Dorset Cancer Update Part 1

Dr Debs Rose, Wessex Cancer Alliance Macmillan GP

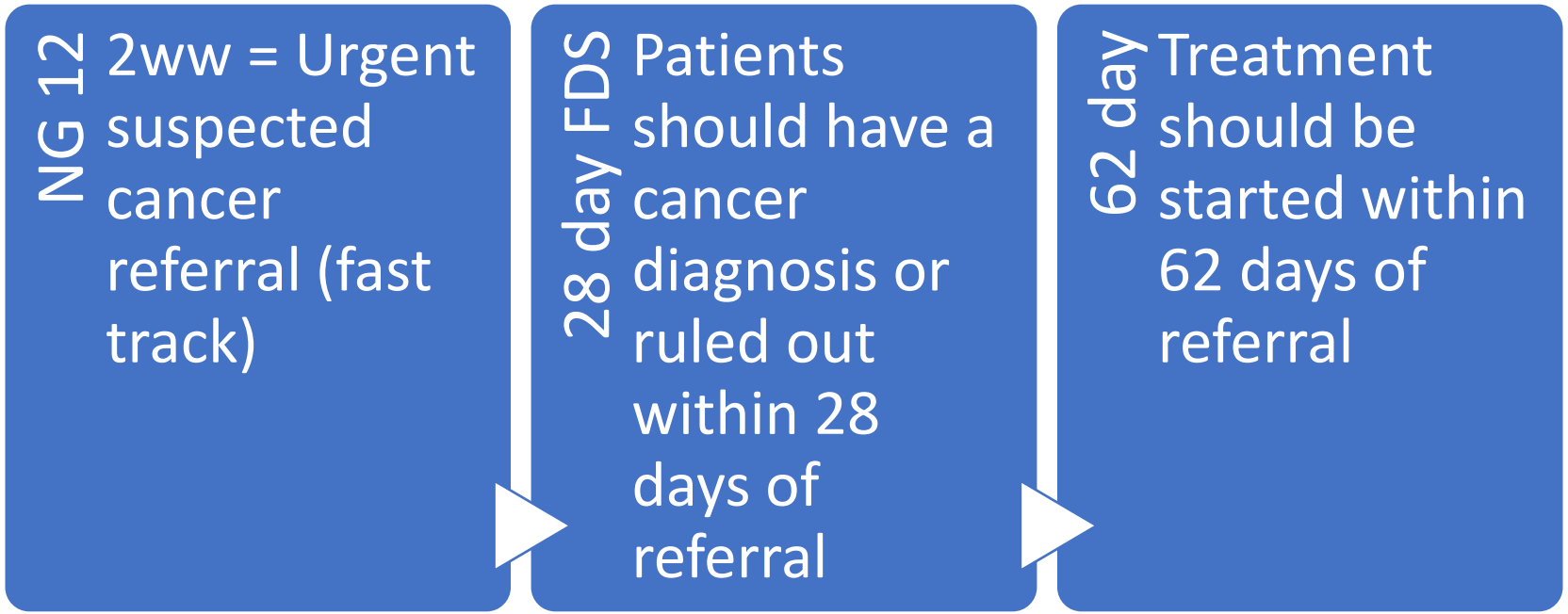
Dr Sarah Arthur, Wessex Cancer Alliance Macmillan GP

- Faster Diagnosis standard
- Lower GI referrals
- Unscheduled bleeding on HRT Pilot
- Lung Cancer and Targeted Lung Health checks
- Urgent Suspected Cancer (2ww) referral form changes
- GP Direct Access

NHS Wessex Cancer Alliance

NHS Dorset

Faster Diagnosis Standard



Provide your patient with written information on what to expect from Cancer Matters Wessex website
https://cancermatterswessex.nhs.uk/fast-track-referrals/

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Lower GI Referrals

- Updated NICE guidance August 2023.
- Jan 2024, FIT < 10 referral pathway discontinued.
- Lower GI Symptoms Decision Flow Chart for Wessex updated.
- Small update due – repeat FIT testing.

