Our Ref: 343/2022

September 2022

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Re: Your request made under the Freedom of Information Act 2000

Please can I request (under the FOIA 2000):

Dear Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust,

Please can I request answers relating to the below questions. A national collation of this information will be made available to any trust requesting it in reply.

1. How many patients in the last 12 months has the trust treated for metastatic Cholangiocarcinoma (CCA) or Acute myeloid leukaemia (AML)?
   a. For each of AML and CCA, how many have IDH-1 mutation?
   b. How many CCA are intrahepatic vs extrahepatic?
      i. How many of each of these present at 2nd line? How many of these at 2nd line have IDH-1 mutation?
   c. For AML, how many patients were not fit for intensive chemotherapy? How many of these AML patients have IDH-1 mutation?

2. How many patients have been treated with pemigatinib (CCA), venetoclax plus azacitadine dual therapy or azacitadine monotherapy (AML)?
   a. What is the average treatment duration for CCA patients treated with pemigatinib and AML patients treated with azacitadine dual therapy and azacitadine monotherapy? What is the preferred azacitadine product?

3. What is the real-world dosing for venetoclax (in combination with a CYP3A4)?
   a. What is the antifungal of choice for patients treated with venetoclax?
   b. What is the antifungal average treatment duration when used in combination with venetoclax ?
   c) what proportion of patients are treated with an antifungal in combination with venetoclax? In what proportion of patients is the antifungal treatment stopped? In what proportion of these pts is the venetoclax dosage altered following cessation of the antifungal?

We cannot answer Q1-3 as to ascertain this data, the Trust would need to perform an audit of each individual patient record, which wouldn't be achievable within the s.12 timescale of the Freedom of Information Act 2000.

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4. Do you routinely test CCA and AML patients for IDH-1 mutation?
a. If so when does the testing take place. E.g. at diagnosis or following 1st line progression? Is this done using NGS panel? Is this done using PCR testing?
B. What is the average turnaround time for these tests?

We do not treat CAA

AML- we routinely test in all suitable patients at diagnosis and relapse using NGS panel

5. Who is responsible for the routine management of patients with CCA and AML?
a. Clinical oncologist / medical oncologist / specialist nurse etc?

We do not TREAT CAA

A Consultant Haematologist is responsible for the care of all AML patients.

6. How many admissions have occurred in the last 12 months for patients with CCA and AML?
a. What is their average length of stay?
b. How many of these patients were readmissions or readmitted during this time? If readmitted, can you state the main reason?

To answer question 6 below, I have used the following criteria

Criteria Used

- All inpatient admissions (elective, daycase, or non-elective) where the primary diagnosis of at least one episode is C221 for CCA
    - In order to identify metastatic CCA specifically, the C221 code is then followed by a secondary code of any of the following: C770, C771, C772, C773 ,C774 ,C775 ,C778 ,C779 ,C780 ,C781 ,C782 ,C783 ,C784 ,C785 ,C786 ,C787 ,C788 ,C790 ,C791 ,C792 ,C793 ,C794 ,C795 ,C796 ,C797 ,C798 ,C799
- All inpatient admissions (elective, daycase, or non-elective) where the primary diagnosis of at least one episode is C920 for AML

- Length of stay is calculated from admission to discharge and includes patients discharged the same day (i.e. zero length of stay). Length of stay is calculated in days, and is the number of midnights passed from admission to discharge

- Re-admissions are identified simply by whether or not the admission was within 30 days of a previous inpatient discharge. Therefore, these re-admissions may be counted as a re-admission from an entirely unrelated inpatient activity. There is no way within our patient admin system to identify an inpatient spell as being a re-admission from another inpatient spell explicitly.
    - Since a large number of AML patients are repeat daycase admissions for treatment, the majority of these inpatient admissions are considered to be re-admissions since there are less than 30 days since the last discharge
    - Since the criteria explicitly requires the primary diagnosis to be CCA or AML, this will be the primary diagnosis for all re-admissions. Our patient admin system does not record reasons for re-admission, so this question cannot be answered.
- Note that question 1 explicitly asks for **metastatic** cholangiocarcinoma (abbreviated to CCA). Therefore, for question 6 I have only answered using **metastatic** CCA, rather than CCA overall, which would produce slightly higher numbers.
- All spells are counted where **admission date** was between 01/10/2021 and 30/09/2022 inclusive.

Figures

diagnosis	readmission	Admission Count	Avg Spell LOS
AML	Non-Readmission	26	1.68
AML	Readmission	351	1.68
Non-metastatic CCA	Non-Readmission	8	7.10
Non-metastatic CCA	Readmission	2	7.10
Metastatic CCA	Non-Readmission	5	7.33
Metastatic CCA	Readmission	1	7.33

The table above summarises the inpatient data as described in the criteria above. The answer to the questions is shown in red below

FOI Question 6

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6. How many admissions have occurred in the last 12 months for patients with CCA and AML?

a. What is their average length of stay?

b. How many of these patients were readmissions or readmitted during this time? If readmitted, can you state the main reason?

6. Metastatic CCA: 6; AML: 377

a. Metastatic CCA: 7.33 days; AML: 1.68 days

b. Metastatic CCA 1 re-admission; AML: 351 re-admissions. Our patient admin system does not record re-admission reason.