Bradford Faculty Workshop

Recognition and Referral of Suspected Cancer 2015 (NICE Guideline 12)

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ACHIEVING WORLD-CLASS CANCER OUTCOMES
A STRATEGY FOR ENGLAND 2015-2020
Report of the Independent Cancer Taskforce
Achieving World Class Cancer Outcomes…

Recommendation 16:
- We recommend the following to take forward the new NICE guidelines:
  - NICE should work with organisations such as Cancer Research UK, the Royal College of GPs and Macmillan Cancer Support to disseminate and communicate the new referral guidelines to GP practices as quickly as possible.
Our common goal?
What is NICE?
NICE Guidance (NG12)

Aim

The aim of the guidelines is to improve cancer diagnosis:

• The timeliness
• The quality
• The consistency
NICE Guidance (NG12) Implementation

“While guidelines assist the practice of healthcare professionals, *they do not replace their knowledge and skills.*”
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Implementation

“For all clinical scenarios it is assumed that the health professional will have a discussion with the patient about the risks and benefits of intervention, enabling the patient to exercise a fully informed decision.”
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• Discuss with patient (or carer where appropriate) preferences for being involved in decision making
• Inform patient they are being referred into a cancer service, reassure and discuss alternative diagnosis
• Provide information on the possible diagnosis (benign and malignant)
• Provide written information on what to expect from the referral
• If the patient has additional needs, convey this to the receiving service (to make appropriate adjustments)
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Implementation

The guideline focuses on those areas of clinical practice:

• That are known to be controversial or uncertain
• Where there is identifiable practice variation
• Where there is lack of high quality evidence
• Where NICE guidelines are likely to have the most impact.
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What is new? (General)

• Many – being symptom centred and using 3% PPV, the ages vary (range 30-60)
• Some criteria have been dropped (no evidence to support them)
• Timeline specifics have gone – replaced with “recurrent” or “persistent”.

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What is new? (Specifics - examples)

• 2ww lung - Haemoptysis **only in 40+**
• **Mesothelioma** now covered
• 2ww breast: **unexplained axillary lump**
• Dermatoscopy suggestive of melanoma  
  → 2ww dermatology
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What is new? (Specifics - examples)

• Persistent bone pain, unexplained fracture: 
do FBC + ESR
• 60+ with hypercalcaemia/↓wbc: 
electrophoresis and BJP within 48h
• Palpable abdominal mass <16 (used to be under 1y)
Navigating NICE
1 Recommendations organised by site of cancer

1.1 Lung and pleural cancers
1.2 Upper gastrointestinal tract cancers
1.3 Lower gastrointestinal tract cancers
1.4 Breast cancer
1.5 Gynaecological cancers
1.6 Urological cancers
1.7 Skin cancers
1.8 Head and neck cancers
1.9 Brain and central nervous system cancers
1.10 Haematological cancers
1.11 Sarcomas
1.12 Childhood cancers
1.13 Non-site-specific symptoms

The following guidance is based on the best available evidence. The full guideline gives details of the methods and the evidence used to develop the guidance.

The wording used in the recommendations in this guideline (for example, words such as ‘offer’ and ‘consider’)
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...
Safety netting

• Ensure a system is in place to review all results
• Be aware of the false negative rates of certain investigations
• Consider planned or patient initiated review for symptoms that may suggest cancer but do not meet referral or further investigative criteria
• Have a system in place to check patient has attended the appointment
• Confirm patients contact details and availability at the time of referral
# Safety netting

<table>
<thead>
<tr>
<th>COMMUNICATE TO PATIENTS</th>
<th>ACTIONS FOR GPS</th>
<th>ACTIONS FOR PRACTICES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Likely time course of current symptoms</td>
<td>DETAIL ANY SAFETY NETTING ADVICE IN THE MEDICAL NOTES</td>
<td>ENSURE THAT YOU HAVE CURRENT CONTACT DETAILS FOR PATIENTS UNDERGOING TESTS OR REFERRALS</td>
</tr>
<tr>
<td>When to come back if symptoms do not resolve in expected time course</td>
<td>CONSIDER REFERRAL AFTER REPEATED CONSULTATIONS FOR THE SAME SYMPTOM WHERE THE DIAGNOSIS IS UNCERTAIN (E.G. THREE STRIKES AND YOU ARE IN)</td>
<td>ENSURE PATIENTS KNOW HOW TO OBTAIN THEIR RESULTS</td>
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<tr>
<td>Specific warning/ red flag symptoms or changes to look out for</td>
<td>ENSURE THE PATIENT UNDERSTANDS THE SAFETY NETTING ADVICE (TAKE INTO ACCOUNT LANGUAGE/ LITERACY BARRIERS)</td>
<td>HAVE A SYSTEM FOR COMMUNICATING ABNORMAL TEST RESULTS TO PATIENTS</td>
</tr>
<tr>
<td>Who should make a follow up appointment with the GP, if needed</td>
<td>CODE ALL SYMPTOMS AND URGENT REFERRALS</td>
<td>HAVE A SYSTEM FOR CONTACTING PATIENTS WITH ABNORMAL TEST RESULTS WHO FAIL TO ATTEND FOR FOLLOW UP</td>
</tr>
<tr>
<td>The reasons for tests or referrals</td>
<td>IF SYMPTOMS DO NOT RESOLVE, CARRY OUT FURTHER INVESTIGATIONS EVEN IF PREVIOUS TESTS ARE NEGATIVE</td>
<td>PUT IN PLACE SYSTEMS TO DOCUMENT THAT ALL RESULTS HAVE BEEN VIEWED, AND ACTED UPON APPROPRIATELY</td>
</tr>
<tr>
<td>If a diagnosis is uncertain</td>
<td></td>
<td>HAVE POLICIES IN PLACE TO ENSURE THAT TESTS/ INVESTIGATIONS ORDERED BY LOCUMS ARE FOLLOWED UP</td>
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Resources:
RCGP Cancer Toolkit
Resources:
RCGP Early Diagnosis Module

Early Diagnosis of Cancer

This course highlights the importance of recognising cancer in its early stages and the essential role of the GP in identifying common delays. It includes reflective cases, risk toolkits and practical suggestions on how to improve your practice and helps you to discover ways to diagnose cancer earlier.

