordinator, haematologists, symptom management specialists (such as palliative care or pain specialists), pharmacist, physiotherapist, occupational therapist, social worker, dietician and psychologist, immediately the diagnosis is established.
- A haematologist expert in stem cell transplantation should be available and consulted to enable early consideration and planning for allogeneic transplantation (including unrelated donor transplantation), if appropriate, although not necessarily at that centre.
- Access to an oral medicine specialist is necessary for some patients.
- An identified individual haematologist should take the lead role for each patient.
- Administrative support is essential for ensuring documentation of the process.

4.3 Next steps in implementation of the treatment program

- A centre treating patients with acute leukaemia should have in place, written, defined protocols for the diagnosis and management of patients with acute leukaemia and its complications. Every patient being considered for active therapy should have samples taken for cytogenetics, flow cytometry and molecular diagnostics prior to the initiation of therapy.
- Immediate treatment is often required before a full meeting ratifies details of the management plan.
- The management plan (possibly in stages) should be conveyed to the patient, preferably in the presence of a carer, by the lead haematologist with the responsible nurse present. A major component of therapy should, where appropriate, be participation in a clinical trial.
- Access to relevant published information and access to support groups must be made available at this point.
- Fertility preservation options must be discussed for appropriate patients at this point.
- Other options for therapy should also be conveyed to the patient, including other clinical trials and supportive care.
- The referring medical practitioner and other care givers should be informed at an early stage of the treatment plan to ensure seamless care subsequent to the inpatient phase. Ideally, a documented summary of the treatment planning meeting would be the source of this information.
 - Rapid communication using modern technology is often appropriate.

Step 5: Implementation of the treatment

5A: Surgery

5A.1 Patient group who will have surgery

- Surgical consultation may be required during the treatment course for supportive care.
- Vascular access devices should only be inserted by proceduralists experienced in such procedures.

5A.2 Qualifications and experience of the person who performs the surgery

- Centres treating patients with acute leukaemia should have surgical expertise available at all times.

Step 5: Implementation of the treatment

5B: RADIOTHERAPY

5B.1 Patient group who will have radiotherapy

- Occasional patients will require palliation with radiation
- Occasional patients will require radiation for treatment of the disease
- Total body irradiation may be required as part of conditioning for allogeneic stem cell transplantation and should only be given in centres with appropriately qualified and experienced staff and equipment.

5B.2 Qualifications and experience of the person who administers the radiotherapy

- An experienced radiation oncologist in a centre familiar with dealing with patients with haematologic malignancies

Step 5: Implementation of the treatment

5C: DRUG THERAPY

5C.1 Patient groups who will have drug therapy

- All patients receiving active therapy

5C.2 Qualifications and experience of the person who administers the drug therapy

- The drug treatment should be determined by a haematologist with expertise in the management of leukaemia
- All prescriptions must be checked and prepared by a suitably qualified and experienced pharmacist in a designated pharmacy facility
- Administration of drugs should be supervised by chemotherapy-accredited nursing staff

5C.3 Characteristics of the treatment facility

- Appropriate inpatient and ambulatory care facilities for managing these patients

- Staffing
 - Always available haematologists and hospital medical officers
 - Designated nursing staff with appropriate qualifications and experience
 - Supportive care staff including intensive care, infectious diseases and other subspecialty services
 - Laboratory support, especially blood banking available 24 hours per day
 - Medical imaging always available
 - Pharmacy services available 24 hours per day
 - Multidisciplinary team members as previously designated
- Ward
 - A designated ward should be available with
 - Isolation rooms
 - Positive pressure ventilation with High Efficiency Particulate Air (HEPA) filtration is optimal
 - A level 1 intensive care unit should be on site
- Drugs
 - Adequate resources to ensure availability of important therapies such as antifungal drugs, cytokines, rasburicase and other supportive medications
- Other
 - Access to emergency apheresis for the management of hyperleukocytosis

5C.3 Additional facility resources or other technical issues important to effective and acceptable implementation of care

- Clinical trial infrastructure is mandatory including research nursing, data management, clinical trials pharmacy and information technology resources.
- Access to appropriate diagnostic testing, in particular molecular diagnostics.
- Staffing should be at a level appropriate to the workflow of the facility as determined by the relevant body

5C.4 Duty of care – communication to the patient and family

- There is a requirement to deliver and have understood essential information about the diagnosis, important toxicities and expectations. The degree of detail communicated should be tailored to the needs and ability to comprehend of the individual patient and carer and may change as the course of therapy proceeds.
- Cultural, ethnic and developmental issues need to be treated with sensitivity.
- Documentation of the details of information imparted is essential.
- Information regarding the maintenance of self image (including wigs) and social functioning.
- Information regarding sexual issues.
- Written information regarding specific complications and action to be taken, particularly neutropenic fever

5C.5 Who will be involved in making decisions leading to and arising from treatment?

- As listed in section 4.2, in consultation with the patient.
- Understanding by the patient or carer of the nature of the diagnosis and treatment is essential.
- Further referrals to appropriate specialties may be required for the management of complications of the disease or treatment.

5C.6 Other relevant issues

- Young adults and adolescent patients should be treated in a facility with services meeting their specific needs.
- School-aged patients still at school may best be treated in a paediatric institution to ensure ongoing education needs are met.

Step 5: Implementation of the treatment **5D: SUPPORTIVE CARE**

5D.1 Supportive care required at this time

- Each patient should have a designated point for nursing contact at the institution
- Symptom control is required in the institution as well as for ambulatory patients both during potentially curative and palliative phases of therapy

5D.2 What else is important to implement supportive care effectively and acceptably?

- Clinical infectious diseases are a major area of impact on outcome for these patients and an adequately resourced reference group for infectious disease management in immuno-compromised patients is required.

5D.3 Duty of care - communication to the patient and family about options for supportive care

- Options relating to supportive care should be discussed and offered to all patients.

Step 6: Follow-up program:

6.1 Appropriate models for follow-up care

- The aims of post-treatment follow-up of patients with acute myeloid leukaemia are broadly:
 - assist with physical and psychological recuperation and recovery from the acute therapy,
 - monitor for evidence of disease recurrence
 - advise on ways of minimising any late adverse effects of therapy and monitor for these, and
 - assist and reinforce general health monitoring and maintenance of a healthy life-style
- The emphasis on these various aspects of follow-up will vary according to the individual circumstances of the patient, the intrinsic risk of relapse of their disease, the treatment intention if relapse were to occur, the long-term risks associated with the initial therapy delivered.
- In the immediate post-therapy setting, the frequency of consultations will be determined by the individual patient's needs, and may be between weekly to every 6 weeks. The primary treating haematologist should co-ordinate these, and input from the full spectrum of allied health professionals including a haematology nurse co-ordinator and psychologist may be required.
- The timing and intensity of surveillance for recurrent / progressive disease will be determined by the intended therapy if recurrent disease were identified. This can vary from palliation directed toward symptom control, in which case intensive surveillance for early detection of asymptomatic disease is not warranted, or prompt and intensive intervention, possibly including stem-cell transplantation with curative intent. Thus a clear decision regarding the likely approach to therapy for relapse should be formulated in each patient before deciding upon a surveillance schedule. A clear decision regarding the possible benefits of (a) Human leukocyte antigen (HLA)-typing of the patient and family members, (b) an extended family search for HLA-compatible donors, (c) an unrelated donor search, and (d) autologous stem-cell collection should be made as part of the primary therapeutic plan, and be implemented prior to, or in parallel with, the post-treatment follow-up of the patient.
- Most recurrences occur in the first 2 – 4 years after therapy, and the risk of recurrence diminishes, but is never totally abolished, beyond this point. When recurrences occur, they are usually detected by investigations of new symptoms, or by abnormalities on full-blood examination. It is very uncommon for asymptomatic recurrences to be detected by routine bone marrow biopsies, in the absence of other abnormalities (Estey Blood 87:3899, 1996) and these are not routinely recommended.
- There are some specific sub-types of AML (acute promyelocytic Leukaemia [APML] with t(15;17), acute myelomonocytic leukaemia – eosinophilic variant [AML M4Eo] with inv(16) and AML with t(8;21)) which are amenable to serial monitoring using sensitive polymerase chain reaction (PCR) tests which are predictive of subsequent haematologic and clinical recurrence of disease. For some of these disorders peripheral blood testing has not been verified to be as sensitive as bone marrow testing, and thus routine marrow samples may be required for serial molecular testing of these specific subtypes where early intervention or intensified surveillance would be implemented on the basis of a positive or rising PCR result.

