Exploring the investigation and management of vague symptoms in Primary Care

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Topics to be covered

- Why vague symptoms?
- What do we know already?
- Local initiatives to manage vague symptoms
- Challenges?

Current landscape

- ~20% of cancers are still diagnosed as emergency presentations in ED
- Cancers which are harder to diagnose more commonly present this way – 45% of pancreatic cancers are diagnosed through emergency route
- Cancers diagnosed as emergencies have substantially lower 1 year relative survival rate
- “Achieving World Class Cancer Outcomes: A Strategy for England 2015-2020 “ - published by the independent task force in 2015 – Earlier Diagnosis was one of 6 strategic priorities identified in order to improve survival

Why Vague Symptoms?

- Updated NICE guidelines on referral for suspected cancer 2015 introduced vague symptoms as something which may require further follow up
- NICE refer to “Vague symptoms” as unexplained weight loss and/or appetite loss, non specific abdominal pain , fatigue, sweats
- Some cancers more commonly present with vague symptoms such as myeloma, pancreatic, stomach and this may cause an extended diagnostic interval, a delay in diagnosis, poorer outcomes and poorer patient experience.

What do we know already?

ACE – a national project to Accelerate, Co-ordinate and Evaluate local initiatives to promote earlier diagnosis of cancer.

Supported by DoH, CRUK, Macmillan and NHS England.

3 year programme named in the 2015 taskforce report.

One cluster , which is now on Wave 2 , was set up to specifically try and define and understand “vague symptoms” and how best to manage them.

Recognised that these patients are currently managed in a variety of ways , in lots of different clinics. Have multiple contacts in primary care and may have many tests. As a rule are diagnosed late, many diagnosed as emergency presentations, and have a poor prognosis.

Key recommendations to providers and commissioners were:

- Consider the need for novel pathways to deal with these patients
- Provide rapid access to diagnostics for primary care
- Streamline pathways – one stop shops, Straight to test
- Improve communication /electronic advice for primary care from secondary care

- Also recognised the merit of symptom based diagnostic pathways for a broader range of diseases other than cancer
- Evaluation of pilots has shown that many patients presenting with these symptoms have non-malignant disease – most commonly gastroenterology conditions – pancreatitis, chronic liver disease and diverticulitis
- The patient experience is improved by these pathways
- Conversion rate for cancer varies between 6.5-45% in the ACE pilots depending on how sick the patient is at presentation! – Remember that NG12 referral criteria have only a 3% PPV and conversion rate from 2WW referrals from Primary Care average at 10%.

SYBND Alliance offer to providers and CCGs

Develop a novel pathway/clinic to manage patients with vague symptoms.

Suggested patient groups included:

1. Unexplained and proven weight loss - >5%, unexplained and recorded, not previously investigated
2. Suspicious but non-specific abdominal symptoms for >3 weeks
3. Recurrent abdominal pain resulting in at least 2 visits to ED or Primary Care in a calendar month, not previously investigated and no likely cause identified.

(4. Painless jaundice)

Non – Specific Symptoms Pathways

Primary Care
Secondary Care

Patient presents in Primary Care with non specific but worrying symptoms or patient has had ED attendance not requiring admission

Clinical history, mood & examination to include oral cavity, breasts, DRE, LNs, weight, BMI, clubbing and abdominal masses

Non specific pain and abdo. symptoms

ICE Panel Request A

Non specific weight loss/appetite loss

ICE Panel Request B

Review by GP

CT Chest/Pelvis Abdo with contrast ICE request

Review by GP

Rapid Consultant Radiologist advice within 72 hour via email

Imaging Co-ordinator ensures scans & reports available

Outcome 1

No clear evidence cancer/disease.
All tests negative

Healthy lifestyle advice

Outcome 2

Non cancer pathology found with no indication of cancer

Further tests and/or

Referral to relevant specialist team

Outcome 3

Likely site specific cancer diagnosis

2ww referral to Relevant Site Specific team

Outcome 4

Evidence of malignancy or metastasis but no primary site identified

2ww referral to CUP team

Non specific ICE investigation request panel:

Non specific weight/appetite loss

- FBC / Ferritin
- U&Es
- LFTs
- Calcium
- CRP
- Coeliac serology
- TFTs
- HbA1c
- LDH

NB: consider PSA (Male) and CA125 (Female) depending on clinical suspicion

Non specific abdominal pain and symptoms

- FBC / Ferritin
- U&Es
- LFTs
- Calcium
- CRP
- Coeliac serology
- TFTs
- CA125 (Female)
- PSA (Male)
- HbA1c
- Immunoglobulins and Bence -Jones protein
- LDH
- Amylase

**?FIT added to both panels

Who and when should we test?

- Unintentional weight loss occurs in 15-20% of older adults >65and is associated with increased mortality and morbidity.
- Observational studies show ~25% of these no cause is found after extensive investigations
- Significant weight loss has been defined as >5%reduction in body weight over 6-12 months
- Causes of weight loss range from malignancy, non-malignant disease, psychological[depression, dementia], social[deprivation, social isolation], side effect from drugs, dental problems*,unknown
- Gastrointestinal disorders account for ~1/3 of unintentional weight loss at all ages
- Is there documented evidence that they meet the criteria?
- Has a good history and examination been completed?

Which tests?

