# Suspected cancer in primary care

A primary care practitioner resource

September 2009

This resource summarises the key evidence-based recommendations and good practice points for selected site-specific cancers, and for children and young people, derived from the evidence-based guideline *Suspected Cancer in Primary Care: Guidelines for Investigation, Referral and Reducing Ethnic Disparities* (2009). The aim of the guideline is to help primary care practitioners make a timely and appropriate referral of patients by alerting practitioners to the features that should raise their suspicion of cancer.

Cancer is now a leading cause of death in New Zealand, accounting for 29% of deaths from all causes. The incidence of cancer is increasing, mainly due to population growth and ageing. In addition, cancer mortality is making an increasing contribution to the gap in life expectancy between Māori and Pacific populations and the non-Māori, non-Pacific population.

## Key messages

Māori and Pacific peoples often present with cancer at a later disease stage. A higher degree of suspicion is therefore indicated when Māori or Pacific people present with symptoms suggestive of cancer

As Māori and Pacific peoples often cite communication with health care providers as a barrier to care, practitioners should provide information to Māori and Pacific peoples, preferably face-to-face and supported with appropriate written information

A high index of suspicion of a new primary or metastatic disease (especially bone, brain, liver or lung) is needed in a person with a history of cancer

A person returning to a primary care practitioner with the same symptom three or more times should be considered an indication for referral

The greater the number of signs and/or symptoms present the more important it is for a practitioner to act

Listening carefully to what caregivers say about a child's symptoms is essential as interpretation of children's symptoms in a clinical situation can be difficult

Practitioners and others providing cancer care should receive training and support in culturally competent, patient-centred care so that barriers to access and referral can be lessened

## Definitions

### Referral times

**Immediate referral**
The patient is seen within a few hours, or more quickly if required

**Urgent referral**
The patient is seen within two weeks

**Referral**
All other referrals

### Symptom terms

**Persistent**
Signs or symptoms that continue to occur beyond a period of time that would normally be indicative of a self-limiting condition

**Unexplained**
Signs or symptoms where no diagnosis has been made to identify the cause after the patient has been assessed by a practitioner

The information in this resource is consistent with the evidence-based guideline *Suspected Cancer in Primary Care: Guidelines for Investigation, Referral and reducing Ethnic Disparities* (2009), published by the New Zealand Guidelines Group. The National Institute for Health and Clinical Excellence (NICE), *Clinical Guideline 27: Referral Guidelines for Suspected Cancer*, published in June 2005 was used, with permission, as the seeding document for the guideline. Where a recommendation is directly derived from the NICE guideline a C Grade is awarded, as such a recommendation represents international expert opinion.

New Zealand GUIDELINES GROUP
Te Rōpū Rarangi Tohutohu
Promoting Effective Health and Disability Services

MINISTRY OF HEALTH
MANATŪ HAUORA

# Lung cancer

Lung cancer is the leading cause of cancer death in New Zealand men and among Māori. It is the second leading cause of cancer death in New Zealand women. Mortality rates are higher in Māori than non-Māori and Māori are more likely to be diagnosed at a later stage.

## Recommendations

| Urgent referral (within two weeks) | Grade |
|---|---|
| A person should be referred urgently to a specialist if they have:<br>• persistent haemoptysis and are smokers or ex-smokers aged 40 years or older<br>• a chest x-ray suggestive of lung cancer (including pleural effusion and slowly resolving consolidation)[1] | C |
| A person should be referred urgently for a chest x-ray if they have:<br>• unexplained haemoptysis<br>OR<br>• any of the following unexplained, persistent (lasting more than 3 weeks or less than 3 weeks in people with known risk factors*) symptoms and signs:<br>– chest and/or shoulder pain<br>– shortness of breath<br>– weight loss/loss of appetite<br>– abnormal chest signs<br>– hoarseness<br>– finger clubbing<br>– cervical and/or supraclavicular lymphadenopathy<br>– cough<br>– features suggestive of metastasis from a lung cancer (eg, in brain, bone, liver or skin)[1]<br>* Current or ex-smokers, smoking-related chronic obstructive pulmonary disease, previous exposure to asbestos, history of cancer (especially head and neck cancer) | C |
| A person should be referred urgently to a specialist if they have a normal chest x-ray, but there is a high suspicion of lung cancer[1] | C |

