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- PEG Protocol

Contributors
Introduction
The following clinical guidelines have been developed in consultation as appropriate with Trust MDTs, Heads of Service and the Chemotherapy, Imaging, Pathology and Radiotherapy Cross Cutting Groups.

The guidelines are subject to review and update on a regular basis. Once ratified by the CNG individual MDTs agree to abide by them.

At the time of approval the guidelines were widely circulated via the Network to Acute Trust Cancer Management Teams for trust-wide circulation and to Head & Neck Clinical Leads for circulation to MDT members.

Section One: Referral guidelines

Primary Care Referral Guidelines for Head and Neck Symptoms - 11-1C-121i

The following pathways outline the referral processes for patients with suspected Head and Neck / Thyroid cancer. Guidelines incorporate agreed network criteria for referral of suspected cancer in line with NICE Guidance – Referral Guidelines for Suspected Cancer (revised 2005).

The Network Board in consultation with the Head and Neck CNG have agreed that the diagnosis and assessment of patients with head and neck symptoms should only be carried out by the designated hospitals (Table 1) whose referral points are given in the Network primary care referral guidelines. The table below provides details of designated clinicians, neck lump clinics and thyroid clinics within designated hospitals in the Merseyside and Cheshire Cancer Network, together with contact points for referral. It is confirmed that the ‘designated’ hospitals have specialised facilities for investigation of head and neck patients, and that they have contracted direct patient care sessions with at least two ‘designated clinicians’ for head and neck diagnosis and assessment. It should be noted that this information relates to adult services in line with Improving Outcomes Guidance. Head and Neck clinicians also see children who have been referred with suspected head and neck cancer symptoms. Specialist children’s services are provided at Alder Hey Hospital, Royal Liverpool Children’s Hospital NHS Trust.

At the time of approval the guideline was widely circulated via the Network to Acute Trust Cancer Management Teams for trust-wide circulation; Head & Neck Clinical Leads for circulation to MDT members; Primary Care Trust Cancer Managers (for circulation to all GP’s and GDP’s via formal PCT communication processes). Any future updates will be circulated to primary care via Area Team to CCG’s & GDP.
Network Agreed Referral Proforma - 11-1C-122i

The Network Board in consultation with the Head and Neck CNG have agreed with the PCT Leads in the Network referral guidelines for Primary Care Practitioners regarding patients with head and neck symptoms suspicious of cancer. The proforma may be used for patients for patients with Upper Aerodigestive Tract (UAT) or Thyroid symptoms which are outside the 'urgent suspicion of cancer' definition. The proforma allows for the referrer to categorise a patient by presenting features, so that the hospital can direct the referral to the relevant specialty (e.g. ENT, OMFS). The network-wide format is made locally specific by identifying a single referral point for each designated hospital.

Jan 2007
SUSPECTED HEAD an
**TABLE 1: Network configuration of Head & Neck Services**

<table>
<thead>
<tr>
<th>Designated Hospital</th>
<th>Name of Trust</th>
<th>Designated Head &amp; Neck Clinicians</th>
<th>Designated Thyroid Surgeons</th>
<th>Neck Lump Clinic</th>
<th>Specialist Thyroid Clinic</th>
<th>Contact Point</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aintree Hospital</td>
<td>Aintree Hospitals NHS Trust</td>
<td>N Roland S Jackson T Jones J Lancaster S Tandon J Brown R Shaw F Bekiroglu S Rogers</td>
<td>S Jackson N Roland J Lancaster S Tandon R Hardy</td>
<td>Yes</td>
<td>Yes</td>
<td>See local arrangements</td>
</tr>
<tr>
<td>Royal Liverpool University Hospital</td>
<td>Royal Liverpool &amp; Broadgreen University Hospitals NHS Trust</td>
<td>S Jackson A Panarese R Shaw</td>
<td>A Waghorn A Panarese S Shore</td>
<td>Yes</td>
<td>Yes</td>
<td>Fax No: 706 5655</td>
</tr>
<tr>
<td>Whiston Hospital</td>
<td>St Helen &amp; Knowsley Hospitals NHS Trust</td>
<td>T Jones M Dodd V Nandapalan</td>
<td>V Nandapalan</td>
<td>Yes</td>
<td>Integrated with neck lump clinic</td>
<td>Patient Booking Service Fax 0151 430 1629 Tel 0151 430 1234</td>
</tr>
<tr>
<td>Warrington Hospital</td>
<td>Warrington and Halton Hospitals NHS Trust</td>
<td>S Hampal J Brown</td>
<td>B Taylor N Sarfraz J Hobson</td>
<td>Yes</td>
<td>Yes</td>
<td>Tel: 01925 662744 Fax: 01925 662372</td>
</tr>
<tr>
<td>Countess of Chester Hospital</td>
<td>Countess of Chester Hospital NHS Foundation Trust</td>
<td>J Tahery K Fleming</td>
<td>J Tahery C Harding McKean</td>
<td>Yes</td>
<td>Yes</td>
<td>Appointments Hotline Tel No: 01244 366663 Fax No: 01244 366165</td>
</tr>
<tr>
<td>Arrowe Park Hospital</td>
<td>Wirral Hospitals NHS Trust</td>
<td>S Jackson D C Jones V Srinivasan G O’Sullivan J Sherman</td>
<td>V Srinivasan S Blair</td>
<td>Yes</td>
<td>Integrated with neck lump clinic</td>
<td>Wirral Booking Service Fax 0151 604 7172 Tel 0151 604 7501</td>
</tr>
<tr>
<td>Ormskirk Hospital</td>
<td>Southport &amp; Ormskirk Hospitals NHS Trust</td>
<td>T Lesser M Boyle N Roland</td>
<td>N Roland</td>
<td>Yes</td>
<td>Integrated with neck lump clinic</td>
<td>See local arrangements for choose and book Fax No: 01695 656819</td>
</tr>
<tr>
<td>Leighton Hospital</td>
<td>Mid Cheshire Hospitals NHS Trust</td>
<td>A Dingle F Bekiroglu</td>
<td>A Dingle A Guy</td>
<td>Yes</td>
<td>Integrated with neck lump clinic</td>
<td>Fax No: 01270 612545</td>
</tr>
</tbody>
</table>
NECK LUMP?

THYROID?

Feature Suspicious of Malignancy?

STRIDOR?

Referral Route

**NECK LUMP?**

- Clinically Thyroid
- Clinically Non-Thyroid

**THYROID?**

- No features suspicious of thyroid cancer

**Feature Suspicious of Malignancy?**

- Solitary nodules increasing in size
- Patient with history of neck irradiation or family history of thyroid cancer
- Patient 65 & over
- Unexplained hoarseness or voice change
- Cervical lymphadenopathy
- Very young (pre-pubertal) patient

**STRIDOR?**

- Same day referral to designated clinician or A&E
- Management of stridor then diagnosis

**NO STRIDOR**

- Fast-track appointment to designated clinician for thyroid
- Neck lump or thyroid clinic

**Referral Route**

- Routine appointment to designated clinician for thyroid
- Neck lump or thyroid clinic

See FIG 2
Primary Care Referral – Neck Lump/Non thyroid - Figure 2

NECK LUMP?

THYROID?

See FIG 1

Clinically Thyroid

Clinically Non- Thyroid

Feature Suspicious of Malignancy?

- Lump persists after 3 weeks despite antibiotics.
- Infectious Mononucleosis excluded
- No associated (non-lump) features of malignancy

Lump has associated (non-lump) features of UAT malignancy +/- stridor.

- Hoarseness > 6 weeks
- Oral mucosa ulcer > 3 weeks
- Oral swelling > 3 weeks
- Unexplained red & white patches (including lichens planus of the oral mucosa that are painful or swollen or bleeding
- Unexplained persistent swelling in parotid or submandibular gland
- Unexplained persistent sore throat or painful throat
- Unilateral unexplained pain in the head & neck area >4 weeks, associated with otalgia (earache) but a normal otoscopy
- Orbital masses

Lump disappears within 3 weeks +/- antibiotics or positive for IM.

No associated (non-lump) features of malignancy.

STRIDOR?

NO STRIDOR

- Fast-track appointment to designated clinician for UAT cancer or Haemat-oncology
- Direct referral or to neck lump clinic

NO STRIDOR

- Same day referral to designated clinician or A&E
- Management of stridor then diagnosis

STRIDOR

- Fast-track appointment to designated clinician for UAT cancer
- Direct referral or to neck lump clinic

Referral Route

Primary Care Referral

– Neck Lump/Non thyroid

- Feature Suspicious of Malignancy?

- Lump has associated (non-lump) features of haematological malignancy +/- stridor.

- Lymphadenopathy (>1cm) persisting for more than 6 weeks.

- Lump disappears within 3 weeks +/- antibiotics or positive for IM.

- No associated (non-lump) features of malignancy.
Patient had features suspicious of UAT cancer but no neck lump +/- Stridor:
- Hoarseness > 6 weeks
- Oral mucosa ulcer > 3 weeks
- Oral swelling > 3 weeks
- Unexplained red & white patches (including lichens planus of the oral mucosa that are painful or swollen or bleeding
- Unexplained persistent swelling in parotid or submandibular gland
- Unexplained persistent sore throat or painful throat
- Unilateral unexplained pain in the head & neck area >4 weeks, associated with otalgia (earaches but a normal otoscopy
- Orbital masses

STRIDOR?
- Same day referral to designated clinician or A&E
- Management of stridor then diagnosis

NO STRIDOR
- Fast-track appointment to designated clinician for UAT cancer
- Direct referral or to neck lump clinic

Referral Route

Patient has non-urgent UAT symptoms and no lump

Routine referral to designated hospital
Guideline for referral of patients with Upper Aero-Digestive Tract (UAT), Skull base and Thyroid Cancer – 11-1C-123i/126i/127i

Within Cheshire and Merseyside Strategic Clinical Networks there is an established Head and Neck MDT hosted by Aintree University Hospitals NHS Foundation Trust. The MDT deals with all cases of UAT cancer, salivary gland tumours, UAT cancer involving the skull base and thyroid cancer.

