Recognition and Referral of Suspected Cancer
- NICE guidance and local initiatives

Dr. Louise Merriman – GP Clinical Lead for South Yorkshire, Bassetlaw and Derbyshire Cancer Alliance
Topics to be covered

• Current landscape for cancer in UK
• What is the Cancer Alliance?
• What can we do better?
• Overview of the NICE guidance – NG12
• Update on local initiatives and pathways
• Helpful resources
Current landscape

• 1 in 2 of those born since 1960 will develop at least one cancer in their lifetime
• >50% of those diagnosed with cancer will now live > 10 years
• Almost 50% of cancer diagnosed will consist of the “big 4”: breast, lung, colorectal and prostate
• Our ageing population will see a rise in the incidence of cancer; 300,000 by 2020 and 360,000 in 2030
• Cancer is now the biggest cause of death in every age group
• We have seen improved survival in melanoma, breast, testicular and prostate cancer
• Still low survival rates in lung, pancreas, oesophageal and brain
Cancer Alliances

• Achieving World Class Cancer Outcomes: A strategy for England 2015-2020 – This document set out the current landscape and identified the direction of future cancer care and how to get there

• 6 strategic priorities:
  1. Upgrade prevention/public health
  2. Earlier diagnosis
  3. Increase patient experience
  4. Improve LWBC
  5. Modernise and improve quality of services
  6. Overhaul process of commissioning, accountability and provision
Cancer Alliances were established towards end of 2016 across England.

- Bring together key partners at a sub-regional level
- Sheffield sits within South Yorkshire, Bassetlaw and North Derbyshire Cancer Alliance
- Cancer Alliances are tasked with delivering the cancer agenda for their STP
- Function: Drive and support improvement in cancer services, integrate care pathways and by using a dashboard of key metrics, decrease inequalities across their footprints
What can we do better?

• Patient awareness of cancer symptoms and risk factors for cancer
• Support Primary Care:
  1. More education
  2. Support roll out and use of 2WW referral templates
  3. Improve access to investigations
  4. Increase access to timely specialist advice
  5. Encourage assessment and communication of functional capacity when referring patients
  6. Provide risk assessment tools
  7. Support better screening within our practice areas
  8. Provide easily accessible patient literature to be given out during consultations
The new guidelines published in June 2015 build upon those published in 2005

**This new document is structured differently:**
- Broken down into site of suspected cancer as well as by symptom clusters and findings of Primary Care investigations
- Section on information and support for patients and carers
- Section on “Safety netting”

**There are key changes to referral criteria:**
- Reliance on new evidence from Primary Care, rather than all secondary care based
- Lowered the threshold for referral from a 5% risk value to 3% positive predictive value and even lower in children and young adults
- Contains a range of recommendations ranging from GP clinical examination and investigations, to immediate specialist referral
- Clear that it expected GPs to have more direct access to diagnostic tests
Direct Access to Diagnostics

- CXRs
- Non-obstetric USS
- Upper GI endoscopy
- CT scans – chest, abdominal and pelvic CT scans with contrast detect the majority of malignancies or metastases but will miss small tumours, have poor sensitivity for gynaecological cancers and don’t get a great view of the bowel!
- MRI brain
- Non-imaging diagnostics include: relevant blood tests, urinary Bence-Jones protein and faecal occult bloods

Be aware of “incidental” findings and always consider taking advice on “the next best test?”
Wording around timeliness can be confusing!

• Immediate
• Very urgent – within 48 hours
• Urgent – within 2 weeks
• Non-urgent (no specified time-frame)
Patient information and safety netting:

- Recommends that patients are fully informed that they are being referred for suspected cancer
- Patient information sheets are helpful
- Ensure that results of investigations are acted upon – the healthcare professional who ordered the investigation should take responsibility for it or explicitly pass on that responsibility
- Consider review, either planned time-frame or patient initiated as instructed i.e.. worsening of a symptom, for anyone with “low risk but not no risk!”
- Consider follow up those who DNA tests, screening invitations and 2WW referrals
- Beware being falsely reassured by negative tests due to low sensitivity or specificity of the test
- Recognition that clinical suspicion by experienced GPs has a high positive predictive value
Changes introduced in NG12 to key referral criteria

Colorectal:
• New age ranges and symptoms
• Loss of stated level of anaemia
• Identifies a sub-set of “low risk” patients who should have further testing with FOBs

Lung:
• >40 with unexplained haemoptysis – refer 2WW
• Loss of appetite, thrombocytosis or chest signs compatible with pleural disease - urgent CXR

Thrombocytosis:
• 40% of people with significantly raised platelets have cancer

Haematuria in females:
• Consider TVUSS to exclude endometrial cause as well as considering urological cause

Vague symptoms:
• Introduced the concept of non-site specific symptoms which need to be followed up and/or referred – weight loss, appetite loss, unprovoked DVT, thrombocytosis
SYBND Cancer Alliance has been awarded Transformation money to deliver its proposals around Early Diagnosis.

