Greater Manchester
Cancer Alliance

Oesophago-Gastric One Stop Cancer Clinic

Javed Sultan[1], Lisa Galligan-Dawson[2], Sarah Lyon[3]

GM Cancer Clinical Lead for OG Cancer1, GM Cancer Performance Director2, GM Cancer Project Manager3

Overview

There are extreme pressures in the OG pathway across Greater Manchester resulting in delayed pathways and patient harm. The reasons for this are multi-factorial with numerous bottle-neck points along the journey from diagnosis to surgery. One relatively straight forward intervention with significant patient benefit and improved efficiency is a joint multi-disciplinary clinic including nurse specialists, dieticians, anaesthetics, surgeons and oncology.

At present, patients with curable OG but considered higher risk for surgery due to comorbidity need to have numerous tests and see multiple specialists in order to make a decision between surgery and radical chemo-radiotherapy. This can include anaesthetic assessment, echocardiograms, shuttle walk test and CPEX testing. Consultation with an anaesthetist is considered best practice in such cases with discussions at a once-monthly high risk MDT which is infrequent due to workforce and availability. This uncoordinated approach creates significant delays with poor patient experience & support, higher levels of psychological harm, prevents real-time cross specialty communication in complex cases, and ultimately physical harm from stage migration or inoperability.

Background

Data from the 2022 published National Oesophago-Gastric Audit has suggested that 20% of patients diagnosed with OG cancer between 2019-2021 waited over 104 days from referral to the start of treatment, 60% waited over 62 days from GP referral to first treatment. The causes are multifactorial but a key cause of the delays can be those patients who are borderline for surgery and have a protracted journey with numerous tests and consultation and ultimately are deemed for chemoradiotherapy.

One of the recommendations from the 2023 State of the Nation Report, published in January 2024, is to identify ways to reduce the proportion of patients waiting more than 62 days from referral to first treatment, leading to a focus on the one stop model in the OG pathway.

Referral Criteria

Absolute Indications	Relative Indications (Consider if one or more of)
Frailty score 4 or above	Previous abdominal / thoracic surgery including nephrectomy, laparotomy, bowel resection
Exercise tolerance less than 1 mile	Overall clinical concerns from F2F contact made
BMI greater than 40	Current Smoker / vaping or ex smoker less than 3 months
GFR below 60	Poor diabetic control (HBA1C greater than 60)
Malnutrition (GLIM based diagnosis)	Intermittent claudication
6 month history of CVA / MI / unstable angina / Thromboembolic event	Difficulty climbing stairs / unable to do shopping
Synchronous cancers	Previous malignancy e.g. lymphoma, colonic
Salvage oesophagectomy / colonic interposition	Alcohol excess history with no cirrhosis / portal hypertension or varices
Post EMR T1B disease	

Scale of the problem in GM

The OG service is under unprecedented pressure with multifactorial causes:

- **Late referrals from district general hospitals: D**ue to lack of pre MDT meetings, PET scans and PET reporting.
- **Volume of work**: 650 new OG cancers are diagnosed within GM per year. Diagnostic capacity and streamlining will help the complex pathway.
- **Workforce challenges**: Anaesthetic expansions and CPET accessibility is required.
- **Complex case and prolonged decision making**: Patients with OG cancer often are older with additional health problems that increase the risk of surgery. Robust changes have been made to the surgical assessment process to facilitate streamlining of decision making but where multidisciplinary assessment is required the process remains fragmented significantly delaying the prompt decision to proceed to surgery, or other radical treatment.

Solution & Aims

The implementation of a “Complex Radical Treatment Multidisciplinary Clinic” where patients with curable OG cancer who are deemed potentially fit enough for radical treatment at the central MDT can have a consultation with a nurse specialist, surgeon, anaesthetist, dietician, personal trainer from PRrehab4cancer, intensivist, theatre co-ordinator, general surgery manager, administration and geriatrician.

Aims of Clinic

1. Patient undergoes a full MDT assessment and an early decision is made whether the patient is a surgical candidate or not. If surgical then a staging laparoscopy can be planned and dates given
2. Medical optimisation as needed such as diabetic control and hypertension
3. Clinical oncology to decide whether case is for radical chemoradiotherapy or high grade palliative radiotherapy
4. Patient can meet a medical oncologist for discussion about the process and risks. At this time point we are not sure if for neo-adjuvant or palliative.
5. Improving patient experience

One Stop Pathway