Pancreatic Cancer UK

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Virtual

Improving Access to Chemotherapy, 17th September 2020, 9 – 11am

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The Bridging Clinic: Treating Medical Complications so Patients are More Likely to Receive Chemotherapy

Mr Bhaskar Kumar, Consultant Upper Gastrointestinal Surgeon, Upper GI Cancer lead, Norfolk & Norwich University Hospitals NHS Foundation Trust

“Bridging Clinic for Upper GI cancer”

Mr. Bhaskar Kumar
Consultant Upper GI Surgeon & Cancer lead
Norfolk & Norwich University Hospital

The current patient pathway

- Attend clinic for diagnosis and “breaking of bad news”
- Most patients and relatives are in a state of shock
- Difficult process for doctors and nurses
- Not ideal time for a full assessment and optimisation

The current patient pathway

- Access to chemotherapy may be improved by patient symptom optimisation
- E.g. analgesia control, nutrition
- May improve start and completion rates

What is a "Bridging Clinic" for?

- Purpose is to cover a range of issues
- Often areas that are overlooked e.g. pain, psychological status
- Away from the shock of diagnosis
- Improved patient experience
- Novel concept ?applicable to many cancer sites

Patient information

Box 1 Guidance on information to be given at the bridging clinic appointment

Information

- Involvement of the Cancer Nurse Specialist from the outset.
- Ideally inform the patient of their diagnosis at a separate initial consultation.
- Information should be given at all times with compassion and empathy.
- Encourage patient to be accompanied by a relative/ friend to their appointment.
- Discuss potential options for their treatment and care .
- Use clear terminology and avoid medical jargon.
- Make available written information for patients to review after their appointment.
- Signposting to organisations providing high-quality, evidence-based information.
- Telephone advice and comprehensive literature (Pancreatic Cancer UK, Pancreatic Cancer Action and Pancreatic Cancer Scotland).

Nutrition Assessment

Box 2 Assessment and management of nutritional issues at the bridging clinic appointment

Nutrition

Assessment

1.Detailed history

Aetiology

- Gastric obstruction/gastroparesis.
- Malabsorption (pancreatic insufficiency)—secondary to pancreatic ductal obstruction.
- Sarcopenia—questionnaire.
- Cancer cachexia.

2. Baseline body mass index

Management

- Gastric outlet obstruction: stent vs surgical bypass (gastrojejunostomy).
- Pancreatic enzyme insufficiency: pancreatic enzyme replacement therapy.
- Upper gastrointestinal dietician involvement.
- Sarcopenia (nutrition, resistance training, etc).

Pancreatic Insufficiency

Box 3 Practical steps in taking pancreatic enzyme supplementation.

Recommendations for initial treatment

- Initial prescription: 50 000 units lipase with meals/25 000 units with snacks.
- Prescribe a tablet of a single strength to enhance compliance, eg, 25 000 units tablet (patient takes two tablets with meals, one tablet with snacks).
- Half the dose (one capsule) to be taken immediately before food and half (one capsule) during the meal.
- Keep pancreatic enzyme replacement therapy (PERT) in a cool place as heat denatures enzymes.
- Do not swallow with hot drinks which denatures the enzymes.

Response to PERT

- Monitor clinical response (weight loss, steatorrhoea) regularly and increase dose if needed.
- Proton pump inhibitor should be co-administered if malabsorption symptoms do not resolve.
- Monitor blood glucose which may increase if absorption is improved and dose titrated.
- Input from specialist dietician for weight loss which is multifactorial and severe.

Diabetes Management

Box 4 Practical steps in the assessment and management of diabetes at the bridging clinic

Diabetes

Assessment

- Assess clinically for polyuria/polydipsia/weight loss.
- Plasma glucose should always be measured.
- Urinalysis/haemoglobin A1c.
- Consider appropriate oral hypoglycaemic therapy.
- Severe hyperglycaemia may require insulin therapy.
- Consider causes of hyperglycaemia (chemotherapy infusions in dextrose solutions, steroids/pancreatic enzyme replacement therapy).

Management

- First-line oral hypoglycaemic=metformin (contraindicated in renal/hepatic impairment).
- Risk factor modification, eg, high body mass index.
- Consider referral to a diabetiologist .

Depression

Box 5 Practical steps in the assessment and management of depression at the bridging clinic

Depression

Assessment

- Early identification of clinical features of depression.
- Aetiology.
  - Anaemia.
  - Hypercalcaemia.
  - Acid-base abnormalities.
  - Nutritional deficiencies (eg, iron or vitamin B12 deficiency).
  - Drug side effects, eg, chemotherapy-induced depression.
- Apply screening tool, eg, Hospital Anxiety and Depression Scale.

Management

- Antidepressant treatment, eg, mirtazapine (appetite stimulant).
- Consider referring for counselling and support usually via palliative care services for severe depression.

Analgesia

Box 6 Practical steps in the assessment and management of analgesia at the bridging clinic

Analgesia

Management

- Pharmacotherapy—first line.
- WHO analgesic ladder (starting with paracetamol/non-steroidal anti-inflammatory drugs/progressing to weak, and then strong morphine-based opioids).
- If ineffective—consider methadone and ketamine, two N-methyl-D-aspartate.
- Requires involvement of palliative care physician.
- Adjunctive treatments: tricyclic antidepressants and gabapentinoids.
- Refractory pain—consider endoscopic ultrasound-guided coeliac plexus neurolysis discussed at the multi-disciplinary team (MDT).

Conclusion

- Streamlined patient pathway
- Comprehensive structured assessment
- Optimise patient physically and mentally
- Can be applied to a number of cancer sites e.g. oesophageal