Oesophago-gastric cancer workshop
21.10.15

Table 1. Summary of the workshop group member discussions according to each section of the scope.

Topic		Notes
	Title of the guideline	
	Oesophago-gastric cancer: diagnosis and management in adults	It was suggested that because the tests used to diagnose oesophago-gastric cancer are so well established, diagnositic topics do not need to be investigated by the guideline. Consequently the title should be changed to 'assessment and management in adults'. Some stakeholders felt that whilst the diagnostic tests were well established, there is currently variation in getting expert pathology review at the MDT to confirm a diagnosis. This can lead to misdiagnoses. The guideline could look at this issue. The value of the Mandard score was also raised as a diagnostic issue that could be investigated. However it was noted that there was not much published evidence in this area.
	Who is the guideline for	
a)	Healthcare professionals involved in the multi-disciplinary care of people with oesophago-gastric cancer: – Upper gastrointestinal surgeons – Gastroenterologists – Clinical oncologists – Medical oncologists – Histopathologists – Radiologists – Clinical nurse specialists – Cancer services managers – Dieticians – Palliative care Commissioners of oesophago-gastric cancer services (including Clinical Commissioning Groups and NHS England Specialised Commissioning) It may also be relevant for: – People using oesophago-gastric cancer services, their family members and carers, and the public. – Healthcare professionals in primary care	No comments were made on this section
	Equality considerations	
		People with Barratt's oesophagus are offered surveillance because they are at higher risk of developing oesophago-gastric cancer. However if they develop cancer the treatment would not be any different. Therefore they do not need specific consideration under equalities.

Topic		Notes
		The South East Asian population have a higher prevalence of oesophago-gastric cancer. However this population in the UK is low and treatment would not be any different. Therefore they do not need specific consideration under equalities. This guideline will not be covering Cancer Drug Fund interventions so issues over availability of high cost drugs caused by devolution will not affect this guideline.
1.1	**Who is the focus?** **Groups that will be covered**	
a)	Adults (18 years and over) with newly diagnosed or recurrent oesophago-gastric cancer	Stakeholders were happy with the guideline covering adults (18 years and over)
	Groups that will not be covered	
a)	Adults (18 years and over) in primary care with suspected oesophago-gastric cancer	Stakeholders were happy with the proposed exclusions. It was suggested that people with familial gastric cancer should also be excluded from the scope because it only affects a few families in the UK.
b)	Adults (18 years and over) referred to secondary care with suspected oesophago-gastric cancer	
c)	People with gastro-intestinal stromal tumours (GIST), neuro-endocrine tumours, sarcoma, melanoma or lymphomas in the oesophagus or stomach	
1.2	**Settings that will be covered**	
a)	All settings in which NHS care is provided	No comments were made on this section
1.3	**Activities, services or aspects of care** **Key areas that will be covered – see notes on section 1.5**	
	Areas from other published guidance that will be updated	
a)	The section on organisation of specialist teams for curative surgery for people with oesophago-gastric cancer from the Improving Outcomes Guidance on Upper Gastro-intestinal Cancers (Department of Health, 2001).	No comments were made on this section
	Areas that will not be covered	
a)	Identification in primary care of people with suspected oesophago-gastric cancer and their referral to secondary care.	It was noted that first line chemotherapy for advanced gastric cancer can now be included in the guideline following discussion with NICE Technology Appraisals.
b)	Initial diagnosis of oesophago-gastric cancer.	
c)	First-line chemotherapy for advanced gastric cancer (covered by TA191).	
1.5	**Key issues and questions**	
1	**Information and support needs specific to**	

