

Salem Health Cancer Center
**Physician diagnostic
algorithms 2024**



Welcome to Salem Health Cancer Center

Salem Health Cancer Center is not limited to one building or clinic. Although the members of our oncology team may have different addresses, they all come together under the virtual roof of Salem Health Cancer Center to provide state-of-the-art cancer care for our community.

The staff at Salem Health Cancer Center is made up of board-certified physicians, oncology certified nurses, and support services from every discipline involved with cancer care.

At Salem Health Cancer Center, we recognize cancer is not one disease, but many. Depending on the type and stage of cancer, the balance of surgery, radiation and systemic therapies may tip in many different directions.

This algorithm booklet is an effort to help guide our primary care colleagues in finding the most direct path for each patient's journey through treatment.

Please find our cancer care physicians at
SalemHealth.org/Cancer

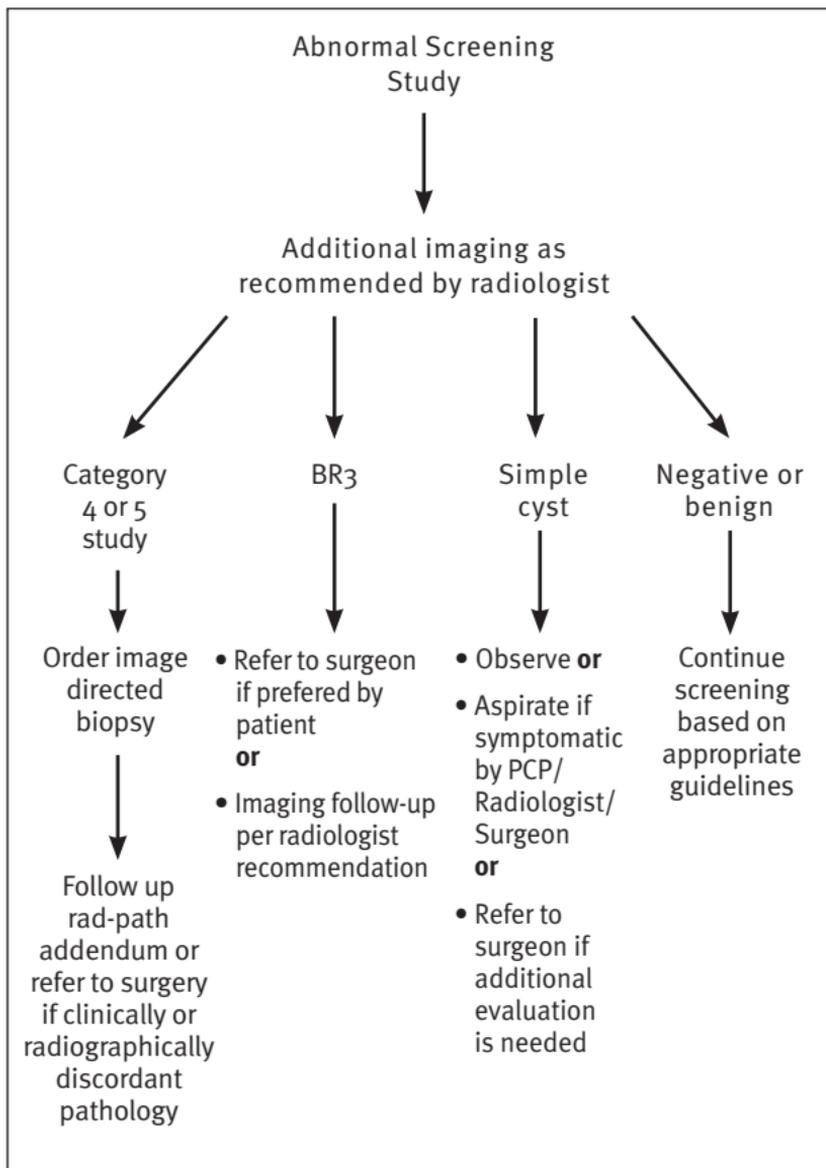
Table of contents

Breast cancer program.....	7
GI cancer program	15
GU cancer program.....	23
Gynecologic oncology program	31
Head & neck cancer program	39
Lung cancer program	47
Neuro cancer program	53

Salem Health Cancer Center

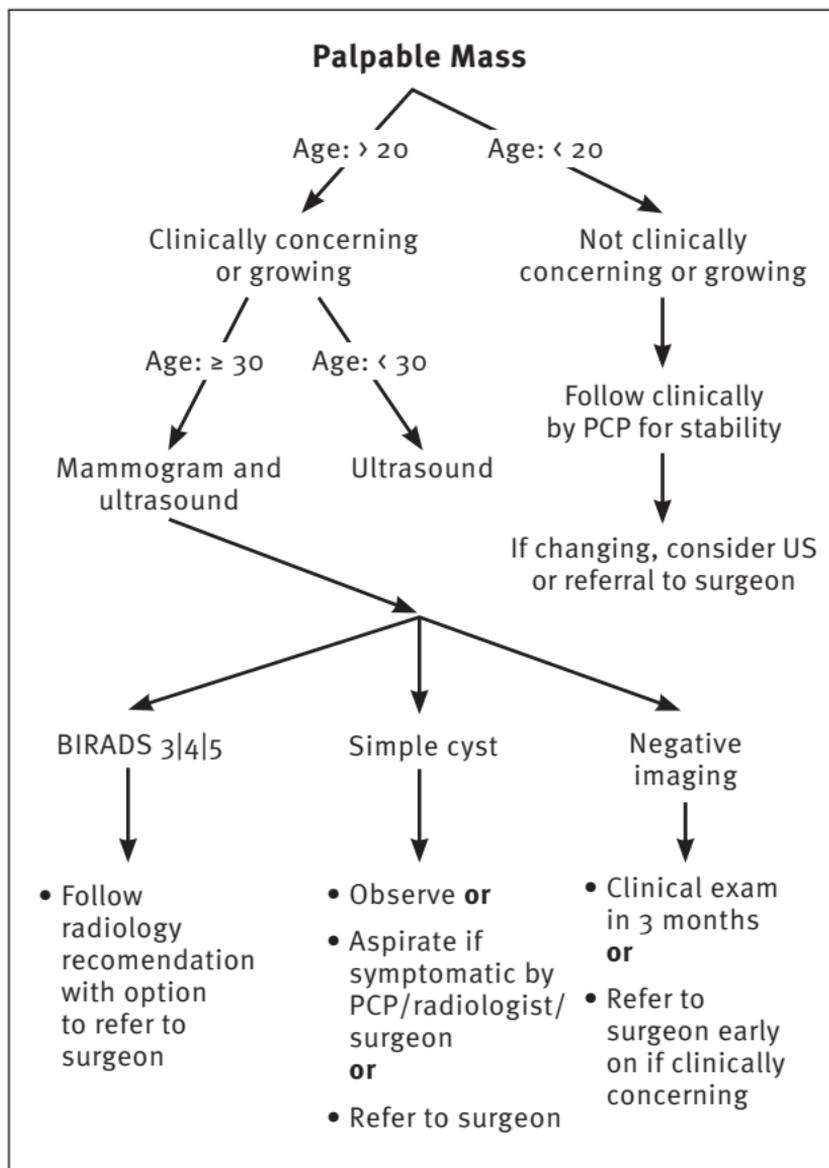
Breast cancer program

Breast cancer imaging detected abnormality



The primary care physician is welcome to refer to a specialist or Salem Health Cancer Center at any point.

