Urgent Suspected Cancer Pathways for Children and Young People

Cheshire and Merseyside Guidance

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Cheshire and Merseyside Cancer Alliance

NHS

Version Control

Version	Version Date	Summary of Changes
1.0	July 2012	First iteration of pathway document
2.0	July 2018	Updated referral pathways
3.0	Nov 2024	Updated cancer wait times, updated suspected cancer pathways, addition of suspected breast lump or children with breast symptoms pathway, example of new children's suspected cancer referral form.

Distribution

Name of individual / group	Issue Date	Version
Children's Clinical Quality Group	DD/MM/YY	[VERSION]
Cheshire and Merseyside Paediatric Network	DD/MM/YY	[VERSION]
GP Clinical Quality Group (CQG)	DD/MM/YY	[VERSION]
Trust Cancer Manager	DD/MM/YY	[VERSION]
DGH Paediatric/POSCU Leads	DD/MM/YY	[VERSION]
Clinical leads for individual pathways		
Relevant disease specific CQG leads		

Approval

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Children's Clinical Quality Group (CQG)	DD/MM/YY	[VERSION]
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Contents

1. Purpose of this Guidance

1.1. Background

The aim of this guidance is to make clear the urgent suspected cancer referral pathways for children and young people (CYP) within the location of Cheshire and Merseyside, North Wales and Isle of Man. The proposed benefit of this will be to improve time to referral for those CYP with suspected cancer and therefore improve time to diagnosis and treatment.

For guidance on whether an immediate, very urgent or urgent suspected cancer referral in CYP is warranted the following guidance should be used:

- NICE Guideline NG12 'Suspected cancer: recognition and referral' (www.nice.org.uk/guidance/ng12)

- Children's Cancer and Leukaemia Group (CCLG) referral guidance for suspected cancer in children and young people (Referral guidance (cclg.org.uk)) – Summary table in Appendix 1

- Links to relevant disease or symptom specific guidance can also be found on the Cheshire and Merseyside Cancer Alliance (CMCA) website.

1.2. Patient Population

The scope of this guidance is for patients aged 0-15years. Alder Hey Children's Hospital is a Principal Treatment Centre (PTC) for CYP 0-15 years and an associated PTC for teenage and young adult (TYA) patients 16-19 years. The referral process for the different age groups are as follows:

- CYP 0-15 years should be referred to local services or the Alder Hey Oncology Team depending upon the urgency of referral or symptom specific pathway*. Referrals should be made using the Urgent Suspected Cancer Form for Suspected Children's Cancer (Appendix 2).

- TYA 16-19 years should be given the choice of referral to local adult services or the TYA service at Alder Hey Children's Hospital. Referrals to Alder Hey should be made using the Urgent Suspected Cancer Form for Suspected Children's Cancer. Referral to adult services should be made via the local adult tumour specific pathway.

*Please see individual referral pathways for details

2. Children's Cancer Pathways

2.1. Cancer Waiting Times

The Cancer Wait Times review recommendations came into effect on 1st October 2023 and implemented the following targets:

- Faster Diagnosis Standard: Maximum 28-day wait to communication of definitive cancer / not cancer diagnosis for patients referred urgently (including those with breast symptoms) and from NHS cancer screening.

- Time to treatment: Recommendation for maximum 31-day time to treat from urgent suspected cancer referral (captured within the adult 62-day time to treatment target).

Although the recommendation for first review within 14 days of receipt of referral has been removed, the aim would be to review any new patient within this time frame. This is to facilitate diagnosis and commencement of treatment at the earliest opportunity from the point of suspicion of a cancer diagnosis.

2.2. Regional Children's Cancer Pathways

The NHS England Children's Cancer Network Service Specifications stipulate that clear referral pathways should be in place for CYP and TYA with suspected cancer. Regional referral pathways for the following have been agreed:

- Suspected solid tumours
- Suspected bone tumours
- Suspected brain or spinal cancer
- Suspected leukaemia
- Suspected retinoblastoma
- Suspected thyroid cancer
- Suspected skin cancer
- Suspected breast lump or children with breast symptoms

2.3. Guidance for Urgency of Referral

Criteria guiding urgency of referral are set out in NICE Guideline NG12 and the (CCLG) referral guidance for suspected cancer in children and young people. A summary table from the CCLG guidance is provided in Appendix 2. The urgency of referral is categorised as below:

- Immediate referral – telephone referral within a few hours of initial review
- Very urgent - review within 48 hours
- Urgent - review within 2 weeks

If there is a high suspicion of cancer (Immediate/Very urgent referral) please contact the consultant oncologist on call at Alder Hey Children's Hospital via switchboard.

All other referrals should be made into local services using the CMCA Urgent Suspected Cancer Form for Children's Suspected Cancers (https://www.nwchildrenscancerodn.nhs.uk/wp-content/uploads/2025/03/USCR-14.03.25-Clean.docx (Appendix 2)). Telephone advice can also be sought from the local general paediatrician on call and a referral form should follow any accepted referrals via the electronic patient referral system.

2.4. Referral from secondary care into Alder Hey Oncology

All referrals from secondary care should be made by telephone to the Oncology consultant on call. Telephone referrals should be followed promptly by a referral letter.

2.5. Rejection/Withdrawal of Urgent Suspected Cancer Referrals

If the receiving trust believes an Urgent Suspected Cancer Referral is suboptimal/inappropriate this needs to be communicated directly with the referring primary care team with the reasons for rejection/downgrade clearly described. The trust should provide advice along with relevant guidance and offer alternative referral routes as appropriate. Only the referrer can downgrade or withdraw a referral.

3. Common Referrals

3.1. Lymphadenopathy

Lymphadenopathy is a very common reason for referral for urgent suspected cancer. To supplement the CCLG guidance, the Alder Hey Children's Hospital Lymphadenopathy Referral Guidelines is included in Appendix 3. Again, where there is uncertainty regarding indication for referral for suspected cancer or urgency of referral a telephone discussion with the local general paediatrician on call is highly recommended.

3.2. Breast Lumps and Breast Symptoms

Urgent suspected cancer referrals for CYP with breast lumps and breast symptoms are not uncommon however there has never been a case of breast malignancy reported in a child under the age of 15 years in the UK. It is important however to consider that other malignancies can affect the soft tissue and bony structures of the chest wall. The Association of Breast Surgery have produced comprehensive guidance on the management of children with breast symptoms, ABS: Guidance and Pathways for the Assessment of Children with Breast Symptoms, this can be found within the Breast Surgery section on the guidance platform page (Guidance & Pathways for the Assessment of Children with Breast Symptoms | Association of Breast Surgery). Review of this is highly recommended prior to urgent suspected cancer referral for breast symptoms in CYP, including breast lumps. Where there is clinical uncertainty regarding indication for referral for suspected cancer or urgency of referral a telephone discussion with the local paediatrician on call is highly recommended.

