

Pancreatic
Cancer
UK

Virtual ANNUAL SUMMIT 2020

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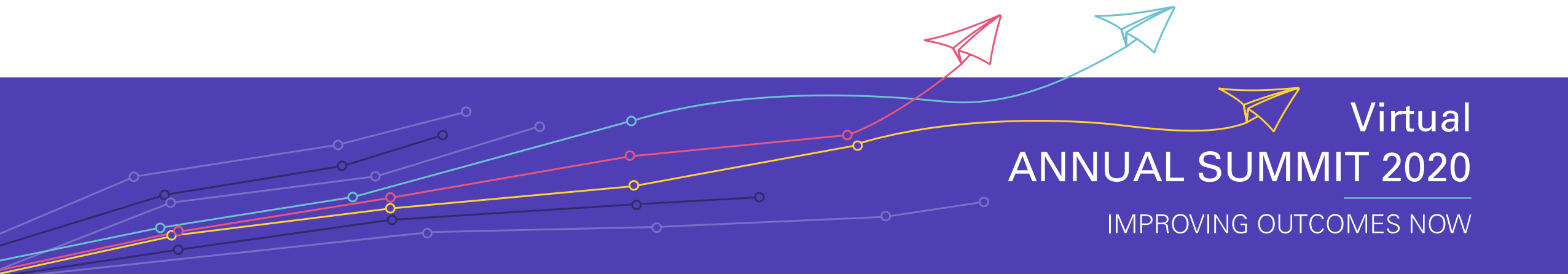
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Variation in the Pancreatic Cancer Pathway

09.05 – 09.15 | Tuesday 29th September 2020 | Zoom Webinar
Anna Jewell - Director of Support, Research & Influencing



Variation in survival

- Despite poor outcomes globally, the UK lags behind the rest of the world, ranking **29th out of 33 countries** for five-year survival.
- One-year survival for pancreatic cancer ranges from **21.3% to 29.1%** and five-year survival ranges from **4.8% to 10.6%** across Cancer Alliances in England
- There is variation in treatment and care for different groups: between young and old, between patients with operable and inoperable pancreatic cancer, and between specialist centres and secondary care.

