GP-Update Red Whale

Summary of the NICE 2015 Suspected Cancer Guidelines

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Definitions	
Offer	A strong recommendation: NICE are confident that for most patients the benefits will outweigh any harms and the intervention will be cost effective.
Consider	NICE are confident the intervention will do more good than harm in most patients and be cost effective. However other options may be similarly cost effective, and there may be more choice around whether or not to have an intervention, or which intervention to have. NICE say more time should be spent considering the options and discussing these with the patient.
Refer via cancer pathway	To be seen within national target for cancer referrals (currently 2 weeks).
Raises the suspicion of	A mass or lesion with characteristics that make cancer a significant possibility.
Unexplained	Symptoms/signs where a diagnosis has not been made after initial assessment of the history, examination and primary care investigations.
Consistent with	Finding has characteristics that could be many things, of which cancer is one possibility.
Persistent	Continuation of symptoms/signs beyond a period normally associated with self-limiting problems.
Immediate	Within a few hours.
Very urgent	Within 48 hours
Urgent	Within 2 weeks
Children	Birth to 15 years
Young people	16–24 years

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Registered in England and Wales no. 7135974
Registered Office: Prospect House, 58 Queens Road, Reading, RG1 4RP
You can contact us at: GP Update, Science & Technology Centre, The University of Reading, Earley Gate, Whiteknights Road, Reading RG6 6BZ

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Suspected cancer: NICE Guidelines

The Red Whale|GP Update Team have produced this summary of the NICE Guidelines on suspected cancer (NG12, 2015). We recognise that the guidelines are complex (even after we have summarised them!), and GPs cannot be expected to memorise them, so we have produced our summary in this handy booklet to keep on your desk.

The key points about the new NICE guidelines, compared with the previous guidance:

- They are based on research undertaken on patients in primary rather than secondary care.
- The guidelines are presented in two ways: first by cancer (lung, breast) (page 2 onwards) and then by symptom (abdominal pain, weight loss) (page 17 onwards).
- In these new guidelines the threshold for referral has been lowered from a positive predictive value (PPV) of 5% to a PPV of 3%. (The PPV of a symptom is the proportion of the people with the symptoms who actually have the disease.)
- The guidelines are more flexible and expect GPs to use their clinical acumen. **If you have a high suspicion of cancer, act on the suspicion <u>even if the patient does not meet the criteria.</u> Equally, if you have a high suspicion, do not be reassured by a negative test.**

When using the guidelines:

- Start with the patient's presenting symptom(s). This may suggest several possible cancer diagnoses.
- Cross reference symptoms to the guideline for each cancer suggested.
- If the patient presents with multiple symptoms, look at the guideline relating to each symptom.

Investigations:

- An FBC is obviously useful to look for anaemia and haematological malignancies but is also useful in other cancers.
  - Raised platelets are part of the referral criteria for lung, oesophageal, gastric and endometrial cancers.
  - A raised white count in those with non-visible haematuria is a trigger for bladder cancer investigations (if aged 60 or older).
- Not all investigations (particularly endoscopy and imaging) are directly accessible to all to GPs.

Remember that safety netting is crucial. NICE recommend:

- Test results are reviewed and acted on by the person who ordered the test (or specifically handed over to another appropriate person).
- Consider a planned review for people with symptoms that are associated with an increased risk for cancer but who do not meet referral criteria. Give patients information about what new symptoms to look out for and what to do if symptoms worsen, recur or persist.

IT support is desperately needed to help identify people who meet the criteria, as the complexity of the guidance means you will not be able to hold every permutation in your head, and there is a risk we will fail to spot people with the relevant collection of symptoms. In the meantime we hope this little book will help to some degree!

