

Cancer Hot Topics

2025/26



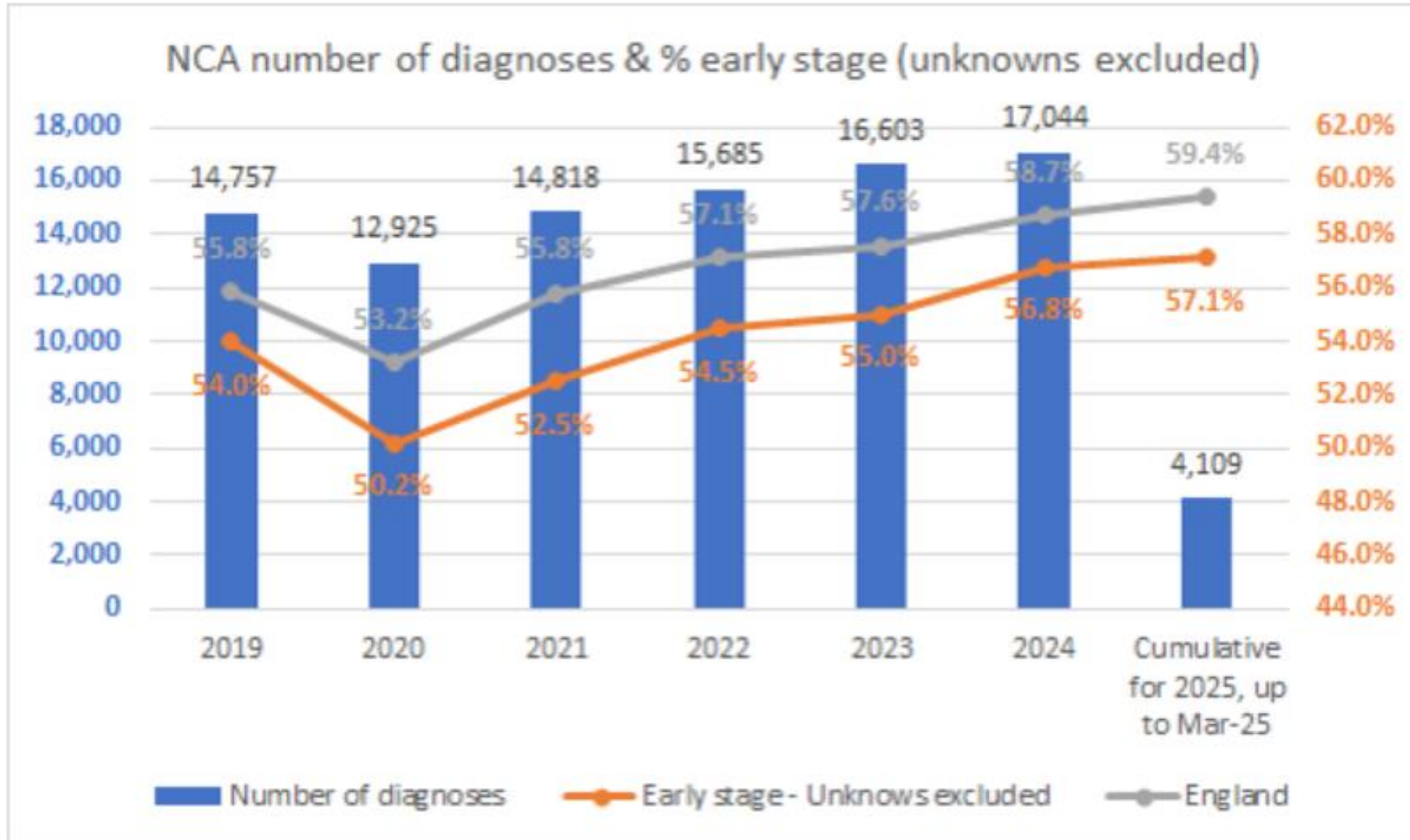
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Early Diagnosis



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All Cancer Early Stage Diagnosis





PCN Direct Enhanced Service Contract

Improving Early Cancer Diagnosis

Section 8

Part A. Clinical and Support Services



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Overview

- To follow is an overview of the PCN DES for Early Cancer Diagnosis and suggested actions/activities against the stated requirements

To Note :

- Cancer element DES has not significantly changed from last year
 - NCA to still provide some specific milestones and actions for specific tumour sites
 - Tumour specific actions outlined to improve referral practices.
 - Main change third tumour site confirmed by the NCA - Bladder Cancer
 - Minimal changes gives continuity - a valuable opportunity to build on last year's QI projects and work.

Released - NCA Planning Template with tips and guidance section. Support materials will be phased in throughout the year. **Submission of Plans to NCA in Early November 2025.**

Collaborating to improve cancer care

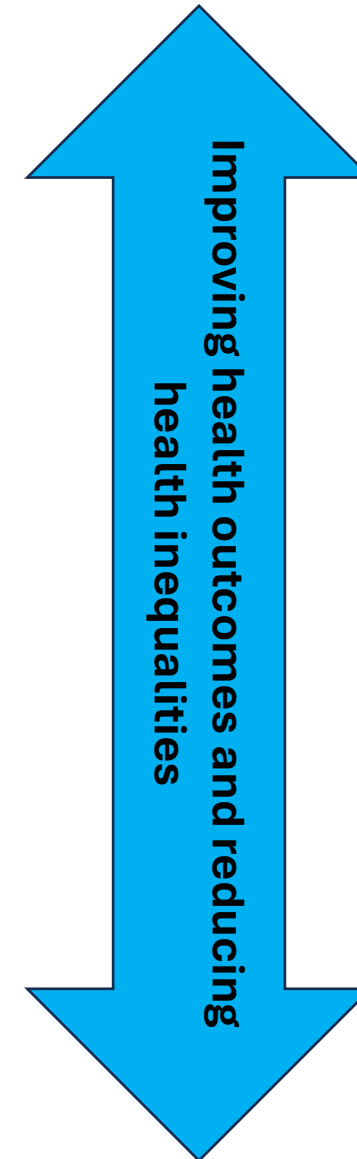
Section 8 Service Requirements

2.1.13
Review Cancer referral practice specified tumour sites
Lung/CRC/ Bladder Cancer

2.1.14
Partnership Working. Use data, NG12, routes to
diagnosis audit. ID pathway improvements

2.1.15
Streamlining Diagnosis & Referral Practice

2.1.16
In partnership improve screening uptake
Breast, Bowel & Cervical





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PCN DES Support Offer

- An offer to work with the PCN Worker / key staff and the practices to support QI activity
- Overview of the main early cancer elements of 2025/26 PCN Early Cancer DES – Full Slide Deck.
- PCN Cancer DES Planning Template to support the PCN to develop its work plans this year with constituent practices and support work thereafter
- DES specific guidance /ask/recommendation from the Northern Cancer Alliance this year . Suggestions and sharing practice ideas.
- Early Cancer Diagnosis/ PCN DES Data pack
- Recorded – Share and Learn Session on NCA Website

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PCN Facilitators – Overview

Area	PCN Facilitator	Contact
Northumberland/ NT	Interim Fiona Anderson	fiona.anderson50@nhs.net
Newc/Gateshead	Emma Shaw	emma.shaw9@nhs.net
South Tyneside	Sarah Kucukmetin	s.kuckumetin@nhs.net
Sunderland	Leanne Rowell	leanne.rowell1@nhs.net
County Durham	Emma Sarsfield	e.sarsfield@nhs.net
North Cumbria	Joel Vilchez	joel.vilchez@nhs.net
Tees Valley	Angela Atkinson	angela.atkinson16@nhs.net



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Urology



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Prostate Cancer

Digital Rectal Examination (DRE)

DRE continues to have a selective but important role in primary care assessment.

1. DRE is not routinely required when PSA is raised.
2. Offer DRE when PSA is normal but suspicion remains.
3. Do not delay referral awaiting DRE results.
4. Continue to apply shared decision-making and good documentation.



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Bladder Cancer

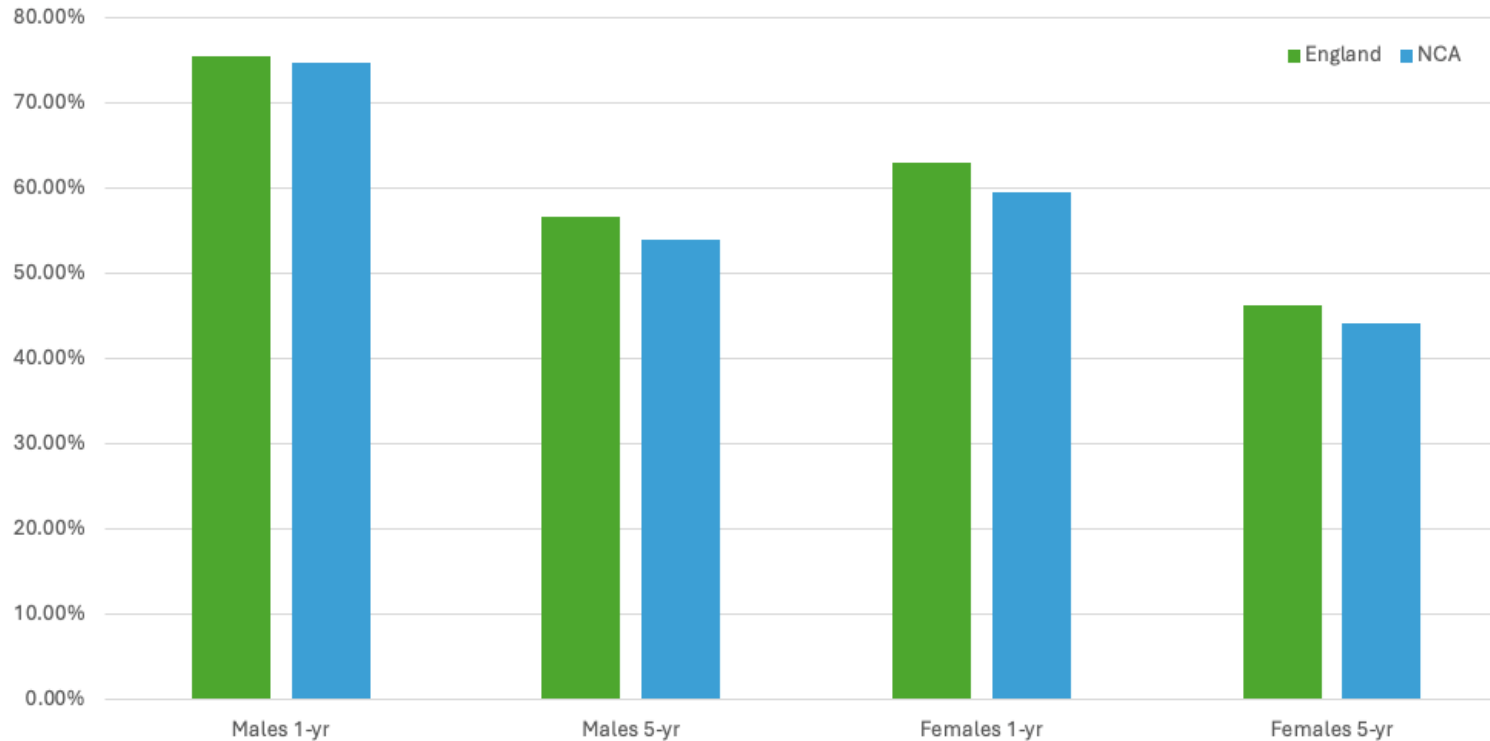
- To reduce the number of people diagnosed late to improve outcomes and survival
- Explore opportunities for more timely recognition of bladder cancer in primary care
- To shift people from emergency presentation to a more managed route.
- To better manage and risk stratify those presenting with UTI or other low risk symptoms in primary care
- Improve guideline concordant care and safety netting for women and those who present with recurrent UTI
- Support better signs and symptom awareness, as well as risk factors, within the public to avoid delayed or advanced diagnosis



