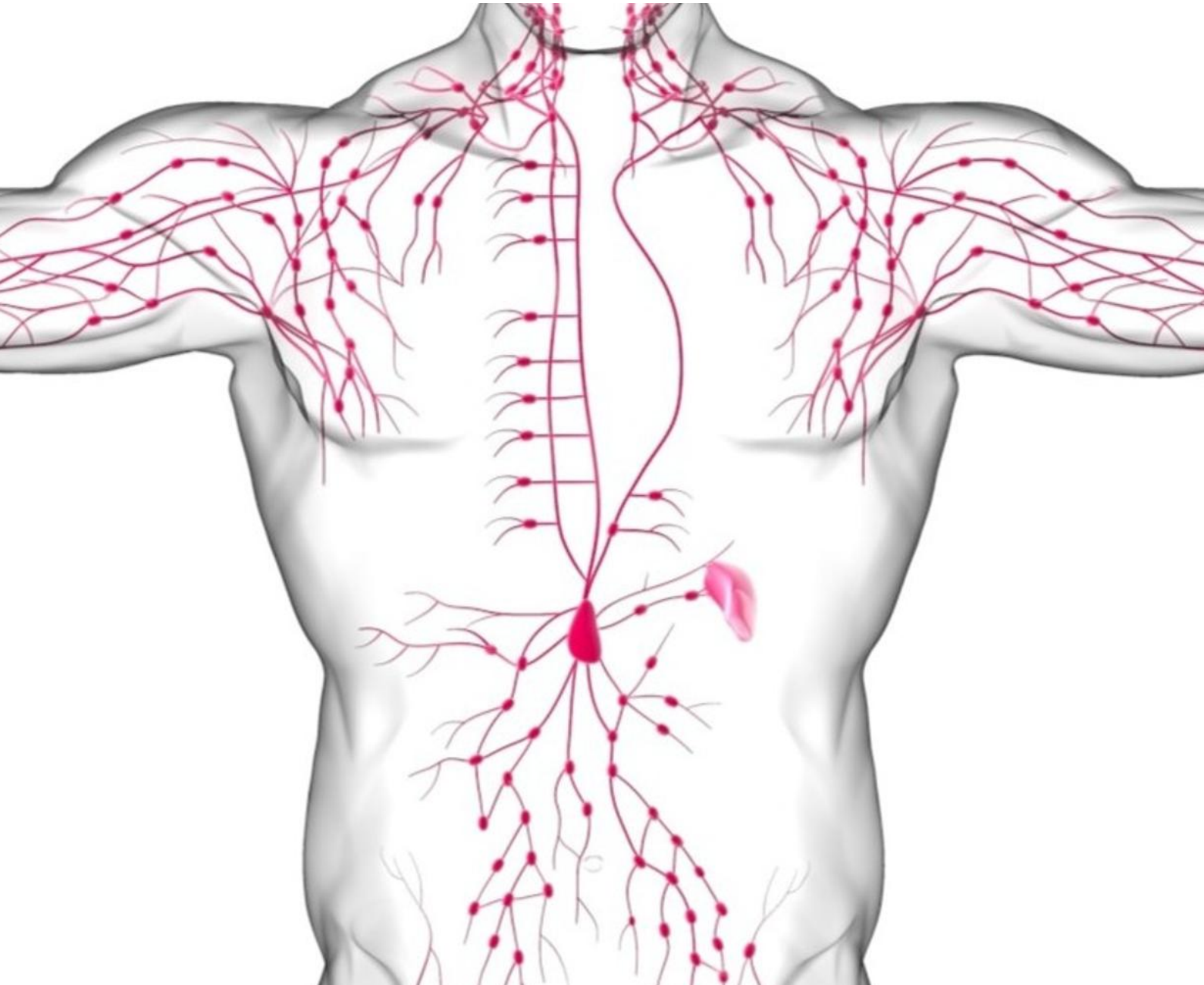
NNHLA
National Non-Hodgkin Lymphoma Audit

NATCAN
National Cancer Audit Collaborating Centre

National Non-Hodgkin Lymphoma Audit
State of the Nation
Patient and Public Report 2026

An audit of care received by people diagnosed with non-Hodgkin lymphoma from 1 January 2023 and 31 December 2023 in England and 1 January 2024 and 31 December 2024 in Wales.

Published September 2026



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The British Society for Haematology (BSH) is the professional body for haematologists. It is one of the key partners of the Audit. Registered Charity no. 1005735.

The Royal College of Radiologists is the professional body for clinical radiologists and clinical oncologists. It is one of the key partners of the Audit. Registered Charity no: 211540.

This work uses data that has been provided by patients and collected by the NHS as part of their care and support. For patients diagnosed in England, the data is collated, maintained and quality assured by the National Disease Registration Service (NDRS), which is part of NHS England. Access to the data was facilitated by the NHS England Data Access Request Service.

NHS Wales recently implemented Cancer Dataset Forms with the latest implementation date being January 2025. These have been designed to improve the data capture and reporting capabilities of NHS Wales. This implementation has impacted the data quality within NHS Wales. NHS Wales has committed to continue to submit audit data annually until data submissions are sourced exclusively from the new cancer informatics solution. This will be from 2027 onwards that NHS Wales will be able to supply quarterly data using this new integrated, and more accessible digital platform.

