

Cancer diagnosis: in the GP's consulting room

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**Chairman: Willie Hamilton, MD, BSc, FRCP, FRCGP
Professor of primary care diagnostics
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Let's go inside – if we can find a parking space

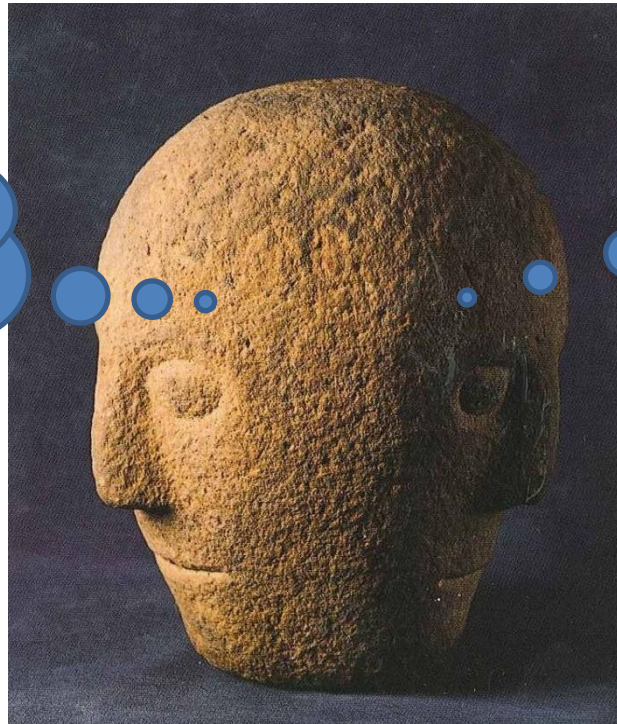


A quarter of us will die of cancer



And around half of the problem is ascribed
to delays in diagnosis

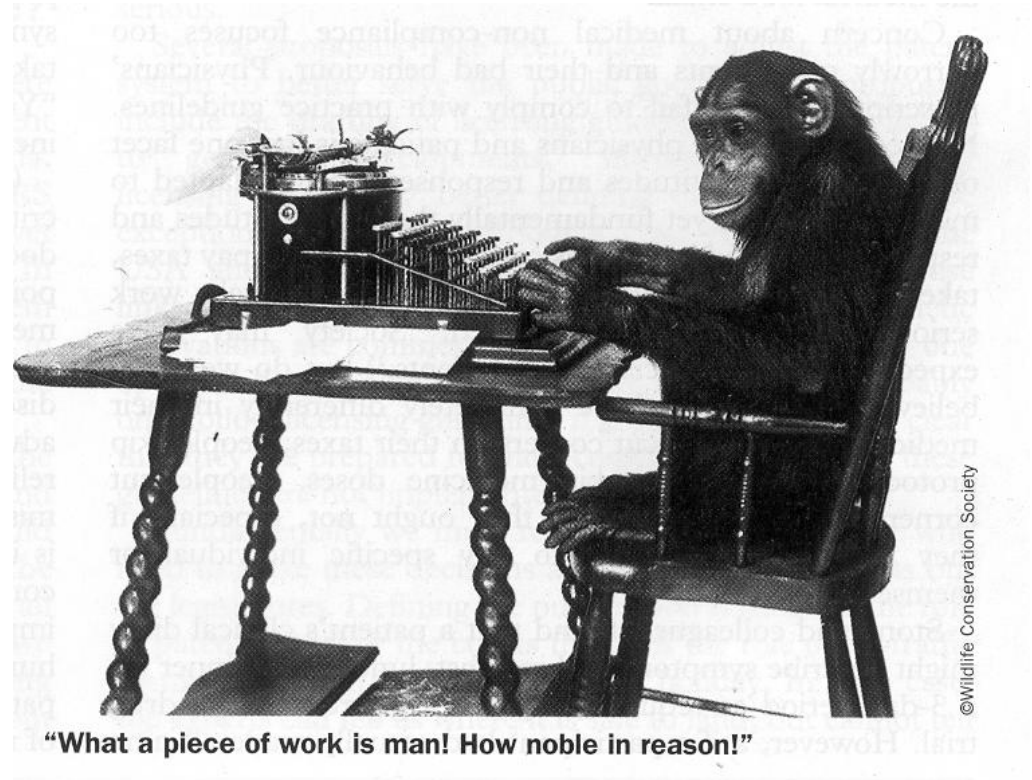
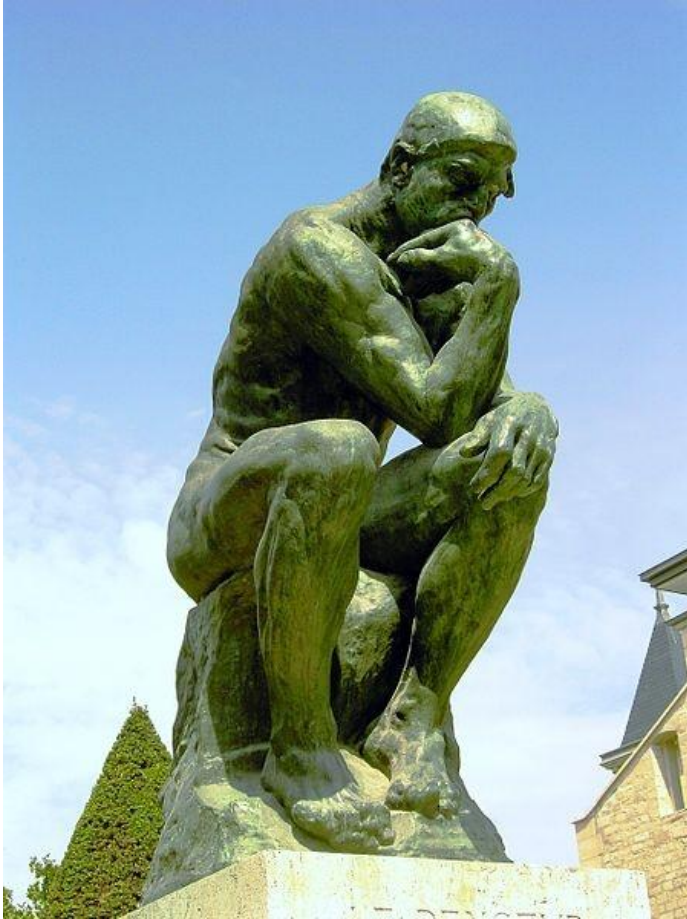
Abdominal pain
and diarrhoea =
Irritable Bowel
Syndrome



