

National Oesophago-Gastric Cancer Audit 2019

Report for public and patients



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Introduction

The National Oesophago-Gastric Cancer Audit (NOGCA) evaluates the quality of hospital care for patients with oesophago-gastric (OG) cancer in England and Wales.

The audit provides information that helps NHS cancer services to compare their performance and to identify areas of care that could be improved.

Since 2012, the audit has also included patients with high grade dysplasia (HGD) of the oesophagus, which is a condition that increases a person's risk of developing cancer.

Over the years, there have been continued improvements in patients' chances of surviving curative surgery, and reductions in the length of stay in

hospital. However, the audit has also identified that some hospitals are struggling to meet national cancer waiting time targets, and that there are regional variations in the use of recommended tests for OG cancer.

In December 2019, the audit published its 11th annual report. It is available for download at:

www.nogca.org.uk/reports/2019-annual-report

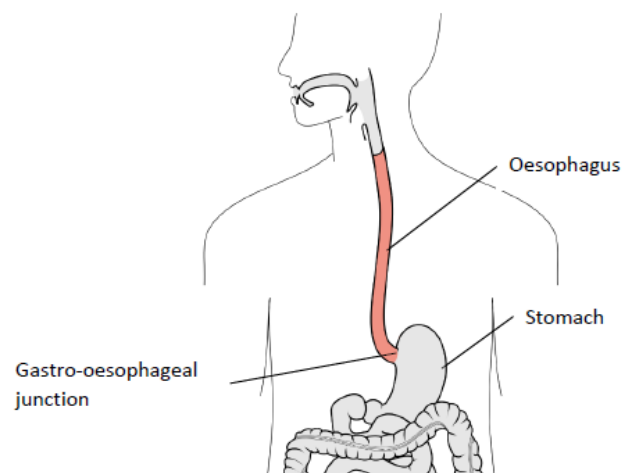
This report is written for patients, family members and carers to highlight key findings from the annual report, and we have provided links to relevant sections of the annual report.

The oesophagus and stomach

The term *oesophago-gastric cancer* covers three types of cancer that occur in:

- the oesophagus – the tube that connects the mouth to the stomach
- the gastro-oesophageal junction (GOJ) – the point where the oesophagus joins the stomach
- the stomach – the organ that helps to digest swallowed food

Cancers of the oesophagus or GOJ are often referred to as oesophageal cancers, while cancers of the stomach are known as gastric cancers.



Oesophago-gastric cancer

Who gets oesophago-gastric (OG) cancer?

Oesophago-gastric cancer is the fifth most common type of cancer in the country, with around 13,000 people diagnosed each year in England and Wales.

The audit received information on 21,417 patients in England and Wales who were diagnosed with OG cancer between April 2016 and March 2018.

Over the last 25 years, the number of cases of stomach cancer has declined as *Helicobacter pylori* infections (which

increase the risk of stomach cancer) have become less common.

The average age of patients was 72 years, and over two-thirds were men.

Oesophageal cancer (cancers in the oesophagus or gastro-oesophageal junction) accounted for 70% of OG cancers, while stomach cancer accounted for 30%.

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How is OG cancer diagnosed?

OG cancer is diagnosed using a procedure called a biopsy. In a biopsy, small pieces of tissue from the oesophagus or stomach are removed and examined under a microscope.

During a biopsy, a tube (endoscope) is placed down the patient's throat and the doctor inserts instruments through the tube to remove samples of tissue. A video that shows how a biopsy is taken can be found on the Cancer Research UK website: www.cancerresearchuk.org/about-cancer/oesophageal-cancer/getting-diagnosed/tests/endoscopy

Most patients will be conscious (awake) for the procedure, but a sedative may be offered to help a patient relax.

Clinical guidelines recommend that if a GP suspects that a patient has OG cancer, the patient should be referred immediately for tests to ensure they are diagnosed as early as possible.

Some patients are diagnosed after an emergency admission to hospital. These patients often have advanced disease, and are less likely to be candidates for curative treatment than patients diagnosed after a GP referral.

