Cancer of Unknown Primary

Disclaimer

See also:
- Palliative Care
- Grief and Bereavement Support
- Cancer Supportive Care

The purpose of this pathway is to give an overview of the management of cancer of unknown primary (CUP) origin. The predominant role of the general practitioner during active treatment is to:
- provide psychosocial support and lifestyle advice.
- monitor medication compliance and side-effects.
- identify complications of treatment e.g., infection associated with neutropenia.
- avoid or defer minor procedures e.g., routine cervical screening during chemotherapy treatment.

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Red Flags

- Symptoms or signs suggestive of treatment side-effects, or metastatic disease (e.g. constitutional symptoms, CNS symptoms or signs)

Background – About Cancer of Unknown Primary

- Cancer of unknown primary (CUP) is confirmed when metastatic epithelial, neuroendocrine or undifferentiated malignancy is identified on the basis of final histology, where a reasonable amount of investigations have failed to identify a primary site with certainty.

- Specific subsets can be identified based on histopathological, molecular, and clinical manifestations. In particular, there is a specific clinico-pathological subset of patients with favourable prognosis that have a pattern of disease similar to known cancer types and may respond well to standard disease-specific treatment. The remaining patients are considered within the non-specific subset of CUP, with their prognosis and suitability for treatment dependent on their Eastern Cooperative Oncology Group (ECOG) performance status.

Assessment

1. Ask and record if the patient identifies as being of Aboriginal or Torres Strait Islander origin. Consider the specific cultural and spiritual needs of each patient.

   Ask if the patient identifies as being of Aboriginal or Torres Strait Islander origin

   If a patient or their family want to know why you are asking this question, you may reply with:
   - We ask this question of everyone.
   - It enables us to help you access extra services that are funded for Aboriginal and Torres Strait Islander peoples, such as support to buy medications and extra funded visits with some health care providers.
   - This information helps our practice and the health care providers we refer you to, to provide culturally safe care.

   For more information, see principles for care provision for Aboriginal and Torres Strait Islander Peoples.

Advice for communicating with Aboriginal and Torres Strait Islander people

- Encourage patients to book a longer consultation, to allow sufficient time for discussion and building trust.
- Only use traditional terminology such as "Aunty" and "Uncle" if invited to do so.
- Consider the role of factors such as gender, kinship, family ties, language barriers and socio-economic issues.
- Offer the patient:
  - the option of seeing a health professional of the same gender or if this is not possible, referral to another service.
  - the option to have support person present, such as a family member, a community member, or an Elder.
  - access to funding assistance to overcome any identified or potential financial barriers e.g., ITC Funding. See also Integrated Team Care Program.

Acknowledge and respect how cultural, spiritual and historical beliefs and experiences impact on decision-making.
**Respecting Aboriginal and Torres Strait Islander people’s decision-making processes**
- Aboriginal and Torres Strait Islander knowledge, values, beliefs, cultural needs, and health history may strongly inform decision-making processes about treatment and ongoing care.
- If possible and if requested by the patient, support the inclusion of cultural practices e.g., involvement of a traditional healer, or performing ceremonies.

- Be aware the term “survivor” may have negative connotations for historical reasons.

- Proactively explore and monitor symptoms of **pain**.

**Considerations for assessing and managing pain in Aboriginal and Torres Strait Islander people**
Aboriginal and Torres Strait Islander patients may not actively report pain or other needs.
- Offer patients the option to discuss their needs with a health professional of the same gender.
- If available, use a pain tool that is culturally appropriate for the local community.
- Allow sufficient time to discuss and explain the options, usage, and side-effects of pain relief in full.
- Be aware of:
  - significant cultural practices regarding which family members can assist with providing pain relief, and how pain medication is administered.
  - fears that pain relief medicines may accelerate the passing of the patient.

- Understand how the concept of **family** is different for Aboriginal and Torres Strait Islander people.

**Considerations when discussing family with Aboriginal and Torres Strait Islander people**
For Aboriginal and Torres Strait Islander people:
- the concept of family is broader than being genetically related.
- be sensitive when taking a family history, as discussing members of the stolen generation may be distressing.
- Be sensitive when referring to people who have died – check and ask permission. There may be cultural taboos in discussing Sorry Business (referring to people who have died).

- Be supportive and understanding if **appointments** are missed, and facilitate follow-up or rebooking.

**Appointments for Aboriginal and Torres Strait Islander people**
- Patients who identify as Aboriginal and Torres Strait Islander people may have complex factors e.g., family and community responsibilities, or previous experiences with mainstream medical services, that make it difficult for them to attend appointments.
- The following supports may facilitate this process:
  - Recall and reminders
  - ITC funding
  - Referral to an Aboriginal Liaison officer, support, or health worker.

- Aboriginal and Torres Strait Islander people are more likely to have multiple co-morbidities that can impact treatment outcomes.