3.3. Skin

The dermatology service is referred a high number of concerning lesions from primary care. Whilst skin malignancies are possible in children, they're extremely unusual (incidence around 1 per million in 1-4 year olds, rising to 10 per million children in 15-19 year olds). Children normally develop new melanocytic naevi, and these will change for a number of years before reaching a stable size, and so the usual criteria for assessment (such as the 7 point checklist) is often inaccurately skewed in the direction of concern. Whilst teledermatology isn't possible without dermatoscopic images, many GPs are now able to take dermatoscopic images and can use these for advice and guidance. This pathway may allow for reassurance that review either isn't required, or can be triaged as urgent or routine, rather than on the suspected cancer pathway. Likewise, if dermatoscopic images aren't available, GPs are asked to avoid the suspected cancer pathway unless very high suspicion and perhaps employ regular monitoring until the children are seen in clinic. Referrals can be upgraded at any point if concerning change is noted.

4. Appendices

4.1. Appendix 1: Table of findings that may be associated with a cancer diagnosis in childhood

Table of findings that may be associated with a cancer diagnosis in childhood.

Symptoms and signs which support decision making around referral have been suggested in the table below.

GREEN: **Reassuring features** - consider watchful wait.

AMBER: **Concerning features** - consider referral or discussion with paediatrician.

RED: **High-risk features** - requires referral:

- Urgent referral
- Very urgent referral (48 hours)
- Immediate referral (telephone referral within a few hours)

	CONSIDER WATCHFUL WAIT	CONSIDER REFERRAL	REQUIRES REFERRAL	
Ear, Nose and Throat		• Otorrhoea (persistent/ recurrent otitis externa) • Persistent/recurrent bloody/purulent discharge from ear/nose • Obstruction of ear/nose	• Swallowing difficulties (in absence of local cause)	Very urgent referral (48hrs)
			• Abnormal mass within the nasopharyngeal space	Immediate referral
Endocrine		• Polyuria/polydipsia • Delayed/arrested puberty • Abnormal growth	• Precocious puberty • Galactorrhoea	Urgent referral
Gastrointestinal		• Constipation not responsive to simple laxatives in appropriate dosage • Abdominal distension	• Persistent vomiting on awakening	Needs referral: urgency depends on length of history and associated symptoms/signs
			• Unexplained palpable abdominal mass	Needs an urgent referral, and in many cases immediate referral if symptoms such as pain, hypertension, reduced urine output, rapid increase in size
			• Unexplained hepatomegaly	Immediate referral
Haematology		• Localised petechiae/ brusing (unexplained) • Bleeding (unexplained) • Pallor • Fatigue (persistent) • Infection (recurrent, persistent or unexplained) • Generalised lymphadenopathy • Generalised bone pain (All should be offered a very urgent FBC and referral to paediatrics considered. Some children with these symptoms will need immediate referral)	• Splenomegaly - either in isolation or in association with night sweats, weight loss, pruritus or fever	Very urgent referral
			• Widespread petechiae/bruising	Immediate referral

Urgent Suspected Cancer Referrals for Children and Young People

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	CONSIDER WATCHFUL WAIT	CONSIDER REFERRAL	REQUIRES REFERRAL	
Lymphadenopathy	• Clear infectious cause • <2cm • Responsive to antibiotics	• Widespread distribution (offer very urgent FBC) • Abnormal consistency (firm or hard) • Non-mobile • Absence of pain	• Persistent enlarged nodes >2cms for >6 weeks with no decrease in size • Supraclavicular site	Urgent referral
			• Associated splenomegaly, night sweats, weight loss or pruritus	Very urgent referral (48hrs)
			• Symptoms/signs of mediastinal mass • Associated bone pain	Immediate referral
Musculoskeletal		• Night pain • Back pain • Pain limiting activities • Pain at rest • Unexplained or persistent generalised bone pain (offer very urgent FBC)	• Unexplained enlarging mass • Soft tissue mass with local lymphadenopathy • Localised unexplained bone pain (consider very urgent x-ray alongside referral) • Ultrasound scan of a mass suggests soft tissue sarcoma or is uncertain and clinical concern persists • X-ray suggests the possibility of bone sarcoma	Urgent referral
			• Limp with fever • Painful scoliosis	Immediate referral
Neurology		• Headache with vomiting • Behaviour or personality change • Reducing school performance	• Afebrile seizures	Urgent referral
			• Increasing head circumference across centiles • Headache worse in the morning or waking from sleep • Persistent headache in a child <4years	Very urgent referral (48hrs)
			• Abnormal gait • Abnormal coordination • Confusion or disorientation occurring with headache • New bladder or bowel dysfunction • Development regression • Focal motor or sensory abnormalities • Abnormal head position, such as wry neck, head tilt, or stiff neck	Immediate referral
Ophthalmology			• Absent red reflex	Urgent referral, but in infants very urgent referral (48hrs) appropriate
			• Proptosis • Abnormal eye movements • Blurred/double vision • Papilloedema	Very urgent referral (48hrs) to ophthalmology and/or paediatrics
			• New onset paralytic (non-concomitant) squint	Immediate referral
Renal			• Persistent unexplained microscopic haematuria • Hypertension (>95th centile, or for children aged 13 and over, >130/80). Severe hypertension needs immediate referral – see below.	Urgent referral
			• Frank haematuria • Severe hypertension (>95th centile +12mmHg or >140/90 – whichever is lower)	Very urgent referral, but consider immediate referral if in association with abdominal mass, hypertension, abnormal renal function or other clinical concerns
Respiratory		• New/changed wheeze/stridor in absence of typical history for asthma/viral induced wheeze	• New wheeze/stridor with orthopnoea • Difficulty breathing with facial swelling • Mediastinal widening on chest radiograph	Immediate referral
Miscellaneous		• Genetic cancer predisposition syndromes • Strong family history of malignancy • Repeated presentation to health professionals • Severe or persistent cradle cap • Unexplained weight loss • Abnormal growth • Blood-stained vaginal discharge • Persistent parental/patient concern or anxiety about symptoms, even if the symptoms are most likely to have a benign cause	• Testicular mass	Very urgent referral (48hrs)

4.2. Appendix 2: Example of Urgent Suspected Cancer Form for Suspected Children's Cancer

https://www.nwchildrenscancerodn.nhs.uk/wp-content/uploads/2025/03/USCR-14.03.25-Clean.docx

