TE AHO O TE KAHU
CANCER CONTROL AGENCY

Optimal cancer care pathway for people with myelodysplastic syndrome

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Whakataukī

Have a sense of the message in the winds...

Anei he taonga nō te mātanga nō Ahitereiria

Koutou maa I takoto te koha ki a mātou

Here is a treasure from the skilled and able specialist in Australia

Greetings for this treasure you have gifted us here in Aotearoa to explore and use

E ki ana te tangi o tatou manu

Ko te manu e kai ana ki te miro, nōnā te ngahere

Ko te manu e kai ana ki te mātauranga nōnā te Ao

It has been reiterated that when our manu cries, we sit up and listen

The bird that feeds upon local berries, local knowledge will prosper

The bird that feeds upon wisdom, our world knowledge will flourish.

It is an exciting time to feed off the wisdom of other cultures

Matua Tau Huirama

We would like to acknowledge The Voices of Whānau Māori Affected by Cancer (2023); He Ara Tangata – Te Aho o Te Kahu Consumer Group; the project team; clinicians; and national and special interest working groups that contributed to the development of the Optimal Cancer Care Pathways.

Special acknowledgement is extended to the Cancer Council Australia, who generously shared their Optimal Care Pathways framework and provided permission for it to be adapted to support people and whānau across Aotearoa New Zealand experiencing cancer.

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For further information including:

- Achieving Pae Ora, equity and whānau insights
- Person/whānau questions
- Definitions
- Myelodysplastic syndrome references and bibliography

Refer to **Optimal Cancer Care Pathway (OCCP) supplementary information.**

Foreword

Kia ora,

On behalf of Te Aho o Te Kahu | Cancer Control Agency, the clinician community, and the people and whānau who contributed to developing this guidance, I am proud to present the myelodysplastic syndrome Optimal Cancer Care Pathway (OCCP) for Aotearoa New Zealand.

Almost everyone across Aotearoa has been affected by cancer in some way. This year over 28,000 people will be diagnosed with cancer, with thousands more supporting loved ones living with this disease. Myelodysplastic syndrome (MDS) affects an increasing number of people with around 250 diagnosed with MDS this year. Around 100 people will die from MDS this year. We all believe that people and their whānau deserve the best cancer care available.

OCCPs are designed to guide the planning, coordination and delivery of best practice cancer prevention and care services across Aotearoa for different types of cancer. Each OCCP has been designed:

- with the needs of the person and their whānau at the heart
- to reflect the best capabilities available in Aotearoa
- to provide a national standard for high-quality cancer prevention and care that we expect for all New Zealanders.

While cancer control services are expanding and improving across the motu | country, there are often unwarranted variations in the risk of getting cancer and in the care experienced by people with cancer. Also, many continue to face barriers in accessing timely and effective cancer care because of where they live, their circumstances, or their ethnic background. Research shows that following best practice guidance like OCCPs, helps to reduce variations and disparities and improves cancer outcomes for people and their whānau. In turn, this will help our overall aim of reducing the burden of cancer on people and communities.

This resource reflects the expertise and experiences from many stakeholders across the country. Many thanks to everyone involved in this initiative, particularly Cancer Council Australia, who granted permission to adapt and adopt their Optimal Care Pathways framework to meet the needs of people in Aotearoa | New Zealand. We would also like to acknowledge the insights from The Voices of Whānau Māori Affected by Cancer (2023); He Ara Tangata – Te Aho o Te Kahu Consumer Group; the project team; clinicians; and national and special interest working groups.

Our thoughts are with the many people and whānau who are living with myelodysplastic syndrome, and those who have lost loved ones. Much of this guidance reflects the voices of those who have received cancer care. We are indebted to them for sharing their experiences to help improve cancer control outcomes and achieve equity.

Ngā mihi nui,

Rami Rahal
Tumuaki | Chief Executive
Te Aho O Te Kahu | Cancer Control Agency

Summary guide of myelodysplastic syndrome OCCP information

Quick reference guide of condensed tumour stream

The Optimal Cancer Care Pathways (OCCP) describe the standard of care that people and whānau across Aotearoa, New Zealand should expect the public health system to be striving for. They follow eight principles[1]: person and whānau-centred care; equity-led; safe, high-quality care; multidisciplinary care; supportive care; coordinated care; effective and timely communication; and knowledge-driven care.

The OCCP guides health providers in ensuring the person and their whānau receive optimal, supportive care at each stage of their cancer diagnosis and treatment.

Step 1: Wellness	Step 1: Checklist
Cancer prevention efforts should be part of all cancer control pathways. This step recommends actions the person/whānau can take to improve their wellbeing and reduce the overall risk of cancer. Evidence-based research shows that general cancer and wellbeing risks can be reduced by: • eating a nutritious diet • maintaining a healthy weight • taking regular, moderate to vigorous-intensity activity • avoiding or limiting alcohol intake • being sun smart • identifying pre-disposing infections such as, Hepatitis C • keeping up to date with immunisations or vaccines such as, Human Papilloma Virus (HPV) • avoiding smoking including marijuana and exposure to second-hand smoke ○ current smokers (or those who have recently quit) should be offered best practice tobacco dependence treatment and an opt-out referral to an intervention service such as Quitline • avoiding vaping • participating in screening services such as breast, cervical, bowel cancer screening • preventing occupational exposure to asbestos, silica, radon heavy metal, diesel exhaust and polycyclic aromatic hydrocarbons.	☐ Carry out a health and wellbeing assessment including discussions around screening services and ways to reduce cancer risk. ☐ Assess the individual's risk of developing cancer. ☐ Encourage eligible people to participate in national screening programmes. ☐ Discuss recent weight changes and monitor weight. ☐ Discuss and record alcohol intake. Offer support for reducing alcohol consumption if appropriate. ☐ Record person's smoking status and offer stop smoking advice/support if appropriate. ☐ Record physical activity. ☐ Consider referral to a dietitian, physiotherapist, or exercise programme. ☐ Give the person education on being sun smart.

[1] Optimal Cancer Care Pathway Principles

Step 2: Early detection	Step 2: Checklist
This step recommends options for early detection for the person and their whānau with suspected myelodysplastic syndrome. **Early detection** Myelodysplastic syndrome non-modifiable risk factors include: • advanced age • gender – myelodysplastic syndrome is more common in males • previous chemotherapy or radiotherapy treatment • an inherited predisposition to myelodysplastic syndrome including Down syndrome, Fanconi's anaemia and neurofibromatosis • exposure to environmental/occupational hazards. Early detection may be achieved through identifying myelodysplastic syndrome in people with mild cytopenia. Some people with cytopenia may not meet the criteria for myelodysplastic syndrome and may be categorised as having clonal cytopenia of uncertain significance. When the clinical significance of such a diagnosis is uncertain, follow up with their General Practitioner (GP), until more severe cytopenia(s) develop, may be appropriate.	☐ Assess and discuss the individual's risk of developing cancer. ☐ Support the person and their whānau to follow surveillance guidance if they're at an increased risk of familial cancer. ☐ Refer to clinical genetic services where appropriate. ☐ Discuss recent weight changes and monitor weight. ☐ If signs and symptoms of cancer are present refer to 'Step 3: Presentation, initial investigation and referral' below. **Communication** Ensure the person and their whānau understands: ☐ when they should receive their results ☐ how to follow up if they don't receive their results ☐ what's involved if they need to be transferred to a specialist service.

Step 3: Presentation, initial investigations, and referral	Step 3: Checklist
This step outlines how to initiate the appropriate investigations and referrals to specialist/s in a timely manner for the person and their whānau with suspected myelodysplastic syndrome. The types of investigations undertaken will depend on many factors, including access to diagnostic tests, the availability of medical specialists and including preferences. A person and their whānau may present via primary care, an emergency presentation or incidental finding indicating a high suspicion of myelodysplastic syndrome. **Signs and symptoms** of myelodysplastic syndrome to investigate include: • persistent tiredness and fatigue • weakness • shortness of breath with minimal exercise • looking pale	☐ Record signs and symptoms. ☐ Complete all cancer assessments. ☐ Inform the person and their whānau of preliminary results. ☐ Referral options of cancer care are discussed with the person and their whānau, including cost implications if private provider requested. ☐ Complete and record supportive care needs assessment and refer to allied health services as required. ☐ Inform the person and their whānau of cultural services and relevant support groups available. ☐ Initiate referrals and arrange further investigation.

- recurring infections, especially chest infections
- fevers
- sore mouth due to mouth ulcers
- easy bruising
- purpura – a rash of small red dots, seen often on the lower limbs initially, due to small superficial capillary bleeds known as petechiae
- tendency to bleed from the nose and gums.

Myelodysplastic syndrome assessment includes the relevant:

- **medical history** including medications
- **physical examination**: Eastern Cooperative Oncology Group (ECOG) Performance Status Scale, frailty assessment, weight, pallor, bleeding, or bruising
- **laboratory investigations:** blood tests to detect abnormalities and exclude other diagnoses – for example: full blood cell count and film review, reticulocyte counts, lactate dehydrogenase, autoimmune screen (ANA/ENA), blood group, B12/folate and iron studies, electrolytes, liver function, renal function, blood cell, haemolysis, and thyroid function (where clinically appropriate) and serum electrophoresis serologies for chronic viral infections such as hepatitis C, hepatitis B and HIV
- **familial cancer history**
- **social history**.

Referral

A clinical suspicion or laboratory/imaging findings suggestive of cancer require further investigation and a referral to hospital specialist services.

Timeframe

- ☐ A person with signs and symptoms that may suggest myelodysplastic syndrome should be promptly assessed by a health professional.
- ☐ Optimally, investigations should be completed **within 2 weeks**.
- ☐ Any of the following indicators requires urgent referral:
  - severity of cytopenia -neutrophils < 0.5 × 10^9 /L or neutrophils > 0.5 and recurrent infections needing antibiotics
  - platelets < 30 × 10^9 /L or bleeding symptoms even if platelets are above threshold
  - symptomatic unexplained anaemia or haemoglobin < 80 g/L.

