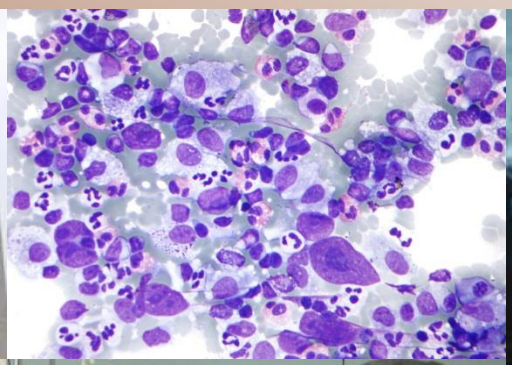
CancerCare Manitoba
COMMUNITY ONCOLOGY PROGRAM

LYMPHOMA *and* LATERAL NECK MASS *cancer diagnosis workshop*

PARTICIPANT GUIDE



www.cancercare.mb.ca/diagnosis

Updated: November 2019

LYMPHOMA & LATERAL NECK MASS
CANCER DIAGNOSIS WORKSHOP ACKNOWLEDGEMENTS

AUTHORSHIP ACKNOWLEDGEMENT

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CancerCare Manitoba
COMMUNITY ONCOLOGY PROGRAM

SUPPORT:

IN SIXTY, Manitoba's Cancer Patient Journey Initiative, was established in June 2011 with a mandate to get patients from suspicion of cancer, through diagnosis, and to their first treatment faster – in sixty days or less – and to do so in a way that also provides a smoother experience for patients. The Cancer Patient Journey Initiative established a partnership of Manitoba Health, CancerCare Manitoba, Diagnostic Services of Manitoba, Manitoba's regional health authorities, Family Physicians and other health care providers, and patients. While In Sixty's five-year mandate came to a close in June 2016, significant cancer journey improvements initiated during that time are still underway in areas of primary care, diagnostics, specialty care, IT support, and communication.

The Early Cancer Diagnosis series was established as a consequence of and with funding from the In Sixty initiative. Ongoing support for the continued development of new modules in the Early Cancer Diagnosis series is provided by CancerCare Manitoba's Community Oncology Program (COP). The COP was established in 2012 with the amalgamation of the Community Cancer Program Network (CCPN) and Uniting Primary Care and Oncology (UPCON). The COP also oversees the work of the Transitions Initiative and CCMB's Underserved Populations Program.

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All modules in the Early Cancer Diagnosis Workshop series are updated annually to reflect current standards of practice.

LYMPHOMA AND LATERAL NECK MASS DIAGNOSIS WORKSHOP OUTLINE

WORKSHOP INTRODUCTION

Collectively, the lymphomas account for approximately 6 percent of all cancers diagnosed in the developed world annually; Hodgkin lymphomas comprise about 10% of all lymphomas; of the Non-Hodgkin Lymphomas that comprise the remaining 90%, the commonest is Diffuse Large B Cell Lymphoma (DLBCL), accounting for approximately 25 percent of NHL cases[1]. Lymphomas may be indolent as in the case of many follicular lymphomas, or rapidly progressive (such as with Burkitt's lymphoma) and associated with an extremely high mortality, especially in the event of diagnostic delays. The 2019 Canadian Cancer Statistics website projects 10,000 new cases of non-Hodgkins lymphoma and 1,000 new cases of Hodgkins lymphoma, with 2,700 deaths from non-Hodgkins lymphoma and 100 deaths from Hodgkins lymphoma for 2019.

Unexplained lymphadenopathy, with or without other symptoms is the commonest presentation for lymphomas. However, the differential diagnosis of unexplained adenopathy is very large and includes other malignancies, infectious diseases, and some connective tissue diseases. The primary care clinician needs to keep this broad differential diagnosis in mind when working up adenopathy.

In the case of neck adenopathy secondary to a primary squamous cell carcinoma of the head & neck, excisional biopsy of a pathologic node as part of the diagnostic work up, if performed prior to definitive treatment, can make subsequent surgery more technically challenging and can put the patient at higher risk of contralateral disease recurrence.

Infectious causes of adenopathy in general and tuberculosis in particular are often associated with diagnostic delays that can have public health consequences as well as negative consequences for the patient.

This module will discuss the diagnostic approach to unexplained adenopathy with a particular view to expediting the diagnosis of lymphoma and navigating Manitoba's cancer care system to the benefit of the patient, the recommended approach to the diagnostic workup of the lateral neck mass when squamous cell cancer is on the differential, and how to properly take into account possible infectious causes of adenopathy, such as HIV and tuberculosis.

WORKSHOP OBJECTIVES

- Recognize clinical scenarios where lymphomas and squamous cell head and neck cancers should be considered in the differential diagnosis
- Recognize clinical scenarios in which infectious causes of adenopathy should be considered in the differential diagnosis
- Explain the implications for the diagnostic work up of cervical adenopathy when a primary squamous cell cancer of the head & neck is on the differential
- Explain how to expedite the diagnostic work up of aggressive lymphomas and bring the patient to the attention of a hematologist-oncologist in a timely fashion

PRE-READINGS (FOUND IN SUPPLEMENTAL MATERIALS)

1. Pathway – Clinical Guidance: Work-up of Lymphadenopathy Suspicious for Lymphoma. In Sixty Manitoba Cancer Patient Journey Initiative (available at CancerCare Manitoba Diagnostic Pathways)

https://www.cancercare.mb.ca/For-Health-Professionals/diagnostic-pathway-for-suspected-cancer-and-blood-disorders

2. For guidelines for referral of patients with suspected Lymphoma to CCMB's Lymphoproliferative Disease Site Group, visit Referral Guidelines. From there you can select Lymphoproliferative Disorders and choose the appropriate disease.

https://www.cancercare.mb.ca/For-Health-Professionals/referral-guidelines-for-physicians

* Please refer to website for the latest version.

