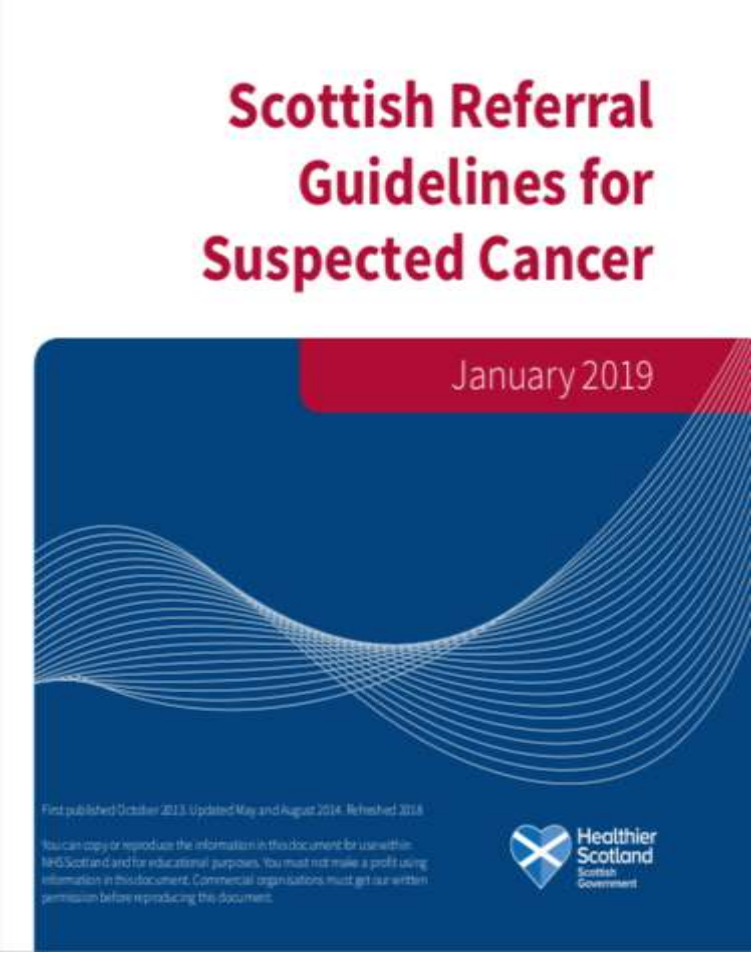
# Welcome! Please enjoy the buffet , take a seat & we will begin shortly…

Cancer Referral Guidelines Education Event

27th March – 18:45 to 21:00

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# Event Programme – 27th March 2019

| | | |
|---|---|---|
| 6:45 – 7:10pm | **Introduction and key messages** | Dr Douglas Rigg, GP Possilpark.<br>*Primary Care Network Clinical Lead, WoSCAN* |
| 7:10 – 8.30pm | **Consultant presentations & Q&A** | |
| | • Lung and Mesothelioma | Dr. Joris van der Horst<br>*Clinical Lead Lung Cancer MCN WoSCAN & Consultant Respiratory Physician GRI*<br>Dr. Stephen Thomson<br>*Consultant Respiratory Physician GGH* |
| | • Breast | Mr. Keith Ogston<br>*Consultant Surgeon GRI/Stobhill* |
| | • Upper GI | Dr Jack Winter<br>*Consultant Gastroenterologist GRI & Lead Clinician GG&C Endoscopy Service* |
| | • Urology | Ms Mary Brown<br>*Consultant Urologist GRI* |
| 8.30 – 8:40pm | **Childhood, Teen and Young Adult Cancers** | Dr Douglas Rigg |
| 8:40 – 8:50pm | **Feedback, Suggestions, Panel questions** | ALL |
| 8:50 – 9:00pm | **Summary and Closing remarks** | Dr Douglas Rigg |

# Scottish Referral Guidelines for Suspected Cancer – Key Messages

Dr Douglas Rigg, GP
Clinical Lead West of Scotland Primary Care Cancer Network

NHS West of Scotland Cancer Network

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# www.menti.com

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# NATIONAL CANCER DIAGNOSIS AUDIT

## KEY FINDINGS - WEST OF SCOTLAND CANCER NETWORK

(with national comparator values provided in brackets)

The National Cancer Diagnosis Audit (NCDA) combined primary and secondary care data for patients diagnosed with cancer in 2014 to better understand patient pathways to diagnosis and, ultimately, improve clinical care and early diagnosis of cancer.

Out of a total of
**73 GP PRACTICES**
and
**2,014 PATIENTS**
nationally

**36 GP PRACTICES**
from the West of Scotland Cancer Network area submitted data on
**1,079 PATIENTS**
to the NCDA

### PLACE OF PRESENTATION[1]

Place where the patient first presented with symptoms ultimately attributed to cancer


### CONSULTATIONS[2]

Number of consultations in primary care before referral


fewer than 3 consultations
**67%**
(65%)


3 or more consultations
**17%**
(20%)

### TYPES OF INVESTIGATIONS[3]

Primary-care led investigations ordered prior to referral

Blood test
**32%**
(37%)

Imaging
**18%**
(19%)

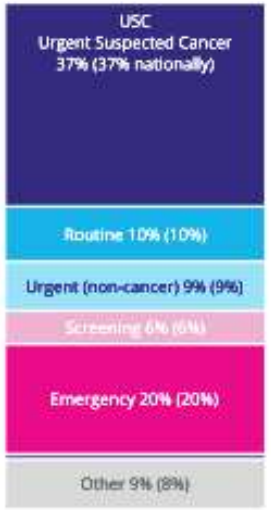
Urinary test
**2%**
(2%)

Endoscopy
**3%**
(3%)

**40%**
had no investigations before referral
(38%)

### TYPES OF REFERRALS[4]

Type of referral that led most directly to a diagnosis of cancer




Private 1% (1%)

LET'S BEAT CANCER SOONER
cruk.org/ncda

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# HCP TRACKER 2018

## CANCER REFERRAL GUIDELINES

**WHAT IS THE HP TRACKER?** An annual survey of UK Health Professionals knowledge, behaviour and attitudes around prevention, early diagnosis and screening, CRUK brand and perceptions and use of information sources. Designed to monitor these over times and identify and track key priorities for P&I. Conducted annually since 2013 by Research Now with their Health Professional panel.

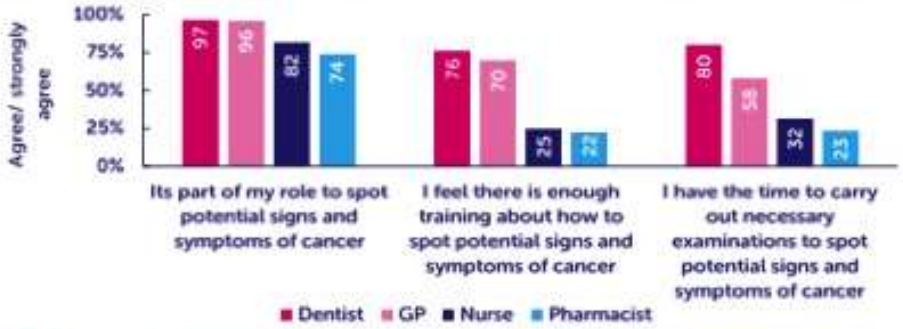
**WHEN DID IT RUN AND WHO TOOK PART?** June 2018, total sample n=1804, GPs (n=801) Dentists (n=201), Practice Nurses (n=403), Pharmacists (n=400). 84% England, 9% Scotland, 5% Wales, 3% Northern Ireland.

## 1

Early Diagnosis role % behaviour:

Most HCPs frequently encourage people to respond to potential signs and symptoms of cancer >65% (expect for pharmacists <35%)

40% of GPs feel they do not have the time to carry out necessary examinations.




## 2

There isn't universal awareness of NG12 amongst English GPs (82% were aware).

71% of Scottish GPs use SCRG and 78% of Northern Irish GPs use NICAN *(Note. Small sample sizes:- Scotland n=69, NI=18).*


## 3

Cancer referrals challenges *(Free text question)*

Common challenges/ barriers were around the difficulty in meeting the criteria, the lack of vague symptoms cancer pathway and access to certain tests.

English GPs more commonly mentioned lack of a vague symptoms pathway than rest of UK.

Other UK regions more commonly mentioned downgraded referrals and delays than English GPs.

## 4

Direct Access to tests during cancer referrals

Direct Access to tests varies between tests and UK regions

Where access is available, Confidence interpreting test results appears high, expect for MRI and CT scans where it is much lower (>70%).


% Direct Access to MRI scan

**Less than 20% of GPs in England are aware of the upcoming Faster Diagnosis Standard (FDS)**

## 5

Overall GPs are confident and feel responsible to offer transparency during a cancer referral. 83% of GPs think it is important to mention 'cancer' to the patient when they are being referred.

Get the full results- Contact Lindsay MacDonald, Cancer Intelligence Team lindsay.macdonald@cancer.org.uk

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# Background

- **Scottish Primary Care Cancer Group** identified need for change
- **"light touch"** refresh, not complete re-write of 2014 guidelines
- **Multidisciplinary subgroups** (GPs, specialists, nurses, third sector, Scottish Government, etc.) met to consider new evidence provided by Healthcare Improvement Scotland (HIS)
- Draft sent out for **peer review** (>100 responses)
- **Cancer sections updated:** lung, breast, lower GI, upper GI, urological, head & neck, brain & CNS, and children, teenagers & young adults (CTYA)
- **Supporting resources**

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MACMILLAN CANCER SUPPORT

SCOTTISH PRIMARY CARE CANCER GROUP

Healthcare Improvement Scotland

NHS SCOTLAND 70 YEARS

# Scottish Referral Guidelines for Suspected Cancer

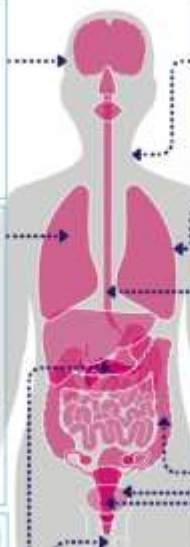
January 2019

First published October 2013. Updated May and August 2014. Refreshed 2018.



Healthier Scotland
Scottish Government

## Scottish Referral Guidelines for Suspected Cancer



**Head and neck (emergency referral)**
- Stridor

**Head and neck**
- Lump >3/52
- Oral mucosa
- Ulceration or swelling/induration >3/52
- Red/white patches >3/52
- Hoarseness – constant >3/52
- Odynophagia or throat pain >3/52
- Thyroid
  - Solitary nodule, increasing size
  - Swelling <16y/o, or
  - Swelling with ≥1 of:
    - Unexplained hoarseness/cervical lymphadenopathy
    - FHx endocrine tumour
    - Hx neck irradiation

**Lung**
- Unexplained signs/symptoms as per 1 below for >6/52 despite normal CXR
- CXR suggestive of lung cancer
- Persistent haemoptysis >40y/o and ex/smoker

**Lung (X-ray)**
- Haemoptysis
- >3 weeks:
  - Cough – new or change in existing
  - Dyspnoea
  - Chest/shoulder pain
  - Appetite loss
  - Weight loss
  - Chest signs
  - Hoarseness (ref ENT if no other symptom to suggest lung cancer)
  - Fatigue (in smokers >40y/o)
- Clubbing (new)
- Chest infection – persistent or recurrent
- Lymphadenopathy – persistent; cervical/supraclavicular (ref ENT if CXR NAD)
- Thrombocytosis (if CXR NAD consider other diagnosis including other cancers)

**Hepatobiliary and pancreatic**
- Jaundice – obstructive
- Unexplained weight loss especially >55 yrs + ≥1 of:
  - Upper abdo or epigastric mass
  - New onset diabetes, suspicious abnormality in hepatobiliary tract on imaging
  - New unexplained back pain
  - Ongoing GI Sx despite negative endoscopy
- Late onset diabetes + weight loss unrelated to the diabetes
- Upper abdominal mass
- Back pain in association with any of the above

**Skin**
- Lesions on any part of the body which have 1 or more of:
  - Mole:
    - Change in size, shape, colour
    - ABCD (Asymmetry, Border irregularity, Colour irregularity, Diameter increasing or >6mm)
  - Nodule (+/- pigment) – new
  - >4/52 with ≥1 of:
    - Ulceration, bleeding/oozing
    - Surrounding inflammation/altered sensation
  - In immunosuppressed
  - Slow-growing, non-healing or keratinising with induration
  - Nail
    - Pigmented line
    - Unexplained lesion
  - BCC in dangerous area, eg. peri-ocular, auditory meatus, major vessel/nerve

**Haematological**
- Abnormal blood count/film, suspicious of:
  - Acute leukaemia
  - Chronic myeloid leukaemia
- Lymphadenopathy
  - ≥1 of:
  - >2cm for >6/52
  - Increasing size
  - Generalised
- Hepatosplenomegaly – without liver disease
- Bone pain – with paraprotein (+/or anaemia
- Bone x-ray suggestive of myeloma
- Consider:
  - Fatigue
  - Night sweats
  - Weight loss
  - Itching
  - Bruising
  - Infections
  - Bone pain
  - Polyuria
  - Polydypsia
  - Check HIV status

