Suspected Cancer:

recognition and management of suspected cancer in children, young people and adults

Update of clinical guideline 27

Appendix J4: Recommendations from NICE clinical guideline 27 (2005) that have been deleted or changed

Recommendations to be deleted

The table shows recommendations from 2005 that NICE proposed deleting in the 2015 update. The right-hand column gives the replacement recommendation, or explains the reason for the deletion if there is no replacement recommendation.

Recommendation in 2005 guideline	Comment
Patients should be able to consult a primary healthcare professional of the same sex if preferred. [1.1.1]	Recommendation has been deleted because it is not specific to the scope of the guideline
Consideration should be given by the primary healthcare professional to meeting the information and support needs of parents and carers. Consideration should also be given to meeting these particular needs for the people for whom they care, such as children and young people, and people with special needs (for instance, people with learning disabilities or sensory impairment). [1.1.8]	Recommendation has been deleted because this information is already covered by other recommendations
The primary healthcare professional should be aware that some patients find being referred for suspected cancer particularly difficult because of their personal circumstances, such as age, family or work responsibilities, isolation, or other health or social issues. [1.1.9]	Recommendation has been deleted because it is not specific to patient information needs
The primary healthcare professional should be aware that men may have similar support needs to women but may be more reticent about using support services. [1.1.11]	Recommendation has been deleted because it is not specific to the scope of the guideline
In situations where diagnosis or referral has been delayed, or there is significant compromise of the doctor/patient relationship, the primary healthcare professional should take care to assess the information and support needs of the patient, parents and carers, and make sure these needs are met. The patient should be given the opportunity to consult another primary healthcare professional if they wish. [1.1.14]	Recommendation has been deleted because it is not specific to the scope of the guideline
Primary healthcare professionals should promote awareness of key presenting features of cancer when appropriate. [1.1.15]	Recommendation has been deleted as meaning is unclear
Diagnosis of any cancer on clinical grounds alone can be difficult. Primary healthcare professionals should be familiar with the typical	Recommendation has been deleted as this was considered to be standard medical practice

presenting features of cancers, and be able to readily identify these features when patients consult with them. [1.2.1]	
Cancers usually present with symptoms commonly associated with benign conditions. The primary healthcare professional should be ready to review the initial diagnosis in patients in whom common symptoms do not resolve as expected. [1.2.2]	Replaced by: Consider a review for people with any symptom that is associated with an increased risk of cancer, but who do not meet the criteria for referral or other investigative action. The review may be: • planned within a time frame agreed with the person or • patient-initiated if their symptoms recur, persist or worsen, or new symptoms develop or the person continues to be concerned. **[new 2015]**
Primary healthcare professionals must be alert to the possibility of cancer when confronted by unusual symptom patterns or when patients thought not to have cancer fail to recover as expected. In such circumstances, the primary healthcare professional should systematically review the patient's history and examination, and refer urgently if cancer is a possibility. [1.2.3]	Replaced by: Consider a review for people with any symptom that is associated with an increased risk of cancer, but who do not meet the criteria for referral or other investigative action. The review may be: • planned within a time frame agreed with the person or • patient-initiated if their symptoms recur, persist or worsen, or new symptoms develop or the person continues to be concerned. **[new 2015]**
Cancer is uncommon in children, and its detection can present particular difficulties. Primary healthcare professionals should recognise that parents are usually the best observers of their children, and should listen carefully to their concerns. Primary healthcare professionals should also be willing to reassess the initial diagnosis or to seek a second opinion from a colleague if a child fails to recover as expected. [1.2.4]	Replaced by: Take into account the insight and knowledge of parents and carers when considering making a referral for suspected cancer in a child or young person. Consider referral for children if their parent or carer has persistent concern or anxiety about the child's symptoms, even if the symptoms are most likely to have a benign cause. **[2015]**
A patient who presents with symptoms suggestive of cancer should be referred by the primary healthcare professional to a team specialising in the management of the particular type of cancer, depending on local arrangements. [1.2.13]	Replaced by: Recommendations for each site specific cancer stating where the referral should be made

In patients with features typical of cancer, investigations in primary care should not be allowed to delay referral. In patients with less typical symptoms and signs that might, nevertheless, be due to cancer, investigations may be necessary, but should be undertaken urgently to avoid delay. If specific investigations are not readily available locally, an urgent specialist referral should be made. [1.2.14]	Replaced by: Recommendations for each site specific cancer stating what investigations should be performed
A patient who presents with symptoms suggestive of lung cancer should be referred to a team specialising in the management of lung cancer, depending on local arrangements. [1.3.1] An urgent referral for a chest X-ray should be made when a patient presents with: • haemoptysis, or • any of the following unexplained persistent (that is, lasting more than 3 weeks) symptoms and signs: − chest and/or shoulder pain − dyspnoea − weight loss − chest signs − hoarseness − finger clubbing − cervical and/or supraclavicular lymphadenopathy − cough with or without any of the above − features suggestive of metastasis from a lung cancer (for example, in brain, bone, liver or skin). A report should be made back to the referring primary healthcare professional within 5 days of referral.	Replaced by: Refer people using a suspected cancer pathway referral (for an appointment within 2 weeks) for lung cancer if they: • have chest X-ray findings that suggest lung cancer or • are aged over 55 with haemoptysis or • are aged 40–55, smoke or have smoked in the past, and have haemoptysis or • are aged 40–55, have never smoked and have haemoptysis and at least 1 of the following symptoms: – cough – fatigue – shortness of breath – chest pain – weight loss – appetite loss. **[new 2015]** Offer a full blood count and chest X-ray to assess for lung cancer in people aged 40 and over who smoke or have smoked in the past and have any one of the following unexplained symptoms: • cough • fatigue • shortness of breath • chest pain • weight loss • appetite loss. **[new 2015]** Offer a full blood count and chest X-ray to assess for lung cancer in people aged 40 and over who have never smoked and have 2 or more of the following unexplained symptoms: • cough • fatigue • shortness of breath • chest pain • weight loss • appetite loss. **[new 2015]** Offer a full blood count to assess for lung cancer in people aged 40 and over who have never smoked and have any of

