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

Friday 8th November 2024, 13:00-17:00

Hotel Du Vin, Narrow Lewins Mead, Bristol, BS1 2NU / MS Teams

This meeting was sponsored by AstraZeneca and MSD

Chair: Mr Paul Wilkerson

REPORT (To be agreed at the next CAG Meeting)	**ACTIONS**
1. Welcome and apologies	
Please see the separate list of attendees and apologies uploaded on to the SWAG website here.	
2. Review of last meeting's report and actions	
As there were no comments following distribution of the report from the meeting on Friday 8th December 2023, the report was accepted as finalised.	
Actions:	
2.1 Development of record of dysplasia treatment booklet:	**P Wilson**
The last diagram for the booklet has now been completed and it will soon be sent for circulation and sign off by the CAG. The booklet is both a Patient Information Leaflet (PIL) of the treatments offered and an explanation of the treatment pathways. There is a section at the back for the OG team to record the dates and types of treatments given. Some patients may need multiple booklets to record their treatments.	
2.2 Referral pathway audit for patients >50:	**H Dunderdale/D Titcomb**
The cohort of patients has been identified and the next steps will be for Dan Titcomb and Helen Dunderdale to meet and decide on the relevant data fields for the audit. All other actions are on the agenda today.	

3. Radical Management of Oesophago-gastric Cancer

Please see the presentation uploaded on to the SWAG website

Presented by Consultant Clinical Oncologist Tom Bird

A service evaluation was undertaken to gather data on the patients who have received radical treatment in BHOC, Weston, Musgrove and Yeovil.

The evaluation comprises two parts, one being the cohort of patients on the surgical pathway who received perioperative FLOT chemotherapy, and the other being the cohort who received chemo-radiation.

Part 1

Background:

FLOT chemotherapy has become standard care for patients with adenocarcinoma following results from the FLOT4 Phase 3 clinical trial which compared MAGIC (ECF/ECX) with FLOT in gastric and junctional cancer. Both had similar safety profiles, but FLOT showed a significant improvement in overall survival.

Another trial, which has yet to be published, compared FLOT versus CROSS in oesophageal cancer, which also showed an improvement in overall survival in the FLOT arm.

Method:

The audit was registered with the UHBW audit team and data was gathered on patients commencing FLOT between March 2018 to March 2023, with a minimum of 6 months follow up. This coincided with the COVID-19 pandemic and also a period of time when recruiting to a different trial not using FLOT.

An older patient cohort, particularly in Musgrove, and a higher number of patients at Stage T4 were treated in comparison to the FLOT trial.

The number of patients who proceeded to surgery was 68% in Somerset and 76% in UHBW.

Those who did not proceed had progressive disease, were deemed unfit, were an open and close or had an out of field node identified.

Results:

Details of the patient cohort, chemotherapy statistics, surgical outcomes and survival data are documented within the presentation.

The evaluation gives reassurance that tolerability of FLOT is acceptable and has favourable survival outcomes.

The audit of timeline to surgery will continue.

Discussion:

The number of patients who did not progress to surgery was approximately 25%, which could mean that more prehabilitation is required.

For the older population in Musgrove, FLOT is generally given at a reduced dose. The question of whether FLOT is deconditioning patients and making them unfit for surgery or if the older patient cohort being treated were never going to be fit for surgery would be useful to assess.

Part 2

The data from this part of the audit is from UHBW only and includes those patients with squamous cell carcinoma and adenocarcinoma who are not suitable for surgery but are appropriate for treatment with chemoradiation (CRT).

Background:

SCOPE1 was the first study where comprehensive radiotherapy quality assurance and staging with PET-CT was undertaken and is the main reference point for this patient group. Chemoradiation is also standard care for squamous cell carcinoma.

Method:

Data was collected between September 2018 and June 2023 on the patients referred for upfront CRT who had either the 11 week or 5 week CRT schedules.

Response assessments are routinely arranged at 3 months using CT and endoscopy. Follow up surveillance is not routinely arranged for all patients, with recurrence identified according to symptoms.