## Good practice points

| Referral/investigation | |
|---|---|
| A person with risk factors* for lung cancer who has consolidation on an initial chest x-ray should have a repeat chest x-ray within 6 weeks to confirm resolution<br>* Current or ex-smokers, smoking-related chronic obstructive pulmonary disease, previous exposure to asbestos, history of cancer (especially head and neck cancer) | ✓ |
| Sputum cytology is not recommended for the investigation of lung cancer[1] | ✓ |

| Key to recommendations | Grade |
|---|---|
| The recommendation is supported by good evidence (based on a number of studies that are valid, consistent, applicable and clinically relevant) | A |
| The recommendation is supported by fair evidence (based on studies that are valid, but there are some concerns about the volume, consistency, applicability and clinical relevance of the evidence that may cause some uncertainty but are not likely to be overturned by other evidence) | B |
| The recommendation is supported by international expert opinion | C |
| Grades indicate the strength of the supporting evidence rather than the importance of the evidence | |

| Key to good practice points | |
|---|---|
| Where no evidence is available, best practice recommendations are made based on the experience of the Guideline Development Team, or feedback from consultation within New Zealand | ✓ |

## Gastric and oesophageal cancer

Gastric cancer is the fourth leading cause of cancer death in New Zealand men. Mortality rates are higher in Māori than non-Māori for both gastric and oesophageal cancer.

### Recommendations

| Gastric and oesophageal cancer | Grade |
|---|---|
| A person of *any age* with dyspepsia should be referred urgently for endoscopy or to a specialist if they have *any* of the following:<br>• gastrointestinal bleeding<br>• dysphagia<br>• progressive unexplained weight loss<br>• persistent vomiting<br>• iron deficiency anaemia<br>• epigastric mass[1] | C |
| A person aged 55 years or older with unexplained and persistent recent-onset dyspepsia solely, should be referred urgently for endoscopy[1] | C |
| A person with dysphagia (specifically, interference with the swallowing mechanism that occurs within 5 seconds of having commenced the swallowing process) should be referred urgently[1] | C |
| For a person with persistent vomiting and weight loss, without dyspepsia, the possibility of upper gastrointestinal cancer and need for urgent referral for investigation should be considered[1] | C |
| For a person with unexplained worsening of their dyspepsia, the need for urgent referral to a specialist should be considered if they have any of the following known risk factors:<br>• Barrett's oesophagus<br>• known dysplasia, atrophic gastritis or intestinal metaplasia<br>• peptic ulcer surgery more than 20 years ago[1] | C |

## Colorectal cancer

Colorectal cancer is the second leading cause of cancer death in New Zealand. Māori are more likely than non-Māori to be diagnosed at a later stage.

### Recommendations

| Urgent referral (within two weeks) | Grade |
|---|---|
| A person aged 40 years and older reporting rectal bleeding with a change of bowel habit towards looser stools and/or increased stool frequency persisting for 6 weeks or more should be referred urgently to a specialist[1] | C |
| A person aged 60 years and older with rectal bleeding persisting for 6 weeks or more without a change in bowel habit and without anal symptoms should be referred urgently to a specialist[1] | C |
| A person aged 60 years and older with a change in bowel habit to looser stools and/or more frequent stools persisting for 6 weeks or more without rectal bleeding should be referred urgently to a specialist[1] | C |

### Good practice points

| Referral/investigation | |
|---|---|
| Faecal occult blood and carcinogenic embryonic antigen testing are of little value in a person with symptoms suggestive of colorectal cancer and should not be used | ✓ |
| A person with any unexplained gastrointestinal symptoms and known high risk factors, for example, familial adenomatous polyposis, hereditary non-polyposis colorectal cancer, other familial colorectal syndromes or a past history of lower gastrointestinal cancer should be referred to a specialist | ✓ |

## Additional recommendations in guideline for:

**Gastrointestinal**
Pancreas
Liver

**Gynaecological**
Cervix
Vulva

**Urological**
Testis
Penis

**Brain and central nervous system (CNS)**

**Bone and soft tissue sarcoma**

**Skin**
Melanoma
Squamous and basal cell carcinomas

**Head and neck**
Oral cancer and laryngeal
Thyroid

**Haematological**
Leukaemia
Lymphoma
Multiple myeloma

## Breast cancer

Breast cancer is the leading cause of cancer death in both New Zealand women and among Māori women. Mortality rates are higher in Māori women than non-Māori women and Māori women are more likely to be diagnosed at a later stage.