Breast cancer palpable breast lump



The primary care physician is welcome to refer to a specialist or Salem Health Cancer Center at any point.

Breast cancer pearls and tips

Follow-up after breast cancer treatment: NCCN guidelines

- Risk of recurrent breast cancer continues for more than 15 years after remission for some types of breast cancer. The risk of new primary cancer on the contralateral breast cancer is 0.5% per year.
- Screening for symptoms such as new lumps, bone pain, chest pain, shortness of breath (SOB) at rest or with activity, abdominal pain, persistent headaches, or arm swelling or stiffness is part of the surveillance follow up visit.
- Rotating follow up visits between surgery, radiation oncology, medical oncology and primary care are strongly encouraged.
- First 3 years: Physical exam and questioning about new symptoms 1-4 times per year along with yearly mammogram.
- Years 4 and 5: As above, every 6–12 months.
- After 5 years: Yearly follow up visits and annual mammogram with primary care and breast specialist if follow up still indicated.
- The following tests are not recommended for routine follow-up because there is no evidence that they contribute to increased survival: FDG-PET scans, CBC or chemistry labs, CXR, liver US, bone scan, or tumor markers.

Breast MRI

- Consensus guidelines from The American Society of Breast Surgeons, American Cancer Society and American College of Radiology support the use of Breast MRI for:
 - ▶ Screening as a supplemental adjunct imaging modality to screening mammography for patients at increased lifetime risk for breast cancer such as patients with a strong family history of breast cancer with a $\geq 20\%$ lifetime risk determined by a mathematical model (Claus, BRCAPRO, BOADICEA and Tyrer-Cuzick), moderate and high penetrance gene carrier mutations for breast cancer,

Breast cancer pearls and tips

women with history of chest irradiation including mediastinal radiation for Hodgkins lymphoma before the age of 30.

- ▶ Women with dense breast tissue diagnosed with breast cancer with indeterminate breast imaging on mammogram and/or breast ultrasound.
- ▶ Women diagnosed with Paget's disease of the nipple or axillary nodal metastasis with an occult breast primary on clinical exam, mammogram and breast ultrasound.
- ▶ Routine MRI of the breast is indicated in a small number of patients diagnosed and treated for breast cancer and typically ordered by the breast cancer specialist.
- When ordering an MRI of the breast is of importance to discuss the pros, cons and limitation of the imaging and explain that it can lead to possible risk of false positive findings, additional imaging.
- Typically, MRI of the breast are ordered by breast specialist for specific indications or after evaluating the risk factors that would warrant supplemental screening.

Nipple discharge

- Benign nipple discharge is usually bilateral, multi-ductal and occurs with breast manipulation. 50–80 % of premenopausal women can express some fluid from the nipple. Bloody or guaiac positive discharge is seen in 20 % of women during pregnancy or lactation.
- Risk of associated cancer is higher when the discharge is spontaneous, bloody, unilateral, uniductal, associated with a breast mass or abnormal imaging, or occurs in a patient > than age 40. Surgical consultation is generally indicated.
- Drugs are a common cause of galactorrhea.

- Cytology, ductogram, culture, prolactin level are rarely helpful. Mammogram and subareolar ultrasound are indicated after age 30; ultrasound alone under age 30. If initial work up is unremarkable, it is prudent to discuss referral with breast surgical specialist for further assessment and discussion of additional imaging such MRI of the breast versus terminal duct excision.
- The most common pathologic finding in younger women is fibrocystic disease and in older women, papilloma. Nipple rash or crusting may need punch biopsy to rule out Paget's disease.

Core biopsy

- Presence of atypical ductal hyperplasia (ADH), atypical lobular hyperplasia (ALH), flat epithelial atypia (FEA), papillary lesion and LCIS warrant referral with breast surgical specialist for additional discussion of management options which include local surgical excision, discussion of high risk screening with annual mammogram and supplemental annual breast MRI, risk reducing medication and other strategies based on core biopsy findings and family history.
- Fibroadenoma or fibroadenomatous change, hyperplasia, and metaplasia generally do not require excision. Refer to surgery if symptomatic and the patient wishes to pursue excision.
- Mammographic BIRADS Category 5 lesion with negative core biopsy should be excised.

Breast cysts

- No treatment required if asymptomatic; continue routine screening.
- Can be aspirated by PCP, surgeon or radiologist for pain or discomfort. Fluid does not go for cytology unless grossly bloody.

- If aspirated and there is a solid component, this would warrant a biopsy at the time of aspiration and placement of a biopsy marker in case surgical excision is warranted based on final biopsy results.

Young patients

- Solid mass under age 20 can be followed clinically by PCP for stability or referred for excision, if requested by patient. Does not require core biopsy.
- Concentric subareolar mass in peri-pubertal girl is breast bud and can be damaged by any kind of biopsy, please refer to surgeon prior to initiating biopsy.
- Gynecomastia in pubertal boy requires reassurance only; always do testicular exam for rare association with testicular cancer.

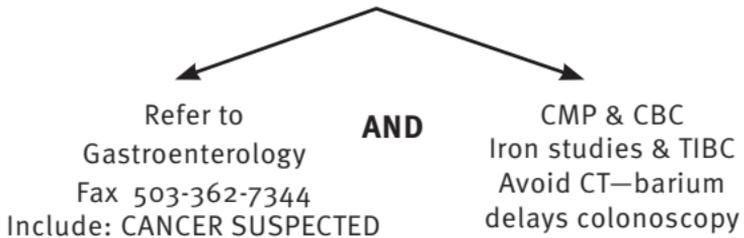
Salem Health Cancer Center
GI cancer program

Colorectal cancer

Cancer suspected

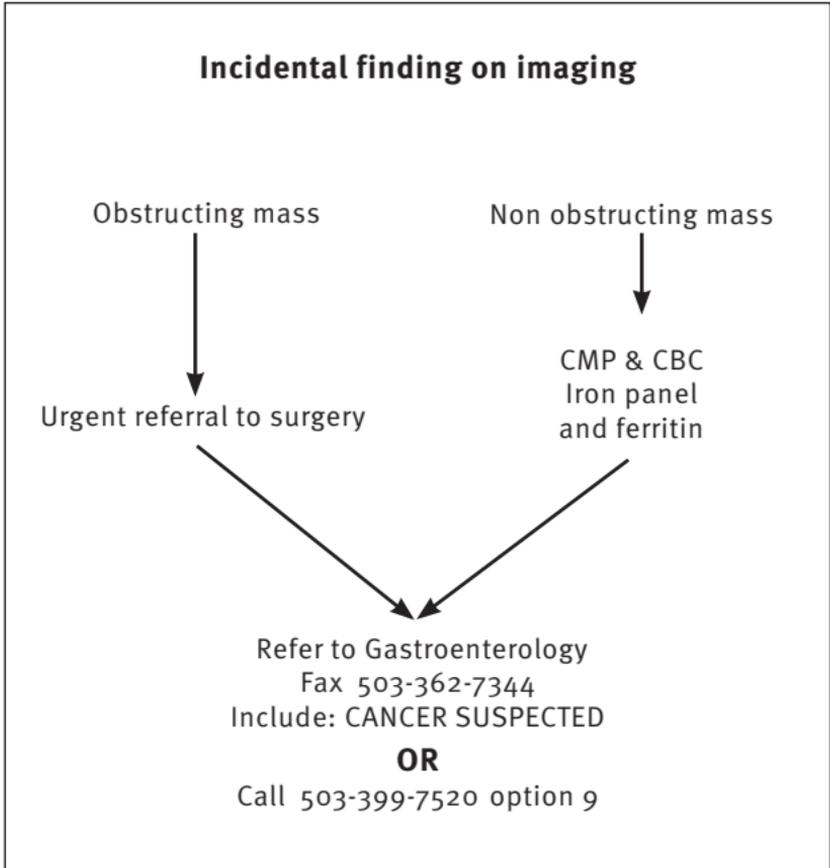
For example:

- Heme (+) stool
- Worrisome change in bowel habits
- Obstructive symptoms
- Iron deficiency anemia



The primary care physician is welcome to refer to a specialist or Salem Health Cancer Center at any point.

