RM Partners
West London Cancer Alliance
Hosted by The Royal Marsden NHS Foundation Trust

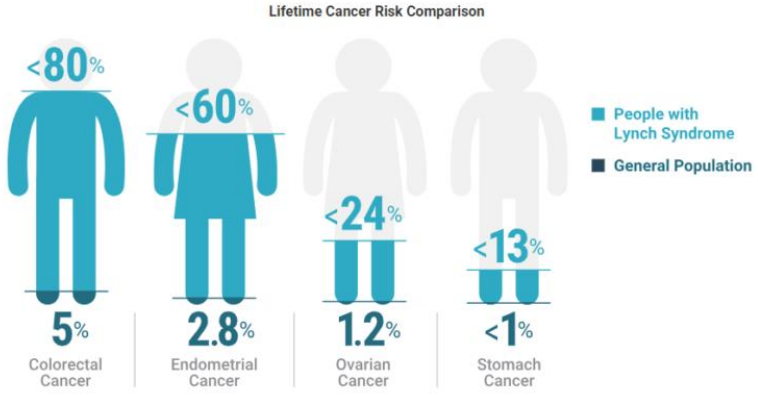
St MARK'S THE NATIONAL BOWEL HOSPITAL

NHS

Lynch syndrome quick guide for Primary Care clinicians

Recommendations for Lynch syndrome patients & their family

Lynch syndrome is a cancer predisposition syndrome in which the main concerns are **colorectal** and **endometrial** cancer. There is also a risk of other cancers, although less frequently.



© *Promega Corporationhttps://www.promegaconnections.co.uk*

Highest Risk
Colorectal
Endometrial

Increased Risk
Ovarian
Urinary tract
Gastric
Small intestine
Hepato-biliary
Pancreatic
Sebaceous gland
CNS

Coding Lynch syndrome as a 'problem' in the primary care record (this information is not considered within insurance applications as per ABI code of Genetic testing and Insurance)
Colonoscopy every 2 years: Chromoendoscopy (with dye spray) is the preferred choice - From the age of **25** for pathogenic variants in ***MLH1, MSH2*** or ***EPCAM*** genes - From the age of **35** for pathogenic variants in ***PMS2*** and ***MSH6*** genes
We recommend a ***low threshold for investigations*** if your patient present with symptoms which could be associated with any of the LS associated cancers
Regular low dose of aspirin (NICE guidelines 2020) from the age of 25 to 65: Aspirin has been shown to reduce the risk of cancer in Lynch syndrome by up to 50%. Trials to determine the best dose of aspirin for cancer prevention are still ongoing [Evidence about aspirin: patient decision aid, NICE, 2020] For now most specialised centres recommend 150 mg daily for individuals with average weight, and 300 mg for individuals with BMI above 30
One-off screening for Helicobacter pylori: Eradication may reduce the risk of gastric cancer by half
Gynaecological surveillance: Currently there is limited evidence about the utility of gynaecological surveillance for early detection of endometrial and ovarian cancer Risk reducing surgery is offered because there is no effective screening test. However, this should be a personalised decision, generally offered from the age of 40, once they have completed their families, taking into consideration their risk factors, genetic mutation, personal preferences and quality of life Consider referral of women around the age of 40 for a discussion about surgery
Family planning for pathogenic variant carriers: Consider referral to clinical genetics for a discussion about embryo selection
First degree relatives (parents, siblings & children): Referral may be discussed from the age of 18, ideally prior the age at which screening commences We recommend a ***low threshold for investigations*** if relatives present with symptoms which could be associated with LS, regardless of age If the familial pathogenic variant is ***MLH1, MSH2 or EPCAM*** and the unaffected relative is **>25y** and declines genetic testing, refer to specialised centre for colonoscopy – 2 yearly If the familial pathogenic variant is ***PMS2 or MSH6*** and the unaffected relative is **>35y** and declines genetic testing, refer to specialised centre for colonoscopy – 2 yearly