



# **3 Counties Cancer Network**

## **Upper GI Cancer**

### **Patient Pathway and Operational Policy**

**June 2005**

## **Introduction**

At an independent review in September 2003 the decision was taken to centralise oesophagogastric cancer resections at Gloucestershire Royal Hospital for the 3-Counties Cancer Centre. This decision was approved by the 3-Counties Network Board. Within the 3-Counties Cancer Network the units are designated as follows for oesophageal and gastric cancer.

Cheltenham General Hospital	)	
Hereford County Hospital	)	DIAGNOSTIC (LOCAL) UNIT
Worcestershire Royal Hospital	)	
Gloucestershire Royal Hospital		SPECIALIST (CENTRAL) UNIT

This operational policy is designed to explain the process by which patients with oesophageal or gastric cancer proceed through the stages of diagnosis, investigation and treatment.

## Timescale for patient events

It is envisaged that the following timescale for patient interventions and transfers provides a framework for meeting the national cancer targets.

- 2-week wait from referral to first consultation
- 31 days from diagnosis (decision to treat) to first definitive treatment
- 62 days from urgent GP referral for suspected cancer to first definitive treatment

### I) Diagnosis and investigation pathway

<u>By day</u>	<u>Event</u>
0	GP referral made
14	<i>OGD &amp; Bx</i>
21	OPD – local MDT inform patient of diagnosis <i>CT scan</i>
28	OPD – decision to refer to specialist unit <i>Cardio-pulmonary function tests</i>
35	OPD – specialist unit <i>CT scan &amp; histology available</i>
38	Admit to specialist unit <i>EUS</i> <i>Laparoscopy (+/- Bx)</i> <i>Anaesthetic assessment</i>
43	Specialist MDT <i>Cardio-pulmonary FT available</i> Patient informed of findings & treatment options
50	Treatment decision finalised <i>(Further Bx may be available)</i>
62	Initiate treatment

## II) Treatment options

### 1. Best supportive care

Delivered within local unit

### 2. Primary radiotherapy +/- chemotherapy

Arranged by specialist MDT directly with Cheltenham Oncology Centre

### 3. Surgery alone

### 4. Neo-adjuvant chemotherapy + surgery

Two cycles of OEO2 regimen (cisplatinium and 5FU)

CT scan 4 to 5 weeks after completion of chemotherapy

OP consultation 1 week prior to resection with CT result

Surgical resection within 6 weeks of completion of chemotherapy

## Diagnosis

- GP referrals for suspected oesophageal or gastric cancer will follow the National Referral Guidelines for suspected cancers (DOH 2000). This process is already operational in all four hospitals (*commonly referred to as “2-week wait referrals”*).
- All patients with histologically confirmed oesophageal, junctional or gastric cancer will be reviewed by the local UGI MDT. The preliminary decision about further investigation and management is made by the local MDT at this stage. (Review of pathology records should ensure 100% compliance).
- All such patients discussed at the local UGI MDT should be registered on the specialist MDT database. Following the local MDT any new case of cancer should be registered by fax or e-mail (*proforma 1*).
- The local unit is responsible for informing the patient and GP of the diagnosis within 24<sup>hrs</sup>. Specialist nurse support should be provided. Written information for the patient about the diagnosis and support groups should be provided (*appendix 1*).