Colorectal cancer



The primary care physician is welcome to refer to a specialist or Salem Health Cancer Center at any point.

Esophageal cancer

Cancer suspected

For example:

- Progressive dysphagia
- Unexplained weight loss
- Obstructive symptoms



CMP & CBC

Refer to Gastroenterology

Fax 503-362-7344

Include: **CANCER SUSPECTED**

OR

Call 503-399-7520 option 9

The primary care physician is welcome to refer to a specialist or Salem Health Cancer Center at any point.

Esophageal cancer

Incidental finding on imaging

Intrinsic mass
(esophageal)



Refer to endoscopy
Fax 503-362-7344
Include: CANCER SUSPECTED
OR
Call 503-399-7520 option 9

Extrinsic mass
(chest mass compressing
esophagus)



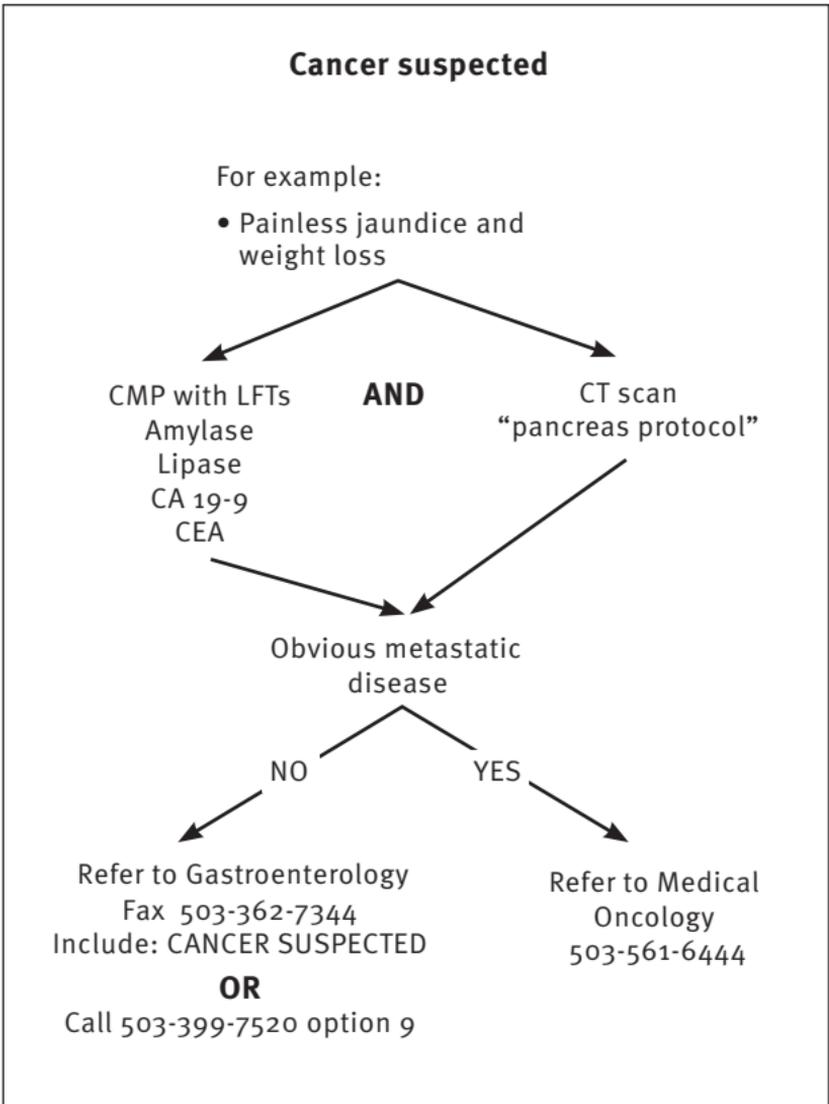
CT of chest, abdomen &
pelvis if not already done
Screening labs,
CBC & CMP



Refer to
Thoracic surgery

The primary care physician is welcome to refer to a specialist or
Salem Health Cancer Center at any point.

Pancreatic cancer



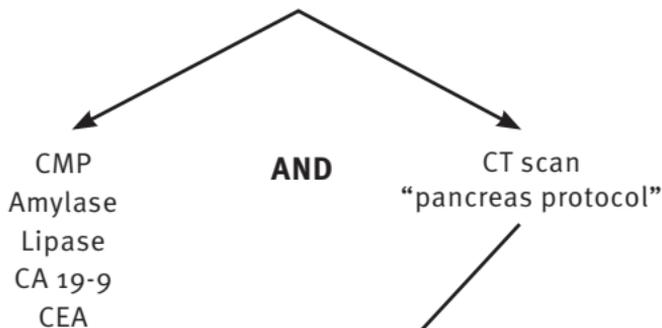
The primary care physician is welcome to refer to a specialist or Salem Health Cancer Center at any point.

Pancreatic cancer

Incidental finding

For example:

- Pancreatic mass
- Dilated biliary tree
- Radiologist indicates suspicion



Obvious metastatic disease

NO

YES

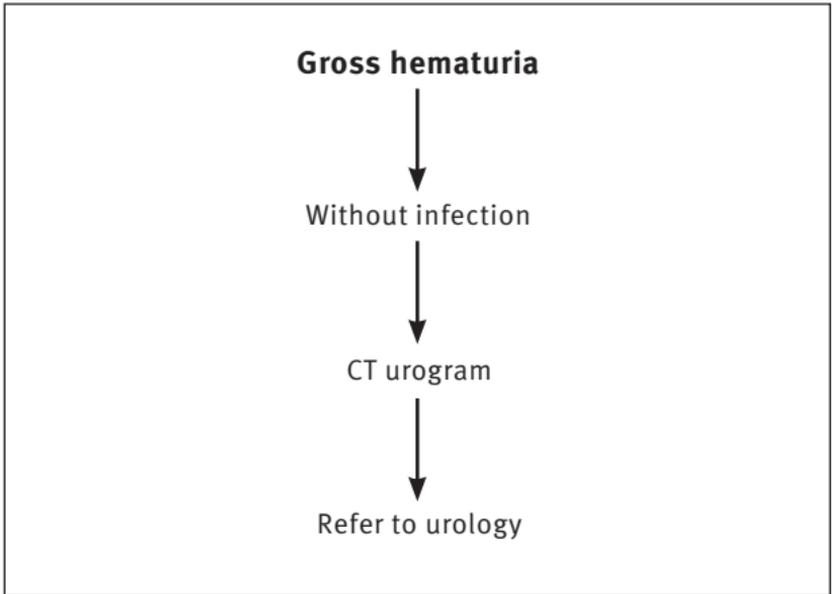
Refer to Gastroenterology
Fax 503-362-7344
Include: **CANCER SUSPECTED**
OR
Call 503-399-7520 option 9

Refer to Medical
Oncology
503-561-6444

The primary care physician is welcome to refer to a specialist or Salem Health Cancer Center at any point.

