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

Meeting of the SWAG Network HPB Cancer Clinical Advisory Group (CAG)

Friday 25th March 2022

Chapter House Lecture Theatre, Bristol Dental Hospital, Lower Maudlin Street, Bristol BS1 2LY

Chairs: James Skipworth and Stephen Falk

NOTES **ACTIONS**

(To be agreed at the next CAG Meeting)

1. Welcome and Introductions

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

2. Clinical Updates and Discussion

2.1 Fast Track Whipple Surgery – A Discussion of the Evidence and UHBW Results

Please see the presentation uploaded on to the SWAG website

Presented by A Strickland

The standard pathway for HPB, including the steps for biliary drainage, involves multiple interventions that can take a long time to organise before a date for surgery can be allocated.

The pre-operative assessment clinic is a vital part of this pathway, where support for nutritional interventions such as Creon, protein pump inhibitors and diabetes control is provided; the CNS team give prehabilitation advice to optimise the patients' fitness for surgery and facilitate organisation of all other relevant pre-operative investigations.

There are complications associated with biliary drainage, including risks of pancreatitis, perforated bowel and bleeding associated with endoscopy, infection due to malfunctioning stents, repeat procedures and delays that may lead to unresectable disease. It can also affect surgical outcomes, potentially increasing post operative fistula rates due to the resulting inflammation.

Although there will always be a cohort of patients that will need biliary drainage, there is now evidence that it is appropriate to fast track certain patients to surgery undrained.

The Dutch Randomised Controlled Trial, NEJM (2010) looked primarily at surgical outcomes in terms of serious complications in patients undergoing early surgery (ES) versus pre-operative biliary drainage (PBD). Secondary outcomes were death and length of stay.

The data showed significantly more post operative complications in the PBD group in comparison with the ES group, with almost half of the patients having cholangitis.

There was no difference with the rate of fistula occurrence.

Although there were fewer deaths in the ES group, it was not significantly different from the PBD group.

The trial used plastic stents and some complications may have been reduced in the PBD group if metal stents had been used, although plastic stents are favoured when looking to reduce the risk of pancreatitis, which can cause significant delays in the treatment pathway.

Surgical Site Infection with gut organisms is another complication of PBD, caused by disrupting the natural barrier between OG and Biliary systems. A recent review found that many of these were antibiotic resistant and increased length of stay; antibiotic coverage has now been optimised.

The Birmingham team put into place a fast-track process in August 2015 with funding for dedicated nursing support. All relevant colleagues were involved early on, and a theatre list was ringfenced one day per week. The aspirational timescales for the pathway are documented in the presentation. The team did manage to improve their timescales and the pathway was found to be safe. Length of Stay was found to be slightly better.

Lessons learnt were that CNS to CNS communication between centres is paramount to ensure that ES can be successfully organised.

ES is now being implemented in UHBW and has been achieved for one recent patient and 9 others since 2019; it has however become challenging during the pandemic.

Discussion:

The Birmingham team had to stop the fast-track pathway during COVID.

Of the patients who have followed the pathway to date, 1 had a PET scan, and a CT is the main requirement to safely plan the surgery; waiting for PET can cause delays.

Action: CAG members are encouraged to contact the surgical team with details of patients that fit the criteria for Fast Track Whipple **HPB CAG**

2.2 Radiological Assessment of Vascular Involvement Pre and Post Chemotherapy for Pancreatic Cancer

Please see the presentation uploaded on to the SWAG website

Presented by Dr H Kateszi

The incidence of pancreatic cancer has been in constant augmentation over the past 25 years; 5 and 10 year survival has not improved significantly over the time period. This is due to the majority of patients being diagnosed at a late stage; less than 2% of patients are diagnosed at Stage I, which has a 5 year survival rate >80%. UK survival data ranking 29th out of 33 countries with comparable data.

CT is the best validated imaging modality to assess the local tumour extension and distant metastases and can accurately assess resectable and unresectable disease.

