Kent and Medway Cancer Collaborative

Thyroid Tumour Site Specific Group meeting
Wednesday 20th September 2023
Ashford International Hotel, Ashford, TN24 8UX
09:30 - 12:30
Final Meeting Notes

Present	Initials	Title	Organisation
Chris Theokli **(Chair)**	**CT**	Consultant ENT Thyroid Surgeon	EKHUFT
Hannah Washington	**HW**	Cancer Pathway Navigator	EKHUFT
Ciara Mulcahy	**CM**	ENT Deputy Ops Manager	EKHUFT
Edmund Lamb	**EL**	Consultant Clinical Scientist / Clinical Director of Pathology	EKHUFT
Ali Al-Lami	**AAL**	Consultant ENT / Head & Neck Surgeon	EKHUFT
Ritchie Chalmers	**RC**	Medical Director	KMCA
Karen Glass **(Minutes)**	**KG**	Administration & Support Officer	KMCA & KMCC
Jonathan Bryant	**JB**	Clinical Lead / GP	KMCA / NHS Kent & Medway ICB
Chris Singleton	**CS**	Senior Programme Manager – Cancer Commissioning	NHS Kent & Medway ICB / KMCA
Annette Wiltshire	**AW**	Service Improvement Lead	KMCC
Colin Chamberlain	**CC**	Administration & Support Officer	KMCC
Kusum Asnani	**KA**	Junior Clinical Fellow	Kings College Hospital NHS Foundation Trust
Maria Acosta	**MA**	Consultant Physician in Nuclear Medicine	MFT
Emma Bourke	**EB**	Macmillan Personalised Care and Support Facilitator	MFT
Debbie Hannant	**DH**	Macmillan Head & Neck CNS	MFT
Debbie Owen	**DO**	Macmillan Head & Neck CNS	MFT
Nadine Caton	**NC**	ENT Consultant	MTW
Milena Truchan	**MT**	Head & Neck CNS	MTW
Melanie Suseeharan	**MS**	Core Surgical Trainee ENT	Royal Surrey County Hospital
Apologies			
Vikram Dhar	**VD**	ENT / Head and Neck Consultant Surgeon	EKHUFT
Sue Honour	**SH**	Macmillan Lead Head & Neck and Thyroid CNS	EKHUFT
Eranga Nissanka-Jayasuriya	**ENJ**	Consultant Head & Neck Histopathologist	EKHUFT
Pippa Enticknap	**PE**	Senior Service Manager – CCHH Care Group	EKHUFT
Sarah Stevens	**SS**	Macmillan Speech and Language Therapist	EKHUFT

Claire Mallett	**CM**	Programme Lead - Living with and beyond cancer/Personalised Care and Support	KMCA
Adam Gaunt	**AG**	Specialty Registrar Otolaryngology, Head and Neck Surgery	MFT
Suzanne Bodkin	**SB**	Cancer Pathway Manager	MFT
Denise Thompson	**DT**	Assistant Project Manager	MFT
Navdeep Upile	**NU**	Consultant Otolaryngologist Head and Neck Surgeon	MFT & QVH
Helen Graham	**HG**	Research Delivery Manager (Cancer)	NIHR Clinical Research
Luisa Roldao Pereira	**LRP**	Nuclear Medicine Superintendent & Advanced Clinical Practitioner Project Lead	MTW

Item		Discussion	Agreed	Action
1.	**TSSG Meeting**	**Apologies** • The formal apologies are listed above. **Introductions** • CT welcomed the members to today's face to face meeting and the group introduced themselves. • If you attended this meeting and are not captured on the attendance list above please contact karen.glass3@nhs.net directly and she will update the distribution list accordingly. **Review previous minutes** • The minutes from the previous meeting which took place on the 31st March 2023 had been reviewed and were signed off as a true and accurate account of the meeting. **Review action log** • The action log was reviewed, updated and will be circulated to the members along with the final minutes from today's meeting.		

