BUT FIRST A MESSAGE FROM THE PRESIDENT

The Ovarian Cancer Audit Feasibility Pilot

In partnership with:

National Cancer Registration and Analysis Service

What is the ovarian cancer audit feasibility pilot?

- The UK government funds clinical audits in other diseases and conditions mapping care pathways, surgery and survival and addressing regional variation. Currently there are clinical audits for cancers including lung, bowel, breast (in women over 70) and oesophago-gastric.
- The ovarian cancer pilot will explore a new approach to clinical audits. Rather than collecting new data, it will make use of data that is collected by gynae-oncology teams across the country right now, and collated, maintained and quality assured by NCRAS.

What is the pilot aiming to achieve?

- The jointly-funded ovarian cancer audit feasibility pilot in England will prepare the ground for a crucial full-scale clinical audit in ovarian cancer, which has not been seen before.
- If successful it is hoped the ovarian cancer audit feasibility pilot results in a regular audit of ovarian cancer to drive improvements in clinical practice as well as providing a model that can be rolled out across other cancers.
- While the pilot is England only, the long-term aspiration is to see audits take place across all four UK nations.

What will the pilot tell us?

- Some things we already know but the pilot will provide us with data at Cancer Alliance and provider level – incidence, mortality, stage, survival and routes to diagnosis data.
- Some new things – outcome by treatment type (eg surgery followed by chemo, just chemo etc), short term mortality, residual disease (what's left post surgery), performance status (is a woman well enough to undergo treatment), outcomes for older women and centre outcomes according to caseload.

How long will it run for?

- The project will run until autumn 2020.
- There will be individual reports on specific data items along the way.
- A final report will pull all the findings together into one place.

A note of caution:

- In some places the data might not be good enough to report on.

How will the findings be shared?

- National Cancer Registration and Analysis Service website (ncin.org.uk). This will publish data at Cancer Alliance level.
- CancerStats – this is a website only the NHS can access. This is where data at provider (hospital) level will be shared. Because this data risks identifying individuals, it cannot be shared publicly.

What the pilot won't tell us

- It won't tell us anything about primary care. This is because data in primary care is collected separately and the only way to link primary and secondary care data is manually.
- We can't map women's pathways, ie track them through treatment. This is because numbers are too low.

Non-operated patients and the patient denominator

Andrew Phillips

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1.4.1.1 If performing surgery for women with ovarian cancer, whether before chemotherapy or after neoadjuvant chemotherapy, the objective should be complete resection of all macroscopic disease.

Is there a “Standard” therapy for Advanced Ovarian Cancer (AOC)?

NICE

In advanced epithelial ovarian cancer, the aim is complete cytoreduction of all macroscopic visible disease, since this has been shown to be associated with a significantly increased OS and PFS [23–25].

Is there a “Standard” therapy for Advanced Ovarian Cancer (AOC)?

ESMO

A

Complete resection of all visible disease is the goal of surgical management. Voluntary use of incomplete surgery (upfront or interval) is discouraged.

Is there a “Standard” therapy for Advanced Ovarian Cancer (AOC)?

ESGO

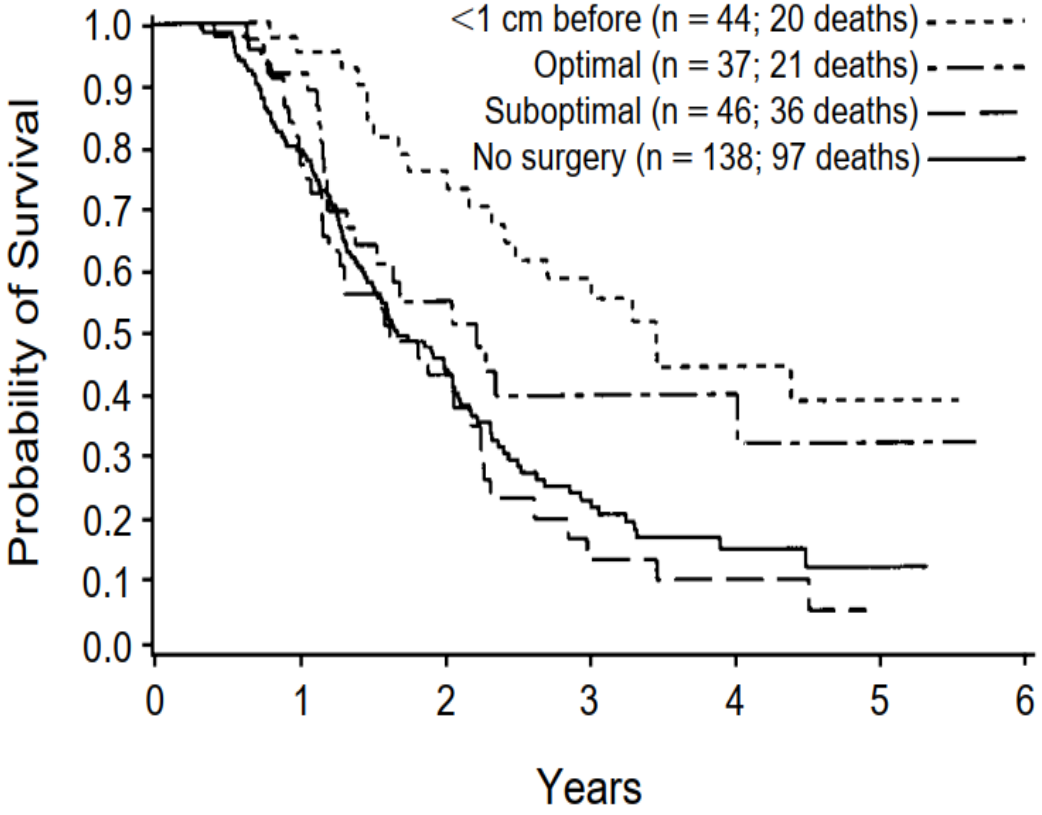
For the majority of women with epithelial ovarian cancer standard therapy consists of a combination of surgery and chemotherapy. Survival is dependent on the stage of cancer at initial presentation *(see Annex 2)*.