CASES

CASE 1: TANIA, AGE 35

Tania presents on a humid Friday afternoon with two complaints: a lump in the right side of her neck and an itchy rash which she says is present everywhere but worst over her back. Aside from a bout of infectious mononucleosis which you diagnosed five years ago, Tania had been in good health prior to the onset of these symptoms. She reports having lost about 7 lbs. in the past three weeks. Tania thinks her diffuse itching is from the stress of her job as inspector at a meat packaging plant. She thinks the hot weather over the past few weeks is also bothering her. She tends to sweat a lot at night, and feels restless when she tries to sleep.

A rounded swelling in the vicinity of the anterior border of the mid-portion of her right sternomastoid is evident. Ovoid, firm, smooth and non-tender, it measures about 3 cm in its vertical axis. The horizontal diameter is difficult to assess because the lateral portion of the node seems to disappear under the muscle belly of the sternomastoid.

QUESTION #1: WHAT QUESTIONS DO YOU HAVE FOR TANIA?

QUESTION #2: WHAT SHOULD THE PHYSICAL EXAMINATION INCLUDE IN A PATIENT WHO PRESENTS WITH A LATERAL NECK MASS?

**Developing a consistent routine will minimize the chances of the inadvertent omission of a portion of the exam.*

<u>Case 1 continued</u>: Tania's resting pulse is 96, her blood pressure (right arm sitting) 104/72, T 36^8, O_2 saturation 95% on room air. Her head & neck examination discloses the enlarged right neck node, which is non-tender and slightly mobile, and a slightly ruddy complexion. The oropharynx appears normal. On careful examination you cannot appreciate any other enlarged nodes of the head, neck, axillae, epitrochlear areas or groins. Her rash consists only of scattered faint scratches over her trunk and limbs, and some larger and slightly inflamed excoriations of her upper back, sparing the areas beyond the reach of her fingers. Her cardiorespiratory and abdominal examinations disclose no other abnormalities.

<u>QUESTION #3</u>: WHAT IS ON THE DIFFERENTIAL DIAGNOSIS OF A LATERAL NECK MASS?

Case 1 continued: you are especially concerned, in view of Tania's cervical lymphadenopathy and constitutional symptoms, and diffuse pruritus, that she might have a malignancy. You are eager to obtain a tissue diagnosis.

QUESTION #4: HOW SHOULD YOU GO ABOUT OBTAINING A TISSUE DIAGNOSIS?

Case 1 continued: You proceed with an FNA of the enlarged neck node on the occasion of that visit. Anticipating the possible need for an excisional biopsy of the node to confirm your suspicion of a malignancy, and concerned about her 'B' symptoms, you dictate a referral letter to a Head & Neck Surgeon, explaining the urgency of the matter to your clinic administrative staff, who promise to get the referral 'out the door in 24'. To further expedite the referral, you telephone the consultant, who advises you he will see your patient within the next 14 days*.

*visit CancerCare Manitoba's website at https://www.cancercare.mb.ca/For-Health-Professionals/diagnostic-pathway-for-suspected-cancer-and-blood-disorders and click on the various disease-specific pathways to see the recommended timelines pertinent to the work-up of a suspected cancer.

QUESTION #5: WHAT OTHER WORK UP SHOULD YOU UNDERTAKE WHILE WAITING FOR THE EXCISIONAL BIOPSY?

<u>Case 1 continued:</u> The chest radiograph report arrives early the next week. It suggests possible mediastinal lymphadenopathy. You telephone the radiologist at the community hospital to which the CT requisition was sent; he agrees to expedite the appointment for the CT scans you have requested.

Tania comes back to see you for review the next week, two weeks after her initial visit with you. The FNA showed numerous lymphocytes but was not adequate for diagnosis. She has already had an excisional biopsy of the enlarged neck node. You telephone the Head & Neck Surgeon, who says he has just received the pathology report which confirms the suspected diagnosis of Hodgkin lymphoma. The CT report, just back this morning, mentions two other enlarged nodes in the neck, including a posterior cervical node and a supraclavicular node, both on the right. Bulky mediastinal lymphadenopathy is also remarked, including a node which impinges on the superior vena cava. Tania notes that along with the work stress she has felt restless at night, she is having insomnia, and she feels particularly agitated if she lies down, so she has been sleeping in her recliner for the past week. As Tania takes a seat in your examination room, you are struck by the ruddiness of her complexion.

<u>QUESTION #6</u>: WHAT CONDITION IS COMPLICATING TANIA'S NEWLY DIAGNOSED HODGKIN LYMPHOMA? HOW WILL YOU MANAGE IT?

CASE 2: BOB, AGE 58

Bob comes to your office complaining of a six week history of a lump in the left neck below the angle of the jaw, a sore tongue, and left otalgia.

Bob has a history of hypertension treated with amlodipine 5 mg od. He works as a mechanic in the rail yards, has moderate bilateral high tone hearing loss and chronic bilateral tinnitus. He has a 30 pack-year smoking history and drinks beer on weekends. He is happily married, with two children in university. He denies any recent change in his mild, chronic cough or in the colour of the small amount of brownish sputum he produces each morning. He has had no recent coryza, rhinorrhea, sore throat or fever. He thinks he might have bitten his tongue about two months ago. It has been sore ever since, and especially for the past week. Bob denies recent fever or night sweats. On account of pain experienced during meals, Bob has been eating less over the past week and thinks he might have lost about five pounds

QUESTION #1: WHAT SHOULD YOUR PHYSICAL EXAMINATION OF BOB INCLUDE, IN ADDITION TO WHAT IS LISTED IN CASE #1?

Case 2 continued: On examination Bob is moderately overweight. His voice, as usual, is gravelly. Inspection of the external ear and the tympanic membranes is unremarkable. There is a firm, non-tender 2.5 cm diameter left jugulodigastric node on palpation of the neck. On inspection of the oral cavity, he has mild-to moderate gingivitis. A raised, ulcerated lesion is visible on the left lateral border of the tongue near the circumvallate line. You estimate its diameter at ~1.5 cm. On palpation of the tongue the lesion is moderately tender, firm, and feels about as deep as it is wide. The examination provokes slight bleeding from the ulcerated portion of the lesion.