2.	**Introduce new Cancer Alliance Medical Director**	**<u>Update provided by Ritchie Chalmers</u>** • CT introduced RC to the group as the new Kent & Medway Cancer Alliance Medical Director. • RC thanked the TSSG Chairs for their support and strong clinical leadership in driving forward their respective TSSG's. • RC explained the K&M CA will soon be embedded within the K&M Integrated Care Board (ICB) and as such will function as a bridge between the CA and the TSSG's. The aim will be to develop the ICB clinical strategy utilising the data, CA funding and to be clinically led by the TSSG's. The TSSG's are key to driving forward the clinical strategy and shaping the service for the next year, 5-years and 10-years. • RC alluded to the pinch-points within particular professions including pathology and radiology which is also a national issue. RC emphasised the importance of having the nurses well represented at these meeting and suggested having a lead nurse within each TSSG from all 4 trusts. RC acknowledged the lead nurse; lead pathologist and lead radiologist should have the required time allocated within their job plans to be able to attend the TSSG meetings. • RC noted the importance of having face to face meetings but to also have hybrid options available for those unable to attend. • RC confirmed 50% of her role has been allocated to the CA and 50% as the Chief of Service at MTW. RC hoped to attend and support most of the upcoming TSSG meetings. • CT explained to RC the longstanding issue regarding obtaining the Thyroid performance data which is amalgamated with the Head & Neck data. As a result of this it would be hard for them to develop a service plan moving forward. RC agreed they need to start by accessing good quality data. She mentioned David Osborne the CA Data Analyst does not currently have access to the InfoFlex data so he can only work within the confines of the data available to him. RC hoped to get this rectified once the CA become part of the ICB. • It was agreed they need comparative data from across all of the trusts which highlights the		

		variation across the region. • HW explained there is a coding issue on InfoFlex specifically for Thyroid which automatically reverts to a Head & Neck case even when entered manually. **Action – RC agreed this issue should be escalated to Chris Hopkins and the team at EKHUFT who are the system architects for InfoFlex to sort out this coding issue. RC and HW agreed to discuss further offline.**		**RC / HW**
3.	**Performance Questions**	**<u>Update by Chris Theokli</u>** • CT referred to the inaccurate Thyroid data in terms of the following Cancer Waiting Times Standards: i) Faster Diagnosis (28-day Referral to Diagnosis) Standard ii) 31-day (Decision to Treat to First Treatment) Standard iii) 62-day (Referral to First Treatment) Standard (GP referral) • David Osborne has provided the performance data on behalf of the Thyroid TSSG and highlighted the following: i) The gaps in FDS data are because Trusts are not coding Thyroid under the FDS Primary Cancer Site field. ii) MFT are the only Trust that regularly coded referrals as Thyroid under the FDS Primary Cancer Site field in the last 6 months. • RC noted from the data that both surgical and treatment capacity is fine, however, diagnostic capacity is the issue. • CT suggested Radiologists and Pathologists could work together to train Biomedical Scientists to help facilitate the requirement for future mass screening.		

4.	**"Moving towards day case Parathyroid surgery – a review of EKHUFT Parathyroid surgery"**	**<u>Presentation provided by Melanie Suseeharan</u>** • MS explained there is mounting evidence to support Parathyroidectomy for day-case surgery. The current practice at EKHUFT supports day-case surgery with a small number of patients who may need to stay overnight. • GIRFT recommendations ensure where clinically appropriate the length of stay for surgical procedures are reduced. 90% of patients having parathyroid surgery for primary hyperparathyroidism should be discharged as a day case. • The current practice at EKHUFT includes: i) Calcium 6 hours post op ii) PTH level iii) Calcium 12 hours post op • MS highlighted the results of a study of 107 patients from October 2019 – October 2022. The demographics included 77 – female and 30 – males patients aged between 22 – 90 years old. 93% of these patients stayed in hospital for 1 night with 7% staying longer due to other reasons including post-operative Haematoma / Hypercalcaemia / Hypocalcaemia. • MS highlighted the pros and cons: i) Day case is generally more favoured by patients ii) Increased bed availability – every additional bed day incurs an estimated cost of £339 to the NHS iii) Scope for increased case turnover iv) Cost savings from overnight stays > day case surgery v) Reduce costs of unnecessary repeat blood tests – every PTH costs £8. • CT thanked MS for her update and suggested the TSSG take forward the recommendations across the trusts as discussed.		**Presentation circulated to the group on the 21st September 2023**

