Coversheet for Network Site Specific Group Agreed Documentation

<table>
<thead>
<tr>
<th>Document Title</th>
<th>Guideline for the Management of Testicular Cancer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Document Date</td>
<td>September 2010</td>
</tr>
</tbody>
</table>
| Document Purpose      | • The referral of patients presenting with symptoms suspicious of testicular cancer.  
                         • The management of patients with testicular cancer. |
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| References            | See document                                      |
| Consultation Process  | Document reviewed by NSSG and amended by Mike Cullen |
| Review Date           | September 2013                                    |
| Approval Signatures:  |                                                   |
| Date Approved by Network Governance Committee | 21 September 2010 |
Guideline for the Management of Testicular Cancer

Version History:

<table>
<thead>
<tr>
<th>Version</th>
<th>Summary of change</th>
<th>Date Issued</th>
</tr>
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<tbody>
<tr>
<td>2</td>
<td>Endorsed by the Governance Committee</td>
<td>Sept 2007</td>
</tr>
<tr>
<td>2.1</td>
<td>Discussed and updated by NSSG and sent to Mike Cullen to review and update</td>
<td>Feb 2010</td>
</tr>
<tr>
<td>2.2</td>
<td>With Mike Cullen's comments</td>
<td>13 April 2010</td>
</tr>
<tr>
<td>2.3</td>
<td>Reformatted by LB, for review by Alan Fergusson and Mike Cullen, Andrew Stanley and the Urology NSSG.</td>
<td>14 April 2010</td>
</tr>
<tr>
<td>2.4</td>
<td>With MC changes. Sent to the urology NSSG</td>
<td>14 April 2010</td>
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<tr>
<td>2.5</td>
<td>With final amendments from MC awaiting comments from NJ</td>
<td>20.08.10</td>
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<td>With Professor Nick James' comments</td>
<td>31.08.10</td>
</tr>
<tr>
<td>2.7</td>
<td>Reviewed at Sub Group meeting</td>
<td>21.09.10</td>
</tr>
<tr>
<td>3.0</td>
<td>Updated with changes from Paul Hutton</td>
<td>Sept 2010</td>
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Changes made since version 2

- An update to the trials available for the teratoma.
- Clarity over surgery for patients with bilateral testicular cancer, or when the tumour is in the patient’s only testis.
- Adjustment to radiotherapy section and flowchart on appendix 2.

1 Scope of the Guideline

This Guidance has been produced to support the following:

- The referral of patients presenting with symptoms suspicious of testicular cancer.
- The management of patients with testicular cancer.

2 Guideline Background

These guidelines are based on the Two Week Wait Guidelines for Referral\(^1\), Improving Outcomes for Urological Cancer – The Manual\(^2\), and the European Association of Urology Clinical Guidelines\(^3\). They have been written by the Pan Birmingham Cancer Network, Network Site Specific Group which consists of local urology teams based at; University Hospital Birmingham Foundation Trust (UHBFT), Sandwell and West Birmingham Hospital, Heart of England Foundation Trust and Walsall Hospital NHS Trust.

In line with the Improving Outcomes Guidance for Urology\(^2\) the Pan Birmingham Cancer Network and Greater Midlands Cancer Network have
agreed to refer all patients requiring treatment for testicular cancer to UHBFT (The Regional Testicular Tumour Centre). Where appropriate, arrangements for the shared care of patients may be made on an individual patient basis.

Guideline Statements

3 Referral

3.1 Patients with suspected urological cancer should be referred from GPs to local urology units, urgently, according to the 2 week wait criteria\(^1\) (outlined below):

a. Any patient with a swelling or mass in the body of the testis.
b. Any patient with ultrasound scan suspicion of testis cancer.

3.2 Referrals deemed inappropriate by consultant urologists will be notified to the referring GP, and to the relevant PCT, according to agreed protocols.

