## Cellular pathology audit template

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| Date of completion | (To be inserted when completed) |
| Name of lead author/ participants | (To be inserted) |
| Specialty | Haematology |
| Title | An audit of compliance with the British Society for Haematology guideline for the management of newly diagnosed large B-cell lymphoma |
| Background | The British Society for Haematology (BSH) was published revised guidance on the management of newly diagnosed large B-cell lymphoma (LBCL). This audit will review compliance with some of the level 1 recommendations made. |
| Aim & objectives | This audit template is a tool to audit degree of adherence to:   1. recommended investigations in the diagnosis of newly diagnosed LBCL 2. recommended clinical management of patients with newly diagnosed LBCL. |
| Standards & criteria | **Criteria range:** 100%, or if variance observed, there is explanatory documentation in the case notes.  **Diagnosis and baseline investigations**   1. Discuss all diagnoses and treatment plans at a fully constituted haemato-oncology multidisciplinary team (MDT) meeting. 2. All patients should have tests for serum lactate dehydrogenase (LDH) and full serology for hepatitis B virus (HBV), hepatitis C virus (HCV) and human immunodeficiency virus (HIV). 3. Baseline whole body positron emission tomography-computed tomography (PET‑CT) should be performed for all patients. 4. Baseline electrocardiogram (ECG) should be performed on all patients. 5. Eastern Cooperative Oncology Group (ECOG) performance status (PS) and International Prognostic Index (IPI) scores should be recorded for all patients. 6. Fluorescence in situ hybridisation (FISH) for *MYC* rearrangements should be performed.   **Supportive care**   1. Primary granulocyte colony-stimulating factor (G-CSF) prophylaxis should be offered to all patients receiving chemo-immunotherapy with curative intent.   **Stage I and II disease**   1. Four cycles of rituximab, cyclophosphamide, doxorubicin, vincristine and prednisolone (R-CHOP) plus two additional infusions of rituximab should be offered to patients 18–60 years with stage I/II, age-adjusted IPI (aaIPI) 0, without bulky disease.   **Primary extra-nodal LBCL – testicular**   1. Central nervous system (CNS) prophylaxis should be offered, guided by the current BSH Good Practice Paper (GPP). 2. Contralateral testicular radiotherapy should be offered following completion of systemic therapy.   **Primary extra-nodal LBCL – gastric**   1. Where *Helicobacter pylori* is detected, eradication therapy should be offered as per current guidance.   **Advanced stage disease**   1. Six cycles of rituximab, cyclophosphamide, doxorubicin and prednisolone (RCHP)-polatuzumab vedotin should be offered as first-line treatment for patients with *de novo* LBCL, fit for full-dose chemotheraphy, with an ECOG PS ≤2 and an IPI score of 2–5. 2. Six cycles of R-CHOP should be offered as first-line treatment for patients with stage III/IV disease and an IPI score of 1.   **Older patients and those with co-morbid conditions**   1. R-miniCHOP (50% dosing of cyclophosphamide [400 mg/m2], doxorubicin [25 mg/m2] and vincristine [1 mg]) should be offered to patients ≥80 years and suitable for anthracycline. 2. Non-anthracycline-based regimens should be offered to patients with cardiac co‑morbidities unsuitable for anthracyclines.   **End-of-treatment response assessment and follow-up**   1. For patients without a complete metabolic response (CMR) on a PET-CT following 2 cycles of chemo-immunotherapy (iPET2) (or for patients who have not undergone an iPET2), an end-of-treatment PET-CT scan should be performed. 2. For patients with residual foci of fluorodeoxyglucose (FDG)-uptake, biopsy of FDG-avid lesions should be undertaken or repeat PET-CT should be offered at an 8- to 12-week interval, where tissue biopsy is not possible. |
| Method | **Sample selection:** (To be completed by the author)  All patients diagnosed with LBCL in the preceding 12 months.  **Data to be collected on proforma (see below).** |
| Results | (To be completed by the author)  The results of this audit show the following compliance with the standards.   |  |  |  |  | | --- | --- | --- | --- | | Investigation | No. audited | No. compliant | % compliance | | Diagnosis and baseline investigations | | | | | 1. All diagnoses and treatment plans were discussed at a fully constituted haemato-oncology MDT meeting. |  |  |  | | 1. All patients had tests for serum LDH and full serology for HBV, HCV and HIV. |  |  |  | | 1. Baseline PET-CT was performed for all patients. |  |  |  | | 1. Baseline ECG was performed on all patients. |  |  |  | | 1. ECOG PS, IPI and CNS-IPI scores were recorded for all patients. |  |  |  | | 1. FISH for *MYC* rearrangements was performed. |  |  |  | | Supportive care | | | | | 1. Primary G-CSF prophylaxis was offered to all patients receiving chemo-immunotherapy with curative intent. |  |  |  | | Stage I and II disease | | | | | 1. Four cycles of R-CHOP plus two additional infusions of rituximab were offered to patients 18–60 years with stage I/II, aaIPI 0, without bulky disease. |  |  |  | | Primary extra-nodal LBCL – testicular | | | | | 1. CNS prophylaxis was offered, guided by the BSH GPP. |  |  |  | | 1. Contralateral testicular radiotheraphy was offered following completion of systemic therapy. |  |  |  | | Primary extra-nodal LBCL – gastric | | | | | 1. Where *Helicobacter pylori* was detected, eradication therapy was offered as per current guidance. |  |  |  | | Advanced stage disease | | | | | 1. Six cycles of RCHP-polatuzumab vedotin was offered as first-line treatment for patients with *de novo* LBCL, fit for full-dose chemotherapy, with an ECOG PS ≤2 and an IPI score of 2–5. |  |  |  | | 1. Six cycles of R-CHOP were offered as first-line treatment for patients with stage III/IV disease and an IPI score of 1. |  |  |  | | Older patients and those with co-morbid conditions | | | | | 1. R-miniCHOP (50% dosing of cyclophosphamide [400 mg/m2], doxorubicin [25 mg/m2] and vincristine [1 mg]) was offered to patients ≥ 80 years and suitable for anthracycline. |  |  |  | | 1. Non-anthracycline-based regimen was offered to patients with cardiac co-morbidities unsuitable for anthracyclines. |  |  |  | | End-of-treatment response assessment and follow-up | | | | | 1. For patients without a CMR on iPET2 (or for patients who had not undergone an iPET2), an end-of-treatment PET-CT scan was performed. |  |  |  | | 1. For patients with residual foci of fluorodeoxyglucose (FDG)-uptake, biopsy of FDG-avid lesions should be undertaken or repeat PET-CT should be offered at an 8- to 12-week interval, where tissue biopsy is not possible. |  |  |  |   **Commentary:** |
| Conclusion | (To be completed by the author) |
| Recommend- ations for improvement | Present the result with recommendations, actions and responsibilities for action and a timescale for implementation. Assign a person(s) responsible to do the work within a timeframe.  **Some suggestions:**  highlight areas of practice that are different  present findings. |
| Action plan | (To be completed by the author – see attached action plan proforma) |
| Re-audit date | (To be completed by the author) |
| References | 1. Fox CP, Chaganti S, McIlroy G, Barrington SF, Burton C, Cwynarski K *et al.* The management of newly diagnosed large b-cell lymphoma: A British Society for Haematology Guideline. *Br J Haematol* 2024;204:1178–1192. |