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Data Driven Focus

1 and 5 year Bladder Cancer survival for males and females
NCA vs England



NCA has **lower** survival rates for 1 and 5 year in both males and females vs England

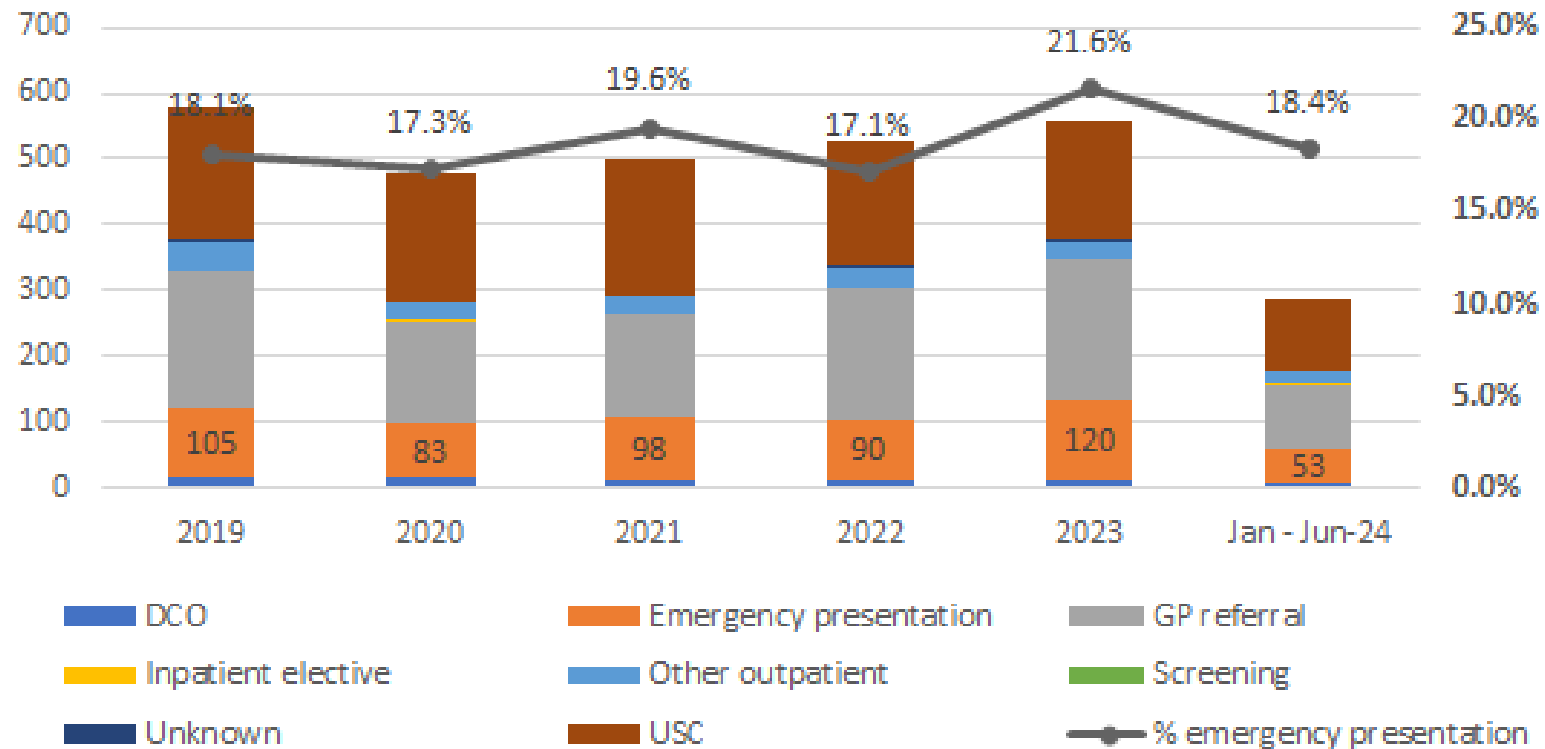
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Data Driven Focus

Route to diagnosis - Bladder

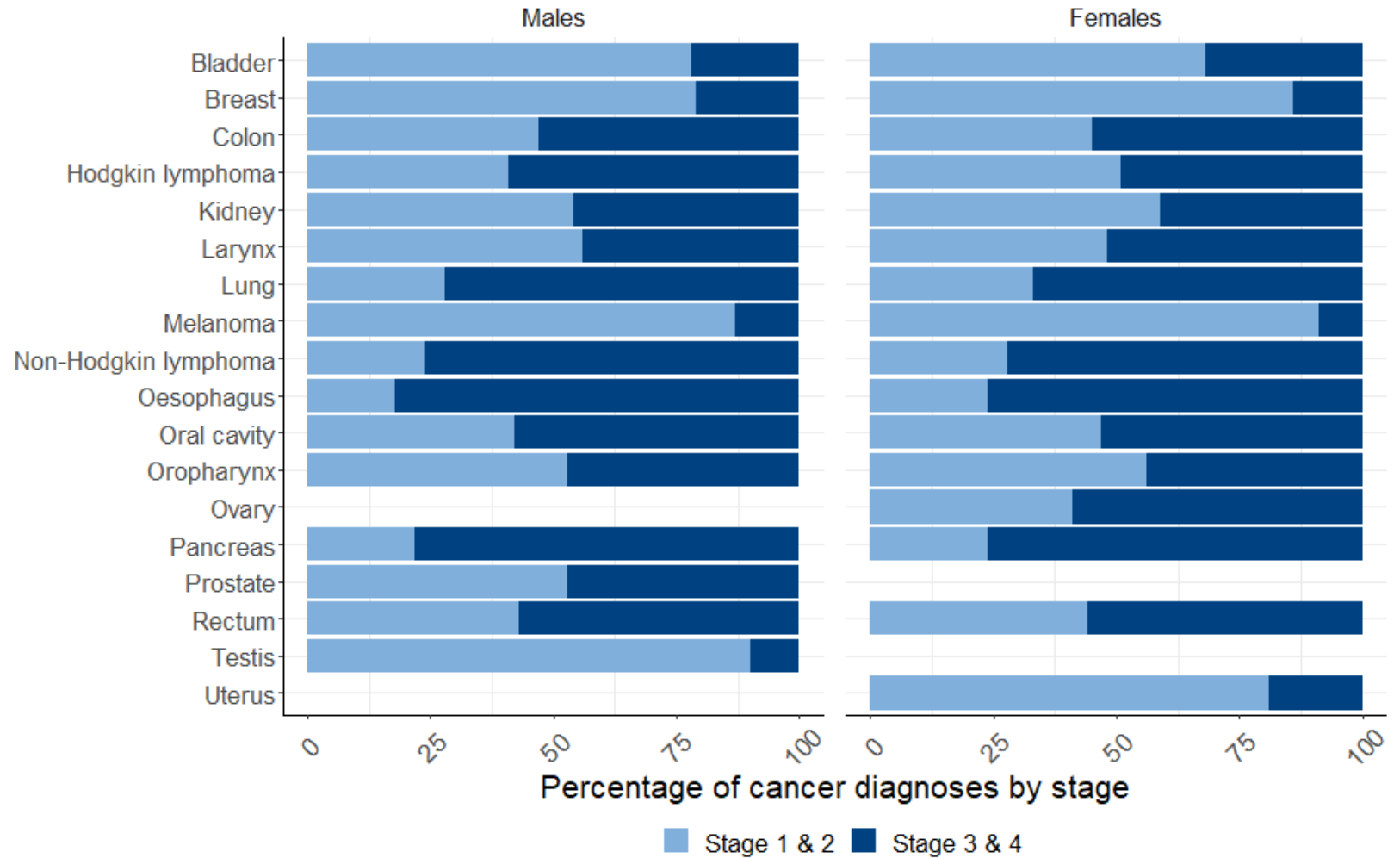


Routine GP referral the **biggest** route to diagnosis; more than USC referral.
Emergency route to diagnosis is 18.4 % and **higher** than England rate of 17.1%

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Females have a higher percentage of early-stage cancer diagnosis for all sites/groups, **except for bladder**

Males had a higher percentage of bladder cancers diagnosed at early stages than females by 10% points (**78% versus 68%**).



<https://digital.nhs.uk/data-and-information/publications/statistical/cancer-registration-statistics/england-2019/females-have-higher-proportion-of-cancers-diagnosed-at-stages-1-and-2>

North of Tyne Urological Guidelines (Teamnet)

- **Recurrent UTIs**

- (F) Over 60s – refer to Urology
- (F) Under 60 - Consider Renal Tract USS and Post Void to assess for referral.

- **Haematuria**

- Visible Vs Non-Visible – see flowchart.
- **Dipsticks are discouraged for UTI diagnosis in >65s, but may still be clinically useful for haematuria detection** when cancer is suspected.
 - Up to 50% of older patients (esp. Care Home) have Asymptomatic Bacteriuria
 - Dipsticks have **low positive predictive value** in older adults vs Antibx Risk.



