

Scottish Referral Guidelines for Suspected Cancer

Quick Reference Guide

January 2019

Quick Reference Guide

The Quick Reference Guide has been produced by the Scottish Referral Guidelines Steering Group, who have worked with specialist guidelines groups, Healthcare Improvement Scotland, Macmillan Cancer Support and the Scottish Government.

The Quick Reference Guide is based on the Scottish Referrals Guidelines for Suspected Cancer. A full version of the current guidelines, including risk factors, indications for routine referral and primary care management is available at <http://www.cancerreferral.scot.nhs.uk/>. A desktop Quick Guide has been developed by the Scottish Primary Care Cancer Group which has been used as the basis for an App for use on mobile devices.

Link to Website:

<http://www.cancerreferral.scot.nhs.uk>



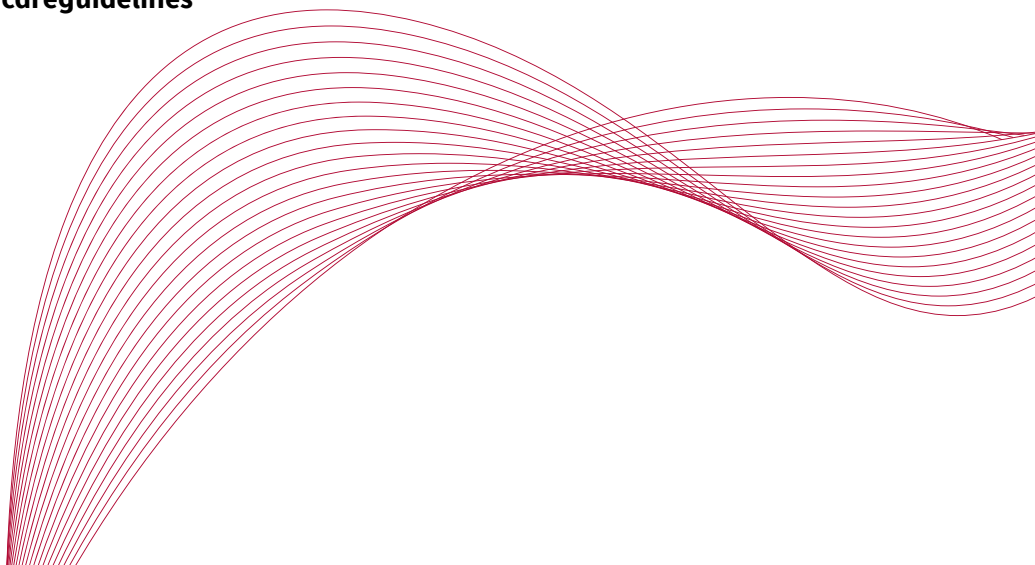
Link to both the Apple App store:

<https://itunes.apple.com/gb/app/cancer-referral-guidelines-quick-reference-guide/id1049728177?mt=8>



and to the Android App store:

<https://play.google.com/store/apps/details?id=com.scet.cancercareguidelines>



Patients' and carers' needs

All healthcare professionals should be sensitive to the needs of patients, carers and relatives when cancer is suspected. Realistic Medicine¹ is the Scottish Government's initiative to put the person at the centre of decision-making and encourages a personalised approach to their care. Good communication is key and five questions to be considered by all involved can help lead to informed decision-making:

- Is this action really needed?
- What are the benefits and risks?
- What are the possible side effects?
- Are there alternative options?
- And, importantly, what would happen if we did nothing?

Good practice includes:

- Being sensitive to the person's wishes to be involved in decisions about their care
- Providing understandable information at a level appropriate to the person's wishes to be informed
- Being aware of, and offering to provide access to, sources of information in various formats
- Using the word "cancer" as a reason for investigation or referral unless there is serious concern about causing unwarranted distress
- Providing information about any referral to other services in format(s) most suitable for the person, including how long they might have to wait, who they are likely to see, and what is likely to happen to them
- Considering carefully the need for emotional and physical support while awaiting an appointment with a specialist and, where appropriate, providing a key contact
- Considering any carers' needs for support and information, taking issues of confidentiality into consideration

1 <http://www.gov.scot/publications/2018/04/6385/downloads>

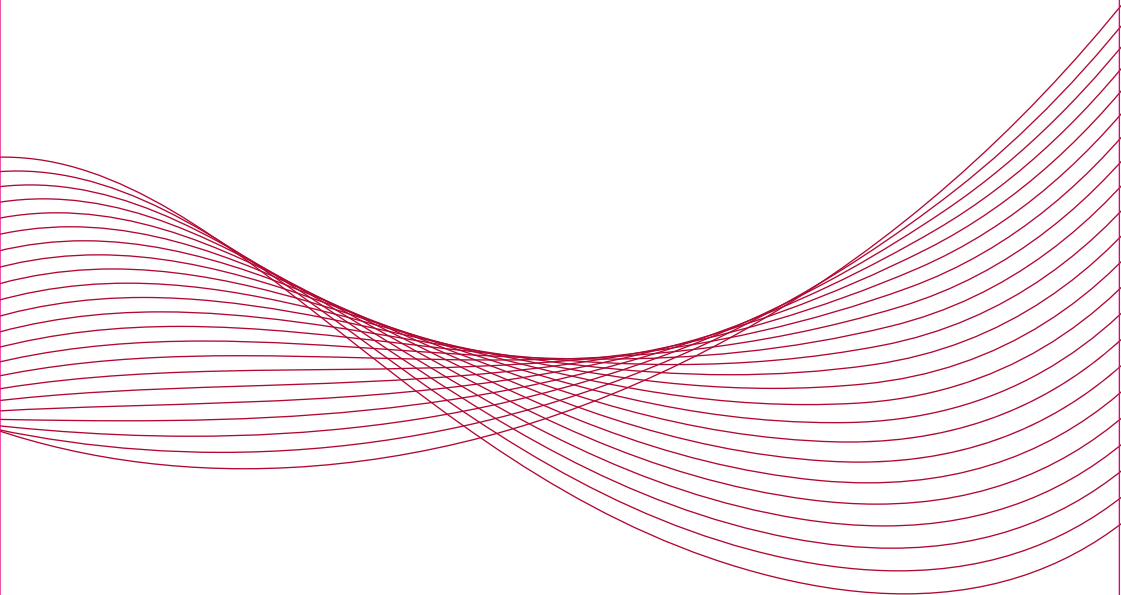
- Taking the individual's particular circumstances into account, for example age, family, work and culture
- Recognising that there are occasions when intrusive intervention is not in a person's best interests. There should be full discussion about alternative approaches, including with relevant others if a person lacks capacity, complying with the Adults with Incapacity (Scotland) Act 2000
- Maintaining a high standard of communication skills, including, for example, in the process of breaking bad news

Referral Process

General Points

- Recent evidence has identified thrombocytosis as a strong risk marker for malignancy, in particular lung, endometrial, gastric, oesophageal and colorectal cancer (acronym "LEGO-C"). With a cancer incidence of 11.6% and 6.2% in males and females respectively, these figures well exceed the 3% threshold to warrant investigation²
- It is good practice to include general fitness or performance status in the referral (e.g. ECOG/WHO scale) in order to facilitate discussion about the most appropriate pathway (see Appendix for ECOG/WHO scale)

