Wessex Cancer Alliance Primary Care Newsletter

June 2021

Some interesting facts

Taken from Roche's website

The word 'cancer' comes from the Latin for 'crab'. Early doctors, when describing certain tumours which had veins or extensions from the main body, called them crab-like, or 'cancerous'.

Cancer was first described by the ancient Egyptians - a papyrus document dating back to about 1,600 BC describes breast tumours removed by a tool called a 'fire drill'.

In the US there are more skin cancers cases caused by indoor tanning than lung cancer cases caused by smoking.

Naked mole rats are immune to cancer - these mammals found in Africa are rich in a substance called hyaluronan, which is a lubricant and stops cancers growing.

Only 5-10% of cancers are entirely hereditary. Most cancers develop through a combination of hereditary and environmental factors, including smoking, alcohol, obesity and diet.

Breast cancer is more common in the left breast. The left side of the body is 5-10% more likely to develop a breast cancer and 10% more prone to melanoma. No one is entirely sure why this is.

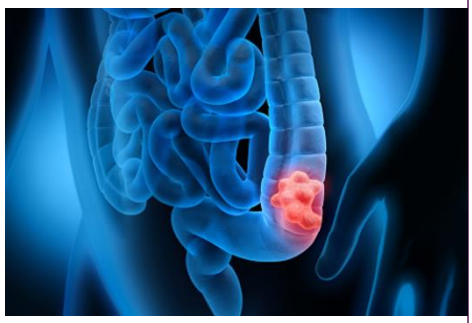
This is the second newsletter focused on cancer and specifically written for the members of the primary care team.

Please share the newsletter with others in your practice who may find the contents useful, such as your practice nurses, social prescribers or clinical pharmacists. We all have an important role to play in the prevention, early diagnosis and management of cancer.

Our first newsletter can be found by clicking here. This includes useful information about the PCN DES and the requirement for the Quality Improvement part of QoF.

This newsletter includes:

Focus on bowel cancer.



Bowel cancer is the fourth most prevalent cancer in Wessex.

In 2017 there were 42,081 people diagnosed with bowel cancer in the UK and 16,571 deaths. Data shows that if bowel cancer is diagnosed at Stage 1, 98% of patients will survive their disease for at least one year compared to 44% of patients diagnosed at Stage 4. The five-year survival rates are 92% for patients diagnosed at Stage 1 and 10% for patients diagnosed at Stage 4.

The risk factors for bowel cancer include diet, obesity, smoking and alcohol consumption and as such this means that the prevalence of this disease will continue to rise as the effects of these risk factors develop within the community unless they are urgently addressed.

A diet that is high in red meat and low in fibre is thought to increase a person's risk and **13% of bowel cancer cases in UK are caused by eating processed meat**. As with other cancers, smoking and alcohol increase an individual's risk of developing bowel cancer. In addition, **11% of cases of colon cancer are caused by overweight and obesity**, and 28% of bowel cancer cases are caused by **eating too little fibre**.

Family history is also important, if a person has a first degree relative who has had bowel cancer diagnosed aged 50 or less, then that person's risk of developing bowel cancer in their lifetime is increased significantly.

Over **82.4% of people with bowel cancer are aged 60 or over** (89.4% 55 and over) and the average age of diagnosis in the general population is 69 years. Although risk increases with age it should not be forgotten that young adults can also develop bowel cancer.

Bowel screening is currently offered to all patients aged between 60 and 75 every 2 years and has been shown to reduce the mortality from bowel cancer. From April 2021 *onwards*, the age of screening will be extended *gradually* to all people aged 56-75,

The current uptake for bowel screening is about 60% but in areas of high social deprivation this can fall to as low as 33%. For every 300 people screened, it stops 2 from getting bowel cancer and saves 1 life from bowel cancer. **Bowel cancer screening could save around 2,000 lives in the UK per year by 2025.**

The NICE guidelines for the recognition and referral for suspect cancer (also called NG12) were update in January 2021. The guidelines for lower gastrointestinal cancer can be found on the NICE website – **click here** to access them.

Useful websites:

Bowel Cancer UK: **www.bowelcanceruk.org.uk**

Macmillan Cancer: **www.macmillan.org.uk/cancer-information-and-support/bowel-cancer**

Faecal immunochemical test (FIT)Testing

FIT testing identifies human blood in faeces and it only requires one sample to be tested. It quantifies how much blood is present.

Bowel screening is offered to patients aged 56-74 years every 2 years using FIT. The threshold for a positive screening FIT test is 120mcg Hb/g faeces whereas the threshold for a positive FIT test when requested by GP is 10mcg Hb/g faeces in most areas. Do not assume a negative screening result excludes bowel cancer in a symptomatic patient.

