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

**Meeting of the SWAG Network Oesophago-Gastric (OG) Cancer Clinical Advisory Group**
**Friday 24th March 2023, 13:00-17:00**

**The Hankridge Arms, Hankridge Way, Riverside, Taunton, TA1 2LR / MS Teams**

**Chair: Mr Paul Wilkerson**

| REPORT | 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. | |
| **2. Review of last meeting's notes and actions** | |
| As there were no comments following distribution of the report from the meeting on 30th September 2022, the report was accepted as finalised. | |
| Actions: | |
| The paper on the streamlined pathway in Cheltenham (combined contrast CT and PET immediately after diagnosis as a single staging intervention) will be shared as soon as available. | **S Higgs/H Dunderdale** |
| The CAG recommend removing the investigative test of ultrasound to rule out abdominal mass in the two week wait pathway, as this is an outdated modality and could lead to false negatives, and should be replaced with CT. | |
| This needs to be updated in the OG pathway presented by GP A Randle at the last meeting; GPs should send any patient with a suspected abdominal mass straight to CT. | **A Randle** |
| To define patient cohort with dysplasia appropriate to send straight to magnified endoscopy to improve earlier diagnosis, as per the related Dutch study, where one in four patients with benign looking Barrat's had random biopsies that identified focal mucosal lesions. | |

There is a shift away from ablating all without a nodule to scope and resect even flat lesions to get confirmation of diagnosis prior to Radiofrequency Ablation. This shouldn't delay the pathway as the patient will be on the same list with the surgical team that can do both procedures.

An update on the Patient Information Portal project is still pending.

Cytosponge, which was discussed at length in the previous meeting, needs to remain on hold at present. Despite RUH pulling out of the national pilot, it is not possible for the Bristol team to take part as the alternative SWAG centre, as the national team want to analyse the data from the first stage of the pilot prior to opening additional centres.

There was an action to investigate the resources currently available and additional resources required to provide all cancer patients with a dietetic assessment, in particular in Yeovil and UHBW, as this was not known at the last meeting.

YDH have two senior specialist dieticians who attend the MDT every week so patients are very well supported. The Bristol team refer YDH patients to their care at an early stage in the pathway.

SFT have a good level of dietetic support.

UHBW does not have dietetic coverage in clinic and the waiting times for patients need to be improved. Not everyone is referred due to limited capacity. The action to look at service requirements will remain open. **UHBW Dieticians**

The dysplasia information leaflet will be updated with information on Endoscopic Submucosal Dissection in the next few weeks. **P Wilkerson**

Proximal Margin Involvement and procedure selection will be audited prior to a future meeting. **Surgical Team**

**3. Clinical Guidelines**

**3.1 PET CT for intestinal type Gastric Cancer initial staging**

The most recent iteration of the Royal College of Radiologists (RCR) guidelines recommends that PET scans are considered in non-diffuse type primary gastric tumours for staging and re-staging when

undergoing treatment with curative intent. It will not be a huge number of patients but does constitute an addition to the current staging pathway.

**Action: MDT will incorporate PET as per the RCR guidelines.** **CAG Recommendation**

The PET will occur prior to staging laparoscopy (lap).

There is concern that this may delay the pathway, and result in patients deteriorating while awaiting confirmation to commence SACT. It would need to be requested concurrently with the staging laparoscopy.

St. Thomas's, who have been routinely staging using PET for some time, have audited outcomes, and found that the PET scans change management in approximately one in ten cases.

There may be other ways to streamline the gastric cancer pathway as the staging is highly protocolised and does not need to come back for MDT opinion for each step to progress.

PET results are currently received via email to individuals which, if directed to the wrong person, can cause delays.

**Action: To further refine steps for protocolising gastric cancer pathway.** **MDT members**

Provision of staging lap is a nationally reported Key Performance Indicator but is avoided in some patients who are clearly unfit for treatment. Some staging laps are still required to access palliative treatment options.

The Alliance Medical Lead who provides PET to patients in UHBW has been informed about the additional staging investigations.

**Action: All centres are to inform PET providers of the additional staging investigation.** **MDT Leads**

**3.2 Clinical Context of Genomic Testing in Upper GI Cancers**

**Please see the presentation uploaded on to the SWAG website**

**Presented by Consultant Medical Oncologist and Genomics Lead, L Medley**

The landscape for genomics and cancer is changing rapidly allowing medicine to become increasingly more personalised, most noticeably for lung cancer, but across the whole of the pathway from prevention and early diagnosis through to living with cancer.

