National Oesophago-Gastric Cancer Audit 2018

Patient report

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Introduction

The National Oesophago-Gastric Cancer Audit (NOGCA) evaluates the quality of hospital care for patients with oesophago-gastric (OG) cancer in England and Wales. It provides information that helps NHS cancer services to compare their performance and to identify areas of care that could be improved. Since 2012, the audit has also included patients with high-grade dysplasia (HGD) of the oesophagus, which is a condition that increases a person's risk of developing cancer.

The audit's tenth annual report was published in September 2018 and mainly focuses on patients diagnosed with OG cancer between April 2015 and March 2017, and patients diagnosed with HGD between April 2012 and March 2017.

The annual report can be downloaded at www.nogca.org.uk/reports/2018-annual-report/.

This patient report is written for patients, family members and carers to highlight key findings from the 2018 annual report and provide information on patient care pathways. You can read this patient report alongside the annual report, and we have provided page numbers for, and direct links to, relevant sections of the annual report.

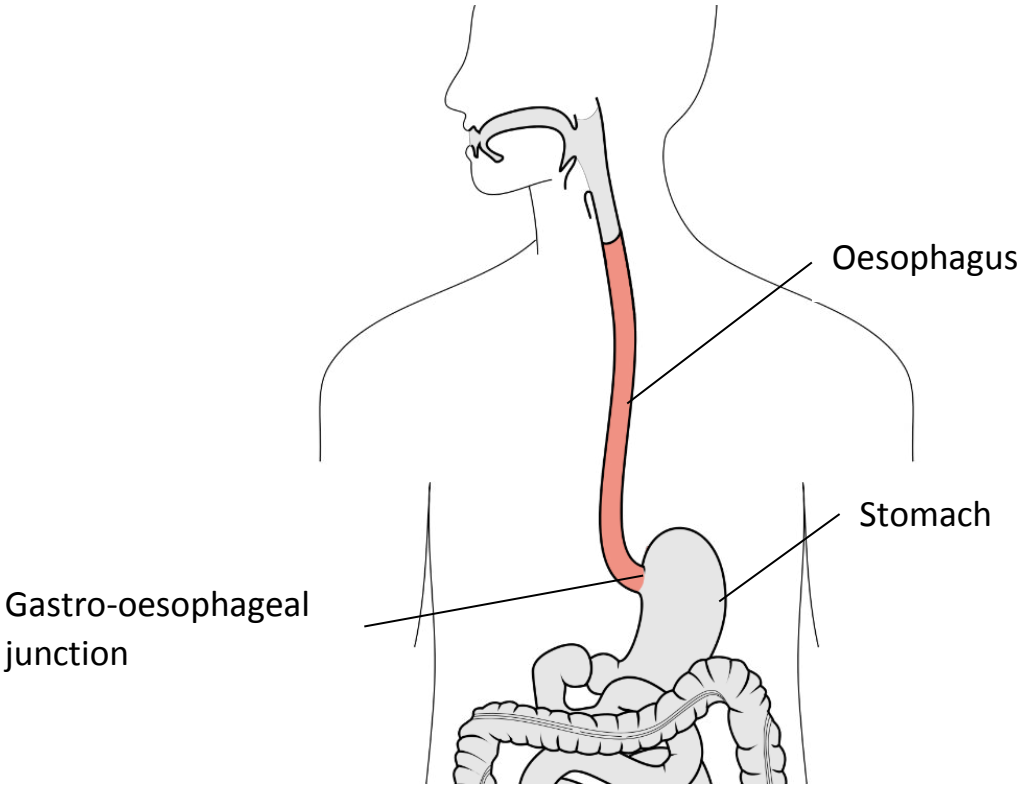
The report is divided into two main parts: the first provides information about oesophago-gastric cancer, and the second is about high-grade dysplasia. At the end of the report, we provide links to resources where you can find out more about these conditions and the audit.

The oesophagus and stomach

The term *oesophago-gastric cancer* covers three types of cancer that occur in:

- the oesophagus – the tube that connects your mouth to your stomach
- the gastro-oesophageal junction (GOJ) – the point where the oesophagus joins the stomach
- the stomach – the organ that stores swallowed food and helps to digest it

Cancers of the oesophagus or GOJ are often referred to as **oesophageal cancers**, while cancers of the stomach are known as **gastric cancers**.



Oesophago-gastric cancer

About oesophago-gastric (OG) cancer

Oesophago-gastric cancer is the fifth most common type of cancer in the country, with around 13,000 people diagnosed each year in England and Wales.