**Aims of work-stream:**
- Achieve a “stage shift” in all cancers
- Improve 1,5 and 10 year survival
- Reduce variation of cancer detection and treatment

**How will they do this?**
- Optimise uptake of screening through public awareness, GP involvement and introducing FIT to bowel screening
- Implement fully NG12 – include increasing access to diagnostics and introducing new and more streamline pathways
- Support GPs to do SEAs on new cancer diagnoses diagnosed through emergency presentations and support safety netting.
ACE – a national project to Accelerate, Co-ordinate and Evaluate local initiatives to promote earlier diagnosis of cancer.
Supported by DoH, CRUK, Macmillan and NHS England.
3 year programme named in the 2015 taskforce report.
One cluster, which is now on Wave 2, was set up to specifically try and define and understand “vague symptoms” and how best to manage them.
Recognised that these patients are currently managed in a variety of ways, in lots of different clinics. Have multiple contacts in primary care and may have many tests. As a rule are diagnosed late, many diagnosed as emergency presentations, and have a poor prognosis.
Key recommendations to providers and commissioners were:
• Consider the need for novel pathways to deal with these patients
• Provide rapid access to diagnostics for primary care
• Streamline pathways – one stop shops, Straight to test
• Improve communication /electronic advice for primary care from secondary care
SYBND Alliance offer to providers and CCGs

Develop a novel pathway/clinic to manage patients with vague symptoms.

Suggested patient groups include:

1. Unexplained and proven weight loss - >5%, unexplained and recorded, not previously investigated
2. Suspicious but non-specific abdominal symptoms for >3 weeks
3. Recurrent abdominal pain resulting in at least 2 visits to ED or Primary Care in a calendar month, not previously investigated and no likely cause identified.

(4. Painless jaundice)
Sheffield, Doncaster & Bassetlaw, Rotherham and Chesterfield Trusts have all submitted their plans for a new pathway to manage these patients and it is likely they will all be funded. Barnsley are still considering their position but being supported to do so in an attempt to ensure equity across the alliance footprint!

All the pathways are very similar except for Doncaster who have proposed an acute based clinic.

The remaining submissions are generally community based pathways with access to particularly radiological advice.
Day 0: Patient presents in Primary Care with non specific but worrying symptoms or patient has had ED attendance not requiring admission.

Clinical history, mood & examination to include oral cavity, breasts, DRE, LNs, weight, BMI, clubbing and abdominal masses

Non specific pain and abdo. symptoms

ICE Panel Request A

Day 14

Review by GP

CT Chest/Pelvis Abdo with contrast ICE request

Outcome 1

No clear evidence cancer/disease. All tests negative

Healthy lifestyle advice

Outcome 2

Non cancer pathology found with no indication of cancer

Further tests and/or Referral to relevant specialist team

Outcome 3

Likely site specific cancer diagnosis

2ww referral to Relevant Site Specific team

Outcome 4

Evidence of malignancy or metastasis but no primary site identified

2ww referral to CUP team
Non-Specific Symptoms Pathways

Day 0
Patient presents in Primary Care with non-specific but worrying symptoms or patient has had ED attendance not requiring admission

Clinical history, mood & examination to include oral cavity, breasts, DRE, LNs, weight, BMI, clubbing and abdominal masses

Non-specific pain and abdo. symptoms
ICE Panel Request A
Day 14
Outcome 1
No clear evidence cancer/disease. All tests negative
Healthy lifestyle advice

Non-specific weight loss/appetite loss
ICE Panel Request B
Review by GP
CT Chest/Pelvis Abdo with contrast ICE request
Review by GP
Outcome 2
Non cancer pathology found with no indication of cancer
Further tests and/or Referral to relevant specialist team
Outcome 3
Likely site specific cancer diagnosis
2ww referral to Relevant Site Specific team
Outcome 4
Evidence of malignancy or metastasis but no primary site identified
2ww referral to CUP team

**GP to provide reassurance and safety netting advice**

**ACE identified more benign than malignant disease**

Key
Primary Care Secondary Care

Rapid Consultant Radiologist advice within 72 hour via email
Imaging Co-ordinator ensures scans & reports available

Day 28
Review by GP
Non specific ICE investigation request panel:
Non specific weight/appetite loss
- FBC
- U&Es
- LFTs
- Calcium
- CRP
- Coeliac serology
- TFTs
- HbA1c
- LDH
NB: consider PSA (Male) and CA125 (Female) depending on clinical suspicion

Non specific abdominal pain and symptoms
- FBC
- U&Es
- LFTs
- Calcium
- CRP
- Coeliac serology
- TFTs
- CA125 (Female)
- PSA (Male)
- HbA1c
- Immunoglobulins and Bence Jones protein
- LDH
- Amylase
**?FIT added to both panels
Outcome measures:

- Number of patients entering the pathway
- Diagnoses identified – cancer or other
- Conversion rate
- Impact on 2ww conversion rate
- Impact on imaging
- Utilisation of radiologist advice service
- Patient and clinical experience
- Cost effectiveness

It is hoped that these pathways will be available and communicated to Primary Care in the near future – original hope was December 2017?!
FIT

NG 12 identified a set of patients who should have FOB or FIT testing:
No rectal bleeding and
• <50 abdominal pain or weight loss
• <60 change in bowel habit or iron deficiency anaemia
• >60 non iron deficiency anaemia

FOB testing was made unavailable for most GPs to request in symptomatic patients and not re-instated by many Trusts. FOB continues to be used by screening but with a plan to replace it with FIT testing.
What is FIT?

- FIT = Faecal immunochemical Test
- Performed on a single sample of faeces
- FOBt detects Heme, the iron containing component of Hb and unfortunately false positive associated with quite a lot of foods, supplements and medication
- FIT uses antibodies to detect human haemaglobin
- FIT is more specific and sensitive to bleeding in the lower part of the GI tract
- FIT can be used in both screening and symptomatic patients BUT the level assayed is set differently in the screening group
- In July 2017 the part of NG12 that recommended FOBt in certain patients was replaced by DG30
DG 30 compares 4 types of FIT testing. It looks at other phenotypical characteristics and also economic analysis.

It talks about the relative cost and safety of current practice – colonoscopy has a larger cost and risks of perforation and is not 100% sensitive but to date is seen as the gold standard.

It notes that the current situation after NG12 is that FOB hasn’t been widely adopted by GPs and if sufficient clinical suspicion, 2WW referrals have been made and as such management of these patients is very variable!

It acknowledges that there are significant analytical and practical advantages to FIT over FOB.

The committee considered that use of FIT in low risk patients in Primary Care needed to be supported with ongoing research and audit.
FIT in SYB & ND?

- SY,B,ND Cancer Alliance has been tasked by West Yorkshire and Humber Coast and Vale Alliances with developing a business case around the use of FIT in symptomatic patients
- Important things to consider:
  1. High and low risk patients?
  2. Test in Primary care or Secondary Care
  3. Which kit?
  4. Where will the kits be tested?
  5. How will introduction of FIT impact on current services particularly colonoscopy?
  6. Educational support for public and health professionals
  7. How do we record usage and what else do we want to record?
  8. What do we want to evaluate and who will do it?
  9. Be mindful of other service evaluations and nationally lead research projects around FIT
  10. How should we manage non-return of kits?
Current thoughts.....

- In line with DG30, the Alliance feels that FIT testing should be easily available in Primary Care to be used as a “Decision support Tool” for patients presenting with low risk symptoms for colorectal disease (those patients identified by NG12 recommending FOB).
- The Alliance is keen to look at the whole population within the tri-alliance footprint.
- They are clear that they also want to carry out an in-service evaluation of FIT in high risk patients – this will involve asking GPs to request a FIT test at the SAME time as making a 2WW referral.
  **it is imperative in these high risk patients not to change or delay usual management as FIT in this high risk group is insufficiently evaluated!**
- The Alliance is having ongoing discussions about exactly which kit and which laboratory?
- Educational support is planned before roll out and includes patient leaflets.
- The use of FIT will be evaluated alongside data from National projects, particularly looking at conversion rate and effect on colonoscopy capacity.
- Ultimately it is hoped that FIT testing will be evaluated as sufficiently sensitive to reduce referrals for colonoscopy and may also be used in polyp and inflammatory bowel surveillance?

We will see FIT rolled out in screening programme from April 2018 and I suspect the access to FIT in Primary Care for low risk symptomatic patients will be hot on it’s heals!
Other initiatives within early diagnosis work-stream?

- Supported updating and rolling out of 2WW templates
- Locally sensitive educational website which is kept up to date with local service/pathway changes and linked to other helpful resources
- Encourage use of SEA’s to look at all new cancer diagnoses outside of 2WW referral process using an Alliance produced standard template, and practices will be encouraged to participate in the 2018 CRUK/RCGP supported National Cancer Audit of new cancer diagnoses
- Development of a multi-professional team to positively support practices struggling to deliver on issues around the cancer agenda
- Cancer champions established to improve public awareness
- Work within secondary care to continue to improve access to diagnostic tests and specialist advice
Tools and resources

• CRUK GP leads working with the Alliance helping to deliver the Early Diagnosis agenda – for SY,B,ND there are 2 GPs working together - Amin Goodarzi and Stephanie Edgar

• CRUK have an interactive desk easel summarizing the NG12 guidelines based on symptoms and useful modules such as safety netting.

• Macmillan have a downloadable version of NG12

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