LUNG CANCER



Urgent suspicion of cancer chest X-ray

- Any unexplained haemoptysis
- Unexplained and persistent (more than three weeks):
 - change in cough or new cough
 - dyspnoea
 - chest/shoulder pain
 - loss of appetite
 - weight loss
 - chest signs
 - hoarseness (if no other symptoms present to suggest lung cancer refer via Head & Neck pathway)
 - fatigue in a smoker aged **over 40 years**
- New or not previously documented finger clubbing
- Persistent or recurrent chest infection
- Cervical and/or persistent supraclavicular lymphadenopathy*
- Thrombocytosis where symptoms and signs do not suggest other specific cancer**
- Any person who has consolidation on chest X-ray should have further imaging no more than six weeks later to confirm resolution

* if CXR normal, refer via Head & Neck pathway

** if CXR normal, consider alternative diagnosis including other cancers

Urgent suspicion of cancer referral

- Any unexplained symptoms or signs detailed above persisting for longer than six weeks despite a normal chest X-ray (other than isolated thrombocytosis or cervical and/or persistent supraclavicular lymphadenopathy)
- Chest X-ray suggestive/suspicious of lung cancer (including pleural effusion, pleural mass and slowly resolving consolidation)
- Persistent haemoptysis in smokers/ex-smokers **over 40 years** of age

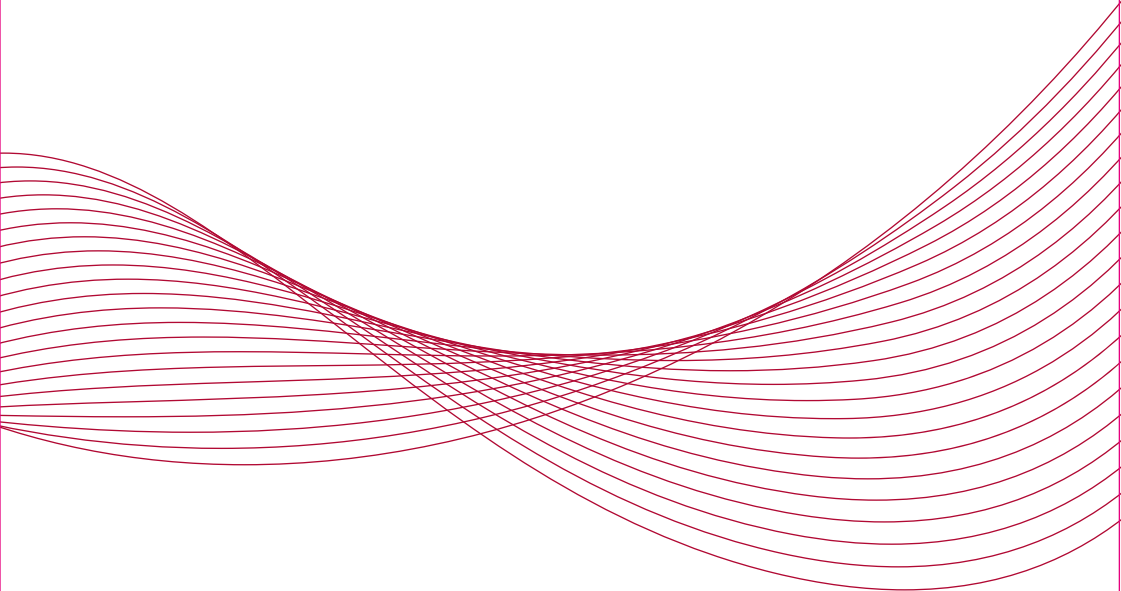
Good practice points

- There should be a locally agreed pathway for radiology to notify the respiratory team of an abnormal chest X-ray suggestive of cancer
- It is good practice for the referrer to consider taking bloods including full blood count and an **assessment of renal function if not done in preceding three months in order to expedite further imaging**
- In people with features suggestive of cancer including suspected metastatic disease, but no other signs to suggest the primary source, consider CT chest, abdomen and pelvis in accordance with local guidelines about the investigation of an unknown primary cancer

Note: a normal chest X-ray does not exclude a diagnosis of lung cancer

There is emerging evidence that thrombocytosis is a risk marker for underlying cancer, including lung. Remember “LEGO-C”.

BREAST CANCER



Urgent suspicion of cancer referral

Lump	<p>Any new discrete lump in patients 30 years and over</p> <p>New asymmetrical nodularity that persists at review after two to three weeks (in patients over 35 years)</p> <p>Unilateral isolated axillary lymph node in women persisting at review after two to three weeks</p> <p>Recurrent lump at the site of a previously aspirated cyst</p>
Nipple Symptoms	<p>Visibly bloodstained discharge</p> <p>New unilateral nipple retraction</p> <p>Nipple eczema if unresponsive to moderately potent topical steroids after a minimum of two weeks</p>
Skin changes	<p>Skin tethering</p> <p>Fixation</p> <p>Ulceration</p> <p>Peau d'orange</p>
Abscess/infection	<p>Mastitis or breast inflammation which does not settle or recurs after one course of antibiotics</p>

Good practice points

	Routine referral	Primary care management - issue relevant advice leaflet (if available)
Lump	<p>Any new discrete lump in patients under 30 years with no other suspicious features</p> <p>New asymmetrical nodularity that persists at review after two to three weeks (in patients under 35 years)</p>	<p>Women with longstanding tender lumpy breasts and no focal lesion</p> <p>Tender developing breasts in adolescents</p>
Nipple Symptoms	<p>Persistent unilateral spontaneous discharge sufficient to stain outer clothes</p>	<p>Transient nipple discharge which is not bloodstained</p> <p>Check prolactin levels in persistent bilateral discharge</p> <p>Longstanding nipple retraction</p> <p>Nipple eczema if eczema present elsewhere</p>
Skin changes		<p>Obvious simple skin lesions such as epidermoid (sebaceous) cysts</p>
Abscess/ infection		<p>Abscess or inflammation - try one course of antibiotics as per local guidelines</p> <p>Any acute abscess requires immediate discussion with secondary care</p>