QUESTION #2: WHAT IS THE MOST LIKELY DIAGNOSIS TO ACCOUNT FOR THE TONGUE LESION AND THE LEFT JUGULODIGASTRIC NODE IN THIS INSTANCE?

QUESTION #3: WHY DOES BOB HAVE EAR PAIN?

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QUESTION #4: WHAT ARE YOUR NEXT STEPS?

*In 2018, CancerCare's Central Referral Office amalgamated with Cancer Navigation Services to form Provincial Cancer Referral and Navigation.

QUESTION #5: WHAT BARRIERS DO YOU PERCEIVE TO THE IMPLEMENTATION IN CLINICAL PRACTICE OF THE RECOMMENDATIONS MADE IN THIS MODULE WITH RESPECT TO:

- **PERFORMING FINE NEEDLE ASPIRATION IN THE WORK UP OF A LATERAL NECK MASS?**
- **CONNECTING YOUR PATIENTS, WHEN APPROPRIATE, WITH CANCER NAVIGATION SERVICES?**

CASE 3: PRATHIKA, AGE 39

Prathika comes to your office for a get acquainted consultation. She is from Punjab, in northern India, and has moved recently along with her husband and their two children on account of a devastating earthquake that destroyed much of the town they lived in prior to immigrating to Canada. In need of a family physician, they called Manitoba Health's 'Family Doctor Finder' who in turn referred Prathika to your clinic.

Prathika complains of a mass on the left side of her neck which has progressively enlarged since she first noticed it about a month ago. She admits to slight fatigue, and thinks she might have had a recurrent fever over the past few weeks, but didn't have a thermometer to measure her temperature. She denies weight loss, drenching sweats, pruritus or pain. She admits to an occasional cough, intermittently productive of tiny amounts of slightly yellowish and off-white sputa. When you ask her if she has a history of tuberculosis, she explains that she had a normal chest X-ray 14 months ago when she came to Canada, but that she was placed on isoniazid shortly thereafter for latent tuberculosis (LTBI), having had a Mantoux skin test with 10 mm of induration as part of an occupational health employment-intake process. She attended a clinic for supervised administration of the INH, of which she completed a nine month course just over a month ago. Her husband and her children are well.

On examination Prathika looks generally well. Her vitals include BP 112/60, T 37.1, P94, RR 18, O2 saturation 96% on room air. She has an approximately 3 cm mildly tender lymph node in the posterior triangle on the left. The node is somewhat rubbery, with no fluctuance. Her oral examination is remarkable only for a carious right mandibular molar tooth; her gums and the remainder of her dentition look healthy. The thyroid is normal to palpation. She has no other palpable adenopathy of the head, neck, epitrochlear regions or groins. Her lungs are clear and her heart sounds are normal. Her abdominal examination reveals a soft, non-tender belly with no mass or organomegaly. The extremities are unremarkable.

QUESTION #1: WHAT CONDITIONS MIGHT EXPLAIN PRATHIKA'S LEFT CERVICAL ADENOPATHY, FATIGUE, AND LOW GRADE FEVER?

QUESTION #2: WHAT INVESTIGATIONS SHOULD BE DONE FIRST?

QUESTION #3: ARE THERE OTHER TESTS YOU MIGHT INITIATE AT THIS VISIT?

Case 3 continued: Concerned about a possible lymphoma, you refer Prathika to CancerCare Manitoba, explaining in your letter that you are deferring the decision to perform an FNA to the consultant. Prathika's chest X-ray shows faint scarring at the left apex and subtle thickening of the adjacent pleura, consistent with a past history of TB. The chest radiograph is otherwise clear. The CT neck, chest and abdomen confirms subtle scarring of the left lung apex and thickening of the adjacent pleura, and enlargement of upper paraaortic, lesser omental, mesenteric, and anterior pararenal lymph nodes, with peripheral enhancement. Sputa for AFB are negative, culture pending.

QUESTION #4: GIVEN THE CXR FINDING AND HER HISTORY, WHAT IS PRATHIKA'S LIFETIME RISK OF TB REACTIVATION? VISIT HTTP://WWW.TSTIN3D.COM FOR AN ONLINE CALCULATOR.

QUESTION #5: DOES THE CT REPORT HELP YOU WITH ESTABLISHMENT OF THE DIAGNOSIS?

Case 3 continued: You call the consultant with the CT result. The consultant advises you that an FNA has already been done and the results, just back that day, are non-diagnostic. In view of this new information he calls the patient back in for an excisional biopsy. The excised lymph node is sent for histology, culture, and nucleic acid testing. A diagnosis of tuberculosis is established, and Prathika is established on a combination of INH, rifampin, ethambutol, and pyrazinamide. The INH is subsequently discontinued in favour of moxifloxacin, when sensitivity testing reveals multi-drug resistance.

QUESTION #6: IF THE PATIENT IN THIS CASE OR IN CASE #1 HAD BEEN A YOUNG ADULT MALE WITH A SUPRACLAVICULAR NODE, AND THE CT HAD SHOWN RETROPERITONEAL AND MEDIASTINAL LYMPHADENOPATHY, HOW WOULD THAT HAVE CHANGED YOUR DIFFERENTIAL DIAGNOSIS? WHAT WOULD YOU HAVE DONE DIFFERENTLY?

QUESTION #7: IF A DIAGNOSIS OF TUBERCULOSIS IS BEING CONSIDERED AT THE TIME OF FNA, HOW SHOULD THE SPECIMEN FOR TB CULTURE BE SENT?

CASE 4: **LIONEL**, AGE 63

You are filling in as a locum tenens for Dr. Smith when Lionel presents to the clinic complaining of fever, sweats, abdominal pain and fatigue which he developed en route while traveling home from a vacation in the Dominican Republic last week. Lionel is a life-long bachelor, and has no immediate family in the city. Lionel had been feeling very well in the six months preceding his vacation, although he did develop some small nodes in his neck just before he left for his vacation about three weeks ago. He wondered if his CLL was becoming active again, but had been looking forward to the vacation and decided he would consult his family physician, Dr. Smith, after his return home. Now those lymph nodes are larger, and somewhat tender.