[1.3.2]	the following unexplained symptoms: • cough • fatigue • shortness of breath • chest pain • weight loss • appetite loss. **[new 2015]** Consider an urgent full blood count and chest X-ray (within 2 weeks) to assess for lung cancer in people aged 40 and over with any of the following: • finger clubbing or • supraclavicular lymphadenopathy or persistent cervical lymphadenopathy or • chest signs compatible with lung cancer. **[new 2015]** Offer an urgent chest X-ray (within 2 weeks) to assess for lung cancer in people with either: • thrombocytosis or • persistent or recurrent chest infection. **[new 2015]**
An urgent referral should be made for either of the following: • persistent haemoptysis in smokers or ex-smokers who are aged 40 years and older • a chest X-ray suggestive of lung cancer (including pleural effusion and slowly resolving consolidation). [1.3.3]	
Immediate referral should be considered for the following: • signs of superior vena caval obstruction (swelling of the face and/or neck with fixed elevation of jugular venous pressure) • stridor. [1.3.4]	
Patients in the following categories have a higher risk of developing lung cancer: • are current or ex-smokers • have smoking-related chronic obstructive pulmonary disease (COPD) • have been exposed to asbestos • have had a previous history of cancer (especially head and neck). An urgent referral for a chest X-ray or to a team specialising in the management of lung cancer should be made as for other patients but may be considered sooner, for example if symptoms or signs have lasted for less than 3 weeks. [1.3.5]	
Unexplained changes in existing symptoms in patients with underlying chronic respiratory problems should prompt an urgent referral for chest X-ray. [1.3.6]	
If the chest X-ray is normal, but there is a high suspicion of lung cancer, patients should be offered an urgent referral. [1.3.7]	
In individuals with a history of asbestos exposure and recent onset of chest pain, shortness of breath or unexplained systemic symptoms, lung cancer should be considered	

and a chest X-ray arranged. If this indicates a pleural effusion, pleural mass or any suspicious lung pathology, an urgent referral should be made. [1.3.8]	
A patient who presents with symptoms suggestive of upper gastrointestinal cancer should be referred to a team specialising in the management of upper gastrointestinal cancer, depending on local arrangements. [1.4.1]	Replaced by: Offer urgent direct access upper gastrointestinal endoscopy (within 2 weeks) to assess for oesophageal cancer in people: • with dysphagia or • aged 55 and over with weight loss and any of upper abdominal pain or reflux or dyspepsia. **[new 2015]** Consider direct access upper gastrointestinal endoscopy to assess for oesophageal cancer in people with haematemesis. **[new 2015]** Consider direct access upper gastrointestinal endoscopy to assess for oesophageal cancer in people aged 55 or over with: • weight loss and nausea/vomiting or • reflux/dyspepsia and nausea/vomiting or • upper abdominal pain and raised platelet count. **[new 2015]** Refer people using a suspected cancer pathway referral (for an appointment within 2 weeks) for pancreatic cancer if they are aged 40 and over and have jaundice. **[new 2015]** Consider an urgent direct access CT scan (within 2 weeks), or an urgent ultrasound scan if CT is not available, to assess for pancreatic cancer in people aged 60 and over with weight loss and any of the following symptoms: • diarrhoea • back pain • abdominal pain • nausea/vomiting • constipation • new-onset diabetes. **[new 2015]** Consider a suspected cancer pathway referral (for an appointment within 2 weeks) for people with an upper abdominal mass consistent with stomach cancer. **[new 2015]** Offer urgent direct access upper gastrointestinal endoscopy (within 2 weeks) to assess for stomach cancer in people with dysphagia. **[new 2015]** Offer urgent direct access upper gastrointestinal endoscopy (within 2 weeks) to assess for stomach cancer in people with weight loss who: • are aged 40 and over with upper abdominal pain lasting 2 weeks or more and either nausea/vomiting or • are aged 55 and over with upper abdominal pain, reflux or dyspepsia. **[new 2015]**
An urgent referral for endoscopy or to a specialist with expertise in upper gastrointestinal cancer should be made for patients of any age with dyspepsia3 who present with any of the following: • chronic gastrointestinal bleeding • dysphagia • progressive unintentional weight loss • persistent vomiting • iron deficiency anaemia • epigastric mass • suspicious barium meal result. [1.4.2]	
In patients aged 55 years and older with unexplained4 and persistent recent-onset dyspepsia alone, an urgent referral for endoscopy should be made. [1.4.3]	
In patients aged less than 55 years, endoscopic investigation of dyspepsia is not necessary in the absence of alarm symptoms. [1.4.4]	
In patients presenting with dysphagia (interference with the swallowing mechanism that occurs within 5 seconds of having commenced the swallowing process), an urgent referral should be made. [1.4.5]	
Helicobacter pylori status should not affect the decision to refer for suspected cancer. [1.4.6]	
In patients without dyspepsia, but with unexplained weight loss or iron	