Details of the techniques used are documented within the presentation; it is extremely important that the quality criteria for CTs can be met as results can change patient management. Repeat scans are required, as demonstrated by comparison of cases with scans of different quality.

MRI imaging is also a useful problem-solving tool in primary staging due to excellent contrast resolution that can delineate the tumour accurately.

When using the terms resectable, unresectable and borderline resectable, it should be noted that the definitions (see NCCN guidelines) are complicated and borderline resectable has no universally accepted definition.

To overcome this, it is important to have close collaboration with the HPB surgical team to understand local resectable criteria.

It can be very difficult to differentiate desmoplastic reaction from true vascular invasion. There are different classifications for vascular invasion, and the peripancreatic venous anatomy is complicated; however, with a good quality CT scan, the majority of the vessels can be clearly visualised.

The highly specific signs of vascular invasion:

- Vessel embedment in tumour
- Venous obliteration
- Encasement
- Vessel wall irregularity
- Calibre stenosis
- Tumour thrombosis in vessel ~~(rare in pancreatic cancer)~~
- Tear drop SMV sign.

A pancreatic cancer reporting template has been developed to standardise reporting, which should now be in use throughout the UK.

Extra-pancreatic neural invasion can be identified, which may be a predictor of poor prognosis in resectable or borderline cases.

The discussion of ten cases demonstrated in detail how radiological staging of pancreatic cancer is reported.

Rationale for neoadjuvant C(R)T:

Neo-adjuvant treatment may change an unresectable tumour to resectable if the tumour has a favourable biology, however, evaluation of response on cross-sectional imaging is very challenging, with many studies showing that CT underestimates response. It is therefore recommended that surgery should be considered in all patients who have had neoadjuvant therapy and no disease progression.

CAG Recommendation

Further case discussions of good response and stable response imaging post neo-adjuvant therapy demonstrated the complexities involved in staging and re-staging.

Discussion:

International trends support the recommendation for more patients to go for surgery post neo-adjuvant treatment. The initial assessment at time of presentation is very important as, if the patient has borderline resectable disease at that point and remains stable after neoadjuvant treatment, the remaining lesion may be post therapy fibrosis rather than tumour and could now be resectable.

Pain prior to surgery is considered a poor prognostic indicator as it means it is likely that the tumour involves the neural plexus.

The complexities involved in reporting vascular invasion were recognised by the group.

Variation in radiological interpreting of imaging, which could result in a change in MDT outcome and the patient pathway, may be reduced now that there is a standardised reporting proforma, which provides a checklist. It could also be helped by having surgical criteria to explain what is resectable.

Action: HPB surgical team will draft surgical criteria to refine definitions of resectable and unresectable disease

Surgical CAG members

It would be useful if other radiologists could attend the MDTM to increase their exposure to the reporting of pancreatic cancer.

Innovative developments need to be explored to detect pancreatic cancer at an earlier stage (ideally at Stage I); a link to an article on Artificial Intelligence and early detection is embedded in the presentation.

Action: H Dunderdale to raise the need for innovations in early detection of pancreatic cancer with the SWAG Cancer Alliance. **H Dunderdale**

A Radiological Fellow is due to start imminently, and it is hoped to identify a second Fellow in the near future.

H Kateszi provides fortnightly teaching sessions for Radiology Registrars.

2.3 Borderline Resectable Pancreatic Ductal Adenocarcinoma (PDAC) - A Discussion of the Evidence and UHBW Results

Please see the presentation uploaded on to the SWAG website

Presented by Mr J Skipworth

Standard optimal treatment for PDAC is resection plus adjuvant chemotherapy. Approximately 50-60% of patients receive and complete their adjuvant chemotherapy, 25% of which will develop disease recurrence within 6 months.

As previously discussed, it is relatively straightforward to define those patients with resectable and unresectable disease, but more complicated if a case is borderline or locally advanced, which make up 40% of patients. Criteria needs to be defined that informs treatment decisions for which cases to upstage to resectable or which should be recommended for Best Supportive Care.