QUESTION #1: WHAT IS ON YOUR DIFFERENTIAL DIAGNOSIS?

QUESTION #2: WHAT DO YOU WANT TO KNOW ABOUT LIONEL?

Case 4 continued: On examination Lionel is afebrile, his pulse 104 and regular, blood pressure 146/92, and O2 saturations 98%. His colour is normal aside from slight pallor. He is visibly anxious. You note several enlarged lymph nodes in his neck, including a roughly 2 cm jugular chain node and a similar right submandibular node adjacent to it. There are no palpable axillary nodes. His lungs are clear. His liver is not palpably enlarged but you can feel a spleen tip and Castell's point is dull to percussion. His abdomen is diffusely and mildly to moderately tender, without obvious masses. His extremities are unremarkable.

QUESTION #3: WHAT IS ON YOUR DIFFERENTIAL DIAGNOSIS NOW? HOW WILL YOU DISCUSS THIS WITH LIONEL?

QUESTION #4: WHAT INVESTIGATIONS DO YOU WANT TO UNDERTAKE?

QUESTION #5: HOW MIGHT LIONEL'S PSYCHOSOCIAL CONCERNS BE ADDRESSED?

Case 4 continued: Lionel's LDH comes back elevated at 486 mU/L, up from 230 a few months ago. The chest radiograph is normal. The CT scans discover bulky retroperitoneal and periaortic lymph nodes, moderate splenomegaly, and a 6 cm mass adjacent to the right kidney, the appearance of which is more in keeping with lymphoma than with renal cell carcinoma, in the opinion of the radiologist. The urgent PET scan arranged by Lionel's hematologist-oncologist shows intense metabolic activity in the peri-renal mass; CT-guided biopsy confirms an aggressive DLBCL.

REFERENCES, LINKS AND RESOURCES

1. Canadian Cancer Society – Cancer Statistics at a Glance: http://www.cancer.ca/en/cancer-information/cancer-101/cancer-statistics-at-a-glance/?region=mb#ixzz2wX4BTbCW

2. Navigation Services: https://www.cancercare.mb.ca/Patient-Family/support-services/cancer-navigation-services

Facilitator Guidelines adapted from the Breast Cancer Workshop, Cancer Care Outreach Program on Education, BC Cancer Agency and University of British Columbia, Continuing Professional Development

SUPPLEMENTAL INFORMATION INCLUDED

Work-Up of Lymphadenopathy Suspicious for LYMPHOMA

Timeline and Legend pg.5

RISK FACTORS: HIGH risk: immune deficiency (ie. HIV or organ transplant), autoimmune disease +/- immune suppressing medications, and history of lymphoma

PRACTICE POINTS: ***Consider your differential diagnosis*** including reactive LN due to infection/inflammation, metastatic malignancy, and autoimmune disease. This document applies to adults 17 years of age or older.

PRACTICE POINTS: **All referrals sent within 24 hrs of visit.** Provide complete information as requested to avoid delays. Ensure patient and family is well informed and receives appointment information. If patient is in distress, offer referral to local counsellor. See ***Supporting Information for Clinicians*** (pg 4) for contacts and resources. Contact the **Cancer Question Helpline for Primary Care** for assistance.

Emergent
- Airway compromise
- Superior vena cava compression
- Spinal cord compression

→ **Send to Emergency Department**

Palpable Lymphadenopathy (LN)
- Abnormal LN: >2-3 cm, persistent enlargement & without obvious cause

Lymphadenopathy on Imaging

→ **History & Physical Exam**
*** Consider your differential diagnosis***
Order CBC, HIV test, Chest X-ray

→ **No ↑ Lymphocyte Count**

High Suspicion / Concerning Features
PROCEED without delay
- HIGH Risk Patients (as above)
- LN + Abnormal Bloodwork (severe anemia, thrombocytopenia, pancytopenia)
- Widespread LN +/- splenomegaly or bulky LN (mass >6cm)
- Mediastinal mass
- LN with rapid growth
- LN & B symptoms (drenching sweats, unexplained fever, weight loss)
- Patient symptomatic from abnormal LN (ie: short of breath, abdominal pain)

→ **If ANY Concerning features - Determine* best site for diagnostic biopsy**
- **Order CT scans if not already done,** including neck, chest, abdomen & pelvis
- **Preference for site of biopsy:** Palpable >Mediastinal >CT guided
- **Order CBC, chemistry (including Ca, LDH, Cr) and INR if not already done**

if assistance is needed contact Hematologist on call for advice

→ **Continue to Diagnostic pathway pg.2**

→ **If NONE Clinical Follow up**

→ **Persistent /progressive LN** on exam (>4weeks) or imaging (after serial examination)

→ **↑ Lymphocyte Count**

→ **Order flow cytometry on peripheral blood** (query CLL vs other lymphoma)

→ **Positive for CLL or monoclonal lymphocyte population**

→ **REFER TO CCMB**

In Sixty → All referrals / orders sent within 24 hrs of visit

In Sixty → In Sixty timeline starts with evidence of concerning features

In Sixty → All imaging done within 2 weeks

Suspicion Pathway Notes:

Sixty day suspicion to first treatment timeline begins on the date of patient visit when a high clinical suspicion of cancer triggers further cancer-focused investigation.
Only requisitions for patients who fit the red pathway should be noted as "urgent " to ensure urgent resources and timeline capacity can be maintained in next stages of the pathway.
Pathways are subject to clinical judgement and actual practice patterns may not always follow the proposed steps in this pathway.

