



**Measuring the impact of educational modules on
NICE referral guidelines for suspected cancer
On Doctors.net.uk**

***Report prepared for:
National Institute for Health and Clinical Excellence***

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1 Summary of Findings

- Significantly more respondents in the group who had participated in a module said that they find the guidelines useful.
- Amongst those who didn't find the guidelines more useful the main reason for this was the presence of local guidelines.
- More respondents who had participated in a module would refer a patient to a specialist within one day of suspecting they had cancer.
- The proportion of respondents who feel they do or don't have the required information and support available did not change between waves.
- Two weeks was selected as the maximum waiting time recommended by NICE. However, more respondents (95% vs 87%) selected this option in the participated group.
- Suspected upper GI cancer guidelines
 - More of those respondents who had participated cited iron deficiency anaemia and persistent vomiting as suspicious symptoms.
 - The majority of participated respondents selected 55 years as the age above which patients with unexplained recent onset dyspepsia should be referred. The pre group would tend to refer age 45 and above.
 - 73% of respondents in the participated group said patients should be free of acid suppression ideally for 2 weeks prior to endoscopy, compared with 52% selecting this option in the pre group.
 - In selection of tests slightly less of the participated group felt that liver and renal function tests are recommended but significant proportions of both groups indicated that these tests, and helicobacter pylori serology, were recommended.
- Suspected gynaecological cancer guidelines
 - 75% of the participated group said that a woman with persistent intermenstrual bleeding and normal pelvic examination should be considered for referral compared with 64% in the pre group.
 - With regard to performing a cervical smear prior to referring a woman with a cervix clinically suspicious of cancer significantly more of the respondents in the participated group said no this was not necessary.
 - Pruritis and vulval pain are recognised features of vulval cancer in both groups.
 - More of the respondents who had participated were aware that abdominal pain and recurrent cystitis are not recognised symptoms of vulval cancer – however the results demonstrate that neither group is clear in these areas.
 - Most respondents in both groups would refer a patient with persistent post menopausal bleeding after cessation of HRT after 4 weeks.
- Suspected urological cancer guidelines
 - There is a change in the profile of tests for men presenting with symptoms suggestive of prostate cancer. Selection of both PSA and DRE rose from 82% in the pre group to 91% in the participated group.
 - The preferred delay between performing a PSA test after a UTI is 2 weeks in both groups.
 - An increased proportion of the participated group would refer patients with painless macroscopic haematuria - 93% of the participated group would refer compared with 79% in the pre group.



- Considering patients over 35 years with recurrent persistent UIT associated with haematuria – respondents generally seem unclear about referral of these patients.
 - The majority of both groups say they would refer patients over 40 with unexplained microscopic haematuria – increasing from 75% in the pre group to 84% in the participated set.
 - Respondents in both groups do not class epigastric pain as an unexplained symptom making a diagnosis of prostate cancer a possibility. However, more of the participated group indicated this to be the case with 70% of the pre group giving this answer rising to 80% in the participated group.
 - The identification of discriminating tests by both groups differs from those set out in the guidelines with respondents generally selecting all tests.
 - The exception to this is the Serum IgA test where a large proportion of both respondent groups are unclear about the recommendation.
- The majority (85%) of respondents had not participated in any other training covering the NICE cancer guidelines.



2 Methodology

The results detailed in this report were collected via two structured on-line surveys amongst General Practitioners who are members of the Doctors.net.uk community.

Wave 1 of the research took place prior to the launch of the educational modules relating the NICE cancer guidelines, 202 respondents participated in this phase of the research.

Wave 2 of the research took place amongst members of the community who had participated in the NICE guidelines education modules which had been made available on the Doctors.net.uk website. This phase covered the same target sample size of 200 GPs who had completed one or modules.

Fieldwork dates for the research were:

- Phase 1 : 15th-16th November 2005
- Phase 2 : 26th January – 15th February 2006. Respondents in phase 2 were not allowed to participate in the survey until 7 days after they had completed the module.

3 Research Objectives

The objectives of the research can be summarised as follows:-

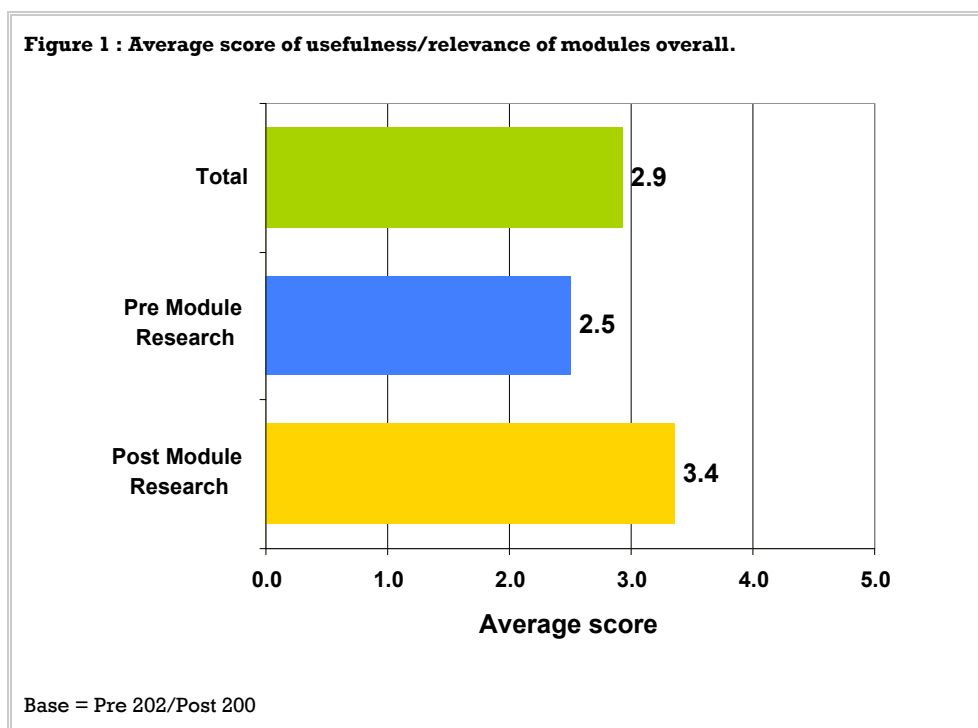
- To understand GPs perceptions of the usefulness of NICE guidelines for referral of suspected cancer.
- To determine their level of knowledge surrounding NICE cancer guidelines.
- To look at certain areas of the guidelines to
 - Establish a baseline of knowledge of the specific content
 - Determine how the results change as a result of participation in an educational exercise covering that content.
- To gather information regarding any other education covering NICE cancer guidelines which participants may have undertaken.



4 Results

4.1 Usefulness of guidelines

4.1.1 How useful/relevant to your daily practice are NICE guidelines for referral of suspected cancer?

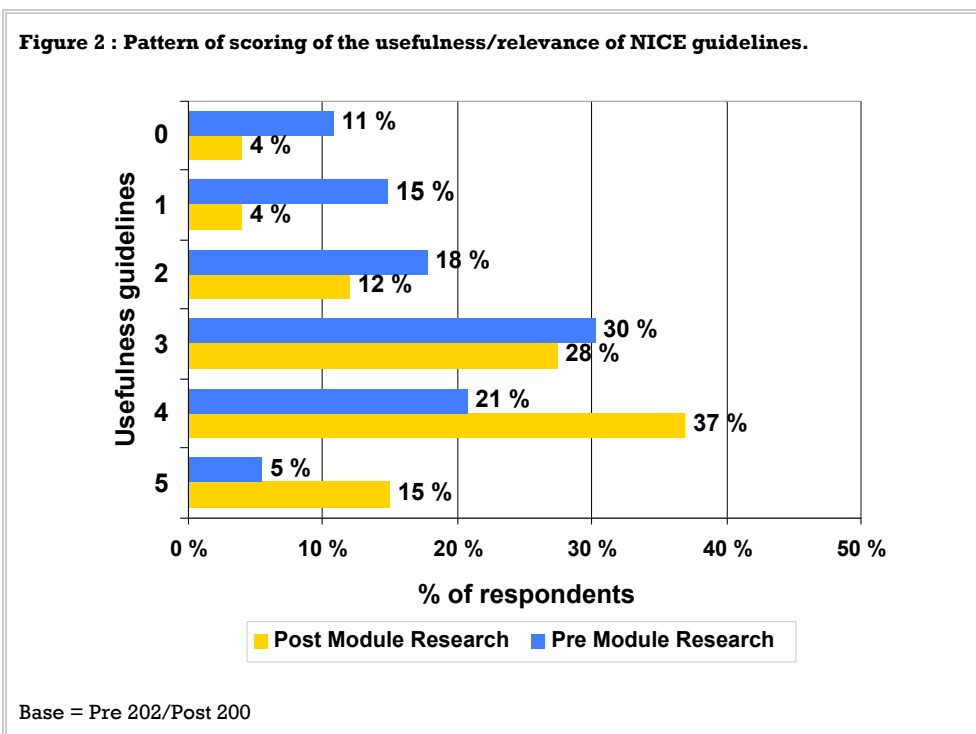


Respondents who had participated in one or more of the modules covering the NICE guidelines for referral of suspected cancer modules ranked the usefulness of guidelines higher than those surveyed prior to the launch of the modules.

On average those researched prior to the modules being available scored the usefulness of guidelines at 2.5 on a scale ranging from 0 to 5 (inclusive).

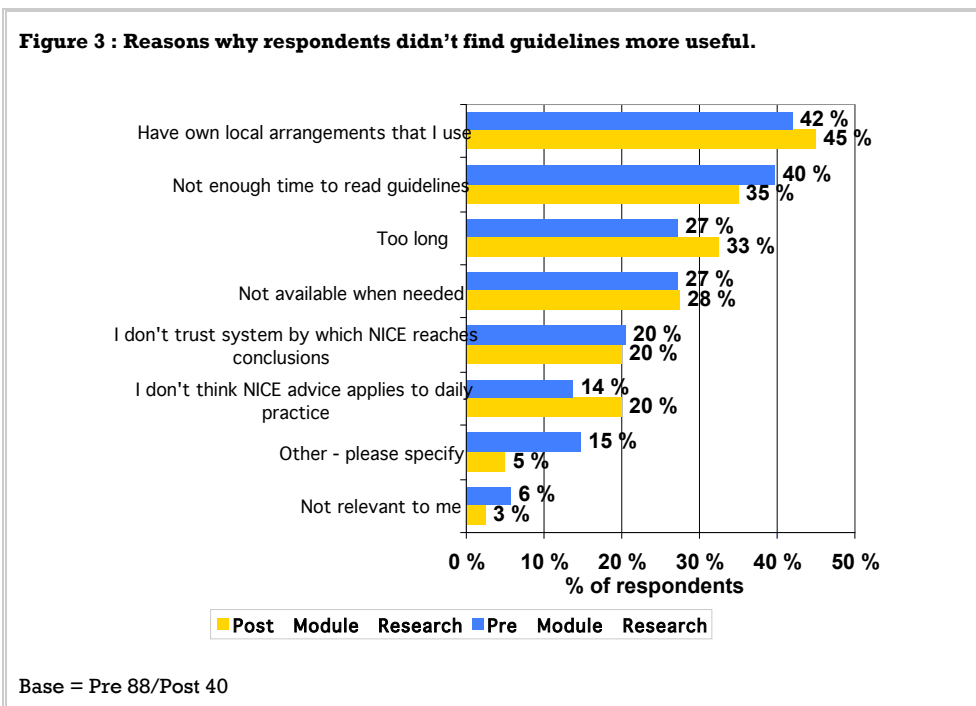
Those who had participated in one or more modules scored the usefulness of guidelines at 3.4 on the same scale.

