Cancer Cascade Workshop

What’s new?
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What’s new?

- Breast cancer presentation
- Very brief intervention
- Colorectal paper
- E-cigarettes
- New CRUK Stats/infographics
- CRUK Local Cancer Statistics
- Catalyst Award
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What’s new?
• BBC News 08.11.16 (NIHR Conference)
• Breast cancer presentation
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Warning over non-lump breast cancers

Around one in six cases of breast cancer begins with symptoms other than a suspect lump, experts are warning.

http://www.bbc.co.uk/news/health-37894360
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What’s new?
UCL Researchers:
1 in 6 cases of breast cancer begin with non-lump symptoms
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NICE NG12 2015

2 week breast referral pathway:
• aged 30 and over and have an unexplained breast lump
• aged 50 and over with any of the following symptoms in one nipple only:
  • discharge
  • retraction
  • other changes of concern. [new 2015]
• skin changes that suggest breast cancer
• aged 30 and over with an unexplained lump in the axilla. [new 2015]
• Consider non-urgent referral in people aged under 30 with an unexplained breast lump with or without pain. See also recommendations 1.16.2 and 1.16.3 for information about seeking specialist advice. [new 2015]
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What’s new?
Very brief advice
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What’s new?
Very brief advice

http://www.bbc.co.uk/news/health-37717594
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What’s new?
Very brief advice:
12 months later average weight loss:
• Advice alone: 1.0kg
• Advice with Tier 2 referral: 2.4 kg

• 1 in 4 lost 5% body weight
• 1 in 10 lost 10% body weight
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What’s new?

"The impact is pretty substantial given the effort - 30 seconds - that went into it.

"If we were year-on-year to knock 2.4kg off the heaviest people in society then that would have a very big effect in health terms."

Prof Paul Aveyard
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What’s new? (nearly!)
RCGP and CRUK working collaboratively to produce an e-Learning VBA tool.
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What’s new?
No such thing as “heavy bones”
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What’s new?

No such thing as “heavy bones”
Colorectal cancer – when to refer?

• When did we refer?
Colorectal cancer – when to refer?

- When did we refer?
Colorectal cancer – when to refer?

- When did we refer?
Colorectal cancer – when to refer?

- When did we refer?
Colorectal cancer – when to refer?

- When did we refer?

Two thousand bowel cancer tumours a year are missing by GPs... before before spotted in casualty: Fifth of patients diagnosed in A&E had previously been turned away by a family doctor

- Patients were sent away by doctors despite having 'red flag' symptoms
- Finding out at a late stage greatly reduces a patient's chances of survival
- 2,000 bowel cancer patients a year could have been diagnosed earlier
- Last year the health watchdog NICE issued GPs with a guide for spotting it

By SOPHIE BORLAND HEALTH EDITOR FOR THE DAILY MAIL

One in five bowel cancer patients diagnosed in an emergency had 'red flag' symptoms that should have been picked up earlier, a study in the British Journal of Cancer suggests.

And 16% of emergency bowel cancer patients had seen their GP three or more times or more with relevant symptoms.
Colorectal cancer – when to refer?

• When did we refer?

Do colorectal cancer patients diagnosed as an emergency differ from non-emergency patients in their consultation patterns and symptoms? A longitudinal data-linkage study in England

CONCLUSIONS: Emergency presenters have similar ‘background’ consultation history as non-emergency presenters. Their tumours seem associated with less typical symptoms, however opportunities for earlier diagnosis might be present in a fifth of them.
Colorectal cancer – when to refer?

- When did we refer?  Variably
Colorectal cancer – when to refer?

- When did we refer? Variably across CCGs

http://www.ncin.org.uk/publications/routes_to_diagnosis (accessed 2.10.16)
Colorectal cancer – when to refer?

• When did we refer? Variably (across time)
Colorectal cancer – when to refer?

- When did we refer? Variably (across time) – improving!

http://www.ncin.org.uk/publications/routes_to_diagnosis (accessed 2.10.16)

http://www.rcgp.org.uk/publications/routes_to_diagnosis (accessed 2.10.16)
Colorectal cancer – when to refer?

- When did we refer? Variably (across time) – improving!

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Colorectal cancer – when to refer?

- When did we refer? Variably (across time) – improving!
- 1 year survival

Colorectal cancer – when to refer?

• When did we refer? Variably (across time) – improving!

CRC cancer rates per 100,000

Incidence
Mortality

Colorectal cancer – when to refer?

- When did we refer? Variably – why is this important?

