Perspectives on the CUP MDT

Dr Richard Griffiths
Consultant in Medical Oncology

CUP 2015, Royal College of Physicians
24th September 2015
MDT Perspectives

• Things to think about......
  – The “CUP” MDT
  – The Patient Pathway

• Three cases

• Panel discussion
What is needed?

- Early assessment by a specialist CUP team
- Cross-sectional imaging
- +/- Histological diagnosis
- Rapid conclusion of investigations terminating in a decision on best supportive care or definitive therapy
What Isn’t Needed

• Excessive ‘hunt the primary’ investigations

• Protracted uncertainty

• Protracted inpatient stay
Patient Pathway

Primary Care

Secondary Care

MUO/CUP ASSESSMENT

DIAGNOSTICS

DECISION MAKING

REFERRAL TO SSMDT

DEFINITIVE ANTI-CANCER THERAPY

SUPPORTIVE CARE

NON-MALIGNANT

CUP MDT MEMBERS

PALLIATIVE CARE

URGENT CARE

RADIOLOGY

PATHOLOGY

OTHER MDTS
Case Presentation – Who Owns the Unknown?

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An unusual presentation

• 45 year old female
• March 2014 increasing dyspnoea on exertion
• Investigated – primary pulmonary hypertension diagnosed September 2014
• Noticed left leg swollen during investigations and enlarged inguinal lymph node
• Referred for pulmonary endarterectomy
December 2014 – CT shows low volume lymphadenopathy in inguinal and para-aortic regions. No clots seen.

Working diagnosis of recurrent pulmonary thromboemboli causing pulmonary hypertension.

Referred to haematology.
• January 2015 – seen by haematology, suspected low grade lymphoma
• Referred for lymph node biopsy
• February 2015 – inguinal node excision confirms metastatic adenocarcinoma
• Immunohistochemistry
  – A/E1+ CK7+ CK20- TTF1- CDX2- CA125+ WT1- S100-
• Serum Ca125 =13000
• Seen by CUP team
• Repeat CT shows gradual enlargement of inguinal and para-aortic lymphadenopathy. Probably affected axillary nodes too
• Discussed at CUP MDT
  – “provisional CUP”
  – MRI pelvis
  – Treat as for female genital tract malignancy
• MRI pelvis – minimally enlarged pelvic nodes and inguinal nodes as previously noted
• Discussed with gynaecological oncology team
  – “This is a CUP – not our responsibility”
  – “Give carboplatin and paclitaxel, get back to us if any problems”
• Reacted to first dose of paclitaxel, given single agent carboplatin
• Achieved a PR after 3 cycles but then CA125 rising and encountering haematological toxicity
• Needed ureteric stent for distal extrinsic compression
• Discussed again
  – gynae oncologists “give single agent gemcitabine”
  – CUP MDT “try abraxane”
  – Pharmacy “abraxane not indicated and not funded”
• Given 3 cycles gemcitabine with stable disease
• CA125 rising
• Now having abraxane
Issues

• Atypical presentation in a young woman – finding of adenocarcinoma was a complete surprise to all concerned

• Ownership of the problem
  – Head & neck nodal CUPs go to H&N MDT
  – Axillary nodal CUPs go to breast MDT
  – What level of confidence do we need to have to send a patient to the site-specific MDT