Minutes

Date: 15 January 2013
Location: IKNL Office, Leiden, The Netherlands
Participants: Annalisa Trama (Istituto nazionale tumori Milan), Boukje van Dijk (IKNL), Carmen Miranda Kleinegris (NET patient group Netherlands), Daniel Zips (ESTRO), Erik Briers (ECPC), Gemma Gatta (Istituto nazionale tumori Milan), Harry Comber (National Cancer Registry Ireland), Henk Hummel (OECI), Jan Maarten van der Zwan (IKNL), Jourik Gietema (UMCG) , Lisa Licitra (Istituto nazionale tumori Milan), Markus Wartenberg (Sarcoma Pat. EuroNet), Nadya Dimitrova (National Cancer Registry Bulgaria), Nicola Nicolai (Istituto nazionale tumori Milan), Otto Visser (IKNL), Paolo Casali (Istituto nazionale tumori Milan / Rare Cancers Europe), Prof. Kjell Öberg (ENETS), Rene Leemans (VUMC/ EHNS), Riccardo Capocaccia (ISS Rome, Italy), Riccardo Soffietti (EANO), Sabine Siesling (IKNL), Sandra Mallone (ISS Rome, Italy), Sandrine Marreaud (EORTC), Sergio Sandrucci (ESSO), Teresinha Evangelista (EUCERD Joint Action), Thera Links (UMCG), Ton Langeveld (LUMC), Vincent Ho (IKNL), Wouter de Herder (Erasmus MC / ENETS)
Chair: Sabine Siesling

Opening:

Sabine Siesling (IKNL) welcomed the participants and invited everyone to introduce themselves and to mention the organization they represent.

Presentation 1: The project "Information network on rare cancers" RARECARENet)

Annalisa Trama (Istituto nazionale tumori Milan) gave a short introduction on the RARECARENet project.
The RARECARENet project aims at: "Building an information network to provide comprehensive information on rare cancers to the community at large."

As a result of the previous project on rare cancers, named RARECARE, some facts on rare cancers were presented to give an idea on the burden of rare cancers in Europe.

- about 500,000 new rare cancers occur each year in Europe
- 22% of all new malignancies
- About 4 million people alive with a diagnosis of a rare cancer
- 24% of the total cancer prevalence

Another major outcome was the fact that rare cancers have a worse 5 year relative survival in comparison to non rare cancers. This might be due to several reasons like:

- late or incorrect diagnosis
- limited access to appropriate therapies and clinical expertise
- limited information about the disease
- lack of clinical trials

To reach the aims of RARECARENet the following actions will be taken:

- Update epidemiological indicators
- Gain information on health care pathways for rare cancers
- Develop information on criteria for centres of expertise
- Gain information on Clinical diagnosis and management (including very rare cancers)
- Develop Information for patients
    - list of centres of expertise
    - list of patient's associations

To come to a final result the RARECARENet project will coordinate with other initiatives that are already in place like Orphanet, Rare cancers Europe, EUCERD and EPAAC.

Presentation 2: Objectives of the meeting

Sabine Siesling (IKNL) presented the objective of the meeting, which is to identify qualification criteria for Centres of Expertise (CoE) for rare cancers (work package 5?). At the end of the project this work package will come with a report identifying criteria indicating the level/quality of expertise for rare cancers management.

The meeting has two parts

1. General criteria > for all rare cancers
2. Specific criteria > for specific tumour types

In the first part of the meeting general criteria for CoE on rare diseases in general will be discussed, using criteria that are already available, for example from

- European Union Committee of Experts on Rare Diseases (EUCERD)
- Multidisciplinary scientific societies
- Patient organizations
- Policy makers

In the second part some tumour specific criteria will be presented, focussing on

- Testicular cancer
- Head and Neck cancer
- Neuroendocrine tumours
- Sarcomas

These tumours were selected based on

- Expected difference in clinical management
- Expected difference in clinical outcome
- Geographical patterns (risk factors) and trends in incidence
- Already work done by other groups
- Not extremely rare

At the end a consensus from all participants is expected in order to continue working on qualification criteria for CoE for rare cancers.