- A reasonable surveillance schedule is and full blood examination (FBE) every 1 – 3 months for the first 2 – 3 years, clinical assessment with a careful history and physical examination every 3 months for the first 2 – 3 years after treatment, then FBE every 3 – 6 months with clinical review every 3 – 6 months until 5 years, then annually indefinitely. Bone marrow biopsies for the above molecular studies may be added in the relevant cases every 3 – 6 months for the first 5 years, dependent on the therapeutic plan for management of relapse.
- Potential late effects of therapy that may require specific screening and monitoring will be determined by the primary treatment used. These may include endocrine surveillance (gonadal), cardiac assessment, osteoporosis, transfusional iron overload and secondary myelodysplasia.
- Finally, general community health recommendations regarding lifestyle and screening tests (PAP smears, mammography, ...) should be reinforced at each visit.

Reference

Estey E, Pierce, S. Routine bone marrow exam during first remission of acute myeloid leukemia Blood 1996; 87:3899-3902

6.2 Who should be involved in patient follow up?

- The primary treating haematologist is best qualified to supervise and guide the follow-up of the patient with the input from other specialists and allied-health practitioners as required. In some areas, specialised “long-term follow-up” clinics are in place and may be appropriate for patients with complex, high-risk or multi-system long-term surveillance needs.

6.3 Duty of Care – communication to the patient and family about the possibilities of recurrence

- The patient, family and GP should be informed in detail and language appropriate to their needs about (a) the risk and timeframe of potential relapse, (b) potential symptoms or signs, (c) the broad treatment intention if relapse were to occur, (d) the planned monitoring schedule, (e) the spectrum of potential late-effects of therapy and measures able to minimise these and the screening tests, if any, planned to monitor for these.

Step 7: Recognition of disease recurrence and determination of treatment program

7.1 Investigative tests and appropriate referrals in the event of recurrence

- Full blood count with blood film examination
- Immediate referral to a specialist haematologist experienced in the management of acute leukaemia and preferably the same physician responsible for the primary treatment of the patient.
- Bone Marrow Aspirate and trephine including flow cytometry and cytogenetic analysis
- HLA typing of patient and first degree relatives if appropriate (age less than 55 - 60, duration of complete remission > 6 months) after consultation with a centre performing allogeneic stem cell transplantation and if not previously done

7.2 Who should manage this part of the program?

- The initial identification of an abnormal blood picture may be managed by the general practitioner or the haematologist depending on when this relapse has occurred.
- Qualifications are as previously described

7.3 Duty of care - communication to the patient and family

- Until the bone marrow biopsy is done, only general information about blood abnormalities should be conveyed.

7.4 Who should be involved in determining the treatment path taken?

- Haematologist in consultation with patient and family

7.5 What psychosocial support should be provided at this time?

- Social worker/clinical psychologist should be available to assist in understanding and coping with implications of recurrent disease

Step 8: Implementation of the treatment program for recurrence

8.1 What treatment/s is it most likely that a patient will have if the cancer recurs?

SURGERY:

- Patients require insertion of a vascular access device to facilitate treatment and supportive care. Surgical excision of lesions for histopathology to confirm extramedullary disease.

RADIOTHERAPY:

- Consider irradiation of infiltrative/mass lesions (solitary choroidomas) and craniospinal irradiation in the event of CNS disease. Total body irradiation (TBI) may be required in selected patients undergoing allogeneic transplantation.

DRUG THERAPY:

- Salvage chemotherapy should be considered in patients aged < 70 years relapsing after durable first remission (>6-12 months).
- Patients < 55 - 60 years of age should be considered for allogeneic transplantation if a compatible donor is identified.
- Consider the use of novel agents (within or outside the setting of a clinical trial) in selected patients (Mylotarg, farnesyltransferase inhibitors etc).
- Oral cytoreductive treatment with agents such as hydroxyurea for palliation of proliferative aspects of the disease (leucostasis, tissue infiltration).

SUPPORTIVE CARE:

- Regular transfusional support with red cells and platelets when appropriate (NHMRC guidelines). Antimicrobials for the treatment and prevention of infections. Analgesia for pain, antifibrinolytics for thrombocytopenic bleeding and corticosteroids for suppression of disease-associated symptoms (bone pain, fever, sweats).

PALLIATION:

- Early referral to the palliative care services which can deliver services in the patients home environment is recommended and involvement of symptom control specialists for difficult symptom issues.

References

National Health and Medical Research Council, Clinical Practice Guidelines for the use of Blood Components CP78 (red blood cells, platelets, fresh frozen plasma, cryoprecipitate), 2001

8.2 Qualifications and experience of the person/s administering the treatment

SURGERY:

- An experienced surgeon in inserting intravascular devices in immuno-compromised patients and those with thrombocytopenia and coagulopathies

RADIOTHERAPY:

- An experienced radiation oncologist in a centre used to dealing with patients with haematologic malignancies

DRUG THERAPY:

- The drug treatment should be determined by a haematologist with expertise in the management of leukaemia

- All prescriptions must be checked and prepared by a suitably qualified and experienced pharmacist in a designated pharmacy facility
- Administration of drugs should be supervised by chemotherapy-accredited nursing staff

SUPPORTIVE CARE:

- As per implementation of initial treatment

PALLIATION:

- Primary treating haematologists may deliver many components of palliative care in these patients but if specialised palliative care personnel are involved, they should have an understanding of the unique needs this group of patients and not be hesitant to use blood products and even chemotherapy for palliation.

8.3 In what way do the requirements for the treatment facilities differ from those required for the initial treatment?

SURGERY:

- No difference

RADIOTHERAPY:

- TBI-base preparative regimens should only be delivered in centres with experience using TBI conditioning and autologous/allogeneic transplantation (minimum 10-15 procedures per year).

DRUG THERAPY:

- If treatment is given with ultimate curative intent, the facilities need to be of the same level as initial therapy although palliative chemotherapy may be deliverable in a less intense environment.
- Allogeneic stem cell transplantation must be delivered only in specialised units with appropriate human and physical resources.

SUPPORTIVE CARE:

- Patients receiving intensive salvage therapy (chemotherapy +/- transplantation) are at high risk of treatment-related complications. Centres must be capable of managing severe mucositis (total parenteral nutrition (TPN), analgesia, mouth care), opportunistic infections (invasive fungal disease, Cytomegalovirus (CMV) infection), graft-versus-host disease, organ toxicity (interstitial pneumonitis, veno-occlusive disease) and the consequences of prolonged intense immunosuppression. Centres should have access to a dental service familiar with mouth care issues in haematology patients. Access to gynaecology/andrology for management of fertility issues.

PALLIATION:

- No difference

8.4 Duty of care - communication to the patient and family

- Discussions should take place when the diagnosis of disease relapse is confirmed and should be mediated by the patient's primary haematologist preferably with the involvement of the primary nurse, and potentially the patient's general practitioner.
- Discussion should include a realistic assessment of prognosis commensurate with age at relapse, duration of first remission, underlying comorbid disease/s, disease subtype/biology and availability of a bone marrow donor.

- The patient and family should be informed of the availability of palliative care and symptom control as an alternative to active anti-leukaemia treatment and be made aware of the full range of supportive treatments available (transfusions etc.) that can support quality of life in the setting of end stage disease.

8.5 Who will be involved in making decisions leading to and arising from treatment?

- Management decisions at the time of relapse will in general be made by the patient's primary haematologist often following discussion with other members of the multidisciplinary team. On occasions referral to another centre may be appropriate when considering stem cell transplantation, access to clinical trials or novel agents.
- Qualifications, experience and supportive care as per 8.1

Step 9: End of life care

9.1 Is this patient group likely to require end of life care at this time?

- A substantial proportion of patients with acute myeloid leukaemia will die of their disease despite optimal therapy
- Palliation is often complex in these patients requiring multidisciplinary care including important roles for palliative chemotherapy, blood product support (and rarely radiotherapy) to support quality of life

9.2 Who should provide end of life care?

- Essential to have close liaison between palliative care team and primary Haematologist through the patient's journey.
- Transfusion support can have a useful role but decisions can be complex requiring specialised clinical transfusion knowledge (phone advice will often suffice)
- Ability to determine which active interventions (including transfusion) are of realistic benefit.

