HBP Pathway Board

#	Date Created	Status	Discussion summary	Action	Action Lead	Update
20-21 Tracker	08/12/2020	Open	**Title: Introduction** **To: Discuss** **Owner: TS** TS welcomed all members to the board. Matters arising - MSI testing: AL updated that in the last meeting this matter was discussed. Nivolumab is now available for patients that have MMR deficiency. AL has been looking into the funding and collating data from literature to support this testing being added to the standardised patient pathway as it is now part of NICE guidance. JV noted that this would be beneficial to a small number of patients, therefore, there we may need to develop a criteria rather than test all patients. The test should be requested once a metastatic diagnosis has been confirmed in MDT, therefore, the results would be available when the patient is seen at The Christie rather than cause an additional delay. AL noted that LF was concerned regarding the funding should the demand for testing increase. Previous meeting actions: all actions that related to on-going agenda items have been closed on this log but carried forward in the meeting.	**A: AL will collate the numbers and estimate the number of patients that may need this test to present. They noted that the pathway board should support this as part of the standard of care.** **A: CG to organise a meeting between AL/LF/JV/SS/TS/CG to discuss further.**	**AL** **CG**	
20-21 Tracker	08/12/2020	Open	**Title: MDT Reform** **To: Inform** **Owner: TS/SB** TS introduced a survey that has been conducted across core members of the MDT in order to start working on improving the function of the specialist MDT. There is a project in GM Cancer led by Kate Williams (Oncoplastic Consultant Breast Surgeon), the remit of which focuses on improving the standardisation of referral forms, efficiency of the meetings and outcomes etc. In order to ensure the MDT supports the implementation of the best timed pathway the team at MFT have been looking at making changes to the frequency of the meetings and the way they are run. The current HPB Pancreas Specialist MDT runs weekly between 8:00-10:30. The average number of cases discussed is 35 and the average time spent discussing each case is less than 4mins. The attending MDT members do not always have direct involvement in the patients care and patients are often discussed with incomplete referral details. The online survey comprising of 17 questions was sent to 143 stakeholders and 24% responded. 53.6% of stakeholders were 'somewhat satisfied' with the efficiency of the MDT. Suggestions were made of improvements to the MDT which will be taken into account and discussed with the MFT team and the GM Cancer MDT Reform project team. TS asked if it should be made mandatory for the referring clinician to present their patient at the MDT. Feedback from the group was that it may be difficult to organise for each clinician to join at the correct time. It is important to ensure that the correct information is present on the referral form to allow effective decision making.	**A: CG/TS to link the GM Cancer team with the lead of the MDT at MFT to progress this work in a joined up approach.** **A: SB/TS to send patient questionnaire to our service user representatives for their input to the design prior to sending out.** **A: Conduct an audit of MDT documented vs actual outcomes.**	**CG** **SB/TS** **SB/TS**	
1	15/06/2021	Open	**Title: Synoptic Reporting for early Pancreatic Cancer** **To: Inform** **Owner: Juan Valle** JV updated the group on a piece of work being undertaken under the National Cancer Research Institute (NCRI) in the pancreatic subgroup. It is a task and finish group that JV and Dan Palmer are leading. They have set up an early stage pancreatic cancer framework, and have identified cross cutting themes that has leads for each theme. The framework has also been split into three cohortss: resectable, borderline resectable, and locally advanced. PCUK (Pancreatic Cancer UK) hosted a meeting in Manchester several years ago and it became clear that groups were comparing the different cohorts and there was no consistant definitions used across the UK making comparison very difficult. There was a large multidisciplinary group set up from across the UK which has support from relevant national bodies. They reviewed all tools that were available for staging pancreatic cancer and combined this into a new one that could be used nationally. The pilot was successful and this tool is being rolled out nationally. This foundation supports research and the standardisation of care moving forward. JV talked through the tool (see slides available). TS asked whether this information will be completed prior to or during the MDT and JV confirmed that is has been done differently so it will need to be a decision made locally.	**A: JV and TS to discuss with RS (lead of Radiology at MFT to provide a consensus).**	**JV**	
