**2 WEEK WAIT GUIDELINES:**

**BRAIN/CNS**

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|  | **# Subacute progressive neurological deficit developing over days to weeks (e.g. weakness, sensory loss, dysphasia, ataxia).** |
|  | **# New onset seizures characterised by one or more of the following:**   * **focal seizures** * **prolonged post-ictal focal deficit (longer than 1 hour)** * **associated inter-ictal focal deficit** |
|  | **# Patients with headache, vomiting and papilloedema** |
|  | **# Cranial nerve palsy (e.g. diplopia, visual failure including optician defined visual field loss,**  **unilateral sensorineural deafness).** |
|  | **Consider urgent referral for:**  **Patients with non-migranous headaches of recent onset, present for at least one month accompanied by features suggestive of raised intra cranial pressure (e.g. woken by headache, vomiting, drowsiness).** |

**BREAST**

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| SYMPTOMS THAT WARRANT A FAST-TRACK REFERRAL | | | | | | |
|  |  |  |  |  |  |  |
| Discreet, hard lump with fixation, with or without skin tethering | YES |  |  | NO |  |  |
|  |  |  |  |  |  |  |
| Age >30 years with a discrete mass persisting after next period | YES |  |  | NO |  |  |
|  |  |  |  |  |  |  |
| Patient with discrete mass presenting after the menopause | YES |  |  | NO |  |  |
|  |  |  |  |  |  |  |
| Men >50 with unilateral, firm sub-areaolar mass | YES |  |  | NO |  |  |
|  |  |  |  |  |  |  |
| **Any of the following:** |  |  |  |  |  |  |
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| Spontaneous unilateral bloody nipple | YES |  |  | NO |  |  |
|  |  |  |  |  |  |  |
| Unilateral eczematous skin or nipple change (unresponsive to treatment) | YES |  |  | NO |  |  |
|  |  |  |  |  |  |  |
| Nipple distortion of recent onset | YES |  |  | NO |  |  |
|  |  |  |  |  |  |  |
| Previously histologically confirmed breast cancer | YES |  |  | NO |  |  |
|  |  |  |  |  |  |  |
| **Patients aged <30 years:** |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| Lump that enlarges, or fixed & hard + reason for concern (e.g. family history) | YES |  |  | NO |  |  |

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| OTHER PRESENTING SYMPTOMS AND SUGGESTED REFERRAL ROUTE | |
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| **SYMPTOM** | **ROUTE** |
| Age under 30 years – benign lumps (e.g. fibroadenoma), or breast pain and no palpable abnormality | A non-urgent referral should be used |

**DERM**

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| **REFERRAL INFORMATION** (please 🗸 boxes) | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
|  |  | | | | | | | | | | | | | | | | |  |
|  | **Suspected Diagnosis:** | | **Melanoma** | | |  | Squamous Cell Carcinoma | | | | | | | |  | |  |  |
|  |  | | | | | | | | | | | | | | | | |  |
| ‘Avoid incisional/excisional biopsies of Suspected Melanoma’ | | | | | | | | | |  |  | |  | | | | |  |
|  | |  | |  |  |  |  |  |  |  |  | |  | | | | |  |
| RISK FACTORS | | | | | | |  | Diagnosis of SCC confirmed on biopsy? | | | | | | | | | | |
| Family History? | | YES | |  | NO |  |  |  |  | YES |  |  | NO |  | |  | | |
|  | |  | |  |  |  |  |  |  |  |  | |  | | |  | | |
| Multiple Naevi? | | YES | |  | NO |  |  |  |  | Location: (e.g. Leg/Back) | | | | | |  | | |
|  | |  | |  |  |  |  |  |  |  | | |
| Fair Skin/Poor Tanning? | | YES | |  | NO |  |  |  |  |  | | |
|  | |  | |  |  |  |  |  |  |  |  | |  | | |  | | |
| Excessive U.V. Exposure? | | YES | |  | NO |  |  |  |  |  |  | |  | | |  | | |

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| MELANOMA | | | | |  | SQUAMOUS CELL CARCINOMA | | | |  | | |
|  |  |  |  |  |  |  | |  |  |  | |  | |
| Change in Size / Shape? | YES |  | NO |  |  | Crusting / Non-Healing? | YES |  | NO |  |
|  |  |  |  |  |  |  | |  |  |  | |  | |
| Irregular Outline? | YES |  | NO |  |  | Subcutaneous Component? | YES |  | NO |  |
|  |  |  |  |  |  |  | |  |  |  | |  | |
| Changing Colour? | YES |  | NO |  |  | Increasing in Size? | YES |  | NO |  |
|  |  |  |  |  |  |  | |  |  |  |  | | |
| Mixed Colour? | YES |  | NO |  |  |  | |  |  |  |  | | |
|  |  |  |  |  |  |  | |  |  |  |  | | |
| Itch? | YES |  | NO |  |  | Immunosuppression?  (e.g. after transplant) | YES |  | NO |  |  | | |
|  |  |  |  |  |  |  |  |  |  | | |
| Oozing / Crusting? | YES |  | NO |  |  |  |  |  |  | | |
|  |  |  |  |  |  |  | |  |  |  |  | | |
| Inflammatory Response? | YES |  | NO |  |  |  | |  |  |  |  | | |

**GYNAE**

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|  | **#** Visible tumour on cervix on speculum. |  | **#** Suspicious pelvic mass on Ultrasound. |
|  | # Visible tumour on vulva on clinical examination. |  | **#** Post menopausal bleeding (not HRT related). |
|  | # Palpable pelvic mass |  | **#** Persistent post coital bleeding (>4 weeks) |

