NHS
Wessex
Cancer Alliance

FIT Cancer update

Dr Nicola Robinson and Mr Paul Nichols

Wednesday 23rd March 2022

CANCER RESEARCH UK
Together we will beat cancer

MACMILLAN CANCER SUPPORT

2022 Cancer Early Detection LIS

Requirements

- Identify a clinical and non clinical cancer lead and complete initial reporting
- Join this introductory webinar and mid point one
- Non clinical lead to act as conduit for sharing the Wessex Cancer Alliance Primary Care newsletter and other important cancer information or educational opportunities within their PCN
- Non clinical lead to work with clinical lead to share targeted messaging with their PCN population about cancer prevention and cancer signs and symptoms
- **Clinical lead to join FIT webinar and review use of FIT within the PCN, identify any areas for improvement and share this learning and plan**
- Clinical lead to join webinar on use of CDST. Trial use of these in the PCN and share reflections of this

Clinical cancer champion

Review the use of **FIT** in your PCN

- Join or access the 1 hour webinar (March) about colorectal cancer and the use of FIT in the pathway or complete the Gateway C e-learning module
- Identify areas for improvement across the PCN

Increase the use of **clinical decision support tools**

- Join or access the 1 hour webinar (May) showcasing clinical decision support tools
- Chose a CDS tool for use in your PCN
- Submit reflections of what has changed at end of agreement

Gateway C

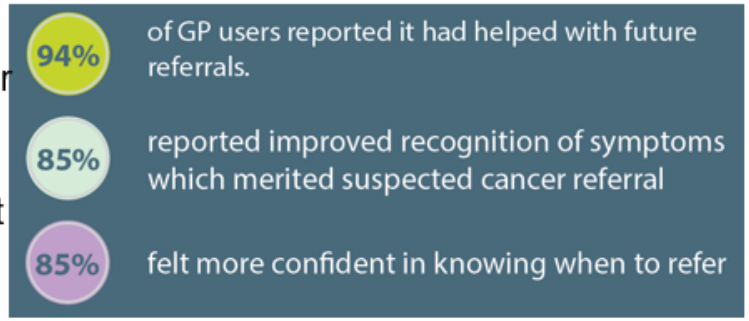
NHS Wessex Cancer Alliance

GatewayC

Online cancer education for primary care

GatewayC is designed to improve cancer outcomes by supporting earlier diagnosis and the patient experience through:

- Improved knowledge of symptoms
- Increased confidence in when/when not to refer
- Improved quality of suspected referrals, reducing delays in the system
- Improved communication to support patients at each stage of their cancer pathway



Register for free at www.gatewayc.org.uk

NHS Health Education England · MACMILLAN. CANCER SUPPORT · CANCER RESEARCH UK · The Christie School of Oncology · RCGP Royal College of General Practitioners

Cancer Matters Wessex

FIT

FIT Testing (the 3 uses)

- FIT is used in the BCSP

(invites patients aged 56 to 74 years)

- FIT is requested by a GP in patients:

<60yrs with changes in bowel habit or iron deficiency anaemia

< 50 yrs with unexplained abdominal pain or weight loss

- FIT is requested by a GP

(2WW referral, RIS or filter test at 2ary care)

What is a positive FIT test?

- BCSP, report is either negative or positive

(above/below **120ug/g in England**, 150ug Wales and 80ug Scotland)

- Diagnostic FIT test positive if >**10ug/g** in most areas (in some areas the result is positive if > 3ug/g)

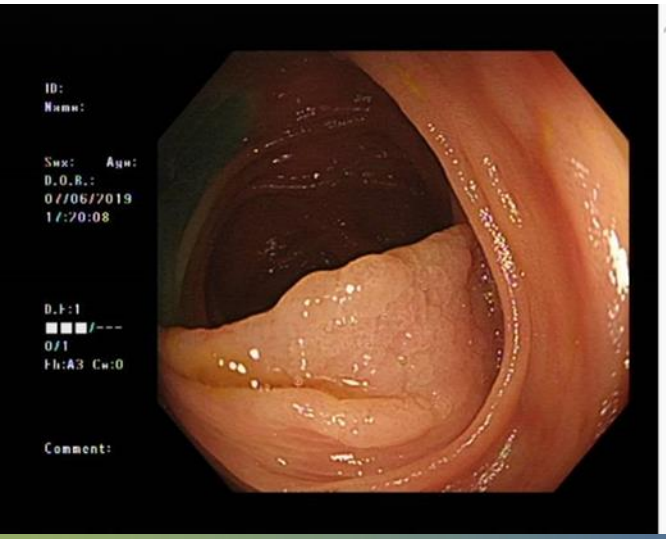
From April 2022 extra points…….

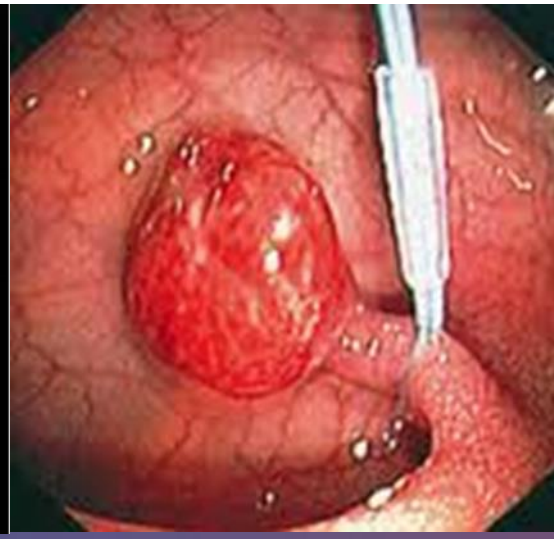
CAN-10: Percentage of lower gastrointestinal two week wait (fast track) cancer referrals accompanied by a faecal immunochemical test result, with the result recorded either in the seven days leading up to the referral, or in the fourteen days after the referral.

- UT: 80%
- LT:40% (22/23), 65% (23/24)
- 22 points

Earlier diagnosis…..

- Colorectal cancer is curable
- Most cancers develop in polyps and polyps can be removed at colonoscopy – before a cancer develops