Is there a “Standard” therapy for Advanced Ovarian Cancer (AOC)?

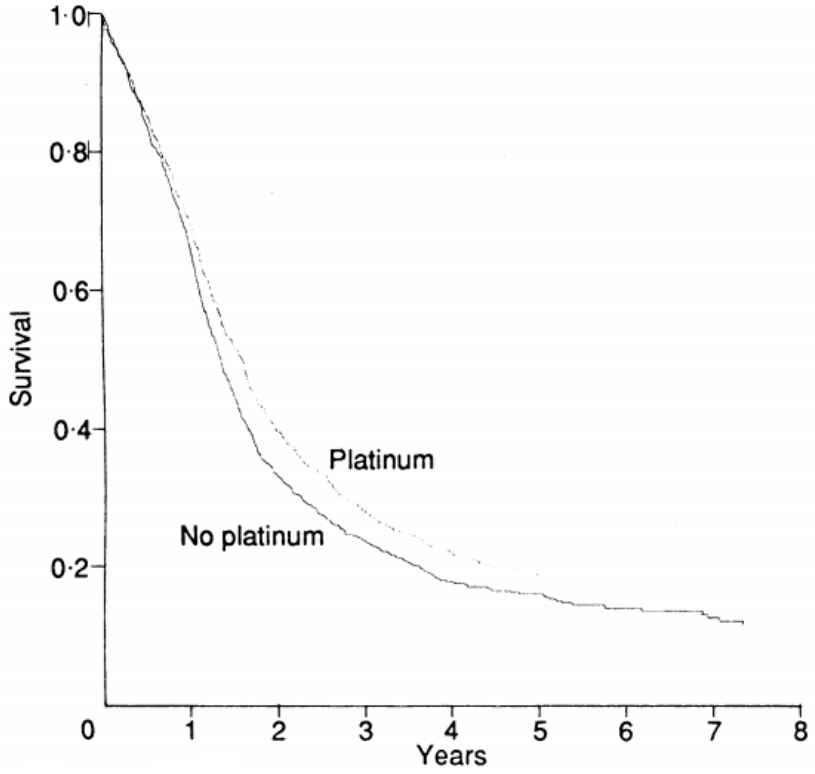
SIGN

What is “Standard” therapy for Advanced Ovarian Cancer (AOC)?

