NICE 2015 Guidelines for Suspected Cancer

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Learning objectives

- Why did we need new guidelines?
- Notable changes in the new guidelines?
- How can we improve cancer referral and diagnosis?

Why did we need new guidelines?

- Cancer survival figures in the UK remain stubbornly behind those in mainland Europe and this may be due to differences in how and when diagnosis is made?
- The original guidelines focused on referral as the main method of obtaining a cancer diagnosis whereas GP clinical suspicion and access to tests in primary care, actually takes us much closer to confirming a cancer diagnosis.
- The previous guidelines were based on evidence mainly from secondary care, compared to the new guidelines which are much more heavily backed by primary care evidence.
- 22% of cancer diagnoses are still from an emergency route in the UK and we know these have a poorer prognosis overall – research has shown that contact in the majority of cases with primary care has occurred prior to the emergency presentation.

How are things looking in Barnsley?

Practices are encouraged to look at “how they are performing?” by looking at data available on Fingertips website. Profiles are available for individual practices and for the CCG as a whole.

Headlines [2014/15]:

Screening for breast , cervical and bowel are all slightly higher compared to the England mean.

2WW referrals for suspected cancer are higher than average but importantly conversion rate is similar!

However, emergency presentation of new cancer cases is higher than the England mean and overall the detection rate [the number of cancers treated as a result of 2WW referral] is lower!

BEST website is useful resource , but current NICE 2WW referral criteria is out of date. (but will be updated once new Barnsley 2ww forms finalized)

(McMillan Rapid Referral Cancer Tool kit is on the website !)

Independent Cancer Taskforce Report 2015

- Every 2 minutes a diagnosis of cancer is made in England
- 50% of those born after 1960 will receive a diagnosis of cancer in their lifetime
- >50% of those diagnosed with cancer will live for more than 10 years
- 2WW referral decreases mortality, but only 27% of cancers are currently diagnosed via this route
- GP gut instinct has a significant conversion factor

What do the new guidelines cover?

- The new guidelines are organised by both tumour site and symptoms
- They make recommendations on the appropriate diagnostic tests
- They suggest appropriate time management for tests and referrals [e.g. within 2 weeks, within 48 hours]
- Section on safety-netting patients
- Recommendations on information and support to provide to those with suspected cancer and their families and/or carers

Notable changes in the new guidelines?

- Symptom threshold lowered to 3% from previous 5% chance of cancer
- For children and young adults the threshold is even lower
- Tests recommended in Primary Care often sit below the 3% value, such as CXR and PSA
- New format hopefully better reflects presentation to Primary Care as section on presenting signs and symptoms
- Recommendations around non-site specific/ vague symptoms
- GPs are encouraged to directly refer for tests such as endoscopies and CT scans, according to symptoms
- Recognition that GP suspicion is important and should not be ignored
- The new sections on safety-netting and information/support for patients and carers.

What is the guidance around safety netting?

- NICE definition of safety netting: “ A process where people at low risk, but not no risk, of having cancer, are actively monitored in Primary Care to see if the risk of cancer changes”
- NICE guidelines 2015:” Consider a review for people who have 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 certain time frame, or be “patient-initiated”, symptoms persist or recur.

Challenges with symptomatic patients where cancer may be a possibility?

- Relative infrequency of cancer [on average GP will see ~8 new cancer cases per year]
- Symptoms are common and non-specific, “cancers don’t read the books and present typically!”
- Variable time course of evolution of clinical features
- Previous “all-clear” or non cancer diagnosis, leading to false reassurance
- Patients lack of awareness and/or ability to prioritise/communicate their symptoms

New NICE criteria for an urgent cancer referral

- Aged over 40 with unexplained weight loss and abdominal pain
- Aged 55 and over with weight loss and upper abdominal pain, reflux or dyspepsia
- Aged 55 or over with upper abdominal pain and raised platelet count
- Aged 60 and over with weight loss and new onset diabetes
- Aged 40 or over with chest signs compatible with lung cancer
- Aged 40-55, have never smoked, have haemoptysis and appetite loss – likely to get CT chest even if negative CXR
- Women aged under 55 with post menopausal bleeding
- Aged over 50 and have “unexplained”rectal bleeding
- Children with unexplained bleeding
- Unexplained ulceration in oral cavity lasting more than 14 days
- HB value now removed for iron deficiency anaemia
- Re-introduction of FOBs!

Use of faecal occult bloods?

- Aged 50 and over with unexplained abdominal pain or weight loss
- Aged under 60 with changes in their bowel habit OR with iron deficiency anaemia
- Aged 60 and over with anaemia even in the absence of iron deficiency

This is all very controversial!

FOB or FIT or neither?

Should Trusts re-categorize these patients into either routine or urgent referral pathways?

Y&H SCN are working on delivering a network wide high value pathway for colorectal cancer and are addressing this issue.

Guideline supports shift in investigative testing by Primary Care

Site specific imaging recommendations:

- Lung - CXR only recommended imaging
- Urology and lower GI– no imaging recommendation prior to referral
- Upper GI – majority of symptoms recommend endoscopy but ?pancreas – CT scan if >60 yr. GB/liver – USS
- Ovarian cancer – Ca125 and U/S abdomen
- Neuro – MRI for progressive neurological dysfunction
- Weight loss , appetite loss, unprovoked DVT, thrombocytosis, “gut instinct” – bloods and CXR and if no obvious organ site, CT Chest, abdo’ and pelvis with contrast
- Haematuria in women >55 with unexplained vaginal discharge, low HB, thrombocytosis, high blood glucose – T/V USS

The Real World!

- Currently access to diagnostics for Primary Care varies widely – both in terms of availability and timeliness
- Capacity for diagnostics varies according to specific test and for different Trusts
- Can we be sure we are ordering the “best next test”?
- Are we confident about how we receive test results and what action is necessary? Could we be falsely reassured?
- Tests are not without potential “harm” or cost
- Are we prepared for the inevitable “incidentalomas”?

What can we do to improve our cancer referrals?

- Use 2WW referral templates which act as reminders/prompts of the guidelines, as well as insuring good communication of the facts to our secondary care colleagues
- Have access to risk assessment tools
- Consider using resources such as Map of Medicine, BMJ Visual overview, Macmillan Rapid Referral Toolkit, Cancer Research UK GP Facilitators
- Be aware of specific cancer charities – Prostate Cancer UK – “consensus statements on PSA measurement”
- CCGs are regularly updated by the cancer network and cancer charities and should ensure that this information is disseminated to their practices – including BCOC headlines

- Good clinical assessment of patients and include assessment of co-morbidities and functional capacity/life expectancy. Is the patient fit for the investigations they are being referred for? Does the patient want further investigation and treatment?
- Ensure patients we refer are fully aware of the reason they are being referred, the importance of attending their appointment and what to expect when they get there!
- Work collaboratively with secondary care colleagues to ensure effective use of valuable resources – consider e-mail access for advice?
- We need to commission a service for “non-site specific symptoms” – Denmark has established multidisciplinary diagnostic clinics for those with vague symptoms – Nationally ACE is piloting MDCs at 6 sites, but what do we do in the meantime?

Impact of new guidelines?

- Increase in overall numbers of 2WW referrals and imaging referrals
- Cost and capacity implications and flip side that those referred routinely may potentially wait longer!
- Earlier diagnosis will hopefully improve survival and reduce the burden of cost for cancer treatment further down the pathway.
- Reduction in emergency presentations of cancer
- Optimise diagnostic processes and more appropriate referrals? Establish MDCs?

Any Questions?