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URGENT SUSPECTED CANCER REFERRAL FORM
SUSPECTED CHILDREN'S CANCERS

Please refer to CMCA Urgent Suspected Cancer Pathways for Children and Young People(link)

As per NICE guidance referrals may be: **Immediate, Very Urgent (48 hours)* or Urgent (2 weeks)***
If there is a high suspicion of cancer (Immediate/Very urgent referral) please contact the consultant oncologist on call at Alder Hey Children's Hospital via switchboard. 0151 228 4811
All other referrals should be made into local services using the CMCA Urgent Suspected Cancer Form - Suspected Children's Cancers *via e-RS (2WW Children and Young People)*

For guidance on urgency of referral, consider telephone conversation with local paediatric consultant or on call oncologist, AHCH. Written guidance can be found:

- NICE NG12 Referral guidance for suspected childhood cancers
- cclg-referral-guidance-april-2021.pdf
- Urgent Suspected Cancer Pathways for Children and Young People, CMCA, 2025

PATIENT ENGAGEMENT – THIS IS A MANDATORY FIELD	
Has the patient, parent or guardian been counselled they are being referred to a suspected cancer service and the reason for referral? NICE ng12 guidance/ patient support	Yes No
Has the patient, parent or guardian been given relevant written information about this referral?	Yes No
Is the patient available within the next 48 hrs /14 days? * If selected no, please explain why?	Yes No
Have you checked all contact details are correct and informed that the initial appointment may be by telephone?	Yes No

REFERRER DETAILS			
Referring GP	Free Text Prompt	GP Code	Usual GP Organisation National Practice Code
Usual GP	Usual GP Title Usual GP Forenames Usual GP Surname		
GP Address	Usual GP Full Address (single line)		
GP Tel. No.	Usual GP Phone Number		
GP secure email	Organisation E-mail Address		
Date seen by GP	Long date letter merged	Decision to refer date	Long date letter merged

PATIENT DETAILS					
Title & Surname	Title Surname		Forename(s)	Given Name	
Date of Birth	Date of Birth	Age	Age	Gender	Gender(full)
NHS Number					
Address	Home Full Address (single line)				
Home Tel No.	Patient Home Telephone	Work Tel No.	Patient Work Telephone		
Mobile Tel No.	Patient Mobile Telephone	Patient email	Patient E-mail Address		
Parent / Guardian	Name Contact Telephone Relationship	Single Code Entry: Patient's next of kin Free Text Prompt Free Text Prompt			

REFERRAL INFORMATION

NHS Number Given Name Surname Urgent Suspected Children's Cancer Referral form CMCAv1.3.1

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Main reason for referral (please explain why you think this child may have cancer) Free Text Prompt		
Please refer to Urgent Suspected Cancer Pathways for Children and Young People link		
Please Indicate with X type of Cancer suspected		Please add additional information of symptoms and/or signs
Abdominal Tumour Palpable abdominal mass or abdominal distension - Very urgent	☐	
Leukaemia- Pallor, fatigue, bruising, petechiae, hepatosplenomegaly - Immediate	☐	
Lymphoma Enlarged lymph nodes fitting the criteria for referral - **Urgent**	☐	
Bone Tumour Chronic pain, palpable mass - **Urgent**	☐	
Soft Tissue Sarcoma Soft tissue mass lesion - **Urgent**	☐	
Retinoblastoma Absent red reflex - **Urgent**	☐	
Brain or spinal tumour Symptoms of raised intracranial pressure, new squint - Immediate	☐	
Skin Cancer Meeting criteria for urgent suspected cancer referral - **Urgent**	☐	
Breast Meeting criteria for urgent suspected cancer referral - **Urgent**	☐	
Thyroid Meeting criteria for urgent suspected cancer referral -**Urgent**	☐	
Not sure / Other (please state)	☐	
ADDITIONAL INFORMATION :		
Other Symptoms	**Detail of symptoms/Length of time**	
Other Exam findings		
Any Additional Information		
INVESTIGATIONS Bloods CXR Please attach if no merged information is pulled through		
Investigations		

NHS Number Given Name Surname Urgent Suspected Children's Cancer Referral form CMCAv1.3.1

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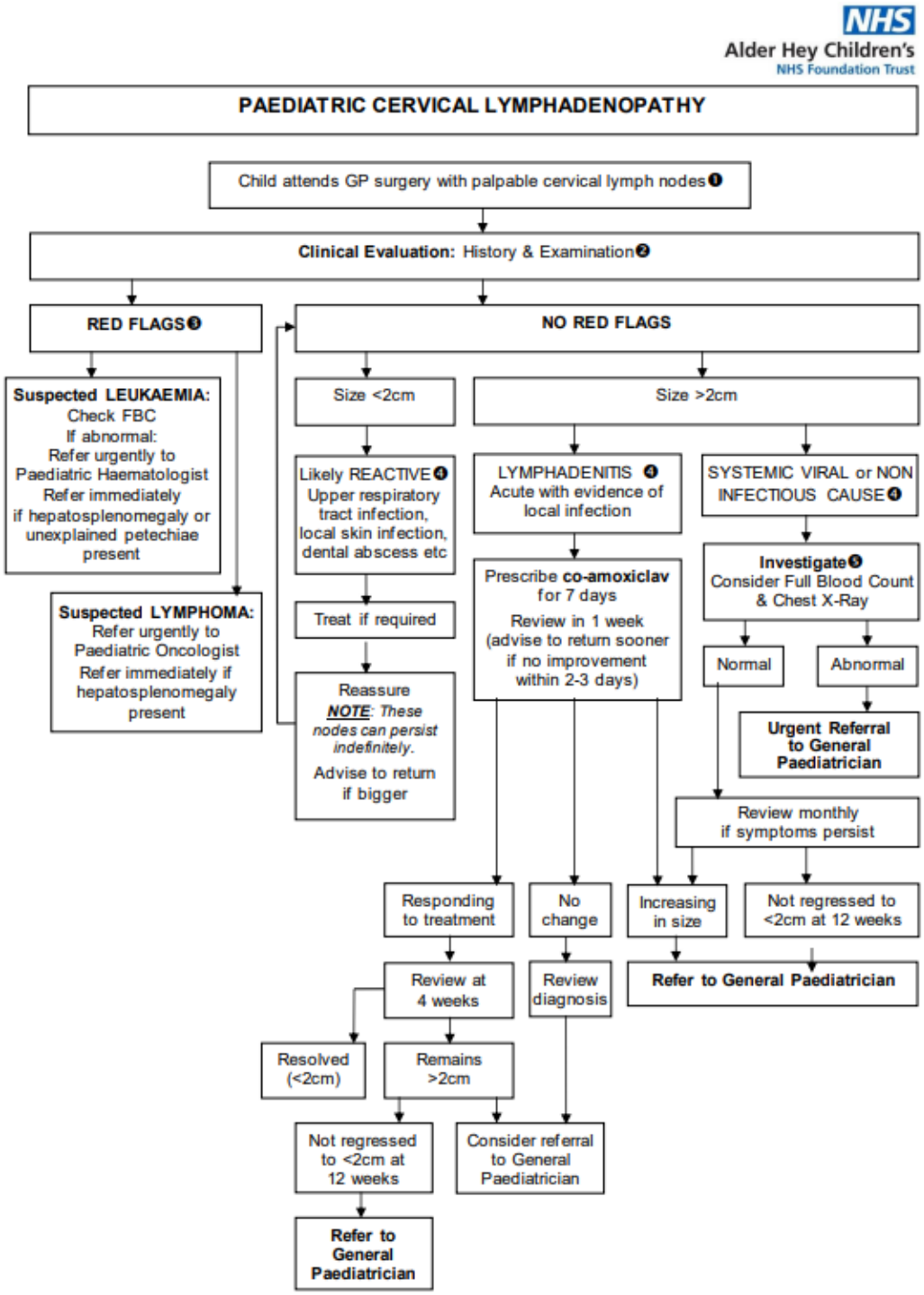
CULTURAL, MOBILITY STATUS AND ASSISTANCE REQUIREMENTS	
Does the patient have any Communication, Mobility or Safeguarding needs	Yes ☐ No ☐
Please detail if there are any reasonable adjustments needed or additional requirements	Free Text Prompt
If the patient requires Translation or Interpretation Services **Please give details**:	
What is the patient's preferred first language?	Main Language
Ethnicity	Ethnic Origin
Religion (if recorded)	Religion
Temporary resident	Yes ☐ No ☐
Overseas visitor	Yes ☐ No ☐
CLINICAL INFORMATION/HISTORY	
Consultations	
Problems	
Values and Investigations	
Medication	
Allergies	