- Ensure contact details are up to date.
• If available, use assessment tools and resources designed specifically for Aboriginal and Torres Strait Islander people.

**Aboriginal and Torres Strait Islander assessment tools and resources**

See SCNAT-IP – online tool that assesses the supportive care needs of Aboriginal and Torres Strait Islander cancer patients and their families.

2. If initial presentation suggests metastatic disease, prioritise early recognition of CUP so that assessment and management is not delayed and futile investigations are avoided. Consider the clinico-pathological subset.

**Early recognition of CUP**

- Undertake a thorough medical history and physical examination
- Order blood tests relevant to the specific clinical presentation. These may include:
  - FBE and film
  - Electrolytes, urea and creatinine
  - Liver function tests
  - Iron studies
- CT of the chest and abdomen/pelvis
- Biopsy
- Additional investigations as indicated based on the specific presentation.

**Clinico-pathological subsets**

- Specific clinico-pathological sub-set:
  - poorly differentiated neuroendocrine carcinoma of unknown primary
  - well-differentiated neuroendocrine tumour of unknown primary
  - peritoneal adenocarcinomatosis of a serous papillary histological type in females
  - isolated axillary nodal metastases in females
  - squamous cell carcinoma involving non-supraclavicular cervical lymph nodes
  - isolated inguinal adenopathy (squamous carcinoma)
  - CUP with an intestinal phenotype and immunohistochemistry (IHC) (including CK20+/CDX2+/CK7−) or molecular profile
  - single metastatic deposit from unknown primary
  - men with blastic bone metastases or IHC/serum prostate specific antigen (PSA) expression
  - poorly differentiated carcinoma with midline distribution (extragonadal germ cell syndrome).

- Non-specific clinic-pathological sub-set – i.e. patients with CUP who do not belong to one of the specific CUP subsets. Examples include:
  - adenocarcinoma metastatic to the liver or other organs
  - poorly differentiated carcinoma

3. For ongoing management of established CUP:

- **take a history**
  Within a comprehensive history, ask about:
  - symptoms, and signs and side-effects of therapy.
  - the impact of the diagnosis and treatment (including the impact on fertility).
  - emotional and psychological issues.
  - medications and use of complementary/alternative therapies to identify any potential toxicity or drug interactions. See the Clinical Oncological Society of Australia’s position statement.
  - the patient’s understanding of their staging and prognosis.
  - social and practical issues.
▪ Support to attend appointments
▪ Isolation from usual social networks
▪ Financial issues
  ▪ Loss of income
  ▪ Additional expenses
▪ Legal issues
  ▪ Advance care planning
  ▪ Power of attorney
  ▪ Creating a will

  o spiritual needs. Patients and families should have access to spiritual support appropriate to their needs.
  o information needs.
    ▪ The patient and their carers may lack appropriate or adequate information about:
      ▪ their type of cancer.
      ▪ how to manage possible alterations in cognitive function and behaviour.
      ▪ safe driving.
    ▪ Patients from culturally and linguistically diverse backgrounds may need information provided in other formats.

▪ screen for physical issues
  o Fatigue and decline in general health
  o Loss of appetite and nutritional deficiencies
  o Pain
  o Lymphoedema
  o Disfigurement or wound odour
  o Cognitive problems and difficulties in communication
  o Vaginal dryness or bleeding

▪ consider the essential components of survivorship care.

  Essential components of survivorship care
  o Prevention of recurrent and new cancers, as well as late effects
  o Surveillance for cancer spread, recurrence or second cancers, and screening and assessment for medical and psychosocial late effects
  o Interventions to deal with the consequences of cancer and cancer treatments (including management of symptoms, distress and practical issues)
  o Coordination of care between all providers to ensure the patient’s needs are met.
  o Educate all patients about managing their own health needs.

4. Review patient’s proposed shared-care follow up plan, which will be outlined in either the patient’s multidisciplinary discharge summary, or via direct correspondence from the oncology treating team.

  Multidisciplinary discharge summary
  Most importantly should include what the patient has been told. This may include:
  • intentions.
  • goals and quantitative benefit of proposed treatment.
  • risks of treatment.
  • recurrence risk if known.
Usually includes:
- diagnostic tests performed and results.
- tumour characteristics and other factors determining prognosis.
- type and date of treatments and a treatment summary.
- expectations of disease course, including expected discharge from oncology services.
- interventions and treatment plans from other health professionals.
- a process for rapid re-entry to specialist medical services for suspected recurrence.
- a list of symptoms that might need prompt investigation.
- a list of supportive care services provided and a plan for community care services, including what each service is to provide.
- contact information for key care providers.

5. Enquire whether Advance Care Planning has occurred.

6. Undertake specific examinations as clinically indicated.

Management

1. If acutely unwell (e.g. cardiovascular compromise, febrile neutropenia, etc.), refer for immediate oncology assessment. Always alert treating oncologist.