3.3 GPs will be notified of the diagnosis of cancer within 24 hours of the diagnosis being made, and will be kept informed of all aspects of the patients care at all times.

3.4 See appendix one for the referral form.

3.5 Referral for Family History Assessment.

3.5.1 Individuals (affected or unaffected with cancer) who have two or more relatives with testicular cancer at any age should be referred to the West Midlands Regional Clinical Genetics Unit, Birmingham Women's Hospital for risk assessment.

3.5.2 The individuals will be assessed and managed using the West Midlands Family Cancer Strategy guidelines. Further details and referral form can be found at www.bwhct.nhs.uk/wmfacs.

4 Diagnosis and Staging

4.1 An urgent ultrasound should be considered in men with a scrotal mass that does not transilluminate and/or when the body of the testis cannot be distinguished.

4.2 90% of cancers can be confirmed with ultrasound. Occasionally a mass cannot be clearly categorised as either benign or malignant on USS. The options for the management of this small group of patients include follow-up scanning or surgery. On the rare occasion that the diagnosis is in doubt, representative samples may be sent for frozen section\(^4\).

4.3 An FNA or percutaneous biopsy should not be carried out under any circumstances.

4.4 When a cancer is diagnosed on ultrasound:

4.4.1 Blood should be taken prior to surgery for tumour markers (AFP, HCG) and LDH.

4.4.2 An Urgent CT of chest, abdomen and pelvis should be booked.
4.4.3 Surgery (orchidectomy) should be offered, and can be carried out at the cancer unit except:
   a. When the tumour is apparently in the patient’s only testis or there are bilateral tumours. In these cases partial testicular preservation may be possible.
   b. When there are clear signs or symptoms of metastatic germ cell cancer (generally unwell, have multiple lung metastases, AFP above >1000ng/ml, HCG >5000iu/ml, or renal obstruction).

Both these groups should be referred immediately to the specialist MDT (at the Regional Testicular Tumour Centre at UHBFT).

4.4.4 All patients should be offered the insertion of a prosthesis at the time of primary surgery.
4.4.5 Histology slides should be sent to UHBFT for review at the time of referral to the lead pathologist for testicular cancer.

5 Management of Testicular Cancer – All Patients.

5.1 Initial treatment is usually with radical orchidectomy (but see 4.4.3 above), and the local urology team should perform this.
5.2 All patients with proven urological malignancy will be discussed by an MDT. Normally this will be the local MDT in the first instance, and the overall responsibility for the patient’s management rests with the local MDT until referral has been agreed.
5.3 Once diagnosis is confirmed, or strongly suspected, the patient should be referred to the regional testicular tumour centre at UHBFT for discussion at the UHBFT Specialist Testicular MDT, and for further treatment planning.
5.4 All non-surgical treatment of these patients is led by the specialist team at UHBFT. 5.5 In limited circumstances there may be a requirement for shared care:
   a. Children under the age of 16 with teratoma are treated at the Children’s Hospital.
   b. Patients aged between 16 and 25 that require inpatient treatment are offered a bed on the young persons unit.
   c. Older patients and those that prefer not to be treated on the young persons unit are admitted to the 5 day treatment unit for inpatient care.
5.6 Where relevant, patients should be offered sperm banking regardless of treatment plan.
5.7 At 12 months following treatment all patients should be offered sperm analysis to determine the need for continued storage of their sperm samples.
5.8 Please see appendix two for an algorithm for the management of testicular germ cell neoplasms by histopathology, stage and IGCCC grouping

6 Management of non-seminomatous germ cell and combined (mixed) seminoma plus non-seminomatous tumours - Stage 1 (see section 9 for seminoma stage 1)

6.1 High Risk Patients (that is those with lymphovascular space invasion [LVS] on histology). These are those with an increased risk of recurrence; that is >45% chance of relapse on surveillance only.
Stage 1 adjuvant treatment for high risk patients:

a. 111 Trial: A single group trial evaluating one cycle of adjuvant BEP chemotherapy in high risk, stage 1 non-seminomatous germ cell tumours of the testis (NSGCTT) should be offered to all these patients.
b. BEP x 2 cycles should be offered to patients declining 111 trial, or those who are ineligible.
c. The Chemotherapy rota reference for these is: o-rota 03 (BEP 120 – adjuvant).