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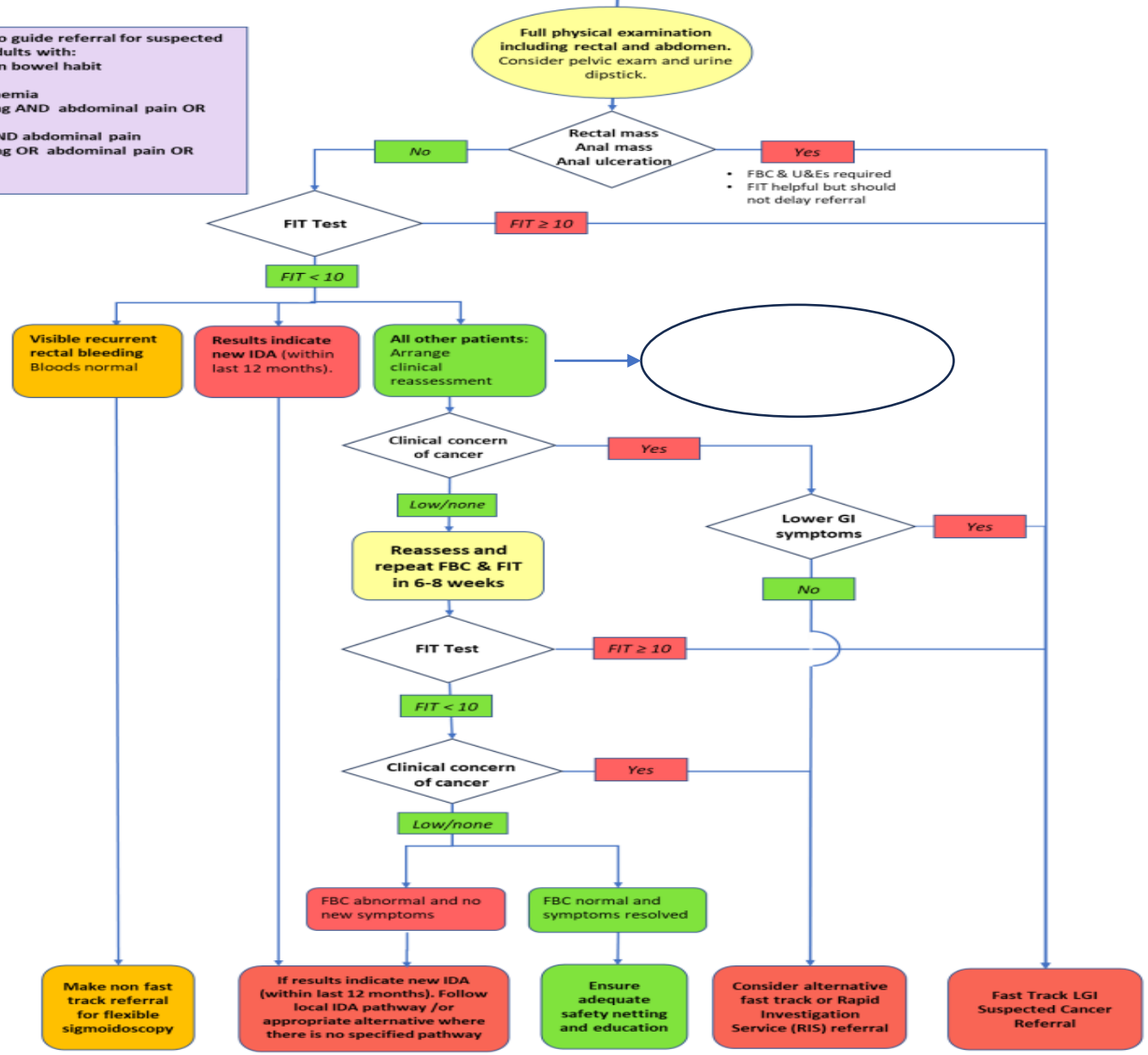
Assessment including history of: change in bowel habit, rectal bleeding, unexplained weight loss, abdominal pain, family history, performance status.
Suggested Bloods FBC, U&Es, Iron studies, Ferritin, CRP, Coeliac screen, Clotting screen & any others indicated e.g. CA125, PSA, LFTs, HbA1c

FIT is recommended to guide referral for suspected colorectal cancer in adults with:

- **Persistent change in bowel habit**
- **Abdominal mass**
- **Iron Deficiency Anaemia**
- **<50y Rectal bleeding AND abdominal pain OR weight loss**
- **≥40y weight loss AND abdominal pain**
- **≥ 50y rectal bleeding OR abdominal pain OR weight loss**
- **≥ 60y any anaemia**