Presentation 3: Criteria in Europe for comprehensive cancer centres following the Organisation of European Cancer Institutes (OECI) recommendations:

Henk Hummel (OECI), gave a short introduction on the mission of the OECI: 'Bring together the cancer research and care institutions in Europe to create critical mass of expertise and competence.'
A timeline was presented, starting in 2002, on how the OECI planned to reach this aim. To understand the context in which the OECI is working an overview was given on the different initiatives working on the quality assessment in health care oncology. One of the main initiatives within the OECI is their accreditation programme including:
- Standards and criteria for quality of multidisciplinary cancer care,
- A tool to collect standardised and quality data from approved cancer centres
- A process allowing to survey the cancer centres, to assess compliance with the standards

Qualitative and quantitative standards within this accreditation program were presented focussing on

- Planning and organisation of integrated care
- Multidisciplinary care
- Integration and translation of research into care
- Education for professionals
- Patient satisfaction
- Constant quality improvement

Using these standards the OECI distinguishes 4 types of Cancer Institutes:

1. Cancer Unit (small number of beds and a small number of scientific publications)
2. Cancer Research Unit (focus on research not on treatment)
3. Clinical Cancer Centre (relative large budget for research and treatment)
4. Comprehensive Cancer Centre (like a Clinical Cancer Centre, but having higher standards)

Presentation 4: ***Criteria for centres of expertise for rare diseases in the EU following the European Union Committee of Experts on Rare Diseases (EUCERD) recommendations***

Teresinha Evangelista (EUCERD Joint Action), started her presentation with an overview on common problems rare diseases are facing, such as:

Patients are rare
Experts are rare

- This results in having more difficulty in gathering experience to improve knowledge, care, diagnostics and treatment.

Developing national plans on rare diseases should support the problems as described, Centres of Expertise are components of these rare disease plans/strategies.

To support the national plans and development of Centres of Expertise for rare disease, the EUCERD developed 45 recommendations including the following 4 main areas;

1. Mission and Scope of the Centres of Expertise
    - how to define
    - What is de coverage
    - Patient focus
    - Core Competencies
    - Role in spreading information and education
    - Role in research
2. Criteria for designation
    - Leadership and credibility
    - Multidisciplinarity and inclusiveness
    - Capacity
    - Links and collaborations
3. Process for designation
    - Core principles of designation
    - Designation criteria
    - Duration of designation
4. European Dimension
    - Not further elaborated

The EUCERD stated that Networking of Centres of Expertise is a key element, to ensure:

- that expertise travels rather than patients;
- exchange of data, biological samples, radiological images, other diagnostic materials
- promotion of e-tools for tele-expertise

"Designated Centres of Expertise at Member State level are the key elements of the future European Reference Networks"

Presentation 5: Criteria for centres of expertise for neuroendocrine tumours

Wouter de Herder (Erasmus MC) started his presentation with an overview how neuroendocrine tumours (NETS) are functioning. This in order to understand better the importance of the different specific items that are important for Centres of Expertise for Neuroendocrine tumours.

Wouter de Herder referred to the European Neuroendocrine Tumour Society (ENETS) criteria for centres of expertise on NETs. Some studies relate these Centres of Expertise to better survival of the NET patients. ENET criteria are focussing on:

- The availability of a Multidisciplinary Team including the following specialists;
    - Internist
    - Endocrinologist
    - Oncologist
    - Gastroenterologist
    - GI/pancreas/thoracic surgeon
    - Transplant surgeon
    - Pathologist
    - Radiologist
    - Nuclear medicine physician
    - Clinical geneticist
    - Dedicated nurse practitioner

  This team is related to the tumour board and patient support group.
- Key role players for Expert Centres are adequate and expert pathologists using the TNM, WHO and grading system for pathological classification.
- Other key role players are the radiologists and nuclear medicine physician, the different imaging strategies were presented
- For treatment the GI/pancreas/thoracic surgeons are most important and should look for close collaboration with the radiologists, oncologists and nuclear medicine physicians. This multidisciplinary way of treatment is seen as the optimal treatment

An overall overview of requirements for improvement in NET outcome was presented which included:

- Refinement of universal classification and grading system.
- Elucidation of cell biology.
- Development of cell lines and animal models.
- Acquisition of genetic information.
- Identification of serum markers for early diagnosis.
- Definition of tissue markers to identify tumour origin.
- Development of molecular pathological profiling to define prognosis.
- Precise identification of topographic information (before and during surgery).
- Identification of molecular therapeutic targets.
- Development of improved (adjuvant) treatment for residual disease.
- Establishment of centres of excellence and multidisciplinary specialty NET clinical teams.
- Construction of central clinical and tissue database resources.
- Government focus on clinical and research funding for an orphan disease.