6.2 Low Risk Patients

Patients with stage I disease who do not possess LVS invasion factors management options include:

a. Surveillance which should be undertaken in Regional Testicular Tumour Centre (UHBFT) according to schedule shown below (12.6.1).
b. Adjuvant chemotherapy BEP x 2 cycles.

On surveillance their risk of recurrence is 15 – 20%. This is reduced to <2% with adjuvant chemotherapy.

7 Management of metastatic malignant teratoma (stage 2 and above):

7.1 Poor Prognosis

factors include:

a. Mediastinal primary or
b. Non-pulmonary visceral metastases (NPVM) or
c. AFP>10,000 ng/L or
d. HCG>50,000 iu/L or
e. LDH >10 x upper limit of normal

Treatment
The primary treatment will be 4 cycles BEP/EP (5 day regimen) plus interval Bleomycin, followed by reassessment after 4 cycles. Depending on outcome, proceed to 2 further cycles, elective surgery or no further action.

7.2 Intermediate Prognosis:

Testicular or retro-peritoneal primary, no NPVM and:

a. AFP >1000 + <10 000 or
b. HCG > 5000 + < 50 000 or
c. LDH > 1.5 x upper limit of normal + < 10 x upper limit of normal.

Treatment
The primary treatment will be 3-4 cycles BEP/EP (BEP-165) plus interval Bleomycin, followed by reassessment. Depending on outcome, proceed to 2 further cycles, elective surgery or no further action.
7.3 **Good Prognosis**

Testicular or retro-peritoneal primary, no NPVM and:

a. AFP <1,000 ng/L **and**

b. HCG <5,000 iu/L **and**

c. LDH <1.5 x upper limit of normal

**Treatment**

The primary treatment will be 3 cycles BEP (BEP-165)

7.4 The chemotherapy rota references are:

a. Poor prognosis: o-rota 04 (BEP 5 day) & o-rota 04a (B)

b. EP 5 (day)

c. Good prognosis & intermediate: o-rota 05 (BEP 165 metastatic) & 05a (B)

d. EP (165 metastatic)

8 **Post Chemotherapy Residual Disease in non-seminomatous germ cell tumours**

Surgical resection of residual para aortic nodes after chemotherapy should be considered in all cases where a residual mass exceeds 1cm and is indicated where the residual lymph node mass is ≥ 2cm. These patients should be discussed at the Specialist MDT and referred to the Lead Consultant Urologist/Retroperitoneal surgeon.

9 **Seminoma Stage 1**

Surveillance is not a practical option for stage 1 Seminoma. Treatment with either chemotherapy or radiotherapy results in a reduction in recurrence rate from 20% to less than 2-3%.

9.1 **Chemotherapy.**

Patients should be offered a single cycle of carboplatin AUC7 (based on EDTA Clearance)

9.2 **Radiotherapy**

9.2.1 A few patients, for whom chemotherapy is inappropriate or who decline it, may be offered 20 Gy/10# / daily for 2 weeks

9.2.2 Localisation

a. Patient supine

b. CT scan plan to ensure localisation of kidneys.

9.2.3 Clinical Target Volume (CTV)

a. Abdominal para-aortic lymph nodes

b. Renal hilar nodes ipsilateral to tumour

c. Patients with prior surgery to groin / scrotum (excluding vasectomy), CTV to include common iliac, external iliac & femoral nodes ipsilateral to tumour.
9.2.4 Planning Target Volume (PTV)
Typical limits to cover the above CTV will be:
   a. Superiorly - T10 / T11
   b. Laterally - Ipsilateral renal hilum, contra-lateral tips of transverse processes
   c. Inferior - L5 / S1
   d. Typical width around 8cm

However, with CT definition of the CTV, these limits are purely indicative as a check and should not be the primary sources for planning purposes.

