Suspected cancer: recognition and referral (NG12)

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Challenges

- Large guideline with many evidence questions
- Specialist subject with a generalist target group
- Heterogeneity of general practitioners
- Finding the balance– how detailed and how prescriptive?
- Limited evidence base
- How to make it usable in the real world

Approach

- Address misconceptions
- Reframe the context – “this guideline is about people with symptoms, not people with cancer”
- Restate the scope – “we are not writing a textbook of general practice”
- Think about language – the Mad Hatter
- User-centric design

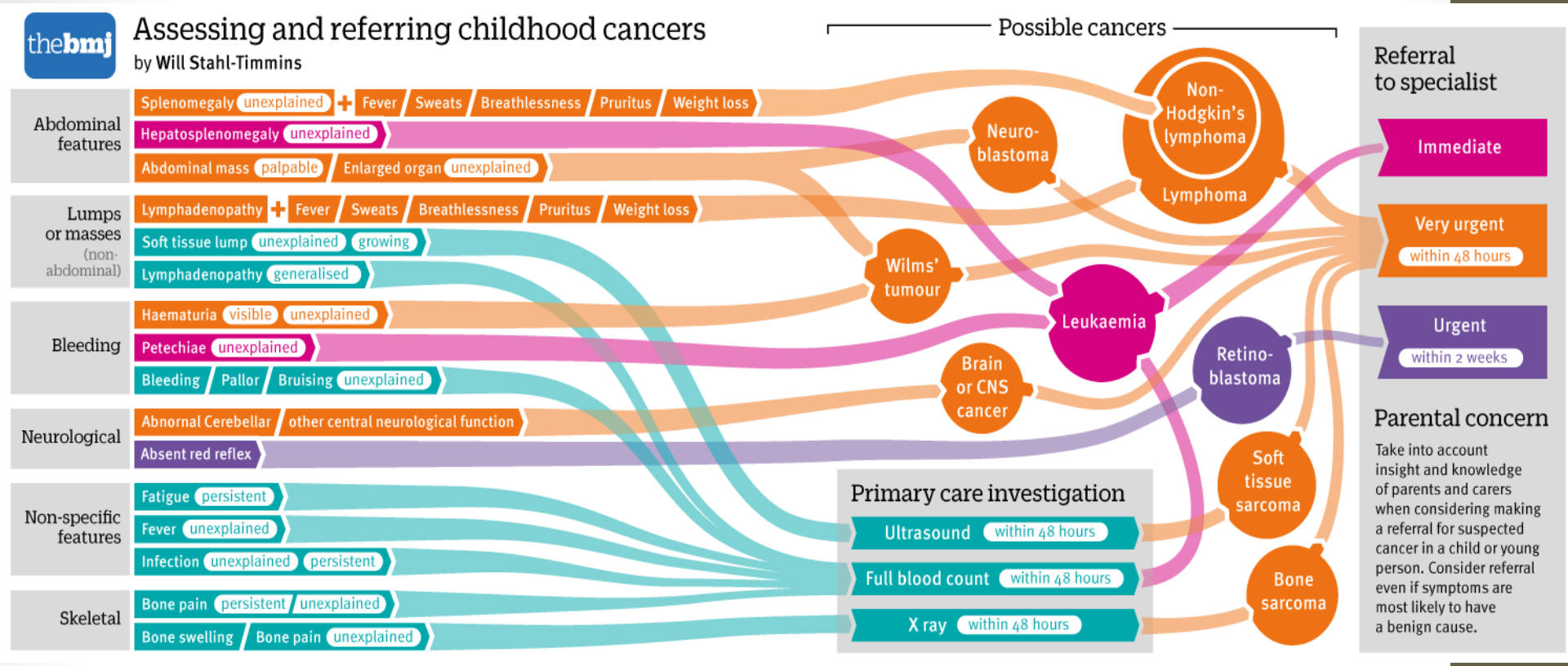
Innovative approaches

- Symptom based approach
- BMJ infographics
- Cumulative PPVs and symptoms of concern

