Somerset, Wiltshire, Avon and Gloucestershire (SWAG) Cancer Services

Meeting of the SWAG Network Oesophago-Gastric Cancer Clinical Advisory Group (CAG)

Friday 30th September 2022, 13:00-17:00
Hotel du Vin, Lewins Mead, Bristol BS1 2NU / MS Teams

Chair: Mr Paul Wilkerson (PW)

	NOTES (To be agreed at the next CAG Meeting)	**ACTIONS**

1. Introductions/review of previous meeting report

Please see the separate list of attendees and apologies uploaded on to the SWAG website here.

As there were no amendments to the report from the previous meeting held on 21st January 2022, the report was accepted as finalised.

Work Programme Progress Report:

009/15: Personalised Care and Support: Implementation of End of Treatment (EoT) draft templates:

The draft EoT templates will be revisited following advice from the Lead Cancer Nurses that they should be addressed to the patient rather than the GP.

002/18: Review of surgical research nurse resource: This has been resolved; action closed.

003/18: Development of a record of dysplasia treatment booklet:

A booklet has been drafted which will be given to patients at diagnosis to inform them about the different procedures and treatment / follow up pathways. It will be used to record details of every appointment and procedure undertaken.

Action: To add further details to the booklet on Endoscopic Submucosal Dissection (ESD); it will then be circulated for use across the region. — **P Wilkerson**

001/19: To seek information from the WesFit Trial:

Action: It was still felt to be relevant to ask a guest speaker from the WesFit trial to provide a presentation on prehabilitation prior to surgery. — **H Dunderdale**

006/19: NOGCA: UHBW audit of proximal margins:

Action: Agenda item for the next meeting — **Surgical team**

009/19: Implementing a timed OG pathway:

A Southwest Endoscopy Group has been established to optimise use of endoscopy resources and so the action can be closed for the OG CAG.

002/22: Highlight the problems with genetic/molecular turnaround times to the Cancer Operational Group:

An email was sent to COG from H Dunderdale on 21st January 2022. Action closed.

003/22: To share details of the streamlined pathway in Cheltenham (combined contrast CT and PET immediately after diagnosis):

Action: A paper is due to be published on the streamlined pathway in the near future which will be an agenda item at a future meeting. **S Dwerryhouse**

004/22: To investigate with NOGCA PET denominator data inclusions to see if this just includes those undertaking curative treatment or if it includes all cases:

NOGCA confirmed it is those with a curative treatment plan intent (per the data items in the 'care plan' section).

This means it includes all patients who have a curative treatment, including chemo-rad, major surgery and endoscopic surgery. Endoscopic Mucosal Resection (EMR) patients will be included and therefore it is unlikely that a result of 100% will be possible as these patients won't necessarily need PET.

It remains a difficult data item to capture with accuracy and to monitor/assure. H Marder is trying different ways to achieve this so hopefully it will improve this year for the UHBW diagnosed patients.

2. Coordination of Patient Care Pathways

2.1 28 Day Pathway Project and RDS Service Update

Please see the presentation uploaded on to the SWAG website

Presented by A Randle

The 28 Day Pathway Mapping Project has been prompted by the national strategy to improve early diagnosis. It will investigate how the pathway can be improved from raising patient awareness of symptoms through to GP referral or alternative referral routes where appropriate.

Work has been undertaken to increase use of Faecal Immunochemistry (FIT) Tests to avoid unnecessary colonoscopies, and a letter will be sent to System Leads, as recommended by the Royal College of Gastroenterologists, to state that patients fitting certain criteria with a negative FIT do not require referral to the colorectal suspected cancer pathway, and should be referred via an alternative route.

This may present a risk to the Upper GI suspected cancer pathway, as this may be considered one of the alternative routes, and although some patients will be

appropriate to refer via this route, it is thought that around 80% of these patients will be suitable for management in Primary Care.

To manage this, there needs to be greater clinical confidence in the effectiveness of the test, and of undertaking a thorough patient centred assessment to make a shared decision about referring onwards or not.

In the interim, there will be a learning period where GPs may refer via different suspected cancer pathways due to concerns that cancers will be missed.