9.3 Characteristics of the facility

- Range of options important due to wide spectrum of need. Home-based care often appropriate with community medical support.
- Symptom control may require reasonably expedient medical review.
- Patients often require recurrent admissions for symptom stabilisation therefore ease of access for family a significant issue.
- Ideally a familiar available inpatient facility with a well resourced and integrated community/domiciliary programme.
- Nursing staff with palliative care expertise and a working knowledge of haematologic malignancy (Role for shared intellectual capital via information systems).
- Access to radiotherapy/chemotherapy facilities for some patients – need not be onsite.
- Transfusion infrastructure

9.5 Duty of care - communication to the patient and family about end of life care

- Due to protean clinical presentations and treatment options in palliation of acute myeloid leukaemia it is important the discussion involves a haematologist with experience in managing advanced/refractory leukaemia to ensure all potential options understood.

9.6 Who will be involved in making decisions leading to and arising from end of life care?

- Decisions require input from both palliative care specialist and primary haematologist as discussed above.

9.7 Other relevant issues

- As in all palliative care situations availability of social work, spiritual care and family support.
- Not uncommonly patients can be from younger age group with special needs (adolescent, parents of young children etc)
- Paediatric patients usually require input from a paediatric oncology unit

Abbreviations

AML	Acute myelocytic leukaemia
AML M4Eo	Acute myelomonocytic leukaemia – eosinophilic variant
APML	Acute promyelocytic leukaemia
CMV	Cytomegalovirus
FBE	Full blood examination
GP	General practitioner
HEPA	High Efficiency Particulate Air
HLA	Human leukocyte antigen
PCR	Polymerase chain reaction
TBI	Total body irradiation
TPN	Total parenteral nutrition

References

- Estey E, Pierce, S. Routine bone marrow exam during first remission of acute myeloid leukemia Blood 1996; 87:3899-3902
- National Comprehensive Cancer Network, Clinical Practice Guidelines in Oncology – Acute Myeloid Leukaemia v2, 2005
- National Health and Medical Research Council, Clinical Practice Guidelines for the use of Blood Components CP78 (red blood cells, platelets, fresh frozen plasma, cryoprecipitate), 2001

Intermediate grade Non Hodgkin's lymphoma

Step 1: At community level, recognition of potential cancer signs or symptoms, or abnormal results from a screening test

1.2 Signs and symptoms that should lead to consultation with a General Practitioner (GP)

- Lump or mass
- Lymphadenopathy
- Persistent lymphadenopathy (up to 4-6 weeks) or lymphadenopathy associated with systemic symptoms e.g. fevers, sweats, weight loss, itch, or pain. Repeat presentation with the same or progressive symptoms is a "flag" for the GP to consider further investigation.
- Symptoms (such as undiagnosed back or abdominal pain) without palpable lymphadenopathy may also be a mode of presentation
- Rarely, sudden onset of new respiratory symptoms may be a presenting feature of mediastinal obstruction, particularly in the paediatric population and may require urgent early imaging

1.3 Timeframe for GP consultation after consumer recognition of signs

- Severe symptoms require immediate consultation
- Persistent or enlarging lumps without other symptoms should be seen within 2-4 weeks
- Symptoms without lumps should be seen after 2 weeks if persistent

1.4 Those at high risk

- All ages and all demographic groups are at risk for lymphoma
- Intrinsically immunosuppressed patients or those receiving therapeutic immunosuppression e.g. transplant recipients, human immunodeficiency virus (HIV) + patients
- Family history is a moderate risk factor
- Any past history of lymphoma (Hodgkin or non-Hodgkin)

Any of these factors suggests a higher than usual level of clinical suspicion is required. There is no current role for routine screening, even in these patient groups

Step 2: Initial diagnostic consultation with General Practitioner

2.1 Required diagnostic tests

- Lump/lymphadenopathy
 - A period of observation of up to 4-6 weeks may be appropriate for patients without any significant or progressive symptoms and normal screening tests (e.g serum lactate dehydrogenase (LDH))
 - Patients with a high likelihood of a malignant process (large mass with significant symptoms such as weight loss or fevers) should be referred immediately for definitive biopsy. Prior discussion with an appropriate specialist may be necessary.
 - Patients not clearly in this higher risk group should have screening blood tests (full blood examination, Urea & Electrolytes (U+E), liver function tests, uric acid, LDH) and imaging of the affected area (ultrasound for peripheral lesions, chest radiography & computed tomography (CT) scan as appropriate. Imaging should be undertaken in an accredited imaging facility).
 - Referral for biopsy should be made in patients with defined lymphadenopathy. Fine needle aspirate, with the aim of diagnosing lymphoma, is inappropriate. While simultaneous fine needle aspirate may be possible in radiology departments, this form of biopsy cannot be used to exclude lymphoma or to establish the type of lymphoma. Prior discussion with an appropriate specialist may be appropriate.
- Symptoms only
 - Screening bloods: full blood examination, U+E, liver function tests, uric acid, LDH.
 - Abnormalities, particularly elevated LDH, uric acid or cytopenias require immediate further investigation. Discussion with an appropriate specialist at this point is often appropriate even in the absence of abnormalities. Early referral to establish a diagnosis is essential.

2.3 Duty of care - optimal referral process

- Ready availability of an appropriately experienced surgeon, specialist haematologist or medical oncologist for early discussion to guide the referral process, is optimal.
- There is a need to refer patients with persistent symptoms even in the absence of a confirmed diagnosis
- Patients with severe symptoms or major test abnormalities should be regarded as a medical emergency and be referred immediately. Others should be seen within 2 weeks.
- Appropriate pathologic investigations on any biopsy material must be assured
- Appropriate documentation including the results of all prior relevant investigations and imaging should be sent with the patient

2.3 Duty of care – communication to patient and family

- The patient must understand the need to return for follow-up appointments, particularly if a period of observation has been decided
- Professional medical interpreters should be made available for non-English speaking patients at all stages
- It must be communicated that a definitive pathologic diagnosis is essential to provide an accurate prognosis and treatment plan.
- That the patient has a responsibility to bring relevant documentation to specialist appointments
- The reason for any referral or test should be explained to the patient

Step 3: Referral to, and diagnosis by, appropriate clinical specialist/s

3.1 To whom should the patient be referred?

- Pre-biopsy discussion with a surgical oncologist, haematologist or medical oncologist is necessary to ensure that appropriate diagnostic tests are performed on the biopsy material.
- If there is high clinical suspicion of lymphoma, the patient should be assessed by an experienced clinical team **prior to** the biopsy.

3.2 Duty of care - communication from GP to specialist

- As in section 2.2
- Relevant past history
- Current medication/allergies
- Relevant psychosocial aspects

3.3 Duty of care - communication to patient and family

- A potentially serious diagnosis with the need for a rapid, confirmed diagnosis by a biopsy to ensure accurate prognosis and therapy
- Preferably, carers should be involved at this stage
- Patients may require the services of support groups such as Cancer Council Victoria, Leukaemia Foundation of Victoria at this point.