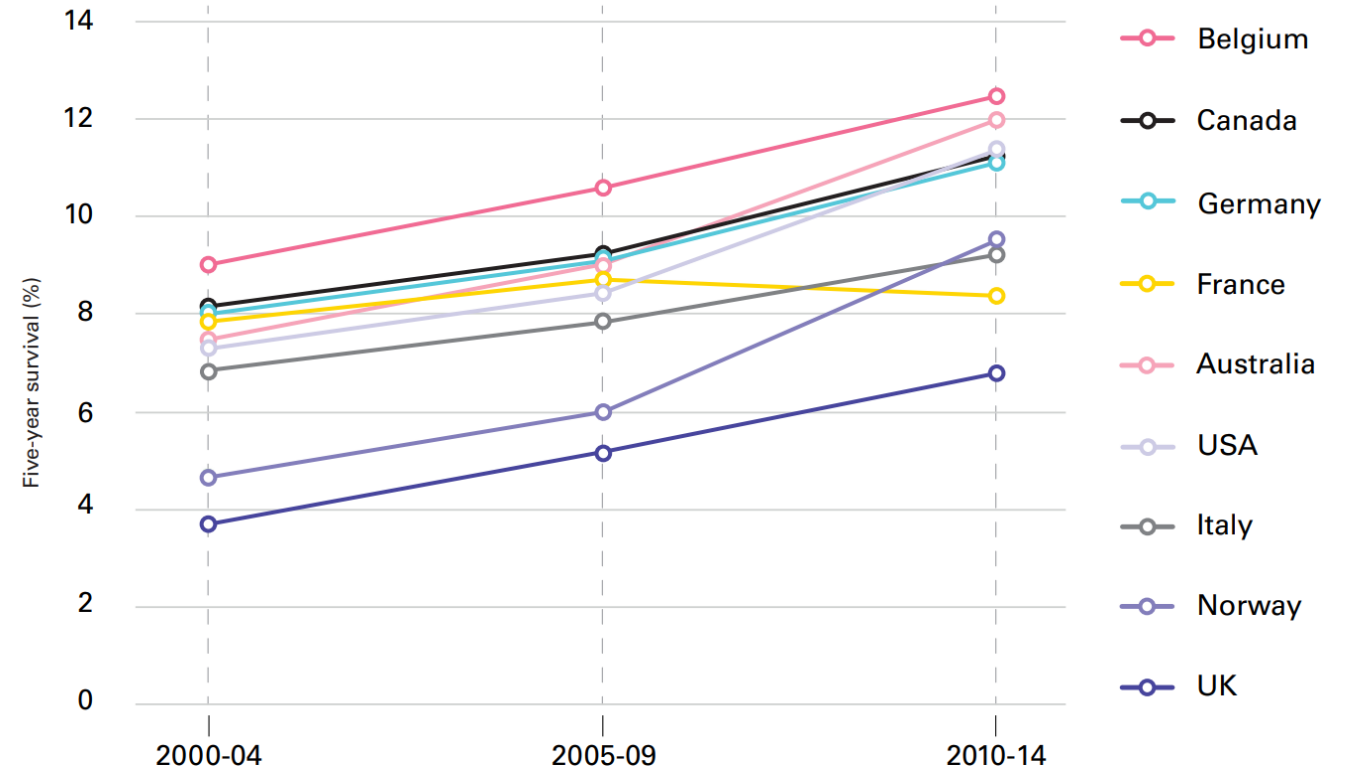
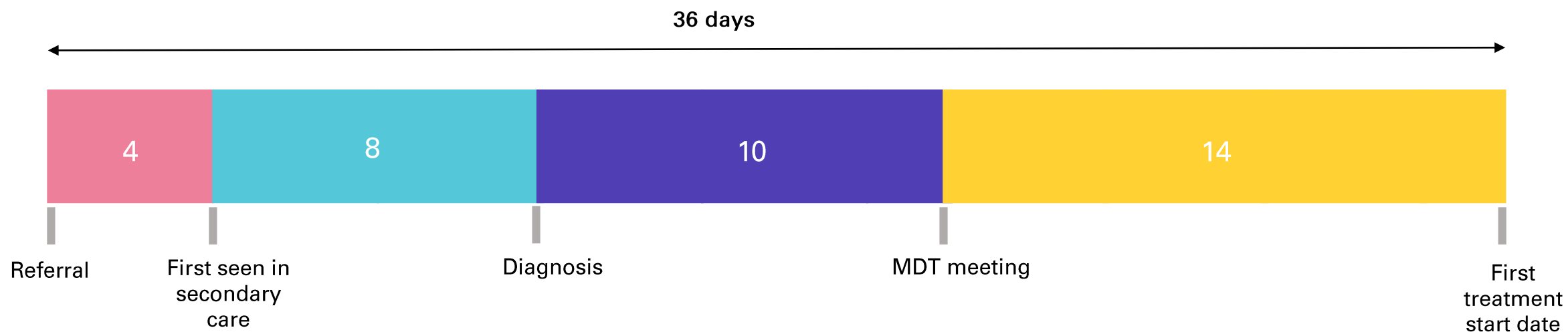
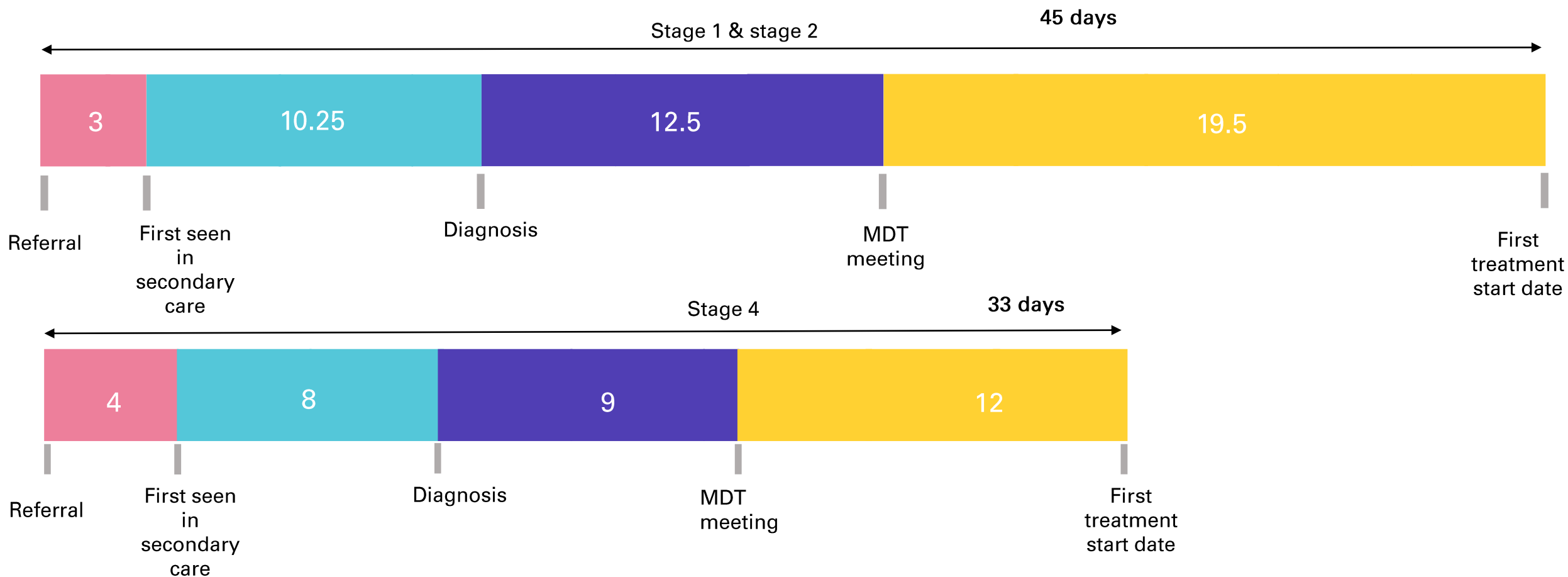


