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

Friday 7th October 2022, 13:00-17:00
Holiday Inn Taunton, Deane Gate Avenue, Taunton TA1 2UA / Hybrid MS Teams

Chair: Claire Newton (CN)

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

1. Attendees and apologies

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

2. NIHR West of England Clinical Research Network (CRN) Update

Please see the presentation uploaded on to the SWAG website

Presented by R Bowen

West of England CRN recruited 875 participants to gynae-oncology trials in 2021/22; 205 participants have been recruited in 2022/23 to date and 88 trials are open on the CRN portfolio.

Trial recruitment from 2019/20 through to the current year shows the effects of the COVID-19 pandemic when many trials were paused, then a spike caused by COVID-19 related trials and now a gradual recovery.

In RUH, 437 participants were recruited to the UK COVID and Gynaecological Cancer Study (UKCOGS) in 2021. This non-interventional study records and assesses changes and outcomes in patient care during the pandemic.

A summary of the trials recently opened and in set up are documented within the presentation.

Trials open in Somerset and Yeovil will be included in the presentation provided by C Barlow in the latter part of the meeting.

At the most recent Gynae NCRI meeting, the following trials were discussed:

- PROTECTOR, open in several sites, is investigating surgical approaches for prevention of ovarian cancer in high-risk women to see if oophorectomy can be delayed by performing an earlier salpingectomy to delay menopause; recruitment is going well
- VALTIVE1 is a non-interventional study looking at Biomarker type 2 in patients who are receiving Bevacizumab as standard treatment for ovarian cancer; recruitment is going well in both RUH and Somerset FT
- BriTROC2 is a non-interventional study for ovarian cancer open in UHBW; recruitment is slightly behind schedule
- FAIR-O is assessing the feasibility of onco-geriatric assessments in women receiving chemotherapy for ovarian cancer. This is open in RUH and Somerset FT; there is a drive to get more recruitment as it is

currently slow. Patients are eligible at both first line or first platinum-sensitive relapse

- ICON9 is open in Cheltenham and Gloucester, which is due to close to recruitment by the end of the year, and is a first line study for platinum sensitive relapsed ovarian cancer looking at Olaparib +/- Cediranib
- Aravive or AxLerate is an international study open in RUH and involves weekly Taxol +/- a GAS6 or AXL inhibitor; recruitment is going well, with five patients recruited in the UK, one of which is in RUH. Any patients interested in other centres can be cross-referred
- ATARI, open in RUH, has received referrals from other centres including Oxford, involves an oral ATR inhibitor Ceralasertib which has shown activity in clear cell gynaecological cancers. The first three cohorts have completed and opening of the endometrial arm for those who have had prior chemotherapy is now awaited. Eligible patients will receive the ATR inhibitor along with the PDL1 inhibitor. This should open in Q1 next year.

There are less studies available at present for endometrial cancers:

- RaNGO is a rare gynae cancer registry open and recruiting in all sites
- COMICE is open in several regional sites and due to complete recruitment in November 2022. It involved oral Olaparib and Cediranib maintenance following first line carboplatin and paclitaxel in metastatic or locally advanced unresectable cervix cancer.

It has not been possible to open the Phase 1 study MR3475-C93 in RUH due to issues in aseptic management.

Further details are available through the NIHR website and members can contact Claire Matthews, West of England Regional Delivery Manager, or Jo Taylor, Peninsula Delivery Manager, for further details.

Action: The full list of open trials will be circulated and uploaded to the SWAG website to facilitate cross-referrals — **R Bowen/H Dunderdale**

3. 28-Day Pathway Mapping Project: Improving Referral Quality and Alternative Routes of Access

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, including self-referral where appropriate, so that access to Primary Care does not become a barrier to early diagnosis of cancer.

Work has been undertaken to increase use of Faecal Immunochemistry (FIT) Tests to avoid unnecessary colonoscopies, and a letter has been 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 managed via an alternative route. This is due to be implemented by January 2023.

The Gynae suspected cancer pathway may be considered as 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.