When used with a threshold of 10mcg Hb /g faeces. FIT gives a negative predictive value for ruling out colorectal cancer of 99.8%. Rectal bleeding is not in itself a contraindication to doing a FIT Test as the sample is taken from inside the bowel motion.

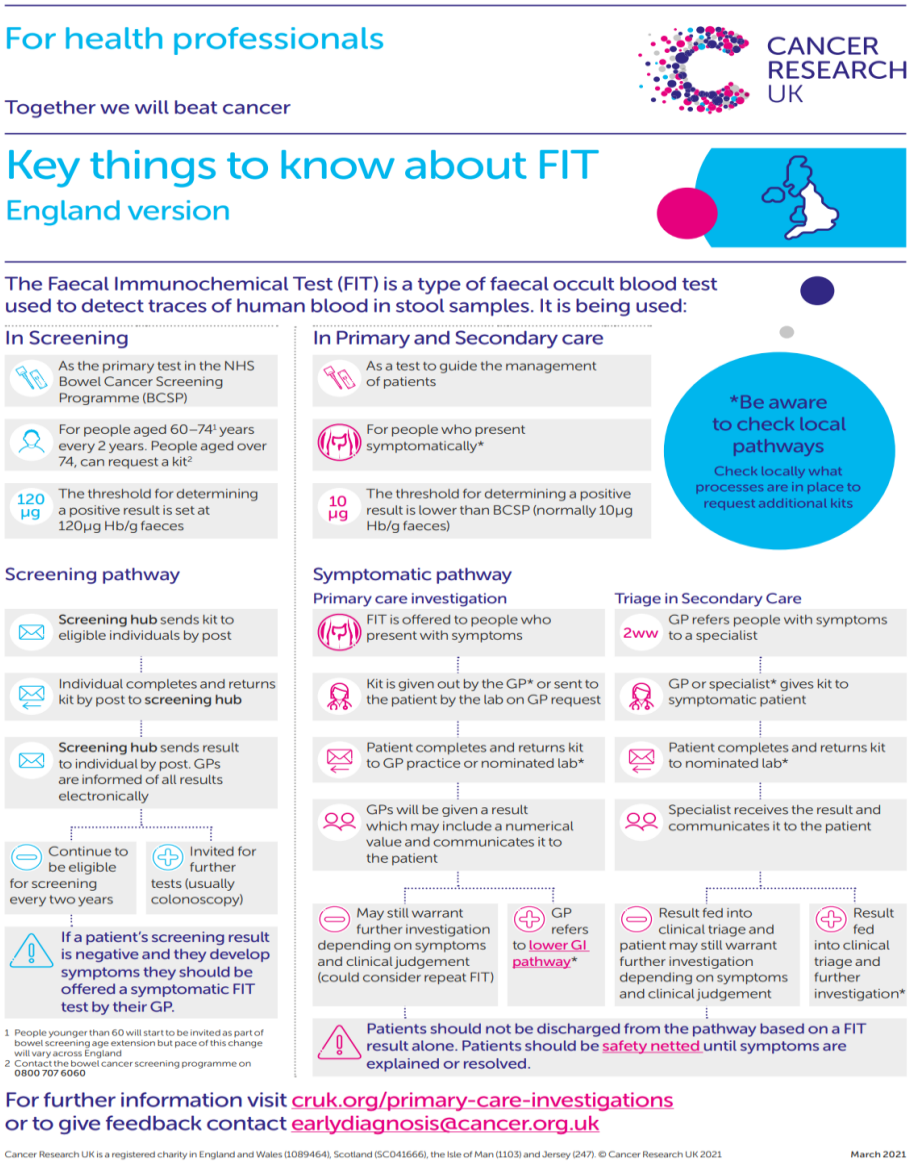
When to use FIT test as a GP

It is NOT designed to replace current fast track referral guidelines. Its place is in patients who are at low risk but not no risk of colorectal cancer and as a tool to help pick up colorectal cancer at an earlier stage. Please request a FIT test prior to a lower GI Fast Track referral.

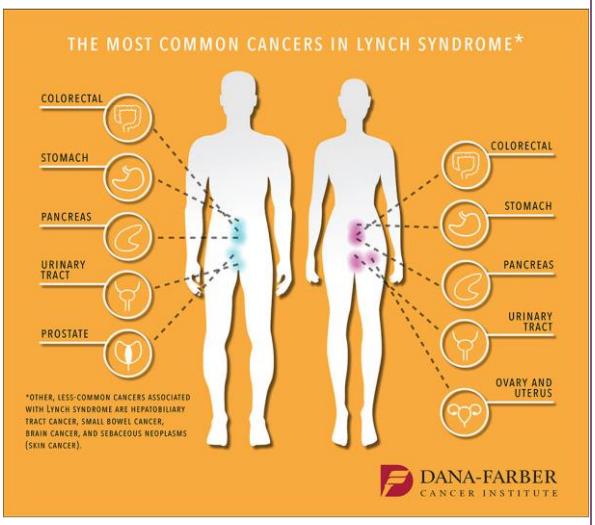
Which patients should have a FIT test?

