BASO~The Association for Cancer Surgery

2014 Annual Scientific Meeting

In case you have missed the news, this year's BASO 2014 annual scientific meeting will be held in Liverpool from 29 to 31 October, in partnership with the 34th ESSO congress. A wide-ranging programme, world-class speakers, hundreds of delegates from around the world, leading trade exhibitors, a sparkling venue and, of course, the unique atmosphere and renowned hospitality of Liverpool itself, will be ready to welcome BASO members to the one surgical oncology meeting of 2014 that you really must attend.

If you wish to pay by cheque in sterling please use the paper registration form downloaded from the website.

Register online www.ecco-org.eu/ESSO34Registration

"I really recommend all BASO members and their colleagues to come to Liverpool this year. The 2014 meeting promises to be an excellent opportunity for hearing some of the world's foremost experts and to meet fellow oncologists from around the globe."

Tibor Kovacs,
BASO Council Member,
Treasurer ESSO

BASO in Leicester

BASO's next training event will be held in Leicester in March 2015. The 1-day modular programme will focus on sarcomas, ortho-oncology and bone (metastatic) cancers and is open to members and non-members of the Association at all stages in their careers, whether seeking to specialise in these areas or just wanting to update their knowledge of current best-practice and technology. *Further details to follow.*

Ronald Raven Travelling Fellowship

Congratulations to Andrew Alalade, Ajay Belgaumkar and Julie Cornish who share this year's Fellowship. The judges' task was made difficult by the extremely high standard of applications this year, but it was particularly pleasing to receive applications from a very wide range of surgical specialisms. Applications for 2015 are now open.

RCS New Good Surgical Practice Guidelines

The guide outlines the standard of skills, values and attitudes that underpin the profession and has been developed with surgeons and patient groups. It has been updated following the recent release of the General Medical Council's re-working of Good Medical Practice and addresses some of the key challenges facing the profession today. To see/download a copy go to: http://www.rcseng.ac.uk/surgeons/surgical-standards/professionalism-surgery/gsp

News in brief

- BASO members will be sad to learn of the death in June of **Professor Gerald "Charlie" Westbury** at the age of 86. A former President of the Association from 1990-92, he pioneered work on sarcomas particularly of the head and neck. More details on the BASO website.

  Professor Roger Blamey, who died on 1 September at the age of 79, had been ill for some time. He was very widely respected, particularly for his role in the treatment of breast cancer, and was BASO President in 1998-99. Both will be remembered with affection and admiration for their enormous contribution to cancer surgery, and BASO offers sincere condolences to their families.

- **The Annual General Meeting of the Association** takes place on Thursday, 30th October, at 18.45 at the Arena and Convention Centre (ACC), Kings Dock, Liverpool Waterfront, Merseyside L3 4PF. A notice of the meeting has been mailed to those Members eligible to vote, and the Agenda and proxy forms will be sent out early in October. If you unable to attend in person and have not received your proxy forms by 15th October please contact the BASO office on 0207 869 6854.

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Thoracic Surgery: who should be performing it?

Mike Shackcloth, Consultant Thoracic and Upper Gastrointestinal Surgeon at Liverpool Heart and Chest Hospital, discusses a key issue

At present in the UK, lung cancer surgery is carried out by a mixture of Cardiothoracic and Thoracic surgeons in 36 hospitals. This is different from Europe and the USA where Thoracic Surgery is sometimes performed by General Surgeons along with Cardiothoracic and Thoracic surgeons. The draft service specification for Thoracic Surgery commissioning in England (NHS England 2014), which is open for consultation at present, has caused controversy among cardiothoracic surgeons by recommending that by 2018 mixed-practice Cardiothoracic Surgeons are replaced by consultants whose job plans consist entirely of thoracic or cardiac surgery.
The relationship between performing a high volume of cases and better outcomes is fairly well established in many cancers at both a surgeon and hospital level. However, Professor Treasure (BMJ 2003) has previously found with regards lobectomy (the most common operation performed for lung cancer) there was no difference between In-hospital mortality and number of procedures performed by a surgeon. In-hospital mortality after lobectomy is only one of a number of quality markers that can be used to assess the quality of lung cancer surgery. The latest report for the UK National Lung Cancer Audit shows there are significant inequalities throughout the country in terms of access to surgery and subsequent surgical treatment rates. The two fold variation between cancer networks with the lowest and highest surgical resection rates is scandalous.

Lau et al. (Journal Clinical Oncology 2013) found the appointment of surgeons with a full-time thoracic job plan at the expense of mixed practice Cardiothoracic surgeons was associated with an increase in lung cancer survival in England, hence the proposals for specialist commissioning.

Over the last decade there has been a natural shift from lung cancer surgery being performed by a junior surgeon at the end of the cardiac list, to it being performed on dedicated thoracic surgical lists by dedicated surgeons (both Thoracic and Cardiothoracic) with an interest in thoracic oncology. Cardiothoracic surgeons with no interest in thoracic oncology have become Cardiac surgeons and been replaced by surgeons with an interest in thoracic oncology (mainly pure thoracic surgeons). This to some extend may explain the findings by Lau et al. (Journal Clinical Oncology 2013).

The service specification has outlined a phased introduction of the 2018 plan. They recommend that all cardiothoracic surgeons should have a dedicated whole-day thoracic surgery list, attend a weekly MDT, take part in the emergency on call rota and have an appraisal with specific reference to Thoracic surgical outcomes. These recommendations seem very sensible and the minimum that one would expect for a surgeon treating patients with lung cancer, but is the move to getting rid of Cardiothoracic surgeons completely by 2018 a step too far? Should the high volume Cardiothoracic Surgeon with a high resection rate for lung cancer and low In-hospital mortality be stopped from performing lung cancer surgery or made to do more?

The volume and outcomes debates can be applied to many other surgical specialties and cancer operations. It is important we do what is best for the patient and not what is best for the surgeon. With regards the surgeon who has good results doing a few operations a year, would they have even better results and patient outcomes if they did more of that operation?

Do you agree? Do you have an alternative view or anything to add?
Write to or email BASO at the address below.

BASO ~ The Association for Cancer Surgery
The Royal College of Surgeons of England
35-43 Lincoln's Inn Fields
London
WC2A 3PE
P: 0207 869 6854
E: marciawoolf@baso.org.uk
www.baso.org.uk
Association Administrator: Marcia Woolf