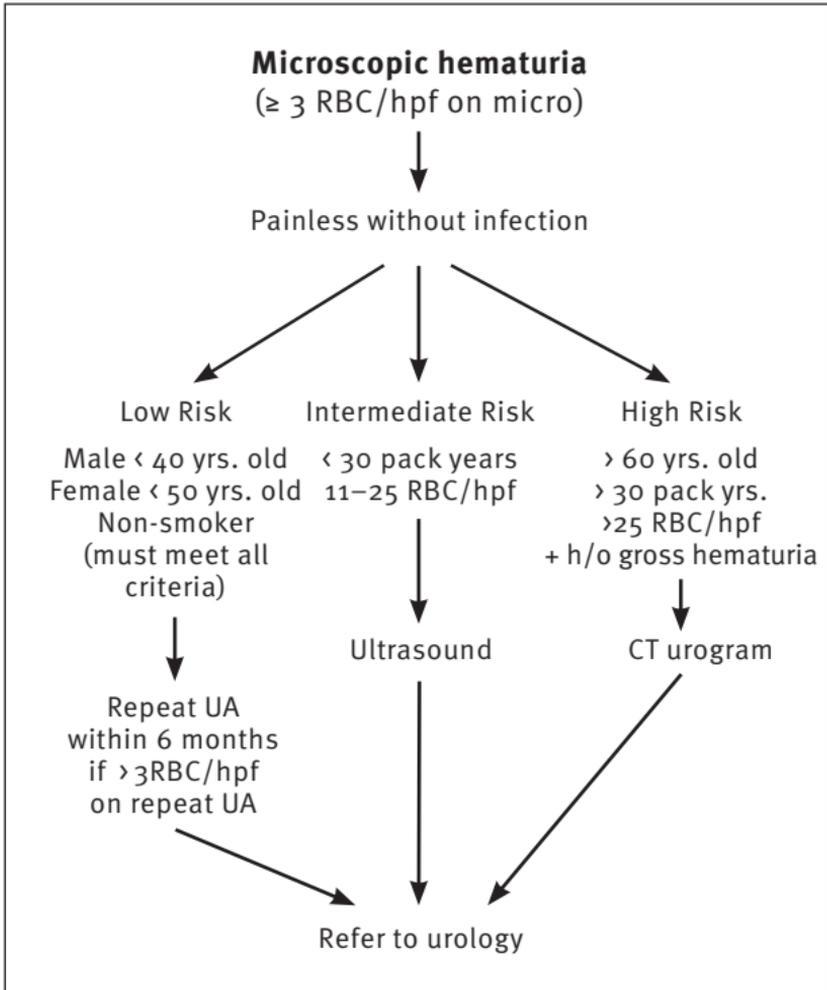
Salem Health Cancer Center
GU cancer program

Bladder cancer



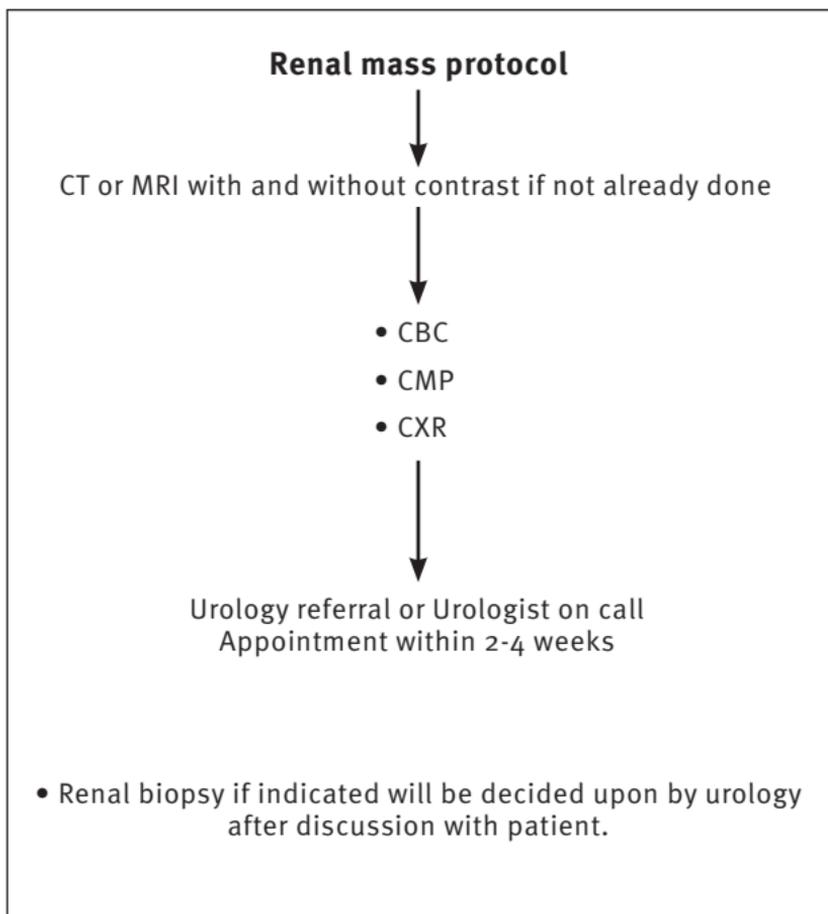
The primary care physician is welcome to refer to a specialist or Salem Health Cancer Center at any point.

Bladder cancer



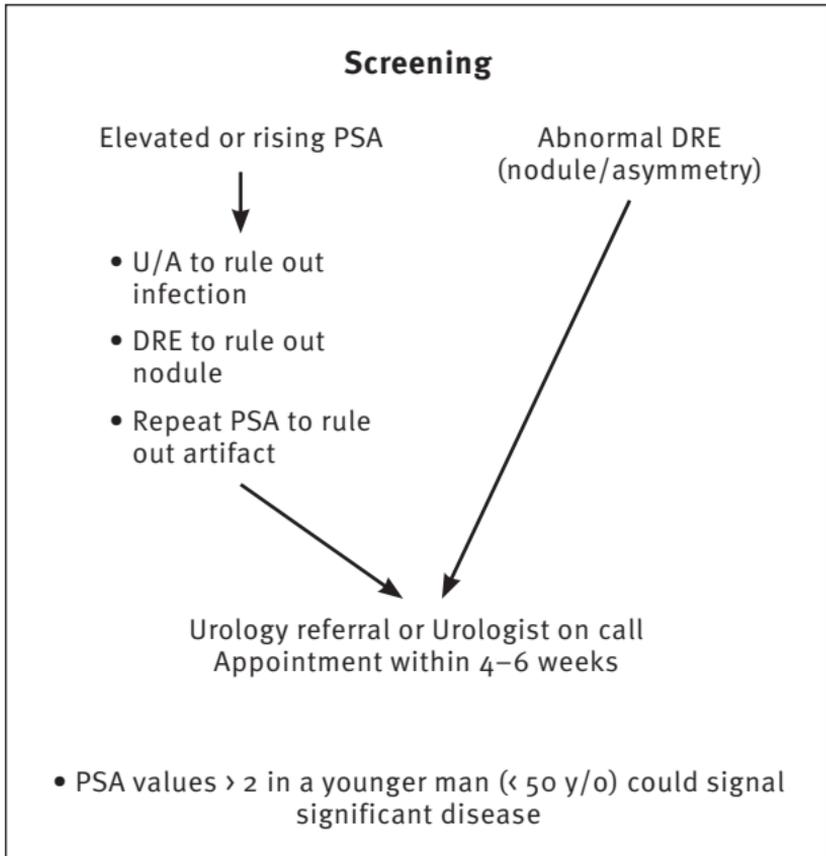
The primary care physician is welcome to refer to a specialist or Salem Health Cancer Center at any point.

