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## **NATIONAL OPTIMAL PATHWAY FOR GASTRIC CANCER:**

**2<sup>nd</sup> EDITION (2023)**

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### **Point of Suspicion to First Definitive Treatment in Adults (aged 16 and over)**

<b>Date of Issue: November 2023</b>
<b>Date of Review: November 2025</b>
<b>Owner: Upper GI Cancer Site Group</b>

# FOREWORD

The NHS Wales National Optimal Pathways (NOPs) have been developed as part of the Suspected Cancer Pathway (SCP) programme of work. They aim to establish consistent generic and site-specific pathways that describe all routes of entry from the point of suspicion (PoS) of cancer. The pathway describes good practice diagnostic and treatment pathways, the diagnostic pathway, including staging, should be performed within 28 days from PoS; and definitive treatment commenced within 21 days from date of Decision to Treat (DTT). The pathways also describes where patients should receive consistent information and support, tailored to meet their needs.

The NOPs aim to provide a platform to standardise care, reduce unwarranted variation and drive improvement whilst increasing quality across each of the cancer pathways to:

- meet the SCP cancer waiting time of 62 days for patients presenting with a suspicion of cancer,
- improve cancer patient experience, and,
- improve cancer patient outcomes throughout Wales to that comparable with the best outcomes in Europe.

The Gastric Cancer NOP is designed to help gastric cancer service providers and their commissioners see the basic structure of an effective and efficient gastric cancer pathway. In essence, this optimal pathway is about ensuring that each stage of the pathway happens quickly, that communications with patients are effective and that the entire team works in a coordinated but flexible way, focusing always on the patient's journey. It is recognised that the introduction of the National Optimal Pathway for Gastric Cancer may present challenges for the multidisciplinary teams. However, introducing a nationally agreed, clinically endorsed pathway will support service improvement. It will also provide clarity and consistency for primary care around the referral process into secondary care, including access to diagnostics, to ensure the patients move through the system in a timely manner.

## GROUP CONSULTATION

The Upper Gastro-Intestinal Cancer (UGI) Site Group (CSG) is led by Dr Carys Morgan. The group includes representation from the full range of professions involved in delivering UGI cancer services. They were all able to contribute and comment on the development of the optimal pathway during a range of pathway workshops, CSG meetings and educational days, commenced in January 2018. An early draft was sent to Multi-Disciplinary (MDTs), Health Boards and Velindre NHS Trust in August 2018. Separate workshops were also held with the Clinical Nurse Specialist (CNS) and Allied Health Professional (AHP) members to embed the Prehabilitation, Rehabilitation and Person-Centred Care (PCC) elements into the pathway, ensuring all patient's needs are assessed and met in a timely manner. Wider consultation was sought in May and June 2019 from NHS Wales's stakeholders, including National Imaging and Pathology Networks and the third sector. 57 responses were received, and these were carefully considered during the revision process, prior to a final version being issued in July 2019.

This edition (2023) of the NOP reflects the changing developments in the treatment of Gastric Cancer since the initial version was first described.