The approach A Randle is taking is to imagine a patient that doesn't have cancer who presents with symptoms that meet NG12 criteria (97% of which won't have cancer) and identify the tests needed to rule out cancer for each symptom.

In the recent colorectal cancer pathway consultation, there were several comments about patient symptoms that would lead to concern of Upper GI cancer and should trigger referral for CT Chest/Abdomen/Pelvis, which is why the UGI pathway is being prioritised next.

A questionnaire has been put together for feedback from the group and other clinicians associated in the referral / diagnostic process. This will inform changes to the suspected cancer referral forms and ensure referrals are appropriate.

Cases will be considered that can bypass the GP and be referred by other clinicians.

The questionnaire details each NG12 symptom separately and the proposed tests.

One of the criteria to be determined is who should be referred to a routine endoscopy rather than an urgent endoscopy.

Action: CAG recommend removing the investigative test of ultrasound to rule out abdomen mass, which is outdated and could lead to false negatives, and replacing with CT prior to circulating the questionnaire. **A Randle**

The only effective investigation to rule out oesophageal and gastric cancer is endoscopy. For all other cancer sites, it is most likely a CT which should be undertaken after identification of any palpable abdominal mass.

GP direct access to CT needs to be available with equity across the region. **CAG recommendation**

To further improve outcomes, it would be beneficial to have the capacity to screen patients with reflux.

The conversion rate of two week wait referrals for endoscopy to cancer diagnosis was requested; H Marder reported that this was currently 5.8%.

The age criteria in NG12 guidelines are thought to be outdated and a barrier to referring appropriate patients.

Action: A project will be undertaken to map the referral pathways of patients diagnosed under the age of 55 for the purpose of identifying causes/mitigating risks of delayed diagnoses in this patient cohort. Cancer Manager H Marder will create a patient list of the UHBW patients. **H Marder / D Titcomb**

Although the team are seeing more patients diagnosed at a younger age, numbers are still relatively low across the network; historical data would need to be analysed to draw any meaningful conclusions.

To get the full picture, it would be useful to look at GP practice contacts and interview patients to see if they delayed making appointments with their GP.

The suspected cancer referral form could then be amended to try and address any themes identified.

The pathway of a recent patient under the age of 40 had already been mapped by the CNS team. Over the course of 18 months, multiple visits were made to the GP and to an Emergency Department until the patient's eventual presentation to the OG team with unresectable metastatic disease.

Although oral endoscopy is the gold standard test at present, wider roll out of naso-endoscopy may be a service improvement that could help with capacity as it requires less infrastructure and as sedation is not needed, recovery time is quicker.

FIT negative patients with chronic diarrhoea should be referred to gastroenterology.

3. Service Developments

3.1 Interventional GI Endoscopy

Presented by P Wilkerson

The UHBW OG service already offer EMR, Radio Frequency Ablation (RFA) and Endoscopic Submucosal Dissection (ESD) for patients with dysplastic Barrett's and early dysplastic squamous lesions. However, ESD is currently a single-consultant service run by Consultant Gastroenterologist E Alexandridis, resulting in longer waiting times in comparison with EMR or RFA.

After trying to source funding for some time, it has now been possible for the cost to be covered by the Cancer Alliance and formal training has been booked in Strasburg for P Wilkerson and B Byrne in November 2022, which will improve scheduling these procedures in the future.

3.2 Artificial Intelligence Platform for Barrett's

Presented by P Wilkerson

Work is underway with a research team from the University of the West of England, aiming to build a machine learning programme for identifying Dysplasia in Barrett's at endoscopy. It is currently at the grant application stage and has three aims:

- To never miss a diagnosis of Barrett's Dysplastic
- To explore whether the machine meets quality standards for assessment of imaging to avoid biopsy. It will be compared with PIVI (Preservation and Incorporation of Valuable Endoscopic Innovations) guidelines for this purpose

- To distinguish between inflammation and low-grade dysplasia to avoid the need to wait 6 months and do another biopsy and endoscopy before a decision to treat can be made.

The machine has already been proven to be more sensitive than the human eye.

A newly published article in the Endoscopy Journal, undertaken by a Dutch centre, showed that patients had flat lesions identified via biopsy that were otherwise indistinguishable on endoscopy, by taking biopsies of low-grade dysplasia and sending for analysis to an expert centre.

