Meeting of the SWAG Urological Cancer Clinical Advisory Group (CAG)

Thursday, 18th November 2021, 12:30-17:00
Hybrid Meeting: Engineers' House, Clifton Down, Bristol/MS Teams

Chair: Mr Jaspal Phull

NOTES **ACTIONS**

(To be agreed at the next CAG meeting)

1. Welcome and apologies

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

Apologies were noted from Co-Chair L Poulton.

2. Clinical Opinion on Network Issues

2.1 Regional MDT Service/MDT Reforms

Presented by J Aning

A pioneering project, sponsored by the Cancer Alliance, is due to commence in NBT on the use of artificial intelligence in prostate cancer MDTMs. The purpose of the presentation today is to provide an overview of how the MDTM has been baseline assessed and the logistics required to enable the project to start.

As all are aware, the NBT MDTM is high volume, with every pathology sample taken discussed, and high pressure; yesterday's MDT ran from 14:00-17:30 for example.

In 2019 (pre-pandemic), a survey of how people felt about the MDTM was conducted by the Cancer Clinical Advisory Group Service. Some quotations include:

- 'The meeting is too long'
- 'Do we really need to discuss all patients'
- 'There are increasing numbers of complex case discussions'.

These are considered familiar themes across the network.

Currently, there is limited time to discuss quality and improvement developments and it is felt that the meeting discussions could be further optimised.

Further baseline assessments were then conducted, including an audit from the point of view of the clinicians and wider urology team, and using the externally validated MDT audit tool MDT-Mode III.

NBT Urology MDTM is currently split into a network (external referrals), bladder and prostate sections.

The local audit, which was undertaken by two House Officers who could take an objective view, concluded that when all information was available, particularly in the pathology section of the meeting, most cases could be protocolised without formal discussion. Similar messages were concluded from the external evaluation, which showed an average discussion time of 2.10 minutes and discussion of clinical trials was recorded for 2 patients over the course of the three meetings assessed, showing a clear need for further optimisation of the meeting.

It was also noted that there is a lack of automated systems to allow data collection for continual audit of practice.

Somerset Foundation Trust is also involved in the project, where a similar baseline audit has been undertaken.

The AI product due to be used to facilitate the protocolisation process that the clinical team would otherwise do has been produced by a company called Deontics, which already has tools in use to successfully manage several other disease types. It achieves this by processing all of the relevant patient information and cross-references this with prostate cancer clinical guidelines (NCCN, NICE and EAU) which are embedded in the system.

Once data has been inputted on the left hand side of the screen, the recommendation for management appears on the right hand side of the screen, with green triangles for recommendations and red for those treatment options not recommended. When you click on the recommendation, it takes you to the page in the actual guideline for confirmation.

By July, funding had been obtained, baseline assessments completed, and the MDT had been process mapped.

Definition of the deliverables, payment to Deontics and confirmation of Information Governance processes then took some time to work through, particularly as the platforms sits on the Cloud. No patient identifiable data is leaving the Trust, but information about cancer parameters is. Information Governance requirements have been stipulated in the contract.

Development of the tool to check that the logic worked was then undertaken over a course of weeks, and now the project is due to commence in the near future so that discrepancies in outcomes from Deontics and actual MDT outcomes can be analysed.

The other aspect is that there is a clear, searchable audit log for all cases entered into the tool, making it possible to search back for example, at all positive surgical margins and check that standards are being maintained.

Thoughts from the group on the priorities for defining success would be appreciated, such as saving time, automated audit ensuring outcomes are accurate, etc.

Discussion:

It was considered possible to configure the platform to perform the same function for all other urological cancers.

Potential MDT Streamlining Initiative

It could be possible to assign consultants to put cases through the platform to generate outcomes and add any nuances around decision making as, from a clinical guideline perspective, there are some subtleties missing.

The provenance is clear that it also protects clinicians when it is occasionally difficult to reach a consensus, which can be demonstrated in the baseline audits, where some cases that take 1 minute discussion in comparison with case discussions that take considerably longer.

It may be possible for the tool to be developed for use in monitoring post-treatment surveillance.

