NHS SCOTLAND

Scottish Referral Guidelines for Suspected Cancer

Quick Reference Guide

The full version of the guidelines is available from the Scottish Government Health Directorates at **www.sehd.scot.nhs.uk/mels/HDL2007_09.pdf**

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SCOTTISH GOVERNMENT

Scottish Referral Guidelines for Suspected Cancer

Quick Reference Guide

This Quick Reference Guide has been produced by the Scottish Primary Care Cancer Group with support from The Scottish Cancer Group and the Scottish Government. An electronic version is available at **www.scotland.gov.uk/quickreferenceguide/suspectedcancer**

The Guide is based on the Scottish Referral Guidelines for Suspected Cancer a copy of which is available at **www.sehd.scot.nhs.uk/mels/HDL2007_09.pdf**

Unless otherwise stated, patients with a suspicion of cancer should be referred urgently.

General Principles

Patients' and carers' needs in the referral process

All health care professionals must:

- Be sensitive to the patient's wishes to be involved in decisions about their care.
- Provide understandable information at a level appropriate to the patient's wishes to be informed.
- Provide information about any referral to other services, whether to secondary or tertiary care, including how long they might have to wait, who they are likely to see, and what is likely to happen to them.
- Consider carefully the need for physical and emotional support whilst awaiting an appointment with a specialist.
- Consider any carer's needs for support and information, taking issues of confidentiality into consideration.
- Take the individual's particular circumstances into account, e.g. age/ family/ work/ culture.
- Be aware of and offer to provide access to sources of information in various formats.
- Maintain a high standard of communication skills, including for example, in the process of breaking bad news.

Breast Cancer

Lumps

- Any new discrete lump.
- New lump in pre-existing nodularity.
- New asymmetrical nodularity that persists at review after menstruation.
- Non-lactational abscess or mastitis which does not settle after one course of antibiotics.
- Abscess in patient >40 even if settles with antibiotics.
- Cyst persistently refilling or recurrent.
- Unilateral axillary lymph node.

Pain

- Unilateral persistent pain in post-menopausal women.
- If associated with a lump.
- Intractable pain that interferes with lifestyle.

Nipple Symptoms

- <50 with discharge which is bloodstained (dipstick) or bilateral and sufficient to stain clothes or persistent single duct discharge.
- All women >50 with discharge.
- New nipple retraction.
- Nipple eczema if none elsewhere or unresponsive to topical steroids.

Skin Changes

- Skin tethering.
- Fixation.
- Ulceration.
- Abscess or inflammation not settled after one course of antibiotics.
- Abscess or inflammation in patient >40 yrs even if settles with antibiotics.

For risk associated with a positive family history,
see section on Assessing Genetic Risk.

Lung Cancer

Referral for CXR

- Haemoptysis.
- Unexplained or persistent (i.e. >3 weeks):

Cough	Chest signs
Chest/shoulder pain	Hoarseness
Dyspnoea	Clubbing
Weight loss	Fatigue in smoker >50 yrs

- Persistent cervical/supraclavicular lymphadenopathy.
- Features suggesting metastases from lung cancer.

Referral to Chest Physician

- CXR suggestive or suspicious of lung cancer (incl pleural effusion and slow-to-resolve consolidation).
- Persistent haemoptysis in smokers/ex-smokers aged >40 yrs.
- Signs of SVC obstruction.
- Stridor (emergency referral).
- Any of CXR referral list persisting >6 weeks despite normal CXR.

Mesothelioma

Over 45 with history of asbestos exposure and recent onset of chest pain, dyspnoea or unexplained systemic symptoms.

Upper Gastrointestinal Cancers

- 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 >55 yrs with at least one 'high risk' feature:
    - Onset of dyspepsia less than one year ago.
    - Continuous symptoms since onset.
- Dyspepsia combined with at least one risk factor:
    - Family history of Upper GI cancer in more than two first degree relatives.
    - Family history of colorectal cancer (familial adenomatous polyposis, hereditary non-polyposis colorectal cancer).
    - Barrett's oesophagus.
    - Pernicious anaemia.
    - Peptic ulcer surgery over 20 years ago.
    - Known dysplasia, atrophic gastritis, intestinal metaplasia.
- Jaundice.
- Upper abdominal mass.
- Back pain and weight loss.

Lower Gastrointestinal Cancers

High Risk Features:

- Persistent rectal bleeding without anal symptoms.
- Persistent change in bowel habit (>6 weeks), especially to looser stools.
- Right sided abdominal mass.
- Palpable rectal mass.
- Unexplained iron deficiency anaemia.
- Significant family history (see section on assessing genetic risk).

"Watch and wait" is appropriate for patients under 40 with low risk features and particularly those with transient symptoms lasting less than six weeks.

Urological Cancer

Urgent Referral

- Frank or macroscopic haematuria in adults (exclude infection in females <35 yrs).
- Microscopic haematuria with persistent irritative lower urinary tract symptoms.
- Swellings in the body of the testes.
- Palpable renal masses.
- Solid renal masses found on imaging.
- Clinically malignant prostate and/or bone pain (PSA generally >20 in metastatic disease).
- Elevated age specific PSA (<70 yrs >3, >70 yrs >5) if radical treatment appropriate. Local laboratory values may vary.
- Any suspected penile cancer.