Appendix 3: Paediatric cervical lymphadenopathy pathway

This pathway is included for guidance only and is not an agreed cheshire and merseyside guideline.

Referrals should be made into local general paediatrics and choice of antibiotic should be directed by local policy.



Lymphadenopathy Pathway: Version 3, April 2021, Page **1** of **4**

❶Cervical lymphadenopathy

Cervical lymphadenopathy is a common presentation in primary care. The aetiology is extremely broad and includes malignant, autoimmune, inflammatory and infective causes. It is important to remember that **palpable lymph nodes** are very common in young children and **usually entirely benign**.

How common are palpable cervical lymph nodes?

Age	% with palpable lymph nodes
<1 month	17
1-6 months	27-38
7-12 months	44-55
13-24 months	48
2 years	68
3 years	59
4 years	65
5 years	74

Reference: Herzog LW Clin Pediatr (Phila) 1983 July 22(7): 485-7

Causes:

COMMON					
Viral	adenovirus	parvovirus	RSV	rhinovirus	EBV
Bacterial	Staph aureus	Group A Strep			
LESS COMMON					
Bacterial	Bartonella	atypical mycobacterium	mycobacterium tuberculosis		
Neoplastic	lymphoma				
Other	Connective tissue disorders (SLE, RA)	Kawasaki disease			
RARE					
Viral	CMV	HIV	rubella	mumps	varicella
Neoplastic	leukaemia				
Other infective	toxoplasmosis	fungal	anaerobic bacteria		
Drugs	Vaccines	phenytoin	isoniazid		

❷Clinical Evaluation

The assessment of children with lymphadenopathy requires a thorough history and careful examination in order to elicit abnormal findings, guide the physician towards the most appropriate differential diagnoses and hence the most appropriate investigations, treatment and referral.

History

Node characteristics:

- How long has the node been enlarged for?
- Is the size changing over time?
- Has the node recently got bigger or smaller?
- Has the overlying skin become red or violaceous?
- Has the node been painful?

Child's health:

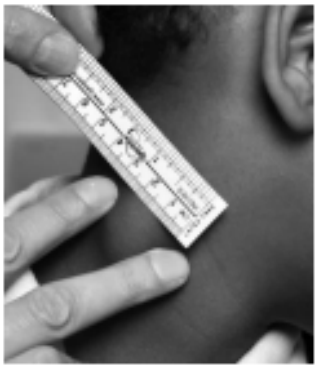
- Is the child systemically unwell (e.g. fever, night sweats, weight loss)?
- Have there been any rashes or skin lesions in the drainage area of the node?
- Has there been a recent ear, nose or throat infection?
- What is the status of the teeth?
- Have there been many previous infections suggestive of immune deficiency?
- Has the child had recent immunisations?
- Is the child taking medications?

Risk factors for infective causes:

- Has there been any exposure to TB or other infection?
- Has there been exposure to kittens or raw/undercooked meat?
- Has the family travelled anywhere significant?

Examination

- Size: Measure with ruler / tape
- Site: Which nodes are affected? What area do they drain?
- Mobility
- Fixation to under or overlying structures
- Tenderness
- Redness and warmth
- Matting



❸RED FLAG SYMPTOMS

(See also NICE: NG12 Suspected cancer: recognition and referral guidelines)

RED FLAGS FOR LYMPHOMA *Refer urgently to Paediatric Oncologist if any of the following:*	**RED FLAGS FOR LEUKAEMIA** *If any of the following – Check FBC. Refer urgently to Paediatric Haematologist if FBC is abnormal*
Supraclavicular nodes involved	Pallor
Other features of general ill health, fever, night sweats, shortness of breath, pruritus or weight loss (lasting more than a week, with no focus of infection)	Persistent fatigue
	Unexplained fever
	Unexplained persistent infection
	Generalised lymphadenopathy
Lymph nodes are progressively enlarging	Persistent or unexplained bone pain
Axillary nodes involved (in absence of local dermatitis or infection)	Unexplained bruising
	Unexplained bleeding
Hepatosplenomegaly (immediate referral)	Hepatosplenomegaly (immediate referral) Unexplained petechiae (immediate referral)

The three most common causes of lymphadenopathy are REACTIVE (to identified local infection) LYMPADENITIS (acute with evidence of local infection) and SYSTEMIC / NON-INFECTIVE.