The audit received information on 21,032 patients in England and Wales who were diagnosed with OG cancer between April 2015 and March 2017.

- *The audit captures information for around 80% of all OG cancer patients*

The average age of patients was 72 years, and over two-thirds were men.

Oesophageal cancer (cancers in the oesophagus or gastro-oesophageal junction) accounted for nearly three-quarters of OG cancers, while stomach cancer accounted for around one quarter. The proportion of OG cancers that are oesophageal has increased over the last five years.

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How is OG cancer diagnosed?

OG cancer is diagnosed using a procedure called a biopsy. In a biopsy, small pieces of tissue from the oesophagus or stomach are removed and examined under a microscope. During the procedure, a tube (endoscope) will be placed down the patient's throat and the doctor will insert instruments through the tube to remove the samples of tissue. Most patients will be conscious (awake) for the procedure, but a sedative may be offered to help a patient relax.

Clinical guidelines recommend that if a GP suspects that a patient may have OG cancer, the patient should be referred immediately for tests. This is to make sure that patients are diagnosed as early as possible. Patients who are diagnosed following an emergency admission to hospital are often found to have advanced disease and so are less likely to be candidates for curative treatment than patients diagnosed after a GP referral.

Two-thirds of patients in the audit were diagnosed following a referral from their GP. However, 13% of patients were diagnosed following an emergency admission.

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What happens following a diagnosis of OG cancer?

Patients diagnosed with OG cancer are referred for further tests to work out the stage (extent) of the disease, which will help doctors to decide what type of treatment is appropriate. The first test will usually be a computerised tomography (CT) scan. A CT scan uses X-rays and a computer to produce detailed images of inside the body. This allows doctors to assess the location and size of the tumour, and whether the cancer has spread.

If the CT scan shows that the cancer is suitable for curative treatment, a patient may have further tests to provide more detailed information about the cancer. Depending on the location of the tumour, tests can include:

- Endoscopic resection (removing lesions using a tube which is placed down the throat)
- Endoscopic ultrasound (a probe which gives off high-frequency sound waves is placed down the throat to produce images of inside the body)
- Positron emission tomography (PET) CT scan (this scan produces detailed 3D images by detecting radiation that is given off by a substance that is injected into the body)
- Laparoscopy (a surgical procedure which allows surgeons to see inside the stomach through small incisions, also known as keyhole surgery).

Clinical guidelines recommend that all patients who are diagnosed with OG cancer have a CT scan for initial assessment of the disease and to look for evidence of metastatic disease (whether the cancer has spread to other parts of the body).

The majority (90%) of patients in the audit had an initial CT scan. This proportion has increased over the last five years, from 86% in 2012.

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What are the treatment options for people diagnosed with OG cancer?

The treatment options for OG cancer depend on the location, stage and type of cancer. If the cancer is at an early stage, the main treatment option is surgery to remove the affected part of the oesophagus or stomach, either alone or combined with chemotherapy (using drugs to destroy cancer cells) or radiotherapy (using radiation to destroy cancer cells), or both. Certain types of early-stage oesophageal cancer may be suitable for treatment with chemoradiotherapy alone (without surgery).

However, these treatments place a great deal of strain on the body, so patients who are frail or very unwell, and their doctors, may decide that curative treatment is not suitable.

More information about surgical procedures for OG cancer can be found on the Cancer Research UK website:

- Surgery for oesophageal cancer
- Surgery for gastric cancer

Overall, 39% of patients in the audit were recorded as having a curative treatment plan. Patients with cancers in the lower part of the oesophagus and those with cancers of the oesophago-gastric junction were more likely to have a plan for curative treatment than those patients with other types of OG cancer.

Over the last five years, there has been an increase in the use of curative chemoradiotherapy (without surgery) for treating some types of oesophageal cancer.

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Some patients may not have surgery despite an original plan for curative treatment due to factors such as poor health, complications of chemotherapy or radiotherapy before surgery, and patient preference.

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If curative treatment is not suitable because the cancer is very advanced or a patient is too unwell for treatment, they may receive palliative therapies which aim to reduce the effect of symptoms and improve their quality of life. Palliative therapies include endoscopic stenting (a tube, known as a stent, is placed into the oesophagus to keep blocked parts of the oesophagus open, which helps the patient to swallow), palliative chemotherapy or radiotherapy, palliative surgery, and best supportive care (no treatment beyond the immediate relief of symptoms).