As final point for discussion the management of a network for Centres of expertise on NETs was presented.

Presentation 6: Data Source for Cancer Centers at EORTC:

Sandrine Marreaud (EORTC) presented a short overview of the available data within the EORTC which might contribute to quality criteria for Centres of Expertise for rare cancers.
EORTC is working with three types of forms;

1. A membership questionnaire
   - collection of general information about cancer centres
2. A feasibility form
   - tailored for a pre-defined trial
3. Case report forms
   - tailored for a specific trial and include information related to patients

Information collected using these different kind of forms might help to contribute to the RARECARENet project.

Presentation 7: Criteria for centres of expertise for testicular cancers

Jourik Gietema (UMCG) started his presentation with an overview on testicular cancer stating that there is a curative model for testicular cancer. Also more insight in needs for diagnose, treatment and follow-up were given. For staging testicular cancer a CT-scan of chest/abdomen and some tumour markers are needed

- LDH (seminoma, non-seminoma)
- ß-HCG (seminoma, non-seminoma)
- AFP (non-seminoma)

The diagnose and treatment should be done in a multidisciplinary team including;

- Urologist
- Pathologist
- Radiologist
- Radiotion oncologist
- Medical oncologist
- Surgical oncologist
- Thoracic surgeon
- Nurse practioner
- Psychologist
- Family doctor

The different types of treatment available for the different stages were presented, dividing seminomas from non-seminomas. Overall, men diagnosed with testicular cancer have an excellent prognosis, but need long follow-up for secondary malignancies and cardiovascular morbidity related to prior treatments.

The following criteria should be put in place as criteria for centres of expertise for testicular cancers

- Multidisciplinary team with routine experience.
- Diagnosis
- Staging
- Treatment
  -radiotherapy
  -chemotherapy
  -surgery
- Follow-up
  - early and late relapse
  - late effects of treatment
- Survivorship care

A focus for rare tumours with long term survivors should be put on the long term and adequate follow up.

Presentation 8: ***Experiences from the urological unit of the National Cancer Institute in Milan***

Nicola Nicolai (Istituto nazionale tumori Milan) presented his experience with the multidisciplinary urology unit/testis surgery unit at *Fondazione IRCCS Istituto Nazionale dei Tumori, Milan, Italy.*

First of all a scenario overview was presented, explaining the specific scenarios for patients dealing with testicular cancer. This scenario described three main factors which were subdivided in the different factors. The three main factors were;

1. Disease (important epidemiologic impact)
2. Individual → (Heavy psychologic burden)
3. Treatments →(Different options)

Per stage of disease for testicular cancer a summary of the health care pathway was presented. The reason for working in multidisciplinary teams (MDT) is summarized as follows:
"Different and often contradictory opinions, which, deriving from clinical uncertainties, arise uncertainty in the patient"
At least the following experts should take place in a MDT: urologist, radiation oncologist, pathologist, radiologist, medical oncologist, psychologist.