Those respondents who had participated in the modules covering the guidelines scored their usefulness/relevance significantly higher than those who had not.



The proportion of respondents scoring the usefulness/relevance of NICE guidelines at the upper end of the scale i.e. 3,4 or 5 in the pre module research was 56%. This rose to 80% in the post module phase.

4.1.2 Why didn't you find the guidelines more useful/relevant?



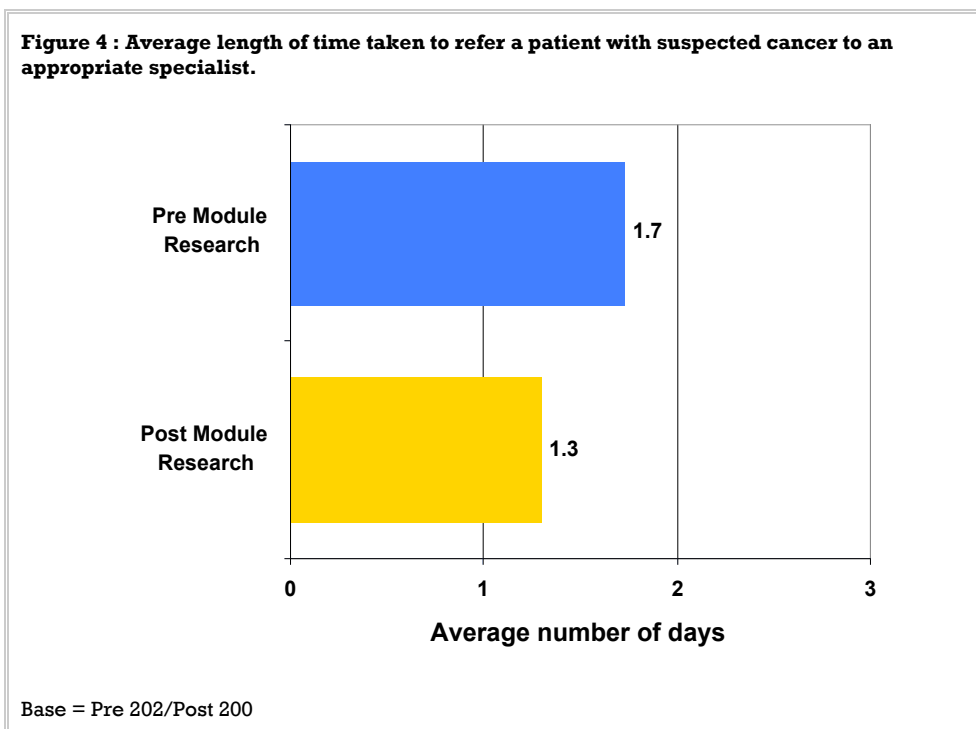


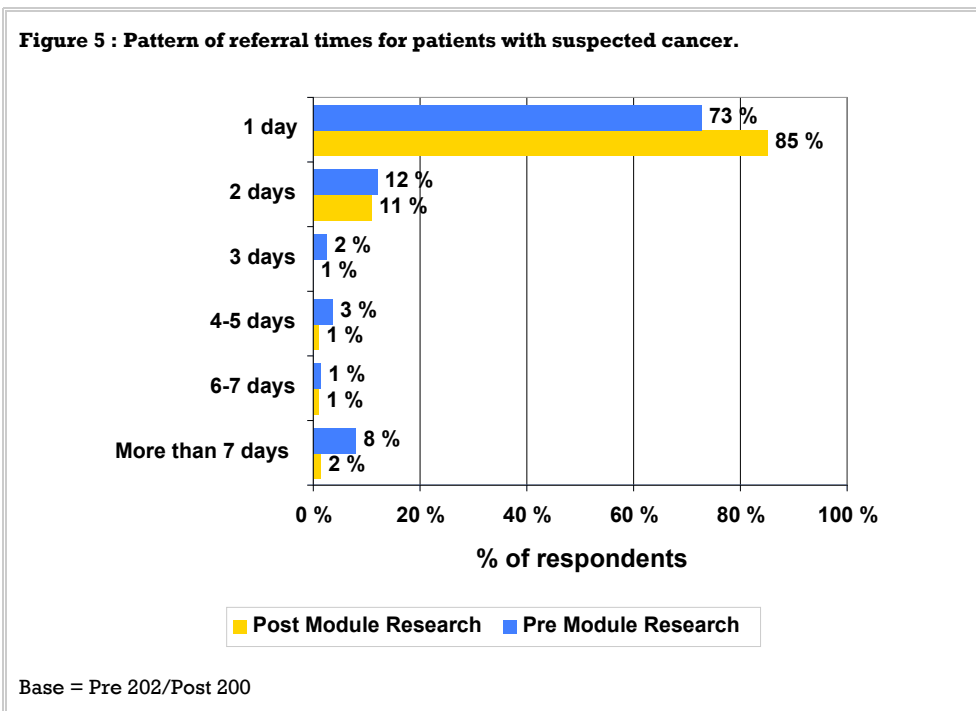
Respondents who had scored the usefulness/relevance of the guidelines as 0, 1 or 2 were asked to say why they didn't find the guidelines more useful.

The main reason respondents in both groups didn't find NICE guidelines more useful/relevant was that they have local arrangements that they use for these situations. Lack of time to read guidelines was also a key reason for not finding them useful. A very small percentage of each group felt that the guidelines were not relevant to them specifically.

4.2 Referral times

4.2.1 How long, (on average) does it take for you to make the referral to the relevant specialist for a patient with suspected cancer?



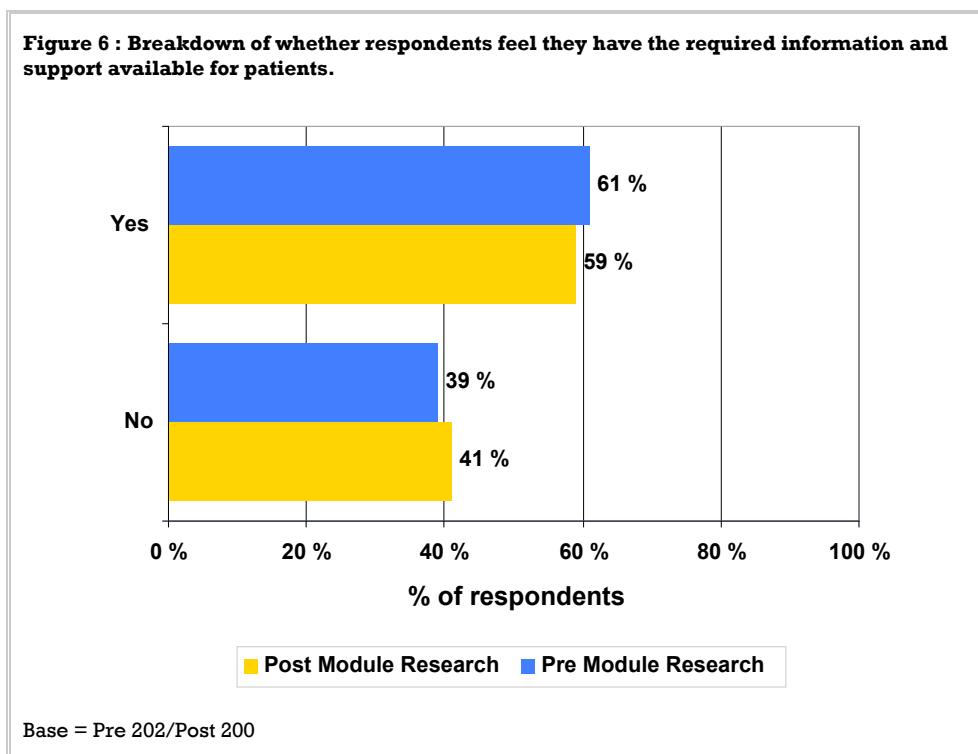


In both respondent sets the majority of respondents refer a patient within one day of suspecting they have cancer. However, the number of respondents who react this quickly is significantly higher in those respondents who had participated in one or more of the modules – 87% of this group would react in one day compared with 73% in the pre-module group.

Contrastingly 8% of respondents in the pre module group, who suspect cancer, would wait more than 7 days to make a referral. This falls to 2% of the group who had participated in a module.



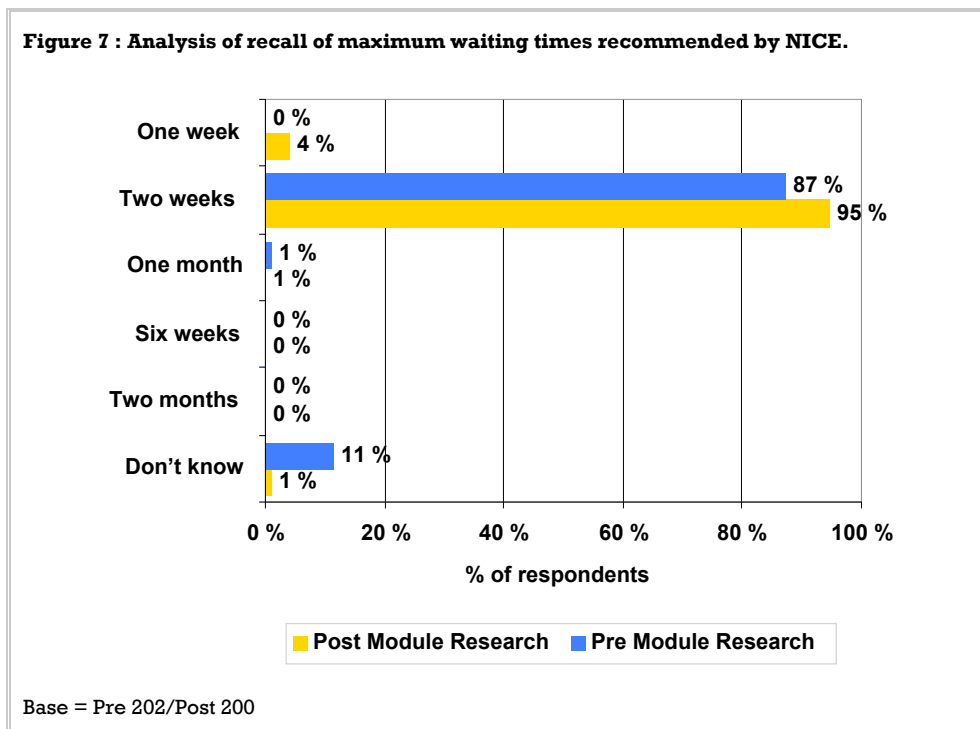
4.2.2 Do you have the information and support available locally for patients who have been referred with suspected cancer?