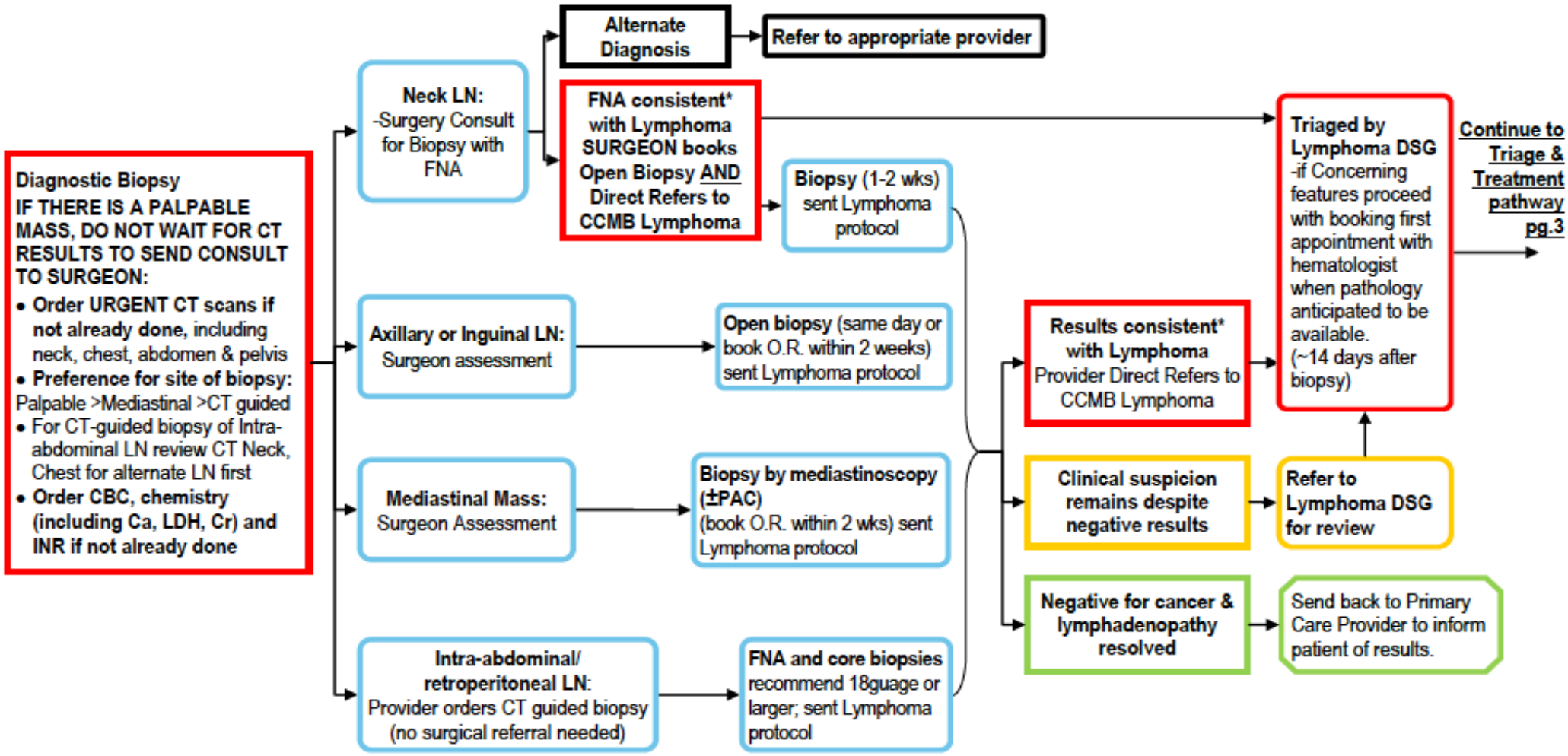
IN60_LYMS
15-05-2015

Diagnostic Pathway LYMPHOMA

Timeline and Legend pg.5

PRACTICE POINTS: Consultation with the Lymphoma Disease Site Group can happen earlier in the pathway if clinicians need additional support or guidance.
*Results Consistent with Lymphoma: ***If flow cytometry from biopsy or FNA is consistent with lymphoma, consult should be sent to CCMB Central Referral for triage by Lymphoma DSG even if final pathology report is not yet complete.***

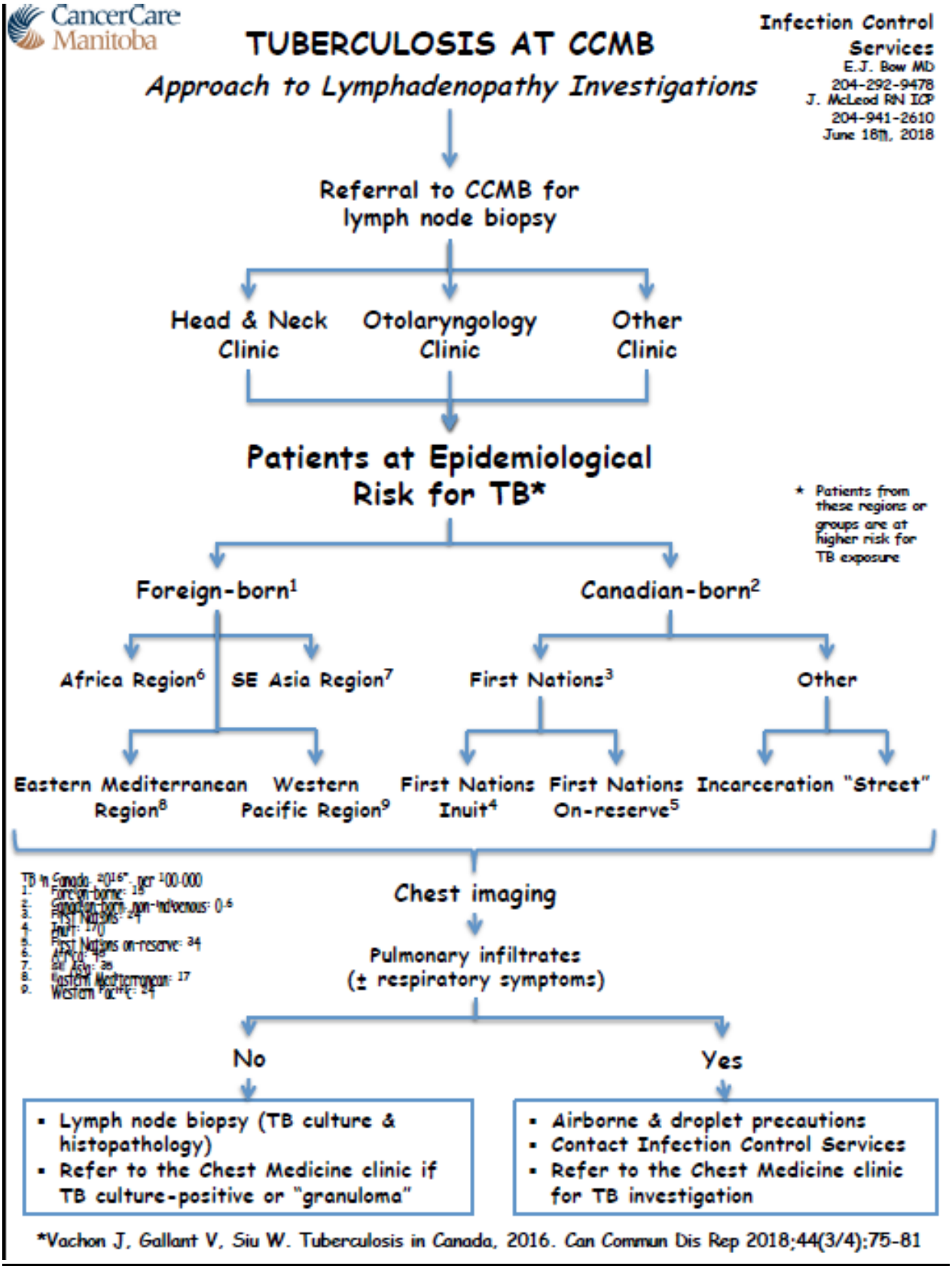
PRACTICE POINTS: Ensure patient is well informed and receives appointment information. Offer patients connections with psychosocial clinicians and cancer navigation services (see ***Supporting Information for Clinicians***, pg 4). Ensure the referring primary care provider is informed of results, direct referrals, and result discussions with patients.



