PROGRESS TOWARDS A NATIONAL GYNAECOLOGICAL ONCOLOGY REGISTRY MODULE 2: ENDOMETRIAL CANCER

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Introduction

Clinical quality registries (CQR) are designed to monitor and drive improvements in the quality of care provided to patients with a disease or condition of interest (Figure 1). The National Gynae-Oncology Registry (NGOR) operates a CQR within the Cancer Research Program (CRP) at Monash University. Established in 2017, the NGOR aims to capture clinical data on newly-diagnosed cancers of the uterus; ovary, fallopian tubes, peritoneum (OTP); cervix and vulva in Australia.

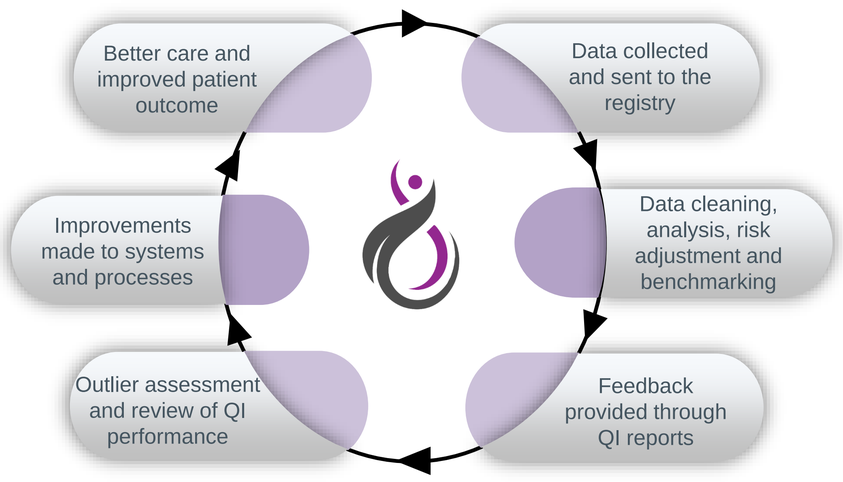

Figure 1. The process of a clinical quality registry, adapted from the Australian Commission on Safety and Quality; https://www.safetyandquality.gov.au/our-work/information-strategy/clinical-quality-registries/

In 2019, the Audrey Voss Gynecological Research Grant resulted in the expansion from the original OTP cancer module. The Epworth-supported expansion project was designed to extend the registry to all patients with gynaecological cancers, namely cancers of the endometrium, cervix and vulva. The endometrial module has been the focus of the expansion project pilot study, as it is the most common gynaecological cancer in high income countries. 1 in 40 women in Australia are diagnosed with endometrial cancer before their 85th birthday, with there being 3,000 new cases a year.

International Collaboration

The NGOR has made contact with similar gynaecological cancer quality registries in the Netherlands, Scotland, Denmark and Sweden. Discussions are ongoing about standardising the QI's and establishing international benchmarks.

Aims

The pilot project aims to determine the ease of data collection required to appropriately and accurately report on quality of care using the quality indicators.

Methodology

The endometrial cancer Working Group (WG) conducted a review of existing evidence-based guidelines and current literature on best practice of care for endometrial cancer. A set of draft QIs was developed and circulated to all clinical participants of the registry. Refinement of the QIs following feedback enabled the QIs to be finalised.

Pilot data collection was retrospective and participating health services sent key details of the last 40 patients they had treated for endometrial cancer to the registry. Eligible patients were invited to participate under an opt-out method or a waiver of consent. Following a two-week period, clinical data about the participant was collected if they had not opted out. Figure 2 illustrates the recruitment and data transfer process.