5.	**A review of Parathyroid surgery at EKHUFT**	**Presentation provided by Kusum Asnani** • KA updated the group on the local clinical audit of 138 patients which took place between 2019 – 2021 at QEQM, KCH and WHH. The aim of the audit was to compare EKHUFT practice with BAETS and NICE guidelines. • Retrospective date collection from 01/12/2018 – 30/11/2021 from Sunrise, clinic letters and discharge summaries. The average age of the patient was 66 with 77% female and 23% male. • KA outlined the details of the functional and surgical outcomes including the inclusion / exclusion criteria. • Recommendations: i) 1st Line: US + MIBI ii) 2nd Line: Consider other scanning methods if neither conclusive. • In conclusion: i) Creating a proforma for patients planning to undergo parathyroidectomy surgery pre- and post-operatively will enable better follow up. ii) Increase surgeries to be conducted as a day case. iii) Recent localization measures e.g. 4D CT, Choline ET CT and ICG gamma camera should be considered for challenging cases – is very expensive. iv) Looking into outcomes specifically for patients having primary surgery and surgery for renal PTH for the next cycle. • CT mentioned day case parathyroidectomy surgery is already being carried out nationally and he would be keen for the TSSG to follow suit. This would be more beneficial for the patient and also more cost effective. • AAL referred to the availability of local scans including SPECT (Single-photon emission computed tomography), Ultrasound and MIBI.		**Presentation circulated to the group on the 21st September 2023**

6.	**Thyroglobulin Ab and interference in thyroglobulin assays**	**Presentation provided by Edmund Lamb** • EL provided the group with an overview of the Thyroglobulin service. EKHUFT clinical biochemistry started thyroglobulin testing in June 2020. In April 2021 they started to receive samples from all other K&M NHS laboratories. Approximately 1500 samples were analysed in 2022/23 (600 of these were from EKHUFT). • The results are reported once a week and sent via electronic links to K&M laboratory partners. • All samples tested for Tg (Thyroglobulin) and TgAb (Thyroglobulin Antibodies) use assays from Abbott Laboratories. • Samples with raised TgAb concentration may give false negative (low) results when measured by the EKHUFT assay. These samples are referred to Birmingham for Tg measurement by radioimmunoassay at a cost of £30 per sample. This assay may produce false positive (high) Tg results in the presence of TgAb. EL explained no Tg result can be relied upon in the presence of TgAb. • In terms of the referrals to Birmingham: i) The limit of detection of the Abbott TgAb assay is 2kU/L. ii) The reference range for the TgAb assay in the "healthy" population is <4.1kU/L. iii) Initially all samples with an TgAb > 2kU/L were referred to Birmingham – 40% of samples iv) In light of clinical experience this cut-off was increased to > 3kU/L (20% of samples) and in late 2021, to > 5kU/L (13% of samples). v) To date the lowest antibody concentration observed to be associated with negative interference in the EKHUFT assay is 13kU/L. • EL outlined the NICE NG230 guidance for Thyroid cancer – assessment and management for post thyroidectomy monitoring of differentiated thyroid cancer.		**Presentation circulated to the group on the 21st September 2023**

		• EL highlighted the turnaround times of sending samples to the Birmingham laboratory are slow and can take up to 6 weeks or more. This has been compounded recently by supply chain issues. • CT mentioned the assay used at EKHUFT has a much faster turnaround time so they can access the results to then stratify the low and high-risk patients. • EL summarised: i) All Tg assays are unreliable / uninterpretable in the presence of TgAb. ii) NICE recommends "further investigations" in this scenario, but no further details. iii) Referral to the Birmingham laboratory for RIA measurement delays reports by at least 6 weeks for a result that probably adds no value and may also mislead. • CT asked if "mass spectrometry" was viable to use. EL explained this is not routinely offered in the UK and would not currently be an option for K&M. • **The Thyroid TSSG group agreed to stop sending samples to the Birmingham laboratory as this does not offer any additional information and can impact on the patient's pathway. The Thyroglobulin and Thyroglobulin Antibody results should be discussed in the MDM for further investigations. Additionally, they agreed to consider further investigations as per NICE guidance.**		
7.	**CNS Update all Trusts**	**<u>EKHUFT update</u>** • There were no EKHUFT CNS' at today's meeting so an update was not provided. **<u>MFT update</u>** • Debbie confirmed the Thyroid clinics have been set up. • They hosted a Health & Wellbeing event recently across all tumour groups, however, no Thyroid cancer patients attended. They are working to rectify this.		