- Fbc – Anaemia is suggestive of organic disease, which should prompt further investigation. Raised white cell count may suggest organic disease, malignant, infectious or inflammatory. Raised platelet count is now recognised as important sign in malignant disease
- U+E – not particularly helpful in terms of diagnosis but important in terms of functional status and when further radiological investigations planned
- Normal LFTs makes serious pathology less likely, Alk phos>300 often suggests underlying malignancy whereas serum albumin >35 makes malignancy less likely. If Alk Phos increased by less than 1.5 times upper limit in asymptomatic individual, consider rpt sample in 3 months
- CRP/ESR – good rule out of serious pathology[myeloma, PMR, infection] but very non specific if raised! ESR >100 likely to represent underlying infection[33-60%], inflammatory disease[14-30%], malignancy [5-28%]
- TFTs and HbA1c are self explanatory

Which Tests?

- Tumour markers can be misleading in the absence of specific symptoms – these are primarily for looking at tumour response to treatment and looking for recurrent disease and not in making diagnoses
- Blind CT scanning , particularly in older patients has high cost, low yield and finds many incidental-omas!
- CT CAP with contrast will detect most malignancies or mets but will miss small tumours and has poor sensitivity for gynae' cancers.
- FOBs are controversial but less invasive than endoscopy and should be considered? (>50 with unexplained abdominal pain and/or weight loss)This will shortly be replaced with FIT

FIT or FOB?

- FOB= Faecal Occult Blood, FIT=Faecal immunochemical Test
- FOB requires 3 samples, FIT is performed on a single sample of faeces
- FOBt detects Heme, the iron containing component of Hb and unfortunately false positive associated with quite a lot of foods, supplements and medication
- FIT uses antibodies to detect human haemaglobin
- FIT is more specific and sensitive to bleeding in the lower part of the GI tract
- FIT can be used in both screening and symptomatic patients BUT the level assayed is set differently in the screening group
- FOB is insufficiently specific or sensitive to use in symptomatic patients , but it is increasingly thought that FIT is, and as such is likely to join the panel of tests performed on those with vague symptoms.

FIT or FOB?

- The section of NG12 which stated certain patients should have an FOB has been replaced with DG30 which supports the use of FIT in low risk symptomatic patients
- FIT will be rolled out from April 2018 by the National Bowel Screening Programme
- Many cancer alliances, including SY,B&ND, are developing a business case to roll out FIT to Primary Care for use in low risk symptomatic patients, those previously recommended to have FOBs and those with vague symptoms
- Work is also progressing both nationally and locally to see how FIT used in high risk patients could be used to establish diagnosis and used in follow up. Watch this space……

Non – Specific Symptoms Pathways

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Secondary Care

Day 0

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Non specific weight loss/appetite loss

ICE Panel Request A

ICE Panel Request B

Day 14

Review by GP

CT Chest/Pelvis Abdo with contrast ICE request

Rapid Consultant Radiologist advice within 72 hour via email

Imaging Co-ordinator ensures scans & reports available

Day 28

Review by GP

Outcome 1

No clear evidence cancer/disease.
All tests negative

Healthy lifestyle advice

**GP to provide reassurance and safety netting advice

Outcome 2

Non cancer pathology found with no indication of cancer

Further tests and/or

Referral to relevant specialist team

**ACE identified more benign than malignant disease

Outcome 3

Likely site specific cancer diagnosis

2ww referral to Relevant Site Specific team

Outcome 4

Evidence of malignancy or metastasis but no primary site identified

2ww referral to CUP team

Local Initiatives

Many CCGs and Trusts are working together to provide vague symptom pathways and in doing so will hopefully improve access to diagnostics in a supported way.

How will we know if these pathways locally are worthwhile?

A number of outcomes will be measured:

- Number of patients entering the pathway
- Cancer diagnoses identified (Conversion Rate)
- Impact on imaging
- Utilisation of radiologist advice service
- Patient and clinical experience
- Cost effectiveness

Challenges of vague symptoms in Primary Care?

- Common
- 10 minute consultation
- Patients do not understand significance of these symptoms and difficult to highlight in symptom awareness campaigns – therefore patients do not prioritise these symptoms
- Vague symptoms or vague patients?
- Generally low conversion rate
- GPs increasingly worried about missing significant disease – increasingly litigiousness society – potential to over investigate.
- Increase in the diagnosis of clinically insignificant pathology – prostate cancer in elderly men
- Increased number of incidental-omas - difficult decisions about clinical significance and psychological stress caused to patients
- “Next best test? – On whom and when?” GPs will need support available for advice in a timely way.

Take home messages!

1. These patients are common and often their symptoms are transient and/or not representative of significant underlying pathology
2. Use the ability to review and also our access to "soft intelligence" to help us decide if patients meet the criteria
3. Never under-estimate the importance of a good history and examination
4. These patients are NOT "target" patients
5. Do not forget that GP suspicion is associated with a high conversion rate, but equally normal blood panel and negative CT scan is very reassuring!
6. This will increase access to diagnostics
7. FIT is coming – Hooray!
8. We are good at working with "vague" – we do it everyday!

Resources

- CRUK GP leads working with the Alliance helping to deliver the Early Diagnosis agenda – for SY,B,ND there are 2 GPs working together - Amin Goodarzi and Stephanie Edgar
- CRUK have excellent GP facilitators – Ben Towler
- CRUK have an interactive desk easel summarizing the NG12 guidelines based on symptoms and useful modules such as safety netting.
- Macmillan have a downloadable version of NG12
- Useful web resources include RCGP e-learning modules
- Risk assessment tools for GP systems

Thank you for listening – any questions?