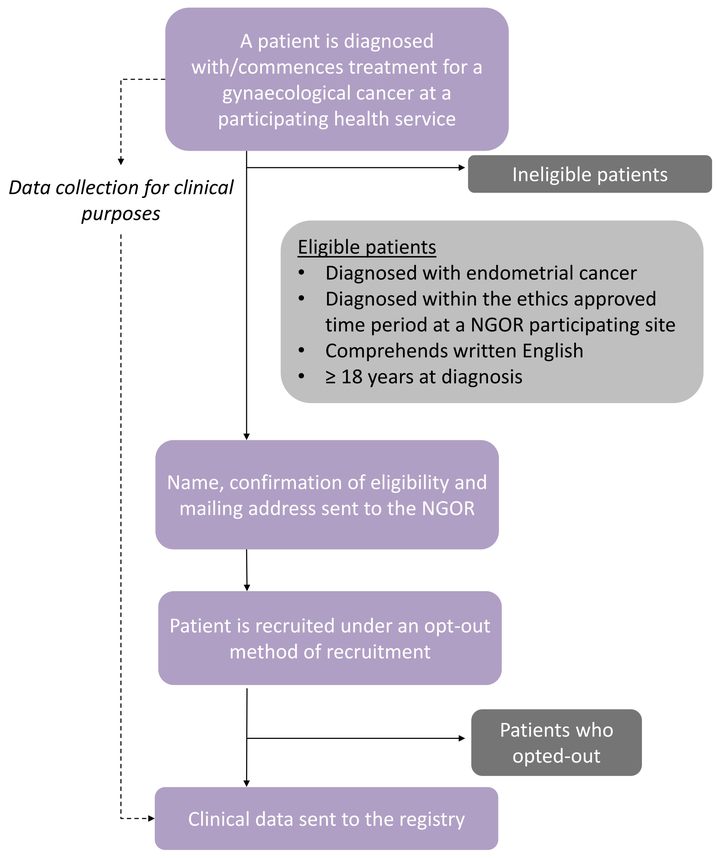

Figure 2: NGOR Recruitment Model

Results

Over 600 participants have been recruited to the endometrial module across five hospitals in Victoria and Tasmania. This poster includes data on 80 participants from three institutions, represented by two health services; health service X and health service Y. Tumour characteristics, such as stage, morphology and grade are illustrated in figure 3 below.