3.4 Duty of care - optimal referral process

- If the initial specialist is a surgeon, he/she should be experienced in biopsy techniques for the diagnosis of lymphoma and have a working relationship with a haematologist or medical oncologist with appropriate experience in the management of lymphoma.
 - If a highly invasive procedure would be required to make the diagnosis (e.g. laparotomy or thoracotomy), consultation with an appropriately experienced haematologist or medical oncologist is required **before** the procedure.
- If the initial specialist is a haematologist or medical oncologist, one with appropriate experience in the management of lymphoma should be chosen

Step 4: Determination of treatment program

4.1 Who should be involved in determining the treatment path taken?

- Pathology specimens referred from an outside source should be reviewed by a pathologist expert in the diagnosis of lymphoma, preferably at the treatment centre before a treatment plan is instituted. Classification should be based on the current World Health Organisation (WHO) classification.
- Synoptic reporting of pathology is optimal as recommended by the Australian Cancer Network (ACN) Lymphoma guidelines.
- A team including a haematologist or medical oncologist and/or a radiation oncologist with expertise in the management of lymphoma should determine the recommended treatment path after reviewing the pathology and staging investigations.
- Details of final diagnosis, staging and treatment plan must be clearly documented.
- Primary imaging should be obtained in an archived digital format to optimise patient flow

4.2 Preferred model to provide multidisciplinary care in different settings

- The multidisciplinary team should include at least haematology nurse coordinator, haematologist/medical oncologist, symptom management specialists (such as palliative care or pain specialists), pharmacist, physiotherapist, occupational therapist, social worker, dietician and psychologist, immediately the diagnosis is established.
- Every patient with apparently localised intermediate grade lymphoma should have access to functional imaging including positron emission tomography (PET). This is of particular importance where disease distribution will have a significant impact on treatment planning.
- If radiation is planned as part of therapy, this should be documented at this stage and the time from end of chemotherapy to radiation monitored
- A haematologist/medical oncologist expert in stem cell transplantation should be available and consulted to enable early consideration of stem cell transplantation although not necessarily at that centre or as part of initial therapy.
- The management plan must include details of proposed response assessment including timing and method of assessment of such

4.3 Next steps in implementation of the treatment program

- A centre treating lymphoma should have, in place, written, defined protocols for the diagnosis and management of lymphomas and its complications. Every patient being considered for active therapy should have samples taken for flow cytometry, molecular diagnostics and potentially cytogenetics prior to the initiation of therapy.
- Immediate treatment is often required before a full multidisciplinary meeting ratifies details of the management plan.
- The management plan (possibly in stages) should be conveyed to the patient, preferably in the presence of a carer, by the lead haematologist with the responsible nurse present. A major component of therapy should, where appropriate, be participation in a clinical trial.
- Access to relevant published information and access to support groups must be made available at this point.
- Fertility preservation options must be discussed for appropriate patients at this point.

- Other options for therapy should also be conveyed to the patient, including other clinical trials and supportive care.
- The referring medical practitioner and other care givers should be informed at an early stage of the treatment plan to ensure seamless care subsequent to the inpatient phase. Ideally, a documented summary of the treatment planning meeting would be the source of this information.
 - Rapid communication using modern technology is often appropriate.
- In some situations, treatment may be initiated prior to a formal multidisciplinary care plan

Step 5: Implementation of the treatment

5A: Surgery

5A.1 Patient group who will have surgery

- Surgery is required occasionally for some patients with lymphoma
- Vascular access devices should only be inserted by proceduralists experienced in such procedures.

5A.2 Qualifications and experience of the person who performs the surgery

- Surgeons with expertise in the management of patients with lymphoma

5A.3 Characteristics of the treatment facility

- As determined by the requirements for the drug treatment facility in section 5C.3.

Step 5: Implementation of the treatment

5B: Radiotherapy

5B.1 Patients group who will have radiotherapy

- Radiation should be considered for adult patients with localised disease (Stage I-II) or those with more advanced disease with a dominant bulky lesion.

5B.2 Qualifications and experience of the person who administers the radiotherapy

- An appropriately trained and experienced radiation oncologist

5B.3 Characteristics of the treatment facility

- Modern linear accelerators
- CT planning for sophisticated radiation planning
- Capacity for PET-CT planning
- Staff to be familiar with lymphoma-specific radiation techniques
- Radiotherapy nurse coordinator(s) essential for monitoring patients through treatment and to ensure smooth transition through phases of treatment
- Activity level of the facility to be adequate to ensure maintenance of expertise for all members of the radiation team
- Department to be resourced and staffed to levels recommended by an appropriated body.

5B.4 Additional facility resources or other technical issues important to effective and acceptable implementation of care

- Resources for accommodation and supportive services

5B.5 Duty of care - communication to the patient and family

- Specific radiation-related information including risk-benefit, alternatives to radiation therapy

- Requirement for long-term follow-up for long-term complications of radiation should be in the initial management plan and details communicated with the referring practitioners

5B.6 Who will be involved in making decisions leading to and arising from treatment?

- Multidisciplinary team

Step 5: Implementation of the treatment **5C: Drug Therapy**

5C.1 Patient groups who will have drug therapy

- The majority of patients being treated with curative intent will have drug therapy. Most other patients are also likely to have drug therapy.

5C.2 Qualifications and experience of the person who administers the drug therapy

- The drug treatment should be determined by a haematologist/medical oncologist(s) with expertise in the management of lymphoma
- All prescriptions must be checked and prepared by a suitably qualified and experienced pharmacist in a designated pharmacy facility
- Administration of drugs should be supervised by chemotherapy-accredited nursing staff
- Some components of less complex therapies may be delivered in a setting where no haematologist or medical oncologist is available, by another qualified physician. This must always be in strict adherence with the detailed treatment plan and with constant communication as decided by the primary managing facility. This adherence must be completely documented and forwarded to the primary treatment centre.
- Response assessments should be undertaken in the primary treatment centre.

5C.3 Characteristics of the treatment facility

- Appropriate inpatient and ambulatory care facilities for managing these patients
 - Staffing
 - Access to an emergency department with written protocols for the management of complications such as neutropenic fever
 - Readily available haematologists/medical oncologists and hospital medical officers
 - Designated nursing staff with appropriate qualifications and experience
 - Accessible supportive care staff including intensive care, infectious diseases and other subspecialty services
 - Imaging available
 - Pharmacy
 - Multidisciplinary team members as previously designated
 - Ward
 - A day centre with chemotherapy-competent nurses
 - Availability of an inpatient facility for the management of complications
 - Drugs
 - Adequate resources to ensure availability of important drug therapies for treatment and supportive care not reimbursed by the PBS.

5C.4 Additional facility resources or other technical issues are important to effective and acceptable implementation of care

- Haematology nurse coordinator to manage patient flow, communication and ensure appropriate adherence to the management plan.
- Patients of school age require access to an education facility during treatment.

5C.5 Duty of care - communication to the patient and family

- Details of prognosis, treatment and outcomes.
- Other options for therapy including supportive care
- Reliable published information about the disease and its management including aspects such as dietary advice during therapy.
- Information regarding the maintenance of self image (including wigs) and social functioning.
- Information regarding sexual issues.
- Written information regarding specific complications and action to be taken, particularly neutropenic fever

5C.6 Who will be involved in making decisions leading to and arising from treatment?

- The responsible haematologist or medical oncologist is responsible for making decisions.
- The full multidisciplinary team should be available for these patients as required. Dietary advice in particular, is often useful.

Step 5: Implementation of the treatment ***5D: Supportive care***

5D.1 Supportive care required at this time

- Psychosocial support
- Dietician
- Social work including return-to-work planning
- Travel support
- Financial support

5D.2 Who should provide supportive care?

- Multidisciplinary team

5D.3 Where should supportive care be provided?

- Some supportive care could be offered locally, others at the primary treatment facility

5D.4 What else is important to implement supportive care effectively and acceptably?

- Clinical infectious diseases are a major area of impact on outcome for these patients and an adequately resourced reference group for infectious disease management in immuno-compromised patients is required.

5D.5 What should be communicated to the patient and family about options for supportive care?

- Options relating to supportive care should be discussed and should be offered to all patients

5D.6 Who will be involved in making decisions leading to and arising from supportive care?