Results:

Eighty one patients were identified; all were staged with PET-CT and the majority had an Endoscopic Ultrasound (EUS).

The median age was 70, ranging from 35-83 and the majority were squamous and Stage IIb or III.

Treatment details are documented in the presentation. All patients who completed their treatment did so within 32 days in accordance with RCR guidelines.

Toxicity rates were high, with 50% requiring a hospital admission, many of which related to feeding tube requirements.

Grade 3 weight loss was 6.9% indicating the need for dietetic input for this patient group.

The long term toxicity of the requirement for endoscopic dilatation was required in approximately on third of patients.

Overall survival at three years was 63% and 58% at four years, which compared favourably with SCOPE1 outcomes.

Disease-free survival at three years was 55% and 49% at four years.

Medium survival after relapse was 6.1 months.

Outcomes from the less intensive chemotherapy given to more elderly patients in comparison with the more intensive regimen, provide reassurance that these patients are not being undertreated.

In conclusion, survival outcomes for SCC are better than the SCOPE1 trial. Outcomes for AdenoCa are poorer. Weight loss is an area of focus and the chemotherapy treatments given are appropriate.

Outcomes from the SCOPE2 trial are pending.

Discussion:

Outcomes for the patients who progressed to a salvage oesophagectomy will be investigated.

Regular CT and endoscopic surveillance is undertaken for the small number of young, fit patients who are thought to be suitable for standard care tri-modality treatment, concluding with a salvage

oesophagectomy.

Practice differs nationally, with some centres progressing patients to surgery as the default pathway.

Practice may evolve in the future to increasingly offering patients CRT rather than surgical therapy for SCC. Non-randomised survival outcomes appear similar and Quality of Life post oesophagectomy results in significant issues. In the future, it is hoped that oesophageal SSC will be entirely treatable by oncological therapies and surgery avoided.

Action: To optimise provision of dietetic support and prehabilitation — **Dietetic Team/Prehab Teams**

Many patients will be motivated to independently engage in prehabilitation activities if prompted.

4. Support of obese patients on an oesophagectomy pathway

Please see the presentation uploaded on to the SWAG website

Presented by Dieticians Sarah Perkins, Tom Landers and Natasha Morris

What the Dietetic Team want:

OG patients need their nutritional needs optimised to improve their surgical outcomes and should ideally have individualised nutritional interventions applied with consistency across the region, throughout the treatment pathway.

What the Dietetic Team have:

There is currently no funding for a dietetic prehab service. Multiple bids have been submitted, and this has been entered on to the Trust risk register. In addition, the Tier 2/3 weight management service was decommissioned in Bristol many years ago.

The current service comprises 2.2 WTE dieticians who cover the malignant and non-malignant Upper GI, HPB, Colorectal inpatient surgery caseload, PN nutrition team caseload, outpatient Upper GI and HPB service and a subset of home enteral feeding patients.

Two WTE dieticians run a dedicated oncology outpatient service to cover all cancer sites in the BRI, and a 0.6 WTE dietician is funded to run a dedicated oncology outpatient service covering all cancer sites in Weston. However, this post is currently vacant.

To manage this large group of patients with limited resources, a model has been proposed which involves an initial assessment in the first surgical UGI clinic to assess the patient's risk of malnutrition or obesity, triage patients who are obese to the resource 'improving your fitness for surgery' and onward referral for all at risk for a face to face appointment with the Adult Nutrition and Dietetics team.

The face to face appointment is encouraged, as this is an opportunity to take measurements other than weight and provide tailored weight management advice.

Onward monitoring is scheduled according to the priority risk level.

A list of resources available to patients is documented in the presentation.

It is hoped to improve regional consistency by clearly documenting the nutrition plan and liaising with the dietitians in local centres.

There are challenges with making sure that the messaging around weight loss advice is correctly interpreted and does not result in malnutrition. Other cancer prehabilitation services do not focus on weight loss due to concerns around deconditioning and instead concentrate on healthy eating and physical exercise.

It is confusing for patients when encouraging them to lose weight at some points and then encouraging them to drink high calorie shakes at others.