Respiratory cancers	
Lung cancer and mesothelioma	
Refer via cancer pathway	• CXR findings are suggestive of lung cancer. • Aged >40y with <u>unexplained</u> haemoptysis.
Offer an <u>urgent</u> CXR	• Aged >40y with the following symptoms that are unexplained (if smoker/ex-smoker/asbestos exposure: 1 symptom is needed, if never smoked, 2 symptoms needed): o Cough. o Fatigue. o Shortness of breath. o Chest pain. o Weight loss. o Appetite loss.
Consider <u>urgent</u> CXR (within 2w)	• Aged >40y with: o Persistent or recurrent chest infection. o Finger clubbing. o Supraclavicular or persistent cervical lymphadenopathy. o Chest signs consistent with lung cancer or pleural disease. o Thrombocytosis.

Gastrointestinal cancers	
Oesophageal and gastric cancer	
Consider cancer pathway referral	• Upper abdominal mass consistent with stomach cancer.
Urgent direct access OGD	• Dysphagia. • Aged ≥55y with weight loss with any of upper abdominal pain/ reflux/dyspepsia.
Consider non-urgent direct access OGD	• Haematemesis *(clearly use your clinical judgement here!).* • Aged ≥55y with: o Treatment resistant dyspepsia. o Upper abdominal pain and low haemoglobin. o Raised platelet count AND any of nausea/vomiting/weight loss/reflux/dyspepsia/upper abdominal pain. o Nausea and vomiting AND any of weight loss/reflux/dyspepsia/ upper abdominal pain.
Pancreatic cancer	
Refer via cancer pathway	• Refer using suspected cancer pathway if aged ≥40y and have jaundice. *(The evidence did not distinguish obstructive from non-obstructive jaundice. Other causes of jaundice were considered more likely if <40y.)*
Consider urgent direct access CT scan (or urgent USS if CT not available)	• ≥60y with weight loss and any of: o Diarrhoea. o Back pain. o Abdominal pain. o Nausea/vomiting. o Constipation. o New onset diabetes. (USS only images the head of the pancreas, CT images the whole pancreas and may detect other cancers.)
Gallbladder cancer	
Consider urgent direct access USS	• Upper abdominal mass consistent with an enlarged gallbladder.

Gastrointestinal cancers (continued)	
Liver cancer	
Consider urgent direct access USS	• Upper abdominal mass consistent with an enlarged liver.
Colorectal cancer	
Refer via cancer pathway	• Aged ≥40y with unexplained weight loss and abdominal pain. • Aged ≥50y with unexplained rectal bleeding. • Aged ≥60y with: o Iron deficiency anaemia *(N.B. in draft guidance NICE defined this as Hb ≤12 in men and Hb ≤11 in women – this was based on primary care research that showed these lower thresholds would pick up more cases – it was removed from final guidance and left to our discretion).* o Changes in their bowel habit. • Positive FOB test taken under the circumstances detailed below.
Consider cancer pathway referral	• Rectal or abdominal mass. • <50y and rectal bleeding with any of the following unexplained symptoms or findings: o Abdominal pain. o Change in bowel habit. o Weight loss. o Iron deficiency anaemia.
Offer FOB testing to assess for colorectal cancer in people without rectal bleeding who:	• Aged 50y and over and have abdominal pain or weight loss. • Aged <60y and have change in bowel habit or iron deficiency anaemia. • Aged 60y and over and have anaemia – even in the absence of iron deficiency.
Anal cancer	
Consider cancer pathway referral	• Unexplained anal mass or ulceration.

Male cancers	
Prostate cancer	
Refer via cancer pathway	• Prostate feels malignant on digital rectal examination (DRE). • PSA above age-specific reference range.
Consider DRE and PSA test to assess for prostate cancer in men with:	• Any lower urinary tract symptoms such as nocturia, urinary frequency, hesitancy, urgency or retention. • Erectile dysfunction. • Visible haematuria (in the absence of UTI or not resolving/ recurring after successful treatment).
Testicular cancer	
	Peak age of onset 30-34y.
Refer via cancer pathway	• Non-painful enlargement or change in shape or texture of the testis.
Consider direct access USS as part of clinical reassessment	• Unexplained or persistent testicular symptoms.
Penile cancer	
Refer via cancer pathway	• Penile mass or ulcerated lesion and STI excluded, or • Persistent penile lesion after treatment for STI completed.
Consider cancer pathway referral	• Unexplained or persistent symptoms affecting the foreskin or glans.