Communication

- ☐ Explain to person and their whānau that they are being referred to a hospital specialist service and why, including:
  - how long this may take
  - who to contact if their symptoms change
  - how to follow up if they do not receive their specialist appointment within the specified time.

Step 4: Diagnosis, staging and treatment planning

This step outlines the process for confirming the diagnosis and stage of cancer and the planning of subsequent treatment.

Diagnosis for myelodysplastic syndrome may include:

Radiology: ultrasound, computed tomography (CT) scan, magnetic resonance imaging (MRI), position emission tomography (PET)-CT scan.

Pathology: bone marrow aspirate or trephine.

Laboratory: blood test to exclude other causes of cytopenia and dysplasia.

Step 4: Checklist

- ☐ Confirm diagnosis.
- ☐ Referral to a cancer care coordinator.
- ☐ Record staging, performance status and comorbidities.
- ☐ Discuss the person's diagnosis at a multidisciplinary meeting (MDM) and inform the person and their whānau of the treatment decision.
- ☐ Consider enrolment in clinical trial.
- ☐ All people with a high suspicion of cancer have a person to coordinate care.

Prognostic assessment

- the International Prognostic Scoring System (IPSS)
- the Revised IPSS (IPSS-R).

Performance status

Assess performance status using the Eastern Cooperative Oncology Group (ECOG) Performance Status Scale to inform prehabilitation and treatment recommendations.

Clinical genetic testing

Referral to clinical genetic services for myelodysplastic syndrome is considered if features of the cancer suggest a genetic predisposition.

For further information see the Genetic Health Service New Zealand website **(genetichealthservice.org.nz).**

Treatment planning

Optimal cancer care requires a multidisciplinary approach to ensure treatment plans are tailored to an individual's needs in collaboration with the whānau and health care team.

- ☐ Assess supportive care needs and refer to allied health services as required.
- ☐ Ensure primary or secondary prehabilitation to optimise overall well-being is initiated.
- ☐ Referral to myelodysplastic syndrome specific support services as required.
- ☐ Give the person and their whānau information on Cancer Society, Canteen, Leukaemia and Blood New Zealand, and/or relevant cultural services and support groups available.

Timeframe

If required, an MDM should occur **within 2 weeks** of the suspected or confirmed diagnosis.

Communication

The lead clinician and team are responsible for:

- ☐ discussing a timeframe for diagnosis and treatment options with person and their whānau
- ☐ explaining the role of the MDM team in treatment planning and ongoing care
- ☐ encouraging discussion about the diagnosis, prognosis, advance care planning and palliative care while clarifying wishes, needs, beliefs, and expectations of the person and their whānau and their ability to comprehend the communication
- ☐ providing appropriate information and referral to support services as required
- ☐ communicating with the GP of the person and their whānau about the diagnosis, treatment plan and recommendations from the MDM.

Step 5: Treatment

This step describes publicly funded optimal treatments for myelodysplastic syndrome by trained and experienced clinicians and team members, in an appropriate environment.

Treatment options

Observation – the person that may benefit from observation includes those with mild cytopenias and/or having a very indolent type of myelodysplastic syndrome.

Systemic anti-cancer therapy – may be indicated for people with lower or higher risk myelodysplastic syndrome.

Step 5: Checklist

- ☐ Health providers/professional, treating specialist has relevant qualifications, experience, and expertise.
- ☐ Discuss the intent of treatment and the risks and benefits with the person and their whānau.
- ☐ Provide the agreed treatment plan with the person and their whānau and GP.
- ☐ Assess supportive care needs and refer to allied health services as required.

Allogeneic stem cell transplant (Allo-SCT) – may be indicated as per American Society for Transplantation and Cellular Therapy (ASTCT) guidelines and European Society for Blood and Marrow Transplantation (EMBT) handbook. **Supportive therapy** – all people with myelodysplastic syndrome will require supportive therapies. **Emerging therapies** – therapy targeting barrow microenvironment and immune checkpoints. **Surgery** – has a very limited role. People that may benefit from surgery include those who require incision and drainage of soft tissue infections and/or abscesses occasionally. **Palliative care** – early referral to palliative care can improve quality of life and in some cases survival. Referral is based on need, not prognosis.	☐ Give the person and their whānau information on the cancer non-governmental organisations (NGOs), cultural services and support groups available. ☐ Consider early referral to palliative care if appropriate. ☐ Discuss advance care planning with the person and their whānau. **Timeframes** ☐ The person with lower risk disease should begin the systemic anti-cancer therapy depending on the clinical presentation and urgency. ☐ The person with higher risk disease should begin the systemic anti-cancer therapy **within the first 6 weeks** of initial specialist consultation. ☐ A referral to a bone marrow transplant specialist should occur once transplantation is considered a potential treatment option. **Communication** The lead clinician and team are responsible for discussing these areas with the person and their whānau: ☐ treatment options including the intent of treatment, risks, and benefits ☐ advance care planning ☐ options for healthy lifestyle support to improve treatment outcomes such as exercise and nutrition.

Step 6: Care after treatment	Step 6: Checklist
The person and their whānau access appropriate follow up and surveillance and are supported to achieve their optimal health after cancer treatment. Provide a summary of the treatment and follow-up care plan to the person, their whānau and their GP outlining: • diagnosis, including tests performed and results • treatment received (types and date) • current toxicities (severity, management and expected outcomes)	☐ Provide a survivorship plan that includes a summary of the treatment and follow-up care plan to the person, whānau and their GP. ☐ Assess supportive care needs and refer to allied health services as required. ☐ Give the person and their whānau information on Cancer Society and/or relevant cultural services and support groups available.

• interventions and treatment plans from other health providers/professionals • potential long-term and latent effects of treatment and care of these • supportive care services provided • a follow-up schedule, including tests required and timing • contact information for key health care providers/professionals who can offer support for lifestyle modification • a process for rapid re-entry to medical services for suspected recurrence or relapse • ongoing assessments of the effects of treatment.	**Communication** The lead clinician (or delegated representative) is responsible for: ☐ explaining the treatment summary and follow-up and surveillance care plan to the person and their whānau ☐ informing the person and their whānau about secondary prevention and healthy living ☐ discussing the follow-up care plan with the GP of the person and their whānau ☐ providing guidance for rapid re-entry to specialist services.

Step 7: Palliative and end-of-life care	Step 7: Checklist
Palliative and end-of-life care provides the person facing life-limiting conditions and their whānau with holistic support and coordinated services based on their specific needs. Palliative care may be provided through: • hospital palliative care • home and community-based care • community nursing, including access to appropriate equipment. Early referral, identification, correct assessment and treatment of pain and other symptoms prevent and relieves suffering. End-of-life care should consider: • appropriate place of care • person's preferred place of death • support needed for the person and their whānau. Awareness of and access to, assisted dying services should be available if the person and their whānau raise this with the health care team. **Communication** A key way to support the person and their whānau is by coordinating ongoing, clear communications between all health providers/professionals involved in providing cancer care.	☐ Early referral to generalist palliative care. ☐ Refer to specialist palliative care services as required. ☐ Refer to supportive care services as required. ☐ Make sure the person and their whānau are aware of the prognosis and what to expect when someone is dying. ☐ Activation of advance care plan, directive, or enduring power of attorney.

How optimal cancer care pathways improve outcomes

Optimal Cancer Care Pathways (OCCPs) are critical tools for guiding the national delivery of consistent, safe, high-quality, evidence-based cancer care for people and whānau across Aotearoa New Zealand. Research shows OCCPs improve the outcomes and experiences of people and their whānau affected by cancer to guide the design and delivery of cancer care services that are systematic, equitable, connected, and timely (Cancer Council Australia, nd).

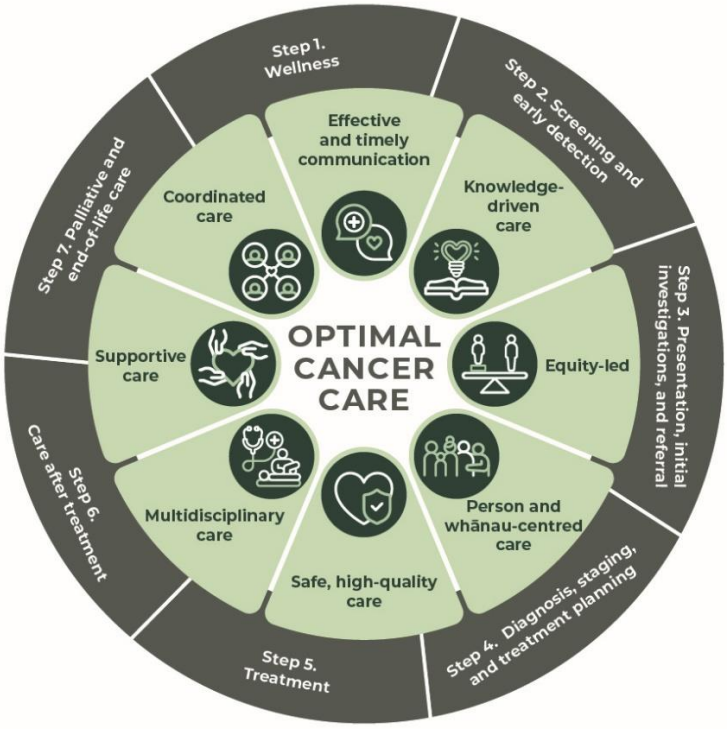
OCCPs are a framework for achieving health equity[2] in cancer control using a person and whānau centred approach to provide people with equitable, high-quality care, regardless of where they live or receive cancer treatment. OCCPs help to:

- identify gaps in existing cancer services
- address barriers and unwarranted variations in accessing high-quality care
- identify opportunities for system improvements
- continually improve the way services are planned and coordinated.