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Welcome

Welcome to the Patient and Public version of the National Non-Hodgkin Lymphoma Audit (NNHLA) State of the Nation report 2026, looking into performance across the 140 trusts and health boards in England and Wales that treat adults for non-Hodgkin lymphoma (NHL). This version of the report is intended for patients and the public and, together with the audit's interactive data dashboard, gives an unprecedented level of transparency into the quality of treatment for this form of blood cancer.

The NNHLA project team and I met recently with a group of patients and members of the public who between them have many years of lived experience of this serious disease. Together we have focused the report on a few key messages for those affected by NHL and for NHS clinical teams. We have included quotes from this group about their experience to show what it feels like to go through treatment.

Approximately 16,000 people are diagnosed with NHL in England and Wales each year. The team at the National Cancer Audit Collaborating Centre (NATCAN) work with the NHS National Disease Registration Service (NDRS) to extract anonymised data for every patient and then track progress along the pathway. This enables us to identify the improvements in outcomes that are being made, as well as highlight those aspects of treatment that need further attention. These include:

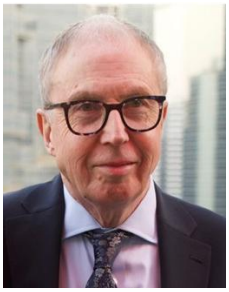
- understanding the reasons for wide variation between hospitals in the time it takes for patients to start chemotherapy and radiotherapy following initial diagnosis
- lowering the significant proportion of patients (almost 30%) who are diagnosed with NHL in A&E
- widening the opportunities for NHL patients to take part in clinical trials
- lessening the risk of patients experiencing severe complication events.

As we gather new data each year for our annual report we deepen our knowledge about the treatment of NHL, and I am confident that the Audit will become a vital source of information for patients and their families. I thank everyone at NATCAN and the wider team who are making this possible.

Frank

Frank Burroughs,

Chair of the NNHLA's Patient and Public Involvement Forum.



1. Introduction

1.1 What is the National Non-Hodgkin Lymphoma Audit?

The National Non-Hodgkin Lymphoma Audit (NNHLA) is part of the work carried out by the National Cancer Audit Collaborating Centre (NATCAN) within the Clinical Effectiveness Unit at the Royal College of Surgeons of England. The audit uses national data to understand how National Health Service (NHS) care is delivered to people with non-Hodgkin lymphoma (NHL) (a type of blood cancer) in England and Wales, with the aim of improving diagnosis, treatment and outcomes for people with NHL.

We measure the quality of care and outcomes for people with NHL across 11 performance indicators, set out in our Quality Improvement Plan. This plan was based on medical guidelines and research, working together with clinical bodies, patients and charities.

1.2 What is the State of the Nation Patient and Public Report 2026?

The NNHLA State of the Nation report 2026 shares important feedback primarily for healthcare professionals on how care has been delivered and outcomes for people with NHL in England (for the year 2023) and Wales (for the year 2024). We have used these findings to create five key recommendations for improvement across both England and Wales. The recommendations are fed back to all relevant organisations, including government, cancer alliances, health boards, trusts and hospitals.

This Patient and Public report aims to explain the key findings of the State of the Nation report 2026 in clear, easy-to-understand language for people with NHL and the wider public. It focuses on what the results mean for your care, what's working well, where improvements are needed, and how the results will be used to improve care.

1.3 Who is included in this report?

All people over the age of 18 who were newly diagnosed with NHL in an NHS trust in England (2023) or in an NHS hospital in Wales (2024) are included.

The NHL subtypes reported in the State of the Nation report include:

- **Mature B-cell lymphomas**: Burkitt lymphoma, Chronic lymphocytic leukaemia (CLL), Follicular lymphoma (FL), Large B-cell lymphomas (LBCL), Mantle cell lymphoma, Marginal zone lymphoma
- **Mature T- and NK-cell lymphomas**: Cutaneous T-cell lymphomas, and Peripheral T-cell lymphomas
- **NHL not otherwise specified**: NOS/Other (includes the more rare or mixed subtypes).

1.4 How else does the audit feedback results?

In addition to the annual State of the Nation report, we update an interactive data dashboard of results every three months (our quarterly reports) to help individual cancer alliances and trusts in England monitor their performance and guide local improvement. Quarterly updated data is currently not available for Wales, but we are working with the Welsh Government to enable more timely and frequent reporting.

2. Snapshot of the Patient and Public Report

2.1 What have we found?

Almost 30% of people with NHL were diagnosed in an emergency setting, such as in A&E. These people tended to have poorer outcomes.

Many people waited longer to start treatment following their initial referral than recommended. 56–62% of people with high-grade NHL started drug treatment for cancer within the 62-day NHS target. Half waited **more than one month** to see a haematologist after referral.

Only **one third** of people who needed radiotherapy after drug treatment started it within 8 weeks**. Just over half** started it within 12 weeks.

Less than 3% of people with NHL received care as part of a clinical trial.

Almost half of people receiving acceptable initial drug treatment for diffuse large B-cell lymphoma (DLBCL) experienced **serious complications** within 8 weeks.

Overall 1-year survival was >80% for all NHL cases; >70% in high-grade cases and >90% in low-grade cases.

Overall 2-year survival was 75% for all NHL cases; >60% for high-grade cases and >80% for low-grade cases.

