# NICE Guideline Suspected Cancer: Recognition & Referral June 2015

NICE have just published their updated guideline for cancer referrals in all cancers which updates the CG27 (2005) Referral guidelines for suspected cancer.

The full guideline, which is a 378 page document is available on the NICE website.

On behalf of the BAUS Section of Oncology we have summarised their findings salient to our urological practice.

Prior guidance used a disparate range of percentage risks of cancer in their recommendations. The guideline development group felt that in order to improve a diagnosis of cancer and thus more patients with cancer would have expedited diagnosis, a positive predictive value threshold lower than 3% was preferable.

The guideline offers recommendations and uses terminology:

- 'Offer' – for the vast majority of patients, an intervention will do more good than harm (based on high quality evidence)
- 'Consider' – the benefit is less certain, and an intervention will do more good than harm for most patients (based on poor quality evidence or no evidence).

**Prostate Cancer Guidance**

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| Recommendations | Refer men using a suspected cancer pathway referral (for an appointment within 2 weeks) for prostate cancer if their prostate feels malignant on digital rectal examination. [new 2015]<br><br>Consider a prostate-specific antigen (PSA) test and digital rectal examination to assess for prostate cancer in men with:<br>• any lower urinary tract symptoms, such as nocturia, urinary frequency, hesitancy, urgency or retention or<br>• erectile dysfunction or<br>• visible haematuria. [new 2015]<br><br>Refer men using a suspected cancer pathway referral (for an appointment within 2 weeks) for prostate cancer if their PSA levels are above the age-specific reference range. [new 2015] |

There is little change in comparison to the 2005 document apart from the removal of PSA testing in men with lower back pain (due to PPV 0.13) and weight loss in the elderly – only a very small number of men with weight loss, without LUTs with a normal DRE have been found in the literature. They suggest investigation into myeloma in primary care in the first instance. There is no mention of an age cut-off for referral or need for a certain life expectancy.

**Bladder Cancer Guidance**

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| Recommendations | Refer people using a suspected cancer pathway referral (for an appointment within 2 weeks) for bladder cancer if they are:<br>• aged 45 and over and have:<br>- unexplained visible haematuria without urinary tract infection or<br>- visible haematuria that persists or recurs after successful treatment of urinary tract infection, or<br>• are aged 60 and over and have unexplained non-visible haematuria and either dysuria or a raised white cell count on a blood test. [new 2015]<br><br>Consider non-urgent referral for bladder cancer in people aged 60 and over with recurrent or persistent unexplained urinary tract infection. [new 2015] |

It is the diagnosis of bladder cancer where there have been major changes for UK Urological practice in this document.

Previously ***any*** painless visible haematuria ***of any age*** was referred by the 2WW guidelines. However as the PPV of ***any*** haematuria was 0.99 for men <45 years and 0.22 for women < 45 years, 2WW referral is recommended only for people with visible haematuria age >45 without a UTI, or persisting/recurring despite treatment of a UTI.

NICE have raised the age limit for **2WW** non-visible haematuria to 60 years of age **with one of the additional findings**:

- Dysuria (PPV 4.5)
- Raised White cell count on blood testing (PPV 3.9)

Asymptomatic non-visible haematuria has a PPV of 0.79% and 1.6% for patients aged 40-59 years and >60 years respectively and **no longer require urgent referral**. (Previously, any patients over 50 years who were found to have unexplained microscopic haematuria – an urgent referral was suggested).

They have recommended a non-urgent referral for patients >60 years with recurrent UTIs (without haematuria) due to PPV 0.5%. The guideline development group considered that this was a population in which cancer could be missed (despite the below threshold PPV) and thus a non-urgent referral has been suggested.

Due to the rising of the age parameters in both visible and non-visible haematuria but with the addition of recurrent/persistent UTIs – NICE expect the exercise to be cost neutral or a small cost increase.

**Renal Cancer Guidance**

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| Recommendations | Refer people using a suspected cancer pathway referral (for an appointment within 2 weeks) for renal cancer if they are aged 45 and over and have:<br>• unexplained visible haematuria without urinary tract infection or<br>• visible haematuria that persists or recurs after successful treatment of urinary tract infection. [new 2015] |

The renal cancer guidance mirrors that of the bladder cancer as above.

PPV for renal cancer for **any** haematuria increases with age. In men from it increases from 4.35% (45-54 years of age) to 11.21% (65-74 years) but the PPV for <45 years of age is 0.99%. In women the chances are lower from 1.34 (45-54 years) rising to 8.53% (>85 years). Again the PPV for age <45 is low at 0.22%. Although the PPVs are different between the sexes – the decision to have a single consistent "haematuria" referral for both bladder and renal cancer has been advised.

NICE also reported that the presence of abdominal pain and microcytosis on a blood test had a PPV of >5% for renal cancer however they recommended referral for this cohort of patients to be directed to colorectal (PPV >10% for colorectal cancer). The finding of a clinical mass on examination should be managed by either a colorectal or gynaecological (ovarian) 2WW appointment rather than a urological referral.

There has been no mention in this document of how to refer the incidental finding of an abdominal mass identified clinically or on imaging that is thought to be arising from the urinary tract.

**Testicular Cancer Guidance**

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| Recommendations | Consider a suspected cancer pathway referral (for an appointment within 2 weeks) for testicular cancer in men if they have a non-painful enlargement or change in shape or texture of the testis. [new 2015]<br><br>Consider a direct access ultrasound scan for testicular cancer in men with unexplained or persistent testicular symptoms. [new 2015] |

Very little change since the 2005 document, however they have advised that if a patient has new testicular symptoms (not a mass) a direct access ultrasound can be arranged without urological involvement.

**Penile Cancer Guidance**

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| Recommendation | Consider a suspected cancer pathway referral (for an appointment within 2 weeks) for penile cancer in men if they have either:<br>• a penile mass or ulcerated lesion, where a sexually transmitted infection has been excluded as a cause or<br>• a persistent penile lesion after treatment for a sexually transmitted infection has been completed. [new 2015]<br><br>Consider a suspected cancer pathway referral (for an appointment within 2 weeks) for penile cancer in men with unexplained or persistent symptoms affecting the foreskin or glans. [new 2015] |

The only addition is that if a STI is suspected – it should be treated in first instance and only referred if a STI is not suspected or the lesion is persistent despite treatment of the STI.