As shown in Figure 1, the OCCPs map seven key steps in providing cancer care based on evidence-based practice, underpinned by eight principles to deliver the optimal level of care. While the seven steps appear linear, in practice, the care a person receives may not be. The steps provided will be tailored to their specific situation and needs, for example the type of cancer they have, when and how the cancer is diagnosed and managed, the person's decisions, and how they respond to treatment.

OCCPs are designed to be used alongside clinical guidelines. The OCCPs do not constitute medical advice or replace clinical judgement or guidance.

Figure 1: Optimal Cancer Care model



[2] Optimal Cancer Care Pathway Supplementary Information

Principles of the optimal cancer care pathway

The principles[3] underpinning OCCPs are essential to achieving the best cancer care, experience, and outcomes of the person and their whānau. OCCPs put the person and their whānau at the centre of care planning throughout their treatment/care and prompt the health care system to coordinate high-quality care. The person and their whānau are informed and involved in decisions throughout their cancer experience, according to their preferences, needs and values.

Figure 2: Principles of optimal cancer care

[3] Optimal Cancer Care Pathway Principles

Optimal timeframes

Evidence based guidelines, where they exist, are used to inform clinical timeframes. Shorter timeframes for appropriate investigations, consultations and treatment can provide an improved experience for people and their whānau and better cancer outcomes. The three steps shown below are a guide for health providers/professionals and the person and their whānau on the optimal timeframes for being assessed and receiving treatment.

Figure 3: Timeframes for care

Step in pathway	Care point	Timeframes
Step 3: Presentation, initial investigations, and referral	Signs and symptoms	A person presenting with symptoms is promptly assessed by a health professional.
	Initial investigations started by GP	Optimally, investigations should be completed **within 2 weeks.**
	Referral to a hospital specialist	Any of the following indicators requires urgent referral: • severity of cytopenias – neutrophils < 0.5 × 10^9 /L or neutrophils > 0.5 and recurrent infections needing antibiotics • platelets < 30 × 10^9 /L or bleeding symptoms even if platelets are above threshold • symptomatic unexplained anaemia or haemoglobin < 80 g/L.
Step 4: Diagnosis, staging, and treatment planning	Diagnosis and staging	Investigations should be completed **within 2 weeks.**
	Multidisciplinary team meeting and treatment planning	Where appropriate, myelodysplastic syndrome cases are discussed or registered in an MDM, before treatment begins.
		MDM takes place **within 2 weeks** of confirmed diagnosis and staging.
Step 5: Treatment	Systemic anti-cancer therapy or supportive therapies	The person with lower risk disease begins the systemic anti-cancer therapy depending on the clinical presentation and urgency.

	The person with higher risk disease begins the systemic anti-cancer therapy within the first 6 weeks of initial specialist consultation.
	A referral to a bone marrow transplant specialist should occur once transplantation is considered a potential treatment option.
	The person begins supportive therapies depending on the clinical presentation, urgency, and disease progression over time.

Optimal cancer care pathway

Seven steps of the optimal cancer care pathway

Step 1: Wellness

Step 2: Early detection

Step 3: Presentation, initial investigations, and referral

Step 4: Diagnosis, staging, and treatment planning

Step 5: Treatment

Step 6: Care after treatment

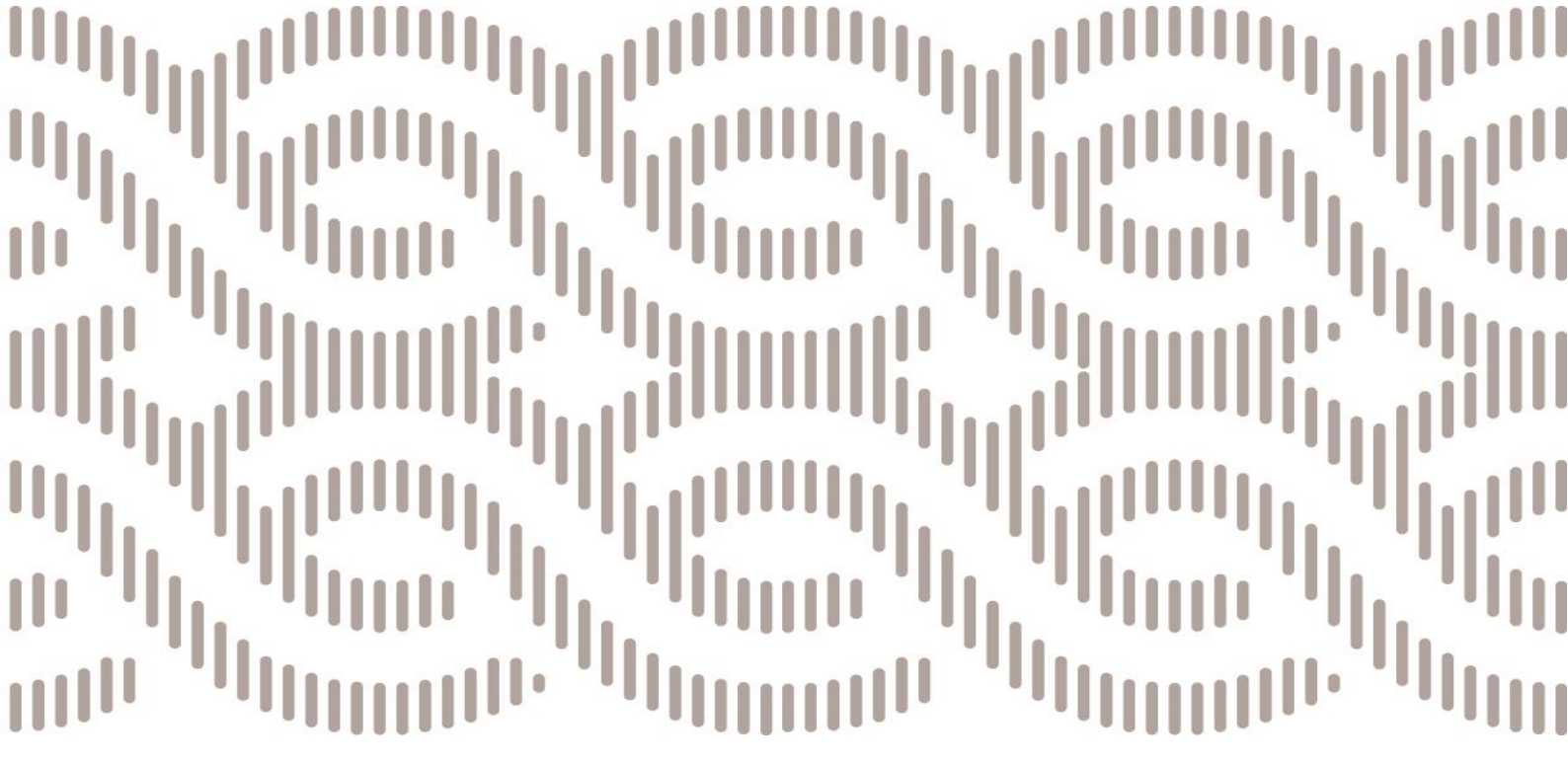
Step 7: Palliative care and end-of-life care

Myelodysplastic Syndrome (MDS) comprises of a heterogenous group of diseases which affect the production of normal blood cells in the bone marrow. Myelodysplastic syndrome is characterised by ineffective haematopoiesis (formation of blood cellular components) leading to low blood levels (cytopenia).

Approximately 30% of myelodysplastic syndrome cases have the potential to progress to acute myeloid leukaemia and therefore can be categorized into lower and higher risk depending on the probability of transforming into acute myeloid leukaemia.

The incidence rate of myelodysplastic syndrome in Aotearoa New Zealand is approximately 2.5 per 100,000 population. Among Māori, the incidence is lower, at 1.9 per 100,000 population.

This pathway covers myelodysplastic syndrome in adults.



Step 1: Wellness

Cancer prevention efforts should be part of all cancer control pathways. This step recommends actions the person/whānau can take to improve their wellbeing and reduce the overall risk of cancer.

Health care providers and services such as primary care, public health units, hospitals and NGOs work collaboratively to prevent cancer (and other conditions) with the person and their whānau and communities. Te Aho o Te Kahu (2022) produced a report outlining evidence-based, best-practice interventions to prevent cancer. Reducing cancer risk factors addresses work to achieve the goals of fewer cancers, better survival, and equity for all.

1.1 Te Tiriti o Waitangi

Health providers/professionals enable and enact Te Tiriti o Waitangi through:

- culturally safe health care providers and practices embedded in all health services and steps of the cancer care pathway
- institutional and personal bias or racism within the health and disability system being acknowledged, identified, and addressed (Harris et al 2012)
- implementation of health and wellness approaches that support ritenga Māori (Māori customary rights) framed by te ao Māori (a Māori world view), enacted through tikanga Māori (Māori customs) and encapsulated with mātauranga Māori (Māori knowledges)
- meaningful partnerships with Māori communities and organisations that benefit Māori
- support and resource health promotion activities co-designed with Māori
- prioritise achieving equity for screening participation rates in national cancer screening programmes (cervical, breast, bowel).

1.2 Modifiable cancer and wellbeing risks

Evidence-based research shows that general cancer and wellbeing risks can be reduced by:

- eating a nutritious diet
- maintaining a healthy weight
- taking regular, moderate to vigorous-intensity activity
- avoiding or limiting alcohol intake
- being sun smart
- identifying pre-disposing infections, such as hepatitis C
- immunisations – for example, HPV
- avoiding smoking including marijuana and exposure to second-hand smoke
    - current smokers (or those who have recently quit) should be offered best practice tobacco dependence treatment and an opt-out referral to an intervention service such as Quitline
- avoiding vaping
- screening services, such as breast, cervical and bowel cancer screening
- preventing occupational exposure to asbestos, silica, radon heavy metal, diesel exhaust and polycyclic aromatic hydrocarbons (Te Aho o Te Kahu 2022).

