Faster Cancer Treatment

MINISTRY OF HEALTH
MANATŪ HAUORA

Faster Cancer Treatment:
High suspicion of cancer definitions

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Introduction

The following definitions have been developed by clinically-led tumour standards working groups to support achievement of the Faster cancer treatment (FCT) health target by clarifying what constitutes a 'high suspicion of cancer' for ten tumour streams.

Faster cancer treatment health target

85 percent of patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks by July 2016, increasing to 90 percent by June 2017.

The FCT health target builds on the significant improvements that have been made in the quality of cancer services over recent years. It provides a lens across the whole cancer pathway to ensure people have prompt access to excellent cancer services.

The following points are applicable across all definitions:

A resource for triaging(or prioritising) clinicians
The definitions have been developed for use, in the first instance, by triaging (or prioritising) clinicians within secondary and tertiary care who are responsible for determining or confirming the 'high suspicion of cancer' flag. DHBs are encouraged to consider how the definitions can be adapted and used to support improved detection and referral of patients with a high suspicion of cancer from primary care.

Apply to the 'high suspicion of cancer' component of the health target
To be included within the FCT health target cohort a patient must have both a high suspicion of cancer *and* a need to be seen within two weeks. The definitions only apply to the 'high suspicion of cancer' component of the FCT health target and are not intended to define the urgency of the referral. The triaging clinician will need to make a separate assessment of whether a patient meets the criteria of needing to be seen within two weeks.

Guidance to help inform clinical judgement
The definitions are intended as guidance to help inform clinical judgement. If other features/symptoms/signs exist that raise concerns, the triaging clinician can still choose to triage as 'high suspicion of cancer'.

Risk factors have been included for some tumour types
Some tumour streams have included risk factors to support their high suspicion of cancer definitions, with particular consideration of specific factors that that may influence the triaging process. It should also be noted that Māori present with cancer at an earlier age than non-Māori across all tumour types.

Referrals with a positive fine needle aspiration and/or biopsy
Patients referred though an outpatient pathway with a positive fine needle aspiration (FNA) and/or biopsy for cancer at the time the referral is received within secondary/tertiary care should be triaged as having a high suspicion of cancer (rather than a confirmed cancer) and included within the FCT health target cohort. This is because these patients will require further investigations and assessment before a confirmed diagnosis and decision on treatment is made. It also supports direct access to diagnostics from primary care.

Gynaecological High Suspicion of Cancer 'Red Flags'

If the patient presents with one or more of the following red flags, then the referral should be triaged as 'High Suspicion of Cancer'
Biopsy-proven or cytology positive gynaecological malignant or premalignant disease[3] or Gestational Trophoblastic Disease
A visible abnormality suspicious of a vulval, vaginal or cervical cancer (such as an exophytic, ulcerating or irregular pigmented lesion)[4]
Significant symptoms (including abnormal vaginal bleeding, discharge or pelvic pain) AND Abnormal clinical findings suspicious of gynaecological malignancy (including lymphadenopathy, vaginal nodularity or pelvic induration)[5]
Post-menopausal bleeding. N.B. High suspicion of cancer may be excluded if physical examination, smear and vaginal ultrasound are normal[6]
A rapidly growing pelvic mass or genital lump[7]
Women with a palpable or incidentally-found pelvic mass (including any large complex ovarian mass >8 cm) UNLESS investigations (ultrasound and tumour markers) suggest benign disease[8]
Women with a documented genetic risk who have a suspicious pelvic abnormality or symptoms[9]

[3] Please see National Cervical Screening Programme recommendations for colposcopy referral.
[4] Women with an undiagnosed visible genital abnormality which is not highly suspicious of malignancy should be referred for gynaecological or dermatology review or undergo a biopsy.
[5] Women with gynaecological abnormalities or symptoms may also have gynaecological malignancy and the development of triage pathways is encouraged. Specific consideration includes premenopausal women with abnormal uterine bleeding. Those with persistent or deteriorating symptoms should be reviewed by a gynaecologist. A raised CA125 supports the need for further investigation in woman with persistent pelvic or abdominal symptoms.
[6] Early access to vaginal ultrasound will reduce demand on secondary services. Women without post-menopausal bleeding but with a thickened endometrium should undergo Gynae review but are not defined as high risk.
[7] Discernible growth within a 3 month period is normally of concern. Undiagnosed external genital lumps with any discernible growth should normally be reviewed by a gynaecologist and/or biopsied.
[8] The development of referral pathways is recommended to ensure rapid assessment of patients with a pelvic mass, early access to pelvic ultrasound is seen as crucial to this process.
N.B. Suspicion of ovarian malignancy is indicated by metastatic disease, ascites or radiologist's impression, a raised CA125 in a post-menopausal woman or germ cell markers in a woman under 25. The risk of malignancy index (RMI) is utilised to triage patients for subspecialty care.
[9] Usually women with strong family history or known hereditary nonpolyposis colorectal cancer (HNPCC) or BRCA mutations.