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), identify where a two week wait referral is not appropriate, and provide GPs with supportive guidance to manage these patients in Primary Care.

Areas where GP assessment does not add value will be identified and alternative routes for referral recommended. One example would be post-menopausal bleeding where there is variable practice in providing pelvic examinations, which would most likely need to be repeated by the Gynae Team.

An initial mapping exercise has been put together for feedback from the group and other clinicians associated in the referral / diagnostic process to see which investigations should be undertaken and where this should occur. This will inform changes to the suspected cancer referral forms and ensure referrals are appropriate.

The mapping exercise details each NG12 symptom separately and the proposed tests.

For patients with less obvious symptoms, which could be an ovarian cancer or caused by other things, NICE guidance states to perform a CA125 and if results are above 35 to refer for an ultrasound of the abdomen and pelvis. If these results are normal and an abdominal examination rules out any obvious masses, Gynae CAG are asked if this could be a group of patients that are appropriate not to refer and to manage in Primary Care.

Another example is patients with post-menopausal bleeding could be offered direct access to Secondary Care clinics. Gynae CAG are asked if the cut-off age of 55 and exact criteria for referral to exclude endometrial cancer as per NICE guidelines is considered reflective of the referrals that are currently received.

Discussion:

Since the introduction of two week wait pathways there have been triage mechanisms to manage suspected cancer referrals. For example, patients would have an initial speculum investigation to rule out a lower genital tract lesion followed by an ultrasound scan to avoid urgent referral to gynaecology services.

For pre-menopausal women who meet other NICE criteria for bleeding, this will not be sufficient to exclude the risk of a mass.

Action: A Randle to liaise with C Newton outside the meeting today.	**A Randle/C Newton**

4. South-West Genomic Medicine Service Alliance (GMSA) Update

Please see the presentation uploaded on to the SWAG website

Presented by T Miles

Associate Director for Nursing and Midwifery for the South West GMSA, T Miles, is available to contact about any genomic related queries: tracie.miles@nhs.net / nbn-tr.SWGLHcancer@nhs.net

There are many transformation projects currently underway.

Projects relating to Gynae:

- Lynch Syndrome
- BRCA
- Nursing and Midwifery
- Circulation Tumour DNA, which will be coming to Gynae services in the next few months.

For nursing and midwifery the GMSA are leading on enabling nurses and midwives to integrate genomics in Breast and Ovarian cancer, to be followed by Colorectal and Lung cancer.

From November 2022, the BRCA variant plus transformation programme will commence with the aim of upskilling Breast and Gynae Clinical Nurse Specialists to mainstream BRCA testing and helping to provide cascade training to other members (surgeons, nurses, medical oncologists) of the team.

Thanks were given to those CAG members who are already helping facilitate mainstreaming, with special mention of CNS G Cannington at UHBW who, with support from A Walther, C Newton and the team, have put together a business case for a genomics clinic. The fine details are just being completed with relevant due diligence; it is then hoped that this can be shared across the region.

The National Genomics Test Directory will include R207 and R208 panels for inherited breast and ovarian cancer panels on samples. This has multiple gene variations in addition to BRCA. The GMSA will provide educational support to understand how to interpret the new panels.

Eligibility criteria can be found on the website:
https://www.england.nhs.uk/publication/national-genomic-test-directories/

At present, SW GMSA is not part of the Whole Genome Sequencing pilot for ovarian cancer. This is partly due to the need to manage service pressures plus appropriate prescribing can be achieved from the existing panel of tests. However, it would be beneficial to take part in WGS in the future due to the related research opportunities.

Homologous Recombination Deficiency (HRD) testing is still being sent to Myriad via the AstraZeneca scheme. NHSE are investigating the use of different assays in the future, such as TSA1500.

A pilot, run by E Davies and L Atherton, has commenced in RUH which involves counselling and consenting for the BRCA genes via digitally inclusive video appointments, working in partnership with Macmillan. It is recognised that this won't be right for every patient. It could potentially be rolled out across the region.

