The Northern Ireland Cancer Landscape: What’s happening?

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The facilitator programme

We support healthcare professionals and organisations to drive improvements in cancer prevention, screening and earlier diagnosis.
Why early diagnosis?

**EARLY AND LATE CANCER DIAGNOSIS**

**STAGE OF CANCER WHEN DIAGNOSED, ENGLAND 2014**

- **EARLY** (STAGE I + II)
- **LATE** (STAGE III + IV)

<table>
<thead>
<tr>
<th>Cancer Type</th>
<th>Early Diagnosis</th>
<th>Late Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast Cancer</td>
<td>85%</td>
<td>15%</td>
</tr>
<tr>
<td>Bowel Cancer</td>
<td>44%</td>
<td>56%</td>
</tr>
<tr>
<td>Lung Cancer</td>
<td>25%</td>
<td>75%</td>
</tr>
<tr>
<td>Melanoma Skin Cancer</td>
<td>91%</td>
<td>9%</td>
</tr>
<tr>
<td>Non-Hodgkin Lymphoma</td>
<td>36%</td>
<td>64%</td>
</tr>
<tr>
<td>Ovarian Cancer</td>
<td>42%</td>
<td>58%</td>
</tr>
</tbody>
</table>


**SURVIVAL BY STAGE OF DIAGNOSIS**

= PEOPLE SURVIVING THEIR CANCER FOR FIVE OR MORE YEARS WHEN DIAGNOSED BETWEEN 2002 AND 2006

**DIAGNOSED EARLIER**

- **At Stage I**
  - **Lung**
    - More than 3 in 10
  - **Bowel**
    - Less than 1 in 10

**DIAGNOSED LATER**

- **At Stage IV**
  - **Lung**
    - Less than 1 in 10
  - **Bowel**
    - Less than 1 in 10
  - **Ovarian**
    - Less than 1 in 10

All data for East of England

*Data for lung cancer 2003–2006*
THE CANCER PATHWAY: Where can we have impact?

- **Patient interval**
  - Potential screening interval
  - First precancerous indicator

- **Doctor interval**
  - First development of cancer
  - First symptom
  - First presentation/clinical appearance

- **System interval**
  - Investigation of related symptoms
  - Referral to secondary care
  - First specialist visit

- **Diagnostic interval**
  - Referral to secondary care

- **Treatment interval**
  - Diagnosis/referral to treatment
  - Start of treatment
Facilitator programme activity:

- Belfast & South Eastern
- Prevention, Screening & Earlier Diagnosis
- Stakeholder Engagement
- Individual practice visits
- Partnership event PHA
- Primary/secondary care workshop
Learning from past 18 months:

- GP Landscape. Challenges and opportunities
- Drivers for change/strategy
- Competing priorities
- Joined-up workplans
Moving forward

- Recruitment
- Steering groups
- Quality improvement agenda
- Partnership working
- Education events
- RCGP CRUK GP Lead NI
Dr Graeme Crawford

GP Bangor Health Centre, Macmillan GP Facilitator, Member of SEHSCT/Cancer Research UK Steering Group
GP Facilitators Northern Ireland

- SHSCT Dr Gerry Millar
- NHSCT Dr Shauna Fannin
- WHSCT Dr Ciara O’Neill & Dr David Flannagan
- BHSCT Dr Sharon Morgan & Dr Jane Russell
- SEHSCT Dr Yvonne McGovern & Dr Graeme Crawford
GP facilitator role

Education:
• Practice visits
• Communication skills training (Sage & Thyme, ACP)
• Developing & Disseminating NICAN guidelines
• Masterclass (Red Whale, Palliative Care, Cancer)

Strategic:
• NICAN Tumour groups (KIS)
• Just in case boxes
The role of primary care in diagnosing cancer earlier

3 CRITICAL CONTROL POINTS:

- Appropriate recognition of potential cancer symptoms
- Appropriate management of patients in primary care, including use of safety netting
- Appropriate referral of patients in primary care
General GP reflections:

- Some uncertainty among GPs – should we refer based in NICAN Guidelines or NG12 from NICE.
- Red flag leaflets for patients could be useful – but GPs may have concerned about setting certain patients expectations.
- Lack of consistency around information on waiting times for red flag referral appointments.
- Need for improved communication with secondary care.
Prostate Cancer in Northern Ireland

• An average of 1039 prostate cancers diagnosed in NI each year (2009-13) rising to 1044 per year for the period 2015/16 - 2017/18

• Prostate Cancer is the most common cancer diagnosed in males

• PSA test is the most commonly used test that can lead to a diagnosis of localised prostate cancer for which potentially curative treatment can be offered

• Not **ALL** men with a raised PSA level will have cancer

• The low specificity of the PSA test has led to over diagnosis and over treatment in up to **50%** of men
### Red Flag referral (Prostate), patients:
- with a hard, irregular prostate typical of a prostate carcinoma. Prostate-specific antigen (PSA) should be measured and the result should accompany the referral. (An urgent referral is not needed if the prostate is simply enlarged and the PSA is in the age-specific reference range.)
- with a normal prostate, but rising/raised age-specific PSA, with or without lower urinary tract symptoms. (In patients compromised by other comorbidities, a discussion with the patient or carers and/or a specialist may be more appropriate.)
- with symptoms and high PSA levels.

