Question 1
Why will the new cancer guidelines inevitably increase referrals for suspected cancer?

Answer:

*Because the threshold for inclusion of symptoms predictive of cancer has been reduced from a previous PPV of 5% to 3*%

Question 2(a)
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 would you make?

Answer:

*History*: is he well/unwell - acute infection, systemic enquiry - any haemoptysis, fatigue, weight loss, anorexia, SOB, chest pains, calf swelling,
*Social history*: employment, asbestos exposure, recent foreign travel, long car journey,
*Examination*: general - temperature, pallor, LN, tracheal position, clubbing; chest signs - fixed wheeze, effusion, consolidation, rub

Question 2(b)
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 would you put in place for follow up?

Answer:

*Urgent CXR FBC consider U&E if no recent result for GFR Advise review with result / scheduled task in case of DNA*

Question 2(c)
CXR and FBC are normal but on review 1 week later he has experienced 2 episodes of haemoptysis. What action would you take?

Answer:
2WW referral (simultaneous staging CT chest and abdo)

Question 3(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 would you undertake and what signs would you look for?

Answer:
Any FH, breast exam - contour, skin, nipple, confirm palpable lump, axillae, possibly Abdo - ? Liver

Question 3(b)
There is a 1.5 cm breast lump in the upper outer quadrant of the left breast, there is no lymphadenopathy. What action would you take?

Answer:
2WW referral

Question 3(c)
What would you do if she were 28?

Answer:
Non urgent referral breast

Question 4
A 45 year old lady with a 2cm lump in the right axilla should be referred via the 2WW breast cancer pathway: True/False

Answer:
True

Question 5
A 51 year old lady with a unilateral nipple discharge and normal examination should be referred via the 2WW breast pathway. - True/False

Answer:
**True**

### Questions 6(a)
A 58 year old man presents with LUTS. What assessment would you make?

**Answer:**

- **Assess severity of LUTS - POW**
- **Examine Abdo/ PR**
- **Dip urine**

### Question 6(b)
His IPSS score is 18 indicating moderate symptoms. Examination of his abdomen is normal - no bladder/renal mass. PR reveals a smooth moderately enlarged benign feeling prostate. Dipstick urine shows a trace of nitrite, no blood. What investigations would you do? He is keen to have a PSA test.

**Answer:**

- **FBC, U&E, PSA, MSSU**

### Question 6(c)
His renal function and FBC are normal, PSA 10 (age specific range-0-4) MSSU reveals raised wcc and rbc 100 with E. coli UTI. What action would you take?

**Answer:**

- **Treat the UTI and repeat MSSU to ensure infection cleared**
- **Repeat PSA in 4-6 weeks**
- **Commence treatment - alpha blocker (if on going LUTS symptoms)**

### Question 6(d)
PSA is now 3.9 MSSU normal what action would you take?

**Answer:**

- **Rep PSA 3-6/12**

### Question 6(e)
PSA repeated after 3/12 is 5.4 his symptoms are only slightly improved on treatment and repeat MSSU is normal. What would you do?

**Answer:**
2ww referral as now > age specific normal range.

**Question 6(f)**
If you had chosen Dutasteride as treatment for his LUTS what are the implications for PSA monitoring.

**Answer:**
Reduces PSA by approx 50% - need to allow for this in monitoring PSA

**Question 7**
A 47 year old man presents with frank / visible haematuria. MSSU is negative He should be referred urgently via a 2ww pathway: True / false ?

**Answer:**
True > 45 with unexplained frank/ visible haematuria

**Question 8(a)**
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 examination would you do?

**Answer:**

**Question 8(b)**
He is not clinically anaemic or jaundiced and examination of his abdomen is normal. What action would you take?

**Answer:**
Urgent U/S or CT Abdo

**Question 8(c)**
CT abdo confirms a suspicious lesion in the pancreas. What action would you take?

**Answer:**
### 2WW upper GI referral

#### Questions 9

A 51 year old man presents with months of intermittent painless rectal bleeding. There is no weight loss or change in bowel habit. Examination of his abdomen is normal and PR NAD. He should be referred via a 2 WW pathway to a colorectal surgeon. True/False?

**Answer:**

*True* - unexplained rectal bleeding >50

#### Question 10(a)

A 63 year old electrician presents with a one month history of gradual onset, non mechanical back pain which is now disturbing his sleep. What assessment would you make?

**Answer:**

*Systemic enquiry – e.g cough, SOB, GI disturbance, wt loss, anorexia, urinary symptoms, saddle anaesthesia, limb weakness
General examination - anaemia, jaundice, Lymph node sites, chest, Abdo- ? liver / spleen, consider PR - prostate if LUTS, spine- localised tenderness, ROM, SLR, lower limb neuro*

#### Questions 10(b)

Systemic enquiry reveals slight loss of appetite but no other significant symptoms referable to any system and no weight loss. Examination reveals no general abnormality, he has FROM of his spine although he is tender locally at L 2, PR NAD. What investigations would you do?

**Answer:**

*FBC CRP ESR calcium*

#### Question 10(c)

His ESR is 70, CRP 66 calcium 2.59 what investigations would you do and how urgently should they be carried out?

**Answer:**
**Very urgent BJP and protein electrophoresis within 48hrs**

**Question 10(d)**  
BJP are positive and serum protein electrophoresis is abnormal how would you proceed?

**Answer:**  
2WW referral to haematology: Suspected Myeloma  
*nb beware Metastatic spinal cord compression*

**Question 11**  
A 58 year old lady presents with weight loss and dyspepsia. Examination of her abdomen is unremarkable and she is not clinically anaemic. What action should you take?

