EXCHANGE

OXFORD BLOOD GROUP

THE QUARTERLY NEWSLETTER OF THE OXFORD BLOOD GROUP

NOVEMBER 2018 | ISSUE 1 | VOL 2

OPPORTUNITIES COMING UP

HAVE YOU HAD RADIOTHERAPY FOR HODGKIN LYMPHOMA?

We have been asked to contribute to the development of a decision-making aid for people facing a choice about radiotherapy for Hodgkin lymphoma. We need people with experience of this situation to guide what the decision aid will include, what it will look like and how it will be used. If you are interested, please email Catriona on OxfordBloodGroup@ouh.nhs.uk

CLINICAL TRIAL INFORMATION PROJECT

'Patient information sheets' are often lengthy documents given to people who might want to take part in a clinical trial. But many people - researchers and patients alike - recognise that they are too long, too complicated, and difficult to absorb. We want to take one such document, and create additional multi-media resources to help people find out what they need to know. If you would like to get involved in this exciting project, please email Catriona on the address above for more information.

IN THIS ISSUE

IMPROVING THE EXPERIENCE OF BONE MARROW BIOPSY

Feedback from patients suggests that we can do much to improve the experience of people having bone marrow biopsies. Have you had one? Could it have been better? How can we improve? We will be setting up a working group of people like you to lead this important improvement to our service. Email Catriona on the address above if you would like to be involved.

WHAT HAVE WE BEEN UP TO?

"PROMISE OF PRECISION"

Oxford Blood Group members contributed to a lively discussion to inform a project that will look at the 'ethos' of precision medicine - the attitudes to new treatments and the way this influences clinical conversations.

We were able to inform the researchers about the realities of recording clinical consultations, and we also contributed to ideas about recruitment and possible research outcomes.

VIDEOS IN DEVELOPMENT

Earlier in the year, we asked Oxford Blood Group members to suggest questions that people might like to ask about clinical trial participation. The plan was to make a series of short films that people can view online.

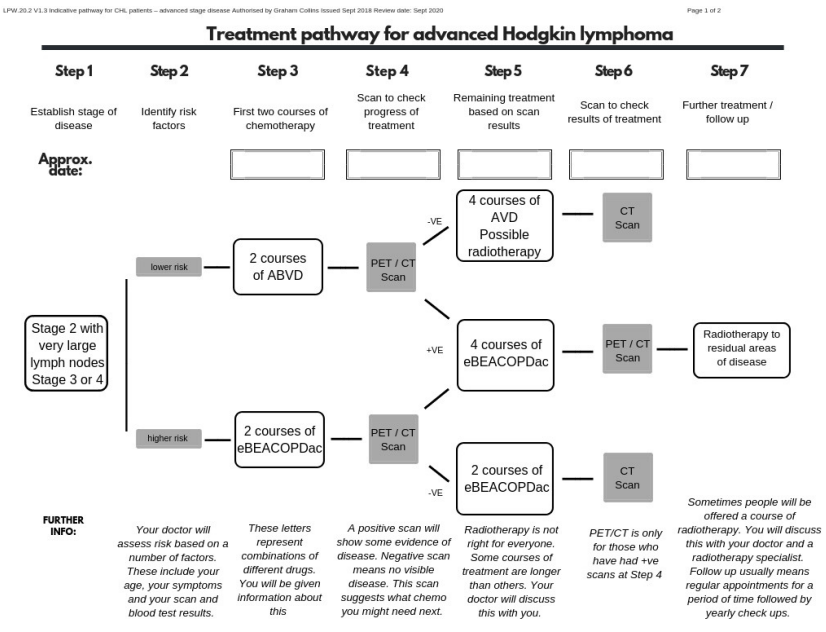
The first of these, which is about 'informed consent', is nearing completion, and we will be sure to let you know when it is ready. Thanks to Oxford University's Dr Karen Melham for her help with this project.

Next up we will discuss 'clinical trial design' and 'what are my choices if I decide not to take part in a trial?'