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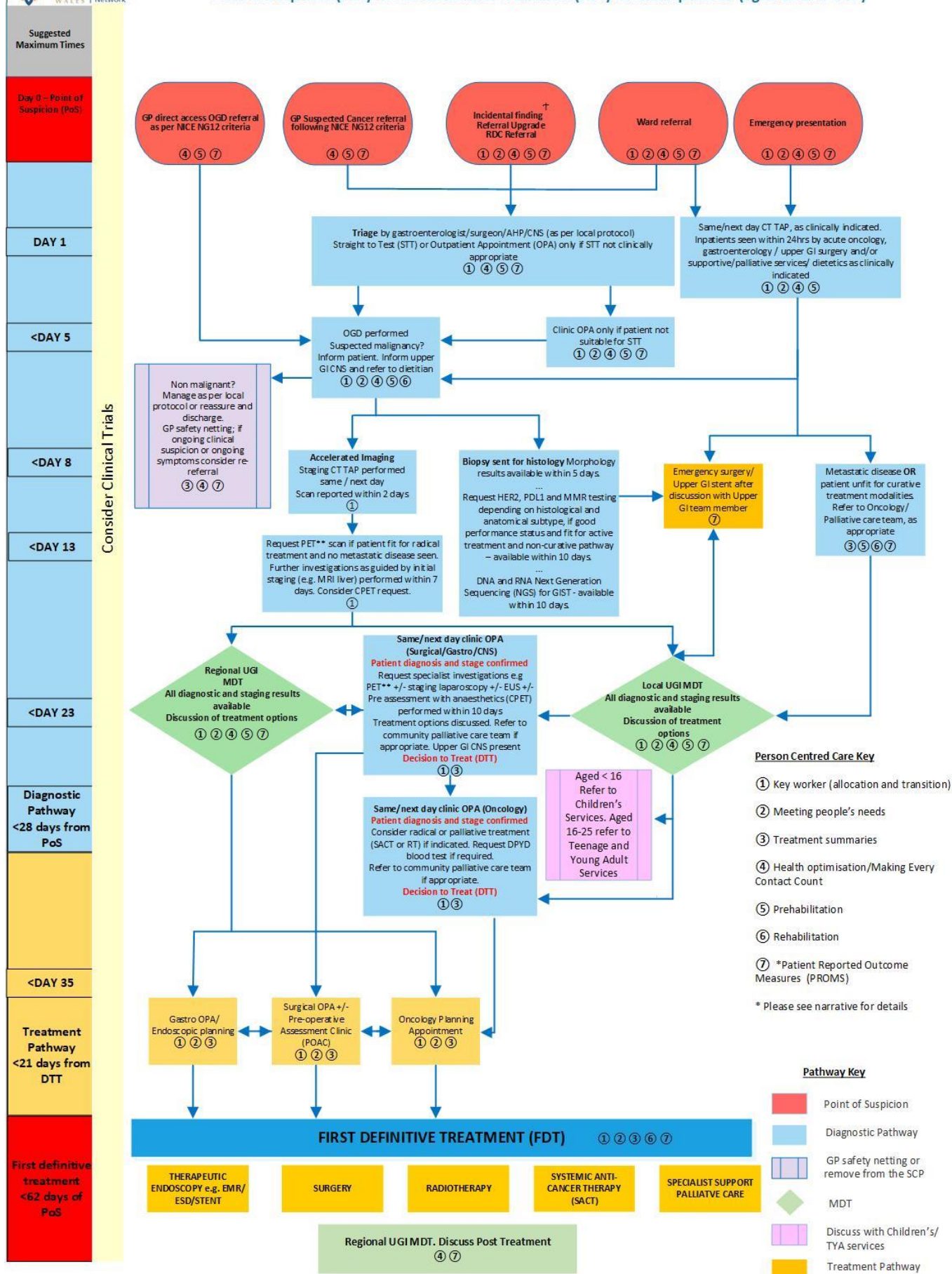
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**Date** 24/11/2023

# National Optimal Cancer Pathway for suspected and confirmed Gastric Cancer: Point of Suspicion (PoS) to First Definitive Treatment (FDT) for adult patients (aged 16 and over)



† Refer to annex 1 PoS (page 21) - <https://www.gov.wales/suspected-cancer-pathway-guidelines-whc202218>

\*\*WHSSC Commissioning Policy: Positron Emission Tomography (PET) - <https://whssc.nhs.wales/commissioning/whssc-policies/all-policy-documents/positron-emission-tomography-pet-commissioning-policy-cp50a-april-2023/>

‡ AWMGS - Cymru Service for Genomic Oncology Diagnoses (CYSGODI) (<https://medicalgenomics.wales.co.uk>)

# BIOMARKER TESTING

Patients with advanced oesophago-gastric/gastric cancers who are of good performance status and deemed to be suitable candidates for active treatment should undergo biomarker testing to guide systemic anticancer treatment selection.

