

Dear Colleagues

Re: Roll Out of Optional GP Direct Access CT Chest for Suspected Lung Cancer Pathway

Following a pilot in North East Glasgow, NHS GG&C are rolling-out an option of GP direct access CT for patients with suspicion of lung cancer pathway for patients who have a normal or equivocal chest x-ray. A copy of the pathway is attached for your information. This is based on the Scottish Referral Guidelines for Suspected Cancer, a copy of which is enclosed, and is an *additional option* to existing referral pathways.

When ordering chest x-rays please mark the request "Urgent Suspected Cancer" (USoC) in Ordercomms. Please also request FBC and U&Es to aid assessment and expedite further imaging.

HAVE A LOW THRESHOLD FOR CHEST X-RAY PARTICULARLY IF AGED OVER 40, SMOKER/EX-SMOKER OR HISTORY OF EXPOSURE TO ASBESTOS.

Chest x-ray reported as equivocal or normal but with persistent concern

If the chest x-ray report is equivocal or shows a minor abnormality, but the report cannot entirely rule out malignancy, or if the chest x-ray report is normal but symptoms persist for longer than six weeks (other than isolated thrombocytosis or cervical and/or persistent supraclavicular lymphadenopathy).

Option 1: GP direct access rapid CT request – refer via Ordercomms for CT chest (mark as USoC)

There are two possible outcomes:-

- CT report is normal / does not show malignancy:-

Please communicate the reassuring report to the patient as per existing practice procedures for communication of results. Any non-malignant conditions will be reported and actions recommended using standardised radiology reporting. Incidental findings are infrequent but may require onward referral.

- CT report shows lung cancer / malignancy:-

Refer using USoC pathways. CT reports suggesting malignancy will be coded / tracked. Respiratory clinics will be informed of the result and request referral if not already processed by practice.

Option 2: Refer as per existing USoC pathways

If chest x-ray report is grossly abnormal / suggests malignancy: no change from current practice

Refer using USoC pathways. This ensures tracking of both patient and the abnormal result.

When referring patients on any USoC pathway please remember to include a *performance status* using the SCI Gateway template. This is very helpful for planning investigations and treatment options prior to clinic appointments, minimising delays in the patient journey.

Should you have any questions regarding the pathway, please refer to the enclosed FAQs document. If you would like more information regarding the background of the pathway pilot these are available via <https://www.nhsggc.org.uk/about-us/professional-support-sites/referral-guidelines/cancer-services/>

If there is a specific query not covered by either the FAQ document or the information on the website please contact Dr Douglas Rigg on Douglas.Rigg@nhs.scot

Yours sincerely



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Scottish Referral Guidelines for Suspected Cancer

Lung Cancer

More than 90% of people with lung cancer are symptomatic at the time of diagnosis. Many symptoms of lung cancer (particularly cough and fatigue), however, are common presentations in primary care, often associated with chronic diseases such as gastric reflux or chronic obstructive pulmonary disease. It is therefore important that changes in symptoms are identified and acted upon.

Chest X-ray findings are abnormal in over 96% of symptomatic people with lung cancer. In most cases where lung cancer is suspected, it is appropriate to arrange an urgent chest X-ray before urgent referral to a chest physician. However, a normal chest X-ray does not exclude a diagnosis of lung cancer. If the chest X-ray is normal but there is a high suspicion of lung cancer, people should be offered urgent suspicion of cancer referral to a respiratory physician.

In people with a history of asbestos exposure, mesothelioma, as well as lung cancer, should be considered. Approximately 80 to 90% of people with mesothelioma will have a history of occupational or close contact exposure. More common presentations include chest pain, dyspnoea and unexplained systemic symptoms.

Urgent suspicion of cancer chest X-ray (CXR)

- 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 and Neck pathway

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

Urgent suspicion of cancer referral

- Any unexplained symptoms or signs detailed on previous page 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

Frequently Asked Questions - Optional GP Direct Access CT Chest for Suspected Lung Cancer Pathway

Will CT scans referrals be tracked?

- If CT scans are suspicious for cancer they are “flagged” and tracked by Radiology. In a similar way to chest x-rays, practices will be informed.
- The Lung cancer service will also be informed of the result and to expect a USoC referral from the GP practice as a “safety net” and for the further information it provides.

How will I know if the patient DNA for the scan?

- Radiology will re-appoint automatically after first DNA.
- If a further DNA occurs then the referrer would be informed as per the current process. This applies to any radiology investigation.

Will there be a delay in scanning and reporting because it is a GP referral?

- It is important to mark both chest x-rays and CT requests as Urgent – Suspected Cancer. This will prioritise the scan and the GG&C aspirational referral to report with in the 7 day target will apply in the same way as it does for secondary care requests.
- The origin of the referrer does not impact the prioritisation of scan.
- Inclusion of appropriate and relevant information at the time of requesting will also minimise potential delays.

Will I understand what the report means?

- Radiology use standardised reporting including explicit instructions regarding incidental findings.
- If there is doubt, Radiology can be contacted for advice.

What do I do with incidental findings?

- Radiology use standardised reporting including explicit instructions regarding incidental findings.
- The volume of incidental findings requiring action is low and is estimated 3-4 incidental findings/year per GP from the pilot findings.

Will this increase my workload?

- This group of patients’ often needs a CT to exclude a lung cancer but no further input from Respiratory teams.
 - Reduces overall volume of referrals to secondary care that are needed.
 - Referrals are replaced by Ordercomms CT request.
- The volume of required onward referrals for incidental findings is low.
- Respiratory Clinicians’ will still accept referrals via USoC pathways and will not “bounce referrals” asking GPs to perform CT instead.

Why should I do this and not just refer to Respiratory clinics?

- Improved patient experience.
- Improves clinician work related satisfaction.
- Reduces patient anxiety.
- Reduces time to “reassurance” for negative results.
- Requires only low dose, non-contrast CT chest so reduces radiation exposure.
- Overall reduction of volume of referrals so those who need USoC clinic are seen quicker.