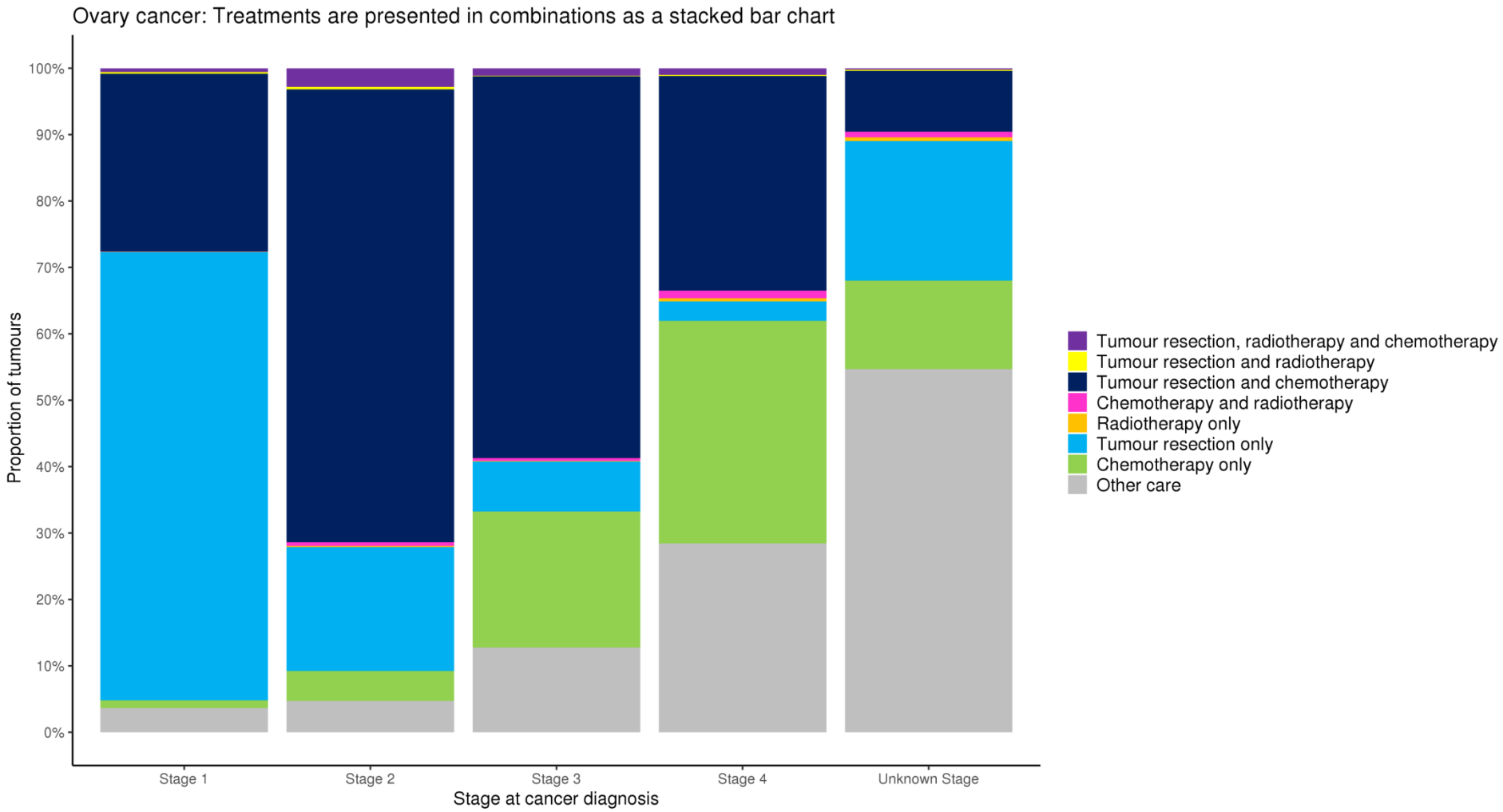
Cytoreductive surgery



Platinum based chemotherapy

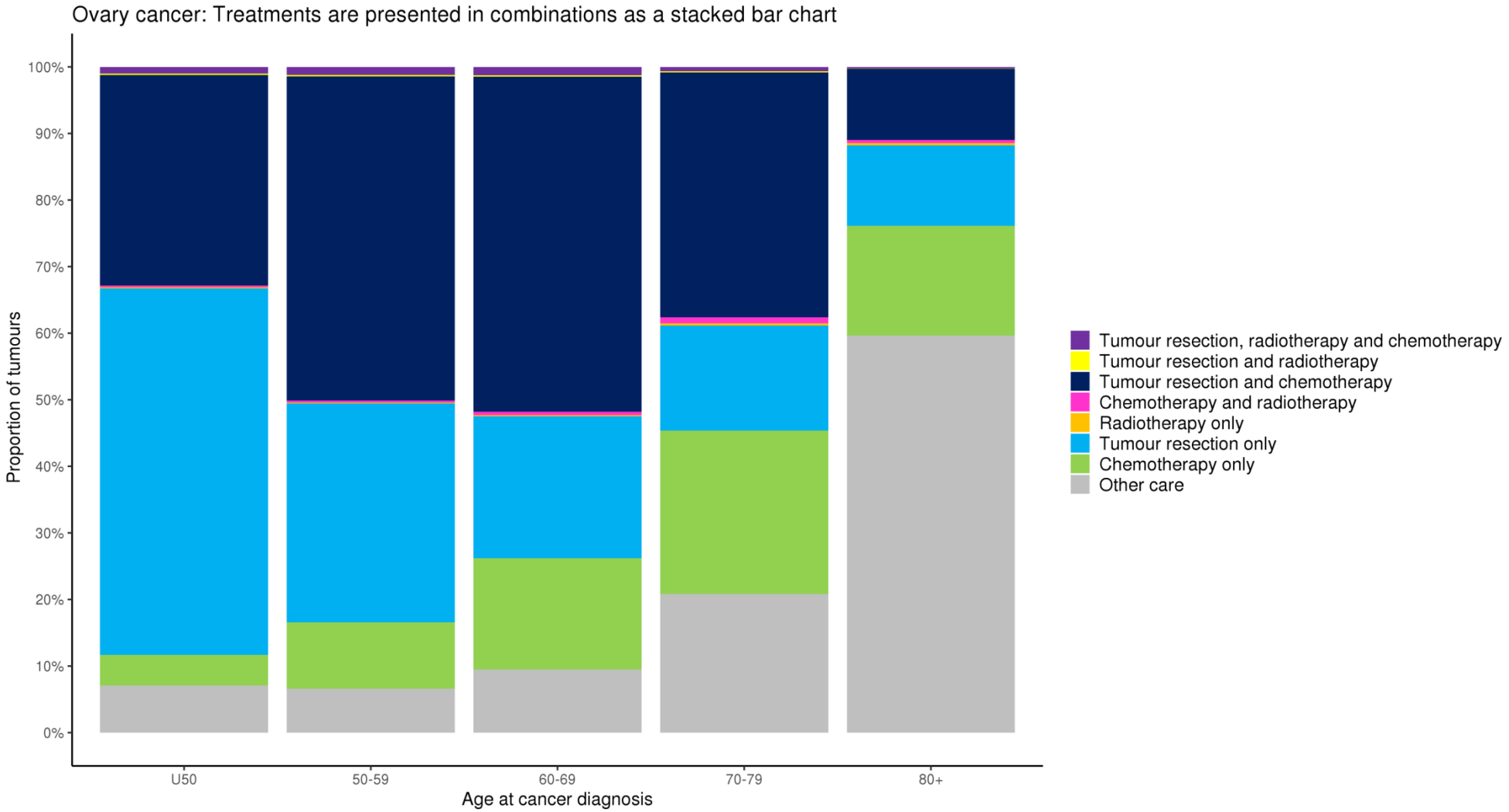


Treatment break down 2013-2015 by stage



This work has been produced as part of the Cancer Research UK - Public Health England Partnership