Diagnosis and assessment of patients with head and neck cancer symptoms takes place in designated hospitals with subsequent referral of all cases of UAT, salivary gland, thyroid cancer, and cancer involving the skull base to a core member of the Specialist Head and Neck MDT. The following guideline has been agreed between the network diagnostic and assessment services and the Head and Neck MDT.

1. At the first head and neck outpatient appointment, initial investigations should be undertaken and imaging requested in line with the agreed head and neck clinical pathway

2. Patients with a clinical diagnosis of head & neck cancer should be referred at an early opportunity to an Aintree Head & Neck Surgeon who is a core member of the SMDT.

3. Patients with a presumptive diagnosis of head & neck cancer, where biopsy or FNAC is necessary for initial diagnosis of malignancy should be referred urgently to a designated clinicians or neck lump clinic. Following further investigation, the patient will be referred to and Aintree Head & Neck Surgeon who is a core member of the MDT.

4. In the absence of a definitive diagnosis where suspicion of cancer remains the patient will be referred to the Joint Head & Neck Clinic for further investigation and opinion.

5. If a patient with thyroid cancer is diagnosed as an incidental finding following thyroid surgery, the patient must be referred to the thyroid part of the Head and Neck MDT for discussion of further management.

6. For discussion at MDT the SMDT proforma should be completed and sent to the Head & Neck MDT Co-ordinator on fax no 0151 529 2780 at Aintree Hospital using the agreed MDT Referral Proforma
Section 2: UAT

Clinical Guidelines – 11-1C-103i


Guidelines for the management of neck lumps

This guideline should be read in conjunction with the network-agreed guidelines for the management of thyroid cancer.

National standards for provision of neck lump clinics can be found within the Manual for Cancer Services - Head and Neck Cancer Measures.

GP Management

Determine if there is a history of:

- sore throat
- hoarse voice
- dysphagia
- night sweats
- smoking/drinking
- foreign travel

Examine:

- for other neck lumps
- oral cavity
- oropharynx
- skin of the head
- and neck

In the presence of lymphadenopathy elsewhere +/- hepatosplenomegaly

- check full blood count and glandular fever screen
- consider referral to Haematology

Referral
Refer any patient with a neck lump that persists for more than three weeks for an urgent outpatient appointment using the Head & Neck Cancer referral proforma or to the urgent neck lump clinic.

For patients with generalised lymphadenopathy or neck lumps with a lymphocytosis, refer to the Haematology Department urgently using the Haematology Cancer referral proforma

Hospital Designated Clinics - Rapid Access Neck Lump

- Joint Head & Neck Clinic (Immediate diagnosis)
- ENT or MFU Out Patient Clinic
- Dedicated neck lump clinic

Rapid Access Clinic Management

- History and full endoscopic examination of the upper aerodigestive tract – to be carried out by an appropriately trained Head & Neck Surgeon.
- Fine needle aspiration biopsy +/- ultrasound guidance – to be carried out by an appropriately trained clinician, cytopathologist or radiologist.
- Consider Chest X-Ray and OPG
- If Head and neck malignancy detected or suspected, order MRI neck and CT Thorax
- In the presence of generalised lymphadenopathy or a history of previous lymphoma when recurrence is suspected arrange lymph node biopsy (core or open)

Management

- If the aspirate is of epithelial, salivary or thyroid malignancy, then proceed in line with the Timed Head and neck guidelines
- If the aspirate is suggestive of lymphoma or lymphoid but with a clinical suspicion of lymphoma refer to Haematology MDT and proceed to biopsy.
- Consider staging scans for lymphoma - CT of neck, chest, abdomen and pelvis
- On biopsy send the sample fresh to the Histopathology department where an appropriate sample will be sent to the cytogenetics department at the Women’s Hospital for further studies.
- If tuberculosis or other infection is suspected, fresh material should be sent to microbiology
- If aspirate is inconclusive, repeat.

Follow up Arrangements

- The local protocol should specify who should inform the patient of the diagnosis and in which clinic the patient should be followed up (Head and Neck/ENT specialist or Haematologist). In principle it is the responsibility of the clinician requesting the test to inform the patient of the result.
- To ensure timely management of patients with a diagnosis of lymphoma, liaison between the Cytologist, Head and Neck Surgeon and Haematologist is of paramount importance.
Head & Neck Imaging Protocols – 11-1C-10Si

This complex group of patients require multiple investigations once the diagnosis is established. It is the responsibility of the referring clinician and radiology department within the diagnostic and assessment service to undertake imaging in line with network protocol. Radioisotope scans are the responsibility of the nuclear medicine department.

1. OPG: All patients with head and neck cancer will have full dental assessment preoperatively. This forms part of that evaluation. Every patient referred to the unit with head and neck cancer therefore requires an OPG.

2. Imaging of the primary site and nodal spread: MRI is the investigation of choice when feasible. CT is used as a second best investigation when MR contraindicated or not possible.

3. Chest imaging: All patients with squamous cell carcinoma of the head and neck (stages T1 – T4 inclusive) should have CT of the thorax. CT of chest covers lung apices to bases not upper abdomen. We advise all malignant parotid tumours and sinus tumours should have the same. At Aintree this is performed unenhanced, however this practice may vary locally.

4. Isotope bone scanning and SPECT of mandible: In oral tumours where tumour is in contact with bone and other investigations are negative for bone invasion, a SPECT scan provides evidence of early bone invasion. It is realised that this is a sub specialised field and Aintree are willing to provide this aspect of the protocol when required.

5. Salivary gland tumours can be evaluated by MR. Some centres may wish to provide an Ultrasound based service combined with guided FNA. MR is required when deep lobe extension is possible.

6. PET CT and MRI should be requested immediately (before biopsy of “high risk sites”) as first line investigations if a patient is considered to be a “primary of unknown origin”.

7. PET CT is also of value in assessing the presence of recurrent disease. Where there is a high clinical index of suspicion of recurrence it would be sensible to perform MR or CT to assess the extent of recurrence. In cases where there is clinical doubt it may be more appropriate to proceed direct to PET CT.

MRI
The protocols are intended for guidance, the full protocol might only be needed at initial tumour staging, and even then all the image sequences may not be needed. Limited sequences may be necessary to reduce scan times if the patient is in discomfort or distress. Modifications may be necessary for unusual disease presentation or pattern.

When MR scanning, it is important that gadolinium is used where indicated. If fat suppressed T1 images are to be employed these should be of high quality with homogenous fat suppression. If this is not possible, then routine Spin Echo post gadolinium T1 weighted images can be provided.
The STIR sequence is used as a survey of the whole neck to assess nodal disease as well as the primary site. It is important therefore to cover from the skull base to as low down to the root of the neck as the head and neck coil will allow.

The remaining sequences should concentrate on the primary tumour site and extent of spread utilising as small a field of view for the relevant site as is possible with slices no thicker than 5 mm but preferably thinner.

A dedicated head and neck coil is required.

### NASOPHARYNX

- Axial T1 SE 5mm.
- Axial STIR 5mm.
- Upper and lower blocks will probably be necessary, 5-8mm. slices can be used for the lower block.
- Coronal T2 TSE 5mm.
- Axial T1 post gadolinium 5mm.
- Coronal T1 post gadolinium (optional)
- Sagittal T1 post gadolinium (optional)

### OROPHARYNX

- Axial T1 SE 5mm.
- Axial STIR 5mm.
- Upper and lower blocks will probably be necessary, 5-8mm. slices can be used for the lower block.
- Either
  - Coronal T2 TSE (anterior tumours)
- Or
  - Sagittal T2 TSE (posterior tumours)
- Axial T1 post gadolinium
- Either
  - Coronal T1 post gadolinium
- Or
  - Sagittal T1 post gadolinium

### HYPOPHARYNX

- Axial T1 SE 5mm.
- Axial STIR 5mm.
- Coronal T2 or STIR
- Sagittal T2 TSE
- Axial T1 post gadolinium
- Sagittal T1 post gadolinium

### LARYNX

- Axial T1 SE 5mm.
- Axial STIR 5mm.
- Coronal T2 or STIR
### Axial T1 post gadolinium

#### SALIVARY GLAND
- Axial T1 SE 5mm.
- Axial STIR 5mm.
- Coronal T2 or STIR
- Axial T1 post gadolinium

#### SINUSES
- Axial T1 SE 5mm.
- Axial STIR 5mm.
- Coronal T1
- Coronal T2
- Axial T1 post gadolinium
- Coronal T1 post gadolinium

#### RECURRENT TUMOUR IN NECK
- Axial T1 SE 5mm.
- Axial T2 TSE 5mm.
- Axial STIR 5mm.
- Axial T1 post gadolinium
- Coronal T1
- Coronal T1 post gadolinium

#### CT

#### HEAD & NECK
- Start position just below skull base.
- End position sternal notch – thoracic inlet.
- 100 ml. IV contrast (300)
- 5mm. Helical acquisition – other parameters machine dependent

#### LARYNX
- Angle of jaw to sternal notch – thoracic inlet
- 100 ml. IV contrast (300)
- 2.5mm. 3.00mm. slice thickness
Pathology Guidelines for Upper Aero-Digestive Tract Cancer – 11-1C-107i

The Head and Neck CNG has agreed network wide pathology guidelines for the diagnosis and assessment of Upper Aero-Digestive Tract (UAT), including salivary gland cancers and UAT cancer involving the skull base. The guidelines address:

- Laboratory and histopathological / histochemical investigations
- Their specific indications
- Which parts of the investigational protocol should be the responsibility of the Diagnostic and Assessment Service and which should be that of the MDT
- The guidelines are distributed to the designated clinicians for UAT cancer
- There is prior discussion of the case with an oncologist or haematology-oncologist (which one, at the clinician’s discretion) before core or excisional biopsies on non-thyroid neck lumps are carried out.