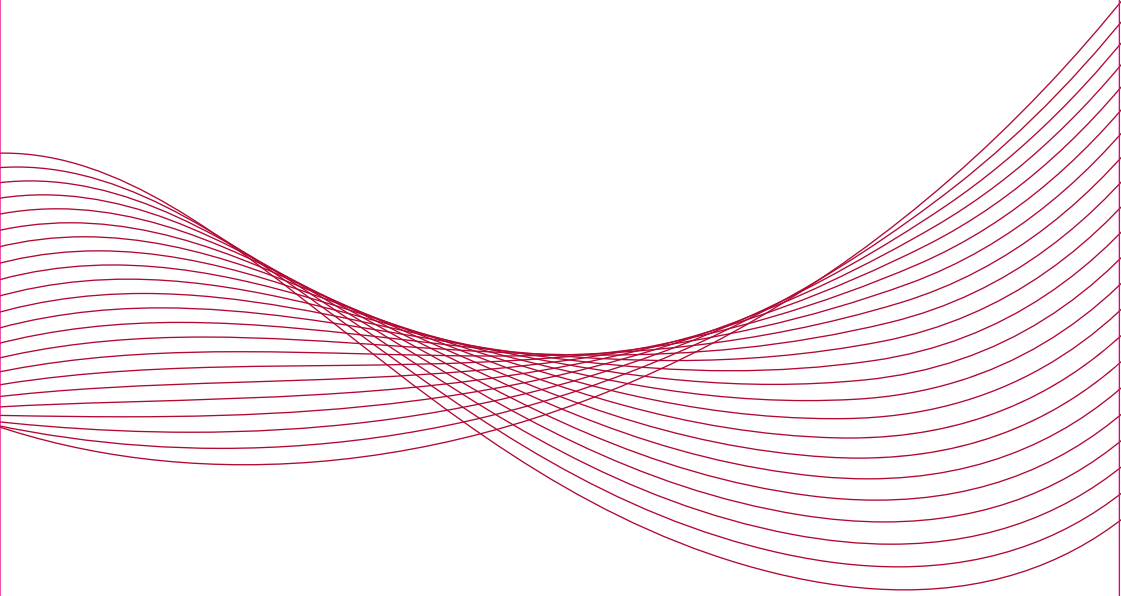
Good practice points

Breast pain	Unilateral pain persisting over three months in post-menopausal women Intractable pain that interferes with the person's lifestyle or sleep	Women with moderate degrees of breast pain and no discrete palpable lesion
Gynaecomastia	Exceptional aesthetics referral to plastic surgery pathway if appropriate (i.e. NOT to the breast service) Exclude or treat any endocrine cause prior to referral	Examine and exclude abnormalities such as lymphadenopathy or evidence of endocrine condition with blood tests as per local guidelines. Review to exclude drug causes
Breast implants	If appropriate, refer to the service that first inserted the implant (usually plastic surgery)	Reassurance is often appropriate if symptoms relate to the implant alone and not to underlying breast tissue

For genetics queries, please refer to regional guidance (see appendix).

LOWER GASTROINTESTINAL CANCER

LOWER GASTROINTESTINAL
CANCER



Urgent suspicion of cancer referral - high risk features

- | | |
|--------------------------------|---|
| Bleeding | <ul style="list-style-type: none">• Repeated rectal bleeding without an obvious anal cause• Any blood mixed with the stool |
| Bowel habit | <ul style="list-style-type: none">• Persistent (more than four weeks) change in bowel habit especially to looser stools - not simple constipation |
| Mass | <ul style="list-style-type: none">• Unexplained abdominal mass• Palpable ano-rectal mass |
| Pain | <ul style="list-style-type: none">• Abdominal pain with weight loss (also consider upper GI cancer) |
| Iron deficiency anaemia | <ul style="list-style-type: none">• Unexplained iron deficiency anaemia |

Quantitative faecal immunochemical testing (qFIT) is being used in symptomatic patients in pilot projects in many Boards. **Each has its own referral guidance which must now be used where available (see local guidance)**. This guideline will be further reviewed once a national strategy has been agreed.

An abdominal and rectal examination plus blood tests to assess renal function (in case of triage straight to CT colonography), liver function tests and to exclude anaemia and thrombocytosis should be performed on all people with symptoms suggestive of colorectal cancer. There is emerging evidence that thrombocytosis is a risk marker for underlying cancer, including colorectal, and this can facilitate appropriate triage in secondary care. A negative rectal examination, or a recent negative bowel screening test, should not rule out the need to refer. The carcinoembryonic antigen test should not be used as a screening tool.

Good practice points

- Consider the possibility of ovarian cancer as per gynaecological cancers guideline
- An abdominal palpation should be undertaken, CA125 blood serum level measured and urgent pelvic ultrasound scan carried out in:
 - any woman over 50 years who has experienced new symptoms within the last 12 months that suggest irritable bowel syndrome, or
 - women (especially those over 50 years) with one or more unexplained and recurrent symptoms (most days) of:
 - abdominal distension or persistent bloating
 - feeling full quickly or difficulty eating
 - loss of appetite
 - pelvic or abdominal pain
 - increased urinary urgency and/or frequency
 - change in bowel habit

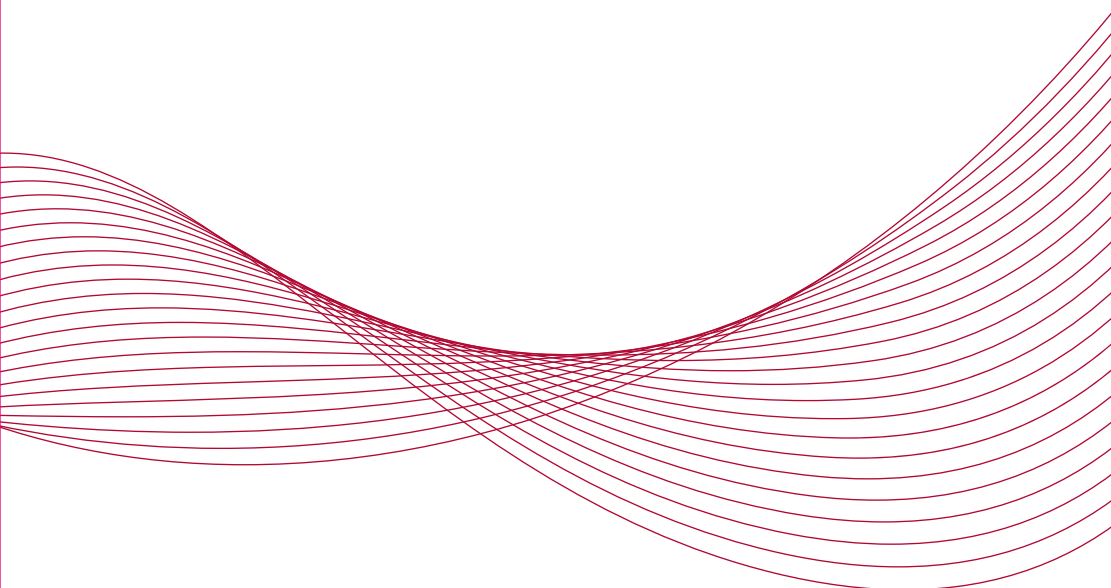
Primary care management

- Low risk features:
 - transient symptoms (less than four weeks)
 - patients under 40 years in absence of high risk features
- Watch and wait (four weeks)
 - Assessment and review
 - Consider bowel diary
 - Appropriate information, counselling and agreed plan for review with GP
 - Refer if symptoms persist or recur

For genetics queries, please refer to regional guidance (see appendix).

