

# Audit of the Expected HPB Faster Diagnosis Pathway Data

A Johnston & K Mann

Liverpool University Hospitals Foundation Trust

## Introduction

- Version 1 of the HPB Faster Diagnosis Pathway was published on 6/9/22 and it due to be rolled out as national guidance in the coming weeks
- The 21-day pathway for **suspected** pancreatic, extrahepatic cholangiocarcinoma and gallbladder cancer was used as a standard to audit current practice of the Mersey and North Wales supra-regional MDT
- The aim is to highlight the standards that will prove difficult to achieve set by the pathway and help find solutions in the anticipation of national rollout

## Methods

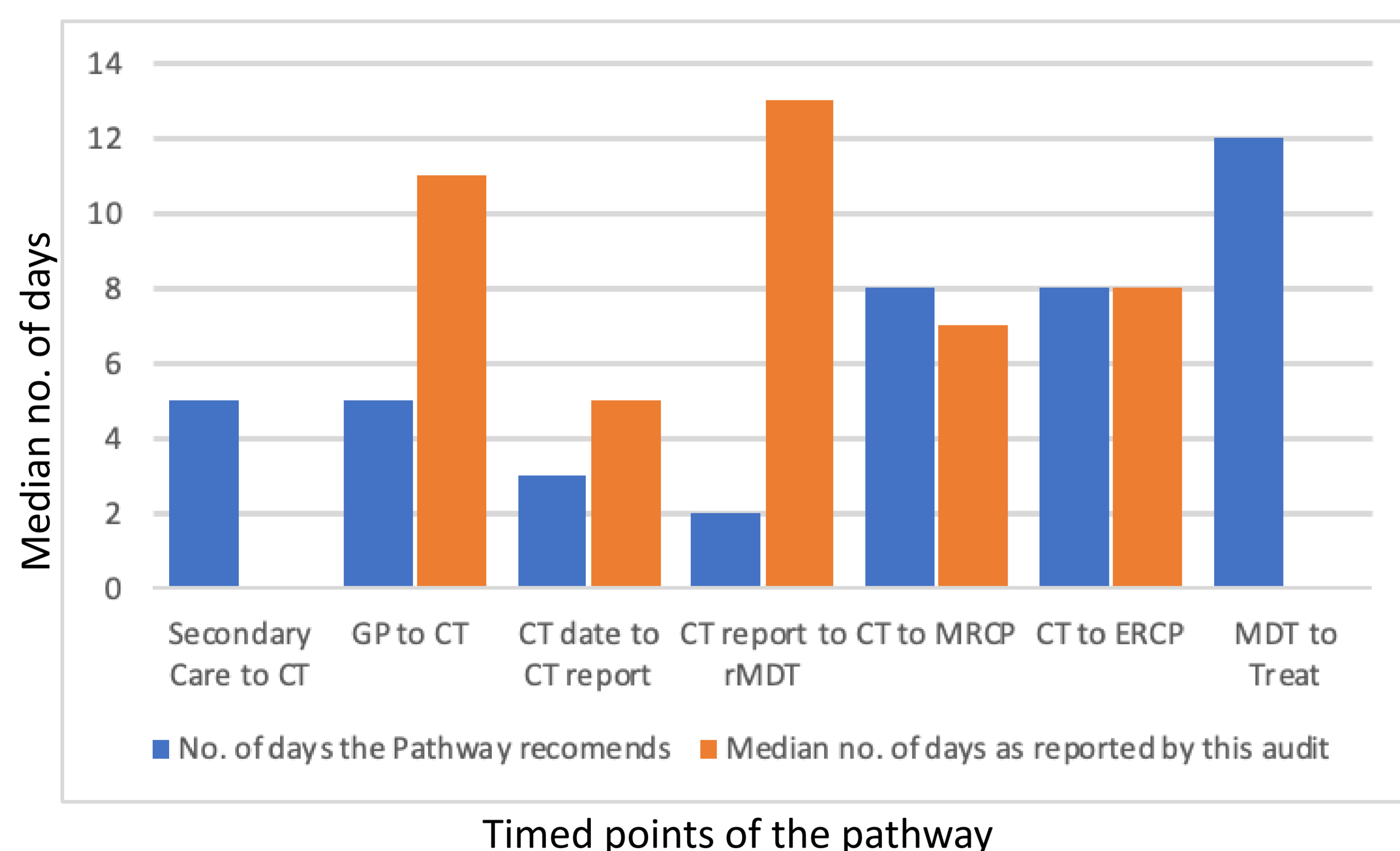
- Data was retrospectively collected via the Somerset Cancer Registry of weekly MDTs between 18/1–15/3/23
- Inclusion criteria was documentation of MDT diagnosis OR high suspicion of pancreatic, extrahepatic cholangiocarcinoma & gallbladder cancers
- Median timed data was collated from the electronic systems of PACS, PENS, EPRO and the Somerset registry

