Recognition and referral of suspected cancer NG12 Guidelines 2015

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CRUK GP South Yorkshire & Bassetlaw Cancer Alliance
Learning objectives

• Overview of the NG12 guidance
• What does this mean for primary care in relation to;
  • Lung Cancer
  • Bowel Cancer
• Safety netting
1 in 2 of us will be diagnosed with cancer in our lifetimes.

Survival has doubled since the 1970s.

But more of us will beat cancer than ever before.

Let's beat cancer sooner.

cruk.org
Our common goal?
What is NG12 guidance?

• They built upon the guidance published in 2005
• It is a far-reaching document;
  • Referral guidance has been updated for almost all tumour groups
  • Both adults and children are now included
  • A lot of the symptom durations have gone

Overall aim is to increase earlier cancer diagnosis
Key recommendations

• Urgent investigations in adults with over a 3% risk of cancer
• Guidance organised by signs and symptoms which better reflects how patients present to primary care
• Recommendations on investigative/ referral process & accessibility of these to primary care
• Recommendations for ‘safety netting’ patients;
• Recommendations on the information and support to provide to people with suspected cancer and their families and/or carers.
Its not always 2WW....

- Immediate
- Very urgent (within 48 hours)
- Urgent (within 2 weeks)
- Non-urgent (no time frame)
Interestingly......

NICE Guidance (NG12)

“While guidelines assist the practice of healthcare professionals, they do not replace their knowledge and skills.”
What does this mean for primary care?

BMJ Suspected Cancer 2015 Hamilton et al
Key changes:

• Lung cancer - Haemoptysis in patient over 40 > urgent referral
  - mesothelioma included
• Upper GI cancer - Use of weight loss as discriminator for urgent endoscopy in over 55s:
  - Upper abdominal pain
  - Reflux
  - Dyspepsia
• Breast Cancer - unexplained axillary lump
• No threshold for anaemia in lower GI referrals
Lung Cancer
Lung cancer

- 47200 new cases per year
- 3rd most common cancer overall
- 13% of all new cancer diagnosis
- 79% are preventable
- Around 75% diagnosed at a late stage
- Emergency presentation most common route to diagnosis
1.1 Lung and pleural cancers

Lung cancer

Recommendations in this section update recommendations 1.1.2 to 1.1.5 in lung cancer, NICE guideline CG121.

1.1.1 Refer people using a suspected cancer pathway referral (for an appointment within 2 weeks) for lung cancer if they:

- have chest X-ray findings that suggest lung cancer or
- are aged 40 and over with unexplained haemoptysis. [new 2015]

1.1.2 Offer an urgent chest X-ray (to be performed within 2 weeks) to assess for lung cancer in people aged 40 and over if they have 2 or more of the following unexplained symptoms, or if they have ever smoked and have 1 or more of the following unexplained symptoms:

- cough
- fatigue
- shortness of breath
- chest pain
- weight loss
- appetite loss. [new 2015]

1.1.3 Consider an urgent chest X-ray (to be performed within 2 weeks) to assess for lung cancer in people
Case study

- John is a 42 year old man, who sees you in surgery with shortness of breath for 4 weeks. He has smoked 20/day for the last 20 years. Examination is normal.

What further assessment do you make?
SHORTNESS OF BREATH

- Ever smoked/asbestos exposed 40+:
  - 19
- With cough/fatigue/chest pain/weight loss/appetite loss 40+:
  - 19
- With unexplained lymphadenopathy:
  - 3
- With unexplained splenomegaly:
  - 5
Results?

- FBC normal
- CXR normal

What do you do?
• He returns 2 weeks later with haemoptysis.

• What is your management now?
• What do you say to him?
• https://www.cancerresearchuk.org/health-professional/diagnosis/suspected-cancer-referral-best-practice/nice-cancer-referral-guidelines#NICE_implementation2
What is new?

• National Optimal Lung Cancer pathway
• Lung Health Checks
• Thrombocytosis
NOLCP

• ‘The National Optimal Lung Cancer Pathway is potentially the most important initiative to improve times to treatment, increase the proportion of patients treated through better performance status, and in reducing variation in clinical practice.’ NHS England

• Abnormal CXR triggers a CT within 3 days

• ‘straight to test’

• Emphasis on GP’s to refer as urgent/ inform patient of potential upgrade/ UE

• If CT positive no longer than 3 days until patient seen
Lung health checks

- NHSE funded pilot cross 10 sites
- Based upon NELSON European study and pilots within UK, especially Manchester
- Selected population of age 55-74 who have ever smoked
- Health check includes spirometry, BP, Q risk and risk assessment
- Those at high risk have LDCT
- All have smoking cessation advice
- Rpt LDCT 2 years later
Thrombocytosis....