Figure 1: Five-year survival trend for pancreatic cancer between 2000-2004 and 2010-2014.
Data adapted after CONCORD-3.

Median pancreatic cancer pathway length

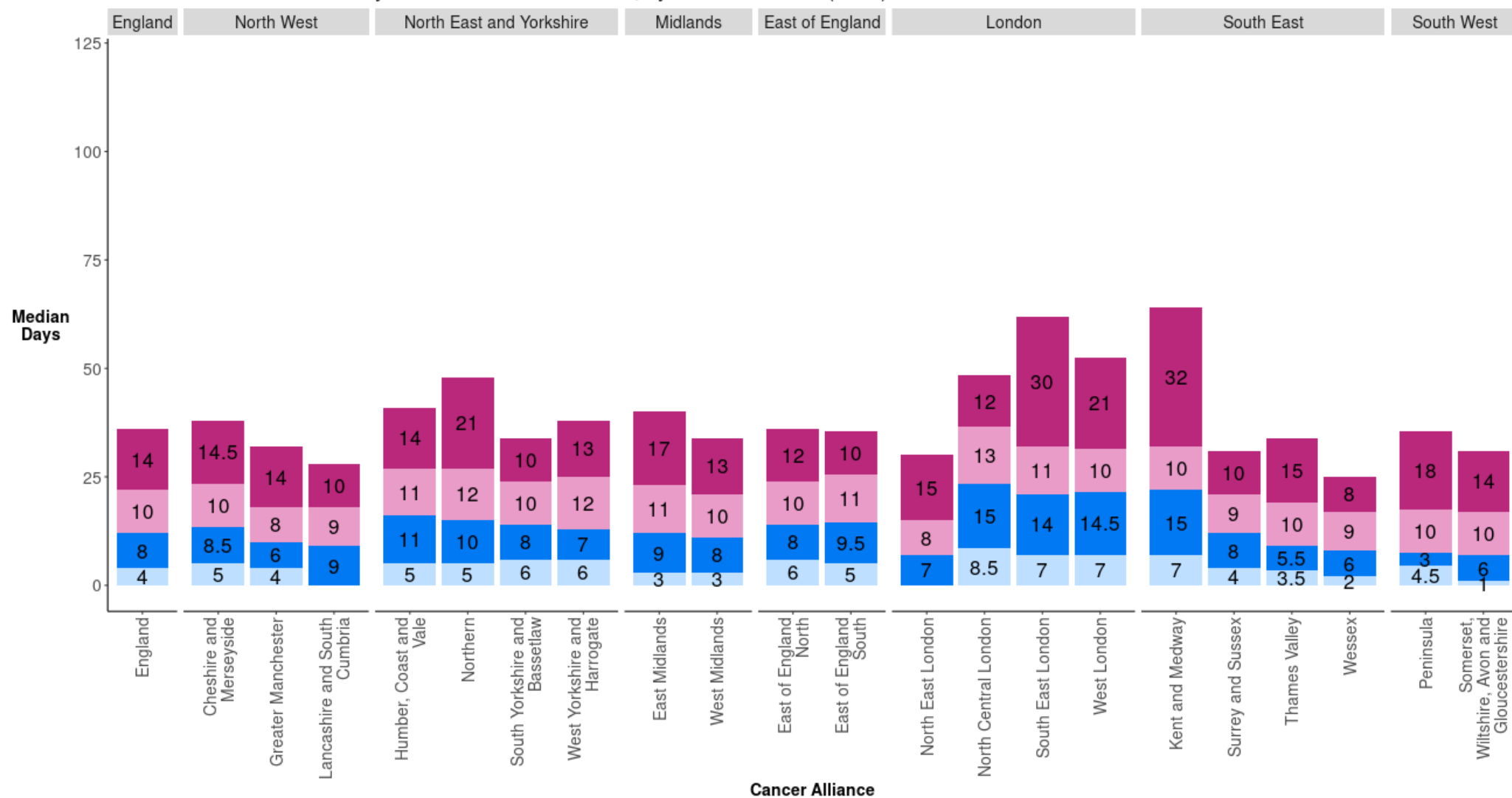


