### East Kent Summary Guidance suspected cancer referrals and notes

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**GP INITIATED DIAGNOSTICS**

**USS**

<table>
<thead>
<tr>
<th>Gall Bladder or Liver</th>
<th>Fast-track ultrasound to assess for gall bladder or liver cancer if:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□ upper abdominal mass consistent with an enlarged gall bladder or an enlarged liver</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pancreas</th>
<th>Fast-track ultrasound to assess for pancreatic cancer if</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□ ≥60 years with weight loss and any of the following:</td>
</tr>
<tr>
<td></td>
<td>□ Diarrhoea</td>
</tr>
<tr>
<td></td>
<td>□ Constipation</td>
</tr>
<tr>
<td></td>
<td>□ Back pain</td>
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<tr>
<td></td>
<td>□ Abdominal pain</td>
</tr>
<tr>
<td></td>
<td>□ Nausea or Vomiting</td>
</tr>
<tr>
<td></td>
<td>□ New-onset diabetes</td>
</tr>
</tbody>
</table>

**Gynae – Use with reference to GYNAECOLOGY 2WW e-Referral Form**

<table>
<thead>
<tr>
<th>Ovarian USS</th>
<th>Carry out if a woman (especially if 50 or over) reports having any of these symptoms on a persistent or frequent basis – particularly more than 12 times a month:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Persistent abdominal distension or bloating, feeling full (early satiety), loss of appetite, pelvic or abdominal pain or increased urinary urgency/ frequency</td>
</tr>
</tbody>
</table>

**Endometrium USS**

<table>
<thead>
<tr>
<th>Consider ultrasound tests at any age if any of the following:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unexplained weight loss, changes in bowel habits or fatigue OR in any woman of 50 years or over who for the first time experiences symptoms that suggests irritable bowel syndrome because IBS rarely presents for the first time in women of this age</td>
</tr>
</tbody>
</table>

**2ww referral being made**

| I have referred this patient for a suspected gynaecological cancer e-Referral (2ww) in order for ultrasound scan report to be available at 2ww suspected cancer hospital appointment |

**Urology – Use with reference to UROLOGY 2WW e-Referral Form**

| Testicular US | Fast-track US for testicular cancer for unexplained or persistent testicular symptoms or signs |

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**Notes:**

- **Gall Bladder or Liver**
- **Pancreas**
- **Gynae**
- **Endometrium USS**
- **Urology**
### CT/MRI

| **Brain** | Fast-track MRI (CT scan if MRI is contraindicated) Brain for adults with  
| **CT** | progressive, subacute loss of central neurological function or other symptoms or signs suggestive of brain cancer; (see next page for guidance on definition) |

| **Chest** | If high clinical suspicion persists despite initial negative CXR |
| **CT** |

| **Pancreatic** | Fast-track CT to assess for pancreatic cancer if ≥60 years with weight loss and any of the following: |
| **CT** | Diarrhoea  
| | Constipation  
| | Back pain  
| | Abdominal pain  
| | Nausea or Vomiting  
| | New-onset diabetes |

### X-ray

Offer an urgent chest X-ray (to be performed within 2 weeks) in people aged 40 and over, if:

- they have 2 or more of the following unexplained symptoms, or
- they have 1 or more of the following unexplained symptoms and have ever smoked, or
- they have 1 or more of the following unexplained symptoms and have been exposed to asbestos:

Please tick as appropriate:

- cough  
- fatigue  
- shortness of breath  
- chest pain  
- weight loss  
- appetite loss

Consider an urgent chest X-ray (to be performed within 2 weeks) to assess for lung cancer in people aged 40 and over with any of the following:

- persistent or recurrent chest infection  
- finger clubbing  
- supraclavicular lymphadenopathy or persistent cervical lymphadenopathy  
- chest signs consistent with lung cancer  
- thrombocytosis

**Guidance on Investigations and other referrals for suspected primary bone tumours:**

Refer for an immediate X-ray a patient with suspected spontaneous fracture.

If the X-ray suggests possible bone cancer, refer urgently as above.

If the X-ray suggests metastatic disease or a benign tumour, refer to your local orthopaedic service.