**Prostate**
- Raised PSA
- Hard, irregular prostate on DRE

**Testicular**
- Enlargement or change in shape/texture
- (Epididymo-)orchitis – treatment-resistant
- Abnormal imaging

**Penile**
- Non-healing lesion
- Painful phimosis

**Sarcoma**
- Soft tissue mass + ≥1 of:
  - Size > 5cm or increasing
  - Deep to fascia
  - Fixed
  - Immobile
  - Regional lymph node enlargement
  - Recurrence after excision

**Sarcoma (X-ray)**
- Bone pain + ≥1 of:
  - Persistent
  - Worsening
  - Non-mechanical
  - Nocturnal or at rest

**CNS (same-day referral)**
- Headache &/or vomiting with papilloedema

**CNS**
- Progressive neurological deficit
- Seizure – new, or changing

**Oesophagogastric**
- Dysphagia or odynophagia
- Vomiting – >2/52
- Upper abdominal pain + ≥1 of:
  - Weight loss
  - Iron-deficiency anaemia
  - Reflux
  - Vomiting
  - Early satiety
  - Dyspepsia – treatment-resistant

**Ovarian**
- Abdo exam, Ca125 & urgent pelvic USS in women especially >50 with unexplained abdo distension/bloating
- Early satiety
- Loss of appetite
- Pelvic or abdo pain
- Increased urinary urgency or frequency
- Change in bowel habit
- Abnormal USS or CA125
- Ascites
- Pelvic mass (ultrasound-confirmed)

**Endometrial**
- PV bleed
  - Post-menopausal (if on HRT, then after cessation for >4/52)
  - Unscheduled, on tamoxifen
  - Intermenstrual, persistent
- Pelvic mass (order USS but refer anyway if suspicious)

**Cervical**
- Clinically suspicious on examination

**Vulval**
- Unexplained lump
- Bleeding ulceration

**Vaginal**
- Clinically suspicious on examination

**Breast**
- New or discrete lump – >30y/o or recurrent at site of previously aspirated cyst
- Asymmetrical nodularity – >35y/o & persists after 2-3/52
- Axillary lymph node(s) – unilateral & persisting 2-3/52
- Nipple
  - Discharge – visible bloodstained
  - Retraction – unilateral
  - Eczema – persistent despite topical steroid for 2/52
- Skin
  - Tethering
  - Fixation
  - Ulceration
  - Peau d'orange
  - Mastitis/inflammation (persists/recurs despite x1 course of antibiotics)

**Colorectal**
- Rectal bleeding – repeated or mixed with stool (without obvious anal cause)
- Bowel habit change (especially looser stools not simple constipation) – >4/52
- Abdominal pain and weight loss
- Unexplained iron-deficiency anaemia
- Abdominal/ano-rectal

**Bladder and renal**
- Unexplained visible haematuria >45y/o (without infection or persists after treatment for infection)
- Non-visible haematuria >50y/o + dysuria or blood test leucocytosis
- Abdominal mass consistent with urinary tract origin

**Bladder and renal (non-urgent referral)**
- Visible haematuria <45y/o
- Non-visible haematuria (asymptomatic)

December 2018

• Symptoms should be new and otherwise unexplained • Referral is urgent suspicion of cancer pathway unless otherwise stated • Adults only • Scotland only • Version 2018 refresh of 2014 guidelines

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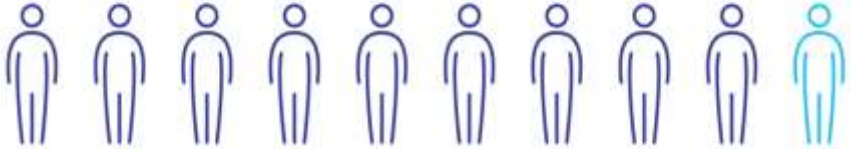
# Your urgent referral explained

## What is an urgent referral?

Your GP has arranged for you to see a hospital doctor (specialist) urgently. You may have some tests to find out what is wrong and whether or not it could be cancer. This is called an urgent suspicion of cancer referral.

## 9 out of 10 people

referred in this way are not diagnosed with cancer.



## 1 What happens now?

- An urgent referral will be processed as quickly as possible and an appointment arranged for you.
- **It's important to go to the appointment.** If you're unable to attend, contact the hospital as soon as possible to rearrange.
- You may receive a phone call from the hospital about your referral. This could be an 0800 number (from NHS Scotland).
- If your symptoms get worse, contact your GP practice.

## Handy Hints

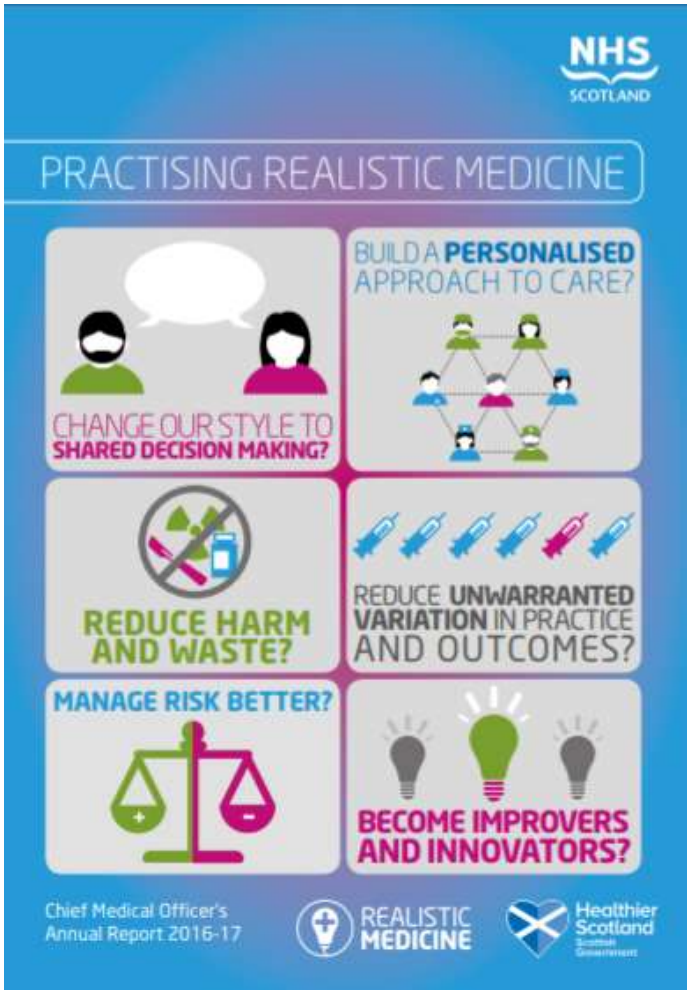
- ☐ Check your GP has your current contact details.
- ☐ If you don't get your appointment details within two weeks, contact your GP practice. Tell them it's an urgent suspicion of cancer referral.

If you don't get your appointment details within two weeks, contact your GP practice.

# Realistic Medicine [new]

**Scottish Government initiative:**

- Person at the centre of decision-making
- Personalised approach to their care
- Good communication is key
- Five questions to be considered by all involved:
  1. Is this action really needed?
  2. What are the benefits and risks?
  3. What are the possible side effects?
  4. Are there alternative options?
  5. And, importantly, what would happen if we did nothing?

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# Include performance status in the referral

It facilitates triage and discussion about best pathway

| GRADE | ECOG /WHO PERFORMANCE STATUS |
|---|---|
| 0 | Fully active, able to carry on all pre-disease performance without restriction |
| 1 | Restricted in physically strenuous activity but ambulatory and able to carry work of a light or sedentary nature, e.g., light house work, office work |
| 2 | Ambulatory and capable of all self-care but unable to carry out any work activities; up and about more than 50% of waking hours |
| 3 | Capable of only limited self-care; confined to bed or chair more than 50% of waking hours |
| 4 | Completely disabled; cannot carry on any self-care; totally confined to bed or chair |
| 5 | Dead |

# Common Issues for Cancer Referrals

## Urgent Suspicion of Cancer (USOC) Referral

- Prioritised, tracked & audited
- Patient should receive treatment within 62 days of referral
- Where negative results are found and concerns still exist, the specialist should consider direct onward referral to another specialty

## Downgrading of USOC referrals

- Referring clinician must be informed timeously
- Give the clinician the opportunity to explain why an USOC referral was requested
- Essential that the patient is kept informed
- GG&C triage will be able to “downgrade” rather than “back to referrer” BUT with letter explaining why and contact details to discuss if needed

## Primary Care Clinicians

- Referrals from ANPs, optometry, dental etc

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# Thrombocytosis [new]

- FIRST detection of platelet count > 400 in patients aged > 40
- Risk marker for malignancy, in particular (**LEGO-C**)
  - lung
  - endometrial
  - gastric
  - oesophageal
  - colorectal
- PPV 11.6% and 6.2% in males and females over 40yrs old respectively – vs symptoms eg rectal bleeding is 2.4%
- For around 1/3rd pts that went on to develop cancer raised platelets was detected when no symptoms or signs (35.7% lung, 32.9% colorectal)
- New raised platelet count should prompt early *evaluation* (symptoms, weight, CXR and qFIT)

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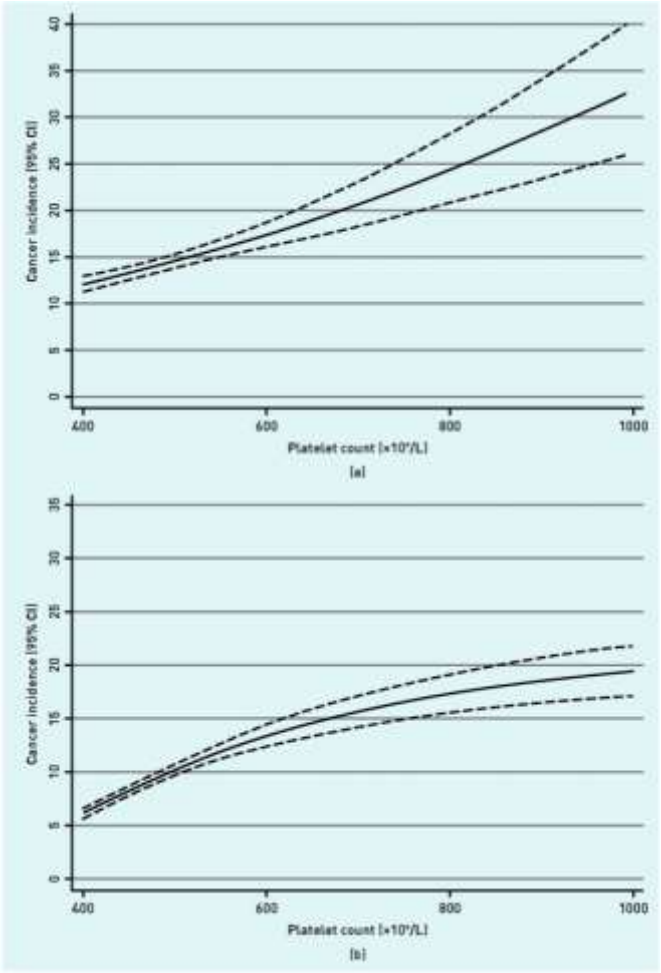
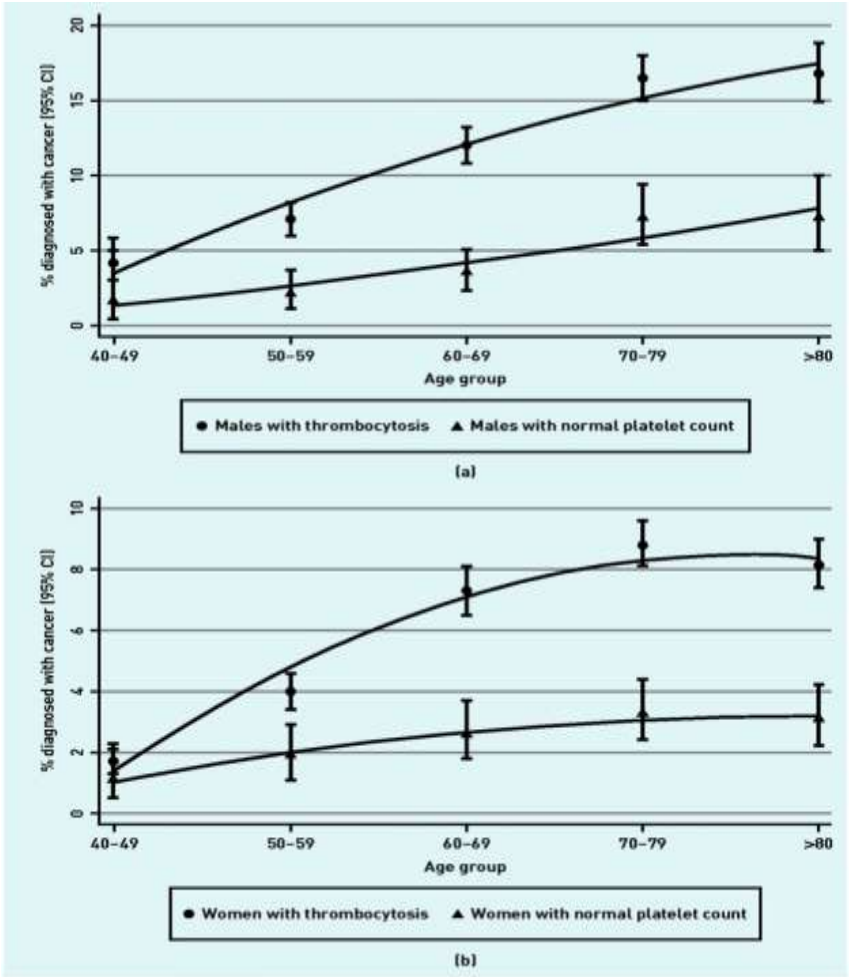
# Clinical relevance of thrombocytosis in primary care: a prospective cohort study of cancer incidence using English electronic medical records and cancer registry data

Sarah ER Bailey, Obioha C Ukoumunne, Elizabeth A Shephard and Willie Hamilton




Cancer incidence (solid line, with 95% CIs indicated by dashed lines) against platelet count as a continuous variable, for males aged ≥40 years. 2b. Cancer incidence (solid line, with 95% CIs indicated by dashed lines) against platelet count as a continuous variable, for females aged ≥40 years. CI = confidence interval.