2.2 What the results mean for people with NHL and the wider public

- People diagnosed with NHL following a referral from their GP have much better outcomes than those diagnosed after an emergency presentation. Be aware of the signs and symptoms of NHL and visit your GP promptly if you have concerns. More information about the signs and symptoms of NHL can be found here: Symptoms of non-Hodgkin lymphoma - NHS.
- NHS guidelines recommend that treatment should begin within 62 days of the first referral. You can check waiting times at your local hospital and compare them with other hospitals through the NNHLA interactive data dashboard and NHS Cancer Waiting Times. If you have concerns about waiting times, speak to your care team about your options.
- Some people benefit from radiotherapy after completing drug treatment. Discuss with your doctor at the earliest opportunity whether radiotherapy is appropriate for you. For people who have radiotherapy as part of their treatment plan, delays may affect their physical and mental wellbeing, as well as practical matters like travel and caring responsibilities.
- Clinical trials can provide access to new treatments and help improve NHL care and outcomes. If you are interested in taking part in a clinical trial, ask your doctor whether there are any opportunities that may be suitable for you. You can find information on available clinical trials from Cancer Research UK and Lymphoma Action.
- Side effects are common during and after treatment. Talk to your doctor about potential side effects before treatment begins so you know what to look out for. Seek medical advice promptly if you do experience any side effects, as most can be effectively managed.

Every person's experience with NHL is unique and the findings in this report may not reflect your individual experience or circumstances. This report is for information only. Speak with your care team if you have questions about the findings of this report and how they relate to your personal care.

3. Diagnosis

3.1 Who is diagnosed with non-Hodgkin lymphoma (NHL)?

Diagnoses per year

England
15,911 diagnosed in 2023

Wales
707 diagnosed in 2024

69 years — **Mean age** at diagnosis (both England and Wales)

NHL was diagnosed in 15,911 people in England in 2023 and 707 people in Wales in 2024. The average age of these people was 69, and over half (58–60%)[1] were male.

Most people diagnosed with NHL were White British (91–98%), were more likely to be from a less deprived background, and were fit and independent, with 75–85% having no more than one serious long-term condition (where recorded).

3.2 At what stage are people with non-Hodgkin lymphoma diagnosed?

Staging (Ann Arbor or Binet) is used to describe how far through the body the cancer has spread (i.e. how advanced the disease is). Prognostic indices use this information and other factors to predict the outcome of an individual's cancer.

Where staging was recorded, 72–73% of people had advanced-stage (3 or 4) disease as per the Ann Arbor Classification staging system at the point they were diagnosed. However, having advanced stage NHL does not necessarily mean treatment will be less effective. Your medical team can explain what your own results mean for you.

People with chronic lymphocytic leukaemia (CLL) were more likely to have early-stage (Binet A) disease at the point of diagnosis, although clear conclusions couldn't be drawn due to the large volume of missing staging data.

The lack of staging data makes it harder to get the full picture of patient outcomes, which is needed to make our recommendations as targeted as possible.

Data completeness

Ann Arbor Staging:	Approx. **1/3** missing data
Binet Staging:	Nearly **2/3** missing data
Prognostic Indices:	Approx. **9/10** missing data

3.3 How many people diagnosed with NHL present as an emergency before being diagnosed?

Some people become seriously unwell before their NHL is diagnosed, meaning they first come into contact with healthcare services through A&E. This can be frightening for patients and families and may mean treatment planning starts while someone is already unwell.

Emergency presentation

England 2023	29%
Wales 2024	29%

Almost 30% of people diagnosed with NHL in England and Wales were either diagnosed in an emergency setting (e.g. A&E) or visited an emergency setting in the 28 days prior to diagnosis. There was little variation between hospitals.

An emergency diagnosis was more common in people aged 80 or over, people from minority ethnic backgrounds, people living in deprived areas, and people with faster-growing (more aggressive) types of NHL, such as Burkitt lymphoma, large B-cell lymphoma and peripheral T-cell lymphoma.

Patients who presented in this way had poorer survival than those diagnosed through routine referrals.

[1] Ranges represent the values reported for England and Wales.

A similar pattern was seen in England in 2021–2022, suggesting this as an ongoing problem (information from previous years is not available for Wales). It may also help explain why some people with NHL are diagnosed at a later stage of the disease.

3.4 What happens after diagnosis?

After someone is diagnosed with NHL, it is important for their tests and results to be discussed in a meeting of specialists. This is called a multi-disciplinary team (MDT) meeting, and it helps make sure each person gets a tailored treatment plan.

In 2023, 61% of people with NHL in England had their cases discussed at an MDT within 4 weeks of diagnosis. This percentage was higher for people with more aggressive (high-grade) lymphoma but varied substantially between hospitals.

This is similar to the percentage of cases discussed in 2022, but lower than in 2020–2021 (this reduction may have been due to resource pressures and reduced capacity after COVID-19). No MDT data is available yet for Wales.

It is also important that people with NHL are supported by a clinical nurse specialist (CNS) through their journey. A CNS can be an important contact point – offering information and support, help managing symptoms and side effects, and signposting to other services when needed. They can also help patients and families communicate with the wider healthcare team.

In England, where the information was recorded, 85% of people with NHL were seen by a CNS, compared to 95% in Wales. These numbers were higher for people with high-grade lymphoma. Overall, the proportion of people with NHL in England and Wales who had contact with their CNS has remained about the same as in previous years.