Topic		Notes
	people with oesophago-gastric cancer and their carers	
1.1)	What are the specific information and support needs after surgical treatment of people with oesophago-gastric cancers?	It was suggested that disease specific dietetic support is needed. It was noted that there is unlikely to be a strong evidence base for this question – so recommendations are likely to be based on consensus.
1.2)	What are the specific information and support needs to manage dysphagia in people with oesophago-gastric cancers?	It was suggested that this could be expanded to include all supportive and palliative care needs as most patients with oesophago-gastric cancer will require supportive/palliative care. It was noted that NICE are in the process of updating the Improving Outcomes Guidance on Supportive and Palliative Care – so this may cover some of the more general issues in this area. It was queried whether psychological care would be covered by the dysphagia question as there are issues with patients not wanting to eat. It was queried whether having a speech and language therapist (SLT) as an expert advisor to the Guideline Committee would be useful. It was noted that people with proximal tumours have been excluded from this guideline, so SLT input would probably not be needed.
2	**Organisation of specialist teams for:** • **curative surgery** • **chemotherapy and radiotherapy**	
2.1)	What is the most effective organisation of specialist teams for curative surgery for people with oesophago-gastric cancer?	The purpose of this question is to identify the constituent members of the MDT. It was suggested that identifying the minimum catchment populations to deliver specialist services and the relationship between surgical volume and outcome would also be of benefit. However this would be an additional question. Stakeholders noted that there is a good evidence base for volume and outcome and also evidence linking centralisation of services to patient outcomes.
2.2)	What is the most effective organisation of specialist teams for chemotherapy and radiotherapy for people with oesophago-gastric cancer?	It was suggested that this question could be removed to make space for a question on catchment populations/surgical volume. Alternatively it was suggested that questions 2.1 and 2.2 could be combined.
3	**Assessment of oesophago-gastric cancer** • **Staging prior to curative treatment**	

Topic		Notes
	• **HER-2 testing**	
3.1)	What is/are the optimal choice and sequence of staging investigations to identify metastatic disease and determine suitability for curative treatment of oesophageal cancer after diagnosis with endoscopy and whole-body CT scan (e.g. EUS, PET-CT, staging laparoscopy)?	It was suggested that whole body MRI could be included in the list of staging investigations. It was noted that the evidence on this intervention was limited. Stakeholders queried if 3 questions on staging were actually needed, or whether they could all be combined into 1 question. It was explained that the questions have been kept separate for the purposes of searching and appraising the evidence.
3.2)	What is/are the optimal choice and sequence of staging investigations to identify metastatic disease and determine suitability for curative treatment of gastric cancer after diagnosis with endoscopy and whole-body CT scan (e.g. EUS, PET-CT, staging laparoscopy)?	
3.3)	What is/are the optimal choice and sequence of staging investigations to identify metastatic disease and determine suitability for curative treatment of oesophago-gastric junctional tumours after diagnosis with endoscopy and whole-body CT scan (e.g. EUS, PET-CT, staging laparoscopy)?	
3.4)	Which pathological subtypes of gastric cancer should be HER-2 tested?	It was queried whether this question was for diffuse or intestinal? People with HER-2+ and FISH+ are currently not treated (as a result of NICE technology appraisal guidance). Is there a need to test all patients since some will not be eligible for treatment?
4	**Management of oesophago-gastric cancer:** • **Curative treatment** • **Palliative treatment** • **Nutritional support**	
4.1)	What is the optimal neo-adjuvant therapy (chemotherapy or chemo-radiotherapy) for oesophageal cancer?	This is an area of uncertainty so is an important question to investigate. It is particularly relevant to T2N0 patients. Guidance on junctional tumours would also be useful, as would guidance on the most effective regimes and protocols.
4.2)	What is the optimal choice and timing of chemotherapy/chemo-radiotherapy in relation to surgical treatment for gastric cancer?	This is an important question to investigate.
4.3)	Does R2 surgical dissection improve outcomes in people with oesophago-gastric cancer?	R2 should be changed to D2
4.4)	What is the most effective surgical treatment (laparoscopic versus open surgery) for oesophago-gastric cancer?	This is an important question to investigate.
4.5)	What is the most effective curative treatment (chemo-radiotherapy versus surgery) of squamous cell carcinoma of the oesophagus?	This should include neo-adjuvant chemotherapy too.