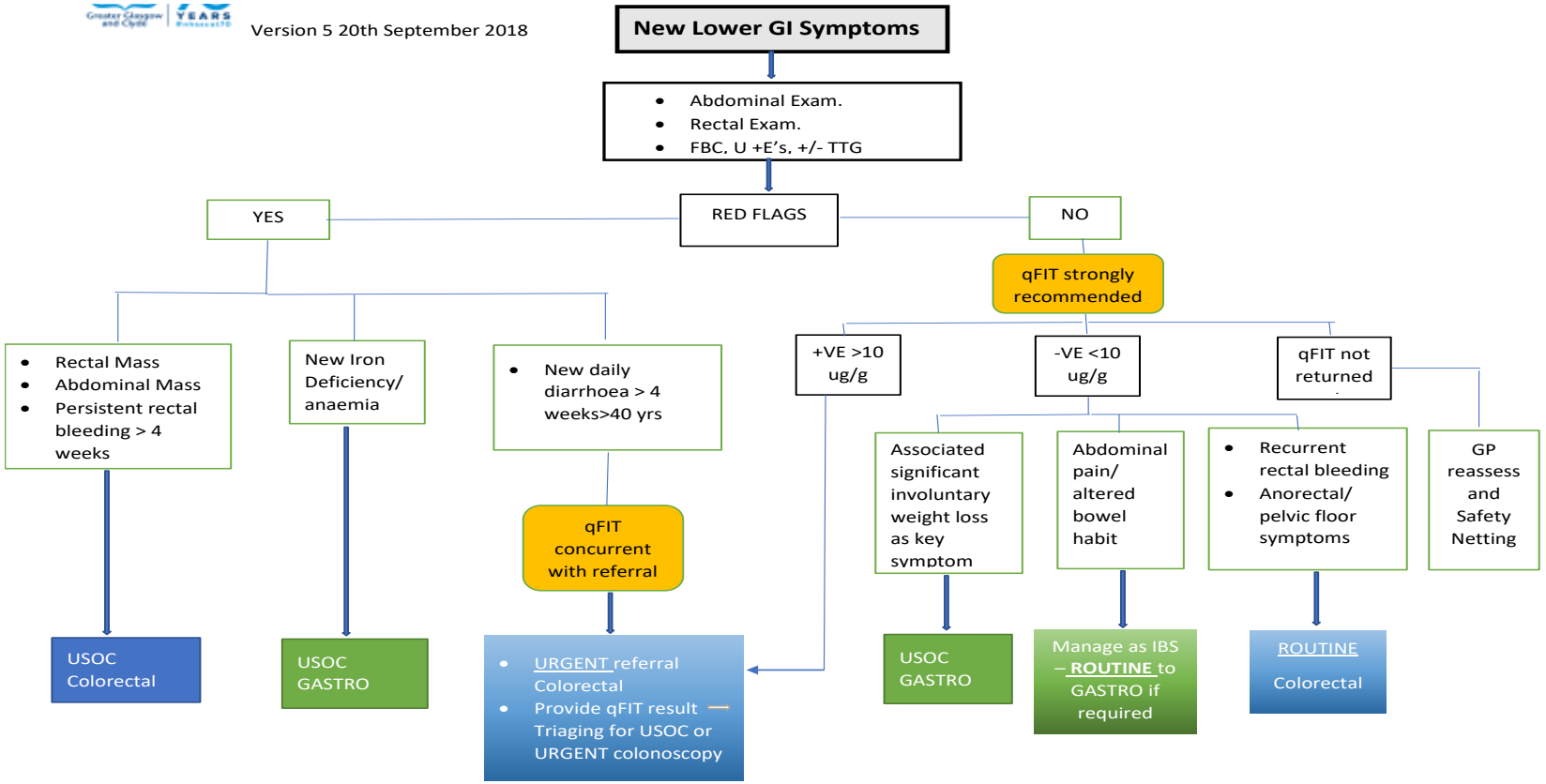



Proportion of males diagnosed with cancer in the thrombocytosis and normal platelet count cohorts by age group, with 95% CI bars. 3b. Proportion of females diagnosed with cancer in the thrombocytosis and normal platelet count cohorts by age group, with 95% CI bars. CI = confidence interval.

Br J Gen Pract 2017; 67 (659): e405-e413

# Access to kits and rejected referrals:

- No high risk referral should be rejected. Use COLORECTAL NOT GENERAL SURGERY
- Has been issues with supply of kits – still limited to 10 per practice per order (1 PACK)
- If no access to qFiT please state this on referral



# Issues for labs – labelling and PID


Example of a wrongly labelled kit

We know that face to face contact/education can make a positive difference as local facilitator Carol found out at a practice visit following our lab visit:

"One GP confessed to neither adding labels or issuing a referral form with the qFIT for all three of the tests he had done so far. Other members of staff had simply done the label when they noticed it was missing rather than actually tell the GP what should happen. He says he will now comply with the correct process!"

# Poo in a bag – literally!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# Scottish Cancer Referral Guidelines – Head & Neck Cancer – GG&C issues

## Key points – Ms Jenny Montgomery

Consultant Head & Neck Surgeon QEUH

- New USOC referrals – vetted to either neck lump or USOC slots
- ENT GGC take the most USOC referrals in the UK
- Cancer hit rate USOC 8% - latest audit more cancers found in routine category
- Symptoms at presentation importantly dictate survival

# Scottish Cancer Referral Guidelines – Changes 2019

## Head & Neck Cancer

- **Dysphagia removed** – refer to upper GI
- **Odynophagia** - Pain on swallowing stays
- **Hoarseness** with other signs of lung cancer – refer via lung cancer pathway. If not & persistent -> ENT. NO CXR needed
- **NO CHANGE in age range for hoarseness and neck lumps** – NICE >45 years – but younger are at risk due to **HPV infection**
- **Role of dentists** – access to urgent suspected cancer referral
- **Thyroid swelling** now <16 years (was “pre-pubertal”)

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# Brain and CNS

## Emergency (same day) referral

- Headache and/or vomiting + papilloedema ***[was urgent] – only 30% brain tumours present with headache***

## Urgent Suspicion of Cancer Referral

- Progressive neurological deficit (including personality, cognitive or behavioural change) in absence of previously diagnosed or suspected alternative disorders (such as multiple sclerosis or dementia)
- Any new seizure or seizures *which change* in character

# Brain and CNS

## Key points – Mr Imran Liaquat

Clinical Lead National Adult Neuro-Oncology MCN

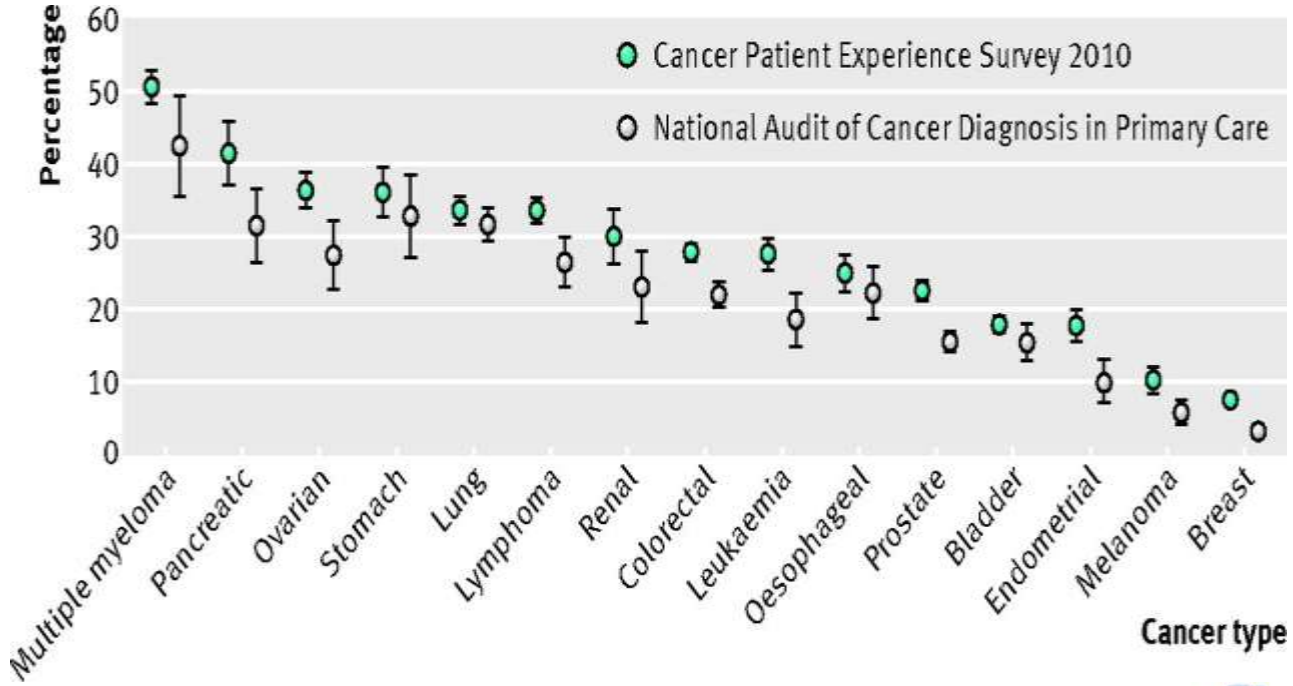
- If uncertainty about papilloedema, refer same day to an optometrist – if papilloedema is confirmed, optometrist should refer directly
- Over 40yrs old ***rare*** to develop new headache disorder – beware of these patients
- Semantic Verbal Fluency – rapid cognitive testing
- Poor outcomes vs other countries in International Cancer Benchmarking primarily due to ease of access and threshold for CT.

# Haematological

## Key points – Dr Grant McQuaker

Clinical Lead WoSCAN Haemato-Oncology MCN

- Myeloma UK have a 5 minute on-line learning module via RCGP Learning:
- https://academy.myeloma.org.uk/resources/rcgp-myeloma-screencast/




**Rethinking diagnostic delay in cancer: how difficult is the diagnosis?**
*BMJ* 2014; 349 doi: https://doi.org/10.1136/bmj.g7400 (Published 10 December 2014)

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# Gynaecological

## Ovarian

An abdominal palpation should be undertaken, CA125 blood serum level measured and urgent pelvic ultrasound scan carried out in:

- Any woman over 50 years who has experienced *new symptoms* within the last 12 months that suggest irritable bowel syndrome, or unexplained abdominal symptoms.

## Endometrial

- 95 % present with postmenopausal bleeding
- Risk factors for endometrial cancer include: tamoxifen, obesity, age over 45 years, nulliparity, family history of colon or endometrial cancer and exposure to unopposed oestrogens
- **THINK about risks if new thrombocytosis**

# Gynaecological

## Key points – Dr Kevin Burton

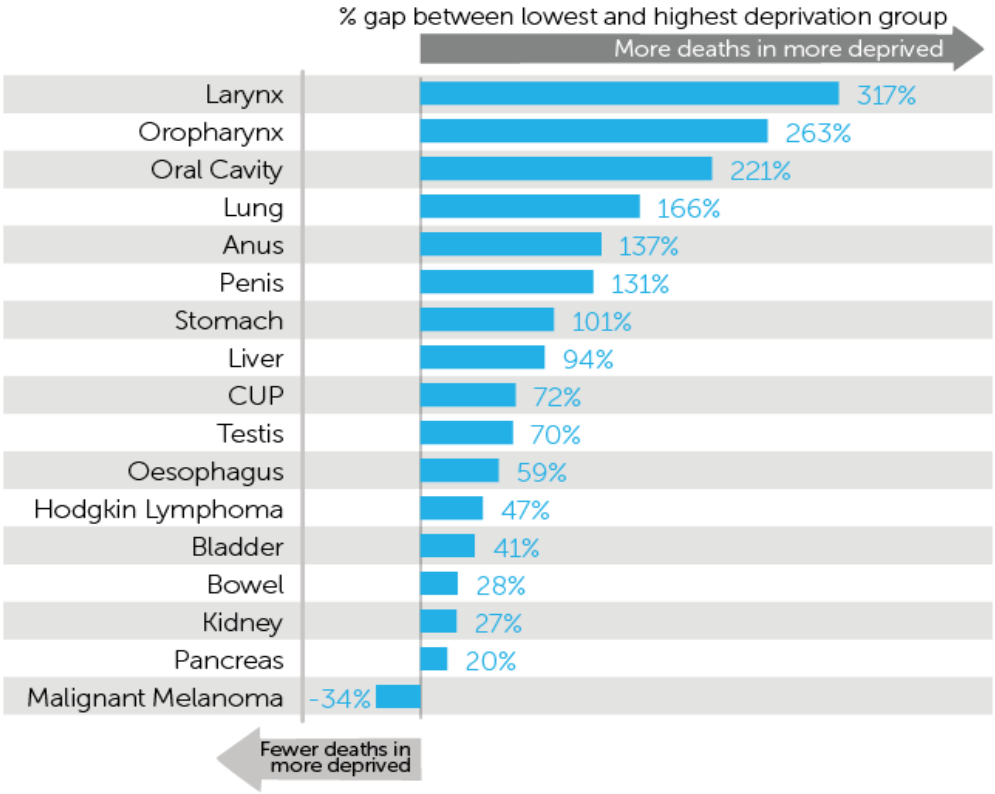
Clinical Lead WoSCAN Gynaecology MCN

- Additional input Dr. Catriona Hardie Consultant Gynaecologist GG&C
- Vulval cancers – often referred after multiple topical treatments and no obvious examination findings noted
- Cervical cancer – screening at lowest uptake. SCCRS will be changing to check HPV as first line and if negative then NO cytology will be done on smears.
- Postmenopausal bleeding – dealt with at one stop clinics. Rapid increase incidence projected at 40% in 7 years – mainly obesity related.
- Heavy menstrual bleeding premenopause - low risk and can be seen routinely (unless other risk factors)
- PCB ( premenopause) – high volume of referrals and high “back to referrer” with advice letters.
- Approx 25 USoC referrals daily and 100+ referrals in total.

