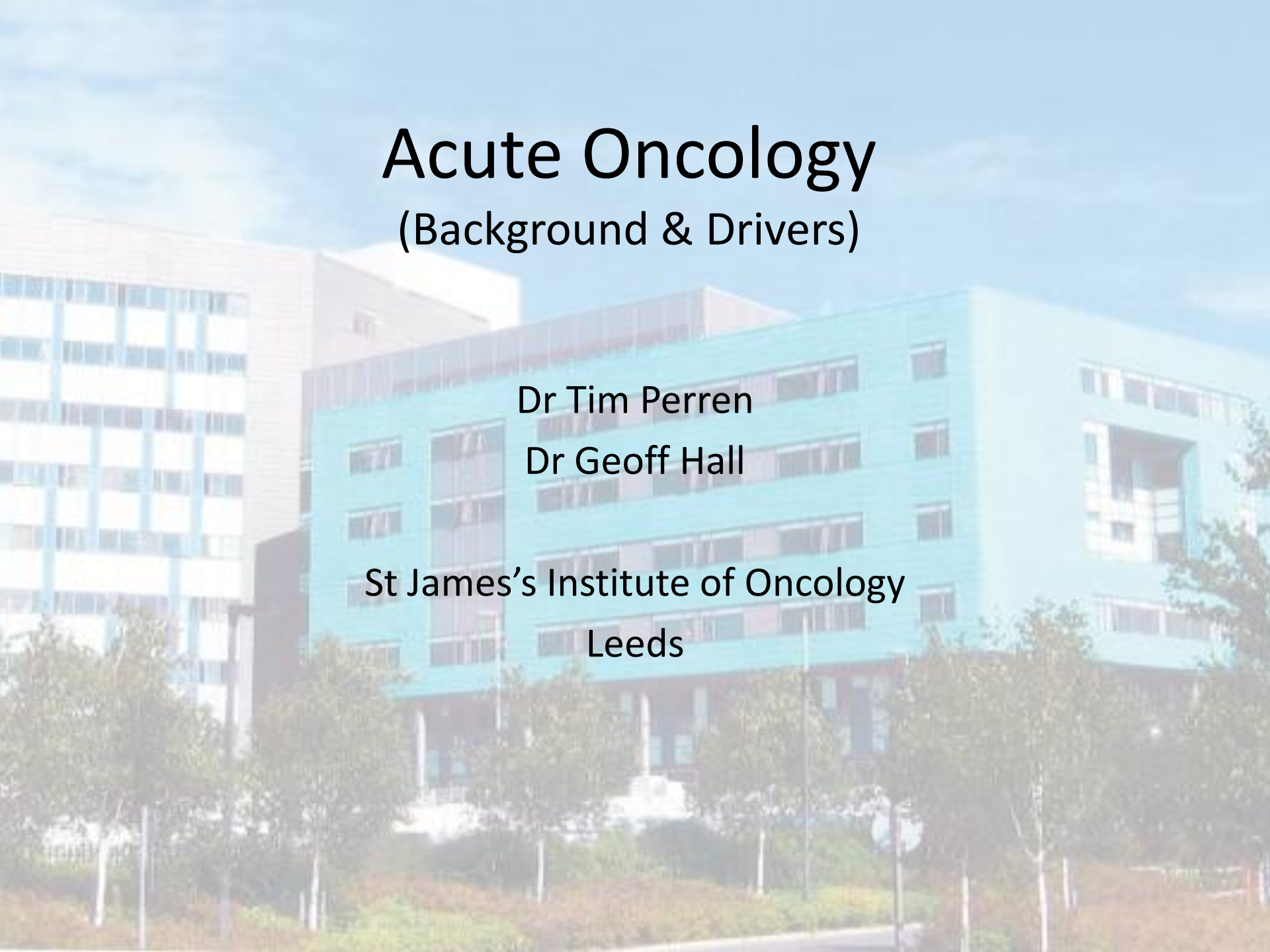


Acute Oncology

(Background & Drivers)

Dr Tim Perren

Dr Geoff Hall

St James's Institute of Oncology

Leeds

National Confidential Enquiry into Patient Outcome and Death

NCEPOD

For better, for worse?