Clinical Guidelines do incorporate frailty score to evaluate life expectancy, which the tool also incorporates. However, this information is often not available to input. The ICE referral form has been adapted to try and improve provision of this data, and is pending approval by the ICE development team.

For the pilot, data needs to be entered in duplicate by a Data Manager, as well as the MDT Coordinator entering data on to the Somerset Cancer Register, although Deontics have a £1 million grant from NHSX to integrate the platform with the Somerset Cancer Registry (SCR) so that data can be pulled in automatically.

There is concern that certain details may be missed from pathology reports. Initially, Deontics intended to just report overall Gleason Grade, but now the tool has been customised to take into account left, right, and targeted biopsies, plus length and all additional factors reported.

If an MRI and biopsy result is discordant, the tool should pick up this and other nuances.

There will be a need to go through the list and pick out patients that need further discussion.

One element missing in the review of MDT processes is feedback that the MDT outcome has been implemented as agreed or, if altered, the reasons why. This could be used to rectify why the decision making did not fit the actual outcome and serve as a safety parameter for MDT governance.

This has been measured as part of the local baseline audit and will be presented once repeated.

Potential future agenda item

From a patient experience perspective, the speed with which decision making was being made may seem alarming. It would be good to clarify if presenting in a different forum that the speed is possible due to a completed dataset and clinical features falling within clear parameters.

Patient representative J Chambers was asked for her perspective, and was of the opinion that developments in AI were exciting as long as assurance processes are in place to make sure nothing is missed, and that patients did not necessarily need to know the detailed process by which an MDT outcome was decided, but more that they were going to be discussed by a group of professionals to determine the best treatment outcome.

Development of any patient information around this should be co-produced with patients and involve input from as many people as possible.

3. Review of last meetings notes and actions

There were no amendments to make to the report from the meeting held on 24th June 2021.

Review of the report highlighted the amount of work that is undertaken to bring together contributions to CAG meetings. Thanks were given to all for the visible and invisible work that goes on in the background to achieve productive meetings.

A presentation from the Cheltenham team on the correlation between Likert score on MRI and final pathology from radical prostatectomy is a project to which the team in RUH would like to contribute.

Streamlining of outpatient appointments had been raised as something to explore in the future.

Potential future agenda item

The presentation from E Rowe on centralisation of radical prostatectomy was awaiting a joint response from the RUH team.

Quality indicators, data extraction and sharing of regional data that translates to service delivery in the era of BAUS data collection coming to an end, was also discussed.

CAG members are asked to consider ideas for how this might be achieved and what outcomes should be collected, with the aim of showcasing how the regional service is governed.

Action 008/21: CAG members to consider how to collect and share regional data. **CAG members**

4. Patient Experience

4.1 National Quality of Life (QoL) Survey Results

Please see the presentation uploaded on to the SWAG website

Presented by J Chambers

As well as being the regional SWAG Cancer Alliance Patient Representative J Chambers is a Patient Representative on the National Cancer Programme Board, and has developed a National QoL survey in response to the ambition set out in the NHS Long Term Plan. She attends today to present findings from the prostate results, first published on 25th October 2021, and available to access via the following link: www.CancerQoL.england.nhs.uk

Although late effects of cancer treatment are reasonably well known, the survey has been developed to further raise the profile of having QoL discussions, and is an opportunity to gather evidence to support service improvements from a QoL perspective.

A personal overview on the effect of cancer treatment on QoL was provided.

It is hoped that the survey results will provide more understanding of the impact of cancer treatment and the balance of those factors in comparison with the priorities of the patient, in order to best support people to live with and beyond cancer.

Patients are invited to complete the survey 18 months post diagnosis, with the aim of capturing feedback from both primary and metastatic patients.

From September 2021, 100% of Breast, Colorectal and Prostate patients were sent the survey, and from October it was rolled out to all cancer sites.

Invites to complete the survey online are automatically sent by the National Cancer Registry; paper copies are available for those who do not wish to complete online. To maximise diverse response rates, it is available in multiple languages and there is a helpline for queries.

The National Personalised Care and Support Team will use the data to prioritise relevant work that needs to be commissioned. At a regional level, the data can be compared with National results to identify areas of best practice and areas of concern.

Patients get a summary of their results to prompt discussion of any problems identified when in consultation with members of the clinical team; positive feedback has already been received from patients that this has helped empower them to raise QoL issues.