# Skin

## Urgent Suspicion of Cancer Referral

- moles with **A**symmetry, **B**order irregularity, **C**olour irregularity, **D**iameter increasing or >6mm
- any unexplained skin lesion in an immuno-suppressed patient

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# Sarcoma & Soft Tissue Tumours

## Urgent Suspicion of Cancer

Mass with one or more of the following :

- size > 5cm
- increasing in size
- deep to fascia, fixed or immobile
- recurrence after previous excision
- regional lymph node enlargement

## Lipoma – reassure & safety net

Mass with ALL of the following :

- size < 5cm
- Soft consistency (lipomatous)
- Superficial
- Smooth edges
- No pain (painful lesions should be referred USoC)
- No growth

# Malignant Spinal Cord Compression

## USOC referral if PMH cancer (esp. prostate, breast, lung or multiple myeloma)- to tumour site team

- Significant localised back pain, especially thoracic
- Severe, progressive pain or poor response to medication
- Spinal pain aggravated by straining (for example, at stool, or coughing or sneezing)
- Nocturnal spinal pain, especially if preventing sleep
- NOTE – Beatson audit 2017 – 30% of MSCC have no PMH of cancer

## Emergency referral for admission

- Radicular pain (for example, round chest, down front or back of thighs) – atypical chest pain?
- Limb weakness or difficulty in walking
- Sensory loss (including perineal or saddle paraesthesia)
- Bladder or bowel dysfunction

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# MSCC ALERT CARD

WE ARE MACMILLAN. CANCER SUPPORT

**You have been given this card because you have cancer and are at risk of malignant spinal cord compression (MSCC).**

**You should contact your hospital team immediately if you develop any of these symptoms:**

- Back or neck pain that becomes severe.
- Pain that feels like a band around the chest or abdomen, or spreads into your lower back, buttocks or legs.
- Pain in the spine that gets worse when you move, lift something heavy, cough or sneeze.
- Pain that keeps you awake at night.
- Numbness/burning feeling or pins and needles in toes, fingers or over the buttocks.
- Feeling unsteady on your feet, having difficulty walking, weakness or legs giving way.
- Problems controlling your bladder, incontinence, passing little urine or none at all.
- Constipation or problems controlling your bowels.

## Information for doctor or health professional:

- This patient is at risk of MSCC.
- They should be nursed as a spinal patient.
- If you suspect MSCC, please arrange an urgent whole spine MRI (or CT if an MRI is contraindicated).
- Contact your local acute oncology service or MSCC coordinator for advice.

Mentimeter

# Ask your questions here!

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Ask a question

Finish



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# Scottish Referral Guidelines for Suspected Cancer – Lung Cancer & Mesothelioma

**Dr. Joris van der Horst , Consultant Respiratory Physician GRI**
**Clinical Lead West of Scotland Lung Cancer MCN**

**Dr. Stephen Thomson, Consultant Respiratory Physician, Gartnavel**

NHS West of Scotland Cancer Network

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# Lung

## Urgent Suspicion of Cancer Referral for CXR

- Haemoptysis
- Unexplained persistent (>3 weeks):
  - cough – new or change
  - chest/shoulder pain
  - weight loss
  - hoarseness (refer ENT if nothing else to suggest lung)
  - dyspnoea
  - appetite loss ***[new]***
  - chest signs
  - fatigue (in smokers >40 years) ***[new]***
- Clubbing (new or not previously documented)
- Chest infection – persistent or recurrent ***[new]***
- Lymphadenopathy – persistent cervical/supraclavicular (refer ENT if no symptoms suggestive of lung cancer or CXR normal)
- Thrombocytosis (if CXR normal consider other diagnosis) ***[new]***

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# Lung

## Urgent Suspicion of Cancer Referral

- Unexplained signs/symptoms as above persisting for >6 weeks despite normal CXR
- CXR suggestive of lung cancer
- Persistent haemoptysis >40 years and smoker/ex-smoker ***[new – was >50]***

- Note: Mesothelioma - **asbestos exposure** (both occupational and **close contact** exposure) is **risk factor also for primary lung cancer**

# Lung

## Good practice points

- Consider checking FBC and renal function if not done in preceding 3 months to expedite further imaging
- Consolidation on chest X-ray should have further imaging no more than 6 weeks later
- Radiology should notify respiratory team of chest X-ray suggestive of cancer - ***[new]***
- Consider CT chest, abdomen and pelvis if features suggestive of cancer (including suspected metastatic disease) but no other signs to suggest the primary source

# Respiratory Medicine - Urgent Suspect Lung Cancer - GGC USC Lung NE Pilot

- **Additional relevant information**
- **Administrative information**
- Chest X-Ray Result:**Suspected Cancer**
- Patient informed about possibility of CT Scan:**Yes**
- eGFR result available (required prior to contrast CT must be within 3 months):**Yes**
- eGFR result:eGFR >60 **30/01/19**
- Smoker/Ex-smoker:**Yes**
- Clubbing:**No**
- Weight Loss**:Unknown**
- Cervical and/or Supraclavicular Lymphadenopathy**:No**
- Chest Signs:**Yes**
- Chest Sign details:**creps**
- Signs of Metastases:**Unknown**
- Signs of Metastases Details:**has prostate and bladder tumours and awaiting review and treatment**
- OK to send correspondence to home address?:**Yes**
- Patient will accept any site:**Yes**
- Patient will accept cancellation or short notice appointment (within 1-6 days):**Yes**
- Referred By:**Referring GP**
- Electronic Attachment Present:**Yes**

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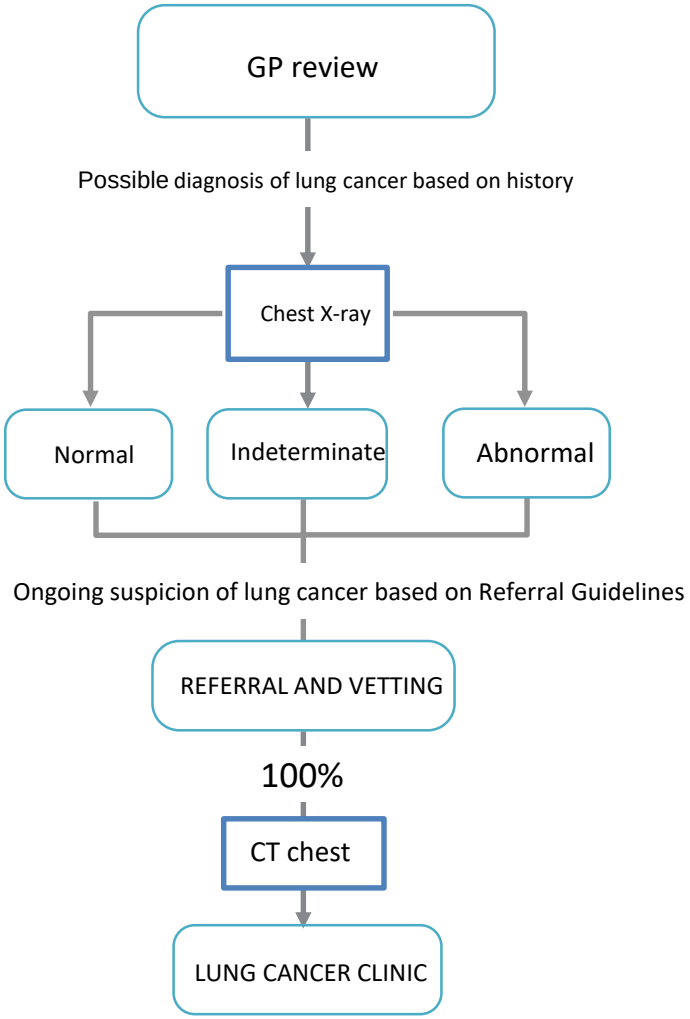
# PROBLEM: PATHWAY

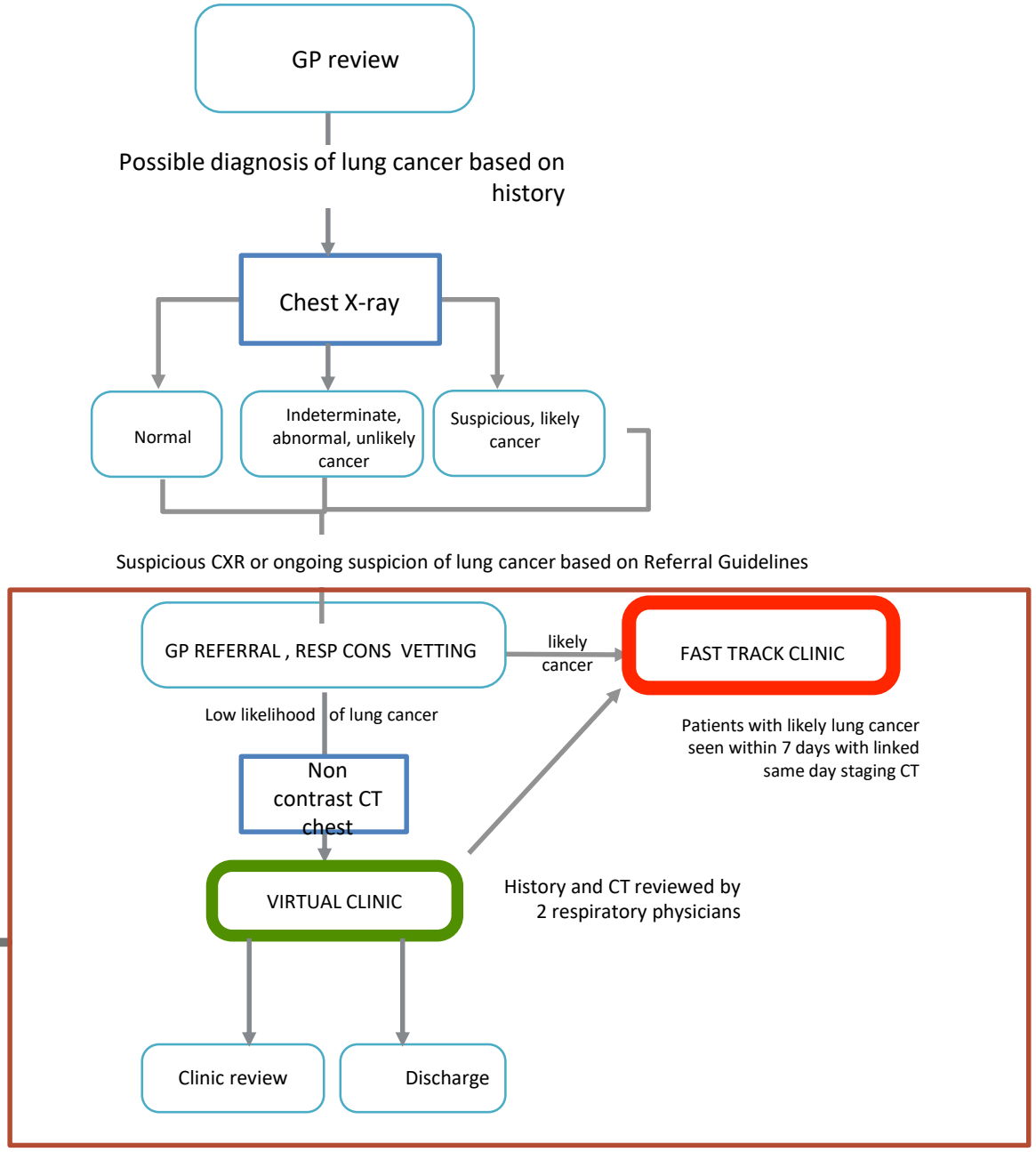
- Pathway developed for patients with likely lung cancer and requiring complex investigations
- Fast track clinic (same day CT/PFTs/bloods/booking of tests- limited number of 40 min slots)
- Not intended for patients with a low index of suspicion
- **Referrals with likely lung cancer competing with patients referred with a low likelihood of cancer for limited number of slots - in the same queue: all wait longer**
- **This increased wait for patients with likely lung cancer  from 8 to 14 days**