Most cancer risk factors are not unique to cancer and are shared by other chronic diseases such as diabetes, heart disease and strokes. (Te Aho o Te Kahu 2022).

1.3 Communication with the person/whānau receiving care

Health providers

- Raise and discuss any modifiable risk factors.
- Provide information and education regarding access to wellness programmes, including kaupapa Māori services.
- Discuss advance care planning, advance directive and/or Enduring Power of Attorney (EPA) as required (for more information, see Principle 1).

"Whānau look at prevention holistically."
Person/whānau insights

Communication between health services

- Inform the person and their whānau of any referrals between health care services and wellness programmes.

1.4 Measuring and monitoring

Below is a list of national measures that inform this step and can be used to monitor and measure cancer care.

- **Smoking and vaping rates** (note: these measures apply to every step on the pathway).
    - The number of current smokers (aged 15 years and above) who smoke daily and have smoked more than 100 cigarettes their whole life as measured by the New Zealand Health Survey, by gender and ethnicity.
    - The number of vapers (aged 15 years and above) who have tried vaping and vape at least once a day as measured by the New Zealand Health Survey, by gender and ethnicity.
- **The New Zealand Health survey** (NZHS) provides information about the health and wellbeing of New Zealanders.
    - Health status and behaviours.
    - Risk factors.
    - Access to health care.

Step 2: Early detection

This step outlines recommendations early detection for the person with suspected myelodysplastic syndrome.

2.1 Te Tiriti o Waitangi

Health providers/professionals enable and enact Te Tiriti o Waitangi through:

- making sure early detection of cancer services are provided in culturally appropriate ways that recognise and support the expression of hauora Māori models of care
- providing access to co-designed kaupapa Māori early detection for cancer programmes, where possible (Te Aho o Te Kahu 2022)
- implementing programmes that enhance access to services.

Māori and Pacific peoples often present at an earlier age than the general population, so awareness and consideration of this needs to factor into assessment and review of signs and symptoms.

2.3 Early detection

Early detection has several benefits, including improved survivorship.

People with mild cytopenia can be identified early on by full blood examination. Others may present with symptoms such as fatigue, bruising or recurrent infections. Some people with cytopenia may not meet the criteria for myelodysplastic syndrome and may be categorized as having clonal cytopenia of uncertain significance. The clinical significance of such a diagnosis is uncertain and follow up with the general practitioner (GP), until more severe cytopenia(s) develop, may be appropriate.

2.3 Myelodysplastic syndrome risk factors

- Age – myelodysplastic syndrome affects older people, and 93% of all those diagnosed are over the age of 60.
- Gender – myelodysplastic syndrome is more common in males than females.
- Previous chemotherapy or radiotherapy treatment – chemotherapy treatment using alkylating agents and purine analogues, and radiotherapy may increase the risk of developing secondary myelodysplastic syndrome.
- An inherited predisposition to myelodysplastic syndrome is seen in one-third of children with paediatric myelodysplastic syndrome, including Down syndrome, Fanconi's anaemia and neurofibromatosis. Work-up for such inherited syndromes should be considered when reviewing a young person with myelodysplastic syndrome.

2.4 Communication with the person/whānau receiving care

Health providers/professionals

- Promote health checks.
- Raise and discuss any cancer risk factors.
- Provide information and education regarding early detection.
- Discuss any investigation results and follow up care as required.

- Discuss available supports, such as funding for travel and accommodation, one-stop clinics, community and/or marae-based services (where available), and same-day access to a chest x-ray.

Communication between health services

- Share results and further tests or referrals required with the appropriate service/specialty.

2.5 Measuring and monitoring

Currently there are no national indicators for this step.

Step 3: Presentation, initial investigations, and referral

This step outlines the process for initiation of the right investigations and referral to the appropriate specialist in a timely manner for the person with suspected myelodysplastic syndrome.

The types of investigations undertaken will depend on many factors, including access to diagnostic tests, the availability of medical specialists, and the preferences of the person and their whānau. Community HealthPathways provide a source of relevant detailed information for a myelodysplastic syndrome assessment from a person's primary care presentation and referral to secondary care to specialist services (**Community HealthPathways**).

The Community-referred radiology (CRR) Referral Criteria are criteria to provide nationally consistent access to imaging. The criteria set out a mandatory minimum level of radiology access to help primary care manage imaging in the community. Refer to: **National Community Referral Criteria for Imaging » Radiology**

3.1 Te Tiriti o Waitangi

Health providers/professionals enable and enact Te Tiriti o Waitangi through:

- prioritising Māori with a 'high suspicion of cancer' referral pathway until symptoms are proven otherwise
- engaging with kaupapa Māori services that are equipped to provide holistic Whānau Ora services in the community
- supporting Māori with access to diagnostics, investigations, and referrals through to the appropriate secondary services.

3.2 Signs and symptoms

The person is assessed for signs and symptoms of myelodysplastic syndrome, including any unexplained, persistent signs and symptoms lasting more than three weeks (or earlier in people with known risk factors). The presence of multiple signs and symptoms, particularly in combination with other underlying risk factors, may indicate an increased risk of cancer.

Māori and Pacific peoples often present at an earlier age than the general population, so awareness and consideration of this needs to factor into assessment and review of signs and symptoms.

Most people with myelodysplastic syndrome are asymptomatic with no signs or symptoms other than cytopenia on routine blood testing. The monitoring strategy includes ruling out reversible causes and referral if they persist. Many people with myelodysplastic syndrome have a combination of symptoms. This is because the production of some or all the blood cell types may be affected by the disease.

The following suspicious signs and symptoms of myelodysplastic syndrome include:

- persistent tiredness and fatigue
- weakness
- shortness of breath with minimal exercise
- looking pale

- recurring infections, especially chest infections
- fevers
- sore mouth due to mouth ulcers
- easy bruising
- purpura – a rash of small red dots, seen often on the lower limbs initially, due to small superficial capillary bleeds known as petechiae
- tendency to bleed from the nose and gums.

Signs and symptoms suspicious of cancer that prompt initial investigations may be via primary care, elective care, or an acute admission. Primary care services work with the person and their whānau to assess, investigate, review, and refer to appropriate services within recommended timeframes (see Optimal Timeframe section). These timeframes are indicated by national Faster Cancer Treatment (FCT) high suspicion of cancer pathways and the **FCT** Indicators: Business Rules and Data Definitions.

Timeframe for general practitioner consultation

A person with signs and symptoms that may suggest myelodysplastic syndrome should be promptly assessed by a health professional.

3.3 Assessment

Myelodysplastic syndrome assessment includes relevant:

- medical history, including relevant medications
- physical examination: Eastern Cooperative Oncology Group (ECOG) Performance Status Scale, frailty assessment, weight, pallor, bleeding, or bruising
- laboratory investigations: blood tests to detect abnormalities and exclude other diagnoses – for example: full blood cell count and film review (Sekeres & Cutler 2014), reticulocyte counts, lactate dehydrogenase, autoimmune screen (ANA/ENA), blood group, B12/folate and iron studies, electrolytes, liver function, renal function, blood cell, haemolysis and thyroid function (where clinically appropriate) and serum electrophoresis serologies for chronic viral infections such as hepatitis C, hepatitis B and HIV.
- familial cancer history
- social history.

3.4 Initiate investigations, including referrals

- Any of the following indicators requires urgent referral:
    - severity of cytopenia – neutrophils < 0.5 × 10^9 /L or neutrophils > 0.5 and recurrent infections needing antibiotics
    - platelets < 30 × 10^9 /L or bleeding symptoms even if platelets are above threshold
    - symptomatic unexplained anaemia or haemoglobin < 80 g/L.
- Indicate if there is a high suspicion of cancer and/or it is urgent, and the person needs to be seen **within 2 weeks**.

It is important to consider the person's overall health, including comorbidities and frailty. In certain circumstances if myelodysplastic syndrome is suspected and the person has mild cytopenia and significant comorbidities, they may be safely monitored by the general practitioner.

Timeframe for completing investigations for the person with suspected myelodysplastic syndrome

Optimally, investigations should be completed **within 2 weeks.**

Referral options are clearly communicated with the person and their whānau, including details of expected timeframes, who to contact if they don't hear from the service referred to within the timeframe given, and any costs for accessing services.

When referring a person and their whānau for investigation or procedures, referrers must ensure that:

- the person is aware and encouraged to have a support person with them
- the procedure or investigation is explained to them in a way that they can understand, including in different formats and with a translator, as required
- Māori are referred to kaupapa Māori services if they choose and as available
- an investigation assessment is undertaken to identify if an individual can tolerate the preparation, procedure, or investigation
- assessment and support are given to address any possible barriers of accessing services – for example:
    - transport
    - financial
    - family situation that may impact on the decision to consent to a procedure
    - coordinating appointments and/or offering the person and their whānau, whānau focused bookings.

To support accurate triage, referral information must include the following information:

- signalled as high suspicion of cancer or urgent
- medication and allergies
- past medical history and current comorbidities
- results of relevant investigations
- notification if an interpreter service is required
- concerns that may require support or affect ability to attend appointments, undergo investigations or treatment.

If symptoms are concerning and the referral is not accepted, primary care 'safety netting' for re-assessment is recommended.

3.5 Supportive care and communication

Assess the supportive care needs of the person and their whānau. Where appropriate, give them:

- access to investigations and care following referral, such as financial, transport and personal support
- help to deal with psychological and emotional distress – for example, anxiety, depression, interpersonal concerns, and adjustment difficulties to a potential diagnosis of cancer
- information regarding supportive services that they can engage with at a time suitable to them
- referrals to kaupapa Māori and Whānau Ora services at their request.