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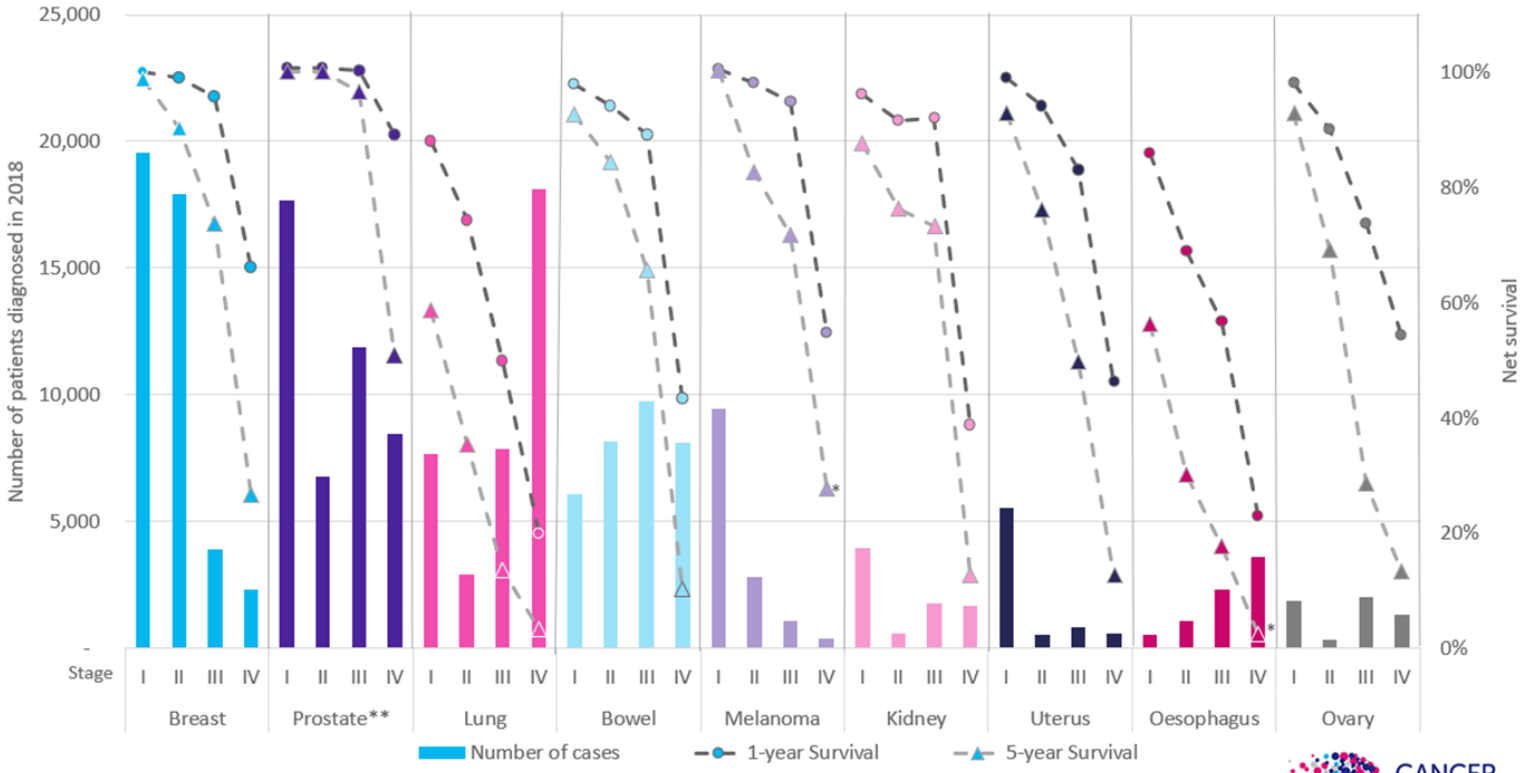
Incidence by stage (2018) with 1-year and 5-year age-standardised net survival by stage (patients diagnosed 2014-18, followed up to 2019), England



*Not age-standardised **5-yr survival estimates not provided for stages 1 & 2 but assumed to be around 100%

Produced by the CRUK Cancer Intelligence team using data from:
PHE, Cancer Survival in England for patients diagnosed between 2014 and 2018 - followed up to 2019. And PHE, Staging Data in England

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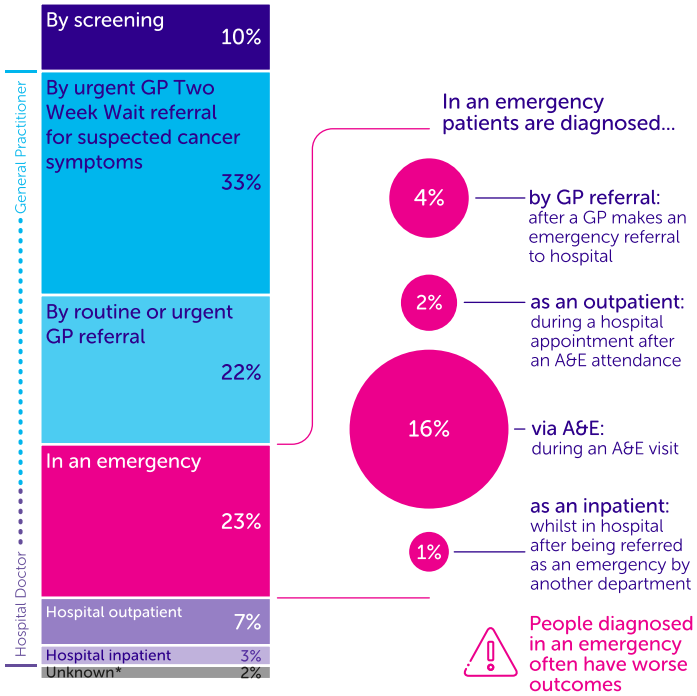
Cancer Matters Wessex

How bowel cancer patients are diagnosed

% of patients diagnosed in England in 2016



*Incomplete data

Source: Public Health England, Routes to Diagnosis 2006-2016 Workbook

cruk.org

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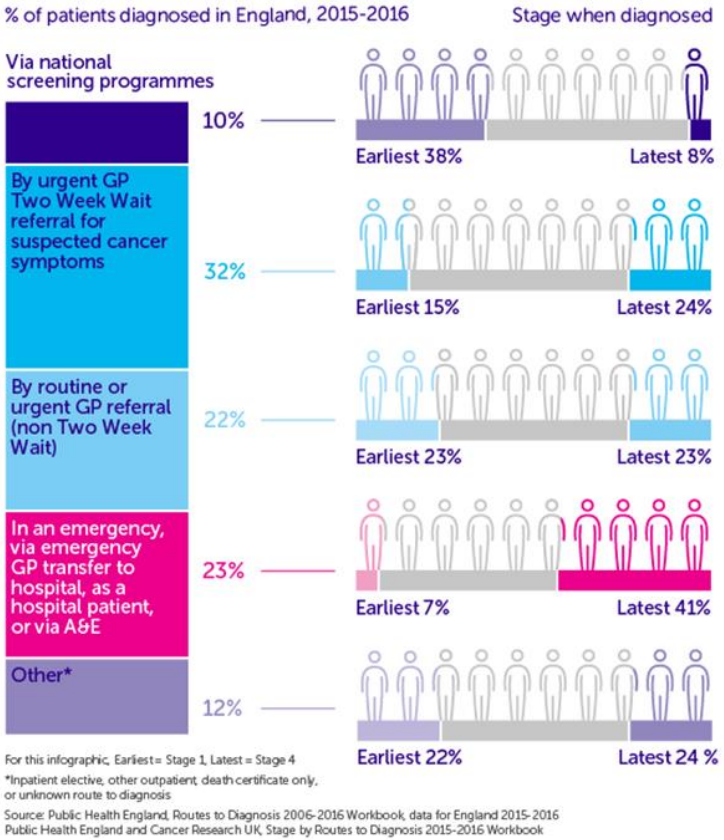
How and when bowel cancer patients are diagnosed



For this infographic, Earliest = Stage 1, Latest = Stage 4

*Inpatient elective, other outpatient, death certificate only, or unknown route to diagnosis

Source: Public Health England, Routes to Diagnosis 2006-2016 Workbook, data for England 2015-2016
Public Health England and Cancer Research UK, Stage by Routes to Diagnosis 2015-2016 Workbook

