

Recurrent and metastatic breast
cancer pilot project.

Why is it important to clinicians?

NCIN Breast Cancer Workshop
Murray Brunt, 19 March 2012

Why is it important to clinicians?

- ✓ It has to be important to clinicians to succeed
- ✓ Data in isolation is not enough
- ✓ So,
 - ✓ It has to provide benefit in the care of patients with (or suspected) recurrent or metastatic breast cancer.
- ✓ IT DOES!

From the Pilot Study

- “Feedback from MDTs indicates that the pilot has stimulated interest in how these patients are managed.”
- The NICE Quality standard for breast cancer (National Institute for Health and Clinical Excellence: August 2011) states that *‘People who develop local recurrence, regional recurrence and/or distant metastatic disease have their treatment and care discussed by the multidisciplinary team’*

From the Pilot Study

- The NICE Quality standard for breast cancer includes a statement that *‘People with recurrent or advanced breast cancer have access to a “key worker”, who is a clinical nurse specialist and whose role is to provide continuity of care and support, offer referral to psychological services if required and liaise with other healthcare professionals, including the GP and specialist palliative care services’*

What is valuable to clinicians?

The MDM

- Change/developing MDM
- Team members aware of EBC to ABC
- Best forum to identify key worker
- Formal forum for management/scan review, not just oncology clinic for example
- Identify trial candidates
- Oh And the data is useful!

Metastatic/Recurrent Breast MDM

- Differing models:
 - Separate MDM
 - Integrated
- Best fit model
- Involve palliative care in MDM
- It requires:
 - Extra time
 - Additional resources

Table 3: Time from original primary breast cancer diagnosis

Year of primary diagnosis	No. in pilot	% in pilot
1970-9	4	1%
1980-9	20	3%
1990-9	88	15%
2000-9	281	47%
2010-	96	16%
unknown	109	18%
All Years	598	100%