### Recommendations

| Urgent referral (within two weeks) | Grade |
|---|---|
| A woman with a palpable hard, fixed or tethered breast lump should be referred urgently to a specialist[1] | C |
| A person presenting with unilateral eczematous skin or nipple change that does not respond to topical treatment, or with nipple distortion of recent onset, should be referred urgently to a specialist[1] | C |
| A person presenting with spontaneous unilateral bloody nipple discharge should be referred urgently to a specialist[1] | C |

### Recommendations

| Referral/investigation | Grade |
|---|---|
| A palpable breast lump in a woman should be investigated[1] | C |
| A woman with an abscess or mastitis which does not settle after one course of antibiotics should be referred to a specialist[2] | C |
| A woman over 40 years of age with a breast abscess that has settled should be referred for mammography[2] | C |
| Persistent, unilateral, unexplained breast pain in a postmenopausal woman should be investigated[2] | C |

## Uterine cancer

Uterine cancer mortality rates are higher in Māori than non-Māori women.

### Recommendations

| Uterine cancer | Grade |
|---|---|
| A woman who is *not* on hormone replacement therapy presenting with unexplained postmenopausal bleeding should be referred urgently to a specialist[1] | C |
| A woman on hormone replacement therapy presenting with persistent or unexplained postmenopausal bleeding after cessation of hormone replacement therapy for 6 weeks should be referred urgently to a specialist[1] | C |
| A woman presenting with postmenopausal bleeding and taking tamoxifen, should be referred urgently to a team specialising in the management of gynaecological cancer as tamoxifen can increase the risk of endometrial cancer[1] | C |
| 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 or to a specialist[1] | C |
| A woman presenting with heavy or irregular menstrual bleeding should have a transvaginal ultrasound of the endometrium if any of the following apply:<br>• weight over 90 kg<br>• age over 45 years<br>• risk factors for endometrial hyperplasia or carcinoma, such as nulliparity, family history of colon or endometrial cancer, exposure to unopposed oestrogens[3] | C |

## Ovarian cancer

Ovarian cancer is the fourth leading cause of cancer death in New Zealand women.

### Recommendation

| Ovarian cancer | Grade |
|---|---|
| In a woman with any unexplained, non-specific abdominal symptoms alone (bloating, constipation, abdominal or back pain, urinary symptoms), ovarian cancer should be considered, abdominal palpation undertaken and a pelvic examination considered[1] | C |

## Bladder and renal cancer

Mortality rates are higher in Māori than non-Māori for both bladder and renal cancers.

Māori are more likely to be diagnosed at a later stage with renal cancer.

**Recommendations**

| Urgent referral (within two weeks) | Grade |
|---|---|
| A person of any age presenting with painless macroscopic haematuria should be referred urgently to a specialist[1]<br>In a younger person, cancer is unlikely to be the cause of the bleeding | C |
| A person aged 40 years and older presenting with recurrent or persistent urinary tract infection associated with haematuria should be referred urgently to a specialist[1] | C |
| A person presenting with symptoms suggestive of a urinary infection who also presents with macroscopic haematuria should be referred urgently to a specialist if investigation does not confirm infection[1] | C |

## Prostate cancer

Prostate cancer is the second leading cause of cancer death in both New Zealand men and among Māori men. Mortality rates are higher in Māori than non-Māori men and Māori men are more likely to be diagnosed at a later stage.

