



## **Appendix 6**

**This appendix was part of the submitted manuscript and has been peer reviewed.  
It is posted as supplied by the authors.**

Appendix to: Burmeister EA, O'Connell DL, Jordan SJ, et al. Factors associated with quality of care for patients with pancreatic cancer in Australia. *Med J Aust* 2016; 205: 459-465. doi: 10.5694/mja16.00567.

Appendix 6: Hazard ratios for the association between receipt of care for each care score item and survival in 1) all patients; 2) non-metastatic<sup>a</sup> and 3) metastatic<sup>a</sup> patients eligible for the care.

Item	Hazard ratio (95% CI) <sup>b</sup> for patients receiving item care compared to those not receiving care		
	All patients	Non-metastatic	Metastatic
All patients with potentially resectable disease should be referred to an hepatobiliary surgeon	0.82 (0.69, 0.96) 0.015	0.82 (0.69, 0.96) 0.015	n/a <sup>c</sup>
All patients with technically resectable disease should be offered a resection or have a valid reason for no surgery	1.94 (0.90, 4.15) 0.09	1.94 (0.90, 4.15) 0.09	n/a <sup>c</sup>
Surgery should be performed by surgeons who perform more than 5 pancreatic surgeries per year	0.83 (0.65, 1.06) 0.14	0.83 (0.65, 1.06) 0.14	n/a <sup>c</sup>
Tumour resectability should be assessed by a MDT at a tertiary hospital	0.93 (0.79, 1.11) 0.43	0.93 (0.79, 1.11) 0.43	n/a <sup>c</sup>
All patients should have a triple phase/ pancreas protocol computerised tomography (CT) scan for staging	0.90 (0.81, 1.00) 0.06	0.97 (0.83, 1.13) 0.68	0.87 (0.75, 1.01) 0.06
Entry into a clinical trial should be considered for all patients	1.01 (0.82, 1.25) 0.90	1.23 (0.87, 1.74) 0.24	0.92 (0.70, 1.21) 0.54
Surgery should take place in tertiary institutions where > 11 resections are performed annually	0.90 (0.70, 1.16) 0.43	0.90 (0.70, 1.16) 0.43	n/a <sup>c</sup>
Each patient should have a care-coordinator assigned with an individualised treatment/ clinical plan	1.00 (0.88, 1.13) 0.98	0.98 (0.81, 1.18) 0.84	0.98 (0.83, 1.17) 0.86
Tissue diagnosis should be obtained where possible	0.66 (0.57, 0.77) <0.001	0.59 (0.47, 0.75) <0.001	0.70 (0.58, 0.84) <0.001
All patients should be presented to a MDT	0.86 (0.77, 0.96) 0.01	0.89 (0.76, 1.05) 0.17	0.84 (0.72, 0.99) 0.04
Biliary obstruction should routinely be managed endoscopically in non-resectable patients	0.97 (0.74, 1.27) 0.82	1.10 (0.72, 1.70) 0.66	0.84 (0.59, 1.21) 0.35
All patients should be offered adjuvant therapy post operatively, assuming performance status is adequate	0.43 (0.33, 0.56) <0.001	0.43 (0.33, 0.56) <0.001	n/a <sup>c</sup>
All patients should be offered psychosocial support	1.24 (1.09, 1.12) 0.001	1.46 (1.20, 1.76) <0.001	1.05 (0.87, 1.26) 0.62
Pancreatic enzyme replacement therapy should be considered for all patients	0.83 (0.73, 0.94) 0.005	0.82 (0.69, 0.97) 0.02	0.83 (0.66, 1.00) 0.05
All patients should see a medical oncologist	1.04 (0.88, 1.23) 0.63	0.98 (0.79, 1.22) 0.85	1.06 (0.82, 1.36) 0.65
A specialist hepatobiliary surgeon should be the initial/primary specialist unless the patient has obvious metastases	0.95 (0.77, 1.17) 0.62	0.95 (0.77, 1.17) 0.62	n/a <sup>c</sup>
All patients should be referred to a dietitian soon after diagnosis	1.00 (0.90, 1.12) 0.98	0.96 (0.80, 1.14) 0.65	1.01 (0.87, 1.17) 0.90
Patients with confirmed metastatic disease should be referred to palliative care	1.42 (1.17, 1.74) 0.001	n/a <sup>c</sup>	1.42 (1.17, 1.74) 0.001

<sup>a</sup> according to clinical staging; <sup>b</sup> adjusted for age, performance status, comorbidities and clinical stage; <sup>c</sup> n/a: not applicable; MDT: multidisciplinary team