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Colorectal cancer – when to refer?

- When did we refer? Variably – why is this important?

Relative survival estimates by presentation route and survival time, Colorectal, 2006-2013

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Colorectal cancer – when to refer?

- What are the “key” symptoms?
Colorectal cancer – when to refer?

- What are the “key” symptoms for colon cancer?
- Rank order for symptoms reported or findings in 30 days prior to diagnosis:

<table>
<thead>
<tr>
<th>Option A</th>
<th>Option B</th>
<th>Option C</th>
<th>Option D</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Rectal bleeding</td>
<td>1. Abdominal pain</td>
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Discuss and choose which is correct ranking.
Colorectal cancer – when to refer?

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- Rank order for symptoms reported or findings in 30 days prior to diagnosis:

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<tbody>
<tr>
<td>1. Rectal bleeding</td>
<td>1. Abdominal pain 15.7%</td>
<td>1. Rectal bleeding</td>
</tr>
<tr>
<td>3. Weight loss</td>
<td>3. Rectal bleeding 4.4%</td>
<td>3. Change in bowel habit</td>
</tr>
<tr>
<td>4. Abdominal pain</td>
<td>4. Change in bowel habit 2.5%</td>
<td>4. Abdominal pain</td>
</tr>
<tr>
<td>5. Anaemia</td>
<td>5. Weight loss 1.8%</td>
<td>5. Weight loss</td>
</tr>
</tbody>
</table>

http://www.nature.com/bjc/journal/v115/n7/pdf/bjc2016250a.pdf
Colorectal cancer – when to refer?

- What are the “key” symptoms for colon cancer?

<table>
<thead>
<tr>
<th>Symptom</th>
<th>30 days pre-Δ</th>
<th>12 months - 30 days pre-Δ</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdominal pain</td>
<td>15.7%</td>
<td>25.1%</td>
</tr>
<tr>
<td>Anaemia</td>
<td>6.2%</td>
<td>19.2%</td>
</tr>
<tr>
<td>Rectal bleeding</td>
<td>4.4%</td>
<td>9.4%</td>
</tr>
<tr>
<td>Change in bowel habit</td>
<td>2.5%</td>
<td>5.5%</td>
</tr>
<tr>
<td>Weight loss</td>
<td>1.8%</td>
<td>3.1%</td>
</tr>
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http://www.nature.com/bjc/journal/v115/n7/pdf/bjc2016250a.pdf
Colorectal cancer – when to refer?

- What are the “key” symptoms?

![Frequency of symptoms in colon cancer]

- Abdominal pain
- Anaemia
- Rectal bleeding
- Change in bowel habit
- Weight loss

http://www.nature.com/bjc/journal/v115/n7/pdf/bjc2016250a.pdf
Colorectal cancer – when to refer?

- What are the “key” symptoms?

![Frequency of symptoms 30 days pre-diagnosis in colon cancer](http://www.nature.com/bjc/journal/v115/n7/pdf/bjc2016250a.pdf)
Colorectal cancer – when to refer?

• What are the “key” symptoms?

[Diagram showing frequency of symptoms in rectal cancer with bars for Abdominal pain, Anaemia, Rectal bleeding, Change in bowel habit, and Weight loss. The bars are differentiated by 30 days pre-Δ, 12 months - 30 days pre-Δ, and another category.]

http://www.nature.com/bjc/journal/v115/n7/pdf/bjc2016250a.pdf
Colorectal cancer – when to refer?

• What are the “key” symptoms?

![Frequency of symptoms 30 days pre-diagnosis in rectal cancer](http://www.nature.com/bjc/journal/v115/n7/pdf/bjc2016250a.pdf)
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E-cigarettes
To vape or not to vape? The RCGP position on e-cigarettes

Dr Richard Roope, RCGP and Cancer Research UK Clinical Champion for Cancer

Smoking tobacco is the single largest cause of preventable illness and premature death, being responsible for around 100,000 deaths a year in the UK. Smoking accounts for 27% of all cancer deaths. 35% of all respiratory deaths and 13% of all circulatory disease deaths. It is in this context that smoking cessation is one of the most effective health interventions. Up until recent years the main tools to support those trying to give up smoking have been nicotine replacement therapy, and oral bupropion or varenicline. Research shows that professional support alongside medication has been the most effective approach. (8% success rates at one year, compared with 3% in those who attempt to quit unaided).