Behavioural change at the time of a cancer diagnosis is also difficult to navigate, and other challenges may be patient specific such as literacy, social circumstances etc.

Should the model be agreed, outcomes would need to be monitored as it would be implementing a different approach to other prehab services.

Discussion:

As the obesity epidemic is expected to get worse, the weight loss approach is felt to be appropriate and necessary.

Before bariatric surgical techniques were available, patients with a BMI >40 would have been deemed unsuitable for surgery.

Behavioural change is thought to be possible at the point of diagnosis and is frequently achieved for cessation of smoking.

Radiological measurements of obesity in high risk patients would also be useful, but this could be very labour intensive and would ideally be measured via artificial intelligence.

When the primary treatment is neo-adjuvant SACT, there is sufficient time for a patient to improve their fitness for surgery.

Action: An initial meeting will be held with the regional dieticians to set the scene.	**Sarah Perkins**
OG CAG will draft the uniform messaging, and an educational day will be arranged to disseminate the information to all MDT members across the region.	**Surgical team**
The existing prehabilitation service has allocated time for a physiotherapist to attend clinic; additional funding is required for nutritional prehab.	**CAG Recommendation**
A prospective audit will be undertaken to monitor the outcomes.	
Action: To define the nutritional prehab dataset.	**Surgical team**

Once the messaging has been clearly defined, this may help with the dietetic workload as this can be distributed by anyone in the team.

As the ultimate aim is to maintain muscle mass while reducing fat mass, radiological measurements would be helpful to include in the audit; tools are available to monitor this, which may be more helpful in clinic than scales alone to ensure that the patient is losing the right kind of weight.

5. Endoscopic Submucosal Dissection (ESD) Service

The ESD service used to be delivered by Consultant Gastroenterologist Stratis Alexandridis alone. Consultant Surgeons Ben Byrne and Paul Wilkerson recently attended formal training and have since been performing cases alongside Stratis. Unfortunately, it has been necessary to halt the service as the endoscopic stacks in Theatre are no longer functioning in an optimal way.

Patients currently listed for the procedure have since been referred to Portsmouth.

New equipment has been purchased and is expected to arrive in approximately 12 weeks.

MDT members need to make sure that patients are made aware that ESD will result in an out of region referral until the new equipment is in place.

6. National Cancer Programme Treatment Variation: Existing and potential solutions to reduce time to treatment for curative patients

Please see the presentation uploaded on to the SWAG website

Presented by SWAG Cancer Alliance (CA) Programme Manager Nicola Gowen

The SWAG CA is in the process of trying to help multiple cancer sites reduce treatment variation by optimising treatment pathways.

The National Cancer Programme Team have looked at results from the National Oesophago-Gastric Cancer Audit (NOGCA) and tasked teams to reduce the number of patients with OG cancer waiting more than 62 days from referral to curative treatment, by identifying and implementing quality improvement interventions to improve the speed and efficiency of treatment planning and delivery.

NHS England are providing funding to Cancer Alliances to identify the causes of unwarranted variation and develop quality improvement initiatives for these to be addressed.

The national focus is to reduce the number of days from the date that a diagnosis is communicated to the patient to the decision to treat date.

It is recognised that the data used to assess this metric is inaccurate. However, it does seem to indicate that waiting times for treatments have increased. More current, accurate data has been requested.

Potential quality improvement initiatives are listed in the presentation, some of which are already underway. Information has also been included on the improvement project undertaken by the team in Oxford.

Project Management Support could be made available from the Cancer Alliance team, and funding can be used to support projects, for example, help with audits and statistical analysis.

Discussion:

At the most recent surgical review meeting, which looked at data from the past two months, 100% of patients were treated within the 31 day Cancer Waiting Time (CWT) target.

Provision of EUS was also significantly better than it has been in previous years as the Trust has focused on improving this area.

Action: To determine if funding can be made available from the CA to support nutritional prehab. **Nicola Gowen**

Automatic referrals to test bundles and moving patients along the pathway based on the results without waiting for MDT meeting reviews, helps to shorten the patient pathway.