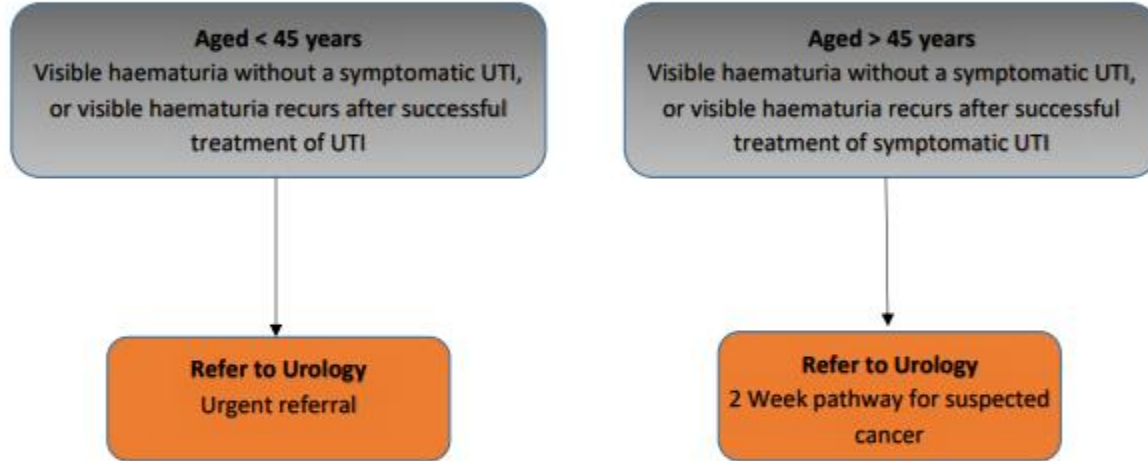
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Haematuria

Visible Haematuria

Taken from North Tyne/Gateshead guidelines for detection, management and referral of adults with kidney disease

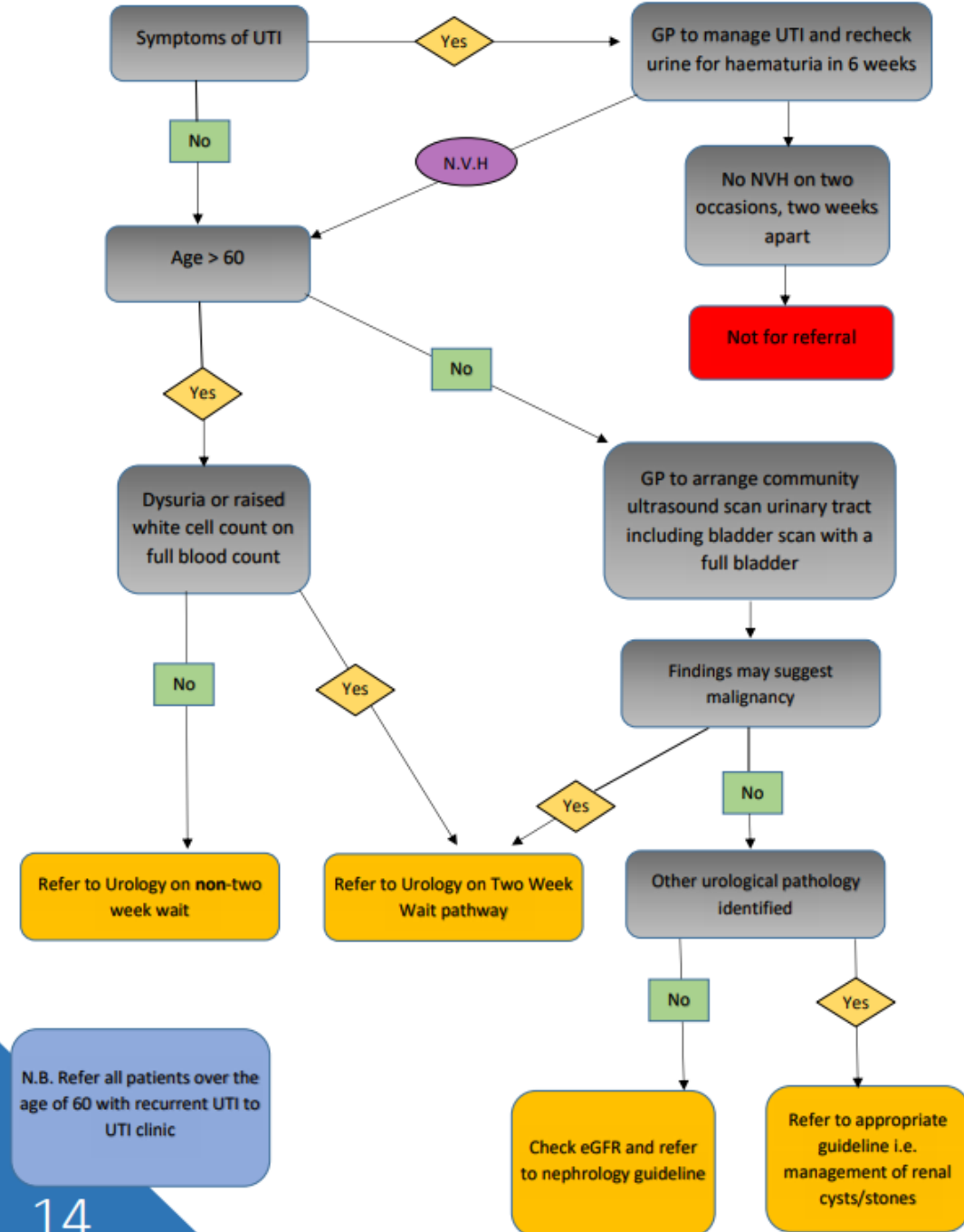
Assessment and referral of patients with visible haematuria



Notes

Visible haematuria should not be attributed to oral anticoagulants in the therapeutic range and/or anti-platelet agents as a cause

Non Visible Haematuria - NVH



N.B. Refer all patients over the age of 60 with recurrent UTI to UTI clinic

Bladder Cancer Audit Process

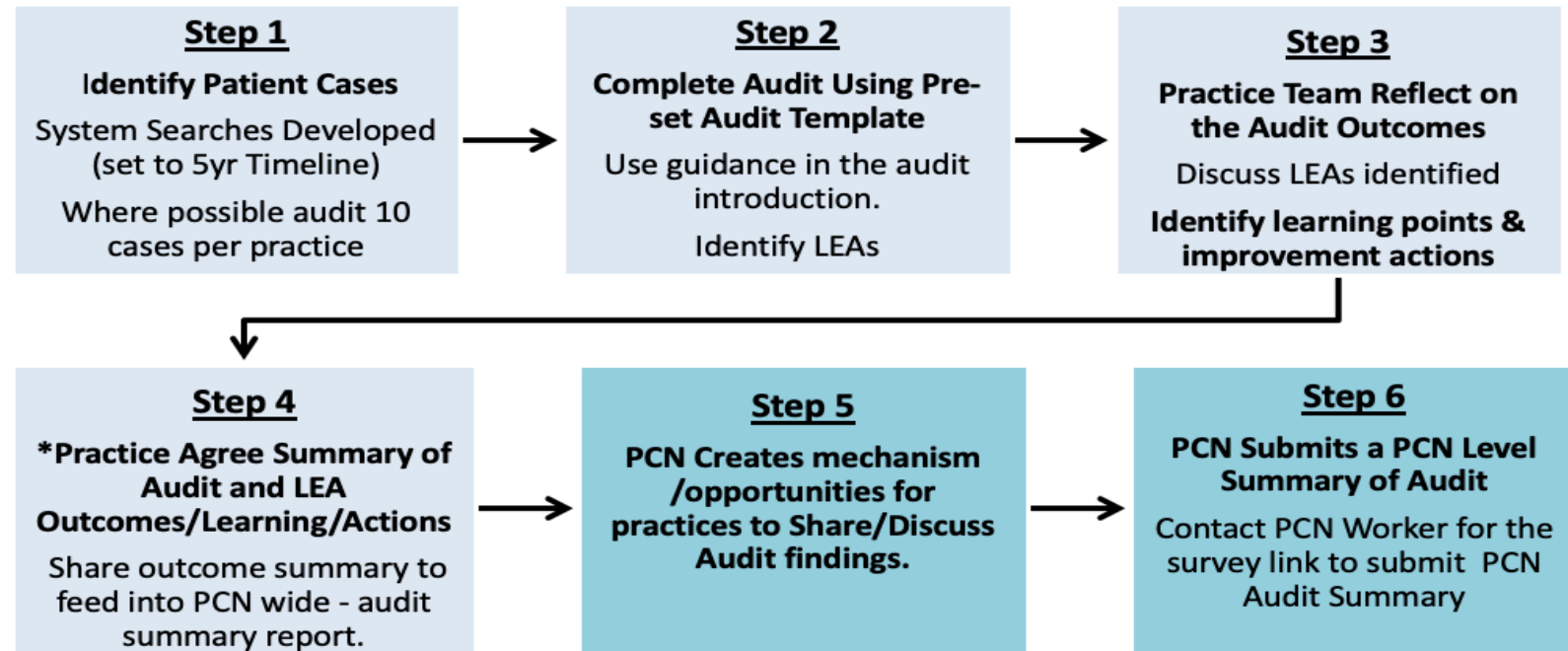
Key:

GP Practice Level Activity

PCN Level Activity

Retrospective
Routes to
Diagnosis Audit

Audit Template
Developed



Key to the above:

*Use the criteria / questions on slide 9 to consistently capture outcomes/learning from the audit
PCN Workers will supply a link to a survey for PCNs to submit their PCN level summary of the main/ common trends, learning, outcomes and actions from the audit. i.e. submit a PCN wide summary not individual practice summaries. Thank you.

Northern Cancer Alliance Webinar

- Lunch & Learn event - October 2025
- Mr Sahadevan – Urology Consultant S Tyneside
- <https://northerncanceralliance.nhs.uk/resources-cancer-academy/webinars/>

NB Medical – Webinar on Bladder Cancer

- Streamed - June 2023
- Dr Kate Rigby
- <https://www.youtube.com/watch?v=r9nzfKVFXL4>

Action Bladder UK; Module on Bladder Cancer

- Hosted by NB Medical
- 1 hour module
- **Link** to register for this module here: <https://bit.ly/BladderCancerCPD>

CRUK; Module on Urological Cancer

- Hosted by Doctors.net in Cancer Learning Centre
- 1 hour module
- <https://www.doctors.net.uk/eClient/cruk/clc/recognition-referral.html>



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Colorectal Cancer & FIT



Colorectal Cancer

- **Third** commonest cancer by incidence
- Increased incidence
- Survival
 - 90% survival at 5 years if stage 1 at diagnosis
 - 10% survival at 5 years if stage 4 at diagnosis
- Highest survival in people with CRC detected by screening
- FIT test before referral helps to get the patient to the right first test



Early Onset Colorectal

- Early onset = Colorectal cancer in people < 50 yrs old
- 10% of all colorectal diagnoses
- Increasing incidence of early onset colorectal cancer worldwide. But less common than in older people
- People <50yr with solitary red flag =1% risk of cancer

Characteristics:

- More **rectal cancer** (42%) in under 50 compared with over 65 (24%)
- **Rectal bleeding** is the commonest reported symptom in younger people
- More likely to be **late stage**
- More likely to present as **emergency**
- More **long-term effects from treatment**