OESOPHAGO- GASTRIC, HEPATOBILIARY AND PANCREATIC CANCERS

OESOPHAGO-GASTRIC,
HEPATOBILIARY AND
PANCREATIC CANCERS



Oesophago-gastric cancer

Urgent suspicion of cancer referral

- **Dysphagia** (interference of the swallowing mechanism that occurs within five seconds of the swallowing process) or **unexplained odynophagia** (pain on swallowing) at any age
- Unexplained **weight loss**, particularly >55 years, combined with one or more of the following features:
 - new or worsening upper abdominal pain or discomfort
 - unexplained iron deficiency anaemia
 - reflux symptoms
 - dyspepsia resistant to treatment
 - vomiting
- New vomiting persisting for more than two weeks

Hepatobiliary and pancreatic cancer

Urgent suspicion of cancer referral

- Painless obstructive jaundice
- Unexplained weight loss, particularly >55 years, combined with one or more of the following features:
 - upper abdominal or epigastric mass
 - new onset diabetes
 - any suspicious abnormality, in the hepatobiliary tract, found on imaging (such as biliary dilatation or pancreatic/liver lesion)
 - new onset, unexplained back pain (consider other cancer causes including myeloma or malignant spinal cord compression)
 - ongoing GI symptoms despite negative endoscopic investigations

Oesophago-gastric cancer

Good practice points

Consider routine referral for people presenting with new upper gastrointestinal pain or discomfort combined with any of the following risk factors:

- family history of oesophago-gastric cancer in a first-degree relative
- Barrett's oesophagus
- pernicious anaemia
- previous gastric surgery
- achalasia (dysfunction of the oesophageal muscle)
- known dysplasia, atrophic gastritis or intestinal metaplasia

Primary care management

- Dyspepsia without accompanying symptoms or risk factors should be managed according to **local or national guidelines**

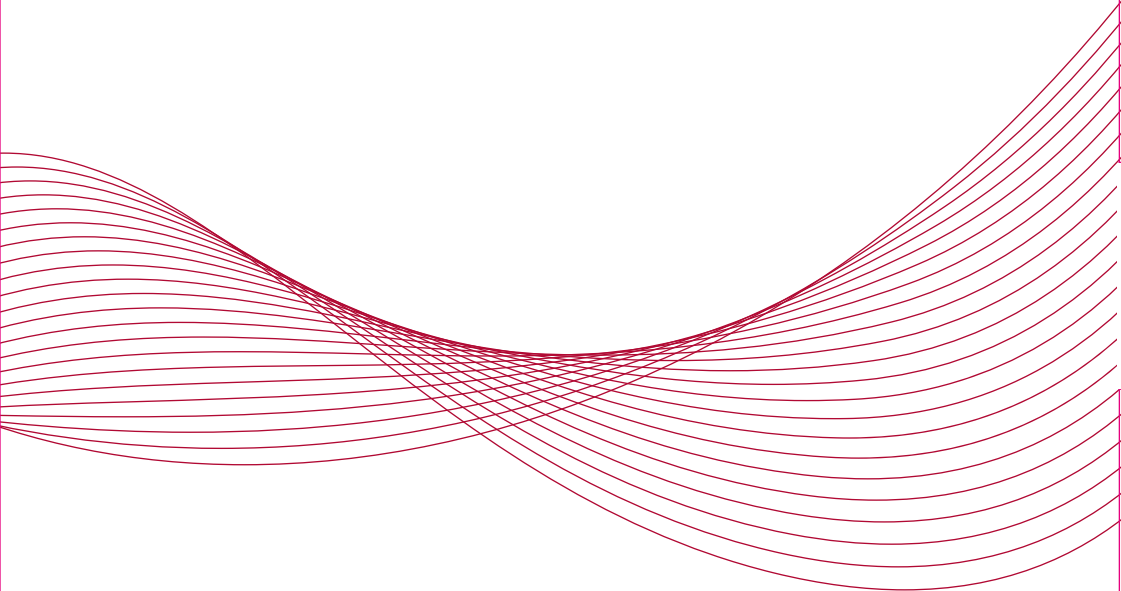
Hepatobiliary and pancreatic cancer

Good Practice Points

- Consider seeking advice in people presenting with new onset GI symptoms with known chronic liver disease

There is emerging evidence that thrombocytosis is a risk marker for underlying cancer, including gastric and oesophageal. Remember "LEGO-C".

UROLOGICAL CANCERS



Urgent suspicion of cancer referral

Prostate Cancer

- Evidence from digital rectal examination of a hard, irregular prostate
- Elevated or rising age-specific Prostate Specific Antigen (PSA). Rough guide to normal PSA levels (ng/ml):
 - Less than 60 years < 3
 - Aged 60-69 years < 4
 - Aged 70-79 years < 5

These figures are a pragmatic aid based on clinical consensus. The principles of Realistic Medicine should be applied when considering referral and, in older men, routine or no referral may be appropriate for PSA levels of:

- Aged 80-85 years > 10
- Aged 86 years and over > 20

Bladder and kidney cancer

- Aged 45 and over and have:
 - **unexplained** visible haematuria without urinary tract infection, or
 - visible haematuria that persists or recurs after successful treatment of urinary tract infection
- Aged 60 and over and have unexplained non-visible haematuria and either dysuria or a raised white cell count on a blood test
- Abdominal mass identified clinically or on imaging that is thought to arise from the urinary tract

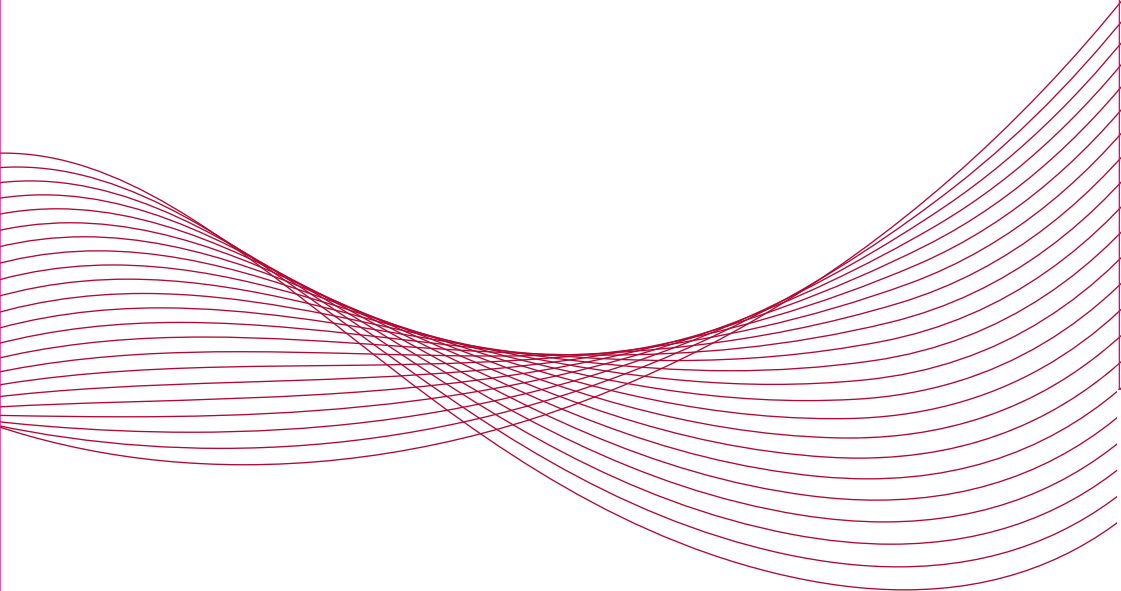
Testicular and penile cancer

- Non painful enlargement or change in shape or texture of the body of the testis
- Suspicious scrotal mass found on imaging
- Men considered to have epididymo-orchitis or orchitis which is not responding to treatment
- Any non-healing lesion on the penis or painful phimosis

Routine referral

- Elevated age-specific PSA **where urgent referral will not affect outcome due to age or comorbidity**
- Asymptomatic persistent non-visible haematuria without obvious cause
- Unexplained visible haematuria < 45 years of age
- Patients over 40 who present with recurrent UTI associated with any haematuria