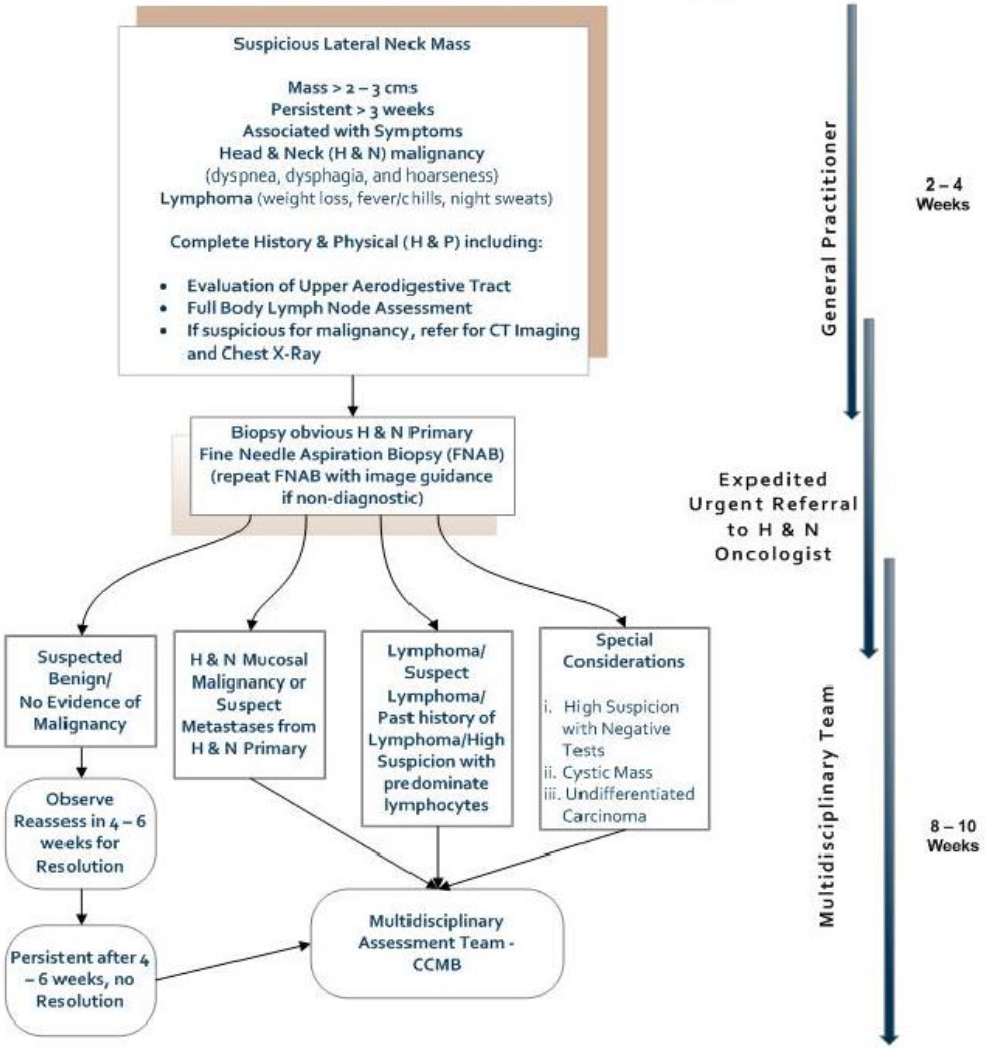
In Sixty — FNA results reported within 2 days (immediate direct referral to CCMB if suspicious of lymphoma)

In Sixty — Biopsy with 2 weeks of surgery consult/assessment/FNA

In Sixty — Biopsy results reported within 14 days. Immediate direct referral to CCMB if suspicious of lymphoma)


