sammanchester

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Suspected Malignancy of unknown primary origin

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Approach to MUO

- A way of acting
- A way of thinking
- A way of communicating

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Definitions

Malignancy of undefined primary origin	Metastatic malignancy identified on the basis of a limited number of tests, without a primary site, before comprehensive investigation.
Provisional carcinoma of unknown primary origin (provisional CUP)	Metastatic epithelial or neuro-endocrine malignancy identified on the basis of histology/cytology, with no primary site detected despite a selected initial screen of investigations, before specialist review and possible further specialised investigations.
Confirmed carcinoma of unknown primary origin (confirmed CUP)	Metastatic epithelial or neuro-endocrine malignancy identified on the basis of final histology, with no primary site detected despite a selected initial screen of investigations, specialist review, and further specialised investigations as appropriate.

National Institute for
Health and Clinical Excellence

Issue date: July 2010

Metastatic malignant disease of unknown primary origin

Diagnosis and management of metastatic malignant disease of unknown primary origin

NICE clinical guideline 104
Developed by the National Collaborating Centre for Cancer

Initial diagnostic phase

- Offer the following investigations to patients with MUO, as clinically appropriate, guided by the patient's symptoms:
  - comprehensive history and physical examination including breast, nodal areas, skin, genital, rectal and pelvic examination
  - *Ask about previous moles*
  - *Examine areas that have been missed*