SKIN CANCERS



Urgent suspicion of cancer referral

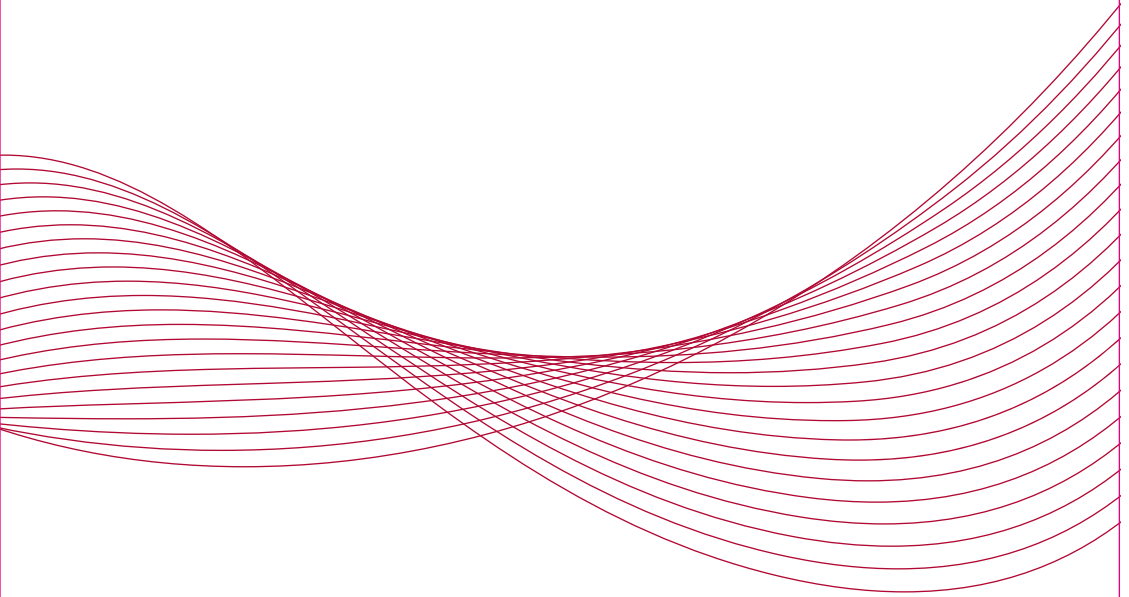
Lesions on any part of the body which have one or more of the following features:

- Change in colour, size or shape in an existing mole
- Moles with **A**symmetry, **B**order irregularity, **C**olour irregularity, **D**iameter increasing or >6mm
- New growing nodule with or without pigment
- Persistent (more than four weeks) ulceration, bleeding or oozing
- Persistent (more than four weeks) surrounding inflammation or altered sensation
- New or changing pigmented line in a nail or unexplained lesion in a nail
- Slow growing, non-healing or keratinising lesions with induration (thickened base)
- Any melanoma or invasive SCC or a high risk BCC diagnosed from biopsy
- Any unexplained skin lesion in an immuno-suppressed patient
- BCC invading potentially dangerous areas, for example peri-ocular, auditory meatus or any major vessel or nerve

Good practice points

- Lesions which are suspicious for melanoma should not be removed in primary care. All excised skin specimens should be sent for pathological examination
- Lesions suspicious of basal cell carcinomas (BCC) may not require urgent referral, except those invading potentially dangerous areas
- Referrals should be accompanied by an accurate description of the lesion (including size, pain and tenderness) and photos if possible, subject to clinical governance arrangements, to permit appropriate triage

GYNAECOLOGICAL CANCERS



Urgent suspicion of cancer referral

- Ovarian cancer**
- Abnormal ultrasound scan and/or CA125 level
 - Ascites and/or ultrasound-confirmed pelvic or abdominal mass (that is not obviously uterine fibroids, gastrointestinal or urological in origin)
- Endometrial cancer**
- Any woman on hormone replacement therapy (HRT), presenting with persistent or unexplained postmenopausal bleeding, after cessation of HRT for four weeks
 - Unscheduled vaginal bleeding in a patient taking tamoxifen
 - Postmenopausal bleeding
 - Persistent intermenstrual bleeding, especially with other risk factors despite a normal pelvic examination
 - A woman presenting with a palpable abdominal or pelvic mass on examination that is not obviously uterine fibroids, gastrointestinal or urological in origin should be referred urgently for an ultrasound scan and, if significant concern, simultaneously to a specialist. Awaiting results of the ultrasound scan should not delay referral
- Cervical cancer**
- Any woman with clinical features (vaginal discharge, postmenopausal, postcoital or persistent intermenstrual bleeding) and abnormality suggestive of cervical cancer on examination of the cervix
- Vulval cancer**
- Any unexplained vulval lump found on examination
 - Vulval bleeding due to ulceration
- Vaginal cancer**
- Any suspicious abnormality of the vagina on speculum examination

Good practice points

An abdominal palpation should be undertaken, CA125 blood serum level measured and urgent pelvic ultrasound scan carried out in:

- any woman over 50 years who has experienced new symptoms within the last 12 months that suggest irritable bowel syndrome or
- women (especially those over 50 years) with one or more unexplained and recurrent symptoms (most days) of:
 - abdominal distension or persistent bloating
 - feeling full quickly or difficulty eating
 - loss of appetite
 - pelvic or abdominal pain
 - increased urinary urgency and/or frequency
 - change in bowel habit

A full pelvic examination, including speculum examination of the cervix, should be carried out in women presenting with:

- significant alterations in their menstrual cycle
- intermenstrual bleeding
- postcoital bleeding
- postmenopausal bleeding
- vaginal discharge, or
- pelvic pain

A vulval examination should be carried out for any woman presenting with any vulval symptom.

If there is significant concern, awaiting the results of any investigation should not delay referral.

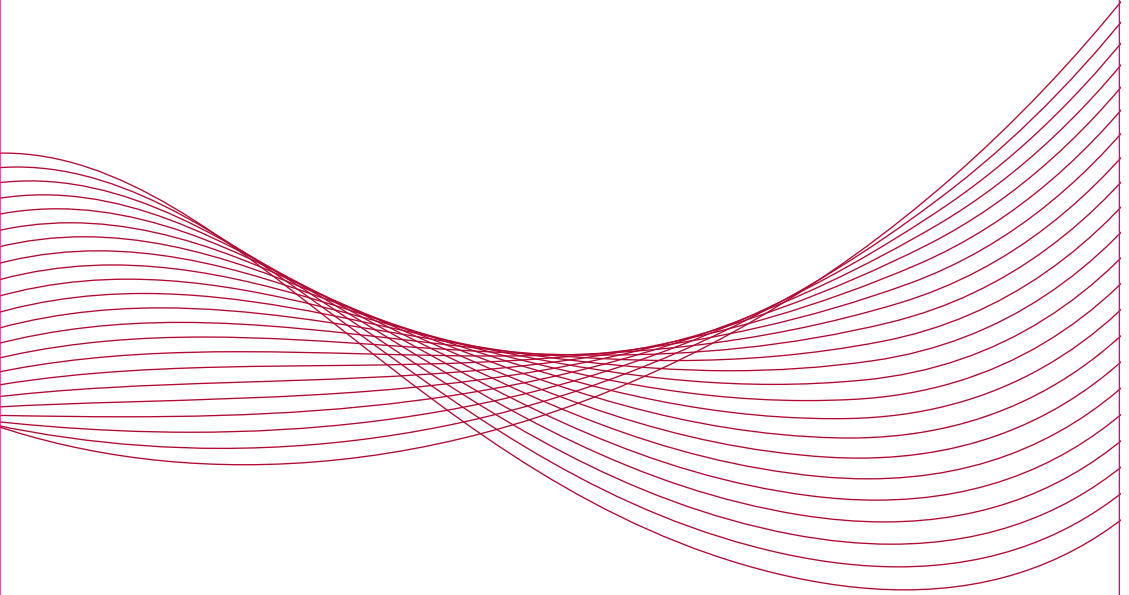
There is emerging evidence that thrombocytosis is a risk marker for underlying cancer, including endometrial. Remember “LEGO-C”.