The study, which had a cohort of 250 patients, found that 25% had high-grade dysplasia or cancer, indicating that it may be appropriate to send these patients straight to magnified endoscopy rather than wait for six-month endoscopy surveillance to improve earlier diagnosis.

Action: P Wilkerson and E Alexandridis will meet outside this meeting for further discussions. **P Wilkerson / E Alexandridis**

4. Research

4.1 NIHR Clinical Trials Update

Please see the presentation uploaded on to the SWAG website

Presented by S Gangadhara / C Matthews

Research Delivery Manager C Matthews manages the cancer portfolio for West of England. Consultant Oncologist S Gangadhara is the Research Sub-Specialty lead for UGI.

National recruitment data to UGI trials shows that 13,499 patients were recruited in April - March 2021/22, which is higher than in 2019/20, and 3,226 from April 2022- September 2023, which is slightly lower to date. The dip in recruitment in 2020 caused by the pandemic, has now resolved.

The list of trials open across the region, broken down into early and advanced disease sections, plus the trials in set up, are detailed in the presentation. CAG members are encouraged to cross-refer patients to relevant trials that are open in alternative centres.

In RUH, trial recruitment has slowed over the last three months due to workforce shortages in the Aseptic Department, causing clinical trials to take a back seat. This is slowly being resolved.

The annual Participant in Research Experience Survey (PRES, 2021/22) undertaken by the CRN received 1924 responses from a wide range of studies: a significant increase from the previous year. 93% of participants would consider taking part in research again and 92% felt the researchers valued their participation.

Positive comments include support from research staff who provided great communication, that participation was easy and well organised, and that it helped to contribute to improving healthcare for others.

Recommendations include improving car parking facilities, some areas for improving communication, availability of test results, clear contact information for the study team, and clinic times out of working hours / at weekends.

NIHR website links and team contact details are available within the presentation.

As raised in the previous meeting, trials are sometimes in competition to recruit from a small pool of patients with similar eligibility criteria, which can cause confusion over which to prioritise. It would be preferable to concentrate on one such trial to ensure recruitment to time and target rather than opening similar trials.

The CRN aim only to open similar trials in one centre across the region and sign a declaration about competing trials as part of the set-up process then use this to guide recruitment targets and identify when the trials might be open.

Action: The CRN will circulate a list of trials with top three eligibility criteria for review within the MDT meetings — **C Matthews**

It may be appropriate to liaise with Consultant Oncologist A Dangoor about providing information on clinical trials as he is working on a patient information portal project.

Action: C Matthews and S Gangadhara to liaise with A Dangoor about the Patient Information Portal Project — **C Matthews, S Gangadhara**

5. Clinical Guidelines

5.1 Systemic Anti-Cancer Therapy Protocols

Please see the presentation uploaded on to the SWAG website

Presented by H Dunderdale on behalf of Network Pharmacist K Gregory

After SACT protocols have been reviewed by site specific oncologists and signed off by Consultant Oncologist J Braybrooke and K Gregory, they are uploaded on to the SWAG website here.

Website activity shows over 27,000 new users over the last 12 months and approximately 300 people accessing the site per day, which currently contains 380 protocols. It is also used by people outside the UK.

There are currently 26 protocols available on the website for UGI, 21 of which need to be reviewed and updated. It is acknowledged that this is a lot of work, but provision of national protocols is not expected soon.

K Gregory requests volunteers to help with the updates. It is anticipated that many will need very few amendments and shouldn't take too long.

The Pembro/Cisp/Cape protocol is currently being drafted.

Action: CAG Oncologists are asked to send request forms for any additional protocols needed. **CAG Oncologists**

6. Service Developments Continued

6.1 Cytosponge – Interim National Data

Please see the presentation uploaded on to the SWAG website

Presented by N Chapman-Hart

Innovation Programme Manager, N Chapman-Hart for the National Cancer Board, is facilitating several innovation projects to support the national strategy to improve earlier diagnosis, one of which is implementation of cytosponge for OG services.

Cytosponge has been developed to diagnose Barrett's oesophagus in patients with reflux disease by R Fitzgerald at the University of Cambridge. Pathology is undertaken centrally by an independent company.