Biomarker testing is performed using immunohistochemistry via cellular pathology laboratories according to histological subtype (squamous cell carcinoma: PDL1 testing; adenocarcinoma: HER2 testing +/- PDL1 testing +/- mismatch repair (MMR) testing). Please see the 'All Wales Biomarker and Lynch syndrome in patients with oesophago-gastric cancer' clinical guidance document for further details: [executive.nhs.uk/networks-and-planning/cancer/wcn-documents/genomics/biomarkers-and-lynch-syndrome-in-patients-with-oesophago-gastric-cancer-clinical-guidance-document/](https://www.executive.nhs.uk/networks-and-planning/cancer/wcn-documents/genomics/biomarkers-and-lynch-syndrome-in-patients-with-oesophago-gastric-cancer-clinical-guidance-document/)

Routine screening for Lynch syndrome in upper GI cancers is not currently recommended. Identification of an MMR deficient (MMRd) tumour does not necessarily mean the patient has Lynch syndrome. However, Lynch syndrome may be incidentally detected during the assessment of MMR status and could allow patient surveillance, risk-reducing interventions and early detection of Lynch syndrome-associated cancers in affected individuals and their family members.

Health board MDTs must have an agreed method for ensuring MMR results are reviewed to identify patients whose results may suggest underlying Lynch Syndrome. If MMRd is identified, MLH1 methylation testing via the All Wales Medical Genomics Service (AWMGS) and/or Clinical Genetics referral is indicated. Please see the 'All Wales Biomarker and Lynch syndrome in patients with oesophago-gastric cancer' clinical guidance document for further details: [executive.nhs.uk/networks-and-planning/cancer/wcn-documents/genomics/biomarkers-and-lynch-syndrome-in-patients-with-oesophago-gastric-cancer-clinical-guidance-document/](https://www.executive.nhs.uk/networks-and-planning/cancer/wcn-documents/genomics/biomarkers-and-lynch-syndrome-in-patients-with-oesophago-gastric-cancer-clinical-guidance-document/)

GI Stromal Tumour (GIST) specimens should be tested with both DNA and RNA Next Generation Sequencing (NGS) if the patient is deemed to be a suitable candidate for active treatment to guide systemic anticancer treatment decision-making. Test request forms are available via AWMGS and should be directed to the pathology laboratory housing the tissue specimen to be tested; request should not be directly sent to AWMGS.

DPYD testing on a blood sample via the AWMGS is indicated prior to commencing 5-FU/capecitabine chemotherapy.

# BEST PRACTICE GUIDANCE

<b>Triage &amp; Vetting</b>	<p>It is recommended that the triage of referrals is undertaken using an electronic system (e.g. Welsh Patient Referral Service) to ensure the timeliness, traceability and governance of pathways.</p> <p>Referrals received as suspected cancer (USC) should be prioritised within 1 day and urgent / routine referrals within 3 days due to the potential need for upgrade to suspected cancer (pathway entry date: date referral originally made by primary care).</p>
<b>Investigation</b>	<p>OGD is the gold standard investigation for people with symptoms of suspected malignancy or iron deficiency anaemia. Barium imaging is a suboptimal test and can miss early abnormalities and may still necessitate OGD if abnormal. Transnasal endoscopy could be considered for people who are unable to tolerate transoral endoscopy as an alternative to GA procedures.</p>
<b>Endoscopy reports</b>	<p>Endoscopy reports should include: anatomical description/site (e.g. Siewert), lesion size, presence/absence of ulceration and adequate photo/video documentation to help inform decision making.</p>
<b>Endoscopic biopsies</b>	<p>Adequate numbers of biopsy samples (minimum of 6 - 8 samples if safe to do so) should be taken if cancer is suspected at OGD to allow for additional biomarker testing to undertaken.</p>
<b>Nutrition and dietetics</b>	<p>Due to the complex nutritional needs of these patients, nutritional assessment and tailored specialist dietetic intervention should be provided early and throughout the pathway to optimise a patient's health and wellbeing and ability to undergo intensive treatment options.</p> <p>In some cases, enteral feeding may be needed while undergoing staging and treatment decisions.</p>
<b>Direct booking diagnostics</b>	<p>It is recommended that patients attending a face-to-face outpatient clinic appointment as their first point of contact can 'direct book' any onward diagnostic tests such as endoscopy on the same day (i.e., leave the hospital with an appointment date and any preparation required for the test).</p>
<b>Accelerated Imaging</b>	<p>It is recommended that following suspected malignant findings at endoscopy, patients should have a staging CT thorax, abdomen, and pelvis (CT TAP) on the same or next day. These scans should be reported within 2 days.</p>
<b>Key worker role</b>	<p>It is recommended that key workers facilitate additional staging radiology (e.g. MRI liver), CPET testing and biomarker testing if indicated to support MDT discussions.</p> <p>It is recommended that the key worker facilitates discussions with the relevant MDT members as timely as possible, without needing to wait until the next MDT meeting.</p>