The first tranche of prostate data was released on the 25th October 2021. The data can be filtered by geographical region, cancer type, age, and gender, plus other factors in the near future including stage of diagnosis and treatment.

The survey does not have an end date and will roll on for the foreseeable future.

There are many different ways to view the data; the presentation today includes only the SWAG specific prostate data.

The majority of responders are from white 60-80 year olds.

The EQ-5D questions, which can be compared with responses from the general population that haven't had cancer, show that a higher percentage of cancer patients report problems in comparison with the general population across all 5 categories assessed. The most common response is that these problems are 'slight', which is difficult to interpret and should not be interpreted as unimportant to address.

Anxiety and depression is more common among the younger age groups, whereas problems with mobility, pain, discomfort and self-care increase as the age range increases.

Moving on to the results from the EM-RTC questionnaire, again, the vast majority of patients report slight problems, but also more severe problems are identified in this set of results, with the most common being physical symptoms such as difficulty sleeping, fatigue, constipation and lack of appetite.

Results are considered to be open to interpretation and can mean very different things to individuals, whose responses may vary depending on the day completed.

Feedback from the survey so far is that the questions are not detailed enough to identify specific areas to address. However, knowing that the majority of patients are reporting slight problems, there are many simple things that can be done.

Below are suggestions of things that could help, if possible:

- Advise that making lists can help to manage chemo brain
- Advise that planning each day's activities can help to manage fatigue
- Advise when a patient should contact the team with concerns and who they should contact
- Reduce 'scanxiety' by getting results to patients as soon as possible
- Provide continuity of care where possible
- Ask the patient what is the most important priority for them.

Patients can be sign-posted to a lot of existing relevant information.

Every contact counts to imbed QoL discussions right from the start.

The QoL comms toolkit is also available via the above link.

For more information, contact details can be found within the presentation.

Discussion:

The main aspect that stood out from the data was that the vast majority of problems were recorded as slight, and could potentially be addressed with minor changes rather than larger service developments that will take time.

It was noted that there was no link with the QoL data that could pick up which patients had been provided with a Holistic Needs Assessment. Further work was being undertaken to access eHNA data to get an overview of particular patient issues where HNAs are completed in the patient pathway, and make this information available to teams.

Action 009/21: To add analysis of HNA data to a future agenda

H Shallcross / H Dunderdale

Ideally, the data should show how a patient's QoL has changed following cancer treatment. At present it only shows how the patient feels at that moment in time.

There are limitations to the questionnaire that need to be addressed.

The decision to send the survey 18 months post treatment was made as it allowed time for the shorter-term side effects to settle down and longer term side effects to become apparent.

QoL studies run in parallel with clinical research trials are also open to criticism for leading to meaningful actions; for example, a recent study which involved analysis of QoL 4 weeks post treatment followed by a 6 week assessment showed a great number of disparities.

The main message to take away from the QoL discussion is that every interaction matters.

5. Research

5.1 Clinical Trials Update

Please see the presentation uploaded on to the SWAG website.

Presented by C Matthews/A Bahl

West of England Research Delivery Manager C Matthews provided an update on research activity for urological cancers.

Apologies were given that it had not been possible to source research data from Taunton and Yeovil in time for the meeting today, as the geography of the research networks differ from the Cancer Alliance footprint.

Since April 2020, over 10,000 patients have been recruited to 141 studies nationally. The vast majority of these have been non-commercial trials, with a fairly even split between observational and interventional.

Trial recruitment is starting to recover post-pandemic, more so than in the majority of cancer sites, and thanks were given for the hard work involved in continuing to recruit patients during this difficult period.

There are currently 15 trials open in the West of England. Those highlighted in green are recruiting to time and target; those highlighted in red are currently below recruitment to time to target, which is not a priority focus at present but is still being monitored.

There are 4 studies included in the managed recovery programme; classed as particularly important to complete:

- Add-Aspirin
- UK P3BEP
- PIVOTALBoost
- Phase 3 study of TAVT-45 (metastatic prostate cancer patients).

TAVT-45 has recruited 2 patients nationally to date, one of which was recruited in Gloucestershire.