		MTW update • Milena had nothing further to add and agreed to feedback the details from today's meeting to Luisa (Roldao Pereira).		
8.	**Clinical Audit updates**	• Parathyroid audit to be taken forward and discussed at the next meeting. MA agreed to discuss with Vikram Dhar offline.		
9.	**Research updates**	**Update provided by Maria Acosta** • HOT clinical trial (USA) – risk of recurrent disease – hemi vs total thyroidectomy for low risk thyroid cancer patients. T1b and T2 to consider as long as there are no lymph nodes / aggressive features. 15 sites have opened across the UK. K&M would like to recruit 3 patients but only have 1 patient recruited currently, which is mainly due to patient choice. They have a lot of patients with T1 / T2 disease so potentially they could recruit more to this trial. • HOT Trial – 6 years – monitor 6-monthly. Patients selected from the MDT, assessed to see if they are suitable and to also have patient agreement. • DH suggested offering the patient leaflet explaining the HOT trial at the same time as "breaking bad news" to the patient. They could use this opportunity to discuss further and allocate extra clinic time to discuss. **Action – MA agreed to send some of the simple patient leaflets which explain the HOT trial to both NC and DH.**		**MA**
10.	**CA Update**	**Update by Chris Singleton** **Please refer to the circulated presentation which provides an overview of the KMCA programmes of work.**		**Presentation circulated to the group on the 21st September**

		• K&M are about to embark on the third and final year of the NHS Galleri Grail trial. K&M are one of 8 Cancer Alliances nationally chosen to be part of this trial. 140,000 patients have been randomly chosen nationally to provide a blood test which is able to detect a cancer signal origin (CSO) before any symptoms are detected. The expected number of patients that would trigger a CSO is 1 – 2%. They have identified a number of early stage thyroid cancers which have been treated locally before symptoms have developed. • The Galleri Grail mobile unit has visited a number of towns across the county including Dartford, Sittingbourne and Ashford. • CS referred to two upcoming GRAIL webinars: i) NHS Galleri-GRAIL clinical webinar on 16th October at 2pm (**details circulated by KG**) ii) Kent & Medway GRAIL lessons learnt webinar – **TBC** • RC referred to the future of Galleri GRAIL screening which she anticipated would become part of the national screening programme alongside breast and bowel. RC explained patients would be referred by GP's into Secondary Care via the Non-Specific Symptoms (NSS) Pathway. • CS provided the group with an update on the national changes coming into effect in October 2023 for the Cancer Waiting Times standards which includes: i) 28-day FDS – diagnose or rule out cancer – 75% target ii) 31-day – first treatment to diagnosis iii) 62-day – treatment from GP referral / Consultant upgrade **Action – CT asked if the 3 targets could be summarised and discussed more fully at the next TSSG meeting as they would then be in place.** • CT thanked CS for today's more focused Cancer Alliance update which he felt was more appropriate than previous updates.		**2023** **CT**
11.	**AOB**	• NC raised concern about seeing a variety of NG12 2ww proformas coming in to SC from PC in		

		her area. It was suggested this could be due to them coming in from an out of area CA. Both RC and CT would be interested to view the differences in forms. **Action – NC to send RC and CT a copy of the different 2ww proformas.**		**NC**
12.	**Next Meeting Date**	• Next meeting date - Thursday in March 2024 – Maidstone venue. Date to be agreed in collaboration with the Head & Neck TSSG meeting which is taking place later today. **Action - KG to circulate the meeting invite to the group once the date had been confirmed.**		**KG**