TREATMENT PATHWAYS

Oxford Blood Group members were vital contributors to the development of 'pathway' diagrams for people with Hodgkin lymphoma. These diagrams are used in clinical consultations to describe what happens after people are diagnosed.

Lymphoma lead, Dr Graham Collins, is delighted with the results, and the pathways have been shared with colleagues across haematology.
The good news is that now everyone wants one for their service too - so you can expect to hear more on this shortly.



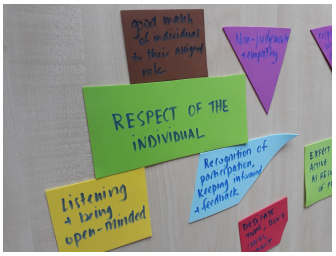
PPI WORKSHOP, SEPTEMBER 26

Members of the Oxford Blood Group, together with a group of researchers from the University, took part in a PPI (patient and public involvement) workshop in September, which was run by a group of PPI researchers at the Nuffield Department of Primary Care Health Sciences. The workshop was developed in response to reviews of the literature on PPI, which suggest that the most successful approaches are those that are designed and agreed locally. The workshop provided the opportunity to articulate our shared values and how those values might look in practice.We had decided that the discussion should revolve around the OxPloreD project being developed by Dr Niamh Appleby, as the Oxford Blood Group had already contributed to the lay summary and PIS.

After lots of discussion, we produced a set of values and principles that will inform whatever engagement activities our group is involved in. We spent a lot of time talking about some of the practical challenges of Dr Appleby's research, and the issues it raises for potential participants. And we also contributed to the scholarship on PPI. Our feedback will refine the workshop model that will hopefully be used nationwide. It was great to work as a team and share differing perspectives, and the researchers commented on how useful it had been to understand things from the patient perspective - in this case, a discussion about bone marrow biopsies. Not bad for a few hours' work, with lunch thrown in.

"A diagnosis of cancer is life-changing and as well as the many obvious negative impacts on your life, there are also some positives. I have learnt a huge amount about medicine, health, the work of clinicians and the NHS over the last 18 months, and now I'm learning about how research is carried out too. This was an empowering experience. I look forward to future involvement."

Sally, workshop contributor



"I thought it was a worthwhile meeting. How medicine has changed in my lifetime with the patient rather than the medical staff being put at the centre at last. Well done!"

Dilys, workshop contributor

The workshop framework is one that could be applied to other research studies, to help you agree your PPI strategy. Get in touch to find out more.

WHAT IS "REAL WORLD DATA?"

Anyone with an interest in haematology research might have heard the term 'real world data.' We asked Dr Toby Eyre, Consultant Haematologist, to explain what this term means and why it is important:

We are used to thinking that clinical trials are the most important sources of data with which to make decisions about treatment. But they are only part of the picture.

Real world data (or RWD) refers to data collection and analysis of what happens to people treated outside of clinical trials – in other words, it refers to the collection of information about people treated in a regular day-to-day setting.

The phrase 'real world' is intended as a contrast to a clinical trial. People treated in a clinical trial are a highly selective group. Clinical trials will typically have very strict eligibility criteria; these are sets of characteristics that must apply to all people in a trial. These criteria are scientifically important, because it is necessary to ensure that people are as alike as possible in order to get the best information about the treatment being tested. Eligibility criteria are also to do with safety, because it might not be safe to offer a new treatment to someone with lots of complex health problems.

In practice, eligibility criteria mean that lots of people are not able to take part in clinical trials for one reason or another – often because of older age and other health problems.

"lots of our patients are very different to the clinical trial population": the uses of real world data

So when it comes to applying the results of trials in the clinic, we find that lots of our patients are very different to the clinical trial population: we can't assume that the results of a trial will apply to all of our patients.