The Royal College of Pathologists guidelines for the reporting of Head and Neck Carcinomas and Salivary Neoplasms are available at the weblinks below:

Oral cavity:  
http://www.rcpath.org/Resources/RCPath/Migrated%20Resources/Documents/G/g110_oralmucosaldataset_dec11.pdf

Pharynx:  
http://www.rcpath.org/Resources/RCPath/Migrated%20Resources/Documents/G/g110_oralmucosaldataset_dec11.pdf

Lymph node excisions and neck dissections:  
http://www.rcpath.org/Resources/RCPath/Migrated%20Resources/Documents/G/g112_neckdissectiondataset_dec11.pdf

Larynx:  
http://www.rcpath.org/Resources/RCPath/Migrated%20Resources/Documents/G/g113_larynxmucosaldataset_dec11.pdf

Nasal cavity and paranasal sinuses:  
http://www.rcpath.org/Resources/RCPath/Migrated%20Resources/Documents/G/g114_noseinesisdataset_dec11.pdf

Salivary glands:  
http://www.rcpath.org/Resources/RCPath/Migrated%20Resources/Documents/G/g115_salivarydataset_dec11.pdf

Colleagues in our Network were closely involved in the development of these national guidelines.

In addition, the following is agreed:
1. Following FNA/biopsy, responsibility for taking action lies with the diagnostic and assessment service. Responsibility for taking action following surgical resection lies with the MDT.

2. Pathology results are sent to the patient’s clinician at University Hospital Aintree, via the consultant secretary. Results requiring a second opinion are sent to Dr T Helliwell, Dr J Sheard or Dr J Woolgar for a specialist review directly from pathology or via the consultant secretary.

3. Following specialist review, the pathology report is despatched to both the referring pathologist and attending specialist.

4. Discussion of the case will take place with an oncologist or haemato-oncologist before core or excisional biopsies of non-thyroid neck lumps are carried out in line with the network agreed guideline for the Management of Neck Lumps (p.12) agreed by the Head and Neck CNG and Haematology CNG.
Timed Head & Neck Pathway

1st appt by DAY 7

Scan results/OPD appt by DAY 14

Endoscopy by DAY 21

MDT discussion by DAY 28

Further investigations/assessment

Referral: GP / GDP / Intra Hospital

Local OPD: ENT / MFU / Head and Neck / Neck Lump Clinic

- To include as appropriate:
  - USS + FNAB
  - Nasendoscopy
  - OPG
  - MRI neck
  - CT chest
  - Oral biopsy
  - PET/CT for unknown primary

Referral to/discussion with Aintree H & N Clinician

- Consider most appropriate place for diagnostic biopsy

Endoscopy not required

- Oral lesions biopsied under LA

GA Assessment at Aintree

- Endoscopy
- Biopsy
- Staging

Endoscopy at referring hospital

- Incidental T1 tumours
- Inoperable tumour

MDT Meeting and Treatment Plan

Joint Head & Neck Clinic/Dental Assessment

- Review of patient and investigations
- Further investigation as appropriate
- Dental Assessment

Pre Treatment Assessment Session

- Same Day as MDT if possible
- Treatment plan discussed with patient
- Psychological Support
- Nutritional Assessment including referral for PEG

Surgery Radiotherapy/Chemotherapy Palliative Care

MDT

- Pathology Results
- Discussion regarding further treatment

Follow Up

- Joint Head and Neck Clinic Aintree
- Local Designated Hospital

Aintree contact details

Please use attached referral form and send to:
ahn–lr.AintreeHeadNeckMDT@nhs.net
or
FAX: 01515292780

Referral: GP / GDP / Intra Hospital
Best practice standard:

- Implement one stop neck lump clinics to enable inadequate FNA to be repeated while patient is in clinic
- Ensure booking at key stages – e.g. arrange scan date before patient leaves clinic
- Ensure immediate referral to/discussion with Aintree clinician at end of local head and neck clinic
- Include date of local scan in referral letter to Aintree clinician
- Upload images prior to referral to MDT
- Ensure full details are provided in the MDT referral form
- Consider allocating slots for MR or CT based on historical demand
- Request PET CT scan for unknown primaries when MR requested – if MR scan shows primary, cancel PET CT immediately
- Make decision regarding location of scope (local or Aintree) at time of first OPD
- Plan endoscopy date when MR date is known
- Agree ‘escalation procedures’ if steps exceed those in the timed pathway
- Ensure non-designated clinicians are aware of internal referral guidelines
Head & Neck Dental Pathway

All OPG images to be uploaded to Aintree servers from peripheral hospitals

Aintree - blue imaging request form needs OPG adding

Local teams – clinicians letter to include OPG request

**Head & Neck Dental Pathway**

**OPD**

- OPG at same time as primary diagnostic imaging MRI, CT etc.

**MDT**

- **OPG review form** to be completed for all new patients having surgery at Aintree.
  - MFU team/C Butterworth
  - (Completed forms to be filed in notes with MDT decision form)

**Surgery**

- Extractions by MFU team and for ENT by arrangement

**Chemo-radiation**

- CCC Dental Clinic to undertake dental assessment and treatment

**Aim:**

100% of patients have OPG available at MDT

100% of patients having surgery for head and neck cancer have OPG assessment form completed at MDT
Section 3: Thyroid

Clinical Guidelines – 11-1C-103i


Guidelines for the Management of Thyroid Tumours - 11-1C-103i

GP Management

Determine if the neck lump is in the thyroid. If it is not, then the patient should be referred to a rapid access neck lump clinic as indicated. If the lump is in the thyroid then ascertain if the lump is suspicious.

Thyroid nodules can afflict up to 35% of the general population and it is important to remember that the vast majority of thyroid nodules will be benign. The aim is to investigate those nodules that are suspicious appropriately and to treat those that are cancerous expeditiously.

Features suspicious of cancer associated with a thyroid lump:

- Solitary nodules increasing in size
- Patient with a family history or history of neck irradiation
- Patient over 65
- Unexplained hoarseness or voice change
- Associated cervical lymphadenopathy
- Very young (pre-pubertal) patient

Referral

All patients should have thyroid function tests checked at the time of referral.

1. Patients with a “suspicous” thyroid lump:
   - Fast track appointment (Head & Neck Cancer Proforma for an urgent outpatient appointment) to the Rapid Access Neck Lump or Thyroid/Endocrine clinic.

2. Patient with Stridor with thyroid lump (or any other neck lump):
   - Same day referral to ENT department or AED

3. No features suspicious of thyroid cancer:
   - Routine appointment to Head & Neck Lump or Thyroid/Endocrine clinic
**Hospital Designated Clinics**
- Rapid Access Neck Lump Clinics (ENT/Head and Neck Surgery Clinics)
- Thyroid / Endocrine Clinics

**Rapid Access Clinic Management**
- History and full examination of the neck – to be carried out by an appropriately trained Head & Neck or Designated Thyroid Surgeon.
- Fine needle aspiration biopsy with ultrasound guidance – to be carried out by an appropriately trained clinician, cytopathologist or radiologist. If FNA is inconclusive or inadequate, discuss with the cytopathologist and consider a repeat biopsy. Core biopsy should also be considered.
- Thyroid Function Tests. Patients who have biochemical hyperthyroidism should have a radio isotope scan as initial investigation.
- If thyroid malignancy is confirmed then the patient should be referred to or managed by the designated clinician with interest in thyroid cancer.

**Management**
- If differentiated thyroid cancer proceed as per Thyroid Cancer and Head and Neck guidelines which will include early liaison with Nuclear Medicine.
- Radiological investigations for head and neck malignant nodes will usually indicate MRI scan Neck/CTS chest as per guidelines.
- Medullary carcinoma should be assessed by an endocrinologist for associated endocrine pathology
- If lymphoma on the FNA refer to Haematology MDT and proceed to biopsy if deemed necessary. Similarly proceed to biopsy where low-grade lymphoma cannot be excluded. Staging scans for lymphoma should be CTS of neck, chest, abdomen and pelvis.

**Thyroid MDT**
- All cases of thyroid cancer must be presented and discussed at the MDT
- Liaison between primary care doctors, radiologists, cytologists, endocrinologists and the attending surgeons at all levels is of paramount importance.

For further detail refer to British Thyroid Association guidelines [http://www.british-thyroid-association.org/Guidelines/](http://www.british-thyroid-association.org/Guidelines/)
Lymph Node Resection for Thyroid Cancer – 11-1C-109i

Hemi-thyroidectomy, total thyroidectomy and level 6 dissection is undertaken outside Aintree for well differentiated thyroid cancer following agreement by the SMDT. Complex thyroid cancer including medullary cancer and those well differentiated cancers that may have local invasion or lymph nodes outside level 6 are undertaken at Aintree.

The following list provides details of the named surgeons authorised to perform lymph node resection on thyroid cancer patients.

Patients who have undiagnosed and unsuspected lymphadenopathy at Level 6 should undergo a clearance at the time of thyroidectomy. The policy pertains to pre-diagnosed cervical lymphadenopathy secondary to thyroid cancer.