**Recommendations**

| Prostate cancer | Grade |
|---|---|
| A man presenting with lower urinary tract symptoms and found to have a hard, irregular prostate on digital rectal examination should be referred urgently to a specialist[1] | C |
| A man presenting with lower urinary tract symptoms and a high PSA (10 ng/ml or more) should be referred urgently to a specialist[1] | C |
| A man with lower urinary tract symptoms in whom the prostate is normal on digital rectal examination but the age-specific PSA† is raised or rising, should be urgently referred to a specialist. For a man whose clinical state is compromised by other comorbidities, a discussion about management options with the man and/or a specialist in urological cancer may be more appropriate[1]<br>† Age-based PSA values (upper limit of normal)<br>40–50 years: 2.5 ng/ml; 50–60 years: 3.5 ng/ml<br>60–70 years: 4.5 ng/ml; 70 years and over: 6.5 ng/ml<br>**Note:** This is an example of an age-based range cited in a New Zealand resource.[4] Differences in PSA assay can lead to differences in age-based ranges reported by laboratories | C |
| A man should be recommended to have a digital rectal examination and a PSA test if he has any unexplained symptom suggestive of metastatic prostate cancer:<br>• lower back pain<br>• bone pain<br>• weight loss, especially in the elderly[1] | C |
| Prior to PSA testing, a practitioner should exclude urinary infection, especially in a man presenting with lower urinary tract symptoms. The PSA test should be postponed for at least 1 month after treatment of a proven urinary infection[1] | C |

# Cancer in children and young people

This section highlights the general recommendations for cancer in children and young people. The recommendations for site-specific cancers are available in the guideline, see list below.

## Recommendations

| General | Grade |
|---|---|
| A child or young person presenting several times (eg, 3 or more times) with the same problem, who is apparently unwell, but with no clear diagnosis, should be referred urgently to a specialist[1] | C |
| A practitioner should take note of caregiver observation, insight and knowledge of the child when considering the need to refer urgently[1] | C |
| A practitioner should refer a child or young person to a specialist if there is persistent caregiver anxiety, even when the practitioner considers that the symptoms are most likely to have a benign cause[1] | C |
| A practitioner should be aware of the association between specific syndromes and some cancers (eg, Down's syndrome and leukaemia, neurofibromatosis and CNS tumours) and should be alert to the potential significance of unexplained symptoms in children or young people with such syndromes[1] | C |

## Good practice points

| General | |
|---|---|
| A child presenting with persistent back pain should be examined and have a complete blood count and blood film.[1] An x-ray or referral to a specialist should also be considered | ✓ |
| For a child or young person presenting with symptoms and/or signs suggestive of cancer, investigation may be instigated by the practitioner, but should not delay referral to a specialist | ✓ |

## Good practice points

| Psychosocial support and information needs | |
|---|---|
| For a child or young person presenting with signs or symptoms suggestive of cancer a practitioner needs to communicate information in a way that meets the needs of that child or young person | ✓ |
| Where there is a reasonable suspicion of cancer in a child or young person, a practitioner should convey that possibility to the child or young person and their parent/guardian | ✓ |

Recommendations for children and young people for the following site-specific cancers are available in the guideline:

- leukaemia
- lymphoma
- brain and central nervous system tumours
- neuroblastoma
- Wilms' tumour
- soft tissue sarcoma
- bone sarcomas
- retinoblastoma


**References**

Where referenced, recommendations and good practice points are consistent with the guidance in the publications listed below.

1. National Institute for Health and Clinical Excellence. Referral guidelines for suspected cancer. NICE Clinical Guideline 27. London: National Institute for Health and Clinical Excellence; 2005.
2. Recommendation consistent with: Scottish Intercollegiate Guidelines Network. Management of breast cancer in women. National clinical guideline No. 84. Edinburgh: Scottish Intercollegiate Guidelines Network; 2005.
3. New Zealand Guidelines Group. Guidelines for the management of heavy menstrual bleeding. Wellington: New Zealand Guidelines Group; 1998.
4. New Zealand Guidelines Group. Testing for prostate cancer: a consultation resource. Wellington: New Zealand Guidelines Group; 2008.



Copies of the guideline and summary are available online at www.nzgg.org.nz or through Wickliffe on 04 496 2277;
Order No. HP: 4768 (guideline); HP: 4769 (summary).

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