LEARNING FROM CANCER DIAGNOSES

ST2 Teaching Programme

Dr Nick Pendleton – December 17th 2019

LET'S MAKE IT...

Better Bolton.

Bolton CCG
Cancer Education Event

With material from Dr Tarek Bakht

Bolton CCG Cancer Lead and Macmillan GP

NHS
Bolton Clinical Commissioning Group

Cancer Presentations

- Case studies in cancer presentations
- Safety-netting
- Shared learning
- Top tips

Tricky Cancer Diagnoses
‘Don’t miss these’

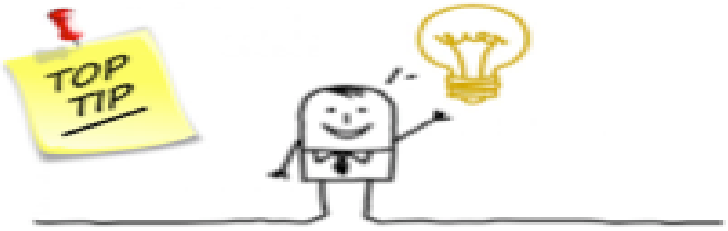
NHS
Bolton Clinical Commissioning Group

Cancer Case Discussions

- **Discuss a cancer case you have seen in practice**
- **Discussed what you have learnt from the case**
- **Share solutions and tips you found useful**

- Mr JA is a 78 year old ex-builder who comes in with a 3 months history of fatigue. Loss of energy and also felt out of sorts. Slight weight loss of about 2Ibs. Also doesn't feel like eating.
- He is an ex-smoker of 20 a day for 30 years
- Examination which is normal
- Bloods tests FBC, U&E, LFT normal

1. How would you manage this patient?
2. What is the patient at risk of?
3. Would you do any further tests?



- Be familiar with the risk factors for cancer
- Have a low threshold for CXRs
- Remember that normal CXR does not always r/o cancer

Suspected Lung Cancer Referral

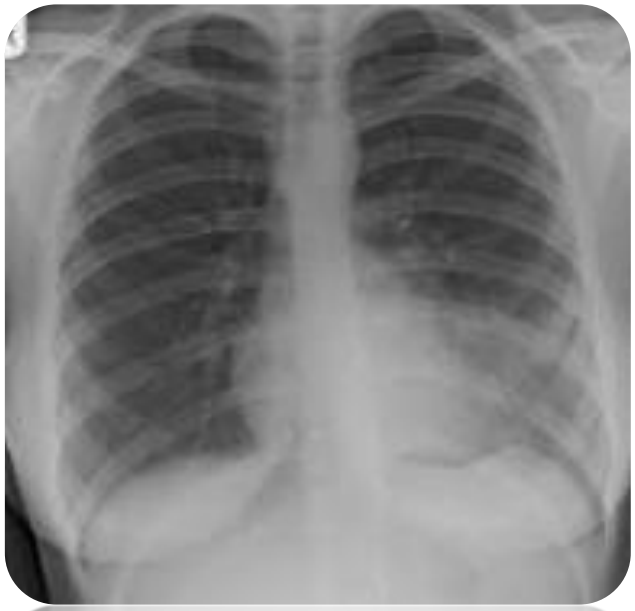
- If CXR suggests lung cancer
- Are aged 40 or more with unexplained hemoptysis

- **Risk factors for lung cancer :**
  - **all current or ex-smokers**
  - **patients with chronic obstructive pulmonary disease**
  - **people who have been exposed to asbestos**
  - **people with a previous history of cancer (especially head and neck).**

