General Principles

Patients’ and carers’ needs
• All healthcare professionals should be sensitive to the needs of patients, carers and relatives when cancer is suspected

Good practice includes:
• being sensitive to the patient’s wishes to be involved in decisions about their care
• providing understandable information at a level appropriate to the patient’s wishes to be informed
• providing information about any referral to other services in a variety of formats, whether to secondary or tertiary care, including how long they might have to wait, who they are likely to see, and what is likely to happen to them
• considering carefully the need for physical and emotional support while awaiting an appointment with a specialist
• considering any carer’s needs for support and information, taking issues of confidentiality into consideration
• taking the individual’s particular circumstances into account, for example, age, family, work and culture
• being aware of, and offering to provide access to, sources of information in various formats
• maintaining a high standard of communication skills, including, for example, in the process of breaking bad news
The Quick Reference Guide has been produced by the Scottish Referral Guidelines Steering Group in conjunction with specialist guidelines groups, with support from NHS Healthcare Improvement Scotland and the Scottish Government.

The Guide is based on the Scottish Referral Guidelines for Suspected Cancer, a copy of which is available at http://tinyurl.com/kfxjznh

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

Breast Cancer

Oesophago-Gastric, Hepatobiliary and Pancreatic Cancers

Urological Cancers

Skin Cancers

Brain/Central Nervous System Tumours

Children, Teenagers and Young Adult Cancers

Lung Cancer

Lower Gastrointestinal Cancer

Gynaecological Cancers

Haematological Cancer

Head and Neck Cancers

Sarcomas and Bone Cancers

Malignant Spinal Cord Compression
Breast Cancer

Urgent suspicion of cancer referral

Lump
- Any new discrete lump (in patients over 35 years)
- New asymmetrical nodularity that persists at review after menstruation (in patients over 35 years)
- Unilateral isolated axillary lymph node in women
- Cyst persistently refilling or recurrent cyst

Nipple symptoms
- Bloodstained discharge
- New nipple retraction
- Nipple eczema if unresponsive to topical steroids (such as 1% hydrocortisone) after a minimum of 2 weeks

Skin changes
- Skin tethering
- Fixation
- Ulceration
- Peau d’orange

Abscess/infection
- Mastitis or breast inflammation which does not settle with single dose of antibiotics
Oesophago-Gastric, Hepatobiliary and Pancreatic Cancers

Urgent suspicion of cancer referral

Oesophago-gastric cancer

• Dysphagia (interference of the swallowing mechanism that occurs within 5 seconds of the swallowing process) or odynophagia (pain on swallowing) at any age
• New onset upper gastrointestinal pain or discomfort in people over 55 years
• New or worsening upper gastrointestinal pain or discomfort combined with one or more of the following features:
  • unexplained weight loss
  • unexplained iron deficiency anaemia
• Persistent vomiting more than 4 weeks
• Upper gastrointestinal pain or discomfort combined with one of following risk factors:
  • family history of oesophago-gastric cancer in more than two first-degree relatives
  • family history of familial adenomatous polyposis in any first-degree relative
  • Barrett’s oesophagus
  • pernicious anaemia
  • gastric surgery over 20 years ago
  • known dysplasia, atrophic gastritis or intestinal metaplasia

Hepatobiliary and pancreatic cancer

• Features of hepatobiliary or pancreatic cancer can be vague and non-specific, and may include:
  • unexplained obstructive jaundice
  • upper abdominal or epigastric mass
  • unexplained back pain (consider other cancer causes such as malignant spinal cord compression)
  • unexplained weight loss
  • any suspicious abnormality, in the hepatobiliary tract, found on imaging (such as biliary dilatation or pancreatic/liver lesion)
• There should be a low threshold for considering investigation (perhaps with discussion about appropriate imaging with a radiologist) or routine referral for patients presenting with:
  • late onset diabetes in a weight-losing patient
  • non responsive dyspepsia following initial test and treat
  • post prandial pain or early satiety
  • new onset irritable bowel syndrome symptoms in middle age
  • steatorrhoea or fat malabsorption
Urological Cancers