Breast cancers	
Breast cancer	
Refer using suspected cancer pathway	• If aged >30y and: o Unexplained breast lump with or without pain. • Aged ≥50y with any of the following symptoms in one nipple only: discharge, retraction, or other changes of concern (e.g. Paget's).
Consider cancer pathway referral	• With skin changes that suggest breast cancer. • In people aged ≥30y with an unexplained axillary lump.

Gynaecological cancer	
Ovarian cancer	
Refer using suspected cancer pathway	• Physical examination suggests ascites and/or pelvic or abdominal mass not obviously a fibroid.
Consider the possibility of ovarian cancer in the following situations and perform primary care tests (CA125 initially)	• Women presenting with the following symptoms, if persistent or frequent (especially if more than 12×/m) and especially if the woman is over 50y: o Persistent abdominal distension. o Early satiety and/or loss of appetite. o Pelvic or abdominal pain. o Increased urinary urgency and/or frequency. OR Any of the following symptoms: o Unexplained weight loss. o Fatigue. o Changes in bowel habit. OR o New onset of IBS symptoms in the last 12m in women aged ≥50y (IBS rarely presents for the first time at this age). (Note: NICE does not include post-menopausal or abnormal bleeding in this list despite it being a sign of ovarian cancer. This is because they would expect us to refer this through the appropriate 2ww guidance.) **If CA125 is 35IU/ml or greater:** arrange urgent USS of abdomen and pelvis . Refer urgently if results suggest ovarian cancer. **If CA125 is less than 35IU/ml OR if Ca125 is raised but USS is norm**al: reassess and safety net carefully – advise return if symptoms become more frequent or persistent.

Gynaecological cancer (continued)	
Endometrial cancer	
Refer suspected cancer pathway	• Aged ≥55y with PMB (unexplained vaginal bleeding >12m after menstruation has stopped because of the menopause).
Consider cancer pathway referral	• Aged <55y and PMB.
Consider direct access USS	Aged ≥55y with: • Unexplained vaginal discharge AND o are presenting with these symptoms for the first time or o have thrombocytosis or o report haematuria. • Visible haematuria and any of: o anaemia o thrombocytosis o high blood glucose levels.
Cervical cancer	
Consider cancer pathway referral	• If appearance of the cervix is consistent with cervical cancer.
Vulval cancer	
Consider cancer pathway referral	• Unexplained vulval lump, ulceration or bleeding.
Vaginal cancer	
Consider cancer pathway referral	• Unexplained palpable mass in or at the entrance to the vagina.

Renal tract cancer	
Bladder/renal tract cancer	
	The age threshold for both visible and nonvisible haematuria has been raised. *Remember that haematuria may be a feature of prostate or endometrial cancer as well as bladder/renal cancer.*
Refer via cancer pathway	• Aged ≥45y and have unexplained visible haematuria without UTI or visible haematuria that persists or recurs after successful treatment of UTI (?bladder or renal cancer). • Aged ≥60y with unexplained non-visible haematuria and either dysuria or raised blood white cell count (?bladder cancer).
Consider <u>non-urgent</u> referral	• Aged ≥60y with recurrent or persistent UTI that is unexplained (?bladder cancer).

Skin cancers	
Malignant melanoma	
Refer suspected cancer pathway	• Dermoscopy suggests malignant melanoma. • Suspicious pigmented skin lesion that scores 3 or more from weighted 7 point checklist: Major features (score 2 points each): o Change in size. o Irregular shape. o Irregular colour. Minor features (score 1 point each) o Largest diameter ≥7mm. o Inflammation. o Oozing. o Change in sensation.
Consider cancer pathway referral	• A pigmented or non-pigmented skin lesion that suggests nodular melanoma.
Squamous cell carcinoma (SCC)	
Consider cancer pathway referral	• A skin lesion that raises the suspicion of SCC. *No recommendations were made on the use of dermoscopy as there is very limited and low quality evidence.*
Basal cell carcinoma (BCC)	
	GPs should ONLY excise suspected BCCs in accordance with NICE guidelines on improving outcomes for people with skin tumours.
Consider routine referral	• A skin lesion that raises suspicion of BCC.
***Only* consider suspected cancer pathway**	• *If* delay in removing a suspected BCC may have an unfavourable impact, e.g. due to the size or location.