Offer urgent CXR

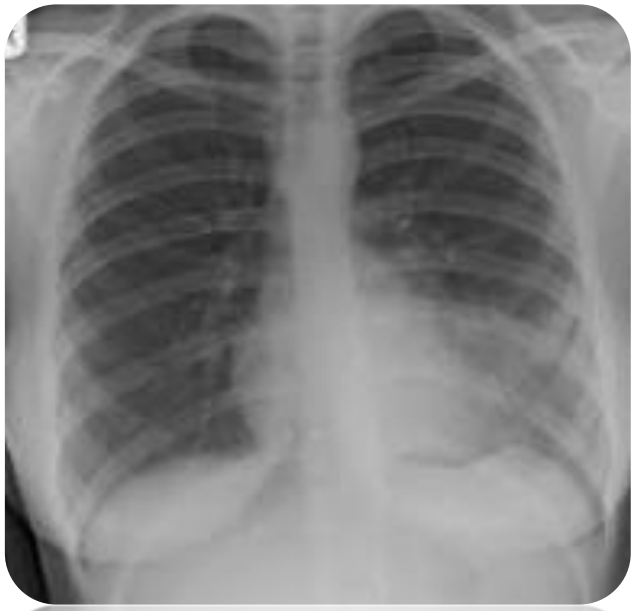
Patient 40 or more with 2 or more of the following unexplained symptoms, or 1 or more if they have ever smoked

- Cough
- Fatigue
- SOB
- Chest pain
- Weight loss
- Appetite loss



Offer urgent CXR

- **Aged 40 or more with**
  - Persistent or recurrent chest infection
  - Finger clubbing
  - Supraclavicular or persistent cervical lymphadenopathy
  - Thrombocytosis



- Mrs P is a 60 year old diabetic lady (new to the practice) who had her diabetic review bloods. This shows that platelets are slightly raised at 490

- Rest of the bloods are normal.

1. What would you do next?
2. Why may be a raised platelet be significant?
3. What would you want to ask the patient?

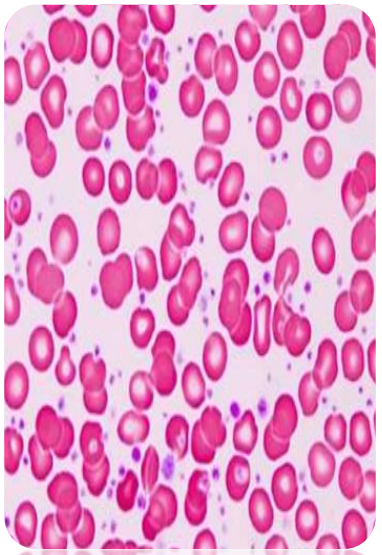
Thrombocytosis

1. Ask about chest symptoms and risk factors of lung ca. Where cause is unclear request urgent CXR **(lung cancer)**

2. Ask about upper GI symptoms in those 55 or over (**stomach/esophageal cancer**)

3. Ask about unexplained vaginal discharge, postmenopausal bleeding in those 55 or over (**endometrial cancer**)

White cell count raised on a blood test with unexplained non-visible haematuria, 60 and over – consider bladder cancer

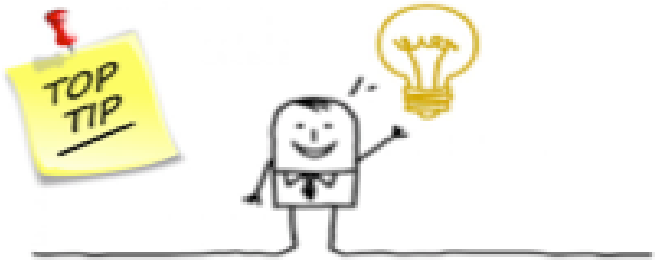


- Mrs RW is a 68 year old lady who over the last year has presented several times with abdominal symptoms, bloating, tummy ache, occasional constipation.
- Initial bloods were normal and she was referred for a colonoscopy which was normal.
- Saw a few GPs over the months who gave her different IBS treatment.
- She comes to see you

1. What would you do next?
2. What else should you think about?

- **Ovarian cancer**
  - Carry out tests for ovarian cancer in any woman above 50 who has experienced symptoms within last 12 months that suggest irritable bowel syndrome
  - IBS rarely presents for the first time in this group

- **Rule of 3**
  - Patients presenting 3 time or more consider further tests or referral



CASESTUDY

- HS is 79 year old man with OA who was seen by GP with mid-lower back pain and groin pain
- Sent for a x-ray of the pelvic and spine which was normal other than severe degenerative disease. Thought to be just OA.