**Answer:**  
*Urgent 2 week direct access upper GI endoscopy*

**Question 12**  
Non urgent upper GI endoscopy is appropriate in the following - True / False

(a) 56 year old man with treatment resistant dyspepsia?

**Answer:**  
**True**

(b) 59 year old man with upper Abdo pain and anaemia (not iron deficient) normal examination?

**Answer:**  
**True (Would be urgent endoscopy if weight loss or mass)**

(c) 40 year old male smoker with dysphagia for solids normal examination?

**Answer:**
(d) 49 year old man with haematemesis normal examination?

**Answer:**

*True* *(any age)*

(e) 60 year old lady with weight loss upper Abdo pain and diarrhoea. Normal examination

**Answer:**

*False*

False *(FBC, urgent CT Abdo: ?? Pancreatic. But would also fit with possible ca stomach or lower GI if CT negative - would need safety net and further assessment for predominant symptoms)*

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## Part 2 – Case Studies

**Abdominal Pain:**

- 64 year old female patient
- Vague diffuse abdominal pain
- Infrequent attender
- “May have lost a few pounds”
- Symptoms persisting over a couple of weeks
- No PR bleeding/change in appetite/bowel habit.
- Never smoked
- No significant PMH/FH/ Meds
- Examination NAD

**Differential diagnosis?**

**What would you do?**
Facilitator Notes:

Multiple possibilities unexplained abdo pain + weight loss
Bloods: new guidance suggests FBC/Ca125
FOB – 50 or over with unexplained abdo pain if available

Later that week....

- FBC - Hb10.6g/dl, WCC 13, platelets 525
- Ca125 normal (< 35IU/ml)

What would you do next?

Facilitator Notes:

Could be referred on several routes:

Colorectal:
- 40+ with unexplained abdo pain and weight loss

Pancreatic: Direct access CT (within 2 weeks)
(10% Pancreatic cancers missed by USS – CT advantageous)
- 60+ weight loss + abdo pain
- 60 + weight loss + colorectal cancer excluded

Upper GI:
2ww Referral: 55+ weight loss + upper abdo pain
Non- Urgent Endoscopy
- 55+ upper abdo pain + low Hb
- 55+ raised platelet count + weight loss/upper abdo pain

NB: New NICE guidance
Cut off for anaemia removed
Thrombocytosis significant in several referral pathways: Lung/Upper GI and Endometrial
**Appetite Loss:**

Jenny is a 55 year old teacher who stopped smoking one year ago. She has been feeling under the weather for a while but in the past 4 weeks has been eating poorly.

Her husband has made her come to surgery because he is worried. She is annoyed that he has made her come and seems irritable.

Jenny has not noticed any urinary symptoms, or worsening of her longstanding cough, she denies symptoms of depression but does feel a bit irritable and she has been sleeping poorly due to pain in her right shoulder/neck region.

She denies dyspepsia/ weight loss /altered bowel habit.

**PMH Hypertension:** last review 5 months ago and she weighed 52 kg. She now weighs 50kg on your scales.

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<th>What would you do?</th>
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**Facilitator Notes:**

Differential diagnosis – multiple possibilities including many non cancer conditions

Review NICE guidance for:

**Non-specific features of cancer: Chest X-Ray within 2 weeks**

- 40 + Fatigue/weight loss/Appetite loss + Ever smoked/Asbestos exposure

**Lung: Chest X-Ray within 2 weeks**

- 40+ and 2 or more (1 or more if ever smoked) Cough/fatigue/SOB/Chest pain/weight loss/appetite loss
Note usefulness of recorded weight in notes.

(Diagnosis: Pancoast Tumour)

Pancoast tumours grow at the apex of the lung.

Fewer than 5 in every 100 cases of lung cancer (5%) are Pancoast tumours.

Most Pancoast tumours are non small cell cancers

Between 35-40% of all lung cancers are squamous cell carcinomas.

Pancoast tumours can be difficult to diagnose because they often don’t show up easily on X-ray – you may need an MRI scan to help diagnose the cancer

Because the cancer is at the top of the lungs, it may put pressure on or damage the brachial plexus. This can cause several very specific symptoms

- Severe pain in the shoulder or the shoulder blade
- Pain in the arm and weakness of the hand on the affected side
- Horner's syndrome.

**Haematuria:**

Mrs W is a 60 year old lady with who attends with dysuria and frequency.

This is the 3rd occasion that she has been seen in 2 months.

Once at the surgery treated for possible UTI with Nitrofurantoin for 3 days (urinalysis: trace blood)

Once at the walk in centre where she was given Trimethoprim for 7 days (no record of urinalysis)

Symptoms come and go.

She denies any history of menopausal bleeding but admits to slight increase in vaginal discharge.

Examination is normal

No significant PMHx.

Urinalysis today: Protein trace Leucs+ Blood+
What would you do next?

Would you give any further antibiotics today?

Facilitator Notes:

FBC/U&Es
Send an MSU
Arrange follow up

What happens next:
You ask Mrs W to have a FBC/U&Es and send an MSU and arrange for her to see you at the end of the week. When you see her she denies any further dysuria or frequency.

Results:
MSU no growth.
Hb 11.2 WCC 7.4 Platelets 490
Renal function Normal

What would you do next?

Facilitator Notes:

Raised Platelets significant in: Lung/ Endometrial/ Upper GI pathways
Endometrial: Direct Access Pelvic USS (non urgent)
  • 55+ with unexplained vaginal discharge and any of the following:
    • Presenting for the 1st time
    • Thrombocytosis
    • Haematuria

Diagnosis: endometrial cancer