CancerCare Manitoba
TUBERCULOSIS AT CCMB
Approach to Lymphadenopathy Investigations
Infection Control Services
E.J. Bow MD
204-292-9478
J. McLeod RN ICP
204-941-2610
June 18th, 2018
Referral to CCMB for lymph node biopsy
Head & Neck Clinic
Otolaryngology Clinic
Other Clinic
Patients at Epidemiological Risk for TB*
* Patients from these regions or groups are at higher risk for TB exposure
Foreign-born1
Canadian-born2
Africa Region6
SE Asia Region7
First Nations3
Other
Eastern Mediterranean Region8
Western Pacific Region9
First Nations Inuit4
First Nations On-reserve5
Incarceration
"Street"
TB in Canada, 2016*, per 100,000
1. Foreign-born: 15
2. Canadian-born, non-Indigenous: 0.6
3. First Nations: 24
4. Inuit: 170
5. First Nations on-reserve: 34
6. Africa: 45
7. SE Asia: 35
8. Eastern Mediterranean: 17
9. Western Pacific: 24
Chest imaging
Pulmonary infiltrates (± respiratory symptoms)
No
Yes
Lymph node biopsy (TB culture & histopathology)
Refer to the Chest Medicine clinic if TB culture-positive or "granuloma"
Airborne & droplet precautions
Contact Infection Control Services
Refer to the Chest Medicine clinic for TB investigation
*Vachon J, Gallant V, Siu W. Tuberculosis in Canada, 2016. Can Commun Dis Rep 2018;44(3/4):75-81

Approach to an Adult with a Lateral Neck Mass



NOTES

Clinical Examination:

1. History – upper aerodigistive tract symptoms; constitutional symptoms; risk factors
2. Physical exam – cranial nerve exam; otoscopy; upper aero digestive tract; neck palpation including lymph node palpation above and below the clavicle.
3. Fiberoptic Nasendoscopy
4. FNAB
5. When referring, include all relevant physical findings.
6. Referral to occur if multiple lymph node groups are involved.

Indications for Open biopsy*:

i. Most cases of lymphoma
ii. Further evaluation of undifferentiated malignancy
iii. Cystic neck mass with no obvious primary
iv. Non diagnostic FNAB (following 2nd biopsy under image guidance)
v. Patient's condition indicates high suspicion for malignancy with negative investigations

*** May be done in conjunction with EUA and panendoscopy in selected instances. Biopsy performed by or in consultation with member of multidisciplinary team**

Special Considerations:

i. Patients with known HIV, solid organ transplant, autoimmune disease, significant lymphadenopathy/splenomegaly, past history of lymphoma
ii. Presence of lymphocytes is a red flag for Lymphoma

SHARING BAD NEWS: A Critical Clinical Skill

Dr. Jeff Sisler, Department of Family Medicine, University of Manitoba

The Six Step SPIKES Protocol[1]

Setting up the interview
Perception of the patient re their illness
Invitation from patient to share info
Knowledge and information conveyed
Emotions responded to empathically
Summary and strategy for follow-up

Sharing Bad News is....

- Remembered vividly by patients
- Stressful to the doctor as well as the patient
- Perhaps the greatest challenge in the domain of communication skills
- An opportunity to be especially helpful at a most significant time in a patient's life

Goal of Sharing Bad News

- **To facilitate patient and family acceptance and understanding of the condition**
- **To minimize the risk to the patient of overwhelming distress, and to avoid prolonged denial or collusion**

1. Setting up the interview

- Anticipate the possibility of bad news, and arrange a follow-up visit after significant scans, etc.
- Avoid telephone
- Private setting, sitting down
- Turn off beeper, no interruptions
- Ensure adequate time
- Lab reports, X-rays present
- Support person present, if desired
- Review the condition basic prognosis and treatments before the visit
- HOPEFUL TONE

2. Assessing the patient's Perception

- Especially important if the patient is not well know to you, OR if visits to consultants have occurred in the interim
- "Assess the Gap" between what the patient knows and the diagnosis
- "What have you already been told about your illness?"
- "What have you been thinking to yourself about this lump/bleeding/ cough

3. Obtaining the patient's Invitation

- Preferably before the visit
- Easier if patient is well-known
- Listen to patient cues
- "Are you the sort of person who likes to know all the details of your condition?"
- "Would you like me to discuss the results of the CT scan with you?"

4. Giving Knowledge and Information

- Align yourself with the patient's understanding & vocabulary
- Start with a warning shot: "I'm afraid that the scan shows that the problem is fairly serious"
- Give diagnosis simply, avoid euphemisms or excessive bluntness
- Provide information in small chunks, checking frequently for understanding
- Check of knowledge or experience with the condition
- Allow for pauses, use repetition
- Will usually want basic info re: treatments and prognosis BUT tune into patient readiness to hear more, and know when to stop

5. Respond to Emotions empathically

- Allow room for emotional reactions
- Kleenex handy, use of touch
- **NURSE the emotion→**

Name the emotion
Understanding, legitimizing
Respect, praise
Support: "I'll do everything I can to help you through this
Explore the emotions further using open ended questions

6. Summary and Strategy for follow-up

- Summarize discussion
- Clear follow-up plan re: referral, tests, next contact (in <48 hours)
- Provide written summary or brochures
- Refer to community resources
- Invite support person for next visit if not present
- End on note of hope and partnership
- AFTER: document well + assess your own reaction

[1]Walter Baile, Robert Buckman, et al in "**SPIKES – a six step protocol for delivering bad news**" *The Oncologist* 2000; 5:302-311

CancerCare MANITOBA

INFORMATION REQUIRED BY CCMB REFERRAL CENTRE— HODGKIN'S LYMPHOMA (LYMPHOPROLIFERATIVE ONCOLOGY DSG)

Key:

shaded text – denotes **required** information

* (asterisk) – denotes optional information
Please send results/reports if done.