deficiency anaemia, the possibility of upper gastrointestinal cancer should be recognised and an urgent referral for further investigation considered. [1.4.7]	Consider direct access upper gastrointestinal endoscopy to assess for stomach cancer in people with weight loss who: • also have appetite loss or • are aged under 55 with dyspepsia or upper abdominal pain lasting 2 weeks or more or • are aged 55 and over with nausea/vomiting. **[new 2015]** Consider direct access upper gastrointestinal endoscopy to assess for stomach cancer in people aged 55 and over with reflux and nausea/vomiting. **[new 2015]** Consider direct access upper gastrointestinal endoscopy to assess for stomach cancer in people aged 55 and over with upper abdominal pain and raised platelet counts. **[new 2015]** Consider an urgent direct access ultrasound scan (within 2 weeks) to assess for gall bladder cancer in people with an upper abdominal mass consistent with an enlarged gall bladder. **[new 2015]** Consider an urgent direct access ultrasound scan (within 2 weeks) to assess for liver cancer in people with an upper abdominal mass consistent with an enlarged liver. **[new 2015]**
In patients with persistent vomiting and weight loss in the absence of dyspepsia, upper gastro-oesophageal cancer should be considered and, if appropriate, an urgent referral should be made. [1.4.8]	
An urgent referral should be made for patients presenting with either: • unexplained upper abdominal pain and weight loss, with or without back pain, or • an upper abdominal mass without dyspepsia. [1.4.9]	
In patients with obstructive jaundice an urgent referral should be made, depending on the patient's clinical state. An urgent ultrasound investigation may be considered if available. [1.4.10]	
In patients with unexplained worsening of their dyspepsia, an urgent referral should be considered if they have any of the following known risk factors: • Barrett's oesophagus • known dysplasia, atrophic gastritis or intestinal metaplasia • peptic ulcer surgery more than 20 years ago. [1.4.11]	
Patients being referred urgently for endoscopy should ideally be free from acid suppression medication, including proton pump inhibitors or H2 receptor antagonists, for a minimum of 2 weeks. [1.4.12]	
In patients where the decision to refer has been made, a full blood count may assist specialist assessment in the outpatient clinic. This should be carried out in accordance with local arrangements. [1.4.13]	

All patients with new-onset dyspepsia should be considered for a full blood count in order to detect iron deficiency anaemia. [1.4.14]	
A patient who presents with symptoms suggestive of colorectal or anal cancer should be referred to a team specialising in the management of lower gastrointestinal cancer, depending on local arrangements. [1.5.1]	Replaced by: Refer people using a suspected cancer pathway referral (for an appointment within 2 weeks) for colorectal cancer if they are aged over 50 and have unexplained rectal bleeding. **[new 2015]** Refer people using a suspected cancer pathway referral (for an appointment within 2 weeks) for colorectal cancer if they are aged 60 and over and have unexplained iron-deficiency anaemia (haemoglobin levels 12 g/dl or below for men and 11 g/dl or below for women). **[new 2015]** Refer people using a suspected cancer pathway referral (for an appointment within 2 weeks) for colorectal cancer if they are aged over 60 and have unexplained changes in their bowel habit. **[new 2015]** Consider a suspected cancer pathway referral (for an appointment within 2 weeks) for colorectal cancer in people with a rectal or abdominal mass. **[new 2015]** Refer people using a suspected cancer pathway referral (for an appointment within 2 weeks) for colorectal cancer if they are aged over 40 with unexplained weight loss and abdominal pain. **[new 2015]** Offer testing for occult blood in faeces to assess for colorectal cancer in people without rectal bleeding who: • have abdominal pain or • have weight loss or • are aged under 60 and have a change in bowel habit or iron-deficiency anaemia (with haemoglobin levels of 12 g/dl or below for men and 11 g/dl or below for women). **[new 2015]** Refer people using a suspected cancer pathway referral (for an appointment within 2 weeks) for colorectal cancer if tests show occult blood in their faeces. **[new 2015]** Consider a suspected cancer pathway referral (for an appointment within 2 weeks) for colorectal cancer in people aged under 50 with rectal bleeding and any of the following unexplained symptoms or findings: • abdominal pain or • change in bowel habit or • weight loss or • iron-deficiency anaemia (haemoglobin levels 12 g/dl or below for men and 11 g/dl or below for women). **[new 2015]**
In patients with equivocal symptoms who are not unduly anxious, it is reasonable to use a period of 'treat, watch and wait' as a method of management. [1.5.2]	
In patients aged 40 years and older, reporting rectal bleeding with a change of bowel habit towards looser stools and/or increased stool frequency persisting for 6 weeks or more, an urgent referral should be made. [1.5.3]	
In patients aged 60 years and older, with rectal bleeding persisting for 6 weeks or more without a change in bowel habit and without anal symptoms, an urgent referral should be made. [1.5.5.]	
In patients aged 60 years and older, with a change in bowel habit to looser stools and/or more frequent stools persisting for 6 weeks or more without rectal bleeding, an urgent referral should be made. [1.5.6]	
In patients presenting with a right lower abdominal mass consistent with involvement of the large bowel, an urgent referral should be made, irrespective of age. [1.5.7]	
In patients presenting with a palpable rectal mass (intraluminal and not pelvic), an urgent referral should be made, irrespective of age.(A pelvic mass outside the bowel would warrant an urgent referral to a urologist or	

gynaecologist.) [1.5.8]	Consider a suspected cancer pathway referral (for an appointment within 2 weeks) for anal cancer in people with an unexplained anal mass or unexplained anal ulceration. **[new 2015]**
In men of any age with unexplained iron deficiency anaemia and a haemoglobin of 11 g/100 ml or below, an urgent referral should be made. [1.5.9]	
In non-menstruating women with unexplained iron deficiency anaemia and a haemoglobin of 10 g/100 ml or below, an urgent referral should be made. [1.5.10]	
In patients with ulcerative colitis or a history of ulcerative colitis, a plan for follow-up should be agreed with a specialist and offered to the patient as a normal procedure in an effort to detect colorectal cancer in this high-risk group. [1.5.11]	
There is insufficient evidence to suggest that a positive family history of colorectal cancer can be used as a criterion to assist in the decision about referral of a symptomatic patient. [1.5.12]	
In patients with equivocal symptoms, a full blood count may help in identifying the possibility of colorectal cancer by demonstrating iron deficiency anaemia, which should then determine if a referral should be made and its urgency. [1.5.13]	
In patients for whom the decision to refer has been made, a full blood count may assist specialist assessment in the outpatient clinic. This should be in accordance with local arrangements. [1.5.14]	
In patients for whom the decision to refer has been made, no examinations or investigations other than those referred to earlier (abdominal and rectal examination, full blood count) are recommended as this may delay referral. [1.5.15]	
A patient who presents with symptoms suggestive of breast	Replaced by:

cancer should be referred to a team specialising in the management of breast cancer. [1.6.1]	Refer people using a suspected cancer pathway referral (for an appointment within 2 weeks) for breast cancer if they are aged 30 and over and have a breast lump with or without pain. **[new 2015]** Refer people using a suspected cancer pathway referral (for an appointment within 2 weeks) for breast cancer if they are aged 50 and over with any of the following symptoms in 1 nipple only: • discharge or • retraction or • other changes of concern. **[new 2015]** Consider a suspected cancer pathway referral (for an appointment within 2 weeks) for breast cancer in people aged 30 and over with an unexplained lump in the axilla. **[new 2015]**
In most cases, the definitive diagnosis will not be known at the time of referral, and many patients who are referred will be found not to have cancer. However, primary healthcare professionals should convey optimism about the effectiveness of treatment and survival because a patient being referred with a breast lump will be naturally concerned. [1.6.2]	
People of all ages who suspect they have breast cancer may have particular information and support needs. The primary healthcare professional should discuss these needs with the patient and respond sensitively to them. [1.6.3]	
Primary healthcare professionals should encourage all patients, including women over 50 years old, to be breast aware in order to minimise delay in the presentation of symptoms.[1.6.4]	
A woman's first suspicion that she may have breast cancer is often when she finds a lump in her breast. The primary healthcare professional should examine the lump with the patient's consent. The features of a lump that should make the primary healthcare professional strongly suspect cancer are a discrete, hard lump with fixation, with or without skin tethering. In patients presenting in this way an urgent referral should be made, irrespective of age. [1.6.5]	
In a woman aged 30 years and older with a discrete lump that persists after her next period, or presents after menopause, an urgent referral should be made. [1.6.6]	
Breast cancer in women aged younger than 30 years is rare, but	

does occur. Benign lumps (for example, fibroadenoma) are common, however, and a policy of referring these women urgently would not be appropriate; instead, non-urgent referral should be considered. However, in women aged younger than 30 years: • with a lump that enlarges, or • with a lump that has other features associated with cancer (fixed and hard), or • in whom there are other reasons for concern such as family history an urgent referral should be made. [1.6.7]	
The patient's history should always be taken into account. For example, it may be appropriate, in discussion with a specialist, to agree referral within a few days in patients reporting a lump or other symptom that has been present for several months. [1.6.8]	
In a patient who has previously had histologically confirmed breast cancer, who presents with a further lump or suspicious symptoms, an urgent referral should be made, irrespective of age. [1.6.9]	
In patients presenting with unilateral eczematous skin or nipple change that does not respond to topical treatment, or with nipple distortion of recent onset, an urgent referral should be made. [1.6.10]	
In patients presenting with spontaneous unilateral bloody nipple discharge, an urgent referral should be made. [1.6.11]	
Breast cancer in men is rare and is particularly rare in men under 50 years of age. However, in a man aged 50 years and older with a unilateral, firm subareolar mass with or without nipple distortion or associated skin changes, an urgent	

referral should be made. [1.6.12]	
In patients presenting with symptoms and/or signs suggestive of breast cancer, investigation prior to referral is not recommended. [1.6.13]	
In patients presenting solely with breast pain, with no palpable abnormality, there is no evidence to support the use of mammography as a discriminatory investigation for breast cancer. Therefore, its use in this group of patients is not recommended. Non-urgent referral may be considered in the event of failure of initial treatment and/or unexplained persistent symptoms. [1.6.14]	
A patient who presents with symptoms suggesting gynaecological cancer should be referred to a team specialising in the management of gynaecological cancer, depending on local arrangements. [1.7.1]	Replaced by: Refer the woman urgently[1] if physical examination identifies ascites and/or a pelvic or abdominal mass (which is not obviously uterine fibroids). Carry out tests in primary care (see recommendations 1.5.6 to 1.5.9) if a woman (especially if 50 or over) reports having any of the following symptoms on a persistent or frequent basis – particularly more than 12 times per month: • persistent abdominal distension (women often refer to this as 'bloating') • feeling full (early satiety) and/or loss of appetite • pelvic or abdominal pain • increased urinary urgency and/or frequency. Consider carrying out tests in primary care (see recommendations 1.5.6 to 1.5.9) if a woman reports unexplained weight loss, fatigue or changes in bowel habit. Advise any woman who is not suspected of having ovarian cancer to return to her GP if her symptoms become more frequent and/or persistent. Carry out appropriate tests for ovarian cancer (see recommendations 1.5.6 to 1.5.9) in any woman of 50 or over who has experienced symptoms within the last 12 months that suggest irritable bowel syndrome (IBS)[2], because IBS rarely presents for the first time in women of this age. Measure serum CA125 in primary care in women with symptoms that suggest ovarian cancer (see recommendations 1.5.1 to 1.5.5).
The first symptoms of gynaecological cancer may be alterations in the menstrual cycle, intermenstrual bleeding, postcoital bleeding, postmenopausal bleeding or vaginal discharge. When a patient presents with any of these symptoms, the primary healthcare professional should undertake a full pelvic examination, including speculum examination of the cervix. [1.7.2]	
In patients found on examination of the cervix to have clinical features that raise the suspicion of cervical cancer, an urgent referral should be made. A cervical smear test is not required before referral, and a previous negative cervical smear result is not a reason to delay referral. [1.7.3]	

[1] An urgent referral means that the woman is referred to a gynaecological cancer service within the national target in England and Wales for referral for suspected cancer, which is currently 2 weeks.