Decision making outside of the MDT meeting environment is supported,

Laparoscopic slots need to be protected, especially now that the team are taking on the RUH workload.

Delays in access to PET-CT need to be resolved.

SFT plan to work with radiology colleagues to improve compliance with the 62 day CWT target as CT capacity is a current issue. It is also planned to refer patients where the endoscopy looks positive for cancer straight to the rapid access clinic prior to histology being reported.

Work is underway to improve timely referral of patients from the onset of symptoms in the Primary Care setting to endoscopy/ the suspected cancer pathway.

CWT metrics need to include if a patient is on a curative or palliative pathway. Fitness for treatment needs to be assessed and documented throughout so that those appropriate for Best Supportive Care are removed from the tracked pathway and avoid unnecessary investigations.

The OG pathway is so complicated, it is often not expected to be able to achieve all steps sooner than 62 days.

Elements of the National Optimal OG Cancer Timed Pathway that are not delivered by UHBW include CT on the same day or day after endoscopy. This was discussed previously and logistically was seen as aspirational but not possible with current radiological resources; ring fenced slots could be considered but the patient may not have an up to date renal function. It is also complicated by the plan for endoscopy to

eventually move to either the Community Diagnostic Centres (CDCs), South Bristol or BRI.

Another element of the pathway that is not current practice is not discussing patients at MDT until all staging investigations are complete. Protocolising the MDT has been discussed previously and can be reconsidered.

Referral to prehab at the point of suspicion of cancer / referral to endoscopy is also recommended, but this is felt to be too early.

Common pathway delays also include image transfers between Trusts and processing pathology.

YDH CNS team triage all patients who are not fit for surgery to slots other than the fast track 3 day CT slots and don't request CTs for all patients, for example a patient >90 years of age who is for BSC, to reduce the impact on radiology.

The next steps in the patient pathway are arranged as soon as the histology and CT results are reported, rather than waiting for the MDT meeting to streamline MDT discussions.

In the lung cancer pathway, patients are told if it looks like they have lung cancer prior to pathology being reported. They are made aware of the ongoing investigations required and asked if they want to be contacted virtually or face to face with the results, which are delivered by the CNS team; this model works well.

A potential improvement could be to fast track the pathway for young, fit patients to a protocolised radical treatment pathway, with the YDH approach to CT within 3 days, which is enough time to rehydrate the patient following OGD. The MDT could then be used for patients where the treatment pathway is equivocal.

Action: To draft a Standard Operational Procedure (SOP) radical treatment pathway that local MDTs can use to request all relevant tests (CT/PET) for young fit patients. **Dan Titcomb**

There will always be a cohort of patients that are more complicated to manage and may need multiple assessments and MDT discussion. Problems with getting timely slots in Theatres needs to be resolved at the same time.

Guidance on requesting EUS will be included in the SOP, but it is not a reflex straight to test option. It is a scarce resource that should be reserved only for the patients that need it.

7. Combined CT and PET as a single staging intervention

From a medical perspective, arranging combined CT and PET as a single staging intervention would be of benefit. However, set up would require the infrastructure to give patients IV contrast, check liver function, and manage any contrast reactions.

Gloucestershire had piloted combined CT and PET in Cobalt during the COVID-19 pandemic, which did streamline the pathway, but it could not continue as it is not a commissioned imaging modality.

CT quality and resolution would need to be the same as a standard staging CT, as this information is used to assess whether the disease is resectable and check its proximity to vessels.

Alliance PET provider is looking into this being included in a future iteration of their contract with the NHS.

Although it is possible to do PET with a contrast enhanced CT in RUH, in the experience of Consultant Radiologist Andrea Phillips, there are some practical concerns. It could compromise the quality of the staging scan, as it requires the patient to have their arms by their side rather than above the head, and the CT component is not done in a breath hold as this tends to cause misregistration artifacts in comparison with the PET. This could miss lung metastases for example and create more motion artifacts.