Kidney cancer



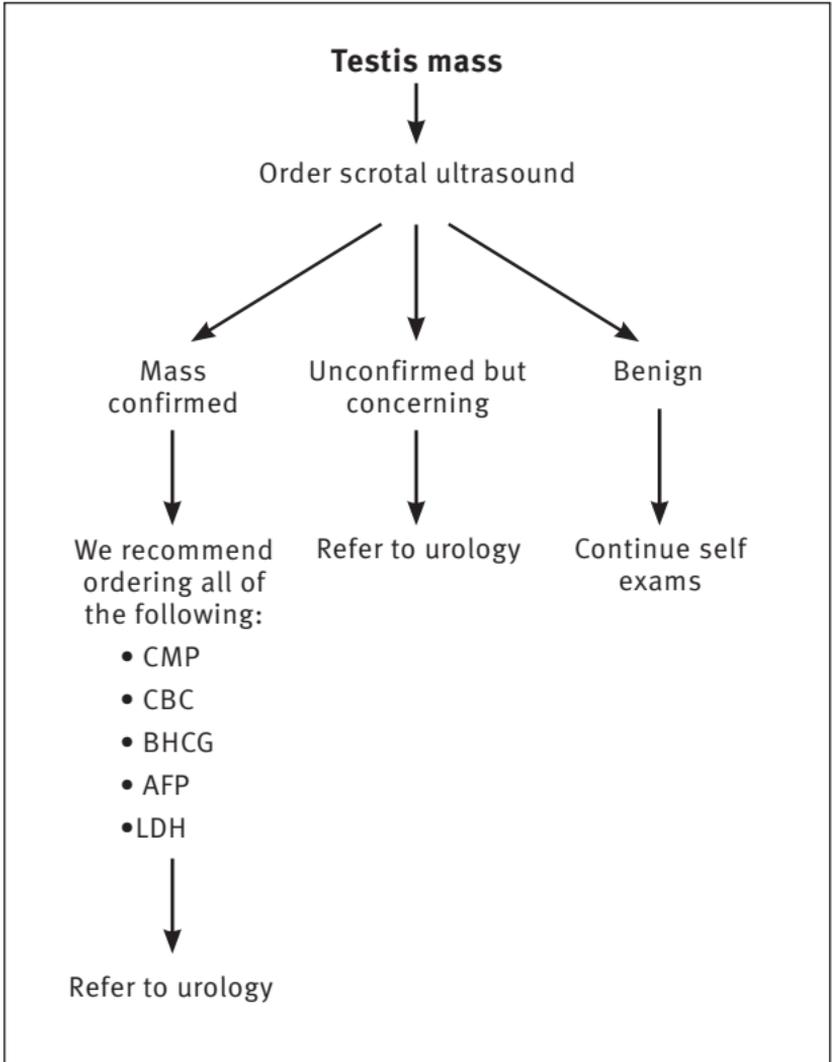
The primary care physician is welcome to refer to a specialist or Salem Health Cancer Center at any point.

Prostate cancer



The primary care physician is welcome to refer to a specialist or Salem Health Cancer Center at any point.

Testicular cancer



Salem Health Cancer Center

Gynecologic oncology program

Ovarian cancer

Cancer suspected

For example:

- Ascites
- Abdominal distension
- Nausea/vomiting
- Bowel obstruction



- CT scan of chest, abdomen, and pelvis
- CBC
- CMP
- CA125



If findings concerning for cancer:

- CEA
- CA 19-9
- CA-125



Refer to GYN/ONC

The primary care physician is welcome to refer to a specialist or Salem Health Cancer Center at any point.

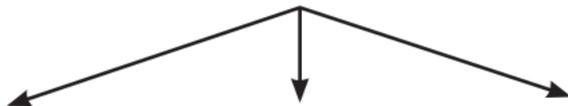
Ovarian cancer

Incidental finding

Complex cyst/mass in adnexa



Order CA-125 and pelvic ultrasound



Postmenopausal
CA-125 elevated
above normal

Premenopausal
CA-125 > 200n

Premenopausal
CA-125 < 200

- CT Scan of chest, abdomen, and pelvis
- CBC
- CMP

Consider referral
to GYN first

Refer to GYN/ONC

The primary care physician is welcome to refer to a specialist or Salem Health Cancer Center at any point.