Patient voice:

"My case was discussed at an MDT meeting, attended by clinicians from several different departments. I was impressed by the close coordination and teamwork shown by all of those who helped in those initial stages." *Frank.*

"My CNS was a real comfort blanket - someone who knew me and my journey, available for any worries or questions I had. Even if I didn't have to call that often, just knowing she was there was hugely beneficial." *Stephen.*

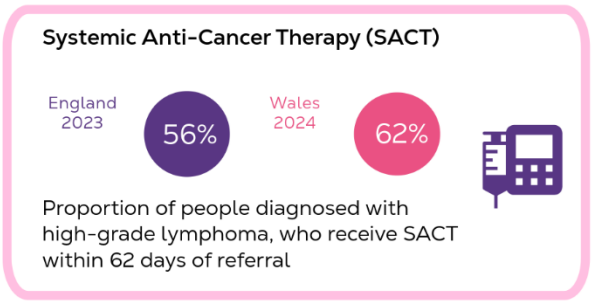
"My CNS was a rock. As well as clinical expertise, she provided a lot of emotional support. She understood that lymphoma affects family and carers and checked how my husband was feeling and tailored information to our level of understanding. We felt we could ask her anything and be guaranteed of reliable evidence-based information delivered in a helpful way. Even after I'd been discharged following remission and was confused by some information in the papers about Covid vaccines and blood cancers, she still responded to an email to reassure me." *Claire.*

"My CNS was such a welcome sight in my initial visits. She attended all my consultations and took time to answer questions from my family, away from me, so that they could ask whatever they needed. She has also been a consistent presence during my fourteen years of follow-ups, even thanking me once for all the volunteering I do and saying how proud they are of me! She is a superstar as far as I am concerned." *Debbie.*

4. Treatment

4.1 What treatment starts first?

The first treatment people with NHL receive is usually cancer drug treatment (systemic anti-cancer therapy, or SACT), which includes medicines like chemotherapy, immunotherapy and targeted therapy. For most people with high-grade NHL, these are the main and most effective first treatments.



A range of different cancer drug treatment options can be given to people diagnosed with high-grade NHL, and these can vary depending on the subtype.

In England in 2023, many different first treatments were recorded, and most people with NHL received treatment considered acceptable for their diagnosis:

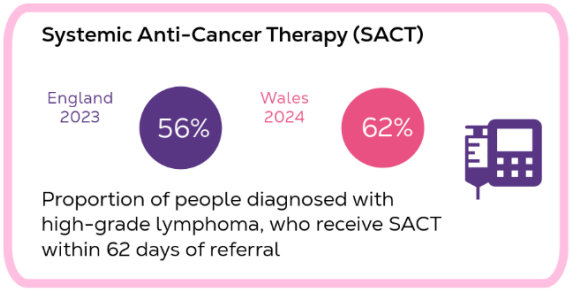
- **Diffuse large B-cell lymphoma (DLBCL, not otherwise specified):** Almost 20 different first treatments were recorded. Nearly everyone (around 97%) received one of the acceptable first treatments.
- **Burkitt lymphoma:** There were 12 different first treatments recorded. Most people (about 83%) received one of the acceptable first treatments.
- **Peripheral T-cell lymphoma (PTCL, not otherwise specified):** There were 13 different first treatments recorded. Everyone (100%) was recorded as receiving one of the acceptable first treatments.

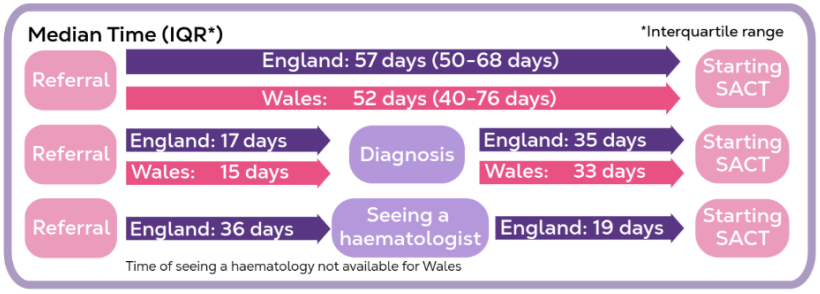
A small number of people in each NHL subtype above were recorded as not receiving the acceptable first treatment. Instead, they were given a different treatment plan. In many cases, this was still the right choice for that individual (e.g. if their overall health meant they could not cope with the more intensive treatment options). These treatments were grouped separately because they may not work as well or are thought to be less effective than the acceptable treatment options.

The figures for DLBCL and PTCL are very similar to those reported in 2021–2022. The figures for Burkitt lymphoma are difficult to compare to those reported in 2021-2022 due to the small number of people with this subtype.

Starting treatment promptly is clinically important and can reduce physical and emotional distress for people with NHL. NHS guidelines recommend that treatment for cancer should begin within 62 days of the first referral. In England, 56% of people with high-grade NHL started treatment within this timeframe, which is similar to 2022 but lower than in 2020–2021. In Wales, the percentage was 62% in 2024, showing an improvement from previous years. There was a lot of variation between hospitals.

The longest wait between steps in the pathway was from referral to seeing a haematologist, with half of people waiting over a month (36 days). This was followed by a wait of 19 days for a person to subsequently start the treatment.