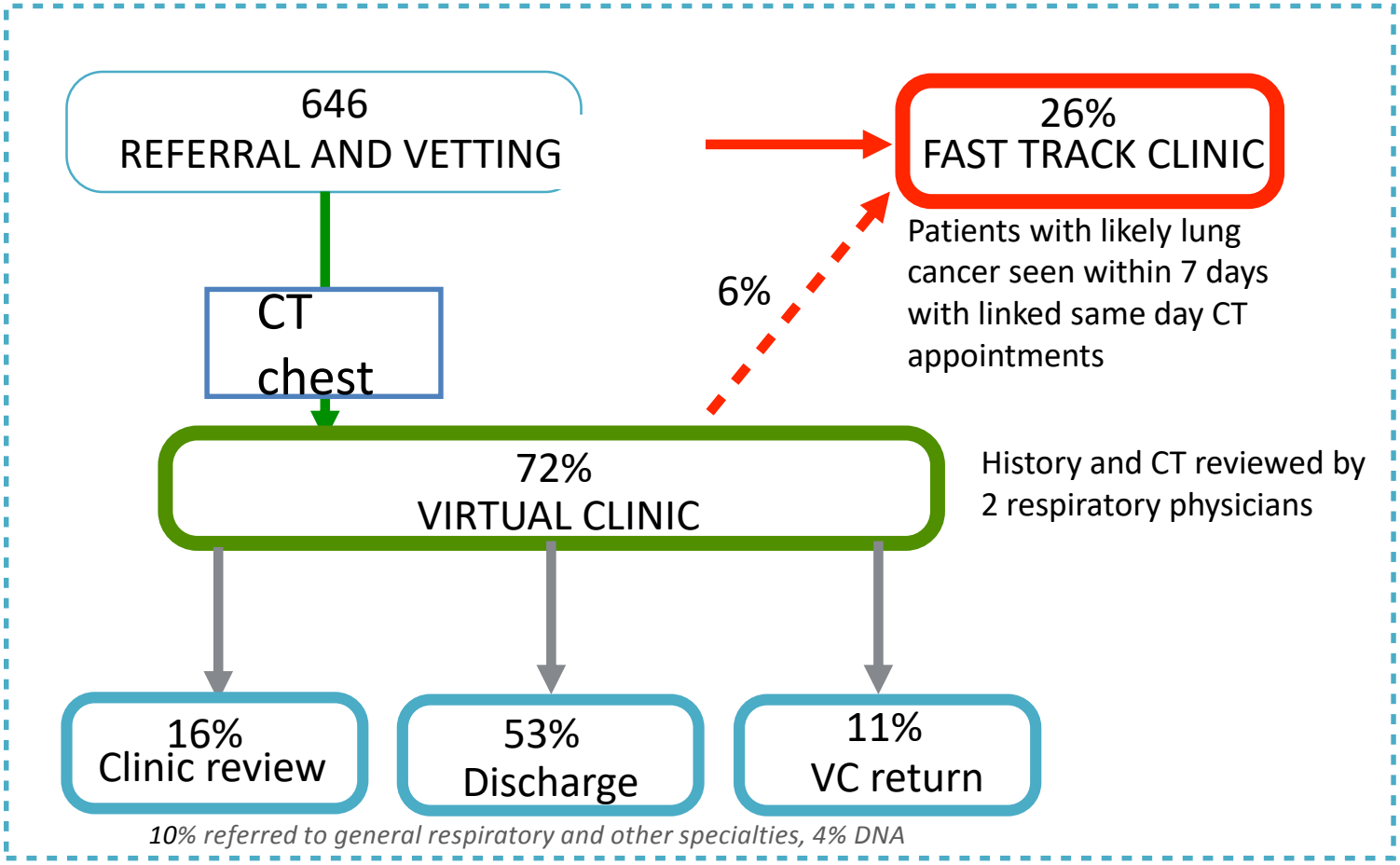
# VIRTUAL CLINIC

CSI Glasgow Cleverer Scheduling of Investigations: episode1

*Splitting the traditional pathway*



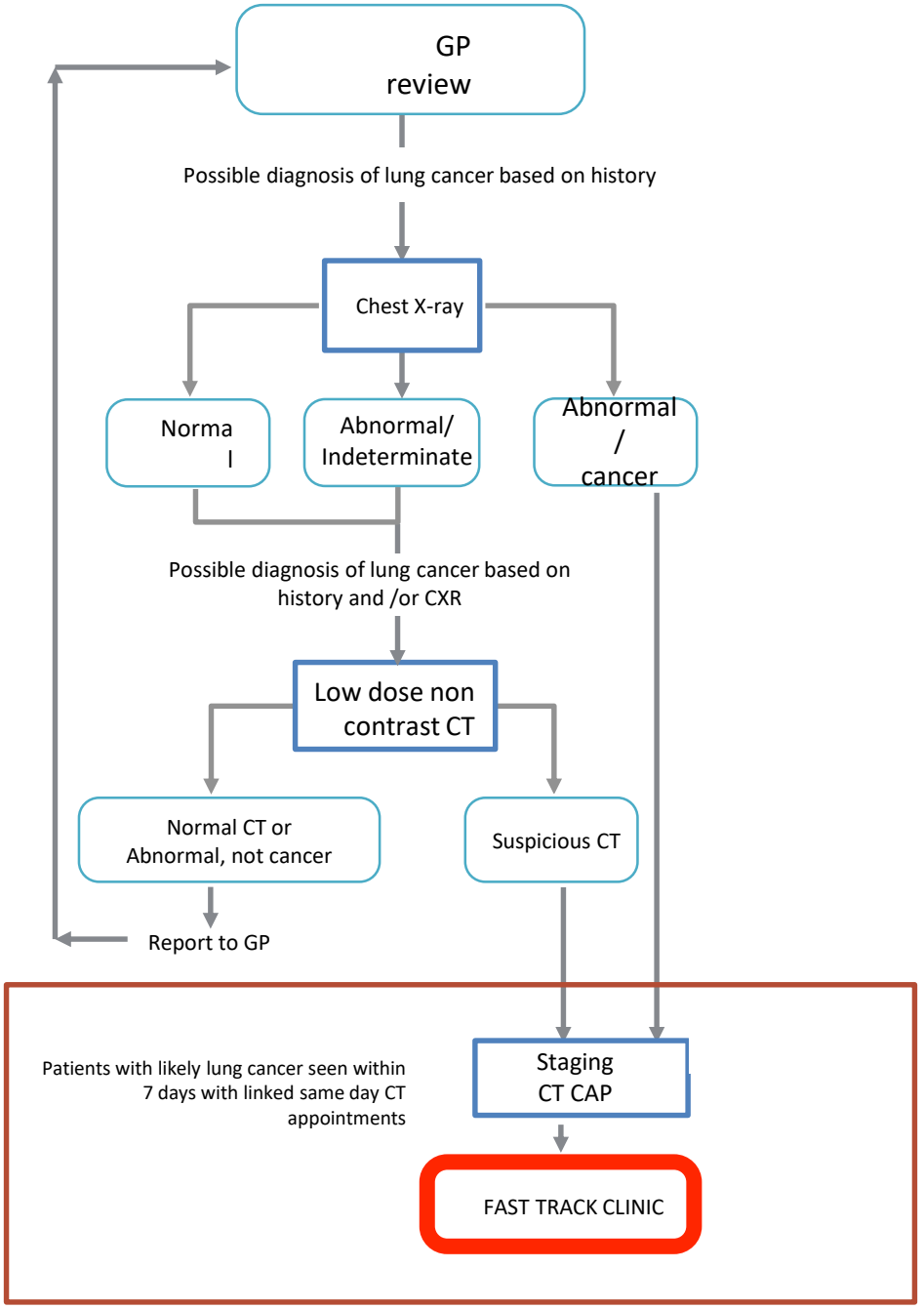
# Evolution of the virtual clinic: Sept 2018–Feb 2019



# GP DARCT

CSI Glasgow

Cleverer Scheduling of Investigations: episode 2

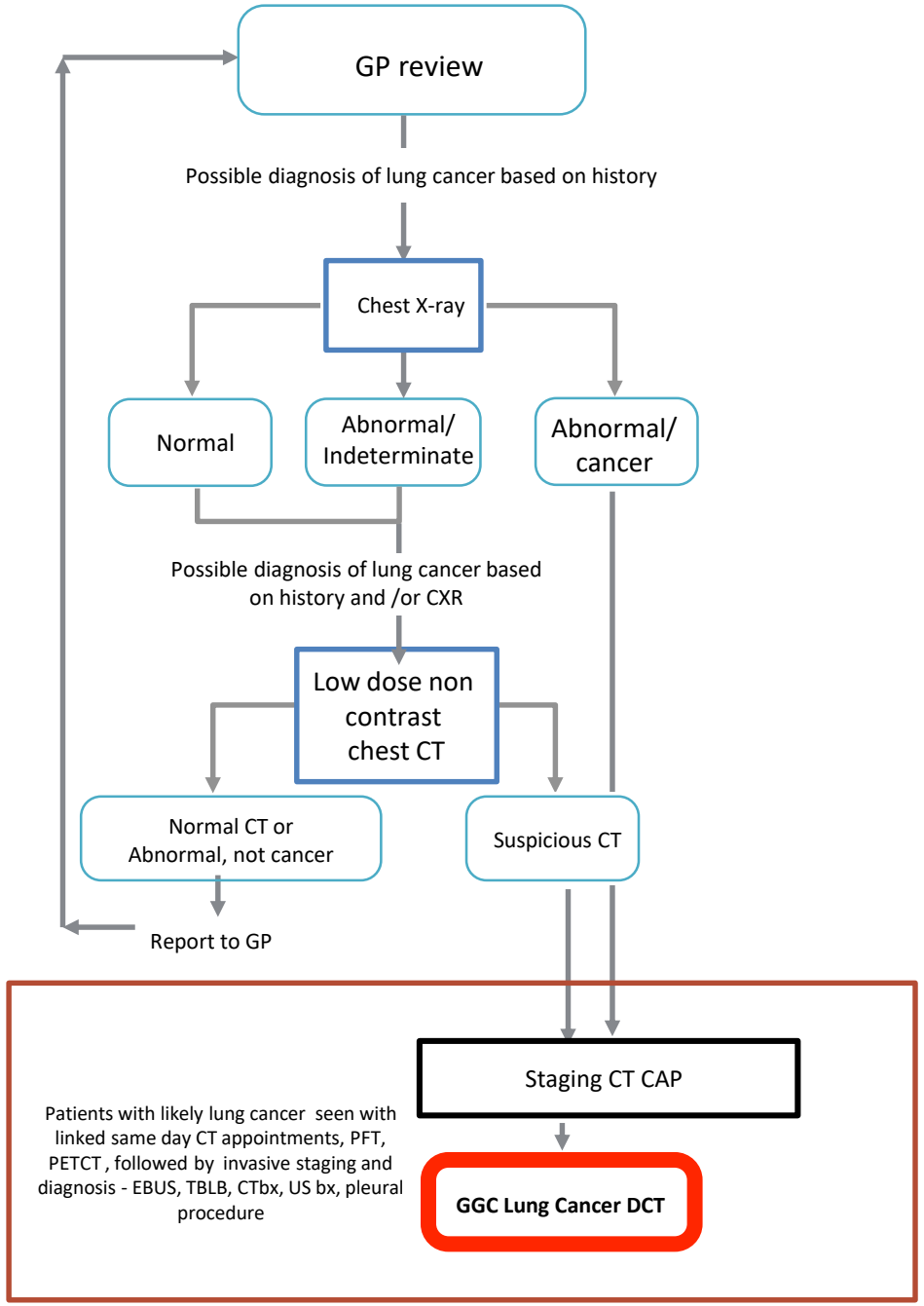



*GP Direct Access Rapid CT*

# GP DARCT and GGC Lung Ca DCT

CSI Glasgow Cleverer Scheduling of Investigations: episode 2

*GP Direct Access Rapid CT*



NHS
West of Scotland Cancer Network

# Scottish Referral Guidelines for Suspected Cancer – Breast Cancer

**Mr Keith Ogston Consultant Breast Surgeon Stobhill**

NHS Greater Glasgow and Clyde

70 YEARS #nhsscot70

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# Age at diagnosis (1991-2015 Scotland)

