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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).

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).

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).

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).

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 7–8 million people.
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
What HIV cohort size should an HIV oncology service cover?

① Any
② 1,000
③ 5,000
④ 10,000
What number of patients with HIV & cancer should an HIV oncology service cover?

① Any
② 20/yr
③ 50/yr
④ 100/yr