Action: T Miles will share the clinic business case once completed **T Miles**

5. South-West Lynch Syndrome (LS) Update

Please see the presentation uploaded on to the SWAG website

Presented by S John

Experienced Colorectal Cancer Clinical Nurse Specialists S John and S John (no relation) have been appointed by the SW GMSA, initially for one year, to embed testing and appropriate ongoing management of lynch syndrome into routine practice.

At least 260 endometrial cancers are caused by LS each year, making it the most common hereditary endometrial cancer.

In more than 50% of people with LS, endometrial is the sentinel cancer diagnosis.

An estimated 175,000 people have LS in the UK, but fewer than 5% of individuals are aware that they have the condition. Since 2017, NICE has recommended that all colorectal cancers are tested for LS and the same for endometrial cancer since 2020. The project will monitor if this is being implemented.

It is important that the initial tumour is sent for MSI or dMMR testing at diagnosis to ensure that the result is received in time to inform treatment options, such as chemotherapy / immunotherapy or it may be appropriate to offer colorectal resections at the same time as oophorectomy / hysterectomy.

Details on the actions of check-point inhibitors on cancer cells are within the presentation.

Initially, support will be provided to help each LS Champion to undertake a baseline audit of current practice.

The team will also provide educational and electronic resources, support to implement any identified improvements and workshops, and further education to optimise mainstreaming the patient pathway.

Gynae services are currently performing well in comparison to colorectal.

A South-West Lynch Coordinator will be appointed to manage a regional database to track follow up and help transfer that information when people move to different areas. This will be a substantive post funded through the South-West Genomics Laboratory Hub, based at NBT. They will check the

patients' aspirin dose and that relevant referrals are made to other cancer services.

Action: Lynch Syndrome Champions are to complete the baseline audit and return to S John and S John — **Lynch Champions**

The audit can be delegated to any staff member; it takes approximately two hours to complete for 30 cases.

There is also a simple hour-long online training course that all MDT members are encouraged to undertake, found here:

https://rmpartners.nhs.uk/lynch-syndrome-early-diagnosis-pathway-endometrial — **All MDT Members**

Discussion:

Dostarlimab has been prescribed for second line treatment of recurrent endometrial cancer; the majority of cases are found to respond. This is the only second line treatment available at present.

SWAGGER recommends that there should be a dedicated service responsible for tracking LS patients; the role of the LS Champions, which is to report all identified LS from the local MDT to the regional MDT, will become increasingly time consuming and should be appropriately job planned. — **SWAGGER Recommendation**

It has been agreed that colonoscopy surveillance will be provided by the bowel screening service from April 2023.

The LS MDT Coordinator will be responsible for tracking the patients and contacting the LS Champions.

Applications are also being developed which will send LS patients reminders. Virtual complex MDT meetings will be set up by the genomics team.

Action: S John to investigate if it is planned to test patients that were diagnosed prior to the test becoming mandatory. — **S John**

Action: H Dunderdale will circulate the Lynch Syndrome guidelines drafted by Colorectal CAG — **H Dunderdale**

The most important thing is to ensure that the diagnosis is reported to the team and the result is documented in the cancer database. IHC results do not diagnose LS, but rather identify those at high risk, who then go on to have germline testing by the genetics service.

Monitoring of many long-term conditions is the responsibility of General Practitioners, and it was questioned if LS should come under the GPs remit.

GP representative G Beard advised against this approach due to workload pressures in Primary Care and also recommends set up of a dedicated service.

Patients will be empowered as much as possible to manage their diagnosis.

A one off OGD will be arranged straight after LS is diagnosed.

6. Granulosa Cell Tumours

Presented by C Newton

Thanks were given to SWAGGER members for providing the data on granulosa cell tumours for this regional multi-centre retrospective audit, which is one of the most comprehensive worldwide, with analysis of 119 patients over the last 20 years.

Granulosa cell tumours are rare sex cord-stromal tumours representing 2% to 5% of all ovarian tumours, with an 85% ten year survival; 25% tend to recur.

The questions that the audit aims to address are if fertility preserving and laparoscopic approaches are safe or affect the incidence of tumour recurrence.