| | | Year of Diagnosis | | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Numbers | | 1991 | 1992 | 1993 | 1994 | 1995 | 1996 | 1997 | 1998 | 1999 | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 |
| | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Under 5 | | - | - | 1 | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - |
| 5-9 | | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - |
| 10-14 | | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - |
| 15-19 | | - | - | - | - | 1 | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - |
| 20-24 | | 2 | 3 | 2 | 5 | - | 2 | - | 2 | 3 | 1 | 1 | 4 | 4 | - | 3 | - | - | - | 2 | 3 | 3 | - | 5 | 4 | 4 |
| 25-29 | | 9 | 23 | 13 | 16 | 13 | 13 | 17 | 12 | 12 | 16 | 9 | 6 | 9 | 9 | 12 | 7 | 17 | 13 | 16 | 13 | 16 | 17 | 14 | 13 | 13 |
| 30-34 | | 57 | 53 | 57 | 64 | 48 | 58 | 51 | 65 | 55 | 52 | 39 | 45 | 53 | 45 | 40 | 46 | 52 | 46 | 34 | 34 | 34 | 46 | 66 | 39 | 53 |
| 35-39 | | 114 | 101 | 98 | 112 | 115 | 109 | 111 | 128 | 137 | 124 | 123 | 112 | 138 | 132 | 142 | 124 | 113 | 126 | 115 | 117 | 96 | 106 | 98 | 112 | 130 |
| 40-44 | | 198 | 181 | 209 | 180 | 181 | 187 | 215 | 203 | 240 | 238 | 223 | 237 | 222 | 254 | 255 | 236 | 244 | 274 | 266 | 258 | 251 | 230 | 237 | 228 | 222 |
| 45-49 | | 279 | 284 | 292 | 300 | 330 | 341 | 315 | 277 | 304 | 302 | 282 | 292 | 330 | 346 | 329 | 349 | 356 | 360 | 391 | 418 | 390 | 437 | 431 | 434 | 391 |
| 50-54 | | 348 | 378 | 380 | 337 | 394 | 421 | 454 | 468 | 524 | 535 | 472 | 522 | 482 | 469 | 444 | 469 | 508 | 457 | 521 | 540 | 572 | 541 | 588 | 570 | 619 |
| 55-59 | | 386 | 418 | 360 | 354 | 403 | 356 | 427 | 429 | 440 | 472 | 437 | 481 | 482 | 492 | 502 | 498 | 449 | 464 | 497 | 465 | 470 | 509 | 519 | 484 | 465 |
| 60-64 | | 486 | 458 | 402 | 426 | 427 | 392 | 409 | 415 | 418 | 472 | 467 | 461 | 475 | 492 | 454 | 498 | 550 | 602 | 603 | 680 | 672 | 620 | 611 | 554 | 528 |
| 65-69 | | 359 | 344 | 317 | 323 | 307 | 345 | 285 | 369 | 340 | 338 | 358 | 330 | 383 | 469 | 502 | 536 | 517 | 568 | 576 | 561 | 633 | 618 | 619 | 658 | 728 |
| 70-74 | | 285 | 293 | 345 | 343 | 379 | 344 | 380 | 388 | 383 | 360 | 336 | 352 | 417 | 386 | 423 | 440 | 403 | 415 | 383 | 428 | 439 | 437 | 422 | 412 | 477 |
| 75-79 | | 269 | 309 | 273 | 267 | 269 | 300 | 343 | 371 | 345 | 321 | 356 | 365 | 368 | 333 | 345 | 344 | 348 | 380 | 421 | 360 | 400 | 414 | 418 | 420 | 449 |
| 80-84 | | 230 | 236 | 270 | 234 | 282 | 268 | 231 | 249 | 234 | 265 | 254 | 280 | 293 | 301 | 327 | 319 | 285 | 310 | 296 | 300 | 321 | 354 | 331 | 338 | 311 |
| 85-89 | | 143 | 161 | 166 | 178 | 176 | 166 | 150 | 172 | 171 | 161 | 180 | 158 | 163 | 166 | 181 | 187 | 194 | 233 | 219 | 227 | 217 | 220 | 250 | 237 | 239 |
| 90+ | | 85 | 82 | 85 | 91 | 105 | 93 | 95 | 91 | 95 | 90 | 103 | 97 | 111 | 112 | 123 | 114 | 121 | 93 | 103 | 124 | 114 | 106 | 117 | 129 | 133 |
| All Ages | | 3,250 | 3,324 | 3,270 | 3,230 | 3,430 | 3,395 | 3,483 | 3,639 | 3,701 | 3,747 | 3,640 | 3,742 | 3,930 | 4,006 | 4,082 | 4,167 | 4,157 | 4,341 | 4,443 | 4,528 | 4,628 | 4,655 | 4,726 | 4,632 | 4,762 |

# Cancers diagnosed under age 30

| Numbers | Year of Diagnosis | | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 1991 | 1992 | 1993 | 1994 | 1995 | 1996 | 1997 | 1998 | 1999 | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 |
| Under 5 | - | - | 1 | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - |
| 5-9 | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - |
| 10-14 | | | | | | | | | | | | | | | | | | | | | | | | | |
| 15-19 | - | - | - | - | 1 | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - |
| 20-24 | 2 | 3 | 2 | 5 | - | 2 | - | 2 | 3 | 1 | 1 | 4 | 4 | - | 3 | - | - | - | 2 | 3 | 3 | - | 5 | 4 | 4 |
| 25-29 | 9 | 23 | 13 | 16 | 13 | 13 | 17 | 12 | 12 | 16 | 9 | 6 | 9 | 9 | 12 | 7 | 17 | 13 | 16 | 13 | 16 | 17 | 14 | 13 | 13 |
| 30-34 | 37 | 33 | 37 | 64 | 48 | 58 | 51 | 65 | 55 | 52 | 59 | 45 | 53 | 43 | 40 | 40 | 52 | 40 | 54 | 54 | 54 | 46 | 66 | 59 | 53 |
| 35-39 | 114 | 101 | 98 | 112 | 115 | 109 | 111 | 128 | 137 | 124 | 123 | 112 | 138 | 132 | 142 | 124 | 113 | 126 | 115 | 117 | 96 | 106 | 98 | 112 | 130 |
| 40-44 | 198 | 181 | 209 | 180 | 181 | 187 | 215 | 203 | 240 | 238 | 223 | 237 | 222 | 254 | 255 | 236 | 244 | 274 | 266 | 258 | 251 | 230 | 237 | 228 | 222 |
| 45-49 | 279 | 284 | 292 | 300 | 330 | 341 | 315 | 277 | 304 | 302 | 282 | 292 | 330 | 346 | 329 | 349 | 356 | 360 | 391 | 418 | 390 | 437 | 431 | 434 | 391 |
| 50-54 | 348 | 378 | 380 | 337 | 394 | 421 | 454 | 468 | 524 | 535 | 472 | 522 | 482 | 469 | 444 | 469 | 508 | 457 | 521 | 540 | 572 | 541 | 588 | 570 | 619 |
| 55-59 | 386 | 418 | 360 | 354 | 403 | 356 | 427 | 429 | 440 | 472 | 437 | 481 | 482 | 492 | 502 | 498 | 449 | 464 | 497 | 465 | 470 | 509 | 519 | 484 | 465 |
| 60-64 | 486 | 458 | 402 | 426 | 427 | 392 | 409 | 415 | 418 | 472 | 467 | 461 | 475 | 492 | 454 | 498 | 550 | 602 | 603 | 680 | 672 | 620 | 611 | 554 | 528 |
| 65-69 | 359 | 344 | 317 | 323 | 307 | 345 | 285 | 369 | 340 | 338 | 358 | 330 | 383 | 469 | 502 | 536 | 517 | 568 | 576 | 561 | 633 | 618 | 619 | 658 | 728 |
| 70-74 | 285 | 293 | 345 | 343 | 379 | 344 | 380 | 388 | 383 | 360 | 336 | 352 | 417 | 386 | 423 | 440 | 403 | 415 | 383 | 428 | 439 | 437 | 422 | 412 | 477 |
| 75-79 | 269 | 309 | 273 | 267 | 269 | 300 | 343 | 371 | 345 | 321 | 356 | 365 | 368 | 333 | 345 | 344 | 348 | 380 | 421 | 360 | 400 | 414 | 418 | 420 | 449 |
| 80-84 | 230 | 236 | 270 | 234 | 282 | 268 | 231 | 249 | 234 | 265 | 254 | 280 | 293 | 301 | 327 | 319 | 285 | 310 | 296 | 300 | 321 | 354 | 331 | 338 | 311 |
| 85-89 | 143 | 161 | 166 | 178 | 176 | 166 | 150 | 172 | 171 | 161 | 180 | 158 | 163 | 166 | 181 | 187 | 194 | 233 | 219 | 227 | 217 | 220 | 250 | 237 | 239 |
| 90+ | 85 | 82 | 85 | 91 | 105 | 93 | 95 | 91 | 95 | 90 | 103 | 97 | 111 | 112 | 123 | 114 | 121 | 93 | 103 | 124 | 114 | 106 | 117 | 129 | 133 |
| All Ages | 3,250 | 3,324 | 3,270 | 3,230 | 3,430 | 3,395 | 3,483 | 3,639 | 3,701 | 3,747 | 3,640 | 3,742 | 3,930 | 4,006 | 4,082 | 4,167 | 4,157 | 4,341 | 4,443 | 4,528 | 4,628 | 4,655 | 4,726 | 4,632 | 4,762 |

383 cancers of 98,918 diagnosed = 0. 4%

# Cancers diagnosed in teenagers

| | | Year of Diagnosis | | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Numbers | | 1991 | 1992 | 1993 | 1994 | 1995 | 1996 | 1997 | 1998 | 1999 | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 |
| | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Under 5 | | - | - | 1 | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - |
| 5-9 | | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - |
| 10-14 | | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - |
| 15-19 | | - | - | - | - | 1 | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - |
| 20-24 | | 2 | 3 | 2 | 5 | - | 2 | - | 2 | 3 | 1 | 1 | 4 | 4 | - | 3 | - | - | - | 2 | 3 | 3 | - | 5 | 4 | 4 |
| 25-29 | | 9 | 23 | 13 | 16 | 13 | 13 | 17 | 12 | 12 | 16 | 9 | 6 | 9 | 9 | 12 | 7 | 17 | 13 | 16 | 13 | 16 | 17 | 14 | 13 | 13 |
| 30-34 | | 57 | 53 | 57 | 64 | 48 | 58 | 51 | 65 | 55 | 52 | 39 | 45 | 53 | 45 | 40 | 46 | 52 | 46 | 34 | 34 | 34 | 46 | 66 | 39 | 53 |
| 35-39 | | 114 | 101 | 98 | 112 | 115 | 109 | 111 | 128 | 137 | 124 | 123 | 112 | 138 | 132 | 142 | 124 | 113 | 126 | 115 | 117 | 96 | 106 | 98 | 112 | 130 |
| 40-44 | | 198 | 181 | 209 | 180 | 181 | 187 | 215 | 203 | 240 | 238 | 223 | 237 | 222 | 254 | 255 | 236 | 244 | 274 | 266 | 258 | 251 | 230 | 237 | 228 | 222 |
| 45-49 | | 279 | 284 | 292 | 300 | 330 | 341 | 315 | 277 | 304 | 302 | 282 | 292 | 330 | 346 | 329 | 349 | 356 | 360 | 391 | 418 | 390 | 437 | 431 | 434 | 391 |
| 50-54 | | 348 | 378 | 380 | 337 | 394 | 421 | 454 | 468 | 524 | 535 | 472 | 522 | 482 | 469 | 444 | 469 | 508 | 457 | 521 | 540 | 572 | 541 | 588 | 570 | 619 |
| 55-59 | | 386 | 418 | 360 | 354 | 403 | 356 | 427 | 429 | 440 | 472 | 437 | 481 | 482 | 492 | 502 | 498 | 449 | 464 | 497 | 465 | 470 | 509 | 519 | 484 | 465 |
| 60-64 | | 486 | 458 | 402 | 426 | 427 | 392 | 409 | 415 | 418 | 472 | 467 | 461 | 475 | 492 | 454 | 498 | 550 | 602 | 603 | 680 | 672 | 620 | 611 | 554 | 528 |
| 65-69 | | 359 | 344 | 317 | 323 | 307 | 345 | 285 | 369 | 340 | 338 | 358 | 330 | 383 | 469 | 502 | 536 | 517 | 568 | 576 | 561 | 633 | 618 | 619 | 658 | 728 |
| 70-74 | | 285 | 293 | 345 | 343 | 379 | 344 | 380 | 388 | 383 | 360 | 336 | 352 | 417 | 386 | 423 | 440 | 403 | 415 | 383 | 428 | 439 | 437 | 422 | 412 | 477 |
| 75-79 | | 269 | 309 | 273 | 267 | 269 | 300 | 343 | 371 | 345 | 321 | 356 | 365 | 368 | 333 | 345 | 344 | 348 | 380 | 421 | 360 | 400 | 414 | 418 | 420 | 449 |
| 80-84 | | 230 | 236 | 270 | 234 | 282 | 268 | 231 | 249 | 234 | 265 | 254 | 280 | 293 | 301 | 327 | 319 | 285 | 310 | 296 | 300 | 321 | 354 | 331 | 338 | 311 |
| 85-89 | | 143 | 161 | 166 | 178 | 176 | 166 | 150 | 172 | 171 | 161 | 180 | 158 | 163 | 166 | 181 | 187 | 194 | 233 | 219 | 227 | 217 | 220 | 250 | 237 | 239 |
| 90+ | | 85 | 82 | 85 | 91 | 105 | 93 | 95 | 91 | 95 | 90 | 103 | 97 | 111 | 112 | 123 | 114 | 121 | 93 | 103 | 124 | 114 | 106 | 117 | 129 | 133 |
| All Ages | | 3,250 | 3,324 | 3,270 | 3,230 | 3,430 | 3,395 | 3,483 | 3,639 | 3,701 | 3,747 | 3,640 | 3,742 | 3,930 | 4,006 | 4,082 | 4,167 | 4,157 | 4,341 | 4,443 | 4,528 | 4,628 | 4,655 | 4,726 | 4,632 | 4,762 |

