Summits have been an opportunity for various tumour streams to assess management and results of cancer treatment and care across the state and to compare outcomes. The conclusions of the second colorectal summit were worthy of interrogation and action. The next challenge was finding a method of acting on those conclusions. We formed the Victorian Colorectal Cancer Advisory Group to ensure that the findings of our summit were investigated.

The benefits of continuing to work together after our summit have been numerous. Meetings were an opportunity to share information and knowledge when discussing presentations. Member understanding was enhanced on topics such as system design, data collection and analysis, and Integrated Cancer Services (ICS)-related initiatives, to name a few.

Presentations have been summarised in the Victorian Tumour Summits e-newsletter.

The second colorectal summit was held in March 2018. The summit noted some significant variation in patient management between ICS. The lack of uniformity and reproducibility of MRI reporting for rectal cancer was also raised. This was highlighted by a Monash Health study discussed at the summit, which revealed a large number of changes to MRI reports as a result of presentation of the imaging at multidisciplinary team meetings (MDMs).

At the summit’s conclusion, there was some enthusiasm among participants for these findings to be further explored. Each ICS was asked to nominate a champion to participate in further evaluation of variations that applied to the champion’s own ICS. The participants investigated variations that had been identified at the summit. An explanation for the variation was sought, as well as some ideas around remediating any variance. Their findings were presented to the colorectal advisory group and discussed.

The problem of inconsistent rectal MRI reporting was also tackled by our group. We have identified a standardised method of performing MRI in these circumstances as well as a system of synoptic reporting. Like synoptic reporting of pathology, this system nominates the data points for each report. This should improve the interpretation of reports and enable more accurate comparisons between treatment centres. The Victorian Colorectal Cancer Advisory Group have distributed the standardised MRI template to radiologists in group members’ CRC MDMs. We are hopeful this will improve the quality and consistency of rectal cancer staging, and as a result improve the decisions we make for our rectal cancer patients.

The formation of the colorectal advisory group has enabled the conclusions of the colorectal summit to be further investigated. Variations observed have been explored and remedies instituted. Deficiencies in treatment planning based on inaccurate imaging have been addressed. The group plans to continue to monitor these issues and audit the measures adopted to improve them.

This is the first such group to be formed out of summits. The group has worked well to investigate variations in care and management. We would like to thank all members of the group for the work required to achieve this outcome. We suggest that this process could serve as a template for other tumour streams to investigate their summit conclusions and initiate change through further collaboration.

The Victorian Tumour Summits project celebrates its fifth birthday this year. Since summits began in 2014, the project has activated seven tumour streams of the optimal care pathways. In February, the Lung Cancer 2019 Summit was held. One hundred and twelve participants developed ideas for local, clinician-led investigation and action arising from summit data. Two new tumour streams, brain and melanoma, will be activated in the first half of 2020.

The Head and Neck 2018 Summit working party has delivered its position statement on best practice care in Victoria. This includes the critical importance of case discussion at multidisciplinary meetings and teams having the expertise and experience required. The Colorectal 2018 Summit working party continues activities as the Victorian Colorectal Cancer Advisory Group. The group has achieved its original purpose of ensuring that findings and conclusions of the latest summit are investigated and acted upon. It plans to monitor the issues actioned and audit the measures adopted to improve them.

Within the broader policy context of summits, the Victorian cancer plan 2016–2020 has undergone public consultation for its next iteration. The Victorian cancer plan monitoring and evaluation framework is the first report of its kind to present the most up-to-date information on the state’s progress.

Not all of VTS advancements have occurred at summits this year. Behind the scenes the project underwent evaluation, receiving supportive feedback from stakeholders and recommendations to enhance the project. One of these recommendations was to incorporate consistent consumer involvement. We met with Cancer Institute NSW to share information and discuss respective program and project similarities. Our steering committee has expanded and we are pleased to have greater regional representation amongst these members.

We must also sincerely thank the clinicians, consumers and Integrated Cancer Services colleagues who contribute to the project in many ways. Your support and ongoing active involvement in summits to improve cancer care for Victorian patients is the driving force for positive change.

The Head and Neck Cancers 2018 Summit Prioritised Variations video is available at <https://bit.ly/2OXipx1>

Many thanks to Andrew Coleman, Stephen Tudge, Jenelle Loeliger, Leesa Lachimia and Beyond Five
Grampians Integrated Cancer Service (GICS) has seen Victorian Tumour Summits as an excellent opportunity to engage with metro and other regional colleagues, as well as DHHS staff. It’s also an opportunity to review our work, demonstrate our commitment to continuous improvement, and highlight our regional work and successes.

In a refreshing turn of events for often politically and managerially cynical clinicians, we have had Grampians representatives (at least four on each occasion) at the prostate, lung, OG, pancreatic, second colorectal, and head and neck summits. This has achieved significant understanding of the challenges of data collection and interpretation, as well as the system modification required to affect continuous improvement for our patients. The optimal care pathways (OCPs) paradigm has been pivotal in creating this insight.

Data from the initial lung summit prompted clinicians to ask for a cancer care co-ordinator and Rapid Access Lung Lesion Clinic. Redesign programs fulfilled these requests. Our initial successes have been reported nationally and internationally, and were very well received at the second lung summit.

