PATIENT PATHWAYS AND NICE GUIDELINES

LENA LOIA HPB CLINICAL NURSE SPECIALIST. HPB UNIT, CAMBRIDGE UNIVERSITY HOSPITALS NHS TRUST
OUTLINE OF TALK

• What is a ‘Patient Pathway’?
• Pancreatic tumours
• Signs and symptoms
• NICE guidelines overview
• Why have specialist pancreatic centres?
• What happens before pancreatic surgery?
• What is the role of the MDT in the pathway?
• Snakes and Ladders – Two players or more.
WHAT IS A ‘PATIENT PATHWAY’?

- Journey, timeline, mapping, care street
- Patient navigation
- Period of hospital admission to discharge
- Route from first contact with NHS member to completion of treatment

Includes

- Complex interventions
- Mutual decision making
- Investigations/diagnosis/treatment
WHAT IS A ‘PATIENT PATHWAY’?

THE..... ‘NOT SO MAGIC ROUNDABOUT’
PATIENT PATHWAY

‘ONCE ON, YOU CAN NEVER GET OFF’
‘PLEASE... JUST LISTEN...’

• ‘Look beyond what you are doing and see me’
• ‘I might not see another Christmas, birthday or wedding’
• ‘I am hurting and don’t know what to do’
• ‘No words can explain...’
• ‘I stand amazed, I am amazed I still stand’

• Remember the person!
**PANCREATIC TUMOURS**

- Endocrine and exocrine tumours
- 95% classified as exocrine
  - 90% of these pancreatic ductal adenocarcinoma (PDAC)
- Less than 5% Neuroendocrine Tumours (NET)
- Within these two groups there are different types
- 60-70% head, 20-25% body and tail, 10-20% whole
- Other -
  - Ampullary tumours
  - Bile duct (Cholangiocarcinoma)
  - Duodenal tumours
SIGNS AND SYMPTOMS

- First symptoms – Vague! Itch?
- Abdominal pain
- Weight loss/ fatigue
- Jaundice
- Dark urine / Pale stools (steatorrhea)
- Nausea and vomiting
- New onset diabetes
- Endocrine tumours
  - Flushing
  - Inflammation inside cheeks and lips
NICE GUIDELINES

- Diagnosing and managing Pancreatic Cancer
- Includes those at high risk
- Adults 18 and over
- England, Wales and Northern Ireland
- Quicker and accurate diagnosis
- Specify most effective treatments
- Not mandatory – take into account when making decisions about care and patients wishes
NICE – MANAGING PANCREATIC CANCER

Adult with Pancreatic Cancer

- Nutrition
- Pain
- Psychological Support
- Relieving biliary/duodenal obstruction

Treatment Options

- Resectable/Borderline
- Unresectable
- Supportive/Palliative/End of life care
- Locally advanced
- Metastatic
NICE- PANCREATIC CANCER OVERVIEW

Pancreatic Cancer

- Adult with an inherited high risk of pancreatic cancer
- Adult referred to secondary care with suspected pancreatic cancer

When to offer surveillance for pancreatic cancer

Specialist pancreatic Multidisciplinary teams

Diagnosis

Staging

Management
WHY HAVE SPECIALIST PANCREATIC CENTRES?

• HPB unit can cover:
  - Benign conditions
    Pancreatitis/Pseudocysts; bile duct injuries
    Liver cysts
  - Pancreatic resections
    Cancer or suspected cancer
  - Liver resections
    Primary or secondary cancer
  - Few other ‘bits and pieces’
    Necrosectomies; Cholecystectomies
WHY HAVE SPECIALIST PANCREATIC CENTRES?

• Managing cancer is a complex task
• Variation in practice throughout England
• Variation in resection rates and 5 year survival
• 2001 NICE published ‘Improving Outcomes Guidance’ (IOG)
• Centralisation of services = improved outcomes
• Provision of
  - Accurate / timely diagnosis
  - Utilization of best practice
WHY HAVE SPECIALIST PANCREATIC CENTRES?

Protocols to enable rapid access
- Evidence based treatment plans

• Integration of care between regional/specialist centres
• Serve a population of 2-4 million
• ‘Network model of care’

NHS Commissioning Board 2013
WHAT HAPPENS BEFORE PANCREATIC SURGERY?

• Key phases in the cancer journey
  - Diagnostic Interval (DI)
  - Mortality increases with longer DI
  - Urgent referral pathways
  - Cancer waiting times
    2 week wait, 31 day rule, 62 day rule
  - Targets
THE PATHWAY

Referral
1) Presentation – GP / A&E / Local Hospital / Fast Track Jaundice Service
2) ‘Incidental’
3) Investigations – USS, CT, CA19.9, LFTs, PET/CT ? MRI ? PTC, ? ERCP

NICE - Obstructive Jaundice => pancreatic protocol
CT BEFORE draining bile duct
- Abnormal pancreas, no jaundice=> CT, PET & or EUS/FNA
THE PATHWAY

NICE – Pancreatic cysts => CT or MRI/MRCP
    High Risk => Surgery
    Need more information=> EUS/FNA (CEA)

4) Local MDT then SMDT (Addenbrookes)
6) SMDT (Addenbrookes)
FAST TRACK JAUNDICE PATHWAY

Jaundiced Patient → Investigations - eg. LFTs → PRIMARY CARE

Ultrasound – linked to Fastrack Jaundice Service → Referral to Local Trust, with referral form → SECONDARY CARE

- Normal liver mass Lesion(s)
  - Hepatologist/ Gastroenterologist → ERCP

- Gallbladder stones with dilated bile duct, Bile duct stones Cholangitis
  - Notification of result to Local UGI MDT → Pancreatic cancer algorithm