## Results

21-day jaundice, pancreatic, extrahepatic cholangio, gall bladder

Day 0	By Day 5	By Day 8	By Day 10	By Day 16	By Day 21
Primary care	Local Diagnostic Centre / Specialist Diagnostic Centre				
Urgent referral based on NG12 NICE guidelines <sup>1</sup> including minimum dataset <sup>2</sup>	Straight to test: Contrast CT <sup>3</sup> with hot reporting (72hrs), Bloods, including tumour markers <sup>3</sup> and commence Pancreatic Enzyme Replacement Therapy (PERT) if required <sup>3,15</sup>	Clinical assessment of CT results by suitably experienced HPB clinician <sup>6</sup> and commence endoscopic retrograde cholangiopancreatography (ERCP), brushings and stent if clinically indicated. Or fast track treatment referral for resectable patient, if required <sup>7</sup>	Local or specialist MDT using agreed standard of care pathways to minimise MDT discussions <sup>9</sup> Booking of ERCP, or EUS guided FNA Biopsy if decided by MDT <sup>7</sup>	Contrast MRI <sup>4</sup> or MRCP <sup>10</sup> Fluorodeoxyglucose PET-CT or selective Laparoscopy / Laparoscopic Ultrasound when resection planned <sup>11</sup> Endoscopic Retrograde Cholangiopancreatography (ERCP) (or other biliary drainage procedure) or Endoscopic Ultrasound guided FNA Biopsy <sup>12</sup>	Confirmation of treatment plan and Ongoing Personalised Care and Support Plan discussion with patient <sup>13,14</sup> Access to a HPB specialist dietitian Referral to prehabilitation programme, if indicated Clinical trial enrolment considered
Secondary care	Emergency presentation and referrals from radiology <sup>1</sup>	Booking of Contrast MRI, MRCP, Fluorodeoxyglucose PET-CT, or Laparoscopy / Laparoscopic Ultrasound, if required <sup>7</sup>			
Patient information Provided in primary care <sup>1</sup>	Patient information Provided in clinic / OPA <sup>5</sup>	Cancer ruled out and communication to patient; Record FDS if patient informed that all cancer has been excluded. Note there are significant 'overlap' for upper GI symptoms. Referred to other secondary care service or discharge <sup>8</sup> OR Cancer likely / diagnosed; Outpatient Clinic and communication to patient; Record FDS if patient is informed they have cancer. Discussion with HPB specialist, CNS and specialist MDT input, Discuss treatment options, subject to staging testing being reported; Personalised Care and Support Plan discussion with patient <sup>8</sup> HPB CNS to discuss symptom management, identify physical, psychological and nutritional care needs as well as refer for any prehabilitation, occupational, nutritional or psychological support as required.			

Figure 1: Comparing timed days from the pathway vs median no. of days of current practice



## Discussion

- Unclear if local MDT meets day 10 target. Unable to audit this target without local information
- 25% patients present acutely when should present to primary care, misrepresenting positive target
- Common presentation comes from investigations such as CT colon/U/S, as opposed to GP booking CT scans, patients do not start on the pathway.
- GP to CT report is crucial and referrals do not comment on whether patients first present to primary or secondary care. Significant resources required to improve reporting from GPs
- Treatment plan occurred within the target demonstrating the robust functioning of the tertiary centre

**Day 0-5: Urgent referral for CT (1<sup>o</sup> or 2<sup>o</sup> care)** NA  
Regional MDT referral form has no specific date documented of first point of referral