- The appropriate specialist or member of the multidisciplinary team

Step 6: Follow-up program

6.1 Appropriate models for follow-up care

- The aims of post-treatment follow-up of patients with intermediate-grade lymphoma are broadly:
 - assist with physical and psychological recuperation and recovery from the acute therapy,
 - monitor for evidence of disease recurrence
 - advise on ways of minimising any late adverse effects of therapy and monitor for these, and
 - assist and reinforce general health monitoring and maintenance of a healthy life-style
- The emphasis on these various aspects of follow-up will vary according to the individual circumstances of the patient, the intrinsic risk of relapse of their disease, the treatment intention if relapse were to occur, the long-term risks associated with the initial therapy delivered.
- In the immediate post-therapy setting, the frequency of consultations will be determined by the individual patient's needs, and may be between weekly to every 6 weeks. The primary treating specialist should co-ordinate these, and input from the full spectrum of allied health professionals including a haematology nurse co-ordinator and psychologist may be required.
- The timing and intensity of surveillance for recurrent / progressive disease will be determined by the intended therapy if recurrent disease were identified. This can vary from palliation directed toward symptom control, in which case intensive surveillance for early detection of asymptomatic disease is not warranted, or prompt and intensive intervention with curative intent. Thus a clear decision regarding the likely approach to therapy for relapse should be formulated in each patient before deciding upon a surveillance schedule.
- Most recurrences occur in the first 2 – 4 years after therapy, and the risk of recurrence diminishes, but is never totally abolished, beyond this point. When recurrences occur, they are usually detected by investigations of new physical findings or patients' symptoms, or by "non-specific" systemic tests such as serum LDH. It is uncommon for asymptomatic recurrences to be detected by routine CT scans, which are relatively expensive.
- A reasonable surveillance schedule is clinical assessment with a careful history and physical examination, full blood examination (FBE) and LDH assessment every 3 months for the first 2 – 3 years after treatment, then every 4 – 6 months until 5 years, then annually indefinitely. Imaging studies would be added to this schedule dependent on the therapeutic plan for management of relapse with the frequency determined by the level of individual patient risk and specific modality (CT or functional imaging) based on the region considered to be at risk and the presence of residual radiological abnormalities, in which structural imaging may be less sensitive to minor changes.
- Potential late effects of therapy that may require specific screening and monitoring will be determined by the primary treatment used, and if radiation was incorporated, the doses used and fields treated. These may include endocrine surveillance (pituitary, thyroid, gonadal), cardiac assessment, osteoporosis,

myelodysplasia, renal function, and secondary malignancies, particularly breast cancer in females where mediastinal radiation was delivered.

- Finally, general population health recommendations regarding lifestyle and screening tests (PAP smears, mammography, ...) should be reinforced at each visit.

References

Australian Cancer Network Working Party on the Diagnosis and Management of Lymphoma (Draft Guidelines) Clinical Practice Guidelines for the Diagnosis and Management of Lymphoma, September 2004

Wooldridge JE, Link BK. Post-treatment surveillance of patients with lymphoma treated with curative intent. *Semin Oncol* 2003; 30: 375-381

6.2 Who should be involved in patient follow up?

- The primary treating clinician is best qualified to supervise and guide the follow-up of the patient with the input from other specialists and allied-health practitioners as required. In some areas, specialised "long-term follow-up" clinics are in place and may be appropriate for patients with complex, high-risk or multi-system long-term surveillance needs.

6.3 Duty of care - communication to the patient and family about the possibilities of recurrence

- The patient, family and GP should be informed in detail and language appropriate to their needs about (a) the risk and timeframe of potential relapse, (b) potential symptoms or signs, (c) the broad treatment intention if relapse were to occur, (d) the planned monitoring schedule, (e) the spectrum of potential late-effects of therapy and measures able to minimise these and the screening tests, if any, planned to monitor for these.

Step 7: Recognition of disease recurrence and determination of treatment program

7.1 Investigative tests and appropriate referrals in the event of recurrence:

- CT scanning with comparison to post-treatment scans, functional imaging with PET scanning can be supportive
- Re-biopsy of lesions may be considered, but is not always required. Bone marrow biopsy may be necessary if aggressive treatment is being considered
- LDH levels, and other testing necessary to determine prognostic and risk factors

7.2 Who should manage this part of the program?

- As for initial diagnosis, a team with a haematologist/medical oncologist +/- radiation oncologist and access to facilities for high-dose therapy and autologous stem-cell transplantation and collection of peripheral blood stem cells

7.3 Duty of care - communication to the patient and family

- Investigations needed to confirm relapse, treatment plan, prognosis
- Involvement of carers
- Involve other members of multidisciplinary team as required for medical treatment, travel, psychological and social support

7.4 Who should be involved in determining the treatment path taken?

- As for 4.1
- Psychological and practical support aimed at managing the patient in their home environment as much as practical
- Liaison and communication with multidisciplinary team
- Alerting clinicians of concerning side-effects and reinforcing need for urgent care in specific circumstances e.g. febrile neutropenia

7.5 What psychosocial support should be provided at this time?

- Multidisciplinary team including social workers
- GP
- Liaison psychiatry, psychology as needed

Step 8: Implementation of the treatment program for recurrence

8.1 What treatment/s is it most likely that a patient will have if the cancer recurs?

- **SURGERY:** Surgery may be required to confirm recurrence and to establish histological category at recurrence, and for insertion of intravenous access devices.
- **RADIOTHERAPY:** Radiotherapy may be required as part of a potentially curative approach, usually in combination with systemic therapy (including Total Body Irradiation (TBI)), or may be used for palliation.
- **DRUG THERAPY:** Systemic chemotherapy is the key component of treatment for recurrent aggressive lymphoma, and may be used with potentially curative intent or for palliative purposes. High dose chemotherapy and autologous stem cell transplantation should be considered in fit patients with recurrent aggressive lymphomas. Rarely, allografting may be considered.
- **SUPPORTIVE CARE:** as for initial management. There may be greater emphasis on end of life issues in patients unsuitable for attempts at curative therapy.
- **PALLIATION:** All patients will require symptomatic care, and for patients with no curative salvage option, symptom management will be progressively required during the illness.

8.2 Qualifications and experience of the person/s administering the treatment?

- **SURGERY:** Surgeon familiar with the requirements for tissue handling for evaluation of haematological malignancy.
- **RADIOTHERAPY:** Radiation oncologist with training, experience and ongoing involvement in the treatment of patients with lymphoma.
- **DRUG THERAPY:** Haematologist/medical oncologist with experience in the management of haematological malignancies.
- An appropriately experienced haematologist / medical oncologist or Transplant physician should manage transplantation in the setting of a centre with adequate resources to support such a programme.
- **SUPPORTIVE CARE:** as for initial management
- **PALLIATION:** as for initial management

8.4 In what way do the requirements for the treatment facilities differ from those required for the initial treatment?

- **SURGERY:** no difference
- **RADIOTHERAPY:** no difference
- **DRUG THERAPY:** Greater likelihood of requiring transplantation facilities.

- SUPPORTIVE CARE: no difference
- PALLIATION: Greater likelihood of requiring palliative care involvement.

8.4 Duty of care - communication to the patient and family

- The patient should be provided with information regarding the diagnosis of recurrence, prognosis and management options, consistent with the patient's educational, intellectual and cultural background, and the types/risks of potential treatment options.
- This information should be communicated as it becomes available, by the managing haematologist/medical oncologist, as well as other members of the management team (eg transplant physician, radiation oncologist)
- Patients need sufficient information about the outlook to make informed decisions about management options, for example with and without aggressive chemotherapy. Patients should be made aware of potentially curative options where relevant. The timing of this discussion will depend on the urgency of decisions required and the patient's abilities to cope.
- All patients should be made aware of the availability of symptomatic treatments and the palliative care team.

8.5 Who will be involved in making decisions leading to and arising from treatment?

- Patients' decisions should be assisted by information/recommendations from the primary treating haematologist/medical oncologist, in consultation with other members of the managing team, including the transplant physician and radiation oncologist.
- The managing haematologist/medical oncologist should have expertise in the management of lymphomas and appropriate communication skills.

Step 9: End of life care

9.1 Is this patient group likely to require end of life care at this time?

- A substantial proportion of patients with intermediate grade lymphoma will die of the disease despite optimal therapy
- Palliation is often complex in these patients requiring multidisciplinary care including important roles for palliative chemotherapy and radiotherapy to optimise quality of life.

9.2 Who should provide end of life care?

- Essential to have close liaison between palliative care team and Haematologist/Medical Oncologist through the patient's journey. This is to ensure optimal symptom control using all modalities that maybe appropriate to the situation – eg high-dose steroids, local radiotherapy, careful management of symptomatic infections such as candida and herpetic ulcers, etc.
- More so than many other types of malignancy the boundary between active treatment and palliation is fluid.