- **A FIT test result ≥ 10 is the most important indication that your patient may have cancer, and applies in cases of rectal bleeding (please ask patients to sample stool where there is no visible blood)**
- **Use Advice and Guidance through secondary care for any clinical queries.**
- **Iron Deficiency Anaemia (IDA) pathways vary across local trusts, ensure the patient is fully investigated**
- **FIT is a very good tool to exclude colorectal cancer, two FIT<10 and normal FBC risk of CRCa <0.04%. BUT no test is perfect, ensure to review/ safety net and if clinical concern remains always refer.**

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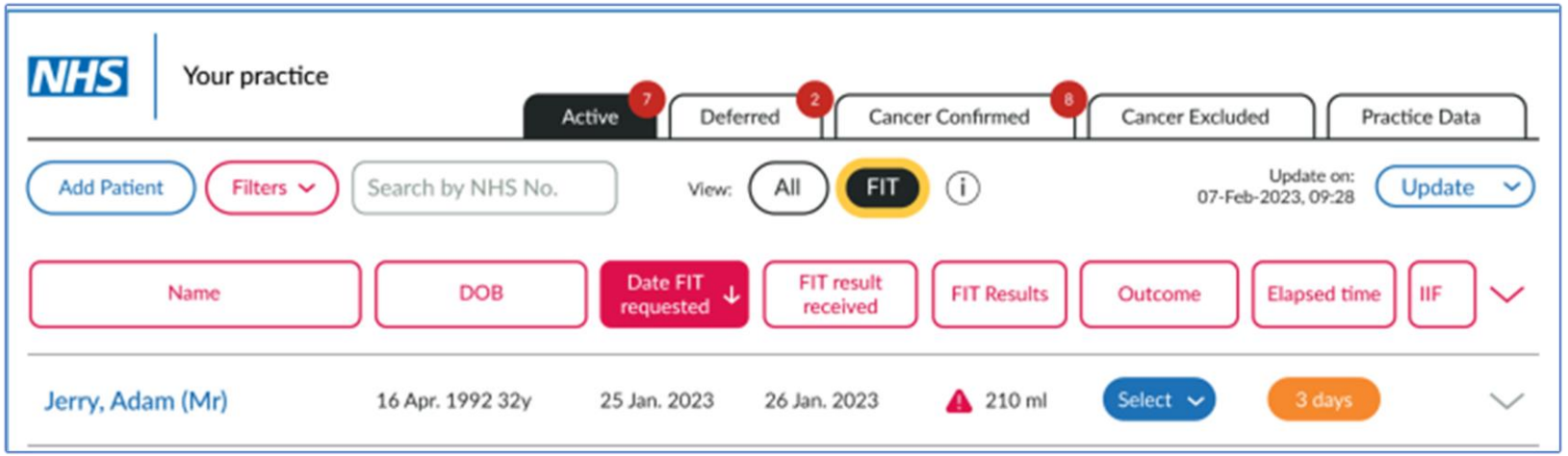
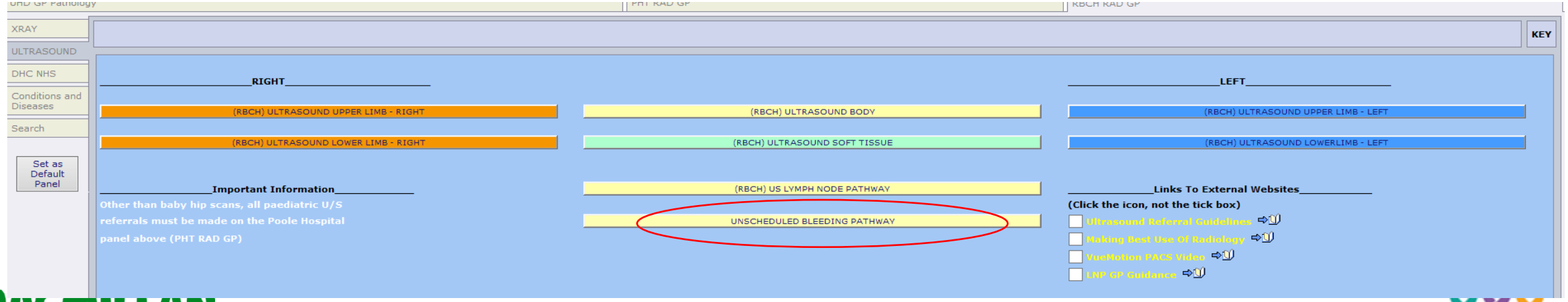
Lower GI Referrals

- C the Signs
  - Access to the referral form and LGI symptoms decision flow chart
  - FIT safety netting Dashboard