This is where RWD comes in. We can take information from our experience treating patients in the clinic and compare it to the results of a clinical trial. It has been demonstrated on numerous occasions that outcomes in the real world setting are not as good as the outcomes from the same treatment in clinical trials. Large databases of RWD can be constructed to answer specific questions about patient care that would not otherwise be possible within clinical trials.

One example relates to the use of a drug called pixantrone in the treatment of diffuse large B cell lymphoma that has relapsed or that has not responded to treatment. The RWD showed that the drug is not as effective as the clinical trial results would suggest. The RWD also revealed that there was a sub-set of people who would be less likely to respond to pixantrone.

When we are using new treatments, it is important for us to understand what we should expect of that treatment in real life. We need to understand whether there are groups of patients who might be less likely to benefit from that treatment, and who would therefore be better off with another treatment. Adding RWD to the data we already have helps us to make better treatment decisions for our patients.

Real world data can also influence access to unlicensed drugs through what are called 'compassionate use programmes.' Licences for a particular drug for a particular disease are based on the results of clinical trials. In cases where a drug doesn't have a license, real world data might provide evidence that it works, which can enable access for individual patients.

"can you give me an example of good PPI?": the problem of PPI reporting

There is no shortage of people who promote the value of involving patients and the public in research (PPI). More and more, the public and the people who fund research want to be reassured that researchers have involved the people who have experience of an illness, and people who can offer a lay perspective on research design and conduct.

But the problem for many researchers is a shortage of published examples about how to do it well. Medical and scientific journals, which publish the results of research, almost never publish information about PPI, what works and what doesn't. A recent review found that only a tiny proportion of authors publish their experience of partnerships with patients and the public.

More publishing on PPI would help to foster collective learning about best practice. The British Medical Journal, in an attempt to improve the situation, asks that all the authors who send articles to their journal report on engagement activities using a tool called GRIPP2. This is the first international guidance tool for reporting PPI in health and social care research, and is in published in a long and a short form. The short form, we suggest, provides an accessible way in to PPI reporting that could be adopted by haematology researchers in Oxford. As illustrated below, it suggests how PPI could be reported within the established framework that researchers use to publish their work.

Staniszewska et al. GRIPP2 reporting checklists. *BMJ* 2017; 358:j3453

Table 2 | GRIPP2 short form

Section and topic	Item	Reported on page No
1: Aim	Report the aim of PPI in the study	
2: Methods	Provide a clear description of the methods used for PPI in the study	
3: Study results	Outcomes—Report the results of PPI in the study, including both positive and negative outcomes	
4: Discussion and conclusions	Outcomes—Comment on the extent to which PPI influenced the study overall. Describe positive and negative effects	
5: Reflections/critical perspective	Comment critically on the study, reflecting on the things that went well and those that did not, so others can learn from this experience	

PPI=patient and public involvement

FREE TRAINING OPPORTUNITY: Improving Healthcare Through Clinical Research

On this free online course, find out how medical treatments are discovered, tested and evaluated to improve healthcare for all. In this course you will explore clinical research – its challenges and its huge benefits to modern healthcare. You will work through case studies and examine how research contributes to the treatment of major diseases, such as cancer and dementia, examining the process of conducting research and the ethical questions raised. You will learn how members of a research team, academics and participants in clinical research all contribute to this process of discovery. To enrol, or for more information visit:

https://www.futurelearn.com/courses/clinical-research

Spotlight on Oxford Haematology Research

When we asked patients what we could do better in the way we conduct research, a unified voice rose to tell us - "Please let us know the results of the studies we are involved in!"

There are lots of reasons why researchers don't keep people informed of research results. This is partly to do with the time it takes for research to reach its conclusion – often it is a process that takes many years. It is also partly to do with failures of communication. So, when we formed Oxford Blood Group, we pledged that we would spend time sharing the results of Oxford haematology research.

So for our first column, let's start with the catchily-titled "Impact of spliceosome mutations on RNA splicing in myelodysplasia: dysregulated genes/pathways and clinical associations". Or, to put it more plainly:

"Inside the protein factory of the cells- where's it all gone wrong?"