Non-urgent referrals

- Elevated age specific PSA and radical or urgent treatment not indicated.
- Microscopic haematuria (on 3 samples) without obvious cause (e.g. UTI, renal calculi).

Afro-Caribbean men have an increased risk of prostate cancer and men with a first degree relative with prostate cancer have double the risk.

Gynaecological Cancers

Urgent Referral

- Lesions suspicious of cancer on cervix or vagina at speculum examination.
- Lesions suspicious of cancer on inspection of vulva.
- Palpable pelvic mass not obviously fibroids.
- Suspicious pelvic mass on ultrasound.
- More than one or a single heavy episode of PMB in women over 55 yrs who are not on HRT.
- Postcoital bleeding age >35 yrs that persists for more than 4 weeks.
- HRT: unexpected or prolonged bleeding persisting for >4 weeks after stopping HRT.

Non-urgent referrals

- Any other women with PMB not on HRT.
- Repeated unexplained postcoital bleeding.
- In women >45 yrs with persistent abdominal pain or distension, ovarian cancer should be considered and pelvic USS requested.

Skin Cancers

Melanoma

Pigmented lesions on any part of the body which have one or more of the following features:

- Rapid growth in height or area.
- Change in colour or more than three colours at presentation.
- Lesion which is significantly different from patient's other moles.
- Growing subungual lesions.
- Lesion with persistent surrounding inflammation or altered sensation.
- Persistent ulceration, bleeding or oozing in absence of trauma.
- New growing nodule whether pigmented or not.

Squamous Cell Carcinoma

Urgent referral for:

- Lesions which grow rapidly over 6 weeks, especially on ear, columella or lip.
- Slow growing, non-healing lesions with induration (esp. face, scalp, back of hand) expanding over 1-2 months.
- If invasive SCC diagnosed from biopsy undertaken in general practice.
- Patients who are immunosuppressed especially after organ transplantation have a higher incidence of aggressive SCC with metastatic potential compared to immune competent patients.

Basal Cell Carcinoma

- The majority of BCCs do not need urgent referral.
- Lesions with very long history (>10 years) have the potential to metastasise.
- Urgent referral for recurrent BCC and those invading potentially dangerous areas, e.g. auditory meatus, eye, base of nose or any major vessel.

Haematological Malignancies

Leukaemias, Lymphomas and Myeloma

- Blood count/film reported as suggestive of acute leukaemia or chronic myeloid leukaemia.*
- Lymphadenopathy (>1 cm) persisting for 6 weeks.
- Hepatosplenomegaly in the absence of known liver disease.
- Bone pain associated with anaemia and an elevated ESR.
- Bone x-rays reported as being suggestive of myeloma.
- Constellation of 3 or more of the following clinical features may also merit urgent referral:

Fatigue	Bruising
Night sweats	Recurrent infections
Weight loss	Bone pain
Itching	Polyuria and polydipsia
Breathlessness	(Hypercalcaemia)

Chronic lymphatic leukaemia in an older person may not require urgent assessment. Ideally all urgent cases should initially be discussed with a Consultant Haematologist.

Arrangements for biopsy of persistent abnormal lymph glands vary locally.

* Will normally be picked up in the laboratory and communicated to the GP for management to be agreed.

Brain/Central Nervous System Tumours

Neurological Deficit

- Subacute progressive neurological deficit (including personality or behavioural change) in the absence of previously diagnosed or suspected alternative disorders.

Seizure

New onset seizures characterised by one or more of the following:

- Focal seizures.
- Significant post-ictal focal deficit (excluding confusion).
- Epilepsy presenting as status epilepticus.
- Associated inter-ictal focal deficit.
- Associated preceding persistent headache of recent onset.
- Seizure frequency accelerating over weeks or months.

Headache

- Headache with vomiting and papilloedema.
- Consider urgent referral for patients with non-migrainous headaches of recent onset, when accompanied by features suggestive of raised intracranial pressure (e.g. woken by headache; vomiting; drowsiness), progressive neurological deficit or new seizure.

The probability of having a brain tumour in the following situations is as follows:

• New onset seizure (any type) in adults	2-6%
• New onset status epilepticus	⩾10%
• Chronic daily headache, without features of raised intracranial pressure	<1%

Head and Neck Cancers

Increased risk if heavy smoker and/or drinker and male >45 yrs. Other forms of tobacco use should also arouse suspicion.

- Stridor - emergency referral.
- Hoarseness lasting >3 weeks.
- Discomfort in throat >3 weeks (especially in smoker or drinker).
- Dysphagia.
- Head and neck lumps for >3 weeks.
- Ulceration of oral mucosa persisting >3 weeks.
- Oral swellings persisting >3 weeks.
- All red or red and white patches of oral mucosa >3 weeks.
- Unexplained tooth mobility not associated with periodontal disease.

Thyroid Cancer

- Solitary nodule increasing in size.
- Thyroid swelling in pre-pubertal patient.
- Thyroid swelling with the following risk factors:
    - Neck irradiation.
    - Family history of endocrine tumour.
    - Unexplained hoarseness.
    - Cervical lymphadenopathy.
    - Age >65.