"Whānau face multiple barriers to primary care". "That safety net had been taken away."
Person/whānau insights

3.5.1 Communication with the person/whānau receiving care

Health providers/professionals

- Provide information regarding their role in the health care team.

- Explain who the person and their whānau is being referred to, the reason for the referral and the expected timeframes for appointments.
- Explain the need for the person and their whānau to return to the GP if signs and symptoms change while waiting for investigations and/or assessment.
- Request that the person notify the delegated clinic or their own GP practice if the specialist has not been in contact within the expected timeframe.
- Discuss the range of services available (including private), referral options, and any costs associated with accessing these services.
- Inform the person and their whānau that they can contact or request a referral to NGOs that provide supportive care, including local Māori health service providers/professionals.
- Give written and verbal information regarding planned investigations and referral services.
- Clarify that the person and their whānau understands the information that has been communicated.

Communication between health services

- Include relevant information in referrals, as identified in Steps 3.3 and 3.4.
- Notify the referrer of the acceptance of referral and expected timeframes to be seen or decline of referral and reasons for decline.
- Notify changes in referral status (either changes to symptoms or wait time changes).
- Ensure roles and responsibilities are understood, including GP/lead clinician responsible for checking and notifying results to the person and their whānau.
- Acknowledge receipt of referrals.

3.6 Measuring and monitoring

Currently there are no national indicators for this step.

Step 4: Diagnosis, staging and treatment planning

This step outlines the process for confirming the diagnosis and stage of cancer and the planning of subsequent treatment in discussion with the person and their whānau.

Health services work with the person and their whānau to diagnose and stage the cancer, provide treatment options and recommendations, and help meet any identified needs. This generally occurs in secondary or tertiary health care services. Assessment and investigation results, including discussions between the appropriate multidisciplinary team members and the person and their whānau, will help to determine the treatment options and subsequent treatment plan.

4.1 Te Tiriti o Waitangi

Health providers/professionals enable and enact Te Tiriti o Waitangi through:

- prioritising access for Māori to diagnostics, staging, and treatment planning
- supporting the person and their whānau to access holistic care, including mātauranga Māori traditional practices, emotional and spiritual support to complement medical treatment
- talking with the person and their whānau and clinicians about current or intended use of rongoā or other complementary therapies to understand the potential benefits, risks, and other implications
- consultation with the person and their whānau regarding what they would like to happen to any bodily tissue or organs removed as part of their diagnostic workup and treatment.

4.2 Specialist investigations (diagnostic work up for myelodysplastic syndrome)

Where possible the diagnosis of cancer is established or confirmed before treatment is planned. The specialist, either before or after taking a medical history and making a medical examination of the person, may request additional investigations. This may be before or after the first specialist appointment and include:

- **Laboratory:** blood tests to exclude other causes of cytopenia and dysplasia.
- **Pathology:** bone marrow aspirate or trephine (depending on the severity of cytopenia, the person's request, comorbidities, and the need for therapeutic intervention) with investigations including:
    - immunophenotyping
    - cytogenetics and, in some circumstances, FISH studies
    - molecular testing or a myeloid gene panel test for some people.
- **Radiology:** to assess people's health status before treatment starts including:
    - ultrasound
    - computed tomography (CT) scan
    - magnetic resonance imaging (MRI)
    - positron emission tomography (PET)-CT scan (see Health New Zealand | Te Whatu Ora National Indications for Publicly Funded PET-CT).

Timeframe for completing investigations

Diagnostic investigations should be completed **within 2 weeks** of the initial specialist assessment.

4.3 Prognostic assessment

For most cancers, staging is a significant contributor to providing a cancer diagnosis (Te Aho o Te Kahu 2021a). For myelodysplastic syndrome, prognostic assessment, rather than staging, is a critical element in treatment planning and should be clearly documented in the person's medical record.

Prognosis and progression to acute myeloid leukaemia can vary among people with myelodysplastic syndrome depending on the risk of their disease. Based on the diversity of myelodysplastic syndrome subtypes, they are categorised into higher or lower risk. This is determined by prognostic systems commonly based on blast percentage, cytogenetic risk groups and cytopenia, but may also include age, performance status, transfusion needs and other clinical (and increasingly molecular) factors.

Commonly used prognostic scoring systems for myelodysplastic syndrome include:

- the International Prognostic Scoring System (IPSS)
- the Revised IPSS (IPSS-R).

Prognostic systems are evolving; please refer to the most current classification systems.
In this document we define:

- higher risk myelodysplastic syndrome as an IPSS score of intermediate (2 or higher), or an IPSS-R score of high/very high risk
- lower risk myelodysplastic syndrome as low/intermediate (1 in IPSS and very low, low, or intermediate in IPSS-R).

Note that 'intermediate' on IPSS-R can be considered higher risk or lower risk depending on the person's individual circumstances.

As prognostic scoring systems evolve, it is likely that results of molecular testing will also be incorporated into such models.

4.4 Performance status

Performance status is assessed to inform prehabilitation and treatment recommendations and documented using the Eastern Cooperative Oncology Group (ECOG) Performance Status Scale (ECOG-ACRIN Cancer Research Group, nd). The degree of benefit of treatment for an individual may vary according to diagnostic, staging and prognostic factors and performance status.

In older people with cancer, a geriatric assessment measures their level of fitness and treatment tolerability. People over the age of 70 years should undergo some form of geriatric assessment (COSA 2022). Screening tools can be used to identify those who will benefit most from these comprehensive assessments.

Geriatric assessments can help tailor the treatment plan, address any issues found with the multidisciplinary team, and provide interventions to optimise the person's general health status (Seghers et al 2023).

4.5 Multidisciplinary meeting

Optimal cancer care requires a multidisciplinary approach to tailor treatment plans to the person's needs in collaboration with their whānau and the health care team.

Referral to MDM for myelodysplastic syndrome, acute leukaemia or stem cell transplant is undertaken if indicated to inform treatment recommendations, further assessment, or investigations.

MDMs are managed and guided by the following standards:

- ***Standards for High-Quality Multidisciplinary Meetings (MDMs) in Aotearoa New Zealand*** (Te Aho o Te Kahu 2024)
- ***HISO 0038.4:2021 Cancer Multidisciplinary Meeting Data Standard*** (Te Aho o Te Kahu 2021b).

Some people with non-complex myelodysplastic syndrome may not require discussion in a MDM; instead, they may have treatment plan protocols applied if the person's case meets MDM terms of reference criteria.

4.5.1 Treatment options and recommendation

Following MDM, treatment options including intent, referral options and recommendations are discussed with the person and their whānau to enable informed decision making in accordance with their rights and ability to exercise independence, choice, and control. The advantages and disadvantages of recommended treatments and associated potential side effects are discussed in plain language with interpreter support as required. Other support may be required for this discussion such as kaumātua/kuia, chaplain and nursing staff as required.

Further discussion between health services (primary care and specialists) and the person and their whānau will ensure comorbidities are well managed. This optimises the person's health to be able to cope with the proposed cancer treatment and its effects.

4.5.2 Fertility preservation

Myelodysplastic syndrome mostly affects older adults, with about 75% aged 60 years and over. However myelodysplastic syndrome can also affect children and young adults and if the case, those in the reproductive age group should be assessed by fertility preservation services before commencing treatment.

The need for ongoing age-appropriate contraception applies to both men and women.

4.5.3 Prehabilitation

Prehabilitation is the process of optimising a person's overall wellbeing prior to undergoing cancer treatment. Ideally, prehabilitation should begin as early as possible after a cancer diagnosis to allow adequate time for interventions to take effect. In haematological malignancies, the urgency of starting treatment in certain cases, such as aggressive or rapidly progressing conditions, may limit the opportunity to implement these measures. When circumstances allow, prehabilitation should still be considered to enhance the person's ability to tolerate intensive treatment. This is particularly beneficial for those undergoing haematopoietic stem cell transplantation. Prehabilitation is initiated and assessed by primary or hospital services and may require referral to additional services for example:

- conducting a physical and psychological assessment to establish a baseline level of function
- identifying impairments and providing targeted interventions to improve the person's functional level
- smoking cessation
- education support for medications to ensure optimisation and correct adherence
- rongoā
- psychosocial support
- physiotherapy or exercise programme – aerobic, respiratory training, resistance training for the person to function at a higher level
- nutrition.

4.5.4 Clinical trials

Where eligible, the person with cancer is offered and supported to participate in research or clinical trials. Many emerging treatments are only available as clinical trials and may require referral to specific trial centres.

4.6 Supportive care and communication

4.6.1 Care coordination

Care coordination supports the navigation through diagnosis, staging, and treatment planning. The person and their whānau receive tailored education and are enabled to ask questions, seek further clarity around treatment options and recommendations, and gain support around the potential next steps in the pathway.

The care coordinator will assist in the coordination and navigation of care, support the person and their whānau, and complete any additional referrals that may be required.

People and their whānau who have someone coordinating their care are often more satisfied with the opportunities provided to them and the decision-making process about their care (Cancer Institute NSW 2010).

The person and their whānau will have a clear understanding of what to expect at each step of the cancer pathway, with a clear point of contact should they require support or further information (refer Principle 6).

4.6.2 Supportive Care

Assess the supportive care needs of the person and their whānau, including:

- care coordinator is in place
- prehabilitation
- contraception and fertility support
- early referral to palliative care
- information and education needs are met (refer Step 3.5).

4.6.3 Communicating with the person/whānau receiving care

Health providers/professionals

- Ensure that person and their whānau have the option to have additional support people with them when having discussions.
- Explain and discuss with person's diagnosis, staging and treatment options and recommendations in plain language.
- Discuss the advantages and disadvantages of treatment options and associated potential side effects.