Uterine cancer

Incidental finding

- Postmenopausal thickened endometrial stripe ≥ 5 mm
- Endometrial polyp



- Endometrial biopsy **OR**
- D&C/hysteroscopy

Complex atypical hyperplasia

OR

Endometrial cancer



- CBC
- CMP
- CA-125 for uterine serous carcinoma



CT of chest, abdomen, and pelvis



Refer to GYN/ONC

Hyperplasia with no atypia or negative

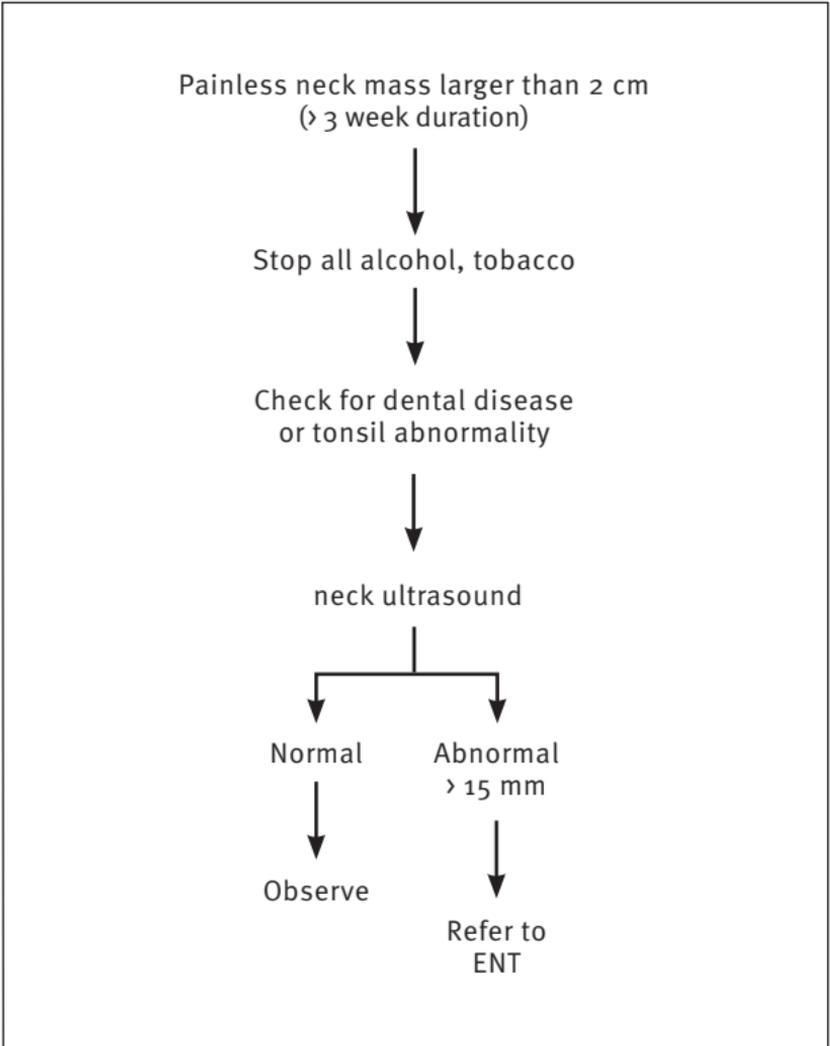


- Refer to OB/GYN
- May consider D&C, hysteroscopy, esp if postmenopausal

The primary care physician is welcome to refer to a specialist or Salem Health Cancer Center at any point.

Salem Health Cancer Center
Head & neck cancer
program

Painless neck mass



The primary care physician is welcome to refer to a specialist or Salem Health Cancer Center at any point.

Painful salivary mass

Acute salivary mass
(< 3 week duration)
with pain



- Stop all alcohol, tobacco
- Hydrate



If parotid or submandibular
areas:

- Hydrate, hot packs to area
- If present for > 1 week, consider 10 days of antibiotic to cover oral microbes and Prednisone if not diabetic
- Multiple antibiotics not needed



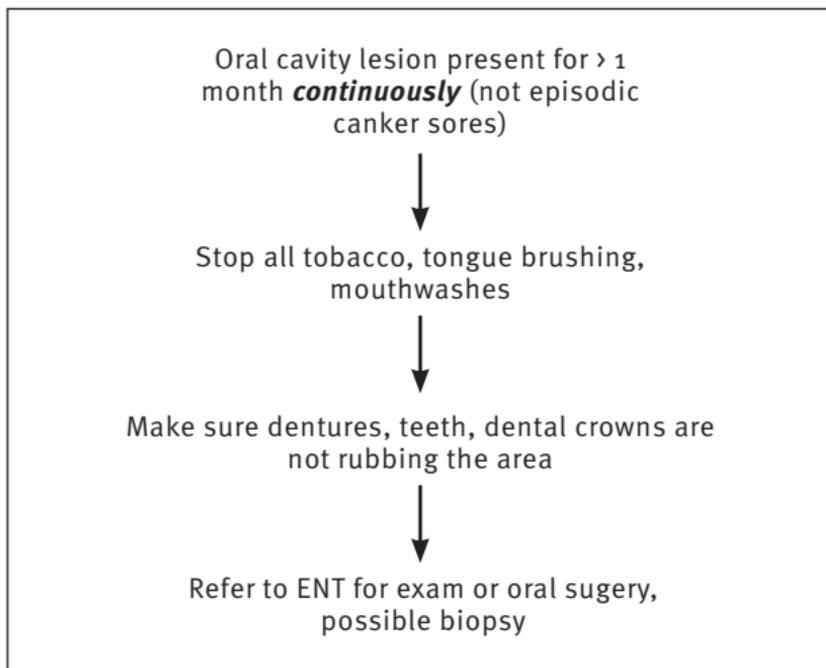
Ultrasound,
if abnormal:



referral to ENT

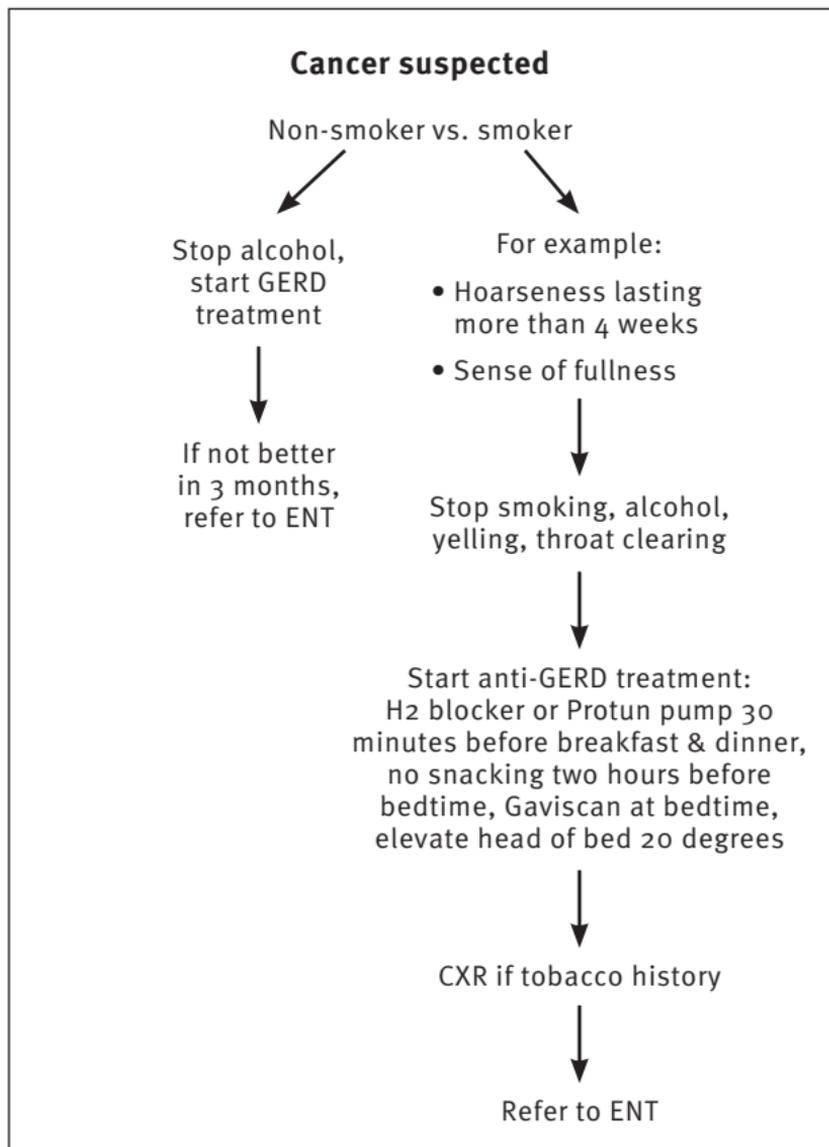
The primary care physician is welcome to refer to a specialist or Salem Health Cancer Center at any point.

Oral cavity mass



The primary care physician is welcome to refer to a specialist or Salem Health Cancer Center at any point.

Laryngeal/pharyngeal cancer



The primary care physician is welcome to refer to a specialist or Salem Health Cancer Center at any point.