Head and neck cancers	
Oral cancer	
	Most are diagnosed by dentists.
Consider urgent referral for assessment by a community dental service	• Unexplained: o Lump on lip or oral cavity that has not been assessed by dental surgeon. o Red or white patch in the oral cavity consistent with erythroplakia or erythroleukoplakia. *(N.B. this is currently outside the remit of this service as it was set up to manage children and people with special needs; people could see their own dentist but this will incur a charge.)*
Consider cancer pathway referral	• A lump on their lip or oral cavity assessed by dental surgeon and consistent with oral cancer. • Unexplained ulceration in oral cavity lasting >21d. • Persistent and unexplained neck lump.
Laryngeal cancer	
Consider cancer pathway referral	• Aged ≥45y with persistent unexplained hoarseness or unexplained neck lump.
Thyroid cancer	
Consider cancer pathway referral	• Unexplained thyroid lump.

Brain and CNS cancer	
Brain and CNS cancer	
Adults: **consider urgent direct access MRI brain scan**	• **Adults** with progressive, sub-acute loss of CNS function (brain MRI is superior to brain CT). *NICE considered allowing GPs direct access to imaging to provide a faster diagnostic process than referral to neurology first. They did not provide alternate recommendations for areas where there is no direct access to imaging, but this is most likely to involve a cancer pathway referral to neurology. If in doubt, discuss with neurology.*
Children and young people: consider <u>very urgent</u> referral	• **Children and young people** with newly abnormal cerebellar or other central neurological function.

Haematological malignancies	
Leukaemia	
Adults: consider FBC within 48h	• **Adults** with any of the following: o Pallor o Persistent fatigue o Unexplained fever o Unexplained persistent or recurrent infection o Generalised lymphadenopathy o Unexplained bruising o Unexplained bleeding o Unexplained petechiae o Hepatosplenomegaly
Children and young people: refer for immediate specialist assessment	• Unexplained petechiae or hepatosplenomegaly (may indicate severe marrow suppression therefore a medical emergency).
Offer FBC within 48h	• **Children and young people** with any of the following: o Pallor o Persistent fatigue o Unexplained fever o Unexplained persistent infection o Generalised lymphadenopathy o Persistent or unexplained bone pain o Unexplained bruising o Unexplained bleeding.

Haematological malignancies (continued)	
Lymphoma: Non-Hodgkin	
Adults: consider cancer pathway referral	• Unexplained lymphadenopathy or splenomegaly. *Take into account any associated symptoms, particularly fever, night sweats, SOB (from mediastinal mass), pruritus or weight loss.*
Children and young people: consider very urgent referral (for appointment within 48 hours)	• Unexplained lymphadenopathy or splenomegaly. *Take into account any associated symptoms, particularly fever, night sweats, SOB (from mediastinal mass), pruritus or weight loss.*
Lymphoma: Hodgkin	
Consider cancer pathway referral	• Unexplained lymphadenopathy. *When considering the referral, take into account associated symptoms, particularly fever, night sweats, SOB, pruritus, weight loss or alcohol-induced lymph node pain.* *N.B. These symptoms are often not present in primary care presentation (see lymphoma article).*
Myeloma	
Offer FBC, serum calcium and plasma viscosity or ESR	• Aged ≥60y with persistent bone pain, particularly back pain or unexplained fracture. *N.B. CRP is often normal.*
Offer protein electrophoresis and Bence Jones protein urine test within 48h	• People aged ≥60y with hypercalcaemia or leucopenia and presentation consistent with possible myeloma. • People with raised plasma viscosity or ESR and presentation consistent with possible myeloma.
Refer using cancer pathway	• If protein electrophoresis suggests myeloma.