Reference: A Chambers et al. BMJ 14-21 June No. 8465 pg.322

Remember risk factors

- Inflammatory bowel disease
- Colorectal polyps
- Obesity
- Family history of colorectal cancer in a first degree relative
- Genetic disorders like Lynch syndrome –
 - watch out for strong hx of other solid tumours in family history
 - Endometrial , ovarian, stomach

Reference: A Chambers et al. BMJ 14-21 June No. 8465 pg.322

Safety Net Symptoms

- **Jess's Rule:** "Three Strikes and We Rethink"
- If the working diagnosis after history, examination (**and PR**) and FBC and FIT test, is irritable bowel / constipation, diarrhoea, diverticulitis, haemorrhoids or anal fissure, **advise patients to return in 4-6 weeks** if the clinical situation has **not improved** or **earlier if worsening** or new symptoms.
- **Recurrent presentation** with the same symptom?
 - Repeat history and examination and FBC
 - Do FIT test or repeat if there is uncertainty.
 - Consider referral or A+G

Reference: A Chambers et al. BMJ 14-21 June No. 8465 pg.322

Colorectal Essentials and FIT

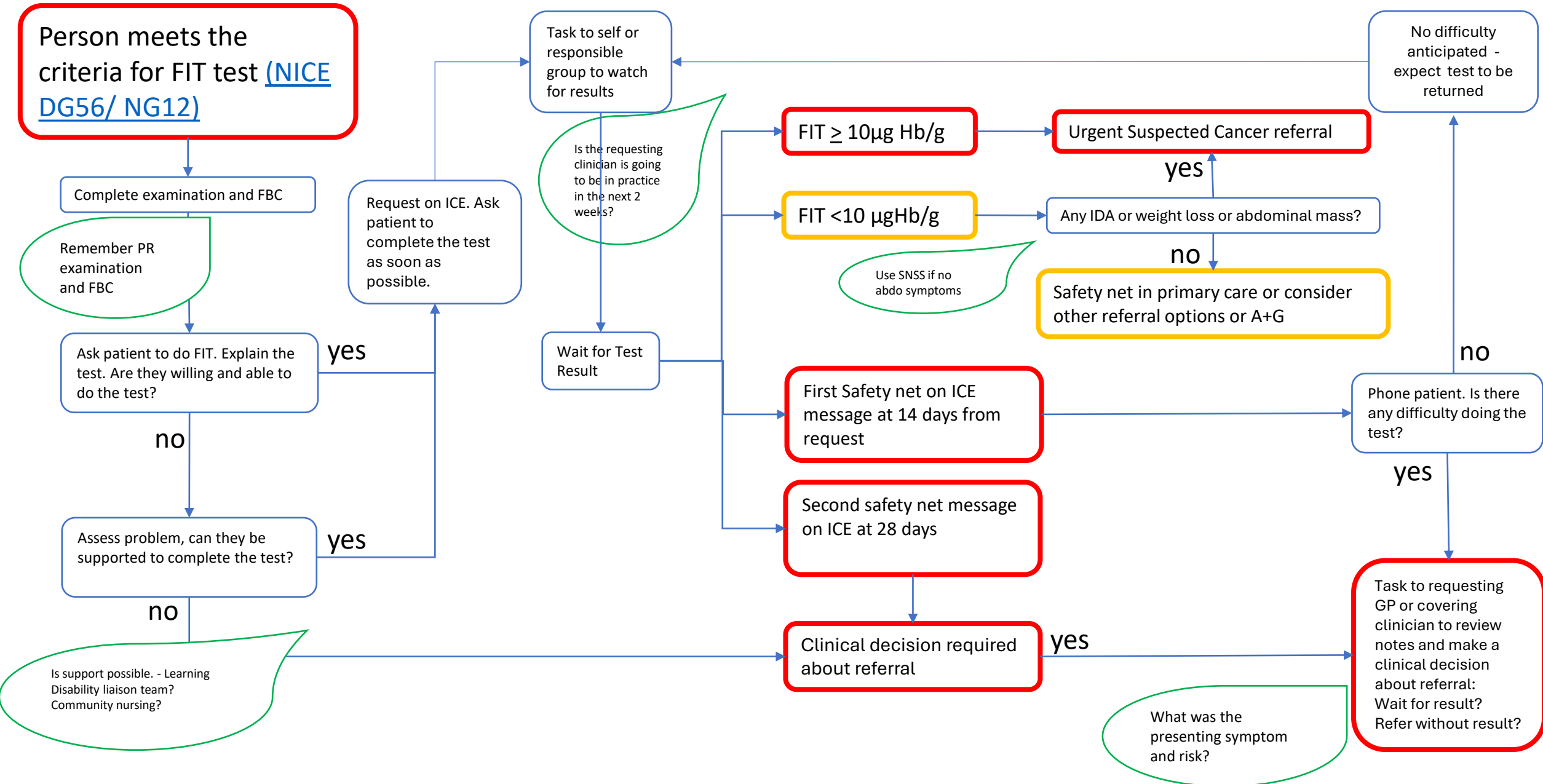
- **History (and FHx), Examination (including PR), FBC , FIT**
 - The risk of colorectal cancer in those with a **negative FIT** result, a **normal examination** and **normal FBC** is **<0.1%**. (NEED ALL THREE!)
 - This is lower than the general population risk
 - ONLY using Neg FIT may miss 10% of cancers!
- **Do a PR** - colonoscopy is not the right test for anal cancer.
 - Anal/ rectal mass goes straight to clinic
 - New onset hemorrhoids in > 70yr – think Cancer!
- Do **not** use FIT in **asymptomatic** people
- **Is it unexplained weight loss?** - Ask about weight loss drugs
 - GI side effects are common
 - Stop the drug and reassess in 4 weeks and offer FIT/ bloods/ examination

Using symptomatic FIT

- Request FIT
 - Tell the patient how to do the FIT test.
 - Ask if they are able to complete the test
 - Provide info in other languages if needed
 - **Rectal bleeding** – STILL DO FIT! - try to avoid frank blood when taking sample.
 - Over **50%** of rectal bleeding USC referrals have **Neg FIT**
- **Wait for the result** & Use the result to **inform your decision** to refer
- If FIT <10µgHb/g and no IDA / weight loss / masses there are options
 - safety net
 - Consider A+G or non-urgent referral
- **DO NOT** use FIT in isolation - nb Examination, **PR**, FBC (urinalysis in IDA)

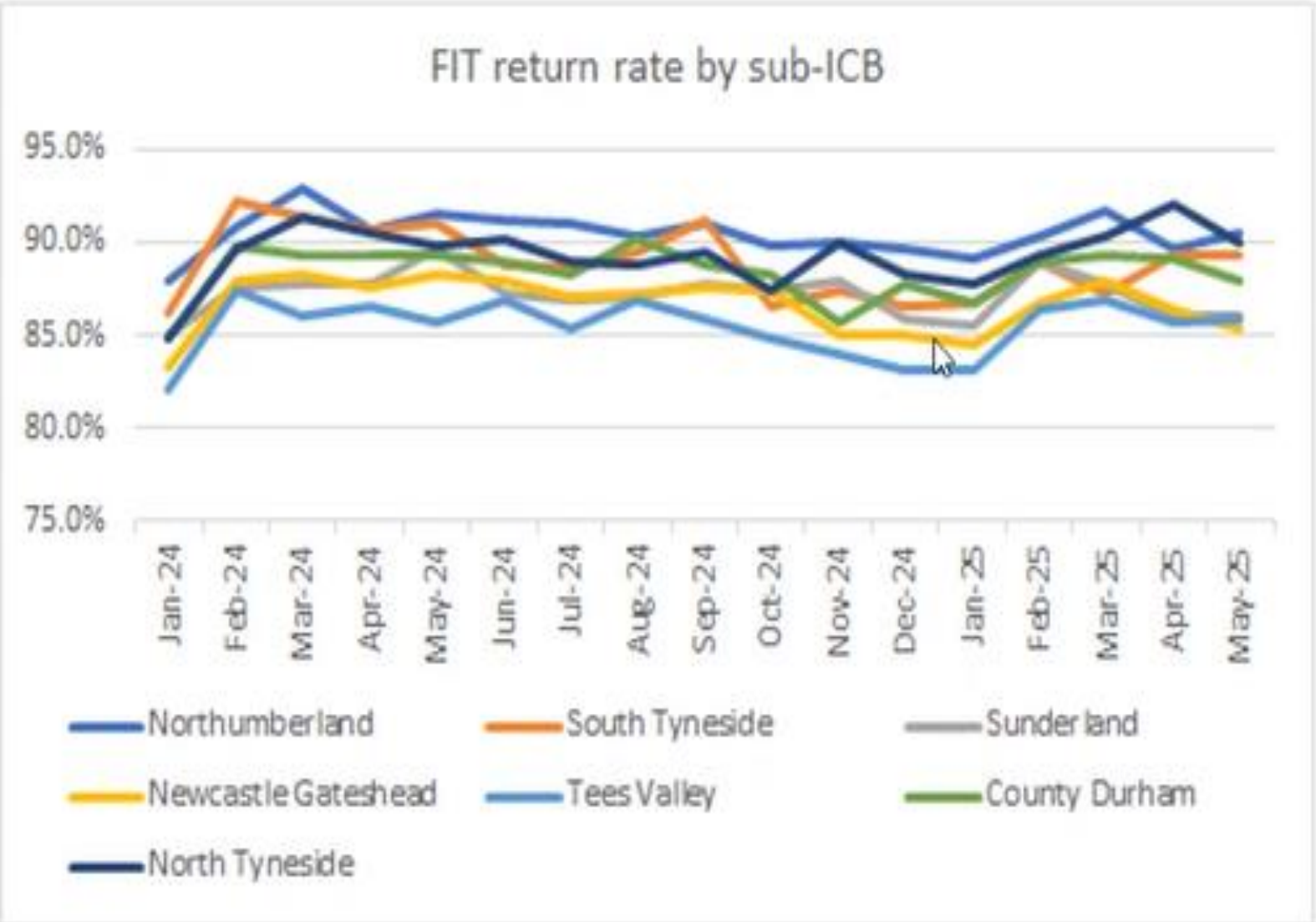
FIT in primary care suggested SOP (North Cumbria practices see local advice)