Unscheduled Bleeding on HRT Pilot

- University Hospitals Dorset (UHD) gynaecology pilot
- Hoping to come to Dorset County Hospital
- UHD ICE ultrasound page - see image below
- Link to flow chart and advice can be found on ICE
- Also, link is on C The Signs USC gynae referral page



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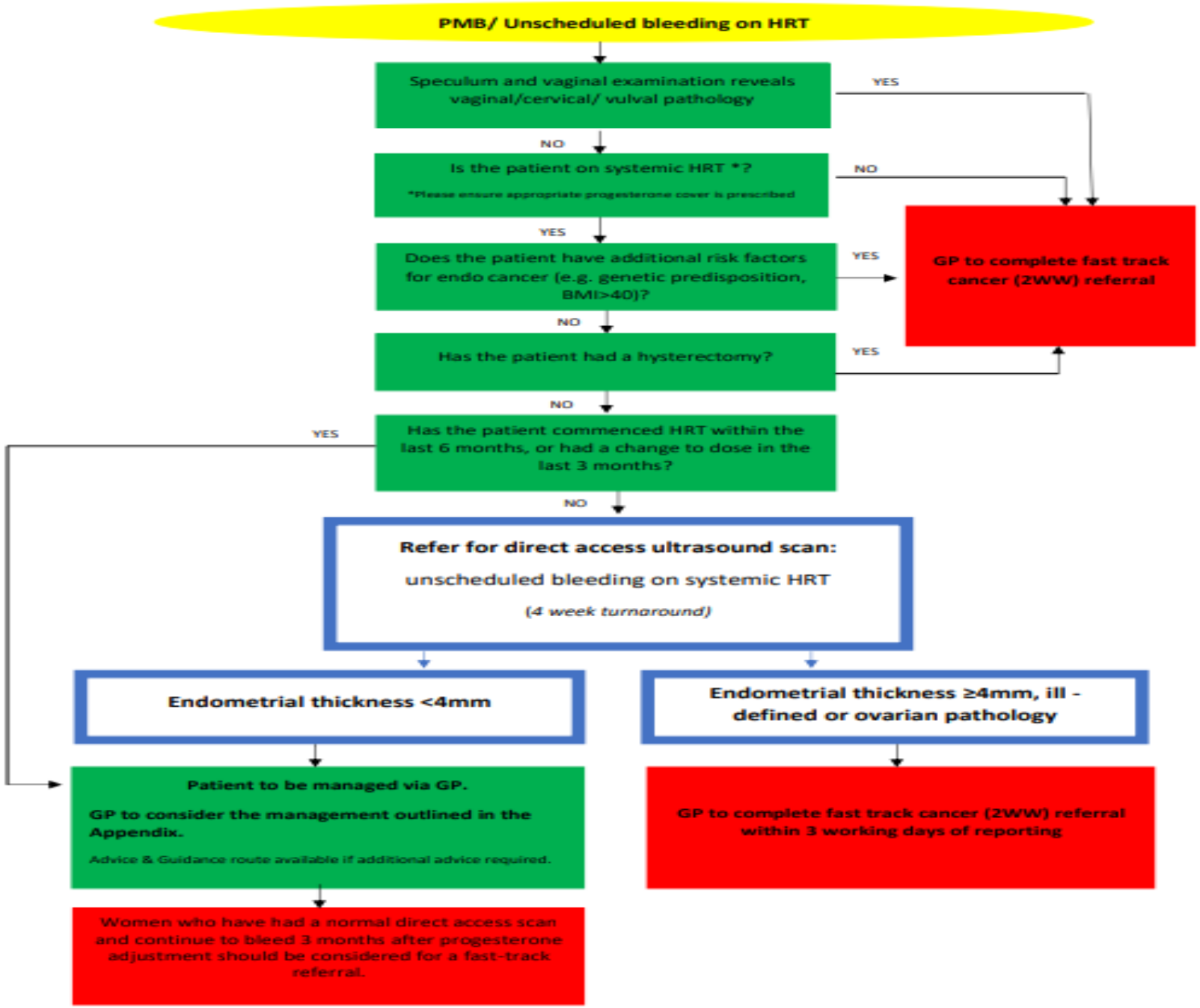
Unscheduled bleeding on systemic HRT- GP direct access ultrasound pathway



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Last updated November 2023

Appendix: HRT guidance for GPs

For advice on HRT preparations and equivalent doses please see following link to the British Menopause Society:

www.Thebms.org.uk/publications/tools-for-clinicians

GP to consider the following management:

- If on sequential HRT regimens, consider increasing dose of progesterone to 300mg micronised progesterone (Utrogestan), or switch to a different progesterone, or increase duration of progesterone intake (can take progestogen for 14 days a month or for 21 days out of a 28-day HRT intake cycle)
- If on continuous combined HRT regimens, consider increasing the dose of progestogen (e.g. increase micronised progesterone daily dose from 100mg to 200mg daily on a continuous basis), particular when combined with higher dose estrogenic regimens or raised BMI
- For continuous HRT regimens in a combined preparation or have the levonorgestrel intrauterine system consider adding micronised progesterone/ medroxyprogesterone acetate or norethisterone
- If breakthrough bleeding occurs after 3 to 6 months after switching from sequential to continuous HRT they can be switched back to sequential for at least one year
- Unscheduled bleeding is higher with transdermal preparations than oral preparations
- If evidence of urogenital atrophy (despite those on systemic HRT) consider vaginal oestrogens

Consider scan if heavy bleeding (flooding) or persistent (almost daily) bleeding arises within 6 months of initiation of HRT, or within 3 months of change in dose/ preparation. Adjustments to comorbidities and progestogen dose should be considered prior to referral to scan and whilst awaiting ultrasound scan.

Consider Advice & Guidance route if additional advice required.

Progestogen in HRT recommended doses

Micronised progesterone
200mg PO 12 days/cycle (cyclical)
100mg PO daily (continuous combined)
Preparations: Utrogestan 100mg PO

Dydrogesterone
10mg for 12-14 days a month (cyclical)
5mg a day (continuous combined)
2.5mg a day (low dose continuous combined)

Medroxyprogesterone acetate (MPA)
10mg for 12 days a month (cyclical)
2.5mg a day (continuous combined)

Norethisterone
5mg for 12 days a month (cyclical)
0.5-1mg a day (continuous combined)

Levonorgestrel IUS
Licensed for 4 years in the UK

Vaginal oestrogen preparations for vaginal atrophy

Intravaginal cream
Ovestin (1 mg estriol in 1 gram cream) - insert one applicatorful daily for a maximum of 4 weeks, reducing to one applicatorful twice a week)

Vaginal tablets
Vagifem vaginal tablets (estradiol 10 micrograms) - insert one vaginal tablet daily for 2 weeks then reduce to one vaginal tablet twice a week.

Vaginal gel
Blissel® (50 micrograms estriol in 1 gram vaginal gel) -insert one applicator dose daily for 3 weeks, reducing to one applicator dose twice a week. Reassess after 12 weeks.

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Lung cancer and Targeted Lung Health Checks

Without lung health checks, **3/4 of people are diagnosed with lung cancer late** due to there often being no signs or symptoms at an early stage.

- **Ex-smokers and current smokers 55-74yrs**
- **If high risk of lung cancer > low dose CT scan of chest**
- Refer on USC form if suspicious symptoms **even if they are due to be seen by** the TLHC programme
- Also:
  - **CXR 23% false negative**> refer with normal CXR if still concerned about cancer
  - Consider lung cancer if **new raised platelets** (LEGO-C)
  - Safety net CXR/FBC results and review patients with ongoing symptoms
  - C The Signs risk assessment (vague symptoms) and dashboard (safetynetting)

Urgent GP Direct Access to diagnostic services

- For people with symptoms not meeting the threshold for an urgent suspected cancer referral
- Over 20% of cancer diagnoses are made in people referred for investigation on non-urgent pathways – symptoms not indicative of significant risk of cancer
- Aims are to:
  - Reduce the time to diagnosis
  - Reduce the number of attendances before investigations are requested
- Other areas- early adopters- going well
- Dorset, CT abdo – improve pancreatic cancer detection, MRI brain later.

Urgent suspected cancer referral forms

- Previously 2 week wait - all changed due to FDS (faster diagnosis standard)
- C The Signs- whole of Dorset can access any changes immediately, all forms made more consistent in appearance to aid completion
- Essential information sections coming soon.
- Forms updated in the last year:
  - Gynae/lower GI/Skin
  - Thyroid- one main tick box-for easier referrals
  - Lung- tick box to show have requested a CXR if referring for haemoptysis
  - Paeds-telephone paeds, they decide next steps, useful information added