### NICE CG12 Guidelines

#### Prostate:
- Refer men using a suspected cancer referral pathway (for an appointment within 2 weeks) for prostate cancer if their prostate feels malignant on digital rectal examination (New 2015)

#### Consider a prostate specific antigen (PSA) test and digital rectal examination to assess for prostate cancer in men with:
- Any lower urinary tract symptoms, such as nocturia, urinary frequency, hesitancy, urgency, or retention OR
- Erectile dysfunction OR
- Visible haematuria

Refer men using a suspected cancer referral pathway (for an appointment within 2 weeks) for prostate cancer if their PSA levels are above the age specific reference range(New 2015)

### Proposed New NICaN Guidance

#### Red Flag Referral (Prostate). Patients:
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Do NOT do a PSA in men with a suspected or confirmed urinary tract infection (UTI)

Refer men using a suspected cancer referral pathway (for an appointment within 2 weeks) for prostate cancer if their PSA levels are above the referral range (as detailed below), at both initial testing and when repeated again at between 2-4 weeks later.

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<th>Age</th>
<th>PSA Referral Range</th>
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<tr>
<td>40 - 49</td>
<td>0 - 2.5 µg/ml</td>
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<tr>
<td>50 - 69</td>
<td>&gt;3 µg/ml</td>
</tr>
<tr>
<td>70 - 79</td>
<td>&gt;6.5 µg/ml</td>
</tr>
<tr>
<td>80+</td>
<td>&gt;10 µg/ml</td>
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Refer men using a suspected cancer referral pathway (for an appointment within 2 weeks) for prostate cancer with a single PSA level of >20 µg/ml

Please note a PSA may be raised in the presence of urinary infection, prostatitis or benign prostatic hypertrophy, and may also be elevated following vigorous exercise, ejaculation or prostate stimulation (e.g. prostate biopsy, digital rectal examination, anal intercourse). Please wait six weeks to do a PSA test if a patient has had an active urinary infection, prostate biopsy, TURP, or prostatitis.
Urological Cancers
Suspect Prostate Cancer Referral Guidance

- Refer men using a suspect cancer referral pathway (for an appointment within 2 weeks) for prostate cancer if their prostate cancer feels malignant on digital rectal examination.

- Consider a prostate specific antigen (PSA) test and digital rectal examination to assess for prostate cancer in men with:
  - Any lower urinary tract symptoms such as nocturia, urinary frequency, hesitancy, urgency, or retention OR
  - Erectile dysfunction OR
  - Visible haematuria

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PSA testing should only be carried out after full advice and provision of information. Patient information leaflet about prostate assessment and PSA testing is available by contacting the Northern Ireland Cancer Network (NICaN) on 028 9536 3305 or can be downloaded by logging onto www.cancerini.net
Primary and secondary care workshop: “Waving the white on red flag referrals” November 2018
Urology

On average 111 GP Red Flag referrals each month:

- 4% increase from previous year
- 37% increase in last 5 years
- 14% cancer conversion rate
- 373 patients diagnosed in 2017/18
- 191 from GP Red Flags
- 182 from other referral sources
- Approximately 44 DNAs
GP reflections - Urology

- Likely to ensure referrals prompted by an elevated PSA test are more appropriate if 2 tests both > age specific age range
- Less referrals would mean those with persistently elevated rising levels seen sooner
- Less chance of over-diagnosis and invasive procedures
- Doubling of workload of GP practices if 2 tests needed prior to referral
- Concern that GP systems not in place to identify defaulters from the repeat test
- Repeating the test goes against the nationally accepted evidence based guidance from NICE (NG12)
Dermatology

On average 300 GP Red Flag referrals each month:

• 38% increase from previous year
• 120% increase in last 5 years
• 9% cancer conversion rate
• 537 patients diagnosed in 2017/18
• 281 from GP Red Flags
• 255 from other referral sources
• Approximately 134 DNAs
GP reflections: Dermatology

• Though referrers take account of the criteria which make up the 7 point checklist for suspicious pigmented lesions, this is unlikely to be explicitly stated in the referral, as it is quite formulaic

• Given the expansion of Dermoscopy into everyday General Practices, any new NICAN guidance should reflect the NG12 reference to referral of dermoscopically suspicious lesions

• No feedback about whether digital photos attached to electronic referral are looked at/useful in decision making/waste of effort

• Timely communication to GP and patient is a priority
Colorectal

On average 219 GP Red Flag each month:

• 12% increase from previous year
• 59% increase in last 5 years
• 5% cancer conversion rate
• 267 patients diagnosed in 2017/18
• 105 from GP Red Flags
• 162 from other referral sources
• Approximately 235 DNAs last year
GP reflections: Colorectal

- Not all GPs want direct access as it extends responsibility to peri-procedure management.
- Introduction of FIT for symptomatic patients may reduce the type of referrals which currently happen due to +ve FOBt results.
- GPs often faced with the dilemma whereby someone has had a negative colonoscopy one year but develops new bowel symptoms a few months later and thus the dilemma whether to reinvestigate. Some guidance over this scenario would help GPs.
- Proactive follow up of those needing repeat colonoscopy at intervals e.g. with certain polyp should be managed by the hospital not GPs.
Primary Care Guidance for Patients within 6 weeks of Systemic Anti-Cancer Therapy (SACT)

Printed copies available
Risk stratification for suspected cancer - Professor William Hamilton

The top row gives the positive predictive value (PPV) for an individual feature. The cells along the diagonal relate to the PPV when the same feature has been reported twice. Thus the constipation/constipation intersect is the PPV for colorectal cancer when a patient has attended twice (or more often) with constipation. Other cells show the PPV when a patient has two different features. For haemoglobin <10g/dl with abdominal tenderness, no controls in the original evaluation had this pair. It was scored as a PPV of >10%. The yellow shading is when the PPV is above 1%. The amber shading is when the PPV is above 2.5%, which approximates to a risk of colorectal cancer of 10 times normal. The red shading is for PPVs above 5.0% approximating to a risk of 20 times normal.
Thank you. Any questions?