Raised Platelet count:

- Lung
- Endometrial
- Gastric
- Oesophageal
What does this mean?

7.8% of patients (11.6% of males, 6.2% of females) will have a 1 year cancer incidence:

If a second blood test shows platelet count to be the same or higher:

18.1% of males and 10.1% of females will have a 1 year cancer incidence
So consider:

- **Lung**: consider CXR in people >40 with TBC
- **Endometrial**: Consider a direct access ultrasound to assess for endometrial cancer in women ≥55 with vaginal discharge & TBC
- **Gastric & Oesophageal**: Consider non-urgent direct access OGD to assess for oesophageal cancer in people ≥55 with TBC and any of nausea, vomiting, weight loss, reflux, dyspepsia, or upper abdominal pain that do not fit 2WW
Learning points

• Do not be falsely reassured by negative CXR
• Re-evaluate the symptoms
• How are ‘normal’ urgent CXR managed within your surgery
• Lung cancer presents late, often with non specific symptoms
• Chronic disease reviews
• Thrombocytosis
Colorectal Cancer
Colorectal Cancer

- Over 42000 cases a year
- 4th most common cancer in the UK
- Accounts for 12% of all new cancer diagnosis
- 54% are preventable
- Incidence rising but survival has doubled in the last 40years
- Over 50% diagnosed at a late stage

Cancer Research UK statistics
Risk Factors

54% of cases are preventable

- 13% caused by eating processed meat
- 11% linked to obesity
- 28% linked to too little fibre

Genetics

IBD

Others
Top Tips

• People who are at high genetic risk or have a certain level of IBD need to be on a surveillance screening programme
• Encourage screening uptake - reduces mortality by 16%
• Abdominal pain is a significant symptom .....so trust your gut!
What is new?

- FIT
- Straight to test
- Lower GI Pathways
FIT

- Used to detect and measure human haemoglobin in stools
- Used in low risk patients, so PPV <3%
- Also being introduced within screening programme
- One sample
- Already showing an increase uptake in screening as a result
- NOT used in high risk patients
As the use of the Faecal Immunochemical Test (FIT) in ‘low risk’ colorectal symptomatic patients (as per NICE DG30, 2017) continues to gather momentum, Cancer Research UK have recently developed an infographic to outline the key differences between FIT screening and symptomatic.
### Colorectal Cancer

**2ww referral if:**

- Aged \( \geq 40 \)y with unexplained weight loss and abdominal pain for a duration of \( \geq 3 \) weeks
- Aged \( \geq 50 \)y with unexplained fresh rectal bleeding alone persisting for \( \geq 3 \) weeks
- Aged \( \geq 50 \)y with unexplained dark red rectal bleeding mixed with stool
- Aged \( \geq 50 \)y with change in bowel habit to looser stools and rectal bleeding

- Age \( \geq 60 \)y with:
  - Iron deficiency anaemia
  - Changes in their bowel habit persisting for \( \geq 3 \) weeks

**ANY AGE** with positive FIT test

### Prior to referring the patient, please confirm:

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is the patient fit for a day-case colonoscopy with home bowel prep?</td>
<td></td>
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<td>Is the patient able to be observed at home, overnight?</td>
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<td>Has the patient had a FBC, U&amp;E and CRP in the last 3 months and ferritin if referring for iron-deficiency anaemia?</td>
<td>Yes</td>
<td>No</td>
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<td>Has the patient on Warfarin or any other anticoagulants or antiplatelets?</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Has the patient had a previous failed colonoscopy or colonoscopy in the last two years?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>If you are referring a patient with a change in bowel habits to looser stools, please tick to confirm that a stool culture has been performed (but do not delay referral)</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Please confirm that you have indicated the WHO functional status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does the patient have the cognitive capacity to discuss undergoing colonoscopy?</td>
<td>Yes</td>
<td>No</td>
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</tbody>
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### Anal Cancer

**Consider 2ww referral if:**

- Unexplained anal mass or ulceration

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### WHO performance status: (please tick for ALL patients)

- I – Able to carry out all normal activity without restriction
  - Restricted in physically strenuous activity but able to walk and do light work
- I! – Able to walk, capable of all self-care. Unable to carry out any work. Up & about 50% of waking hours
- I – Capable of only limited self-care, confined to bed or chair more than 50% of waking hours
- I – Completely disabled. Cannot carry out any self-care. Totally confined to bed or chair

**Consider 2ww referral if:**

- Rectal or abdominal mass

**ALL patients:**

- \( \geq 50 \)y and rectal bleeding persisting for \( \geq 3 \) weeks with any of the following unexplained symptoms:
  - Abdominal pain
  - Change in bowel habit
  - Weight loss
  - Iron deficiency anaemia