Topic		Notes
4.6)	What is the optimal treatment for patients with local disease in the oesophagus or stomach who are not suitable for surgery?	It was suggested that oesophagus and stomach need to be considered separately. Stakeholders reported that there are a group of patients that have factors that make surgery unappealing and so they turn it down. However if they have surgery they will do well. It was queried whether this question will be able to identify these patients.
4.7)	What is the optimal management (endoscopic mucosal resection versus surgery) of T1N0 oesophageal cancer?	This is a rapidly changing field but guidance is needed so it is an important question to investigate. It has become a bigger issue in recent years as more patients are in this group.
4.8)	What is the optimal first-line chemotherapy for locally advanced and metastatic oesophageal cancer?	This question can now investigate oesophago-gastric cancer, not just oesophageal cancer.
4.9)	What is the optimal second-line chemotherapy for locally advanced and metastatic oesophago-gastric cancer?	Ramicurimab will be excluded from this question as it is covered by an existing NICE Technology Appraisal. Only 30% of patients receive second-line chemotherapy, despite the evidence. So this is an area of great disparity. It was suggested that third-line chemotherapy could also be investigated.
4.10)	What nutritional interventions improve outcomes for patients with oesophago-gastric cancer receiving curative treatment?	There could be numerous sub-questions within this question. It would be important for the guidance to be broken down according to what treatment the patient was having. Dietetic assessment is also important.
4.11)	What nutritional interventions improve outcomes for patients with oesophago-gastric cancer on palliative treatment?	Patient choice is paramount in this area. Patients need support and patient experience varies considerably. Requirements can be quite individual which may make it difficult to create generic recommendations. However it is important this area is covered as there is lots of conflicting information on what should be done. Access to a dietitian may not be available everywhere so there should be an additional question on dietetic assessment.
4.12)	What is the optimal treatment of dysphagia for patients with oesophago-gastric cancer on palliative treatment?	This is a useful question to investigate. It was suggested that it could also include the use of brachytherapy.

Topic		Notes
5	**Follow-up of people with oesophago-gastric cancer**	
5.1)	What is the most effective follow-up protocol for curatively treated patients with oesophago-gastric cancer?	Nurse-led follow up and other areas such as dietetics also need to be covered in this question. Suggestion that this question should also look at follow-up for patients receiving palliative care.
Additional topics to include		
		The following additional topics/areas were suggested: • Management of elderly patients • Role of PET-CT in treatment planning and monitoring response to treatment • Role of salvage treatment • Structure and quality of peri-operative care • Fitness assessment for surgery • Assessment of quality of life • Survivorship issues It was noted that currently the scope focuses on treatment. The guideline could also focus on the earlier diagnosis of cancer.
1.6	**Main Outcomes**	
	Overall survival Disease-free survival Disease-related morbidity Treatment-related morbidity Treatment-related mortality Health-related quality of life Patient reported outcome measures	No comments were made on this section
3	**Context**	
3.1	**Key facts and figures**	
		No comments were made on this section
3.2	**Current practice**	
		No comments were made on this section

Summary of the workshop group member discussions concerning the proposed GC member and expert advisor lists.

The proposed list was:

- Upper GI surgeon (2)
- Gastroenterologist (1)
- Clinical Oncologist (1)
- Medical Oncologist (1)
- Radiologist (1)
- Clinical Nurse Specialist (2)
- Cancer Services Manager (1)
- Dietitian (1)
- Palliative care (1)
- Patients/carers (2)

The following were suggested as additional group members:

- Someone with expertise in PROMS

- Geriatrician

It was suggested that :
- There should be 2 gastroenterologists on the group
- The radiologist should have experience in PET-CT.
- The dietitian should be a specialised clinician.

The following were suggested as expert advisors:
- Psychologist
- Anaesthetist