WHAT & WHY?

• Scottish Cancer Referral Guidelines 2014
• Scottish Primary Care Cancer Group identified need for some changes
• not all cancers – only lung, breast, lower GI, upper GI, urological, head & neck, brain & CNS, and children, teenagers & young adults
WHO?

• potential referrers for suspected cancer
  – GPs, advanced nurse practitioners, practice nurses, pharmacists, dentists, optometrists, NHS 24, ambulance, A&E

• sign-posting
  – GP receptionists & navigators, patients, carers, public

• secondary care specialists
  – to encourage equity of access
HOW?

- full guideline
- Quick Reference Guide
- website: www.cancerreferral.scot.nhs.uk
- desktop access
- App for smartphones / tablets
- SCI-Gateway referral protocols
SCOTTISH CANCER REFERRAL GUIDELINES REVIEW 2018

PROCESS

• Healthcare Improvement Scotland (HIS)
  – literature review

• Steering Group
  – Scottish Government, HIS, Scottish Primary Care Cancer Group, Macmillan Cancer Care, etc.

• Cancer specific groups convened
  – primary and secondary care clinicians, Third sector, Scottish Government, etc.
TIME-LINE

• draft guideline out to peer review August 2018
• publication – late Oct. / early Nov. 2018

OTHER CANCERS NOT CHANGED

• gynaecological, haematological, skin, malignant cord compression
• members from 2014 guideline development groups asked to comment about need for change
PEER REVIEW

- over 80 responses so far
- mostly favourable
- some critical of it not being a full re-write
- most contentious areas are upper and lower GI
- some substantial changes are inevitable – and welcome
GENERAL CHANGES

• Realistic Medicine – the need to put the person at the centre of decision-making and setting sensible goals

• extended roles of the full Primary Care Team
  – advanced nurse practitioners, practice nurses, pharmacists, dentists, optometrists, etc.
GENERAL CHANGES

- **thrombocytosis** as a risk marker for cancer (especially lung and colorectal)

- include **fitness / performance status** in a referral note

- pathway for Primary Care **access to imaging** in difficult to diagnose unknown primary cancer (not yet implemented in every Health Board)
LUNG CANCER

- **thrombocytosis** as a risk marker – CXR if no clues to other cancers
- age range now **>40 years for haemoptysis** or fatigue in smokers (was >50)
- persistent or recurrent **chest infection** added
- **referral to Head & Neck** in cervical lymphadenopathy or hoarseness without other signs to suggest lung cancer
- mesothelioma - **asbestos exposure** (both occupational and close contact exposure) is **risk factor also for primary lung cancer**
- recommendation that **radiology notify respiratory team** if high suspicion of cancer on CXR
BREAST CANCER

- age range now >30 years for lumps (was 35)
- nipple eczema, trial of moderately potent topical steroids instead of 1% hydrocortisone
- unilateral isolated axillary lymph node in women persisting at review after 2-3 weeks
- use local guidelines about antibiotic use in abscess or inflammation
- comment about gender reassignment
LOWER GI CANCER

- thrombocytosis as a risk marker
- abdominal mass – “unexplained” not just “right sided”
- emerging role of qFIT in symptomatic patients – various pilots going on across Scotland
- consider ovarian cancer as per gynae’ guideline
UPPER GI CANCER

- **table of symptoms/signs** – overlap of presentation of oesophago-gastric (OG) and hepatobiliary & pancreatic (HPB) cancers
- upper GI endoscopy *initially* for OG cancer, and CT for HPB
- investigate for other cancers if first test is normal (i.e. CT or endoscopy) – patients **should not be returned to the referrer** without this
UPPER GI CANCER

• investigation of dyspepsia – use local / national guidance
• persistent vomiting – refer if >2 weeks (was 4)
• upper abdominal pain with other alarm features >55 years (was any age)
• upper abdominal pain associated with risk factors such as family history, etc. – consider routine, not urgent referral
• for HPB cancer, unexplained back pain by itself removed
UROLOGICAL CANCER

• PSA test – full counselling important (reference range not changed)
• age range now 45 years and over for unexplained visible haematuria (no age range before)
HEAD & NECK CANCER

- **dysphagia removed** – refer to upper Gi – but pain on swallowing stays
- **hoarseness** with other signs of lung cancer – refer via lung cancer pathway
- **NO CHANGE in age range for hoarseness and neck lumps** – NICE >45 years but younger are at risk due to HPV infection
- **unexplained unilateral ear pain** new reason to refer
- **role of dentists** – access to urgent suspected cancer referral
- **thyroid swelling** now <16 years (was “pre-pubertal”)
BRAIN & CNS CANCER

- neurological deficit, behavioural change and seizure clarified
- seizure that changes in character added
- local pathways for headache investigation / access to imaging
- role of optometrists in assessing vision and possible papilloedema
CHILDREN, TEENAGERS AND YOUNG ADULTS

• unexplained petechiae or purpura need emergency referral (was urgent)
• unexplained haematuria added
• failure to thrive, persistent pallor and weight loss added
• consider discussion with senior paediatrician if continuing concern
CHILDREN, TEENAGERS AND YOUNG ADULTS

• brain tumours
  – **new red flags** – loss of balance, increasing head circumference, failure of closure of fontanelles and abnormal head positions
  – **new neurological signs** (such as weakness, loss of balance, etc.) especially if associated with **behavioural change** or deterioration in normal daily or school performance

• **Headsmart** campaign resources mentioned
For more information on the Scottish Referral Guidelines for Suspected Cancer Review process or supporting materials please contact:

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