Intelligence

National Cancer Action Team
Part of the National Cancer Programme

NHS

National Cancer Peer Review Programme

Upper Gastrointestinal Clinical Lines of Enquiry

Briefing Paper for National Cancer Peer Review

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These lines of enquiry have been developed to evaluate aspects of the management and outcome for patients with upper gastrointestinal cancers. The selected topics include qualitative and quantitative measures using data, which is currently recorded nationally. These sources include Cancer Registry databases, National Oesophago-Gastric Cancer Audit (NOGCA), the Hepato-pancreato-biliary surgery audit and Hospital Episode Statistics (HES). The aim of the lines of enquiry is to stimulate discussion and debate on the current approaches to upper GI cancer across England with the intention of improving patient outcome. It is also hoped that such discussion will raise further topics for local audit.

Centre Workload

1. The number of new cases treated and recorded in National Audits

This refers to the volume of work undertaken by a Specialist oesophago-gastric (O-G) or hepato-pancreato-biliary (HPB) centre.

Involvement in National Audit is a key process to ensure accurate information about outcome. Data is available from NOGCA particularly relating to case ascertainment – the number registered with the audit compared with the total number of cases recorded by the Registries. This line of enquiry should provide a focus for discussion of the value of a national audit to the teams and how teams that do not actively engage with it understand, plan and develop their service. The data for each Trust is benchmarked against 70% case ascertainment (the overall national value), providing a reference point for discussion. Further information on the national audits can be obtained from www.ic.nhs.uk and www.augis.co.uk.

Similar data is steadily accumulating in the HPB audit. In the absence of national audit data for HPB, should discuss annual numbers of new referrals and number discussed at MDT meetings recorded in Centres' annual reports.

A key issue with the current revision of the National Core Dataset is the ability to record data and Unit and Centres should describe how they record data – eg electronically at MDM or manually, with reference also to their response to this in the measure included in the Manual for Cancer Services.

Cancer Services

2. The number of cases with confirmed histology

Histology is the objective method of diagnostic confirmation of cancer. However, it is not uncommon for an MDT to decide to make the diagnosis on 'clinical' (usually CT-based) grounds alone, particularly for pancreatic cancer. This creates difficulty both in differentiating chronic pancreatitis and pancreatic cancer and in selecting appropriate medical therapies. There is no accepted rate for histological confirmation, however data is provided by the Registries at Network level and it is possible to estimate the national average from Registry data. Teams which fall below the national average should seriously look at their practices.

3. The proportion of patients in whom stage of disease is recorded

Cancer treatment should be stage related. Furthermore it is impossible to compare different results of treatment unless due allowance is made for stage of disease. The Cancer Registries do not currently routinely record staging data. However the need to record stage for every patient is a national priority. Trusts should be able to produce a record of the stage of disease for each patient. Since less than 25% of upper GI cancer patients undergo any surgery the majority will be staged on clinical criteria. Pathological stage will be possible on those who have undergone a resection. The proportion of patients in whom stage is recorded should be documented. Trusts are expected to provide explanations where there are difficulties with recording stage.

Treatment

4. The percentage having a surgical resection

Radical surgery is the only treatment which can produce long term survival for most upper GI cancers. Data on resection rates is available from HES data and this can be presented by Cancer Network and Specialist Centre. The first NOGCA reported resection rates of 23% for gastric cancer, 24% for junctional cancer and 10% for oesophageal cancer.

Resection rates for pancreatic cancer range from 10-15%. Data is provided from NATCANSAT on number of procedures for Major Resections per Trust (a list of relevant codes is provided). Trusts should be willing to discuss these in comparison to their local data on MDT workload, and Reviewers should enquire about possible reasons where a Trust is found to be an outlier against the national average. Those achieving rates well below or well above the national average should review their indications for surgery to ensure they are not being too selective or not being selective enough.

Data on number of procedures is provided by NATCANSAT as a basis for discussion. Much of this work is dependent on accurate coding from within trusts. It is hoped that any discussion on discrepancies will lead to improvements in accurate coding for onward submission to national bodies.