Each member is a core member of the Head and Neck MDT.

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mr N J Roland</td>
<td>Consultant ENT/Head &amp; Neck Surgeon</td>
<td>Aintree University Hospital NHS Foundation Trust</td>
</tr>
<tr>
<td>Mr S Jackson</td>
<td>Consultant ENT/Head &amp; Neck Surgeon</td>
<td>Aintree University Hospital NHS Foundation Trust</td>
</tr>
<tr>
<td>Mr T Jones</td>
<td>Consultant ENT/Head &amp; Neck Surgeon</td>
<td>Aintree University Hospital NHS Foundation Trust</td>
</tr>
<tr>
<td>Mr J Lancaster</td>
<td>Consultant ENT/Head &amp; Neck Surgeon</td>
<td>Aintree University Hospital NHS Foundation Trust</td>
</tr>
<tr>
<td>Mr S Tandon</td>
<td>Consultant ENT/Head &amp; Neck Surgeon</td>
<td>Aintree University Hospital NHS Foundation Trust</td>
</tr>
</tbody>
</table>
Thyroid Clinical Pathway

**GP Referral**
- Intra Hospital Referral

**OPD**
- Neck Lump Clinic/Specialist Thyroid Clinic
  - Clinical Assessment
  - Thyroid Function Tests
  - FNAB with ultrasound guidance
  - Ultrasound neck
  - Radioisotope Scan in presence of Hyperthyroidism and a palpable nodule prior to USS

**Medullary Carcinoma**
- Refer to Head & Neck Surgeon
- Family Screening
- RET Proto-Oncogene.
- Calcitonin.
- Urinary Catecholamines
- MRI Neck
- CT Chest/Abdo
- In\(^{111}\) Octreotide scan

**Differentiated Thyroid Cancer**
- MRI +/- CT Thorax recommended if suspicion of invasive or nodal disease.

**Anaplastic Cancer**
- Follow Thyroid Cancer Pathway unless acute presentation e.g. stridor when emergency airway management needed

**Lymphoma**
- Refer to Haemato-oncologist
- Open biopsy thyroid or node
- CT Chest/Abdo/Pelvis

**MDT Meeting and Treatment Plan**

**Radio Iodine**

**Surgery**

**RXT ± Chemo**

**Palliative Care**

**MDT**
- Post Op Review
- Pathology Results
- Plan for Future Treatment
- Recurrence

**Follow Up**
- Local Designated Thyroid Clinician and Nuclear Medicine if Isotope Ablation (Shared Care)
**Imaging strategy for thyroid cancer - 11-1C-106i**

Ultrasound guided FNAB is the first investigation in all cases of suspected Thyroid Nodule (as per Thyroid Management Guidelines) unless the patient is biochemically hyperthyroid when they should have an initial radioisotope scan. It is the responsibility of the referring clinician and radiology department within the diagnostic and assessment service to undertake all other imaging in line with network protocol.

Ultrasound of the neck for assessment of a thyroid mass should include report on the following:-

- The number and maximum diameter of nodules seen in both thyroid lobes.

- Comment on the appearance of the thyroid nodules
  - their echogenicity in relation to normal thyroid tissue
  - the presence or absence of cystic change
  - the presence or absence of macro and micro calcification
  - the presence of abnormal blood flow within the nodule

- There should be a report of all of the nodal drainage areas of the neck on both sides.
<table>
<thead>
<tr>
<th>Clinical presentation</th>
<th>Differentiated Thyroid Cancer (DTC)</th>
<th>Medullary Cancer of Thyroid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Localised thyroid nodule</td>
<td>Ultrasound neck + FNA*</td>
<td>Ultrasound neck + FNA</td>
</tr>
<tr>
<td>Pre-op</td>
<td>CXR (unenhanced CTS in aggressive disease)</td>
<td>MR neck</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CT chest &amp; abdomen</td>
</tr>
<tr>
<td></td>
<td></td>
<td>In\textsuperscript{111} Octreotide scan</td>
</tr>
<tr>
<td>Neck node metastases</td>
<td>Ultrasound neck + FNA*</td>
<td>As above</td>
</tr>
<tr>
<td>Pre-op</td>
<td>CXR</td>
<td></td>
</tr>
<tr>
<td></td>
<td>MR neck &amp; chest (mediastinum)</td>
<td></td>
</tr>
<tr>
<td>Distant metastases at presentation</td>
<td>Ultrasound neck + FNA*</td>
<td>As above</td>
</tr>
<tr>
<td></td>
<td>I\textsuperscript{131} scan (whole body)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>CT chest (no IV contrast if within 8 weeks of proposed I\textsuperscript{131} scan) for lung metastases</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Isotope bone scan for bone metastases</td>
<td></td>
</tr>
<tr>
<td>Early post-op period</td>
<td>I\textsuperscript{131} scan (neck)</td>
<td>Nil routinely</td>
</tr>
<tr>
<td>Post I\textsuperscript{131} ablation</td>
<td>I\textsuperscript{131} scan (whole body)</td>
<td>N/A</td>
</tr>
<tr>
<td>Rising biochemical markers on F/U</td>
<td>I\textsuperscript{131} scan (whole body)</td>
<td>Ultrasound neck +/- FNA</td>
</tr>
<tr>
<td></td>
<td>CXR</td>
<td>MR scan neck</td>
</tr>
<tr>
<td></td>
<td>If –ve: Ultrasound neck +/- FNA</td>
<td>CT scan chest &amp; abdomen</td>
</tr>
<tr>
<td></td>
<td>If –ve: CT chest (no IV contrast if within 8 weeks of proposed I\textsuperscript{131} scan)</td>
<td>In\textsuperscript{111} Octreotide scan (if –ve, consider I\textsuperscript{123} MIBG scan)</td>
</tr>
<tr>
<td></td>
<td>If –ve: PET/CT</td>
<td>Dotanoc - Ga\textsuperscript{68} if available</td>
</tr>
<tr>
<td>Clinical recurrence (neck)</td>
<td>As for neck nodes pre-op</td>
<td>As for localised thyroid nodule</td>
</tr>
<tr>
<td>Clinical recurrence (distant)</td>
<td>As for metastases on presentation</td>
<td>As for localised thyroid nodule</td>
</tr>
<tr>
<td>Other investigations</td>
<td>Thyroid Function Tests (TFTs)</td>
<td>TFT, Calcitonin, Urinary Catecholamines</td>
</tr>
</tbody>
</table>
Pathology Guidelines for thyroid cancer - 11-1C-108i

The Head and Neck CNG has agreed network wide pathology guidelines for the diagnosis and assessment of thyroid cancer. The guidelines address:

- Laboratory and histopathological/histochemical investigations
- Their specific indications
- Which parts of the investigational protocol should be the responsibility of the Diagnostic and Assessment Service and which should be that of the MDT
- A policy whereby any diagnostic biopsy sample that shows or is thought to show thyroid cancer is sent for review to a histopathologist core member of the thyroid MDT

The guidelines are distributed to the designated clinicians for thyroid cancer

The Head and Neck CNG has adopted the Royal College of Pathologists guidelines as follows:

Guidance on reporting of thyroid cytology specimens:
http://www.rcpath.org/Resources/RCPath/Migrated%20Resources/Documents/G/g089guidanceonthereportingofthyroidcytologyfinal.pdf

Dataset for thyroid cancer histopathology reports:
http://www.rcpath.org/Resources/RCPath/Migrated%20Resources/Documents/G/g098datasetforthyroidcancerhistopathologyreportsfinal.pdf

The following policy also refers.

1. Any pathology to the point at which cancer is diagnosed is the responsibility of the diagnostic and assessment service. Responsibility for any subsequent surgery lies with the MDT.
2. Any diagnostic biopsy sample that shows or is thought to show thyroid cancer is sent for review by Dr T Helliwell or Dr J Sheard. Both Consultant Histopathologists are core members of the Head and Neck MDT.
3. Guidelines for the Management of Thyroid Tumours have been agreed by the Head and Neck CNG (p.22).
Section 4: Oncology

Chemotherapy Treatment Algorithms - 11-1C-114i

The CNG, in consultation with the Network Chemotherapy Group (NCG) has agreed a list of acceptable chemotherapy treatment algorithms

Responsibility for updating the protocols has been delegated to The Clatterbridge Cancer Centre NHS Foundation Trust. An electronic version of the protocol book which is available on CCC internet site and subject to bi-annual review and as a result will be updated as required during the year.

Radiotherapy Protocols -11-1C-103i

The CNG, in consultation with the Network Radiotherapy Group (NRG) has agreed a list of acceptable radiotherapy protocols. A hard copy is available at network-level.