Patient voice:

"This felt like being in limbo. It was confusing and worrying and I remember time really dragging between investigations, appointments and results, everything seemed to take forever. I had a lump on my neck and could see it growing while I was waiting for a confirmed diagnosis and treatment." *Claire.*

"I found waiting for treatment very stressful. To me it was more like being in a burning building than standing on a high-speed rail track. You know that the cancer is advancing and doing you harm day by day, and I was longing to hit it hard with treatment. It felt like a race against time to have maximum chance of getting out alive." *Neil.*

4.2 What about radiotherapy?

Radiotherapy is often given after cancer drug treatment to add to or strengthen its effect for people with high-grade NHL. If radiotherapy is recommended, it should start within 8 weeks of completing cancer drug treatment, based on the consensus from our Clinical Reference Group.

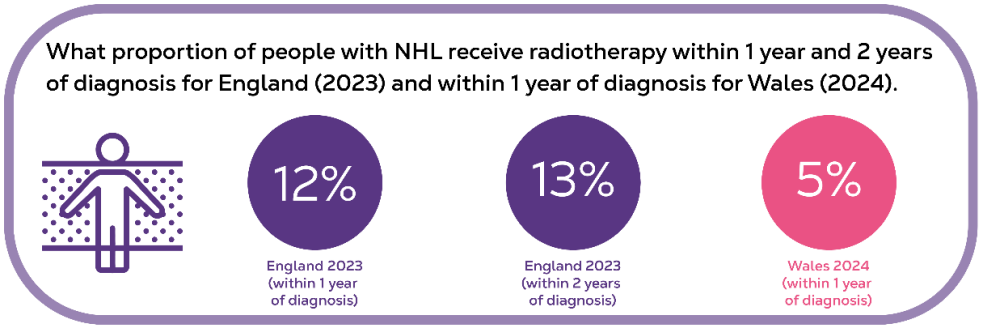
32% of people in England who received radiotherapy began the treatment within 8 weeks of completing their first cancer drug treatment. This percentage varied between hospitals. This information is currently not available for Wales.

The figure for England is similar to 2022 but lower than 2020–2021. The variation between hospitals requires ongoing assessment and review by hospital teams.

Radiotherapy can also be given by itself for a range of NHL subtypes, either with the intention of curing a patient or simply to manage their symptoms (palliative care).

In England, more than one in ten people were recorded as having received radiotherapy within one year of diagnosis, compared with only one in twenty people in Wales. However, this difference may partly be due to gaps in record keeping rather than fewer people receiving radiotherapy.

Large B-cell lymphoma and follicular lymphoma were among the most common NHL subtypes to receive radiotherapy in both England and Wales, with cutaneous T-cell lymphoma also commonly receiving radiotherapy in England and mantle cell lymphoma in Wales. Compared to results from last year's report, there has been no major change in which subtypes receive radiotherapy, but the rates differed between hospitals.



Patient voice:

"The timing of my radiotherapy worked out very nicely. My last chemotherapy cycle was at the end of November, allowing a few weeks recovery and rest over Christmas and a start to radiotherapy in early January." *Neil.*

4.3 How many people experience serious complications from cancer drug treatment?

Cancer drug treatment can cause side effects. Most of these are mild and can be managed effectively. However, some side effects can be serious and, in rare cases, life-threatening. In this report, a serious complication is one that leads to an overnight hospital stay or requires a blood transfusion.

In England, about 47% of people with DLBCL who received acceptable first cancer drug treatment experienced serious complications within 8 weeks. Infection was the most common scenario, followed by blood-related and digestive system problems. However, the symptoms and severity of treatment-related side effects vary substantially between individuals, and most can be managed effectively.

Patient voice:

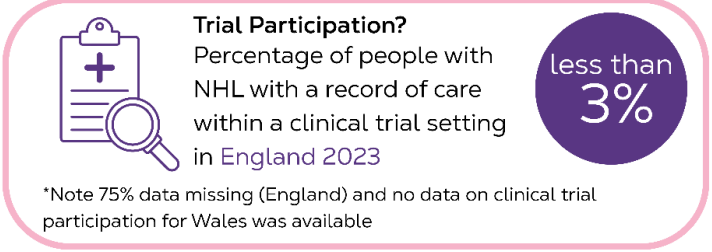
"The side effects that I experienced from chemotherapy were much less than I had feared at the outset. I never experienced sickness and never needed the antiemetics… I did become neutropenic which is dangerous, but I managed not to catch any infections… I realised that I was lucky, meeting some other patients who had had a much tougher time from side effects, including peripheral neuropathy… Ten years later I have been left with two small reddish patches of skin on my chest but no cancer!" *Neil.*

"I had an elevated temperature during chemotherapy treatment and called the support line provided by my CNS at the Royal Marsden. Luckily, they managed to find a bed for me and I was admitted overnight for IV antibiotics. Whilst worrying initially, the prompt action meant I recovered quickly and was able to continue treatment the next week." *Stephen.*

"I finished my course of chemotherapy in early 2019 and this was followed by 2 years of maintenance immunotherapy. I coped well with the chemotherapy and had no serious side effects, either during the treatment or while I was recovering. I made a full recovery and have been well since." *Frank.*

4.4 What about clinical trial participation?

Clinical trials test new or improved treatments and can offer people with NHL access to new therapies that may not otherwise be available. Taking part is entirely optional, and choosing not to join a trial does not mean someone will receive worse care.



In England, fewer than 3% of people with NHL received care through a clinical trial in 2023 (where records were available). However, this information was not recorded for three quarters of cases. This information is not available for Wales.