9.3 Characteristics of the facility

- Range of options important due to wide spectrum of need. Home based care often appropriate with community medical support.
- Symptom control may require reasonably expedient medical review.
- Patients often require recurrent admissions for symptom stabilisation therefore easy of access for family a significant issue.
- Ideally an available inpatient facility with a well resourced and integrated community/domiciliary programme.
- Nursing staff with palliative care expertise and a working knowledge of haematologic malignancy (Role for shared intellectual capital via information systems).
- Access to radiotherapy/chemotherapy facilities and transfusion support for some patients – need not be onsite.

9.4 What other facility resources or other technical issues are important to implement end of life care effectively and acceptably?

- Discussed above

9.5 Duty of care - communication to the patient and family about end of life care

- Due to protean clinical presentations and treatment options in palliation of lymphoma it is important the discussion involves a haematologist/medical oncologist with experience in managing advanced/refractory lymphoma to ensure potential options understood.

9.6 Who will be involved in making decisions leading to and arising from end of life care?

- Decisions require input from both palliative care specialist and haematologist/medical oncologist as discussed above

9.7 Other relevant issues

- As in all palliative care situations availability of social work, spiritual care and family support.
- Not uncommonly patients can be from younger age group with special needs (adolescent, parents of young children etc)

Abbreviations

ACN	Australian Cancer Network
CT	Computerised tomography
FBE	Full blood examination
GP	General practitioner
HIV	Human immunodeficiency virus
LDH	Lactate dehydrogenase
PET	Positron emission tomography
TBI	Total body irradiation
U & E	Urea & Electrolytes
WHO	World Health Organisation

References

National Comprehensive Cancer Network, Clinical Practice Guidelines in Oncology – Non-Hodgkin’s Lymphoma v1, 2005

Wooldridge JE, Link BK. Post-treatment surveillance of patients with lymphoma treated with curative intent. *Semin Oncol* 2003; 30: 375-381

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- Barton M, et al. *A Cancer Services Framework for Victoria and future directions for the Peter MacCallum Cancer Institute*. The Collaboration for Cancer Outcomes Research and Evaluation (CCORE), July 2003.
- National Comprehensive Cancer Network, *Clinical Practice Guidelines in Oncology – Acute Myeloid Leukaemia v2*, 2005
- National Comprehensive Cancer Network, *Clinical Practice Guidelines in Oncology – Non-Hodgkin's Lymphoma v1*, 2005
- Australian Cancer Network Working Party on the Diagnosis and Management of Lymphoma (Draft Guidelines) *Clinical Practice Guidelines for the Diagnosis and Management of Lymphoma*, September 2004
- Consan Pty Ltd, *Report on the Patient Management Framework Workshop sponsored by the Ministerial Taskforce for Cancer*, March 2005

Appendix 1: Membership of the steering committee

- Professor Bob Thomas, Chair, Clinical Services Working Group of Ministerial Taskforce for Cancer
- A/Professor Jeff Szer, Department of Haematology and Medical Oncology, Royal Melbourne Hospital
- Dr John Seymour, Department of Haematology, Peter MacCallum Cancer Centre

Appendix 2: List of Attendees

NAME	ORGANISATION
Professor David Ashley	Royal Children's Hospital
Dr Philip Campbell	Barwon Health
Dr Lynda Campbell	St Vincent's Hospital Melbourne
Mr Jeff Deslandes	Lymphoma Patient Support
Ms Leanne Fagg	Cancer Connect
Professor Dick Fox	Royal Melbourne Hospital
Dr Michelle Gold	Alfred Hospital
Dr John Hounsell	St John Of God Hospital Warrnambool
A/Prof Surender Juneja	Royal Melbourne Hospital
Ms Katrina Lewis	Alfred Hospital
Dr Raymond Martyres	The Rathdowne Street Surgery
Ms Yvonne Panek-Hudson	Royal Melbourne Hospital
A/Professor Miles Prince	Peter MacCallum Cancer Centre
Dr John Seymour	Peter MacCallum Cancer Centre
Professor Richard Smallwood	Chair, Ministerial Taskforce for Cancer
Dr Carole Smith	Austin Health
A/Professor Ray Snyder	St Vincent's Hospital
Dr Andrew Spencer	Alfred Hospital
A/Professor Jeff Szer	Royal Melbourne Hospital
Professor Robert Thomas	Chair, Clinical Services Working Group, Ministerial Taskforce for Cancer
Dr Peter Waxman	Department of Human Services
A/Prof Andrew Wirth	Peter MacCallum Cancer Centre

Appendix 3: Computer template

Tumour:

STEP 1: AT COMMUNITY LEVEL, RECOGNITION OF POTENTIAL CANCER SIGNS OR SYMPTOMS, OR ABNORMAL RESULTS FROM A SCREENING TEST

APPROXIMATE TIME FOR STEP 1: 30 MINUTES

1.3 What are the symptoms that might be indicative of cancer and should lead to consultation with a General Practitioner?

GROUP VIEWS:

List **References** supporting these views or indicate level of consensus.

1.5 What is the preferable timeframe for consultation with GP after signs are recognised by the consumer?

GROUP VIEWS:

List **References** supporting these views or indicate level of consensus.

1.3 Who constitutes high risk for this cancer?

- What should be done for high-risk patients and others at higher than normal risk?
- Who should be involved?

Group views:

1.5 Other relevant issues

Group views:

STEP 2: INITIAL DIAGNOSTIC CONSULTATION WITH GENERAL PRACTITIONER

APPROXIMATE TIME FOR STEP 2: 40 MINUTES

TESTS

2.1 What are the diagnostic tests required to identify the cause of the symptom complex or screening issue?

Include:

- How should this happen?
- Who should undertake the testing?
- How quickly should this happen?
- What is the optimal timeframe for receipt of results?
- Is prior discussion with a specialist useful?

Group views:

List **References** supporting these views or indicate level of consensus.

DUTY OF CARE

2.4 What is the optimal referral process?

Group views:

2.3 What should be communicated to the patient and family?

Include:

- How should this happen?
- Who should be involved?

Group views:

List **References** supporting these views or indicate level of consensus.

2.4 Other relevant issues

Group views:

GENERAL ISSUES RELATING TO STEPS 1 & 2

SUGGESTED TIME: 10 MINUTES

Important consumer issues relating to Steps 1& 2:

Group views:

What should be recorded so that it is possible to monitor that best practice has occurred in Steps 1 & 2?

Group views:

How can the process be modified to account for the following?

- residence in rural/regional areas
- cultural/racial background
- socio-economic class
- financial issues

Group views:

STEP 3: REFERRAL TO, AND DIAGNOSIS BY, APPROPRIATE CLINICAL SPECIALIST/S

APPROXIMATE TIME FOR STEP 3: 40 MINUTES

DUTY OF CARE

3.1 Who should the patient be referred to?

- What is the preferable time before referral occurs?

Group views:

3.2 What should be communicated from General Practitioner to specialist?

- What should be done by the General Practitioner to ensure that an appointment is made and that the consumer attends the appointment?

Group views:

3.3 What should be communicated to the patient and family?

Include:

- How should this happen?
- Who should be involved?

Group views:

3.4 What is the optimal referral process?

Include:

- What qualifications and experience should the initial specialist possess?
- Might it be necessary for the initial specialist to make a further referral?
- If so, to whom?

Group views:

List **References** supporting these views or indicate level of consensus.

3.6 Other relevant issues

Group views:

GENERAL ISSUES RELATING TO STEP 3

SUGGESTED TIME: 10 MINUTES

Important consumer issues relating to Step 3:

Group views:

What should be recorded so that it is possible to monitor that best practice has occurred in Step 3?

Group views:

How can the process be modified to account for the following?

- residence in rural/regional areas
- cultural/racial background
- socio-economic class
- financial issues

Group views:

STEP 4: DETERMINATION OF TREATMENT PROGRAM

APPROXIMATE TIME FOR STEP 4: 40 MINUTES

MULTIDISCIPLINARY TREATMENT PLANNING

4.1 Who should be involved in determining the treatment path taken?

Include:

- What qualifications and experience should they possess?
- Is there a role for organised second opinion before surgery or other treatment?
- When should multidisciplinary treatment planning take place for this cancer?

