Cancer Cascade Workshop

The Studio, Glasgow

1st December 2016

Dr Richard Roope
RCGP and Cancer Research UK Cancer Clinical Champion
Senior Clinical Advisor Cancer Research UK
Cancer Cascade Workshop

What’s new?
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What’s new?

• Breast cancer presentation
• Very brief intervention
• Colorectal paper
• E-cigarettes
• New CRUK Stats/infographics
• Dismantling Scottish QOF
• Formation of GP Clusters
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What’s new?
• BBC News 08.11.16 (NIHR Conference)
• Breast cancer presentation
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Warning over non-lump breast cancers

Around one in six cases of breast cancer begins with symptoms other than a suspect lump, experts are warning.

http://www.bbc.co.uk/news/health-37894360
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What’s new?
UCL Researchers:
1 in 6 cases of breast cancer begin with non-lump symptoms
2 week breast referral pathway:
• aged 30 and over and have an unexplained breast lump
• aged 50 and over with any of the following symptoms in one nipple only:
  • discharge
  • retraction
  • other changes of concern. [new 2015]
• skin changes that suggest breast cancer
• aged 30 and over with an unexplained lump in the axilla. [new 2015]
• Consider non-urgent referral in people aged under 30 with an unexplained breast lump with or without pain. See also recommendations 1.16.2 and 1.16.3 for information about seeking specialist advice. [new 2015]
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What’s new?
Very brief advice
What’s new?
Very brief advice

Doctors who spend 30 seconds telling patients they need to lose weight can have a dramatic impact, a study shows.

Some people, who had no intention of shedding the pounds, lost 10% of their body weight after being offered a free weight-loss programme.

http://www.bbc.co.uk/news/health-37717594
What’s new?
Very brief advice:
12 months later average weight loss:
• Advice alone: 1.0kg
• Advice with Tier 2 referral: 2.4 kg

• 1 in 4 lost 5% body weight
• 1 in 10 lost 10% body weight
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What’s new?

"The impact is pretty substantial given the effort - 30 seconds - that went into it.

"If we were year-on-year to knock 2.4kg off the heaviest people in society then that would have a very big effect in health terms."  

Prof Paul Aveyard
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What’s new?
No such thing as “heavy bones”
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What’s new?

No such thing as “heavy bones”

https://www.google.co.uk/search?q=heavy+bones+mri&biw=1440&bih=770&source=lnms&tbnid=isch&sa=X&ved=0ahUKEwjB_f65gZnQAhUJDMAKHQoFBusQ_AUIBigB#imgdii=fhmxHoHSCs8KM%3A%3BfhmxHoHSCs8KM%3A%3B6LKv_QYXM9BiM%3A&imgrefurl=https://www.google.co.uk/search?q=heavy+bones&m新形势=V3H4&docid=6LKV_QYXM9BiM%3A&imgrefurl=https://www.google.co.uk/search?q=heavy+bones&m新形势=V3H4&docid=6LKV_QYXM9BiM%3A
Colorectal cancer – when to refer?

• When did we refer?
Colorectal cancer – when to refer?

- When did we refer?
Colorectal cancer – when to refer?

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Colorectal cancer – when to refer?

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Colorectal cancer – when to refer?

- When did we refer?

Two thousand bowel cancer tumours a year are missing by GPs... before before spotted in casualty: Fifth of patients diagnosed in A&E had previously been turned away by a family doctor

- Patients were sent away by doctors despite having ‘red flag’ symptoms
- Finding out at a late stage greatly reduces a patient’s chances of survival
- 2,000 bowel cancer patients a year could have been diagnosed earlier
- Last year the health watchdog NICE issued GPs with a guide for spotting it

By SOPHIE BORLAND, HEALTH EDITOR FOR THE DAILY MAIL

One in five bowel cancer patients diagnosed in an emergency had ‘red flag’ symptoms that should have been picked up earlier, a study in the British Journal of Cancer suggests.

And 16% of emergency bowel cancer patients had seen their GP three times or more with relevant symptoms.

RCGP
Royal College of General Practitioners
Colorectal cancer – when to refer?

• When did we refer?

Do colorectal cancer patients diagnosed as an emergency differ from non-emergency patients in their consultation patterns and symptoms? A longitudinal data-linkage study in England

CONCLUSIONS: Emergency presenters have similar ‘background’ consultation history as non-emergency presenters. Their tumours seem associated with less typical symptoms, however opportunities for earlier diagnosis might be present in a fifth of them.
Colorectal cancer – when to refer?

• When did we refer? Variably
Colorectal cancer – when to refer?