The percentage of emergency admissions for each hospital trust can be found here: www.nogca.org.uk/trust-results/

Overall, two-thirds of patients in the audit were diagnosed following a referral from their GP, and 13% were diagnosed after an emergency admission.

For oesophageal cancer, 11% of patients were diagnosed following an emergency admission, compared to 20% of patients with stomach cancer.

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What tests are needed following a diagnosis of OG cancer?

Patients diagnosed with OG cancer are referred for tests to work out the stage (extent) of the disease. The stage helps doctors to decide what treatment options are appropriate.

The first test will usually be a computerised tomography (CT) scan. A CT scan uses X-rays and a computer to produce detailed images of inside the body. This allows doctors to assess the location and size of the tumour and whether the cancer has spread.

If the CT scan shows the cancer has not spread from the oesophagus or stomach, a patient may have further tests to provide more precise information about its size.

After the CT scan, and depending on the location of the tumour, tests can include:

- endoscopic ultrasound (a probe which gives off high-frequency sound waves is placed down the throat to produce images of inside the body),
- positron emission tomography scan (PET-CT scan) (this produces detailed 3D images by detecting radiation that is given off by a substance injected into the body),
- laparoscopy (a surgical procedure which allows access to the stomach through small incisions, also known as keyhole surgery).

More information about these tests can be found on the Cancer Research UK website:

Tests for oesophageal cancer: www.cancerresearchuk.org/about-cancer/oesophageal-cancer/getting-diagnosed/tests

Tests for stomach cancer: www.cancerresearchuk.org/about-cancer/stomach-cancer/getting-diagnosed/tests-stage

Clinical guidelines recommend that all patients who are diagnosed with OG cancer have a CT scan for initial assessment of the disease and to look for evidence of metastatic disease (spread to other parts of the body).

The majority (94%) of patients in the audit had an initial CT scan.

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What treatments are available for OG cancer?

The treatment options for OG cancer depend on the location, stage and type of cancer.

If the cancer is at an early stage, the main treatment option is surgery to remove the affected part of the oesophagus or stomach. For very early stage cancers, it may be possible to remove just the abnormal areas in the lining of the oesophagus or stomach using a tube (endoscope) placed down the throat.

Patients may also have chemotherapy (using drugs to destroy cancer cells) and/or radiotherapy (using radiation to destroy cancer cells) before or after surgery.

Certain types of early-stage oesophageal cancer may be suitable for treatment with only chemoradiotherapy (without surgery).

More information about surgical procedures for OG cancer can be found on the Cancer Research UK website:

- Surgery for oesophageal cancer: www.cancerresearchuk.org/about-cancer/oesophageal-cancer/treatment/surgery
- Surgery for stomach cancer: www.cancerresearchuk.org/about-cancer/stomach-cancer/treatment/surgery/types

However, these treatments place a great deal of strain on the body, so patients who are frail or very unwell may decide, together with their doctors, that curative treatment is not suitable.

If curative treatment is not suitable because the cancer is very advanced or a

patient is too unwell for treatment, they may receive palliative therapies which aim to reduce the impact of symptoms and improve quality of life but do not cure the cancer.

Palliative therapies include endoscopic stenting (a tube, known as a stent, is placed into the oesophagus to keep blocked parts of the oesophagus open, which helps the patient to swallow), palliative chemotherapy or radiotherapy, and best supportive care (no treatment beyond the immediate relief of symptoms).

Information about treatment planning at each hospital trust can be found here:

www.nogca.org.uk/trust-results/

Overall, 38% of patients in the audit had a plan for curative treatment, including 40% of patients with oesophageal cancer and 34% of patients with stomach cancer.

Younger patients and those with less advanced disease (who are overall more fit for surgery) were more likely to have a plan for curative treatment. Among patients aged under 80 years whose tumour had not spread to other organs (stages 0 to 3), over half had a curative treatment plan. For patients aged under 70 years with less advanced cancer (stages 0 to 2), over 70% had a curative treatment plan.

Among patients who were not suitable for curative treatments, 48% had an initial plan for palliative chemotherapy or radiotherapy.



How long do patients have to wait for treatment?

NHS services in England and Wales aim to start treatment for cancer within 62 days of an urgent GP referral.

