Survivorship – Peripheral T-Cell Lymphoma

THE UNIVERSITY OF TEXAS
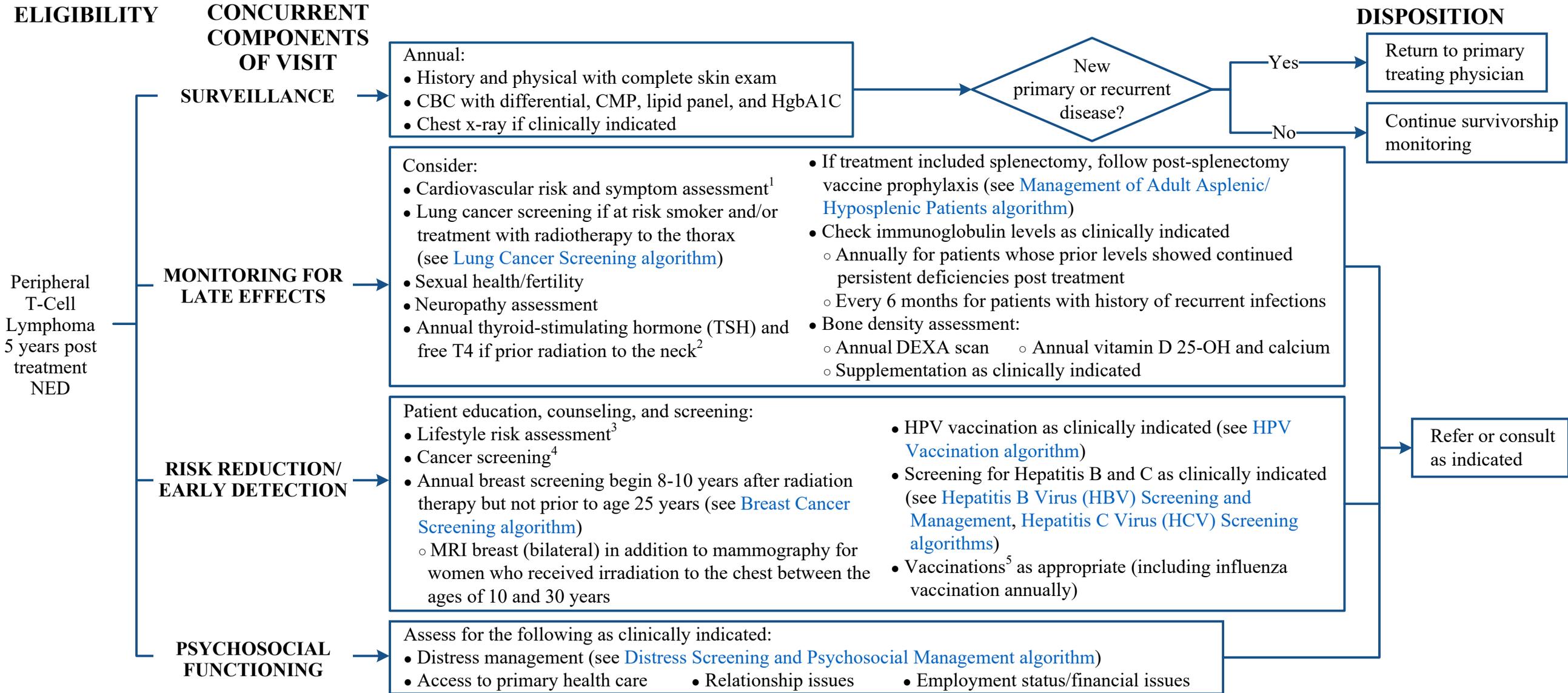MD Anderson Cancer Center
Making Cancer History®

Disclaimer: This algorithm has been developed for MD Anderson using a multidisciplinary approach considering circumstances particular to MD Anderson's specific patient population, services and structure, and clinical information. This is not intended to replace the independent medical or professional judgment of physicians or other health care providers in the context of individual clinical circumstances to determine a patient's care. This algorithm should not be used to treat pregnant women.

ELIGIBILITY

CONCURRENT COMPONENTS OF VISIT

DISPOSITION

Peripheral T-Cell Lymphoma 5 years post treatment NED

SURVEILLANCE

Annual:
- History and physical with complete skin exam
- CBC with differential, CMP, lipid panel, and HgbA1C
- Chest x-ray if clinically indicated

New primary or recurrent disease?
- Yes → Return to primary treating physician
- No → Continue survivorship monitoring

MONITORING FOR LATE EFFECTS

Consider:
- Cardiovascular risk and symptom assessment[1]
- Lung cancer screening if at risk smoker and/or treatment with radiotherapy to the thorax (see Lung Cancer Screening algorithm)
- Sexual health/fertility
- Neuropathy assessment
- Annual thyroid-stimulating hormone (TSH) and free T4 if prior radiation to the neck[2]

- If treatment included splenectomy, follow post-splenectomy vaccine prophylaxis (see Management of Adult Asplenic/ Hyposplenic Patients algorithm)
- Check immunoglobulin levels as clinically indicated
  ○ Annually for patients whose prior levels showed continued persistent deficiencies post treatment
  ○ Every 6 months for patients with history of recurrent infections
- Bone density assessment:
  ○ Annual DEXA scan
  ○ Annual vitamin D 25-OH and calcium
  ○ Supplementation as clinically indicated

RISK REDUCTION/ EARLY DETECTION

Patient education, counseling, and screening:
- Lifestyle risk assessment[3]
- Cancer screening[4]
- Annual breast screening begin 8-10 years after radiation therapy but not prior to age 25 years (see Breast Cancer Screening algorithm)
  ○ MRI breast (bilateral) in addition to mammography for women who received irradiation to the chest between the ages of 10 and 30 years

- HPV vaccination as clinically indicated (see HPV Vaccination algorithm)
- Screening for Hepatitis B and C as clinically indicated (see Hepatitis B Virus (HBV) Screening and Management, Hepatitis C Virus (HCV) Screening algorithms)
- Vaccinations[5] as appropriate (including influenza vaccination annually)

Refer or consult as indicated

PSYCHOSOCIAL FUNCTIONING

Assess for the following as clinically indicated:
- Distress management (see Distress Screening and Psychosocial Management algorithm)
- Access to primary health care
- Relationship issues
- Employment status/financial issues

NED = no evidence of disease
CMP = comprehensive metabolic panel
DEXA = dual-energy x-ray absorptiometry

[1] Consider use of Vanderbilt's ABCDE's approach to cardiovascular health
[2] Patients who received radiation therapy should consult with their Radiation Oncology team for site specific screening guidelines

[3] See Physical Activity, Nutrition, and Tobacco Cessation algorithms; ongoing reassessment of lifestyle risks should be a part of routine clinical practice
[4] Includes breast, cervical (if appropriate), colorectal, liver, lung, pancreatic, prostate and skin cancer screening
[5] Based on Centers for Disease Control and Prevention (CDC) guidelines

Department of Clinical Effectiveness V5
Approved by the Executive Committee of the Medical Staff on 12/14/2022

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SUGGESTED READINGS

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DEVELOPMENT CREDITS

This cancer survivorship consensus algorithm is based on majority expert opinion of the Survivorship Lymphoma Faculty at the University of Texas MD Anderson Cancer Center. It was developed using a multidisciplinary approach that included input from the following:

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