[2] See Irritable bowel syndrome in adults (NICE clinical guideline 61).

This recommendation has been updated and replaced by section 1.1. in 'Ovarian cancer: the diagnosis and initial management of ovarian cancer' (NICE clinical guideline 122, 2011) [1.7.4]	If serum CA125 is 35 IU/ml or greater, arrange an ultrasound scan of the abdomen and pelvis. If the ultrasound suggests ovarian cancer, refer the woman urgently[3] for further investigation.
Any woman with a palpable abdominal or pelvic mass on examination that is not obviously uterine fibroids or not of gastrointestinal or urological origin should have an urgent ultrasound scan. If the scan is suggestive of cancer, or if ultrasound is not available, an urgent referral should be made. [1.7.5]	For any woman who has normal serum CA125 (less than 35 IU/ml), or CA125 of 35 IU/ml or greater but a normal ultrasound: • assess her carefully for other clinical causes of her symptoms and investigate if appropriate • if no other clinical cause is apparent, advise her to return to her GP if her symptoms become more frequent and/or persistent.
When a woman who is not on hormone replacement therapy presents with postmenopausal bleeding, an urgent referral should be made. [1.7.6]	Refer women using a suspected cancer pathway referral (for an appointment within 2 weeks) for endometrial cancer if they are aged 55 and over with post-menopausal bleeding (unexplained vaginal bleeding more than 12 months after menstruation has stopped because of the menopause). **[new 2015]** Consider a suspected cancer pathway referral (for an appointment within 2 weeks) for endometrial cancer in women aged under 55 with post-menopausal bleeding. **[new 2015]**
When a woman on hormone replacement therapy presents with persistent or unexplained postmenopausal bleeding after cessation of hormone replacement therapy for 6 weeks, an urgent referral should be made. [1.7.7.]	Consider a direct access ultrasound scan to assess for endometrial cancer in women aged 55 and over with unexplained symptoms of vaginal discharge who: • are presenting with these symptoms for the first time or • have thrombocytosis or • report haematuria. **[new 2015]**
Tamoxifen can increase the risk of endometrial cancer. When a woman taking tamoxifen presents with postmenopausal bleeding, an urgent referral should be made. [1.7.8]	Consider a direct access ultrasound scan to assess for endometrial cancer in women aged 55 and over with visible haematuria and any of the following: • low haemoglobin levels or • thrombocytosis or • high blood glucose levels. **[new 2015]**
An urgent referral should be considered in a patient with persistent intermenstrual bleeding and a negative pelvic examination. [1.7.9]	Consider a suspected cancer pathway referral (for an appointment within 2 weeks) for women if the appearance of their cervix is consistent with cervical cancer. [new 2015] Consider a suspected cancer pathway referral (for an appointment within 2 weeks) for vaginal cancer in women with an unexplained palpable mass in or at the entrance to the vagina. **[new 2015]**
When a woman presents with vulval symptoms, a vulval examination should be offered. If an unexplained	Replaced by: Consider a suspected cancer pathway referral (for an

[3] An urgent referral means that the woman is referred to a gynaecological cancer service within the national target in England and Wales for referral for suspected cancer, which is currently 2 weeks.

vulval lump is found, an urgent referral should be made. [1.7.10]	appointment within 2 weeks) for vulval cancer in women with an unexplained vulval lump, ulceration or bleeding. **[new 2015]**
Vulval cancer can also present with vulval bleeding due to ulceration. A patient with these features should be referred urgently. [1.7.11]	
Vulval cancer may also present with pruritus or pain. For a patient who presents with these symptoms, it is reasonable to use a period of 'treat, watch and wait' as a method of management. But this should include active follow-up until symptoms resolve or a diagnosis is confirmed. If symptoms persist, the referral may be urgent or non-urgent, depending on the symptoms and the degree of concern about cancer. [1.7.12]	
A patient who presents with symptoms or signs suggestive of urological cancer should be referred to a team specialising in the management of urological cancer, depending on local arrangements. [1.8.1]	Replaced by: Refer men using a suspected cancer pathway referral (for an appointment within 2 weeks) for prostate cancer if their prostate feels malignant on digital rectal examination. **[new 2015]** Consider a prostate-specific antigen (PSA) test and digital rectal examination to assess for prostate cancer in men with: • any lower urinary tract symptoms, such as nocturia, urinary frequency, hesitancy, urgency or retention or • erectile dysfunction or • visible haematuria. **[new 2015]** Refer men using a suspected cancer pathway referral (for an appointment within 2 weeks) for prostate cancer if their PSA levels are above the age-specific reference range. **[new 2015]**
Patients presenting with symptoms suggesting prostate cancer should have a digital rectal examination (DRE) and prostate-specific antigen (PSA) test after counselling. Symptoms will be related to the lower urinary tract and may be inflammatory or obstructive. [1.8.2]	
Prostate cancer is also a possibility in male patients with any of the following unexplained symptoms: • erectile dysfunction • haematuria • lower back pain • bone pain • weight loss, especially in the elderly. These patients should also be offered a DRE and a PSA test. [1.8.3]	
Urinary infection should be excluded before PSA testing, especially in	