**HAEM**

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|  | # Blood count/film reported as suggestive of acute leukaemia or chronic myeloid leukaemia. |
|  | # Lymphadenopathy (>1cm) persisting >6 weeks. |
|  | # Hepatosplenomegaly. |
|  | # Bone pain associated with anaemia and a raised ESR (or plasma viscosity). |
|  | # Bone X-Ray reported as being suggestive of myeloma. |
|  | # Constellation of 3 or more of the following symptoms: fatigue, night sweats, weight loss, breathlessness, bruising, recurrent infections, bone pain. |

**HEAD/NECK**

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|  | E.N.T. **# Lump in neck for >3 weeks.** |  | **# Husky voice (smoker or ex-smoker) persisting for >3 weeks.** |
|  | Oral Surgery **# Ulceration of oral mucosa persisting for >3 weeks.** |  | **# All red or red and white patches of the oral mucosa.** |
|  | **# Oral swellings persisting for >3 weeks.** |  | **# Unexplained tooth mobility not associated with periodontal disease.** |
|  | **Ophthalmology**  **# Suspected tumour of eyelids or adjacent skin.** | **# Leukocoria** | |
|  | # Raised lesion of choroid |  | |

**LOWER GI**

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|  | # Rectal bleeding WITH change in bowel habit to looser stools and/or increased frequency of defecation persistent for 6 weeks – all ages. |
|  | # A definite palpable right-sided abdominal mass – all ages. |
|  | # A definite palpable rectal (not pelvic) mass – all ages. |
|  | # Change of bowel habit to looser stools and/or increased frequency of defecation, WITHOUT rectal bleeding and persistent for 6 weeks – over 60 years. |
|  | # Iron deficiency anaemia WITHOUT obvious cause (Hb<11g/dl in men or <10g/dl in post menopausal women). |
| NB: Patients with the following symptoms and no abdominal or rectal mass, are at a very low risk of cancer. | |
|  | # Rectal bleeding with anal symptoms. Anal symptoms include soreness, discomfort, itching, lumps and prolapse as well as pain. |
|  | # Change in bowel habit to decreased frequency of defecation and harder stools. |
|  | # Abdominal pain without clear evidence of intestinal obstruction. |

**LUNGS**

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|  | #Cough |  |  | #Consolidation |  |
|  | #Dyspnoea |  |  | #Effusion |  |
|  | #Haemoptysis |  |  | #Fixed Wheeze |  |
|  | #Weight Loss |  |  | #Hoarse Voice |  |
|  | #Pain |  |  | #SVC Obstruction |  |
|  | #Other (specify) |  |  | #Stridor |  |
|  |  |  |  | #Metastasis (Site?) |  |

**PAEDS**

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|  | # **Abnormal blood count – if Consultant Haematologist says urgent further investigation required.** |
|  | # **Petechiae – GP should do blood count, then see above.** |
|  | # **Abdominal mass.** |
|  | # **Bone pain > 7 days.** |
|  | # **Lymphadenopathy – if not responding to two weeks broad spectrum oral antibiotics.** |
|  | # **Headache – of recent origin with one or more of the following features:**   * **associated with early morning vomiting** * **increasing in severity or frequency** * **noted to be worse in the mornings or causing early wakening** * **associated with neurological signs (i.e. squint, ataxia)** * **associated with behavioural change or deterioration in school performance.** |
|  | # **White Pupillary reflex.** |
|  | # **Cancer found on GP testing (e.g. chest mass on CXR, lytic bone lesion on X-Ray)** |
|  | # **Soft tissue mass – any mass which occurs in an unusual location should be considered suspicious particularly if:**   * **shows rapid or progressive growth - fixed or deep to fascia** * **size 3cm in maximum diameter - associated with regional lymph node enlargement** |

**SARCOMA**

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|  | A soft tissue mass with one or more of the following characteristics:   * size > 5cms * painful * increasing in size * deep to fascia * recurrent after previous excision |
|  | Patients with radiological suspicion of a primary bone tumour based on evidence of bone destruction, new bone formation, soft tissue swelling and periosteal elevation. |

**UPPER GI**

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|  | **# Dysphagia – food sticking on swallowing (any age).** |
|  | **# Dyspepsia at any age combined with one or more of the following ‘alarm’ symptoms: weight loss, proven anaemia, vomiting.** |
|  | **# Dyspepsia combines with at least one of the following known factors: family history of upper GI cancer in more than 2 first degree relatives, Barrett’s oesophagus, pernicious anaemia, peptic ulcer surgery over 20 years ago, known dysplasia, atrophic gastritis, intestinal metaplasia.** |
|  | **# Jaundice.** |
|  | **# Upper abdominal mass.** |

**UROLOGY**

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|  | **#** Macroscopic Haematuria in adults. |  |  | **#** Swellings in the body of testis. |
|  | **#** Microscopic Haematuria in adults >50. |  |  | **#** Palpable renal masses. |
|  |  |  |  | **#** Solid renal mass found on imaging. |
|  |  |  |  | **#** Any suspected penile cancer. |

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|  | **#** A high PSA (>20ng/ml) in men with malignant prostate or bone pain. |  |  | The following PSA ranges apply to men with a life expectancy of more than 10 years. |
|  |  | |  | **#** A PSA (of >3ng/ml) in men under 60. |
|  |  | |  | **#** A PSA (of >4ng/ml) in men between 60-69. |
|  | **#** A PSA (of >5ng/ml) in men between 70-75. |