- When did we refer? Variably across CCGs

http://www.ncin.org.uk/publications/routes_to_diagnosis (accessed 2.10.16)
Colorectal cancer – when to refer?

- When did we refer? Variably (across time)
Colorectal cancer – when to refer?

- When did we refer? Variably (across time) – improving!

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Colorectal cancer – when to refer?

- When did we refer? Variably (across time) – improving!
- 1 year survival

[Graph showing net survival by period of diagnosis, with separate data for men, women, and adults, showing an overall increase over time.]
Colorectal cancer – when to refer?

- When did we refer? Variably (across time) – improving!

**CRC cancer rates per 100,000**

Colorectal cancer – when to refer?

- When did we refer?  Variably – why is this important?

http://www.ncin.org.uk/publications/routes_to_diagnosis (accessed 2.10.16)
Colorectal cancer – when to refer?

- When did we refer? Variably – why is this important?

Relative survival estimates by presentation route and survival time, Colorectal, 2006-2013

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Colorectal cancer – when to refer?

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Relative survival estimates by presentation route and survival time, Colorectal, 2006-2013

http://www.ncin.org.uk/publications/routes_to_diagnosis (accessed 2.10.16)
Colorectal cancer – when to refer?

- What are the “key” symptoms?
Colorectal cancer – when to refer?

- What are the “key” symptoms for colon cancer?
- Rank order for symptoms reported or findings in 30 days prior to diagnosis:

<table>
<thead>
<tr>
<th>Option A</th>
<th>Option B</th>
<th>Option C</th>
<th>Option D</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Rectal bleeding</td>
<td>1. Abdominal pain</td>
<td>1. Abdominal pain</td>
<td>1. Rectal bleeding</td>
</tr>
</tbody>
</table>

**Option B**
- 1. Rectal bleeding
- 2. Change in bowel habit
- 3. Weight loss
- 4. Abdominal pain
- 5. Anaemia

**Option C**
- 1. Abdominal pain
- 2. Weight loss
- 3. Rectal bleeding
- 4. Change in bowel habit
- 5. Anaemia

**Option D**
- 1. Rectal bleeding
- 2. Anaemia
- 3. Change in bowel habit
- 4. Abdominal pain
- 5. Weight loss
Colorectal cancer – when to refer?

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Discuss and choose which is correct ranking.
Colorectal cancer – when to refer?

- What are the “key” symptoms for colon cancer?
- Rank order for symptoms reported or findings in 30 days prior to diagnosis:

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</thead>
<tbody>
<tr>
<td>Option B</td>
<td>1. Abdominal pain 15.7%</td>
<td>2. Anaemia 6.2%</td>
<td>3. Rectal bleeding 4.4%</td>
<td>4. Change in bowel habit 2.5%</td>
<td>5. Weight loss 1.8%</td>
</tr>
</tbody>
</table>
Colorectal cancer – when to refer?

- What are the “key” symptoms for colon cancer?

<table>
<thead>
<tr>
<th></th>
<th>30 days pre-Δ</th>
<th>12 months - 30 days pre-Δ</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Abdominal pain</td>
<td>15.7%</td>
<td>25.1%</td>
</tr>
<tr>
<td>2. Anaemia</td>
<td>6.2%</td>
<td>19.2%</td>
</tr>
<tr>
<td>3. Rectal bleeding</td>
<td>4.4%</td>
<td>9.4%</td>
</tr>
<tr>
<td>4. Change in bowel habit</td>
<td>2.5%</td>
<td>5.5%</td>
</tr>
<tr>
<td>5. Weight loss</td>
<td>1.8%</td>
<td>3.1%</td>
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http://www.nature.com/bjc/journal/v115/n7/pdf/bjc2016250a.pdf
Colorectal cancer – when to refer?

- What are the “key” symptoms?

![Frequency of symptoms in colon cancer](http://www.nature.com/bjc/journal/v115/n7/pdf/bjc2016250a.pdf)

http://www.nature.com/bjc/journal/v115/n7/pdf/bjc2016250a.pdf
Colorectal cancer – when to refer?

- What are the “key” symptoms?

Frequency of symptoms 30 days pre-diagnosis in colon cancer

1. Abdominal pain
2. Anaemia
3. Rectal bleeding
4. Change in bowel habit
5. Weight loss

Non-EP  EP

http://www.nature.com/bjc/journal/v115/n7/pdf/bjc2016250a.pdf
Colorectal cancer – when to refer?

- What are the “key” symptoms?

Frequency of symptoms in rectal cancer

- Abdominal pain
- Anaemia
- Rectal bleeding
- Change in bowel habit
- Weight loss

References:
Colorectal cancer – when to refer?

