National Clinical Guidelines for Cancer, Translating Evidence into Practice: The Irish Experience

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nccp National Cancer Control Programme

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

The National Cancer Control Programme Ireland

Mandate for National Clinical Guidelines

- Diagnosis Staging and Treatment Guidelines
  - Breast
  - Prostate
  - Gynaecology
  - Lung
  - Gastrointestinal

Governance

- Governance of the guideline development process was provided by a multidisciplinary Guideline Steering Group
- Membership included the following:
  - Chairs of the NCCP Guideline Development Groups
  - Methodologist
  - Librarian
  - Palliative Care
  - Irish College of General Practitioners
  - National NCCP Leads for Surgery, Radiation and Medical Oncology
  - NCCP Executive

National Guideline Development Groups

- Disease site-specific oncologists
  - Surgical oncologist
  - Radiation oncologist
  - Medical oncologist
- Diagnostic Specialists
  - Radiologists
  - Pathologists
- Methodologist
- Project Manager
- Librarian

Evidence Based Guidelines – A Paradigm Shift

- Aim to improve the quality of clinical care
- Aim to prevent variation in practice
- Aim to address areas of clinical care with new and emerging evidence
- They are based on the best research evidence in conjunction with clinical expertise and population values
- They are developed using a clear evidence-based internationally used methodology.

Guideline Development Training

- Learning Aims
  - Developing clinical questions - PICOT
  - Acquiring the evidence
  - Critical appraisal of the evidence
  - Generating recommendations

Guideline Methodology

- Step 1 — Develop Clinical Questions
  - » Defines the scope of the Guideline
- Step 2 — Search for and find the evidence
  - » International Guidelines
  - » Primary Literature
- Step 3 — Appraise the literature
  - » For validity and applicability
- Step 4 — Make recommendations
  - » Applying the evidence in conjunction with clinical expertise and population values
- Step 5 — Draft Guideline
  - » Implementation Plan, Economic Analysis and Budget Impact Statement
  - » National stakeholder review
  - » International expert review
  - » Endorsement by the Department of Health
- Step 6 — Implement, Audit and Update of the Guideline

Increasing Value, Reducing Waste

Breast Guideline

Radiology

Question 2.2 7 In women with breast cancer, who/what subgroups should have staging investigations performed to detect metastases?

Recommendation 2.2.7.1	Grade
In newly diagnosed patients with breast cancer who have symptoms suggestive of metastases, appropriate imaging investigations should be performed, regardless of tumour stage.	B

Recommendation 2.2.7.2	Grade
In newly diagnosed asymptomatic patients with breast cancer, evidence does **not** support the use of routine imaging for metastatic disease in pathological stage I and II disease.	B

Recommendation 2.2.7.3	Grade
In newly diagnosed asymptomatic patients with breast cancer, use of staging imaging for metastatic disease is recommended for stage III and IV disease.	B

Patient Values – Shared Decision Making

Radiation Oncology Question 2.5.3

In otherwise healthy patients with breast cancer who have undergone breast conserving surgery, are there any sub populations in terms of age, tumour size and nodal involvement where radiotherapy is not necessary?