Action: Feedback on how combined CT and PET was achieved in Gloucestershire should ideally be shared at a future meeting.	**Gloucestershire Team**

It is understood that the method is also deployed in Switzerland.

Action: The possibility of endoscopists requesting PET for a cohort of patients following a positive OGD will be explored.	**Dan Titcomb**

8. Clinical trials update

Please see the presentation uploaded on to the SWAG website

Presented by Consultant Oncologist Sharath Gangadhara

National clinical trial recruitment from April 2024- October 2024 shows recruitment to Upper GI cancer trials has dropped in comparison with the previous year, although there are another 5 months where it may be possible to improve recruitment. The majority of trials are non-commercial; there is an even split between observational and interventional.

The list of trials open in each centre is documented in the presentation.

In set-up:

ZODIAC trial is evaluating peri-operative Zimberelimab (Anti-PD-1) versus Zimberelimab in combination with Domvanalimab (Anti-TIGIT) in Resectable Mismatch Repair Deficient/Micro-satellite Unstable Gastric and Gastrooesophageal Junctional Adenocarcinoma.

Similar trials in colorectal cancer and particularly rectal cancers have shown a complete pathological response and three year disease free survival rates.

Despite initial responses to chemotherapy and immunotherapy, patients can develop resistance fairly quickly, so the trial aims to see if long lasting durable responses can be achieved by combining the two and comparing outcomes with FLOT.

ROSE trial is the use of a web based information tool for Reporting Outcomes and Symptoms Electronically after surgery. 206 patients undergoing surgery for oesophago-gastric cancer will be recruited at six NHS hospitals in England and randomised to use the tool to report symptoms versus usual care.

Depending on the seriousness of reported symptoms, the ROSE tool will provide information about how to manage these symptoms and/or inform them to contact their healthcare team.

AZD0901 Ph3 Gastric trial is a Phase III multi-centre, open-label, sponsor-blinded, randomized study of AZD0901 monotherapy compared with Investigator's choice of therapy in second or later-line adult participants with advanced/metastatic Gastric or Gastroesophageal Junction Adenocarcinoma expressing claudin18.2.

Pressurised Intra-Peritoneal Aerosolised Chemotherapy (PIPAC) in the management of cancers of the colon, ovary and stomach is a randomised controlled Phase II trial of efficacy in peritoneal metastases (PICCOS). Eligible patients must have visible, measurable peritoneal lesions on CT. Further inclusion and exclusion criteria are documented in the presentation.

In the intervention arms, PIPAC is given via laparoscopy directly into the abdominal cavity at Cycle 3, 6 and 9 in the Cycle 1 equals 2 weeks arm and at Cycle 3, 5 and 7 in the Cycle 1 equals 3 weeks arm.

The trial will open for the interventional arm in RUH. SFT, UHBW and Salisbury FT will open as satellite centres where patients can be recruited and the control arm chemotherapy can be provided.

It has already commenced in Cardiff.

Consultant Gynaecology Surgeon Jonathan Frost has been trained to perform PIPAC, and 2 Consultant Colorectal Surgeons have also been trained.

World-wide, the cases undertaken to date have shown it to be safe in carefully selected patients. Some UK patients have travelled to Europe to have the treatment via the Independent Sector.

Patients with stents are excluded due to concerns of potential perforations.

Patients with microscopic disease are excluded as response assessments must be measurable on CT. A video response assessment is also undertaken during the procedure to measure the response.

The Associate PI training scheme is still available should anyone want to shadow a Local PI for 6 months.

The Research Delivery Network is a new organisation established in October 2024. It used to be the Clinical Research Network but has transitioned to improve support provided to researchers by making this more consistent across the country, and to reflect the growing portfolio of non-clinical trials.

Instead of monitoring trial performance on an individual basis, the organisation will take a more strategic view of the research provision.

The networks are dropping from 15 to 12. The West of England will expand to include Dorset and Salisbury and will be renamed South West Central.

Useful links and contact details are available in the presentation.

Date of next meeting: Friday 20th June 2025, 13:00-17:00, Apex City of Bath Hotel, James St West, Bath, BA1 2DA

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