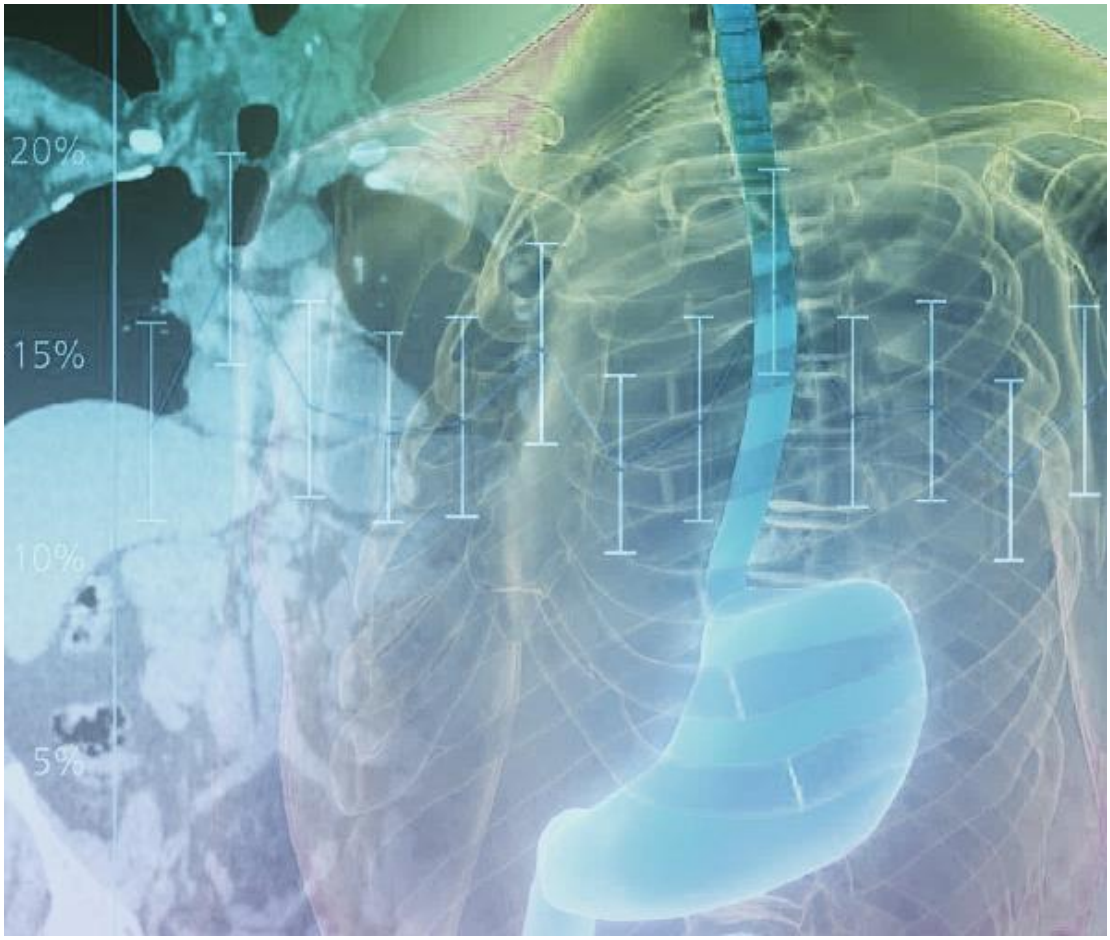
National Oesophago-Gastric Cancer Audit 2021

Report for public and patients



April 2022

Contents

Introduction

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

The audit provides information that enables 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.

In December 2021, the audit published its 13th annual report. It is available at: www.nogca.org.uk/reports/2021-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.

COVID-19 and OG cancer care

The 2021 annual report focuses on patients diagnosed with OG cancer or oesophageal HGD between April 2018 and March 2020, the majority of whom received or started their treatment before the COVID-19 pandemic began in early 2020.

