Direct Access to CT of Chest/Abdomen/Pelvis for Patients with Unidentified Suspected Malignancy

Imaging Pathway from Primary Care for NHS Greater Glasgow & Clyde

NW Glasgow HSCP Pilot

Adapted from Scottish Clinical Imaging Network Pathway Oct 2015

Dr Douglas Rigg

Lead GP for Cancer, NHS GG&C. Aug 2021
## Contents Page

1. Introduction . . . . . . . . . . . . . . 3

2. Underlying Principles . . . . . . . . . . . . . . . . . . . . 4

3. Recommendations for Pathway implementation . . . . . . . . 4

4. Imaging Pathway . . . . . . . . . . . . . . . . . . . . . 5

   - Referral criteria . . . . . . . . . . . . . . . . . . . . 5

   - Communication with Radiology . . . . . . . . . . . . . . 5

   - Booking of scan . . . . . . . . . . . . . . . . . . . . . 6

   - Receipt of report . . . . . . . . . . . . . . . . . . . . . 6

   - Recommendations for Radiology Services and for Primary Care . . . . . . . . 7

5. Proposed ICE question flow diagram. . . . . . . . 8

6. Clinicians consulted. . . . . . . . . . . . . . . . . . . . . . 9

7. FAQs . . . . . . . . . . . . . . . . . . . . . . . . . . . . 10

8. References . . . . . . . . . . . . . . . . . . . . . . . . . . . 11
Introduction

The Scottish Government’s Healthcare Quality Strategy lays out a blueprint for patient care in Scotland, with safety, equity, efficiency and timeliness at its heart.

There is currently highly variable direct access for CT scanning for Primary Care Practitioners in Scotland illustrated in the map below. There are some areas which provide this access for General Practitioners for specific indications and others that do not. The Scottish Clinical Imaging Network (SCIN), which is one of 4 National Managed Diagnostic Networks under the auspices of National Services Division (NSD), set up a subgroup in 2014 to look specifically at this issue.

CT access from Primary Care across Scotland in 2019:

<table>
<thead>
<tr>
<th>Key</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>GREEN</td>
<td>GP access permitted</td>
</tr>
<tr>
<td>RED</td>
<td>No GP access permitted</td>
</tr>
<tr>
<td>AMBER</td>
<td>Work on-going to support GP access</td>
</tr>
<tr>
<td>GREY</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>

In those areas with access to CT scanning this has been used appropriately with high rates of detection of cancer and significant other pathology.

Research has not demonstrated any increase in demand from patients nor test use. Direct access avoids a substantial proportion of outpatient appointments reduces waiting times, is preferred by patients and generally cuts costs without increasing GP workload. Direct access also reduces waiting times and is associated with high satisfaction for both patients and clinicians.
The SCIN group, with Imaging and Primary Care representation, focused on patients with unidentified suspected malignancy, who the GPs felt were most difficult to manage without access to CT scanning. The lack of a defined pathway for this group of patients leads, in some cases, to delays in referral to the correct specialty. This aligns to the core role of general practitioners in the Scottish GP contract: “The key direct clinical care role for the GP as expert medical generalist is in undifferentiated presentations which require the skills of a doctor trained in risk management and holistic care with broad medical knowledge.”

Direct access for GPs to CT scanning of chest/abdomen/pelvis for this group of patients could enable a cancer diagnosis to be made directly from primary care and aid more appropriate onward secondary care referral. In other cases, it could guide the GP how best to manage the patient within a primary care setting.

This document outlines the SCIN pathway developed by the group for this specific group of patients, through consultation with Imaging and Primary Care colleagues from across Scotland which is adapted for use in NHS Greater Glasgow & Clyde. The pathway has been based on the principles outlined in the document *Quality Imaging Services for Primary Care: A Good Practice Guide (2012)* which was produced in collaboration between the Royal College of General Practitioners, the Royal College of Radiologists and the Society and College of Radiographers.