There is little difference between the two respondent groups regarding how they feel about the information and support they have available to them. Generally 60% of respondents feel they do have the support and 40% feel they don't have suitable support and information available locally.



4.2.3 What is the maximum waiting time recommended by NICE guidelines for patients with suspected cancer?



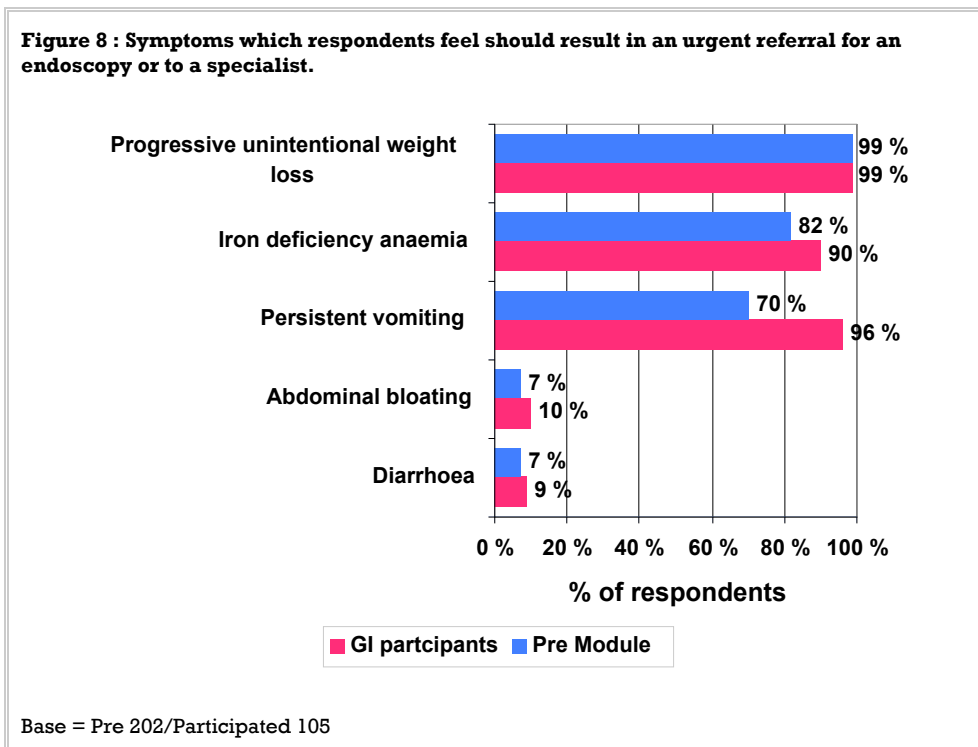
Again in both groups the majority of respondents chose two weeks as the maximum waiting time for patients with suspected cancer. However, the proportion of respondents selecting this option is higher amongst module participants with 95% selecting this option versus 87% in the pre group.

11% of the pre modules group said they didn't know what the maximum recommended waiting time was. This fell to 1% in the post module group.



4.3 Upper GI cancer referral guidelines

4.3.1 Which of the following symptoms in patients with dyspepsia should result in an urgent referral for endoscopy or to a specialist with an interest in upper GI cancer?

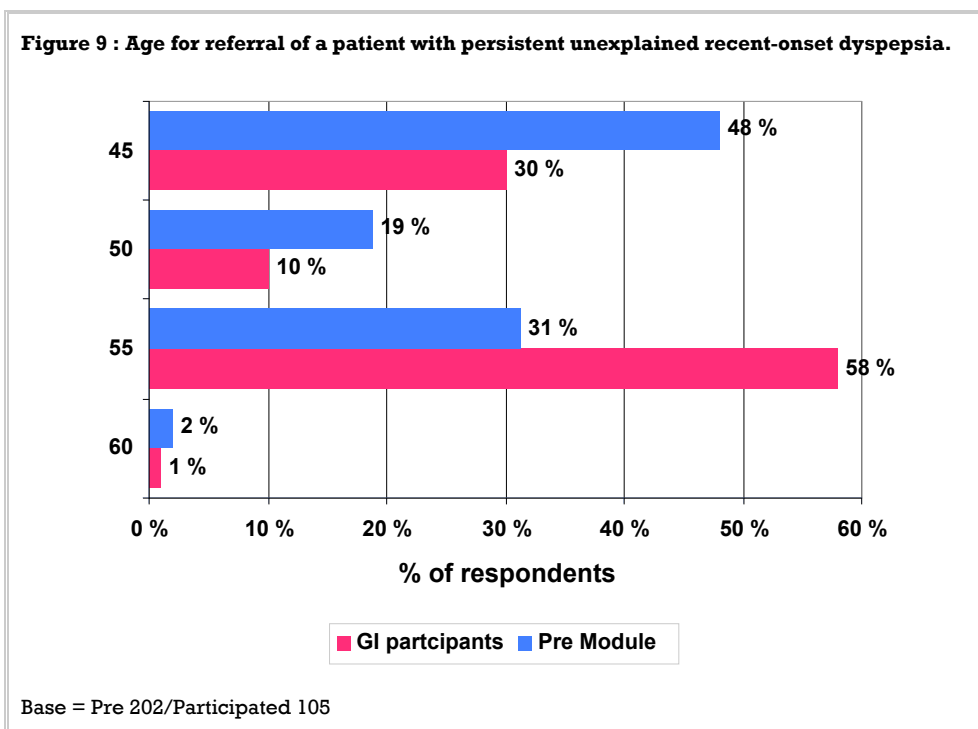


All respondents recognised that progressive, unintentional weight loss in a patient should result in an urgent referral for further investigation. However, more respondents in the group who had participated in the GI module recognised that patients with iron deficiency anaemia or persistent vomiting should also be referred.

Slightly more respondents who had participated in the GI module also felt that abdominal bloating and diarrhoea were also symptoms that should result in a referral compared with those who had not seen the module.



4.3.2 Above what age should you refer for investigation a patient with persistent unexplained recent-onset dyspepsia for a possible upper GI malignancy?

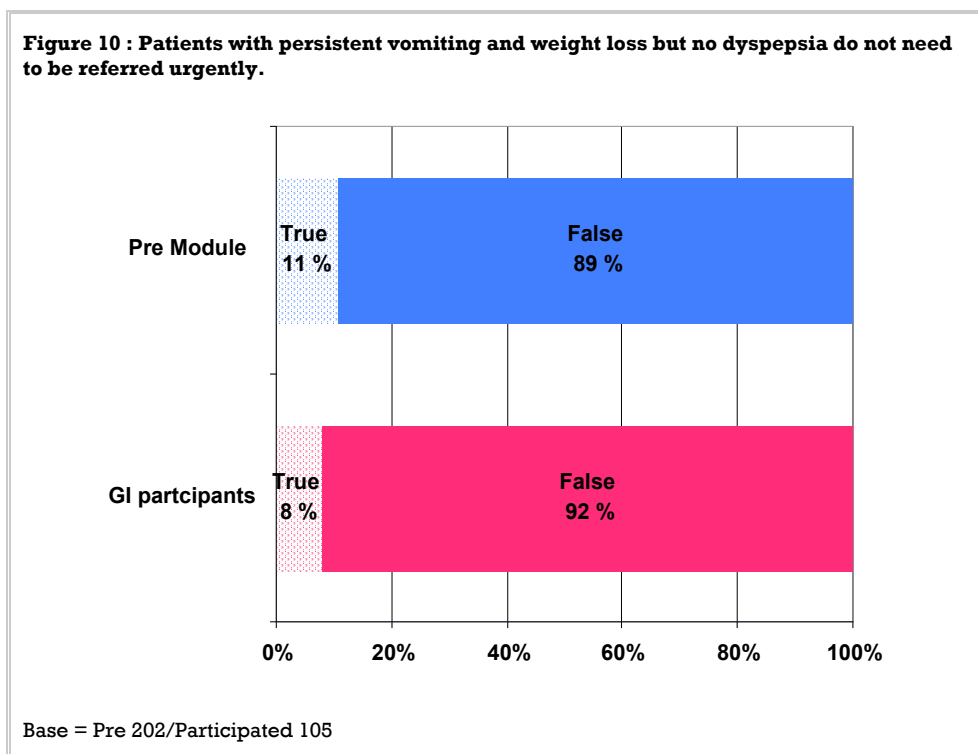


Those respondents who participated in the pre module research most often chose above the 45 years category most often as the age point for referral for further investigation of persistent, unexplained, recent-onset dyspepsia. 48% of respondents in this group selected this category compared with 31% who selected the 55+ category.

The majority (58%) of those who had participated in the GI module selected the 55 age group for referral in these circumstances compared with 30% who would refer patients with these symptoms at age 45.