For further information on the studies, please follow the links embedded in the presentation, plus contact C Matthews and A Bahl for any other queries.

There are four studies currently in set-up in the SWAG region:

- SPLASH
- Volga
- MK6482-011
- Phase 3 study of Viralym-M in patients with virus associated HC.

Further information on their current status will be requested from the Principal Investigators.

It was recognised as a challenging time to open new studies while at the same time trying to recover from the pause during the pandemic.

Nationally, there is a list of studies that are not being set up in SWAG at present; CAG members are invited to contact the team if interested in opening any of them in one of the SWAG sites.

As usual, the Clinical Research Network (CRN) remains accountable to the Department of Health and Social Care for delivering the High-Level Objectives detailed in the presentation, in order to secure continued funding.

Teams involved in the priority studies are to contact the CRN If additional resources are required to support recruitment.

A Participant in Research Experience Survey (PRES) is used to measure participant experience. There was a target of 1,155 responses to meet this year, based on the previous year's recruitment figures and, despite current pressures, 928 surveys have been returned to date.

The aim is for 5% of participants recruited to return surveys. Returns vary across Trusts. It is thought that they are generally handed out by Research Nurses. The CRN or local R&D departments will have supplies of them.

It is important to ensure that the study identifier is written on paper copies for these responses to be included in the metrics.

Links to further information on the studies and the CRN contact details are included in the presentation.

Strategies to ensure equity of access for patients to take part in trials open in other centres, by a more formal route, are being investigated by C Matthews and Research Lead H Winter. Currently, cross-referrals in SWAG do occur on an informal basis. This was an outstanding action on the CAG Work Programme.

Action 010/21: A Bahl, J Phull, H Winter and C Matthews will meet to discuss how to further incentivise cross-centre referrals	**A Bahl/J Phull/H Dunderdale/C Matthews**

6. Clinical Guidelines

6.1 Updated Supra-regional Penile Cancer Guidelines

Please see the presentation uploaded on to the SWAG website

Presented by A Manjunath

Since the last iteration there have been changes made to the Penile Cancer Guidelines, which now need to be ratified by the group so that they can be disseminated to all referring hospitals and other Cancer Networks that follow the Supra-Regional Guidelines.

The network covers the footprint of the previous Three Counties, SWAG and the Peninsula Cancer Alliances, covering a population of approximately 5 million. The North Bristol Trust service is one of nine across the UK.

Changes to the guidelines:

Personnel

Previously, Consultant Surgeon D Dickerson was the only designated Surgeon. Now Consultant Surgeon A Manjunath has joined the service, along with additional support from pathology and Clinical Nurse Specialists.

NHS England penile cancer care guidelines 2019

In 2019, NHS England published an updated service specification; penile cancer services sits under the centralised funding body of specialised commissioning. This specifies how the service should be organised as a Supra-Network, with all operations carried out at the specialist MDT site by the dedicated specialist team.

Occasionally, surgical cases may be devolved to another hospital, if, for example, the patient is too frail to travel or doesn't require a very specialist treatment, although these cases are in the minority.

All penile cancer cases must be discussed at the specialist MDT meeting to ratify the treatment and discuss the histology.

The core minimum team comprises 2 surgeons, and specialist oncologist specialist CNS, pathologist, radiologist representatives and other allied support, such as palliative medicine and lymphoedema, as advised by NHS England.

Clinical pathways

Previously, a biopsy was required before patients were referred, however, now in cases where there is a clinically obvious penile tumour, referrals will be accepted to speed up the patient pathway.

If there is a phimosis and the extent of the tumour is not easy to assess, teams should avoid circumcising these patients, which can make definitive organ sparing surgery and reconstruction more complicated. Instead, a dorsal slit and biopsy is recommended.

The penile cancer MDT meeting is held every Wednesday afternoon. CAG members are welcome to join virtually or attend in person.

In a two week cycle there are three specialist clinics and seven operation lists mitigating the risk of any delay in treating these patients.

The terminology used to describe pre-malignant penile lesions terminology has changed, with all cases now described as Penile Intra-epithelial Neoplasia (PeIN), and categorised as either Undifferentiated, HPV driven, with a higher chance of invasive malignancy, or Differentiated, with a low risk for malignant transformation.