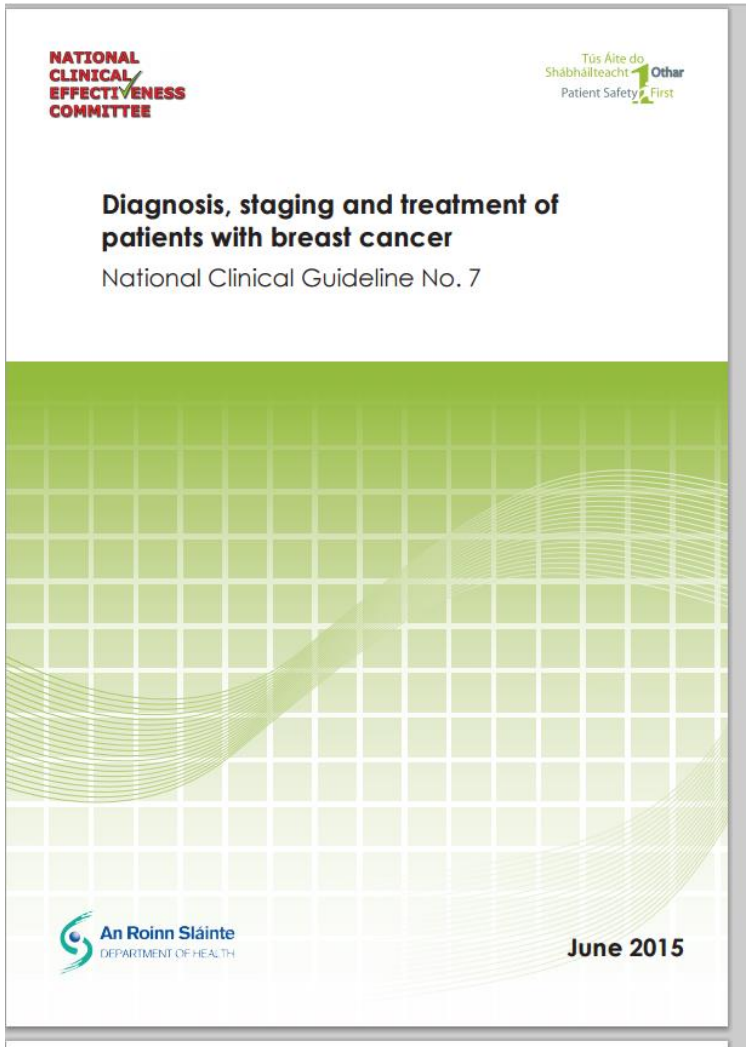
oestrogen receptor positive breast carcinoma treated by lumpectomy. Participants were randomised to receive tamoxifen and RT or tamoxifen alone. Median follow-up is now 12.6 years. At 10 years, freedom from locoregional recurrence was significantly improved in women receiving RT and tamoxifen compared to tamoxifen alone (98% versus 90%, 95% CI, 85% to 93%). There were no significant differences in time to mastectomy, time to distant metastasis, breast cancer–specific survival, or overall survival between the two groups. Ten-year OS was 67% (95% CI, 62% to 72%) and 66% (95% CI, 61% to 71%) in the tamoxifen and RT and tamoxifen groups, respectively. Of the 636 women in this study, only 21 (3%) have died as a result of breast cancer, whereas 313 (49%) have died as a result of other causes (only 6% of deaths attributed to breast cancer). The authors conclude that, depending on the value placed on local recurrence, tamoxifen alone remains a reasonable option for women age ≥70 years with ER positive early-stage breast cancer. (Hughes et al., 2013)

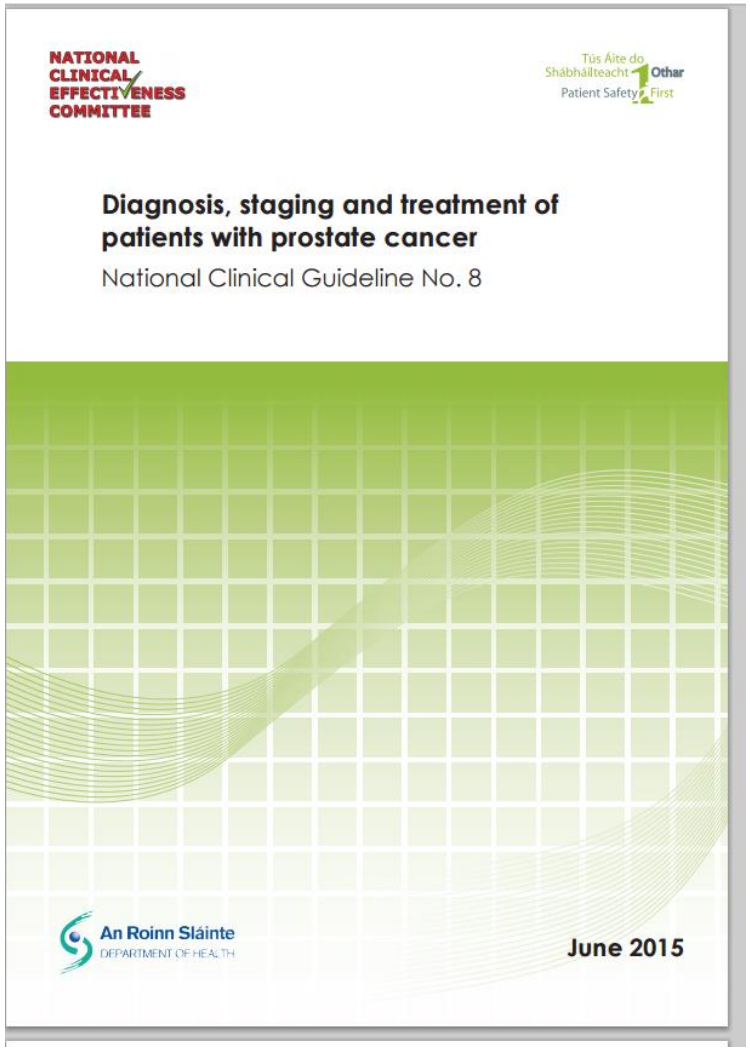
Fyles et al. (2004) in a Canadian study recruited women at least 50 years of age with node negative breast cancer <5cm in size who had undergone lumpectomy. Participants were randomised to receive RT plus tamoxifen or tamoxifen alone. At five years, only 0.6% of the women in the group given tamoxifen plus irradiation had a local relapse, whereas 7.7% of the women in the group given tamoxifen alone had had a recurrence in the breast. There was no difference in overall survival between groups, although the trial was underpowered to detect small differences in survival. (Fyles et al., 2004)

