Meeting of the South West Academic Gynae-Oncology Group for Education and Research (SWAGGER)

Friday 11th October 2019, 09:30-13:30, The Castle Hotel, Castle Green, Taunton TA1 1NF
This meeting was sponsored by AstraZeneca, Kyowa Kirin, Rocket Medical and Stryker

Chair: Claire Newton (CN)

NOTES **ACTIONS**
(To be agreed at the next SWAGGER meeting)

1. Welcome and apologies

Please see the separate list of attendees and apologies uploaded on to the South West Clinical Network website here.

2. Review of previous meeting's notes and actions

The notes from the meeting on Friday 12th October 2018 will be amended to clarify User Representative Christine Teller's role in Patient and Public Involvement (PPI), acting as a mentor to PPI Lead Katy Horton-Fawkes. As there were no further comments the notes were then accepted.

Actions:

The SWAGGER paper on cases of malignant vulval melanoma has been revised and re-submitted for publication.

A SWAGGER patient information leaflet has been drafted to assist with the consent process for radical hysterectomy, and will be circulated in the near future.

A regional brachytherapy audit has yet to be completed; a local audit was recently completed by the Cheltenham team.

Matters arising:

A pilot project on Enhanced Supportive Care (ESC) for palliative cancer is due to commence, launched by Bristol North Somerset, South Gloucestershire Clinical Commissioning Group and hosted by UH Bristol; £500,000 has been allocated.

3. Blood Products in Gynaecological Cancer Surgery

Please see the presentation uploaded on to the SWCN website here.

Presented by Olly Pietroni (OP)

Aims: To improve transfusion care, reduce un-necessary transfusions and establish the role of Rotational Thromboelastometry (ROTEM).

Method: A retrospective audit of High Dependency Unit (HDU) admissions post gynae-oncology surgery identified 39 cases, 20 of which received donor blood products (51%); 10 of which intra-operatively (32 units) and 13 post operatively (29 units); guidance is to transfuse when a patient's haemoglobin is less than 70 g/L.

Results: ROTEM reduces the need for donor blood products, the risk of infections and reduces length of stay (LOS). When looking at pre and post-operative Hb

levels, results suggest over-infusion for those receiving donor blood products.

ACTIONS

Conclusions:

- Transfusions can be reduced by treating pre-operative anaemia
- A high proportion of patients are anaemic
- In the Royal Cornwall Hospital (RCH) audit, the average post-op Hb is significantly higher than 70g/L
- 8 patients finished with a higher post op Hb
- All transfused women had Hb>105g/L
- Early referral for anaemia treatment is key (consider IV iron approximately 10 days prior to surgery).

Waiting for 10 days to treat anaemia could impact on Cancer Waiting Time (CWT) performance unless it is possible to define this as the 'first treatment' rather than the surgery.

At a 'Dragons' Den' event in December, the RCH team are making a pitch to fund the purchase of a haemoglobin oximeter for the rapid non-invasive determination of Hb levels.

It was noted that the use of ROTEM in orthopaedic surgery at RCH has dramatically reduced the need for donor blood products.

There is currently no evidence of detrimental outcomes for using cell salvage in comparison with donor blood for cancer cases with disseminated disease; however no Phase 1 human trials have been completed as of yet, only animal studies.

Transfusion rates may be reduced by replacing primary debulking surgery with neoadjuvant chemotherapy and interval debulking surgery, although transfusions may also be required due to immunosuppression caused by the chemotherapy.

Cell salvage versus donor blood is not of equivalent volume; there is a better Hb increment from donor blood, although cell salvage quality is better due to the physiological match and because it has not been stored.

Transfusion rates will be compared across the SWAGGER region, including transfusions given in Recovery and on the ward post HDU.

SWAGGER AUDIT

It would be useful if General Practitioners could request Hb levels in parallel with sending a referral. This could be included on the suspected cancer referral forms, as is the case for suspected colorectal cancer referrals; this will be fed back to the Clinical Commissioning Groups responsible for managing the referral forms.

HD to contact CCGs

4. Interventions for Intractable Cancer Pain

Please see the presentation uploaded on to the SWCN website here.

ACTIONS

Presented by Nilesh Chauhan (NC)

Provision of a Complex Cancer Pain Service fits in with the aforementioned Enhanced Supportive Care project.

