**FOI Ref: 6598**

**Category(ies): Clinical - Service Activity**

**Subject: Metastatic Cholangiocarcinoma (CCA) and Acute myeloid leukaemia (AML)**

**Date Received: 06/09/2022**

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| **Your request:** | **Our response:** |
| 1. How many patients in the last 12 months has the trust treated for metastatic Cholangiocarcinoma (CCA) or Acute myeloid leukaemia (AML)? 2. For each of AML and CCA, how many have IDH-1 mutation? 3. How many CCA are intrahepatic vs extrahepatic?    1. How many of each of these present at 2nd line? How many of these at 2nd line have IDH-1 mutation? 4. For AML, how many patients were not fit for intensive chemotherapy? How many of these AML patients have IDH-1 mutation? | Metastatic Cholangiocarcinoma – 0 patients (not treated at TRFT)  AML-   1. This information is not currently recorded 2. Not treated at TRFT 3. TRFT do not hold/collect this information |
| 1. How many patients have been treated with pemigatinib (CCA), venetoclax plus azacitadine dual therapy or azacitadine monotherapy (AML)? 2. 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? | Pemigatinib – 0 patients  Venetoclax + Azacitadine- 4 patients  Azacitadine- 10 patients  Preference is based on availability of stock |
| 1. What is the real-world dosing for venetoclax (in combination with a CYP3A4)? 2. What is the antifungal of choice for patients treated with venetoclax? 3. What is the antifungal average treatment duration when used in combination with venetoclax? 4. 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? | 1. posaconazole 2. During the course of the treatment then stop 3. All patients with venetoclax are treated with antifungal prophylaxis. Unable to comment on the proportion of patients that had antifungal prophylaxis stopped. If antifungal is stopped, then the dose is adjusted of the venetoclax for all patients. |
| 1. Do you routinely test CCA and AML patients for IDH-1 mutation? 2. 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? 3. What is the average turnaround time for these tests? | 1. NGS panel done at diagnosis 2. ~6 weeks |
| 1. Who is responsible for the routine management of patients with CCA and AML? 2. Clinical oncologist / medical oncologist / specialist nurse etc? | Clinical Haematologist, Specialist nurses |
| 1. How many admissions have occurred in the last 12 months for patients with CCA and AML? 2. What is their average length of stay? 3. How many of these patients were readmissions or readmitted during this time? If readmitted, can you state the main reason? | 92 ordinary admissions where diagnosis contains ICD-10 code C22.1, C24.0, or C92.0 and patient classification contains 1 (i.e. day cases are excluded)  9.0 days  11 of the 92 admissions were emergency admissions (admissions where admission method contains 21, 22, 23, 24, 25, 28, 2A, 2B, 2C, or 2D) within 30 days of the last, previous discharge from hospital.  Reasons for each emergency admission are listed below:   1. Rigors + hypokalaemia 2. Fever and generally unwell 3. Worsening renal function 4. Fever 5. Hypokalaemia 6. pyrexia, vomiting 7. Shortness of breath 8. FALL/INJ TO CHEST 9. Neutropenic sepsis 10. Infection in perineum area 11. HAVING CHEMO -VOMITING / HYPO |