The common features of each group are summarised below:

REACTIVE (bacterial or viral)	LYMPHADENITIS	SYSTEMIC VIRAL & NON-INFECTIVE CAUSES
Duration usually less than 6 weeks	Localised lymph node tenderness	Duration depends on cause
URTI symptoms present	Warmth and/or erythema	Sore throat, fever
Dental infection/pain	Fever	Hepatosplenomegaly (EBV)
Local skin infection / inflammation (eg eczema)		
Lymph nodes may be tender		May have rash (rubella, measles)
Lymph nodes mobile and soft		Arthralgia, headaches
No red flags		Lymph nodes may be tender
No supraclavicular lymph nodes		No supraclavicular lymph nodes
No organomegaly		Lymph nodes mobile and soft

Non-Infectious causes (any age)

Neuroblastoma	Leukaemia
Lymphoma	Rhabdomyosarcoma
Metastatic disease	Kawasaki disease
Systemic Lupus Erythematosus (SLE)	Juvenile rheumatoid arthritis (RA)

Investigation in Primary Care

Most cases of cervical lymphadenopathy are reactive and do not require investigation.
Tender lymph nodes are usually due to acute infection, especially if accompanied by erythema, warmth or induration.

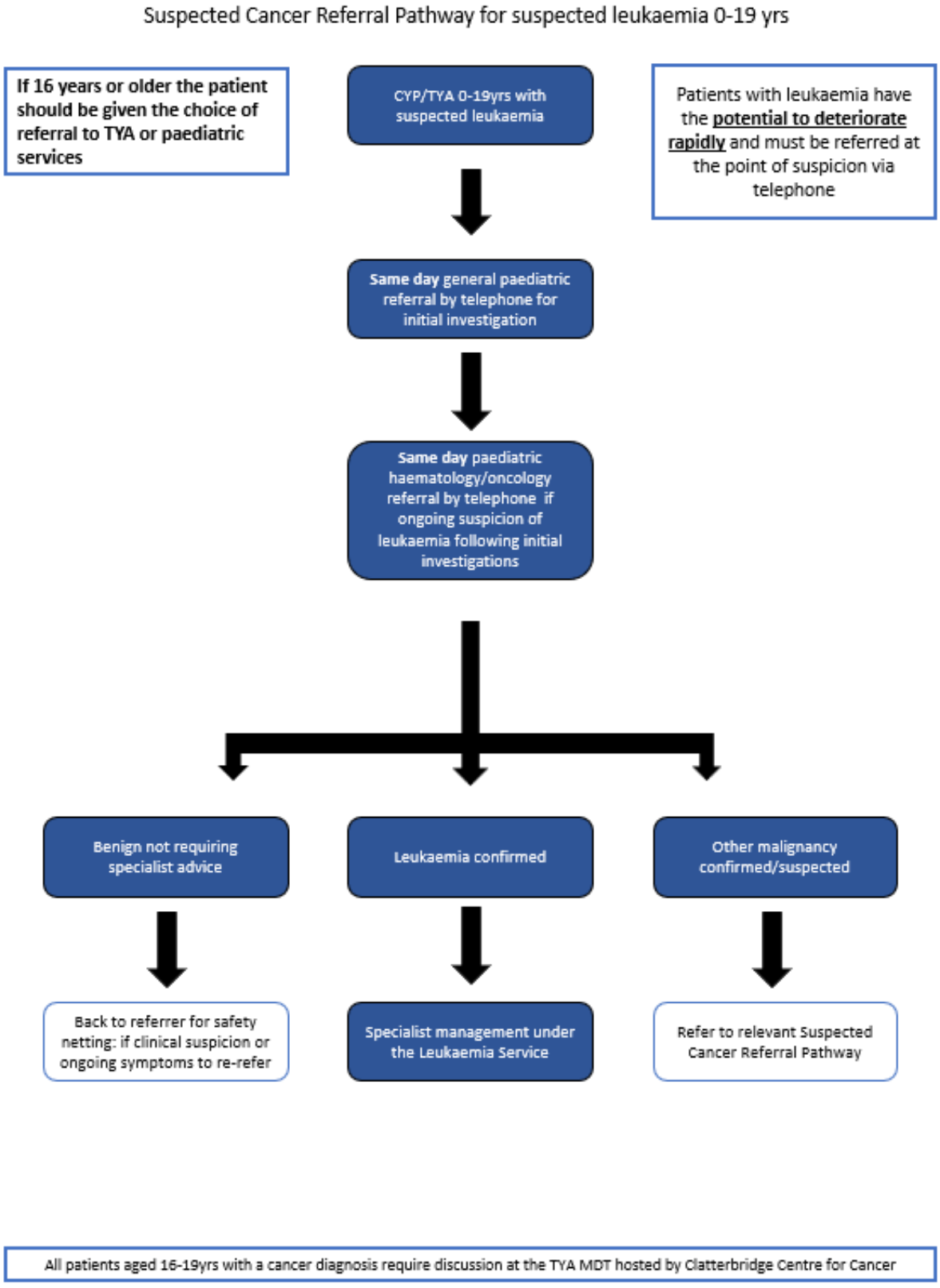
Any red flags for leukaemia should be investigated with a FBC and urgent referral if the result is abnormal.

If any red flags for lymphoma are found, an urgent referral should be made.
Consider FBC and chest X-ray if systemic viral or non-infective cause. A child with an abnormal CXR should be referred urgently.

