PATIENTS WITH ACUTE OR SIGNIFICANT HAEMATEMESIS SHOULD BE REFERRED FOR AN IMMEDIATE ASSESSMENT FOR STABILISATION/RESUSCITATION IF REQUIRED. CONSIDER REFERRAL FOR AN IMMEDIATE ASSESSMENT IN PATIENTS WITH JAUNDICE

WHERE GPS DO NOT HAVE DIRECT ACCESS TO THE APPROPRIATE INVESTIGATIONS THE PATIENT SHOULD BE REFERRED AS AN URGENT SUSPECTED CANCER REFERRAL (FOR AN APPOINTMENT WITHIN 2 WEEKS) OR AS A ROUTINE REFERRAL DEPENDING ON THE CLINICAL FEATURES BELOW

OESOPHAGUS/STOMACH

- Dysphagia
- Weight loss with any of the following:
  - upper abdominal pain (also consider pancreatic cancer), reflux or dyspepsia

→ Offer an **URGENT DIRECT ACCESS UPPER GASTROINTESTINAL ENDOSCOPY** (to be performed within 2 weeks). The upper GI endoscopy request form should state that this is an urgent request (to be performed within 2 weeks). The possibility of cancer diagnosis should be discussed with the patient and safety-netting/follow up arrangements should be made.

OESOPHAGUS/STOMACH

For some of these symptoms please also consider other possible cancer sites e.g. lower GI, lung and non-cancer diagnoses

- Age 55 and over with any of the following:
  - Treatment-resistant dyspepsia
  - Upper abdominal pain with low haemoglobin levels
- Recent episode of haematemesis or non-acute bleed
- Raised platelet count with any of the following: nausea, vomiting, weight loss, reflux, dyspepsia or upper abdominal pain
- Nausea or vomiting with any of the following: weight loss, reflux, dyspepsia or upper abdominal pain, recurrent haematemesis or where there is clinical concern

→ Offer a **NON URGENT DIRECT ACCESS UPPER GASTROINTESTINAL ENDOSCOPY**. The possibility of cancer diagnosis should be discussed with the patient and safety-netting/follow up arrangements should be made.

Recent eGFR / renal function (within 3 months) is required as contrast may be used for imaging. When GP direct access investigations are performed the GP has clinical responsibility for ensuring appropriate follow up and onward referral is arranged. In many cases positive results may be forwarded directly to the cancer team but the GP must ensure a referral has been made and that appropriate safety-netting arrangements are in place.

RECOMMENDATIONS FOR PATIENTS WITH GASTRO-OESOPHAGEAL REFLUX DISEASE [NICE CG184, 2014]

- Adults with dyspepsia/reflux presenting to community pharmacists are given advice about lifestyle changes, using over-the-counter medicines and when to consult their GP.
- Adults with dyspepsia/reflux are referred for urgent direct access endoscopy to take place within 2 weeks if they have dysphagia, or age 55 and over with weight loss.
- Adults with dyspepsia/reflux have a 2 week washout period before a test for Helicobacter pylori if they are receiving proton pump inhibitor therapy.
- Adults age 55 and over with treatment resistant dyspepsia/reflux have a discussion with their GP about referral for non-urgent direct access endoscopy.

PANCREAS

People aged 60 and over with weight loss and any of the following: diarrhoea, back pain, abdominal pain, nausea, vomiting, constipation, new-onset diabetes

→ Offer **URGENT DIRECT ACCESS CT SCAN** (to be performed within 2 weeks) to assess for pancreatic cancer
PLEASE NOTE: The CT scan request form should state that this is an urgent request (to be performed within 2 weeks). The possibility of cancer diagnosis should be discussed with the patient and safety-netting/follow up arrangements should be made.
PLEASE NOTE: 10% of pancreatic cancers are missed by abdominal ultrasounds, whilst tumours smaller than 3cm will not be visible using an ultrasound. CT scans have the advantage of staging at the same time. New onset diabetes can appear two years before a pancreatic tumour is detectable by ultrasound. CT is the preferred imaging method.

Pan-London Suspected Cancer Referral Guide – Upper GI

LIVER/GALL BLADDER
Upper abdominal mass consistent with an enlarged gall bladder or liver

Offer **URGENT DIRECT ACCESS ULTRASOUND SCAN** (to be performed within 2 weeks) to assess for gall bladder/liver cancer.
PLEASE NOTE: The ultrasound scan request form should state that this is an urgent request (to be performed within 2 weeks). The possibility of cancer diagnosis should be discussed with the patient and safety-netting/follow up arrangements should be made.

OESOPHAGUS/STOMACH

- Abnormal upper GI endoscopy suggestive of cancer (or high grade dysplasia of oesophagus)
- Upper abdominal mass consistent with stomach cancer
- Suspicious symptoms or signs (see box above) but no GP direct access to urgent upper GI endoscopy

PANCREAS

- Abnormal abdominal CT or ultrasound scan suggestive of pancreatic cancer
- ≥ 40 years old with jaundice (consider a referral for same day assessment if appropriate)
- Suspicious symptoms or signs (see box above) but no GP direct access to urgent pancreatic CT scan

LIVER/GALLBLADDER

- Abnormal abdominal ultrasound scan suggestive of liver/gallbladder cancer
- Upper abdominal mass consistent with an enlarged liver/gall bladder
- Suspicious symptoms or signs (see box above) but no GP direct access to urgent ultrasound scan

SUSPECTED UPPER GI CANCER REFERRAL

RESOURCES:

1. Suspected cancer: recognition and referral NICE guidelines [NG12], 2015 http://www.nice.org.uk/guidance/ng12
2. NICE Clinical Knowledge Summary: Iron Deficiency Anaemia. NICE, 2013 http://cks.nice.org.uk/anaemia-iron-deficiency
3. Gastro-oesophageal reflux disease and dyspepsia in adults: investigation and management. NICE guidelines [CG184], 2014 https://www.nice.org.uk/guidance/cg184
4. Pancreatic Cancer Action & RCGP Pancreatic Cancer: Early Diagnosis in General Practice http://elearning.rcgp.org.uk/course/view.php?id=103
5. BMJ Learning The diagnosis and management of gastric cancer http://learning.bmj.com/learning/module-intro/.html?moduleId=10046335&searchTerm=%E2%80%9CThe%20diagnosis%20and%20management%20of%20gastric%20cancer%E2%80%9D&page=1&locale=en_GB