- 2 months later came with SOB / localised chest wall pain diagnosed with MSK pain.
- 2 months later had groin pain, ankle oedema and abdominal bloating – USS – normal.
- As ongoing groin/back pain referred to MSK as routine but waiting time was over 6 weeks so the patient saw orthopaedics privately and blood tests showed raised PSA.

- Referred to urology and diagnosed with metastatic prostate cancer

TOP TIP

1. Don't be falsely reassured by normal routine bloods tests, x-rays and US scan – they don't fully rule out cancer

2. Be more cautious in elderly presenting with severe on-going bone/back pain

3. Easy to attribute symptoms to pre-exiting conditions, but take a step back and consider other differentials.

Elderly with back pain

In any elderly patients with new or severe back pain, think about :

- **Prostate in males (do PSA)**
- **Myeloma screen**
- **Mets especially if previous history of cancer**

T-spine back pain is a red flag

When to do PSA?

- LUTS
- Erectile dysfunction
- Visible haematuria

- ***Note PSA being normal does not r/o prostate cancer - always examine the prostate***

Bladder or Vaginal?

- PM is 57 year old lady who presents with blood in the urine noticed after wiping and on underwear
- Sent as 2ww to urology and all tests are neg.
- 2 months later presents with possible PV bleeding and lower abdominal pains. US scan shows endometrial thickening and further tests confirm endometrial cancer.

In post menopausal women with haematuria with negative urological tests, if bleeding persists think could it be endometrial.

Safety Netting In Cancer

Learning from case studies

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What are the challenges around general practice that increases risk of delayed diagnosis?

- Time pressures
- Work force – continuity of care/new ways of working
- More complex older patients
- Multiple comorbidities

RF is a 35 year old lady who comes in with a UTI, tennis elbow and a pill check. After 30 minutes she asks the GP to look at a mole on her back that she was worried about. The GP was running 50 minutes late and had a quick look at the mole which he said seemed ok but she should return in 2 weeks for further review of this.

She does not return but 6 months later presents with shortness of breath. A CXR shows multiple metastases and diagnosed with melanoma as primary.

1. Mistakes can be made when we are rushed
2. If you are too short of time to do a proper assessment bring the patient back
3. Safety-net: explain when and why they should return

- Mrs E is 65 and presents with LUTS.
- You see in her notes she has already presented 4 times over the last 6 months with UTI.

- She has had 2 MSSUs which show WBC and RBCs but no bacterial growth.
- You ask her to send off another MSSU and give her trimethoprim. You advise her to ring for the tests and to return if symptoms get worse.
- MSSU come back as **microscopic haematuria** (actioned as 'to see GP')

- 2 months later patient presents to A&E with frank haematuria – diagnosed with **bladder cancer**

1. Is there anything you would have done differently to diagnose the cancer earlier ?
2. What are the learning points?

NICE CKS – RECOGNITION OF UROLOGICAL CANCERS

Dysuria with unexplained non-visible haematuria, age 60 and over	Bladder	Refer people using a suspected cancer pathway referral (for an appointment within 2 weeks)
Haematuria (visible and unexplained) either without urinary tract infection or that persists or recurs after successful treatment of urinary tract infection, age 45 and over	Bladder or renal	Refer people using a suspected cancer pathway referral (for an appointment within 2 weeks)
Haematuria (non-visible and unexplained) with dysuria or raised white cell count on a blood test, age 60 and over	Bladder	Refer people using a suspected cancer pathway referral (for an appointment within 2 weeks)
Urinary tract infection (unexplained and recurrent or persistent), age 60 and over	Bladder	Consider non-urgent referral for bladder cancer in people aged 60 and over with recurrent or persistent unexplained urinary tract infection
White cell count raised on a blood test with unexplained non-visible haematuria, age 60 and over	Bladder	Refer people using a suspected cancer pathway referral (for an appointment within 2 weeks)

Learning points

1. NICE Guidelines 2015: *'**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 referra**l 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'*

*2. **Repeated attendances:** If patient come 3 or more times for the same symptom/vague symptoms the consider referral*

- Mr L is 45 year old HGV driver who travels the UK. He is a smoker of 20 a day. He attends A&E with history of chest pain and slight cough for 6 weeks. They diagnosed musculoskeletal pain and discharged.