Primary care management

- Symptoms (as above) persisting or worsening for any woman who has a normal CA125 with normal ultrasound, assess for other clinical causes and investigate as appropriate or refer to appropriate secondary care services, depending on local arrangement
- Women presenting with vulval symptoms of pruritus or pain should be examined prior to initiation of any treatment and follow up should also include examination until symptoms are resolved or a diagnosis is confirmed
- Refer urgently or routinely, if symptoms persist, depending on the symptoms and the degree of concern about cancer

HAEMATOLOGICAL CANCERS



Urgent suspicion of cancer referral

- Blood count/film reported as suggestive of acute leukaemia or chronic myeloid leukaemia*
- Lymphadenopathy (>2cm) persisting for six weeks or increasing in size or generalised (HIV status should always be checked if generalised)
- Hepatosplenomegaly in the absence of known liver disease
- Bone pain associated with a paraprotein and/or anaemia
- Bone x-rays reported as being suggestive of myeloma
- The following clinical features may also merit urgent referral:
 - fatigue
 - night sweats
 - weight loss
 - itching
 - bruising
 - recurrent infections
 - bone pain
 - polyuria and polydipsia (hypercalcaemia)

*will normally be identified in the laboratory and communicated to the clinician for management to be agreed.

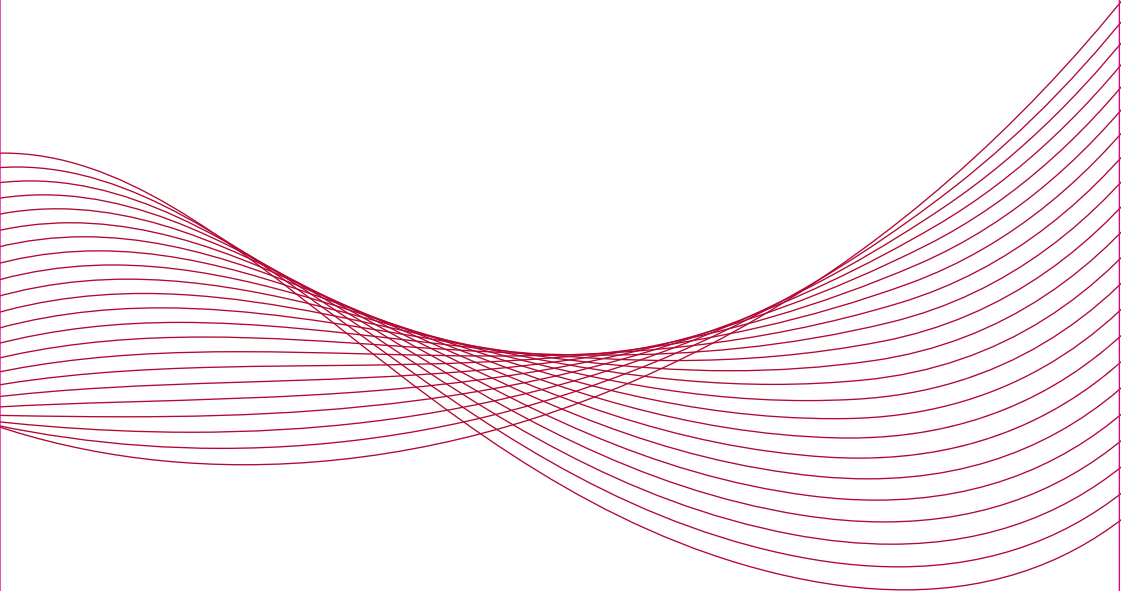
Good practice points

- For people presenting with non-specific symptoms, the clinician should always consider checking human immunodeficiency virus (HIV) status along with other routine investigations
- Routine tests and investigations should be repeated at least once if a person's condition remains unexplained
- If myeloma is suspected, urine as well as serum electrophoresis should be performed

Primary care management

- CLL in an older person should be discussed with a local haematologist but many cases do not require detailed haematological review
- Asymptomatic monoclonal gammopathy may be followed up in primary care depending on local arrangements – consider discussion with a haematologist if any concern

HEAD AND NECK CANCERS



Emergency referral

- Stridor

Urgent suspicion of cancer referral**Head and neck Cancer**

- Persistent unexplained head and neck lumps for >three weeks
- Unexplained ulceration or unexplained swelling/induration of the oral mucosa persisting for >three weeks
- All unexplained red or mixed red and white patches of the oral mucosa persisting for >three weeks
- Persistent (not intermittent) hoarseness lasting for >three weeks. If other symptoms are present to suggest suspicion of lung cancer, refer via lung cancer guideline
- Persistent pain in the throat or pain on swallowing lasting for >three weeks

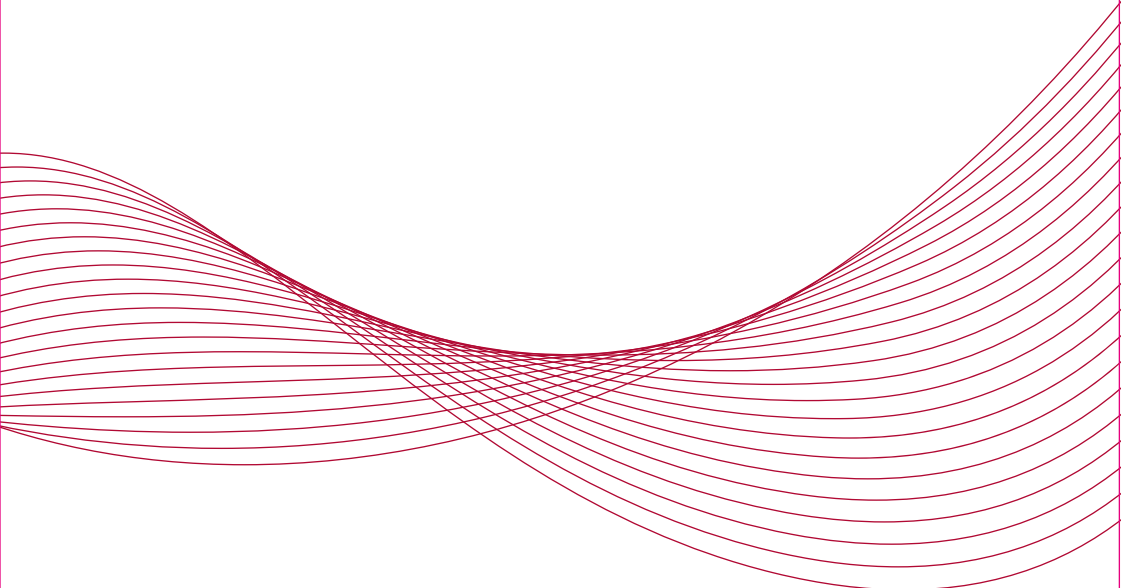
Thyroid cancer

- Solitary nodule increasing in size
- Thyroid swelling age 16 and under
- Thyroid swelling with one or more of the following risk factors:
 - neck irradiation
 - family history of endocrine tumour
 - unexplained hoarseness
 - cervical lymphadenopathy