If the X-ray is normal but symptoms persist, follow up and/or request repeat X-ray, bone function tests or make a non-urgent referral.
Brain (changes made)

- Scan confirms/suggests primary brain tumour or suspicion on the report. In this instance, in addition to making a 2ww referral to the local service please simultaneously make a referral to King’s Neurosciences MDT via their website link: https://www.kch.nhs.uk/service/a-z/neuro-oncology
- Referral is due to GP not having direct access to urgent Brain MRI/CT and patient is presenting with symptoms which raise suspicion of brain cancer (the GP MUST give full clinical details in the ‘additional clinical information’ box at time of referral)

Notes
No definition of ‘progressive sub-acute loss of central neurological function’ has been provided in the NG12 2015 NICE guidance, but the 2005 NICE guidance for suspected cancer includes signs or symptoms that may cause concern, including: Progressive neurological deficit, new-onset seizures, headaches, mental changes, cranial nerve palsy.

Headaches of recent onset accompanied by features suggestive of raised intracranial pressure, e.g. vomiting, drowsiness, posture-related headache, pulse-synchronous tinnitus, or other focal or non-focal neurological symptoms, such as blackout or change in personality or memory.

Investigations in Primary Care: In a patient with new, unexplained headaches or neurological symptoms, undertake a neurological examination guided by the symptoms, but including examination for papilloedema. Note that the absence of papilloedema does not exclude the possibility of a brain tumour.

Patient presents with seizure, take a detailed history from the patient and an eyewitness to the event. Carry out a physical examination, including cardiac, neurological and mental state, and developmental assessment, where appropriate

Breast (no changes to criteria; format of form has changed)

- Discrete lump in any woman 30 years and older that persists after their next period or presents after menopause
- Aged 30 or over with an unexplained lump in the axilla.
- At any age Discrete, hard lump with fixation +/- skin tethering OR A lump that enlarges OR Previous history of breast cancer with a new lump or suspicious lesion OR Ultrasound blood stained nipple discharge OR Unilateral nipple eczema not responding to treatment OR Recent nipple retraction (<=3 months) OR Skin distortion.
- Male over 50 with unilateral firm sub areola mass +/- nipple discharge or associated skin changes

Notes: Women who can be managed, at least initially, by their GP:
Young women with tender lumpy breasts and older women with symmetrical nodularity, provided they have no localised abnormality
Women with minor and moderate degrees of breast pain who do not have a discrete palpable lesion
Women under 50 who have nipple discharge that is from multiple ducts or is intermittent and is neither blood stained nor troublesome

Family History: Referrals should be made in accordance with NICE Guidance and referred directly to the Family History Clinic

Colorectal (new criteria & new format)

- Any age with rectal or abdominal mass:
- Age 40 and over with – Unexplained weight loss and abdominal pain
- Aged under 50 with rectal bleeding AND any of the following unexplained symptoms or findings – abdominal pain; change in bowel habit; weight loss; iron deficiency anaemia,
- Age 50 or over with unexplained rectal bleeding
- Age 60 and over with any of the following iron-deficiency anaemia; changes in bowel habit
- Unexplained anal mass or unexplained anal ulceration

Notes: Occult blood in faeces test for suspected cancer is currently not available. QFIT (Quantative Faecal Immunochemical Test) dates of availability to be confirmed in 2018.

Gynaecology (new criteria, new format & new guidance on Primary Care Investigations)

- Vulva – Lesion suspicious of cancer on clinical examination – unexplained vulval lump ulceration or bleeding.
- Cervix - Lesion suspicious of cancer on cervix
- Vagina - vagina: Unexplained palpable mass in or at the entrance (excluding prolapse and urethral caruncle)
- Ovary - Palpable pelvic mass not obviously fibroids OR Suspicious pelvic or abdominal mass on ultrasound OR Ascites and/or peritoneal nodularity on examination or ultrasound (Ascites and/or peritoneal nodularity on examination or ultrasound, where a cardiac or hepatic cause is not suspected).
- Endometrium - Postmenopausal bleeding in women who are not on HRT (see below for definition) OR Women on HRT: unexpected or prolonged bleeding persisting for more than 4 weeks after stopping the HRT OR Postmenopausal bleeding in women on tamoxifen

Please consider referring for urgent suspected cancer ultrasound from alongside suspected cancer 2ww if not already done

Notes: Vulva The majority of malignant lesions of the vulva are ulcerated or exophytic. Patients complaining of vulval itch or discomfort do not merit urgent 2 week wait referral unless examination reveals a localised lesion, or vulva shows a gross generalised abnormality.