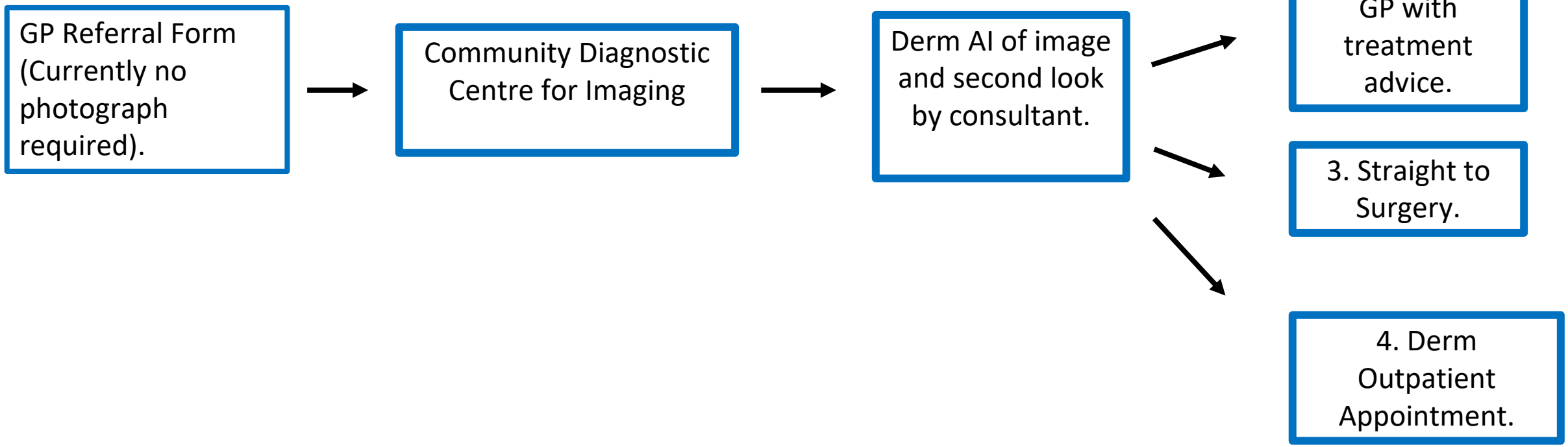
Dorset Cancer Update Part 2

Dr Debs Rose, Wessex Cancer Alliance Macmillan GP
Dr Sarah Arthur, Wessex Cancer Alliance Macmillan GP

- Urgent Suspected Skin Cancer Pathway Pilot
- Multi-Cancer Blood Test
- Cytosponge
- Genomics/Lynch
- Admin and Reception Guide to Cancer

Urgent Suspected Skin Cancer Pathway Pilot

Teledermatology Pilot



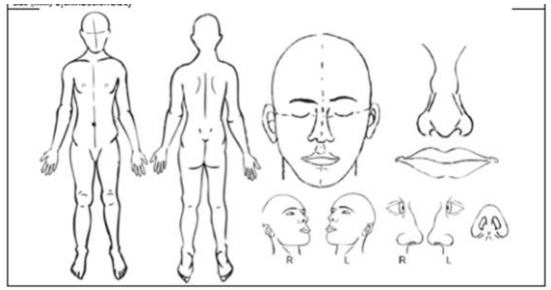
NHS Wessex Cancer Alliance

Urgent Suspected Skin Cancer Referral Form

NHS Dorset

Please complete to allow Trust to identify suitability for patient to go straight to photography (Teledermatology)
Can the lesion(s) be clearly seen and identified, photographed and accessed by a dermatoscope? ☐ Yes ☐ No
Does the lesion have a thick crust that cannot be removed? ☐ Yes ☐ No
More than two suspected skin cancers? ☐ Yes ☐ No
Does the lesion require redressing by a health professional? ☐ Yes ☐ No
Is the lesion on the patient's genitals? ☐ Yes ☐ No
Is the patient able to mobilise safely (with any personal walking aids) and manage their toilet needs? ☐ Yes ☐ No
Does the patient require transport? ☐ Yes ☐ No

SPECIFIC URGENT SUSPECTED CANCER REFERRAL INFORMATION		
Melanoma	**Squamous Cell Carcinoma**	**High Risk Basal Cell Carcinoma**
Suspicious lesion scoring ≥ 3 on the weighted list (please mark)	☐ Lesion is suspicious of a squamous cell carcinoma.	☐ Concerning site or size (i.e. periocular involvement)