The impact of the pandemic on cancer care in England can be viewed on the National Cancer Registration and Analysis Service (NCRAS) CancerData website: www.cancerdata.nhs.uk/covid-19/rcrd. The NCRAS Covid-19 dashboard enables users to view changes in OG cancer incidence, and treatment activity (including time to treatment) for chemotherapy, radiotherapy and surgery. This information can be viewed by patient characteristics (such as age, sex, ethnicity and deprivation) and for specific geographical regions.

Oesophago-gastric cancer

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.

Signs and symptoms of OG cancer

Symptoms of **oesophageal cancer** can include:

Symptoms of **stomach cancer** can include:

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.

OG cancer is more common at older ages but can occur at any age, and a number of other factors can increase the risk.

For example, smoking, obesity and alcohol have been identified as contributing to the risk of oesophageal cancer. Reflux (often called heartburn, when stomach acid escapes from the stomach into the oesophagus) is also a risk factor. Persistent reflux (heartburn) can lead to a condition known as Barrett's oesophagus, a long-standing change in the lining of the oesophagus. Barrett's can increase the risk of oesophageal cancer, although most people with heartburn or Barrett's will not go on to develop oesophageal cancer.

Infections (notably *Helicobacter pylori* infection) and smoking are significant contributors to stomach cancer risk. Over the last 25 years, the number of cases of stomach cancer has declined as *Helicobacter pylori* infections have become less common.

Information about OG cancer incidence in England (nationally and by region) can be viewed on the National Cancer Registration and Analysis Service (NCRAS) CancerData website: www.cancerdata.nhs.uk/incidence_and_mortality

The audit received information on 20,319 patients in England and Wales who were diagnosed with OG cancer between April 2018 and March 2020.

The average age of patients was 72 years, and 70% were men.

Oesophageal cancer (cancers in the oesophagus or gastro-oesophageal junction) accounted for 72% of OG cancers, while stomach cancer accounted for 28%.

Annual Report Page 21

How is OG cancer diagnosed?

OG cancer is diagnosed using a procedure called endoscopy, or sometimes referred to as gastroscopy. During an endoscopy, a tube with a camera at the end is placed down into the patient's oesophagus or stomach. Instruments are inserted through the tube, enabling small pieces of tissue from the oesophagus to be removed, which is called a biopsy.

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, which means that offering curative treatment can be more challenging than for patients diagnosed after a GP referral with early symptoms.

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

Overall, 65% of patients in the audit were diagnosed following a GP referral, and 13% were diagnosed after an emergency admission.

For oesophageal cancer, 10% of patients were diagnosed following an emergency admission, compared to 19% of patients with stomach cancer.

Annual Report Page 22

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).

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 spread to other parts of the body.

The majority (93%) of patients in the audit had an initial CT scan. This figure has increased from 86% in 2012.

Annual Report Page 24

What treatments are available for OG cancer?

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

Curative treatment

If the cancer is at an early stage, the main treatment option is surgery to remove the affected part of the oesophagus or stomach.

Certain types of oesophageal cancer may be suitable for treatment with chemoradiotherapy or radiotherapy (without surgery).

For very early stage cancers, it may be possible to remove just the abnormal areas in the lining of the oesophagus or stomach using an endoscopy (tube) 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.

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.

Palliative treatment

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).

Overall, 39% 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 70 years with less advanced cancer (stages 0 to 2), over three-quarters had a curative treatment plan.

Among patients who were not suitable for curative treatments, 71% had an initial plan for palliative chemotherapy or radiotherapy.

Annual Report Page 26-28

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 referral.

More information about cancer waiting times standards can be found on the websites for NHS England: www.england.nhs.uk/statistics/statistical-work-areas/cancer-waiting-times/

and NHS Wales: https://gov.wales/nhs-cancer-waiting-times-april-2005-onwards

For patients undergoing curative surgery, chemotherapy or radiotherapy, the time from OG cancer diagnosis to the start of treatment was typically two months.

However, waiting times were long for many patients, with 53% waiting more than 62 days from urgent referral to first curative treatment. Average waiting times have not improved over the last five years.