The majority of UK centres are using the NCCN criteria, which are quite convoluted, and there are a lot of differences between these and criteria available from America and Canada, with NCCN guidelines being much less aggressive. It also contains vague wording around what constitutes solid tumour contact with other structures.

Neoadjuvant treatment commenced in line with the PREOPANC trial, a multi-centre randomised controlled trial of neoadjuvant versus upfront surgery, with both arms receiving adjuvant treatment. This showed a significant improvement in complete resection rate and overall survival in the neoadjuvant arm.

FOLFIRINOX then underwent a systematic review; results showed a resection rate of 68%, with more than 30% of patients being taken to theatre found to be inoperable. However, the R0 rate was very high overall, implying favourable outcomes for the resectable patients.

ESPAC-5F trial has just been published which looked at borderline resectable pancreatic cancer with 4 different arms. Analysis showed a significant difference in the R0 rate in the neoadjuvant arms and in 1 year survival. Long term survival outcomes are ongoing.

In the sub-analysis, FOLFIRINOX was the most favourable neoadjuvant therapy.

The American HPB association consensus statement (along with others) now recommends neoadjuvant therapy for borderline PDAC as more than 80% of

these patients have metastatic disease at presentation, so this allows time to assess tumour biology and pick out the cases suitable for surgery.

Radiological response on CT is not always possible or required, with the most important factor being if it was resectable at the beginning of the borderline pathway.

Biological response should include CA19-9 stabilizing or lowering. Normalisation of CA19-9 predicts improved long-term survival.

All these patients should undergo operative exploration.

From an intra-operative perspective, the ideal goals are to achieve a margin negative safe resection with comparable/improved long-term outcomes.

Literature shows histological vein involvement in >60% of these cases; the vein should always be resected.

CAG Recommendation

The vein resection requires histology to be interpreted in a different way as the margin is no longer the tumour but the upper and lower part of the vein. Going into this surgical plane helps to clear out the superior mesenteric artery (SMA). As soon as the vein goes into formalin it shrinks disproportionately and so it is necessary to send separate margins from the top and bottom of the vein to inform the histology report.

Vein resection may result in increased blood loss and operative time but has a lower pancreatic fistula rate and there is no increase in morbidity and mortality or any drop in safety in doing this.

In 2020, the UHBW team formalised a pathway, the details of which are within the presentation. Following 6 cycles of FOLFIRINOX, the patient is re-staged in the last week and, if there is evidence of progression, goes on to have palliative care, or, if no change or smaller, goes on to have a surgical resection once recovered from SACT treatment.

Details of procedures undertaken in the last 12 months showed no complications and a 60% resection rate, which is in line with current literature.

Discussion:

The examples of cases that had up front surgery and no neoadjuvant therapy in the systemic review were those where vein involvement was only identified in Theatre.

Both the Fast Track Whipple pathway for early-stage cancer and the neoadjuvant pathway for borderline are considered the most appropriate for their specific patient cohort at present. It would be challenging to undertake a clinical trial in this area as it is such a heterogenous group of patients.

It was noted that Quality of Life was significantly affected post Whipple; it is unclear how this is further impacted by neoadjuvant treatment, but the option is treatment compared with palliative care.

No particular pathological subtype had been identified in the patients eligible for fast-track Whipple.

2.4 Use of Stereotactic Body Radiation (SABR) in HPB Malignancy

Please see the presentation uploaded on to the SWAG website

Presented by Dr S Falk

The mechanical delivery of radiotherapy has evolved over time to enable high doses to be given to targeted areas.

In the UK at present, very few patients with hepatobiliary cancer are treated with radiotherapy in comparison with other cancer sites.

SABR means:

- Stereotactic - shaped
- Ablative – high dose, low fraction
- Body – (not brain)
- Radiotherapy.

It is a technique that was first developed in the 1960's, however it is only available now that that the technology is in place to allow treatment areas to be accurately pinpointed by the movements of the machine.