Although our urology team do not conduct their multidisciplinary meeting under GICS auspices, prostate summit data persuaded them to be part of the Prostate Cancer Outcomes Registry program and to describe their own model of care (facilitated with a GICS-sponsored clinician engagement dinner) as a baseline for ongoing improvement. In the colorectal space, our conversations on radiotherapy led to a review of local data, discussed in detail at another clinician engagement dinner. This was attended by hospital CEOs and medical services directors from public and private institutions in both cases. The outcome of the dinner was the development of an MRI reporting template and a recommendation that all rectal cancer be presented to a multidisciplinary team meeting (MDM).

As a consequence of the OG and pancreatic summits’ recommendations that all OG/HPB cases be routinely presented, our GI MDM will soon split off into upper and lower GI meetings. As part of our general deliberations, volume and complexity concerns led to yet another clinician dinner/dinner, supported by Euan Wallace from Safer Care Victoria. The importance of our regional ability to rescue (support patients with complications of treatment) and maintenance of advanced skills, along with regular MDM participation, was emphasised. All dinners were attended by members of our consumer advocacy group and their input was clearly valued by our clinicians.

In my view, Victorian Tumour Summits and OCPs learnings have been the key impetus and drivers for the above described developments. This is important in a regional setting where many regional clinicians work across more than one tumour stream and in both public and private settings, and where MDMs add to an already demanding work load.

Change is always challenging. However, Victorian Tumour Summits has demonstrated how a mature and maturing use of data, combined with intentional metro-regional collaboration, can bring a new respect for how data and collaboration can work to affect the change we all wish for to improve our patient care.

The support of our local Integrated Cancer Service and the Victorian Tumour Summits team, along with their encouragement to ask probing questions, has been invaluable. Long may it continue.

Thank you to summit working party chair and co-chairs:
- Brian Hodgkins and Geoff Chong
- Lymphoma 2015 Summit
- Stephen Tudge and Andrew Coleman
- Head and Neck 2018 Summit
- Gavin Wright and David Ball
- Lung 2019 Summit
- Stephen Opat
- Colorectal 2018 Summit
- Ahmad Aly and Paul Cashin
- Oesophageal and Gastric 2016 Summit
- Charles Pilgrim and Christopher Christophi
- Pancreatic 2017 Summit
- Jeremy Millar and Damien Ballantyne
- Prostate 2016 Summit
- And to Ella Stuart and Lucie Marveldt for data analytics

**David Deutscher (surgeon)**
Clinician perspective

Steve Monegatti once famously said, ‘Melbourne is not far from Ballarat, but Ballarat is a long way from Melbourne!’

Certainly, regional clinicians feel that, despite our unremitting commitment to best care of our patients (both personal and ‘best evidence care’), metro colleagues give the impression they think we sometimes underperform—seemingly evidenced by poorer regional health outcomes.

Cassy Morris was diagnosed with lung cancer in June 2017 and died one year later. Cassy’s husband, Kane Morris, attended the Lung 2019 Summit to share his family’s experience of diagnosis and treatment, and discuss where improvements in lung cancer care could be made.

My wife Cassy was a healthy, beautiful, 43-year-old mother to our beautiful daughters – life was great. What we thought was an overuse injury causing thoracic spine pain turned out to be the most sinister of diseases that turned our world upside down. It snatched the most incredible human I have ever known away from us within a year.

Cassy was diagnosed with extensive metastatic disease. Her initial PET scan showed the primary tumour in her upper left lung had not only spawned a secondary nearby, but had also spread to her lymph nodes, liver and sternum, ribs, shoulders, thoracic spine, lumbar spine, hips, pelvis, and right femoral head.

What I also learned was that 50% of stage IV lung cancer patients develop some form of brain metastasis.

Following six months of targeted therapy, Cassy was admitted to hospital with a severe migraine. She was given a CT scan which showed no cancer. She was treated with painkillers and sent home.

Three weeks later she presented with an episode where she became disoriented – losing her perception of stability and feeling like the room was turning upside down. She was hospitalised and scanned again. Another CT scan was taken, again the all clear was given. The emergency doctor at the time kept her overnight. The next day she had an MRI. That afternoon we learned Cassy had developed leptomeningeal disease—an extremely dangerous form of brain cancer. Generally, the patient has six to eight weeks should it not be treated.

After this diagnosis, MRIs became routine. They were based on when the treatments would be known to be effective and used to track progression once symptoms presented in the later stages of Cassy’s life.

Given the probability of Cassy getting some form of brain cancer, I ask:

- Why was Cassy’s brain not scanned at the time of initial diagnosis?
- Why are Stage IV patients not scanned routinely as part of their standard of care?
- This could be done every six to eight weeks.
- Why are inferior technologies used, such as CT scan compared to MRI?
- It is not cheaper to do CT scans if you end up doing MRIs anyway.

If this is cost-based medicine, the options should be represented to the patient. They should have control and input into their care. If they are happy to pay for scans to improve their chances of survival through early intervention, this should be an option.

The system needs to be challenged. These patients need to be given every opportunity to be as well as they possibly can for as long as they possibly can. If proactively looking for changes can detect progression in its early stages, why not do this, rather than reacting to symptoms once the progression may have become an insurmountable challenge?

Those of us living without stage IV lung cancer owe it to those who are to give them the best possible care, the best and least destructive treatment, and the best possible outcome.

**Kane Morris**
Consumer perspective

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