Symptom based approach

Symptom and specific features	Possible cancer	Recommendation
Ascites and/or a pelvic or abdominal mass (which is not obviously uterine fibroids) identified by physical examination, women	Ovarian	Refer the woman urgently
Rectal or abdominal mass	Colorectal	Consider suspected cancer pathway referral
Upper abdominal mass consistent with stomach cancer	Stomach	Consider suspected cancer pathway referral
Upper abdominal mass consistent with enlarged gall bladder or enlarged liver	Gall bladder or liver	Consider urgent direct access ultrasound scan
Abdominal pain with weight loss (unexplained), 40 and over	Colorectal	Refer using suspected cancer pathway
Abdominal pain (unexplained) with rectal bleeding, under 50	Colorectal	Consider suspected cancer pathway
Abdominal pain (without rectal bleeding)	Colorectal	Offer testing for occult blood in faeces
Upper abdominal pain with weight loss, 55 and over	Oesophageal or stomach	Offer urgent direct access upper gastrointestinal endoscopy

BMJ summaries with infographics



Hamilton, W Hajioff, S, Graham, J Schmidt-Hansen, M. Suspected cancer (part 2 – adults): visual overview of updated NICE guidance. BMJ 2015; 350:h2418

Hamilton, W Hajioff, S, Graham, J Schmidt-Hansen, M. Suspected cancer (part 1 – children and young adults): visual overview of updated NICE guidance. BMJ 2015; 350:h3036

Symptoms of concern

Symptom and specific features	Possible cancer	Recommendation
Appetite loss (unexplained)	Multiple, including lung, oesophageal, stomach, colorectal, pancreatic, bladder or renal	Carry out an assessment for additional symptoms, signs or findings that may help to clarify which cancer is most likely and offer urgent investigation or suspected cancer pathway referral
Deep vein thrombosis	Multiple, including urogenital, breast, colorectal or lung	Carry out assessment for additional symptoms, signs or findings that may help to clarify which cancer is most likely and consider urgent investigation or suspected cancer pathway referral
Fatigue (persistent), adults	Leukaemia	Consider very urgent full blood count
Fatigue (unexplained), 40 and over, ever smoked	Lung or mesothelioma	Offer chest X-ray
Fatigue with cough or shortness of breath or chest pain or weight loss or appetite loss (unexplained), 40 and over, never smoked		
Fatigue (unexplained), women	Ovarian	Consider carrying out tests Measure serum CA125
Fever (unexplained)	Leukaemia	Consider very urgent full blood count
Infection (unexplained and persistent or recurrent)		
Weight loss (unexplained)	Multiple, including colorectal, gastro-oesophageal, lung, prostate, pancreatic or urological cancer	Carry out assessment for additional symptoms, signs or findings that may help to clarify which cancer is most likely and offer urgent investigation or suspected cancer pathway referral

The recommendations

- Broadening thresholds
- Safety netting
- Direct access testing
- FOB testing

Broadening thresholds

- Previous (2006) guidance had an implicit PPV threshold of 5%
- In England and Wales 10,000 people a year above the EU average are dying of cancer
- Half of these are due to late diagnosis
- Late diagnosis, in additional to poorer prognosis, also drives increased treatment cost and workload
- A PPV threshold of 3% was made for urgent cancer investigation or referral.
- Lower thresholds were used for non urgent investigations and for suspected cancer in children
- This equates, conservatively, to approximately 17% increase in referrals overall, many will be for direct access diagnostics.

Safety netting

- Ensure that the results of investigations are reviewed and acted upon appropriately, with the **healthcare professional who ordered the investigation taking or explicitly passing on responsibility** for this. Be aware of the possibility of false-negative results for chest X-rays and tests for occult blood in fæces.

- 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.

Direct access testing

- Shortening the journey
- Urgent cancer investigations (2ww)
- All direct access tests recommended are already working in some part of England and Wales
- Upper GI endoscopy
- Colonoscopy
- MRI head
- CT/ultrasound abdomen

Occult blood in fæces

- For people with symptoms not severe enough to merit colonoscopy or referral
- Not screening as symptomatic population
- Orders of magnitude more cost-effective for these patients than:
  - Colonoscopy
  - CT colonography
  - Ba studies
  - Watchful waiting
- Permissive wording, does not specify modality
- Will probably save more lives than any other recommendation

Questions