The most common subtypes to receive care as part of a clinical trial were follicular lymphoma (4%), mantle

cell lymphoma (3%) and the subtype 'other' (5%). People with low-grade NHL were slightly more likely to take part in a trial than those with high-grade NHL in 2023.

In England, the percentage of people with NHL taking part in trials has slightly risen from less than 2% in 2021–2022 to less than 3% in 2023, showing a possible continued return to more normal research activity after the COVID-19 pandemic.

Patient voice:

"I was not offered a place on a clinical trial as the available treatment was known to be effective" *Frank.*

"I was invited to take part in a trial but declined. The patient information was about 30 pages long and not written from the participant's perspective. It was too complex and the purpose of the study wasn't clear to me. The additional investigations involved felt overwhelming. I think all of that could be done much better." *Claire.*

5. Outcomes

5.1 What are the outcomes for people with non-Hodgkin lymphoma?

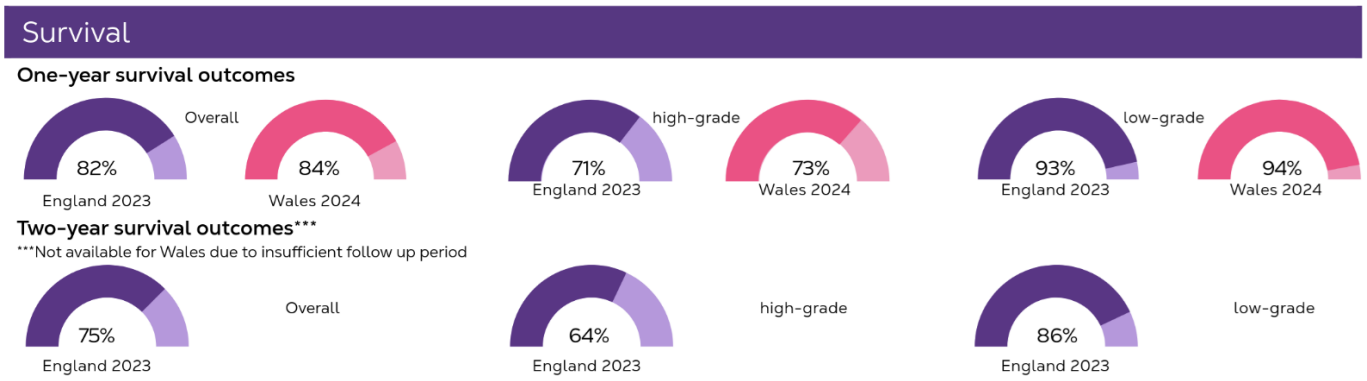
It is important for people with NHL to understand the likely outcomes of their treatment, particularly survival. This information is not only useful for people undergoing treatment but is also used to guide treatment decisions.

Overall, more than 80% of people with NHL lived at least one year after diagnosis (in England and Wales), and around 75% lived at least two years following an NHL diagnosis (in England only; not enough data to follow up outcome beyond the first year for Wales).

In high-grade cases, over 70% of people lived at least one year and over 60% lived at least two years after diagnosis. In low-grade cases, over 90% of people (93%) were alive at least one year following diagnosis, and over 86% were alive at least two years following diagnosis.

It is important to remember that the survival outcomes shown here are averages or estimates. They don't predict exactly what will happen for any one person. Everyone is different, and factors like general health, the type of NHL, and response to treatment can all affect survival. If you would like to know more about what these figures mean for you personally, please speak with your healthcare professional.

The NNHLA team will assess the feasibility of reporting longer-term survival outcomes, such as 5- and 10-year survival. However, this would require longer follow-up time and would need to be balanced against the aim of keeping the reported cohort as up to date as possible.



6. Summary

6.1 What are the implications of the State of the Nation 2026 Report?

The results of the performance indicators in this year's NNHLA State of the Nation report highlight areas where care needs improving and variation between hospitals needs to be reduced. Trends over time can be seen in Supplementary Figure 4 and Supplementary Table 12 in the following link: Supplementary Tables. This includes changes from 2020 to 2023 in England and from 2022 to 2024 in Wales.

One of the main issues identified is in delays in starting cancer drug treatment, especially for those with high-grade lymphoma. Delays in discussions in being seen by a haematologist and being discussed in a multi-disciplinary setting may delay treatment decisions. Delays in starting radiotherapy after cancer drug treatment were also reported. Starting treatment as quickly and safely as possible is important to improve outcomes for people with NHL.

A high number of people are diagnosed with NHL in an emergency setting. There are many reasons that could be contributing to this, which will remain a focus for further work within the audit. This highlights the need for hospitals to review their referral pathways to facilitate earlier diagnoses.

Almost half of people with DLBCL experienced serious complications during or after completing cancer drug treatments. Hospitals need to monitor this rate, explore the risk factors and actively take steps to reduce the number of people this affects. This may include carrying out appropriate risk assessments before starting treatment and ensuring effective safety monitoring takes place.

The difference in 1- and 2-year survival outcomes between hospitals should continue to be monitored. These figures do not, on their own, tell us why the differences exist. Differences may be related to various factors such as access to specialist services, treatment, data quality and other factors.

The audit will continue working on developing results for the other performance indicators and analysing up-to-date data over the coming years. It will publish these findings to provide the most current overview of care.

We will also continue to update our interactive data dashboards that provides timelier feedback and allows hospitals to check their performance and progress more regularly.