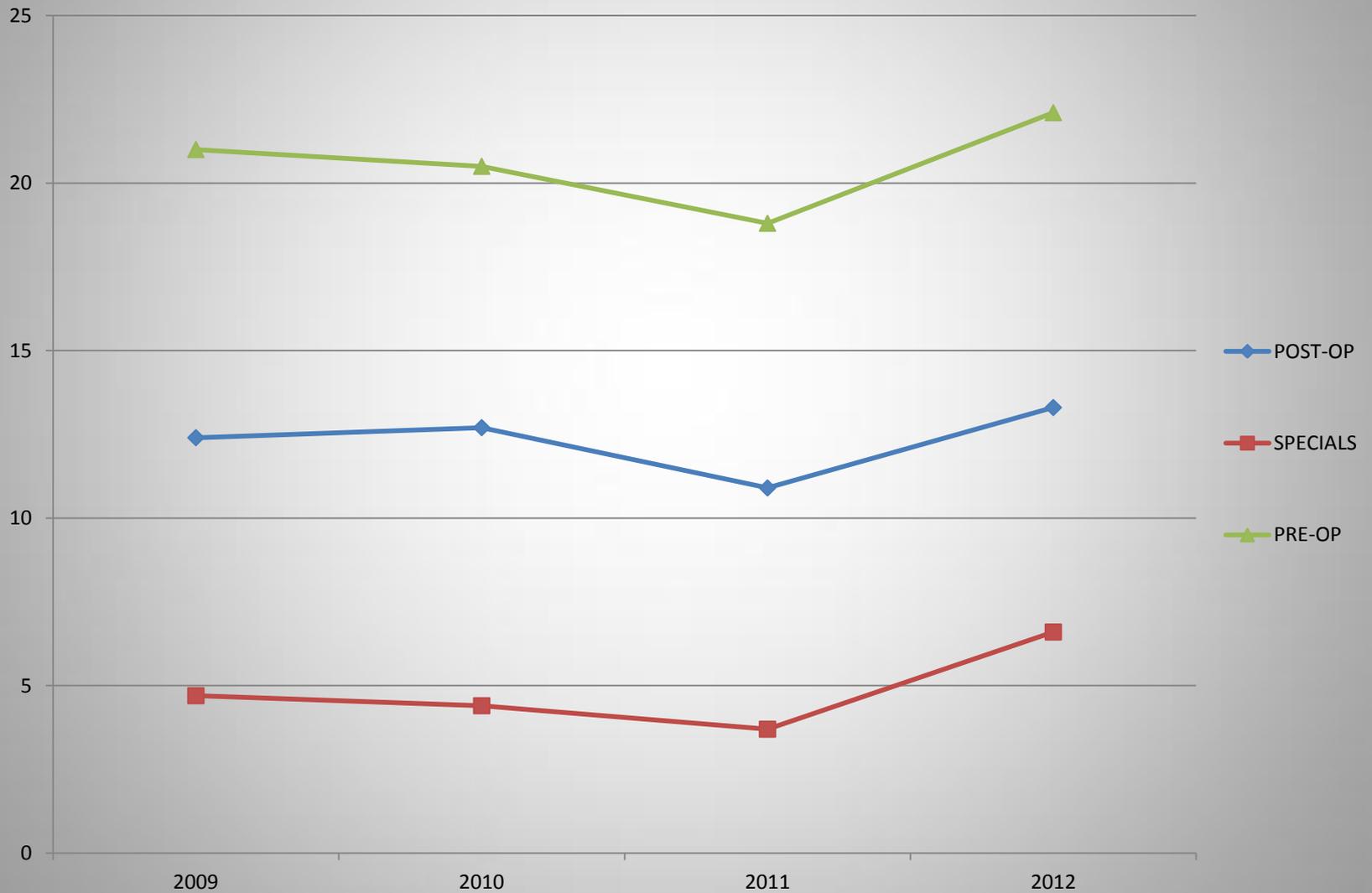
Table 4: Presentation routes

Route of presentation	No. in pilot	% in pilot
Symptomatic 'cancer waiting time' referral	151	25%
Routine clinical follow-up	116	19%
Emergency admission	78	13%
Routine imaging follow-up	72	12%
NHSBSP screening	38	6%
Internal referral from within hospital	38	6%
Other GP referral	21	4%
Other follow-up	16	3%
Referral from other hospital	19	3%
Unknown	16	3%
Other	14	2%
Patient self-referral	12	2%
At diagnosis/treatment of primary tumours	7	1%
Total	598	100%

The MDM

- Various routes into meeting, make this widely known, including referral from one meeting to another
- Patients from as far back as 1970s, so
 - Many discharged
 - Beyond screening age
- Open access to meeting is required
 - ie. access to a multidisciplinary opinion

UHNS Breast MDM Jan/Feb



Specials at MDM

- 2009 majority were review of breast imaging on follow-up/initial episode
- Initial imaging queries now in pre-op section
- 2012 involved oncologists for majority

2012 Specials - Examples

- 49 yrs, upper mantle radiotherapy for Hodgkins aged 24yrs. ?mastectomy.
- 73 yrs, medical ward pleural aspiration, review cytology, breast cancer 14 yrs ago. Referred by lung MDT
- 58yrs, large ER negative primary for consideration of neo-adjuvant chemotherapy

2012 Specials – More Examples

- 65 yrs, back pain surgical clinic, to review MRI scan new bone metastases and plan management
- 69 yrs, Lobular Ca breast 1999, Ca Caecum 2011 with solitary liver metastasis. Review histopath of liver (ER pos) and plan management. Referred lower GI MDT
- 89 yr old extensive fixed regional recurrence routine clinic pick-up, to plan management

For clinicians the pilot will lead to:

- It will require additional input in time and resource
 - MDM time
 - Appropriate management will result in more face-to-face clinician:patient resource
- But it should enhance not only the direct medical care but also the overall care of the patient

Thank you for your
attention