West of Scotland Cancer Network

Upper GI Cancer
Managed Clinical Network

Upper Gastro-intestinal Cancer

Regional Follow-up Guideline

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Upper GI Cancer Regional Follow-up Guidelines Review

The purpose of the Upper GI Cancer Regional Follow-up Guideline is to ensure consistency of practice across the West of Scotland and the principles of any revision to the follow-up guideline will continue to ensure that management of patients after initial treatment for upper GI cancer are:

- Patient-centred;
- Aligned to recognised current best practice;
- Equitable across the region;
- Clinically safe and effective; and
- Efficiently delivered.

The guideline continues to be developed on the basis that the key aims underpinning the purpose of follow-up are to:

- Manage and treat symptoms and complications;
- Provide psychological and supportive care; and
- Detect and treat recurrent disease.

Follow-up practice has to be patient-centred and, ideally, supported by empirical evidence of improved outcomes and survival. In the absence of good quality evidence, care should be tailored to the needs and preference of patients. The construction of appropriate follow-up guidance requires balancing perceived patient needs with effective utilisation of resources.

These guidelines were initially published in 2012, and considered to be the standard practice for follow-up of patients with upper GI cancer, as a series of 5 treatment dependant pathways:

1. Best supportive care
2. Palliative chemotherapy
3. Palliative radiotherapy
4. Surgery with curative intent
5. Radical chemoradiotherapy and radical radiotherapy with curative intent

A review in May 2015 determined that the guidelines remained current and they were reissued as extant guidance.

A subsequent review during 2018 determined that an additional pathway was required to be included in relation to Chemoradiotherapy with potential for salvage oesophagectomy. This is included in Table 6.

During the 2018 review, it was also recommended that all patients receiving treatment for UGI cancers should undergo a holistic needs assessment (HNA) by a suitably trained individual at defined time points during follow up care.

The review in 2023, highlighted that clarification was required regarding follow up endoscopy for patients undergoing Radical chemoradiotherapy and radical radiotherapy with curative intent and Chemoradiotherapy with potential for salvage oesophagectomy (Tables 5&6). These guidelines have been updated to reflect this.

Regional Cancer Clinical Leads are asked to consider the additional pathway proposed for inclusion in the guideline and provide continued support to the practices as detailed within.

Best Supportive Care

Summary of future model for *best supportive care for primary cancer follow-up care is outlined in table 1.

Table 1: Best Supportive Care

Visit	Post treatment	Purpose
	Any Time	• Primary Care services clinical assessment ** Local provision of generic palliative care in the community Access to nutritional assessment and onward referral to Dietetics as clinically indicated
		Rapid access to CNS*** / Endoscopic services • For progressive local symptoms from primary tumour
		Rapid access to Oncology services as indicated • Oncologist involvement via MDT as appropriate
		Rapid access to Specialist Palliative Care services • For complex symptom control and psychosocial support
		Development of new or progressive symptoms require o Assessment o Investigation as clinically indicated

Notes:

*Patients are not on radical or palliative oncology pathways.

**Primary Care Setting GP is lead provider
**Secondary Care Setting CNS is lead provider

***Patient generated contact with secondary care CNS as required (via answering machine).

Supporting Documentation

- Written points of contacts given to patient to ensure rapid access into the service.
- Written end of treatment letter prepared for GP to ensure rapid access into the service.
- List of symptoms to look out for (checklist).
- No further treatment is an option and this should be clearly communicated to specialist palliative and primary care services.

Palliative Chemotherapy
Summary of future model for palliative chemotherapy for primary cancer follow-up care is outlined in table 2.

Table 2: Palliative chemotherapy *

Visit	Post treatment Timing	Purpose
1	4-8 weeks**	• Oncological assessment and detection of disease progression CT imaging*** - protocolised
	Any Time	Development of new or progressive symptoms require o Assessment o Investigation as clinically indicated o Endoscopic palliation for local symptoms Access to nutritional assessment and onward referral to Dietetics as clinically indicated May require input from Specialist Palliative Care Services

Notes:

*Palliative chemotherapy indicated for management of symptoms.

** Following initial post treatment assessment further follow up visits will be driven by the patient and/or clinician dependant on symptoms, further available treatment options and patient fitness and patient's wishes.

*** CT imaging will be dictated by clinical symptoms and not routinely undertaken unless mandated by a clinical trial protocol.

Further systemic therapy may be indicated at progression depending on performance status, clinical assessment and may include a clinical trial.

If patient not a candidate for palliative chemotherapy at initial presentation or subsequent relapse they should follow the best supportive care pathway.

No further treatment is an option and this should be clearly communicated to specialist palliative and primary care services.

Palliative Radiotherapy
Summary of future model for palliative radiotherapy for primary cancer follow-up care is outlined in table 3 below.

Table 3: Palliative radiotherapy

Visit	Post treatment	Purpose
1	After last XRT	• Oncological Clinical assessment List of symptoms to look out for (checklist)
	Any Time	• Best supportive care follow up plan May include direct referral to oncologist
	Any Time	Development of new or progressive symptoms require o Assessment o Endoscopic investigation and palliation as clinically indicated Access to nutritional assessment and onward referral to Dietetics as clinically indicated May require input from Specialist Palliative Care Services

Notes:

No further treatment is an option and this should be clearly communicated to specialist palliative and primary care services.

Surgical with curative intent
Summary of future 5-year model for surgical (with curative intent) for primary cancer follow up care is outlined in table 4 below.