CT is also incorporated to ensure that the treatment occurs in the same place every time, and an automatic breath hold technique is undertaken to compensate for the movement of the liver, which moves by 2-3 cms when a patient breathes in and out.

There are various machines, but the one used by the BHOC team is the Linear Accelerator.

In a SABR plan there is a 3-5 mm radiation tolerance. An example was shown of a lung tumour that disappeared after treatment.

It is hoped to open a local research trial to further understand assessment of liver response to radiation.

There is current interest in exploring treatment with SABR for oligometastatic disease, which is the transitional state when disease progresses from localised to widespread systemic disease.

The RCT SABR COMET, which compared SABR with RT and CT, showed sufficient evidence of survival advantage for the Government to agree to fund the treatment.

SABR was initially funded via the Commissioning by Evaluation scheme as there was some concern about who was going provide the treatment; BHOC became one of 17 centres to provide it between 2015-2018. This showed a local control rate at 2 years of around 70% and a very low toxicity rate.

HCC is now commissioned for treatment with SABR along with medically inoperable lung cancer and oligometastatic disease.

It would also be beneficial to be able to treat oligo-progressive and Stage IV disease, but this has yet to be commissioned.

Eligibility criteria:

- Metastatic carcinoma with histologically proven primary
- 1-3 sites of metastatic disease
- Maximum size 5 cm
- Disease free interval > 6 months (not CRC)
- Life expectancy > 6 months
- PS 0-2
- Includes any cancer type.

Patients initially attend for a coaching session on the breath hold technique. A scan is then taken to draw on the area that needs treatment. This can be very complicated, especially with the pancreas, and radiological colleagues will be asked to peer review these contours. There is already an MDT where all contours undergo peer review.

Treatments usually take up to 45 minutes as multiple scans and adjustments are required to ensure that the patient is in the correct position. The treatment itself takes approximately 1 minute. There are usually 3-5 treatments on alternative days.

It is rare to see toxicities; there are occasionally some fatigue and skin reactions and there has been one chest fracture. No liver disease has been detected yet; the doses used to treat the liver are meticulously calculated. There has been some biliary obstruction as a consequence of treatment.

There are some constraints with giving radiotherapy to certain organ structures. The duodenum is very sensitive and will need to be avoided. The common bile duct is thought to be more sensitive than the current dose constraint suggests.

BHOC are one of the largest centres for treating liver metastases in the UK. It is yet to be treated with parity across the region.

HCC is yet to be included in the EASL guidelines (2018), however NHS E have included it as an option after review of a meta-analysis that showed excellent local control rates. Radio frequency ablation is still standard care, but SABR can now be offered as a complementary, not competing, option for treatment.

CAG Recommendation

The next ambition will be to offer Selective Internal Radiation Therapy (SIRT). This is already commissioned in some other centres and would make sense to set up in BHOC as the relevant radiation services and licences are already in place; this makes it a useful tool regarding interventional radiology service improvements for the Trust and HPB team.

Discussion:

HPB CAG is pleased to have increased the number of complementary treatment options for non-resectable cases.

Post SABR treatment scans differ from post RFA scans and interpretation is a learning process at present. Current guidelines on descriptions of local control also vary.

It is possible to treat without a biopsy, but approximately two thirds of patients do have biopsies; national biopsy rates are currently being audited and it is expected that UHBW will be a positive outlier due to this becoming routine as it was a research trial requirement.

Electroporation is not currently being explored as the evidence base is limited.

The potential for SABR to be used in combination with Systemic Anti-Cancer Therapies should be answered by the TACE III trial.

3. Clinical opinion on network issues

HPB MDT Meeting (MDTM) Restructuring

Presented by J Skipworth

The SWAG HPB Service covers a catchment population of approximately 2.5 million across 6 main centres that are configured differently; some have a local MDT and some a tertiary MDT.