- A letter arrives at the surgery from A&E ' please see CXR report'. The CXR says there is some hazy shadowing in left lobe likely infection, please treat and repeat CXR in 6 weeks

- You ask for patient to be contacted and patient is not answering phone. So letter sent to address.

3 months later he presents to A&E again with chest pain and haemoptysis. CXR showed mass in the left lung, diagnosed with lung cancer. (Patient had changed his number and moved house)

1. Is there anything you would have done differently to diagnose the cancer earlier ?

2. What are the learning points?

Learning points

1. *Give clear instructions that if symptoms do not resolve to come back*
2. *Make sure you ask all patients current contact details/address where possible*
3. *System in place to follow up patients who fail to attend*

- Frank is 63 and presents with persistent nausea and dyspepsia for 6 weeks. He has been taking PPI with no response. He has also lost about 5kg in weight over that period (normal weight is 76kg).

- You refer him for urgent 2ww OGD which he has and this shows just gastritis but nothing else.
- Report is file as 'no action needed'

- Patient presents 8 weeks later with jaundice and soon diagnosed with **pancreatic cancer.**

1. Is there anything you would have done differently to diagnose the cancer earlier ?

2. What are the learning points?

3. What would you do around safety netting:
   - Communicate with patient
   - GP consultation
   - Practice systems

Learning points

1. Give clear instructions that if symptoms do not resolve to come back
2. Arrange follow up after test or have a system to check results and review patient
3. Cannot assume the specialist will follow through with further tests
4. If symptoms do not resolve then do additional tests

- Jeff is 75 and have moderate COPD. He come to see you for a persistent cough. Examination is normal and you give him some antibiotics and steroids.

- He returns after 2 weeks with no resolution of cough. You tell him its likely due to COPD but you will get CXR just in case.
- Patient had CXR which is normal and actioned as 'tell patient CXR normal'

- Patient returns 3 months later feeling tired and significant weight loss. Referred as 2ww and CT showed lung cancer.

1. Is there anything you would have done differently to diagnose the cancer earlier ?

2. What are the learning points?

3. What would you do around safety netting:
   - Communicate with patient
   - GP consultation
   - Practice systems

Learning points

1. Don’t attribute all symptoms to existing comorbidities
2. Be aware of risk factors for cancer
3. A normal CXR doesn’t rule out lung cancer
4. Tell patient to return if symptoms don’t resolve and explain red flags to them

- David is 62 and was referred to the urologist for LUTS. He was found to have a slightly raised PSA (7.2). He had a biopsy which was negative. He was discharged back to the GP to do annual PSA monitoring on him.

- Patient had PSA done in year 1 – raised at 7. The result 'already seen urologist', patient lost to recall.

- 4 years later c/o worsening LUTS and PSA was 430.

1. Is there anything you would have done differently to diagnose the cancer earlier ?

2. What are the learning points?

3. What would you do around safety netting:
   - Communicate with patient
   - GP consultation
   - Practice systems

Learning points

1. *Patients should be given clear written instructions on why they need to have the blood tests every year*
2. *Explain to the patient uncertainly of diagnosis, red flags, why you have done the tests.*
3. *Make sure the recall systems in practice are robust.*

CASESTUDY

- Eva is a 55 and recently come over from Romania. She tells you through language line that she has had weight loss and abdominal pain.
- <u>You refer her under 2ww</u>

- 8 weeks later you receive a discharge letter stating she was admitted with acute abdomen and diagnosed with gastric cancer and you note she never went for the 2ww referral.

- You ask her to see you in clinic. She explains that one of her kids was unwell so she didn't attend the 2ww.