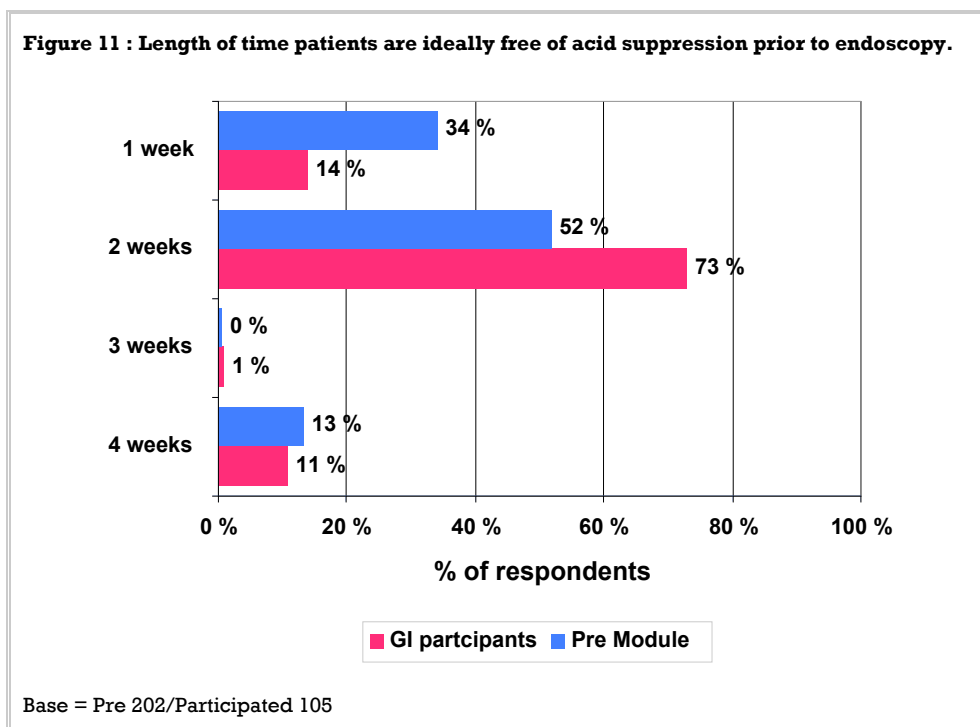
4.3.3 Patients with persistent vomiting and weight loss but no dyspepsia do not need to be referred urgently to a specialist.



The majority of both groups felt that this statement was false. Slightly more respondents in the group who had participated in the module selected false here – 92% compared with 89%.



4.3.4 Patients referred urgently for endoscopy should ideally be free of acid suppression medication for a minimum of:



The majority of both groups (52% pre/73% participated) chose 2 weeks as the ideal time for patients to be free of acid suppression prior to endoscopy.

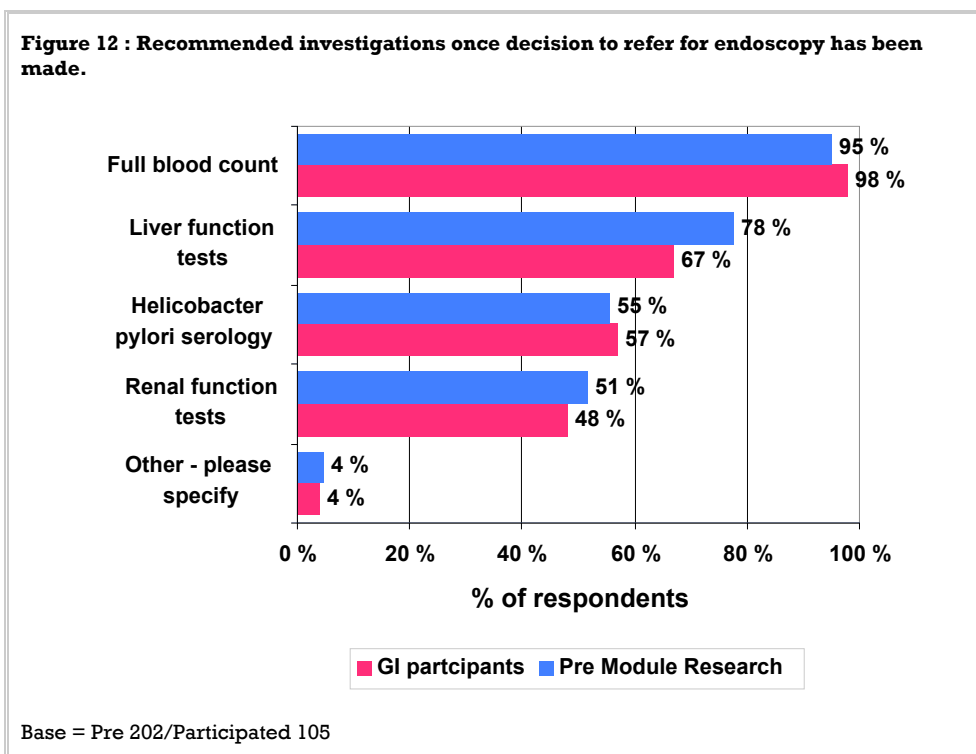
Considering those respondents who had not participated in the modules, 34% felt that 1 week was the ideal length of time that a patient would be free of acid suppression prior to endoscopy. This was significantly more than those in the group who had participated.

In the group who had participated in the GI module the majority (73%) felt that 2 weeks was a suitable length of time for patients to be free of acid suppression prior to the procedure.

13% of the pre group and 11% of the participated group felt that 4 weeks was an appropriate length of time.



4.3.5 Once a decision to refer for endoscopy has been made, which of the following investigations are recommended?



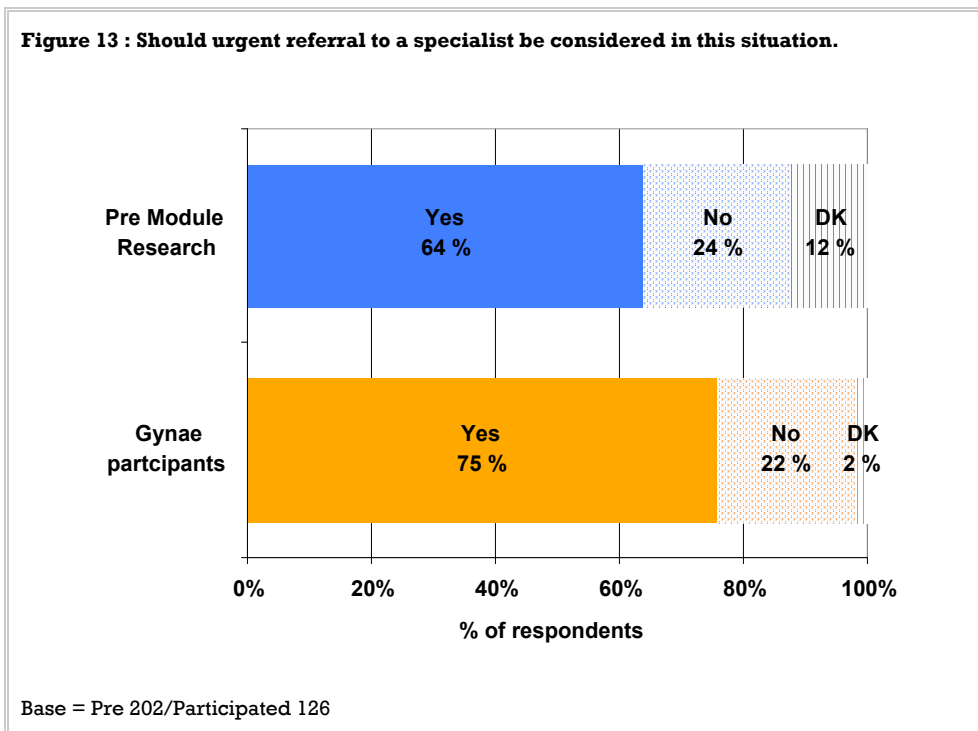
There is consensus in both groups that a full blood count is a recommended investigation once the decision to refer for and endoscopy has been made.

Significantly fewer respondents in the group who had participated in the GI module felt that liver function tests were recommended. The number of respondents who felt that renal function tests and helicobacter pylori serology were required was very similar across the two groups.



4.4 Gynaecological cancer referral guidelines

4.4.1 In a woman with persistent intermenstrual bleeding and a normal pelvic examination should urgent referral to a specialist be considered?

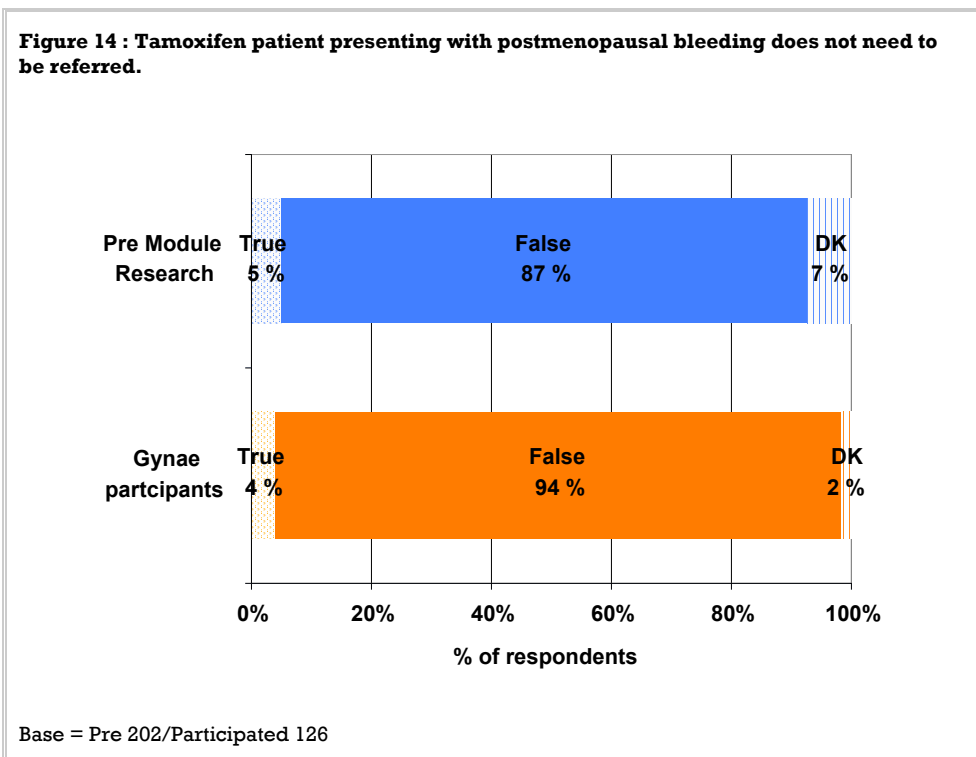


More respondents who had participated in the gynaecological cancer module felt that a patient with this profile should be referred urgently to a specialist for further examination – 75% of those who had participated answered yes to this question compared with 64% in the pre research group.

The group who answered no to the question, in both groups, was very similar (24% pre/22% participated), however, the group who said they don't know fell from 12% in the pre group to 2% in the participated group suggesting that respondents were now much clearer about what to do in these circumstances where they were previously unsure.