Abdominal pain
and diarrhoea =
Colorectal cancer



90% of cancers present initially to GPs



Hamilton W, British Journal of General Practice 2010;60:121-28



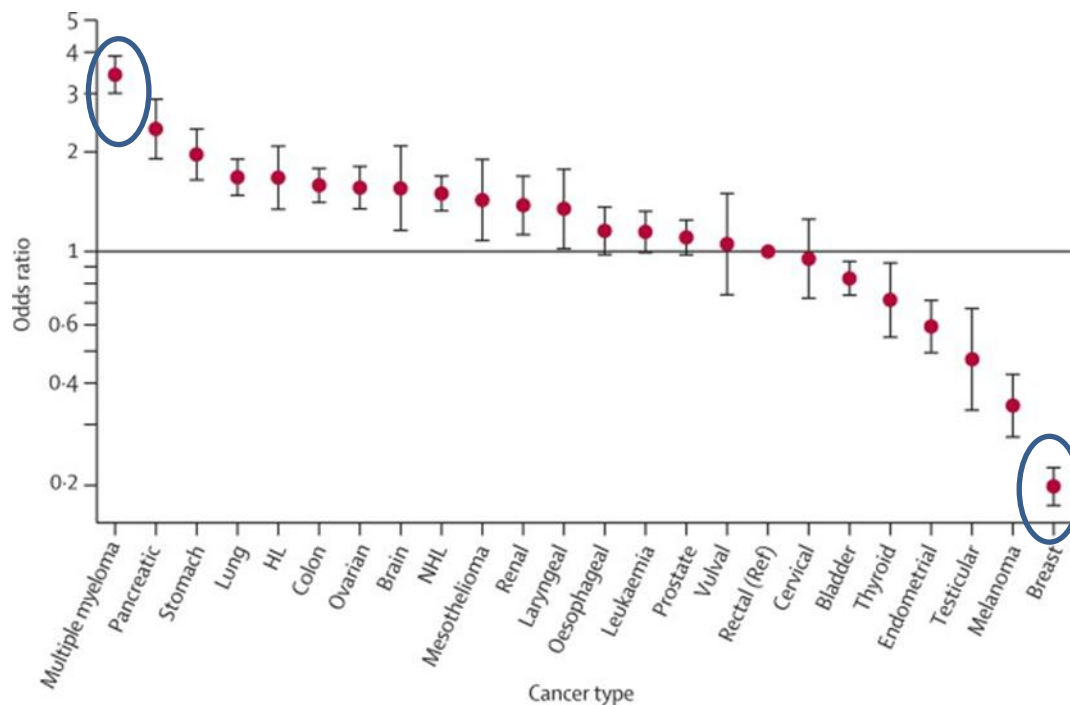
But what is going on in a GP's mind?

Firstly, very few consultations relate to cancer, even remotely

And even when it's remotely possible we may not even think of it



Does not thinking of cancer exist?



Odds ratios and 95% CIs for three or more general practitioner consultations before hospital referral, by cancer type. The information in this figure is derived from the main effects model.

Georgios Lyratzopoulos, Richard D Neal, Josephine M Barbiere, Gregory P Rubin, Gary A Abel. **Variation in number of general practitioner consultations before hospital referral for cancer: findings from the 2010 National Cancer Patient Experience Survey in England.** The Lancet Oncology, Volume 13, Issue 4, 2012, 353 - 365

Myeloma

- What is the commonest symptom?
- We are all taught in medical school to think of rib pain. Yet rib pain was recorded in only 3% of cases in a recent paper.
- Some of you probably even remember the ‘pepperpot skull’
- But the commonest symptom in myeloma (reported by 28%) is backache.

Who would possibly think of myeloma in backache?



Breast

- Every GP in the land will think of breast cancer when a woman presents with a lump
- And (almost) every woman in the land will think of breast cancer when she finds a lump
- So it is well nigh impossible the subject is omitted from discussion



Thinking, but not thinking enough

- Diagnosis is not a linear process
- Several theories abound, and different conditions probably require different schemas
- Olga Kostopoulou