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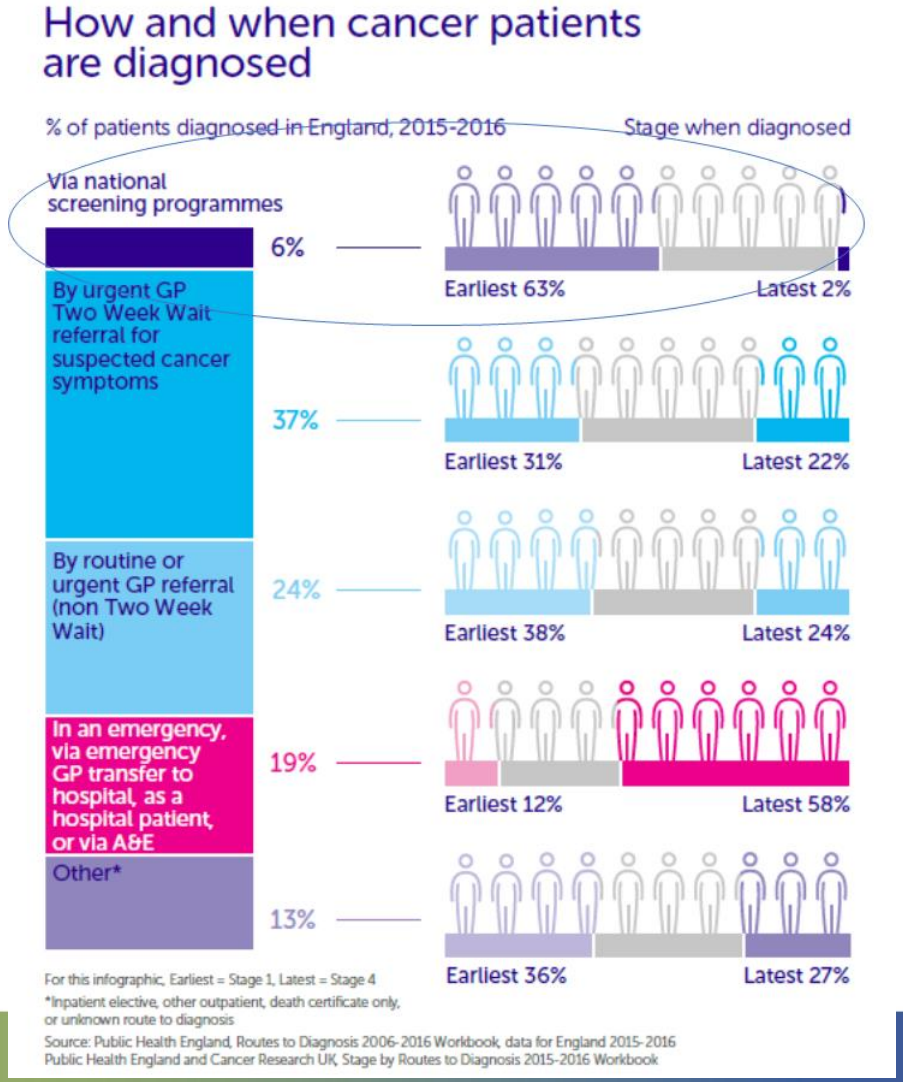
Why is screening important?



- **Screening reduces the number of people dying from cancer by:**
- **Detecting cancer early**
  - 63% of cancers detected through screening are at the earliest stage (stage I)
- **Preventing cancer**
  - Bowel and cervical screening can prevent cancer

How can we spot them?

- Red flags 2WW
- Emergency presentation
- Vague Symptoms
- Incidental findings e.g. low Hb
- High risk screening pick up
- Bowel Cancer Screening

Can FIT help?

- Higher the FIT test result, the greater the risk of bowel cancer including in those patients with rectal bleeding
- FIT test has both high sensitivity and specificity for bowel cancer
- Risk stratify patients with non-specific symptoms speeding up investigation
- Risk stratify in secondary care (highest risk patients are investigated most rapidly)

Bowel cancer screening

Cancer Matters Wessex

BCSP at the moment

- From 55th birthday every two years (dropping to age 50yr)
- Recall stops age 74yr
- Bowel scope stopped
- If missed, spoilt kit or wish to continue screening call: 0800 707 6060


Instructions on how to use your test kit
NHS
1
2
3
4
Write the date on the sample bottle in biro
Use a container or layers of toilet paper to catch your poo
Do not let your poo touch the toilet water
Twist cap to open the sample bottle
Collect sample by scraping the stick along the poo until all grooves are covered
We only need a little poo to test – please do not add extra!
Put the stick back in bottle and 'click' the cap to close it
Do not reopen the bottle after use
Please wash your hands after use
Make sure you have written the date on the sample bottle
Put the sample bottle in the return envelope supplied
Peel off the tape, seal the envelope and post.
Please post as soon as possible
please recycle this paper carton
please recycle the plastic tray
NHS
NHS


LOT
26AFB
2018-02
REF
63281
Date of Sample

….the future….

- Age of recall reducing
- Capture pts not invited through bowel scope
- Lynch Syndrome individuals to be added to BCSP – April 2023

- Role of primary care?
- BCSP invite letter
- Contact non-attenders
- Clarity that this is screening NOT for symptomatic

Why variation?

Deprivation

Men

BAME

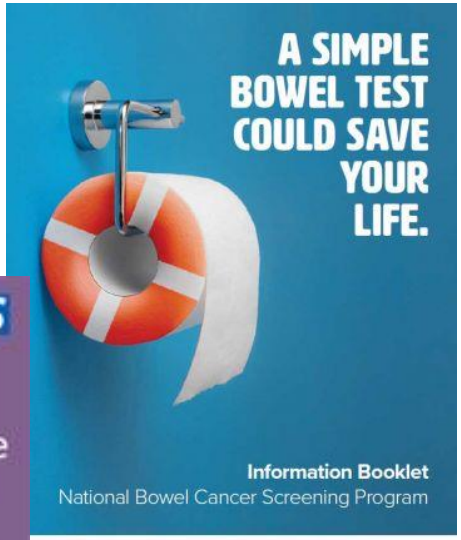
Role of primary care?

- Health checks e.g. LD
- Practice results
- Practice website, pt notes, reminders
- Targeted campaigns

Healthcare role….

- Primary care
  - Screening
  - Early diagnosis (access, investigations..)
- Secondary Care
  - Investigations
  - Treatment
- Motivational Interviewing
- Brief intervention

Information



Move your Butt

Lynn's bowel cancer campaign

Presentation

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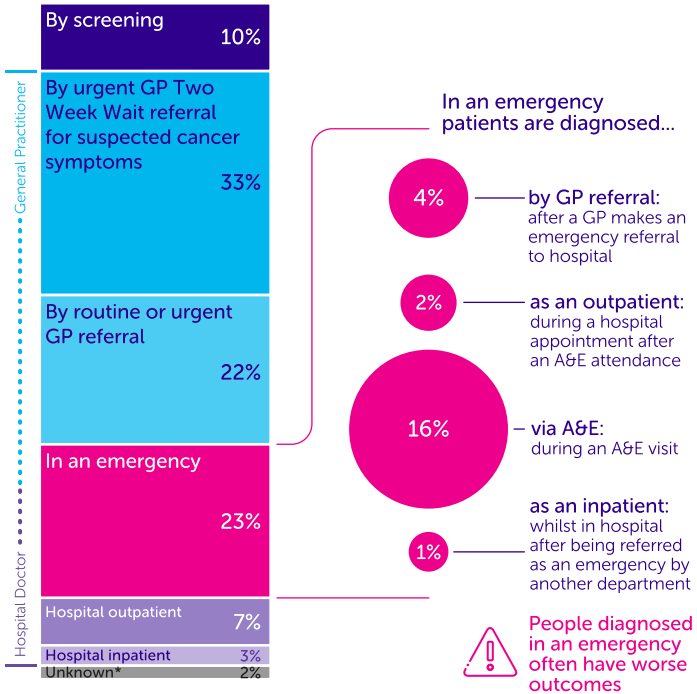
How bowel cancer patients are diagnosed