The aim of management of the primary tumour is for organ sparing surgery whenever oncologically safe to do so. The most recent data from 2018 showed that a surgical margin of 1 mm appears to be safe, revolutionising the amount of organ preservation that is possible.

In appropriate patients, simultaneous penile reconstruction is offered. There is data awaiting publication from NBT that shows the benefit of this for sexually active patients.

Penile MRI scan is not a mandatory referral requirement and can be arranged by the specialist MDT. If it is performed locally, it is important that it is done with an artificial erection.

It is now possible to offer dynamic sentinel lymph nodes biopsies (SLNB) for inguinal nodes in the setting of non-palpable nodes. Previously these patients were either monitored or had inguinal lymph node dissection, which comes with a much greater morbidity.

It is expected that there will be a move towards minimally invasive inguinal lymph node dissections for those with palpable lymph nodes or a positive SLNB in the near future. It is hoped that this will reduce morbidity; there is some data showing that it reduces length of stay and wound complications.

Now, it is more common to offer robotic ipsilateral pelvic lymph node dissection to suitable patients with advanced inguinal node disease.

Oncological therapies include neoadjuvant chemotherapy in bulky, fixed inguinal node mass and adjuvant chemotherapy or radiotherapy in patients with pN2 and pN3 inguinal or pelvic nodal disease.

Relevant research trials include Impact, a global randomised multicentre study looking at management of palpable inguinal nodes, and EPIC, an oncology trial in locally advanced/metastatic disease.

Follow up

New follow up schedules are detailed within the updated guidelines, some of which devolve the follow up back to the local team to negate the need for patients to travel where appropriate.

Action 007/21: The Guidelines will be incorporated in the main SWAG guidelines — **Penile Cancer Guidelines Ratified**

Discussion:

It is possible for the regional centres to refer patients back to NBT for psychological support. Referrals can be made to the clinical team, who will refer the patient on to Macmillan.

Action 011/21: The penile cancer patient support group needs to be reinstated. — **Penile Cancer Team**

The service received between 50-70 new patients per annum.

The EPIC trial, which started in BHOC and is now open in 10 centres, gives the opportunity to access chemotherapy and immunotherapy for treatment of advanced/metastatic penile cancer. Although the PI would like to open recruitment to other sites across the South West, especially as there are limited treatment options for this patient group, unfortunately the BHOC has only been funded to provide Systemic Anti-Cancer Therapies to surgical patients. The specialist MDT will give their opinion on oncological treatments, but this must be delivered back in the local centres.

As a rare cancer group it would be preferable for the treatment to be centralised, although it wouldn't be appropriate for all patients who may not want to travel.

Action 012/21: To assess the patients' preference/numbers and funding resources required to make a case for centralising SACT treatment for appropriate cases. — **A Bahl/J Phull**

It is intended to distribute the updated guidelines via the other relevant network groups and also by providing some courses.

7. Coordination of Patient Care Pathways

7.1 Innovation in Bladder Cancer Management

Presented by H Burden

There have been a number of innovations in urinary biomarkers over the past year. The opinion of the group is sought on one particular option to potentially put forward to the SWAG Cancer Alliance and Commissioners to incorporate as a pilot pathway.

Biomarkers have been under investigation for many years; it would be ideal to have a marker that negates the need for a flexible cystoscope. Bladder cancer often has a long, intensive follow up schedule, at a substantial cost to the NHS, and in quite a comorbid patient population.

Over the past 5-10 years, none of the biomarkers had been sensitive or specific enough to compete with a flexible cystoscope. However, new ones coming through have taken a different approach.

The ideal biomarker would be easy to use, affordable, reliable, with a high degree of sensitivity and specificity and unaffected by other benign conditions.

Now the focus is on looking for a high negative predictive value (NPV), as recommended in European Association of Urology (EAU) Guidelines.

The potential test in mind detects MCM protein expression which is a marker of cell proliferation. The test is done in a standard ELISA format, doesn't need to be sent to a specialist laboratory, and requires 10 mls of mid-stream urine. Results are available in 2.5 hours at a cost of £35, compared to a flexi which is £300.

Two large multi-centre trials have been undertaken, both in the diagnostic and surveillance setting.

