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BHIVA Malignancy Guidelines 2013

Guideline progress

Chapters: 11

Authors: 15 (6 HIV, 4 Haem Onc, 2 Med Onc, 2 Clin Onc, 1 Surgeon)

BHIVA members: 7/15

Completion rates: 10/11

Missing chapter (2 HIV, both BHIVA members)

Chapters

Introduction & MDT working

AIDS defining malignancies

- KS
- Cervical cancer
- NHL
  - Burkitt lymphoma
  - Diffuse large B cell lymphoma
  - Primary effusion lymphoma
  - Plasmablastic lymphoma
  - Primary cerebral lymphoma

Chapters

Non AIDS defining malignancies

- Anal cancer
- Hodgkin lymphoma
- Other NADM (lung, germ cell, liver)

OI prophylaxis

Where should we treat PLWH and cancer?

Expertise v Access

Integration of HIV and oncology service

Network approach

Accreditation on quality of service

How many patients should be cared for in a centre ?

EVIDENCE

Cochrane review have shown that the more HIV patients treated by a centre, the better the outcomes (1-3) (level of evidence IIa).

Refs: 1. Crit Care Med. 1998; 26:668-75.
2. AIDS Care. 2012; 24:267-82.
3. *Cochrane Database Syst Rev*, 2011.

How many patients should be cared for in a centre ?

EVIDENCE

"Improving Outcomes in Haematological Cancer" published by NICE in 2003 included a systematic review of published evidence suggesting that higher patient volumes are associated with improved outcomes and that outcomes in specialist centres are better (level of evidence IIb).

Ref: http://www.nice.org.uk/nicemedia/live/10891/28787/28787.pdf;

How many patients should be cared for in a centre ?

EVIDENCE

North London audit 2004 confirmed the better management of patients with AIDS-related lymphomas in HIV centres with cohorts of >500 patients (level of evidence III).

Ref: Int J STD AIDS. 2004; 15:765-6.

How many patients should be cared for in a centre ?

EVIDENCE

Audit in Canada also showed that clinicians treating larger numbers of patients with AIDS-related lymphoma provided better care (level of evidence III).

Refs: Ann Hematol. 2007; 86:631-8.

How many patients should be cared for in a centre ?

An additional benefit could be greater uptake of HIV testing amongst patients diagnosed with cancers including lymphomas as advocated in BHIVA testing guidelines (1).

This remains a concern since UK lymphoma clinicians are often overly reluctant to adopt universal testing (2) and uptake remains low even for AIDS defining malignancies (level of evidence III) (3).

Refs: 1. Clin Med. 2009; 9:471-6.
2. HIV Med. 2010; 11:59-60.
3. HIV Med. 2012; 13:34

How many?

Population for specialist MDT

Haem onc 0.5M

Testis cancer 2M

Penile cancer 4M

HIV cohort size

Volume for clinician

Lung cancer >100/yr

Breast cancer >50 ops/yr

Melanoma >16 LN dissections/yr

Bone sarcoma NICE guidance 2006

Soft tissue sarcoma MDT (100/yr) is likely to serve a population of 2–3 million people

Bone sarcoma MDT (50/yr) is likely to serve a population of of 7–8 million

Your advice...

Are you a member of BHIVA?

① Yes

② No

Your advice...

What job do you do?

① Community rep

② Nurse

③ Non-consultant grade doctor

④ Consultant grade doctor

⑤ Other

Your advice...

What should commissioning of HIV oncology services be based on?

① Geography (population served)

② Volume (HIV cohort size)

③ Experience (number of HIV cancer patients)

Your advice...

What total population should an HIV oncology service cover?

① Any

② 1 Million

③ 5 Million

④ 10 Million

Your advice...

What HIV cohort size should an HIV oncology service cover?

① Any

② 1,000

③ 5,000

④ 10,000

Your advice...

What number of patients with HIV & cancer should an HIV oncology service cover?

① Any

② 20/yr

③ 50/yr

④ 100/yr