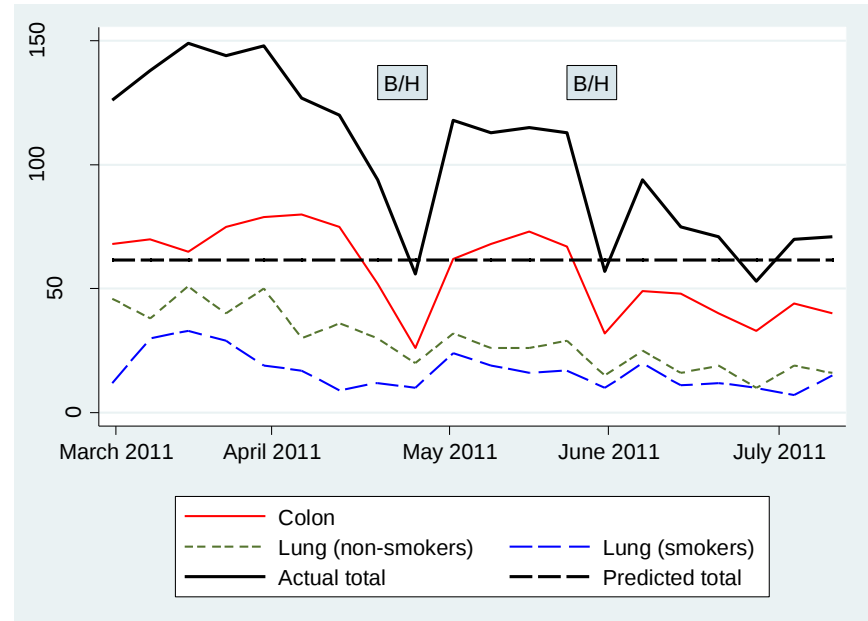
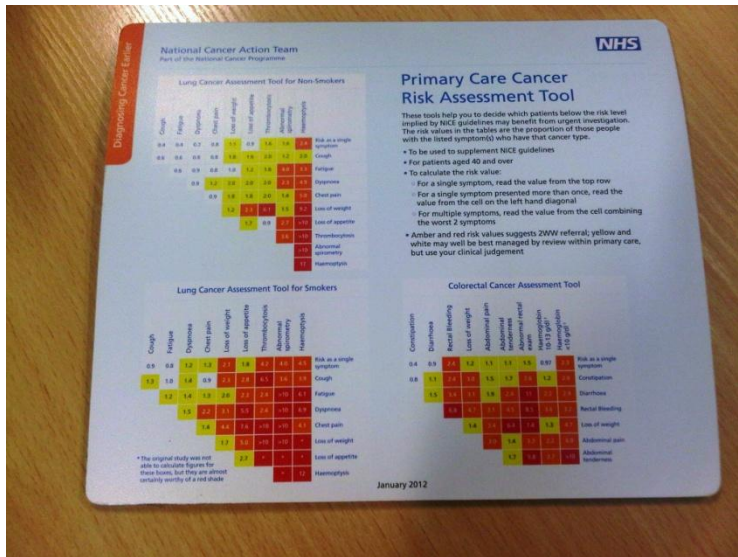


Thinking, but not acting

- There are several potential barriers to taking action, once cancer has been considered as a possibility
- It's a tricky subject to broach – though we know patients are keen to have cancer investigated even if the risks are low.
- We also don't discuss this with our patients, and even if we refer we do so in 'coded' language.
- We may get investigation 'refused' – as national guidance doesn't suggest it.
- This can be combatted by 'legitimising' referrals.