- Provide information, education support and resources in a format that is useful to the person and their whānau (and that they can share with others as they wish).
- Identify any barriers or challenges that may prevent the person and their whānau from accessing services or attending treatment.
- Discuss with the person and their whānau ways to improve health outcomes and wellbeing prior to and during treatment.
- Advise the person and their whānau of their lead clinician and care coordinator.
- Clarify that the person and their whānau have understood the information that has been communicated.
- The person and their whānau may require time to process the information that has been relayed, prior to consenting to treatment.
- Coordinate scheduling of appointments with the person and their whānau to ensure access barriers are minimised and attendance is supported.
- Discuss with the person and their whānau the need to update or complete their advance care planning and/or advance directive.

"A lot of people need to travel hours to get to an appointment and don't have vehicles or family support."
Person/whānau insights

Communicating between health services

- Coordinate appointments among health services, in discussion with the person and their whānau to make best use of their time and resources and to support access.
- Communicate the diagnosis, MDM recommendations and treatment plan between health services.
- Discuss and agree shared care arrangements, in symptom and co-morbidity management, supportive care and referral to local services.
- Confirm the lead clinician and provide handover details, as necessary.

4.7 Measuring and monitoring

Below is a list of national measure that can inform this step and used to monitor and measure cancer care.

- **MDM Standards**

For audit compliance with standards and standards audit tool the following may be used:

  - ***Standards for High-Quality Multidisciplinary Meetings (MDMs) in Aotearoa New Zealand*** (Te Aho o Te Kahu 2024)
  - ***HISO 0038.4:2021 Cancer Multidisciplinary Meeting Data Standard*** (Te Aho o Te Kahu 2021b).

Step 5: Treatment

This step describes publicly funded optimal treatments for myelodysplastic syndrome by trained and experienced clinicians and team members, in an appropriate environment.

The treatment of myelodysplastic syndrome is informed by the following guidelines:

- European Society of Medical Oncology: *Myelodysplastic syndromes ESMO clinical practice guidelines for diagnosis, treatment and follow up* **esmo-clinical-practice-guidelines-haematological-malignancies**
- American Society for Transplantation and Cellular Therapy (ASTCT) practice guidelines **astct-publications**
- European Society for Blood and Marrow Transplantation (EMBT) handbook **ebmt-handbook**

5.1 Te Tiriti o Waitangi

Health providers/professionals enable and enact Te Tiriti o Waitangi through ensuring that:

- services achieve equity of access and outcomes irrespective of where treatment occurs
- equity in access to treatment is facilitated through active and coordinated support of financial and social barriers to treatment
- tikanga Māori and rongoā is integrated and applied in discussion with treating clinicians
- a referral to the Kia Ora E Te Iwi (KOETI) programme (Cancer Society) occurs as required
- the person and their whānau have all the information and resources to support their mana motuhake (empowerment).

5.2 Treatment intent

The treatment intent should be clearly documented in the person's medical record and shared with the person and their whānau as appropriate. Discuss the advantages and disadvantages of recommended treatments and associated side effects in plain language to support the person and their whānau to make an informed decision. If there is more than one suitable treatment option, services could facilitate the decision making of the person and their whānau by having all specialties involved in a single appointment.

Timeframes for starting treatment are informed by evidence-based guidelines where available. The treatment team recognises that shorter timeframes for appropriate consultations and treatment often provide a better experience for people. Initiate advance care planning discussions with the person and their whānau before treatment begins (this could include appointing a substitute decision-maker and completing an advance care directive).

Confirm decisions, and consent for treatment. If treatment is agreed, develop a treatment care plan that includes:

- what the treatment and intent is, alongside likely impacts
- ways to improve health outcomes and wellbeing during treatment, this includes where they can receive support and information
- expected timeframes.

5.2.1 Additional considerations

Undertake a needs assessment and address any possible barriers or challenges (such as financial, social, care coordination and cultural obligations) that may prevent the person and their whānau from accessing treatment. Formally involving the palliative care team/service early can benefit the person receiving care, so it is important to know and respect each person's preference.

The person's current or intended use of any traditional or complementary therapies, including rongoā, will need to be discussed. Information resources should be provided so the person and their whānau can review and take these away for further reflection and sharing, including contact information for services and key care coordinators.

If initial treatment is declined, discuss next steps fully with the person and their whānau. This includes the option to re-engage with initial treatment if they change their minds, with the understanding it may no longer be viable and/or suitable.

Ensure prehabilitation is underway (as appropriate) to optimise treatment outcomes, and manage any comorbidities, prior to treatment. Depending on the treatment decided, additional prehabilitation activities may need to be initiated.

Ensure an escalation plan with key contact people is developed if the person becomes unwell before treatment begins.

5.3 Treatment options

The type of treatment recommended for myelodysplastic syndrome depends on the disease factors (such as: risk scores, cytopenia, symptoms), the likelihood of haemopoietic stem cell transplant (HSCT) being required, the person's age, health, and preferences. Treatment may include a combination of the items listed below, concurrently, or sequentially, to maximise outcome.

People with myelodysplastic syndrome may receive supportive care including education, active surveillance and monitoring, transfusions as appropriate and prompt infection control. Those with lower risk myelodysplastic syndrome who are not on any active intervention may be suitable for monitoring and surveillance with their general practitioner.

The range of disease-specific/directed additional treatment options varies across different risk groups depending on age and comorbidities. Options include:

- chemotherapy – low dose or more intensive
- haemopoietic stem cell transplant
- transfusion support
- supportive interventions such as Granulocyte Colony-Stimulating Factor (GCSF) or Endogenous Erythropoietin (EPO) in some people
- other specific agents depending on the person's clinical presentation or karyotype. The funding status of various treatment approaches is dynamic. Prescribers should ensure familiarity with eligibility criteria and discuss any financial implications of all treatment recommendations with the person/whānau before starting treatment.

The person may also be supported to participate in research or clinical trials where available and appropriate. Many emerging treatments are only available as clinical trials and may require referral to specific trial centres.

- **Observation -** (e.g., watchful waiting) – the person that may benefit from observation including those:
    - with mild cytopenia and/or
    - having a very indolent type of myelodysplastic syndrome.

They may be monitored in the community via their primary healthcare providers.

- **Systemic anti-cancer therapy –** may be indicated for people with lower or higher risk myelodysplastic syndrome.

For people suitable for systemic anti-cancer therapy (SACT) please refer to The Model of Care for Adult Systemic Anti-Cancer Therapy Services in Aotearoa (Te Aho o Te Kahu 2024).

In people with lower risk myelodysplastic syndrome, anaemia is the most common cytopenia. Erythropoiesis-stimulating agents may be used as first line therapy. Available treatment options include:

- immunomodulatory drugs (ImiD)
- hypomethylating agents (HMAs)
- immunosuppressive therapy to provide some hematological response among selected people.

In people with higher risk myelodysplastic syndrome, if appropriate, standard therapy include:

- Hypomethylating agents (HMAs). Treatment is usually continued for at least 6 months and continued based on response, though dose reductions or delays may be required in some patients
- Acute myeloid leukaemia induction chemotherapy. This can be considered in those with a high blast count and who are eligible for intensive therapy
- haematopoietic stem cell transplantation close to the time of diagnosis, depending on the patient's goals of therapy. Consider proceeding to transplantation soon after an optimal donor is located
- in the interim period before transplantation, HMA therapy, acute myeloid leukaemia induction chemotherapy or enrolment in a clinical trial should be considered to prevent disease progression, although the optimal pre-transplantation therapy is unknown.

Timeframes for starting treatment

For people with lower risk disease, the timeframe for staring treatment should be guided by clinical presentation and urgency.

For people with symptomatic higher risk disease, a decision about disease-specific therapy should be made and treatment begun **within the first 6 weeks** of initial specialist consultation. At times, depending on disease stability and symptoms, ongoing close monitoring could be considered depending on the person's circumstances.

- **Allogeneic stem cell transplant (Allo-SCT) –** may be indicated as per American Society for Transplantation and Cellular Therapy (ASTCT) guidelines and European Society for Blood and Marrow Transplantation (EMBT) handbook.

For people suitable for allogeneic stem cell transplant (AlloSCT) please refer to The Model of Care for Transplant & Cellular Therapy Services in Aotearoa (Te Aho o Te Kahu 2024).

In this procedure, the person receives blood-forming cells (stem cells) from a healthy donor (related or unrelated) to replace their own stem cells following chemotherapy and, in some cases, radiation.

People with myelodysplastic syndrome may have additional supportive care requirements to address the immunosuppressive effects and long-term side effects of stem cell transplantation. Issues may include infertility, graft-versus-host disease (GVHD), increased risk of infection, iron overload or anaemia, bleeding, mouth ulcers and fatigue.

Timeframes for starting treatment

A referral to a bone marrow transplant specialist should occur once transplantation is a potential treatment option.

Early referral to a transplant specialist is recommended for people under 70 years of age and with higher risk myelodysplastic syndrome. Age-specific frailty scores and performance status should be considered for such a referral rather than an absolute age cut-off.

- **Supportive therapies –** all people with myelodysplastic syndrome will require supportive therapies. Supportive therapies may be the only long-term treatment required for those with lower risk disease, or for older and/or unfit people plus those who have not responded to other treatments.

Supportive therapy may include the following:

  - conduct regular blood tests and review appointments with the person's general practitioner and specialist to monitor progress and symptoms
  - manage anaemia, including red blood cell transfusions – frequency will be determined by symptoms and comorbidities
  - manage bleeding, which may include platelet transfusions or tranexamic acid when indicated
  - manage infections – prompt antibiotics for infection and consideration of short-term use of growth factors (e.g., GCSF). Infectious disease consultation may be required if infections recur. Anti-fungal prophylaxis may be considered in people with persistent severe neutropenia depending on local guidelines and practice
  - consider iron chelation therapy for transfusional iron overload. In general, this is considered for people with significant transfusion burden and evidence for iron overload. Although both oral and parenteral chelation therapy options are available, oral iron chelators are not funded by PHARMAC, since they have not been shown to give an overall survival advantage
  - manage gastrointestinal symptoms such as nausea, vomiting, loss of appetite, dysgeusia, diarrhoea or constipation as a result of treatment. This
  - requires optimal symptom control with medicine, nutritional advice, analgesia, and mouth care (referral to a dietitian may be required if dietary intake is affected).