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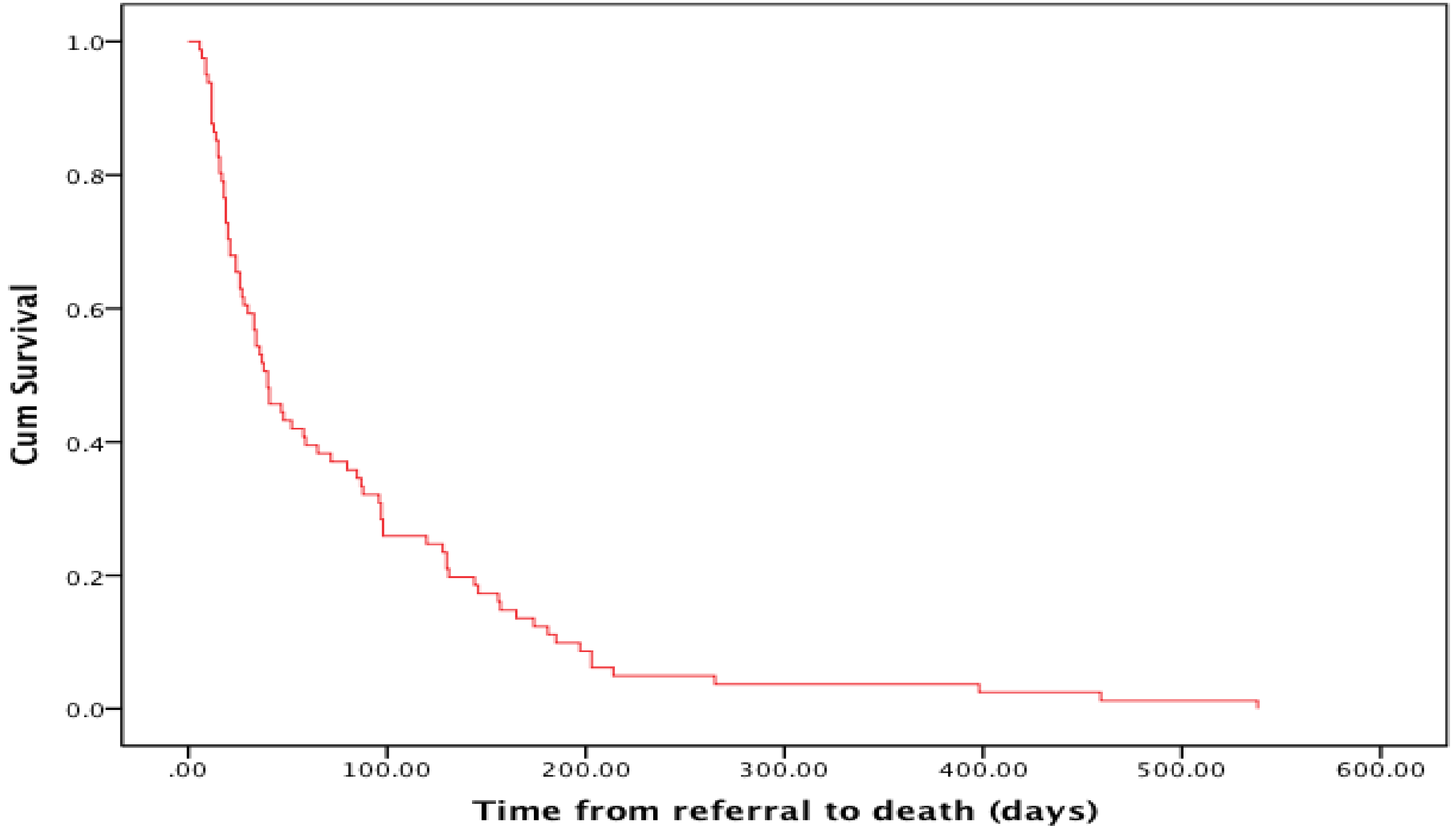
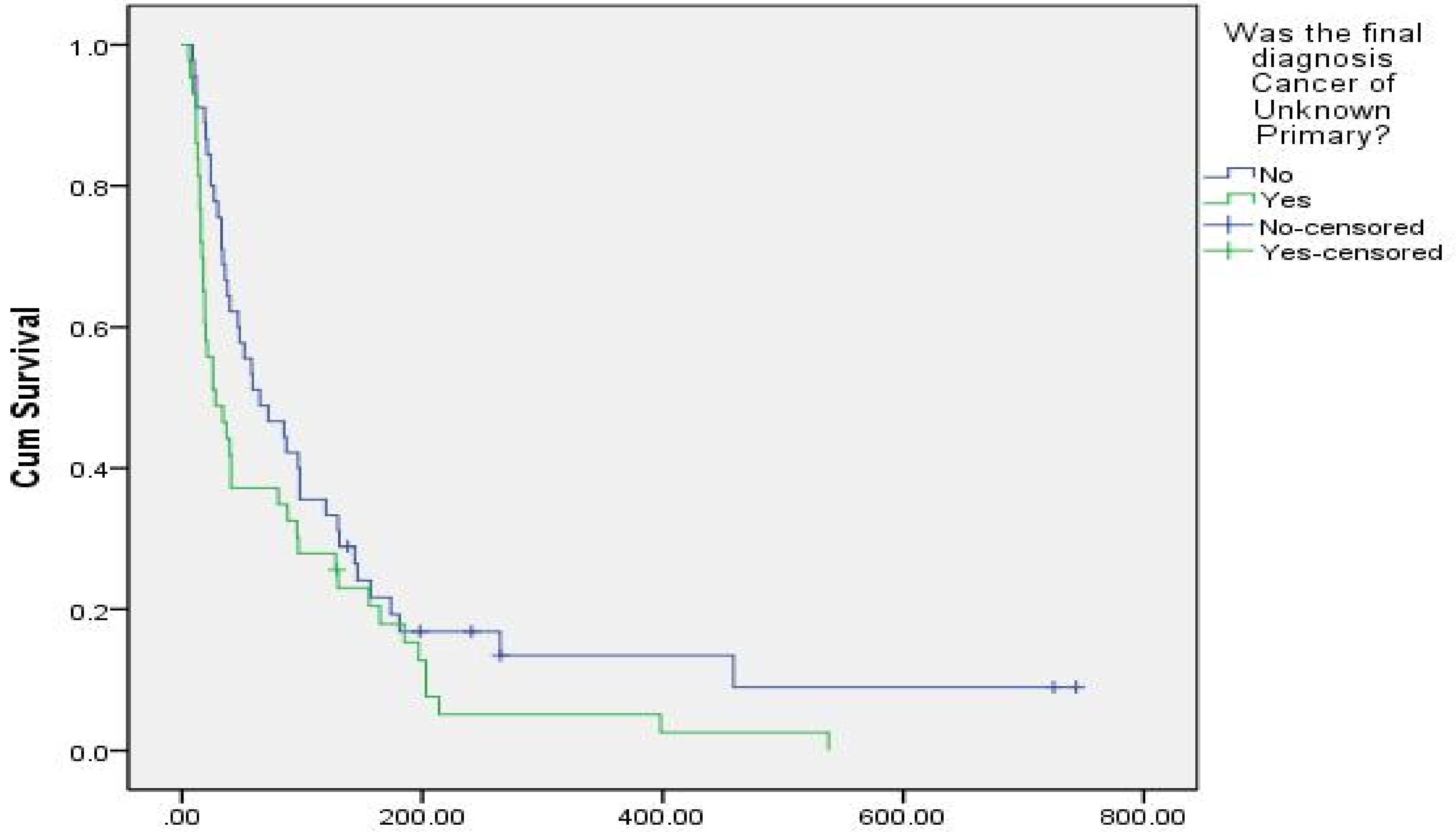
Stop think

- What are the possibilities here diagnostically?
- What is the patient fit for?
- What are the patient’s priorities?
- What does the patient want and not want?