Median pancreatic cancer pathway length



Median pancreatic cancer pathway length

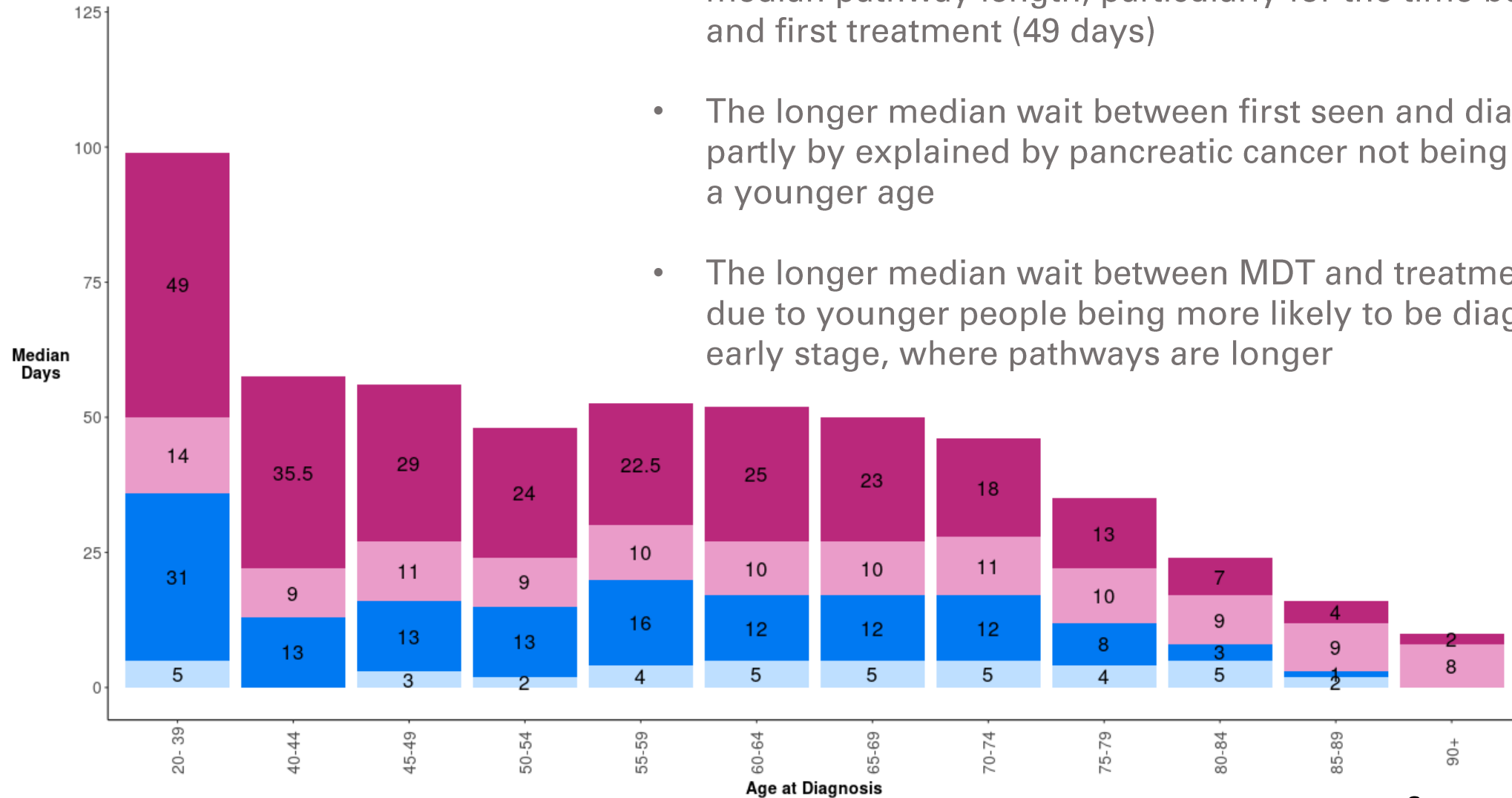
Pancreas cancer: median days from referral to treatment, by Cancer Alliance (2018)