Childhood cancers	
Neuroblastoma	
	Most occur in children <5y.
Consider specialist assessment within 48h	• Children with a palpable abdominal mass or unexplained enlarged abdominal organ.
Retinoblastoma	
Consider urgent referral (within 2w) for ophthalmological assessment	• Children with an absent red reflex.
Wilms' tumor	
	Usually children 1–3y. Embryonal tumour of the kidney.
Consider specialist assessment within 48h	• Children with a palpable abdominal mass or unexplained enlarged abdominal organ or unexplained visible haematuria.
Non-site-specific symptoms in children	
Consider referral for children	• If their parent/carer has persistent concern or anxiety about the child's symptoms even if most likely to have a benign cause. Take into account insight and knowledge of parents/carers when considering referral. *N.B. The positive predictive value of parental concern has not been studied.*

Non-site-specific symptoms	
Non-site-specific symptoms	
	I'm sure we've all seen patients that give us the uneasy feeling that they probably have cancer somewhere but are restricted by access to investigations and cancer-specific referral pathways. This can lead to referral to multiple specialists before a diagnosis is reached. *NICE has recognised this problem and found that the symptoms of unexplained weight loss, appetite loss or DVT all have a positive predictive value >3% for cancer.* *They suggest we carry out an assessment for additional symptoms/signs/other findings that may help to identify which cancer is most likely and then refer starting with this pathway. I'm sure we all do this already!* *If you are still stumped then they give the cancer sites for each of these symptoms in descending order of the positive predictive value (i.e. 1st in the list most likely cancer site):*
Unexplained weight loss	• Colorectal, gastro-oesophageal, lung, prostate, pancreas, urological cancer.
Unexplained loss of appetite	• Lung, oesophageal, stomach, colorectal, pancreatic, bladder, renal cancer.
DVT	• Urogenital, breast, colorectal, lung cancer.

Patients present to us with symptoms and signs that may have several malignancies as differential diagnoses. NICE have recognised this by presenting their recommendations as an A–Z of symptoms and signs with possible underlying cancers. We have summarised below what we think are the more common primary care presentations where there are important cancer differentials to consider.

Abdominal or pelvic mass or organomegaly	
Presenting symptom/sign	**Action (suspected cancer)**
Children with palpable abdominal mass or unexplained enlarged abdominal organ	**Very urgent referral** (?Neuroblastoma or Wilms' tumour)
Women with pelvic or abdominal mass (not obviously uterine fibroids) and/or ascites	**Measure Ca 125** Urgent referral (?Ovarian cancer)
Rectal or abdominal mass	**Cancer pathway referral** (?Colorectal cancer)
Upper abdominal mass consistent with stomach cancer	**Cancer pathway referral** (?Stomach cancer)
Upper abdominal mass consistent with enlarged gallbladder	**Urgent USS** (?Gallbladder cancer)
Upper abdominal mass consistent with an enlarged liver	**Urgent USS** (?Liver cancer)
Children and young people with unexplained hepatosplenomegaly	**Immediate referral** (?Leukaemia)
Adults with unexplained hepatosplenomegaly	**Consider FBC within 48h** (?Leukaemia)
Adults with unexplained splenomegaly	**Consider cancer pathway referral** (?Non-Hodgkin's lymphoma)