% of patients diagnosed in England in 2016



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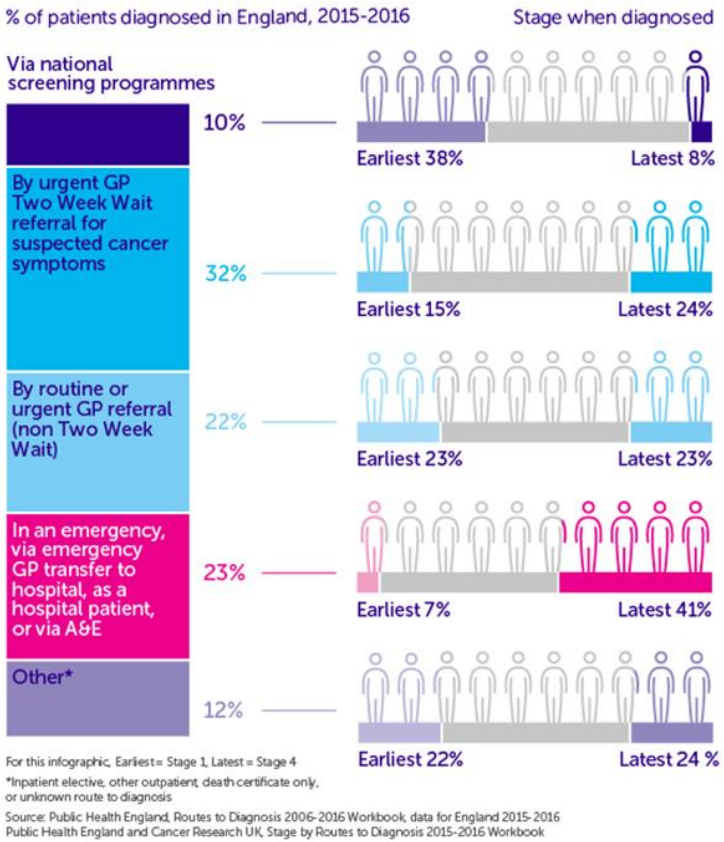
How and when bowel cancer patients are diagnosed



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Where CRCa is being diagnosed

Emergency presentation – obstruction, bleed

Bowel Cancer Screening

High risk screening pick up

Primary care :

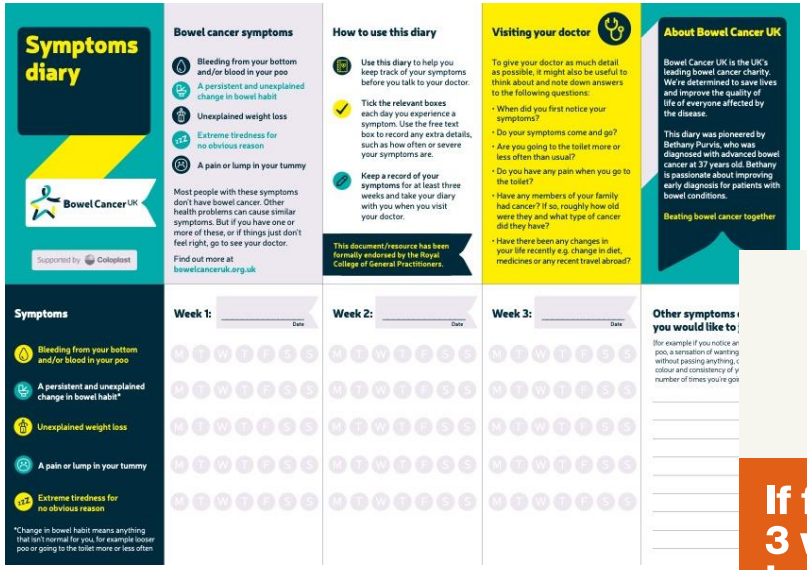
Vague symptoms

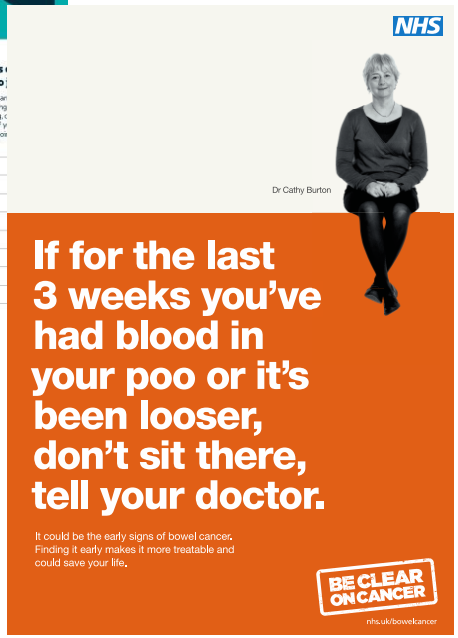
2WW referrals

Routine referrals

Campaigns….

Bowel Cancer UK





Red Flags

Anaemia….

The importance of anaemia in diagnosing colorectal cancer: a case–control study using electronic primary care records 2008

Age (years)	Annual incidence of colorectal cancer in this age group (%) (Cancer Research UK, 2003)	Haemoglobin (g dl^{-1})					
		<9.0	9.0–9.9	10.0–10.9	11.0–11.9	12.0–12.9	⩾13.0
30–59	0.026	1.3 (0.4, 4.3)	1.4 (0.2, 10)	0.8 (0.3, 2.2)	0.8 (0.2, 2.9)	0.2 (0.1, 0.3)	0.1 (0.1, 0.1)
60–69	0.19	7.6 (3.4, 16)	7.2 (2.9, 17)	2.3 (1.1, 4.8)	1.4 (0.9, 2.3)	0.7 (0.5, 1.0)	0.3 (0.3, 0.3)
70–79	0.35	8.8 (5.4, 14)	4.0 (2.5, 6.3)	3.2 (2.2, 4.8)	1.5 (1.2, 2.0)	1.0 (0.7, 1.2)	0.4 (0.3, 0.4)
⩾80	0.43	6.8 (4.2, 11)	6.0 (3.4, 10)	1.6 (1.1, 2.2)	1.0 (0.8, 1.4)	0.6 (0.5, 0.8)	0.4 (0.3, 0.5)

Abbreviation: PPV = positive predictive value.

NG12 (2015)

Refer on suspected cancer pathway if:

- Aged ≥40 with unexplained weight loss and abdominal pain.
- Aged ≥50 with unexplained rectal bleeding.
- Aged ≥60 with:
    - Iron deficiency anaemia (there is no threshold – any iron deficiency anaemia is sufficient).
    - Changes in bowel habit.

Positive faecal blood test taken under the circumstances recommended below.

- Consider suspected cancer pathway referral pathway if:
    - Rectal or abdominal mass.
    - <50y and rectal bleeding with any of the following unexplained symptoms or findings:
        - Abdominal pain.
        - Change in bowel habit.
        - Weight loss.
        - Iron deficiency anaemia.

- Offer faecal immunochemical testing to assess for colorectal cancer in people without rectal bleeding who have unexplained symptoms that could be suggestive of colorectal cancer, but who meet no other referral criteria.

2WW form…

Wessex Cancer Alliance

Suspected lower gastrointestinal tract cancer 2 week wait referral

Date of decision to refer: Date referral received at Trust:

Patient Details

Surname:	First Name:	Title:
Gender:	DOB: / /	NHS Number:
Ethnicity:	Language:	
Interpreter required:	Transport required:	
Patient Address:		
		Postcode:
Contact numbers:		
Home:	Mobile:	Email:

Practice Details

Usual GP Name:		
Practice Name :		
Practice Address:		Practice Code:
Direct line to the practice (Bypass):		
Main:	Fax:	Email:
Referring Clinician:		

SPECIFIC 2WW INFORMATION

Colorectal cancer

Aged ≥60yr with
- ☐ Iron deficiency anaemia or
- ☐ Change in bowel habit*

Aged <50y with rectal bleeding and any of
- ☐ Abdominal Pain
- ☐ Weight loss
- ☐ Change in bowel habit *
- ☐ Iron-deficiency anaemia

*Change in bowel habit is defined as "CHANGE TO LOOSE STOOLS &/or increased frequency of defecation" not constipation

Aged ≥50yr with
- ☐ Unexplained rectal bleeding

Aged ≥40yr with
- ☐ Unexplained weight loss and abdominal pain

At any age** with
- ☐ Abdominal or rectal mass (intraluminal not pelvic)

** FOB or alternative testing may be added in future

Anal Cancer

At any age with	☐	anal mass (unexplained)
	☐	anal ulceration (unexplained)

This pathway may involve the patient going straight to test (flexisigmoidoscopy, colonoscopy or colonography) and requiring an enema at home, please tick YES if any of the following apply to your patient:

Yes	
☐	Patient is not independently mobile or fit for colonoscopy
☐	Bleeding is bright, on paper/pan
☐	Bleeding is dark and mixed through stool
☐	Will not manage a home enema and getting to the clinic
☐	Is taking ACE inhibitors which cannot be omitted for 48 hours prior to procedure
☐	Has impaired renal function (please ensure recent eGFR, within 6 weeks)

Investigations

Please ensure the following recent blood results are available (less than 6 weeks old):
☐ **FBC** ☐ **Ferritin** ☐ **U&E**
(tumour markers are only indicated for disease monitoring, not diagnosis)

Anticoagulation and / or antiplatelet medication – please state indication and medication taken:
Please provide details and the latest INR if applicable:

Clinical Information

Further information:
(Clarification &/or further information provided will help ensure patients receive the most appropriate first line management; please include the following: significant & relevant medical history, smoking status, alcohol intake, co-morbidities, current medication and allergies) ***Please indicate if any previous bowel investigations, inflammatory bowel disease or family history of bowel cancer.***

WHO Performance Status (please circle)
- **0** Fully active
- **1** Restricted in physically strenuous activity but ambulatory and able to carry out light work
- **2** Ambulatory and capable of self-care, unable to carry out work activities, up & about 50% of waking hours
- **3** Capable of only limited self-care, confined to bed/chair 50% of waking hours
- **4** No self-care, confined to bed/chair 100%

☐ This case has been discussed with the secondary care clinical team, please specify with whom and when:

I confirm that I have:
- ☐ discussed the possibility that the diagnosis may be cancer
- ☐ discussed the 2 week wait (2WW) process with the patient
- ☐ provided the patient with the 2WW referral leaflet
- ☐ told the patient the appointment will be within the next two weeks, and attendance is advised

Please note any dates the patient is NOT available for an appointment in the next 2 weeks.

Fast track referral Information:

An administration team at the trust receives this referral. Based on the information you provide, some patients will go straight to diagnostics before they see a member of the clinical team. Providing information such as WHO performance and renal function will help decide if a endoscopy or further imaging could be tolerated or possible.

If your patient cannot attend in the next two weeks, please consider the timing of the referral, as the trust is obliged to offer an appointment within two weeks.

Useful websites: e-CDS Genetics and Family History Q-Cancer RAT

	Trust	Phone	FAX	Electronic
☐	Basingstoke	01256 486798	01256 313430	No
☐	Bournemouth	01202 704741	01202 704470	E – Referral
☐	Chichester	01903205111 ext 84997	01903 285098	Cancer.appointments@nhs.net
☐	Dorchester	01305 255849	01305 255646	E – Referral
☐	Frimley	01276 526400	01276 604506	No
☐	IoW	01983 534018	01983 552434	No
☐	Poole	01202 442823	01202 442824	E- Referral
☐	Portsmouth	023 9268 1700	023 9268 1701	No
☐	Royal Surrey	None	01483 464848	No
☐	Salisbury	01722 336262 ext 4235	(Do not accept faxes)	Shc-tr.salisbury-rapidreferralcentre@nhs.net
☐	Southampton	02381 201019	No	E- Referral
☐	Winchester	01962 828395	01962 825169	No

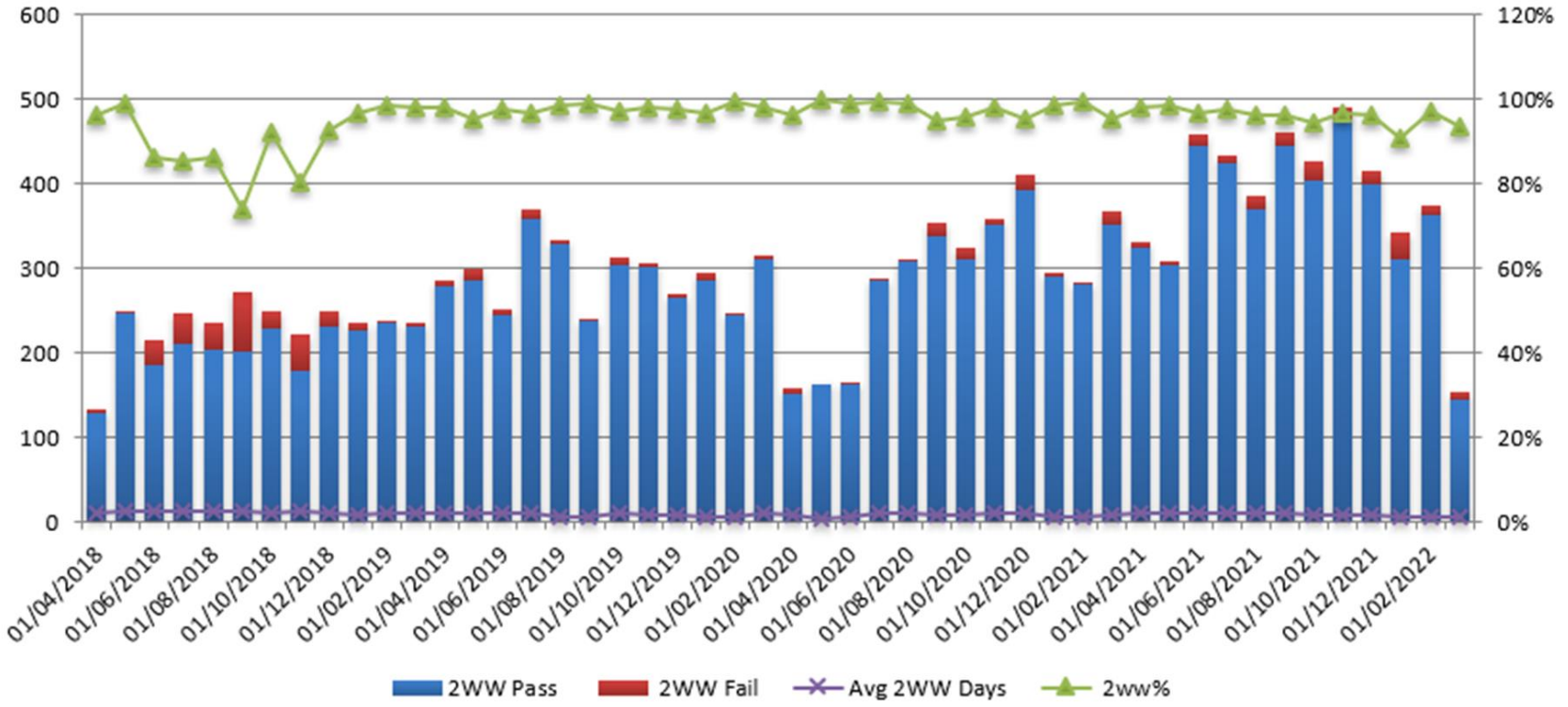
NG12 (2015)

- Based on primary care data and pulled in symptoms & signs
- Lowered threshold for referral

- DG30 – advice on use of FIT for symptomatic

- RAT/Q-cancer
- Under 50yr RAT

Activity in Southampton



Cancer Matters Wessex

Uses for Symptomatic FIT

- NICE DG30:
  - Aged 50 years and over with unexplained abdominal pain or weight loss
  - Aged under 60 years with changes in their bowel habit
  - Aged under 60 years with iron deficiency anaemia (consider IDA fast track referral in addition)
  - Aged 60 years and over and have anaemia – without iron deficiency
- 2WW referral
- Referring to the RIS
- Use in patients with rectal bleeding

So how good a test is FIT?