The sponge is in a capsule on a string. The patient swallows the capsule while holding on to the string. Once in the stomach, the capsule dissolves, the sponge expands over a few minutes and then withdrawn using the string which takes a cell sample that is then sent for analysis. TFF3 biomarker has been shown to diagnose Barrett's with a sensitivity of 80% and a specificity of 94%. Cytosponge can also detect other clinically relevant oesophageal conditions.

In response to the COVID-19 pandemic, the pilot has been implemented in Secondary Care in 30 Trusts in England to be used as a triage tool to reduce endoscopy demand. It is dispensed by endoscopy nurses for patients on a routine referral for acid reflux and for surveillance for those diagnosed with Barrett's. It is hoped that it can be moved away from Secondary Care into community settings.

From between September 2020 to August 2022, 4,200 patients have been seen via the pilot.

At the beginning, the focus was on patients with reflux, but now it is increasingly used in Barrett's surveillance.

The flow chart for management of results is documented in the presentation.

A small proportion of patients had inadequate samples, which is usually due to problems swallowing the sponge and it reaching the stomach. The test is usually repeated or an endoscopy may be necessary at that point.

Data to date shows about 1% of patients being referred for urgent endoscopy, 24% going to routine endoscopy and 75% discharged back to their GP with support for symptom management, saving 75% of endoscopies.

Further follow up data was required on how many false positive and false negatives might be in that 75% group.

It was noted that the pilot is only in low risk patients with reflux and no other alert symptoms.

There was a case where cytosponge didn't pick up an advanced cancer, but there were a number of alert signs that should have resulted in a referral straight to endoscopy.

There was another case where cytosponge picked up abnormal cells but not P53; the patient was referred on to endoscopy anyway and the cancer was picked up.

If there are any problems with the sponge, such as blood staining or a slack string, training instructs that the sample should be repeated on the spot or the patient should be sent for endoscopy.

The Barrett's cytosponge result flowchart takes into consideration clinical risk factors to decide on the surveillance schedule according to the BSG guidance. 90% of patients were found to be in the low risk category and were not referred for endoscopy.

There are evidence gaps and so the pilot is being evaluated by NICE to support wider roll out. This will include assessing the impact of the device, health economics and evaluating the patient experience. The reflux assessment is due in March 2023, and Barrett's later next year.

Preliminary data suggests that it is effective at reducing endoscopy and preferred by patients. The device is £300, whereas the endoscopy tariff is £400.

Whether it is most appropriate to continue in Secondary Care or move to a community setting has yet to be decided.

It was not considered possible to compare the consumable cost of a product with a service tariff. The consumable cost of endoscopy was the cost of the biopsy and nasal cannular which are relatively inexpensive, and the tariff includes workforce and investment in equipment. If changing to cytosponge, the workforce cost will need to be calculated.

It is hoped that the cost of the cytosponge will be reduced.

Data on the sensitivity / specificity for identifying dysplasia in patients that have been diagnosed with Barrett's is required. A paper comparing results from endoscopy versus cytosponge was published recently.

Action: To circulate publication on endoscopy versus cytosponge for assessment of dysplasia in patients diagnosed with Barrett's. N Chapman-Hart

Long term evaluation will be required to give reassurance that it is appropriate to replace a highly accurate endoscopic procedure with cytosponge. It is felt that this should be targeted towards the lowest risk patients and not for those patients with subtle lesions that can be offered treatments to avoid oesophagectomy.

The early phase study CYTOFLOC has recently been published, which used cytosponge to assess for residual disease post chemo-radiotherapy. It was found to be safe to use for surveillance as an adjunct to endoscopic surveillance. Phase 2 and 3 studies are now required.

7. Personalised Care and Support

7.1 Dietetic Assessments for New OG Patients

Please see the presentation uploaded on to the SWAG website

Presented by S Perkins

The dietetic team were asked two questions:

- Where in the patient pathway should a patient diagnosed with oesophago-gastric cancer have access to a dietetic assessment?
- What is the recommendation for liver reducing diets in obese patients with oesophago-gastric cancer?

Early dietetic screening is recommended to identify patients at risk of complications after surgery to improve outcomes. Funding is currently available to support this due to the drive to implement prehabilitation initiatives. After providing this service for patients with Head and Neck cancer, the benefit of building relationships early on with patients to quickly address malnourishment, advise on healthy weight loss, and monitor progress over time have been observed.