There is a need to think about how genomics can be incorporated right at the beginning of the two week wait pathway.

The National Genomics Medicine Service is driving this work forwards to ensure that there is equity of access to routine testing across the country, with the work delivered by the seven regional genomic laboratories.

The South West Genomic Medicine Service Alliance (GMSA) covers a sprawling geography, which has made the regional set up quite challenging, but pathways are being developed.

The eligibility criteria and tests available are listed in the National Genomic Test Directory, found here: National Genomic Test Directory - Genomics Education Programme (hee.nhs.uk)

It is best to look at this live as it is regularly updated. It is possible to make recommendations to add tests that the group consider of clinical importance.

The South West Genomic Hub for cancer testing is based in NBT and information on submitting samples can be found on the website here along with the test request form:
South West Genomic Laboratory Hub | North Bristol NHS Trust (nbt.nhs.uk)

In addition to HER2, PDL1 and DYPD, there is now MMR/MSI for OG cancers and all solid tumours are eligible for an NTRK panel and associated game changing inhibitor is available if a rearrangement is identified.

NTRK is very rarely found in OG cancer, but most commonly in GIST.

Whole Genome Sequencing is available for solid tumours where all other treatment options have been exhausted. This involves submitting fresh tissue. However, turnaround time is not quick and results can be difficult to interpret and act upon; referrals should be made with this in mind when introducing this option to the patient.

It is currently complicated to integrate the genetic report results with existing Trust systems.

Results include the most up to date clinically relevant findings, as sourced from the National Test Directory, and don't include all the genetic panels completed if nothing else relevant is found to ensure the report is succinct; this can however be made available on request. Work is constantly underway to identify additional actionable findings and inform new areas of research into therapies.

In future, it is hoped that liquid biopsies can be provided at key points in the patient pathway to help inform treatment decisions.

The Christie team are opening the first national precision medicine trial DETERMINE, which is tumour agnostic and open to anyone with a gene alteration; it is currently in set-up in UHBW. The Principal Investigator is a Paediatric Oncologist but it will also be available for adults to access new treatments.

There is also a useful tool on the Genomics website that provides example clinical scenarios.

Contact information is in the last slide of the presentation and picking up the phone to talk through individual cases is recommended.

**Discussion:**

It is understood that HER2 and PDL1 assays are currently being outsourced as there are insufficient resources in Southmead Pathology to process the results in a timely manner.

It can be complicated when getting results back from numerous different sources.

Although the genomics laboratory sits next to Southmead pathology, they are two separate services and these assays are managed by local pathology.

MSI and NTRK will be done by the genomic laboratory services.

Once the genomic form is complete and emailed to the technicians, there is no tracking mechanism to see how the sample is being progressed.

It is recommended that each Trust employs a genomics navigator; this has been piloted by the GMSA, although it the task is undertaken by MDT Coordinators in some Trusts.

**GMSA Recommendation**

**4. Clinical Opinion on Network Issues**

**4.1 Round table review of developments in each site**

**SFT:**

There is now a full complement of Clinical Nurse Specialists for the first time in many years.

Significant workload pressures have been caused by a reduction in rapid access cancer clinics from 48 to 36; 16 patients had to be seen in 12 slots prior to the meeting today, which is for patients referred via the two week wait pathway plus delivering diagnoses. There is a risk that this will lead to delays in the patient pathways.

A local endoscopic ultrasound (EUS) service will commence later in the summer for gastric lesion biopsies.

There are issues with compliance with service specifications as recruitment has not been possible to the 5 vacancies in the Gastroenterologist workforce; there are currently 6 WTE post holders in place.

The service is also configured differently from the UHBW service. There is less direct surgical input into the MDT and many competing priorities.

Oncology is also short staffed, having just lost a specialty doctor and are currently managing by booking extra clinic spaces.