Among patients who were not suitable for curative treatments, 50% had an initial plan for palliative chemotherapy or radiotherapy. This figure varied across regions of England and Wales, ranging from 36% to 62%.

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How long do people have to wait for treatment?

NHS standards state that patients with cancer should begin treatment within 31 days of the decision to treat (the date that a patient agrees to a treatment plan for their cancer). Most patients can expect to begin treatment within one month of agreeing a treatment plan with their doctor.

Standard cancer waiting times include the portion of time from the decision to treat (DTT) to the start of treatment. They do not include the time from referral to DTT. In the audit, we examined average waiting times from referral to the start of treatment for patients diagnosed between April 2015 and March 2017.

For patients having surgery only, the average waiting time was 94 days from referral. For patients having chemotherapy or radiotherapy before surgery, the average waiting time to their first treatment session was shorter (62 days from referral). However, there was variation in waiting times for curative treatment across regions.

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Where do people go for OG cancer surgery?

For patients in England and Wales, surgery to treat OG cancer will take place in one of 41 specialist surgical centres. This means that patients may have to travel to another part of the country for their operation. The map on page 13 shows the locations of these surgical centres, and the NHS trusts (England) or local health boards (Wales) they are based in.

What are the outcomes of OG cancer surgery?

Among patients in the audit who had curative surgery (surgery that aims to cure the cancer), over 96% were alive 90 days after surgery.

Over the last five years, here has been a steady decrease in the average length of stay in hospital after surgery, from 10-12 days to 7-9 days.

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How do I find out more about my local OG cancer service?

The audit produces information that can be used to monitor the performance of specific surgical centres and individual surgeons. You can find this information in the following places.

www.NOGCA.org.uk
This is the audit's main website, where you can download audit reports and find information about the outcomes for specific NHS trusts (England) and local health boards (Wales).

www.augis.org/outcomes-data-2018
Surgical outcomes from the audit, for example, mortality rates (the number of deaths) and length of stay in hospital after surgery, are published each year by the Association of Upper Gastrointestinal Surgeons.

www.nhs.uk/Service-Search/performance/search
Information is available for the full range of NHS services, including the audit's surgical results.

The NOGCA 2018 annual report makes a series of recommendations for organisations that deliver, commission and regulate OG cancer care. These can be found on pages 10 to12 of the annual report.

Care pathway for people with oesophago-gastric cancer

Routes to OG cancer diagnosis

- **Referral by GP**
- **Emergency admission**
- **Other referral**

66% of patients in the audit were referred for tests by a GP, and 13% were diagnosed after an emergency admission to hospital

Tests

1

- **Initial CT scan**
- **Other investigations**

90% of patients in the audit had an initial CT scan

39% of patients in the audit were recorded as having a curative treatment plan

Treatment intent

2

Cancer cannot be treated → Non-curative or palliative pathway

Cancer can be treated → Curative pathway

Treatment options

3

Palliative options

- **Chemotherapy or radiotherapy**
- **Surgery**
- **Endoscopic therapy**
- **Best supportive care**

- 50% of patients on the non-curative pathway had an initial plan for palliative chemotherapy or radiotherapy
- 12% of patients had an initial plan for endoscopic therapy
- 35% of patients had an initial plan for best supportive care

3

Curative options

- **Surgery, with or without chemotherapy or radiotherapy**
- **Chemoradiotherapy**

- The majority of patients with stage 2 or 3 cancer are treated with surgery combined with chemotherapy or radiotherapy
- Among patients who had curative surgery, over 96% were alive 90 days after surgery
- The average length of stay in hospital after surgery was 7 to 9 days

High-grade dysplasia of the oesophagus

What is high-grade dysplasia (HGD) of the oesophagus?

High-grade dysplasia (HGD) of the oesophagus means that there are abnormal cells (precancerous cells) in the lining of the oesophagus, which can turn into cancer if left untreated.

Who is affected by HGD?

The audit received information on 2,059 patients in England who were diagnosed with HGD of the oesophagus between April 2012 and March 2017.

The average age of patients was 71 years, and 74% were men.

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How is HGD diagnosed?

HGD is diagnosed using a procedure called a biopsy. In a biopsy, small pieces of tissue from the oesophagus are removed and examined under a microscope. During the procedure, a tube (endoscope) will be placed down a patient's oesophagus and the doctor will insert instruments through the tube to remove the samples of tissue. Most patients will be conscious (awake) for the procedure, but a sedative may be offered to help a patient to relax.

National guidelines recommend that people with suspected HGD should have their diagnosis confirmed by two specialist doctors (pathologists).