**Underlying Principles**

1. There should be equity of access in relation to this pathway for GPs
2. All Imaging should be undertaken in compliance with the Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R) and subsequent amendments
3. The service should be of the same quality to that of secondary care imaging
4. Referrals for this specific patient group should have the same turnaround times for acquisition and reporting as equivalent secondary care scans.
5. This does not replace current pathways for USoC referrals for patients with site specific symptoms.

**Recommendations for Implementation of the Pathway**

1. Details of the pathway is communicated to all GP practices and Imaging services
2. The pathway is piloted for a time or volume of scans period.
3. There is audit of the demand, resources required and impact on the current imaging service throughout the pilot period.
Pathway for Primary Care Direct Access to CT of Chest/Abdomen/Pelvis for Patients with Unidentified Suspected Malignancy

Referral Criteria

1. Clinical assessment of patient by General Practitioner leading to very strong suspicion of suspected underlying malignancy with, for example, unexplained significant weight loss of > 10% body weight.

2. If there is any indication of localising signs, symptoms or laboratory tests to suggest malignancy in a specific system, direct referral to secondary care should be made using the appropriate established pathway without ordering a CT scan.

3. Prior to requesting a CT scan of chest/abdomen/pelvis the GP must ensure the following has been completed.
   - Appropriate history & examination including psychosocial assessment
   - Relevant blood testing (including FBC to exclude anaemia and blood cancers and eGFR if not done within the last 3 months to allow contrast)
   - CXR
   - Consideration of principles of realistic medicine

4. CXR - no evidence of primary intrapulmonary malignancy.

5. Patient is 40+ years of age. For patients under 40 use of existing referral pathways and/or discussion with consultant colleagues initially.

6. Exclude pregnancy. If patients are known to be pregnant CT CAP is not an appropriate investigation. If significant concern discuss with obstetrician. If possibility of pregnancy cannot be excluded discuss with radiologist prior to referral.

Communication with Radiology

Dialogue with the local radiology department should not be routinely necessary if the patient fulfils all the criteria for this pathway. It is, however, recommended if there is uncertainty as to the suitability for a CT scan via duty radiologist.
Booking of scan

1. Request a CT of chest, abdomen and pelvis uses Ordercomms Radiology. (See FAQs)

2. Should there be any need to make a request on paper include contact details for the radiology department to contact the primary care referrer if there are any problems with the request and to communicate urgent significant results.

3. Referrer must include all relevant information at point of request to demonstrate compliance with the referral criteria. This will be aided by an ICE process embedded in Ordercomms.

4. Ordercomms will default priority to urgent suspicion of cancer in order to qualify for scan a reporting prioritised to comply with 2-week referral to report time.

5. Ensure that a current (within 3 months) eGFR result is included in the request or the request may be refused or delayed. Contrast CT scans can further compromise impaired renal function. Further safety questions relating to asthma, diabetes and allergies will be built into request process.

Receipt of Report

1. Obtain report from Radiology via current reporting mechanisms for other radiological investigations. Reports are also available on clinical portal.

2. Contact Radiology by phone if any queries with the report

3. Responsibility for reading and acting on the results, including onward referral, lies with the referrer.

4. Each radiology service has a process in place for the communication of urgent unsuspected results.

5. Each radiology service has a process in place for the communication of non-attendance for urgent investigations.

6. Each Radiology service has a process in place for the communication of critically urgent findings which require action that day. This would normally be via a telephone call to the GP surgery during normal working hours.

7. Only if there are immediate and high-risk findings (such as dissection of AAA) the GP out-of-hours service should be informed if out with normal working hours.
8. If the scan is positive for malignancy, the reporting radiologist should activate a cancer tracking mechanism, in order to ensure that the results are acted upon. (T coded). The recommendation is that communication to primary care regarding a positive cancer scan should be undertaken in addition to the usual method of conveying results.

9. Each radiology service has a process in place for the communication of non-attendance for investigation. This is using current processes in place for all radiology investigations.

**Recommendations for Radiology Services and for Primary Care**

1. Each radiology service should ensure that adequately staffing and resources are in place to support this pathway to avoid adverse impact on the existing service.