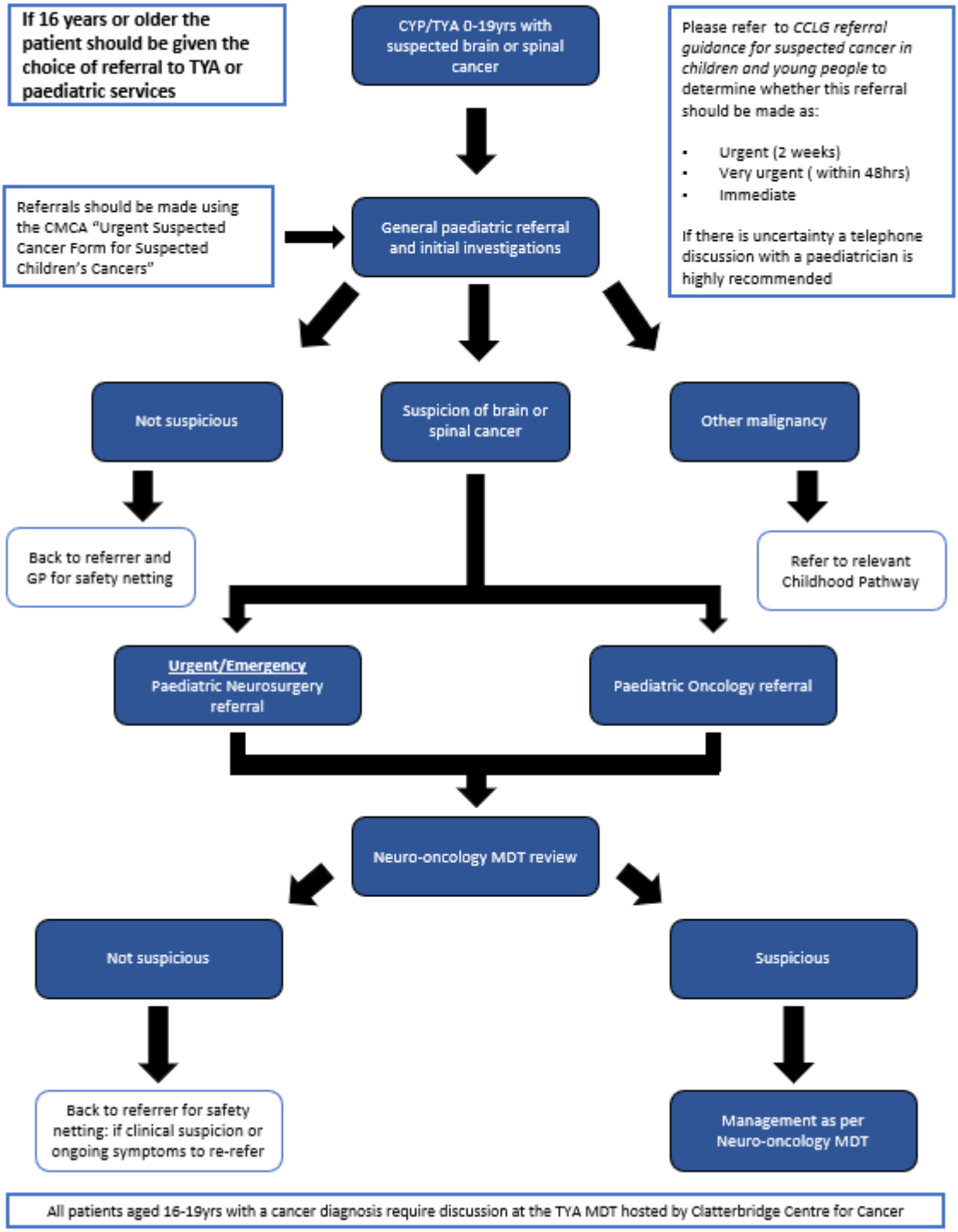
If you suspect a differential diagnosis other than lymphadenopathy (such as a branchial cleft cyst etc) then ultrasound may be useful at this stage.

Author: Francine Verhoeff
Approved by: Medicine Divisional Governance Group on 23/04/2021
Review date: April 2024

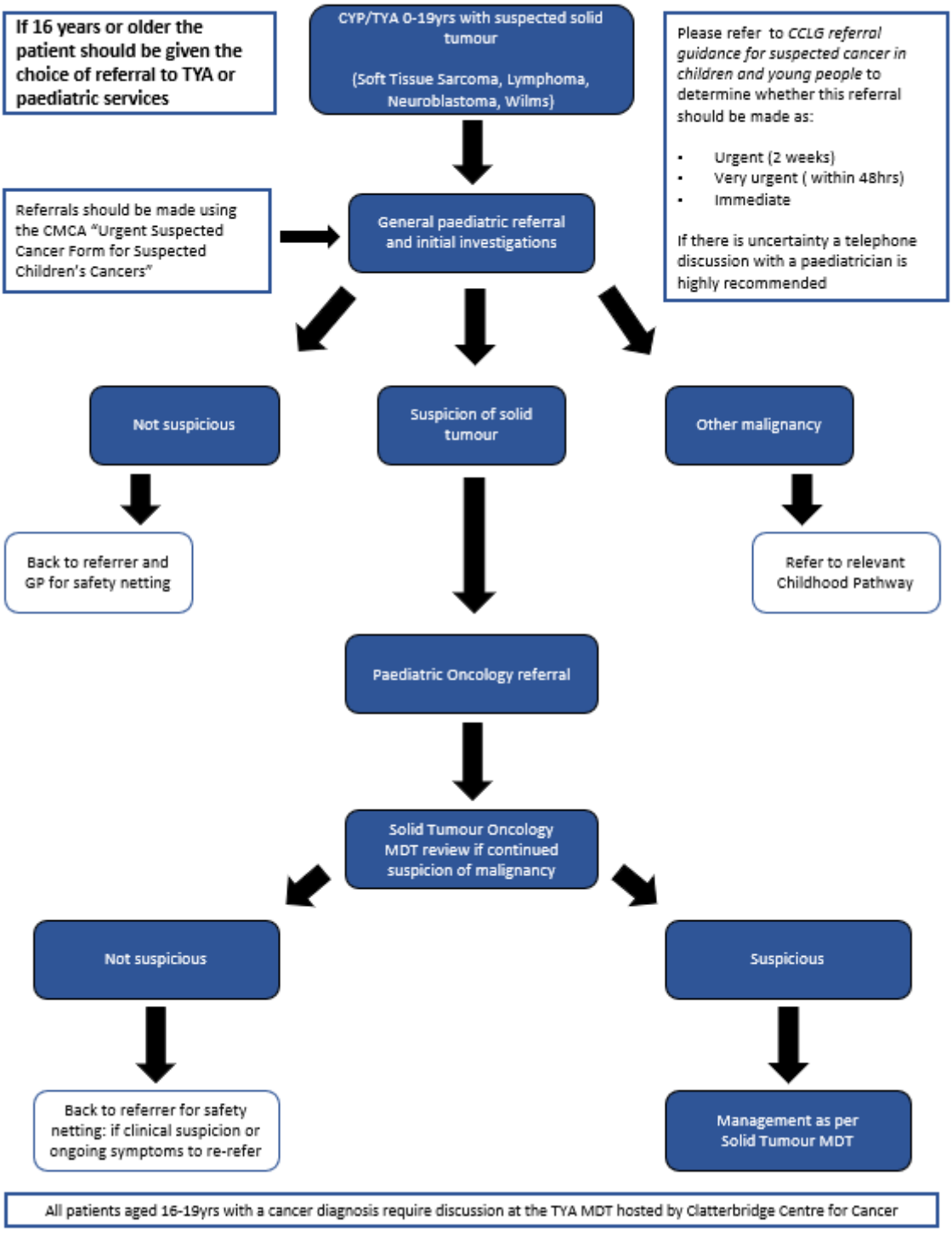
4.4 Appendix 4: Disease specific suspected cancer referral pathways