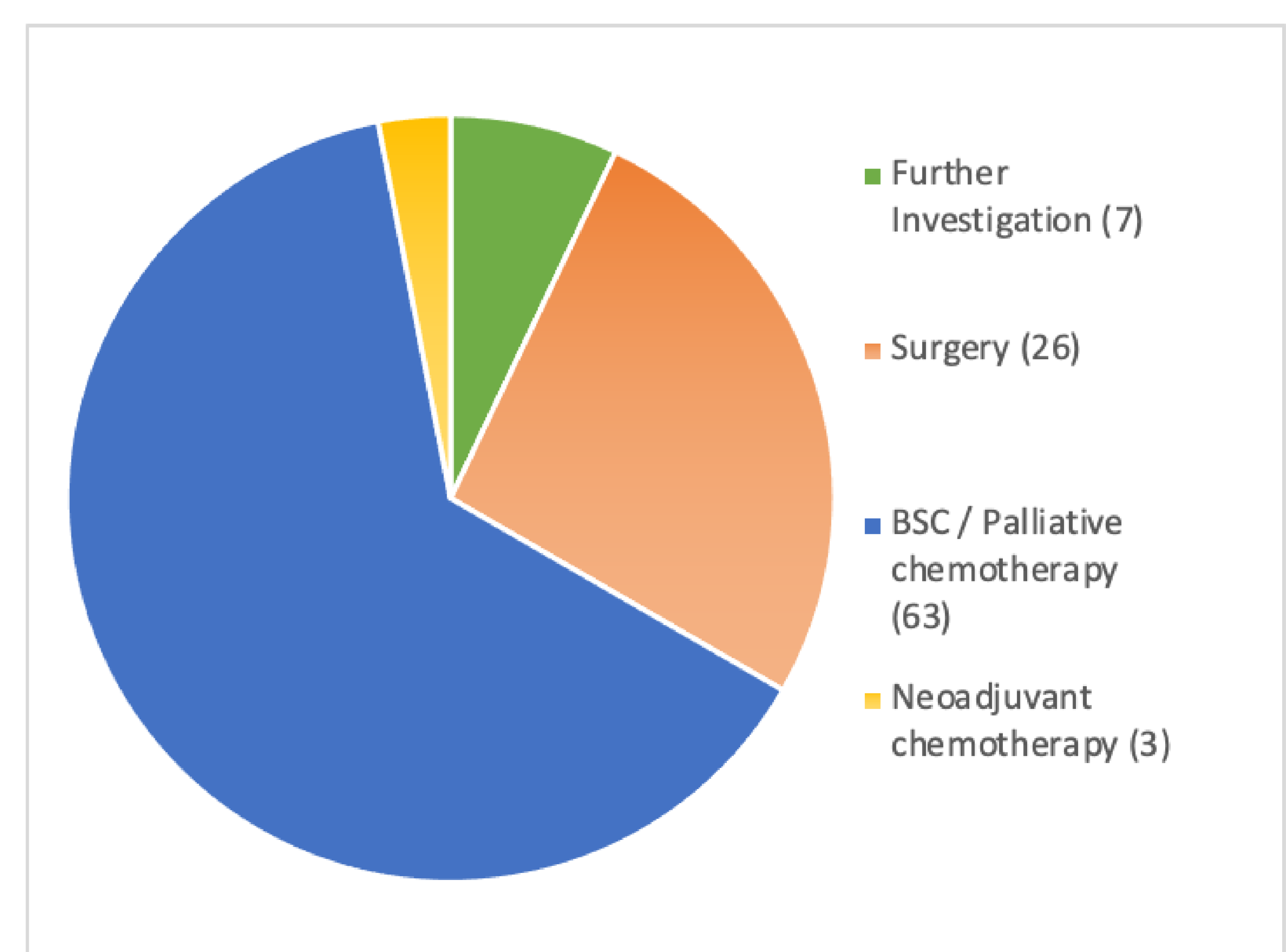
**Day 5-8: Date of CT to date of report** 5 days  
Recommends 72hr 'Hot reporting' for high suspicion

**Day 8-10: CT report to MDT discussion** 13 days

**Day 8-16: CT to MRCP or ERCP** Low frequency  
Few patients had further tests recommended

**Day 16-21: Further investigations to confirmed treatment plan** Not possible  
Very difficult to assess. Lack of documented dates of MDT outcomes enacted outside of tertiary centre

Figure 2: A pie chart showing the number of patients recommended the following MDT outcomes



## Key areas to improve

Accurate data recording from referring trusts and outcome delivery  
Hot CT reporting and onwards referral