In the diagnostic setting, it was shown to have a 99% NPV. In the surveillance setting, it was shown to have a 99.5 NPV if you exclude low grade disease, and 93% NPV if included.

There could be advantages and challenges with introducing this to the patient pathway, as documented in the presentation.

This could potentially relieve the pressure on flexi lists.

The biomarker is yet to be incorporated in NICE guidance, which has not been updated in over 5 years.

In the diagnostic setting, it could be really helpful in the non-visible haematuria patient population, who are a relatively high burden on two week weight referral numbers. It could be undertaken alongside an ultrasound, and maybe stratify those that are negative to a routine flexi, and stratify those that are positive to go through the two week wait pathway. It could also be used in the non-urgent haematuria pathway, which currently doesn't have investigative guidelines.

Discussion:

In the surveillance pathway, initially it would probably be too risky to use in the high-risk group; potentially this could be the area where it would be most useful in the future.

If it was introduced in the low to medium risk group, even if it missed some recurrences, these would be picked up at the next cystoscopy.

Potentially you could replace this at various points in the surveillance schedule.

The management of patients on a low-risk pathway who subsequently develop a high-risk tumour should be picked up as it is very sensitive for detecting high grade disease.

Action 013/21: A Survey Monkey poll will be circulated to establish who would be interested in piloting use of the biomarker, and in what part of the patient pathway to establish consensus **H Burden**

7.2 Rapid Diagnostic Service Update

Please see the presentation uploaded on to the SWCN website

Presented by B Hill

SWAG Cancer Alliance Rapid Diagnostic Service (RDS) Project Manager, B Hill, attended to provide an update on the ongoing progress of the service in prostate cancer.

The seven RDS principles, which are part of the NHS E Long term plan to implement in all cancer pathways by 23/24, are intended to facilitate meeting the 28 day Faster Diagnosis Cancer Waiting Time Target (patient informed of diagnosis).

The principles include:

- Early identification
- Timely referral
- Broad assessment of symptoms
- Coordinated testing
- Timely diagnosis
- Appropriate onward referral
- Excellent patient coordination and support.

Key milestones being achieved in 6 out of 7 centres are clinical triage on Day 3 (with Day 0 being GP referral), MRI before biopsy, and LATP biopsy.

Key milestones that have yet to be consistently achieved are Biopsy by Day 9, MDT by Day 21, and Patient Informed by Day 28, which is understandable due to current capacity issues, although all are making steps towards meeting these.

Two sites are imminent to 'go live' with the pathway largely in place. Other centres are in the process of getting the necessary things in place, such as recruiting to navigator and CNs roles.

Support is offered from the Cancer Alliance to help implement the service; CAG members are invited to contact B Hill about how the service could be improved and where it might be possible to roll out to other urology patients.

Next steps are to continue discussions to achieve RDS deliverables as soon as possible while appreciating current pressures.

Once the services are live, RDS data will be reported nationally, which should hopefully show a gradual improvement in Cancer Waiting Time performance over time.

Discussion:

The site specific RDS can be best described as a way to access national funding to upgrade existing two week wait pathways.

Non-site specific RDS's for patients with vague symptoms have been launched in Somerset, and for some Primary Care Networks that feed in to RUH for GP referrals, where patients are referred for a number of filter tests before being referred on to the relevant site specific pathway.

Funding of navigator roles is one of the most effective ways to manage these services.

Existing pressures will limit how this service can improve capacity. It is hoped that bottlenecks can be addressed using the funding, for example, as with the provision of training for the LATP biopsy procedure.

It was not expected to increase capacity, and may reduce capacity if the triaging process at Day 3 is robust, and sifts out inappropriate referral. RUH are planning to run the service based on existing referral numbers and see if this is the case once the pathway goes live.

It is felt that this will improve the two week wait process and improve the patient experience by providing a diagnosis at an earlier stage.

Often, GP referrals contain very little information, which makes the ability to triage effectively difficult. It is hoped that the service will improve communication between Primary and Secondary care.

Responses from patients that have been through the fast tracked service are in general favourable, but it is important to tell patients not to be anxious about how quickly they are being investigated.

Questionnaires completed by patients after a pilot in Taunton did indicate that some patients thought the process was almost too quick.