- What are the “key” symptoms?

Frequency of symptoms 30 days pre-diagnosis in rectal cancer

- Abdominal pain
- Anaemia
- Rectal bleeding
- Change in bowel habit
- Weight loss

http://www.nature.com/bjc/journal/v115/n7/pdf/bjc2016250a.pdf
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E-cigarettes
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E-cigarettes – RCGP November Clinical News

To vape or not to vape? The RCGP position on e-cigarettes

Dr Richard Roope, RCGP and Cancer Research UK Clinical Champion for Cancer

Smoking tobacco is the single largest cause of preventable illness and premature death, being responsible for around 100,000 deaths a year in the UK. Smoking accounts for 27% of all cancer deaths. 35% of all respiratory deaths and 13% of all circulatory disease deaths. It is in this context that smoking cessation is one of the most effective health interventions. Up until recent years the main tools to support those trying to give up smoking have been nicotine replacement therapy, and oral bupropion or varenicline. Research shows that professional support alongside medication has been the most effective approach. (5% success rates at one year, compared with 3% in those who attempt to quit unaided).

ENDS are battery-powered devices that allow the inhalation, or “vaping” of an aerosol containing nicotine, with the option of flavouring. They became available in 2004, following their invention in China in 2003. and global use has increased year on year. By May 2016 2.8 million adults in Great Britain were using ENDS. Of these, approximately 47% were ex-smokers and 51% were using both cigarettes and ENDS.
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E-cigarettes

Toxicity:

• Smoking tobacco: >7000 chemicals¹
• Vaping: 42 chemicals² – though will vary

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E-cigarettes

Toxicity:

Eur Addict Res 2014;20:218-225
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E-cigarettes
Concerns:
1. Entry into smoking?
2. Safety?
3. Is it effective in cessation?
4. Is passive vaping of concern?
5. Should we wait for more research?
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E-cigarettes

Concerns:
1. Entry into smoking?
   • Use in children is rare – of those who do, most are ex-smokers
   • Youth smoking: 1996 13% → 2014 3%\(^1\)

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E-cigarettes

Concerns:
1. Entry into smoking?
2. Safety?
   • Long term safety profile not yet known – but much safer than cigarettes\(^1\)
   • PHE report 95% safer than cigarettes\(^2\)

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E-cigarettes
Concerns:
1. Entry into smoking?
2. Safety?
3. Is it effective in cessation?
   • Since 2013 ECs are England’s most successful quitting aid

1. Smoking Toolkit Study [www.smokinginengland.info](http://www.smokinginengland.info)
E-cigarettes
Concerns:
1. Entry into smoking?
2. Safety?
3. Is it effective in cessation?
4. Is passive vaping of concern?
   • No identified hazards to bystanders\(^1\)

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E-cigarettes

Concerns:
1. Entry into smoking?
2. Safety?
3. Is it effective in cessation?
4. Is passive vaping of concern?
5. Should we wait for more research?
   • No – the benefits are so large, there are lives to be saved...
E-cigarettes
Position statement now adopted

Recommendations

In line with recommendations from PHE\textsuperscript{10}, it is recommended that:

1. All Primary Care Clinicians (PCCs) provide accurate advice on the relative risks of smoking and e-cigarette use, and providing effective referral routes into stop smoking services.
2. PCCs engage actively with smokers who want to quit with the help of e-cigarettes.
3. Where a patient is wanting to quit smoking and has not succeeded with other options, PCCs should recommend and support the use of ECs.
4. PCCs recognise ECs offer a wide reach, low-cost intervention to reduce smoking in more deprived groups in society and those with poor mental health, both having elevated rates of smoking.
5. All PCCs encourage smokers who want to use e-cigarettes as an aid to quit smoking to seek the support of local stop smoking services.
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Cigarette smoking prevalence


http://www.smokinginengland.info/latest-statistics/ Accessed 6.10.16
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% of smokers trying to stop

Percent of smokers trying to stop


E-cigs
NRT OTC
NRT Rx
Champix
Beh'l supp
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Cigarette smoking prevalence

% smoking/% of use of e cigs for cessation

% smoking
% using e cigs to stop
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What’s new?
• New CRUK Stats/infographics
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New CRUK Stats/infographics

WHAT’S THE MOST SUCCESSFUL WAY TO STOP SMOKING?
SUCCESS OF POPULAR METHODS COMPARED WITH GOING COLD TURKEY

- Cold Turkey: Quitting with no support
- NRT: Using Nicotine Replacement Therapy without professional support
- E-Cigarettes: Using electronic cigarettes without professional support
- Support and Medication: Combined specialist support and prescription medication

No more successful than cold turkey – probably because people don’t use enough

60% More successful

225% More successful

*Available free from your local Stop Smoking Service nhs.uk/smokefree

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New CRUK Stats/infographics

Cancer Cascade Workshop

New CRUK Stats/infographics

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New CRUK Stats/infographics

https://pbs.twimg.com/media/B2uE_6vCQAAB_pK.png last accessed 8.10.16
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New CRUK Stats/infographics

What difference does breast screening make?