10 Seminoma Stage Ila and Iib
10.1 Radiotherapy may be appropriate if RT volume permits curative doses, if not, chemotherapy with cisplatin and etoposide should be offered.

10.2 Localisation
CT localisation as for Stage I disease.

10.3 CTV
Macroscopic tumour + node chains superiorly & inferiorly 5 cm from gross tumour volume. 2cm laterally.

There is no indication for routine post-chemotherapy radiotherapy.

11 Seminoma stage III / IV / bulk disease
4 cycles cisplatin + etoposide should be offered.

12 Follow-up and recurrent disease.

12.1 In testis tumours the aims of follow-up are:
   a. To detect relapse as early as possible in all stages
   b. To detect an asynchronous contra lateral carcinoma of the testis in an early phase.
   c. To encourage healthy lifestyles, particularly important is smoking cessation counselling.

12.2 The intensity of follow-up is dictated by the risk of recurrence over time. A series of follow-up schedules have been developed to reflect these differences in patient groups. Shared care may be appropriate in some circumstances.

12.3 Whether in early or advanced stages follow-up attendances should include:
   a. Enquiry concerning testicular self-examination (TSE), and advice to report any concerns promptly, not necessarily waiting for next scheduled appointment.
b. Physical examination is only required routinely in symptomatic patients, those who are concerned about an abnormality on TSE or those where investigations raise concerns.

c. Serum Tumour Markers determination (AFP, beta-hCG and LDH),

d. Chest, Abdominal and pelvic CT (see schedules in 12.5 below).

e. Post chemotherapy semen analysis at 12 months or at other times if requested and indicated.

f. Brain CT or MRI in case of neurological symptoms and bone scan in case of suspicious bone pain.

12.4 Surveillance should continue for 5 years for teratoma and seminoma.

12.5 Patients who have been recruited into a clinical trial will be followed up as defined in the protocol.

12.6 Follow-up schedules

12.6.1 Five year Follow-up Stage 1 non-seminoma germ cell tumour Surveillance

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
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<tbody>
<tr>
<td>Patient self-examination reminder</td>
<td>12 times</td>
<td>6 times</td>
<td>4 times</td>
<td>3 times</td>
<td>twice</td>
</tr>
<tr>
<td>LH, FSH, Testosterone</td>
<td>twice</td>
<td>If indicated</td>
<td>If indicated</td>
<td>If indicated</td>
<td>If indicated</td>
</tr>
<tr>
<td></td>
<td>(3 and 12 months)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tumour markers</td>
<td>12 times</td>
<td>6 times</td>
<td>4 times</td>
<td>3 times</td>
<td>twice</td>
</tr>
<tr>
<td>Chest X-ray</td>
<td>10 times</td>
<td>6 times</td>
<td>4 times</td>
<td>3 times</td>
<td>twice</td>
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<tr>
<td>CT scan chest, abdomen and pelvis</td>
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<td>none</td>
<td>none</td>
<td>none</td>
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</tr>
<tr>
<td></td>
<td>(3 and 12 months)</td>
<td></td>
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</table>

12.6.2 Five year follow-up schedule post adjuvant chemotherapy for Stage 1 non-seminoma germ cell tumour

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4 and 5</th>
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<td>Once/year</td>
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<tr>
<td>Tumour markers</td>
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<td>Once/year</td>
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<tr>
<td>FBC, UE’s</td>
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<td>Once</td>
<td>If indicated</td>
<td>If indicated</td>
</tr>
<tr>
<td>LH, FSH, Testosterone</td>
<td>Twice (3 and 12 months)</td>
<td>Once</td>
<td>If indicated</td>
<td>If indicated</td>
</tr>
<tr>
<td>Chest X ray</td>
<td>Once</td>
<td>Once</td>
<td>none</td>
<td>none</td>
</tr>
<tr>
<td>CT scan chest, abdomen and pelvis</td>
<td>Once</td>
<td>If indicated</td>
<td>If indicated</td>
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</tr>
</tbody>
</table>
### 12.6.3 Five year follow up protocol for testicular seminoma: Stage 1 Post-Adjuvant and >stage 1 CR post-therapy

