

P193 THE VALUE OF A REGIONAL MESOTHELIOMA MULTIDISCIPLINARY TEAM MEETING—AN AUDIT

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Both the British Thoracic Society 2007 guidelines (1) and the National Mesothelioma Framework (2) advocated the development of regional mesothelioma multidisciplinary team (MDT) meetings to discuss all mesothelioma cases on a regional basis. The Avon, Wiltshire and Somerset cancer network regional mesothelioma MDT team was established in 2008. We undertook a retrospective audit to evaluate its value.

Methods All patients referred for discussion in the 12-month period, 1st January 2009 to 31st December 2009, were included in the audit. The referral information and MDT outcomes were reviewed.

Results In total 76 patients were discussed; 66 males, median age 72 (40–88) and 10 females, median age 71.5 (46–88). WHO performance status was 0 in 15/67 (22%), 1 in 36/67 (53%), and 2 in 9/67 (13%). All 76 cases had a tissue diagnosis of mesothelioma made at their local hospital. Biopsy techniques included CT guided biopsy 28/68 (41%), local anaesthetic thoracoscopy 16/68 (24%) and VATS 19/68 (28%). All histological specimens were reviewed by the MDT. The final diagnosis was mesothelioma in 74/76 cases. The histological subtypes were; epithelioid 53 (69%), sarcomatoid 17 (22%), biphasic 3 (4%) and histiocytoid 1. In two (3%) cases, the diagnosis of mesothelioma was changed to severe reactive pleuritis only. Clinical follow-up and interval CT confirmed no evidence of malignancy. In addition, a further case with suspicious histology was confirmed to be reactive pleuritis only. Consideration of chemotherapy was felt appropriate in over two thirds of patients and patients could also have entered into a clinical trial. A total of 26/65 (40%) patients went on to have at least one cycle of chemotherapy and of these patients 19/26 (73%) entered a clinical mesothelioma trial.

Conclusions This audit supports the valuable role a regional mesothelioma MDT can play, both in the confirmation of the diagnosis and in evaluating eligibility for potential clinical trials.

REFERENCES

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P194 THE RISE OF EBUS: THE FALL OF MEDIASTINOSCOPY?

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Introduction EBUS is a minimally invasive procedure that can be used instead of mediastinoscopy to investigate mediastinal lymphadenopathy, including the staging of lung malignancy. However, its impact on the use of mediastinoscopy is unknown. We wished to determine the efficacy of a recently introduced EBUS-TBNA service and its impact on the number of cervical mediastinoscopies at our institution.

Methods We analysed the results of a prospectively recorded database of all cases referred for EBUS-TBNA over a 1-year period following its introduction in June 2009, and compared them with the number of cervical mediastinoscopies performed in the year before and after its implementation.

Results 216 patients underwent EBUS-TBNA (1st quarter 30, 2nd 56, 3rd 56, and 4th 74), with an average time from referral to procedure

5 days (range 1–15). Two who were intolerant were excluded from subsequent analysis: of the remainder 189 underwent lymph node biopsy, 16 peribronchial lesions and 9 a combination. 346 lymph node stations (144 lower paratracheal, 104 subcarinal, 83 hilar, 9 upper paratracheal, 3 paraoesophageal, 2 lobar and 1 retrotracheal) were biopsied with an average size of 1.3 cm (0.5–6): <1 cm nodes were biopsied in 50 patients (65 lymph nodes). Adequate samples were obtained in 203 patients (95%): 105 carcinoma, 27 sarcoidosis, 2 tuberculosis, 2 cysts, 1 cryptococcus, 1 lymphoma, and 65 benign lymphoid tissues. Of the latter, 36 were confirmed benign by surgery or clinical follow-up, 2 await mediastinoscopy/resection, 22 could not be confirmed, 3 were subsequently diagnosed as lymphoma and 2 with sarcoidosis. 2 patients (>6 biopsies each) developed self-limiting pyrexia (<12 h) and 1 patient developed a COPD exacerbation, which required intensive treatment for 24 h. During the same period, 67 patients underwent mediastinoscopy compared to 105 in the preceding 12 months (37% reduction).

Conclusion Our experience suggests that EBUS is a safe and effective alternative to mediastinoscopy in the diagnosis of patients with mediastinal lymphadenopathy and the staging of lung cancer patients. Its introduction was accompanied with a reduction in the use of cervical mediastinoscopy, saving NHS costs and improving the experience of patients undergoing this diagnostic pathway.

P195 TEMPORAL TRENDS AND DISTRIBUTION OF RECURRENT DISEASE FOLLOWING LUNG CANCER SURGERY AND RELATIONSHIP TO PRE-OPERATIVE PET SCAN

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This audit based on 10 years of data held within the Salford Lung Cancer Team was designed to identify the temporal pattern and distribution of recurrent disease (RD) following surgery and how these may have been affected by the introduction of PET scanning to our service in 2004.

From 2000 to 2009, 118 lung cancer resections were carried out within our service with curative intent. 1 and 2-year survival rates (2000–2007) are 92/86% respectively for 1A/B disease, 88/59% for 2A/B and 86/57% for 3A. Thus far, 47 patients in the whole cohort (40%) have developed RD of which 35 (30%) have died. Rates for fatal recurrence by post-operative stage were 18.2% for 1A, 30.3% (1B), 27.3% (2A/B), 18.2% (3A) and 6% for 3B/1V.

The temporal pattern of RD revealed that the majority of recurrence occurred within 2 years after surgery; the cumulative recurrence rate was 38.7% at 1 year, 75.3% at 2 years and 86.6% by 3 years.

The distribution of RD revealed that the ratio of intra-thoracic to extra-thoracic metastasis was broadly similar (46%:54%, respectively). Extra-thoracic metastases developed in the Brain (17%), Bone (14%), Extra-thoracic Lymph nodes (7%), Liver (4%), Skin (3%), others (9%). The Abstract P195 Table 1 below sets out the relationship between the temporal pattern of recurrence and sites of metastasis.

Of note, in the cohort of patients with 2 years of follow-up from 2000 to 2007, rates of recurrence were similar in the 40 patients undergoing pre-operative PET scan (45%) versus the 39 patients having conventional CT staging (54%). Similarly, rates of RD were similar in both groups for intra-thoracic and extra-thoracic recurrence.

Conclusions

1. The peak incidence for RD after lung cancer surgery is within the first 2 years of follow-up. This is the time for intensive pro-active monitoring.