Neuro-oncology clinical guidelines

Extracted from the SELCN and KMCN operational policy for the care of patients with suspected Neurological malignancy

Increased awareness and a low threshold of suspicion are probably the most important means of decreasing the delay in diagnosis of brain tumours. Patients with brain tumours usually present with symptoms of raised intracranial pressure such as headaches, nausea and vomiting; focal neurological deficits such as hemiparasis and cranial nerve palsy or epilepsy.

Agreed referral criteria and treatment protocols will determine which patients the specialist team will treat, or refer back to the local unit. The patient pathway for access to the specialist MDT is attached. The pathway will be subject to network ratification and annual review. This ensures that all patients are discussed by a member of the relevant specialist team prior to commencement of treatment

GP consultation

Once a brain tumour is suspected, GP's can refer patients via the two-week wait office to the local hospital for review and investigations by the specialist, which will predominantly be the local neurologists. These require the two week wait referral forms to be completed

SELCN GUIDELINES FOR REFERRAL TO CNS CLINICS

The following should sound alarm bells with General Practitioners:

- Subacute progressive neurological deficit developing over days to weeks (e.g. weakness, sensory loss, dysphasia, ataxia)

- New onset seizures characterised by one or more of the following:
    - o Focal seizures
    - o Prolonged post-ictal focal deficit (longer than one hour)
    - o Status epilepticus
    - o Associated inter-ictal focal deficit

- Patients with headache, vomiting and papilloedema

- Cranial nerve palsy (e.g. diplopia, visual failure including optician defined visual field loss, unilateral sensorineural deafness).

Consider urgent referral for:

- Patients with non-migrainous headaches of recent onset, present for at least one month, when accompanied by features suggestive of raised intracranial pressure (e.g. woken by headache, vomiting, drowsiness).

NB: This last guideline is intended to provide the primary care physician with the discretion to decline urgent referral if there are other known features (e.g. depression, somatisation disorder) making a diagnosis of brain tumour very unlikely.

Patients should be aware of and understand the reason for referral to the Neuro-Oncology service

Initial investigations such as CT scan of the brain may be organised by the general practitioners while waiting for the clinic appointment in the local hospital. However, the above investigations should not delay referral. If the radiological investigations suggest or confirm a neurological malignancy, the patient should then be referred to the neuro-oncology centre for discussion in the MDT meeting. It is expected that these patients will be discussed in the Unit MDT meeting prior to referral. The unit may be requested to further investigate and stage the tumour by the neuro-oncology MDT.

Appropriateness and timeliness of urgent and suspected neurological tumours GP referrals

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Appropriateness - All the urgent GP referral under the two week wait rule are audited. Those referrals that do not meet the Two Week Wait guidelines in terms of appropriateness are fed back. The data is then forwarded to the PCTs and SELCN Primary Care Service Improvement Lead on a monthly basis.

Timeliness – the two week wait database produces reports on this which, as above, are sent to PCTs and SELCN Primary Care Service Improvement Lead on a monthly basis.

6.2 Referral Guidelines – South East London Cancer Network and Kent and Medway Cancer Network referring diagnostic teams

All patients with radiological suspicion of a neurological malignancy should be referred to the Neuro-oncology MDM for discussion on further management.

Neurosurgical Registrar at Kings College hospital on mobile 07747 562 094 or page KH0777 (via switchboard 020 3299 9000) acts as a contact for Neurosurgical emergency advice.

Investigations prior to referral

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Patients with a scan showing a possible abscess, tumour with associated hydrocephalus, spinal cord compression, posterior fossa or midline or 3rd ventricular tumour, or GCS 13/15 or less warrant emergency referral and must have the following investigations undertaken:

- Brain contrast CT scan, preferably a contrast MRI scan
- Chest x-ray
- Full blood count/U+E/Clotting screen

- If patient us on Aspirin, Warfarin, Clopidogrel or Dipyramidole, they must be stopped
- Commence patient on Dexamethasone 8mgs bd and Omeprazole 20mgs od (**unless abscess suspected)**

All other patients must have the following investigations done prior to referral

- Brain MRI with Gadolinium scan (contrast CT if patient cannot tolerate MRI)
- Chest x-ray
- If metastatic disease suspected: Chest/Abdomen/Pelvis CT scan and tumour markers
- If spinal tumour suspected: whole neural-axis MRI scan
- Full neurological examination
- Full blood count/U+E/Clotting screen
- If patient is on Aspirin, Clopidogrel or Dipyramidole they must be stopped
- Stop anticoagulants eg warfarin unless high risk such as metallic heart valve, intra-cardiac thrombus or pulmonary embolus in the previous 6 months. In these cases may switch over warfarin to intravenous heparin infusion.
- Commence patient on Dexamethasone 8mgs bd and Omeprazole 20mgs od (**unless abscess suspected)**

The neuro-oncology MDT may require the local hospital/ referring team to perform further investigations before a definitive management plan can be formulated or patient transferred to the neurosciences centre. Specialist imaging maybe organized after MDT discussion

Please refer to the Network Imaging Guidelines for further detailed information