MYELOID NEOPLASIA

CME Article

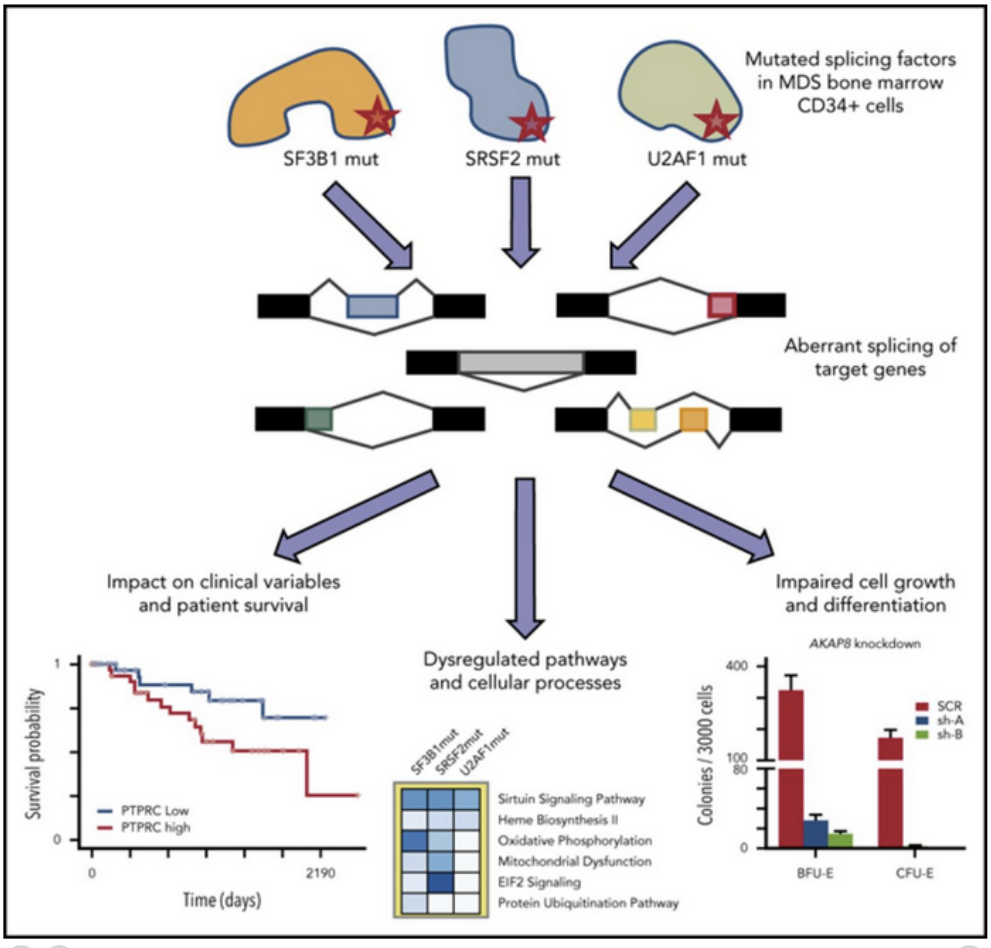
Impact of spliceosome mutations on RNA splicing in myelodysplasia: dysregulated genes/pathways and clinical associations

Andrea Pellagatti,[1,2,*] Richard N. Armstrong,[1,2,*] Violetta Steeples,[1,2,*] Eshita Sharma,[3] Emmanouela Repapi,[4] Shalini Singh,[1,2] Andrea Sanchi,[1,2] Aleksandar Radujkovic,[5] Patrick Horn,[5] Hamid Dolatshad,[1,2] Swagata Roy,[1,2] John Broxholme,[3] Helen Lockstone,[3] Stephen Taylor,[4] Aristoteles Giagounidis,[6] Paresh Vyas,[7-9] Anna Schuh,[10] Angela Hamblin,[10] Elli Papaemmanuil,[11] Sally Killick,[12] Luca Malcovati,[13,14] Marco L. Hennrich,[15] Anne-Claude Gavin,[15] Anthony D. Ho,[5] Thomas Luft,[5] Eva Hellström-Lindberg,[16] Mario Cazzola,[13,14] Christopher W. J. Smith,[17] Stephen Smith,[18] and Jacqueline Boultwood[1,2]

In this paper, published in the medical journal, Blood, in September 2018, the Oxford research team studied the bone marrow cells of patients with myelodysplasia, or MDS.