A review of the care of patients who died within 30 days of receiving systemic anti-cancer therapy

Aim

- Identify remediable factors in the care received by patients
- Proposed by the JSC and JCCO as there was a belief that the standard of care was not uniform across the country

NCEPOD

Inclusion criteria

- Patients aged 16 years or over
- Solid tumours **or** haematological malignancies
- Received chemotherapy, monoclonal antibodies or immunotherapy during the study period
- Died within 30 days of receiving treatment

NCEPOD

Cases identified

- 47,050 (SACT) treatment cases
- 55,710 deaths from any cause
- 1415 cases identified who had died within 30 days of SACT

NCEPOD

Data returned

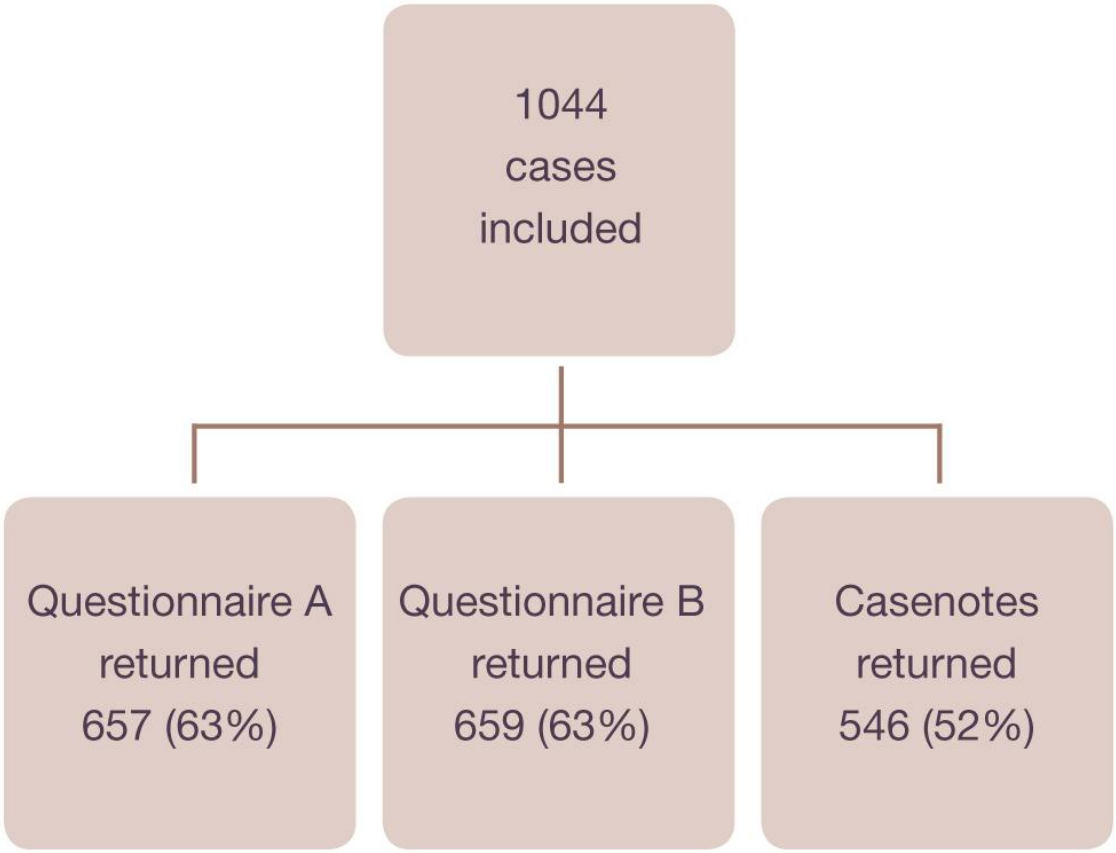


Figure 2.1 Data returns

NCEPOD

Overall quality of care

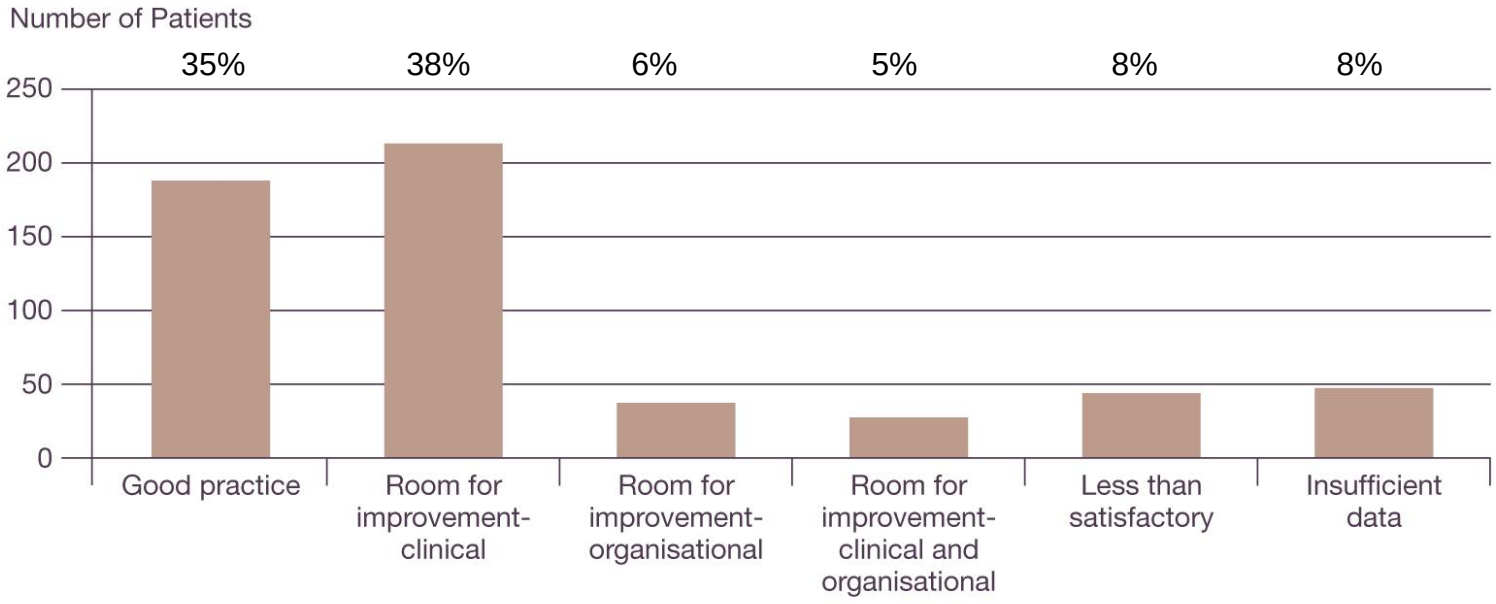


Figure 2.2 Overall assessment of care - advisors' opinion

NCEPOD

Overall opinion on final cycle of SACT

- Inappropriate in 154/435 (35%)
  - Inappropriate decision to initiate final COURSE of SACT
  - Inappropriate timing or doses of final CYCLE of SACT
  - Progressive disease