- Dilated bile duct, Pancreatic mass
  - CT, if negative EUS → MRCP

- Dilated intra and extrahepatic ducts, no mass
  - Referral to Pancreatic/HPB Centre SMDT

- Dilated intrahepatic ducts only

REFERRAL FORMS
- Referred to Local Trust
- Referred to Pancreatic/HPB Centre

INVESTIGATIONS
- eg. LFTs

PRIMARY CARE

SECONDARY CARE
AngCN HPB Patient Pathway - referral to treatment
(including GFOCW & timelines)

Referral to extended MDT services at any point in pathway eg Palliative care specialists; Psychologists; Liaison psychiatrists; Pharmacists; Cosmetic camouflage service advisors: Clinical geneticist / genetic counsellors; Lymphoedema therapists; Occupational therapists; Prosthetics and orthotics staff; Physiotherapists; Radiographers; Speech and language therapists

- Tertiary Referral? Upgraded already
- GP Referral
  - FT Jaundice Clinic Ultrasound
  - Ultrasound/CT/MR
- LMDT
- SMDT
- Further Investigations (eg. ERCP, Laparoscopy, EUS)
- DTT Oncology
- DTT Surgery
- ERCP/PTC/Stent
- Chemotherapy
- Radiotherapy
- Palliative Surgery
- Surgery
- Chemotherapy
- Radiotherapy

Consultant upgrade points eg referral meets NICE criteria; at first seen, during or after diagnostic tests; on or before MDT date and decision to treat date. +62 days from these upgrade point dates Please refer to the AngCN Consultant Upgrade Policy at www.anglicancernetwork.nhs.uk.

Ref Rec'd Day 0
Up to Day 14
Day 31
Day 35-41
Day 49-62
Day 0
By Day 31

Elapsed time for follow up or presentation of recurrence or mets

KEY:
- Unit
- Centre
- Unit or Centre
- Access to specialist services
- GFOCW

+/- Post Tx MDT to assess Fitness for subsequent treatment
Earliest clinically appropriate date Clinic for Decision on Subsequent Treatment
Chemo
Therapy
Surgery
Palliative Care
WHAT IS THE ROLE OF THE MDT IN THE PATIENTS PATHWAY?

- MDTs facilitate individual disciplines working in partnership; attempts to meet standard goals are interrelated and reliant on a performance that is geared towards delivering optimal care and meeting targeted specifications’
  
  (DOH 2011)

‘Formulate the design regarding resectional, oncological or palliative treatment’

(NHS commissioning Board 2013)
WHAT IS THE ROLE OF THE MDT IN THE PATIENTS PATHWAY?

• SMDT
  - Discuss suspected or confirmed HPB cancer
  - Histopathologists, surgeons, oncologists, radiologists, dietitian, CNS, secretary, MDT co-ordinator
  - Via teleconference

• Bedford, Hinchingbrooke, Kings Lynn, Norfolk and Norwich, James Paget, Ipswich, West Suffolk, Addenbrookes
WHAT IS THE ROLE OF THE MDT IN THE PATIENTS PATHWAY?

• Decision
  - Inoperable
    - BSC / Palliative Chemotherapy / Trials
      Treatment carried out locally if possible
  - Operable
    - Whipples / Distal pancreatectomy / Total pancreatectomy
WHAT IS THE ROLE OF THE MDT IN THE PATIENTS PATHWAY?

- Curative surgery and post op care carried out at Addenbrookes
- Surgical clinic / inpatient => told diagnosis
  - NICE – Emotional support, Managing pain, Nutrition, Assessment => ? Plan relieving blocked bile duct/ duodenum
- Pre op assessment
- DOSA – L2
- Theatre
- Intensive Overnight Recovery (IOR)
- Intermediate Dependency Area (IDA)
- Ward F6
- Clinic (histology)
WHAT IS THE ROLE OF THE MDT IN THE PATIENTS PATHWAY?

• Re discussed at SMDT 2 weeks post surgery
  - Final histology & decision
• Follow up
  - ? Refer to oncology (chemo / trials)
  - Surgical follow up
    CT, CA19.9 six monthly for two years
    CT, CA19.9 yearly until five years
  ? Discharge
• Recurrence => SMDT
NICE => Monitoring if
- Hereditary pancreatitis and PRSS1 fault
- BRCA1, BRCA2, PALB2 or CDKN2A & one or more first-degree relatives with pancreatic cancer
- Peutz-Jeghers syndrome
- Two or more first-degree relatives with pancreatic cancer, across two or more generations
- Lynch syndrome & any first-degree relatives with pancreatic cancer
SNAKES AND LADDERS!
MAKE A DIFFERENCE

• ‘The man who moves a mountain begins by carrying away small stones’
  Confucius

Start where you are, with what you have, to do what you can

Effective leadership and
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ANY QUESTIONS?
• www.cancerresearchuk.org
• www.pancreaticcancer.org.uk
• www.pancreaticcanceraction.org
• www.pcrf.org.uk
• www.nice.org. Pancreatic cancer in adults
• Department of Health 2011 – DOH website
• www.nice.org.uk/guidance
• NHS Commissioning Board 2013 (NHS England Website)
• Jensen H; Torring ML; Olesen F; Overgaard J; Fenger Gron M and Vedsted P (2015)
Diagnostic intervals before and after implementation of cancer patient pathways- a GP survey and comparison of three cohorts of cancer patients. BMC Cancer 15:308
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- Anderson B. Cancer Management: The difficulties of a target driven healthcare system
- Johnstone M; Halloran CM; Ghaneh P; Sutton R; Neoptolemos JP and Raraty MGT (2012) 10 years on from the Improving Outcomes Guidance – Development of a Tertiary Pancreatic Cancer Unit
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