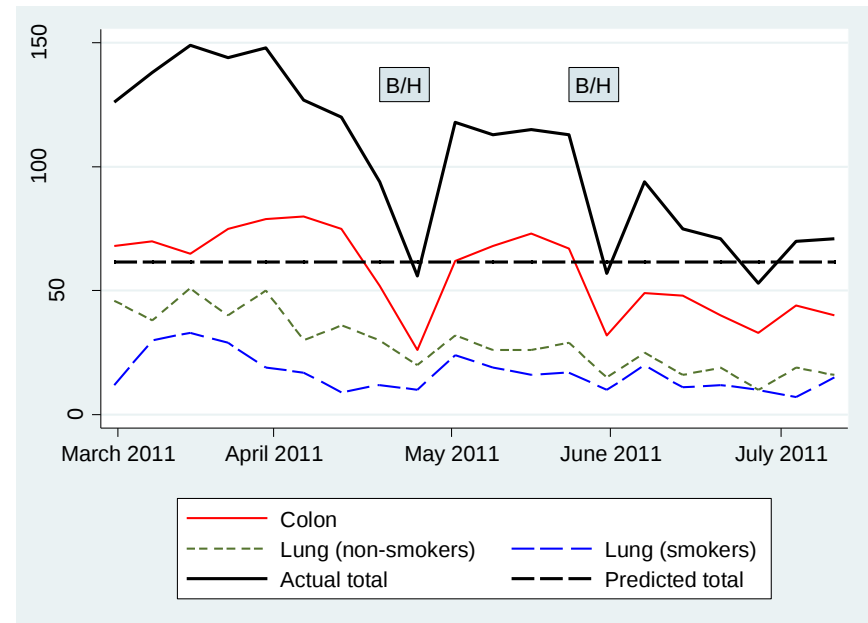
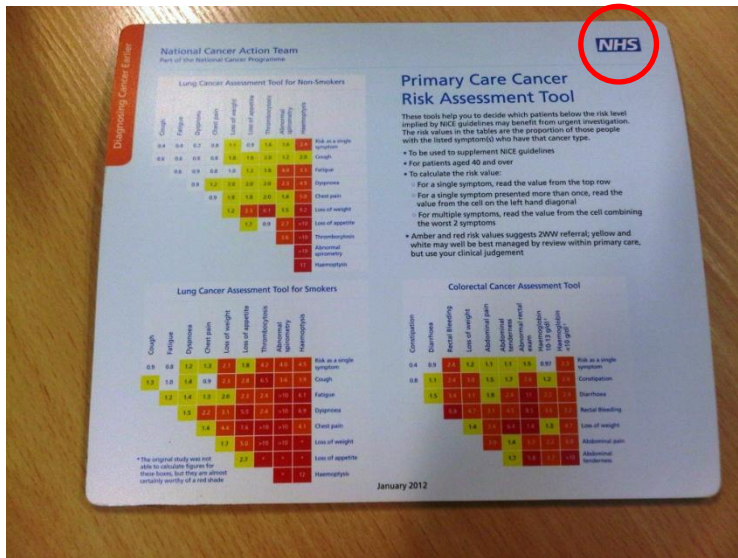
What's the most important bit of this mousemat that made it popular?



National Cancer Action Team
Part of the National Cancer Programme



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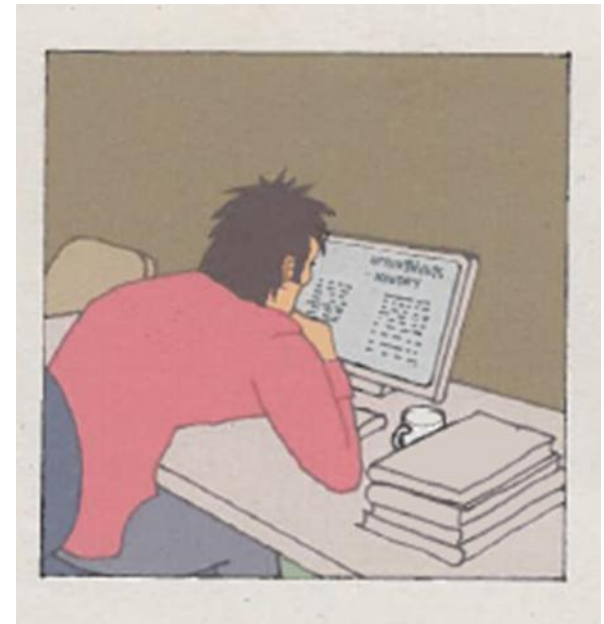
Where do computers fit in?

- They have three main functions in cancer diagnosis
- As a repository of information (national guidance, risk compilation, etc.)
- As an electronic prompt – popping up whenever current information summates to a risk above an agreed level.
- As an audit tool, which runs regular searches within the GP's system to identify patients above an agreed threshold.



Computers as an audit tool

- Things get missed (sorry, but they do)
- Computers don't mind 'fat file patients'
- Tom Marshall



Computers as a prompt

- A prompt can pop up at the start of the consultation, alerting the GP to the possibility of cancer
- It can show the precise risk estimate, and can include several cancers
- Most GPs like and use them (either based on RATs or on QCancer) and they seem to provoke appropriate diagnostic activity.
- But not all GPs like them



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And do patients approve?

- But what about patients?
- They are equal partners, of course
- After all "Listen to your patient, he is telling you the diagnosis."
- Trish Green