PATIENT INFORMATION	
☐	I have informed the patient they have symptoms/lesions which may be caused by skin cancer, that they are being referred to the rapid access suspected cancer clinic, and the nature of the tests likely to take place.
☐	The patient has been provided with a cancer pathway leaflet
☐	The patient is aware and able to attend an outpatient appointment within the next two weeks
☐	I have informed my patient that if they are suitable for the Teledermatology pathway they will attend to have their lesion photographed, following which a Consultant Dermatologist will review their images and the patient will be informed of any next steps by post or telephone.
☐	My patient is aware that they will be offered the first available appointment at any one of our hospitals or community diagnostic centres

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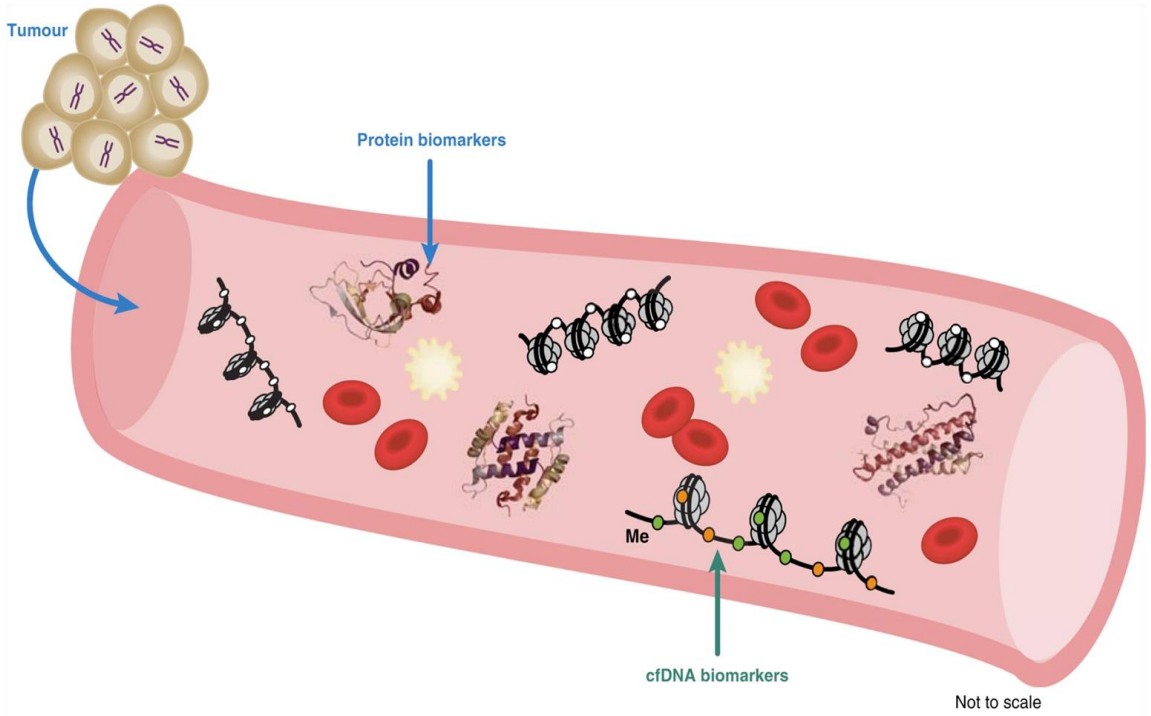
Multi-Cancer Blood Tests

- Also referred to as **GRAIL / GALLERI**
- Tumours shed tumour cells, proteins and cell-free DNA into the blood.
- Multi-cancer blood tests look for these biological substances in a blood sample.
- Looks for a “Cancer Signal”, predicting the top 1 or 2 organs/tissue sites
- Screening individuals for any cancer, instead of screening for individual cancers.
- Complement existing screening approaches.



Cytosponge

- Capsule swallowed > sponge released > gently pulled out > cells collected > analysed > if concerning changes > urgent endoscopy.
- Pilot at Wareham Surgery, The Adam Practice, Shore Medical and Wimborne Hospital on behalf of UHD
- Two categories of patients:

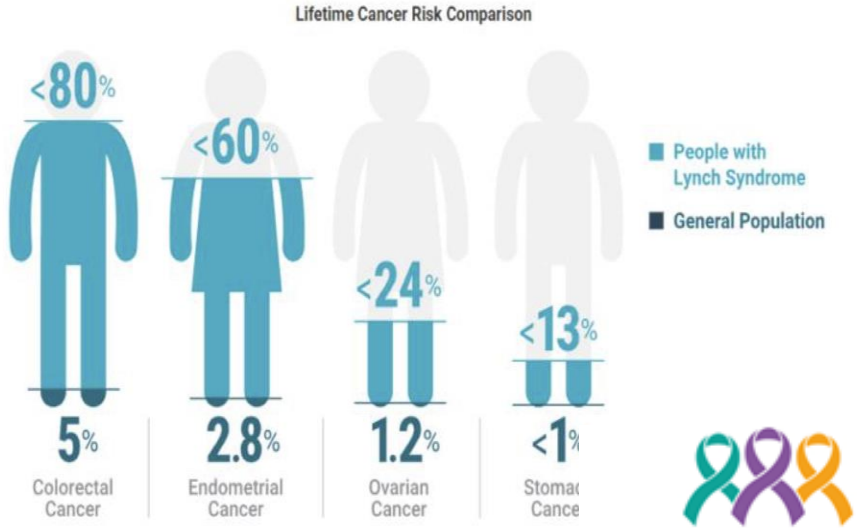
  -patients with known Barrett's oesophagus

  -patients with repeat prescriptions of PPI and no previous endoscopy

Lynch Syndrome

- Inherited genetic condition, increases the risk of cancer
- Mainly colorectal and endometrial significantly higher risk than general population
- Also: ovarian, stomach, small intestine, pancreas, hepatobiliary. urinary (ureter, bladder), prostate, skin, CNS- glioblastoma, sarcoma
- 95% of people with this condition **do not know they have it** (possibly 190,000 people)
- How primary care can help:
  - **Code it** in problem list
  - Follow RM (Royal Marsden) advice for primary care & patient leaflet- links below
  - **Low threshold to investigate and refer** – think other cancers…..

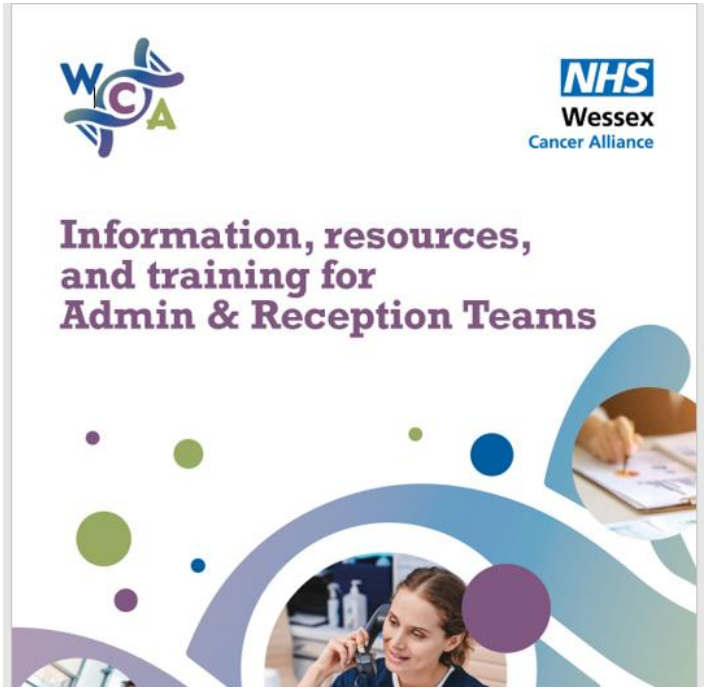
- Lynch Syndrome online training for primary care clinicians - RM Partners
- A beginner's guide to Lynch Syndrome | Royal Marsden Patient Information Library



Coming to Dorset soon:
WCA Admin & Reception Guide

Admin and reception teams have many skills that can be utilised to support cancer patients and improve standards of care in a GP Practice and PCN. This guide covers:

- Prevention & early diagnosis
- Screening
- Urgent Cancer Referrals
- Cancer treatments
- Red Flags
- Palliative/End of Life Care
- Cancer Care-Coordinators
- and much more…..



https://wessexcanceralliance.nhs.uk/resources-for-administrators/

Resources

- Wessex Cancer Alliance Primary Care Toolkit -

  Primary Care Toolkit - Welcome to Wessex Cancer Alliance

- Cancer Matters Wessex website -

  Welcome to Cancer Matters Wessex - Cancer Matters Wessex

- C the Signs resources - C the Signs Dorset resource hub
- Wessex Cancer Alliance Newsletters/Bulletin- contact WCA to sign up
- Wessex Cancer Alliance Lunch and Learn – recordings on WCA toolkit
- Dorset Network Contract DES support pack/reporting template – this will be sent out with the conference slides
- Gateway C, Cancer Research UK, Macmillan