Table 4: Surgical with curative intent

Visit	Postoperative Timing	Purpose
1	4 weeks	• Post operative wound check • Assessment of nutritional risk • Discussion of pathology results • Referral for further treatment •
2	3 months	• Nutritional assessment * • Identify non-malignant causes of morbidity
3	6 months	• Nutritional assessment * • Identify non-malignant causes of morbidity
4	9 months	• Nutritional assessment * • Identify non-malignant causes of morbidity
5	12 months	• Nutritional assessment * • Identify non-malignant causes of morbidity
6	18 months	• Nutritional assessment * • Identify non-malignant causes of morbidity
7	24 months	• Open access to surgical team if any new concerning symptoms
8	36 months	Hospital clinic visit (or GP if preferred)
9	48 months	Hospital clinic visit (or GP if preferred)
10	60 months	Hospital clinic visit (or GP if preferred)
	Any Time	Development of new or progressive symptoms require ○ Assessment ○ Investigation - Initial CT chest/abdomen/pelvis and endoscopy with further investigation as clinically indicated (PET-CT, bone scan, US)

Notes:

* It is widely recognised that this group of patients are at continued nutritional risk, and access to nutritional assessment and onward referral to dietetic services, where appropriate, should be available.

Radical chemoradiotherapy and radical radiotherapy with curative intent not fit for salvage surgery

Summary of future 5-year model for radical chemoradiotherapy and radical radiotherapy (with curative intent) for primary cancer follow up care is outlined in table 5.

Table 5: Radical chemoradiotherapy and radical radiotherapy with curative intent

Visit	Post treatment Timing	Purpose
1	4-6 weeks	• Oncological Review for post radiotherapy toxicities
2	3 months	• CT Imaging and Endoscopy Assessment of response to treatment MDT review to review above and assess whether patient suitable for potential salvage follow up approach
3	3-4 months	• Oncological Review results of investigations
4	6 months	• Oncological Nutritional assessment* Identify non-malignant causes of morbidity o Any symptomatic problems
5	9 months	• Oncological Clinical assessment
6	12 months	• Oncological Nutritional assessment * Identify non-malignant causes of morbidity o Any symptomatic problems
7	18 months	• Oncological Clinical examination
8	24 months	• Oncological clinical for clinical and nutritional assessment
9	36 months	Hospital clinic visit (or GP if preferred)
10	48 months	Hospital clinic visit (or GP if preferred)
11	60 months	Hospital clinic visit (or GP if preferred)
	Any Time	• Development of new or progressive symptoms require o Assessment o Investigation - Initial CT chest/abdomen/pelvis and endoscopy with further investigation as clinically indicated (PET-CT, bone scan, US) • Review results of investigation and if patient symptomatic then refer to surgical / gastroenterology team • Endoscopic palliation / systemic therapy / best supportive care

Notes:

No further treatment is an option and this should be clearly communicated to specialist palliative and primary care services.

* It is widely recognised that this group of patients are at continued nutritional risk, and access to nutritional assessment and onward referral to dietetic services, where appropriate, should be available.

Endoscopy follow up should be carried out by a clinician or endoscopy nurse specialist with experience of scoping post chemo-radiotherapy patients within oesophageal carcinomas.

Frequency and duration of follow up may be altered depending on patient's fitness and wishes.

Chemoradiotherapy with potential for salvage oesophagectomy

Summary of future 5-year model for chemoradiotherapy with potential for salvage oesophagectomy radical radiotherapy for primary cancer follow up care is outlined in table 6.

Table 6: Chemoradiotherapy with potential for salvage oesophagectomy

Visit	Post treatment Timing	Purpose
1	4-6 weeks	• Oncological • Review for post radiotherapy toxicities
2	3 months	• CT Imaging and Endoscopy Assessment of response to treatment MDT review to review above and assess whether patient suitable for potential salvage follow up approach
Discussion at WoS MDT, decision made based on fitness/co-morbidity as to whether patient suitable for salvage surgery. If **NO**, then continue with radical chemoradiotherapy and radical radiotherapy with curative intent follow up schedule as per **table 5 - radical chemoradiotherapy and radical radiotherapy with curative intent** If, **YES**, then continue with the following schedule		
3	6 months	Endoscopy Oncological for clinical assessment and review of results
4	9 months	Endoscopy Oncological for clinical assessment and review of results
5	12 months	Endoscopy CT (chest, abdo, pelvis) Oncological for clinical assessment and review of results
6	15 months	Endoscopy Oncological for clinical assessment and review of results
7	18 months	Endoscopy CT (chest, abdo, pelvis) Oncological for clinical assessment and review of results
8	21 months	Endoscopy Oncological for clinical assessment and review of results
9	24 months	Endoscopy CT (chest, abdo, pelvis) Oncological for clinical assessment and review of results
10	36 months	Endoscopy Oncological for clinical assessment and review of results
11	48 months	Endoscopy Oncological for clinical assessment and review of results
12	60 months	Endoscopy Oncological for clinical assessment and review of results
	Any time	• Development of new or progressive symptoms require ○ Assessment ○ Investigation - Initial CT chest/abdomen/pelvis and endoscopy with further investigation as clinically indicated (PET-CT, bone scan, US) • Review results of investigation and if patient symptomatic then refer to surgical / gastroenterology team • Salvage surgery / endoscopic palliation / systemic therapy / best supportive care

Frequency and duration of follow up may be altered depending on patient's fitness for salvage oesophagostomy and wishes.

Notes:

Endoscopy follow up should be carried out by a clinician or endoscopy nurse specialist with experience of scoping post chemo-radiotherapy patients within oesophageal carcinomas.