There are a number of innovative interventions available via the UH Bristol Pain Management Team for end of life care:

- Neurolytic saddle blocks for intractable perineal pain, which involves an injection of phenol into the spine. This temporarily destroys the perineal nerves (they can regrow) for approximately 3 months, and can enable patients to sit up comfortably in bed and reduce the risk of lung infections. Side effects can include damage to the bladder and bowel nerves, causing incontinence, and foot-drop
- Cordotomy for uncontrolled pain below C4 which is particularly suitable for patients with mesothelioma and chest wall pain; patients need to be able to lie flat for an hour and travel to Portsmouth
- Intrathecal Drug Delivery (IDD, funded by NHS England) for patients with severe cancer pain below the diaphragm (approximately 5-15% of cancer patients) with a life limiting illness that require pain management for 3 months or more and can tolerate an anaesthetic. This is a cost-effective alternative to systemic drugs that allows small doses of drugs to be applied directly to CNS receptors via a catheter placed in the spine. A randomised controlled trial (RCT) of opioids versus IDD shows IDD as preferable in terms of reduced toxicities and improved survival. The catheter can be refilled (approximately once every 3 months) in the outpatient pain clinic.

Peripheral nerve blocks are also available. MDT members are encouraged to ask cancer survivors if they have residual pain, as there are thought to be previous patients with unmet pain management needs that could be addressed.

MDT members

Patient Information Leaflets have been developed that detail the benefits versus risks of each intervention.

The pain management team hold a monthly MDT on the first Wednesday of the month with the palliative care team. At present, referrals are restricted to the Bristol area, with a plan to set up a network service at some point in the future.

It is not uncommon for patients to have unexplained pain in the early stages of recovery. If investigations show no obvious pathology, they should be referred to the pain team. For patients with true neuropathic pain, low dose amitriptyline may be helpful, but can take a couple of months before patients begin to get relief from symptoms.

The IDD pump is only licenced for use with morphine. Baclofen has been found to corrode the pump mechanism. Pumps cost £20,000.

To refer Bristol patients, please email: Bethany.wright1@nhs.net

5. South West Genomics Laboratory Hub Update

ACTIONS

Please see the presentations uploaded to the SWCN website here.

Presented by Jonathan Frost (JF) and Daniel Nelmes (DN)

5.1 South West Genomics Laboratory Hub overview

Provision of genetic and genomic test panels is now transitioning from a project to a standard NHS service. The number of laboratories has been reduced from 25 to a network of 7 Genomic Laboratory Hubs (GLHs), all processing a core set of samples according to the same standards. North Bristol Trust was successful in the bidding process to become one of the GLHs in partnership with Royal Devon and Exeter Trust. Each hub has been given the responsibility for processing a number of additional specialist tests, which are divided so it is clear who is doing what for each indication / disease. The Director of the laboratory is Genetic Scientist Rachel Butler (RB).

National genomic test directories for rare diseases and cancer have been published here to give equity of access across the country. These define the genetic and genomic tests that will be made available via NHS England at some point in the near future (potentially April 2020); directories will be reviewed by a panel of experts on an annual basis. This includes access to tests for inherited cancer, whole genome testing for all patients with sarcoma, leukaemia and paediatric cancers (which will include patients up to 24-years-old), and genetic panels for other tumours. Therefore all samples suspicious of a gynae sarcoma would ideally be sent fresh frozen to the laboratory.

Surgical Team

In the interim, BRCA tests are available via AstraZeneca. Result turn-around time is generally within the month, but can be fast-tracked if necessary by contacting the laboratory directly. Requests need to be sent via nhs.net to comply with the Data Protection Act.

The tests available to patients with gynaecological cancer or rare inherited diseases are listed in the presentation. The South West GLH is proposing a gene panel that includes 500 genes in the hope that further relevant gene alterations and targeted therapies can be identified in the future.

CAG are to contact the genomics team if there are additional tests that would be useful to include in the directories; there is no funding for tests that are not included.

All SWAGGER Members

Somatic and Germline testing pathways have been developed and are available on the website.

Patient Information Leaflets are in the process of being drafted by CNS Tracie Miles, who can be contacted when providing feedback about the pathways:

tracie.miles@nhs.net

A national results database is in the process of being developed.