Abdominal pain		
Weight loss and rectal bleeding are important associated symptoms. Consider FBC to check for iron deficiency anaemia and raised platelets. The guidelines recommend a DRE is offered to all patients with unexplained symptoms related to the lower GI tract.		
Presenting symptom	**AND the following**	**Action (suspected cancer)**
Abdominal pain and >50y	NO rectal bleeding	**Offer FOB test** (?Colorectal)
>40y with abdominal pain	Unexplained weight loss	**Cancer pathway referral** (?Colorectal)
Aged <50y with unexplained abdominal pain	Rectal bleeding	**Consider cancer pathway referral** (?Colorectal)
≥55y and any upper abdominal pain	Weight loss	**Urgent direct access upper GI endoscopy** (?Oesophageal or stomach)
≥55y with upper abdominal pain	Raised platelets or low Hb or nausea/vomiting	**Consider direct access upper GI endoscopy** (?Oesophageal or stomach)
≥60y with abdominal pain	Weight loss	**Consider urgent direct access CT or USS** (?Pancreatic)
Women, especially if >50y with persistent or frequent pelvic or abdominal pain		**Ca 125, if ≥35U/ml refer for USS** (?Ovarian)
Women ≥50y with new symptoms suggestive of IBS in the last 12m		**Ca 125, if ≥35U/ml refer for USS** (?Ovarian)

Appetite loss or early satiety		
Unexplained appetite loss may be a symptom of lung, oesophageal, stomach, colorectal, pancreatic, bladder or renal cancer – ask about and look for features of these.		
Presenting symptom	**AND the following**	**Action (suspected cancer)**
Unexplained appetite loss alone (no age specified)	No specific localising symptoms or signs	**Gather more information – offer urgent investigation and referral as appropriate** (?Lung, oesophageal, stomach, pancreas, colorectal, bladder, renal)
Unexplained appetite loss and age >40y	Ever smoked or exposed to asbestos	**Do CXR** (?Lung or mesothelioma)
Unexplained appetite loss and age >40y	Cough or fatigue or SOB or chest pain or weight loss	**Do CXR** (?Lung)
Women, especially if ≥50y with persistent or frequent early satiety and/or loss of appetite		**Measure Ca 125, if ≥35U/ml refer for transvaginal USS** (?Ovarian)
Loss of appetite (no age specified)	Weight loss	**Consider direct access upper GI endoscopy** (?Stomach)

Change in bowel habit		
A DRE should be offered to all patients with unexplained symptoms related to the lower GI tract.		
Presenting symptom	**AND the following**	**Action (suspected cancer)**
<50y with change in bowel habit	Rectal bleeding	**Consider cancer pathway referral** (?Colorectal)
>60y with unexplained change in bowel habit	No other features	**Cancer pathway referral** (?Colorectal)
<60y with change in bowel habit	No rectal bleeding	**Offer FOB** (?Colorectal)
Women ≥50y with new symptoms of IBS in last 12m		**Do Ca 125.** If ≥35U/ml refer for USS (?Ovarian)
Women with unexplained change in bowel habit		**Do Ca 125.** If ≥35U/ml refer for USS (?Ovarian)
≥60y with diarrhoea or constipation	Weight loss	**Consider direct access urgent CT or USS** (?Pancreatic)

Dyspepsia including reflux and nausea/vomiting		
Presenting symptom	**AND the following**	**Action (suspected cancer)**
Dyspepsia and ≥55y	Treatment resistant	**Non-urgent upper GI endoscopy** (?Oesophagogastric)
Dyspepsia and ≥55y	Weight loss	**Urgent upper GI endoscopy** (?Oesophagogastric)
Dyspepsia and ≥55y	Nausea/vomiting or raised platelets	**Non-urgent upper GI endoscopy** (?Oesophagogastric)
Nausea/vomiting and ≥60y	Weight loss	**Consider urgent access CT (or USS if not available)** (?Pancreatic)
Nausea/vomiting and ≥55y	Raised platelets or weight loss or reflux or dyspepsia or upper abdominal pain	**Non-urgent upper GI endoscopy** (?Oesophagogastric)
Fatigue		
Presenting symptom	**AND the following**	**Action (suspected cancer)**
Unexplained fatigue and age ≥40y	Ever smoked or exposed to asbestos	**CXR** (?Lung/mesothelioma)
Unexplained fatigue and age ≥40y	Cough, weight loss, SOB, chest pain, appetite loss	**CXR** (?Lung/mesothelioma)
Persistent unexplained fatigue		**FBC within 48h** (?Leukaemia)

