

## Local Cancer MDT Lynch Champion

### Who they should be

- A cancer MDT clinician e.g. gastroenterologist, surgeon, CNS, pathologist, oncologist
- A responsible individual within each colorectal cancer MDT

### Where they should be

- Within every local CRC MDT
- The exception would be if all new cancer cases (without exception) are managed by a regional MDT, in which case the champion may be located there
- They will be linked to a regional expert service, but should not be expected to deliver a regional service themselves (i.e. they are managing their own patients only)

### Roles and responsibilities

- Ensure delivery of NICE DG27 or DG42 i.e. universal testing for Lynch syndrome for newly diagnosed patients
  - Allocate specific responsibilities within their team
  - Eligible patients are referred for genetic testing OR offered genetic testing locally via 'mainstreaming' pathway
- Link to regional network via cancer/genomic alliance
  - Streamline referrals i.e. ensure a robust mechanism for referrals is implemented
  - Refer new Lynch syndrome patients for colonoscopic surveillance
  - Complex case management: can be discussed with regional centre
- Complete the brief national survey: To assess current state of service within their MDT and identify support required [https://www.surveymonkey.co.uk/r/lynch\\_survey](https://www.surveymonkey.co.uk/r/lynch_survey)
- Training
  - Complete short online training modules <https://rmpartners.nhs.uk/lynch-syndrome-early-diagnosis-pathway/>
  - 2-yearly focused CPD delivered by regional expert centre

### General Principles

- All newly diagnosed CRC patients who are identified as likely to have Lynch Syndrome should be referred for genetic testing (either locally or specialised genetics centre) in line with NICE guidelines DG27 and DG42.
- Each cancer MDT should identify a responsible local lead for the Lynch diagnostic pathway (a 'Lynch champion'), who may identify specific tasks for others within the MDT.
- Each cancer MDT is responsible for the delivery of the pathway locally. To deliver this pathway each cancer MDT should work with regional genetics expert centres/GMSAs.

- Each MDT should choose to offer either genetic testing via ‘mainstreaming’ (Cancer MDT clinician designated by the national testing directory) or referring patients to their linked genetics centre. Thus local cancer MDTs should aim to achieve either
  - Timely referral of patients for genetic testing only after completion of IHC +/- methylation testing, **or**
  - Mainstreaming of genetic testing ‘in-house’

Other Resource: Pathway model from NSHE for cancer MDTs

<https://www.england.nhs.uk/publication/implementing-lynch-syndrome-testing-and-surveillance-pathways/>

This handbook sets out guidance to support local systems to implement Lynch syndrome pathways nationally for both colorectal and endometrial cancer. It is intended to be helpful and set out best practice, but of course will need to be adapted to local circumstances.