Urgent suspicion of cancer referral

Prostate cancer
• Evidence from digital rectal examination of a hard, irregular prostate
• Elevated or rising age-specific PSA. Rough guide to normal PSA levels:
  • men less than 60 years – less than 3ng/ml
  • men aged 60–69 years – less than 4ng/ml
  • men aged 70 years and over – less than 5ng/ml

Bladder and kidney cancer
• Patients with painless visible haematuria
• Patients with visible haematuria and symptoms suggestive of UTI but with sterile MSU
• Abdominal mass identified clinically or on imaging that is thought to arise from the urinary tract

Testicular and penile cancer
• Swelling in body of 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 penis or painful phimosis
Skin Cancer

Urgent suspicion of cancer referral

- Lesions on any part of the body which have one or more of the following features:
  - change in colour, shape or size of an existing mole
  - moles with Asymmetry, Border irregularity, Colour irregularity, Diameter increasing or >6mm
  - new growing nodule with or without pigment
  - persistent (more than 4 weeks) ulceration, bleeding or oozing
  - persistent (more than 4 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 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
Brain and Central Nervous System Cancers

**Urgent suspicion of cancer referral**

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

**Change in behaviour**
- Progressive deterioration in cognitive, psychological, behavioural and higher executive functions, in the absence of previously diagnosed or suspected alternative disorders (such as dementia or multiple sclerosis)

**Seizure**
- Any new seizure
- Seizures characterised by one or more of the following:
  - focal seizures
  - significant post-ictal focal deficit (excluding confusion)
  - epilepsy presenting as status epilepticus
  - associated inter-ictal focal deficit
  - associated preceding persistent headache of recent onset
  - seizure frequency accelerating over weeks or months

**Headache**
- Patients with headache, vomiting and/or papilloedema

**Consider urgent investigation/referral for**
- patients with non-migrainous headaches of recent onset, when accompanied by features suggestive of raised intra cranial pressure (for example, woken by headache; vomiting; drowsiness), progressive neurological deficit or new seizure disorder

Many health boards have pathways which allow GPs access to CT or MRI.
Children, Teenagers and Young Adult Cancers

Urgent suspicion of cancer referral

Emergency Referral

Any new signs of neurological dysfunction

General recommendations

• Refer any patient with repeat presentations (3 or more times) of any physical symptoms which do not appear to be resolving or following a normal pattern, taking into account parental and patient concern

• Changes in behaviour patterns and deteriorating school performance can be signs of serious illness, including CNS tumours so this warrants neurological assessment. Persisting unexplained changes should prompt paediatric referral. Where there are concomitant neurological findings this should be urgent

Specific recommendations

• Unexplained petechiae or purpura:
  • always an indication for urgent investigation

• Unexplained fatigue

• Any new persistent unexplained pain, particularly back pain or nocturnal pain

• Unexplained abdominal mass or distension

• 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 >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
  • worse in morning or causing early wakening or
  • associated with vomiting, squint or any neurological signs

• Soft tissue mass if:
  • shows rapid or progressive growth
  • size >2cms 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
  • change in pupillary red reflex to absent or white
Lung Cancer

Urgent chest x-ray

• Any haemoptysis
• Unexplained/persistent (more than 3 weeks):
  • change in cough
  • dyspnoea
  • chest/shoulder pain
  • weight loss
  • chest signs
  • hoarseness
  • fatigue in smoker aged over 50 years
• New or not previously documented finger clubbing
• Features suggestive of metastatic disease
• Cervical and/or persistent supraclavicular lymphadenopathy

Any person who has been referred for an urgent chest X-ray and it shows consolidation should have a repeat chest X-ray no more than 6 weeks later to confirm resolution.