**Other FIT testing for the following people:**

- Without rectal bleeding aged \( \geq 50 \)y and have abdominal pain or weight loss
- Without rectal bleeding aged \( \geq 60 \)y and have change in bowel habit and iron deficiency anaemia
- Without rectal bleeding aged \( \geq 60 \)y and have anaemia, even in the absence of iron deficiency
- Those found to have low ferritin in the absence of anaemia

### Lower GI

**Fast Track Referral – 2 Week Wait**

*Please refer via the e-Referral Service*
Learning points

• 94% bowel cancer diagnosed in the over 50’s
• Increasing incidence in the under 50’s
• Consider use of FIT in low risk symptomatic patients
• Know the difference between symptomatic and screening FIT
• Follow up non responders to bowel screening
Safety netting
Safety-netting: Definition

- Safety netting is a ‘diagnostic strategy’ or ‘consultation technique’ and requires effective systems and processes to ensure timely re-appraisal of a patient’s condition.

- NICE definition: ‘A process where people at low risk, but not no risk, of having cancer are actively monitored in primary care to see if the risk of cancer changes’
What is the guidance around safety netting?

- **NICE Guidelines 2015**: ‘Consider a review for people with any symptom that is associated with an increased risk of cancer, but who do not meet the criteria for referral or other investigative action.

The review may be:
- **planned** within a time frame agreed with the person, or
- **patient-initiated** if new symptoms develop, the person continues to be concerned, or their symptoms recur, persist or worsen’
What does it mean to me?

• What do I expect to happen?
• How will I know if I’m wrong?
• What would I do then?

R Neighbour
What is the guidance around safety netting?

Safety-netting summary

3 elements:

- Patient communication
- GP consultation
- Practice systems

Patient communication
<table>
<thead>
<tr>
<th>Communicate to Patients</th>
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<tbody>
<tr>
<td>Likely time course of current symptoms</td>
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<tr>
<td>When to come back if symptoms do not resolve in expected time course</td>
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<tr>
<td>Specific warning/ red flag symptoms or changes to look out for</td>
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<tr>
<td>Who should make a follow up appointment with the GP, if needed</td>
</tr>
<tr>
<td>The reasons for tests or referrals</td>
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<tr>
<td>If a diagnosis is uncertain</td>
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</tbody>
</table>
GP consultation
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<thead>
<tr>
<th>ACTIONS FOR GPS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Detail any safety netting advice in the medical notes</td>
</tr>
<tr>
<td>Consider referral after repeated consultations for the same symptom where the diagnosis is uncertain (e.g. three strikes and you are in)</td>
</tr>
<tr>
<td>Ensure the patient understands the safety netting advice (take into account language/literacy barriers)</td>
</tr>
<tr>
<td>Code all symptoms and urgent referrals</td>
</tr>
<tr>
<td>If symptoms do not resolve, carry out further investigations even if previous tests are negative</td>
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Practice systems
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<th>ACTIONS FOR PRACTICES</th>
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<tbody>
<tr>
<td>Ensure that you have current contact details for patients undergoing tests or referrals</td>
</tr>
<tr>
<td>Ensure patients know how to obtain their results</td>
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<tr>
<td>Have a system for communicating abnormal test results to patients</td>
</tr>
<tr>
<td>Have a system for contacting patients with abnormal test results who fail to attend for follow up</td>
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<tr>
<td>Put in place systems to document that all results have been viewed, and acted upon appropriately</td>
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<tr>
<td>Have policies in place to ensure that tests/ investigations ordered by locums are followed up</td>
</tr>
<tr>
<td>Have systems that can highlight repeat consultations for unexplained recurrent symptoms/ signs</td>
</tr>
<tr>
<td>Make sure practice staff involved in logging results are aware of reasons for urgent tests and referrals under the two week wait</td>
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<tr>
<td>Conduct significant event analyses for patients diagnosed as a result of an emergency admission</td>
</tr>
<tr>
<td>Conduct an annual audit of new cancer diagnoses</td>
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</table>
Next steps

• Facilitator session within practice
• NCDA
Exciting times......

**Milestones for cancer**

- From 2019 we will start to roll out new Rapid Diagnostic Centres across the country.
- In 2020 a new faster diagnosis standard for cancer will begin to be introduced so that patients receive a definitive diagnosis or ruling out of cancer within 28 days.
- By 2020 HPV primary screening for cervical cancer will be in place across England.
- By 2021, where appropriate every person diagnosed with cancer will have access to personalised care, including needs assessment, a care plan and health and wellbeing information and support.
- By 2022 the lung health check model will be extended.
- By 2023, stratified, follow-up pathways for people who are worried their cancer may have recurred. These will be in place for all clinically appropriate cancers.
- By 2028, the NHS will diagnose 75% of cancers at stage 1 or 2.
Thank you - Any questions?

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