Potential solutions:

- Further escalate the need to prioritise recruitment and retention to the gastroenterology and oncology workforce (which has already been escalated to the highest level)

**SFT Team**

- Agree an adapted service specification that is realistic about what can be delivered locally, given the current resource shortages — **OG CAG**
- Risk stratify follow up to reduce wherever appropriate
- Improve the communication of patient pathways between centres — **OG CAG**
- Enable CNS workforce to request relevant imaging in SFT by transcribing the requesting Consultants' instructions. It is planned for the team in SFT to get access to make requests in the next few months. A named Consultant in the Trust needs to be added to the request which should detail that this should be Cc'd to the nursing team to forward on — **SFT CNS Team**
- UHBW team to see if it is feasible to request scans via the Integrated Care Environment (ICE) system, with instructions to radiology to arrange in Taunton or Yeovil (Honorary Contracts may be required to comply with IRMER guidelines). This is the arrangement when requesting PET, which then gets referred to Alliance Medical. — **P Wilkerson/H Dunderdale**

The majority of patients in Somerset prefer not to travel to Bristol for imaging and other follow up; this needs to be considered in the plan for how to support the SFT service and improve the patient experience.

Often problems arise, such as the patient can't lie flat or there are other issues which are difficult to manage when the patient is not known to the SFT team.

The role of the gastroenterologist in UGI cancer includes screening, surveillance, diagnosis, onward referral, nutrition, endoscopy, and palliative care input. It is therefore necessary to cut extra administrative tasks wherever possible and clearly define the tasks that are not within the remit of the role with management.

Data on OG activity can be provided to help inform gastroenterology workload mapping.

**YDH:**

The service is nurse-led with Lead CNS R Newport assessing all two week wait referrals in clinic and CNS L Genes due to undertake this work as well in the near future. Gastroenterologist involvement is concentrated on the interventional part of the pathway, and there is supportive communication between team members with no issues arising.

A Gastroenterologist post has been vacant for some time, and another Gastroenterologist is due to retire in the near future.

The Oncologist workforce has been sporadic over a number of years but is more stable at present.

YDH CNSs want oversight of booking the scans requested by UHBW as they will contact the patient at that point to offer support and arrange local follow up.

**UHBW:**

The CNS team is expected to increase to full complement by the end of March, which will enable CNS led clinics to be arranged again.

Along with E Alexandridis, Consultant Surgeons P Wilkerson and B Byrne have undertaken Endoscopic Submucosal Dissection (ESD) training and will be able to offer this as a new service from the New Year. A shift to use ESD in preference to EMR is expected for treatment of squamous dysplasia.

The first of two new robots has arrived in BRI Theatre.
P Wilkerson and S Strong will be involved in wave 1 of the training which, once up to speed, will be followed by J Wheat and B Byrne.

**Action: A robotic surgery update will be provided at the next meeting.** **P Wilkerson**

**5. Research**

**5.1 National RCTs in OG cancer surgery patients – ROSE and SARONG**

**Presented by Consultant Surgeon B Byrne and Associate Professor in Applied Health and Care Research K Avery**

**ROSE:**

ROSE is a multi-centre randomised controlled trial (RCT) looking at use of a digital intervention to provide online post-operative support following oesophagectomy versus normal follow up for adults, after discharge, to help with their recovery.

Symptoms are monitored in real time via the software application (app).

A pilot study called e-rapid has already been undertaken in UHBW which proved feasibility, and qualitative feedback showed that it improved the patient experience, making them feel less isolated as, often, patients can feel very alone once treatment is over.

It also provides information and advice on how to manage common problems, for example reflux, or shortness of breath, at the time that the symptom occurs.

It excludes patients who are going to be discharged to a facility other than home; they need to have access to a computer or mobile with internet and sufficient English.

The patient reported outcome measures in the app contain algorithms that stratify the symptoms to different levels that indicate if they just need advice, need to contact a clinician in the next few days, or need to seek urgent medical attention.

Primary outcomes are calculated by plotting recovery using a questionnaire at 4 weeks. Secondary outcomes include an economic analysis, disease specific symptoms and healthcare resource use to see how this affects demands and see if it is possible to upscale use and make routine.

It is planned to recruit 200 patients across 6 sites.

Patients will be offered the opportunity to consent at the pre-operative clinic in Bristol and asked to complete a baseline questionnaire. Post operative questionnaires are given immediately prior to discharge and the patient is randomised at that point and shown how to use the app if allocated to the interventional arm.