Treatment break down 2013-2015 by Age



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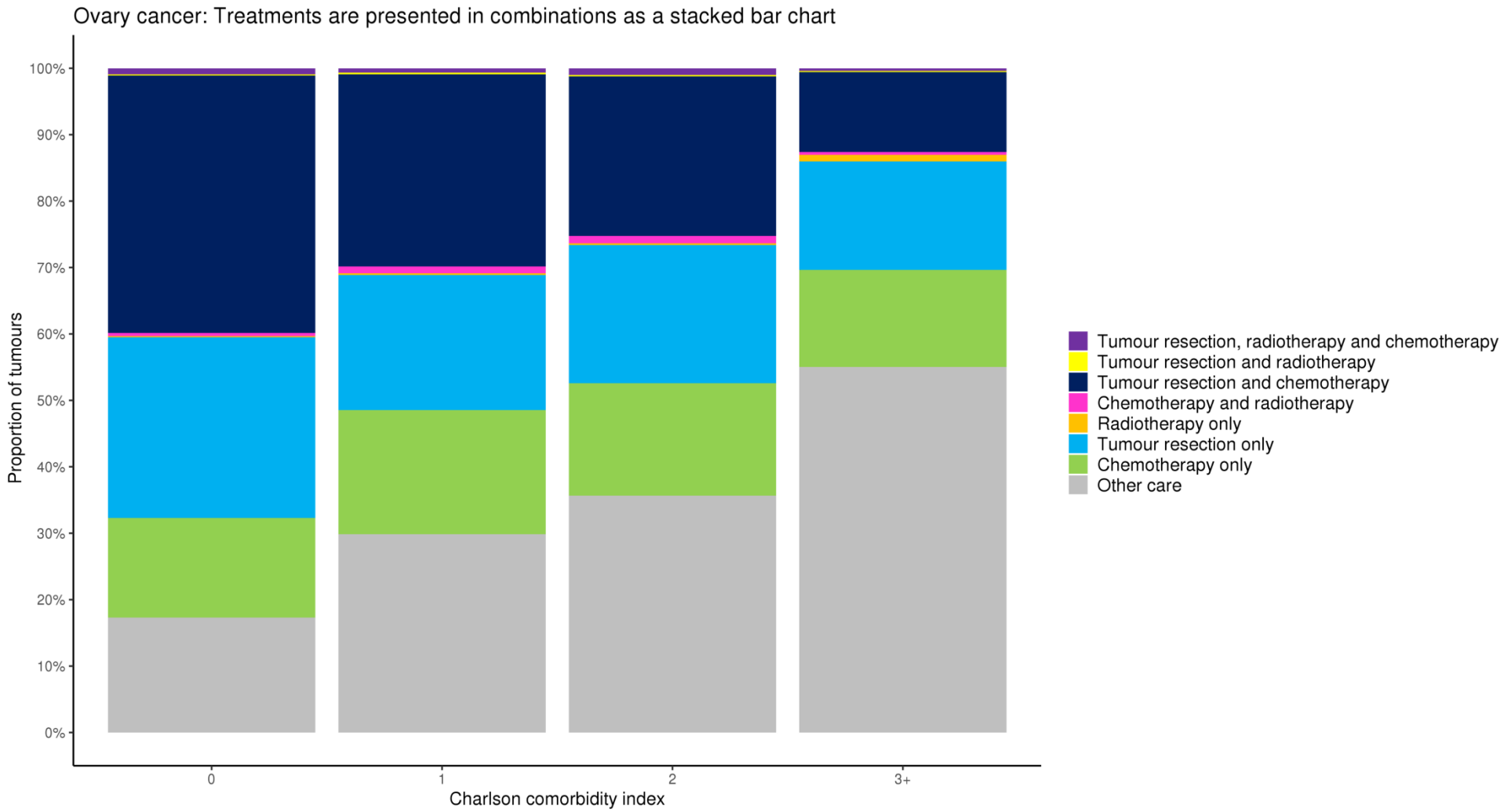
Treatment break down 2013-2015 by CCI



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Non surgically operated patients the derby experience.

6th January 2003 – 10th August 2018

647 patients diagnosed

242 – No surgical treatment

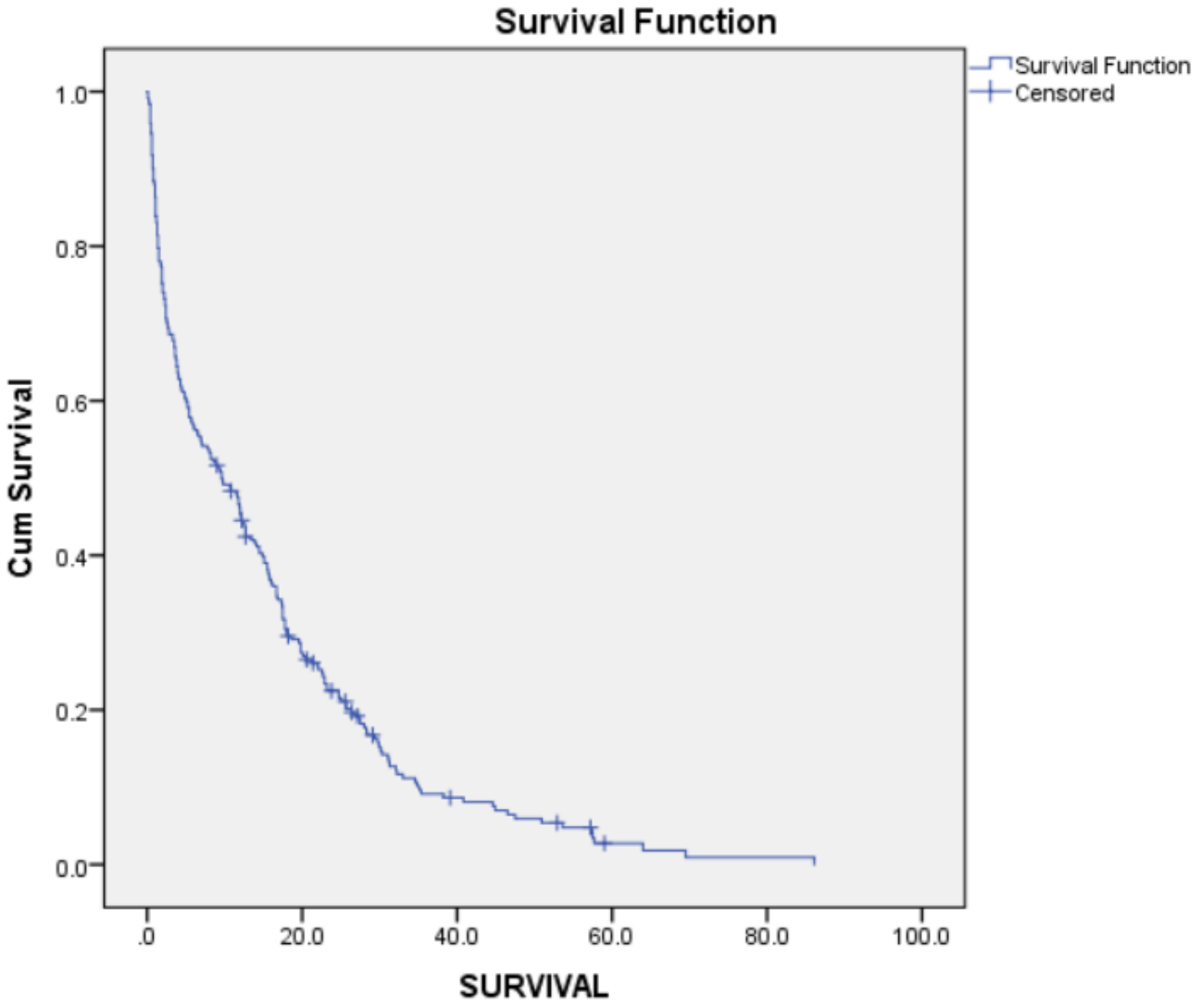
(10 exclusions – under NACT, transferred to other centres etc)