The test result is needed to inform a cancer pathway referral



FIT Data

Source FIT Lab
Data



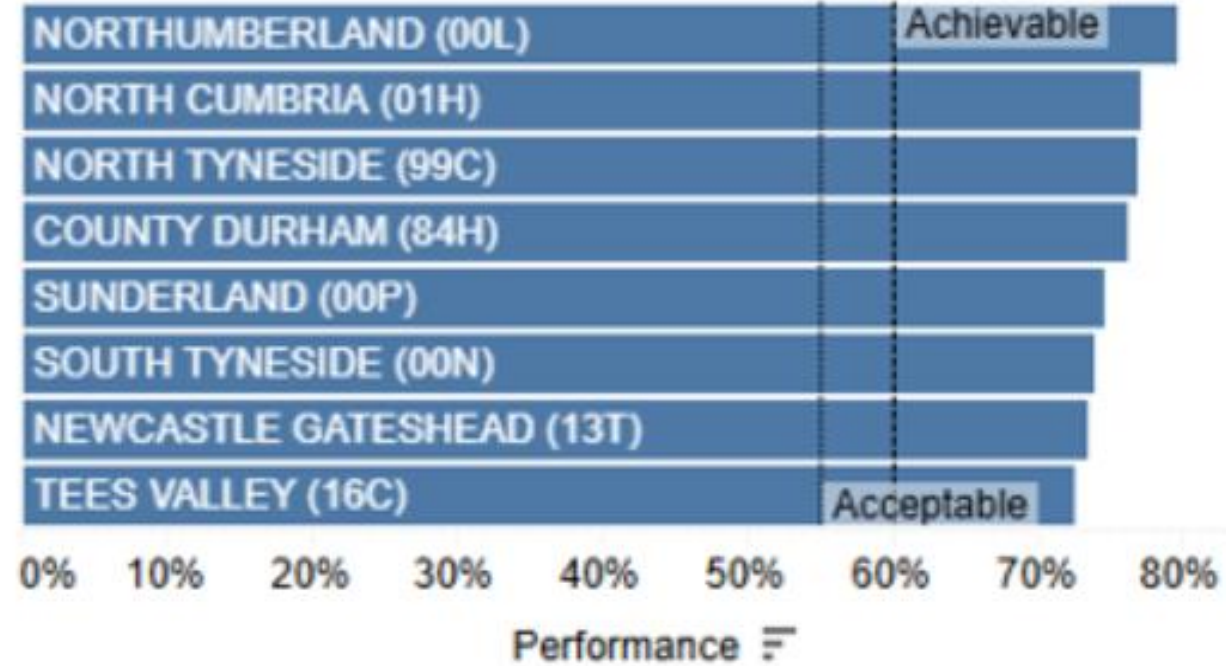
Bowel Screening Uptake

Uptake 60-74 years old



Ranked performance for BowelCancer Uptake 60 - 74 years old.
Latest date: December 2024

Coverage 60-74 years old

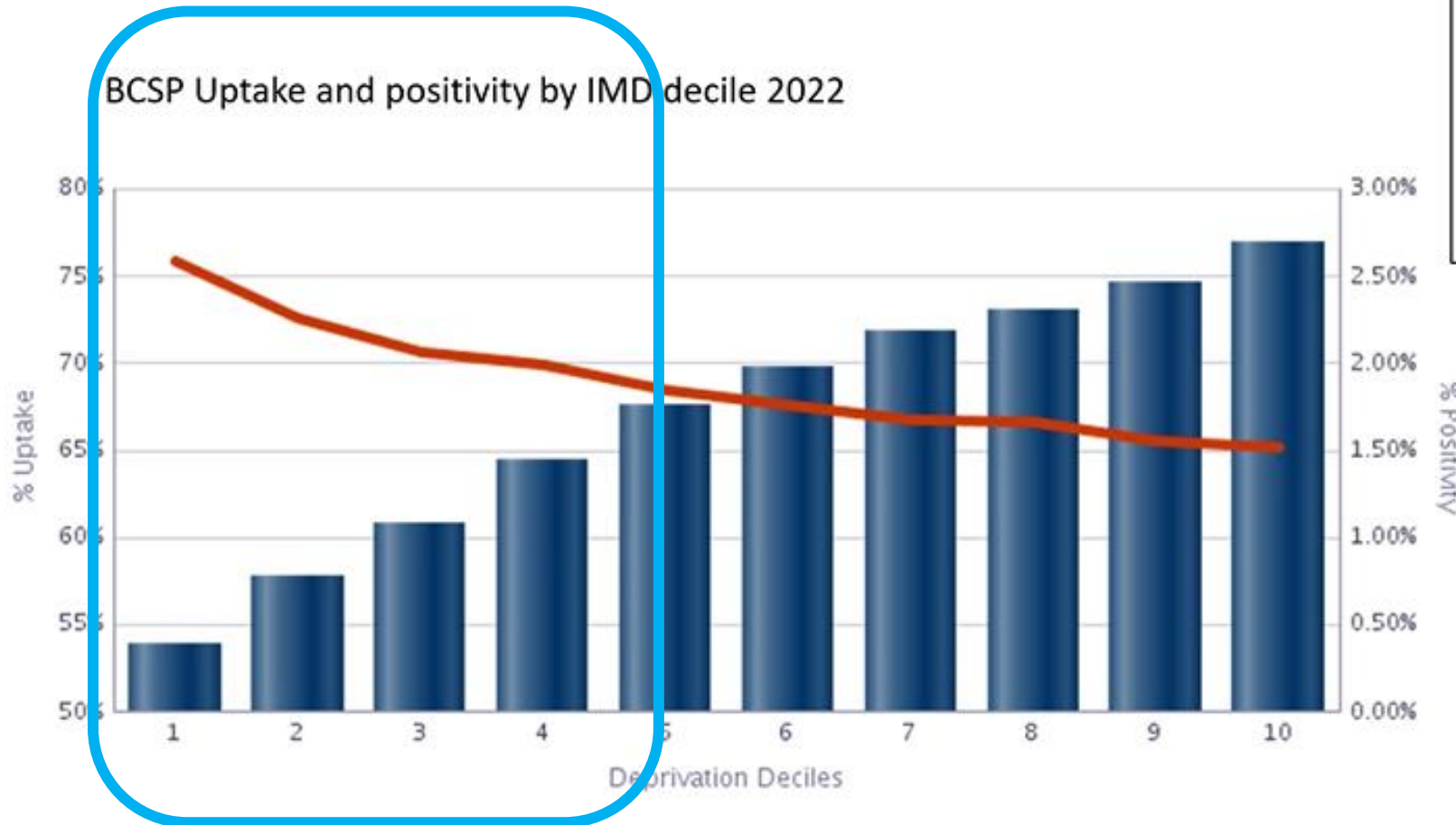


Ranked performance for BowelCancer Coverage 60 - 74 years old.
Latest date: December 2024



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How can we find people at risk of CRC?



- If quintiles 1-4 have average uptake of 67% an extra 160,000 would have an adequate screen.
- This equates to approximately 3,700 additional positive test which could lead to an additional 330 cancer diagnosis.

50 % of all CRC cancer treatments are in quintiles 1-4

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FIT and Inequalities

Use your PCN / Practice profile data – ask your PCN Facilitator

- What are your practice **demographics**?
- What is your **screening rate**?
- What is your **symptomatic FIT return rate**? (? and request rate)
- How do you **compare** with the PCN?
- What can you do to **support** FIT test **returns**?
 - What do you **tell** the patient?
 - **Safety net** process in practice
 - Local **community** work? - are you linked in with the Cancer Community Awareness Worker?
- Use the result to inform your decision to refer.



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Education resources for Colorectal cancer

- Our Courses – Gateway C
 - Colorectal Cancer [Here](#)
- Gateway C FIT Infographics
 - FIT for Clinicians [Here](#)
 - FIT for Administrators [Here](#)
- Bowel Cancer UK Training (via Pulse Sign Up) – [Here](#)



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Gynaecology

**Unscheduled Bleeding on HRT
and Endometrial cancer**

BMS Guidance for Primary care



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Aims

- New guidance and New referral form.
- Resources
- Take away messages



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Definition of Unscheduled Bleeding

- **For women taking Continuous combined HRT:** Irregular bleeding after initiating or changing a preparation which should be bleed free. Assessment / investigation recommended if bleeding is more than 6 months after initiating HRT or more than 3 months after a change in dose or preparation is already established on HRT or after achieving amenorrhoea.
- **For women taking sequential HRT:** Bleeding in addition to the scheduled monthly withdrawal bleeds or if there is an increase in heaviness, duration of bleeding or irregular bleeding.

Heavy, prolonged or persistent and bleeding in any time scale needs earlier assessment

Why is new guidance needed?

Unscheduled bleeding within the first 6 months of initiating any HRT, or within 3 months of change in dose or preparation in those already established on HRT, is **common**.

- More HRT prescribed now
- **40%** of women **taking HRT** have unscheduled bleeding
- **Referrals** for suspected endometrial cancer have **increased by 40%** in the last **3 years** but the incidence of endometrial **cancer** has **only increased** by **2%**
- The BMS joint guidelines are designed to **find the highest risk women** and pull them into investigations and **protect lower risk women from over investigation**

Understanding risks with HRT

- **Post menopausal bleeding** is **not the same** as unscheduled bleeding on HRT. It is defined as vaginal bleeding > 12 months after the cessation of menses due to menopause.
- **Women with post-menopausal bleeding:** Risk of endometrial cancer is highest in women with post-menopausal bleeding who are not taking HRT.

Understanding risks of endometrial changes with HRT

HRT prep	No unscheduled bleeding	Unscheduled bleeding
Continuous combined ccHRT	<p>Women who are amenorrhoeic and postmenopausal on standard dose oestrogen and proportionate progesterone. Risk of endometrial cancer seems to be lower than in non-HRT users</p> <p>Greatest effect in women BMI \geq 30</p>	<p>Low/ standard dose oestrogen, no individual risk factors and thickened endometrium,</p> <p>risk of endometrial hyperplasia and cancer appears less than for women with post menopausal bleeding. Risk increases with duration of use</p> <p>Moderate/ high dose oestrogen risk is unknown</p>
Sequential/ cyclical sHRT	<p>Over 50 and using proportionate progestogens. Risk is the same as in non-HRT users for up to 5 years. Change to ccHRT after that</p> <p>Risk increases by x3 If progestogens are used for <10 days for 6months</p>	<p>Low/ standard dose oestrogen and thickened endometrium</p> <p>risk of endometrial hyperplasia and cancer appears less than for women with post menopausal bleeding.</p> <p>Moderate/ high dose oestrogen risk unknown</p>
Unopposed oestrogen or tricycling daily oestrogen with progesterone every 3 months	<p>Significant risk factor</p>	<p>Significant risk factor</p>

When to assess / investigate

- **No HRT** Post Menopausal Bleeding = **Urgent Suspected Cancer**
- History
- Examination – cervical lesion will go to a different **USC** clinic



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Low / Medium / High Estrogen

Table 2: Prescribed estrogen dose for ultra-low, low, standard, moderate and high dose regimens

	Ultra-low dose	Low Dose	Standard dose	Moderate dose	High dose
Oestrogel	½ pump	1 pump	2 pumps	3 pumps	4 pumps
Sandrena	0.25 mg	0.5 mg	1 mg	1.5-2 mg	3 mg [*]
Lenzetto spray	1 spray	2 sprays	3 sprays	4-5 sprays [*]	6 sprays [*]
Patch	12.5 µg	25 µg	50 µg	75 µg	100 µg
Oral estradiol	0.5 mg	1 mg	2 mg	3 mg [^]	4 mg [^]

^{*} Off-license use
mg = milligrams

[^] Off-license use – rarely required to achieve symptom control
µg = micrograms

Recommended dose of progesterone

Table 3: Progestogen dose per licensed estrogen dose in the baseline population

Estrogen dose	Micronised Progesterone		Medroxy progesterone		Norethisterone		LNG-IUD (52mg)
	continuous	sequential	continuous	sequential	continuous	sequential	
Ultra/Low	100 mg	200 mg	2.5 mg	10 mg	5 mg*	5 mg*	One – for up to 5 years of use
Standard	100 mg	200 mg	2.5-5 mg	10 mg	5 mg*	5 mg*	
Moderate	100 mg	200 mg	5 mg	10 mg	5 mg	5 mg	
High	200 mg	300 mg	10 mg [^]	20 mg [^]	5 mg	5 mg	

* 1 mg provides endometrial protection for ultra-low to standard dose estrogen but the lowest stand-alone dose currently available in the UK is 5 mg (off-license use of three noriday POP i.e. 1.05 mg, could be considered if 5 mg is not tolerated).