Responsibility for updating the protocols has been delegated to The Clatterbridge Cancer Centre NHS Foundation Trust. An electronic version of the protocol book which is available on CCC intranet site and subject to bi-annual review and as a result will be updated as required during the year.
Post-op Radiotherapy Pathway – Surgery to Radiotherapy

Days | Pathway | Process
--- | --- | ---
Day 0 | Surgery | • Patient identified by MDT co-ordinator as listed for surgery – provisionally listed for MDT for pathology discussion within **14 days**

Day 14 | Post Op MDT | • Histology checked by MDT Co-ordinator to confirm diagnosis and confirm MDT date.
• Date for F/U OPD to be checked. ? same day as MDT if possible

| Joint head and neck clinic(s) | • Pathology reviewed at MDT – Decision made for Radiotherapy.
• CARP form generated from SCR and sent to CCC

By Day 21 | Clatterbridge CC | • Referral letter sent to CCC within 48 hours of patient being seen in clinic – typed and faxed by Medical Secretary to CCC

Day 42 | Radiotherapy | ---

Approved: 18.06.2013
Review Date: June 2014
Section 5: Local Support Team

Role of Local Support Team - 11-1C-125i

In order to provide aftercare and rehabilitation to patients following treatment, local support teams have been established by each designated hospital. Protocols have been developed that outline the role of the specialist team at Aintree, The Clatterbridge Cancer Centre and that of the local support teams in each of the above localities. These protocols are supported by a number of key principles that define the role of the local support teams as follows:

- To manage the aftercare and rehabilitation of head and neck cancer patients within the relevant locality
- To work closely with the Head and Neck MDT and other health professionals involved in the care of patients
- To co-ordinate local provision of services for each individual across different agencies and disciplines
- To ensure that appropriate levels of service are achieved and that gaps in service are highlighted to Locality Groups for resolution
- To work to agreed network protocols and ensure liaison with the MDT when specialist input/advice is required.

Distribution of Local Support Team - 11-1C-124i

The agreed configuration of local support teams is detailed below:

<table>
<thead>
<tr>
<th>Local Support Team</th>
<th>Designated Hospital</th>
<th>Locality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aintree</td>
<td>Aintree Hospital</td>
<td>Sefton</td>
</tr>
<tr>
<td>Southport &amp; Ormskirk</td>
<td>Ormskirk Hospital</td>
<td>Sefton</td>
</tr>
<tr>
<td>Liverpool</td>
<td>Royal Liverpool University Hospital</td>
<td>Liverpool</td>
</tr>
<tr>
<td>St Helens</td>
<td>Whiston Hospital</td>
<td>Eastern Sector</td>
</tr>
<tr>
<td>Knowsley</td>
<td>Whiston Hospital</td>
<td>Eastern Sector</td>
</tr>
<tr>
<td>Warrington &amp; Halton</td>
<td>Warrington Hospital</td>
<td>Eastern Sector</td>
</tr>
<tr>
<td>Wirral</td>
<td>Arrowe Park Hospital</td>
<td>Wirral</td>
</tr>
<tr>
<td>Chester</td>
<td>Countess of Chester Hospital</td>
<td>Western Cheshire</td>
</tr>
<tr>
<td>Mid Cheshire</td>
<td>Leighton Hospital</td>
<td>Central Cheshire</td>
</tr>
</tbody>
</table>
### Dietetic Protocol - 11-1C-125i

#### Diagnosis/Pre-treatment
- Undertake full nutritional assessment (social history, biochem/refeeding risk)
- Assess potential impact of treatment on patient’s status (req dysphagia, NG, PEG, JEJ)
- Offer practical dietary advice and advise patient of importance of optimal nutritional status during treatment
- Develop a nutritional care plan to achieve optimal status
- Liaise with MDT and other health professionals

#### Treatment – Surgery/Chemotherapy/ Radiotherapy and Immediate Aftercare
- Assess patient status including anxiety / depression and body image issues, especially if feeding tube present
- Advise patient regarding nutritional plan post-treatment
- Implement plan appropriate to patient need – e.g. dietary supplements/NG feeding/parenteral nutrition/PEG
- Liaise with enteral feeding home delivery service if required
- Ensure dedicated access route for parenteral nutrition and liaise with Pharmacy regarding supply of parenteral nutrition
- Review nutritional care plans
- Liaise with MDT and other health professionals
- Provide on-going advice and support to patient and carers
- Discuss weight management issues if relevant
### Rehabilitation Phase including Transfer to the Local Support Team

- Assess dietetic treatment options
- Assess intake including via feeding methods/combinations e.g. NG, gastrostomy, JEJ feeding
- Liaise with enteral feeding home delivery service if required
- Ensure dedicated access route for parenteral nutrition and liaise with Pharmacy regarding supply of parenteral nutrition
- Provide on-going advice
- Communicate nutritional care plan with GP and community based named dietitian from the Local Support Team
- Communicate PEG management plan to local team
- Liaise with MDT and other health professionals
- Provide education and training to local named dietitian as appropriate (e.g. pump training, DXT side effects)
- Provide on-going support to patient and carers
- Be available to provide specialist advice if required
- Take appropriate action within 2 weeks of referral to local team
- Provide support to patients with enteral feeding tubes (e.g. PEGs, RIGs)
- Provide ongoing advice and support to patient and carers, including weight management issues if required.
- Be aware of nutritional care plan communicated by the specialist dietitian
- Liaise with other health professionals
- Identify training needs and liaise with specialist dietitian
- Maintain and monitor patients’ progress against care plan and revise as appropriate
- Contact specialist dietitian following assessment

### Palliative Phase

- Assess patient need and liaise with palliative care team as required
- Contact specialist dietitian if advice required
- Be available to provide specialist advice if required

**Key:** *Italics*  
*Specialist input - Aintree/CCO*  
*Non Italics*  
Local Support Team
### Nursing Protocol - 11C-125i

#### Pre-Diagnosis
- Aware of patients in ‘system’
- Where appropriate monitor local diagnostics (timeliness/results) as per network protocols

#### Diagnosis/Pre-treatment
- Meet patient/family at time of diagnosis and inform them of the CNS role
- Provide information about the diagnosis and next steps in appropriate format
- Act as patient key worker and provide contact details
- Undertake initial holistic needs assessment (HNA) and action onward referrals to appropriate support services
- Check all appropriate investigations have been ordered/booked
- Check OPD appointment booked for specialist review
- Inform GP of diagnosis and treatment plan via the Serious Diagnosis Proforma within 24 hours
- Inform District Nursing Team of diagnosis and treatment plan via Serious Diagnosis Proforma within 24 hours.
- If patient diagnosed in the Locality, CNS/local nurse to fax information to CNS at specialist centre using the Inter Hospital Referral Form
- Explain key worker handover to patient and inform patient of specialist key worker contact details
- Refer to dietician
- Where local arrangements are in place, arrange PEG insertion & provide appropriate support and care in collaboration with dietetics.
- If PEG’s are performed in the Locality send a copy of the patient’s Endoscopy form with further advice regarding nutritional management plan to the specialist CNS at CCO and to Specialist Team at Aintree
- **If PEG’s are performed at UHA Send a copy of the patient’s Endoscopy form with further advice regarding nutritional management plan to the specialist CNS at CCO and to Locality Team**
- (PEGs at Aintree with the exception of Leighton)
- Inform GP of treatment plan
- Inform locality nurse for local follow up.
### Treatment

**Surgery/Chemotherapy/Radiotherapy and Immediate Aftercare**

- Act as patient key worker and ensure contact details provided
- Act as patient key worker and ensure contact details provided
- Provide support and education to ward nurses, radiographers, dieticians, nutritional nurse, and advise of special nursing interventions
- Assess need for prophylactic enteral feeding in liaison with nutritional nurse, dietetic and ward staff
- Assess analgesia needs and adjust medication in liaison with medical staff as required
- Carry out ongoing assessment of side effects and provide timely interventions for the management of symptoms and side effects
- Provide written and verbal information about treatment side effects and symptom management.
- Assess analgesia needs and adjust medication in liaison with medical staff as required. If patients are receiving palliative treatment refer to specialist palliative care team in a timely manner when necessary
- Provide health promotion advice (such as healthy eating if necessary smoking cessation, alcohol withdrawal and refer to appropriate services)
- Advise staff in a timely manner about patient needs and ensure that appropriate equipment is available in hospital
- For radiotherapy and chemotherapy patients, continually assess need for enteral feeding and if required arrange safe insertion of Nasogastric tube/Gastrostomy tube
- Provide timely advice to patients of need for adequate nutrition
- Supervise care of enteral feeding tubes in conjunction with ward and dietetic staff and nutritional nurse
- If chemotherapy given synchronously with radiotherapy, ensure all staff are aware of possible radio sensitising effects of some cytotoxic monoclonal antibodies drugs
- Advise and support ward staff and discharge team to commence discharge planning
- Contact Macmillan Head and Neck CNS at CCO if post-operative radiotherapy required. Where key worker role is transferred inform patient and provide key worker contact details using inter hospital referral form

### Rehabilitation Phase

**including Transfer to the Local Support Team**

- Post treatment at CCO, Macmillan Head and Neck CNS to complete inter hospital referral form and forward to CNS at tertiary centre and in Locality to ensure that timely follow up appointments and support can be arranged.
- Post radiotherapy, if rehabilitation is complex and there is a requirement for further specialist in patient assessment/support ensure referral back to relevant Specialist Team at Aintree from CCO
- Ensure discharge plans are in place with named locality nurse and that the local support team has information regarding patients’ needs and treatment plan
- Provide discharge planning training to community staff (e.g. in relation to altered airway management/surgical voice
<table>
<thead>
<tr>
<th>Palliative Phase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Offer emotional and practical support</td>
</tr>
<tr>
<td>Act as patient’s advocate</td>
</tr>
<tr>
<td>Ensure patients’ needs are met and link with members of the SMDT</td>
</tr>
<tr>
<td>Work closely with the Palliative Care Team, Chaplaincy and other members of the MDT</td>
</tr>
<tr>
<td>Onward referrals to appropriate support services</td>
</tr>
<tr>
<td>Where key worker role is transferred to Palliative Care Team, inform patient and provide key worker contact details</td>
</tr>
<tr>
<td>Act as an information resource and offer specialist advice where necessary</td>
</tr>
<tr>
<td>Liaise with the specialist nursing team where there are specific airway management/surgical voice restoration/wound problems</td>
</tr>
</tbody>
</table>

| Key: Italic                                                                 |
| Specialist input - Aintree/CCO                                               |
| Non Italic                                                                  |
| Local Support Team                                                          |

restoration) to expedite discharge
- Register patient who has undergone laryngectomy/tracheostomy with a home delivery service.
- Arrange follow up
- Refer to Surgical Voice restoration Clinic.
- Explain key worker handover to patient and inform patient of local key worker contact details

