

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

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“Bridging Clinic for Upper GI cancer”

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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



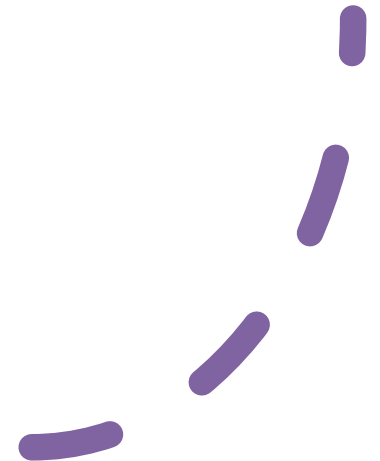
The current patient pathway

- 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 dietitian 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 diabetologist .

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

