Achieving earlier diagnosis of cancer in Lincolnshire

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February 2018
The state of Lincolnshire Cancer Care

• Lincolnshire: The worst part of the country for early diagnosis of cancer?

• National Cancer Ratings for October 2016

• NHS Constitutional standards relating to cancer care not being met particularly 62 day RTT target
As National Cancer Dashboard data

Patients diagnosed at either stage 1 or 2
Relates to Year 2015

Lincolnshire West CCG 35%
Lincolnshire East CCG 36%
Lincolnshire South West CCG 40%
Lincolnshire South CCG 51%
Aims of session

• Discuss NICE guidance (NG12) 2015 regarding best referral practice

• Case discussions relating to investigation and referral

• Local initiatives to achieve earlier diagnosis, treatment and better outcomes for patients
GP role in achieving earlier diagnosis

A) Patient notices symptoms and decides whether to present

**Improved patient awareness**

B) Patient presents (usually in Primary Care)

Support primary care in the quest for earlier diagnosis

C) Doctor recognises cancer is a possibility and refers accordingly

**Access to investigations**

D) Definitive Investigations

E) Treatment Begins

Scope for avoiding delays in the patient pathway

* Screening services for the asymptomatic
The New NICE Guidance

- The new guidelines (NG12) build upon those published in 2005
- The document is far-reaching;
  (i) referral guidelines have been updated for almost every tumour group and
  (ii) both adults and children are affected
- Recommendations broken down by tumour group & symptom clusters
- Symptoms durations gone
New NICE guidance: An Overview

Key changes include:

- Reliance on new evidence from primary, rather than secondary care
- Recommends urgent investigations in adults with a $\geq 3\%$ risk of cancer but uses a lower threshold for children & young people
- Contains a range of recommendations ranging from a GP clinical examination to immediate referrals to specialists
- Clear in its expectation that GPs should have more direct access to diagnostic tests
Direct Access to Diagnostics

The new guidance advocates GP direct access to:

- CXRs
- Non-obstetric USS
- Upper GI endoscopy
- CT scans (abdomen)
- MRI brain

Non-imaging diagnostics recommended include; relevant blood tests, urinary Bence-Jones protein and faecal occult bloods
Beware: it’s not necessarily a “2 week rule”!

Broadly, 4 tiers of urgency (for diagnostics and referrals) advocated in the guidance;

• ➤ Immediate
• ➤ Very urgent (within 48 hours)
• ➤ Urgent (within 2 weeks) or
• ➤ Non-urgent (no time-frame specified)
Patient info and safety netting....

- It is recommended that patients are informed they are being referred for suspected cancer
- Patient information sheets may help
- Consider a review of people with any symptom that is associated with an increased risk of cancer – Beware tests with high false – ves (e.g. CXRs, FOBts)

Ensure results of investigations are acted upon - the healthcare professional who ordered the investigation should take or explicitly pass on responsibility for this
The difficulties facing a GP

- To refer or not to refer: That is the question
- Investigate or refer to outpatients?
- Urgent or non-urgent?
- Patients’ symptoms often vague and non-specific
- How rigidly to follow referral guidelines
- Avoiding accusations of both under and over referral
- Remembering all of the detail in NG12
The Top 4 Cancers

and how to use the new referral criteria
Lung Cancer

- A large-scale, UK based lung cancer study (involving 20,142 patients who consulted with Primary Care) was published in Thorax and the BMJ.
- Results revealed out of 20,142 patients:
  - 1 in 20 were diagnosed at death
  - 1 in 10 died within 1 month of diagnosis
  - 15% died between 1-3 month of diagnosis

Thorax
An International Journal Of Respiratory Medicine
Lung Cancer Top Tips

• Encourage smoking cessation. Prevention though smoking cessation have the biggest impact on our national lung cancer profile

• Patients with a cough for 3 weeks or more should have a CXR

• Ensure there is a robust system in place to follow up abnormal initial chest X-Rays

Q) What % of lung cancer patients have a personal history of smoking? a) 95% b) 90% c) 86%
National Lung Cancer Optimum Pathway (NLCOP)

- Developed by National Lung Cancer Clinical Advisory Group (now renamed National Lung Cancer Clinical Senate)
- Designed to improve flow through the pathway
- Very specific to enable clinicians to target areas of bottleneck in their own pathways
- Sets national standards
- Enables commissioners to scrutinise pathways and work with providers to streamline flow
- Option for primary care to triage referrals and optimise those with definite non-lung cancer CT
Lung Cancer

Q1) Mark, a 41 year old man, presents with cough for the past 6 weeks. He has smoked 20 cigarettes per day for 23 years - What further assessment should we make?