- Provide a telephone advice handover for health care professionals to support complex patients
- Ensure patients have access to information about cancer support groups and Macmillan Cancer Information Centre.
- Offer holistic needs assessment (HNA) and action onward referrals to appropriate support services
- Liaise with specialist nursing team and ensure discharge plans are in place with community team and that the local support team has information regarding patients’ needs and treatment plan
- Provide discharge planning training if appropriate (e.g. in relation to altered airway management/ surgical voice restoration)
- Provide appropriate nurse led clinic for the management of altered airway and complex wounds.
- Support patients requiring valve/airway /complex wound management
- Where local arrangements are in place provide appropriate clinic for the management of surgical voice restoration
- Provide ongoing support & education to local community teams
### Physiotherapy Protocol - 11C-125i

| Diagnosis/Pre-treatment | • Offer advice and support  
| | • Provide information regarding role of physiotherapist and the post-operative processes regarding physiotherapy  
| | • Undertake assessment of patient’s respiratory status, mobility, circulation and function of neck and shoulders  
| | • Establish equipment required for post-operative care e.g. Therabite / facial nerve stimulator  
| **Treatment – Surgery/Chemotherapy/Radiotherapy and Immediate Aftercare** | • Advise patient on impact of treatment and provide information regarding respiratory exercises and care  
| | • Administer physiotherapy to maintain/improve range of movement and muscle strength  
| | • Assessment and treatment of limited mouth opening  
| | • Teach patient and carers tracheostomy care where appropriate  
| | • Teach pain relief techniques  
| | • Liaise with MDT and other health professionals  
| **Rehabilitation Phase including Transfer to the Local Support Team** | • Communicate physiotherapy care plan with named physiotherapist within the Local Support Team  
| | • Provide on-going assessment and review of function through ward based clinic and Joint Cancer Clinic (JCC)  
| | • Provide information to patient and carers regarding symptom control, exercises and on-going care  
| | • Liaise with MDT and other health professionals e.g. District Nurses for provision of respiratory equipment  
| | • Provide education and training to local named physiotherapist as appropriate  
| | • Provide a specialist regional outpatient service for patients suffering from trismus  
| | • Be available to provide specialist advice if required  
| | • Take appropriate action within 2 weeks of referral to local team  
| | • Provide ongoing advice and support to patient and carers  
| | • Be aware of physiotherapy care plan communicated by the specialist physiotherapist  
| | • Liaise with other health professionals  
| | • Identify training needs and liaise with specialist physiotherapist  
| | • Maintain and monitor patients’ progress against care plan and revise as appropriate  
| | • Contact specialist physiotherapist if required  

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Head & Neck CNG – Clinical Guidelines  
Reviewed: September 2013  
Review Date: April 2016
**Palliative Phase**

- Assess patient need and liaise with palliative care team as required
- Contact specialist physiotherapist if advice required
- Provide information and advice
- *Be available to provide specialist advice if required*

**Key:**  *Italic*  Specialist input - Aintree/CCO  
Non *italic*  Local Support Team
**SALT Protocol - 11-1C-125i**

### Diagnosis/Pre-treatment
- Explain role in relation to rehabilitation post-surgery/treatment
- Assess patient’s understanding of proposed treatment and its affects on function, e.g. speech, voice, eating and drinking, swallowing
- Undertake full assessment and any specialist investigations to detect any dysfunction of above and introduce short term strategies/techniques to deal with the immediate deficit e.g. communication aid, modifications in oral intake, alternative forms of feeding
- Assess patients ability to understand and express verbal and written language where there are signs of breakdown
- Communicate plan of care with appropriate goals and aims for post-operative intervention
- Offer information, advice and support to patient and carers
- Refer to other services, where appropriate
- Assess suitability for surgical voice restoration including cognitive, visual and auditory function and manual dexterity
- Notify local support team of complex cases by early referral letter to local SALT

### Treatment – Surgery/Chemotherapy/ Radiotherapy and Immediate Aftercare
- Undertake full assessment which may include complex interventions, of speech, voice, eating and drinking and swallowing
- Evaluate the neuroanatomy and physiology of the oral, pharyngo-oesophageal and laryngeal mechanisms and carry out investigations e.g. nasendoscopy, videofluoroscopy and Taub Test, as required.
- Assess timing and ability for surgical voice restoration training, where appropriate
- Primary SVR – provide ongoing development of voice, speech and valve maintenance
- Advise patient regarding impact of treatment on speech, voice and swallowing function and provide information
- Instruct patient in therapeutic techniques and assist patient to maintain speech, voice and swallowing as treatment progresses
- Instigate exercise programmes to maintain function and well-being.
- Liaise with MDT and other health professionals
<table>
<thead>
<tr>
<th>Rehabilitation Phase including Transfer to the Local Support Team</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Ensure means of non-verbal communication is established, where necessary and provide a communication aid if appropriate</td>
</tr>
<tr>
<td>• Set goals of intervention to facilitate neuromuscular recovery / adaptation</td>
</tr>
<tr>
<td>• Communicate SLT care plan with named speech and language therapist within the Local Support Team</td>
</tr>
<tr>
<td>• Provide on-going assessment and review of function for SVR, speech, voice, and swallowing – in exceptional circumstances.</td>
</tr>
<tr>
<td>• Liaise with MDT and other health professionals</td>
</tr>
<tr>
<td>• Provide detailed discharge report to local SLT &amp; SLT at CCO, where appropriate</td>
</tr>
<tr>
<td>• Be available to provide specialist advice / input / training, if required e.g. Taub Test, Videofluoroscopy, FEES/FNE, Valve care/use/changes</td>
</tr>
<tr>
<td>• On-going SVR management – (available at AUH, RLBUHT, Arrowe Park, Leighton – see Appendix 1)</td>
</tr>
<tr>
<td>• To make contact with a patient within 2 weeks post treatment.</td>
</tr>
<tr>
<td>• Provide ongoing therapy advice and support to patient and carers, including videofluoroscopy</td>
</tr>
<tr>
<td>• Identify training needs as services develop and liaise with specialist speech and language therapist</td>
</tr>
<tr>
<td>• Liaise / refer with other professionals, as required</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Palliative Phase</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Liaise with appropriate palliative care team &amp; Specialist SLT, as required</td>
</tr>
<tr>
<td>• Provide information and advice regarding swallowing and voice function, including the use of communication aid equipment.</td>
</tr>
<tr>
<td>• Be available to provide specialist advice and support, if required</td>
</tr>
</tbody>
</table>

Key:  *Italicics*  Specialist input - Aintree/CCO/RLBUH  
*Non Italics*  Local Support Team
Appendix 1: Network Referral Pathway for SVR
## Named Local Support Team - 11-1C-124i

| Southport | Clinical Nurse Specialist | Sally Lane (MFU)  
|           |                            | Lesley Dempsey (ENT)  
|           | Speech & Language Therapist | Elizabeth Scanlon - North Sefton  
|           |                            | Lisa Houghton - South Sefton  
|           | Dietician | Lucy Howarth - North Sefton  
|           |                            | Rachel Skelly - South Sefton  
|           | Nurse | Bernie Connell - Community Nurse Lead, North Sefton  
|           | (responsible for management of stomas, nasogastric tubes & tracheo-oesophageal valves) | Christine Hastie - Community Nurse Lead, South Sefton  
|           | Dental Hygienist/Dental input | German Martin-Roger  
|           | Person responsible for psychological support of head & neck cancer patients | Dominic Bray/Jim Anderson - North Sefton  
|           |                            | Dominic Bray - South Sefton  
|           | Physiotherapist | Nicola Ivanovic - North Sefton  
|           |                            | Ruth Carpenter - South Sefton  
|           | Occupational Therapist | Nicola Ivanovic - North Sefton  
|           |                            | Helen Davies – South Sefton  
|           | Social worker | Customer Access Team - Sefton MBC  