[^] There is limited evidence in relation to optimal MPA dose with high dose estrogen; the advised dose is based on studies reporting 10 mg providing protection with up to moderate dose estrogen.

Appendix 3: Recommendations pertaining to investigation outcomes in women taking HRT

Investigation Result	Pathway	Management Recommendation
TVS: Endometrial thickness (ET) \leq 4 mm if ccHRT and \leq 7 mm if sHRT	N/A	Offer adjustments to the HRT preparation for 6 months
TVS: ET $>$ 4 mm if ccHRT and $>$ 7 mm if sHRT (thickened endometrium)	USCP	Endometrial assessment (endometrial biopsy and / or hysteroscopy)
TVS: Incomplete assessment of the endometrium (e.g. fibroids/IUD obscuring) but visualised portion within normal ultrasound limits	Urgent (within 6 weeks)	Endometrial assessment (endometrial biopsy and / or hysteroscopy)
TVS: Asymptomatic (no unscheduled bleeding) with incidental ET \geq 10 mm and <i>no</i> risk factors for endometrial cancer.	Urgent	Hysteroscopy + biopsy (preferable) or blind biopsy alone – resources dependent
TVS: Asymptomatic (no unscheduled bleeding) but incidental ET \geq 10 mm with risk factors for endometrial cancer (x1 major or x2 minor)	USCP	Hysteroscopy + biopsy (preferable) or blind biopsy alone – resources dependent
TVS: Normal ET (\leq 4 mm if ccHRT and \leq 7 mm if sHRT) but, <ul style="list-style-type: none"> • Recurrent unscheduled bleeding six months after HRT adjustments or, • Heavy or Persistent (almost daily) bleeding or, • Intracavity fluid and x1 major or x2 minor risk factors for endometrial cancer 	Urgent	Endometrial assessment (endometrial biopsy and / or hysteroscopy)

When to refer after assessment and TVUS in primary care

Summary

- **Unscheduled bleeding on HRT is common.**
- **Assess** the patient for **abnormal examination findings** or **major risk factors**
- **Adjust / optimise HRT** if indicated.
- Use **direct access TVUS** for people who do not need urgent referral
- Use **USS result to inform** the decision to refer
- Use **advice and guidance** if in doubt
- Post menopausal bleeding **NOT on HRT** - **Urgent suspected cancer referral**

Take aways from today

- Let colleagues know about the **new USC referral form** and **summary guidance**
- Amenorrhoeic women on ccHRT may be at lower risk of endometrial cancer
- Check compliance with HRT and check progesterone dose
- If USS pelvis is indicated from your assessment, **specify "unscheduled bleeding on HRT"** and inform the patient that **transvaginal USS will be offered**.
- Check where your local sources of A+G support for menopause / unscheduled bleeding are.



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References

[BMS joint guidelines management of unscheduled bleeding on HRT](#)

[BMS guidelines management of unscheduled bleeding on HRT \(Summary\)](#)

[BMS Unscheduled bleeding on HRT FAQ document](#)

[NCA Summary of BMS Joint Guidelines Management of Unscheduled Bleeding on HRT](#)

[NENC ICB Management of the Menopause](#)



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Lung Cancer



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National Lung Cancer Screening Programme

- Eligible for all ex-smokers, aged 55-75 years
- Low Res CT every 2 years
- Currently pick up rate ~0.7% lung cancers (Regionally)
- ~80%+ Early Stage (Stage 1&2.)

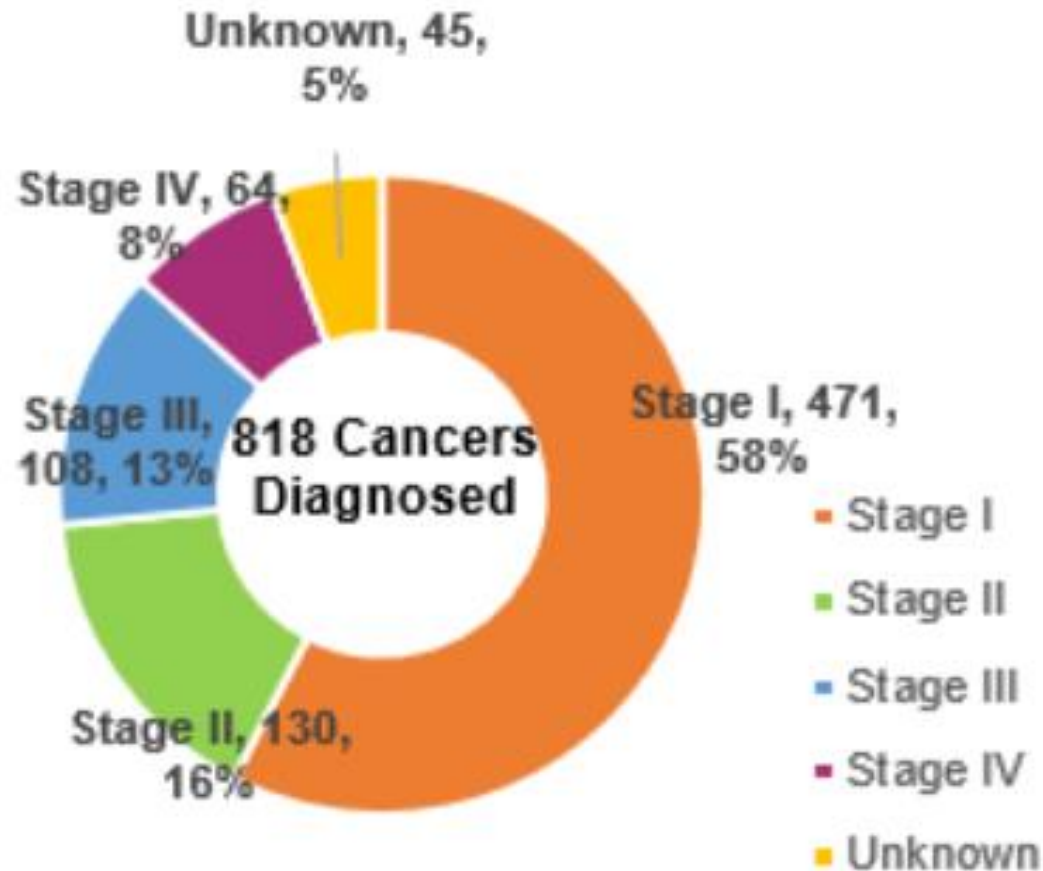
- Please ensure Non-smokers coded appropriately
- Encourage Smokers and Ex-smokers to opt-in (Currently ~63%)
- Proactive search for and engagement with eligible patients with no smoking status recorded
- Trusted health professional really makes a difference here.

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NENC ICB Lung Cancer Screening Programme



- Diagnosed **818 lung cancers**
- **74%** at stage I or II



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Dermatology



Teledermatology



- Teledermatology enables Photos & Dermatoscope images of concerning skin lesions to be attached to Urgent Suspected Cancer (USC) Skin referrals.
- These images can be **viewed by the Dermatologists remotely** and **triaged** into:
 - Reassured and Discharged
 - Direct to Face-to-Face appt
 - Direct to Surgery



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Telederm Advantages:

Patient benefits

- Less travel
- Quicker to have cancer excluded
- Directed to the right surgical clinic / team (derm/ plastics/ maxfac)

Essential elements

- Confidence in recognising benign conditions (**Avoid overload**)
- Good quality images required (**Essential for triage**)
- High-quality triage in Secondary Care. (**Essential for efficiency**)

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How can practices embed Telederm?

1. How can the equipment by maintained and accessible

- Where is the Equipment?
 - Tracking and checking the equipment out.
- Is it Charged?
 - Both iPod/iPhone & Dermatoscope need charging
- Is it Working properly?
 - Mechanical and Technical issues eg Broken cables, attachments etc
- Who reports problems? Clear responsibilities

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2. Training on how to use the equipment and take Quality Images?

- Are all required staff trained to use equipment and to take high quality images
 - Use [Alcohol Gel](#) with the Dermatoscope.
 - Take time to [check that the Quality](#) of the images are high, not blurred.
 - Always assess [FACE-TO-FACE](#) if possible – Don't refer based on Patient's images.
- [Training for the transfer of images](#) to GP IT System
- [Training for Admin / Sec](#) to attach images to referral and **safety netting**
 - Empower Admin / Sec to [feedback](#) to Clinician if image quality poor

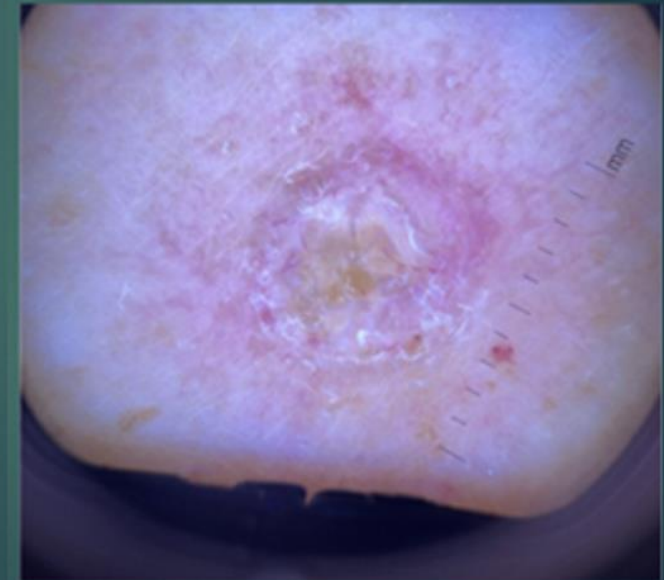
20cm



Close up



Dermoscopy





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3. How can we minimise the Clinical Time taken for this?