2	15/06/2021	Open	**Title:Management of gastric varices in patients with advanced HCC due to receive atezolizumab/bevacizumab** **To: Inform and Approve** **Owner: Richard Hubner** RH presented regarding patients being considered for atezolizumab/bevacizumab with advanced Hepatocellular Carcinoma (HCC) and the management of potential or actual gastric varices. RH recapped the IMBrave150 trial, which compared Sorafenib (then Standard of Care) against atezolizumab/bevacizumab which were both given intravenously on a three weekly basis, 500 patients were randomised with overall survival being the primary endpoint. There was a benefit in overall survival; median survival was 19 months with atezolizumab/bevacizumab compared to 13 months with Sorafenib. As a result, this combination is now the new Standard of Care. A potential issue is variceal bleeding; bevacizumab has the potential to cause bleeding. Acknowledging that OGD (Oesophago-Gastro-Duodenoscopy) within 6 months was an eligibility criteria for all patients recruited to IMBrave 150 trial but is unlikely to be feasible during the COVID-19 pandemic, therefore the following guidelines have been developed: 1. Patients with no evidence of portal hypertension as evidenced by imaging showing normal spleen size, no varices and platelet count of ≥150: Recommendation - no requirement for OGD 2. Patients with portal hypertension but no history of variceal bleeding: Recommendation - should be treated with carvedilol 12.5 mg daily and no requirement for OGD 3. Patients with portal hypertension who have history of variceal bleeding > 6 months ago and may already be on carvedilol: Recommendation - should have OGD within 6 months of starting Atezo/Bev with optimal endoscopic treatment and addition of carvedilol if not already on treatment 4. Patients with portal hypertension and history of upper GI bleed within 3 months or who have bleed within 6 months and have incompletely treated varices: Recommendation: should not be treated with Atezo/Bev 5. Patients with no cirrhosis but evidence of tumour thrombus in main portal vein should be managed using above criteria due to risk of portal hypertension Consensus moving forward: • Follow UK consensus guidelines (subject to agreement at GM HPB Pathway Board) • Consider need for endoscopy at HPB MDT and medical oncology appointment • Refer patients who need endoscopic evaluation to MRI/Wythenshawe for rapid access to endoscopy (facilitated by Dr Martin Prince and Dr Varinder Athwal) The group agreed that the guidelines will be followed and shared with all units through the members of the pathway board.	**A: Group consensus to use this current guidance moving forward during the COVID pandemic.** **A: All members of the pathway board to ensure that their teams are aware of this guidance.**	**ALL**	

3	15/06/2021	**Open**	**Title: Selective Internal Radiation Therapy (SIRT) for patients with hepatocellular carcinoma** **To: Inform/Discuss** **Owner: Richard Hubner** SIRT is now NICE approved for patients with HCC (Hepatocellular Carcinoma). SIRT is a liver directed therapy using Yttrium-90 loaded spheres/beads that lead to a local delivery. It is non-embolic and delivers the achieves anti-tumour activity via the radiation dose which means it can be considered for patients with branch or main portal vein thrombosis. It is delivered by interventional radiologists at The Christie. Dosimetry is used to improve outcomes. The evidence base for SIRT consists of early phase and anecdotal data currently suggesting responses, there are three randomised controlled trials. NICE have approved SIRT for HCC: NICE guidance, TA688 The guidance has been discussed nationally, the Manchester HCC research group discussed this further and they have created a consensus that the following patients should be considered for SIRT: Consider SIRT for following patient groups (without extrahepatic disease) • Multifocal liver disease with largest lesion >7cm (hence not ideal for TACE, Hap score B at least) • Patients with disease refractory to TACE • Main PVT or main branch PVT (hence unsuitable for TACE) • Unsuitable for TACE for other reason and also not suitable for SBRT • Patients who have received palliative systemic therapy and experienced progression of liver disease Also medical oncologist to consider the following: • Alternative therapy would be systemic therapy (atezo/bev or sorafenib) • Consider for systemic therapy following SIRT	**A: The group are asked to consider these criteria and ensure that this potential line of treatment is discussed in MDT**	**ALL**	
4	15/06/2021	**Open**	**Title: Early Diagnosis: Rapid Diagnostic Centres and Radiology Reporting** **To: Inform/Discuss** **Owner: Thomas Satyadas** Work is ongoing to open the HPB specific RDC pathway at NCA (Northern Care Alliance) and MFT (Manchester University Foundation Trust). Queries have been raised regarding the bilirubin level threshold and NICE guidance in relation to patients being admitted versus invited to an RDC. It is acknowledged that this is a local issue, however, the pathway board view is that there should be a consensus on a GM wide approach to the treatment of these patients. TS confirmed that the NICE guidance doesn't specifically refer to painless jaundice patients, and it notes that the patients must have a secondary care assessment which is the CT scan provided at RDC. https://cks.nice.org.uk/topics/jaundice-in-adults/management/management-of-jaundice-in-adults/ The group agreed that there is a need for a Greater Manchester protocol on the management of painless jaundice. Radiology Reporting: CG attended the regional radiology group to present a paper written with TS to ask their opinion and for suggestions on finding a way to identify and flag up patients that have a pancreatic cancer more quickly than waiting for the radiologist to send the report back to the referring clinician. There was a suggestion of using codes so that there would be a robust process rather than a manual task and CG/TS will take this further by arranging another meeting and report back at the next pathway board.	**A: CG to organise the writing of a protocol on the management of painless jaudice across GM.** **A: CG to work with SS/BD to set up a meeting with TS to discuss further** **A: CG to arrange a meeting with TS and radiology colleagues to discuss radiology reporting further.**	**CG**	