Patients with hyper or hypothyroidism and an associated goitre should be referred routinely to an endocrinologist.

Children's Tumours

Abnormal blood count

- If reported as requiring urgent further investigation.

Petechiae/Purpura

- Always an indication for urgent investigation.

Fatigue in a previously healthy child and associated:

- Generalised lymphadenopathy.
- Hepatosplenomegaly.

Bone Pain especially if:

- Diffuse or involves the back.
- Persistently localised at any site.
- Requiring analgesia.
- Limiting activity.

Lymphadenopathy if any of the following:

- Non tender, firm/hard and >3 cms in maximum diameter.
- Progressively enlarging.
- Associated with other signs of general ill health, fever, weight loss.
- Involves axillary nodes (no local infection or dermatitis) or supraclavicular nodes.
- Mediastinal or hilar mass on CXR.

Headache if any following:

- Increasing in severity or frequency.
- Worse in the morning or causing early wakening.
- Associated with vomiting.
- Associated with neurological signs (e.g. squint, ataxia).
- Associated with behavioural change or deterioration in school performance.

Soft Tissue Mass if any of the following:

- Shows rapid or progressive growth.
- Size >3 cms in maximum diameter.
- Fixed or deep to fascia.
- Associated with regional lymph node enlargement.

Sarcomas

Soft tissue mass with one or more of the following:

- Size >5 cms.
- Increasing in size.
- Deep to fascia, fixed or immobile, regardless of size.
- Painful (soft tissue sarcomas often painless).
- Recurrence after previous excision.

Bone Cancer

X-ray if unexplained bone pain of:

- Increasing severity or
- persistent or
- tender or
- non-mechanical bone pain particularly disturbing rest or sleep.
- If symptoms persist but x-ray is normal, repeat x-rays and consider referral.
- Spontaneous or minor trauma fracture should raise suspicion of bone cancer.

Further causes of bone pain in older adults include metastases, myeloma and lymphoma.

Malignant Spinal Cord Compression (MSCC)

Many patients with cancer are at risk of MSCC but particularly those with lung, breast, prostate cancer or multiple myeloma.

Some health boards have specific pathways for suspected MSCC with arrangements for direct referral via an MSCC Coordinator.

Seek immediate advice as an emergency from Duty Clinical Oncologist or MSCC Coordinator on patients with cancer and symptoms or signs suggestive of spinal metastases or MSCC:

- Radicular pain.
- Limb weakness or difficulty in walking.
- Sensory loss (including perineal or saddle paraesthesia).
- Bladder or bowel dysfunction.

Refer urgently (within 24 hours) to MSCC Coordinator or Duty Clinical Oncologist to discuss the care of patients with cancer and any of the following symptoms suggestive of spinal metastases:

- Pain in the middle (thoracic) or upper (cervical) spine.
- Progressive lower (lumbar) spinal pain.
- Severe unremitting lower spinal pain.
- Spinal pain aggravated by straining (e.g at stool, or when coughing or sneezing).
- Localised spinal tenderness.
- Nocturnal spinal pain preventing sleep.

Perform frequent clinical reviews of patients with cancer who develop lower spinal pain that is clinically thought to be of degenerative or non-specific origin (i.e. not progressive, severe or aggravated by straining and has no accompanying neurological symptoms).

Assessing Genetic Risk of Cancer

Cancer may occur as a result of a genetic predisposition particularly if the affected individual is young or there are several cases in the family. Referral guidelines have been developed for breast, ovarian and colorectal cancer and are listed below.

Carriers of known gene mutations and their first degree relatives will be at higher risk.

Where there is concern in asymptomatic patients, a detailed family history should be taken and patients should be referred to the Regional Cancer Genetics Unit for a comprehensive risk assessment and screening as appropriate.

Breast Cancer

- One 1st degree relative with breast cancer diagnosed age <40.
- One 1st degree relative with male breast cancer at any age.
- Two 1st or one 1st and one 2nd degree relative with breast cancer age <60 or ovarian cancer at any age.
- Three 1st or 2nd degree relatives with breast or ovarian cancer on the same side of the family where one is a 1st degree relative of the patient or patient's father.
- Bilateral breast cancer is the equivalent of two affected relatives.

Ovarian Cancer

- Two or more 1st or 2nd degree relatives at any age.
- Two 1st or one 1st and one 2nd degree relative with ovarian cancer at any age or breast cancer age <50.
- One ovarian and two breast cancers diagnosed <60 on same side of family in 1st degree relatives or 2nd degree via a male.
- Two 1st or 2nd degree relatives with colorectal cancer and an endometrial cancer and one ovarian cancer.
- One affected relative with ovarian cancer and hereditary non-polyposis colon cancer.

Colorectal Cancer

- One affected 1st degree relative diagnosed <50.
- Two affected individuals who are 1st degree relatives of each other, one of whom is a first degree relative of the patient.
- Three relatives with colorectal or endometrial cancer who are 1st degree relatives of each other and one a 1st degree relative of the patient.

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