NON-OPERATED SURVIAL

- 30 day mortality = 33 (14%)
- 90 day mortality = 76 (31%)

- Median OS = 9.6 months

- 1 year survival 45%
- 2 year survival 22%
- 3 year survival 9%
- 4 year survival 6%
- 5 year survival 2%



Questions

"Its only because they are old"

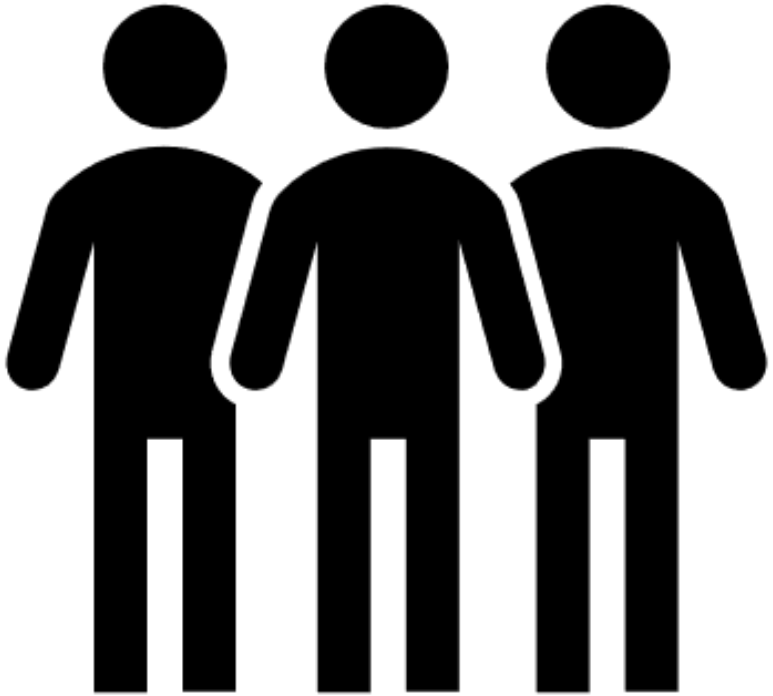
- Age <59: Median OS 15.6 months
- Age 60-69: Median OS 12.6 months
- Age 70-79 Median OS 12.1 months
- Age >80 Median OS 3.9 months

"The patients that die within the first 90 days bring down the survival"