men presenting with lower tract symptoms. The PSA test should be postponed for at least 1 month after treatment of a proven urinary infection. [1.8.4]	
If a hard, irregular prostate typical of a prostate carcinoma is felt on rectal examination, then the patient should be referred urgently. The PSA should be measured and the result should accompany the referral. Patients do not need urgent referral if the prostate is simply enlarged and the PSA is in the age-specific reference range. [1.8.5]	
In a male patient with or without lower urinary tract symptoms and in whom the prostate is normal on DRE but the age-specific PSA is raised or rising, an urgent referral should be made. In those patients whose clinical state is compromised by other comorbidities, a discussion with the patient or carers and/or a specialist in urological cancer may be more appropriate. [1.8.6]	
Symptomatic patients with high PSA levels should be referred urgently. [1.8.7]	
If there is doubt about whether to refer an asymptomatic male with a borderline level of PSA, the PSA test should be repeated after an interval of 1 to 3 months. If the second test indicates that the PSA level is rising, the patient should be referred urgently. [1.8.9]	
Male or female adult patients of any age who present with painless macroscopic haematuria should be referred urgently. [1.8.9]	Replaced by: Refer people using a suspected cancer pathway referral (for an appointment within 2 weeks) for bladder cancer if they are aged 45 and over and have unexplained visible haematuria without urinary tract infection or visible haematuria that persists or recurs after successful treatment of urinary tract infection. **[new 2015]** Refer people using a suspected cancer pathway referral (for an appointment within 2 weeks) for bladder cancer if they are aged 60 and over and have unexplained non-visible
In male or female patients with symptoms suggestive of a urinary infection who also present with macroscopic haematuria, investigations should be undertaken to diagnose and treat the infection	

before consideration of referral. If infection is not confirmed the patient should be referred urgently. [1.8.10]	haematuria and either dysuria or a raised white cell count on a blood test. **[new 2015]** Consider referral for bladder cancer in people aged 60 and over with recurrent or persistent urinary tract infection that is unexplained. **[new 2015]** Refer people using a suspected cancer pathway referral (for an appointment within 2 weeks) for renal cancer if they are aged 45 and over and have unexplained visible haematuria without urinary tract infection or visible haematuria that persists or recurs after successful treatment of urinary tract infection. **[new 2015]**
In all adult patients aged 40 years and older who present with recurrent or persistent urinary tract infection associated with haematuria, an urgent referral should be made. [1.8.11]	
In patients under 50 years of age with microscopic haematuria, the urine should be tested for proteinuria and serum creatinine levels measured. Those with proteinurea or raised serum creatinine should be referred to a renal physician. If there is no proteinuria and serum creatinine is normal, a non-urgent referral to a urologist should be made. [1.8.12]	
In patients aged 50 years and older who are found to have unexplained microscopic haematuria, an urgent referral should be made. [1.8.13]	
Any patient with an abdominal mass identified clinically or on imaging that is thought to be arising from the urinary tract should be referred urgently. [1.8.14]	
Any patient with a swelling or mass in the body of the testis should be referred urgently. [1.8.15]	Replaced by: Refer men using a suspected cancer pathway referral (for an appointment within 2 weeks) for testicular cancer if they have a non-painful enlargement or change in shape or texture of the testis. **[new 2015]** Consider a direct access ultrasound scan as part of clinical reassessment for testicular cancer in men with unexplained or persistent testicular symptoms. **[new 2015]**
An urgent ultrasound should be considered in men with a scrotal mass that does not transilluminate and/or when the body of the testis cannot be distinguished. [1.8.16]	
An urgent referral should be made for any patient presenting with symptoms or signs of penile cancer. These include progressive ulceration or a mass in the glans or prepuce particularly, but can involve the skin of the penile shaft. Lumps within the corpora cavernosa not involving penile skin are usually not cancer but indicate Peyronie's disease, which	Replaced by: Refer men using a suspected cancer pathway referral (for an appointment within 2 weeks) for penile cancer if they have a penile mass or ulcerated lesion, and sexually transmitted infection has been excluded as a cause or a persistent penile lesion after treatment for a sexually transmitted infection has been completed.. **[new 2015]** Consider a suspected cancer pathway referral (for an appointment within 2 weeks) for penile cancer in men with

does not require urgent referral. [1.8.17]	unexplained or persistent symptoms affecting the foreskin or glans. **[new 2015]**
A patient who presents with symptoms suggesting haematological cancer should be referred to a team specialising in the management of haematological cancer, depending on local arrangements. [1.9.1]	Replaced by: Consider a very urgent full blood count (within 48 hours) to assess for leukaemia in adults with any of the following symptoms: • pallor • persistent fatigue • unexplained fever • unexplained persistent or recurrent infection • generalised lymphadenopathy • unexplained bruising • unexplained bleeding • unexplained petechiae • hepatosplenomegaly. **[new 2015]** Offer a very urgent full blood count (within 48 hours) to assess for leukaemia in children and young people with any of the following symptoms: • pallor • persistent fatigue • unexplained fever • unexplained persistent infection • generalised lymphadenopathy • persistent or unexplained bone pain • unexplained bruising • unexplained bleeding. **[new 2015]** Refer children and young people for immediate specialist assessment for leukaemia if they have unexplained petechiae or hepatosplenomegaly. **[new 2015]** Offer a full blood count, blood tests for calcium and plasma viscosity or erythrocyte sedimentation rate to assess for myeloma in people aged 60 and over with persistent bone pain, particularly back pain, or unexplained fracture. **[new 2015]** Offer very urgent protein electrophoresis (within 48 hours) to assess for myeloma in people aged 60 and over with hypercalcaemia or leucopenia and a presentation that is consistent with possible myeloma. **[new 2015]** Consider very urgent protein electrophoresis (within 48 hours) to assess for myeloma if the plasma viscosity or erythrocyte sedimentation rate and presentation are consistent with possible myeloma. **[new 2015]** Refer people using a suspected cancer pathway referral (for an appointment within 2 weeks) if the results of protein electrophoresis suggest myeloma. **[new 2015]** Consider a suspected cancer pathway referral (for an
Primary healthcare professionals should be aware that haematological cancers can present with a variety of symptoms that may have a number of different clinical explanations. [1.9.2]	
Combinations of the following symptoms and signs may suggest haematological cancer and warrant full examination, further investigation (including a blood count and film) and possible referral: • fatigue • drenching night sweats • fever • weight loss • generalised itching • breathlessness • bruising • bleeding • recurrent infections • bone pain • alcohol-induced pain • abdominal pain • lymphadenopathy • splenomegaly. The urgency of referral depends on the severity of the symptoms and signs, and findings of investigations. [1.9.3]	
In patients with a blood count or blood film reported as acute leukaemia, an immediate referral should be made. [1.9.4]	
In patients with persistent unexplained splenomegaly, an urgent referral should be made. [1.9.5]	
Investigation of patients with	