Runner Model:

- **This is similar to a chaperone model.**
- Practices may want to consider Clinicians requesting the dermatoscope from Admin, and then Admin bring the equipment to them.
- **They will wait until photos are taken and bring the equipment back for checks and charge.**
- This could save considerable time for the clinician and ensure that the whereabouts and responsibilities for the equipment are always clear.
- Admin would have the same equipment responsibilities as the admin station model.



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Admin Station Model:

- A member or Position of staff is made **responsible** for the Telderm Equipment.
- **Charging** of the iPhone and Dermatoscope attachment, at the start of the day and throughout the day
- **Checking that everything works**
- **Reporting any issues**
- They would also **sign out the equipment** and **track it** when in use
- **Check** equipment **when returns.**



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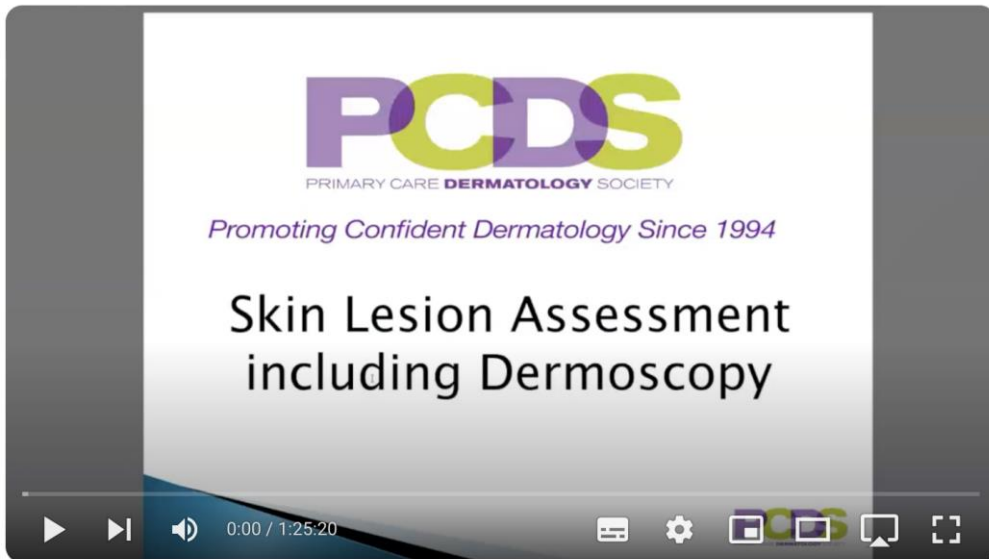
Photo Clinic Model:

- Patients are advised by Clinician to have **photos taken by another member of staff.**
- This can be at **same visit** or **come back for appt** at another time.
- **Within the practice** or **within a PCN Hub.**
- Need to ensure that the **Photo Clinic has access to well-maintained Telederm equipment** (someone needs responsibility).
- They all need training.
- **Lesions need to be marked** to ensure correct lesion is captured.
- Extra visits and travel **may disadvantage some patient groups.**
- Needs a **SAFETY NETTING PROCESS** to ensure that patient returns to have images.

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4. How can we avoid referring benign lesions?

- Clinician involved in referring USC skin referrals could review the [NCA Skin Education video](#).
- Utilise the [Skin lesion Diagnostic tool on PCDS](#)



NCA GP Education | Differentiating Benign from Malignant Skin Lesions in Primary Care

The Cunliffe (TP) Skin Lesion Diagnostic Tool

For benign and cancerous skin lesions (dermoscopic images excluded from melanocytic lesions as considerable e

Skin Lesion Diagnostic Table
Head and neck
Trunk (chest, abdomen, back) / buttocks / axillae / groin
Arms and legs
Hands
Feet
Nails
Genital conditions



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Cancer
Alliance**

The Cunliffe (TP) Skin Lesion Diagnostic Tool

for benign and cancerous skin lesions (dermoscopic images excluded from melanocytic lesions as considerabl

Skin Lesion Diagnostic Table

1: Head and neck

Brown / black / blue / grey

Skin-colour / pink-red / purple

White / white-yellow

Yellow / orange

Deep-seated (much of lesion under skin surface)

Lips

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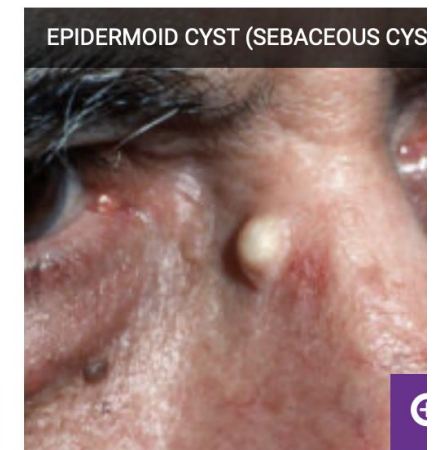
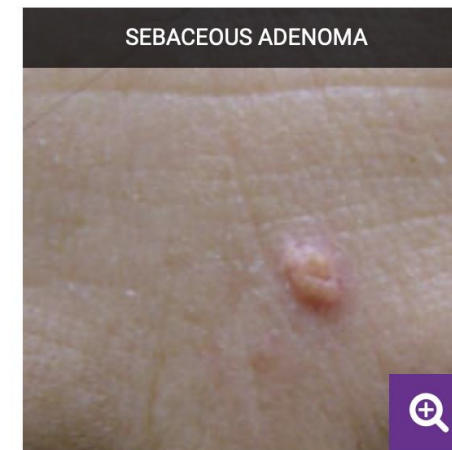
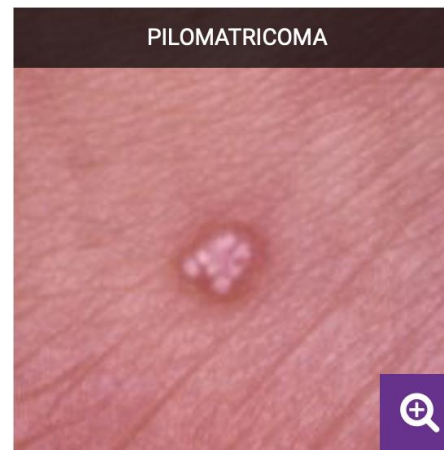
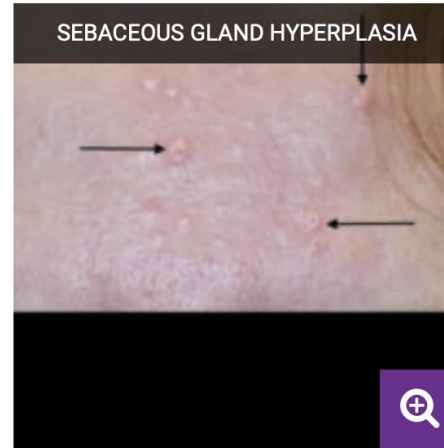
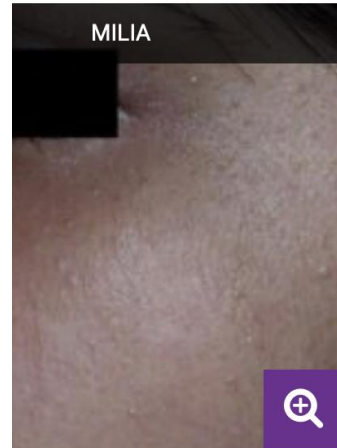
A visual diagnostic tool for benign and cancerous skin lesions (dermoscopic images excluded from melanocytic lesions as considerable experience required)

Skin Lesion Diagnostic Table

1: Head and neck

2: White / white-yellow

Results



4. How can we avoid referring benign lesions?

- Ensure **supervision available** for FT's, GPST's ... &
- Ensure **support available** for inexperienced clinicians
 - **Knock on door** for 2nd opinion
 - **Ask experienced clinician for opinion** on the images within GP IT system prior to referral

5. How can we avoid delays in USC referrals?

- Patients waiting for images or having to revisit practice or attend hub may lead to DNA or Delay.
- **Safety netting is key** to pick up on patients that may DNA.
- It is **reasonable to take upto 7 days to capture good quality images** for teledermatology prior to the the referral on the USC Skin Pathway.



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Resources to help with Teledermm processes.

NCA Website:

- <https://northerncanceralliance.nhs.uk/primary-care/dermatology-primary-care/>

The screenshot shows the Northern Cancer Alliance website. The top navigation bar includes links for Home, Primary Care, Covid-19, About Us, Alliance Blog, and a search icon. The NHS logo is also present. The main content area is titled 'Dermatology – Primary Care'. On the left, there is a sidebar menu with options for Primary Care, Breast – Primary Care, Dermatology – Primary Care (highlighted), QI: Digital Dermatology, and Urology – Primary Care. The main content area features a training video titled 'TRAINING VIDEO – PCDS Skin Lesion Assessment including Dermatology:'. Below the title is a link to 'Download the presentation here (PDF 14mb)'. The video player shows a man in a red shirt speaking in a clinical setting. The video title is 'NCA GP Education | Differentiating Benign fro...'. Below the video player is the text 'Digital Dermatology Pathway'.

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Resources to help with Telederm processes.

NCA Website:

[QI: Digital Dermatology Page.](#)

The screenshot shows the Northern Cancer Alliance website. The top navigation bar includes links for Home, Primary Care, Covid-19, About Us, Alliance Blog, and a search icon. The NHS logo is also present. The main content area is titled "QI: Digital Dermatology" and features a sidebar with navigation options: Primary Care, Dermatology – Primary Care, and QI: Digital Dermatology. The main text discusses the coordination of a Cancer Referral Quality Improvement project for Digital Dermatology, listing key actions such as appointing a PCN lead, ensuring clinical and non-clinical champions, and suggesting review times for referrals. It also provides considerations for reviewing referrals, such as ensuring digital images are included and of acceptable quality.

northern cancer alliance

Home Primary Care Covid-19 About Us Alliance Blog Q NHS

Primary Care

QI: Digital Dermatology

Dermatology – Primary Care

QI: Digital Dermatology

Cancer Referral Quality Improvement: Digital Dermatology example

This will be coordinated by PCN but likely PCN GP practices will have different issues.

- Appoint **PCN lead** for the project to coordinate
- Ensure that each practice has a **Clinical Champion** and **Non-Clinical champion**.
- Suggest review **20 to 30**, Fast Track Suspected Cancer referrals skin referrals in each practice within the PCN.

On review of the referrals, could consider:

- Does referral **contain Digital Images** (Three appropriate images OR appropriate reason why missing)
- Check **Image Quality for acceptability** – ie Images in Focus, Correct views.