Thames Valley Cancer Alliance

FIT performance per 1,000 patients tested

CA125 (≥35 U/ml)

23% ovarian cancers missed

PSA

25% prostate cancers missed

CXR

20% lung cancers missed

FIT (≥10 ug/g)

10% colorectal cancers missed

SAFETY NET PATIENTS WITH NEGATIVE TESTS AND PERSISTENT SYMPTOMS

Thresholds and detection

Thames Valley Cancer Alliance

FIT performance per 1,000 patients tested

FIT Threshold (µg/g)	Positive FITs n (%)	Cancers detected n (%)	Positive FITs to detect one cancer "number needed to scope"	Negative FITs n (%)	Patients with cancer and a negative FIT "the cancer miss rate"
≥7	111 (11)	10 (91)	11	889 (89)	1
≥10	96 (10)	10 (91)	10	904 (90)	1
≥20	71 (7)	9 (85)	8	929 (93)	2
≥50	44 (4)	8 (74)	6	956 (96)	3
≥100	30 (3)	7 (61)	5	970 (97)	4
≥120	28 (3)	6 (57)	5	972 (97)	5
≥150	25 (2)	6 (54)	4	975 (98)	5

Case 1

66yr man

Normal BCSP in 2019

Ignored the 2021 kit

Getting more tired playing with grandchildren

Trying to lose weight as wife diagnosed with diabetes

What next?

Case 1…

Questions – bowels looser (diet improved), no blood

Investigations:

Bloods

Examination

Weight

FIT

Case 1…

- Hb 118 MCV 68
- Ferritin 27, CRP 6
- B12, Folate, Coeliac all neg

- FIT 77

- 2WW referral

Case 1 learning points

Reminder about BCSP – 2 yr recall

Pt can self diagnose symptoms as not being anything as previous normal BCSP

Wt loss – not always due to diet

Case 2

57 yr man

MI summer 2021, started on aspirin and prasugrel

6 months of looser bowels

2 months of fresh rectal bleeding

1 month of abdo pain

Wt stable

FH – mother CRCa aged 67y

Case 2…

Investigations…

Repeat bloods inc haematinics

Examination – proctoscope fleshy lesion

(?pile ?polyp)

FIT 167

Case 2…

Consider family history

2WW referral

Seen in clinic as concern about lower lesion

Colonoscopy

lesion was hemorrhagic pile

x2 polyps removed

Case 2 learning points

FIT in rectal bleeding

DRE – the importance of this

Medication affect on the bowel

Case 3

42yr old woman

General tiredness

Loose motions

Stressful job, working from home

Told IBS by previous practice – tried various OTC

Next steps…

Case 3…

Questions

Gynecology questions

Investigations:

Bloods

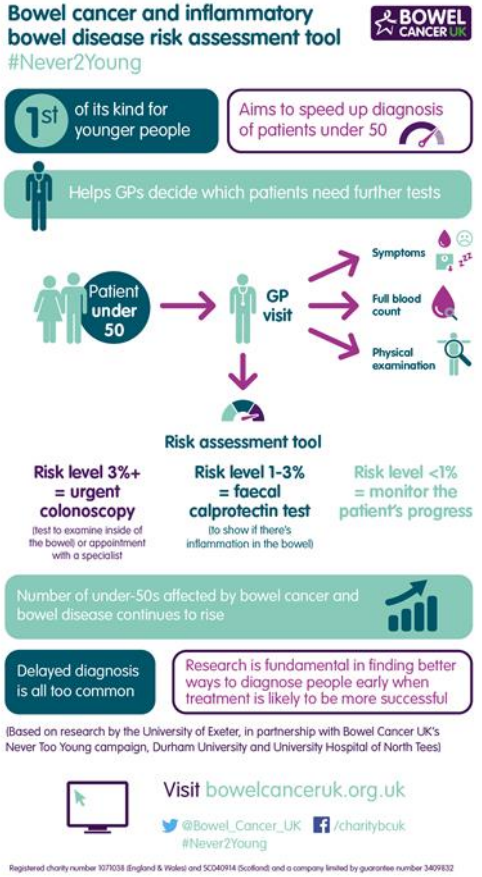
Examination

FIT

Calprotectin

….never too young…

Rectal bleeding	Change in bowel habit	Diarrhoea	Abdominal pain	Low mean red cell volume	Raised white cell count	Raised platelets	Abnormal liver function	Low haemoglobin	Raised inflammatory markers	
1.2 (1.1 to 1.4)	1.0 (0.8 to 1.3)	0.5 (0.5 to 0.6)	0.2 (0.2 to 0.2)	0.4 (0.3 to 0.4)	0.3 (0.3 to 0.3)	0.8 (0.7 to 0.9)	0.1 (0.1 to 0.1)	0.3 (0.3 to 0.3)	0.5 (0.5 to 0.6)	PPV as a single symptom
2.4 (1.9 to 3.2)	2.0 (0.9 to 4.4)	3.7 (2.2 to 6.3)	1.5 (1.1 to 2.2)	3.2 (1.3 to 7.4)	2.7 (1.3 to 5.3)	5.3 [-]	1.7 (1.0 to 2.7)	3.3 (1.7 to 6.2)	5.2 (2.9 to 9.1)	Rectal bleeding
	3.3 (1.6 to 6.9)	1.4 (0.8 to 2.5)	1.0 (0.6 to 1.6)	5.5 [-]	2.1 (-)	3.1 [-]	1.0 (0.5 to 1.9)	9.6 [-]	2.1 (1.1 to 3.9)	Change in bowel habit
		1.5 (1.2 to 1.9)	0.9 (0.7 to 1.1)	2.1 (1.3 to 3.5)	2.8 (1.9 to 4.2)	6.9 (3.7 to 13)	1.1 (0.8 to 1.5)	2.1 (1.5 to 3.1)	2.8 (2.0 to 3.7)	Diarrhoea
			0.4 (0.4 to 0.5)	1.0 (0.7 to 1.4)	0.7 (0.6 to 0.9)	2.7 (1.8 to 4.0)	0.3 (0.3 to 0.4)	0.8 (0.6 to 1.0)	1.2 (1.0 to 1.5)	Abdominal pain
					0.9 (0.7 to 1.3)	1.3 (1.0 to 1.8)	0.4 (0.3 to 0.6)	0.6 (0.5 to 0.7)	1.7 (1.2 to 2.3)	Low mean red cell volume
						1.3 (1.0 to 1.7)	0.4 (0.3 to 0.5)	0.5 (0.4 to 0.6)	1.0 (0.8 to 1.2)	Raised white cell count
							1.0 (0.7 to 1.4)	1.2 (0.9 to 1.5)	2.0 (1.5 to 2.6)	Raised platelets
								0.5 (0.4 to 0.6)	0.5 (0.4 to 0.6)	Abnormal liver function
									1.4 (1.1 to 1.7)	Low haemoglobin