Screening catches more cancers earlier
Cancer is unpredictable, so it's not possible to know how a woman's cancer would have grown had it not been caught and treated.

Some would grow quickly
Some would grow slowly
Some of these would go on to spread
If these spread to vital organs, they may cause death

Some of these would never cause harm
Some women live healthy, full lives healthier and unaware of these cancers

If we look at 1,000 women over 20 years

If they were not screened, 58 would be diagnosed with breast cancer
21 die from breast cancer
57 are treated and survive their disease
17 live healthy lives not affected by their cancer

With screening, 75 are diagnosed with breast cancer
16 die from breast cancer
59 are treated and survive their disease
Lives saved by screening
This many women would have died if breast screening had not caught their cancer early
1,300 lives saved a year in the UK
For every one life saved, three women are overdiagnosed

Overdiagnosed due to screening
This many women are treated for breast cancers that are real, but would not have caused them any harm
4,000 women treated a year when there would have been no harm

So, breast screening saves lives, but causes some women to be treated who didn't need to be
On balance, Cancer Research UK recommend that women go for breast screening when invited.

bit.ly/screening-review

http://www.cancerresearchuk.org/prod_consump/groups/cr_common/@cah/@gen/documents/image/cr_123923.png last accessed 8.10.16
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New CRUK Stats/infographics

What difference does breast screening make?

Screening catches more cancers earlier

Cancer is unpredictable, so it's not possible to know how a woman's cancer would have grown had it not been caught and treated.

Some would grow quickly, some would go on to spread, some of these would go on to spread.

If these spread to vital organs, they may cause death.

If we look at 1,000 women over the age of 45-64...

If they were not screened, 58 would be diagnosed with breast cancer.

21 die from breast cancer.

75 are diagnosed with breast cancer.

16 die from breast cancer.

Lives saved by screening

Many women would have died if breast screening had not caught their cancer early.

For every one life saved, three women avoid having unnecessary treatment due to screening.

1,300 lives saved a year in the UK.

So, breast screening saves lives, but causes some women to be treated who didn’t need to be.

On balance, Cancer Research UK recommends that women go for breast screening when invited.

http://publications.cancerresearchuk.org/downloads/Product/prostate_screening_info.pdf last accessed 8.10.16
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- Dismantling Scottish QOF
- Formation of GP Clusters
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• Dismantling Scottish QOF
• Formation of GP Clusters

RCGP Publication:
Setting the strategy for Quality in Scotland’s General Practices
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RCGP Publication:
Setting the strategy for Quality in Scotland’s General Practices

Setting the strategy for Quality in Scotland’s General Practices

‘Every system is perfectly designed to deliver the results it gets’

This well known quote from Paul Batalden (1), an expert on quality improvement in healthcare, is our starting point. At RCGP Scotland we have a responsibility to discover and apply the knowledge, tools, skills necessary for leading the innovation and continual improvement of health and health care. This will require a dramatic change across the NHS in Scotland in order to achieve and sustain high quality care, and 2016 presents us with a unique opportunity in primary care.

1. Challenges

The dismantling of the Scottish Quality and Outcomes Framework (QOF) in 2016/17 (2) grants us an unprecedented opportunity to shape the governance of Scottish general practice. However, timescales are very short, and the landscape is shifting rapidly.

In future we need to be in a situation where quality improvement (QI) activity is an essential and integral part of the role of all clinicians in primary care, rather than an optional add-on with which individuals may or may not engage.

In order to build quality teams in primary care, General Practitioners (GPs) must also have a role in ensuring that generalist skills are recognised, developed and protected in other clinical colleagues; this should happen within existing teams, as well as across the various interfaces. Practice Managers are also an important group to consider when planning training requirements around QI: their role will change as we move away from current activities around the QoF.
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RCGP Publication:
Setting the strategy for Quality in Scotland’s General Practices

RCGP Scotland is committed to building QI activities into the role of all members of the primary health care team and to the inclusion of the patient/public voice in designing QI activities at all levels from individual practices to national organisations.
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What’s new?
• LOTS...!!!

KEEP
CALM
EXCITING
TIMES
AHEAD
!!
THANK YOU