Annual Report Pages 29-31

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 37 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 11 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. It is estimated that 60% of these patients survive for three years or more after surgery.

The length of stay in hospital was typically 11 days for patients who had an oesophagectomy, and 9 days for patients who had a gastrectomy.

Postoperative survival and length of hospital stay have improved significantly over the last 10 years.

Two thirds of patients having curative surgery were placed on an 'enhanced recovery after surgery' (ERAS) protocol. ERAS protocols are care pathways designed to help early recovery after surgery and typically include preoperative counselling, nutrition support and early mobilisation after surgery. The proportion of patients on an ERAS pathway has increased since the audit began collecting data about the use of ERAS protocols in 2016, when only half of surgical patients followed an ERAS pathway.

Among patients who did not experience surgical complications, ERAS protocols were associated with a 1.2 day reduction in average length of hospital stay.

Annual Report Chapter 9

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 605 patients diagnosed with HGD of the oesophagus between April 2018 and March 2020 in England.

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

Annual Report Page 13

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, an endoscope (tube) 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).

88% of patients in the audit had their initial diagnosis of HGD confirmed by a second pathologist.

Annual Report Page 13

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.

93% of patients in the audit were discussed by a multidisciplinary team.

Annual Report Page 14

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).

74% of patients in the audit had a plan for endoscopic treatment.

Annual Report Pages 15-16

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, HGD cells will be present at the edges of the removed section (positive margins), and patients may need further treatment to ensure complete removal of the abnormal tissue.

In the audit, 14% of endoscopic resections had positive deep margins. The majority of patients with this outcome had a plan for further endoscopic treatment.

Annual Report Pages 16-17

OG cancer specialist surgical centres

Name (in alphabetical order)
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 and 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
Liverpool University Hospitals NHS Foundation Trust
Mid and South Essex NHS Foundation Trust
Norfolk and Norwich University Hospitals NHS Foundation Trust
Nottingham University Hospitals NHS Trust
Oxford University Hospitals NHS Foundation Trust
Portsmouth 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 and Weston 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?

For more information about the audit and its findings:

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

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
Heartburn Cancer UK	www.heartburncanceruk.org/
Action Against Heartburn	www.actionagainstheartburn.org.uk/
Oxfordshire Oesophageal and Stomach Organisation	https://ooso.org.uk/
Maggie's	www.maggiescentres.org
Guts UK	https://gutscharity.org.uk/

OG cancer statistics for Scotland and Northern Ireland:

- Public Health Scotland: https://beta.isdscotland.org/find-publications-and-data/conditions-and-diseases/cancer
- Northern Ireland Cancer Registry: https://www.qub.ac.uk/research-centres/nicr/CancerInformation/official-statistics/BySite

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Prepared in partnership with:

HQIP Healthcare Quality Improvement Partnership	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. Registered charity Number: 1127049
Royal College of Surgeons ADVANCING SURGICAL CARE	The Royal College of Surgeons 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
AUGIS ASSOCIATION OF UPPER GASTROINTESTINAL SURGERY OF GREAT BRITAIN AND IRELAND	The Association of Upper Gastrointestinal Surgery of Great Britain and Ireland is the speciality society that represents upper gastrointestinal surgeons. It is one of the key partners leading the audit. Charity number: 1093090
bsg BRITISH SOCIETY OF GASTROENTEROLOGY	The British Society of Gastroenterology is the speciality society of gastroenterologists. It is one of the key partners leading the audit. Charity number: 1149074
RCR The Royal College of Radiologists	The Royal College of Radiologists is the professional body for clinical radiologists and clinical oncologists. It is one of the key partners leading the audit. Charity number: 211540
NHS Digital	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.
OPA The Oesophageal Patients Association Caring for the cancer patient & their family; HEARTBURN CANCER UK; ACTION AGAINST HEARTBURN; OCSO Oxfordshire Oesophageal and Stomach Organisation Registered Charity No: 1152733; GUTS UK!	