Haematuria		
Presenting symptom	**AND the following**	**Action (suspected cancer)**
Children with unexplained visible haematuria		**Very urgent referral (within 48h)** (?Wilms' tumour)
≥45y unexplained visible haematuria	Without UTI or Persists or recurs after successfully treating UTI	**Cancer pathway referral (within 2w)** (?Bladder or renal)
Women ≥55y with visible haematuria	Any of: • Unexplained vaginal discharge • Low haemoglobin • Thrombocytosis • High blood glucose	**Consider direct access transvaginal USS to assess endometrial thickness** (?Endometrial)
Men with visible haematuria		**Consider PSA and DRE** (?Prostate)
≥60y unexplained non-visible haematuria	Either dysuria or FBC shows raised WCC	**Cancer pathway referral (within 2w)** (?Bladder)

Lymphadenopathy	
Presenting features	**Action (suspected cancer)**
Generalised lymphadenopathy	**Very urgent FBC (within 48h) (?Leukaemia)**
Unexplained lymphadenopathy	**Consider cancer pathway referral taking into account any associated symptoms: fever, night sweats, SOB, pruritus, weight loss or alcohol-induced lymph node pain** (?Lymphoma)
Supraclavicular or persistent cervical lymphadenopathy in people ≥40y	**Consider FBC and CXR** (?Lung)

Weight loss		
Unexplained weight loss is a symptom of several cancers including colorectal, haematological, gastro-oesophageal, lung, prostate, pancreatic and urological.		
Cancer and potential other associated features	**Presenting features**	**Action**
Colorectal cancer • Abdominal pain • Rectal bleeding • Change in bowel habit • Iron deficiency anaemia	>40y unexplained weight loss and abdominal pain	**Cancer pathway referral**
	<50y with unexplained weight loss and rectal bleeding	**Consider cancer pathway referral**
	Unexplained weight loss alone AND age ≥50y	**Offer FOB test**
Lung cancer or mesothelioma • Cough • Fatigue • SOB • Chest pain • Appetite loss • Haemoptysis (lung cancer only)	Unexplained weight loss, aged ≥40y, ever smoked or exposed to asbestos	**CXR**
	≥40y non-smokers with unexplained weight loss and at least one other unexplained symptom from: cough, fatigue, SOB, chest pain, appetite loss	**CXR**
Lymphoma • Fever • Night sweats • SOB • Pruritus	Unexplained lymphadenopathy is the key finding when considering referral for suspected lymphoma Non-Hodgkin's lymphoma may have unexplained splenomegaly and Hodgkin's lymphoma may be associated with alcohol-induced lymph node pain	**Consider cancer pathway referral taking into account the presence of associated symptoms**

Weight loss (continued)		
Cancer and potential other associated features	**Presenting features**	**Action**
Oesophago-gastric cancer • Dysphagia • Reflux • Dyspepsia • Nausea/vomiting • Upper abdominal pain • Raised platelet count	≥55y with weight loss and any of upper abdominal pain or reflux or dyspepsia	**Urgent direct access upper GI endoscopy**
	≥55y with weight loss and nausea/vomiting or raised platelets	**Consider direct access upper GI endoscopy**
Pancreatic cancer	≥60y with weight loss and any of: • Diarrhoea • Back pain • Abdominal pain • Nausea/vomiting • Constipation • New onset diabetes	**Consider urgent direct access CT or USS**
Ovarian cancer • Early satiety/appetite loss • Pelvic or abdominal pain • Change in bowel habit • Increased urinary urgency or frequency • Fatigue • New onset IBS symptoms in last 12m in women ≥50y • Ascites or pelvic/abdominal mass	Women with unexplained weight loss, fatigue or change in bowel habit	Consider Ca125, and if Ca125 is **≥35U/ml refer for USS** **Refer urgently if pelvic/ abdominal mass/ascites/ other evidence of malignancy**