Adjuvant RT reduces risk of recurrence in all subgroups; however in some cases the benefit may be small. There may be very low-risk patients in whom RT can safely be avoided and tamoxifen therapy alone considered. Age, tumour size, lymphovascular invasion status, hormone-receptor status, tumour grade, comorbid conditions and performance status need to be considered in individual cases.

Recommendation 2.5.4.1	Grade
In patients who have undergone breast conserving surgery for early breast cancer, adjuvant radiotherapy shows a benefit in all subpopulations.	A

Good practice point
Although there is a benefit across all subpopulations, there may be a justification for avoiding adjuvant radiotherapy in certain patients with low-risk breast cancer, following discussion at a multidisciplinary team meeting.





www.hse.ie/nccpclinicalguidelines/

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Improving the process – Methodology

- Limit the guideline to 30 questions
- A full literature search on each clinical question
- All appraisals should be carried out by a methodologist, project manager and two clinicians (content experts)
- Research scientists extract the data into evidence tables for accuracy

Improving the process – Project Management

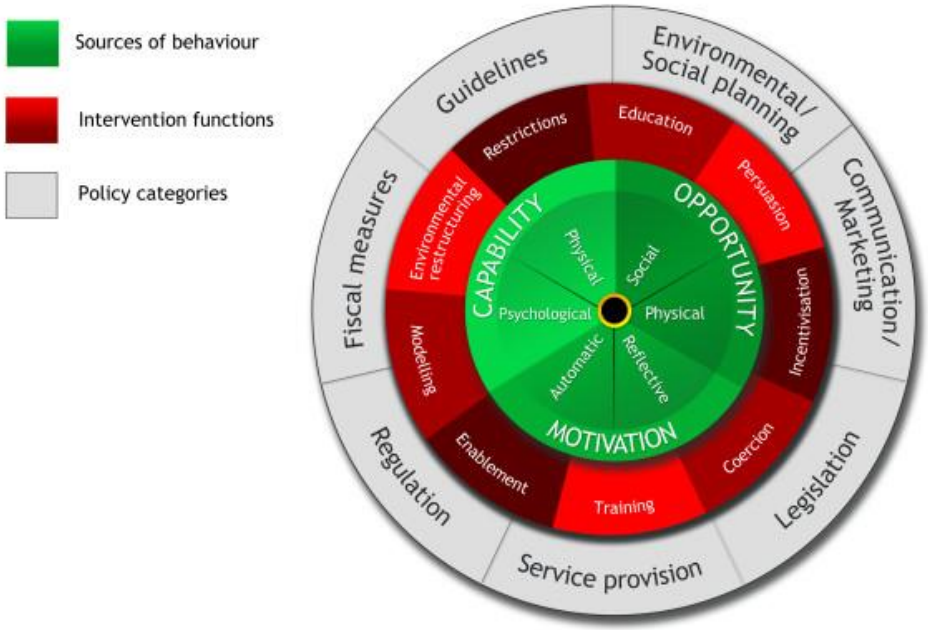
- Membership of the GDG – Lead clinician support
- Clinicians time
- Specialist Registrars (Trainees)
- Essential resources
  - Project Manager
  - Methodologist
  - Librarian
  - Research staff
  - Health Economist
- Guideline development is labour intensive and requires a substantial commitment from all involved

Future Challanges - Implementation, Audit and Updating the Guideline

Implementation

Clinicians

NCCP



DoH

Behaviour Change Wheel; Michie et al (2011) *Implementation Science*

HIQA

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Audit and update of the guideline

- Audit criteria are outlined in the guideline
- Updating the guideline
  - Two way communication
    - Clinicians
    - NCCP

- guidelines@cancercontrol.ie

- www.hse.ie/nccpclinicalguidelines/

Outcome

These evidence-based clinical guidelines will ensure standardised multidisciplinary care for patients, putting evidence into practice to improve patient outcomes.

Acknowledgements

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