MDS is a rare condition that affects the bone marrow – the spongy material in our bones that makes blood cells. MDS affects about 30 out of every 100,000 people aged over 70. MDS means that something goes wrong with the 'programming' of the cells in the bone marrow. As a result, the bone marrow doesn't make enough healthy blood cells. It also means that the blood cells produced by the marrow don't work as well as they should.

Scientists have been on the hunt for many years to work out what goes wrong. If we knew how things go wrong, we would be a step closer to trying to stop that process happening. We have uncovered a lot of mutations (like 'spelling mistakes' in the genes that code for our proteins), but it's been difficult to find out precisely how the mutations cause MDS.



In this study, Oxford researchers used the cells kindly donated from the bone marrow samples of eighty four people with MDS, and were able to measure the proteins produced by these MDS cells.

They picked patients who had mutations in genes that control how the cell's factory assembles proteins like beads on a string, and found that this led to a common set of abnormalities between the samples.

As the authors put it, these mutations affect "processes that are fundamental for the flow of information from the genome to proteins". In other words, the mutations interfere with the communication between the genes and the cells. When cells accumulate these mutations, they are no longer able to protect themselves against damage and they struggle to make enough energy to stay alive.

All cells in our body have an intrinsic 'cell-death' get-out clause in case they become too abnormal to function. The scientific term for this is apoptosis. In MDS, the abnormalities explained above become too grave for the cell to function normally and it activates its cell-death pathway. This is why patients have too few red blood cells, white blood cells or platelets.

The research has helped shed some light onto what exact pathways are behaving abnormally in some MDS patients that leads to this cell death. This is an important step in understanding the relationship between gene mutations and MDS. We would like to thank all of our patients who kindly donated some of their marrow samples for this study to have been made possible.

Did you understand your diagnosis?

Every year, NHS England commissions a National Cancer Patient Experience survey to find out how people feel about all aspects of their cancer care.

The results from the 2017 survey, which collected responses up to April of this year, have just been published.

Broadly speaking, people treated for cancer are very happy with their NHS care at Oxford University Hospitals NHS Trust. However, only 56% of people with haematological cancers felt that they completely understood what was wrong with them.

The reasons for this situation are not clear from the survey. Perhaps the complexities of blood cancers, and the many different subtypes of diseases like lymphoma or leukaemia, mean that they are difficult to explain. It doesn't help that people are trying to take in information when they are under stress in a clinic situation.

We would like to hear from you. What is your experience? Did you understand what you were told about your illness? Do you have suggestions about how communication of a haematology diagnosis could be improved? Email us with your comments.

The 2017 Cancer Patient Experience Survey can be read here: http://www.ncpes.co.uk/

What does "quality care" mean to you?

It can be hard to say precisely what "good quality" means. It means different things to different people. It can also be difficult to quantify.
One way to help us understand "quality" is to use an example to illustrate it. Individual stories bring something abstract to life, and patient stories are increasingly being used in quality improvement.
We want to hear about your experience of treatment. Was there something that really made an impression on you? What things do you remember that you found helpful or not helpful?
Will you share your story with us? Email to find out more.

and lastly...

We are an involvement and engagement group for anyone with experience of a haematological illness. Your experience gives you a perspective that can be valuable in research and service improvement.

But, we need our professional colleagues and researchers to get involved with us too - so get in touch with any project that would benefit from involving patients.

a **BIG**

to all of those who have helped with our work so far.