2. If patient with a newly identified disease pattern suggesting CUP, refer early for urgent or routine oncology assessment (request appointment within 2 weeks, as per the Optimal Care Pathway guidelines).

3. Individualise CUP management according to the clinico-pathological subset and the suspected primary site:
   - Treat specific clinic-pathological sub-sets according to existing tumour specific pathways.
   - See Fig.2: "Clinical Management of Patients presenting with CUP", page 26 of Cancer Council Victoria – Optimal Care Pathway for People with Cancer of Unknown Primary.

4. Refer for urgent or routine oncology assessment, or to the relevant specialty, if:
   - any complications resulting from treatment.
   - symptoms of progressive cancer.

5. Following the start of specialist treatment, discuss the intention of treatment and risk of recurrence with the patient, and determine their understanding of it.

   The intention of treatment
   - Curative
   - Improved longevity or quality of life
   - Palliative

6. Explore the patient’s understanding of treatment options, including palliative care.
   - Consider palliative care interventions for all patients diagnosed with CUP.
   - It is preferable for specialist palliative care to be initiated during the diagnostic stage, and for many patients this will remain the most important intervention during their illness.
   - Palliative radiation treatment is often useful for bone metastases.
   - Palliative care has been associated with improved well-being for carers.
• Early referral to palliative care can improve the quality of life for people with cancer including improving the capacity of patients to sit comfortably with diagnostic and prognostic uncertainty and better management of physical and psychological symptoms.

See Palliative Care Australia.

7. Manage any physical issues or intercurrent health problems detected. Management of physical issues
• Fatigue and decline in general health
• Loss of appetite and nutritional deficiencies
• Pain
• Lymphoedema
• Disfigurement or wound odour
• Cognitive problems and difficulties in communication
• Contact the treating specialist if there have been any significant intercurrent health events or co-morbidity changes. This can alter treatment and prevent futile interventions.

8. If patient identifies as Aboriginal or Torres Strait Islander, understand their specific cultural and spiritual needs when discussing and delivering treatment options.

Cultural and spiritual considerations for Aboriginal and Torres Strait Islander People
• Offer referral to culturally appropriate social and emotional wellbeing services.
• Consider including an expert in the multidisciplinary team, to provide culturally appropriate care to Aboriginal and Torres Strait Islander people.
• Provide culturally appropriate information or resources about the signs and symptoms of recurrent disease, secondary prevention, and healthy living.

Ongoing care and support

1. Provide the patient with the Cancer Council Australia – Cancer of Unknown Primary factsheet.

2. See Cancer Supportive Care for general advice on:
   • lifestyle changes.
   • psychological needs.
   • financial, legal, and practical needs.
   • managing physical sequela.
   • support groups and referral services.

3. Refer to palliative care services where appropriate.

4. Provide ongoing support, of patient and family, throughout the course of cancer treatment and survivorship, with options such as:
   • advance care planning.
   • counselling support. Consider employing a mental health treatment plan template under the Better Access program.
   • GP management plan and team care arrangement.
   • referral to social worker, occupational therapist, if significant impact on social/practical needs.
   • referral to a lymphoedema practitioner for assessment and management of lymphoedema.
Referral

- If acutely unwell (e.g. cardiovascular compromise, febrile neutropaenia, etc.), refer for immediate oncology assessment. Always alert treating oncologist.
- If patient with a newly identified disease pattern suggesting CUP, refer early for urgent or routine oncology assessment (request appointment within 2 weeks, as per the Optimal Care Pathway guidelines).
- Refer for immediate oncology assessment, or to the relevant specialty, if:
  - any complications resulting from treatment.
  - symptoms of progressive cancer.
- Refer to a lymphoedema practitioner for assessment and management of lymphoedema.
- Refer to palliative care services when appropriate.
- Refer for psychological assessment and treatment if indicated.
- Refer to social worker, occupational therapist, if significant impact on social/practical needs.
- If Aboriginal or Torres Strait Islander patient, offer referral to specific Indigenous services. For all referrals, to both mainstream and Indigenous services, ensure Indigenous status is clearly marked on the referral.

**Referral Options for Aboriginal and Torres Strait Islander people**

- For hospital referrals, consider engaging support from the Aboriginal Hospital Liaison Officers.
- For community referrals, consider referral to an Aboriginal Community Controlled Health service.
- For care coordination, support and advocacy throughout treatment, consider referral to Integrated Team Care Program.

Information

For health professionals

**Further information**

- Cancer Council Victoria:
  - Optimal Care Pathway for Cancer of Unknown Primary
  - Optimal Care Pathways for Cancer of Unknown Primary: Quick Reference Guide
- Palliative Care Australia – Healthcare Professional’s Role in Palliative Care

For patients

Cancer Council Victoria - Cancer of Unknown Primary

References

1. Diagnosis and management of metastatic malignant disease of unknown primary origin. AU: NICE; 2010. [updated 2017 Nov 01].
Select bibliography


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