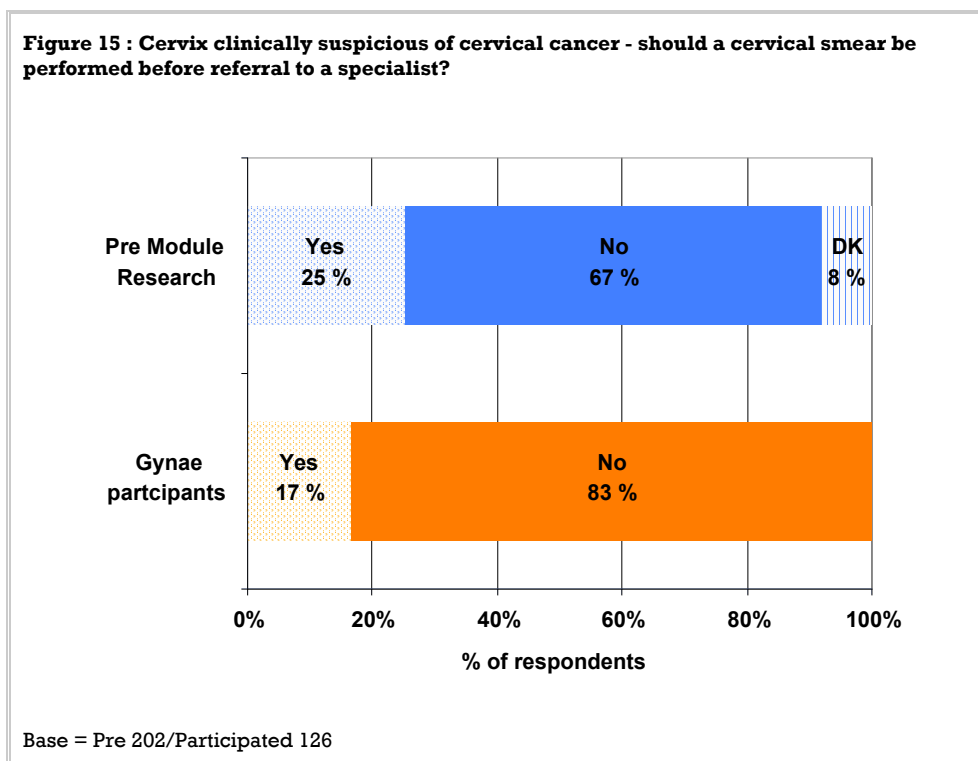
4.4.2 A woman taking tamoxifen who presents with postmenopausal bleeding does not need to be referred urgently to a specialist



Both groups were generally clear that this statement was false. A slightly higher proportion said false in the participated group versus those in the pre group. Again the increase seems to come from the group who 'don't know'. The number who say don't know is reduced to 2% in the participated group from 7% in the pre set of respondents.

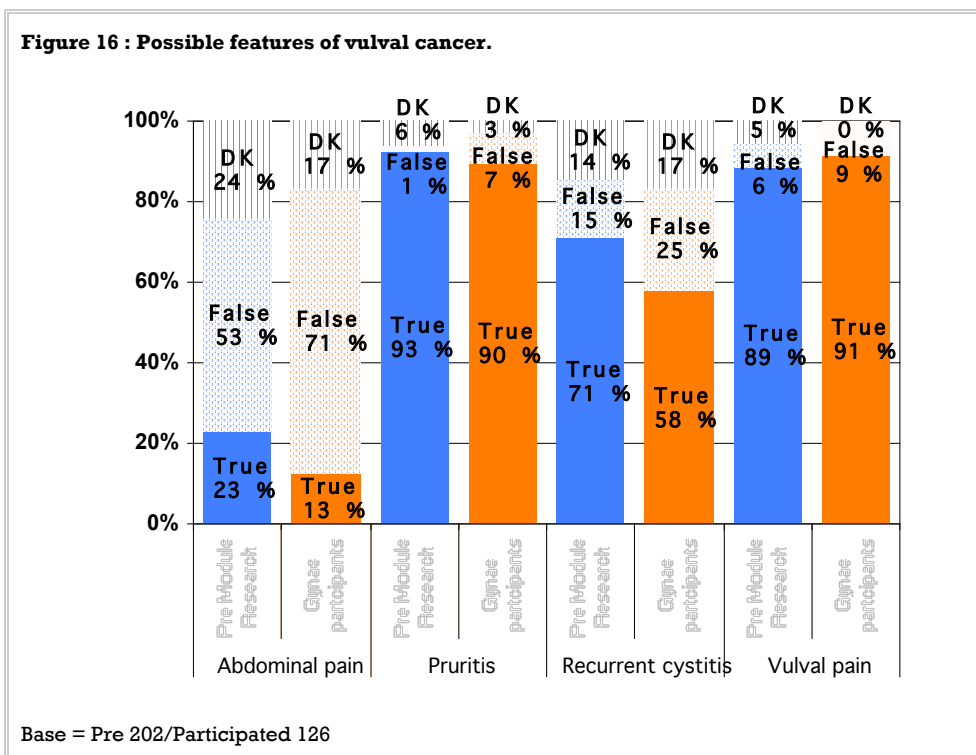


4.4.3 If a woman, on examination, has a cervix clinically suspicious of cervical cancer should a cervical smear be performed before referral to a specialist?



Significantly more respondents in the participated group said that no, a cervical smear, was not required in this situation and prior to referral to a specialist. In the pre group only 67% answered no to this question, 25% answered yes and 8% didn't know, versus 83% yes, 17% no and 0% don't know in the participated group.

4.4.4 The following are recognised features of vulval cancer

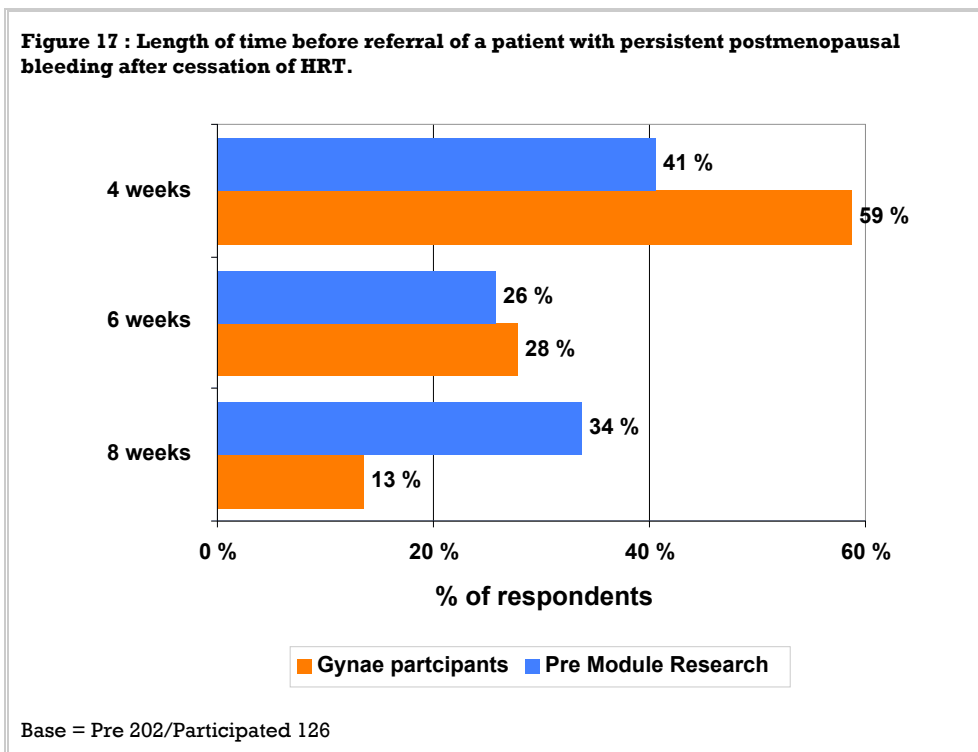


Both sets of respondents recognised that pruritis and vulval pain are recognised features of vulval cancer. Significantly more of the pre respondents said that recurrent cystitis was also a recognised symptom, compared with those in the participated set. 71% of the pre group felt this was true versus 58% in the participated group.

With regard to abdominal pain, almost a quarter (24%) of respondents in the group didn't know whether this was a feature of vulval cancer or not. This reduced to 17% in the participated group. Overall 71% of respondents in the participated group said that it was false that abdominal pain was a recognised feature of vulval cancer compared with 53% in the pre group.



4.4.5 Persistent postmenopausal bleeding after cessation of HRT requires urgent referral if it persists longer than:

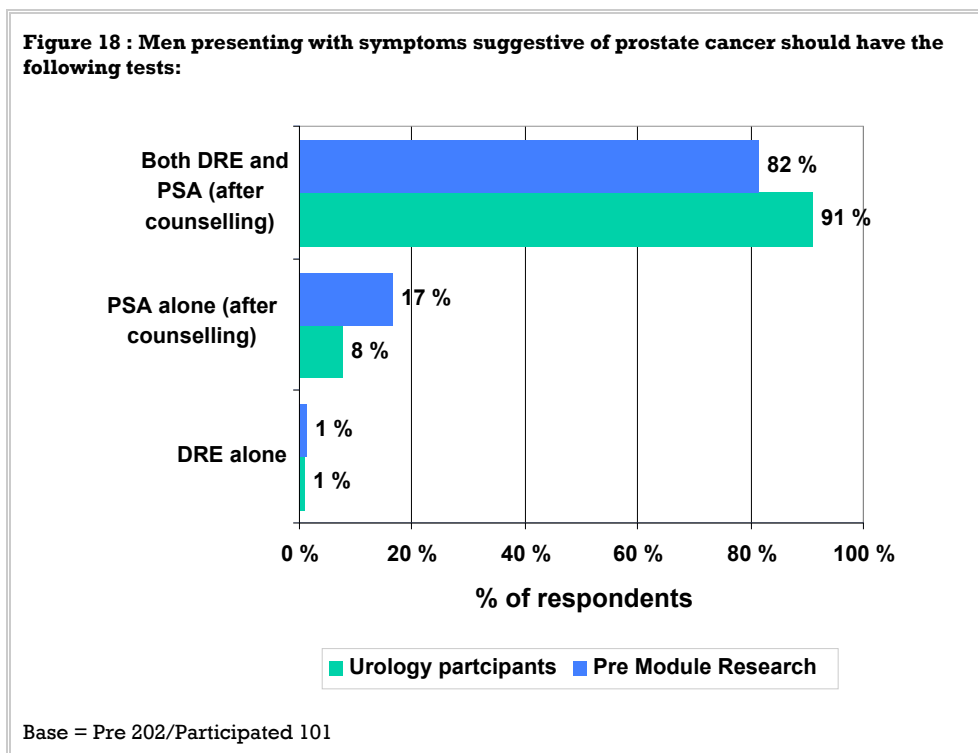


In both groups the majority of respondents felt that urgent referral should take place 4 weeks after cessation of HRT but a significantly higher proportion of respondents in the participated group felt that 4 weeks was a suitable period of time.

A third of the pre group felt that the length of time between HRT cessation and referral of patients with persistent postmenopausal bleeding should be 8 weeks. This was reduced to 13% of the participated group.