Pathway Interval Referral to First Seen First Seen to Diagnosis Diagnosis to MDT Date MDT Date to Treatment

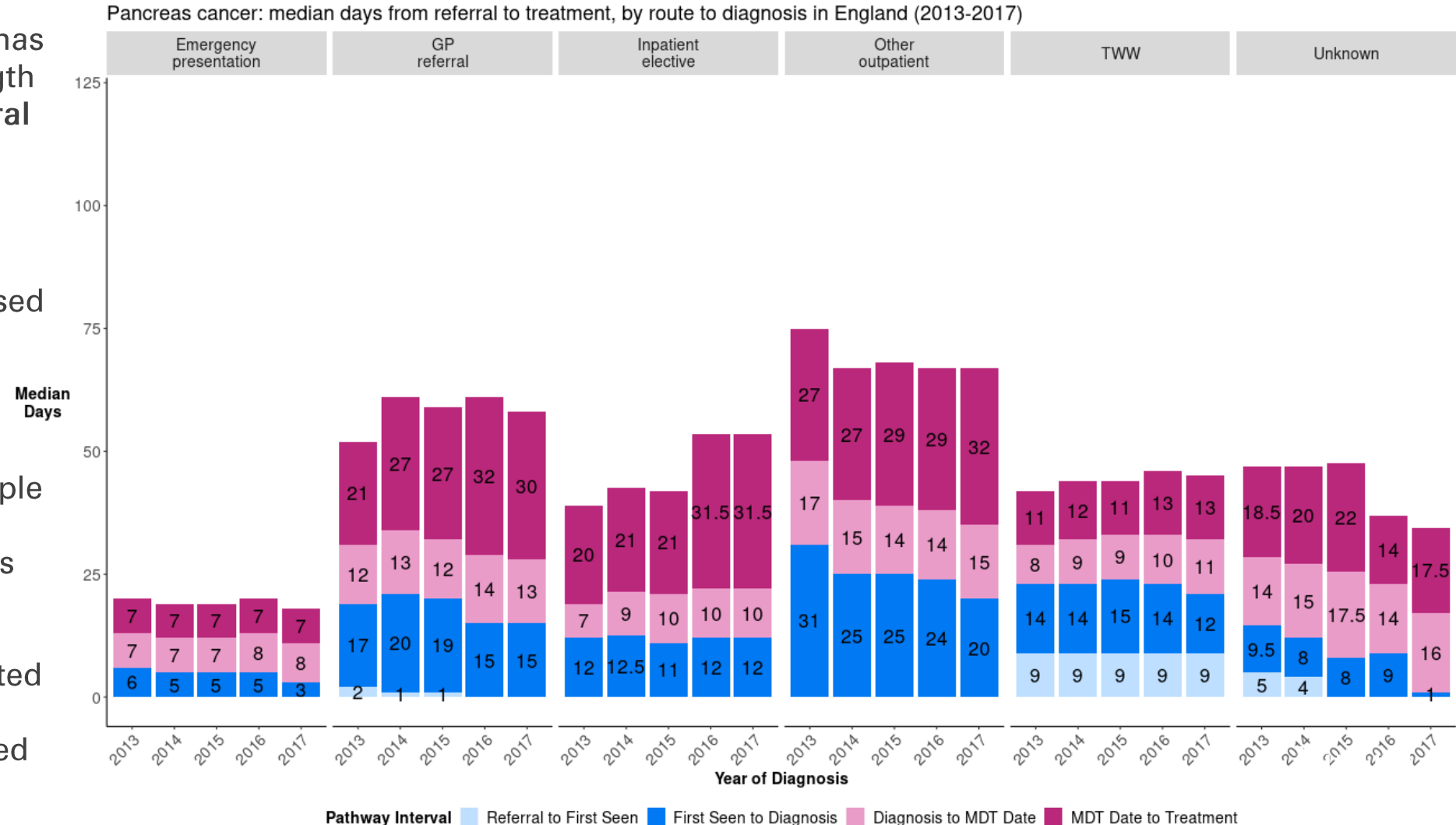
Age & pathway length

- There is a strong correlation between younger age and longer median pathway length, particularly for the time between MDT and first treatment (49 days)
- The longer median wait between first seen and diagnosis could partly be explained by pancreatic cancer not being suspected at a younger age
- The longer median wait between MDT and treatment could be due to younger people being more likely to be diagnosed at an early stage, where pathways are longer