NCEPOD

Specialty of first admission during last 30 days of life

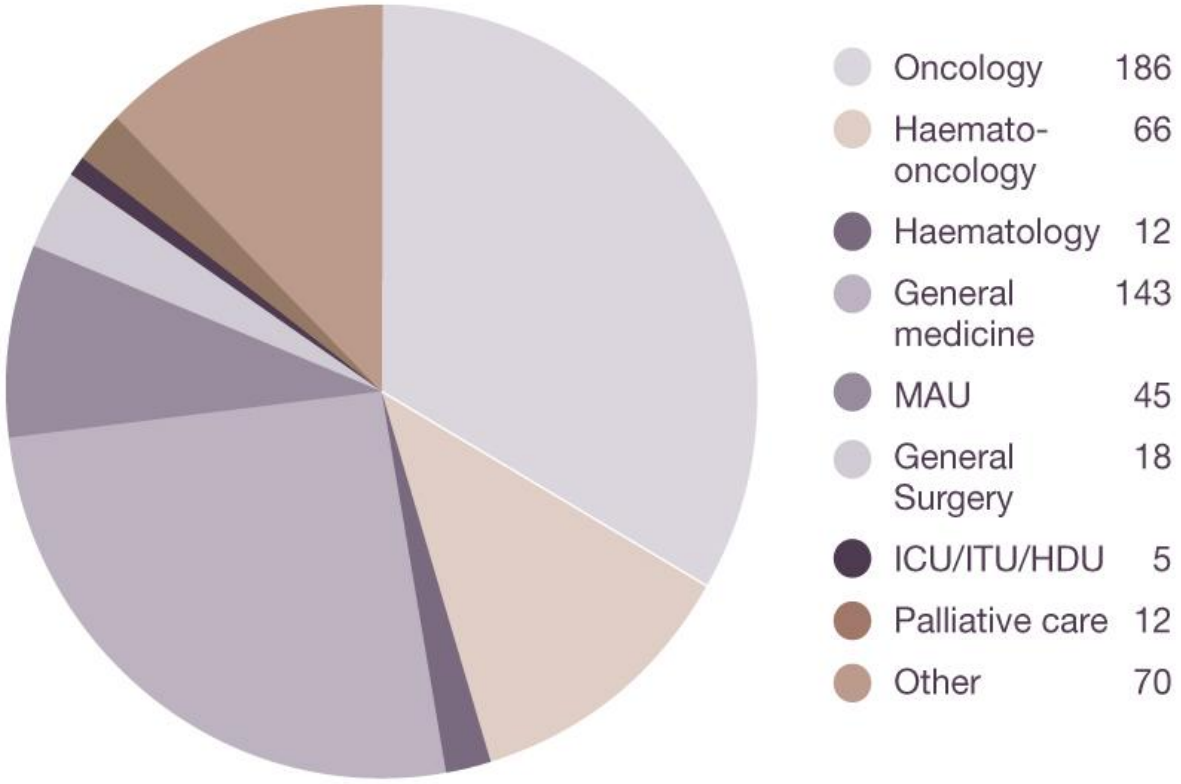


Figure 7.1 Specialty of first admission during last 30 days of life

Time to review by oncologist

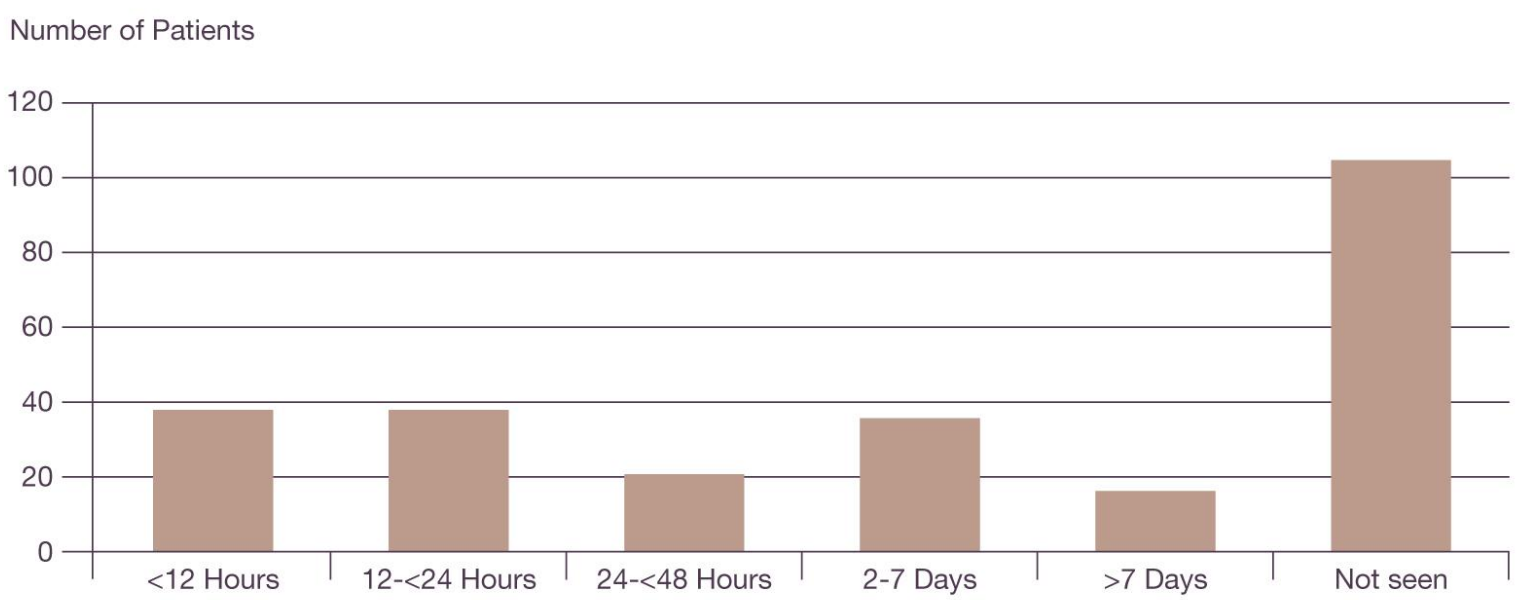
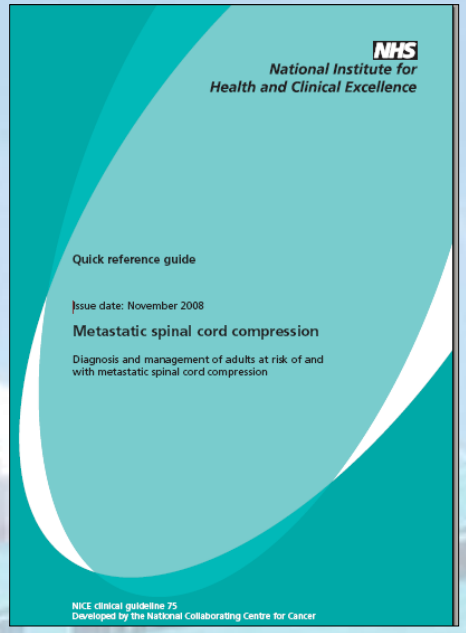
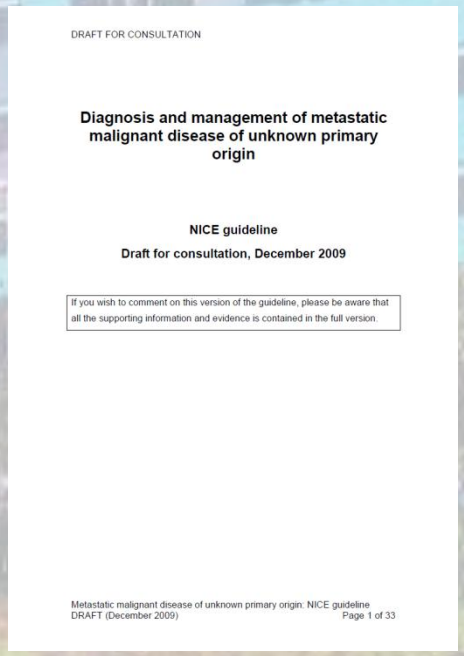


Figure 7.4 Time to review by oncology/haemato-oncology team

NCEPOD


For better, for worse?
A review of the care of patients who died within 30 days of receiving systemic anti-cancer therapy
NCEPOD


NHS
National Institute for Health and Clinical Excellence
Quick reference guide
Issue date: November 2008
Metastatic spinal cord compression
Diagnosis and management of adults at risk of and with metastatic spinal cord compression
NICE clinical guideline 75
Developed by the National Collaborating Centre for Cancer


