NHS England

West Midlands Cancer Alliance

Best Practice Pathways for the Management of Gastric Carcinoma and Oesophageal Carcinoma

Reviewed by: Upper GI Expert Advisory Group – 29 March 2016

Approved by: Rob Gornall, Clinical Director, West Midlands Cancer Alliance and Duncan Beardsmore, Chair of UGI Expert Advisory Group - 24 August 2017

Distribution: Upper GI Cancer EAG members
Trust Cancer Lead Clinicians
Cancer Trust Managers
Clinical Commissioning Groups within Cancer Alliance footprint

Version History:

Date	Version	Review
29 March 2016	V0.1	Reviewed and agreed at EAG March 2016
24 August 2017	V0.2	Minor amendments
5 October 2017	V1.0	
21 Aug 2019	V1.1	Updated to reflect the 2017 NICE Guidelines 2WW Referral indications, Ewen Griffiths, EAG Chair

Contents

1.0 Treatment Pathway for West Midlands

This document deals with the overall patient pathway. Local Upper GI Cancer MDT Operational Policies will reflect the recommendations made in this Operational Framework but will be tailored to meet local needs. The document will be updated as new evidence is available.

It was agreed that the timed pathways represent an aspirational future position to be worked towards. It is acknowledged that in many cases, services will NOT currently be delivering the pathways as described. The pathways should be used to facilitate improvement work to ensure that both the 62 day cancer waiting time standard and the 28 day cancer diagnosis standard can be met once introduced in 2020.

The tumours covered in this Operational Framework are:

- Gastric Carcinoma
- Oesophageal Carcinoma

2.0 Referral guidelines and process

2.1 Introduction

Oesophageal and gastric (OG) cancers are some of the rarer cancers. Survival rates remain poor however.

2.2 Referral of patients suspected of having upper GI cancer

The guidelines for urgent referral, in accordance with the National Institute for Health and Care excellence (NICE) recommendations are:

Oesophageal cancer

1.2.1 Offer urgent direct access upper gastrointestinal endoscopy (to be performed within 2 weeks) to assess for oesophageal cancer in people:

- with dysphagia **or**
- aged 55 and over with weight loss **and** any of the following:
    - upper abdominal pain
    - reflux
    - dyspepsia. **[new 2015]**

1.2.2 Consider non-urgent direct access upper gastrointestinal endoscopy to assess for oesophageal cancer in people with haematemesis. **[new 2015]**

1.2.3 Consider non-urgent direct access upper gastrointestinal endoscopy to assess for oesophageal cancer in people aged 55 or over with:

- treatment-resistant dyspepsia **or**
- upper abdominal pain with low haemoglobin levels **or**
- raised platelet count with any of the following:
    - nausea
    - vomiting
    - weight loss
    - reflux
    - dyspepsia
    - upper abdominal pain, **or**
- nausea or vomiting with any of the following:
    - weight loss
    - reflux
    - dyspepsia
    - upper abdominal pain. **[new 2015]**

Stomach cancer

1.2.6 Consider a suspected cancer pathway referral (for an appointment within 2 weeks) for people with an upper abdominal mass consistent with stomach cancer. **[new 2015]**

1.2.7 Offer urgent direct access upper gastrointestinal endoscopy (to be performed within 2 weeks) to assess for stomach cancer in people:

- with dysphagia **or**
- aged 55 and over with weight loss **and** any of the following:
    - upper abdominal pain
    - reflux
    - dyspepsia. **[new 2015]**

1.2.8 Consider non-urgent direct access upper gastrointestinal endoscopy to assess for stomach cancer in people with haematemesis. **[new 2015]**

1.2.9 Consider non-urgent direct access upper gastrointestinal endoscopy to assess for stomach cancer in people aged 55 or over with:

- treatment-resistant dyspepsia **or**
- upper abdominal pain with low haemoglobin levels **or**
- raised platelet count with any of the following:
    - nausea
    - vomiting
    - weight loss
    - reflux
    - dyspepsia
    - upper abdominal pain, **or**
- nausea or vomiting with any of the following:
    - weight loss
    - reflux
    - dyspepsia
    - upper abdominal pain. **[new 2015]**

2.3 Emergency referrals

Patients with OG cancer may present as emergency admissions through ED. Those patients need to be referred to the upper GI MDT meetings and managed accordingly.

In all cases, the expectation is as follows:

- Where possible patients presenting as an emergency, both within and out-of- hours, to non-members of the Upper GI Cancer MDT should have their condition stabilised then be passed to the surgical core members of the Upper GI Cancer MDT for discussion of their further care.