Q2) He is well, has a long standing morning cough with clear phlegm. Full examination is normal - What investigations would you request in primary care? What arrangement/safety net should we put in place for follow-up?

Q3) CXR and FBC are normal but on review 1 week later he has experienced 2 episodes of haemoptysis - What action is required?
Breast Cancer

- The commonest cancer in the UK
- The incidence has risen by 7% in the last decade
- The lifetime risk of being diagnosed with breast cancer is 1 in 8 for women in the UK
The Australian singer was diagnosed with breast cancer in 2005. Minogue was misdiagnosed initially and told that she was healthy. She persisted in getting an accurate diagnosis and it was only after repeat investigations that her tumour was detected.

Sheila Hancock was diagnosed with breast cancer many years ago. She said "I actually detected mine quite early. I did it myself by regularly feeling my breast and discovering that something was slightly amiss. My instinct told me I needed to pursue it, which I did."
2 week wait breast referral issue

• Struggling 2 week wait clinics due to staffing issues and organisational issues

• “inappropriate referrals”

• Rigidity of clinic systems and lack of alternatives to a 2 week wait referral
Breast Cancer – NG12 in practice

• **Q1)** Sarah a 38 year old lady presents with a history of having felt a lump in her left breast. It is painless, there is no history of trauma, she is not breastfeeding – **What further assessment do we undertake and what signs should we look for?**

• **Q2)** There is a 1.5 cm breast lump in the upper outer quadrant of the left breast, there is no lymphadenopathy – **What action should we take?**

• **Q3)** A 45 year old lady with a 2cm lump in the right axilla should be referred via the 2WW breast cancer pathway: **True or False**

• **Q4)** A 51 year old lady with unilateral nipple discharge only should be referred via the 2WW breast pathway: **True or False**
Prostate cancer
• The commonest cancer in UK males
• The strongest risk factor for prostate cancer is age
• Men who have a family history of the disease in a 1\textsuperscript{st} degree relative have an increased risk (2-3 times)

Q1) Prostate cancer is commoner in Afro-Caribbean male: True/False

Q2) Asian men have a lower risk of prostate cancer than white men: True/False
## Influence of family history of prostate cancer on lifetime risk of developing prostate cancer

<table>
<thead>
<tr>
<th>Family History</th>
<th>Lifetime Risk</th>
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</thead>
<tbody>
<tr>
<td>No Family History</td>
<td>8% Men</td>
</tr>
<tr>
<td>Father with Ca Prostate ≥ 60</td>
<td>12%</td>
</tr>
<tr>
<td>1 brother affected ≥ 60</td>
<td>15%</td>
</tr>
<tr>
<td>Father affected &lt; 60</td>
<td>20%</td>
</tr>
<tr>
<td>1 brother affected &lt; 60</td>
<td>25%</td>
</tr>
<tr>
<td>2 male relatives with prostate cancer</td>
<td>30%</td>
</tr>
<tr>
<td>3 or more male relatives affected</td>
<td>35-40%</td>
</tr>
</tbody>
</table>
Prostate Cancer Issues for GPs

• Is early diagnosis good or bad?
• What is rational approach to PSA testing?
• NICE guidance on prostate cancer CG175
• PSA testing patient advice sheets
• Digital rectal examination
Prostate cancer

• Beware of recurrent presentations of back or pelvic pain, especially in men over 50 – is a PSA/DRE needed

• Early prostate cancer can be asymptomatic

• Up to 15% of people with prostate cancer will have a normal PSA so if the DRE is abnormal, always refer (regardless of PSA)

• A new presentation of ED is a significant symptom & after discussion with the patient, a PSA & DRE may be appropriate
Prostate cancer – NG12 in practice

Q1) Tom is a 58 year old man who presents with LUTs – **What further assessment should we undertake?**

Q2) Examination of his abdomen is normal. PR reveals a smooth moderately enlarged benign feeling prostate. Dipstick urine shows a trace of nitrite. **What do we do next? Patient is keen to have a PSA**

Q3) His renal function and FBC are normal, PSA 10 (age specific range -0-4) MSU reveals an E.coli UTI. **What action do we take?**

Q4) PSA is now 3.9. MSU is normal & symptoms only slightly improved – **What action should we take?**

Q5) PSA is now 5.4 after 3 months. MSU is normal & symptoms only slightly improved? **What action should we take?**

Q6) If you chose dutasteride as a treatment for his LUTs – **What are the implication for PSA Testing?**
Prostate cancer resources

• Patient decision making aids and other useful information for patients and professionals [https://prostatecanceruk.org](https://prostatecanceruk.org)

• Lincolnshire West CCG and ULHT podcast on PSA testing and referrals to prostate 2 week wait clinic [https://vimeo.com/235647893](https://vimeo.com/235647893)