## Investigation (Local Unit)

- The local unit is responsible for the initial investigation of the patient.
- All patients should undergo CT scan<sup>\*</sup> of the thorax and abdomen according to set protocol (*appendix 2*). Exception to this would be rare as this investigation provides prognostic information relevant to non-operative care.
- If the CT scan detects metastatic disease then best supportive care, which may include chemo-radiotherapy, will be organised by the local unit, together with the specialist nurse, palliative care team, dietician, social services and oncology department.
- If the CT shows no metastases, the possibility of resectional surgery should be discussed with the patient. This is best provided by the local UGI surgeon and specialist nurse. Assessment at this point should focus on:
  - Co-morbidity
  - Overall fitness for radical surgery
  - Patient choice including non-operative therapy and/or chemo-radiotherapy
- If the patient is thought potentially fit for surgical resection further baseline investigations are to be performed.
  - ECG
  - PFT
  - Cardiac function tests
    1. echocardiogram - if normal and no previous cardiac history no additional test required
    2. exercise ECG - required for patients with abnormal echo or previous cardiac history
- If these investigations reveal contraindication to surgical resection, or if the patient declines referral for possible resection, then best supportive care is provided by the local unit.
- A patient still deemed resectable should be referred at this point to the specialist team (*proforma 2*).
- Reason for non-referral will be transmitted to the specialist MDT
- <sup>\*</sup> It is likely in the future that PET-CT will supersede CT as the initial investigation for local invasion or metastatic disease.
- <sup>\*</sup> If there is uncertainty regarding the CT finding, then PET scan should be considered for clarification.

## Investigation (Specialist Unit)

- Once formal referral to the specialist MDT is received, the diagnosis and investigation will be reviewed at the specialist MDT.
- The patient will be seen in out-patients at the specialist unit (*letter to be sent to patient – appendix 3*).
- The patient will be admitted for completion of staging investigations.
- The patient will be admitted for a short hospital stay (2 – 4 nights) for:
  - Laparoscopy (distal  $\frac{1}{3}$  oesophagus, junctional and gastric malignancy)
  - EUS
  - Anaesthetic assessment
  - Specialist nurse assessment
  - Dietetic assessment
- If these investigations determine contraindication to resection, the patient will be informed at the end of the short hospital stay. The findings will be discussed with the Oncology team. If palliative chemotherapy or radiotherapy are offered and accepted, arrangements for commencement of treatment will be made before discharge.
- If there is to be no resection or chemo-radiotherapy, referral will be made back to the referring surgeon or specialist nurse at the local unit, so that non-operative management may be instituted locally.
- If there is no contraindication to resection and after discussion the patient chooses surgical resection, arrangements for neo-adjuvant chemotherapy or surgical admission will be made before discharge home.
- Patients will be offered time to make their decision (in some cases further histology will be awaited) and these patients will be seen in out-patients at the specialist unit within 1 week.
- Patients with oesophageal and Type I junctional malignancy should be considered for neo-adjuvant chemotherapy. Again arrangements for this treatment will be made directly by the specialist unit.
- The local unit and GP will be informed of the decision within 24<sup>hrs</sup> (*proforma 3*).

### **Treatment (Local Unit)**

- For patients not undergoing resection, treatment aims are palliation of symptoms, maintenance/improvement of quality of life and, if possible, increased survival time
- A number of modalities are available and are tailored to the individual patient's needs. This will usually require the involvement of the local palliative care, dietetic and oncology teams.

## Treatment (Specialist Unit)

- Resection surgery to be performed at Gloucestershire Royal Hospital
- Patients will be admitted the day prior to planned resection.
  - Proximal  $\frac{1}{3}$  oesophagus    McKeown 3-phase oesophagectomy (rarely resectable)
  - Middle  $\frac{1}{3}$  oesophagus    McKeown or Ivor-Lewis
  - Distal  $\frac{1}{3}$  oesophagus    Ivor-Lewis or trans-hiatal
  
  - Proximal and middle  $\frac{1}{3}$  stomach    Total gastrectomy
  - Distal  $\frac{1}{3}$  stomach    80% distal gastrectomy
- Post-operative care initially on ICU/HDU before transfer to surgical ward base.
- Once the patient is self-caring and managing full diet arrangements for discharge are made
  - Directly to home
  - To local unit for further convalescence
- Written discharge information to the local unit and GP will accompany the patient and be sent by fax/e-mail within 24<sup>hrs</sup>(*proforma 4*).