86% of patients in the audit had their initial diagnosis of HGD confirmed by a second pathologist.

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What happens following a diagnosis of HGD?

A specialist team of doctors (known as a multidisciplinary team or MDT) will discuss the patient's condition and make sure that the appropriate treatment options are identified.

National guidelines recommend that people with HGD should have their treatment discussed at a specialist multidisciplinary team meeting.

86% of patients in the audit had their treatment discussed by a multidisciplinary team of clinicians.

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What are the treatment options for people diagnosed with HGD?

The main treatment option is to remove the abnormal cells from the lining of the oesophagus using a tube called an endoscope. The endoscope is placed down the patient's oesophagus, and the doctor inserts instruments through it to remove the abnormal tissue. Abnormal tissue can be removed by cutting it away with a thin wire (endoscopic mucosal resection or EMR), or using heat (radiofrequency ablation).

A small number of people may need an operation to surgically remove the affected part of the oesophagus.

National guidelines recommend that people with HGD should receive endoscopic treatment (for example, endoscopic mucosal resection or radiofrequency ablation).

65% of patients in the audit received endoscopic treatment. This proportion has increased since 2012.

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Where do people go for treatment of HGD?

Treatment for HGD will usually be provided in a specialist centre which treats a large number of HGD patients each year. This means that patients may have to travel to a hospital other than their local hospital for treatment.

What are the outcomes of treatment for HGD?

The majority of treatment procedures will result in complete removal of the abnormal cells. This will be confirmed by a doctor, who will examine the removed tissue under a microscope. In some cases, patients may need further treatment to make sure all of the abnormal tissue is removed.

In the audit, 67% of endoscopic procedures resulted in complete removal of abnormal cells.

Among patients whose procedures did not remove all the abnormal cells, two-thirds went on to receive further treatment (repeat endoscopic treatment or surgery).

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Care pathway for patients with high-grade dysplasia of the oesophagus

Patient has symptoms of HGD or is referred following surveillance of abnormal cells (Barrett's oesophagus)

1

Biopsy indicates HGD

2

Diagnosis confirmed by a second pathologist

86% of patients in the audit had their initial diagnosis of HGD confirmed by a second pathologist

3

Treatment plan discussed by a specialist multidisciplinary team

86% of patients in the audit had their treatment discussed by a multidisciplinary team

4

Treatment (endoscopic treatment recommended) at a high-volume tertiary referral centre

65% of patients in the audit received endoscopic treatment, 4% had surgery, 17% were placed on surveillance, and 8% had no active treatment

5

Complete removal of abnormal cells, or further treatment

Locations of NHS surgical cancer centres and regional boundaries

Key for surgical cancer centres is on the next page

Code on map	Name of hospital	Region
		England
REM	Aintree University Hospital, Liverpool	Cheshire and Merseyside
RQ6	Royal Liverpool University Hospital, Liverpool	
RTG	Royal Derby Hospital, Derby	East Midlands
RWE	Leicester Royal Infirmary, Leicester	
RX1	Nottingham City Hospital, Nottingham	
RGT	Addenbrooke's Hospital, Cambridge	East of England
RM1	Norfolk and Norwich University Hospital, Norwich	
RQ8	Broomfield Hospital, Chelmsford	
RWG	Watford General Hospital, Watford	
RM2	Wythenshawe, Manchester	Greater Manchester
RM3	Salford Royal Hospital, Salford	
RW3	Manchester Royal Infirmary, Manchester	
RWA	Castle Hill Hospital, Cottingham	Humber, Coast and Vale
RXN	Royal Preston Hospital, Preston	Lancashire and South Cumbria
RF4	Queen's Hospital, Romford	North Central and East London
RRV	University College Hospital, London	
RTD	Royal Victoria Infirmary, Newcastle upon Tyne	North East and Cumbria
RTR	Friarage Hospital, Northallerton	
RK9	Derriford Hospital, Plymouth	Peninsula
RA7	Royal Bristol Infirmary, Bristol	Somerset, Wiltshire, Avon & Gloucestershire
RTE	Gloucestershire Royal Hospital, Gloucester	
RJ1	Guy's Hospital, London	South East London
RHQ	Royal Hallamshire Hospital, Sheffield	South Yorkshire, Bassetlaw, North Derbyshire and Hardwick
RA2	Royal Surrey County Hospital, Guildford	Surrey and Sussex
RXH	Royal Sussex County Hospital, Brighton	
RTH	Churchill Hospital, Oxford	Thames Valley
RDZ	Royal Bournemouth Hospital, Bournemouth	Wessex
RHM	Southampton General Hospital, Southampton	
RHU	Queen Alexandra Hospital, Portsmouth	
RPY	The Royal Marsden Hospital, London	West London
RYJ	St Mary's Hospital, London	
RJE	Royal Stoke University Hospital, Stoke-on-Trent	West Midlands
RKB	University Hospital Coventry, Coventry	
RR1	Heartlands Hospital, Birmingham	
RRK	Queen Elizabeth Hospital Birmingham, Birmingham	
RAE	Bradford Royal Infirmary, Bradford	West Yorkshire
RR8	St James's University Hospital, Leeds	
		Wales
7A1	Wrexham Maelor Hospital, Wrexham	North Wales
7A3	Princess of Wales Hospital, Bridgend	Abertawe Bro Morgannwg University (ABMU)
7A4	University Hospital of Wales, Cardiff	South Wales
7A5	Royal Glamorgan Hospital, Llantrisant	