Head & neck cancer pearls and tips

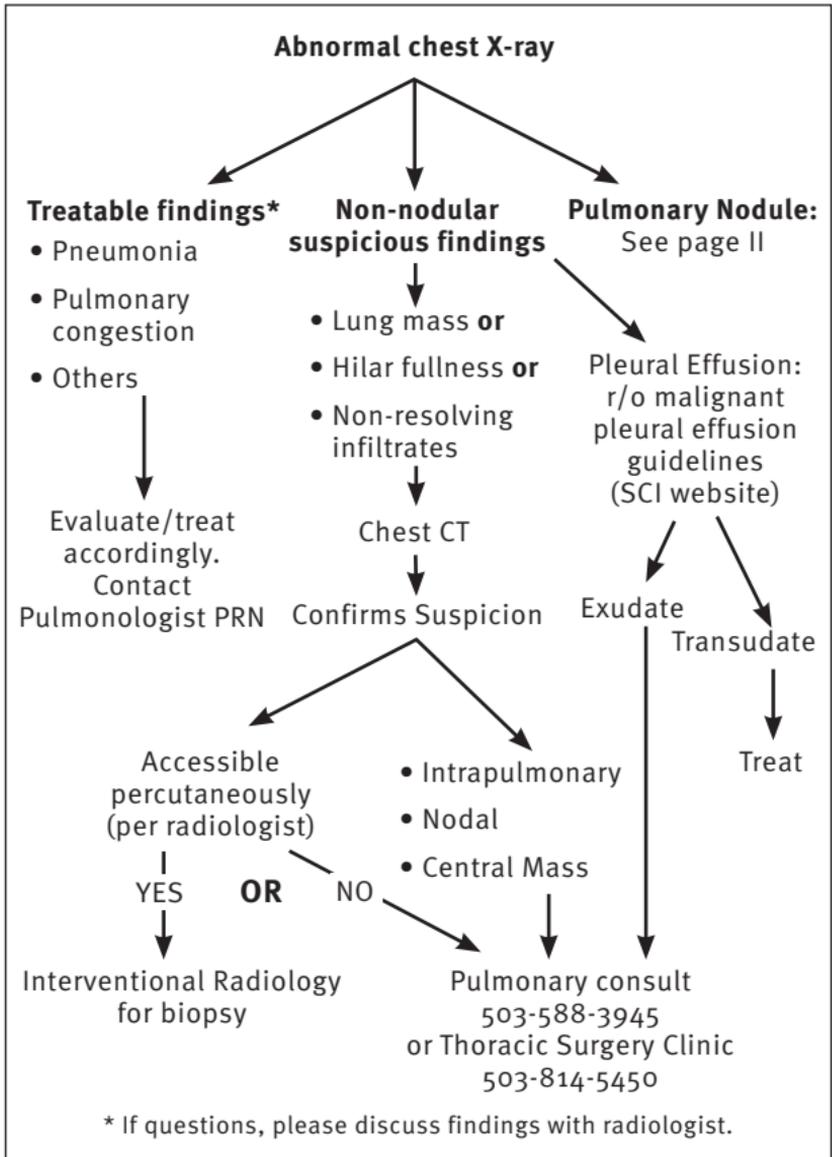
Risk factors/signs of head and neck cancer

- All forms of tobacco, betel nut, alcohol
- 20 lb. unintentional weight loss with dysphagia
- Severe hoarseness
- > 2 cm neck mass
- Trismus
- Hemoptysis
- Hematemesis

Salem Health Cancer Center

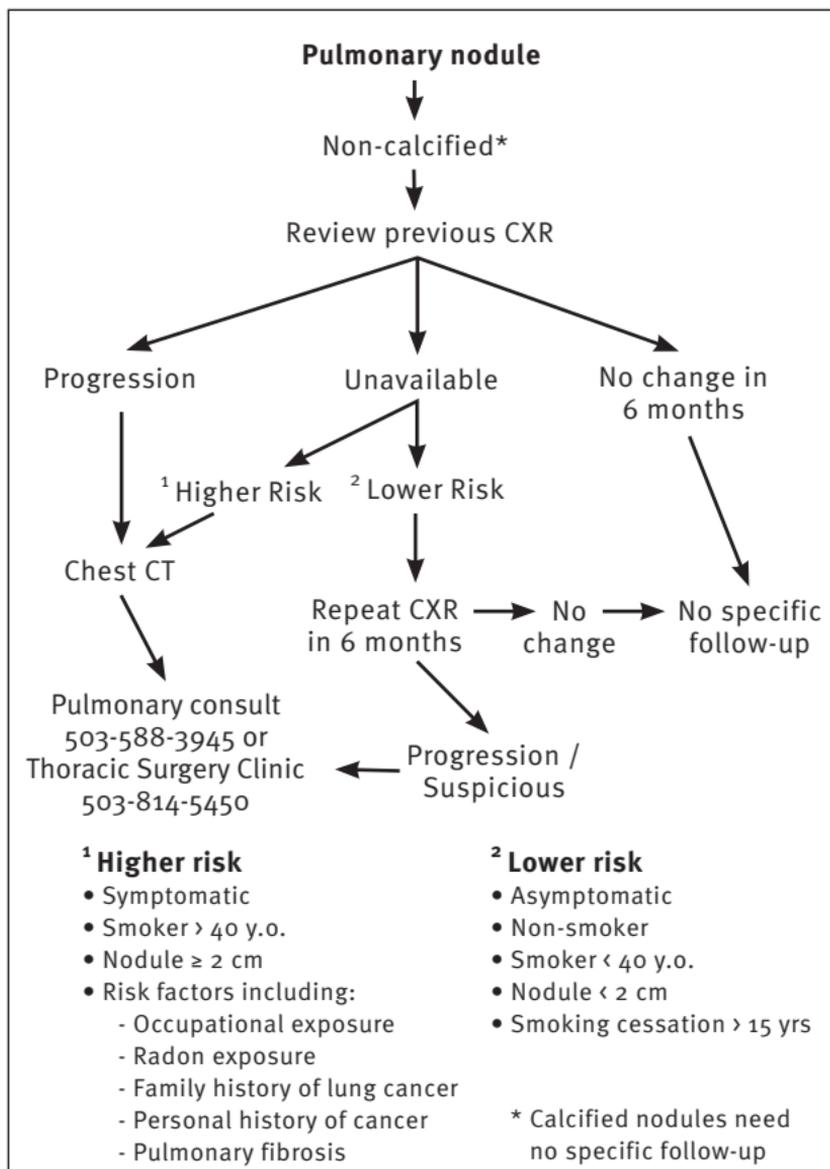
Lung cancer program

Lung cancer abnormal chest X-ray - I



The primary care physician is welcome to refer to a specialist or Salem Health Cancer Center at any point.