For patients undergoing surgery, chemotherapy or radiotherapy, the time from diagnosis to the start of treatment was typically 1-2 months.

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Where can patients go for OG cancer surgery?

For patients in England and Wales, surgery to treat OG cancer will take place in one of 39 specialist surgical centres.

This means that patients may have to travel to another part of the country for their operation.

A list of specialist centres can be found on page 10 of this report.

What are the outcomes of OG cancer surgery?

Among patients in the audit who had curative surgery (surgery that aims to cure the cancer), over 96% were alive 90 days after surgery.

The length of stay in hospital was typically 12 days for patients who had an oesophagectomy, and 9 days for patients who had a gastrectomy.

Over half of patients having curative surgery were placed on an 'enhanced recovery after surgery' protocol, and on average these patients had shorter stays in hospital.

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Information about surgical outcomes for each specialist centre can be found here: www.nogca.org.uk/trust-results/

High grade dysplasia of the oesophagus

Who is affected by high grade dysplasia (HGD) of the oesophagus?



When someone is diagnosed with high grade dysplasia (HGD) of the oesophagus, it means that there are severely abnormal cells (precancerous cells) in the lining of the oesophagus. It is not cancer, but can turn into cancer if it is left untreated.

The audit received information on 797 patients diagnosed with HGD of the oesophagus between April 2016 and March 2018 in England.

The average age of patients was 71 years, and three-quarters were men.

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How is HGD diagnosed?

HGD is diagnosed using a procedure called a biopsy. In a biopsy, small pieces of tissue from the oesophagus are removed and examined under a microscope.

During the procedure, a tube (endoscope) is placed down the patient's throat and the doctor inserts instruments through the tube to remove the samples of tissue.

Most patients will be conscious (awake) for the procedure but a sedative may be offered to help a patient relax.

National guidelines recommend that people with suspected HGD should have their diagnosis confirmed by two specialist doctors (pathologists).

89% of patients in the audit had their initial diagnosis of HGD confirmed by a second pathologist.

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What happens following a diagnosis of HGD?

A specialist team of doctors (known as a multidisciplinary team or MDT) will discuss the patient's care to ensure that they are considered for the most appropriate treatment options.

Patients should be offered an appointment with their doctor to discuss the team's recommendations.

National guidelines recommend that people with HGD should have their treatment discussed at a specialist multidisciplinary team meeting.

86% of patients in the audit were discussed by a multidisciplinary team.

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What are the treatment options for people diagnosed with HGD?

The main treatment option is to remove the abnormal cells from the lining of the oesophagus using a tube called an endoscope.

The endoscope is placed down the oesophagus, and the doctor inserts instruments through the tube to remove the abnormal tissue.

Abnormal tissue can be removed by cutting it away with a thin wire (endoscopic mucosal resection or EMR), or using heat (radiofrequency ablation).

A small number of people may need an operation to surgically remove the affected part of the oesophagus.

National guidelines recommend that people with HGD should receive endoscopic treatment (e.g. endoscopic mucosal resection or radiofrequency ablation).

70% of patients in the audit had a plan for endoscopic treatment.

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Where do people go for treatment of HGD?

Treatment for HGD will usually be provided in a specialist centre which treats a large number of HGD patients each year.

This means that patients may have to travel to another hospital for treatment.

What are the outcomes of treatment for HGD?

The majority of treatment procedures will result in complete removal of the abnormal cells (complete excision).

In some cases, patients may need further treatment to ensure complete removal of the abnormal tissue.

In the audit, 69% of endoscopic procedures resulted in complete removal of abnormal cells (complete excision).

In cases where the procedure did not result in complete excision, three-quarters of patients required further treatment.