1. Is there anything you would have done differently to diagnose the cancer earlier ?
2. What are the learning points?
3. What would you do around safety netting:
   - Communicate with patient
   - GP consultation
   - Practice systems

Learning points

1. Patient should be given clear written instructions on why they need to be referred urgently
2. Have a system to make sure patients do attend 2ww referrals
3. Emergency cancer diagnosis admissions – important to discuss and reflect on these

- Sandra is 58 and presents with bloating and abdominal pains. She see's a locum GP who notes that she has has a history of irritable bowel.
- He gives he some peppermint oil capsules and does some bloods including Ca125.
- Patient presents 6 weeks later with abdominal distention and US scan shows large ovarian mass (ovarian Ca diagnosed)
- The original Ca125 – for some reason did not come back to the practice.

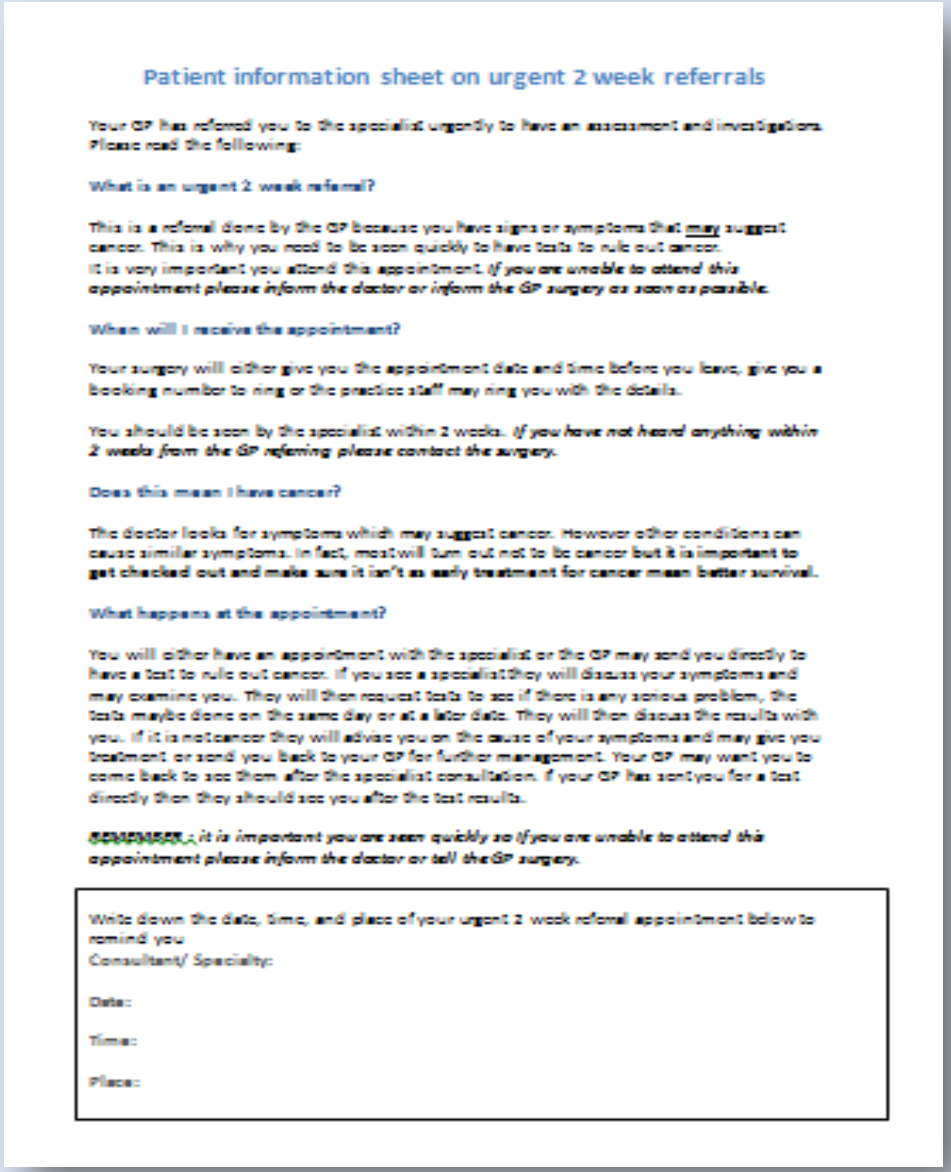
1. Is there anything you would have done differently to diagnose the cancer earlier ?
2. What are the learning points?
3. What would you do around safety netting:
   - Communicate with patient
   - GP consultation
   - Practice systems