4.5 Urological cancer referral guidelines

4.5.1 Recommendations are that men presenting with symptoms suggestive of prostate cancer should have the following.

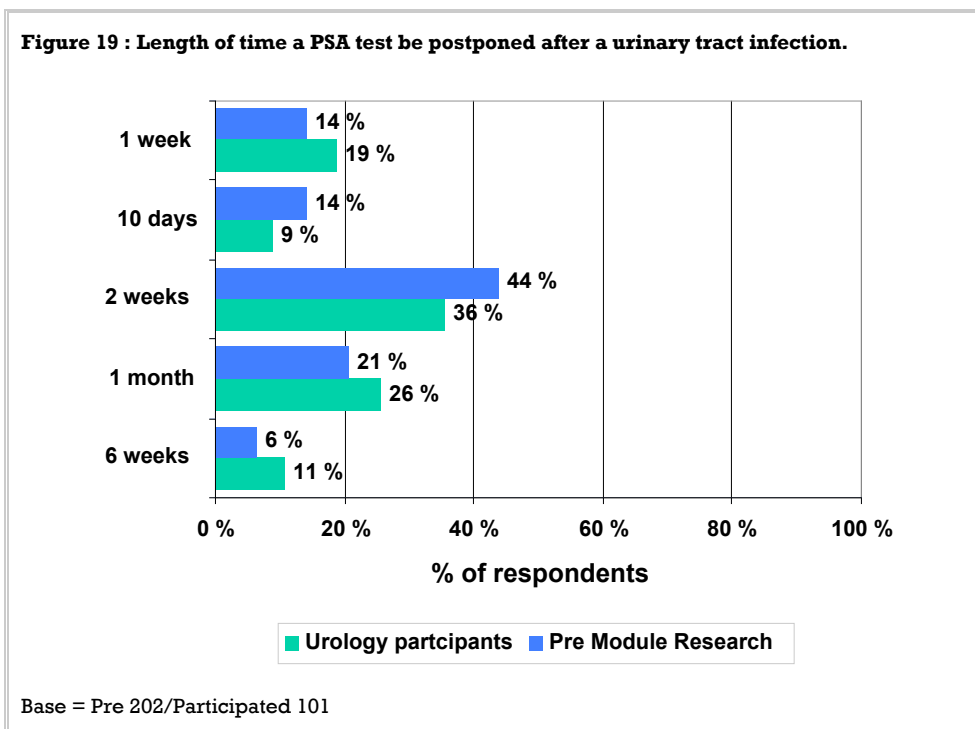


In both respondent groups the majority of respondents stated that both tests should be performed on men presenting with symptoms suggestive of prostate cancer.

The proportion selecting this option was higher in the group who had participated in the urological cancer module than in those who had not. These respondents have moved from performing a PSA test alone.



4.5.2 For how long should a PSA test be postponed after a urinary tract infection?

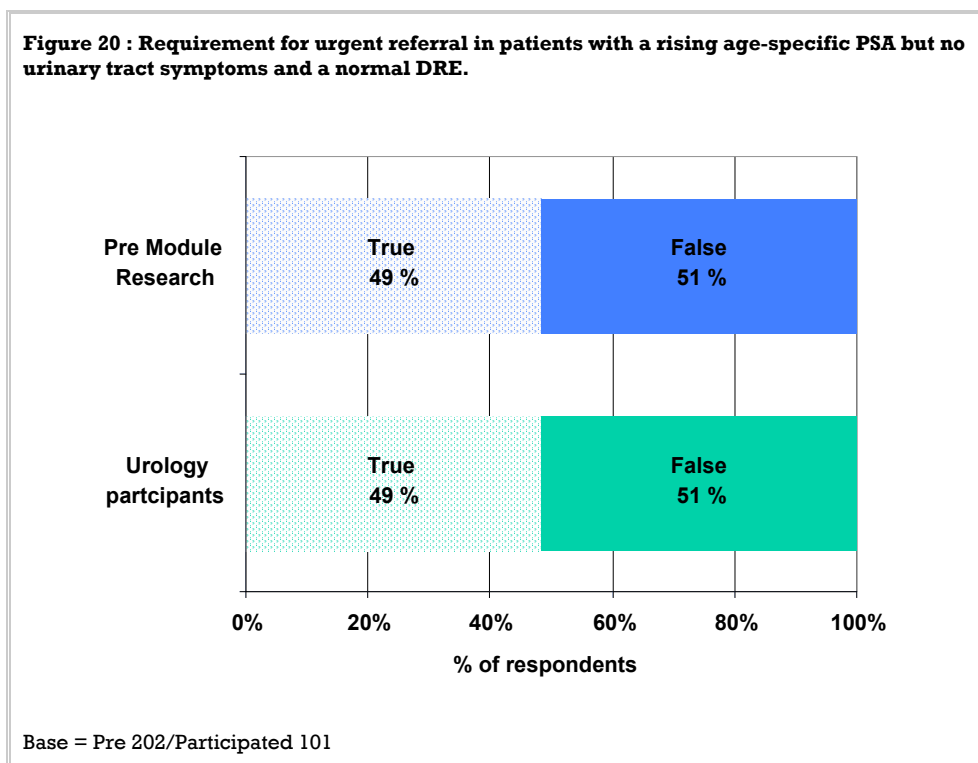


There is no strong consensus in either group regarding the length of time a PSA test should be postponed after a urinary tract infection. The preferred option in both groups is 2 weeks. 8% more respondents in the pre group selected this option than in the participated group.

21% of the pre group selected 1 month as the delay period whereas 26% of the participated group selected this option.



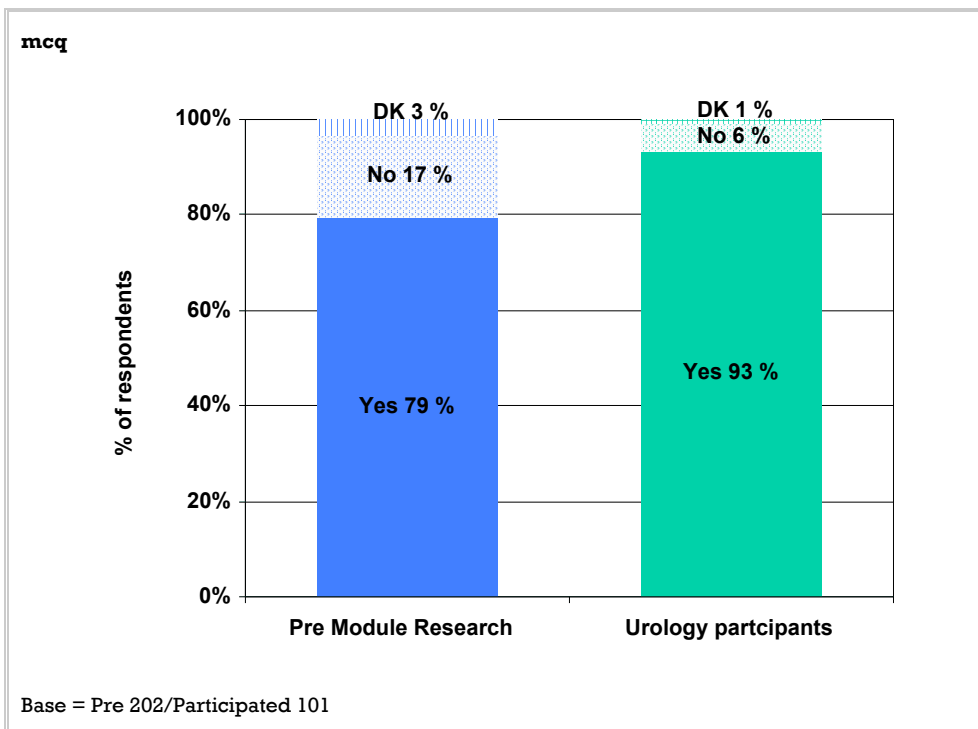
4.5.3 An urgent referral is NOT required in patients with a rising age-specific PSA but no urinary tract symptoms and a normal DRE.



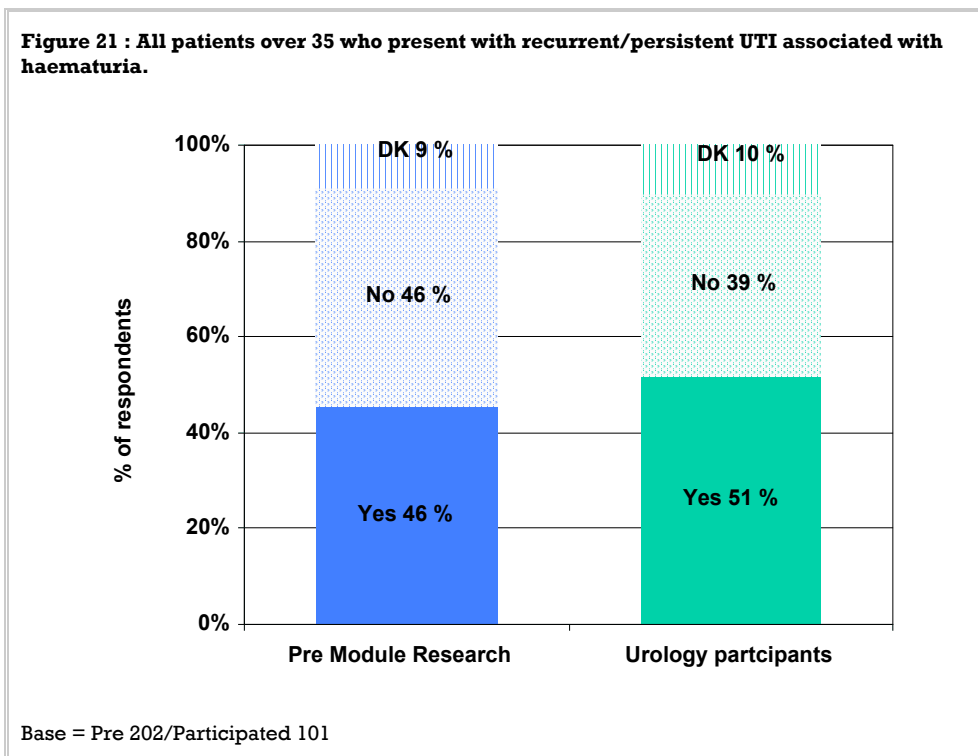
In both sets respondents are generally unclear on this point. The profile of answers across the two groups is exactly the same and shows that respondents are split on this question with 49% saying this scenario is true and 51% saying it is false.