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OG cancer specialist surgical centres

Information about outcomes for each specialist surgical centre can be found here:

www.augis.org/outcomes-data-2019/

Name (in alphabetical order)
Aintree University Hospital NHS Foundation Trust
Barking, Havering and Redbridge University Hospitals NHS Trust
Betsi Cadwaladr University Health Board
Bradford Teaching Hospitals NHS Foundation Trust
Brighton and Sussex University Hospitals NHS Trust
Cambridge University Hospitals NHS Foundation Trust
Cardiff & Vale University Health Board
Cwm Taf Morgannwg University Health Board
Gloucestershire Hospitals NHS Foundation Trust
Guy's and St Thomas' NHS Foundation Trust
Hull University Teaching Hospitals NHS Trust
Imperial College Healthcare NHS Trust
Lancashire Teaching Hospitals NHS Foundation Trust
Leeds Teaching Hospitals NHS Trust
Manchester University NHS Foundation Trust
Mid Essex Hospital Services NHS Trust
Norfolk and Norwich University Hospitals NHS Foundation Trust
Nottingham University Hospitals NHS Trust
Oxford University Hospitals NHS Trust
Portsmouth Hospitals NHS Trust
Royal Liverpool and Broadgreen University Hospitals NHS Trust
Royal Surrey County Hospital NHS Foundation Trust
Salford Royal NHS Foundation Trust
Sheffield Teaching Hospitals NHS Foundation Trust
South Tees Hospitals NHS Foundation Trust
Swansea Bay University Health Board
The Newcastle Upon Tyne Hospitals NHS Foundation Trust
The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust
The Royal Marsden NHS Foundation Trust
University College London Hospitals NHS Foundation Trust
University Hospital Southampton NHS Foundation Trust
University Hospitals Birmingham NHS Foundation Trust
University Hospitals Bristol NHS Foundation Trust
University Hospitals Coventry and Warwickshire NHS Trust
University Hospitals of Derby and Burton NHS Foundation Trust
University Hospitals of Leicester NHS Trust
University Hospitals of North Midlands NHS Trust
University Hospitals Plymouth NHS Trust
West Hertfordshire Hospitals NHS Trust

Where can I find more information?

High-grade dysplasia:

Cancer Research UK <https://about-cancer.cancerresearchuk.org/about-cancer/oesophageal-cancer/stages-types-and-grades/stage-0>

Oesophago-gastric cancer:

NHS Choices www.nhs.uk/conditions/oesophageal-cancer

www.nhs.uk/conditions/stomach-cancer

Cancer Research UK www.cancerresearchuk.org/about-cancer/oesophageal-cancer

www.cancerresearchuk.org/about-cancer/stomach-cancer

Macmillan Cancer Support www.macmillan.org.uk/information-and-support/oesophageal-gullet-cancer

www.macmillan.org.uk/information-and-support/stomach-cancer

The Oesophageal Patients Association www.opa.org.uk

Maggie's www.maggiescentres.org

For more information about the audit and its findings:

Visit the National Oesophago-Gastric Cancer Audit website at: www.nogca.org.uk

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HQIP is led by a consortium of the Academy of Medical Royal Colleges, the Royal College of Nursing and National Voices. Its aim is to promote quality improvement, and in particular to increase the effect that clinical audit has on the quality of healthcare in England and Wales. HQIP hosts the contract to manage and develop the National Clinical Audit and Patient Outcomes Programme (NCAPOP). Its purpose is to involve clinicians across England and Wales in systematically evaluating their clinical practice against standards and to support and encourage improvement in the quality of treatment and care. The programme includes more than 30 clinical audits that cover care provided to people with a wide range of medical, surgical and mental-health conditions.



The Royal College of Surgeons (RCS) of England is an independent professional body committed to helping surgeons to achieve and maintain the highest standards of surgical practice and patient care. As part of this, it supports the audit and evaluation of clinical effectiveness for surgery. Registered charity number: 212808.

The RCS analysed the audit data and wrote the content of the 2017 annual report.



The Association of Upper GI Surgeons is the speciality society that represents upper gastrointestinal surgeons. It is one of the key partners leading the audit.



The British Society of Gastroenterology is the speciality society of gastroenterologists. It is one of the key partners leading the audit.



The Royal College of Radiologists is the speciality society of radiologists. It is one of the key partners leading the audit.



NHS Digital is the new trading name for the Health and Social Care Information Centre (HSCIC). They provide 'Information and Technology for better health and care'. The Clinical Audit and Registries Management Service of NHS Digital manage a number of national clinical audits in the areas of cancer, diabetes and heart disease. It manages the audit on behalf of the RCS.