| Aintree | Clinical Nurse Specialist | Sally Lane (MFU)  
|         |                            | Lesley Dempsey (ENT)  
|         | Speech & Language Therapist | Lisa Houghton  
|         | Dietician | Rachel Skelly  
|         | Nurse | Sally Lane  
|         | (responsible for management of stomas, nasogastric tubes & tracheo-oesophageal valves) | Lesley Dempsey  
|         | Dental Hygienist/Dental input | G Martin Roger  
|         | Person responsible for psychological support of head & neck cancer patients | Jim Anderson (Emotional Support)  
|         |                            | Dominic Bray - Clinical Psychologist  
<p>|         | Physiotherapist | Barry Scott |</p>
<table>
<thead>
<tr>
<th>Occupational Therapist</th>
<th>H Davies</th>
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<tbody>
<tr>
<td>Social worker</td>
<td>On a named referral basis Benefits Advisor - Macmillan Cancer Relief Mr M Hughes – Sefton Area</td>
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<table>
<thead>
<tr>
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<tr>
<td></td>
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<td>Sam Ater</td>
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<td>Sue Bragan Helene Bryant Alison Young - Nutritional Support Nurse Consultant</td>
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<td>Dental Hygienist/Dental input</td>
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<td>Person responsible for psychological support of head &amp; neck cancer patients</td>
<td>Dr Jan Ablett</td>
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<td>Heather Tweedle</td>
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<td>Rinta Peter-Yuvaraj</td>
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<tr>
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<th>Lorraine Soudani - STHK Sally Lane - Aintree</th>
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<tbody>
<tr>
<td></td>
<td>Speech &amp; Language Therapist</td>
<td>Lisa Houghton - Aintree Catriona Fleming/Karen Bridge/ Heulwen Sheldrick - Bridgwater Nancy Harrington - WHH</td>
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<tr>
<td>Dietician</td>
<td>Rachel Skelly - Aintree Maria Moss/Shauna Clarke - 5 Boroughs Anne Betteley - WHH Lisa Black - Knowsley</td>
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<tr>
<td>Nurse</td>
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<td>Abbot service Lorraine Hodson - Bridgewater</td>
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<td>Person responsible for psychological support of head &amp; neck cancer patients</td>
<td>Dominic Bray / Jim Anderson - Aintree</td>
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<td>Gillian Hunt / Hannah Anstey - STHK</td>
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<td>Physiotherapist</td>
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<td>Gill Dickson - 5 Boroughs</td>
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<tr>
<td>Occupational Therapist</td>
<td>Hazel Henricksen - 5 Boroughs</td>
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<td>Nurse</td>
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<td>(responsible for management of stomas, nasogastric tubes &amp; tracheo-oesophageal valves)</td>
<td>Lorraine Hodson - Bridgewater</td>
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<td>Chris Butterworth – Aintree</td>
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<tr>
<td>Person responsible for psychological support of head &amp; neck cancer patients</td>
<td>Dominic Bray / Jim Anderson – Aintree</td>
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<td>Gillian Hunt / Hannah Anstey - STHK</td>
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<tr>
<td>Physiotherapist</td>
<td>Judith Heaton - Service Lead STHK, Knowsley KIPS</td>
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<tr>
<td>Occupational Therapist</td>
<td>Hazel Henricksen - Service Lead, 5 Boroughs</td>
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</table>
| Warrington | Clinical Nurse Specialist | Sally Lane (MFU/ENT) - Aintree  
| Lesley Dempsey (cover) – Aintree  
| Lorraine Soudani – STHK  
| Peter Doherty – OPD Staff Nurse - WHH |
| Speech & Language Therapist | Helen Turner – WHH |
| Dietician | Anne Betteley – WHH |
| Nurse | Jacqui Tudor – Bridgewater Community Trust  
| (responsible for management of stomas, nasogastric tubes & tracheo-oesophageal valves)  
| Airway Management, stoma & valves:  
| Sally Lane/Lesley Dempsey – Aintree |
| Dental Hygienist/Dental input | Chris Butterworth – Aintree  
| Cerie Conway – local support lead |
| Person responsible for psychological support of head & neck cancer patients | Jim Anderson/Dominic Bray – Aintree  
| Rachel Plant – Mental Health Matters |
| Physiotherapist | Sarah Travers – WHH |
| Occupational Therapist | Tracey Vaughan-Hodkinson - WHH |
| Social worker | Alison Evans – Warrington Borough Council |

| Halton | Clinical Nurse Specialist | Sally Lane (MFU/ENT) - Aintree  
| Lesley Dempsey (cover) – Aintree  
| Lorraine Soudani – STHK |
| Speech & Language Therapist | Heulwen Sheldrick - Bridgewater Community Trust |
| Dietician | Debbie Eckersley - WHH |
| Nurse | Lorraine Hodson - Bridgewater Community Trust  
| (responsible for management of stomas, nasogastric tubes & tracheo-oesophageal valves)  
| Airway Management, stoma & valves:  
| Sally Lane/Lesley Dempsey - Aintree |
| Dental Hygienist/Dental input | Chris Butterworth - Aintree  
| Kerry Davies - local support lead |
| Person responsible for psychological support of head & neck cancer patients | Jim Anderson/Dominic Bray - Aintree  
<p>| Janice Callaghan (CPN) - Open Minds 5 Boroughs Partnership |</p>
<table>
<thead>
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<tr>
<td>Physiotherapist</td>
<td>Sarah Travers – WHH</td>
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<tr>
<td>Occupational Therapist</td>
<td>Mary Chawner - VHH</td>
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<td>Social worker</td>
<td>Sally Rimmer - Halton Borough Council</td>
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<td>Clinical Nurse Specialist</td>
<td>Clare Norman (ENT)</td>
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<td>Sally Lane (MFU)</td>
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<tr>
<td>Speech &amp; Language Therapist</td>
<td>Pam Young - Wirral Community Trust , covering WUTH and CCC</td>
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<tr>
<td>Dietician</td>
<td>Fiona Sinnott - WCT</td>
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<tr>
<td>Nurse</td>
<td>Lisa Noguera, (PEG)</td>
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<td></td>
<td>Claire Norman (tracheostomy and valves) Wirral Community Trust</td>
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<td>Dental Hygienist/Dental input</td>
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<td>Person responsible for psychological support of head &amp; neck cancer patients</td>
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<tr>
<td>Physiotherapist</td>
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<td>Maddie O’Loughlin - WCT</td>
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<td>Speech &amp; Language Therapist</td>
<td>Frederike Hester - CoCH</td>
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<tr>
<td>Dietician</td>
<td>Kirsty Mullan - CoCH</td>
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<tr>
<td>Nurse</td>
<td>Sharon Phillips (PEG )</td>
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<td>Nigel Evans - (Tracheostomies)</td>
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<td>Airway Management, stoma &amp; valves: Sally Lane /Lesley Dempsey - Aintree</td>
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<td>Dental Hygienist/Dental input</td>
<td>Cherie Conway</td>
</tr>
<tr>
<td>Person responsible for psychological support of head &amp; neck cancer patients</td>
<td>Liz Taylor - Macmillan Support and Information Manager</td>
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<tr>
<td>Mid Cheshire</td>
<td>Physiotherapist</td>
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<tr>
<td>Occupational Therapist</td>
<td>Adrian Bunnel - CWP community care</td>
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<tr>
<td>Social worker</td>
<td>Karen Stringfellow - CWAC</td>
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<th>Mid Cheshire</th>
<th>Clinical Nurse Specialist</th>
<th>Margaret Doyle</th>
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<tr>
<td>Speech &amp; Language Therapist</td>
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<td>Susan Higgins/Lynn Armstrong</td>
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<td>Lorraine McGrath/Lorna Santry</td>
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<tr>
<td></td>
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<td>(Home Tube Feeding Team)</td>
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<tr>
<td>Nurse</td>
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<td>Valves, stomas:</td>
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<td>Margaret Doyle/Ann Rayner/Caroline Thomson/ Caroline Parker</td>
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<td>Chris Butterworth - Aintree</td>
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<tr>
<td>Person responsible for psychological support of head &amp; neck cancer patients</td>
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<td>Physiotherapist</td>
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<td>Occupational Therapist</td>
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<td>Macmillan Therapy Team</td>
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<tr>
<td>Social worker</td>
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<td>Tracy Aston</td>
</tr>
</tbody>
</table>
Section 6: Supporting Pathways/Protocols

Teenage and Young adult initial pathway - 11-1C-115i

1. **Patient registration to NWCS and TYAC**
   - TYA MDT outcome form sent to referring MDT
   - TYA MDT weekly Tuesday at CCC
     - All TYA patients will be discussed at this MDT. Member of site specific team to present patient.
     - Agree treatment plan made by site specific MDT.
     - Team to discuss patients individual support networks, identify any psychosocial issues to address.
     - Clinical trials to be considered
   - Identify TYA team members input (social worker, psychologist, lead nurse, youth support)
   - TYA team to make contact with patient and discuss required support

2. **Suspected cancer referral (GP/A&E/screening/other referral route)**
   - Diagnostic tests leading to confirmed diagnosis (final responsibility for diagnostic process lies with site specific MDT)

3. **Cancer Diagnosis**
   - Notify TYA MDT when diagnosis confirmed, complete TYA referral form Fax or email to MDT coordinator.

4. **Treatment Planning**
   - Communication, agreed plan and key worker recorded by both MDTs

5. **In Treatment**
   - Aged 16-18 years treatment at Principal Treatment Centre in age appropriate setting
   - 19-24 years treatment location choice at principal treatment centre in age appropriate setting or designated hospital

6. **Post Treatment**
   - Palliative care/end of life care
   - Follow up pathway according to site specific protocols
   - Progression/relapse
   - Further information on reverse of page.
Teenage and Young adult follow up pathway - 11-1C-116i

TYA MDT

Continuing TYA team involvement, co-ordination of age appropriate clinical and psychological care

CLIC Sargent social worker will send introduction letter with information and offer initial grant for a person 16 to 24 years at diagnosis and relapse. A more in-depth service will be offered on assessed needs.