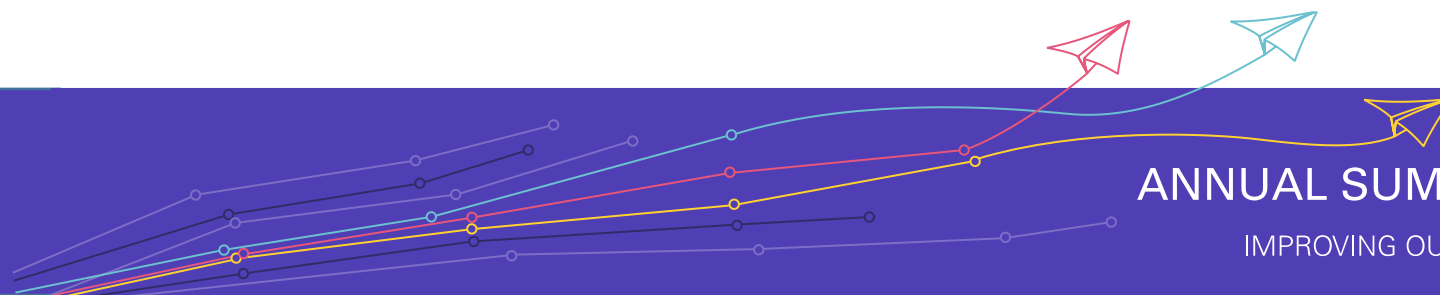


Routes to diagnosis

- Emergency presentation has the quickest pathway length – **18 days between referral and first treatment**
- 44% diagnosed through emergency presentation, where most often diagnosed at a late stage and put on quicker palliative care pathways.
- One-year survival for people diagnosed through emergency presentation is only 12%
- 51% of those who presented as an emergency presentation had presented to a GP within 6 months before the diagnosis with symptoms.



Symptom presentation to diagnosis pathway

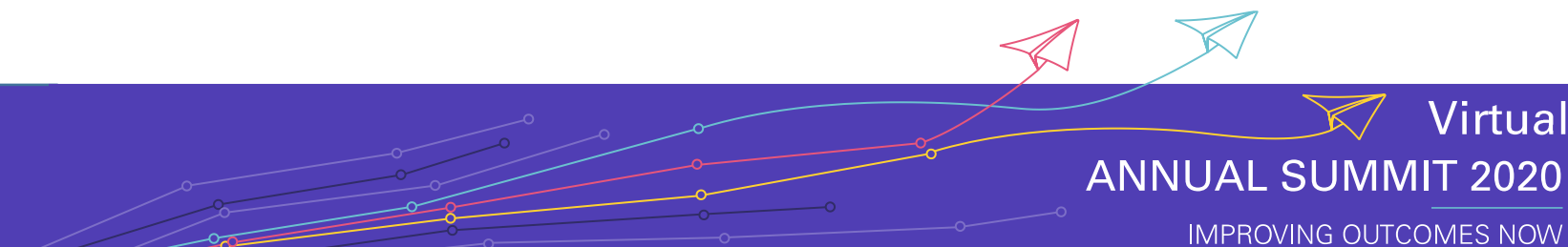


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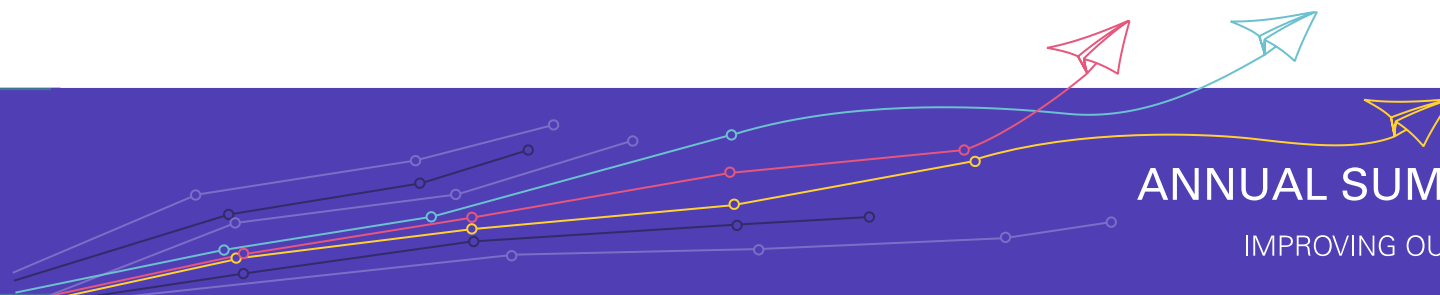
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Delays in primary care:

- People with pancreatic cancer often have multiple appointments with GPs before referral, with people presenting a **median of 3 occasions with alarm symptoms** prior to diagnosis
- 91% of patients had relevant symptoms in the 2 years prior to diagnosis
- A quarter visited their GP on more than four occasions with alarm symptoms in the year prior to diagnosis.