## Follow Up

- Non-resected patients will be followed up in the local unit. Frequency and need for follow-up will be determined locally by the upper GI surgeon and patient.
- For resected patients initial follow-up will be shared by the specialist and local unit. The following is suggested:
  - 6 weeks                    specialist unit
  - 3 months                local unit
  - 6 months                specialist unit
  - 9 months                local unit
  - 12 months              specialist unit
  - thereafter              local unit
- Patients will have access to open appointments via the specialist nurse or specialist centre office.
- Each follow-up report should be copied to the local unit/specialist unit and GP.
- If histology is not available prior to discharge the patient will be seen at one week.

Signed:

Mark Vipond  
Chair of NSSG  
Date:

Simon Hairsnape  
Chair of Network Board  
Date:

Proforma 1 (Registration)

**REGISTRATION OF OESOPHAGEAL/GASTRIC MALIGNANCY**

To: Gloucestershire Royal Hospital Upper GI MDT

Diagnosis of UGI malignancy was confirmed by the MDT at:

Cheltenham  Hereford   
Gloucester  Worcester

Patient:

Hospital No:	.....
Address	.....
	.....
	.....
Contact Tel:	.....

GP: Name ..... Surgery .....  
Tel: .....  
Fax: ..... Post code .....

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Histology: adenocarcinoma   
squamous cell carcinoma   
other   
(state .....) )

Site: Oesophagus ..... cms proximal 1/3   
middle 1/3   
distal 1/3

Junctional type I   
type II   
type III

Stomach proximal 1/3   
middle 1/3   
distal 1/3

Signature ..... Date .....

Proforma 2 (Specialist Investigation)

**REFERRAL FOR POSSIBLE OESOPHAGEAL/GASTRIC RESECTION**

To: Gloucestershire Royal Hospital Upper GI MDT

Diagnosis of UGI malignancy was confirmed by the MDT at:

Cheltenham  Hereford   
Gloucester  Worcester

Patient:

Hospital No:	.....
Address	.....
	.....
	.....
Contact Tel:	.....

GP: Name ..... Surgery .....  
Tel: .....  
Fax: ..... Post code .....

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Histology: adenocarcinoma  squamous cell carcinoma   
other   
(state .....) )

Site: Oesophagus ..... cms Junctional  
proximal 1/3  type I   
middle 1/3  type II   
distal 1/3  type III   
Stomach proximal 1/3   
middle 1/3   
distal 1/3

ASA  Wt. ....kg ECG .....

Co-morbidity ..... PFT FEV1 .....l  
..... FVC .....l

Drugs ..... Echo .....

CT findings ..... Ex. ECG .....

Signature ..... Date .....

**RESULTS OF SPECIALIST INVESTIGATION FOR POSSIBLE  
OESOPHAGEAL/GASTRIC RESECTION**

To: Cheltenham  Hereford   
Gloucester  Worcester

Patient:

Hospital No:	.....
Address	.....
	.....
	.....
Contact Tel:	.....

GP: Name ..... Surgery .....  
Tel: .....  
Fax: ..... Post code .....

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Diagnosis .....

EUS ..... Laparoscopy .....  
.....

Anaesthetic assessment .....

The findings have been discussed with the patient and the following management plan agreed:

- Resection
- Neo-adjuvant chemotherapy
- + resection
- Awaiting further histology
- No resection

Free Text: .....  
.....  
.....  
.....

Signature ..... Date .....

Proforma 4

**TRANSFER OF PATIENT FOLLOWING UGI RESECTION**

To: Cheltenham  Hereford   
Worcester

Patient:

Hospital No:	.....
Address	.....
	.....
	.....
Contact Tel:	.....

GP: Name ..... Surgery .....  
Tel: .....  
Fax: ..... Post code .....

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Original diagnosis .....

Neo-adjuvant chemotherapy      yes/no

Surgical procedure ..... Date .... /... /....

Days in ITU/HDU

Complications .....

.....

.....

.....

Histology report      T     N

Proximal margin clear              yes / no

Distal margin clear                yes / no

Circumferential margin clear      yes / no

Free Text: .....

.....

.....

.....

Date of follow up at specialist centre      .... /... /....

Signature ..... Date .....