**Discussion:**

The app, which is entirely patient facing, has been designed on the back of the e-rapid programme, which has been used in numerous cancer pathways and then tailored by the local team with the algorithms for OG symptoms.

If proven to be of benefit, it may be developed further so that the symptoms reported can be accessed by the clinical team.

It would be helpful if a similar system was available for patients receiving chemotherapy and radiotherapy.

**AGREED**

The ROSE trial has the support of the OG CAG.

**SARONG:**

SARONG is another RCT trial of standardised follow up versus intensive surveillance after surgery for either oesophagectomy or gastrostomy for cancer to see if this can improve survival outcomes and quality of life.

International guidance on post-op surveillance currently varies. The USA and National Cancer Network recommend frequent scans, whereas European guidelines do not. Practice in the UK varies between centres, and further better-quality evidence is required.

There is increased interest in the treatment of oligometastatic disease which, in order to be identified, will require more investigations.

From a patient perspective, more frequent scans can either be found to be reassuring or raise anxiety, which will be monitored as part of the trial.

A retrospective observational trial ENSURE, undertaken across the USA and Europe, showed overall survival improved with intensive surveillance in a particular patient group, but an RCT is still required.

Eligibility criteria is ≥16 years having curative intent surgery.

Patients will not be eligible if undergoing surveillance for any other cancer.

Patients will have CT scans every 6 months for 36 months plus an endoscopy after 12 months.

The primary outcome is 3 year survival and the secondary outcomes are the number of cancers detected and treated and the impact on Quality of Life.

Patient information is given at discharge; recruiting and consenting will take place at the first post operative clinic appointment.

Questionnaires will be distributed centrally by the study team.

**Discussion:**

Current practice in UHBW is not to scan unless a patient becomes symptomatic.

It will need to be made clear to patients during the consent process that the increase in follow up does not mean that it will be possible to treat any disease recurrence that is identified, and that the standard practice not to scan is considered an equipoise alternative.

**Action: To keep a log of the number of patients approached who decline to consent** — **B Byrne**

It may be appropriate to record the consent conversations, as with the ROMEO trial, as a drop out rate is predicted. This had been raised with the Qualitative Recruitment Intervention Team, who considered that this would be quite straightforward to explain.

Although there is some question over how successful trial recruitment may be, it was considered important to look at the differences in surveillance practice to clarify the preferred practice.

**Action: OG CAG are to decide where each CT scan can be arranged so that this can be factored in to the consent discussions.** — **OG CAG/Radiology Colleagues**

It was noted that risk stratification of follow up was not included in the trial design.

It is planned to undertake a bolt-on biomarker trial alongside SARONG, looking at ctDNA and other markers to further refine the surveillance.

**5.2 Clinical Trials update**

**Please see the presentation uploaded on to the SWAG website**

**Presented by Research Sub-Specialty Lead S Gangadhara and Research Delivery Manager C Matthews**

National clinical trial recruitment from April 2022- March 2023 shows that recruitment to Upper GI cancer trials has halved in comparison with 2021/22 due to the closure of a large trial, SIMPLIFY. However, research activity is on track, with the NIHR bioresource study recruiting significantly more patients in 2022/23.

A comparison between national and regional recruitment levels shows the SWAG region performing well.

The trials open across the region and in set up were described in detail, as documented within the presentation.

The Question 58 in the National Cancer Patient Experience Survey 'Cancer research opportunities were discussed with the patient' scored below average across SWAG (42%) in comparison with the national average. Upper GI patients scored higher (50%) however, all CAG are being asked how to increase conversations about research.

**AGREED**

Patient Representative feedback is to let the patient know that research trials have been considered, even if the outcome is that there is no eligible trial available.

An NIHR 6-month Associate Principal Investigator (PI) role is open to any interested clinician who doesn't have research in their current role. It allows associates to work alongside current PIs on studies (as documented in the presentation) signed up to the scheme.

Any PI interested in getting help from an associate while helping their personal development is to get in touch.

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

**Discussion:**

There are ongoing issues with capturing all the trials open across the region.

There are a number of trials open that will support patients to travel to other centres by helping with travel expenses and childcare costs.

Further information on the trials available across the region needs to be shared to enable cross-referrals. Consultant Oncologist R Bowen manages this for Gynae by updating the list of trials directly from investigators.