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Breast Pain Pathway



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Important

- **Urgent suspected cancer referral criteria is unchanged**
- One stop clinics
- **Breast pain alone is not a symptom of breast cancer**
- Breast pain pathway supports symptom management in primary care and outlines secondary care approach.
- Obtain a **family history** and refer patients above population risk to a breast family history clinic. (Genetics)



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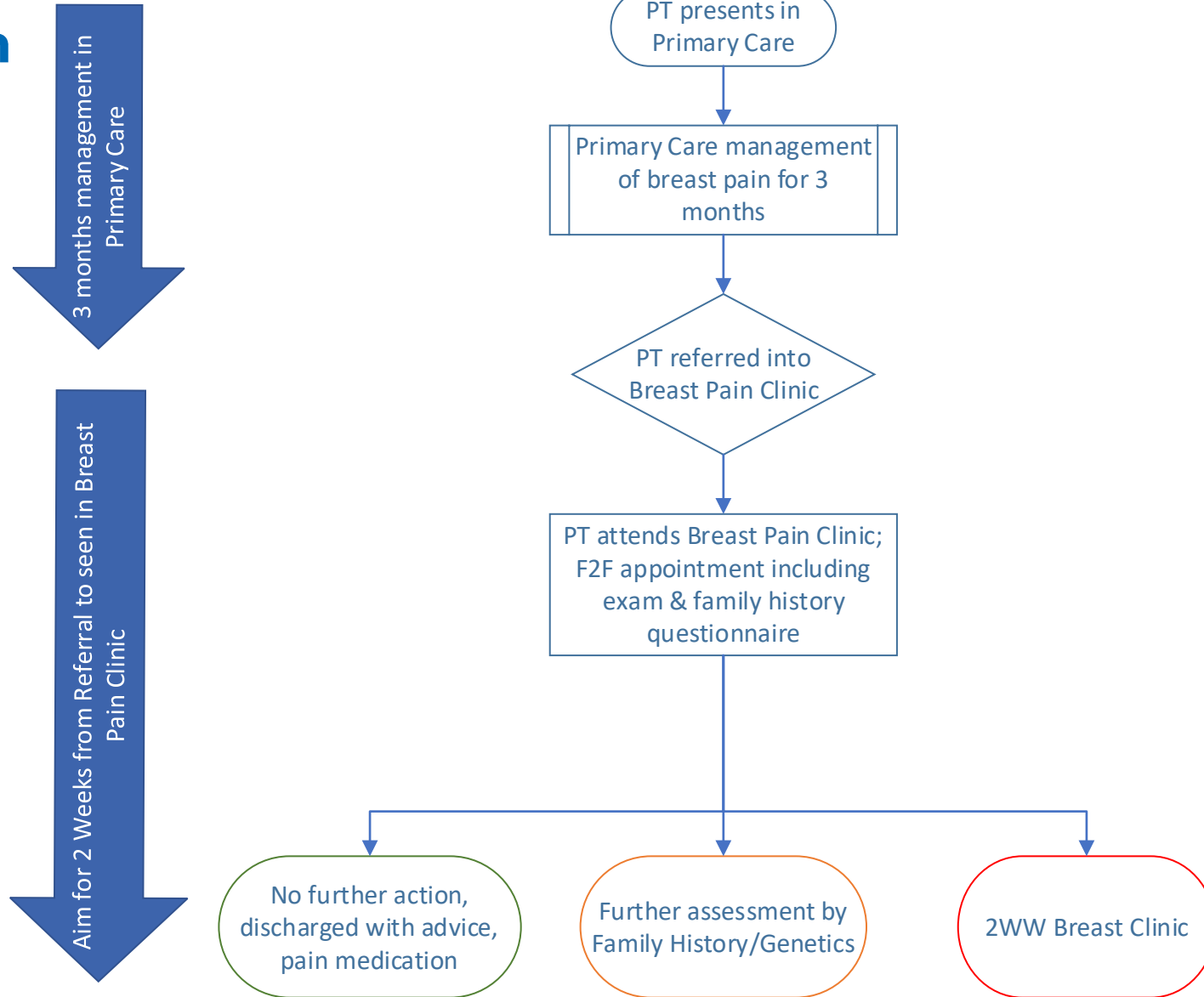
Why develop a breast pain pathway?

- Breast pain as only symptom
- Limited options for referral (USC, symptomatic pathway,)
- All previously managed as USC.
- **Risk of cancer is less than for screened population**
- Imaging **not** needed
- Improved resource management
- Experience from East Mid, Manchester, ABS Aspire study positive

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Making a referral

**Suspected Cancer in Adults
URGENT 2WW and Non-Urgent
BREAST**



Join our Journey

CDRC Supporting Clinical Decisions North East and North Cumbria



Date of referral **Short date letter merged**

Name:	Full Name	DOB:	Date of Birth	NHS No	NHS Number
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Attach this form to the e-referral within 24 hours

If the ERS not available, then send [this form](#) AND 'Referral header sheet' by secure email

- Patient has been informed that this is an urgent referral for suspected cancer
- The patient is available and willing to attend for tests/appointment within 14 days
- The patient has been given the 2WW patient information leaflet

Hyperlinks to: [NICE GUIDANCE](#) [Patient info leaflet including easy read](#) [GP Breast Pain Pathway Information](#) [Breast Pain Patient Leaflet](#)

Symptomatic	Yes	2ww Suspected Cancer	Yes
Cancer NOT suspected		Please use this section if your patient is LIKELY to have Breast Cancer	

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Symptomatic Cancer NOT suspected	Yes	2ww Suspected Cancer Please use this section if your patient is LIKELY to have Breast Cancer	Yes
Patients with breast pain alone (no palpable abnormality). I confirm prior recent primary care management as cancer extremely unlikely i.e 12 weeks regular NSAID or paracetamol as a minimum in line with NICE guidance NHS Breast Pain Info can be found here .	<input type="checkbox"/>	Aged 30 and over and have an unexplained breast lump with or without pain	<input type="checkbox"/>
People aged < 30 years with a lump	<input type="checkbox"/>	Aged 50 and over with any of the following symptoms in one nipple only: discharge retraction Other changes of concern	<input type="checkbox"/>
Asymmetrical nodularity/lumpiness or thickening (without discrete lump) that persists at review after menstruation	<input type="checkbox"/>		
Infection or inflammation that fails to respond to antibiotics	<input type="checkbox"/>	Skin changes that suggest breast cancer	<input type="checkbox"/>
Unilateral, eczematous skin of areola or nipple without other worrying signs such as lump, discharge, bleeding or ulceration. I confirm recent topical treatment (such as 0.1% mometasone) was applied for 2 weeks with no clinical response.	<input type="checkbox"/>	Aged 30 and over with an unexplained lump in the axilla.	<input type="checkbox"/>
Unilateral, spontaneous, non-bloody nipple discharge that is persistent or troublesome in people under 50yrs	<input type="checkbox"/>		

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Useful information

- Information for primary care
 - [Breast - Primary Care - Northern Cancer Alliance Northern Cancer Alliance](#)
 - [breast pain pathway information for GPs](#)
- Patient information Leaflet:
 - [Breast pain patient information leaflet](#)



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Information for GP's on Breast Pain - Flow Chart



Key:

Primary Care

Secondary Care

Family history assessment based on NICE CG164 or FaHRAS toolkit

Reassurance:

- a) No association between breast pain alone and breast cancer
- b) Risk of breast pain only as a symptom of breast cancer is less than population risk

Take history including enquiring about family history
EXAMINE BREASTS

No breast lump or other clinical signs on examination

Family history suggested near population risk

Family history suggests moderate / high risk

Clinical sign present e.g. lump, discharge

Refer to breast clinic as appropriate

Information

<https://breastcancernow.org/information-support/have-i-got-breast-cancer/benign-breast-conditions/breast-pain>
<https://www.nhs.uk/conditions/breast-pain/>
<https://www.nhs.uk/common-health-questions/mens-health/what-is-gynaecomastia/>

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CYCLICAL

Management

(Same advice whether uni- or bilateral)

Review possible treatment options with patient.
Can be offered concurrently.

- Advise to get bra fitting checked (& wear supportive underwear 24hrs/day).
- OTC treatment: Paracetamol 1g QDS, daily for 2 weeks.
- Stop if no improvement. Further 2 weeks if improvement.
- OTC treatment: NSAID topical gel for 2-3 months
- OTC treatment (not to be prescribed): Oil of evening primrose*(EPO). A standardised capsule of EPO (500mg) contains approximately 40mg of gamolenic acid (GLA). The dose is usually 120-160 mg of gamolenic acid twice daily

*A randomised controlled trial reported a 12% decrease in number of days with breast pain for evening primrose oil compared with 14% for placebo. NICE clinical knowledge summaries.

If no improvement or pain persists then refer to breast clinic for review

NON-CYCLICAL

Management

Consider causes of pain referred to the breast: e.g. costochondritis, axilla, idopathic, infections, periductal mastitis. If infective consider breast unit referral if necessary.

Review possible treatment options with patient. Can be offered concurrently.

- OTC treatment: Paracetamol 1g QDS, daily for 2 weeks.
- Stop if no improvement. Further 2 weeks if improvement.
- OTC treatment: NSAID topical gel for 2-3 months

If specific reason (e.g. new sign such as lump or infection) or persistent severe pain then refer to breast clinic

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Things to know if you have breast pain



Breast Pain is very common in women of all ages.

Having breast pain alone without a lump or other changes, means breast cancer is unlikely.

There are different types of breast pain

- Pain that comes and goes at different times, sometimes linked to a woman's periods
- A pain that doesn't go away, or lasts a long time

If your breast pain doesn't go away, go to your GP who will examine you to check for any other symptoms.



About breast pain

Most breast pain will clear up on its **own within 3 months** and will not need any treatment.

Sometimes pain that feels as though it's in the breast is coming from somewhere else, such as a pulled muscle in the chest. This is known as chest wall pain. Your doctor can help you understand the pain and if any treatment is needed.



Treatment

Your GP may recommend you try some of the following to help you with your breast pain

- Bra fitting
- Pain relief tablets or Pain relief gel
- There are herbal remedies that your GP may suggest, such as Oil of Evening Primrose

If these treatments don't help, your GP can refer you to a breast pain clinic. The nurse will talk to you about symptoms and also your family history.



We understand breast pain can be upsetting, however in most cases it will be the result of normal changes that occur in your breasts.

Having breast pain alone without a lump or other changes, means breast cancer is unlikely. However, it is still important to be breast aware and go to your GP if the pain gets worse or changes, or you notice any other changes to your breasts.



More information can be found in the Breast Cancer Now booklets

Breast Pain: bit.ly/3R3EB8q

Know your Breasts: bit.ly/3ZND61X



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**North East and
North Cumbria**

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