42y
CIBH
Pain

Hb 110
Plt 434

Calprotectin
FIT

Rectal bleeding	Change in bowel habit	Diarrhoea	Abdominal pain	Low mean red cell volume	Raised white cell count	Raised platelets	Abnormal liver function	Low haemoglobin	Raised inflammatory markers	
1.2 (1.1 to 1.4)	1.0 (0.8 to 1.3)	0.5 (0.5 to 0.6)	0.2 (0.2 to 0.2)	0.4 (0.3 to 0.4)	0.3 (0.3 to 0.3)	0.8 (0.7 to 0.9)	0.1 (0.1 to 0.1)	0.3 (0.3 to 0.3)	0.5 (0.5 to 0.6)	PPV as a single symptom
2.4 (1.9 to 3.2)	2.0 (0.9 to 4.4)	3.7 (2.2 to 6.3)	1.5 (1.1 to 2.2)	3.2 (1.3 to 7.4)	2.7 (1.3 to 5.3)	5.3 (-)	1.7 (1.0 to 2.7)	3.3 (1.7 to 6.2)	5.2 (2.9 to 9.1)	Rectal bleeding
	3.3 (1.6 to 6.9)	1.4 (0.8 to 2.5)	1.0 (0.6 to 1.6)	5.5 (-)	2.1 (-)	3.1 (-)	1.0 (0.5 to 1.9)	9.6 (-)	2.1 (1.1 to 3.9)	Change in bowel habit
		1.5 (1.2 to 1.9)	0.9 (0.7 to 1.1)	2.1 (1.3 to 3.5)	2.8 (1.9 to 4.2)	6.9 (3.7 to 13)	1.1 (0.8 to 1.5)	2.1 (1.5 to 3.1)	2.8 (2.0 to 3.7)	Diarrhoea
			0.4 (0.4 to 0.5)	1.0 (0.7 to 1.4)	0.7 (0.6 to 0.9)	2.7 (1.8 to 4.0)	0.3 (0.3 to 0.4)	0.8 (0.6 to 1.0)	1.2 (1.0 to 1.5)	Abdominal pain
					0.9 (0.7 to 1.3)	1.3 (1.0 to 1.8)	0.4 (0.3 to 0.6)	0.6 (0.5 to 0.7)	1.7 (1.2 to 2.3)	Low mean red cell volume
						1.3 (1.0 to 1.7)	0.4 (0.3 to 0.5)	0.5 (0.4 to 0.6)	1.0 (0.8 to 1.2)	Raised white cell count
							1.0 (0.7 to 1.4)	1.2 (0.9 to 1.5)	2.0 (1.5 to 2.6)	Raised platelets
								0.5 (0.4 to 0.6)	0.5 (0.4 to 0.6)	Abnormal liver function
									1.4 (1.1 to 1.7)	Low haemoglobin

Under 50s

- Bowel cancer incidence rates have remained stable overall in some broad adult age groups in females and males combined in the UK since the early 1990s, but have increased or decreased in others
- **Rates in 25-49s have increased by 39%,** in 50-59s have remained stable, in 60-74s have decreased by 5%, in 75-79s have remained stable, and in 80+s have remained stable.

Case 3…

- DRE & proctoscope
- Routine referral
- Lower rectal cancer – stage 4

Case 3 learning points

FIT in rectal bleeding

Don’t assume a diagnosis of IBS is correct

Gut feeling

Case 4

- 84 yr old man
- Previous pancreatic Ca
- Bowels a bit looser
- Borderline Hb (long standing)
- Negative FIT

Case 4…

- Re-examine
- Repeat bloods
- Repeat FIT – positive at 37

Case 4 learning points

- **Safety net** and review
- Referred and lower rectal Ca

Role of FIT

FIT

Screening level 120ug/grm

Symptomatic 10ug/grm

- unexplained symptoms
- low but not no risk
- ineligible for urgent referral
- rectal bleeding
- request on 2WW referrals – why?

Questions…

Easy read leaflets

FIT when bleeding?

Why do 2ary care need a DRE if they are going to see them?

Can I do a FIT sample from a DRE finger?

Why are there two local thresholds?

Coding

April 2022 extra points…

CAN-10: Percentage of lower gastrointestinal two week wait (fast track) cancer referrals accompanied by a faecal immunochemical test result, with the result recorded either in the seven days leading up to the referral, or in the fourteen days after the referral.

- UT: 80%
- LT:40% (22/23), 65% (23/24)
- 22 points

Coding

Ardens code 4791 when FIT requested on tick box.

Awaiting codes from NHSE –

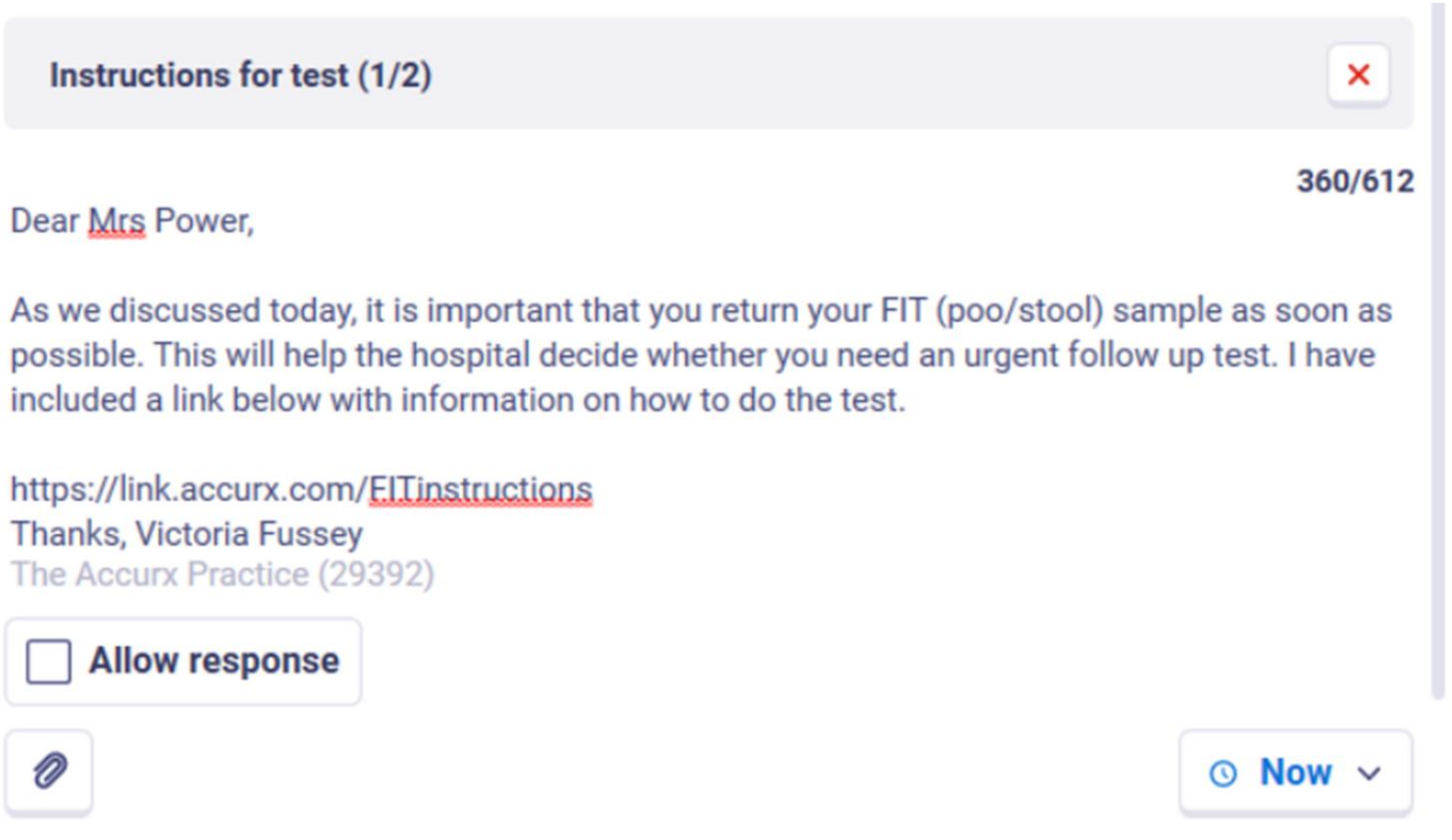
4791 / 167666002 (SNOMED) – faecal occult blood test requested