The majority of cases were diagnosed at Stage 1a. There was some data missing to refine full staging criteria. There were a few patients who were diagnosed at Stage 2 and 3.

Primary management was mixed, with some patients having a hysterectomy with Bilateral Salpingo Oophorectomy (BSO), some had an omentectomy and a few had a lymphadenectomy. 62% had an open procedure, 32% had laparoscopic and 3% had vaginal surgery.

There was a complete total reduction in 94% of cases. Two patients had residual disease in the liver.

49 cases did not have complete staging but a further 10 went on to have completion of staging.

19 patients retained an ovary.

Details on the adjuvant treatments given and surgical complications are within the presentation.

The data seems to indicate that risk of recurrence is not necessarily related to Stage at diagnosis.

Recurrence occurred in 30.8% of cases that had laparoscopic surgery and 19% following open surgery, but this may not be statistically significant. Risk of recurrence appears to be lower if an ovary is not retained, which raises the question, if the patient has completed their family, should both ovaries be removed.

Average time to first recurrence is 41 months. Four patients had more than 3 recurrences. Median age of death was 81 years.

Further analysis is required before any conclusions can be drawn from the data.

Action: To discuss potential analysis of morphological features — **C Newton/T Mandalia**

Action: To further analyse the reason that radiotherapy was given, which it is thought may be due to endometrial cancer — **C Newton**

It will be taken into consideration that some of the Stage 1A patients are likely to be undiagnosed Stage 1B.

7. British Gynaecological Cancer Society (BGCS) Clinical Oncology Forum and Adjuvant Treatment Flowchart

Presented by H Booz

H Booz commenced the BGCS clinical oncology forum one year ago; there have been three meetings to date (two of which were virtual). The last meeting was arranged to coincide with the annual BGCS conference and convened face to face the day before.

The purpose of the forum is to bring together the clinical oncologist community to present and discuss complex cases. Details are on the BGCS website; registration is free and three to four cases are discussed over the two hour session.

The Bristol Gynae Oncology virtual two day course, which had been paused for several years, has now got accreditation from the Royal College of Obstetrics and Gynaecology, and is approved for trainees.

The first one was held in March last year and the next one will be held on the 1st and 2nd February 2023.

All aspects of MDT discussions are covered by the surgeons, oncologists, specialist nurses and palliative medicine. All trainees are encouraged to attend. Feedback has been very positive, in particular that the course is available via a virtual platform.

The ESGO endometrial treatment guidelines have been simplified into a colour-coded flowchart decision making tool. This has been trialled in the MDT and works well.

It has been published in the International Journal for Gynae-Oncology and the colour schemes match those in the ESGO table.

The next step will be looking at the nodal discussion and where nodal status may make a difference.

Action: H Dunderdale will circulate the adjuvant treatment flowchart and make it available on the website. — **H Dunderdale**

8. NIHR Clinical Research Update: Somerset

Please see the presentation uploaded to the SWAG website

Presented by Claire Barlow

An overview of the global performance of gynae cancer trial recruitment from 2021/22 and 2022 to date shows that the Peninsula is 4th out of the 15 networks, with the whole of the South West performing well.

Data from individual Trusts shows the importance of making the most of those studies that are easy to recruit to, particularly when there is limited access to larger interventional studies.

There have been two such studies that have kept recruitment afloat during COVID-19.

The list of open studies is comparable to those open in the West of England CRN and will be made available on the website.

Rather than the large interventional trials of the past, there will now be a move to open smaller trials with sub-sets of patients according to molecular stratification. This may be more work intense for clinical trials teams, as it will involve opening more studies with smaller relevant patients.

It is hoped to open FAIR-O and MONITOR in more sites.

The new OCTOPUS trial is now on the horizon; all sites will be contacted about the new arm in the near future.

NCRI Gynae Group can be contacted via R Bowen to help address any queries about patient eligibility criteria when there are complex cases that could be eligible but don't exactly fit trial protocol specifications.

Date of next meeting: Friday 6th October 2023, via MS Teams.

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