This course was developed in partnership with Cancer Research UK. This course is FREE to all healthcare professionals in the UK.

Time to complete this course:
30 minutes

Date of publication:
November 2012

Reviewed and updated:
October 2018

When you have completed the activities a link to your eCertificate will appear above.

Learning Sessions

Work your way through the course by clicking on the links below.
Case Discussions
Questions and feedback
Thank you
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Early Diagnosis Group Work
Q1. Why will the new cancer guidelines inevitably increase referrals for suspected cancer?
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Early Diagnosis Group Work

• Q2a. 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?
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Early Diagnosis Group Work

• Q2b. 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?
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Early Diagnosis Group Work

• Q2c. CXR and FBC are normal but on review 1 week later he has experienced 2 episodes of haemoptysis. What action would you take?
Q3a. 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?
Q3b. 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?
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Early Diagnosis Group Work

• Q3c. What would you do if she were 28?
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Early Diagnosis Group Work

• Q4. A 45 year old lady with a 2cm lump in the right axilla should be referred via the 2WW breast cancer pathway: True/False
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Early Diagnosis Group Work

• Q5. A 51 year old lady with a unilateral nipple discharge and normal examination should be referred via the 2WW breast pathway. - True/False
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Early Diagnosis Group Work

• Q6a. A 58 year old man presents with LUTS. What assessment would you make?
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Early Diagnosis Group Work

• Q6b. 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.
Trainers’ Workshop

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Early Diagnosis Group Work

• Q6c. 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?
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Early Diagnosis Group Work

• Q6d. PSA is now 2.9 MSSU normal what action would you take?
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Early Diagnosis Group Work

• Q6e. 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?
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Early Diagnosis Group Work

• Q6f. If you had chosen Dutasteride as treatment for his LUTS what are the implications for PSA monitoring.
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Early Diagnosis Group Work

• Q7. A 47 year old man presents with frank / visible haematuria. MSSU is negative He should be referred urgently via a 2ww pathway: True / false ?
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NICE Guidance (NG12)
Early Diagnosis Group Work

• Q8a. 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?
NICE Guidance (NG12)

Early Diagnosis Group Work

• Q8b. He is not clinically anaemic or jaundiced and examination of his abdomen is normal. What action would you take?
NICE Guidance (NG12)

Early Diagnosis Group Work

• Q8c. CT abdo confirms a suspicious lesion in the pancreas. What action would you take?
Q9. 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?
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Early Diagnosis Group Work

- Q10a. 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?
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NICE Guidance (NG12)
Early Diagnosis Group Work

• Q10b. 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?
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Early Diagnosis Group Work

• Q10c. His ESR is 70, CRP 66 calcium 2.59 what investigations would you do and how urgently should they be carried out?
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Early Diagnosis Group Work

• Q10d. BJP are positive and serum protein electrophoresis is abnormal how would you proceed?
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Early Diagnosis Group Work

- Q11. 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?
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Early Diagnosis Group Work

• Q12. Non urgent upper GI endoscopy is appropriate in the following - True / False

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

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

• c) 40 year old male smoker with dysphagia for solids normal examination?
NICE Guidance (NG12)
Early Diagnosis Group Work

• Q12. Non urgent upper GI endoscopy is appropriate in the following - True / False

• d) 49 year old man with haematemesis normal examination?

• e) 60 year old lady with weight loss upper abdo pain and diarrhoea. Normal examination
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Early Diagnosis Group Work

- **Abdominal Pain:**
- 64 year old female patient with vague diffuse abdominal pain for 2 weeks. “May have lost a few pounds”
- Infrequent attender
- No PR bleeding/change in appetite/bowel habit.
- Never smoked
- No significant PMH/FH/ Meds
- Examination NAD
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NICE Guidance (NG12)
Early Diagnosis Group Work

- Abdominal Pain:
  - 64 year old female patient with vague diffuse abdominal pain for 2 weeks. “May have lost a few pounds”
  - Infrequent attender
  - No PR bleeding/change in appetite/bowel habit.
  - Never smoked
  - No significant PMH/FH/ Meds

Examination NAD  

Differential diagnosis, and what next?
NICE Guidance (NG12)
Early Diagnosis Group Work

• Abdominal Pain:
  • 64 year old female patient

• Later that week....
  • FBC - Hb10.6g/dl, WCC 13, platelets 525
  • Ca125 normal (< 35IU/ml)
NICE Guidance (NG12)
Early Diagnosis Group Work

- Abdominal Pain:
- 64 year old female patient

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

- What next?
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NICE Guidance (NG12)

- **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.

**Differential diagnosis; what next?**
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- **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.
- No significant PMHx.
- Examination is normal, ex dipstick: Protein Tr, wbc+, rbc+.
  - **What next?**
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- Haematuria:
- 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 Wbc 7.4 Platelets 490
- Renal function Normal

What next?