Lung cancer abnormal chest X-ray - II

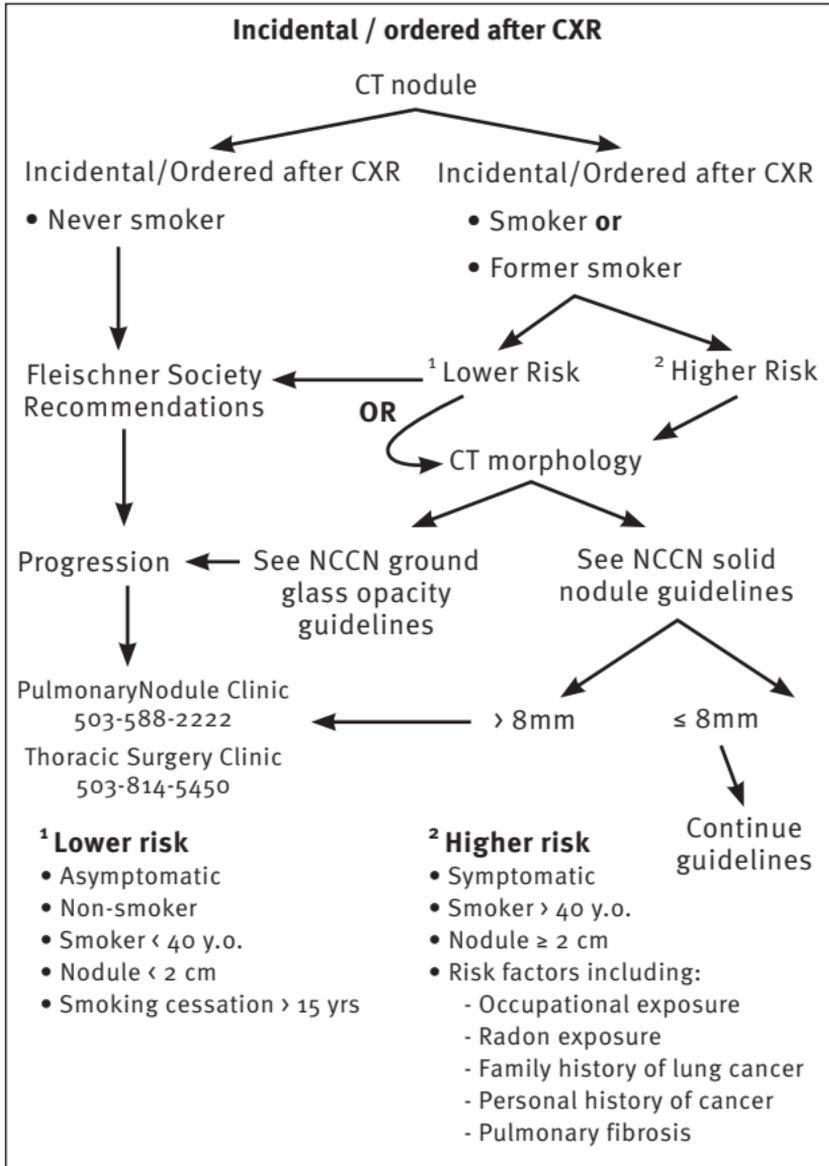


The primary care physician is welcome to refer to a specialist or Salem Health Cancer Center at any point.

Lung cancer abnormal chest X-ray

If there are persistent clinical concerns based on abnormal CXR findings, providers are encouraged to order a Chest CT and can refer to Pulmonary Medicine or Thoracic surgery clinic.
503-588-3945 503-814-5450

Lung cancer abnormal CT

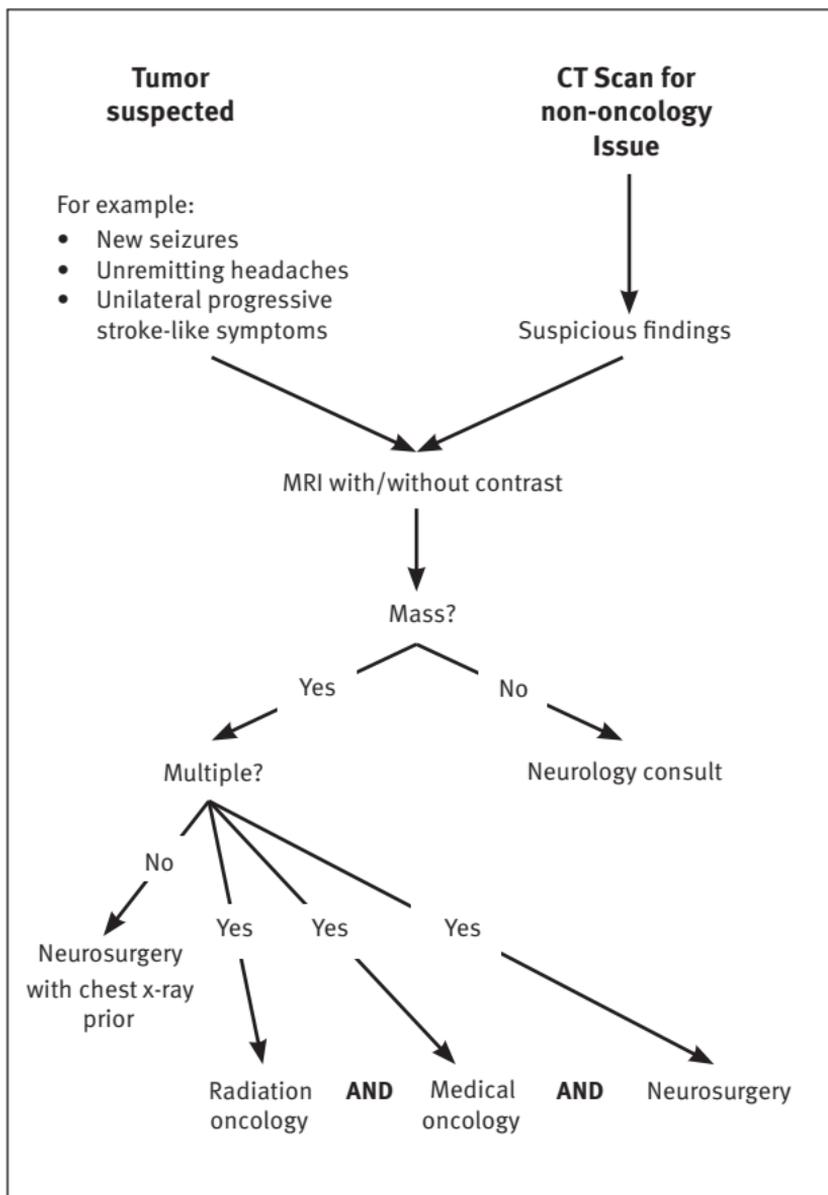


The primary care physician is welcome to refer to a specialist or Salem Health Cancer Center at any point.

Salem Health Cancer Center

Neuro cancer program

Neurosurgical cancer



The primary care physician is welcome to refer to a specialist or Salem Health Cancer Center at any point.

© 2024 Salem Health, last updated August 2024.

The information contained herein is provided “as is” without warranty of any kind, express or implied, including without limitation, any warranty, concerning the accuracy, adequacy or completeness of such information or material or the results to be obtained from using such information or material. Nothing contained herein is or should be considered, or used as a substitute for, medical advice, diagnosis or treatment. Neither Salem Health or any subsidiaries thereof nor any participating entity or author shall be responsible for any claim attributable to errors, omissions or other inaccuracies in the information or material contained herein. In no event shall Salem Health or any subsidiaries thereof nor any participating entity or author be liable for direct, indirect, special, incidental or consequential damages arising out of the use of such information or material. Neither Salem Health or any subsidiaries thereof nor any participating entity or author assumes any liability for the information contained herein.