persistent unexplained fatigue should include a full blood count, blood film and erythrocyte sedimentation rate, plasma viscosity or C-reactive protein (according to local policy), and repeated at least once if the patient's condition remains unexplained and does not improve. [1.9.6]	appointment within 2 weeks) for non-Hodgkin's lymphoma in people presenting with unexplained lymphadenopathy or splenomegaly. When considering referral, take into account any associated symptoms, particularly fever, night sweats, shortness of breath, pruritus or weight loss. **[new 2015]** Consider a suspected cancer pathway referral (for an appointment within 2 weeks) for Hodgkin's lymphoma in people presenting with unexplained lymphadenopathy. When considering referral, take into account any associated symptoms, particularly fever, night sweats, shortness of breath, pruritus, weight loss or alcohol-induced lymph node pain. **[new 2015]**
Investigation of patients with unexplained lymphadenopathy should include a full blood count, blood film and erythrocyte sedimentation rate, plasma viscosity or C-reactive protein (according to local policy). [1.9.7]	
Any of the following additional features of lymphadenopathy should trigger further investigation and/or referral: • persistence for 6 weeks or more • lymph nodes increasing in size • lymph nodes greater than 2 cm in size • widespread nature • associated splenomegaly, night sweats or weight loss. [1.9.8]	
Investigation of a patient with unexplained bruising, bleeding, and purpura or symptoms suggesting anaemia should include a full blood count, blood film, clotting screen and erythrocyte sedimentation rate, plasma viscosity or C-reactive protein (according to local policy). [1.9.9]	
A patient with bone pain that is persistent and unexplained should be investigated with full blood count and X-ray, urea and electrolytes, liver and bone profile, PSA test (in males) and erythrocyte sedimentation rate, plasma viscosity or C-reactive protein (according to local policy). [1.9.10]	
In patients with spinal cord compression or renal failure suspected of being caused by myeloma, an immediate referral	

should be made. [1.9.11]	
A patient presenting with skin lesions suggestive of skin cancer or in whom a biopsy has been confirmed should be referred to a team specialising in skin cancer. [1.10.1]	Replaced by: Refer people using a suspected cancer pathway referral (for an appointment within 2 weeks) if dermatoscopy suggests malignant melanoma of the skin. **[new 2015]**
All primary healthcare professionals should be aware of the 7-point weighted checklist (see recommendation 1.10.8) for assessment of pigmented skin lesions. [1.10.2]	Refer people using a suspected cancer pathway referral (for an appointment within 2 weeks) for malignant melanoma if they present with a suspicious pigmented skin lesion that has a weighted 7-point checklist score of 3 or more. Major features of the lesions (scoring 2 points each): • change in size • irregular shape • irregular colour.
All primary healthcare professionals who perform minor surgery should have received appropriate accredited training in relevant aspects of skin surgery including cryotherapy, curettage, and incisional and excisional biopsy techniques, and should undertake appropriate continuing professional development. [1.10.3]	Minor features of the lesions (scoring 1 point each): • largest diameter 7 mm or more • inflammation • oozingg • change in sensation.[**new 2015]**
Patients with persistent or slowly evolving unresponsive skin conditions in which the diagnosis is uncertain and cancer is a possibility should be referred to a dermatologist. [1.10.4]	Consider a suspected cancer pathway referral (for an appointment within 2 weeks) for people with a skin lesion that raises the suspicion of squamous cell carcinoma. **[new 2015]** Consider routine referral for people if they have a skin lesion that raises the suspicion of a basal cell carcinoma[4]. **[new 2015]**
All excised skin specimens should be sent for pathological examination. [1.10.5]	Consider a suspected cancer pathway referral (for an appointment within 2 weeks) for for people with a skin lesion that raises the suspicion of a basal cell carcinoma if there is concern that a delay may have an unfavourable impact, because of factors such as lesion site or size. **[new 2015]**
On making a referral of a patient in whom an excised lesion has been diagnosed as malignant, a copy of the pathology report should be sent with the referral correspondence, as there may be details (such as tumour thickness, excision margin) that will specifically influence future management. [1.10.6]	GPs should only excise suspected basal cell carcinomas in accordance with the NICE guideline on improving outcomes for people with skin tumours including melanoma. **[new 2015]**
Change is a key element in diagnosing malignant melanoma. For low-suspicion lesions, careful monitoring for change should be	

[4] Typical features of basal cell carcinoma include: an ulcer with a raised rolled edge; prominent fine blood vessels around a lesion; or a nodule on the skin (particularly pearly or waxy nodules).

undertaken using the 7-point checklist (see recommendation 1.10.8) for 8 weeks. Measurement should be made with photographs and a marker scale and/or ruler. [1.10.7]	
All primary healthcare professionals should use the weighted 7-point checklist in the assessment of pigmented lesions to determine referral: Major features of the lesions: • change in size • irregular shape • irregular colour. Minor features of the lesions: • largest diameter 7 mm or more • inflammation • oozing • change in sensation. Suspicion is greater for lesions scoring 3 points or more (based on major features scoring 2 points each and minor features scoring 1 point each). However, if there are strong concerns about cancer, any one feature is adequate to prompt urgent referral. [1.10.8]	
In patients with a lesion suspected to be melanoma (see recommendation 1.10.8), an urgent referral to a dermatologist or other suitable specialist with experience of melanoma diagnosis should be made, and excision in primary care should be avoided [1.10.9]	
Squamous cell carcinomas present as keratinizing or crusted tumours that may ulcerate. Non-healing lesions larger than 1 cm with significant induration on palpation, commonly on face, scalp or back of hand with a documented expansion over 8 weeks, may be squamous cell carcinomas and an urgent referral should be made. [1.10.10]	