Survival

- From CUP referral to death
  - Median time 40 days
  - Mean 82 days
  - Inter quartile range 19-124 days


Survival Function
Cum Survival
1.0
0.8
0.6
0.4
0.2
0.0
.00
100.00
200.00
300.00
400.00
500.00
600.00
Time from referral to death (days)



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Cum Survival
1.0
0.8
0.6
0.4
0.2
0.0
.00
200.00
400.00
600.00
800.00
Was the final diagnosis Cancer of Unknown Primary?
No
Yes
No-censored
Yes-censored

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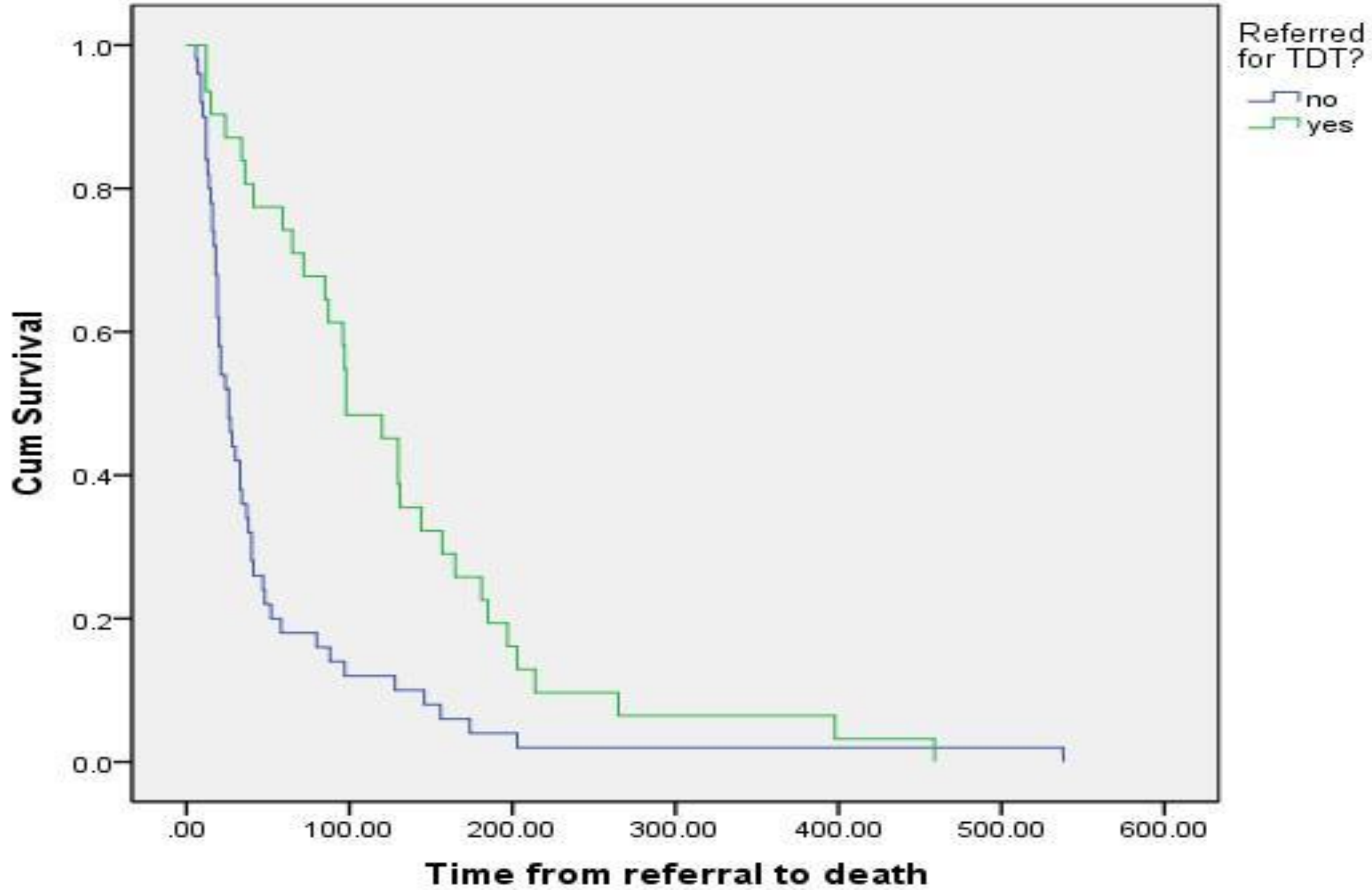

Referral and management

- Refer with MUO to the Unknown Primary team immediately
  - Outpatients using the Fast Track system
    - 2 week wait
  - Inpatients UP team assessment by the end of the next working day
- The UP team should take responsibility for ensuring that a management plan exists which includes:
  - appropriate investigations
  - symptom control
  - access to psychosocial support
  - provision of information.