Timeframes for starting treatment

The timeframe for starting treatment should be guided by clinical presentation, urgency, and disease progression over time.

- **Emerging Therapies**

Examples of non-chemotherapy approaches include therapy targeting marrow microenvironment and immune checkpoints.

Combinations of HMAs, especially with immune checkpoint inhibitors, have shown promising signals in both the frontline and HMA-refractory setting.

- **Surgery –** has a very limited role. The person that may benefit from surgery including those who require incision and drainage of soft tissue infections/abscesses occasionally.
- **Palliative Care**

Palliative care is an integral part of cancer treatment and care. It offers specific assessments, supportive care programmes, and services focused on living with and dying from cancer. Early referral and access to palliative care is a critical aspect of best practice. The person and their whānau who cannot be offered curative treatment, or declines curative treatment, as well as those with a significant symptom burden, should be offered prompt access to palliative care services.

Treatment includes managing the impact of cancer therapy, including the management of physical symptoms, distress, and other clinical issues a person and their whānau may experience.

Early referral to palliative care and other health services is recommended to help manage:

- side effects resulting from treatments
- nutritional support
- sexual dysfunction
- peripheral neuropathy
- fatigue.

5.3.1 Clinical Trials

The person is supported to participate in research or clinical trials where available and appropriate. Many emerging treatments are only available as clinical trials and may require referral to certain trial centers (refer principle 8).

Participation in clinical trials, patient registries, and tissue banking, where available, is encouraged for people with myelodysplastic syndrome. Cross-referral between clinical trial centres should be encouraged to facilitate participation.

5.4 Treatment summary

A treatment summary will be provided by the treating service to the person and their whānau and clinicians (including primary care) involved in their follow up care. The summary includes:

- relevant diagnostic tests performed and results
- cancer diagnosis, characteristics, stage, and prognosis
- treatment received
- current toxicities (severity, management and expected outcomes)
- interventions and treatment plans from other health providers/professionals
- potential long-term and late effects of treatment
- supportive care services provided
- recommended follow up and surveillance.

5.5 Supportive care and communication

Supportive care needs for the person and their whānau are assessed for all cancer treatment modalities, including surgery, chemotherapy, radiation, and palliative care.

The challenges and changes in health status that may arise for the person and their whānau due to their treatment, including:

- access to expert health providers/professionals with specific knowledge about the psychosocial needs of people undergoing myelodysplastic syndrome care
- potential isolation from normal support networks, particularly for rural people who are staying away from home for treatment
- general health care issues (such as smoking cessation and sleep disturbance), which can be referred to a general practitioner
- altered cognitive function due to chemotherapy or radiation therapy, which requires strategies such as maintaining written notes or a diary and repetition of information
- loss of fertility, sexual dysfunction or other symptoms associated with treatment or surgically or chemically induced menopause, which requires sensitive discussion and possible referral to a clinician skilled in this area
- decline in mobility or functional status
- management of physical symptoms such as pain, arthralgia, and fatigue
- early management for acute pain postoperatively to avoid chronic pain
- side effects of chemotherapy such as neuropathy, cardiac dysfunction, nausea, and vomiting – managing these side effects is important in protecting the person's quality of life
- managing complex medication regimens, multiple medications, assessment of side effects and assistance with difficulties swallowing medications – referral to a pharmacist may be required
- weight changes – may require referral to a dietitian before, during and after treatment
- hair loss and changes in physical appearance – referral to Look Good Feel Better
- assistance with beginning or resuming regular exercise – referral to an exercise physiologist or physiotherapist.

The person and their whānau may also need to manage:

- financial issues related to loss of income (through reduced capacity to work or loss of work) and additional expenses as a result of illness or treatment
- advance care planning, which may involve appointing a substitute decision-maker and completing an advance care directive
- legal issues (completing a will, care of dependent children) or making an insurance, superannuation or social security claim based on a terminal illness or permanent disability.

5.5.1 Care coordination

Care coordination will support the person and their whānau through treatment. The care coordinator supports the implementation and activation of supportive care needs through the provision of information, education and referral regarding the concerns and issues that have been raised by the person and their whānau (refer Principle 5).

5.5.2 Communication with the person/whānau receiving care

Health providers/professionals

- Confirm lead clinician and other treatment teams/members involved in care.
- Advise the person and their whānau of the expected timeframes for treatment and ensure they have a key contact person.
- Clarify that the person and their whānau understand the information that has been communicated.
- Refer the person to supportive care and other health care services to optimise wellbeing.

Communication between health services

- Confirm the lead clinician and handover as necessary.
- Confirm the diagnosis, treatment intent, recommendations, and plan, including potential side effects.
- Communicate supportive, treatment plan and referrals between health services.
- Advise of any enrolment in clinical trial as appropriate.
- Advise of changes in treatment or medications.

"A whānau need to have a choice of services including rongoā, mirimiri etc. and know how to access tohunga, particularly for whānau who may be disconnected from te ao Māori"
Person/whānau insights

5.6 Measuring and monitoring

Monitoring and measuring are key components of contemporary best practice. Below is a list of national measures that inform this step and can be used to monitor and measure cancer care.

- **Haematology treatment timeframe**
  - Category A - urgent within 48 hours
  - Category B – semi-urgent within 2 weeks
  - Category C – routine within 4 weeks
- **Medical oncology treatment timeframes**
  - Category A – urgent within 48 hours
  - Category B – semi-urgent within 2 weeks
  - Category C – routine within 4 weeks
  - Category D – combined modality treatment (determined by scheduling of the two treatment modalities).

Step 6: Care after treatment

The person accesses appropriate follow up and surveillance and is supported to achieve their optimal health after cancer treatment.

The transition from active treatment to care after treatment is critical to supporting long-term health. Survivorship care planning is the umbrella term for care described in this step, and whilst aspects of this care begin at diagnosis (prehabilitation, supportive care, etc) the term itself is not often used until this part of the pathway.

In some cases, people will need ongoing specialist care, and in other cases a shared follow up care arrangement with their general practitioner may be appropriate. This will be informed by the type and stage of a person's cancer, the treatment they have received and the needs of the person and their whānau (refer Principle 5).

The following references inform care after treatment for the person with myelodysplastic syndrome:

- European Society of Medical Oncology: *Myelodysplastic syndromes ESMO clinical practice guidelines for diagnosis, treatment and follow up* **esmo-clinical-practice-guidelines-haematological-malignancies**

6.1 Te Tiriti o Waitangi

Health providers/professionals enable and enact Te Tiriti o Waitangi through:

- offering options for holistic recovery and wellness care within hauora Māori models of care
- providing access to clinical, psychological, social, financial, and cultural support to transition back into recovery and life after cancer treatment.
- offering options for holistic recovery and wellness care within hauora Māori models of care
- provide access to clinical, psychological, social financial and cultural support to transition back into recovery and life after cancer treatment.

6.2 Survivorship care planning

After completing initial treatment, a designated member of the multidisciplinary team (most commonly nursing or medical staff involved in the person's care) should undertake survivorship care planning with the person and their whānau.

The survivorship care plan should cover, but is not limited to:

- the provision of a treatment summary
- information on what medical follow up and surveillance is planned
- how care after treatment will be provided, including by whom and where, and contact information
- inclusion of care plans from other health providers to manage the consequences of cancer and cancer treatment
- information about wellbeing and primary and secondary prevention health recommendations that align with chronic disease management principles (Step 1)
- rehabilitation recommendations and any referrals
- available support services, including cancer NGO survivorship programmes/services (these may be tumour specific)

- signs and symptoms to be aware of that may indicate the cancer has recurred/relapsed
- the process for rapid re-entry to specialist medical services.

As people are often followed up for five or more years after treatment, this plan needs to be regularly reviewed and updated to reflect changes in the person's clinical and psychosocial status. All health providers involved in the follow up care are responsible for updating the care plan.

6.3 Treatment summary

A treatment summary will be provided by the treating service(s) to the person and their whānau and to those clinicians involved in follow up care.

The summary includes:

- the diagnostic tests performed and results
- cancer diagnosis, characteristics, stage, and prognosis
- treatment received (types and dates)
- current toxicities (severity, management and expected outcomes), including who to contact should they have any concerns about these
- interventions and treatment plans from other health providers
- potential long-term and late effects of treatment.

6.4 Rehabilitation and recovery

Rehabilitation may be required at any point in the care pathway. Issues that may need to be dealt with at this stage include managing cancer-related fatigue, coping with cognitive or physical changes, returning to study or work, and ongoing adjustment to cancer and its sequelae.

For people with myelodysplastic syndrome, assessment for referral to the following rehabilitation or recovery services should be undertaken.

- Blood and Leukaemia Foundation.
- Psychological cancer services.

6.5 Follow up and surveillance

Follow up and surveillance can have multiple functions, including:

- evaluation of treatment response
- early identification of recurrence/relapse
- early detection of new primary tumours
- monitoring and management of complications
- optimisation of rehabilitation
- provision of support to the person and their whānau.

Care after treatment is driven by predicted risks and an individuals' clinical and supportive care needs.

Care includes regular physical examinations and medical tests and is based on the medical guidelines for the specific type and stage of cancer, the treatment that's been received, and the needs and wishes of the person and their whānau.