4.5.4 Regarding haematuria, in which of the following scenarios should an urgent referral be made?



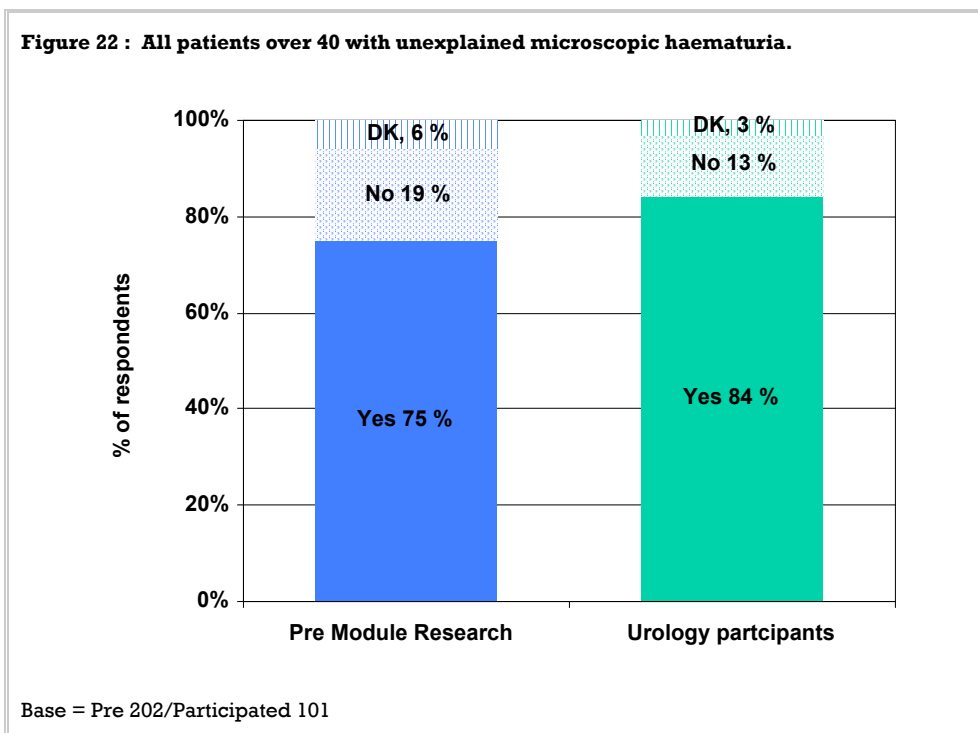
93% of respondents in the participated group said that all patients with painless macroscopic haematuria should be urgently referred. The corresponding figure in the pre group was 79%.





In the pre group the respondent group was split with 46% saying the patient should be referred and 46% of respondents saying they should not be referred. The profile changes slightly in the participated group where 51% of respondents say that such patients should be referred and 39% saying they should not.

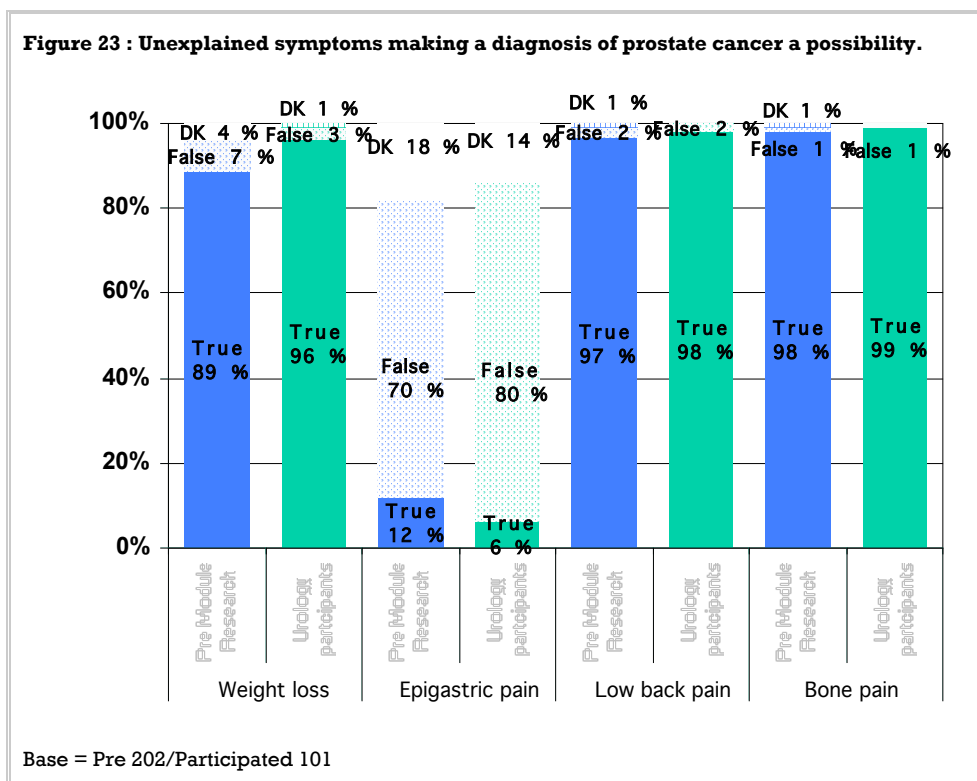
The proportion of respondents who don't know whether a patient in this situation should be referred or not, is similar (9%/10%) across both groups.



The consensus across both groups was that patients over 40 with unexplained microscopic haematuria should be referred for further investigation. Slightly more of the respondents who had participated, 84% versus 75% in the pre group, thought this was the case. The participated group has less respondents saying they don't know.



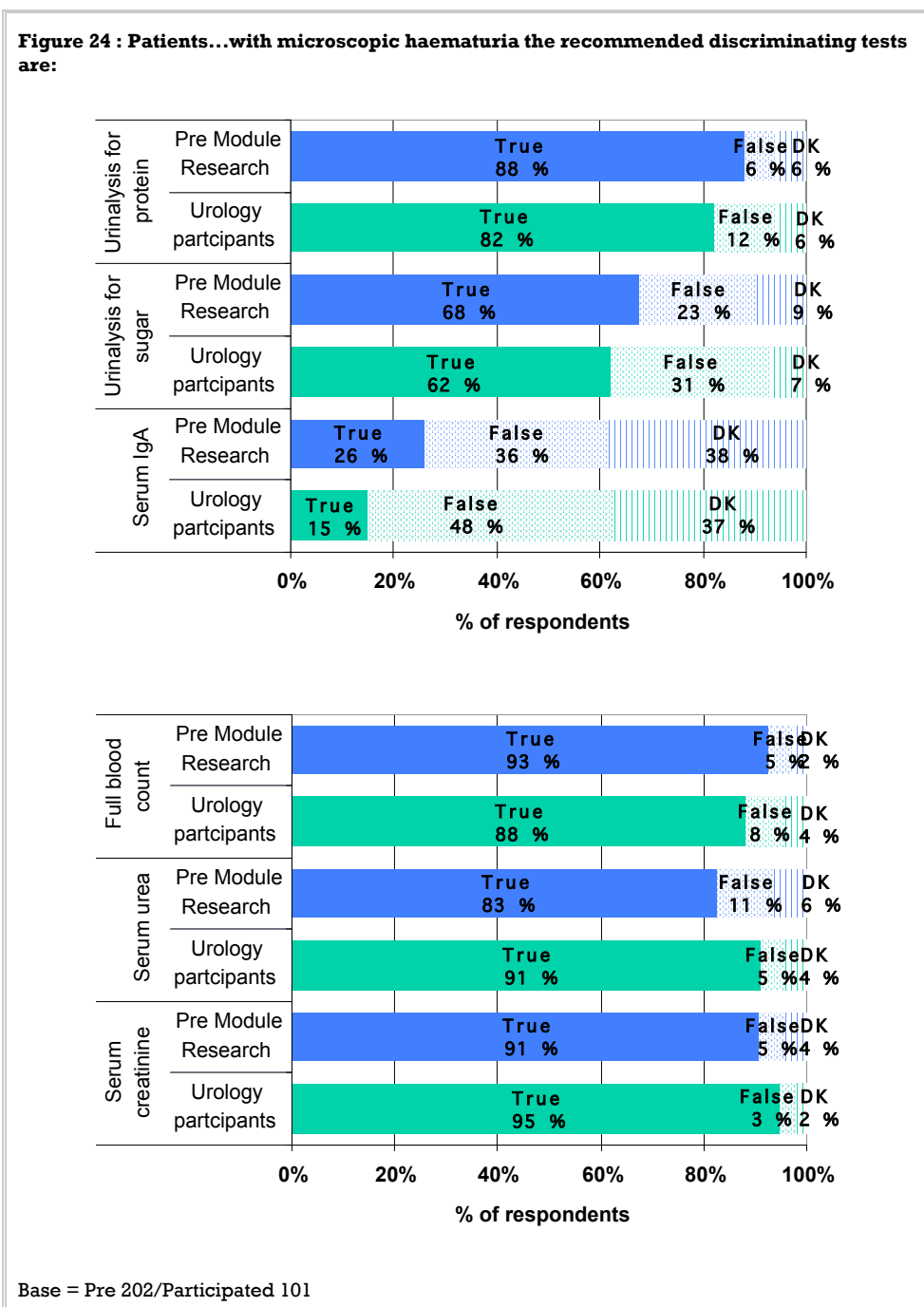
4.5.5 Which of the following unexplained symptoms make a diagnosis of prostate cancer a possibility?



The profile of responses between the pre group and the participated group is very similar for this set of symptoms, particularly for weight loss, low back pain and bone pain.

For epigastric pain there are slight differences. 12% of the pre group felt that epigastric pain is an unexplained symptom of prostate cancer and 18% did not know whether this was the case or not. The corresponding figures in the participated group are 6% saying that it is a symptom of prostate cancer and 14% saying they don't know.

4.5.6 In patients under 50 years of age with microscopic haematuria the recommended preliminary (discriminating) tests are:

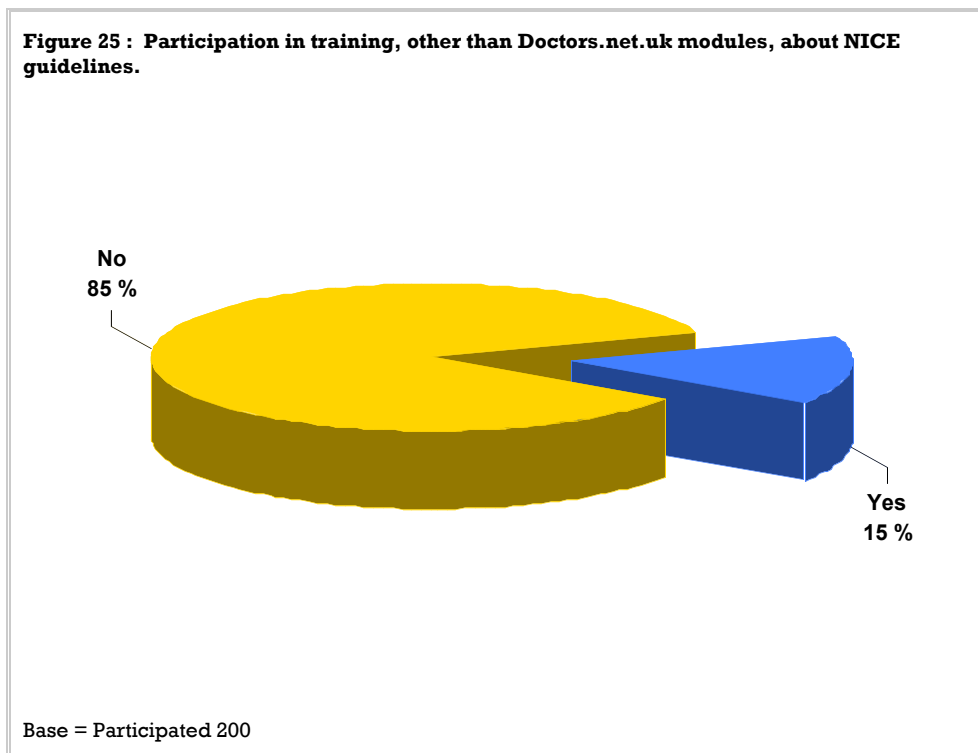


The research shows that, with the exception of Serum IgA respondents feel that the tests listed are appropriate for patients under the age of 50 with microscopic haematuria.