<b>Physiological optimisation</b>	<p>It is recommended that if diagnostic investigations (endoscopy or radiology) identify a suspected cancer, that teams give thought to patient fitness optimisation to run concurrently with pathological staging investigation. This could include consideration of the need for respiratory or cardiology (e.g. echocardiogram) investigation.</p> <p>Patients should undergo an objective assessment of peri-operative risk to help inform peri-operative care requirements. They should also have access to peri-operative optimisation resources such as nutritional support, smoking cessation advice, exercise prehabilitation and intravenous iron.</p>
<b>Preservation of tissue for genomics</b>	<p>It is recommended that the preservation of tissue for genomic testing is taken into account when preparing the initial biopsy sample. Optimal fixation time for genomics requires the specimen not be in formalin for more than 24 hours. Cutting sections up front, (to reduce waste at the microtome) and/or splitting the material over more than one block may also reduce the amount of waste at the microtome (as well as speeding up subsequent requests). Each Health Board can identify their own practice for this that is suited to local arrangements.</p>

## DEFINITIONS

<b>Decision to Treat</b>	<p>The DATE on which a <b>Decision To Treat</b> is made. For the cancer data sets, the <b>DECISION TO TREAT DATE</b> is the DATE that the consultation between the PATIENT and the clinician took place and a Planned Cancer Treatment was agreed.</p> <p>Source: NHS Data Dictionary</p>
<b>Direct to Test</b>	<p>GPs have direct access to diagnostic endoscopy, ultrasound, MRI, X-ray and CT for people with suspected cancer.</p> <p>Source: <a href="#">National Institute for Health and Care Excellence, Quality Standard 2016 (QS 124)</a></p>
<b>First Definitive Treatment</b>	<p><b>First Definitive Treatment</b> is the <b>first</b> CLINICAL INTERVENTION intended to manage a PATIENT's disease, condition or injury and avoid further CLINICAL INTERVENTIONS. What constitutes <b>First Definitive Treatment</b> is a matter of clinical judgement in consultation with others, where appropriate, including the PATIENT.</p> <p>Source: NHS Data Dictionary</p>
<b>Next Generation Sequencing (NGS)</b>	<p>The advent of next generation sequencing (NGS) technology has revolutionised the scale at which genetic testing can be performed, enabling the analysis of many more genes within the same assay. This allows multiple variants (mutations) to be detected per sample. Large gene panel tests (&gt;500 genes) for cancer testing are rapidly being adopted in the UK.</p> <p>Source: <a href="#">Genome UK: the future of healthcare 2020</a></p> <p><a href="#">AWMGS - Cymru Service for Genomic Oncology Diagnoses (CYSGODI) (medicalgenomicswales.co.uk)</a></p>

<b>Safety Netting</b>	<p>“Safety netting is a management strategy of patients, tests and referrals used in the context of diagnostic uncertainty in healthcare. It aims to ensure patients are monitored until signs and symptoms are explained or resolved.”</p> <p>Source: Royal College General Practitioners</p>
<b>Straight to Test</b>	<p>“Following clear referral criteria into secondary care (usually NICE guidance) the secondary care clinician (defined as per local protocol) will arrange a diagnostic procedure as the first episode of care in place of an outpatient episode. The clinician will retain clinical responsibility for the result including acting on the result.”</p> <p>Source: <a href="#">Delivering Cancer Waiting Times NHSE</a></p>
<b>Teenagers and Young Adults (TYA) Service</b>	<p>Young people (aged 16-24 years) with cancer have their diagnosis treatment and support agreed and delivered by a cancer-site specific multidisciplinary team and a teenage and young adult multidisciplinary team.</p> <p>Source: <a href="#">National Institute for Health and Care Excellence (NICE), 2014. Cancer services for children and young people (QS55)</a></p>