- Median OS of all non-surgical patients living >90 days = 16.8 months

16th August 2017 – 15th August 2018

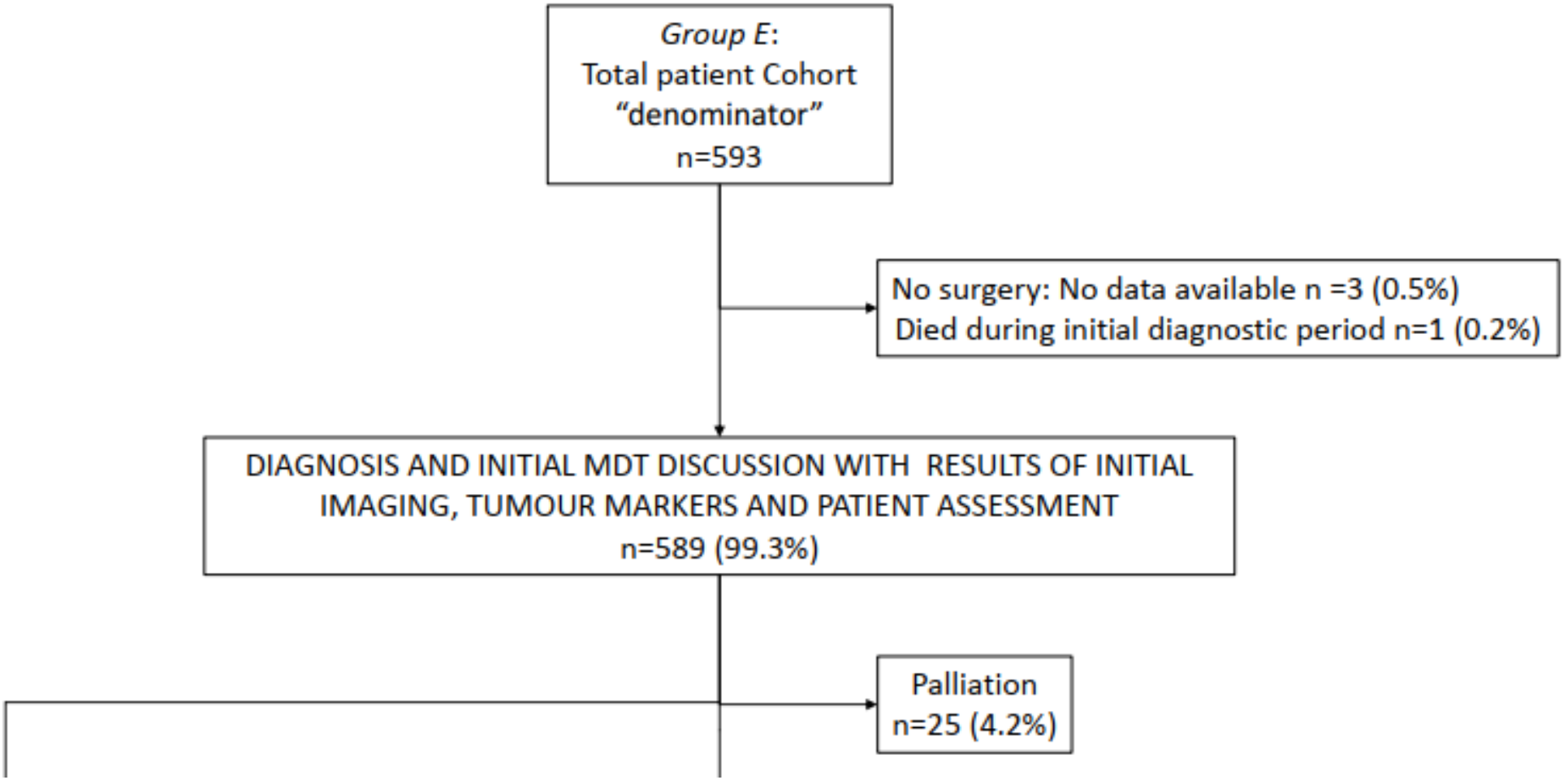
- 58 patients
- 14 PDS
- 1 left UK
- 2 died prior to starting NACT.
- 2 not fit for NACT
- 2 died during NACT
- 3 unable to tolerate NACT
- 3 progressed on NACT
- 4 fit for but declined surgery
- 8 unfit for required surgery
- 1 Awaiting IDS
- 2 under NACT
- 16 IDS