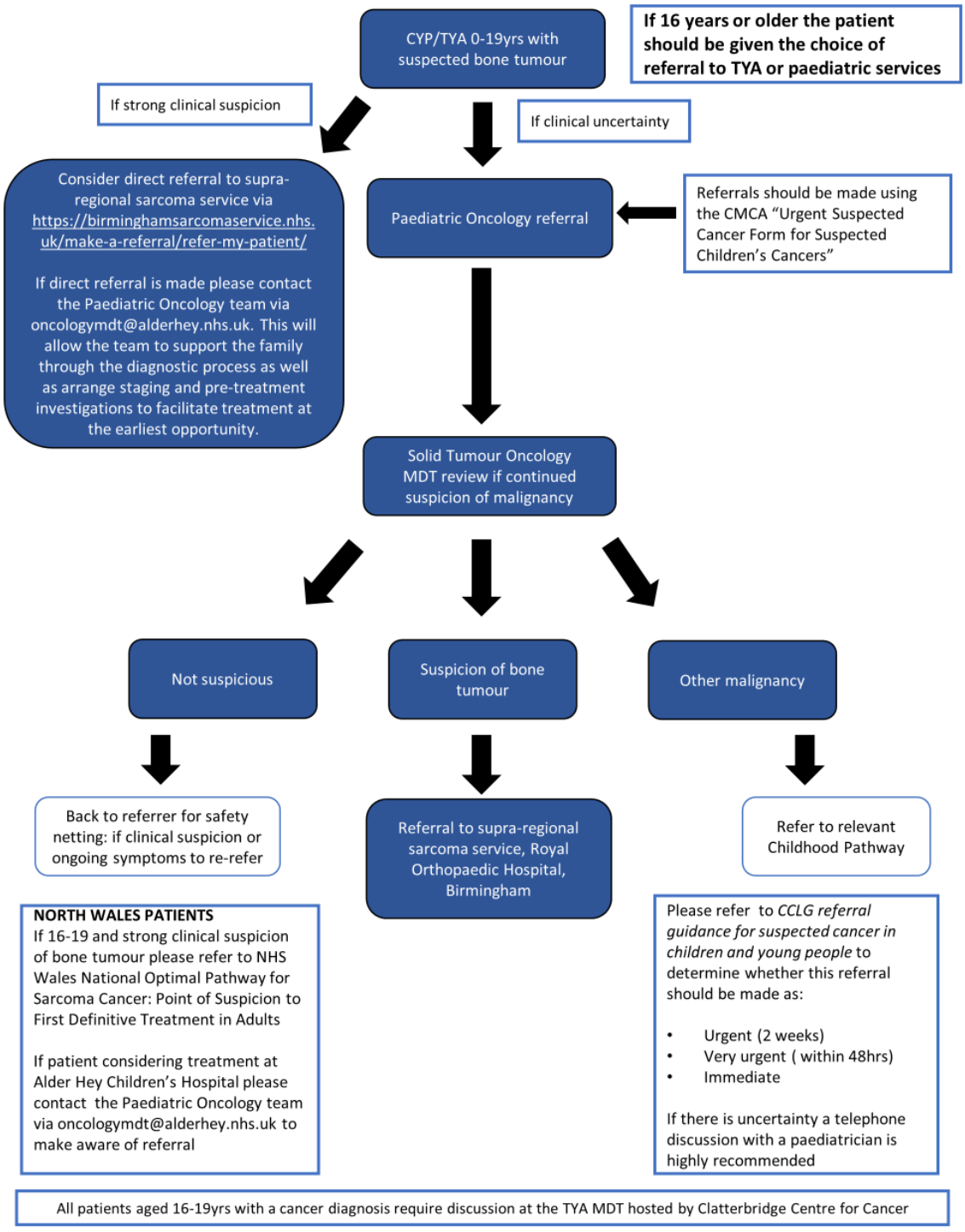
Suspected Cancer Referral Pathway for suspected children's brain or spinal cancer 0-19 yrs



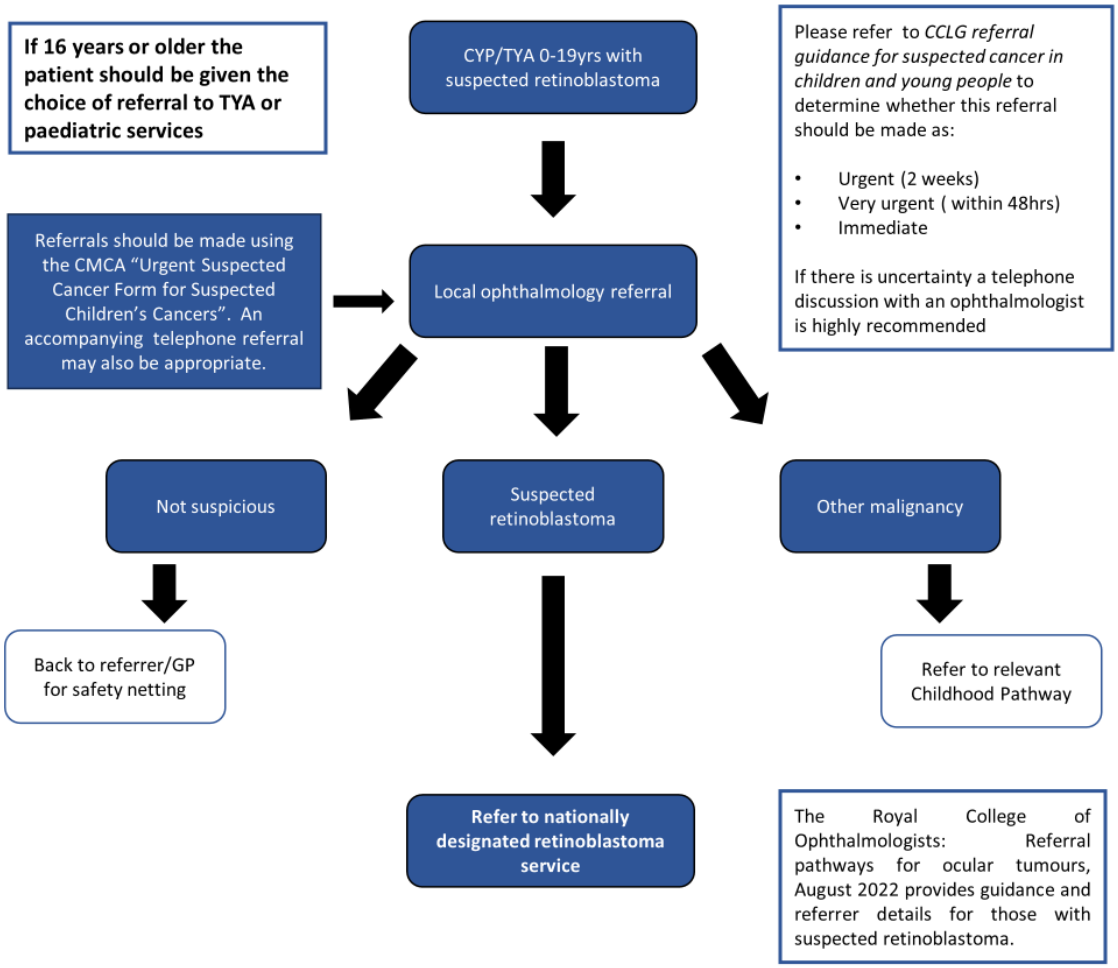
Suspected Cancer Referral Pathway for suspected children's solid tumours 0-19 yrs