At least the following actions should take place within the MDT for stage I-IIA non seminomas:

- Review of imaging
- Review of histologic slides
- Sperm banking proposal
- Discussion on clinical data
- Different alternatives are proposed considering risk factors, characteristics of the patient

After elaborating on other types of rare urogenital cancers an overview was given on similarities and differences for centres of expertise between units focussing on rare cancer and common cancer. Some examples were presented:

Requirements	**Prostate Unit**		**Rare GU Cancer Unit?**	
ORGANIZATION				
Exclusive staff	Highly recommended		Professionals involved in other fields	
Multidisciplinary team	Clinics (staff/professionals education) Case discussion		Clinics (staff/professionals education) Case discussion	
Service availability	Under the Unit supervision		Under the Unit supervision	
Core Rx setting	Surgery RT/BRT AS HT ChT	All available within but outsourcing is possible	Surgery RT AS ChT % HDChT	All available within. **Outsourcing is exceptional**
Equipment	High-Tech Diagnostics High-tech Therapeutics		Dedicated technology	

Presentation 9: Criteria for centres of expertise for head and neck cancers

Lisa Licitra (Istituto nazionale tumori Milan) presented the criteria for centres of expertise for head and neck cancers. She started the discussion using the already available draft document on indicators for centres of expertise. The main point of discussion was on the volume criteria and on the grouping of rare head and neck tumours. Five major points that should be taken into account concerning the criteria for centres of expertise for head and neck cancers are the following;

1. H&N cancers are mostly curable even in advanced stage
2. Integrated often simultaneous treatment for these cancers are provided by different specialist
3. Special patient population
4. Optimal treatment decisions in Multi Disciplanair Team with the patient
5. Optimal supportive care should be upfront decided and followed

Lisa gave an overview of the already available guidelines and criteria towards centres of head and neck cancer in Europe. The following documents are also available:

- Germany; guidelines on Head Neck
- UK; NICE 2010
- France; RARE TUMOR INCA
- Netherlands; general guidelines 2010, NWHHT

For hospital volume on head and neck tumours a volume criterion of 100-200 incident cases was proposed. A single multidisciplinary team should discuss at least 100 new cases a year. This is important because head and neck cancer is well known to occur simultaneous with other diseases and is related to socioeconomic factors. Optimal treatment should be given in consultation with the patient, supportive care depending on social situation of the patient.

Within cancer networks decisions will be made upon the hospitals for diagnose, treatment and care for patients with head and neck cancer. This, for instance, might be related to stage of disease at diagnosis (dedicated clinics). All these centres of expertise should be physical and not based on virtual network.

A possible indicator next to the already existing indicators should be:

- time to treatment after being instituted; this should be within 30 calendar day for 80% of all patients
- First contact to first visit to specialist should be measured
- Minimal collection of the following data
    - Data which are related to quality of care
    - Referral
    - Stage
    - Outcome (recurrence, outcome)
- Availability of psychosocial care

Some remarks on using data for benchmarking were made;

- Internal information on outcome, not for comparing individual centres!
- Pooling data should not be used for comparison but for checking whether volume is influencing the outcome
- Outcome analysis on sample size is difficult to adjust for in survival analysis, using a large study period is difficult, because management changes over time.

Presentation 10: Criteria for centres of expertise for sarcomas

Paolo Casali (Istituto nazionale tumori Milan / Rare cancers Europe) started his presentation raising the following issues upon Centres of Expertise for rare cancers and sarcomas:

- Which clinical decisions need to be multidisciplinary? The very first one? All the «strategic» ones? Those at the beginning of any new «treatment phase»? All?
- All in-house? Something outside, inevitably, but how should it be available?
- Multidisciplinary decision-making also allowed over a network? Or is it allowed to resort to a decision made multidisciplinarily by others?
- How to accommodate the complexity of all this?
- Ubiquitous anatomical site of origin (several surgeons involved, unlikely to be all in-house…)
- Much health migration, which should be mitigated as much as possible: e.g., medical therapy can well be provided close to where patient lives, provided its selection was shared with centres of expertise (over a network, through occasional teleconsultations, through a second-opinion visit elsewhere?)
- Not so much evidence-based, maybe…
- Only patients on treatment at the centre? Also second-opinions, or at least those patients shared over a network with full clinical responsibility?
- What about centres resorting to remote consulting or distance patient-sharing over a network?
- Extreme variability of clinical presentations
- Even compliance with CPGs may mask serious inappropriateness due to the lack of clinical expertise
- Is involvement in clinical research a requirement for a reference centre? (for example, this would be a difference from frequent cancers!)
- Publishing in rare cancers is easier on average for reference centres but may be much more difficult for a centre outside a selected circle, though its quality of care can be high, all the more if collaborating effectively
- The extreme variability of presentations makes it difficult to use standard outcome indicators (this might even discourage hi-tech, innovative, borderline treatments…)
- In a rare cancer, with patients often travelling, follow-up may not be easily available