Urgent suspicion of cancer referral

• Any symptoms or signs detailed above, persisting for more than 6 weeks despite normal chest X-ray
• Chest X-ray suggestive/suspicious of lung cancer (including pleural effusion, pleural mass and slowly resolving consolidation)
• Persistent haemoptysis in smokers/ex-smokers over 50 years of age

Urgent suspicion of mesothelioma referral

• Individuals over 50 years with history of asbestos exposure and recent onset of:
  • chest pain
  • dyspnoea
  • unexplained systemic symptoms

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

Urgent suspicion of cancer referral

High risk features

• Bleeding:
  • Repeated rectal bleeding without an obvious anal cause
  • Any blood mixed with the stool

• Bowel Habit:
  • Persistent change in bowel habit especially to looser stools (more than 4 weeks)

• Mass:
  • Right-sided abdominal mass
  • Palpable rectal mass

• Iron deficiency anaemia:
  • Unexplained iron deficiency anaemia

• Other:
  • Past history of lower gastrointestinal cancer with any of the symptoms above

Good practice points

• An abdominal and rectal examination and a full blood count should be performed on all patients with symptoms suggestive of colorectal cancer. These findings can facilitate appropriate triage in secondary care. A negative rectal examination, or a recent negative faecal occult blood result, should not rule out the need to refer. The carcinogenic embryonic antigen (CEA) test should not be used as a screening tool

• Guidance for referral to regional genetics centres for those with a family history of colorectal cancer is available at www.sehd.scot.nhs.uk/mels/HDL2001_24Guide.pdf. In patients with ulcerative colitis, a plan for follow up should be agreed
Gynaecological Cancers

• 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

Urgent suspicion of cancer referral

Ovarian cancer
• Abnormal ultrasound scan and/or CA125 level
• Ascites and/or ultrasound-confirmed pelvic 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 4 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 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 on examination
• Vulval bleeding due to ulceration

Vaginal cancer
• Any suspicious abnormality of the vagina on speculum examination
Haematological Cancer

Urgent suspicion of cancer referral

• Blood count/film reported as suggestive of acute leukaemia or chronic myeloid leukaemia
• Lymphadenopathy (>2cm) persisting for 6 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)

Good practice points

• For patients presenting with these non-specific symptoms, the GP should always consider checking the human immunodeficiency virus (HIV) status along with other routine investigations
• Routine tests and investigations should be repeated at least once if a patient’s condition remains unexplained
• If myeloma is suspected, urine as well as serum electrophoresis should be performed
Head and Neck Cancers

Emergency referral
• Stridor

Urgent suspicion of cancer referral

Head and neck cancer
• Persistent unexplained head and neck lumps >3 weeks
• Ulceration or unexplained swelling of the oral mucosa persisting for >3 weeks
• All red or mixed red and white patches of the oral mucosa persisting for >3 weeks
• Persistent hoarseness lasting for >3 weeks (request a chest X-ray at the same time)
• Dysphagia or odynophagia (pain on swallowing) lasting for >3 weeks
• Persistent pain in the throat lasting for >3 weeks

Thyroid cancer
• Solitary nodule increasing in size
• Thyroid swelling in a pre-pubertal patient
• Thyroid swelling with one or more of the following risk factors:
  • neck irradiation
  • family history of endocrine tumour
  • unexplained hoarseness
  • cervical lymphadenopathy
Sarcomas and Bone Cancers

Urgent suspicion of cancer referral (soft tissue sarcoma)

- 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 of 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

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 X-ray is suggestive of bone tumour, refer urgently to sarcoma service
- 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
Malignant Spinal Cord Compression

Urgent suspicion of cancer referral

For patients with known cancer (particularly prostate, breast, lung or multiple myeloma) 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, coughing or sneezing)
- nocturnal spinal pain, especially if preventing sleep
- radicular pain (for example, around chest, down front or back of thighs)
- limb weakness or difficulty in walking
- sensory loss (including perineal or saddle paraesthesia)
- bladder or bowel dysfunction

Locally agreed MSCC pathways can be found on:

- SCAN: www.scan.scot.nhs.uk/HealthProfessionals/MSCC/Pages/default.aspx
- NOSCAN: www.noscan.scot.nhs.uk/HealthProfessionals/MSCC/Pages/default.aspx