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3-4</th>
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<td>Patient self-examination reminder</td>
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<td>Three times</td>
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<td>Once</td>
</tr>
<tr>
<td>Tumour markers</td>
<td>Four times</td>
<td>Three times</td>
<td>Twice</td>
<td>Once</td>
</tr>
<tr>
<td>FBC, UE’s</td>
<td>Once</td>
<td>Once</td>
<td>Once</td>
<td>If indicated</td>
</tr>
<tr>
<td>LH, FSH, Testosterone</td>
<td>Once</td>
<td>Once</td>
<td>Once</td>
<td>If indicated</td>
</tr>
<tr>
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### 12.6.4 Five year follow up for NSGCTT: >stage 1 CR post chemotherapy + / - RPLND

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<td>Tumour markers</td>
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<td>Three times</td>
<td>Twice</td>
<td>Twice</td>
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<tr>
<td>FBC, UE’s</td>
<td>Twice</td>
<td>Once</td>
<td>If indicated</td>
<td>If indicated</td>
<td>If indicated</td>
</tr>
<tr>
<td>LH, FSH, Testosterone</td>
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<td>Once</td>
<td>Once</td>
<td>If indicated</td>
<td>If indicated</td>
</tr>
<tr>
<td>Chest X-ray</td>
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<td>none</td>
<td>none</td>
<td>none</td>
<td>none</td>
</tr>
<tr>
<td>CT scan chest, abdomen and pelvis</td>
<td>Twice (6 and 12 months)</td>
<td>Once (24 months)</td>
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<td>If indicated</td>
<td>If indicated</td>
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### 12.6.5 Seven year follow up for Residual Radiological abnormalities Post-chemotherapy + / - Surgery / RT

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<td>Twice</td>
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<td>Once yearly</td>
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<tr>
<td>Tumour markers</td>
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<td>Four times</td>
<td>Three times</td>
<td>Twice</td>
<td>Twice</td>
<td>Once yearly</td>
</tr>
<tr>
<td>FBC, UE’s</td>
<td>Twice</td>
<td>Once</td>
<td>Once</td>
<td>Once</td>
<td>Once</td>
<td>If indicated</td>
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<tr>
<td>LH, FSH. Testosterone</td>
<td>Twice</td>
<td>Once</td>
<td>If indicated</td>
<td>If indicated</td>
<td>If indicated</td>
<td>If indicated</td>
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<tr>
<td>Chest X-ray</td>
<td>Once</td>
<td>If indicated</td>
<td>If indicated</td>
<td>If indicated</td>
<td>Once</td>
<td>If indicated</td>
</tr>
<tr>
<td>CT scan chest, abdomen and pelvis</td>
<td>Three</td>
<td>Twice</td>
<td>Once</td>
<td>Once</td>
<td>If indicated</td>
<td>If indicated</td>
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</tbody>
</table>
13 Recurrence

13.1 Recurrence following primary treatment of stage 1 germ cell cancers is curable in the vast majority of cases and management is generally with chemotherapy in the first instance. Referral to the regional testicular tumour centre is required in all cases.

13.2 Recurrence following treatment of metastatic disease is also treated with curative intent with chemotherapy (e.g. POM-ACE, TIP, Gem-TIP trial), surgery or radiotherapy alone, or in combination. Referral to the Regional Testicular Tumour Centre is required in all cases.

