

Cancer Patient Follow-up

Concepts:

Intensive follow-up of colorectal cancer has been shown to positively affect survival. Recurrence from colon and rectal cancer will almost always occur within five years, after which cure is likely to have been achieved. Clinical follow-up is therefore not indicated after 5 years but colonoscopic surveillance will continue to the age of 75, except in the case of ill-health. Intensity of follow-up should be tailored to the individual and will be scaled back in the case of ill-health or advanced chronologic age (usually 80yrs or above).

Where feasible the treatment of recurrent colorectal cancer is primarily surgical; chemotherapy and radiotherapy may be used in an adjuvant to surgery or primarily as palliation. Follow-up is therefore targeted at detection of potentially resectable recurrences (usually anastomotic or hepatic) or of metachronous cancers. Where there is concern regarding recurrent disease referral should be made back to the operating surgeon.

Year 1-3:

Initial Follow-up by surgeon at 6 weeks post-operatively. Dukes C carcinomas will be referred for chemotherapy by the operating surgeon.

If total colonoscopy did not take place prior to surgery a follow-up colonoscopy will be performed within six months post-operatively

Clinical Review 6 monthly

- History and examination ^{appendix 1}
- Rectal examination for rectal cancer patients (see appendix)

Investigations obtained prior to clinical review

- LFT's, CBC, CEA
- liver ultrasound

Year 3-5

First Surveillance colonoscopy at three years

Clinical review annually

- CEA and ultrasound are not routinely indicated after three years but should be performed if there is clinical concern

After 5 years

Routine clinical follow-up no longer necessary. New symptoms should be reported and appropriately investigated.

Colonoscopy will occur at intervals, usually at year 6 and thereafter five-yearly until the late 70's.

Appendix 1: History and Examination Specifics for Colon cancer

History should elicit:

General well-being

- Energy
- Weight change

Abdominal symptoms

- pain
- bloating, borborygmi

Changes in bowel habit

- changes in the frequency and nature of stools
- presence of blood or mucus

Examination

General features

- pallor
- check lymph node basins
- measure weight

Abdomen

- assess operative scar for potential underlying incisional hernia
- full abdominal examination for tenderness, mass, organomegaly

Rectal examination

Providing the patient is in a colonoscopy program DRE is not usually required for carcinomas above the rectum. All rectal cancer patients having restorative procedures should have DRE on every clinical review. Where the sphincter complex has been removed during abdominoperineal excision of a low rectal cancer, DRE is not possible but the perineum and natal cleft should be palpated for evidence of pelvic recurrence and vaginal examination should be performed in females.

DRE after rectal cancer

- The anastomosis should be palpable. Examine for palpable evidence of local recurrence, stenosis of staple line, extrinsic mass, blood on the glove
- Any concerns regarding the digital findings mandate sigmoidoscopy and biopsy.

Breast Cancer Follow-up

Concepts:

Breast cancer follow-up aims to achieve early detection of three negative outcomes: local recurrence, systemic recurrence and development of new metachronous cancer. The oncologist plays the central role in recurrent breast cancer and surgery is usually only indicated in isolated local recurrence. In contrast to colon cancer, there is no point of pronouncement of cure for breast cancer, though the risk of recurrent disease continues to fall with each passing year.

Intensive follow-up has not been shown to improve survival in breast cancer. There is no general agreement about the correct period of clinical follow-up; some women prefer to be kept under surveillance and others find annual review an unpleasant reminder of their original diagnosis and treatment.

The risk of developing a new cancer after a breast cancer diagnosis is approximately twice normal. Annual Screening mammography should continue into old age, presuming that good general health is maintained.

Different therapeutic options present varying needs in follow-up (mastectomy +/- reconstruction vs breast preservation). Special scenarios may indicate greater scrutiny in follow-up (eg close surgical margins, unusually aggressive disease or large numbers of involved lymph nodes).

Year 1 - 2

Initial post-operative follow-up by surgeon at 4-6 weeks.

Clinical follow-up 6 monthly for two years (higher risk disease should be followed 3 monthly)

- History ^{appendix 2}
- General physical and breast examination ^{appendix 2}

Mammogram

- After mastectomy the contralateral breast is examined with two-view mammography annually
- Surveillance mammography of reconstructed breasts is not routinely performed

Year 3-5

Clinical follow-up annually

Annual mammography

Thereafter

Offer discharge from clinical follow-up

Annual mammography to continue as long as general health is maintained

Appendix 2: History and Examination Specifics for Breast Cancer

History should elicit:

General well-being

- Energy
- Weight change
- Musculoskeletal pain (?bony metastasis)
- New respiratory symptoms (?pulmonary/pleural metastasis)
- Arm swelling (?lymphoedema)

Breast symptoms

- lumps
- skin changes
- nipple discharge

Examination

General features

- pallor/jaundice
- measure weight
- Percuss vertebral column and spring ribs to assess for tenderness

Contralateral breast

- standard breast examination

Operated breast

- Examine for nodularity, new lumps
- Any skin lesion within mastectomy flaps needs assessment with FNA +/- biopsy

Lymph nodes

- assess both axillae and supraclavicular fossae

Abdomen

- Palpate for hepatomegaly

Melanoma Follow-up

Concepts:

Post-operative follow-up of melanoma is tempered by the lack of effective oncologic treatment for secondary disease. Lymph node dissection is sometimes effective for isolated nodal recurrence but systemic disease is almost universally fatal. Follow-up is primarily aimed at detection of new melanomas and of nodal disease. Typically the patient will find recurrent disease before the clinician.

Thin (<1mm Breslow thickness) melanomas have low risk of recurrence (<5%) relative to thicker lesions (≥20%). Patients should be educated about the need to represent early for new pigmented skin lesions and for palpable lumps in the relevant nodal basin(s). Note that trunk/head/neck melanomas may drain to multiple lymphatic regions, and that patterns of nodal recurrence can be anatomically unexpected.

Thin melanomas (<1mm Breslow thickness)

Patient education as above

Long-term surveillance not required

Thick Melanomas

Clinical review four monthly for two years, 6 monthly until five years, annually thereafter lifelong

Clinical review should include

- total body inspection for new lesions
- palpation of primary site
- palpation along draining lymphatic pathways
- examination of all nodal basins
- abdominal examination

New suspicious skin lesions should be formally excised for histology.

Palpable lymphadenopathy should be assessed initially with FNA.

Any positive results should be referred to SOPD for CT and clinical reassessment.