It can be challenging to achieve due to existing resources and starting conversations about nutrition when a patient has just received a cancer diagnosis.

There are currently disparities across SWAG, with patients at NBT receiving an hour-long specialist dietetic review at diagnosis on the Monday morning clinic. Patients with a pancreatic diagnosis will be started on Creon at this point.

The UHBW team often don't see patients until later in the pathway.

In RUH, there is a dietician available to which patients are referred if there is any dietary cause for concern.

A part-time dietician covers OG clinics in Weston General.

SFT have recently received Macmillan funding for dietetic support for OG and Head and Neck. The dietician attends the oncology huddle where the CNS team alert them to patients requiring dietetic support. There is no specific clinic, but this has much improved access.

YDH have a similar process, with most patients picked up by dietetic services prior to seeing an oncologist.

It was not possible for the majority to see every patient at diagnosis with existing resources although this was considered preferable as, in NBT, it has been shown to prevent emergency admissions with complete dysphagia and can lengthen the time before a stent is required.

The UHBW team consider that a high proportion of patients would benefit from earlier dietetic input, and either the model of seeing everyone at diagnosis or via ad hoc referral would significantly improve the current service.

Reduction of emergency admission by providing patient education is recommended; dietetic support for all patients should be the gold standard.

Provision of dietetic advice also provides patients and carers with a level of control on managing the impact of the diagnosis.

A dietician would need to start attending the OG clinic on a weekly basis and absorb the additional workload of associated follow up.

The first step to which the group should aspire is attendance at clinic where patients with symptoms of concern can be identified and all patients can be given initial information, and the volume of work for ongoing monitoring can be assessed.

NOGA data on dietetic support is currently optional, but more than likely to become mandatory data collection, which may help drive these service improvements.

Dietetic support is currently very limited in UHBW, with the vast majority focused on surgical inpatient care.

There needs to be additional resources for OG Specialist Dieticians to assess patients during neoadjuvant treatment prior to their curative intent surgery.

It is planned to recruit a dietician to work with the Cancer Supportive Care service.

Retaining the Dietetic post in NBT is a constant pressure for the staff as it requires resubmitting a business case for approval every year, despite being able to show the benefit to patients.

Although it is felt that some patients may find dietetic information at the point of diagnosis overwhelming, many find it helpful; the NBT service have never had a patient refuse a dietetic consultation.

In conclusion, it is currently not feasible to have a standardised approach across each centre due to existing resources. At a minimum, patients with symptoms of concern should be identified at diagnosis for dietetic referral, with the ideal set

up, when resources allow, being referral of all patients and appropriate ongoing monitoring.

Action: To investigate the dietetic support available to non-oncology patients in YDH — **P Wilkerson/L Toy**

Action: UHBW to investigate resource needed to move towards seeing every patient — **UHBW Dietetics**

7.2 Liver Reducing Diet

Please see the presentation uploaded to the SWAG website

Information on the current evidence, practice, potential risks, benefits and limitations are available in the presentation.

The diet is being used for increasingly more cancer sites prior to surgery, and a balance needs to be struck between making surgery safer for obese patients and managing nutritional needs to facilitate recovery.

It is challenging to monitor which patients are ideally suited for the diet; the decision cannot be made based on BMI alone as it could be an obese patient that is particularly malnourished.

The changes in dietary advice at different points in the pathway need to be clearly communicated to patients.

It will be clarified that the diet is specifically for those undergoing cholecystectomy, and alternative early healthy eating advice can be provided to other cancer patients.

If it is felt that the liver reducing diet should be used prior to other surgical procedures, there would need to be a plan to ensure that it could be safely evaluated.

Discussion:

Some patients will not be eligible for surgery unless they lose weight. It is ideal that this happens over a longer period of time rather than the rapid weight loss liver reducing diet, which again emphasises the need for early dietetic input.