The NNHLA has launched a national quality improvement initiative in late 2025, aiming to work with hospitals in England to improve the quality of key data collection. This initiative is due for an evaluation later this year when any areas for improvement will be fed back to providers. For further details, please see our NNHLA web pages.

6.2 Key recommendations to healthcare professionals

The following five key recommendations have been fed back to healthcare professionals at national and local level (cancer alliances, health boards, trusts and hospitals) alongside an Action Plan Template to help guide improvement initiatives.

1. Reducing emergency diagnoses:

- Understanding why emergency diagnoses happen
- Understanding treatment timelines for people diagnosed in this way particularly in hospital

2. Reducing waiting times for starting cancer drug treatment:

- Understanding reasons for delays across cancer alliances, health boards, trusts and hospitals
- Finding ways to shorten the time from being referred to seeing a haematologist and from being diagnosed to starting treatment

3. Reducing waiting times for starting radiotherapy:

- Making sure all the necessary specialists are present at multidisciplinary team (MDT) meetings
- Deciding earlier which people might benefit from radiotherapy

4. Increasing the number of people with NHL who are involved in clinical trials:

- Ensuring fair access to clinical trials
- Improving record keeping of people taking part in trials

5. Monitoring and reducing serious complications from cancer drug treatment:

- Understanding why these complications happen
- Improving safety checks and using tools that help identify who may be at higher risk of serious complications before treatment begins

7. Further information and support

Guidelines:

British Society of Haematology: https://b-s-h.org.uk/guidelines/about-our-guidelines
National Institute for Health and Care Excellence: https://www.nice.org.uk/guidance/ng47
NHS Long Term Plan: https://www.longtermplan.nhs.uk/
National Cancer Plan for England: https://www.gov.uk/government/publications/national-cancer-plan-for-england

Charities:

Lymphoma Action: https://lymphoma-action.org.uk
Blood Cancer UK: https://bloodcancer.org.uk/
Cancer Research UK: https://www.cancerresearchuk.org/about-cancer/non-hodgkin-lymphoma
Macmillan: https://www.macmillan.org.uk/cancer-information-and-support/lymphoma/non-hodgkin

NNHLA

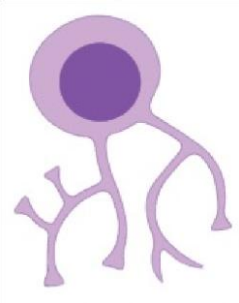
Web pages: https://www.natcan.org.uk/audits/non-hodgkin-lymphoma/
State of the Nation Report 2026: https://www.natcan.org.uk/reports/nnhla-state-of-the-nation-report-2026/
State of the Nation Report 2026, Supplementary Tables: https://www.natcan.org.uk/library/nnhla-sotn-supplementary-tables-2026/
State of the Nation Report 2026, Glossary: https://www.natcan.org.uk/library/nnhla-sotn-glossary-2026/
Quarterly report and State of the Nation report dashboard: rcs-ceu.shinyapps.io/NNHLA/
Quality Improvement plan: https://www.natcan.org.uk/audits/non-hodgkin-lymphoma/quality-improvement/
Statistics cheat sheet: https://www.natcan.org.uk/library/nnhla-statistics-cheat-sheet/
Blog: https://www.natcan.org.uk/news/the-power-of-data-how-using-statisticalanalysis-will-generate-insights-and-identify-best-practice-for-the-quality-of-care-of-people-with-adiagnosis-of-non-hodgkin-lymphoma/

Our Audit email address is: NHLaudit@rcseng.ac.uk

Our Audit social media accounts are:
Bluesky: @nnhla-natcan.bsky.social
LinkedIn: @National Non-Hodgkin Lymphoma Audit

8. Appendix Information

What is NHL?



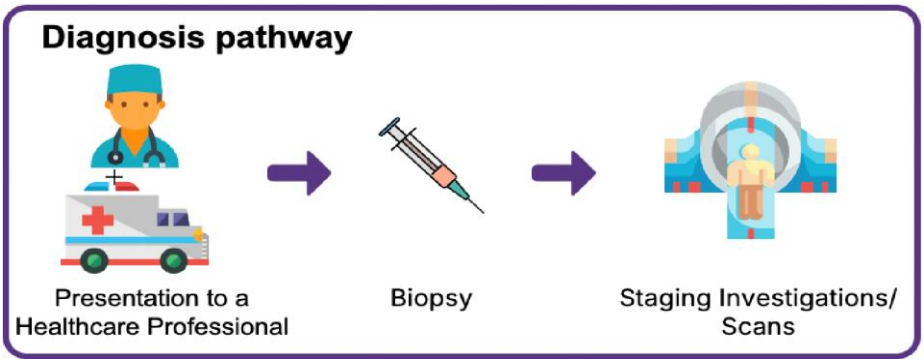
Non-Hodgkin lymphoma (NHL) is a type of blood cancer that affects white blood cells called lymphocytes. They can be found in the lymphatic system, which is the body's own plumbing network that helps fight off infections and filter out abnormal cells to keep the body safe. This is part of the immune system. However, in NHL, the white blood cells divide continuously and in an abnormal way, so they do not develop or behave in the way they should. This leaves the body vulnerable to infections and other illnesses.

NHL is a complex cancer with almost 200 different subtypes. We can group these simply by either:

1) The type of cell: T-cell or B-cell; or
2) The grade, which is an indicator of how fast growing the cells are: high-grade or low-grade.