## CLINICAL EVIDENCE

<b>Point of Suspicion/ Referral</b>	<p>The point of suspicion is when a clinician refers a patient or requests a test concerned that a patient may have cancer. Pathway start dates are defined in the following guidance:</p> <p><a href="#">Single Suspected Cancer Pathway Definitions (December 2018)</a></p> <p>Additional information:</p> <p><a href="#">Cancer Risk Assessment Tool (RAT)</a></p> <p><a href="#">Q Cancer Risk Assessment Tool</a></p>
<b>Diagnosis and Management</b>	<p>NICE NG83 <a href="#">Overview</a>   <a href="#">Oesophago-gastric cancer: assessment and management in adults</a>   <a href="#">Guidance</a>   <a href="#">NICE</a></p> <p>ESMO gastric cancer <a href="#">Clinical Practice Guideline – Gastric Cancer (esmo.org)</a></p>

# PERSON CENTRED CARE

Person-centred cancer care is culturally embedded and supported by a common approach to assessing and managing people's needs and care should be co-produced to ensure people affected by cancer to achieve the outcomes that matter to them' (Cancer Quality Statement, 2021).

<b>Key Worker</b>	<p>QS 14: Patients are made aware of who to contact, how to contact them and when to make contact about their ongoing healthcare needs. <a href="#">National Institute for Health &amp; Care Excellence (NICE, 2012) CG138 Clinical Guideline: Patient Experience in adult NHS services</a></p> <p>A cancer key worker is <i>"a person who, with the patient's consent and agreement, takes a key role in coordinating the patient's care and promoting continuity, ensuring the patient knows who to access for information and advice"</i>.</p> <ol style="list-style-type: none"> <li>1. All cancer patients must have an allocated key worker</li> <li>2. Allocation / Review of key worker to take place at key time points including: <ol style="list-style-type: none"> <li>a. Around the time of diagnosis <i>*please note: allocation of key worker <b>may</b> occur earlier than time of diagnosis, if there is a very high level of suspicion of cancer e.g. evidence obtained via pathology, radiology, endoscopy.</i></li> <li>b. Commencement of treatment</li> </ol> </li> </ol> <p><a href="#">Key workers for cancer patients (Welsh Health Circular /2014/001) GOV.WALES</a></p> <p><a href="#">Cancer Improvement Plan for Wales</a></p>
<b>Meeting People's Needs</b>	<p>QS 4: Patients have opportunities to discuss their health beliefs, concerns and preferences to inform their individualised care.</p> <p>QS 10: Patients have their physical and psychological needs regularly assessed and addressed, including nutrition, hydration, pain relief, personal hygiene and anxiety. <a href="#">National Institute for Health &amp; Care Excellence (NICE, 2012) CG138 Clinical Guideline: Patient Experience in adult NHS services</a></p> <p>Assessment and discussion of patients' needs for physical, psychological, social, spiritual and financial support should be undertaken at key points including:</p> <ul style="list-style-type: none"> <li>• Around diagnosis <i>*please note: undertaking a Holistic Needs Assessment <b>may</b> occur earlier than time of diagnosis, if there is a very high level of suspicion of cancer e.g. evidence obtained via pathology, radiology, endoscopy; and it is supported by professional judgement.</i></li> <li>• At commencement, during, and at the end of treatment.</li> </ul> <p><a href="#">National Institute for Clinical Excellence (NICE, 2004) CSG4 Improving Supportive &amp; Palliative care for adults with cancer</a></p> <p>Ideally Holistic Needs Assessments should be undertaken electronically. <a href="#">Cancer Improvement Plan for Wales</a> The Macmillan eHNA is <i>one</i> tool which is both valid and reliable. <a href="#">Snowden A &amp; Fleming M (2015) Validation of the electronic HNA.</a></p> <p>Where appropriate, the impact of the cancer and its treatment on future fertility should be discussed between the person diagnosed with cancer and their cancer team at the earliest opportunity. The eligibility criteria for infertility treatment are set out in the WHSSC Specialist Fertility Commissioning Policy, CP38 (link below). Opportunity should be provided to explore any individual concerns and address any unmet needs and early speciality referral should also be offered.</p> <p><a href="http://whssc.nhs.wales/commissioning/whssc-policies/fertility/specialist-fertility-services-commissioning-policy-cp38-feb-2020/">whssc.nhs.wales/commissioning/whssc-policies/fertility/specialist-fertility-services-commissioning-policy-cp38-feb-2020/</a></p>