DRAFT FOR CONSULTATION
Diagnosis and management of metastatic malignant disease of unknown primary origin
NICE guideline
Draft for consultation, December 2009
If you wish to comment on this version of the guideline, please be aware that all the supporting information and evidence is contained in the full version.
Metastatic malignant disease of unknown primary origin: NICE guideline
DRAFT (December 2009)
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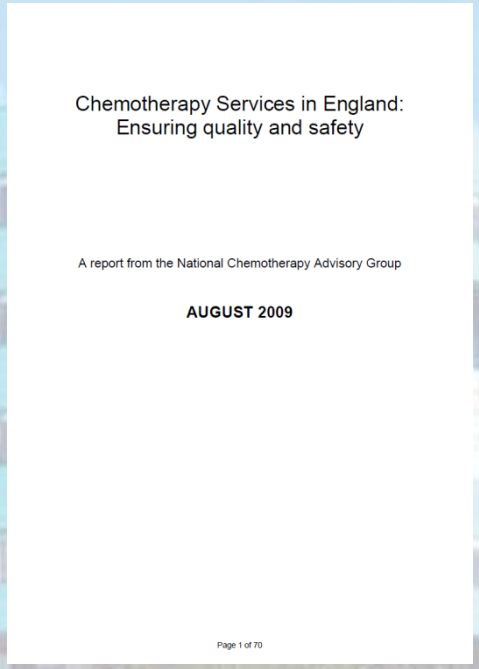
Chemotherapy Services in England: Ensuring quality and safety
A report from the National Chemotherapy Advisory Group
AUGUST 2009
Page 1 of 70

Key recommendations

- Actions related to:
  1. Elective chemotherapy services
  2. Acute oncology (management of complications and management of emergency admissions with previously undiagnosed cancer)
     - Involves A&E and acute medicine as well as oncology disciplines

Acute oncology

- All hospitals with an A&E should establish an 'acute oncology service' bringing together emergency medicine, acute medicine and oncology disciplines
  - Local policies and procedures (agreed with network)
  - Training of junior doctors and other staff
  - 24 hour access to specialist oncological advice
  - Routine audit of emergency admissions with cancer

Malignant Spinal Cord Compression

- MSCC is a rare complication of cancer and is usually an oncological emergency.
- Some patients experience significant delays from the time when they first develop symptoms to referral.
- Nearly half of all patients with MSCC are unable to walk at the time of diagnosis.
- Early detection, treatment and care can reduce the risk of developing avoidable disability and premature death.
- Early surgery may be more effective than radiotherapy at maintaining mobility.

MSCC Team

- MSCC coordinator.
  - ensuring timely and effective communication between all relevant healthcare professionals involved in the care of patients with MSCC, including primary care and palliative care
- Radiologist
- Spinal surgeon
- Clinical Oncologist
- Palliative Care

MSCC Early detection

- Inform patients with cancer who are at risk of MSCC information about the symptoms of MSCC and what to do and who to contact if those symptoms develop.

- Discuss with the MSCC coordinator **immediately** patients with cancer who have symptoms of spinal metastases and neurological **symptoms or signs suggestive of MSCC** and view as an emergency.

- Discuss with the MSCC coordinator **within 24 hours** patients with cancer who have **symptoms suggestive of spinal metastases**.

MSCC Investigation & Treatment

- It is important that MRI should be done quickly, dependent upon signs and symptoms.
- Start definitive treatment, if appropriate, before any further neurological deterioration and ideally within 24 hours of the confirmed diagnosis of MSCC.
- Carefully plan surgery to maximise the probability of preserving spinal cord function without undue risk to the patient, taking into account their overall fitness, prognosis and preferences.
- Ensure urgent (within 24 hours) access to and availability of radiotherapy and simulator facilities in daytime sessions, 7 days a week, for patients with MSCC requiring definitive treatment or who are unsuitable for surgery.

Diagnosis and management of metastatic malignant disease of unknown primary origin

Trusts should establish a CUP team, consisting of an oncologist, a palliative care physician and a CUP specialist nurse/key worker as a minimum. The team should have administrative support and sufficient designated time in their job plans for this specialist role.

Unknown Primary Site Cancer

A member of the CUP team should see inpatients with malignancy of undefined primary origin by the end of the next working day after referral. Outpatients should be seen within 2 weeks. The CUP team should take responsibility for ensuring that a management plan exists which includes:

- appropriate investigations
- provision of information
- symptom control
- access to psychological support.

The Challenge of Acute Oncology

- Acute Oncology Service Provision in large cancer centres
  - *Dr Geoff Hall, St James's Institute of Oncology, Leeds*
- Acute Oncology Service Provision in smaller cancer centres
  - *Dr Ernie Marshall, St Helen's Hospital, Liverpool*