With regard to the Serum IgA test the majority of respondents who had participated (48%) felt that this test was not necessary compared with 36% of the pre group. A quarter of the pre group (26%) said that this was a recommended test. However a large proportion of both groups (38% pre/37% participated) did not know whether this test was recommended or not.

4.6 Other education covering cancer referral guidelines

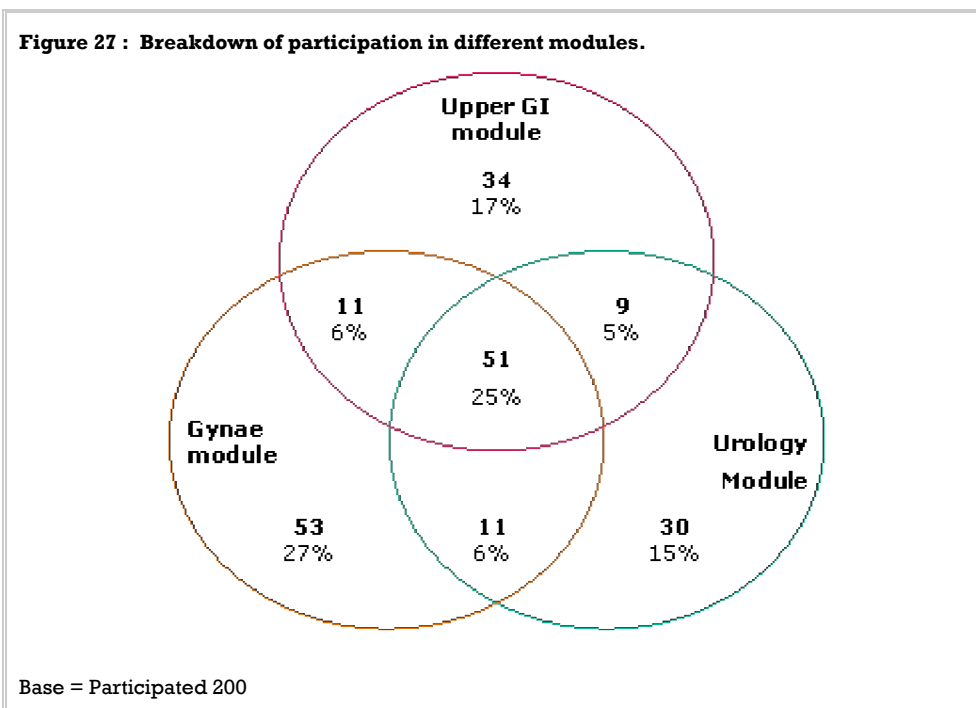
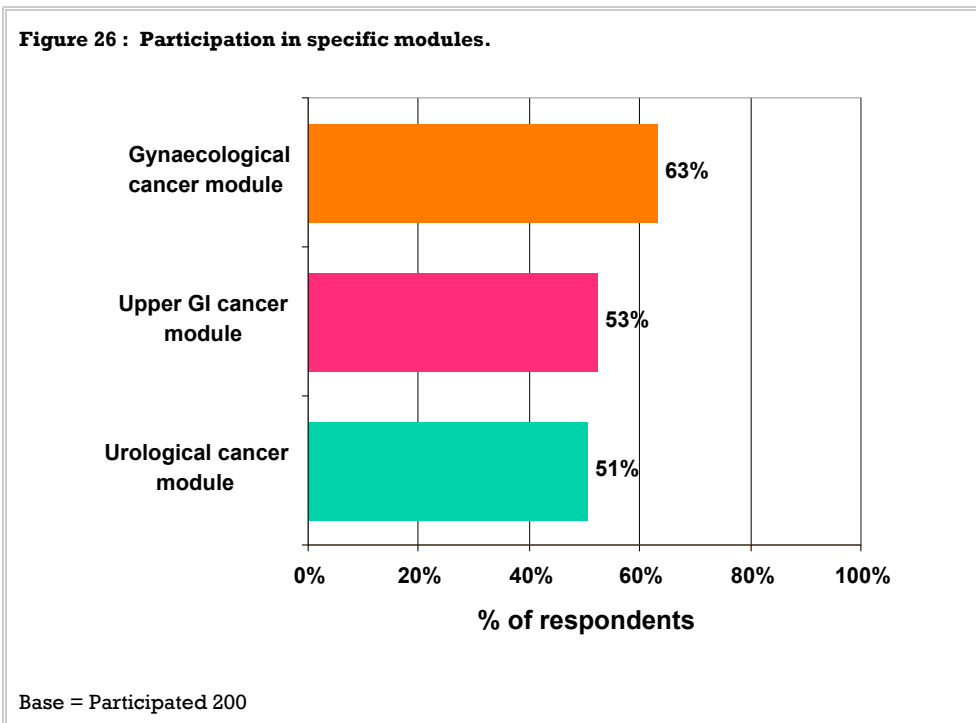
4.6.1 Excluding the educational modules offered on Doctors.net.uk, have you taken part in any other training about NICE Cancer Referral Guidelines?



In total 15% of respondents said that they had participated in training covering the NICE cancer guidelines, other than the modules offered by Doctors.net.uk

5 Appendices

5.1 Appendix 1: Module participation





5.2 Appendix 2: Questionnaire

How useful/relevant to your daily practice are NICE guidelines for referral of suspected cancer?

Where 0 is not at all useful to 5 extremely useful

(Check one alternative per row)

	0	1	2	3	4	5
NICE guidelines for referral of suspected cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Why didn't you find the guidelines more useful/relevant?

(Check all that apply)

- Not available when needed
- Too long
- Not relevant to me
- Not enough time to read guidelines
- Have own local arrangements that I use
- I do not think NICE advice applies to daily practice
- I do not trust system by which NICE reaches conclusions
- Other - please specify

How long (on average) does it take for you to make the referral to the relevant specialist for a patient with suspected cancer?

(Check one)

- 1 day
- 2 days
- 3 days
- 4-5 days
- 6-7 days
- More than 7 days

Do you have information and support available locally for patients who have been referred with suspected cancer?

(Check one)

- Yes
- No



What is the maximum waiting time recommended by NICE guidelines for patients with suspected cancer?

(Check one)

- One week
- Two weeks
- One month
- Six weeks
- Two months
- Don't know

Which of the following symptoms in patients with dyspepsia should result in an urgent referral for endoscopy or to a specialist with an interest in upper GI cancer?

Please check all that apply

(Check all that apply)

- Iron deficiency anaemia
- Persistent vomiting
- Abdominal bloating
- Diarrhoea
- Progressive unintentional weight loss

Above what age should you refer for investigation a patient with persistent unexplained recent-onset dyspepsia for a possible upper GI malignancy?

(Check one)

- 45
- 50
- 55
- 60

Patients with persistent vomiting and weight loss but no dyspepsia do not need to be referred urgently to a specialist.

(Check one)

- True
- False



Patients referred urgently for endoscopy should ideally be free of acid suppression medication for a minimum of:

(Check one)

- 1 week
- 2 weeks
- 3 weeks
- 4 weeks

Once a decision to refer for endoscopy, which of the following investigations are recommended:

(Check all that apply)

- Liver function tests
- Full blood count
- Renal function tests
- Helicobacter pylori serology
- Other - please specify

In a woman with persistent intermenstrual bleeding and a normal pelvic examination should urgent referral to a specialist be considered?

(Check one)

- Yes
- No
- Don't know

A woman taking tamoxifen who presents with postmenopausal bleeding does not need to be referred urgently to a specialist.

(Check one)

- True
- False
- Don't know



If a woman, on examination has a cervix clinically suspicious of cervical cancer should a cervical smear be performed before referral to a specialist?

(Check one)

- Yes
- No
- Don't know

The following are recognised features of vulval cancer.

(Check one alternative per row)

	True	False	Don't know
Abdominal pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pruritis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Recurrent cystitis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Vulval pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Persistent postmenopausal bleeding after cessation of HRT requires urgent referral if it persists longer than:

(Check one)

- 4 weeks
- 6 weeks
- 8 weeks

Recommendations are that men presenting with symptoms suggestive of prostate cancer should have the following:

(Check one)

- DRE alone
- PSA alone (after counselling)
- Both DRE and PSA (after counselling)



For how long should a PSA test be postponed after a urinary tract infection?

(Check one)

- 1 week
- 10 days
- 2 weeks
- 1 month
- 6 weeks

An urgent referral is NOT required in patients with a rising age-specific PSA but no urinary tract symptoms and a normal DRE.

(Check one)

- True
- False

Regarding haematuria, in which of the following scenarios should an urgent referral be made:

(Check one alternative per row)

	Yes	No	Don't know
All patients with painless macroscopic haematuria	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
All patients over 35 who present with recurrent/persistent UTI associated with haematuria	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
All patients over 40 with unexplained microscopic haematuria	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Which of the following unexplained symptoms make a diagnosis of prostate cancer a possibility?

(Check one alternative per row)

	True	False	Don't know
Weight loss	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Epigastric pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Low back pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bone pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



In patients under 50 years of age with microscopic haematuria the recommended preliminary (discriminating) tests are:

(Check one alternative per row)

	True	False	Don't know
Urinalysis for protein	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Urinalysis for sugar	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Serum IgA	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Full blood count	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Serum urea	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Serum creatinine	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Excluding the educational modules offered on Doctors.net.uk, have you taken part in any other training about NICE Cancer Referral Guidelines?

(Check one)

- Yes
- No

From whom did you receive this training?

(Type text)