Suspected Cancer Referral Pathway for suspected children's bone tumours 0-19 yrs

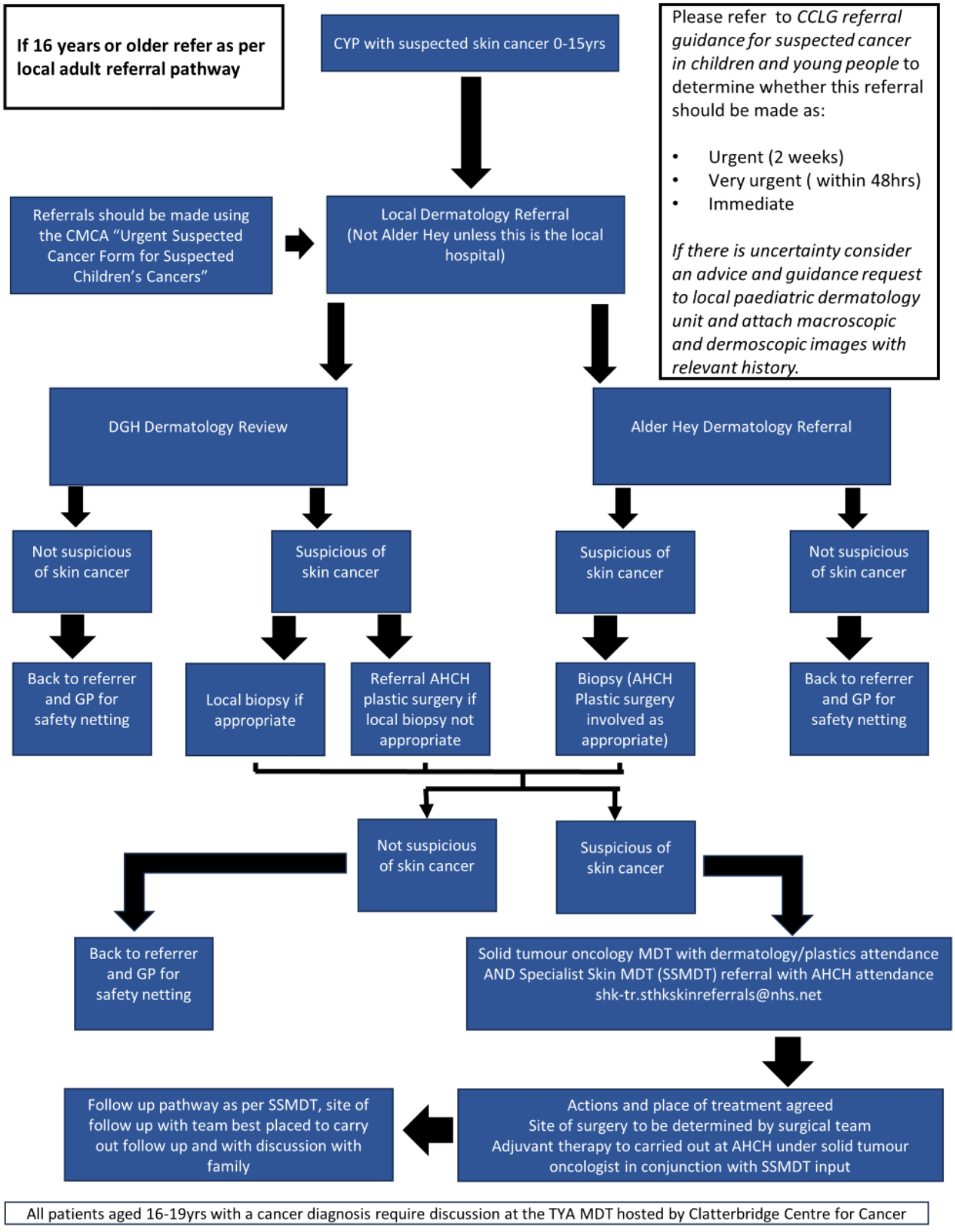


Suspected Cancer Referral Pathway for suspected retinoblastoma 0-19 yrs



All patients aged 16-19yrs with a cancer diagnosis require discussion at the TYA MDT hosted by Clatterbridge Centre for Cancer

Suspected Cancer Referral Pathway for suspected skin cancer 0-15 yrs



Suspected Cancer Referral Pathway for breast symptoms and breast lumps in girls and boys 0-15 yrs

If 16 years or older refer as per local adult referral pathway

CYP 0-15yrs with suspected cancer involving breast

Please refer to *CCLG referral guidance for suspected cancer in children and young people* to determine whether this referral should be made as:

- Urgent (2 weeks)
- Very urgent (within 48hrs)
- Immediate

If there is uncertainty a telephone discussion with a paediatric surgeon is highly recommended

Review of ABS Guidance and Pathways for the assessment of children with breast symptoms

If 15 years or younger and continued suspicion of cancer after review of ABS guidelines

Referrals should be made using the CMCA "Urgent Suspected Cancer Form for Suspected Children's Cancers"

Review in Paediatric Surgery clinic

Not suspicious of cancer

Back to referrer for onward referral or safety netting: if clinical suspicion or ongoing symptoms to re-refer

Suspicion of cancer

Management as per Solid Tumour MDT

Referral to specialist Breast MDT for suspected solid lesions BreastMDTCoordinator@sthk.nhs.uk

Treatment plan agreed between specialist Breast MDT and AHCH Solid Tumour MDT

Actions and place of treatment agreed

- Location of surgery ideally AHCH, to be discussed on a case-by-case basis by surgical teams
- Adjuvant chemotherapy to be delivered at AHCH under solid tumour oncologist
- Radiotherapy treatment delivered at The Christie Cancer Centre

Suspected Cancer Referral Pathway for thyroid tumours 0-19yrs