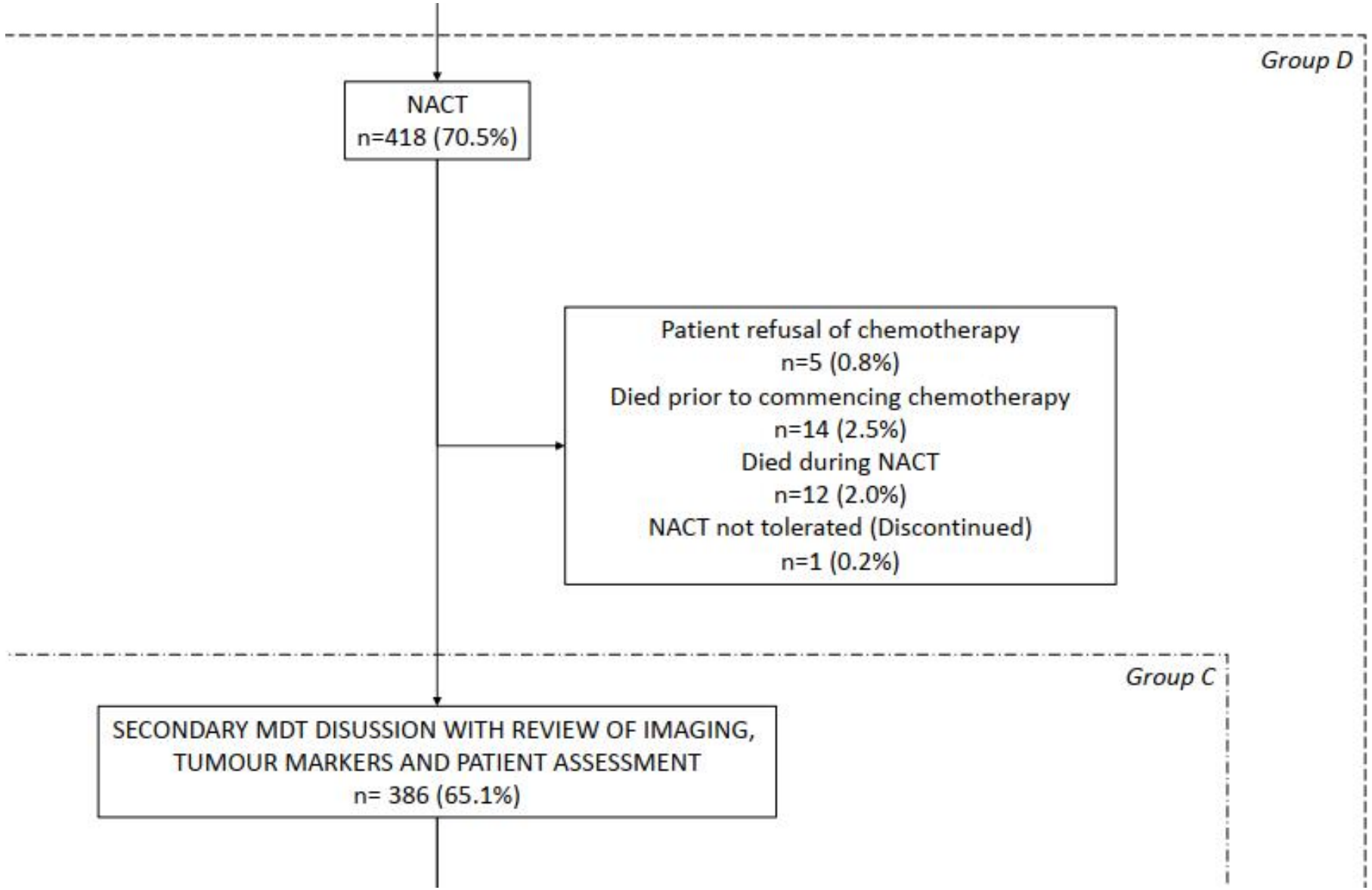


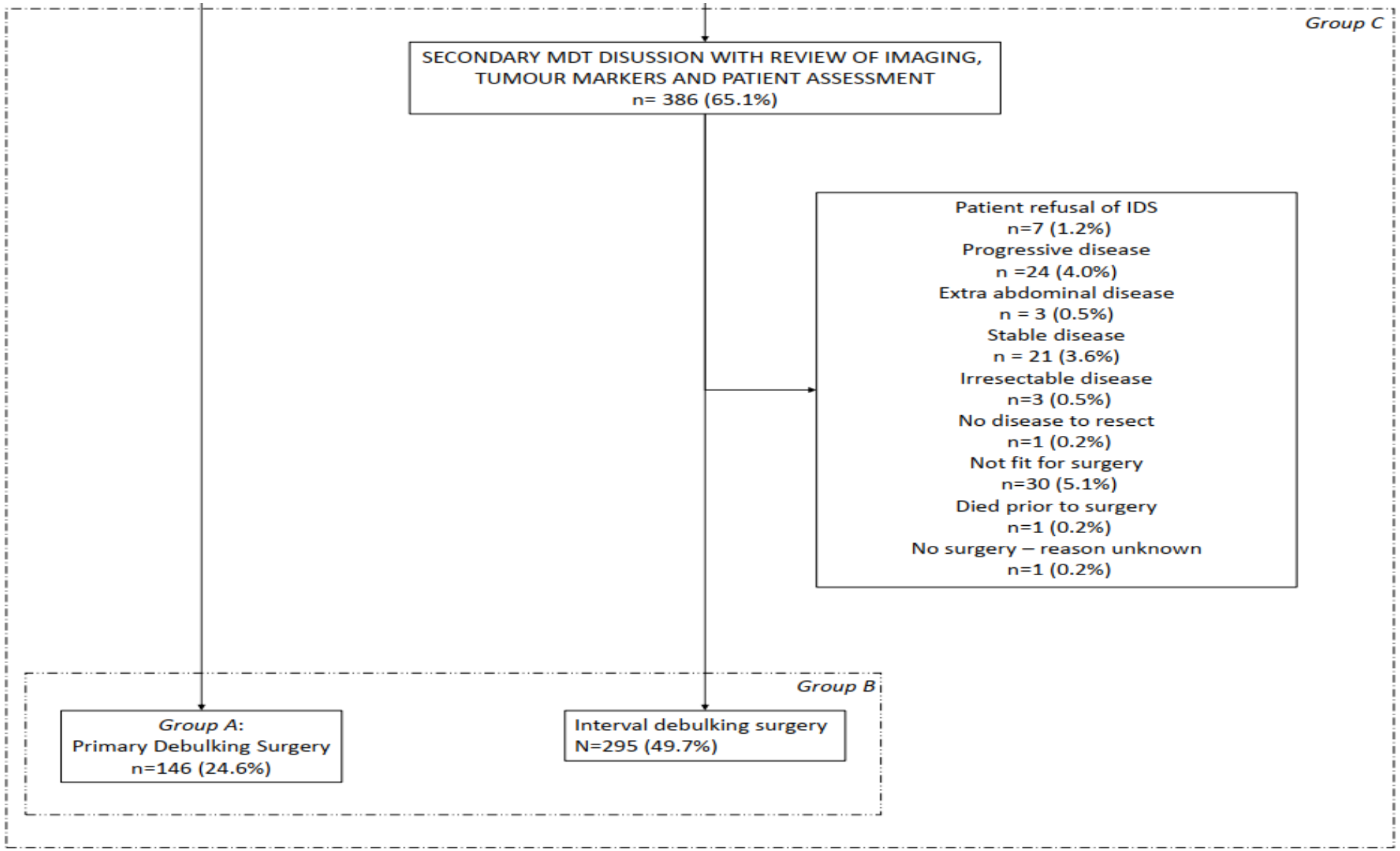
Denominator

All patients managed in a center.