5	15/06/2021	**Open**	**Title: Jaundice Pathway - Stockport** **To: Update and Inform** **Owner: Steph Gooder** SG updated on the work her team have been doing at Stockport in relation to giving the emergency department access to the jaundice pathway. The HPB GP suspected cancer referrals are triaged by the Hepatology CNS team, there are three allocated radiology slots per week for USS/CT scans and patients can be filtered in. When this pathway was initially set up they focused on engagement and education for primary care on the provision of this pathway. There has been a reduction in the number of GP referrals throughout COVID, however, the number of presentations to the emergency department has increased which has enabled this work to progress. It was agreed that the emergency department teams would have access to the pathway that is already in place, they have all agreed a process. SG is going to set up training with the teams and will report back to the pathway board when any further progress is made. This pathway supports the RDC principles. There will be access to an RDC in every Trust over the next few years, however, it is also acknowledged that 40% of patients diagnosed with pancreatic cancer first present at the emergency department and those patients also need equitable access to a faster diagnostic pathway. It was also noted that a focus of the work programme for the year is primary care education, there will be a GatewayC webinar and other plans for education within this financial year.	**A: SG to update the board further once further progress is made.**	**SG**	
6	15/06/2021	**Open**	**Title: Improving access to clinical trials** **To: Inform** **Owner: Thomas Satyadas** TS noted that improving access to clinical trials for patients remains a priority. The alliance leads have asked the HPB board to move forward with a pilot of an interactive web based tool that could be used prior to the MDT that filters trials specifically for HPB cancers using commonly used eligibility criteria. There will be a small working group developed to discuss this further and report an update at the next pathway board.	**A: TS/CG to set up small working group to progress this further.**	**CG**	
7	15/06/2021	**Open**	**Title: Personalised Care - follow-up** **To: Update** **Owner: Astrid Greenberry** Personalised Care for Cancer is a project at GM Cancer which is supporting teams to implement stratified follow-up in their pathways. There are some tumour groups e.g. Breast/Colorectal/Prostate and Gynae in which there is a large evidence base for this practice so the pathways are being implemented across all Trusts in GM. For the tumour groups that lack this evidence base, there are a series of pilot projects. These teams will be provided with a cancer care co-ordinator and remote monitoring system to support implementation. Infoflex has been chosen as the remote monitoring tool, it has been built on the GM Digital Platform and has interfacing capabilities with other systems. Patients on stratified follow-up are given a long appointment at the end of a treatment modality with the CNS and care co-ordinator in which a personalised care and support plan is developed to address any unmet needs and they are provided with a treatment summary. They are also given rapid reaccess to the specialist team and this can then support the release of the patient from any pre-determined scheduled outpatient appointments if appropriate. In HPB, the test site will be MFT and the focus will be on pancreatic cancer patients that have had surgery. The cancer co-ordinator role is out to advery and the team have done a mapping exercise. TS noted that the co-ordinator will also support the collation of Quality of Life data from referral through the pathway.	**A: AG to update at the next pathway board**	**AG**	

8	15/06/2021	**Open**	**Title: PERT PCUK National Campaign** **To: Inform** **Owner: Claire Goldrick** CG noted that there is a national campaign being launched by Pancreatic Cancer UK to increase the use of PERT (Pancreatic Cancer Replacement Therapy): https://www.pancreaticcancer.org.uk/get-involved/make-a-difference/join-our-campaigns/transform-lives-prescribe/ CG intends to organise a meeting with GM colleagues to discuss how to support this campain in GM.	**A: CG to arrange meeting with colleagues in GM to discuss the pathway further.**	**CG**	
9	15/06/2021	**Open**	**Title: AOB** **To:** **Owner: ALL** <u>Liver Mets Pathway</u> In the previous board in March we mentioned the development of the Breast Liver Mets pathway, Lucy Foster queried reporting for resections and the Breast oncologists have confirmed that they want breast receptors done on all resections - ER/PR and Her-2			