13.3 Contralateral tumours
The risk of a second contralateral tumour is about 1%. Management varies enormously between individuals based on prospects and wishes for maintaining fertility and an endogenous androgen source whilst maximising the chance of cure. Radical orchidectomy is usually, but not invariably required. Urgent referral to the Regional Testicular Tumour Centre prior to orchidectomy is required to discuss options for individualised care.

14 Patient Information and Counselling

14.1 All patients, and with their consent, their partners will be given access to appropriate written information during their investigation and treatment, and on diagnosis will be given the opportunity to discuss their management with a clinical nurse specialist who is a member of the relevant MDT. The patient should have a method of access to the team at the regional testicular tumour centre at all times.

14.2 Access to psychological support will be available if required. All patients should undergo a Holistic Needs Assessment and onward referral as required.

15 Palliative Care
Palliative care services will be made available to all patients as deemed appropriate by the MDT.

16 Clinical Trials

16.1 Wherever possible, patients who are eligible should be offered the opportunity to participate in National Institute for Health Research portfolio clinical trials and other well designed studies.

16.2 Where a study is only open at one Trust in the Network, patients should be referred for trial entry. A list of studies available at each Trust is available from Pan Birmingham Cancer Research Network. Email: PBCRN@westmidlands.nhs.uk.
16.3 Teratoma:
   a. NCRI 111 – A single group trial evaluating one cycle of adjuvant BEP chemotherapy in high risk, stage 1 non-seminomatous germ cell tumours of the testis (NSGCTT) (recruiting)
   b. NRCl Testis Clinical Studies Group – Phase II multicentre trial of salvage chemotherapy with Gem- TIP for relapsed germ cell cancer (approved).

16.4 Seminoma:
   a. NRCl Testis Clinical Studies Group – Phase II multicentre trial of salvage chemotherapy with Gem- TIP for relapsed germ cell cancer (approved).

17 References
1 Department of Health, 2000. Referral guidelines for suspected cancers (www.dh.gov.uk),
4 Clinical Oncology (2000) 12:S181-182, Royal College of Radiologists

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Paul Hutton  Clinical Nurse Specialist Testicular Cancer
Mike Cullen  Consultant Clinical Oncologist
Alan Ferguson  Urology Project Manager
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Peter Guest  Consultant Radiologist
Lara Barnish  Deputy Nurse Director
Nick James  Professor of Clinical Oncology
Lucy Burgess  Genetics Associate

Approval Date of Network Site Specific Group  Date: 30 June 2010
Approval Date by the Clinical Governance Committee  Date: 21 Sept. 2010

Approval Signatures
Pan Birmingham Cancer Network Clinical Governance Committee Chair
Name:  Doug Wulff
Signature  Date 21 Sept. 2010

Pan Birmingham Cancer Network Manager
Name:  Karen Metcalf
Signature  Date 21 Sept. 2010

Network Site Specific Group Clinical Chair
Name:  Dev Sarmah
Signature  Date 21 Sept. 2010
Appendix 1

**URGENT REFERRAL FOR SUSPECTED UROLOGICAL CANCER**

(Version 2.0)

If you wish to include an accompanying letter, please do so. **On completion please FAX to the number below.**

These forms should only be used for suspected cancer and in conjunction with the NICE Referral Guidelines for Suspected Cancer, June 2005

### Patient Details

<table>
<thead>
<tr>
<th>Surname</th>
<th>Forename</th>
<th>D.O.B.</th>
<th>Gender</th>
<th>Address</th>
<th>Postcode</th>
<th>Telephone</th>
<th>NHS No</th>
<th>Hospital No</th>
<th>Interpreter</th>
<th>Y / N</th>
<th>First Language</th>
<th>Date of Decision</th>
<th>Date of Referral</th>
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### Suspected cancer:

<table>
<thead>
<tr>
<th>Prostate</th>
<th>Symptoms:</th>
<th>Hard irregular prostate on DRE</th>
<th>Significant symptoms (inc. symptoms of metastases) and raised PSA</th>
<th>Raised age-related PSA</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>PSA value</td>
<td>ng/ml</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Age related cut-off measurements: 50-59 > 3.0 ng/ml; 60-69 > 4.0 ng/ml; 70-80 > 5.0 ng/ml

Elderly patients (over 80yrs) or those with significant co-morbidity do not require urgent referral for mildly elevated PSA in the absence of symptoms. PSA measurements are NOT valid in the presence of urinary tract infection and need to be repeated once the infection has resolved.