Good practice points

- With the changing pattern of disease (in particular HPV associated cancers), age, non-smoking or non-drinking status should not be a barrier to referral
- Dentists are key to identifying early cancer in the head and neck. There should be systems in place for urgent suspicion of cancer referral pathways for dentists

BRAIN/CENTRAL NERVOUS SYSTEM TUMOURS



Emergency (same day) referral

Headache

- Patients with headache and/or vomiting with papilloedema

Urgent suspicion of cancer referral

Neurological deficit

- Progressive neurological deficit (including personality, cognitive or behavioural change) in the absence of previously diagnosed or suspected alternative disorders (such as multiple sclerosis or dementia)

Seizure

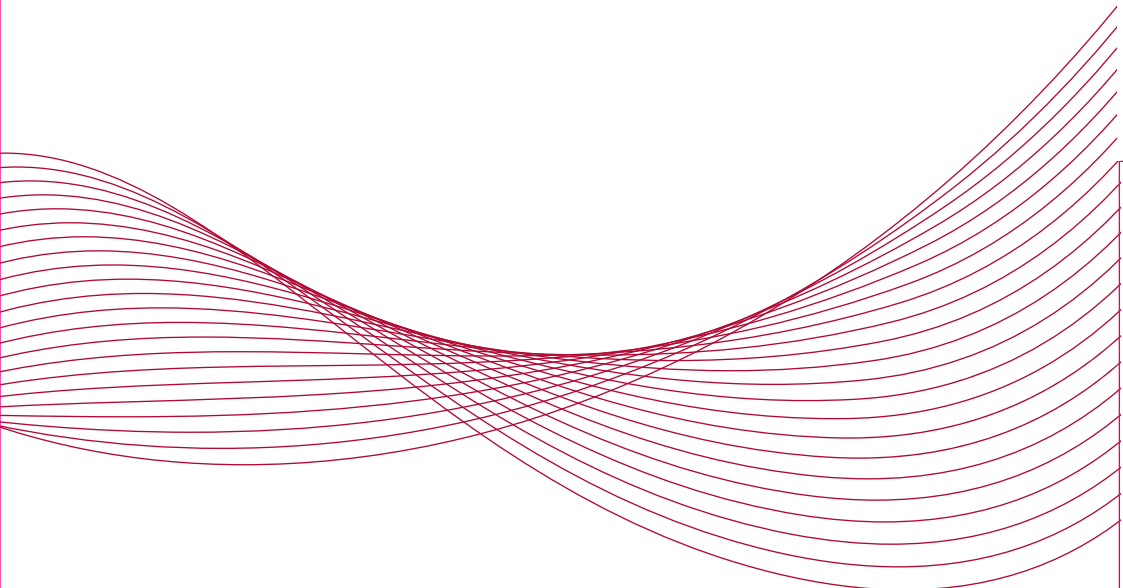
- Any new seizure
- Seizures which change in character such as post-ictal deficit, headache, increased frequency, etc

Good practice points

- Consider urgent investigation/referral for patients with non-migrainous headaches of recent onset, when accompanied by 'red flag' features suggestive of raised intra cranial pressure (for example: woken by headache; vomiting; drowsiness), progressive neurological deficit or new seizure disorder
- All NHS Boards have pathways for investigation of headaches which should include primary care direct access to imaging
- If any uncertainty about the presence of papilloedema, the person should be urgently referred to an optometrist for assessment. If there are red-flags suspicious of cancer as detailed above, a simultaneous urgent suspicion of cancer referral to secondary care should be made. If papilloedema is confirmed, the optometrist should refer directly to secondary care
- An urgent, suspicion of cancer pathway should exist in all NHS Boards for optometrists to refer directly to secondary care for people with optic discs suspicious of papilloedema

SARCOMAS AND BONE CANCERS

SARCOMAS AND BONE CANCERS



Urgent suspicion of cancer referral (soft tissue sarcoma)

A soft tissue mass with one or more of the following characteristics:

- size >5cm
- increasing in size
- deep to fascia, fixed or immobile
- recurrence after previous excision
- regional lymph node enlargement

Investigation for suspected bone cancer

An X-ray of the appropriate area should be requested on patients who have:

- unexplained bone pain or tenderness, which is:
 - persistent
 - increasing
 - non-mechanical
 - nocturnal or at rest

If X-ray is suggestive of bone tumour, refer as urgent suspicion of cancer to sarcoma service.

Good practice points

- Sarcomas of the long bones are usually excluded by normal X-ray but further investigation may be required for spine, pelvis, ribs or scapula
- If symptoms persist but X-ray is normal, repeat X-ray (following discussions with radiologist) and consider referral
- Suspected spontaneous or low impact fracture should raise suspicion of underlying malignancy

CHILDREN, TEENAGERS AND YOUNG ADULT CANCERS

Urgent Suspicion of cancer referral

- Unexplained petechiae or purpura is always an indication for **emergency referral**.
- Unexplained fatigue, persistent pallor, failure to thrive or weight loss.
- Any new persistent unexplained pain, particularly back pain or nocturnal pain.
- Unexplained abdominal mass or distension.
- Unexplained visible haematuria.

Bone pain, especially if:

- diffuse or involves the back
- persistently localised at any site
- nocturnal pain
- limping
- requiring analgesia, or
- limiting activity

Lymphadenopathy, if:

- non-tender, firm/hard and greater than 2cms in maximum diameter
- progressively enlarging
- associated with other signs of general ill health, fever or weight loss
- involves axillary nodes (no local infection or dermatitis) or any supraclavicular lymphadenopathy

Headache, if increasing in severity or frequency and:

- worse in the morning or causing early waking or
- associated with vomiting or any new neurological signs

Any new neurological signs, (such as weakness, loss of balance, etc.) especially if:

- associated with behavioural change or deterioration in normal daily or school performance



Urgent Suspicion of cancer referral

Other possible signs of brain tumours:

- increasing head circumference
- failure of fontanelle closure
- abnormal head position such as wry neck, head tilt or stiff neck

Soft tissue mass, if:

- shows rapid or progressive growth
- size greater than 2cm maximum diameter
- deep to fascia, fixed or immobile, regardless of size
- recurrence after previous excision of sarcoma
- associated with regional lymph node enlargement

Eyes:

- any new squint, if associated with headache or other neurological signs (otherwise consider optometrist and ophthalmology assessment)
- change in pupillary red reflex to absent or white