- This should be by the end of the first working day after presentation.

However if further delay would be life threatening then non-core members of the Upper GI Cancer MDT should proceed to the treatment that is required to ensure the patient's safety

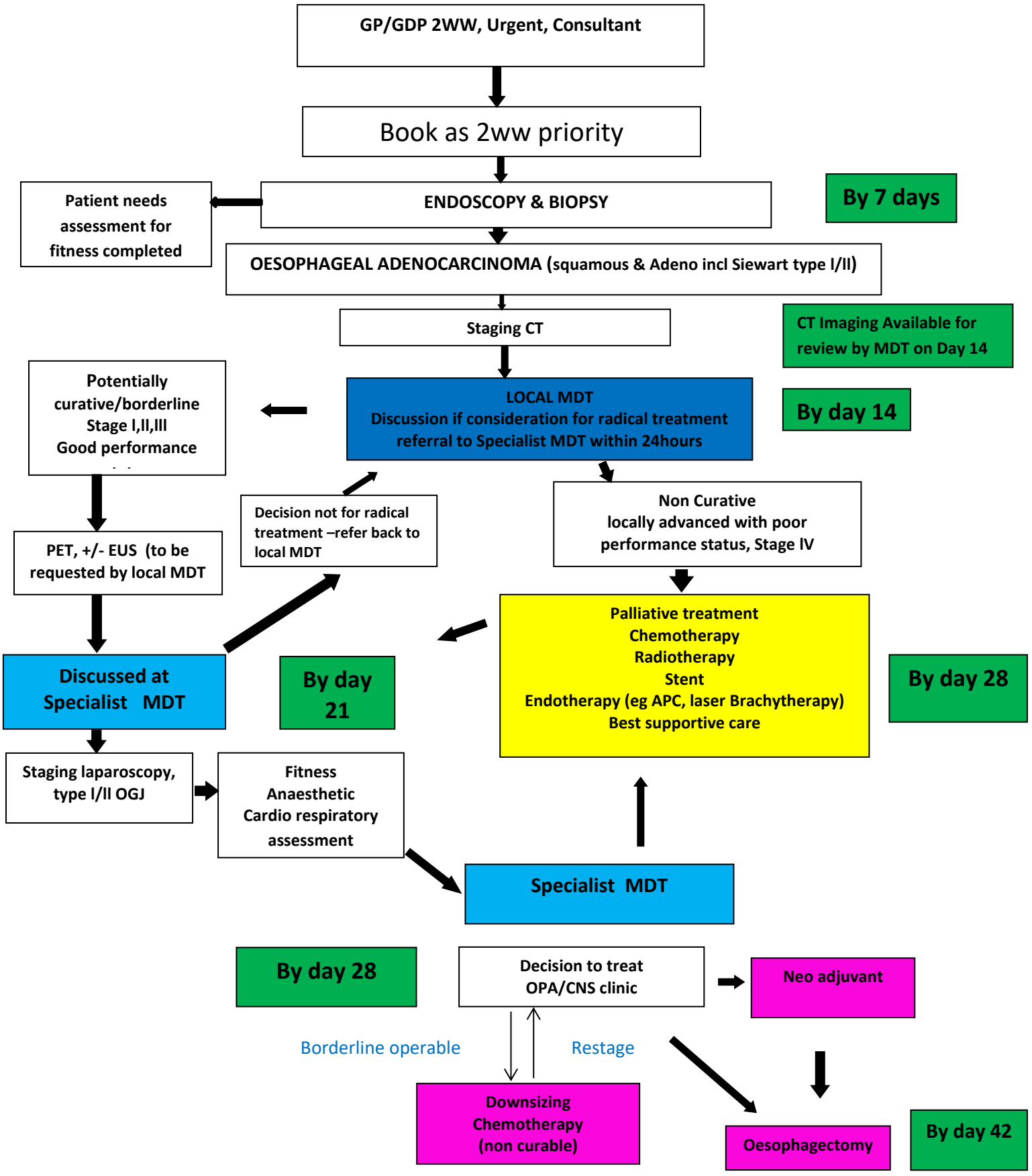
The responsibility for referral to the Upper GI Cancer MDT core member rests with the receiving surgeon

The methods of contact are compliant with the policy of the individual Trusts and include:

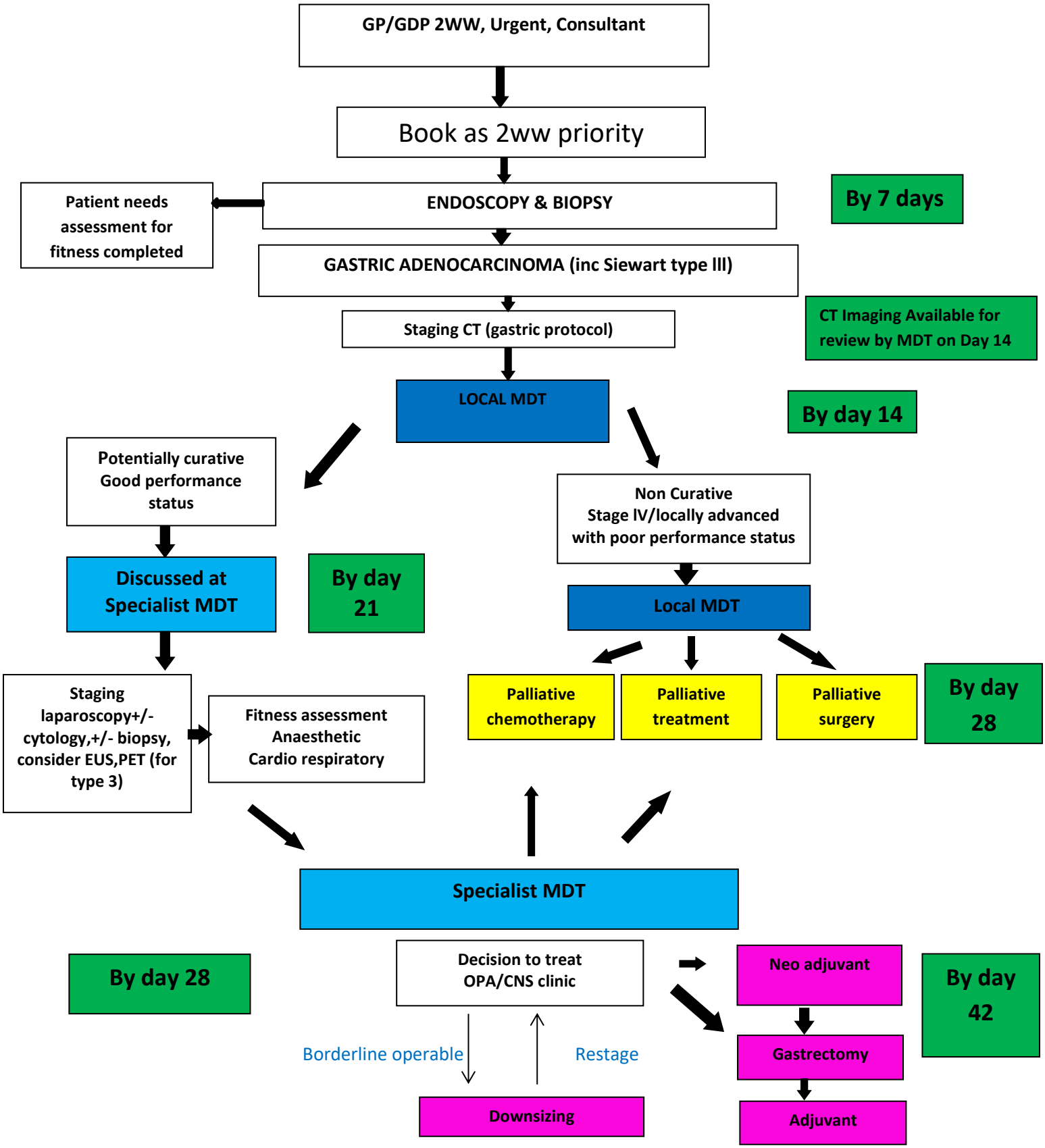
- Direct by telephone to consultant or PA
- By fax with clearly marked priority
- Person to person contact

3.0 Upper GI Pathways

Ideal Management Pathway for Oesophageal Carcinoma (exc EOC/HGD)



Ideal Management Pathway for Gastric Carcinoma (exc EGC/HGD)



West Midlands Expert Advisory Group UGI: Oesophageal Carcinoma Pathway June 2016. Please note: Timings are currently aspirational and seek to define activities necessary to achieve the planned new 2020 NHS cancer targets

REFERENCES:

NICE GUIDELINES Suspected cancer: recognition and referral
NICE guideline [NG12] Published date: June 2015 Last updated: July 2017