# Lump

## Urgent Suspicion of Cancer Referral

- Any new discrete lump in patients >30 years ***[new – was >35]***
- New asymmetrical nodularity >35 years & persists after 2-3 weeks ***[changed - was after menstruation]***
- Unilateral isolated axillary lymph node persisting after 2-3 weeks ***[new – no review previously]***
- Recurrent lump at site of previously aspirated cyst

## Routine referral

- New discrete lump <30 years with no other suspicious features
- New asymmetrical nodularity <35 years that persists after 2-3 weeks

## Primary care management

- Longstanding tender lumpy breasts and no focal lesion
- Tender developing breasts in adolescents

# Nipple symptoms

## Urgent Suspicion of Cancer Referral

- Visibly bloodstained discharge
- New unilateral nipple retraction
- Nipple eczema despite moderately potent topical steroids for minimum of 2 weeks ***[new – was after 1% hydrocortisone]***

## Routine referral

- Persistent unilateral spontaneous discharge staining outer clothes

## Primary Care management

- Transient nipple discharge – not bloodstained
- Check prolactin levels in persistent bilateral discharge
- Longstanding nipple retraction
- Nipple eczema if eczema present elsewhere

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# Skin changes

## Urgent Suspicion of Cancer Referral

- skin tethering
- fixation
- ulceration
- peau d ’orange

## Primary Care management

- obvious simple skin lesions such as epidermoid (sebaceous) cysts

# Abscess / infection

## Urgent suspicion of cancer referral

- Mastitis or breast inflammation which does not settle or recurs after one course of antibiotics

## Primary Care management

- Abscess or inflammation – try one course of antibiotics as per local guidelines
- Any acute abscess requires immediate discussion with secondary care

# Pain

## Routine Referral

- Unilateral pain persisting >3 months in post-menopausal women
- Intractable pain that interferes with lifestyle or sleep

## Primary Care Management

- Moderate degrees of breast pain and no discrete palpable lesion

# Gynaecomastia

## Routine Referral

- Exceptional aesthetics referral to plastic surgery pathway if appropriate
- Exclude or treat any endocrine cause prior to referral

## Primary Care Management

- Examine and exclude abnormalities such as lymphadenopathy or evidence of endocrine condition with blood tests as per local guidelines
- Review to exclude drug causes

# Breast implants *[new]*

## Routine Referral

- If appropriate, refer to the service that first inserted the implant (usually plastic surgery)

## Primary Care Management

- Reassurance is often appropriate if symptoms relate to the implant alone and not to underlying breast tissue

# Gender reassignment *[new]*

- Provide sensitive and clinically appropriate care depending on individual circumstances and taking into account any hormone therapy involved

# Local Pathways

- Previous breast cancer patients can contact their CNS directly.
- New family history risk assessment should be referred directly to genetics
- Advice (Mon-Fri in hours) – breast CNS will usually be able to advise.
- Acute breast abscess that needs in-patient assessment goes to general surgery (whatever they may say).

# Scottish Referral Guidelines for Suspected Cancer – GI Cancers

Dr Jack Winter

Consultant Gastroenterologist GRI & Lead Clinician
GG&C Endoscopy Service

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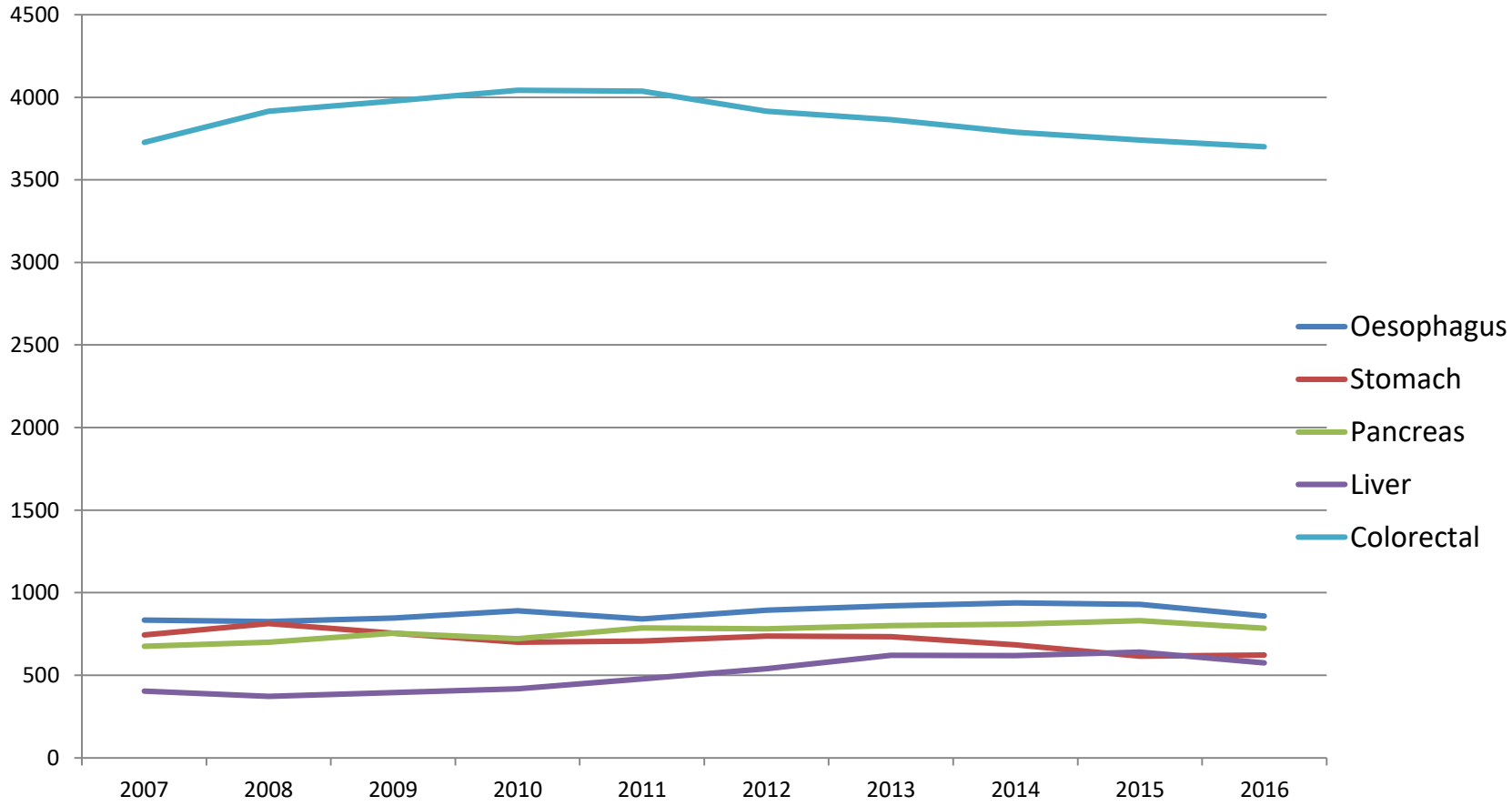
# GI Cancers

- Upper GI
  - Oesophageal
  - Gastric
  - Pancreatic
  - Biliary
  - Liver

- Lower GI
  - Colorectal

# Cases of GI Cancer in Scotland 2007-16

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# GI Cancers

- Colorectal Cancer is more common than all other upper GI cancers combined

- Colorectal Cancer is more amenable to detection at early stage and therefore has better prognosis

- There is a national screening programme for colorectal cancer

# Lower GI Cancer

## Urgent suspicion of cancer referral

- bleeding – repeated rectal bleeding (without an obvious anal cause) or any blood mixed with the stool
- bowel habit – persistent (>4 weeks) change in bowel habit especially to looser stools (not simple constipation)
- mass – unexplained abdominal or palpable ano-rectal mass
- pain – abdominal pain with weight loss ***[new]***
- iron deficiency anaemia – unexplained

**USE LOCAL REFERRAL GUIDELINES**

**WHERE qFIT TRIAL IN PLACE *[new]***

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# Lower GI Cancer

## Primary Care management

- low risk features:
  - transient symptoms (less than four weeks)
  - patients under 40 years in absence of high risk features
- watch and wait (four weeks)
  - consider bowel diary
  - appropriate information, counselling and agreed plan for review
  - refer if symptoms persist or recur

# Lower GI Cancer

## Good practice points

- qFIT
- Bloods to assess renal function (in case of triage straight to CT colonography), LFTs and to exclude anaemia and thrombocytosis should be performed ***[new]***
- thrombocytosis is risk marker for underlying cancer, including colorectal ***[new]***
- Negative rectal examination, or a recent negative bowel screening test, should not rule out the need to refer
- CEA test should not be used as a screening tool

# Scottish Cancer Referral Guidelines – Notes:

## Upper GI Cancer

- Substantial **overlap in presentation of OG and HPB cancer** so table listing symptoms – **greater likelihood of cancer if multiple symptoms**
- Investigation is usually **upper GI endoscopy initially for OG** cancer, and **CT initially for HPB**
- Investigate further if first test is normal (i.e. move on to CT or endoscopy) – patients **should NOT be returned to the referrer** without this
- **Thrombocystosis** a risk marker for OG cancer

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# Oesophago-gastric cancer

## Urgent suspicion of cancer referral

- Dysphagia or unexplained odynophagia at any age
- Unexplained weight loss, particularly **>55 years**, combined with one or more of: ***[was any age and focus previously was on pain and others, rather than weight loss and others]***
  - ➢ new or worsening upper abdominal pain or discomfort
  - ➢ unexplained iron deficiency anaemia
  - ➢ reflux symptoms
  - ➢ dyspepsia resistant to treatment
  - ➢ vomiting
- New vomiting persisting >2 weeks ***[was 4 weeks]***

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# Oesophago-gastric cancer

## Good practice points

- **Dyspepsia** (no red flags) – manage in Primary Care, use local / national guidance about investigation – **NOT** urgent suspicion of cancer referral
- Consider investigation or routine referral for new upper GI pain or discomfort combined with at least one of:
  - FH of O-G cancer in a 1st degree relative
  - Barrett's oesophagus
  - pernicious anaemia
  - previous gastric surgery
  - achalasia
  - known dysplasia, atrophic gastritis or intestinal metaplasia

  ***[new – was USOC referral]***

# Upper GI Cancer– Hepato-Biliary and Pancreatic

- **Painless, obstructive jaundice** by itself
- Unexplained **weight loss, particularly >55 years, plus**:
  - upper abdominal or epigastric mass
  - new onset diabetes ***[was routine]***
  - abnormality in hepatobiliary tract on imaging
  - new onset, unexplained back pain (consider other cancer causes including myeloma or malignant spinal cord compression)
  - ongoing GI symptoms despite negative endoscopy

# Upper GI Cancer– Hepato-Biliary and Pancreatic

## Good practice points

- seek advice in new onset GI symptoms with known chronic liver disease ***[new]***
- there should be a low threshold for considering CT chest, abdomen and pelvis (perhaps with discussion about appropriate imaging with a radiologist) or routine referral for patients presenting with:
  - non-responsive dyspepsia following initial test and treat
  - post prandial pain or early satiety
  - new onset irritable bowel syndrome symptoms in middle age
  - steatorrhoea or fat malabsorption

# O-G and HBP Cancers

## Good practice points

- Abdo exam and do blood tests (e.g., FBC, ferritin, U&Es, LFTs and HbA1c) – thrombocytosis is risk marker for cancer
- Usual initial test is upper GI endoscopy for O-G cancer, and CT for HPB cancer – specialist should investigate for other cancer if 1st test normal (i.e. move on to CT or endoscopy) – patients should NOT be returned without this ***[new]***
- Symptoms and signs of O-G and HPB cancers overlap – following table summarises these (but not by themselves reasons to refer) ***[new]***

# Upper GI

| Associated symptoms / signs | Pancreas, liver and gall bladder cancer | Oesophago-gastric cancer |
|---|---|---|
| Dysphagia | | √ |
| Iron deficiency anaemia | | √ |
| Haematemesis | | √ |
| Reflux symptoms | | √ |
| Vomiting (>2 weeks) | √ | √ |
| Upper abdominal pain | √ | √ |
| Unexplained weight loss | √ | √ |
| Upper abdominal mass | √ | √ |
| Post-prandial pain | √ | √ |
| Early satiety (feeling full up after a small amount of food) | √ | √ |
| Unexplained obstructive jaundice | √ | |
| Unexplained back pain | √ | |
| Late onset diabetes | √ | |
| New onset irritable bowel syndrome over age 40 | √ | |
| Steatorrhoea or malabsorption | √ | |