Colorectal cancer

- At least 100 people are diagnosed with colorectal cancer in the UK every day
- The 4th most common cancer
- Incidence risen by 6% in the last decade
- Earlier diagnosis is essential
Colorectal cancer in Lincolnshire

- Straight to test pathway with nurse triage referrals
- Variable uptake of national bowel screening programme
- Flexible sigmoidoscopy screening programme being rolled out across the county
- National FIT screening starts April 2018
- RTT 62 performance below average
Colorectal cancer – top tips

- Where possible, encourage screening uptake, it reduces mortality by **16%** (yet average uptake of FOB screening is just **58%**)

- Be aware that patients who are at a high genetic risk or have IBD need to be in a surveillance screening programme

- Studies show abdominal pain is a significant symptom due to its PPV

- If you have a clinical suspicion, trust your instincts
NG12 in practice

Q1) Ken, a 62 year old man presents for a new patient diabetes review having seen the nurse 2 weeks previously. His diabetes was diagnosed ‘opportunistically’ following a CV Risk appointment. His BMI is 22, there is no FH of DM he asks if this would explain his recent weight loss (4kg in 5 weeks) and upper abdominal discomfort. **What further assessment would you undertake?**

Q2) He is not clinically anaemic or jaundiced and examination of his abdomen is normal – **What action would you take?**
NG12 in practice

Q1) Non-urgent upper GI endoscopy is appropriate in the following situations (True or False)

a) A 58 year old presenting with weight loss and dyspepsia. Examination of her abdomen is unremarkable and she is not clinically anaemic?

b) 56 year old man with treatment resistant dyspepsia?

c) 59 year old man with upper abdominal pain, anaemia (not iron deficient) and a normal examination?

d) 40 year old male smoker with dysphagia for solids & a normal examination?

e) 60 year old lady with weight loss, upper abdominal pain, diarrhoea and normal examination?
But there are still some quick wins!

- NICE have given greater importance to GP-accessible tests, including:
  - FBCs – thrombocytosis in the presence of ....

1. Weight loss or nausea or vomiting or dyspepsia or reflux or upper abdominal pain, should prompt an OCG in those $\geq 55$

2. A patient who is $\geq 40$ years old should prompt an urgent CXR

3. Visible haematuria or vaginal discharge in women $> 55$, should prompt consideration of a direct access TVUSS to exclude endometrial cancer (but don’t forget to also exclude urological causes if haematuria).
Quick wins continued

• A raised WCC in the presence of unexplained microscopic haematuria in $\geq 60$, should prompt a 2 WW referral to urology

• Haemoglobin
  ❖ If $\geq 60$ with any unexplained ID anaemia, refer via 2WW
  ❖ If $<50$ with any unexplained ID anaemia AND PR bleeding, refer via 2WW
  ❖ If $\geq 55$ with a low Hb & visible haematuria in women, consider TVUSS (and potential urological causes)
Quick wins continued

➢ Blood Glucose
  ▶ If levels high in a woman with visible haematuria $\geq 55$, consider TVUSS (and potential urological causes)
  ▶ New onset diabetes in a patient 60 or over with weight loss should prompt an urgent abdo USS if CT available

➢ CA-125
  ▶ If $\geq 18$ and CA-125 is $\geq 35$, arrange an urgent TVUSS to exclude ovarian cancer

➢ PSA
  ▶ Refer via 2WW if above age-specified reference range
Patients with vague symptoms

- Weight loss
- Tiredness
- Back pain
- Abdominal pain
- Loss of appetite
- Bloating
- Constipation
Risk stratifying patients

• Put symptoms into context

• Consider likely other causes physical, psychological and social

• Consider cancer risk scoring tool e.g. Q cancer

• Investigate or refer according to probabilities

• Be aware of thrombocytosis as being an indicator of possible underlying cancer
Lincolnshire Find out Faster project

- Aim to speed investigations of patients with vague symptoms presenting in primary care

- Use of Q-cancer risk scoring tool

- Alternative to Danish multi-disciplinary diagnostic centre model in a rural county

- Outcomes and lessons learned
Take home messages

• The new NICE guidance give you much more freedom to refer / investigate/ use your clinical judgement

• There is a great focus on symptoms and how they present in Primary Care

• Thrombocytosis is important. A number of small studies have suggested that up to 40% of people with raised platelets have cancer

• There is a greater emphasis on safety-netting & informing patients it’s referral for suspected cancer
Tools and Resources to support GPs

- A downloadable version of NG12 can be found on the Macmillan website

- CRUK have produced an interactive desk easel, summarising the guidelines based on symptoms (PDF Format)

- Useful web resources include RCGP e-learning modules
Thank you for listening.