NICE has produced guidance (DG 30) - click here:

- Aged 50 or over with unexplained abdominal pain or weight loss
- Aged under 60 with changes in bowel habit or iron deficiency anaemia
- Aged 60 or over with non-iron deficiency anaemia
- Prior to referral to Rapid Diagnostic Service



Lynch Syndrome



Background

Most colorectal cancers are not hereditary, though having a family history of colorectal cancer can increase the background risk. There are two major genetic disorders which increase the risk of developing colorectal cancer. These are:

Familial adenomatous polyposis coli - this causes multiple adenomatous polyps throughout the bowel. The lifetime risk of cancer is around 100% by the age of 40 years. Early screening and colectomy are usually offered. Inheritance is autosomal dominant. This condition is responsible for around 1% of colorectal cancers.

Lynch syndrome (hereditary non-polyposis colorectal cancer) - this is responsible for around 4% of colorectal cancers. Inheritance is also autosomal dominant - the mutation causes a mismatch in repair genes. An estimated 175,000 individuals in the UK have the syndrome but most are unaware. The average age of colorectal cancer diagnosis in Lynch syndrome is 45- 65 years.

Why do GPs need to know about Lynch syndrome?

Patients with Lynch syndrome are at increased risk of other cancers e.g. endometrial and ovarian cancer, small bowel, renal tract, stomach, pancreatic and hepatobiliary cancers. In 2017 NICE recommended that all patients with colorectal cancer should be tested for Lynch syndrome and more recently have recommended that patients diagnosed with endometrial cancer should also be tested. Additionally, NICE recommends treating some Lynch syndrome patients with aspirin to prevent cancers.

We are likely to encounter patients who have been diagnosed with Lynch syndrome themselves or a family member may have been diagnosed. We may also encounter patients who are concerned about their family history of cancer. The diagnosis can be clinically suspected if the family history fulfils the Amsterdam 11 criteria.

Amsterdam 11 criteria - 3 or more relatives with a histologically verified Lynch syndrome associated cancer (one must be a first degree relative of the other 2) and cancer involving at least 2 generations and one or more cancers diagnosed under 50 years. Patients meeting these criteria should be referred to the genetics department.

It is thought that Amsterdam 11 may underestimate the risk of Lynch syndrome. If we as GPs have concerns, checking with the genetics department may be sensible.

NG151 recommends: Consider daily aspirin, to be taken for more than 2 years, to prevent colorectal cancer in people with Lynch syndrome. There is a useful decision support document NICE have developed – **click here** to access the document.

What impact has the Covid pandemic had on cancer referrals?

It has been widely reported that during the pandemic cancer services have been adversely affected. Locally there has been a lot of work to ensure that referral pathways remain open, and patients have access to all treatments.

During the early part of the pandemic the number of fast-track referrals fell significantly (in some areas this was reported to be up to 60%) with the concern that more cancers would be diagnosed at a later stage. Following the first 'lockdown' the referrals in the Wessex Cancer Alliance area recovered more quickly than in other areas.

In the week ending 28th April 2019 there were 2,075 fast-track referrals in Dorset, Hampshire and the Isle of Wight. This can be compared to the week ending 25th April 2021 when there were 2,131 fast-track referrals. This would suggest that locally referrals have almost returned to the pre pandemic level.

Week ending Working day adjusted	25 Apr 21	28 Apr 19	18 Apr 21	% change from 28 Apr 19	% change from 18 Apr 21
Referrals seen	2,131	2,075	2,042	+3%	+4%
Breast	527	368	494	+43%	+7%
Gynae	157	156	167	+0%	-6%
Haem	6	8	7	-20%	-14%
Head&Neck	275	246	292	+12%	-6%
Lower GI	358	349	344	+3%	+4%
Lung	43	83	29	-48%	+48%
Skin	410	419	351	-2%	+17%
Upper GI	140	166	160	-16%	-13%
Urological	197	243	179	-19%	+10%
All others	18	39	19	-54%	-5%

This doesn't provide the whole picture and when you look at site specific cancers there is a somewhat different story to tell.

The key pathways with low referrals compared to previous years are:

- Lung
- Urology
- Upper GI

The pathway which has seen the largest increase in referrals is for breast. This has been observed in many Cancer Alliances and is not unique to Wessex. It is thought that the reason for this is multifactorial and includes women delaying presentation because of the Covid risk, all breast symptoms being referred via a fast-track pathway and a lack of other pathways relevant to this area.

In future Newsletters we will focus on some of these areas to try and understand the reason for the variation and where appropriate review the pathways and the criteria that is used to access these services.