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Stop think

- What are the possibilities here diagnostically?
- What is the patient fit for?
- What are the patient’s priorities?
- What does the patient want and not want?

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Costs

- During the period 2006-07
  - 25,318 episodes of care for patients in England
  - 308,359 NHS bed-days.
  - approximately 2.0% of all cancer-related inpatient episodes during 2006-07
- average length of stay of between 8 and 10 days
- average length of stay for patients with CUP was higher than for all NHS patients (6.3 days).

Hospital Episode Statistics (admitted patient care), England 2006-07

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Stop think

- What are the possibilities here diagnostically?
- What is the patient fit for?
- What are the patient’s priorities?
- What does the patient want and not want?
- Does the patient really need to be investigated as an inpatient?

Initial diagnostic phase

- Offer the following investigations to patients with MUO, as clinically appropriate, guided by the patient's symptoms:
  - full blood count; urea, electrolyte and creatinine; liver function; calcium; urinalysis; lactate dehydrogenase
  - chest X-ray
  - myeloma screen (where there are isolated or multiple lytic bone lesions)
  - symptom-directed endoscopy
  - computed tomography (CT) scan of the chest, abdomen and pelvis

Wot no tumour markers?

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Tumour markers

- in patients with presentations compatible with germ cell tumours (particularly those with mediastinal and/or retroperitoneal masses and in young men).
  - AFP and hCG
- in patients with presentations compatible with hepatocellular cancer.
  - AFP
- in men with presentations compatible with prostate cancer.
  - PSA
- in women with presentations compatible with ovarian cancer (including those with inguinal node, chest, pleural, peritoneal or retroperitoneal presentations).
  - CA125
    - Carefully interpret the results because of limited test specificity.

Specific presentations

- in men with a presentation compatible with germ cell tumour
  - testicular ultrasound
- In women clinical or pathological features are compatible with breast cancer
  - offer mammography

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Presentations that may benefit from radical treatment

- Squamous carcinoma involving upper or mid-neck nodes
  - Refer to a head and neck MDT.
- Adenocarcinoma involving the axillary nodes
  - Refer to a breast cancer MDT.
- Squamous carcinoma involving the inguinal nodes
  - Refer to a specialist surgeon in an appropriate MDT, to consider treatment with curative intent.
- Radical treatment for solitary metastases
  - Do not investigate a tumour inappropriately because this may make radical treatment ineffective.
  - Consider that an apparent metastasis could be an unusual primary tumour.
  - Refer patients with a solitary tumour in the liver, brain, bone, skin or lung to the appropriate MDT to consider radical local treatment.

When to stop investigations

- Do not offer further investigations to identify the primary site of origin of the malignancy to patients who are unfit for treatment.
- Perform investigations only if:
  - the results are likely to affect a treatment decision
  - the patient understands why the investigations are being carried out
  - the patient understands the potential benefits and risks of investigation and treatment and
  - The patient is prepared to accept treatment.
- Explain to patients and carers if further investigations will not alter treatment options.
  - Provide appropriate emotional and psychological support, information about CUP, treatment options and palliative care.

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Communication

- Don’t wait until the fat lady sings to communicate
- Explain the possibilities and the probabilities
  - One of the possibilities is....
  - Initial tests are suggesting this may be...
  - On the tests we have done so far it is very likely that you have....
    - Cancer
- Explain how you will be sure and when

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Communicate

- Be willing to talk about the possibilities
  - The best case scenario in this situation is that we find this is lymph node swelling due to infection or inflammation.
  - If we do find a cancer then the more treatable ones can be held at bay for many years.
  - However it is possible that we find a cancer where the treatments only buy a few months at best.
  - While we are all hoping for the best it is important to be prepared for the worst.
  - If you want to know which is more likely in your situation....

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Approach to MUO

- A way of acting
  - Start again – history, examination?
- A way of thinking
  - What are the possibilities, what are the patient's priorities, what will change management?
- A way of communicating
  - What do we know, how will we know more and when?
  - Hope for the best but be prepared for the worst.