Group views:

4.2 What is the preferred model to provide multidisciplinary care in different settings?

- What is needed for this model, i.e. key elements
- Who should take the lead role in this group?

Group views:

List **References** supporting these views or indicate level of consensus.

DUTY OF CARE

4.3 What needs to happen next to implement the treatment program?

Include the following

- Who is responsible for this?
- What should be communicated to the patient and family, and when?
- What should be communicated to other health professionals (including GP), and when?
- How is this documented?

Group views:

List **References** supporting these views or indicate level of consensus.

4.4 Other relevant issues

Group views:

GENERAL ISSUES RELATING TO STEP 4

SUGGESTED TIME: 10 MINUTES

Important consumer issues relating to Step 4:

Group views:

What should be recorded so that it is possible to monitor that best practice has occurred in Step 4?

Group views:

How can the process be modified to account for the following?

- residence in rural/regional areas
- cultural/racial background
- socio-economic class
- financial issues

Group views:

Step 5: Implementation of the treatment

5A: SURGERY

APPROXIMATE TIME FOR STEP 5A: 40 MINUTES

BEST PRACTICE CARE – SURGERY

Is this patient group likely to have surgery?

If **yes** → continue with questions below

If **no** → proceed to **Section 5B**

Specify which patient groups will have surgery:

5A.1 What should be the qualifications and experience of the person who administers the treatment?

Group views:

List **References** supporting these views or indicate level of consensus:

TREATMENT FACILITY

5A.2 What characteristics would the treatment facility possess?

Consider:

- What resources would it require?
- What equipment would be needed?
- What staffing would be needed?
- How easy for patients to access? (parking, public transport, patient transport service, opening hours, costs).

Group views:

5A.3 What other facility resources or other technical issues are important to implement care effectively and acceptably?

Group views:

List **References** supporting these views or indicate level of consensus:

DUTY OF CARE

5A.4 What should be communicated to the patient and family about the treatment?

Group views:

List **References** supporting these views or indicate level of consensus:

MULTIDISCIPLINARY CARE

5A.5 Who will be involved in making decisions leading to and arising from treatment?

- What qualifications and experience should they possess?
- Are further referrals necessary?
- If yes, to whom?
- What qualifications and experience should they possess?

Group views:

List **References** supporting these views or indicate level of consensus:

5A.6 Other relevant issues

Group views:

GENERAL ISSUES RELATING TO STEP 5A – SURGERY

SUGGESTED TIME: 10 MINUTES

Important consumer issues relating to surgical treatment:

Group views:

What should be recorded so that it is possible to monitor that best practice has occurred in surgical treatment?

What could be monitored to measure best practice?

Group views:

How can the process be modified to account for the following?

- residence in rural/regional areas
- cultural/racial background
- socio-economic class
- financial issues

Group views:

5. Implementation of the treatment
5B: RADIOTHERAPY

APPROXIMATE TIME FOR STEP 5B: 40 MINUTES

BEST PRACTICE CARE – RADIOTHERAPY

Is this patient group likely to have radiotherapy?

If **yes** → continue with questions below

If **no** → proceed to **Section 5C**

Specify which patient groups will have radiotherapy:

5B.1 What should be the qualifications and experience of the person who administers the treatment?

Group views:

List **References** supporting these views or indicate level of consensus:

TREATMENT FACILITY

5B.2 What characteristics would the treatment facility possess?

Include:

- What resources would it require?
- What equipment would be needed?
- What staffing would be needed?
- How easy for patients to access? (parking, public transport, patient transport service, opening hours, costs).

Group views:

5B.3 What other facility resources or other technical issues are important to implement care effectively and acceptably?

Group views:

List **References** supporting these views or indicate level of consensus:

DUTY OF CARE

5B.4 What should be communicated to the patient and family about the treatment?

Group views:

List **References** supporting these views or indicate level of consensus:

MULTIDISCIPLINARY CARE

5B.5 Who will be involved in making decisions leading to and arising from treatment?

- What qualifications and experience should they possess?
- Are further referrals necessary?
- If yes, to whom?
- What qualifications and experience should they possess?

Group views:

List **References** supporting these views or indicate level of consensus:

5B.6 Other relevant issues

Group views:

GENERAL ISSUES RELATING TO STEP 5B – RADIOTHERAPY

SUGGESTED TIME: 10 MINUTES

Important consumer issues relating to radiotherapy:

Group views:

What should be recorded so that it is possible to monitor that best practice has occurred in radiotherapy?

What could be monitored to measure best practice?

Group views:

List **References** supporting these views or indicate level of consensus:

How can the process be modified to account for the following?

- residence in rural/regional areas
- cultural/racial background
- socio-economic class
- financial issues

Group views:

5. Implementation of the treatment
5C: DRUG THERAPY

APPROXIMATE TIME FOR STEP 5C: 40 MINUTES

BEST PRACTICE CARE – DRUG THERAPY

Is this patient group likely to have drug therapy?

If **yes** → continue with questions below

If **no** → proceed to Section **5D**

Specify which patient groups will have radiotherapy:

5C.1 What should be the qualifications and experience of the person who administers the treatment?

Group views:

List **References** supporting these views or indicate level of consensus:

TREATMENT FACILITY

5C.2 What characteristics would the treatment facility possess?

Include:

- What resources would it require?
- What equipment would be needed?
- What staffing would be needed?
- How easy for patients to access? (parking, public transport, patient transport service, opening hours, costs).

Group views:

5C.3 What other facility resources or other technical issues are important to implement care effectively and acceptably?

Group views:

List **References** supporting these views or indicate level of consensus:

DUTY OF CARE

5C.4 What should be communicated to the patient and family about the treatment?

Group views:

MULTIDISCIPLINARY CARE

5C.5 Who will be involved in making decisions leading to and arising from treatment?

- What qualifications and experience should they possess?
- Are further referrals necessary?
- If yes, to whom?
- What qualifications and experience should they possess?

Group views:

List **References** supporting these views or indicate level of consensus:

5C.6 Other relevant issues

Group views:

GENERAL ISSUES RELATING TO STEP 5C – DRUG THERAPY

SUGGESTED TIME: 10 MINUTES

Important consumer issues relating to drug therapy:

Group views:

What should be recorded so that it is possible to monitor that best practice has occurred in delivery of drug therapy?

- What could be monitored to measure best practice?

Group views:

List **References** supporting these views or indicate level of consensus:

How can the process be modified to account for the following?

- residence in rural/regional areas
- cultural/racial background
- socio-economic class
- financial issues

Group views:

5. Implementation of the treatment 5D: **SUPPORTIVE CARE**

APPROXIMATE TIME FOR STEP 5D: 30 MINUTES

BEST PRACTICE CARE – SUPPORTIVE CARE

5D.1 What types of supportive care will this patient group require at this time?

Group views:

5D.2 Who should provide supportive care?

- What qualifications and experience should they possess?

Group views:

List **References** supporting these views or indicate level of consensus:

5D.3 Where should supportive care be provided?

Consider:

- Variety of supportive care services
- How easy for patients to access? (parking, public transport, patient transport service, opening hours, costs)
- What resources would be required?
- What staffing would be needed?

Group views:

5D.4 What else is important to implement supportive care effectively and acceptably?

Group views:

List **References** supporting these views or indicate level of consensus:

DUTY OF CARE

5D.5 What should be communicated to the patient and family about options for supportive care?

Group views:

List **References** supporting these views or indicate level of consensus:

MULTIDISCIPLINARY CARE

5D.6 Who will be involved in making decisions leading to and arising from supportive care?

- What qualifications and experience should they possess?
- Are further referrals necessary?
- If yes, to whom?
- What qualifications and experience should they possess?

Group views:

List **References** supporting these views or indicate level of consensus:

5D.7 Other relevant issues

Group views:

GENERAL ISSUES RELATING TO STEP 5D – SUPPORTIVE CARE

SUGGESTED TIME: 10 MINUTES

Important consumer issues relating to supportive care:

GROUP VIEWS:

What should be recorded so that it is possible to monitor that best practice has occurred in supportive care?