ENDS are battery-powered devices that allow the inhalation, or “vaping” of an aerosol containing nicotine, with the option of flavouring. They became available in 2004, following their invention in China in 2003, and global use has increased year on year. By May 2016 2.8 million adults in Great Britain were using ENDS. Of these, approximately 47% were ex-smokers and 51% were using both cigarettes and ENDS.
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E-cigarettes
Toxicity:
• Smoking tobacco: >7000 chemicals\(^1\)
• Vaping: 42 chemicals\(^2\) – though will vary

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E-cigarette Toxicity:

Eur Addict Res 2014;20:218-225
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E-cigarettes
Concerns:
1. Entry into smoking?
2. Safety?
3. Is it effective in cessation?
4. Is passive vaping of concern?
5. Should we wait for more research?
E-cigarettes Concerns:
1. Entry into smoking?
   • Use in children is rare – of those who do, most are ex-smokers
   • Youth smoking: 1996 13% → 2014 3%¹

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E-cigarettes
Concerns:
1. Entry into smoking?
2. Safety?
   - Long term safety profile not yet known – but much safer than cigarettes\(^1\)
   - PHE report 95% safer than cigarettes\(^2\)

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E-cigarettes
Concerns:
1. Entry into smoking?
2. Safety?
3. Is it effective in cessation?
   • Since 2013 ECs are England’s most successful quitting aid\(^1\)

1. Smoking Toolkit Study [www.smokinginengland.info](http://www.smokinginengland.info)
E-cigarettes

Concerns:
1. Entry into smoking?
2. Safety?
3. Is it effective in cessation?
4. Is passive vaping of concern?
   • No identified hazards to bystanders\(^1\)

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E-cigarettes
Concerns:
1. Entry into smoking?
2. Safety?
3. Is it effective in cessation?
4. Is passive vaping of concern?
5. Should we wait for more research?
   • No – the benefits are so larger, there are lives to be saved...
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E-cigarettes
Position statement now adopted

Recommendations

In line with recommendations from PHE\textsuperscript{10}, it is recommended that:

1. All Primary Care Clinicians (PCCs) provide accurate advice on the relative risks of smoking and e-cigarette use, and providing effective referral routes into stop smoking services.
2. PCCs engage actively with smokers who want to quit with the help of e-cigarettes.
3. Where a patient is wanting to quit smoking and has not succeeded with other options, PCCs should recommend and support the use of ECs.
4. PCCs recognise ECs offer a wide reach, low-cost intervention to reduce smoking in more deprived groups in society and those with poor mental health, both having elevated rates of smoking.
5. All PCCs encourage smokers who want to use e-cigarettes as an aid to quit smoking to seek the support of local stop smoking services.
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Cigarette smoking prevalence

% smoking

http://www.smokinginengland.info/latest-statistics/ Accessed 6.10.16
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% of smokers trying to stop

Percent of smokers trying to stop

- E-cigs
- NRT OTC
- NRT Rx
- Champix
- Beh'l supp
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Cigarette smoking prevalence

% smoking/% of use of e cigs for cessation

% smoking % using e cigs to stop

RCGP Royal College of General Practitioners

Cancer Research UK
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What’s new?

• New CRUK Stats/infographics
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New CRUK Stats/infographics

WHAT’S THE MOST SUCCESSFUL WAY TO STOP SMOKING?
SUCCESS OF POPULAR METHODS COMPARED WITH GOING COLD TURKEY

The study used going cold turkey as the baseline
No more successful than cold turkey – probably because people don’t use enough

225% More successful

COLD TURKEY
Quitting with no support

NRT
Using Nicotine Replacement Therapy without professional support

60% More successful

E-CIGARETTES
Using electronic cigarettes without professional support

SUPPORT AND MEDICATION
Combined specialist support and prescription medication*

*Available free from your local Stop Smoking Service nhs.uk/smokefree


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New CRUK Stats/infographics

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New CRUK Stats/infographics

https://pbs.twimg.com/media/B2uE_6vCQAAB_pK.png last accessed 8.10.16
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New CRUK Stats/infographics

What difference does breast screening make?

Screening catches more cancers earlier
Cancer is unpredictable, so it's not possible to know how a woman's cancer would have grown had it not been caught and treated.

Some would grow quickly
If these spread to vital organs, they may cause death.

Some would grow slowly

Some of these would go on to spread
Some women live healthy, full lives unharmed by and unaware of these cancers.

Some of these would never cause harm

If we look at 1,000 women over 20 years

If they were not screened, 58 would be diagnosed with breast cancer

21 die from breast cancer

57 are treated and survive their disease

17 live healthy lives not affected by their cancer

With screening, 75 are diagnosed with breast cancer

16 die from breast cancer

59 are treated and survive their disease

Lives saved by screening
This many women would have died if breast screening had not caught their cancer early.