## Data collection proforma for patients (the management of newly diagnosed large B-cell lymphoma)

## Audit reviewing practice

Patient name:

Hospital number:

Date of birth:

Consultant:

Case number:

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| **Standard** | **1**  **Yes** | **2**  **No** | **3**  If shaded box not ticked, was there documentation to explain the variance? **Yes/No** plus free-text comment. | **4**  Compliant with guideline if shaded box ticked or an appropriate explanation from column 3 **Yes/No**  (Record if standard not applicable.) |
| **Diagnosis and baseline investigations** | | | | |
| **1** All diagnoses and treatment plans were discussed at a fully constituted haemato-oncology MDT meeting. |  |  |  |  |
| **2**  All patients had tests for serum LDH and full serology for HBV, HCV and HIV. |  |  |  |  |
| **3**  Baseline PET-CT was performed for all patients. |  |  |  |  |
| **4**  Baseline ECG was performed on all patients. |  |  |  |  |
| **5**  ECOG PS, IPI and CNS-IPI scores were recorded for all patients. |  |  |  |  |
| **6**  FISH for MYC rearrangements was performed |  |  |  |  |
| Supportive care | | | | |
| **1**  Primary G-CSF prophylaxis was offered to all patients receiving chemo-immunotherapy with curative intent |  |  |  |  |
| Stage I and II disease | | | | |
| **1**  Four cycles of R-CHOP plus two additional infusions of rituximab were offered to patients 18–60 years with stage I/II, aaIPI 0, without bulky disease. |  |  |  |  |
| Primary extra-nodal LBCL – testicular | | | | |
| **1**  CNS prophylaxis was offered, guided by the current BSH GPP. |  |  |  |  |
| **2** Contralateral testicular radiotherapy was offered following completion of systemic therapy. |  |  |  |  |
| Primary extra-nodal LBCL – gastric | | | | |
| **1**  Where *Helicobacter pylori* was detected, eradication therapy was offered as per current guidance |  |  |  |  |
| Advanced stage disease | | | | |
| **1**  Six cycles of RCHP-polatuzumab vedotin was offered as first-line treatment for patients with *de novo* LBCL, fit for full-dose chemotherapy, with an ECOG PS ≤2 and an IPI score of 2–5. |  |  |  |  |
| **2**  Six cycles of R-CHOP were offered as first-line treatment for patients with stage III/IV disease and an IPI score of 1. |  |  |  |  |
| Older patients and those with co-morbid conditions | | | | |
| **1**  R-miniCHOP (50% dosing of cyclophosphamide [400 mg/m2], doxorubicin [25 mg/m2] and vincristine [1 mg]) was offered to patients ≥ 80 years and suitable for anthracycline. |  |  |  |  |
| **2**  Non-anthracycline-based regimen was offered to patients with cardiac co-morbidities unsuitable for anthracyclines. |  |  |  |  |
| **End-of-treatment response assessment and follow-up** | | | | |
| **1**  For patients without a CMR on iPET2 (or for patients who had not undergone an iPET2), an end-of-treatment PET-CT scan was performed. |  |  |  |  |
| **2** For patients with residual foci of fluorodeoxyglucose (FDG)-uptake, biopsy of FDG-avid lesions should be undertaken or repeat PET-CT should be offered at an 8- to 12-week interval, where tissue biopsy is not possible. |  |  |  |  |

**List of investigations** (To be completed by the author)

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| **Audit action plan**  An audit of compliance with the BSH guideline for the management of newly diagnosed large B-cell lymphoma | | | | | | |
| Audit recommendation | Objective | Action | Timescale | Barriers and constraints | Outcome | Monitoring |
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