A possible solution for the issues raised is not thinking in the way of developing Centres of Expertise but come to the development of specialized networks guaranteeing the continuity of care, including shared decision making

Markus Wartenberg (Sarcoma Pat. EuroNet) presented potential criteria out of patient perspective are;

1. There is an experienced and balanced sarcoma dedicated MDT with all key skills (to be defined)
2. Number of new patients seen (by first diagnosis or first referral) is 100 or more per annum…
3. The Centre is running a weekly “Sarcoma Board” (…not only a Tumour Board…)
4. MDT follows protocols based on published evidence-based guidelines (e.g. ESMO or national guidelines) in diagnosing, treating and monitoring patients
5. MDT is a member of a network (national, EU) to which individual patients with rare sub-types, unusual presentations etc, are referred to a centre with special expertise
6. MDT is a recognised (contributing) clinical trial centre (EORTC, intergroup, or other)
7. Leading MDT members have a recent publication record
8. There is an active and long-term collaboration with local/regional or national sarcoma patient groups (to be defined) >>> More details: How well is the patient involved?
9. MDT is a member of the national sarcoma network (if applicable) and has other relevant affiliations (e.g. EORTC-STBSG, EMSOS, CTOS, etc.)
10. All case data are provided to a cancer registry and/or to a specific sarcoma registry

11. MDT can minimize travel for patients by providing local support under the MDT's direction to ensure treatment standards for systemic therapy are met
12. The centre provides an excellent therapy and side effect management of systemic treatments, including oral targeted therapies

Presentation 11: Pilot study on rare cancers and places of diagnosis/treatment

Riccardo Capocaccia (ISS Rome Italy) presented the results of a pilot study done on rare cancers in relation to the hospital of diagnosis and treatment. The background to come to this pilot study was mentioned as follows: “Referral to a few specialized centres is often indicated as the optimal strategy for effective management of rare cancer patients”

Resulting in three main questions:

- To what extent centralization is actually realized?
- Is the information on specialized centres available to patients and doctors?
- Which evidence is supporting this strategy ?

Desirable indicator properties:

- Applicable to rare cancers
- Sensitive
- Comparable across population
- Comparable across cancers
- Simple meaning

The pilot as presented focussed on oesophageal cancer in Italy, using data from 2006. First, a relation between number of hospital patients and number of admissions in 2006 was shown. Secondly, the hospital volume distribution was presented showing all cases and operated cases in a graph including the number of hospitals and number of patients. The same was done but then presenting the proportions in stead of the number of cases.

Another objective to establish within this project is ‘Mapping High-Volume hospitals for Rare Cancers’

The following problems and cautions towards mapping were presented;

- Public diffusion of hospital name and characteristics
- Definition of high volume hospitals
- Patients’ migration
- Delay in analyses related to the actual (changing) situation
- Already existing networks
- High volume surgeons/oncologists/radiotherapists treating in low volume hospitals
- Good quality services in low volume hospitals and *vice versa*

We can conclude that volume analysis is widely carried out and used for health care planning and evaluation. In RARECARENet it will be applied in two new settings:

1. Rare cancers
2. International comparisons

The results as presented gave an example for possible case volume indicators

Presentation 12: Summary / Conclusion

Sabine Siesling (IKNL) gave a short wrap up to summarize the outcome of this meeting. Also a focus on the way forward was presented asking the audience to further cooperate with the RARECARENet project to come to high quality indicators on Centres of Expertise for rare cancers.

In conclusion, this meeting was successful because of the wide selection of participants who all were willing to give their opinion, using their different perspectives on Centres of Expertise. However, this meeting did not result in adequate indicators, we created a focus to work on for the coming time. Using the arguments and results of the discussion, this day will result in a new proposal of indicators on centres of expertise for rare cancers, which will be sent to all participants and to people who were invited but not able to attend.
A new meeting for the participants is scheduled for 2014 in order to present and approve the final results.