The challenge is trying to meet the needs of each centre. Other differences include the case mix, attendees, and the different levels of feedback required, for example for those centres where no one can attend.

Data gathered on the total number of MDTM cases discussed each month from 2011-2016 shows case numbers increasing year on year. The same data collected more recently shows that the team are discussing approximately 50 patients per week / 200 per month, and when looking at new patient referrals rather than discussions, there is a huge increase from around 200-300 per year 6 or 7 years ago to 860 in 2020.

At the MDTM baseline assessment there was an average of 1.8 minutes to discuss each patient, and the pace required to manage this workload was highly stressful. This is the lowest amount of time per patient in comparison with other HPB MDT across the UK, with some centres organising their MDT differently by splitting cases into multiple different meetings. It was clear that the MDT required additional resources to manage the ever-increasing number of patients appropriately.

MDTM reforms have now commenced to try and address these issues, first of all by looking at how the number of case discussion could be reduced, with the right cases discussed at the right time. An MDTM proforma has been developed for this purpose to ensure a succinct discussion with all relevant information available at one point in time. This can help reduce repeat discussions and allow decisions to be made outside the MDTM.

The proforma also helps to manage radiology and pathology workloads by providing accurate information prior to the meeting.

Case discussions have now been arranged anatomically rather than geographically, which allows the radiologists to split their input and ensures that each Centre gets equal time as, previously, cases on the end of the list would get less time than those at the beginning.

It is understood that this makes it more difficult for people from other centres to attend for a specific slot, and this also needs to be addressed.

The length of the meeting has now been increased to 2 hours, increasing average discussion time to 2.4 minutes per patient. This is still less time than the other UK MDTs. Time constraints mean that the meeting is still very didactic, with very little input from other centres and clinicians.

A new room with better AV capabilities is now available.

Although the proforma is unpopular with referring centres, it does improve MDT preparation time.

Also, there is now a dedicated MDT Coordinator, which has improved standardisation of information and consistency.

Future solutions could be attendance at local MDTs and pre-MDT screening and protocolisation of cases, for example filtering out pancreatic cysts which make up about 14% of the current meeting. Job planned preparation time would be required to manage this.

As there is still insufficient time, despite the recent increase, the potential to run a second or multiple meetings, as many centres already do, could be explored. Some centres have separate pancreas, liver metastases and HCC MDTMs.

Increasing the time would make the meeting less didactic and allow more contributions from the wider team.
AV systems still require some work to ensure that outcomes can be seen on the screen at the same time as other information.

The etiquette around holding hybrid meetings will continue to be assessed and improved.

Feedback from the anonymous 10 question survey is included in the presentation.

Actions: Surgical Team are to negotiate job planned MDTM preparation time	**Surgical Team**
To increase the time of the MDTM so that patients can be discussed in a more holistic way	**J Skipworth**
To develop pathways to protocolise patients with certain clinical features (straight to EUS, pancreatic cysts, palliative, for example) so that they are listed for information but not for MDT discussion	**J Skipworth**
To repeat the survey in 6 months	**H Dunderdale**
To add patient preferences and the 'Question for the MDT' box to the MDT Proforma	**J Skipworth**

Somerset team are unable to attend at present and would value expert input into their local MDT. The CNS team have not attended recently due to workforce shortages, and it is difficult to attend for 2 hours instead of 15 minutes.

Regional CNS teams are invited to attend the Bristol MDT as part of their induction. The CNS team need to be supported to contribute their input as the patients' advocate.

The MDTM is an important educational opportunity; individual organisations could be contacted to ask that attendance at the longer meeting is supported for this purpose.

Patients with pancreatic cancer are scanned on multiple scanners therefore achieving standardized image quality with appropriate contrast administration is challenging. Further work on this is required.

4. Research

NIHR Clinical Research Update

Please see the presentation uploaded on to the SWAG website

C Matthews / S Gangadhara

C Matthews is the Research Delivery Manager for the West of England CRN and manages the cancer portfolio. S Gangadhara is the Sub-Specialty Lead for UGI.