XaEgU / 104435004 (SNOMED) – faecal occult blood screening

Information will be shared once it comes through

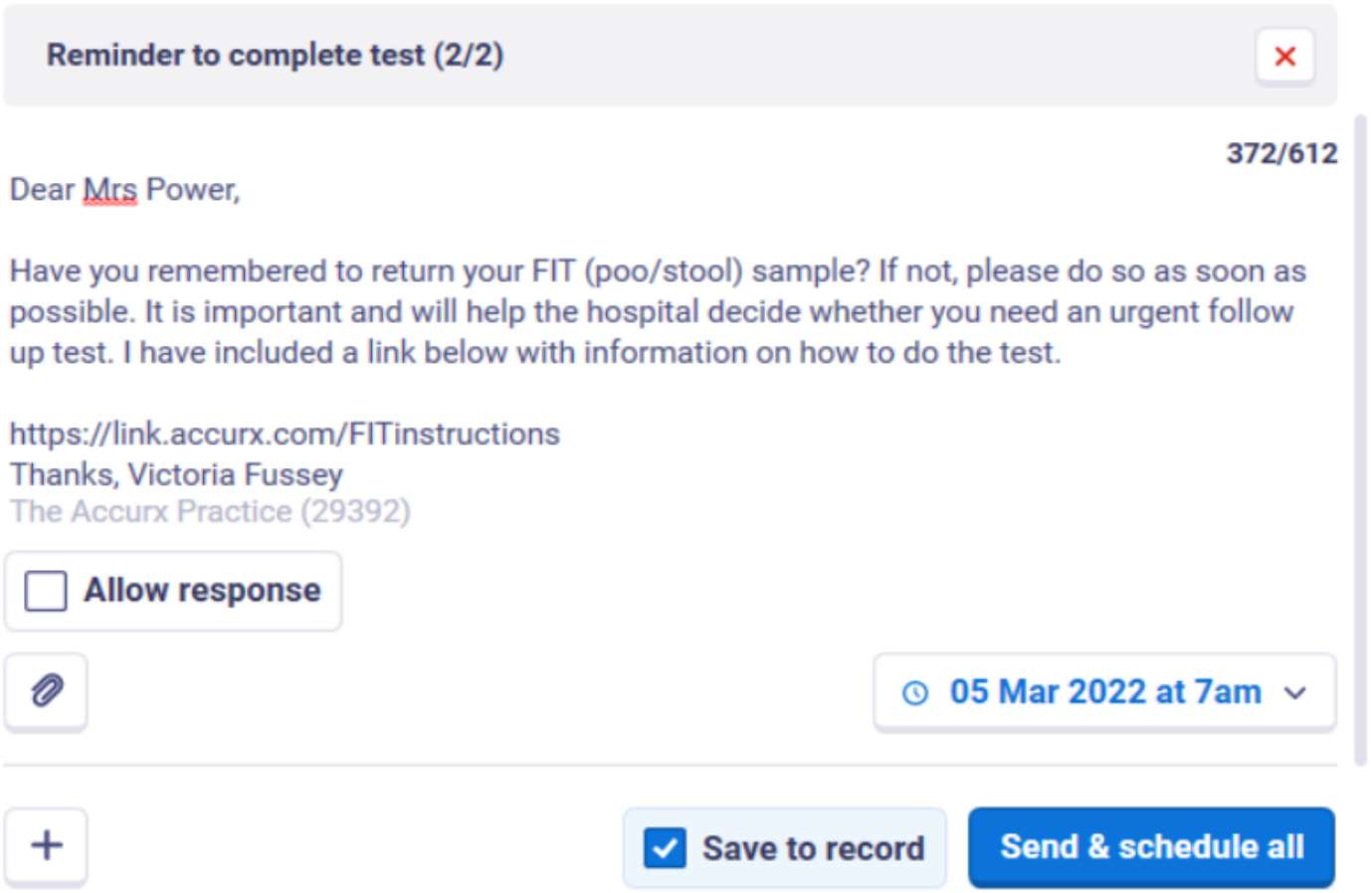
https://support.accurx.com/en/articles/6022435-fit-sample-reminder-pathway

AccuRx



Cancer Matters Wessex

AccuRx



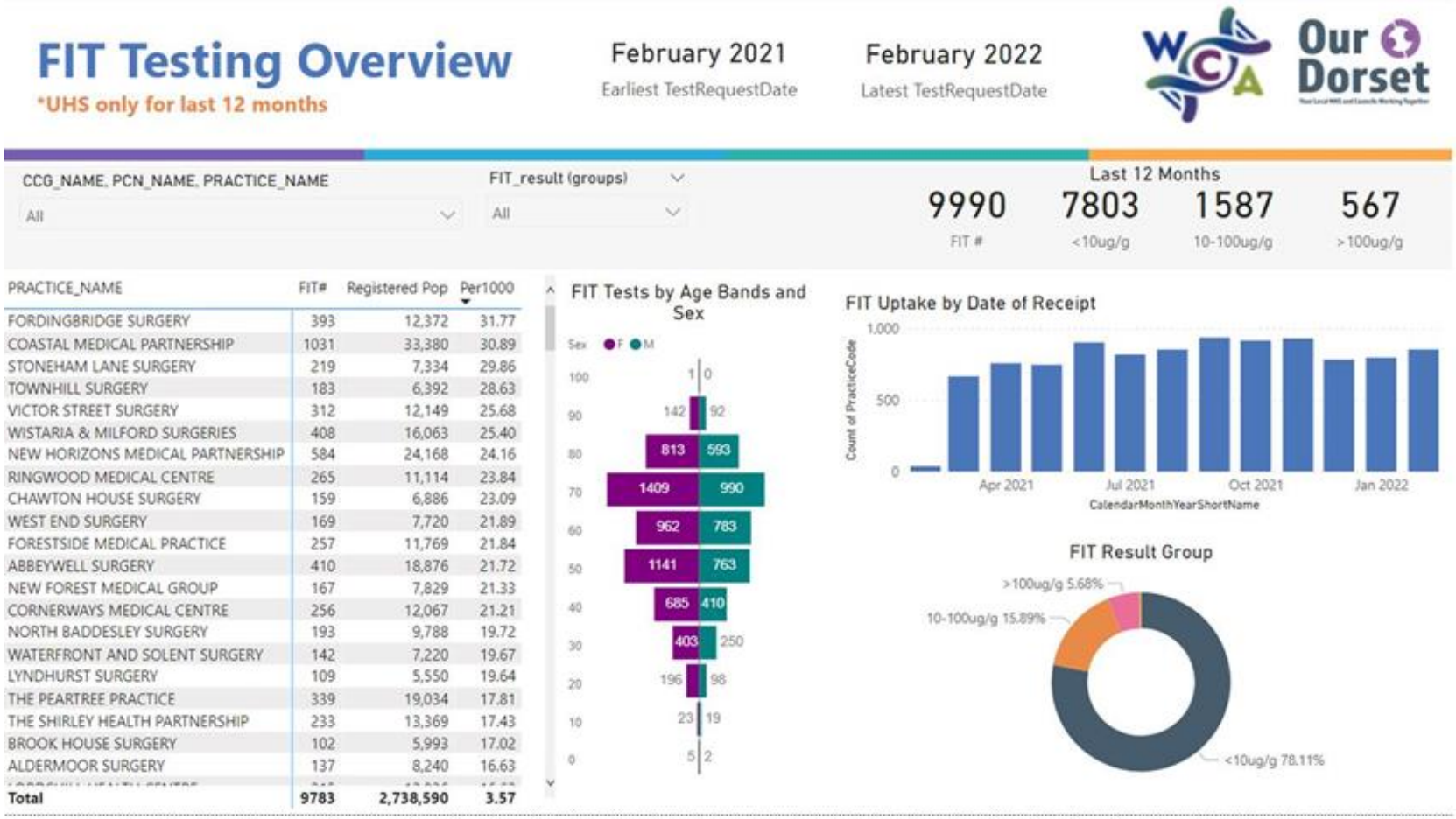
Cancer Matters Wessex

Safety netting

- Recall of FIT kits not returned
- Negative FIT results – what action?
- Positive FIT results, system to follow up?

- Should a FIT be repeated?
  - Studies at the moment
  - Clinical decision based on symptoms
  - X2 Negative FITs

Wessex FIT Dashboard Coming soon!



Cancer Matters Wessex

Take home messages

- Use FIT more
- Follow guidelines on use and use with GI symptoms
- Review safety net at the practice for patients with vague symptoms, negative FIT
- Review and develop FIT admin
- Know where the kits are, how to explain use and what needs to go back to the lab to ensure processed (labelled and form)

Questions