Learning points

1. Arrange follow up after test or system to check results and review patient.
2. Explain to the patient uncertainly of diagnosis, red flags, why you have done the tests and process for review
3. Don’t assume symptoms are due to pre-existing comorbidity

NICE Cancer Quality Standard

- People with suspected cancer who are referred to a cancer service are given written information encouraging them to attend.



Patient information sheet on urgent 2 week referrals

Your GP has referred you to the specialist urgently to have an assessment and investigations. Please read the following:

What is an urgent 2 week referral?

This is a referral done by the GP because you have signs or symptoms that may suggest cancer. This is why you need to be seen quickly to have tests to rule out cancer.
It is very important you attend this appointment. *If you are unable to attend this appointment please inform the doctor or inform the GP surgery as soon as possible.*

When will I receive the appointment?

Your surgery will either give you the appointment date and time before you leave, give you a booking number to ring or the practice staff may ring you with the details.

You should be seen by the specialist within 2 weeks. *If you have not heard anything within 2 weeks from the GP referring please contact the surgery.*

Does this mean I have cancer?

The doctor looks for symptoms which may suggest cancer. However other conditions can cause similar symptoms. In fact, most will turn out not to be cancer but it is important to get checked out and make sure it isn't as early treatment for cancer mean better survival.

What happens at the appointment?

You will either have an appointment with the specialist or the GP may send you directly to have a test to rule out cancer. If you see a specialist they will discuss your symptoms and may examine you. They will then request tests to see if there is any serious problem, the tests maybe done on the same day or at a later date. They will then discuss the results with you. If it is not cancer they will advise you on the cause of your symptoms and may give you treatment or send you back to your GP for further management. Your GP may want you to come back to see them after the specialist consultation. If your GP has sent you for a test directly then they should see you after the test results.

[redacted], *it is important you are seen quickly so if you are unable to attend this appointment please inform the doctor or tell the GP surgery.*

Write down the date, time, and place of your urgent 2 week referral appointment below to remind you
Consultant/ Specialty:

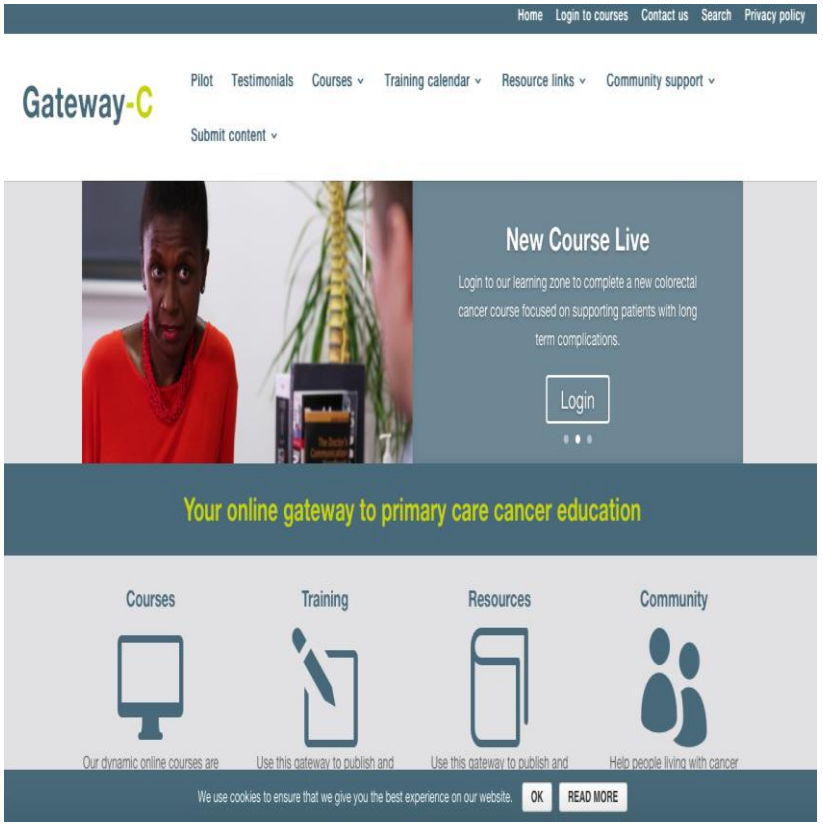
Date:

Time:

Place:

Gateway C

- Free online learning resource
- Free educational modules
- Really useful for CPD
- Please register – anyone from the practice can register



Bolton Macmillan Cancer Information & Support

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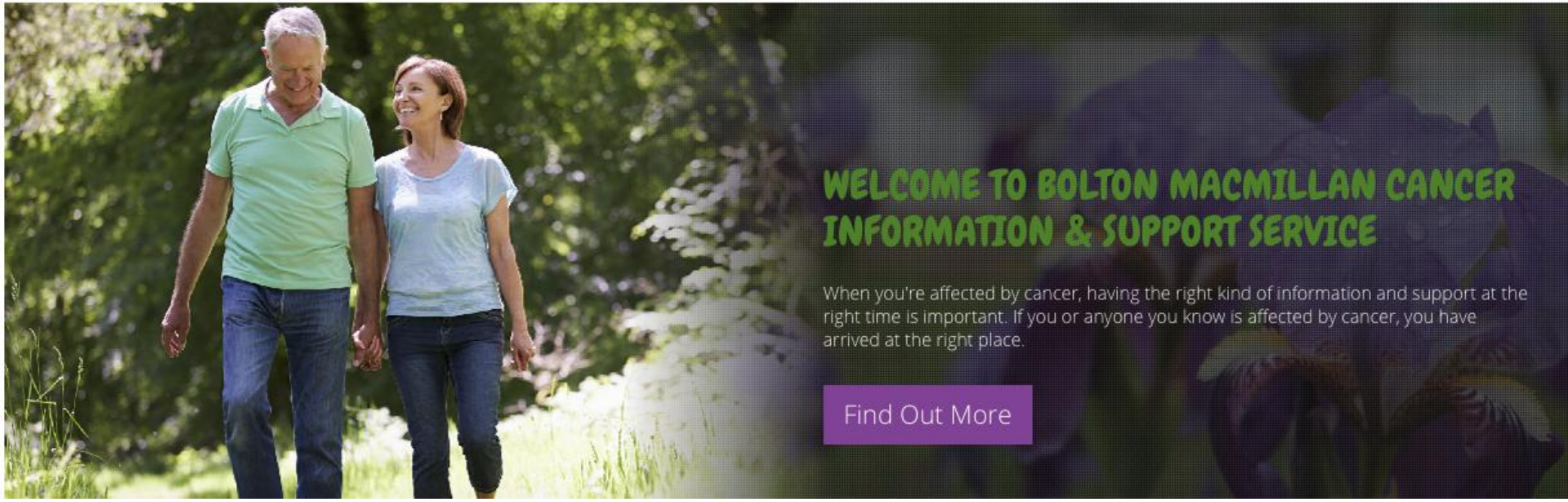

You can call our helpline on **01204 663059 or 462442**.
Our lines are open Monday-Friday 9am-4pm

Upcoming teaching sessions

- 21st January 2020: Genetics and Genomics (Dr Glenda Beaman, University of Manchester)
- ***29th January 2020: AKT Exam Sitting***
- 18th February 2020: MSK (Ana Toole)
- 3rd March 2020: Asylum Seekers Healthcare (Dr Sarah Kiely)