Where can I find more information?

High-grade dysplasia

Cancer Research UK	http://www.cancerresearchuk.org/about-cancer/oesophageal-cancer/stages-types-grades/stage-0

Oesophago-gastric cancer

NHS Choices	https://www.nhs.uk/conditions/oesophageal-cancer/
	https://www.nhs.uk/conditions/stomach-cancer/
Cancer Research UK	http://www.cancerresearchuk.org/about-cancer/oesophageal-cancer
	http://www.cancerresearchuk.org/about-cancer/stomach-cancer
Macmillan Cancer Support	https://www.macmillan.org.uk/information-and-support/oesophageal-gullet-cancer
	https://www.macmillan.org.uk/information-and-support/stomach-cancer
The Oesophageal Patients Association	https://www.opa.org.uk/
Maggie's	https://www.maggiescentres.org/

For more information about the audit and its findings:

National Oesophago-gastric Cancer Audit	https://www.nogca.org.uk/

This report was prepared by:

Clinical Effectiveness Unit, The Royal College of Surgeons of England:
Min Hae Park, Assistant Professor
David Cromwell, Professor of Health Services Research

The Association of Upper GI Surgeons (AUGIS):
Nick Maynard, Consultant Surgeon

The Royal College of Radiologists (RCR):
Tom Crosby, Consultant Clinical Oncologist

The British Society of Gastroenterology (BSG):
Nigel Trudgill, Consultant Gastroenterologist

NHS Digital:
Alison Roe, Project Manager
Rose Napper, Audit Co-ordinator

Prepared in partnership with:

HQIP Healthcare Quality Improvement Partnership	HQIP is led by a consortium of the Academy of Medical Royal Colleges, the Royal College of Nursing and National Voices. Its aim is to promote quality improvement, and in particular to increase the effect that clinical audit has on the quality of healthcare in England and Wales. HQIP hosts the contract to manage and develop the National Clinical Audit and Patient Outcomes Programme (NCAPOP). Its purpose is to involve clinicians across England and Wales in systematically evaluating their clinical practice against standards and to support and encourage improvement in the quality of treatment and care. The programme includes more than 30 clinical audits that cover care provided to people with a wide range of medical, surgical and mental-health conditions.
Royal College of Surgeons ADVANCING SURGICAL CARE	The Royal College of Surgeons (RCS) of England is an independent professional body committed to helping surgeons to achieve and maintain the highest standards of surgical practice and patient care. As part of this, it supports the audit and evaluation of clinical effectiveness for surgery. Registered charity number: 212808. The RCS analysed the audit data and wrote the content of the 2017 annual report.
AUGIS Association of Upper Gastrointestinal Surgeons of Great Britain and Ireland	The Association of Upper GI Surgeons is the speciality society that represents upper gastrointestinal surgeons. It is one of the key partners leading the audit.
bsg BRITISH SOCIETY OF GASTROENTEROLOGY	The British Society of Gastroenterology is the speciality society of gastroenterologists. It is one of the key partners leading the audit.
RCR The Royal College of Radiologists	The Royal College of Radiologists is the speciality society of radiologists. It is one of the key partners leading the audit.
NHS Digital	NHS Digital is the new trading name for the Health and Social Care Information Centre (HSCIC). They provide 'Information and Technology for better health and care'. The Clinical Audit and Registries Management Service of NHS Digital manage a number of national clinical audits in the areas of cancer, diabetes and heart disease. It manages the audit on behalf of the RCS.