Diagnosis to first treatment pathway

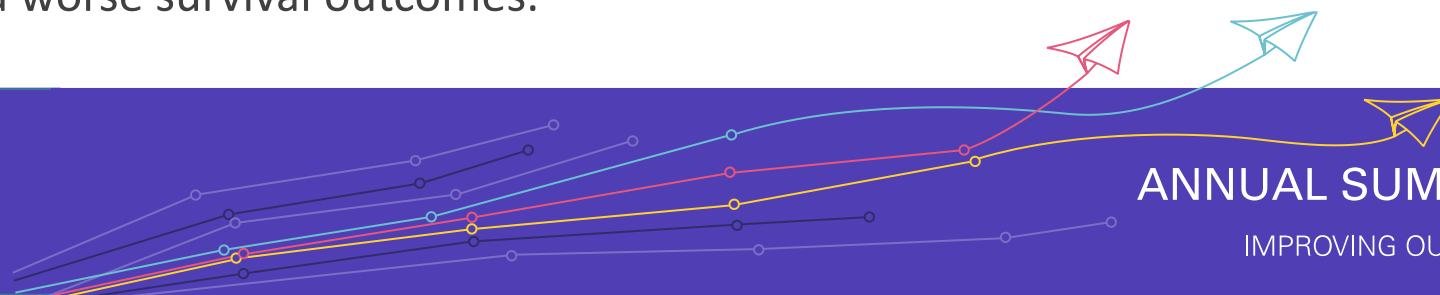


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Diagnosis to treatment:

- Often hear through our Support Line and through discussions with pancreatic cancer specialists that there is inconsistency in how care is delivered across the UK.
- Can be avoidable delays occurring between diagnosis and treatment for both operable and inoperable patients due to coordination problems between clinical specialists and different hospitals as well as a lack of standardised clinical pathways, workforce and resources.
- Median pathway length between **diagnosis and treatment** for people diagnosed at an early stage is **32 days**. The longer people with pancreatic cancer wait from diagnosis to have surgery, the higher the risk the cancer will metastasise, preventing them from being eligible for surgery.
- Longer waiting times to surgery and chemotherapy have been shown to reduce the numbers having treatment and worse survival outcomes.



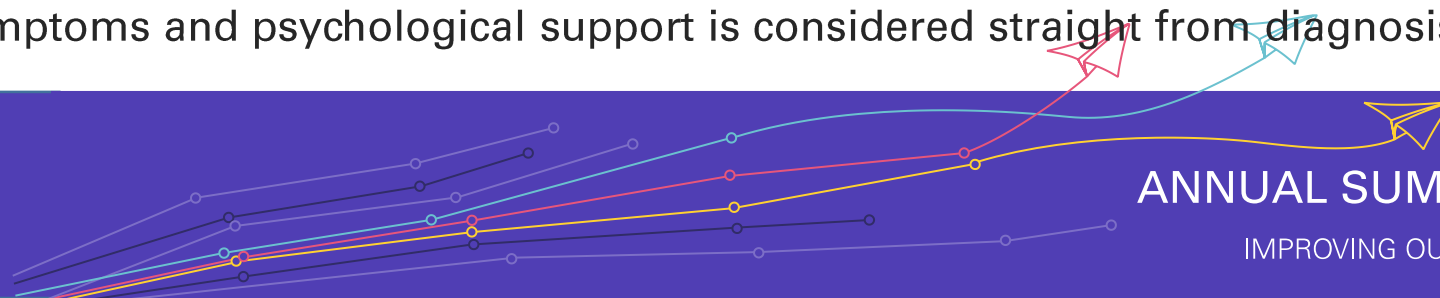
Pancreatic cancer optimal care pathway

There is variation in the pancreatic cancer median pathway length between Cancer Alliances and there are differences in diagnostic and treatment pathways as well as clinical practice and models of care across England.

We need to work with the clinical community to share and highlight best practice and start to reduce unjustified variation in care and outcomes through building consensus on a **pancreatic cancer optimal care pathway**.