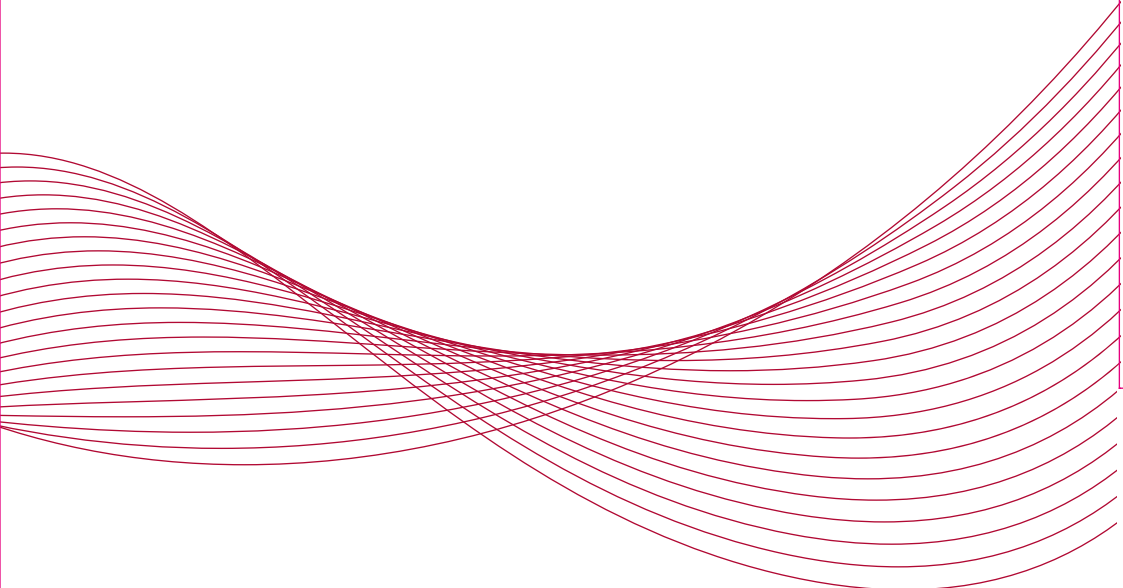
Good practice points

- **Consider referral** for any patient with repeat presentations (three or more times) of any symptoms which do not appear to be resolving or following an expected pattern, taking into account parental or carer and patient concern
- In a child where symptoms and signs do not clearly fit with these guidelines but nevertheless lead to concern about excluding cancer, the referrer should consider discussing the case with a senior paediatric colleague at their earliest convenience
- Many of the tumour specific guidelines in this document are relevant to all ages e.g. melanoma, brain and CNS, sarcoma etc

Primary care management

- X-ray if there is unexplained bone pain of:
 - increasing severity
 - persistent
 - tender
 - non-mechanical bone pain particularly if disturbing rest or sleep
- If symptoms persist but X-ray is normal, repeat X-ray (after discussion with a radiologist) and consider referral, especially if the patient presents three or more times
- Spontaneous or minor trauma fracture should raise suspicion of bone cancer

MALIGNANT SPINAL CORD COMPRESSION



Urgent suspicion of cancer referral for patients with known cancer (particularly prostate, breast, lung or multiple myeloma)

People with a history of cancer and any of the following symptoms:

- significant localised back pain, especially thoracic
- severe, progressive pain or poor response to medication
- spinal pain aggravated by straining (for example, at stool, or coughing or sneezing)
- nocturnal spinal pain, especially if preventing sleep
- radicular pain (for example, round chest, down front or back of thighs)
- limb weakness or difficulty in walking
- sensory loss (including perineal or saddle paraesthesia)
- bladder or bowel dysfunction

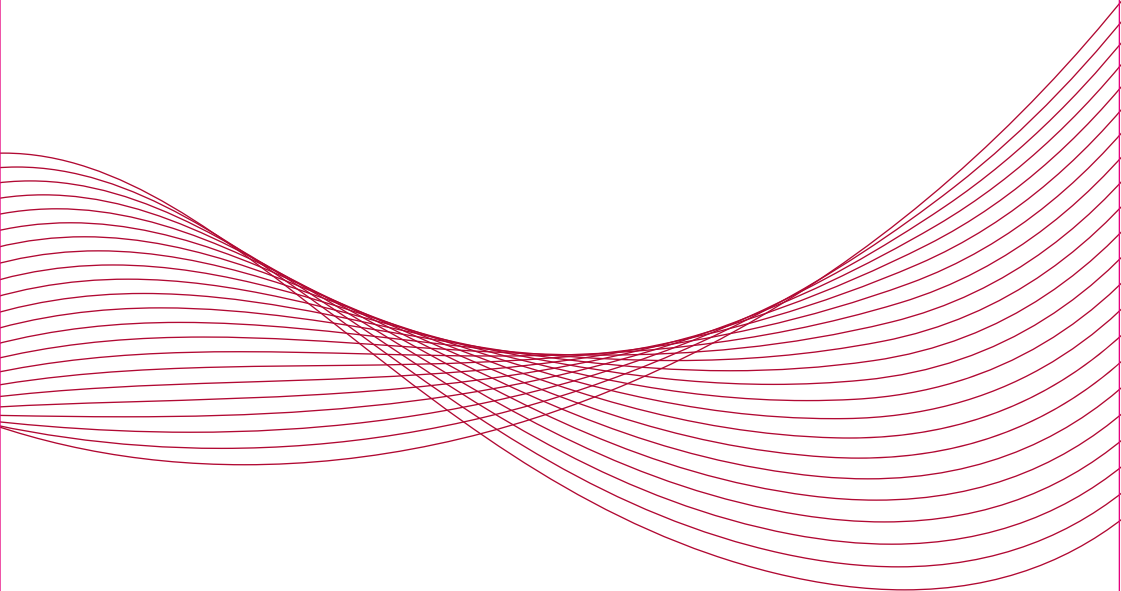
All Scottish cancer networks have developed locally agreed MSCC pathways. More information is available via the Scottish Palliative Care Guidelines website:

<https://www.palliativecareguidelines.scot.nhs.uk/guidelines/palliative-emergencies/malignant-spinal-cord-compression.aspx>

Good Practice

- A normal neurological examination does not preclude epidural disease or evolving MSCC
- The definitive method of investigation is MRI of the whole spine
- All patients with bone metastasis, or considered by their clinician to be at high risk of developing MSCC, should be given written guidance on early symptoms with advice to contact a health care professional promptly. This information should also be sent to the GP
- Written information on early symptoms should also be given to patients following treatment for MSCC

APPENDIX



REGIONAL GENETICS CENTRES

Advice about referral pathways to clinical genetics is available from each of the Regional Genetics Centres.

- **Glasgow:** www.nhsggc.org.uk/about-us/professional-support-sites/west-of-scotland-genetic-services/clinical-genetics/
- **Edinburgh:** www.nhslothian.scot.nhs.uk/Services/A-Z/ClinicalGeneticsService/Pages/default.aspx
- **Dundee:** www.nhstayside.scot.nhs.uk/OurServicesA-Z/Genetics/index.htm
- **Aberdeen:** www.nhsgrampian.org/medicalgenetics/

ECOG/WHO Performance Status Scale

Grade	ECOG/WHO Performance Status
0	Fully active, able to carry on all pre-disease performance without restriction
1	Restricted in physically strenuous activity but ambulatory and able to carry work of a light or sedentary nature, e.g., light house work, office work
2	Ambulatory and capable of all self-care but unable to carry out any work activities; up and about more than 50% of waking hours
3	Capable of only limited self-care; confined to bed or chair more than 50% of waking hours
4	Completely disabled; cannot carry on any self-care; totally confined to bed or chair
5	Dead





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ISBN: 978-1-78781-529-2

Published by The Scottish Government, January 2019

Produced for The Scottish Government by APS Group Scotland, 21 Tennant Street, Edinburgh EH6 5NA
PPDAS466106 (01/19)