# GP ACCESS to MRI

Dr J Lewis

# INITIATIVE

- To make earlier cancer diagnosis
- Over 50% brain tumour non GP presentations – figure likely to be higher for malignant tumours
- Mapping exercise and review evidence base

# REMIT TO AID EARIER DIAGNOSIS

- Distribution of questionnaires to Hospital Radiology Departments and all GP Practices across NECN.
- Analysis of data to assess actual and perceived service provision across the network
- 10 Hospital Radiology departments responded to the questionnaire.
- 17.5% of GP's/Practice's within the Network responded to the questionnaire

# SURVEY OUTCOME

- Only 17.5% practices replied
- Of these 30% confirmed direct access exists
- Approx 8% didn’t know!
- Sunderland only provides direct access on basis of fund holding contracts

# Referral Protocols

- Not clear not used on a regional basis
- No awareness of waiting times from GP practise but hospitals reflect 14 day figure for urgent referrals
- Wait time for reports longer from GP prospective than those quoted by hospital-admin time

# CONCLUSIONS of SURVEY

- Most hospitals already offer direct access (approx 70%) but GP's aren't aware of this
- Need to raise awareness and encourage protocols for appropriate referrals
- Promote electronic report communication
- Ensure equity of service

# SURVEY CONCLUSION

"MRI brain has been the most contentious of the direct access tests. This mapping along with further discussions with the Brain & CNS NSSG and primary care is require to agree Network guidelines"

# PRIMARY CARE CONTEXT

- BJGP 2007
- 3500 cases over 8 yrs (aged match controls)
- New seizure risk tumour 1.2% overall and in 60-69yrs 2.3%
- Headache alone to primary care risk tumour less than 1 in 1000

# NICE GUIDANCE updated 2011

In any patient with symptoms related to the CNS (including progressive neurological deficit, new-onset seizures, headaches, mental changes, cranial nerve palsy, unilateral sensorineural deafness) in whom a brain tumour is suspected, an urgent referral should be made. The development of new signs related to the CNS should be considered as potential indications for referral.

# NICE position

- All serious signs neurological – referral
- All new symptoms eg new acute headache – consider referral
- Seizure – referral

- Nil mention GP to arrange imaging

# Non Incidental Tumours

- Low Grade Glioma
- Malignant Glioma
- Large Meningioma
- Others

- Gliomas constitute majority

# Management Pathway LGG

- Identify suspected LGG
- Biopsy or resection
- Depending on histology and pt factors upfront RT versus WW
- Median survival 5-7 yrs

# Malignant Glioma

- Nil published series re early diagnosis
- Turnaround time primary care MRI approx 28 days
- Symptomatic period approx 3-4 weeks
- Nil evidence in literature that primary screening would increase survival

# Essentially discussing headache investigation

- BJGP 2008 D Kernick et al
- UK GP consult rate headache is 4.4% pts
- 3% of these referred to secondary care
- Advocate a flag system of investigation red flags equate to 1% risk of underlying tumour

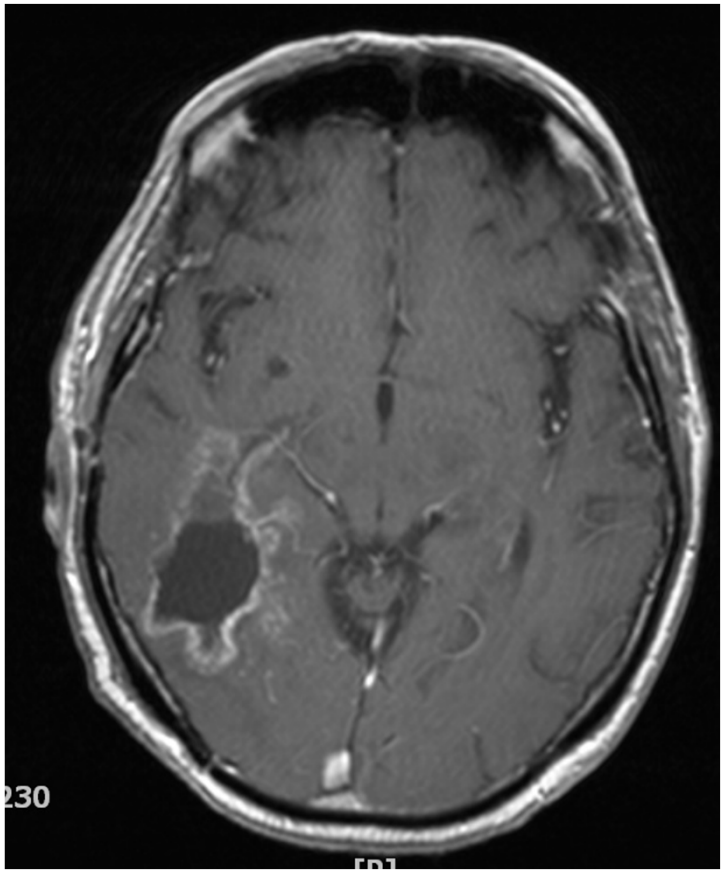
# BJGP PUBLISHED GUIDANCE

- **Red flags — presentations where the probability of an underlying tumour is likely to be greater than 1%. These warrant urgent investigation**.
- Papilloedema
- Significant alterations in consciousness, memory, confusion, or coordination
- New epileptic seizure
- New-onset cluster headache (imaging, particularly of the region of the pituitary fossa, required but non-urgent)
- Headache with a history of cancer elsewhere particularly breast and lung
- Headache with abnormal findings on neurological examination or other neurological symptoms (although evidence base suggests orange flag)

# Conclusion

- Negative scan still need to monitor
- Lead GP in practise to develop expertise and screen referrals
- Not recommended mode of scan CT vs MRI
- Not scanning not likely to be an issue in medico-legal case law vs failure to illicit neuro signs
- Absence of high quality research in primary care to inform guidance

# Patient View




- 66 yr old retired GP
- GBM 2012 (abdo pain presentation)

- Need for advise to primary care as to which pts to scan
- Believes would be helpful to minimise referrals to secondary care
- Doesn't believe GPs will have problem being guided by clear protocols

# DISADVANTAGES OF INCREASE AVAILABILITY SCANS

- Incidental findings eg small meningioma – incidence as high as 2.8-10%
- Rate of non sig findings 5-10 higher than rate of significant condition
- Referrals required to seek advise / reassurance on incidental findings
- Evidence exists that reassurance gained from normal scan in headache pt lasts 3 months only

# ORIGINAL QUESTION

Q - Is primary access to MRI helpful in early detection of brain tumours

A - Evidence would suggest yield is low

Q - Is access to scanning helpful in reassuring chronic headache sufferer

A - Not for more than 3 months

# Questions

- Q - Does early detection of brain tumour improve outcomes of treatment
- A - Evidence is lacking due to natural history of commonest tumours

# THE WAY FORWARD

- GP's need to be made aware of existing access and this should be equitable across the region
- GP's are likely to welcome clear guidance as to who to scan – red flag system appears sensible
- NICE guidance should be updated to include advise as to selection of patients to scan
- Practises should be encouraged to elect a lead in cancer diagnostic services perhaps with a remit to help screen referrals