The geography of West of England CRN differs from the SWAG region; data from SFT and YDH will be sourced from the Peninsula CRN for future meetings.

National data (combined oesophago-gastric and hepatobiliary) from the start of the pandemic to date shows that there has been recruitment to 146 trials, the majority of which are non-commercial and non-randomised. There is a different trend than with the majority of cancer sites, in that recruitment increased during the pandemic, between April 2020 to March 2022 in comparison with 2018-2020. This is mainly due to one multi-cancer large trial on early diagnosis that happens to have been included in the UGI report.

The study is not open in the West of England CRN, but recruitment can be seen to be recovering well.

Studies currently open and in set up are documented in the presentation. These have been divided into advanced/metastatic and others to make it easier to navigate. There are currently no early disease trials open.

Advanced/Metastatic:

TACE-3: This is a two-arm multi-stage (TAMS) seamless phase II/III randomised trial to investigate if the addition of immunotherapy agent nivolumab in combination with TACE, can improve overall survival and general outcomes for patients with intermediate stage HCC. Although known to be effective, nivolumab is known that immune-relapse will be seen in a certain proportion of patients. TACE can provide a backbone for addition of other systemic treatment options.

ABC-07: This is addition of stereotactic body radiotherapy (SBRT) to systemic chemotherapy (Cis/Gem) in locally advanced biliary tract cancers. There was an initial feasibility study prior to opening the RCT. Patients will be randomised to either 8 cycles of Cis/Gem or 6 cycles followed by SBRT. Eligibility criteria is for histologically confirmed biliary tract tumours who have been confirmed by the MDTM as not suitable for surgery, with a tumour cut off size >6cm. Restaging CT scan will take place after 4 cycles (12 weeks). If no progression, they will be randomised to the investigative arm for 2 more cycles along with 5 fractions of SBRT. It is currently recruiting well.

Paediatric Hepatic International Tumour Trial (PHITT): Adults up to 30 years of age are included.

PRIMUS 001: This is a study comparing FOLFOX and nab-paclitaxel with gemcitabine and nab-paclitaxel for patients with metastatic pancreatic cancer with an integrated biomarker evaluation. It is an open label two arm Phase 2 interventional trial.

PrecisionPanc: This is looking at personalising treatments for pancreatic cancer. Patients with confirmed pancreatic cancer will be asked to provide biopsy material for molecular target driven analysis, after which they can enrol in the PRIMUS study.

Other:

UK-EDI: UK Early Detection Initiative for Pancreatic Cancer. This observational study is looking at different ways to try and find early signs of pancreatic cancer. It is open to people who are at least 50 years old and have been recently diagnosed with type 2 diabetes. Participants visit the study site on 5 occasions 6 months apart. Blood samples and clinical data are collected.

Checkpoint Inhibitor-induced Liver Injury (ChILI): This is a prospective observational trial to identify incidence and risk factors of toxicities caused by check-point inhibitors. As there is a move towards combined use of immunotherapy and chemotherapy, this will be useful to delineate between the effects of each agent.

In set-up:

Nationally, there is a questionnaire for the assessment of health-related quality of life (HRQoL) in patients with pancreatic adenocarcinoma and a Phase II study of neoadjuvant cisplatin and gemcitabine chemotherapy versus upfront surgery in patients with resectable proximal biliary tract cancer.

In the West of England, there are 3 studies in set up.

NIS793 in combination with gemcitabine and nab-paclitaxel for mPDAC. NIS793 is a monoclonal antibody specific for Transforming Growth Factor Beta, which is expressed by some of these cancers and can make systemic treatments ineffective.

FOENIX-CCA3: this is a multi-national, open label, parallel 2 arm, Phase 3 RCT evaluation of the safety of futibatinib versus standard care as a first line treatment for patients with advanced/unresectable intrahepatic cholagiocarcinoma with FGFR2 gene arrangements.