<b>Health Optimisation / MECC</b>	<p>QS 9: Patients experience care that is tailored to their needs and personal preferences, taking into account their circumstances, their ability to access services and their coexisting conditions.</p> <p><a href="#">National Institute for Health &amp; Care Excellence (NICE, 2012) CG138 Clinical Guideline: Patient Experience in adult NHS services</a></p> <p>Health Optimisation refers to a proactive approach to supporting people who present to NHS services with concurrent comorbid health conditions (e.g. anaemia, diabetes), or health risk behaviours (e.g. smoking, physical inactivity).</p> <p><a href="#">Welsh Government (2018) A Healthier Wales.</a></p> <p><a href="#">Welsh Government (2015) Wellbeing of Future Generations Act.</a></p> <p>Making Every Contact Count (MECC), is a behaviour change approach that helps health and social care professionals to help people to improve their health and wellbeing through prevention and early intervention. <a href="#">Public Health Wales Strategic Plan 2018-2021</a></p> <p><b><i>Lifestyle advice / resources are available from <a href="#">Making Every Contact Count</a> (MECC)</i></b></p> <p><i>*Please note: Whilst addressing concurrent comorbidities and health risk behaviours is the responsibility of <b>all</b> health and social care professionals, at <b>every</b> contact throughout the pathway; earliest possible intervention <b>may</b> impact on cancer treatment choices / outcomes (especially in respect to tobacco smoking). <a href="#">National Institute for Clinical Excellence (NICE, 2018) NG92 NICE Guideline Stop Smoking Interventions and services.</a></i></p>
<b>Prehabilitation</b>	<p>All patients should be given multimodal prehabilitation advice and support covering physical activity, emotional wellbeing, eating well, stopping smoking and reducing alcohol intake prior to undergoing treatment in order to enhance patient outcomes. Patient needs and goals should be evaluated on an individual basis and appropriate levels of support, from universal self-management advice to specialist support which includes timely access to allied health professional should be provided.</p> <p>Patients should have the opportunity to take part in evidence-based education and rehabilitative activities, including self-management programmes, <i>where available</i>, that promote their ability to manage their own health if appropriate.</p> <p><a href="#">National Institute for Health &amp; Care Excellence (NICE, 2012) CG138 Clinical Guideline: Patient Experience in adult NHS services</a></p> <p><a href="#">Welsh Government (2018) A Healthier Wales.</a></p> <p><a href="#">Welsh Government (2015) Wellbeing of Future Generations Act.</a></p> <p><a href="#">The Quality Statement for Cancer.</a></p>
<b>Rehabilitation</b>	<p>All patients will have their needs for rehabilitation services assessed, with referral to an appropriate level of rehabilitative support, throughout the patient pathway, including timely access to allied health professional to meet individual holistic patient needs and goals.</p> <p><i>*Please note: not <b>all</b> patients will require specialist cancer rehabilitation services. Referral into non-cancer rehabilitation, self-management, and fitness services <b>may</b> be suitable to meet some patients' needs.</i></p> <p><a href="#">National Standards for Rehabilitation of Adult Cancer Patients (2010) GOV WALES</a></p> <p><a href="#">National Institute for Health and Care Excellence (NICE) CSG4 (2004) resources for improving supportive and palliative care for adults with cancer.</a></p>
<b>Patient Reported Outcome Measures (PROMs) /</b>	<p>Patient Reported Outcome Measures (PROMs) are questionnaires that patients are asked to complete <b>before</b> and <b>after</b> treatment to assess the impact on health and wellbeing.</p> <p><b>Some</b> of the Cancer Site Groups (CSGs) have been working with the International Collaboration for Health Outcome Measurement (ICHOM), Value Based Healthcare Team,</p>