1. GENERAL INFORMATION

- Demographic information (New Patient Referral Form)
- Letter of referral
- History and physical (including rectal and gynecological examinations)
- Co-existing medical conditions
- Allergies
- Previous malignancy information (diagnosis and previous treatment)

2. PATHOLOGY REPORTS

Attach copy of ORIGINAL REPORT(S):

- ALL tissue biopsy report(s) (FNA, core biopsy, excisional biopsy)
- Bone marrow aspiration and biopsy -unilateral *
- Pathology review (biopsy and marrow)-by HSC or St. B hematopathologist *

3. OPERATIVE REPORTS

- Notes from any surgical biopsy procedure(s)

4. IMAGING REPORTS / STAGING INVESTIGATIONS

- Chest x-ray PA and lateral views
- CT scan of the chest *
- CT scan of the abdomen and pelvis *
- Gallium scan total body *

5. BLOODWORK

- CBC and differential; ESR
- Biochemistry including uric acid, calcium, albumin, creatinine, urea, total bilirubin, alkaline phosphatase, AST, ALT, LDH *

6. OTHER INFORMATION

- Pulmonary function testing (for patients with COPD; smoking history; previous radiation to the thorax) *

Note: *If referring physician has ordered tests, but they are not yet done, please provide dates (if available) and location where test is being done.*

CancerCare MANITOBA

INSTRUCTIONS FOR PREPARING & SUBMITTING–
CancerCare Manitoba's *New Patient Referral Form*

You can fill in the CCMB ***New Patient Referral Form*** *(next page of this pdf file) using an Adobe Acrobat application (e.g. Reader, Pro) on your computer. If you are using Adobe Reader5.0 or higher to perform this task, please note that* ***Adobe has disabled the "save form" feature.*** *Therefore, after you fill in the form, be sure to print a copy(ies) before closing the window to avoid losing your data. Alternatively, you may print a blank form and fill it in by hand.*

As you do so, please follow these instructions:

1. Attach the "required referral information" specific to the DSG (or area of specialization) that is detailed in the preceding page(s) of this download package.

2. If the referring physician has ordered investigations that have not yet been completed or results are pending, please provide dates and location in the space provided on the referral form. For those referring offices that submit referral information from an electronic chart source, we request that the referral information be sent as separate documents, each labeled with the patient's name and health number. (i.e. x-ray report on one page, CBC on a separate page, operative report on another page, CT scan on its own page, etc.).

3. Have the Referring Physician **SIGN THE FORM**.

4. Please send above information together with the CCMB referral form by **FAX** to (204) 786–0621.

5. If the referring physician has or will be referring the patient to a community medical oncologist, please indicate this on the referral letter.

6. Please note if any investigations indicated were not completed or if the results are still pending. Lack of pertinent information **MAY DELAY** the scheduling of the patient's appointment. Additional investigations may be organized prior to the patient's first appointment.

7. If the referral is **emergent** (i.e.: your patient needs to be seen within 24 to 48 hours for immediate treatment with chemotherapy, radiation therapy or surgery for a life-threatening oncological emergency), please phone the Medical or Radiation Oncologist or surgical service on-call through paging at Health Sciences Centre: (204) 787-2071 or at St. Boniface General Hospital: (204) 237-2053.

8. For **hematologic emergencies** please page the on-call hematologist at the above phone numbers.

9. **Is the patient aware of the diagnosis?** All patients should be made aware of their diagnosis by the Referring Physician prior to being referred to CancerCare Manitoba. CancerCare Manitoba staff will be contacting new patients by telephone to provide further information about their first appointment. If the patient is not aware of their diagnosis and referral to CancerCare Manitoba, they may experience undue stress and anxiety.

If you have a referral-related inquiry, please call (204) 787–2176.

CancerCare Manitoba
ActionCancerManitoba

Central Referral Office
Referral by Fax: 204-786-0621
Inquiry: 204-787-2176

*For a complete Referral Package, please use the Referral Guide for the disease site involved.
Patient Identifiers required on each sheet submitted.

Referral Information Sheet

PATIENT INFORMATION LABEL / ADDRESSOGRAPH

Today's Date:

PATIENT INFORMATION

Required Information to accompany Referral Letter or Consult Request

Surname: _____
Given Name & Initial: _____
Maiden or Previous Name(s): _____
DOB: DAY / MONTH / YEAR Gender: ☐ M ☐ F
MB Health #: _____
PHIN: _____
Other: _____

Address: _____
_____
City: _____
Postal Code: _____
Home Phone: _____
Work Phone: _____
Cell Phone: _____

Is English the patient's primary language?
☐ Yes ☐ No
If no, provide patient's primary language: _____
Need for interpreter? ☐ Yes ☐ No

Does the patient have any special needs?
☐ Wheelchair ☐ Stretcher
☐ Portable Oxygen
☐ Other: _____

Patient Location:
☐ Home
☐ Hospital-Specify Unit: _____
Unit Phone: _____

REFERRAL INFORMATION

Diagnosis: _____
☐ Confirmed ☐ Presumptive

Reason for consultation:
☐ Newly Diagnosed ☐ Second Opinion
☐ Recurrent/Progressive Disease

Is patient aware of diagnosis? ☐ Yes ☐ No
If no, please explain: _____

Referring Physician's Name: _____
Phone: _____ Fax: _____
Surgeon (If not referrer): _____
Family Physician/Nurse Practitioner: _____

Comments:

www.cancercare.mb.ca/referrals - *Use the disease site specific Referral Guide for completeness, missing items may cause delay in triage process*

REFERRAL PACKAGE CHECKLIST:	If result pending, state date and place done:
☐ Referral Letter (with history & physical, co-existing conditions, allergies, previous malignancy)	
☐ All Pathology & Operative Reports	
☐ All Diagnostic Imaging	
☐ All Blood Work	
☐ Other:	

ADDITIONAL CREDITS

You can claim up to 5 self-learning credits on-line by completing a Linking Learning to Practice Exercise

1. Go to www.cfpc.ca and access your member portal
2. Log in
3. Click on “Add a CPD Activity to my Record”
4. Click on “Enter a CPD Activity”
5. Select “Self-Learning” for Category
6. Select “Certified” for Certification Type
7. Select “Linking Learning to Practice” for Activity Type
8. Start filling your Linking Learning to Practice Exercise:

   This workshop’s program ID # is _____