Investigations & notes in Primary Care (Ovary):
- Carry out test (CA125 and ultrasound scan (see Form A) if indicated) if a woman (especially if 50 or over) reports having any of these symptoms on a persistent or frequent basis – particularly more than 12 times a month:
  Persistent abdominal distension OR bloating OR feeling full (early satiety) OR loss of appetite OR pelvic OR abdominal pain OR increased urinary urgency/ frequency.
- Consider CA125 and/or ultrasound tests at any age if any of the following:
  Unexplained weight loss OR changes in bowel habits OR fatigue OR in any woman of 50 years or over who for the first time experiences symptoms that suggests irritable bowel syndrome because IBS rarely presents for the first time in women of this age

(For further information please refer to https://www.nice.org.uk/guidance/ng12)
Guidance for Ca125 results table below:

<table>
<thead>
<tr>
<th>CA125</th>
<th>Arrange Urgent USS (see Form A)</th>
<th>Abnormal</th>
<th>Refer Urgent 2 week wait</th>
</tr>
</thead>
<tbody>
<tr>
<td>≥35 iu/ml</td>
<td>Reassess</td>
<td>Normal</td>
<td>Investigate further</td>
</tr>
<tr>
<td>&lt;35 iu/ml</td>
<td></td>
<td>Abnormal</td>
<td>Reassess, safety netting</td>
</tr>
</tbody>
</table>

Guidance for USS ovarian cyst findings:
If the scan suggests an ovarian cyst: not all ovarian cysts merit referral to the urgent 2 week wait clinic as the risk of malignancy may be low.

Refer to the Urgent 2 week wait Clinic if:
- Ovarian cysts on scan > 5 cm in diameter
- Ovarian cysts on scan with cystic and solid areas irrespective of size
- Ovarian cysts of any size in a post-menopausal woman
- Other scan finding suggestive of ovarian malignancy (e.g. ascites, peritoneal seedlings)

Other ovarian cysts may be managed by re-scan in 6-8 weeks and referral to routine gynaecological clinics

Investigation and notes in Primary Care (Endometrium):

Investigations in Primary Care (Endometrium):

Consider a direct access ultrasound scan (see Form A) to assess for endometrial cancer in women aged 55 and over with:
- Unexplained symptoms of vaginal discharge who: Are presenting with these symptoms for the first time OR have thrombocytosis OR report haematuria
- Visible haematuria and: Low haemoglobin levels OR thrombocytosis or
- High blood glucose levels
- Postmenopausal DEFINITION Women NOT on HRT:
  - Aged 55 plus with bleed more than 12/12 since cessation of periods: REFER Rapid Access Clinic
  - Aged <55 with bleed more than 12/12 since cessation of periods: CONSIDER REFERRAL
  - Bleeding less than 12/12 since cessation of periods may merit referral but not through 2 week wait clinic.
  - Caution- UROLOGY Rapid Access Pathway may be appropriate for some women presenting with haematuria, please refer to relevant form

Haematology (no changes):

- Suspected Acute or Chronic Leukaemia: Abnormal FBC and any of the following clinical findings:- Bleeding Infection, Site... Lymphadenopathy
  - Fatigue
  - Enlargement
  - Spleno &/or Liver
  - Night Sweats
  - Pruritus
  - Alcohol induced Lymph Node Pain
  - Unexplained bone pain
- Suspected Lymphoma: Lymphadenopathy Hepatosplenomegaly Fever Night Sweats Weight Loss Unexplained bleeding, bruising Unexplained Petechia Persistent or recurrent infection Unexplained bone pain
- IF FBC normal and cervical lymphadenopathy above the clavicle refer to head & neck lump clinic via the Head & Neck 2WW
- Suspected myeloma or plasma cell neoplasm Refer via 2ww if a paraprotein is present at the following levels:
  - IgG >15g/l
  - IgA >10g/l
  - IgM >10g/l
  - BJJP >0.5g/l
  - Profound immune paresis At other levels refer non-urgently unless: Anaemia/OR Hypercalcaemia OR Renal impairment OR Lytic lesions OR Bone pains OR Pathological Fractures

Head & Neck & Thyroid (no changes):

Any of Signs and symptoms - Unresolving neck lump > 3 weeks, Ulceration of tongue / oral mucosa > 3 weeks, Persistent and unexplained hoarseness with no mass on CXR (arrange & check urgent CXR first), Unexplained neuropathy of cranial nerves, Red or red & white patch of oral mucosa with pain, swelling or bleeding, Unexplained tooth mobility not associated with periodontal disease, Unilateral middle ear effusion persisting more than 4 weeks, Orbital mass, Persistent swelling or lump in parotid or submandibular gland > 3 weeks, Persistent sore throat, Unilateral otalgia > 4 weeks with normal ear examination, Oral / facial swelling > 3 weeks, Dysphagia > 3 weeks where food is sticking in throat area (refer Gastro if site of obstruction probably lower i.e. in oesophagus) Unilateral nasal obstruction with blood or purulent discharge thought to be due to neoplastic disease