Planning needs for follow up and surveillance include:

- who will be providing follow up care for example, their specialists, their primary care provider (including palliative care) or if there will be a shared care approach (see Principle 1). Generally, people will have at least one clinic visit with the specialist(s) involved in a person's treatment and care to date
- what tests (such as blood or radiological tests) need to be carried out, who is responsible for ordering them, how frequently they need to be done, and who will discuss the results with the person and their whānau
- the frequency people should be seen and for what timeframe
- follow-up appointments are more frequent initially, becoming less frequent as time goes on
- who the person and/or their whānau should contact if they have any concerns.

Note that for some people follow-up appointments are reassuring; however, for others this may be anxiety-inducing.

6.6 Signs and symptoms of recurrent, relapsed, or progressive disease

Myelodysplastic syndrome is generally considered incurable, except for those who have a successful allogeneic stem cell transplant. Many people who relapse after initial therapy have worsening symptoms, transfusion dependence and/or progress to acute myeloid leukaemia. Some people will have relapsed or progressive disease on initial presentation, while others may present with symptoms of refractory or progressive disease after a previous myelodysplastic syndrome diagnosis.

Educating the person and their whānau about potential symptoms of recurrence or relapse is critical for timely management.

Myelodysplastic syndrome signs and symptoms that necessitate further investigation include:

- progressive cytopenia and presence of or increasing blasts on the blood film
- progressive fatigue
- bleeding and bruising
- recurrent infections
- increasing transfusion dependence.

6.6.1 Rapid re-entry to specialty services

Service providers will have a process for rapid re-entry to specialty services for suspected recurrence and advise people and their whānau of how to do this if required.

6.7 Clinical trials

Where eligible, the person with cancer is offered and supported to participate in research or clinical trials. These might include studies to understand survivor's issues, to better manage treatment side effects, or to improve models of care and quality of life.

6.8 Supportive care, care coordination and communication

As the person and their whānau transition from active treatment, their needs often change, and health providers need to support people and their whānau to cope with life beyond their active treatment (refer Principles 5, 6 and 7).

Health providers work with people and their whānau to assess and address their needs, including:

"The need for care doesn't stop when treatment finishes."
"Whānau feel forgotten when treatment ends."
Person/whānau insights

Supportive care

Health providers undertake a needs assessment to inform the survivorship care plan and make appropriate referrals.

Coordinated care

Follow up care is provided closer to home and appointments coordinated to make access easier for the person and their whānau, where possible.

Continuity of care is provided where possible and appropriate – for example, people and their whānau should have the ability to continue to be supported by members of the care coordination team who they have developed a relationship with during their journey.

Effective and timely communication

The person and their whānau are provided with a copy of their survivorship care plan, including information on any referrals that have been made.

Health providers involved in the follow up care of an individual have access to the up-to-date care plan, especially if primary care is involved, and can update the plan as required.

6.9 Measuring and monitoring

Currently there are no national indicators for this step.

Step 7: Palliative and end-of-life care

Palliative and end-of-life care provides the person facing life-limiting conditions with holistic support and coordinated services based on their specific needs.

Palliative and end-of-life care is an essential health service to optimise the person's quality of life until they die. This involves supporting the person's physical, psychosocial, spiritual, and cultural needs, and supporting their whānau with bereavement support. It is appropriate at any stage in a serious illness.

> **"You matter because you are you. You matter to the last moment of your life, and we will do all we can to help you not only die peacefully, but also to live until you die."**
>
> Dame Cecily Saunders

7.1 Te Tiriti o Waitangi

Health providers/professionals enable and enact Te Tiriti o Waitangi through ensuring that:

- the person and their whānau have the choice to access Kaupapa Māori support services for living with cancer (stable, progressive or end-stage)
- rurality does not restrict access to critical clinical, social, cultural and resource support for the person and their whānau
- palliative and end-of-life care is integrated across health services.

7.2 Palliative care

Palliative care prevents and relieves suffering through the early identification, correct assessment and treatment of pain and other symptoms, whether physical, psychosocial, or spiritual, and improves the quality of life (World Health Organisation 2020).

Palliative care should be provided by all health professionals. Palliative care uses a team approach with non-specialist services (primary care, community care and primary/generalist hospital services) supported by specialist palliative care services (hospitals, hospices). Palliative care services must be integrated with primary, community and secondary care, responsive and locally appropriate.

In many cases the whānau are the primary caregivers, and it is the responsibility of health providers/professionals to support the whānau. Health and social service providers/professionals will work together to ensure that the care for the person and their whānau is seamless, and that resources are used efficiently and effectively.

Primary, secondary, and palliative care services work alongside the person and their whānau to decide an appropriate place of care and the support required to implement the advance care plan.

Palliative care is provided in different settings, depending on availability and the needs and preferences of the person and their whānau. Settings include:

- in the community/a person's own home
- aged residential care
- hospice care
- hospital care.

Palliative care is most effective when considered early in the course of an illness. Early palliative care not only improves quality of life for the person and their whānau but also reduces unnecessary hospitalisations and use of health care services.

Referral to specialist palliative care services will be appropriate for those with a level of need that exceeds the resources of the primary/generalist palliative care provider. Referral criteria for adult palliative care services in New Zealand are available on the **Ministry of Health |Manatū Hauora website**.

Clinical trials may improve palliative care and support the management of a person's symptoms of advanced cancer (Cancer Council Australia, nd; Cancer Council Victoria, nd). The treatment team should support the person and their whānau to participate in research and clinical trials where available and appropriate.

7.3 End-of-life care

The person with advanced cancer may reach a time when active treatment is no longer appropriate, symptoms are increasing, and functional status is declining. Dying is a normal part of every person's life course and every person has the right to die well.

Te Ara Whakapiri: Principles and guidance for the last days of life (Ministry of Health | Manatū Hauora 2017b) defines the essential components (baseline assessment, ongoing assessment, after-death care) and considerations required to provide quality end-of-life care for adults. This covers all care settings, including the home, residential care, hospitals, and hospices.

The multidisciplinary team needs to share the principles of a palliative approach to care when making end-of-life decisions with the person and their whānau. Honest communication is essential to ensure they have time to prepare and appropriate support is in place.

If the person does not already have an advance care plan or advance directive in place, a designated member of the team should encourage them to develop one in collaboration with their whānau.

It is essential for the treatment team to consider the appropriate place of care, the person's preferred place of death, and the support needed for the person and their whānau.

The treatment team should also ensure that whānau receive the information, support, and guidance about their role according to their needs and wishes.

7.4 Assisted dying

The person requesting assisted dying information are supported to access this service. Health providers/professionals are required to be aware of their rights and responsibilities regarding assisted dying services, should the person raise this with the health care team. For more information visit **regulation-health-and-disability-system/assisted-dying-service.**

7.5 Supportive care and communication

An essential component of palliative and end-of-life care is assessing and ensuring the needs of the person and their whānau are met. A number of supportive care needs may arise, including:

- assistance for dealing with emotional and psychological distress from grief and fear of death and dying

- specific support for the person and their whānau where a parent is dying and will leave behind bereaved children or adolescents
- facilitating conversations with the person and their whānau regarding an advance care plan, an advance directive and appointing an EPA
- access to appropriate equipment
- supporting whānau with carer training
- information and education around 'What to expect when someone is dying'
- identifying a key contact person.

7.5.1 Care coordination

Palliative care services must be integrated, responsive and well-coordinated. The person receiving palliative/supportive and end-of-life care may require several different types of care from different services and/or providers. The primary care team/palliative care team assists in coordinating care with the wider health care team. It is important that the different providers and services are aware of and responsive to the various facets of care that the person and their whānau require.

7.5.2 Communicating with the person/whānau receiving care

Health providers/professionals

- Encourage the person and their whānau to designate a lead person(s) to communicate with care providers.
- Encourage discussions about the expected disease course, considering personal and cultural beliefs and expectations.
- Discuss shared goals of care.
- Discuss palliative care options, including community-based services as well as dying at home.
- Empower the person and their whānau to determine the care that they may want to provide, with or without support services.
- Refer the person to palliative care in the community according to their wishes.
- Discuss supportive care options available.

"The difference in his wellbeing after rongoā was huge. He was still dying, but he didn't look sick anymore."
Person/whānau insights

7.5.3 Communicating between health services

Clear communication between all providers/professionals involved in coordinating care is essential. This includes:

- confirming the lead clinician and handover as necessary
- providing updates on the person's prognosis
- initiating supportive and palliative care referrals
- advising on end-of-life care planning.

"Palliative care is a tapu space and requires a careful, holistic approach."
Person/whānau insights

7.5.4 Palliative care and end of life key national guidelines

- *Advance care planning.* (Te Tahu Hauora | Health Quality & Safety Commission New Zealand. 2022.) **hqsc.govt.nz.**
- *A Guide For Carers. (***Hospice New Zealand** 2019).
- *Mauri Mate: A Māori palliative care framework* (**Hospice New Zealand**.2019).

- *Te Ara Whakapiri: Principles and guidance for the last days of life* (**Ministry of Health** | Manatū Hauora 2017b).
- *The Palliative Care Handbook* (**Hospice New Zealand** 2019b).
- *Information on assisted dying for the public* (**Health New Zealand** | Te Whatu Ora, nd).

7.6 Measuring and monitoring

- ***Ngā Paerewa Pairuri Tāngata | Standards for Palliative Care*** (Hospice New Zealand 2019a)
    - Standard 1: Assessment of needs
    - Standard 2: Developing the care plan
    - Standard 3: Providing the care
    - Standard 4: Supporting and caring for the family, whānau and carers
    - Standard 5: Transitions within and between services
    - Standard 6: Grief support and bereavement care
    - Standard 7: Culture of the organisation
    - Standard 8: Quality improvement and research
    - Standard 9: Staff qualification and training

- **National palliative care outcomes and reporting framework** (under development)