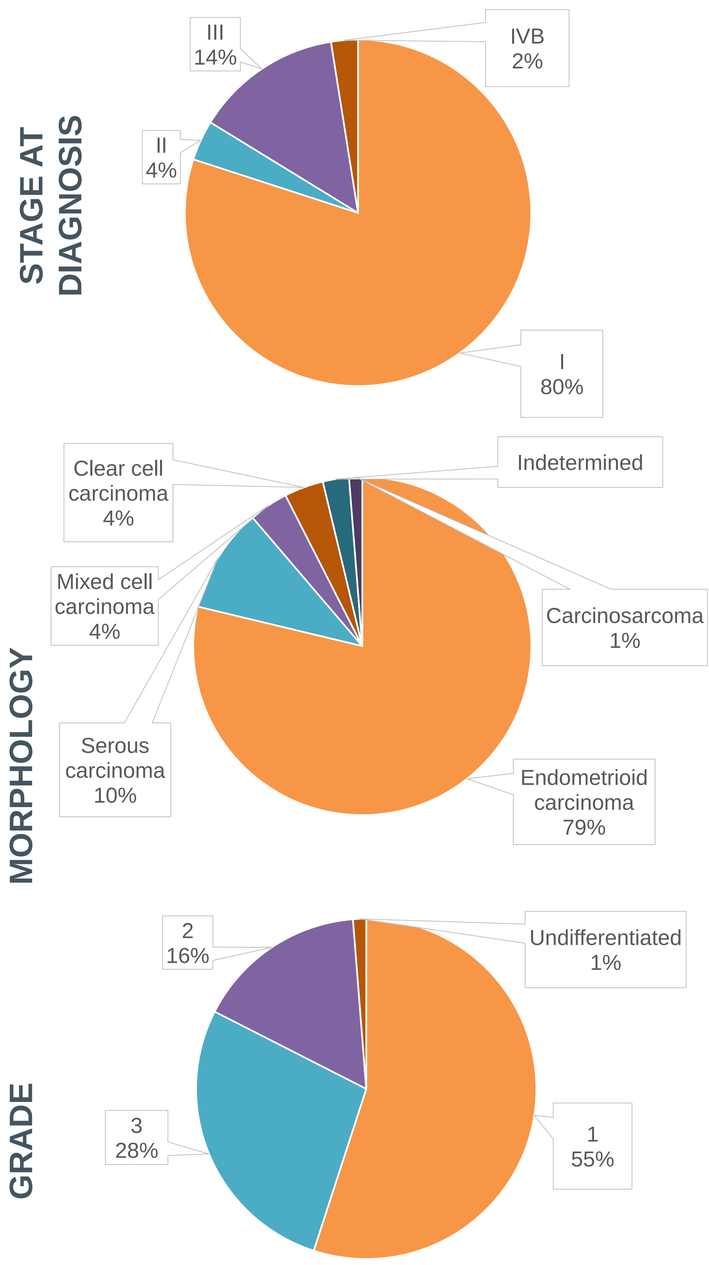

Figure 3: Health service X & Y's combined Stage, Morphology and Grade

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Endometrial Cancer Quality Indicators

1. Proportion of patients with newly diagnosed endometrial cancer whose case is discussed at a **multi-disciplinary team meeting.**

Health service X: 40 of 40 (100%)

Health service Y: 40 of 40 (100%)

2. Proportion of patients with newly diagnosed endometrial cancer who have **imaging to stage** their cancer prior to starting treatment**.**

Health service X: 16 of 36 (40%)

Health service Y: 38 of 40 (95%)

3. Proportion of patients undergoing **primary surgery** for endometrial cancer which includes a **hysterectomy by a minimally invasive approach** *(laparoscopic or robotic)*

Health service X: 0 of 36 (0%) Primary surgery not done: 4

Health service Y: 36 of 39 (92%) Primary surgery not done: 1

4. Proportion of patients who are at risk for spread* because of high-risk histology and/or stage who have **surgical staging**

Health service X: 13 of 15 (87%) - 9 sentinel node sampling

Health service Y: 14 of 15 (93%) -13 sentinel node sampling

5. Proportion of patients undergoing primary surgery for endometrial cancer who suffer one or more **unplanned significant intraoperative events.**

Health service X: 2 of 36 (11%) - 2 Estimated blood loss >500ml. 1 required internal iliac artery ligation.
Health service Y: 3 of 40 (7.5%) - 3 Conversion of endoscopic to open surgery.

6. Proportion of patients who suffer one or more serious **Adverse Events** which are Clavien-Dindo ≥ grade III severity in the first 30 days after primary surgery for endometrial cancer.

Health service X: 0 of 36 (0%)

Health service Y: 3 of 39 (7.7%)

7. Proportion of patients with endometrial cancer whose **pathology report** contains the minimum required elements.

Health service X: 40 of 40 (100%)

Health service Y: 40 of 40 (100%)

8. Proportion of patients with newly-diagnosed histologic high-risk stage IA, stage IB, II and stage III endometrial cancer who **received postoperative adjuvant treatment.**

Health service X: 12 of 36 (33%) (7 RT alone; 3 chemo RT, 2 chemotherapy)

Health service Y: 16 of 39 (41%) (13 RT alone; 3 chemotherapy)

9. Proportion of patients with endometrial cancer undergoing radiotherapy for whom the **interval from hysterectomy to the start of radiotherapy (RT) is 60 days or less**.

Health service X: 7 of 11 (64%)

Health service Y: 6 of 12 (50%)

10. Proportion of patients with endometrial cancer found to have loss of staining (LOS) for DNA mis-match repair proteins not due to methylation, who were **referred for consideration of genetic testing.**

Health service X: IHC 29; LOS 7; incomplete data

Health service Y: IHC 11; LOS 8; incomplete data

11. Proportion of patients with endometrial cancer who are enrolled in a **clinical trial or translational research**.

Health service X: 1 of 40 (2.5%)

Health service Y: 1 of 40 (2.5%)

Please scan the QR code to see the endometrial QI's and calculations

Discussion

One of the major challenges and limitations was that the relevant data resided in several different silos and was not simple to collect or compare. This made data collection a time-consuming process. It was found that minimal adjustments to the database following feedback from data managers during the pilot data collection phase has allowed the registry to streamline the data collection process.

Conclusion

The endometrial QIs will continue to evolve over time Ongoing funding will be sought in order to continue support for this project and expand it to all states.

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