Relevant signs thyroid - Any Unexplained or Enlarging thyroid lump, Thyroid lump in patient >65 or<18 years of age, Previous neck irradiation, Family history thyroid cancer, Thyroid swelling and voice change / hoarseness, Associated cervical lymphadenopathy

Lung (new criteria & new format new guidance on Primary Care Investigation – Chest X-ray request):

- Abnormal CXR findings suggestive of a possible Lung Cancer
- >40 years with unexplained haemoptysis

Notes on CXR

Offer an urgent Chest Xray (to be performed within 2 weeks ) in people aged 40 and over if they have 2 or more of the following unexplained symptoms, OR they have 1 or more of the following unexplained symptoms and have ever smoked, OR they have 1 or more of the following unexplained symptoms and have been exposed to asbestos:

Symptom list : cough, fatigue, shortness of breath, chest pain, weight loss, appetite loss

Consider an urgent chest X ray (to be performed within 2 weeks) to assess for lung cancer in people aged 40 and over with any of the following:

- Persistent or recurrent chest infection
- Finger clubbing
- Supraclavicular lymphadenopathy
- Persistent cervical lymphadenopathy

OR chest signs consistent with lung cancer OR thrombocytosis

Direct Urgent Access CT lung – on East Kent GP Urgent Direct Access CT/MRI form
- If high clinical suspicion persists despite initial negative CXR
Skin (very similar criteria slight change in format)
Melanoma: Major features: change in size, irregular in shape, irregular colour
Minor features: largest diameter 7mm, oozing, inflammation, change in sensation
Any major feature should prompt referral; any 3 minor features should prompt referral

It is not recommended that patients with suspected melanoma are biopsied in a general practice setting. Refer using a suspected cancer pathway if dermoscopy suggests melanoma of the skin. Consider a suspected cancer referral for melanoma in people with a pigmented or non-pigmented skin lesion that suggests nodular melanoma

Squamous Cell Carcinoma characteristics: Commonly face, scalp, back of hand >1cm Crusting non-healing lesion with induration. Documented expansion over 8 weeks. Risk Factors: Organ transplant, Immuno-suppressive therapy. Squamous Cell Carcinoma in-situ (Bowen’s Disease) does not require an urgent appointment

Basal Cell Carcinoma: refer majority of cases non-urgently via the routine appointment system. Only refer via the 2ww pathway if there is particular concern that a delay may have a significant impact because of factors such as site or size (e.g. large destructive /periificial).

Upper GI – Oesophageal, Gastric & Pancreatic (new criteria, new format and new guidance on Primary Care Investigations)

Liver/ Gallbladder- ultrasound suggestive of Liver or Gallbladder cancer
Pancreas
Unexplained jaundice if ≥40yrs
Imaging suggestive of pancreatic cancer

Criteria to request rapid access CT abdomen for pancreatic cancer are if ≥60 years with weight loss and any of the following: Diarrhoea or Constipation OR Back pain OR Abdominal pain OR Nausea or Vomiting OR New-onset diabetes

Oesophagus/Stomach
Dysphagia – food sticking on swallowing
Upper abdominal mass consistent with stomach cancer
Age at 55 and over with weight loss PLUS at least one of: Upper abdominal pain OR Gastric/acid Reflux OR Dyspepsia
NICE 2015 guidance “Suspected cancer: recognition and referral” NG12 consider ‘non urgent direct access OGD’ – consider seeking advice and guidance via the electronic Referral System (eRS) IF aged over 55’ with either one of : Treatment resistant dyspepsia OR Upper abdominal pain and low haemoglobin OR Raised platelet count AND any of nausea/vomiting/weight loss/reflux/dyspepsia/upper abdominal pain OR Nausea and vomiting AND any of weight loss/reflux/dyspepsia/ upper abdominal pain.

Urology (new criteria, similar format)

Visible haematuria in any patient age 45 and over without infection
Persistent / recurrent UTI with visible haematuria in patient aged 45 years and over
Unexplained non-visible / dipstick haematuria without infection in patients aged 60 years or over with either dysuria or raised white cell count on blood test

Unexplained non-visible haematuria is significant if 1+ or greater in an asymptomatic individual, or on any occasion with symptoms in absence of infection. Non-2ww urgent referral if asymptomatic non-visible haematuria with normal WCC, or patient aged <60. Haematuria does NOT require verification with microscopy. Exclude menstruation.