- What could be monitored to measure best practice?

Group views:

List **References** supporting these views or indicate level of consensus:

How can the process be modified to account for the following?

- residence in rural/regional areas
- cultural/racial background
- socio-economic class
- financial issues

Group views:

STEP 6: FOLLOW-UP PROGRAM

APPROXIMATE TIME FOR STEP 6: 20 MINUTES

6.1 What are appropriate models for follow-up care?

Include:

- What are the appropriate time frames for follow up care?
- What investigative tests are required and at what intervals?
- What referrals may be necessary?
- What support is available for families?

Group views:

List **References** supporting these views or indicate level of consensus:

6.2 Who should be involved in patient follow up?

- What qualifications and experience should they possess?
- If more than one specialist, which is most appropriate for follow up?
- What is the role of the GP?
- What information needs to be supplied to the GP?
- Is a specialist required for follow up care?
- What options do rural patients have?

Group views:

List **References** supporting these views or indicate level of consensus:

DUTY OF CARE

6.3 What should be communicated to the patient and family about the possibilities of recurrence?

- When should this happen?
- Who should be involved?
- What symptoms and signs should the patient be advised to watch out for?
- What support should be provided for patients, families and carers living with cancer?

Group views:

List **References** supporting these views or indicate level of consensus:

6.4 Other relevant issues

Group views:

GENERAL ISSUES RELATING TO STEP 6

SUGGESTED TIME: 10 MINUTES

Important consumer issues relating to Step 6:

GROUP VIEWS:

What should be recorded so that it is possible to monitor that best practice has occurred in Step 6?

Group views:

How can the process be modified to account for the following?

- residence in rural/regional areas
- cultural/racial background
- socio-economic class
- financial issues

Group views:

STEP 7: RECOGNITION OF DISEASE RECURRENCE AND DETERMINATION OF TREATMENT PROGRAM

APPROXIMATE TIME FOR STEP 7: 10 MINUTES

7.1 In the event of recurrence:

- What investigative tests may be required?
- What referrals may be necessary?

Group views:

List **References** supporting these views or indicate level of consensus:

7.2 Who should manage this part of the program?

- What qualifications and experience should they possess?

Group views:

List **References** supporting these views or indicate level of consensus:

DUTY OF CARE

7.3 What should be communicated to the patient and family?

- When should this happen?
- Who should be involved?

Group views:

List **References** supporting these views or indicate level of consensus:

MUTIDISCIPLINARY CARE

7.4 Who should be involved in determining the treatment path taken?

- What qualifications and experience should they possess?
- What specifically is the GP involvement?

Group views:

List **References** supporting these views or indicate level of consensus:

7.5 What psychosocial support should be provided at this time?

- Who should provide this?
- What qualifications and experience should they possess?

Group views:

List **References** supporting these views or indicate level of consensus:

7.6 Other relevant issues

Group views:

GENERAL ISSUES RELATING TO STEP 7

SUGGESTED TIME: 10 MINUTES

Important consumer issues relating to Step 7:

GROUP VIEWS:

What should be recorded so that it is possible to monitor that best practice has occurred in Step 7?

Group views:

How can the process be modified to account for the following?

- residence in rural/regional areas
- cultural/racial background
- socio-economic class
- financial issues

Group views:

STEP 8: IMPLEMENTATION OF THE TREATMENT PROGRAM FOR RECURRENCE

APPROXIMATE TIME FOR STEP 8: 10 MINUTES

8.1 What treatment/s is it most likely that a patient will have if the cancer recurs?

Group views:

SURGERY:

RADIOTHERAPY:

DRUG THERAPY:

SUPPORTIVE CARE:

PALLIATION:

List **References** supporting these views or indicate level of consensus:

8.2 What should be the qualifications and experience of the person/s administering the treatment?

Group views:

SURGERY:

RADIOTHERAPY:

DRUG THERAPY:

SUPPORTIVE CARE:

PALLIATION:

List **References** supporting these views or indicate level of consensus:

8.5 In what way do the requirements for the treatment facilities differ from those required for the initial treatment?

Group views:

SURGERY:

RADIOTHERAPY:

DRUG THERAPY:

SUPPORTIVE CARE:

PALLIATION:

List **References** supporting these views or indicate level of consensus:

DUTY OF CARE

8.4 What should be communicated to the patient and family about the treatment?

Include:

- When should this happen?
- Who should be involved?
- What should be communicated to the patient and family about the outlook?
- When should this happen?
- Who should be involved?
- If appropriate, what should be communicated to the patient and family about palliative care?
- When should this happen?
- Who should be involved?

Group views:

List **References** supporting these views or indicate level of consensus:

MULTIDISCIPLINARY CARE

8.5 Who will be involved in making decisions leading to and arising from treatment?

- What qualifications and experience should they possess?
- Are further referrals necessary?
- If yes, to whom?
- What qualifications and experience should they possess?
- What supportive care should be offered?

Group views:

List **References** supporting these views or indicate level of consensus:

8.6 Other relevant issues

Group views:

GENERAL ISSUES RELATING TO STEP 8

SUGGESTED TIME: 10 MINUTES

Important consumer issues relating to treatment after recurrence:

Group views:

What should be recorded so that it is possible to monitor that best practice has occurred in treatment after recurrence?

- What could be monitored to measure best practice?

Group views:

How can the process be modified to account for the following?

- residence in rural/regional areas
- cultural/racial background
- socio-economic class
- financial issues

GROUP VIEWS:

STEP 9: END OF LIFE CARE

APPROXIMATE TIME FOR STEP 9: 15 MINUTES

BEST PRACTICE CARE

9.1 Is this patient group likely to require end of life care at this time?

Group views:

List **References** supporting these views or indicate level of consensus:

9.2 Who should provide end of life care?

- What qualifications and experience should they possess?

Group views:

List **References** supporting these views or indicate level of consensus:

TREATMENT FACILITY

9.3 What characteristics would the facility possess?

Consider:

- Variety of palliative care services (home, community, hospice)
- Where would it be located?
- How easy for patients to access? (parking, public transport, patient transport service, opening hours, costs)
- What resources would it require?
- What equipment would be needed?
- What staffing would be needed?

Group views:

9.4 What other facility resources or other technical issues are important to implement end of life care effectively and acceptably?

Group views:

List **References** supporting these views or indicate level of consensus:

DUTY OF CARE

9.5 What should be communicated to the patient and family about end of life care?

Group views:

List **References** supporting these views or indicate level of consensus:

MULTIDISCIPLINARY CARE

9.6 Who will be involved in making decisions leading to and arising from end of life care?

- What qualifications and experience should they possess?
- Are further referrals necessary?
- If yes, to whom?
- What qualifications and experience should they possess?

Group views:

List **References** supporting these views or indicate level of consensus:

9.7 Other relevant issues

Group views:

GENERAL ISSUES RELATING TO STEP 9 – END OF LIFE CARE

SUGGESTED TIME: 10 MINUTES

Important consumer issues relating to end of life care:

Group views:

What should be recorded so that it is possible to monitor that best practice has occurred in end of life care?

- What could be monitored to measure best practice?

Group views:

List **References** supporting these views or indicate level of consensus:

How can the process be modified to account for the following?

- residence in rural/regional areas
- cultural/racial background
- socio-economic class
- financial issues

Group views:

Appendix 4: Program

Tuesday 26 April 2005

Time	Item	Facilitator
8.30 – 8.45 am	Welcome	Professor Richard Smallwood Chair, Ministerial Taskforce for Cancer
8.45 – 9 am	Overview of objectives and uses of workshop outputs	Professor Robert Thomas, Chair, Clinical Services Working Group Ministerial Taskforce for Cancer
9.15 – 12.30 pm	Patient management framework – Steps 1, 2, 3 & 4	Group discussion
	Working Morning Tea at 10.30am	
12.30 – 1 pm	Lunch	
1 – 3 pm	Patient management framework – Steps 5	Group discussion
3.15 – 3.30 pm	Afternoon tea	
3.30 – 6 pm	Patient management framework – Steps 6, 7, 8 & 9	Group discussion