The liver reducing diet is used to make the liver softer and less prone to injury, which makes the diet appropriate and safer for those patients with a stiff fatty liver requiring urgent surgery where the liver needs to be manipulated. This will be for a low number of carefully selected patients per year where initial attempts for healthy weight loss have failed. It is hoped that the number will reduce when early dietetic input has been put in place. **AGREED**

The team in Plymouth, where there is a bespoke bariatric unit, may have information to share that will help inform governance on use of the diet.

It was noted that no concerns have been raised since practice had changed to stop automatically providing jejunal feeding post operatively.

8. Patient Experience

8.1 Cancer Supportive and Palliative Care Service

Please see the presentation available on request

Presented by Consultant in Palliative Medicine C Chamberlain

The initial Enhanced Supportive Care pilot was paused during the COVID-19 pandemic, but has now recommenced in UHBW, with access to a Consultant in Palliative Medicine 24/7 plus two outpatient clinics a week, providing timely support to patients with a severe life-threatening or life-limiting diagnosis in BHOC or beyond. It is a Trust wide service split between medical and surgical presentations.

Evidence from national trials on implementing supportive interventions months before someone dies show significant benefits in terms of Quality of Life, improvement in life expectancy in some cases, helps carers manage bereavement, and has health service cost savings, reducing emergency admissions and length of stay.

Changing the terminology of the service to supportive care, focused on managing symptoms, rather than using the term palliative, encourages patient engagement.

The service was first launched in The Christie in 2014 for patients with incurable and curable cancer. Other Trusts also provide the service for patients with other diseases.

Evidence from UH Plymouth is available that shows the cost benefits and includes a patient experience survey that shows how many Oncology and GP interactions were avoided by having access to supportive care; total savings over 12 months were £55,000.

The positive impact on QoL was provided by increased access to relevant Allied Health Professionals providing tailored support.

A cumulative increase in referrals was seen across the three cohorts (UGI, Lung and HPB).

In UHBW, the service has ring-fenced funding from BNSSG for two years, and will initially be provided for HPB patients, then roll out to OG after the first three months. It is hoped to expand to Lung and other cancer sites if resources are expanded.

As well as access to the Consultant in Palliative Medicine / Specialty Doctor, the team will include 1.2 WTE Clinical Nurse Specialist and a Dietician, Occupational Therapist and Physiotherapist one day per week; the roles are due to be advertised in October 2022.

The service will be continually evaluated.

It is hoped that patients with incurable cancer can be optimised to tolerate further cycles of SACT, and that links can be forged with geriatric oncology to further tailor treatment options.

Finding clinic space was a challenge. Approaching the chemotherapy unit in South Bristol Community Hospital was recommended.

All patients flagged for Best Supportive Care (BSC) who are eligible for a palliative therapy can be referred via the MDT.

The CNS team currently refer patients for BSC to the hospice, who only accept the referrals when the patient is symptomatic or very near end of life; the Supportive Care service will address this gap in oncology care provision which is currently managed by the CNS team.

A similar Supportive Care Service has been running in SFT. This hasn't reduced the patient support provided by the CNS team, but rather runs alongside and complements it.

Most hospitals have an ESC service now; RUH is an outlier.

There is a National ESC steering group that will define how to measure the service and help develop business cases.

The transition between ESC and community palliative care, which are really short of resources at present, needs to be optimised.

8.2 CNS Update

From the previous meeting, a discussion was had about the psychological harm caused by same day cancellation of surgery.

There was an action to raise this with the psychology network group and look into the information that could be provided on the day; this will be revisited.

Action: H Dunderdale will recirculate the draft PIL and contact the Psychology Network Group to add to the agenda of their next meeting. **H Dunderdale**

In the interim, the team try to manage patients' expectations by letting them know that there is a one in three chance of being cancelled on the day, and providing them with a new date before they are discharged.

8.3 National Cancer Patient Experience Survey Results (2021)

Please see the presentation uploaded on to the SWAG website

Action: Due to time constraints, results from the NCPES will be circulated after the meeting. **H Dunderdale**

9. Any Other Business

Asymptomatic patients are not routine scanned post resection in the 6 month follow up clinics. A trial is underway that will hopefully refine recommendations for surveillance in the near future.

It is helpful to flag which patients need a feeding Jejunostomy in the MDT so that they can be booked as an inpatient to the correct theatre list.

Date of next meeting: To be agreed by Doodle Poll, Spring 2023

-END-