### Bladder or Renal

<table>
<thead>
<tr>
<th>Symptoms:</th>
<th>PAINLESS macroscopic haematuria (any age)</th>
<th>Haematuria associated with PERSISTENT UTI (over 40)</th>
<th>Unexplained microscopic haematuria (over 50)</th>
<th>Palpable renal mass or solid renal mass on U/S scan</th>
</tr>
</thead>
</table>

### Testicular

<table>
<thead>
<tr>
<th>Symptoms:</th>
<th>Swelling / mass in BODY of testicle</th>
</tr>
</thead>
</table>

### Penile

<table>
<thead>
<tr>
<th>Symptoms:</th>
<th>Ulceration / mass in the glans or the prepuce</th>
</tr>
</thead>
</table>

### Clinical Details:

- History/Examination/Investigations
  
- Medication

### For Hospital Use

- Appointment Date
- Was the referral appropriate Yes No
- Clinic Attending
- (if no please give reason)

### UROLOGY CLINICS WITH RAPID ACCESS FACILITIES

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Tel</th>
<th>Fax</th>
</tr>
</thead>
<tbody>
<tr>
<td>City</td>
<td>0121 507 5805</td>
<td>0121 507 5075</td>
</tr>
<tr>
<td>Good Hope</td>
<td>0121 424 7476</td>
<td>0121 7376</td>
</tr>
<tr>
<td>Heart of England</td>
<td>0121 424 5000</td>
<td>0121 424 5001</td>
</tr>
<tr>
<td>Queen Elizabeth (UHBFT)</td>
<td>0121 627 2485</td>
<td>0121 460 5800</td>
</tr>
<tr>
<td>Walsall Manor</td>
<td>01922 721172 ext 6876 or 7227</td>
<td>01922 656773</td>
</tr>
<tr>
<td>Sandwell</td>
<td>0121 507 3834</td>
<td>0121 507 3723</td>
</tr>
</tbody>
</table>

The age-specific cut-off PSA measurements recommended by the Prostate Cancer Risk Management Programme are as follows: aged 50–59 years ≥ 3.0 ng/ml; aged 60–69 years ≥ 4.0 ng/ml; aged 70 years and older ≥ 5.0 ng/ml. (Note that there are no age-specific reference ranges for men aged over 80 years. Nearly all men of this age have at least a focus of cancer in the prostate. Prostate cancer only needs to be diagnosed in this age group if it is likely to need palliative treatment.)
Appendix 2: Algorithm for the Management of Testicular Germ Cell Neoplasms by Histopathology, Stage and IGCCC Grouping

Testicular cancer

Pure seminoma

- Stage 1
  - Single dose Carboplatin AUC7 EDTA clearance

Stage 2A
- Para-aortic RT, or Cisplatin+ Etoposide 120 x3

Stage 2B or more advanced
- Cisplatin+ Etoposide 120 x3/4

NSGCTT or mixed seminoma + NSGCTT

Staging

- Stage 1 VI-
  - BEP 120 x2 adj’t for mixed S+NS Surveillance
  - Or BEP 120 x2 adj’t for NS Patient choice

Stage 1 VI+
- 111 Trial
- BEP 120 x2 adjuvant

IGCCCG
- Good
  - BEP 165 x3

IGCCCG
- Intermediate
  - BEP 165 x3/4

IGCCCG
- Poor
  - BEP 100 x4

Consider surgical resection of residual masses >1-2 cm in TM normal or plateau cases

Patient choice