5. The morbidity and mortality following surgery

Surgery for upper GI cancer is the most complex of all cancers and as a result is associated with appreciable morbidity and mortality. Data is available from the NOGCA showing the types of morbidity as well as the 30 and 90 day mortality. The third NOGCA reported postoperative hospital mortality for oesophago-gastrectomy at 3.1% and 4.2% for gastrectomy.

This data can be extrapolated to include both hospital and surgeon volume comparisons. Where the rates differ widely, Trusts should be willing to discuss the reasons for their morbidity and mortality figures, however such data must not be taken in isolation but must be considered in the context of available confounding variables including comorbidity.

6. The percentage of patients having palliative interventions

Since only 25% at most of patients with upper GI cancer undergo surgery, rates of palliative intervention are important. This may include symptomatic intervention or interventions with radical intent where disease extent was underestimated. The first NOGCA report describes endoscopic and radiological interventions in approximately 30% of oesophageal and junctional cancers not treated surgically. Approximately 5% of gastric cancers were bypassed surgically. In addition approximately 30% received some form of oncological intervention with palliative intent.

Data on palliative endoscopic, radiological and surgical interventions (bypass; open and close) are available from HES. Rates of palliative interventions reflect the diagnostic and staging assessments by the MDT and its approach to palliation. Trusts should use this information to reflect on their approach to palliation.

7. Postoperative length of stay

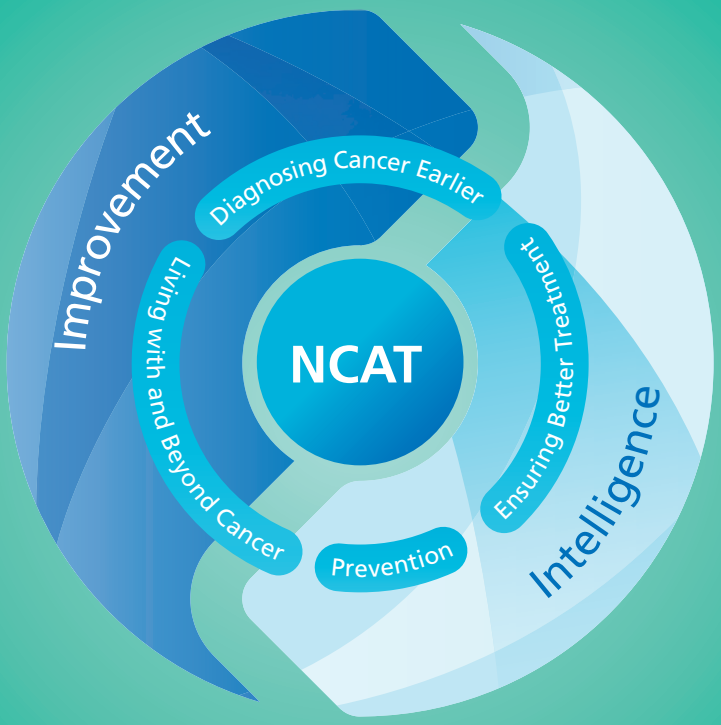
Length of stay following upper GI surgery is determined by a number of factors. Trusts should provide any local length of stay data for discussion. The 3rd NOGCA report found median stay after oesophago-gastrectomy was 14 days (Interquartile range 11 – 21) and after gastrectomy was 11 days (IQR 8 – 17). Similar lengths of stay are reported after pancreatic and liver surgery. Postoperative recovery is influenced by disease stage, comorbidity and complication rates. Current interest in enhanced recovery may reduce lengths of stay but such approaches require multidisciplinary effort. Significant deviation from these medians should be carefully reviewed.

Survival

8. The rates of survival from diagnosis and with or without intervention

Survival is an obvious and essential outcome measure. It is influenced by a variety of factors including comorbidity, stage at diagnosis, patterns of treatment and social deprivation.

Data on 12 month, 2 and 5 year survival is readily available from Cancer Registry and HES databases, and this is provided here at Network level. Outliers against the national average should discuss the possible reasons for this, understanding however that assessment of the measurable confounding variables is essential when comparing survival outcomes.



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