**6. MDT meeting: anonymous survey**

**The presentation is available to MDT members on request**

**Presented by P Wilkerson**

The MDT survey was distributed three years ago pre-COVID and generated no recommendations for improvements. It has now been repeated to see if anything has changed.

The majority thought that the duration of the MDT meeting was correct.

The need for a system to track histology from endoscopically treated patients outside the MDT was raised.

There were three suggestions for restructuring the meeting:

- For all OG surgeons to attend
- To protocolise cases, embed genomics and clinical trial discussions
- To add Yeovil cases at an earlier time slot.

**Action: BRI and Weston cases will be moved to the end of the list and Yeovil and Taunton moved to the beginning for a one month trial.** — **MDT Lead/Coordinator**

After the meeting today, all are signed up to further consider embedding research and genomics.

It is not possible for all OG surgeons to attend as this would result in numerous theatre session cancellations. More than one is required to attend to ensure that there is appropriate debate. Particularly complicated cases are discussed prior to the meeting so that the surgeon presenting can give the combined view of the surgical team.

In relation to the question 'Do you think there is sufficient time allocated for preparing patients' cases for discussion?:

- More trainees prepping and presenting

This was agreed and would be ideal if there was sufficient time available for the trainees to be freed from other tasks.

A positive comment was included:

- OG surgeons prepare well and MS Teams enables extra information to be gathered in real time.

There were also comments on clarifying who should present each case.

As the OG Surgeons need to prepare each case discussion, it was decided that the history and treatment will be presented first, then the referring centre who know the patient, will be invited to add patient-centred information.

Responses in relation to the question about the time discussing and reviewing radiology were mostly very positive. Many reviews also occur outside the meeting. The issue of scan availability from other centres is an ongoing problem.

SFT resolved this by giving access to import the images to the MDT Coordinator and Navigator, but progress has stalled due to sick leave and again due to recent technical issues with PACs and the system to which it is exported. This has a detrimental effect on the patient experience when having to inform them that the MDT discussion has been deferred to the next meeting.

**Action: The radiology department in SFT will be contacted to ask for solutions for timely export of images.** **P Wilkerson**

In relation to the question 'Do you think there is sufficient time allocated for discussion of pathology?' the staffing crisis in pathology and its effect on the MDT discussions in terms of delays was noted, and it is hoped that this can be resolved as soon as possible.

In relation to the question 'What do you think about the time spent discussing the patients' preferences to adequately contribute to care plans?' It was considered difficult to incorporate this into the MDT

process and beneficial if patient preference and fitness could be discussed more.

If a decision is made after clinic review that a patient is not fit for surgery and needs to be referred to oncology, the detail relayed in that conversation needs to be provided for the clinician who sees the patient next. This process is already in place, with the information exchanged between the CNS teams.

Actual discussion of patient preferences within the MDT meeting could be enhanced to facilitate MDT decision making.

In relation to the question 'Are there cases that could remain on the MDT list for information, but not be discussed in the MDT meeting, as they would be appropriate to protocolise to a standardised treatment pathway (unless there was a particular cause for concern)?'

As there is a very protocolised staging protocol, there is a number of patients that can continue to the next investigation from endoscopy to CT and CT to PET without the need for an MDT discussion as long as nothing is flagged up in the reports. This would speed up the patient pathway.

**Action: To re-write the MDT Standard Operation Procedure to streamline MDT discussions where appropriate, with the caveat that this will not restrict patients from being included on the list if there is a particular cause for concern.** **P Wilkerson**

In relation to the question 'Do you feel enabled to contribute your concerns and feel that your contribution to the MDT is valued?

The majority of responses were positive but, as previously discussed, ensuring everyone has the opportunity to have a collegial discussion will be encouraged.

The responses to the survey were appreciated and very useful.

**Action: The survey will be repeated every 2 years** **H Dunderdale**

**Discussion:**

The response rate was low in comparison to the number of OG delegates.

Response rates for other cancer MDT meeting surveys tend to be higher where numerous improvements are required.

**7. Any other business**

Future CAG meetings will have educational input and generate Continual Professional Development points.

OG CAG doesn't have a Patient Representative member at present. A patient representative brief was circulated to all present should a patient be identified who wants to volunteer for the role.

**Date of next meeting: To be determined by Doodle Poll in Autumn/Winter 2023**

**-END-**