1,300 lives saved a year in the UK

For every one life saved, three women are overdiagnosed

Overdiagnosed due to screening
This many women are treated for breast cancers that are real, but would not have caused them any harm.

4,000 women treated a year when there would have been no harm

So, breast screening saves lives, but causes some women to be treated who didn't need to be.

On balance, Cancer Research UK recommend that women go for breast screening when invited.

http://www.cancerresearchuk.org/prod_consump/groups/cr_common/@cah/@gen/documents/image/cr_123923.png last accessed 8.10.16
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New CRUK Stats/infographics

What difference does breast screening make?

Screening catches more cancers earlier

Cancer is unpredictable, so it’s not possible to know how a woman’s cancer would have grown had it not been caught and treated.

Some would grow quickly

Some would grow slowly

If those spread to vital organs, they may cause death.

If we look at 1,000 women over 50:

If they were not screened, 58 would be diagnosed with breast cancer.

21 die from breast cancer

57 are treated and survive their diagnosis.

With screening, 75 are diagnosed with breast cancer.

16 die from breast cancer

59 are treated and survive their diagnosis.

Lives saved by screening

1,300 lives saved in the UK for every one life saved.

So, breast screening saves lives, but causes harms to women to be treated who didn’t need to be.

On balance, Cancer Research UK recommends women go for breast screening when invited.

http://publications.cancerresearchuk.org/downloads/Product/prostate_screening_info.pdf last accessed 8.10.16
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• Welsh Data
Cancer Cascade Workshop

• Welsh Data

Cancer Cascade Workshop

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Cancer incidence for all cancers combined

Cardiff and Vale University (HB) 644.2
National Average 635.4

Scotland 645.6
Wales 635.4
England 614.8
NI 592.0

Powys Teaching HB Abertawe Bro Betsi Cadwaladr Cardiff & Vale University Hywel Dda HB Anwerin Bevan HB Cwm Taf HB

Royal College of General Practitioners
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• Welsh Data

62 Day Treatment

70.8
Cardiff and Vale University (HB)

85
National Average

Scotland 90.8
Wales 85.0
England 82.4
NI 70.8
Cancer Cascade Workshop

• Welsh Data
Cancer Cascade Workshop

• Welsh Data
Cancer Cascade Workshop

What’s new?
• Catalyst Award

CATALYST AWARD
FUNDING MULTIDISCIPLINARY COLLABORATION IN POPULATION RESEARCH

Expression of interest deadline:
1 December 2016

Applicant joint meeting:
22 February 2017

Full application deadline:
May 2017

Funding decision:
November 2017

To find out more, visit: cru.org/catalyst-award
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What’s new?
• Catalyst Award

NEW RESEARCH TO ACT AS CATALYST TO HELP GPs DIAGNOSE CANCER

A revolutionary Cancer Research UK-funded project will investigate ways of bringing new and improved cancer diagnostic tests to GPs. *

The CanTest Collaborative will aim to improve and develop new ways of diagnosing cancer in GP surgeries. It will assess the accuracy, cost effectiveness and suitability of a range of diagnostic methods and tools for both patients and GPs.

This £5 million funding is part of Cancer Research UK’s Catalyst Award which aims to help researchers deliver trailblazing progress in their field with long-lasting results.

Professor Willie Hamilton, a lead researcher from the University of Exeter, said: “As a GP myself, I know that it can be frustrating to wait weeks for results before making any decisions for my patients. We’re trying to reduce this time by assessing ways that GPs could carry out these tests by themselves, as long as it’s safe and sensible to do so.

“We’re open to assessing many different tests, and we’re excited to hear from potential collaborators.”

CanTest will involve researchers based at Cambridge University, the University of Exeter, UCL and Leeds University in the UK, and a number of international institutions. In addition to GPs, the researchers will also seek to collaborate with scientists from multiple disciplines who are looking at diagnostic tests.

The collaborative will help build a community of scientists and clinicians for diagnostic research, helping place the UK at the forefront of developing and implementing new cancer tests. To build the research community, the Collaborative will establish an International School for Cancer Detection Research in Primary Care which will train and support a new generation of scientists seeking to make the leap into this field.
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What’s new?
• LOTS...!!!
Cancer Cascade Workshop

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KEEP CALM EXCITING TIMES AHEAD!!
THANK YOU