ACTIONS

Consent is required as results are stored on a research database and will be facilitated by standardised record of discussion forms.

A buddy system will be available to support MDTs.

A Genomics Educational Event will be held in January 2020 at Taunton Racecourse.

The minimum tissue required from biopsy samples is 5 micron sections; NHS England is publishing biopsy guidance. If there is inadequate tissue, cytology can be sent.

Ideally samples should be sent to the laboratory within 24 hours, but should be sent anyway if this is not possible.

6. Sentinel Nodes in Gynaecological Malignancies: SWAGGER and British Gynaecological Cancer Society (BGCS) Guidelines Update

Please see the presentation uploaded on to the SWCN website here.

Presented by Claire Newton (CN)

Images of the use of indocyanine (ICG) which, in fluorescent mode, allows the surgeon to visualise the lymph channels and follow them to identify nodes, are included in the presentation. This reduces the number of nodes that need to be removed, lessening related morbidities.

Sentinel lymph node (SLN) practice currently varies across the SWAGGER region, which is a reflection of national practice.

In the experience of the Bristol team, who have had 40 cases to date, the SLN can sometimes be outside the expected area. Of the 14 cases at Grade 2, 7% had a positive node and of the 26 cases at Grade 3, 4% had a positive node, informing the treatment options to include chemotherapy as well as radiotherapy.

Of the 40 cases, there have been 3 local and 3 distant recurrences, and 3 deaths.

The data on Grade 2 and 3 patients will be analysed separately in the next review.

Evidence of the use of SPECT will hopefully be provided by the next randomised controlled trial.

BGCS sentinel node guidelines on vulval, cervical, and endometrial cancer are documented within the presentation.

For vulval cancers, blue dye is used as opposed to ICG as there is insufficient evidence to prompt a change in techniques at present.

The SWAG Clinical Guidelines will be updated to include the most recent evidence. **SWAG Chair/HD**

ACTIONS

The PORTEC-3 trial, which compared chemo-radiotherapy (CT/RT) with radiotherapy alone for patients with high risk endometrial cancer, showed a clinically significant improvement in overall survival in the CT/RT group, with no significant difference in serious adverse events. There was an increase in Grade 2 adverse events, in particular sensory neuropathy. No treatment related deaths were reported. This raises the question, should all patients with endometrial cancer be treated with CT/RT regardless of stage. It is hoped that this will be answered by PORTEC-4.

7. Review of Trachelectomy Service Provision

Presented by Amit Patel

A proper review cannot take place at today's meeting, as it has not been possible for surgical representatives to attend from the Peninsula. A proactive plan to move towards a centralised trachelectomy service is felt to be preferable due to the rarity of relevant cases and the need to have sufficient numbers to provide robust training and audit outcomes. The group could decide who should provide the service and identify appropriate locations, ideally divided across the network, to reduce the need for patients to travel. This will be revisited at a future meeting. **Surgical team**

8. British Gynaecological Cancer Society (BGCS) Programme 2020

Presented by Philip Rolland (PR)

Cheltenham is hosting the BGCS conference on Thursday 9th and Friday 10th July 2020, with an additional day just for clinical oncologists on Wednesday 8th July 2020. Guest speakers need to be identified, and an agenda planned with topics that include all clinical groups, with input from charities and patients. CNS Tracie Mills (TM) had observed some excellent patient speakers at a recent conference, and will contact the organiser for their details. Potentially, the 5 cancer charities could collaborate to present something along with patient representatives in 5-10 minute slots. Feedback from previous conferences will be used to inform the structure of each day. The conference could include the following:

- Clinical trials update (DESKTOP III looking at secondary cytoreductive surgery for recurrence of ovarian cancer is due to report, and potentially INTERLACE)
- Unit leads session
- MDT meeting reforms
- Nursing forum
- Review of the latest Artificial Intelligence / technical innovations
- Thursday evening social event
- Pathology section
- Radiology section
- Genomics update
- National Ovarian Cancer Audit
- Systemic treatment review
- BGCS guidelines
- Molecular profiling
- Hormone Replacement Therapy in cancer survivors
- Circulating tumour cells.

It would be helpful to have networking slots early in the conference schedule. **ACTIONS**

Formal invites will be sent out in December 2019. **PR**

9. Date of next meeting: Friday 9th October 2020 in Exeter; time and venue to be confirmed.

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