Belfast Health and Social Care Trust
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FOI/27898

30 September 2022

Metastatic Cholangiocarcinoma (CCA) and Acute myeloid leukaemia (AML)

1. **How many patients in the last 12 months has the trust treated for metastatic Cholangiocarcinoma (CCA)**
   - 59

   or Acute myeloid leukaemia (AML)?
   - 667

   a. **For each of AML and CCA, how many have IDH-1 mutation?**
   We don't routinely test cholangiocarcinoma patients for IDH-1 mutations currently. This information is not easily available for patients with AML.

   b. **How many CCA are intrahepatic vs extrahepatic?**
   Metastatic is not specified.

      i. **How many of each of these present at 2nd line? How many of these at 2nd line have IDH-1 mutation?**
      We do not routinely test cholangiocarcinoma patients for IDH-1 mutations currently.

   c. **For AML, how many patients were not fit for intensive chemotherapy? How many of these AML patients have IDH-1 mutation?**
   This information is not easily available for patients with AML.

2. How many patients have been treated with pemigatinib (CCA), venetoclax plus azacitadine dual therapy or azacitadine monotherapy (AML)?

CCA:	AML:
Pemigatinib <5 Capecitabine 12 Gemcitabine & Carboplatin 40 OMDG 7	This information is not easily available for patients with 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?

CCA - <5 patients who started in Aug 22 & treatment is ongoing.
AML - vidaza is the preferred product. The average treatment duration is unknown.

3. **What is the real-world dosing for venetoclax (in combination with a CYP3A4)**.
   When used in combination with azacitadine the dose of venetoclax is 400mg once daily (without Azole) or 100mg once daily (with Azole).

   a. **What is the antifungal of choice for patients treated with venetoclax?**
   Posaconazole.

   b. **What is the antifungal average treatment duration when used in combination with venetoclax ?**
   The duration is the same as the length of time on 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?
   Prior to NICE approval of Azacitadine and Venetoclax all patients were treated with an antifungal in combination with venetoclax. Since NICE approval some patients do not require an antifungal and are therefore given venetoclax is 400mg once daily. We do not have the information to answer the latter 2 questions.

4. **Do you routinely test CCA and AML patients for IDH-1 mutation?**
   We do not routinely test cholangiocarcinoma patients for IDH-1 mutations currently. AML patients who are fit for treatment (intensive or non intensive) are tested for IDH-1 mutations.

   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?**
   At diagnosis by myeloid panel NGS

   b. **What is the average turnaround time for these tests?**
   It is very difficult to provide information on turnaround times, as we have had to use several different NGS providers however; the results are usually not readily available and may take several months.

5. **Who is responsible for the routine management of patients with CCA and AML?**
   a. Clinical oncologist / medical oncologist / specialist nurse etc?
   CCA: X 3 Consultant Oncologists. CNS support.
   AML: Consultant Haematologist

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6. **How many admissions have occurred in the last 12 months for patients with CCA and AML?**
   - 2045

   a. What is their average length of stay?
   - 3 DAYS

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