<p><b>Patient Reported Experience Measures (PREMs)</b></p>	<p><a href="#">National PROMS, PREMS, &amp; Effectiveness Programme (NPP&amp;EP)</a> and other partners, to pilot tools and data capture methods, which will inform a consistent approach to PROMS &amp; PREMS for cancer. <a href="#">The Quality Statement for Cancer</a></p> <p><i>*Please note: there are outstanding questions relating to tool selection, data capture intervals, data capture methods and data analysis / reporting which <b>may</b> prevent the implementation of PROMS &amp; PREMS across all pathways at this time. PROMS &amp; PREMS have been included in the pathways, in recognition of this work, and will be updated pending further advice from the CSGs.</i></p> <p>Patient Reported Experience Measures (PREMs) are questionnaires that patients are asked to complete at <b>any time</b> during their pathway to help professionals to understand their experience of NHS services. This information is crucial to understanding the value of healthcare as perceived by patients. <a href="#">Welsh Government (2018/19). Chief Medical Officer Annual Report</a></p> <p><i>*Please Note: Whilst it is good practice to collect PREMS throughout the pathway, there is no current standard for cancer PREMS in Wales; further advice regarding this will be sought via the CSGs in due course.</i></p>
<p><b>Communication</b></p>	<p>Clinicians must ensure patients are kept up to date about their care pathway and are supported to make individualised choices about their treatment.</p> <p>Clinicians should consider the value of interventions and discuss with the patient the likely outcome of treatment options.</p> <p>Clinicians in secondary and tertiary care must ensure that all decisions relating to a patient's care or treatment are communicated to the patient and their primary care clinician in a timely manner and within 24 hours of diagnosis.</p> <p>Clinicians must ensure that the clinical intention of any intervention such as tests or treatment is clear to patients, and whether it is just a stage of the agreed pathway or considered start of first definitive treatment and as such ends the pathway.</p> <p>Clinicians must make contemporaneous records of discussions and decisions and include reasons for deviations from recommended clinical practice in the patient's clinical record. Decisions should be made in a timely manner, and any onward referrals be completed promptly, according to local/national guidelines and optimal pathways and include adequate information to allow the receiving clinician to initiate appropriate interventions with the minimum of delay. Referrers must ensure that the patient is aware and agrees for a suspected cancer referral to be made.</p> <p><a href="#">Suspected cancer pathway: guidelines (WHC/2023/025)   GOV.WALES</a></p> <p><b>Treatment Summary</b></p> <p>A treatment summary is a tool completed by secondary care professionals after a significant phase of a patient's cancer treatment. A treatment summary describes the patient's cancer diagnosis, prognosis, and aim, types and side effects of any treatment that they have had. It also highlights any signs and symptoms of recurrence that the patient needs to be aware of. It is designed to be shared with the person living with cancer and their GP either electronically or as a paper document, and should use easy to understand, clear and concise language. Additionally, it can be used by the person affected by cancer to help inform other health and social care professionals, employers/occupational health or financial institutions e.g. benefits services or banks, about their cancer care and treatment.</p>

	<p><b>Endoscopy</b></p> <p>Patient information for all relevant procedures is given to patients ahead of the procedure.</p> <p>There are a range of communication methods and materials to inform patients about what they should expect from the service (such as a website, written information, or specialised communication, e.g., pictures).</p> <p>Patients are informed if they are suspected of having a malignancy on the same day as the procedure unless considered to be in the patient's best interest not to do so. This should be documented.</p> <p>Patients and carers are told the outcome of the procedure and ongoing care, accompanied with a copy of the endoscopy report (or a patient-centred version).</p> <p>If a cancer is suspected, the patient is referred to a relevant cancer clinical nurse specialist (CNS) / key worker who offers contact with the patient before or soon after discharge from their diagnostic procedure.</p> <p>Endoscopy reports are completed on the day of the procedure and include follow-up details, and are sent to the patient's GP and the referring clinician (if different) within 24 hours of the procedure.</p> <p>There is a process for referring patients with a suspected or definitive cancer diagnosis to the multidisciplinary team (MDT).</p> <p><a href="#">Guidance - GRS standards UK 2023.pdf (thejag.org.uk)</a></p>
<p><b>Research</b></p>	<p>Patients should have the opportunity to take part in research and clinical trials where available.</p> <p><a href="#">People in research   Health Care Research Wales (healthandcareresearchwales.org)</a></p> <p><a href="#">EC Trial Finder   ECMC (ecmcnetwork.org.uk)</a></p>