2. Radiology services should consider the institution of a Duty Radiology system if not already in place. Currently Radiology Trainees have duty system for enquiries.

3. All requests for this service should be vetted – the request should be queried or refused if deemed inadequate information or not meeting referral criteria and this information urgently fed back to the referrer.

4. Radiology services should consider appointing a Primary Care Lead radiologist as the liaison with general practitioners. They would have responsibility for coordinating contact between the two groups of professionals, audit and education.

5. Each radiology service should set up a regular meeting with GP representation to follow up on issues with this service.

6. Each Radiology service should audit the referral patterns for this pathway.

7. Each radiology service should engage in regular training sessions for local GPs on referral for complex imaging.

8. Radiologists should continue to word their reports to aid the referrer
   - giving guidance on benign findings and what issues require onward referral
   - See also Royal College of Radiologists guidance

9. If trainee Radiologists are available within your board area, they should be involved in the local system of dialogue with primary care referrers as part of their training.

10. Consideration of setting up a single centralised point of contact into Radiology for Primary care colleagues if this is deemed a more efficient use of resources.
ICE: CT CAP Proposed Question flow v5

- Request item
  - eGFR results in just 3 months? (Yes) View previous results? (Yes) Display previous eGFR results
  - No

  - Patient < 40? (Yes) Cancel request
  - No

  - Guidance
    - Suspicion of malignancy or alternative diagnosis (Yes) Cancel request
    - No

    - Female aged 40-55? (Yes) Pregnant? (Yes) Cancel request
      - No
        - Pregnancy physically impossible? (Yes) LMP known (Yes) Reason LMP
        - No
          - LMP

  - eGFR Conditions? (Yes) eGFR checked in past 3 months? (No) Switch request from CT CAP to U&E
    - Yes
      - eGFR result and date
        - Safety Questions
        - Booking questions
        - CT CAP Request complete
      - No

  - Canceled by ICE

Last Revision GP 06/08/2021
Clinicians consulted during development of pathway:

Dr. Douglas Rigg. Lead GP for Cancer, NHS GG&C

Dr. Ross MacDuff. Clinical Lead Radiology, NHS GG&C.

Dr. John Ip. NHS GG&C GP sub-committee.

Dr. Pauline Grose. Consultant Physician, GRI.

Dr. Anne MacKillop. Consultant Oncologist & lead clinician Cancer Unknown Primary Service. QEUH, Glasgow.
FAQs

GP Sub-committee queries and responses in red (Dr Rigg and Dr MacDuff)

1. That this pathway for CT CAP should not lead to changes in any other USOC pathway e.g., referrals sent back to referrer and told to order a CT CAP. No changes to current pathways foreseen. This is a new pathway to cover the gap in the current system for patients without localising symptoms.

2. Will CT reports that positively identify a malignancy be Cancer Tracked? All radiology reports on this pathway that are suspicious of malignancy will be tracked by the extant T coding system.

3. Helpful to have a duty radiologist contact for any GP questions about the CT report. Agreed - will need to see how this might work in practice during pilot phase.

4. If a scan shows a malignancy, GP need to know which speciality is most appropriate for onward referral. Radiology reports typically include the suspected source of the underlying primary or a comment suggesting no obvious primary identified.

5. CT reports should not be phoned to OOHs unless there is an immediate and high-risk need. E.G ruptured AAA or dissection (should be very rare). Agreed - this aligns with the current radiology guidance.

6. What safety net or recall will be in place for patients who DNA their CT CAP? We hear often anecdotal reports of letters are not delivered or the wrong address. Will be same as for current radiological investigations – requester will receive notification of DNA. The Scottish Patient Safety Programme recommends that practices have a safety netting system in place to ensure all requests and results are matched.

7. Where can I request the scan on ordercomms?

Item placement: Radiology Panel -> HD, Chest, Spine tab -> Computed Tomography section
References


4. Royal College of Radiologists: https://www.rcr.ac.uk/publication/management-incidental-findings-detected-during-research-imaging