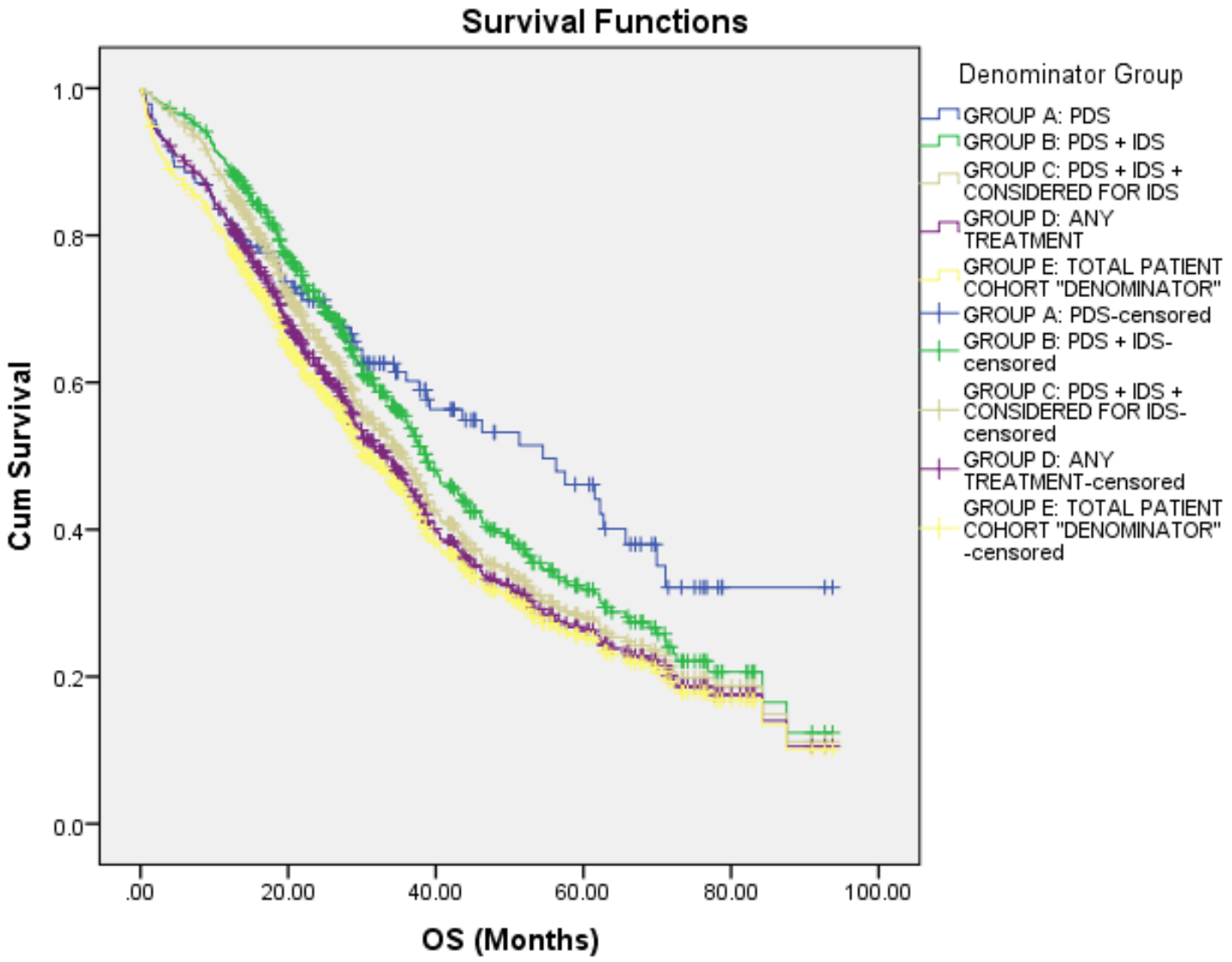
Non-operated + Operated patients.


Group E:
Total patient Cohort
"denominator"
n=593
No surgery: No data available n =3 (0.5%)
Died during initial diagnostic period n=1 (0.2%)
DIAGNOSIS AND INITIAL MDT DISCUSSION WITH RESULTS OF INITIAL IMAGING, TUMOUR MARKERS AND PATIENT ASSESSMENT
n=589 (99.3%)
Palliation
n=25 (4.2%)


Group D
NACT
n=418 (70.5%)
Patient refusal of chemotherapy
n=5 (0.8%)
Died prior to commencing chemotherapy
n=14 (2.5%)
Died during NACT
n=12 (2.0%)
NACT not tolerated (Discontinued)
n=1 (0.2%)
Group C
SECONDARY MDT DISUSSION WITH REVIEW OF IMAGING,
TUMOUR MARKERS AND PATIENT ASSESSMENT
n= 386 (65.1%)


Group C
SECONDARY MDT DISUSSION WITH REVIEW OF IMAGING, TUMOUR MARKERS AND PATIENT ASSESSMENT
n= 386 (65.1%)
Patient refusal of IDS
n=7 (1.2%)
Progressive disease
n =24 (4.0%)
Extra abdominal disease
n = 3 (0.5%)
Stable disease
n = 21 (3.6%)
Irresectable disease
n=3 (0.5%)
No disease to resect
n=1 (0.2%)
Not fit for surgery
n=30 (5.1%)
Died prior to surgery
n=1 (0.2%)
No surgery – reason unknown
n=1 (0.2%)
Group B
Group A:
Primary Debulking Surgery
n=146 (24.6%)
Interval debulking surgery
N=295 (49.7%)

Group A	PDS
Group B	Group A + IDS
Group C	Group B + patients considered for IDS (but did not get it)
Group D	Group C + patients treated with chemotherapy alone
Group E	The total patient cohort ‘denominator’ and represented all patients seen at the PBGCC


Survival Functions
Cum Survival
1.0
0.8
0.6
0.4
0.2
0.0
.00
20.00
40.00
60.00
80.00
100.00
OS (Months)
Denominator Group
GROUP A: PDS
GROUP B: PDS + IDS
GROUP C: PDS + IDS + CONSIDERED FOR IDS
GROUP D: ANY TREATMENT
GROUP E: TOTAL PATIENT COHORT "DENOMINATOR"
GROUP A: PDS-censored
GROUP B: PDS + IDS-censored
GROUP C: PDS + IDS + CONSIDERED FOR IDS-censored
GROUP D: ANY TREATMENT-censored
GROUP E: TOTAL PATIENT COHORT "DENOMINATOR" -censored

ESGO quality standards

SPECIFICATIONS	i) Complete resection rate: • *Numerator*: number of patients with advanced ovarian cancer undergoing complete surgical resection. • *Denominator*: all patients with advanced ovarian cancer referred to the center. ii) Proportion of patients who are operated upfront : • *Numerator*: patients who are offered upfront surgery. • *Denominator*: all patients not previously treated.
TARGETS	i) Complete resection rate: • *Optimal target*: > 65%. • *Minimum required target:*> 50%. ii) Proportion of p rimary debulking surgeries: ≥50%

Conclusions

The prognosis for patients not undergoing surgery is poor.

Patients fail to obtain standard therapy due to a mixture of adverse events, tumour factors and consent/expectation issues.

Many of these are modifiable!

The non-operated patient population is a significant contributor to the overall patient denominator.

Survival data without the overall denominator data should be treated with suspicion.

ANY QUESTIONS