The only way to make any further gains with speeding up the pathway would be to get to the point where radiologists could hot report.

The upcoming merger of Weston with NBT needs to be considered. It is thought that pathology is already procced in NBT.

8. Service Development

8.1 Genomic Laboratory Hub Update

Please see the presentation uploaded on to the SWCN website

Presented by R Butler

Professor R Butler is the current Operational Director for the South West Genomic Laboratory Hub, and attended to update the group on the tests available for prostate cancer.

There are seven GLHs in the country, SW GLH covers from Gloucestershire down to the Peninsula and comprises 2 laboratories; one in Exeter and one in Bristol. All tests for cancer are processed in the Bristol laboratory.

The GLH is commissioned by NHS E genomics unit to ensure access to genomics testing is available with equity across the country.

All tests available are accessible via the National Genomic Test Directory here, which can be filtered by tumour type. Members of the clinical team can inform future versions of the directory by applying for additional tests to be included via the GLH team.

At present, prostate does not have many tests included in the directory; BRCA, NTRK and HRR genes are included and it is expected that more will be added in the near future.

The strategy for processing the samples is detailed in the presentation. The first step of which is for the clinical team to request that their local pathology lab prepare a sample to send to the GLH, who then extract DNA or RNA depending on the test being performed. Next Generation Sequencing (NGS) is then performed on the sample to assess the genes of interest. If the gene alterations are identified, a report is issued to the MDT detailing relevant treatment options and opportunities for research trials.

One of the problems with processing prostate archived samples is that there will be quite a high failure rate (approx. 30%) due to the age of the samples and the way that the samples have been fixed. Fixation maintains and preserves tissue architecture.

Ideal sample preparation to maximise DNA/RNA quality and quantity:

- Formalin fixation should be within 1 hour of removal
- Fixation time is dependent on the tissue volume
- Additional sections for molecular analysis should be cut at the time of morphological analysis to maximise tissue
- IHC analysis should be limited and balanced with the requirement for molecular analysis
- Samples should be prepared with a clean blade and water-bath.

Molecular analysis FAILS because there is (a) insufficient tissue or (b) tissue is not suitable.

Alternative strategies could be to take another sample, or perform a germline (approx. 50% of BRCA patients would be picked up via this test) or liquid biopsy to look for circulating tumour DNA, both of which involve blood tests and are not as sensitive as NGS.

The GLH is now preparing for Urology CAG to start making these requests.

Action 014/21: Urology CAG members are to start making NGS requests **Urology CAG**

The contact for this service: Laura.yarram-smith@nbt.nhs.uk

Discussion:

Further information will be sought on the tests available for other urological cancer in particular, there is a link with urothelial cancers and lynch syndrome.

There is a national project underway on Lynch Syndrome; Neil Ryan is the clinical lead and will be contacted about the guidelines around this.

Action 015/21: H Dunderdale to contact N Ryan about upper tract urothelial cancers and testing for lynch syndrome **H Dunderdale**

8.2 Gynae Exenterations

Presented by J Frost

Since the 1999 publication of the Improving Outcomes Framework, gynaecological services were centralised into cancer units and, in this region, surgery was assigned to UHBW, RUH, SFT and Cheltenham. Within each surgical unit are sub-specialty surgeons.

There is a cohort of patients, mostly with cervical cancer, who have surgery followed by radiotherapy, or radiotherapy for recurrence. One of the main treatments is exenteration (posterior, anterior or total).

Currently, the governance of offering the anterior component is complicated due to the cystectomy procedure.

The possibility of consolidating the expertise across the region to offer this to local patients was raised.

The number of patients would be very small; during COVID there had been none as patients had presented with inoperable disease.

The gynae procedure has changed to open following publication of a large randomised controlled trial, which showed a clear oncological benefit to open versus laparoscopic.

Patients require a critical care admission post-treatment and benefit from the support of a gynaecological clinical nurse specialist to aid physical and mental recovery.

This will be discussed further outside the meeting with a small team of urologists from NBT.

Action: H Dunderdale and J Phull to facilitate meeting between J Frost and relevant parties to discuss gynae exenteration **H Dunderdale**

Date of the next meeting: To be agreed (June 2022) in hybrid format

-END-