Pallpable renal mass on examination
Solid renal mass identified on imaging
Non-painful swelling in body of testicle suspicious of cancer (it would speed up the diagnostic process if the GP initiated an urgent USS) • • • Suspected penile cancer – penile mass / ulcer where STI has been excluded or persists after treatment, or unexplained persistent symptoms affecting foreskin or glans
Malignancy on biopsy, cytology or other investigation
Abnormal prostate on DRE suggestive of carcinoma (urgent referral is not needed if the prostate is simply enlarged and the PSA is in the age specific reference range)
Elevated age specific PSA in absence of UTI

Age adjusted PSA normal values: (*Prostate Cancer Risk Management Programme)

<table>
<thead>
<tr>
<th>Age</th>
<th>PSA below (ug/L)</th>
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<th>Age</th>
<th>PSA below (ug/L)</th>
</tr>
</thead>
<tbody>
<tr>
<td>40-49</td>
<td>2.5</td>
<td>50-59</td>
<td>3.0</td>
<td>60-69</td>
<td>4.0</td>
<td>70 and over</td>
<td>5.0</td>
</tr>
</tbody>
</table>

Paediatric & Younger People (no change to criteria or format)
Any child or young person with suspected cancer should be discussed with the on Paediatric team at your local acute hospital referral criteria as a guide include:

Fatigue or shortness of breath in a previously healthy child combined with one or more of the following: lymphadenopathy OR hepatosplenomegaly OR clinical evidence of anaemia or petechiae
Bone pain and / or swelling: diffuse or persistent ORX-ray indicative of cancer; mediastinal or hiliar mass on chest X-ray.
Lymphadenopathy which has one or more of the following characteristics: non tender / firm, persisting for four weeks OR progressively enlarging, or hard OR unresolved after a course of antibiotics OR associated with signs of generalised ill health, night sweats, fever and/or weight loss OR involves axillary or supraclavicular nodes
Soft tissue mass which has one or more of the following characteristics: size > 2 cms OR shows rapid or progressive growth OR fixed or deep to fascia OR associated with regional lymph node enlargement OR non-tender
Headache of recent origin with one or more of the following features: increasing frequency or severity (e.g. causing nocturnal awakening) OR associated with significant behavioural change OR deterioration in school performance OR associated with neurological signs or symptoms of raised intracranial pressure OR new-onset seizures OR gait abnormality.
Haematuria: with bruises (Leukaemia) OR with abdominal mass (Wilm's Tumour) OR With symptoms suggestive of neuroblastoma (proptosis, unexplained back pain, leg weakness, unexplained urinary retention).
Signs suggestive of Retinoblastoma: Cataract OR New squint or change in visual acuity.
**Cancer of Unknown Primary (CUP)** – (new no formal pathway or form as yet see guidance below)
If a cancer of unknown primary is detected usually as a finding on a CT scan the referral should be directed to the upper GI pathway, please give relevant clinical details ( further information on local Referral Support Tool )

**Suspected Sarcoma or Bone Tumour** (no change to previous criteria or form)
This pathway has not changed and is provided by the London South East Sarcoma Network (LSEN), if you have concerns or queries we would recommend seeking advice from local on call orthopaedic team. (further information on local Referral Support Tool OR www.lsesn.nhs.uk/referrers.htmlhttp

SUSPECTED PRIMARY BONE TUMOUR* Suspicious X-ray showing: - Spontaneous Fracture OR Bone Destruction OR Soft Tissue Swelling OR New Bone Formation OR Periosteal Elevation
SUSPECTED SOFT TISSUE SARCOMA- Soft tissue mass with one or more of the following : > 5cm in size OR Deep to Fascia OR Recurrence following Excision, OR Painful OR Increasing in size OR Fixed OR Immobile Or other

Guidance on Investigations and other referrals for suspected primary bone tumours:
Refer for an immediate X-ray a patient with suspected spontaneous fracture.
If the X-ray suggests possible bone cancer, refer urgently as above.
If the X-ray suggests metastatic disease or a benign tumour, refer to your local orthopaedic service.
If the X-ray is normal but symptoms persist, follow up and / or request repeat X-ray, bone function tests or make a non-urgent referral.

Urgently investigate increasing, unexplained or persistent bone pain or tenderness, particularly pain at rest (and especially if not in the joint), or an unexplained limp. Consider whether the patient has a history of previous malignancy. In older people metastases, myeloma or lymphoma, as well as sarcoma, should be considered.
If you suspect metastatic disease, refer to your local orthopaedic service.
If you suspect myeloma or lymphoma, refer urgently to your local Haematology service using the Haematology Urgent Suspected Cancer Referral proforma.
If you suspect bone sarcoma, refer urgently as above.