# Scottish Referral Guidelines for Suspected Cancer – Urological Cancers

**Ms Mary Brown, Consultant Urologist GRI**

**March 2019**

NHS West of Scotland Cancer Network

NHS Greater Glasgow and Clyde 70 YEARS #nhsscot70

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# Urology

## Prostate Cancer

### Urgent Suspicion of Cancer Referral

- Digital rectal examination – hard, irregular prostate
- Elevated or rising age-specific PSA – rough guide to normal (ng/ml):
  - less than 60 years **< 3**
  - aged 60-69 years **< 4**
  - aged 70-79 years **< 5**

  These are a pragmatic aid based on clinical consensus – in older men, routine or no referral may be appropriate for PSA levels of ***[new]*** :
  - aged 80-85 years **> 10**
  - aged 86 year and over **> 20**

### Routine Referral

- Elevated age-specific PSA where urgent referral will not affect outcome due to age or comorbidity

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# Urology

## PSA (prostate specific antigen) test

- PSA test may be raised within:
  - 3 days of ejaculation
  - 6 weeks of a proven UTI
  - 6 weeks of catheterisation
  - 6 weeks of other invasive procedure such as prostate biopsy

- Effect of digital rectal examination is considered negligible ***[new]***

# Urology

## Bladder and kidney cancer

### Urgent Suspicion of Cancer Referral

- > 45y ***[new – no age range before]*** plus:
  - unexplained visible haematuria without urinary tract infection, or
  - visible haematuria that persists or recurs after successful treatment of urinary tract infection
- >60y plus unexplained non-visible haematuria and either dysuria or a *raised white cell count* on a blood test ***[new]***
- Abdominal mass consistent with urinary tract origin

### Routine referral

- Asymptomatic persistent non-visible haematuria without obvious cause
- Unexplained visible haematuria < 45 years of age
- >40y who present with recurrent UTI associated with any haematuria

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# Urology

## Testicular and Penile Cancer

### Urgent Suspicion of Cancer Referral

- Non painful enlargement or change in shape or texture of the testis
- Suspicious scrotal mass found on imaging
- Epididymo-orchitis or orchitis not responding to treatment
- Non-healing lesion on the penis or painful phimosis

Testicular cancer is sometimes very aggressive – secondary care should triage referrals ***[new]***

# Scottish Referral Guidelines for Suspected Cancer – Children, Teenagers & Young Adult Cancers

Dr Douglas Rigg, GP
Clinical Lead West of Scotland Primary Care Cancer Network

NHS West of Scotland Cancer Network

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# Children, Teenagers & Young Adult Cancers

## General recommendations

- Consider referral if 3 or more repeat presentations of symptoms not resolving or following a normal pattern ***[was always refer]***
- Refer as USOC unexplained fatigue, persistent pallor, failure to thrive or weight loss
- ***Tumour site specific guidance also applies to CTYA where no age specified.***

# Children, Teenagers & Young Adult Cancers

## Urgent Suspicion of Cancer Referral – key differences to adult guidelines

- **Brain:**
  - New neurological signs with behavioural change or deterioration in normal daily or school performance
  - increasing head circumference or failure of fontanelle closure
  - abnormal head position such as wry neck, head tilt or stiff neck
- **Haematology:**
  - Unexplained petechiae or purpura - emergency referral
- **Renal**
  - Unexplained visible haematuria (adults only over 45)
- **Sarcoma & bone:**
  - Size greater than 2cm maximum diameter (**NB vs adults >5cm**)
  - New persistent unexplained pain (esp. back or nocturnal pain)

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# REGIONAL RED FLAGS FOR CHILDHOOD CANCER

**EYES:**
Leukocoria (white glow to pupil), visual disturbance, new squint

**PALPABLE MASS:**
Of any location - soft tissue, bony or lymphadenopathy

**ABDOMEN:**
Distension, organomegaly, refractory constipation, nausea

**SYSTEMIC:**
Recurrent viral illnesses, weight loss, night sweats

**BRAIN:**
Headaches, early morning vomiting, change in behaviour, abnormal movements

**PALLOR,**
increased bleeding, bruising, exhaustion

**GENITOURINARY:**
Haematuria or difficulty voiding

**BONE:**
Back pain, new limp or persistent pain of any location

## DON'T FORGET:

**CONCERN ANOREXIA NO. OF ATTENDANCES (3) COMPLEXION EXHAUSTION RECURRENT PYREXIA**

Early diagnosis saves lives, please listen to the concerns of the caregiver

Grace Kelly Ladybird Trust

**For childhood cancer awareness and research into solid tumours in children and young people**

# Scottish Referral Guidelines for Suspected Cancer –

# Reflections, next steps and closing remarks

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# Next steps

## Direct access to investigation

- GP sub committee policy
- Concerns over creating demand in primary care and workload
- Cancer tracking
- Radiology reporting times

## SCI gateway

- Liaise with referral management group
  - Add link to guidelines and CRUK leaflet

## Downgrading procedures

## Address issue with discharge after single test

# West of Scotland Cancer Genetics Service

www.woscan.scot.nhs.uk

**The Service**

The service is for those who are well but at moderate or high risk of cancer (see guidance).
However:

- Some individuals at low risk of cancer may still request a referral despite reassurance from their doctor or nurse. Please highlight this within the referral letter so that the genetics service is aware or the patient will not be given an appointment.
- If someone has a complex family history of several unusual cancers (**not** covered by this guidance) then please consider referral.

**Cancer Risk (*see notes regarding first degree relatives)**

| Breast Cancer | Low Risk | Moderate Risk | High Risk |
|---|---|---|---|
| **1 Relative:** Over 40 years at time of diagnosis | Reassure | | |
| Under 40 years at time of diagnosis * | | Refer | |
| With bilateral breast cancer * | | Refer | |
| Who is male (Male breast cancer) * | | Refer | |
| With both breast & ovarian cancer (double primary) * | | | Refer |
| **2 Relatives:** 2 relatives over 60 years | Reassure | | |
| 2 relatives under 60 years * | | Refer | |
| 1 under 60 years **&** 1 relative with ovarian cancer * | | Refer | |
| 1 relative under 40 years and 1 relative with a childhood cancer | | | Refer |
| **3 Relatives:** Any age * | | Refer | |
| **4 or More Relatives:** 4 or more relatives under 60 years | | | Refer |

| Ovarian Cancer | Low Risk | Moderate Risk | High Risk |
|---|---|---|---|
| **1 Relative:** Any age | Reassure | | |
| **2 Relatives:** Or more * | | | Refer |
| 1 relative with ovarian cancer (any age) **and** 1 relative with breast cancer under 50 years* | | Refer | |
| **3 Relatives:** 1 relative with ovarian cancer (any age) **and** 2 relatives with breast cancer under 60 yrs * | | Refer | |
| **4 Relatives:** 3 with colorectal cancer (1 under 50 years) **and** 1 relative with ovarian cancer * | | | Refer |

| Colorectal Cancer | Low Risk | Moderate Risk | High Risk |
|---|---|---|---|
| **1 Relative:** Over **50** years | Reassure | | |
| **1 Relative:** Under **50** years * | | Refer | |
| **2 Relatives:** With average age under 60 years* or **2** relatives at any age where both are 1st degree relatives | | Refer | |
| **3 or More Relatives:** All over 50 years * | | Refer | |
| With 1 diagnosed under 50 years * | | | Refer |

**Notes:**

*One relative must be a **first degree** relative unless through an intervening male and all on the same side of the family.

- **1st Degree** = Mother, sister, daughter, father, brother, son.
- **2nd Degree** = Grandmother, granddaughter, aunt, niece, grandfather, grandson, uncle, nephew.

# Scottish Referral Guidelines for Suspected Cancer App

**The Guidelines app**

The Referral Guidelines app is currently available for Android and Apple devices via the iTunes Store or Google Play Store. To coincide with a recent clinical refresh of the Guidelines, work is underway with the University of the West of Scotland to further develop the app to enable potential referrers to access and engage with the Guidelines in a more interactive way.

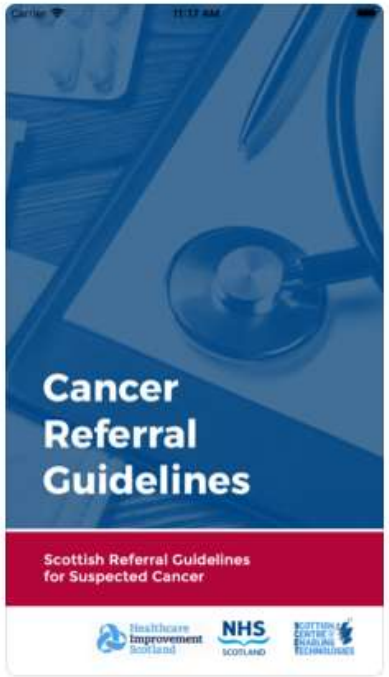
**Improving the app**

**Your help is needed** to explore how the Guidelines are currently accessed and explore what functions you would benefit from day-to-day. To register your interest and find out more email the team below.

**Quick Reference Guide**

To order additional copies please e-mail the team below

Scottishcancerguidelines2018@gov.scot




Healthier Scotland
Scottish Government
NHS SCOTLAND

# Support from Cancer Research UK

Email: Westscotland.facilitators@cancer.org.uk

**Lisa Cohen (Facilitator Manager - West of Scotland)**
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Thank you! Please complete your evaluation form and trade in for your certificate!

Focus your smartphone camera on the QR code for the Referral Guidelines App

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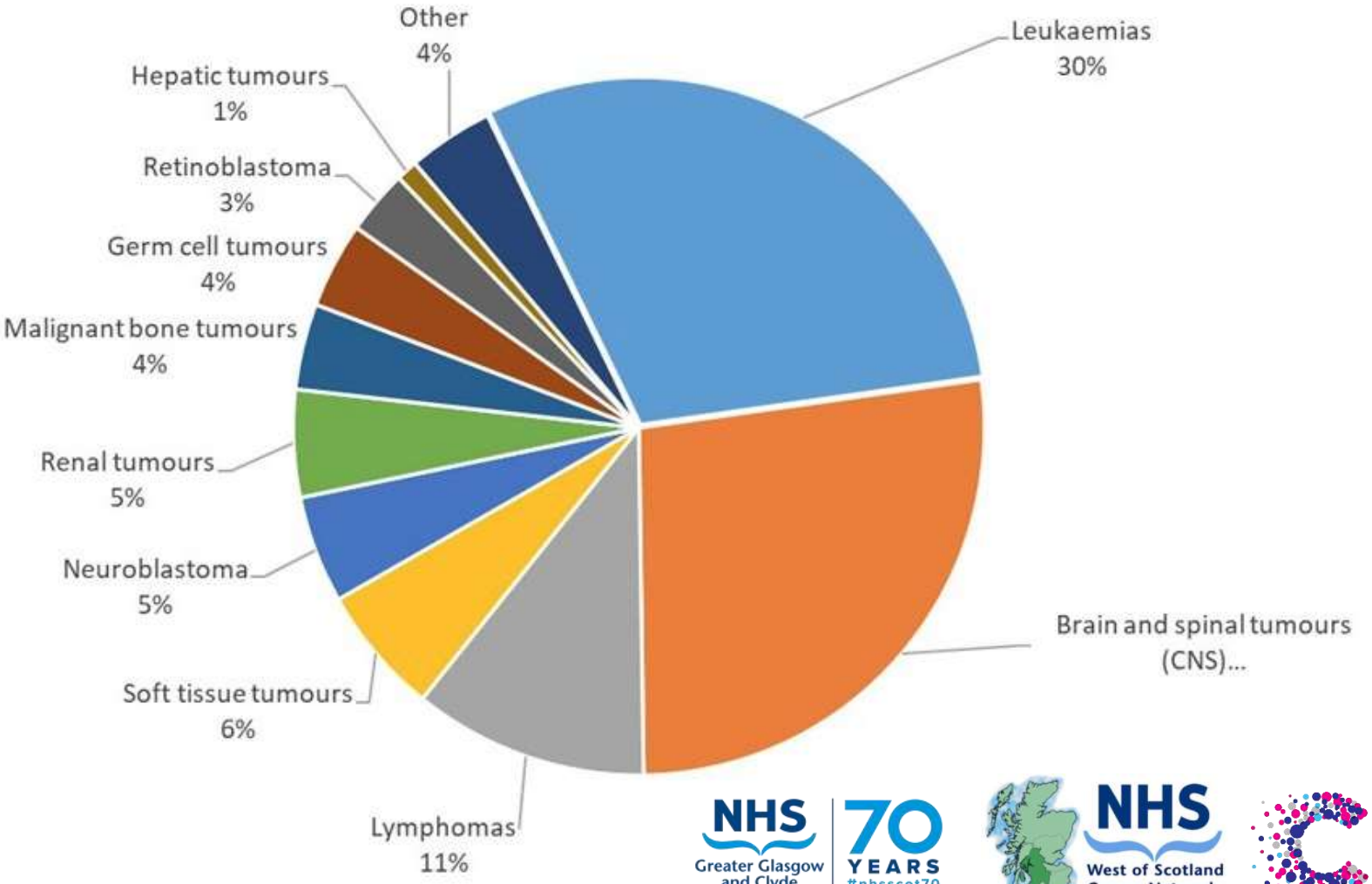
# 300 new CTYA cancers per year in Scotland
# (120 <age 15, majority age <4yrs old)

## "Average" GP only one diagnosis over 35 year career &
## "Average" practice will diagnose one every 7-8 years

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