PRIMUS 004 may also be opening in the region.
Useful links and contact details are documented in the presentation.

Action: The CRN will investigate how to compile information on regional research trials to make this more accessible to teams. C Matthews

5. Faster Diagnostic Service

Please see the presentation uploaded on to the SWAG website

Presented by B Hill

In the absence of a national best practice time pathway for HPB, members of the team collaborated to produce a one-page aspirational document that details all of the steps that would be required to meet the Cancer Waiting Time 28 day Faster Diagnostic Standard. It is presented to the meeting today for final ratification. It has also been shared with Pancreatic Cancer UK and the National Cancer Board and is being used to shape national guidance.
It is recognised that it is an ambitious pathway, elements of which will be very difficult to consistently meet as it is such a complicated pathway.

Cancer Managers have been asked to submit plans to the Cancer Alliance detailing what would be required to work towards implementing the pathway.

Action: To circulate the HPB pathway for final ratification after the meeting **H Dunderdale**

6. Community Liver Health Checks

F Gordon

The Bristol Hepatology Unit is one of twelve centres across the country to secure funding to pilot a project to improve surveillance for HCC. The funding has come via the Hepatitis C network for which F Gordon is the local representative. The Hep C network maps to the cancer network, although Somerset FT is not included.

The remit is to target HCC due to late presentations of cancer and poor ability to detect at an early stage. The UK has a high prevalence of liver disease due to alcohol dependence, hepatitis C and fatty liver disease. These are also often linked to deprivation.

The plan is to extend the outreach services via mobile clinics to examine high risk patients with use of a fibroscan, and then directly book patients with liver disease for an ultrasound.

The pilot will commence at the beginning of April 2022 for 12 months prior to being considered for wider roll out – potentially in 2025.

It is intended to fibroscan 2000 people within the 12 months across the region, which is double the amount scanned last year. Patients will be identified using the following criteria:

- More than 10 years of excess alcohol consumption or
- Current or past viral hepatitis or
- Non alcoholic fatty liver disease (NAFLD).

Delivery mechanisms include expanding the existing peer support roles that currently exist, and provision of transport to get people to attend the clinics.

There are many key performance indicators that need to be collected to demonstrate the success of the pilot; this is incorporated into a Registrar's work plan.

It will be necessary to liaise closely with the cancer network to forge links with radiology colleagues. The way that HCC surveillance is arranged currently varies across the region and help is required to find the key people to facilitate the programme.

The main constraint to the pilot is the time frame. Plans are underway and the Hep C team are available to start the pilot. It will be necessary to meet monthly with the National team to feedback progress.

The Hep C networks have been incredibly effective and have nearly eradicated the disease, with a 90% reduction.

Discussion:

There is currently a record low number of sonographers in the BRI. The pilot is expected to have impact on their workload.

Funding of extra radiology sessions was included in the bid; this is for across the region and could potentially be used to address any gaps. The national team are aware of the constraints on radiology.

The national ambition to diagnose 75% at Stage 1 and 2 by 2028 was considered a huge undertaking. The GRAIL trial is undertaking genetic testing looking at methylation. The test is very good at picking up advanced disease and it picks up approximately 50% of Stage 1 and 2 disease. They are recruiting 65,000 patients over 9 months and results will be returned in 1 year, which could help reach this ambition. The trial team are targeting areas of deprivation.

7. SACT protocol update

Two new protocols need to be signed off: FGFR inhibitor and FOLFOXIRI in the neoadjuvant and adjuvant setting for pancreatic cancer will be ratified so that patients can be treated in a dose reduced way.

8. Any other business / date of next meeting

The next meeting will focus on MDT reforms and any other major updates along with discussion of an audit of clinical outcomes.
J Rees has worked with Pancreatic Cancer UK to establish resources to enable early access to PERT. These are available on the Pancreatic UK website here: https://www.pancreaticcancer.org.uk/health-professionals/pert-hub/

Date of next meeting: To be agreed by Doodle Poll