This helps us predict how the NHL will behave, the types of treatment to offer and the likely outcome.

How is NHL diagnosed?



People with NHL are diagnosed after seeing their GP with certain symptoms or after abnormalities are picked up on a blood test. The most common symptom is a lump. The individual is then referred to the team specialising in where the lump is located; for example, a neck lump is referred to an ear, nose and throat specialist.

Alternatively, if the individual has noticed symptoms such as weight loss or night sweats (which are often referred to as B symptoms), blood tests may be carried out first, and the individual may be directly referred to a haematology specialist. In some cases, they can become unwell very quickly so are first seen in the emergency department. These cases are often more advanced.

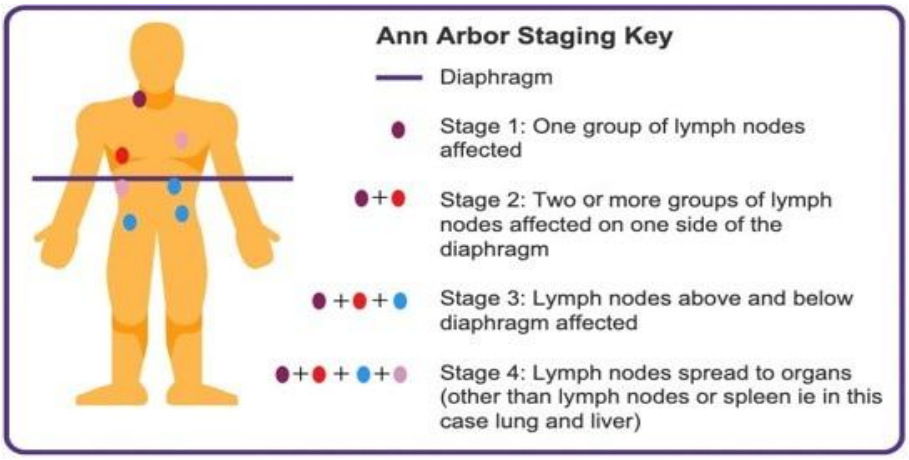
To make a diagnosis a sample of a concerning lymph gland will be taken or the lymph gland will be removed completely, otherwise known as a biopsy. This is then sent to be looked at by a pathologist under a microscope to determine if it is a cancer; if so, further specialised tests can be carried out on the sample to give us more information about the cancer. This information can then help doctors decide the best treatment for the individual.

Once a diagnosis of cancer has been confirmed, scans called staging scans (often PET/CT) are organised to assess if other parts of the body are involved. In the case of follicular lymphoma, a sample from the bone marrow is also often arranged. If the bone marrow is not involved, this implies an earlier stage of disease, so more conservative approaches to treatment can be considered.

What are the stages of NHL?

The 'stages' of NHL describe the extent of the body affected by NHL. Along with other tests and factors, they help doctors decide the best course of treatment and predict the outcome of these treatments.

Most subtypes of NHL are described using the Ann Arbor Classification system, which uses Roman numerals from I to IV (1–4). This considers the number and location of lymph glands involved in relation to the diaphragm (a muscle that divides the chest and abdomen). Stage 1 and 2 describe a limited or earlier stage of disease; stage 3 and 4 cases are more advanced. Sometimes, letters are also used after the numbers to help provide more information (A, B, X).



The Binet Classification system is used to described staging for chronic lymphocytic leukaemia cases only. These cases are grouped into A, B and C based on information from blood tests and the number of lymph nodes that are enlarged, with C being the most advanced stage.

Prognostic indices are a scoring system. There is IPI (International Prognostic Index), which is used for most subtypes of NHL, and FLIPI (follicular lymphoma IPI) for follicular lymphoma. These are calculated by combining information about the stage of cancer, blood tests and patient characteristics to help predict outcomes like survival.

Who is involved in my care?

There is a team of specialists who deliver care for people with NHL. When someone is diagnosed with NHL, they are discussed in a haematology or lymphoma specialist multi-disciplinary team setting (MDT) with all the specialists present to determine the best management plan for each individual. This team consists of:

- NHL clinical nurse specialists (CNS)
- Haematology specialist doctors
- Oncology specialist doctors
- Pathology specialist doctors
- Radiology specialist doctors and
- Multi-disciplinary team co-ordinators.

Other healthcare professionals may also be involved in your care, such as your GP, pharmacists, dieticians, physiotherapists or occupational therapists.

What are the treatment options?

The treatment options vary on a case-by-case basis:

- **Active monitoring** (often called 'watch and wait' approach) (often seen in early stage/low-grade follicular lymphoma).
- **Cancer drug treatment (systemic anti-cancer therapy or SACT)**– this is an umbrella term for medication (often given through a drip or as a tablet form) that travels around the body. This damages cancer cells and stops them from growing. This can include medications like chemotherapy, immunotherapy and targeted therapy. It can be given by itself, with CAR-T treatment or with radiotherapy, and can also be given with either curative or palliative (symptom management) intent.
- **Radiotherapy** – this is high-dose X-ray treatment delivered to areas of concern in the body. The aim of radiotherapy is to damage cancer cells in a targeted way and stop them from growing. This can be given alone, following completion of cancer drug treatment (to enhance its effect) or as a bridge to further treatment. Radiotherapy can also be given with either curative or palliative (symptom management) intent.
- **Other treatment options** include stem cell transplants/CAR-T and clinical trials.