Calling all men in black communities over the age of 45 to request a PSA test – with or without symptoms!

Wessex Cancer Alliance (WCA) is currently **Raising Prostate Cancer Awareness in Black Communities** by working closely with them, encouraging them to communicate with each other about Prostate cancer, to get a PSA test done if over 45 years of age and to see a Doctor if they have symptoms.

Please encourage and welcome your male patients over 45 years old from the Black Communities to have a PSA test and consider asking them about Urinary Tract symptoms when consulting for other reasons.

WHY?

Black men are 2 x more likely to get Prostate Cancer than white men.

Black men are 2.5 x as likely to die from it.

1 in 4 black men will get prostate cancer in their lifetime.

Black men are more likely to develop Prostate cancer at an early age.

The risk increases after the age of 45 years and with a father or brother with a history of Prostate cancer.

Black men quote a large and varied number of reasons for not seeking medical advice even when a family member has been affected, including a macho attitude toward health, an aversion to the Digital Rectal Examination and the feeling that GPs do not listen if they have no symptoms. (WCA is working to explore a consistent pathway approach that does not include DRE).

Remember also that:

1 in 7 men with a normal PSA may have prostate cancer.

1 in 50 of men with a normal PSA may have fast growing cancer.

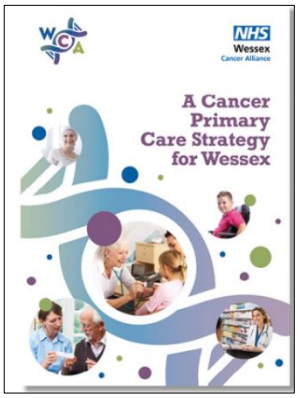
When investigating Erectile Dysfunction remember to include a PSA level.

The numbers are small in Wessex, so we do not expect the workload to be onerous for the potential gains by detecting Prostate cancer in this population earlier.

1 in 4 black men will get prostate cancer | Stronger Knowing More – this is an excellent video which is only 2 minutes long – **click here to view.**

News items

A Primary Care Strategy for Cancer in Wessex



In September 2020 it is estimated that there were 588,904 appointments with GPs and 611,464 appointments with other practice staff in Wessex. This does not cover the whole remit of Primary Care (which also includes community, pharmacy, dental and optometry services) but indicates the vast number of patients seen and opportunities presented for conveying key messages with these contacts.

'Our Cancer Plan for Wessex 2019-2024' sets out how Wessex will deliver the aspirations relating to cancer as laid out in the NHS Long Term Plan. The purpose of this strategy is to set out the priority areas for cancer in Primary Care and describe how these will be achieved, across Wessex.

Click here to access the strategy.

Action man

Wessex Cancer Trust has launched a men's health campaign called ActionMan. Funded by Action Hampshire, it will encourage men to be aware of the signs and symptoms of cancer and contact their GP if they have any concerns.

ActionMan has been launched in response to the results of a study carried out by a group of junior doctors in Hampshire. It found that 43% of men would feel discouraged from talking about worrying changes to their body for fear of 'making a fuss' and 23% would be too embarrassed.

To find out more – **click here.**

Iron deficiency anaemia (IDA) and coeliac screening

University Hospital Southampton (UHS) has asked us to highlight an issue which is happening with patients referred on a suspected cancer pathway for iron deficiency anaemia.

Quite often referrals are received without primary care requesting a coeliac screening blood test. This is leading to more patients having to have duodenal biopsies which in turn is putting pressure on the pathology lab. If UHS request coeliac screening at the hospital prior to endoscopy this delays the endoscopy.

UHS request that primary care does request coeliac screening as part of the investigations for IDA and to avoid delays in the pathway.

Wessex Cancer Matters

Your patients can find support near where they live. Click here for more information**.**

Cancer Matters Wessex has teamed up with Cancer Care Map to provide you with up-to-date information and support available to help your patients on their cancer journey, whether that is helping them to connect with a local support group or finding up to date information from a national charity. You can search for what you need under the categories or explore what's going on in your local area.

There is an excellent section related to clinical pathways with links to information about common cancers. The Cancer Alliance is aiming to produce some information for you to be able to use for your website to direct patients to relevant information, and also information for your practice waiting room screens when we return to seeing more patients in the surgery.

Cancer Care Maps

Cancer Care Map is a stand-alone, comprehensive, independent, free to use online directory of cancer support services in the UK providing verified and trusted information, regularly checked and updated and accessible to all.

They provide information on support for families, loved ones and carers as well as those living with cancer themselves and collaborate with organisations across the UK including charities, NHS services, private practice and support groups.

All information is checked and verified by their team.

Listings are updated every 3-6 months to ensure details are correct.

They signpost psychological and emotional support, health and wellbeing services, and practical help wherever you are in the UK.