Peer Support:
Young people will be invited to peer support activities for 2 years post treatment and can access the Youth Support Co-ordinator in this time

Discussion and outcomes sent to GP and site specific consultant as appropriate

Patient completed first line treatment. (Could include any combination of surgery, chemotherapy and/or radiotherapy)

CLIC Sargent TYA Psychologist will continue to provide support and accept new referrals for those completing treatment

Head and Neck MDT

End of treatment summary (disease status/prognosis, treatments recorded, toxicities) and care plan produced by medical team within six months of treatment

Disease progression supportive care only

Clinical follow up as per tumour pathway

Local palliative care team referral and discussion at palliative care MDT, symptom management

Surveillance monitoring; imaging and/or laboratory investigations as protocol

Referred to tya mdt, continue as tya initial management pathway as appropriate

Notes:
- There will be unhindered access into the tya mdt if clinicians have concerns about any patient after completion of first line treatment or if the patient wishes to be discussed
- Late effects: 5 years post diagnosis, the TYA MDT co-ordinator will contact the site specific team to consider referral to the late effects service and late effects mdt if appropriate as part of the patients care plan.
TYA MDT Details-
TYA MDT co-ordinator Theresa Otty
Clatterbridge Cancer Centre, Tuesday 9am JKD library. Lead Clinician Dr Nasim Ali

Head and Neck MDT Details-

Aintree: (0151 525 5980)
   UAT/ skull based head and neck MDT lead clinician: Professor J S Brown
   Thyroid MDT lead clinician: Dr L Smith
   TYA lead Clinician Dr Lynny Yung

Version: 1.0
Author: Laura Elder
Approved: 18.06.13 (TYA CNCG & Head & Neck CNG)
Review Date: June 2015
TYA MDT details:

TYA MDT co-ordinator Theresa Otty
Clatterbridge Cancer Centre, Tuesday 9 am JKD library
Lead Clinician Dr Nasim Ali

Head and Neck MDT details

Aintree: 0151 552 5980

Upper aerodigestive tract MDT Lead: Mr Jeff Lancaster
Skull base MDT Lead: Mr James Brown
Thyroid MDT Lead: Dr Linda Smith
TYA Clinical Lead: Dr Lynny Yung

TYA Options for location of care

UAT tumours in 16-24 year olds

Surgery at Aintree designated specialist trust
Chemotherapy and radiotherapy at Clatterbridge Cancer centre

Thyroid tumours

Under 16 year olds

Surgery at principle treatment centre – Alder Hey
Radio Iodine at Christie Hospital, Manchester

16-18 year olds

Surgery at principle treatment centre - Alder Hey or Royal Liverpool Hospital
Radio Iodine at Royal Liverpool Hospital

19-24 year olds

Surgery at principle treatment centre or designated hospital:
Royal Liverpool, Wirral, St Helens and Knowsley, Aintree
Radio Iodine at Royal Liverpool
Pathway for Patients with Head & Neck Sarcomas

Aims
To ensure that patients with sarcomas affecting the head and neck region, including skull base, are discussed at the appropriate specialist MDT meeting(s).

Background
All patients with sarcomas arising from the soft tissues, airways or bones of the head and neck region should be discussed by both the Network Specialist Head and Neck or Skull Base Multidisciplinary Team (MDT), and by the Network Sarcoma MDT. The paper also considers Network-wide data capture to ensure comprehensive governance and audit to support Sarcoma Peer Review.

The following diagnoses may be relevant to this discussion:
- Soft tissue sarcomas of the head and neck arising de novo or following radiotherapy treatment of primary carcinomas
- Sarcomas (usually chondrosarcomas) arising from the laryngeal cartilages
- Sarcomas arising from the bones of the skull or skull base

Note that Kaposi sarcoma and sarcomas of the skin are not included.
The proposals described here are not prescriptive and there are likely to be situations outside this guidance when professional discussions are entirely appropriate and relevant for optimal patient care and to support continuing professional development.

Proposals
The default position is that patients with head and neck sarcomas which are limited to the head and neck region should be managed by the specialist head and neck cancer multidisciplinary team; the opinion of the soft tissue sarcoma MDT should also be sought in all cases, at an early stage, as soon as possible at diagnosis. Site-specific surgery is usually the best primary therapeutic option.

Follow-up protocols for ‘soft tissue’ type sarcomas of the head and neck region should reflect those for truncal and extremity sarcomas

Referral from Head and Neck MDT members to the Sarcoma MDT members may occur in a range of contexts and situations, for formal MDT discussion. Advice may be sought from colleagues in a range of contexts:
- Clinical – known or suspected sarcomas where the most appropriate management option is unclear.
- Pathological – to ensure that accurate diagnosis is achieved on biopsy/resection material. Note that the Sarcoma Peer Review measures (11-1C-1131) indicate that all new diagnoses of soft tissue sarcoma should be reviewed by a Specialised Sarcoma Pathologist.
- Oncological – If oncological therapy (mainly chemotherapy) required for neoadjuvant or metastatic settings.

Formal discussion at the Sarcoma MDT is particularly important for patients with:
- Locally extensive disease for which adjuvant therapy may be useful.
- Disseminated disease for which systemic therapy may be useful.
- Those types of sarcoma where neoadjuvant therapy should be considered e.g. rhabdomyosarcoma, Ewing’s sarcoma. This list is likely to expand in the future as new therapeutic options are developed.

As appropriate, pathology reports on resection specimens will following the guidelines of the Royal College of Pathologists in the Dataset for Soft Tissue Sarcomas (2).

Data collection and audit within the Merseyside and Cheshire Cancer Network and Lancashire and South Cumbria Cancer Network. The primary responsibility for the collection of activity and audit data for head and neck sarcomas lies with the specialist head and neck cancer MDTs at Aintree University Hospital and Lancashire Teaching Hospitals, and the soft tissue sarcoma MDT at RLBUHT. Data will be reviewed by the Sarcoma Advisory Group to demonstrate compliance with peer review.

Referral to the soft tissue sarcoma MDT is via FAX to 0151 706 5027 (MDT coordinator) or via info@nhs.net (Sarcoma MDT Coordinator is at RLBUHT Tel: 0151 706 4884)
Rehabilitation Pathway

### Clinical Indicators for Referral to Head and Neck Cancer Rehabilitation Pathway

Patients are at risk of developing or experiencing the following clinical indicators and should be assessed for referral to rehabilitation pathway interventions at all stages in the cancer care pathway as described below:

<table>
<thead>
<tr>
<th>Diagnosis &amp; Care Planning</th>
<th>Treatment</th>
<th>Post Treatment</th>
<th>Monitoring/Survivorship</th>
<th>Palliative Care</th>
<th>End of life Care</th>
</tr>
</thead>
</table>

#### Consider level of intervention required:
- Information support
- General rehabilitation services
- Specialist oncology/palliative rehabilitation.
- Ensure patient has contact details for timely future access to rehabilitation services (see local cancer services directory-rehabilitation services).

<table>
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<tbody>
<tr>
<td></td>
<td>- Difficulty walking and getting around</td>
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<td>- Breathing difficulties/cough</td>
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<td>- Fatigue/tiredness</td>
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<td>- Tingling in hands and feet</td>
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<td>- Weakness and loss of muscle strength (focal or generalised)</td>
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<td>- Pain</td>
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<td>- Sensory changes</td>
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<td>- Body image concerns</td>
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<td>- Impaired Balance</td>
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<td>- Equipment/information needs</td>
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<td></td>
<td>- Painful/stiff shoulder post op</td>
</tr>
<tr>
<td></td>
<td>- Management of secretions/tracheostomy</td>
</tr>
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<td></td>
<td>- e.g. post laryngectomy</td>
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<tr>
<td></td>
<td>- Recurrent chest infection</td>
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</tbody>
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<table>
<thead>
<tr>
<th>Occupational Therapy</th>
<th>Difficulties with functional activities of daily living, leisure and work:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>- Difficulty walking and getting around</td>
</tr>
<tr>
<td></td>
<td>- Breathing difficulties</td>
</tr>
<tr>
<td></td>
<td>- Fatigue/Tiredness</td>
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<tr>
<td></td>
<td>- Impaired balance/weakness</td>
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<td></td>
<td>- Anxiety/Depression/loss of</td>
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<td></td>
<td>- motivation/isolation</td>
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<td></td>
<td>- Adjustment to role and function change</td>
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<tr>
<td></td>
<td>- Body image/Facial disfigurement</td>
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<tr>
<td></td>
<td>- Cognitive impairment</td>
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<tr>
<td></td>
<td>- Equipment/information needs</td>
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<tr>
<td></td>
<td>- Tingling in hands and feet</td>
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<tr>
<td></td>
<td>- Pain management</td>
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<tr>
<td></td>
<td>- Fatigue/tiredness</td>
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<tr>
<td></td>
<td>- Nausea and vomiting</td>
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<tr>
<td></td>
<td>- Difficulties swallowing</td>
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<td></td>
<td>- Information needs</td>
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<table>
<thead>
<tr>
<th>Dietsitician</th>
<th>Nutrition and diet:</th>
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<tbody>
<tr>
<td></td>
<td>- Reduced appetite (anorexia)</td>
</tr>
<tr>
<td></td>
<td>- Malnutrition</td>
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<tr>
<td></td>
<td>- Weight loss/Weight management (cachexia)</td>
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<td></td>
<td>- Fatigue/tiredness</td>
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<tr>
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<td>- Nausea and vomiting</td>
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<td>- Difficulties swallowing</td>
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<td></td>
<td>- Information needs</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Speech &amp; Language Therapist</th>
<th>Impaired communication, eating and drinking:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>- Coughing/choking on eating or drinking</td>
</tr>
<tr>
<td></td>
<td>- Food sticking in the throat</td>
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<tr>
<td></td>
<td>- Aspiration related chest infections</td>
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<tr>
<td></td>
<td>- Weak or hoarse voice/Loss of volume</td>
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<td></td>
<td>- Weak cough</td>
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<td></td>
<td>- Difficulty understanding or speaking</td>
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<tr>
<td></td>
<td>- Poor intelligibility/Sounding nasal</td>
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<td></td>
<td>- Stridor related to vocal cord problems</td>
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<td></td>
<td>- Dry mouth</td>
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<tr>
<td></td>
<td>- Laryngectomy care including surgical voice restoration, stoma care, heat moisture exchangers, use of or maintenance of artificial larynx</td>
</tr>
</tbody>
</table>
PEG Protocol
In development
Contributors

The Head & Neck CNG acknowledge the efforts of the many contributors in the production of the following guidelines.

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