Pancreatic cancer optimal pathway:

- An optimal pathway should cover the whole spectrum of care - from presentation of symptoms to diagnosis, access to best treatment and supportive care for those living with and beyond pancreatic cancer.
- It should be a holistic approach to ensure that patients access supportive care to ensure management of symptoms and psychological support is considered straight from diagnosis



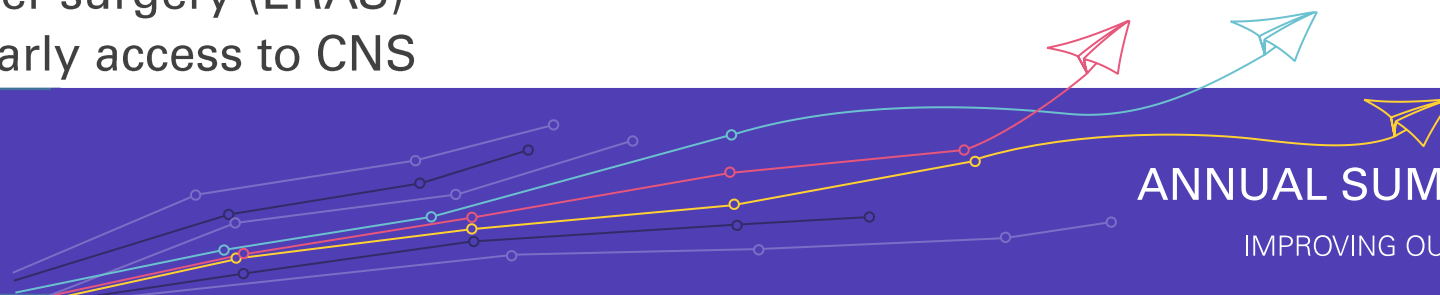
Key pancreatic cancer optimal care pathway features

Symptom presentation to diagnosis:

- Rapid Diagnostic Centres for vague and non-specific symptoms
- Rapid access jaundice clinic

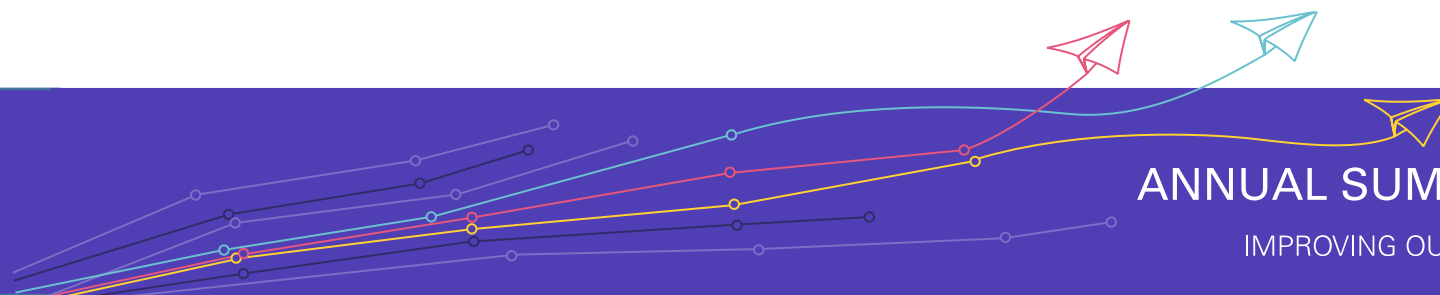
Diagnosis to treatment:

- One stop clinics
- Bridging clinics – considering supportive care needs early
- Centralised chemotherapy / Dedicated pancreatic cancer clinics for inoperable patients
- Prehabilitation before treatment
- Faster treatment pathways
- Enhanced recovery after surgery (ERAS)
- Patient navigators & early access to CNS



Unanswered questions...

- Does the median pathway length data reflect clinical experience?
- What do clinicians record as first treatment in the CWT ? Are stents/prehabilitation recorded as first treatment and does this need to change?
- Are these pathways fast enough? Where does the pathway need to be faster?
- What are innovations in practice and care that would increase the speed from referral to treatment?
- What is the balance between best standard quality care and faster pathways?



We need innovative solutions

- As part of the **Virtual Annual Summit 2020** today, we will be exploring innovative practice that aims to improve the pancreatic cancer pathway.
 - The Latest in the Pathway (Andrew Millar)
 - Improving the MDT function (Alastair Young)
 - From the GP Surgery to treatment (Thomas Satyadas)
 - Early engagement of Clinical Nurse Specialists (Anya Adair)