Squamous cell carcinomas are common in patients on immunosuppressive treatment, but may be atypical and aggressive. In patients who have had an organ transplant who develop new or growing cutaneous lesions, an urgent referral should be made. [1.10.11]	
In any patient with histological diagnosis of a squamous cell carcinoma made in primary care, an urgent referral should be made. [1.10.12]	
Basal cell carcinomas are slow growing, usually without significant expansion over 2 months, and usually occur on the face. Where there is a suspicion that the patient has a basal cell carcinoma, a non-urgent referral should be made. [1.10.13]	
All pigmented lesions that are not viewed as suspicious of melanoma but are excised should have a lateral excision margin of 2 mm of clinically normal skin and cut to include subcutaneous fat in depth. [1.10.14	
A patient who presents with symptoms suggestive of head and neck or thyroid cancer should be referred to an appropriate specialist or the neck lump clinic, depending on local arrangements. [1.11.1]	Replaced by: Consider a suspected cancer pathway referral (for an appointment within 2 weeks) for laryngeal cancer in people aged 45 and over with persistent unexplained hoarseness. **[new 2015]** Consider a suspected cancer pathway referral (for an appointment within 2 weeks) for laryngeal cancer in people aged 45 and over with an unexplained lump in the neck. **[new 2015]** Consider an urgent referral (for an appointment within 2 weeks) for assessment for oral cancer by the community dental service in people with an unexplained lump on the lip or in the oral cavity that has not been assessed by a dental surgeon. **[new 2015]** Consider a suspected cancer pathway referral (for an appointment within 2 weeks) for people with a lump on the lip or in the oral cavity that has been assessed by a dental surgeon to be consistent with oral cancer. **[new 2015]**
Any patient with persistent symptoms or signs related to the oral cavity in whom a definitive diagnosis of a benign lesion cannot be made should be referred or followed up until the symptoms and signs disappear. If the symptoms and signs have not disappeared after 6 weeks, an urgent referral should be made. [1.11.2]	
Primary healthcare professionals should advise all patients, including those with dentures, to have regular	

dental checkups. [1.11.3]	Consider a suspected cancer pathway referral (for an appointment within 2 weeks) for oral cancer in people with unexplained ulceration in the oral cavity lasting for more than 14 days. **[new 2015]** Consider a suspected cancer pathway referral (for an appointment within 2 weeks) for oral cancer in people with a persistent and unexplained lump in the neck. **[new 2015]**
In a patient who presents with unexplained red and white patches (including suspected lichen planus) of the oral mucosa that are: • painful, or • swollen, or • bleeding an urgent referral should be made. A non-urgent referral should be made in the absence of these features. If oral lichen planus is confirmed, the patient should be monitored for oral cancer as part of routine dental examination. [1.11.4]	
In patients with unexplained ulceration of the oral mucosa or mass persisting for more than 3 weeks, an urgent referral should be made. [1.11.5]	
In adult patients with unexplained tooth mobility persisting for more than 3 weeks, an urgent referral to a dentist should be made. [1.11.6]	
In any patient with hoarseness persisting for more than 3 weeks, particularly smokers aged 50 years and older and heavy drinkers, an urgent referral for a chest X-ray should be made. Patients with positive findings should be referred urgently to a team specialising in the management of lung cancer. Patients with a negative finding should be urgently referred to a team specialising in head and neck cancer. [1.11.7]	
In patients with an unexplained lump in the neck which has recently appeared or a lump which has not been diagnosed before that has changed over a period of 3 to 6 weeks, an urgent referral should be made. [1.11.8]	
In patients with an unexplained persistent swelling in the parotid or	

submandibular gland, an urgent referral should be made. [1.11.9]	
In patients with unexplained persistent sore or painful throat, an urgent referral should be made. [1.11.10]	
In patients with unilateral unexplained pain in the head and neck area for more than 4 weeks, associated with otalgia (ear ache) but with normal otoscopy, an urgent referral should be made. [1.11.11]	
With the exception of persistent hoarseness (see recommendation 1.11.7), investigations for head and neck cancer in primary care are not recommended as they can delay referral. [1.11.12]	
In patients presenting with symptoms of tracheal compression including stridor due to thyroid swelling, immediate referral should be made. [1.11.13]	Replaced by: Consider a suspected cancer pathway referral (for an appointment within 2 weeks) for thyroid cancer in people with an unexplained thyroid lump. **[new 2015]**
In patients presenting with a thyroid swelling associated with any of the following, an urgent referral should be made: • a solitary nodule increasing in size • a history of neck irradiation • a family history of an endocrine tumour • unexplained hoarseness or voice changes • cervical lymphadenopathy • very young (pre-pubertal) patients • patients aged 65 years and older. [1.11.14]	
In patients with a thyroid swelling without stridor or any of the features indicated in recommendation 1.11.14, the primary healthcare professional should request thyroid function tests. Patients with hyper- or hypothyroidism and an associated goitre are very unlikely to have thyroid cancer and could be referred, nonurgently, to an endocrinologist. Those with goitre and normal thyroid	

function tests who do not have any of the features indicated in recommendation 1.11.14 should be referred non-urgently. [1.11.15]	
Initiation of other investigations by the primary healthcare professional, such as ultrasonography or isotope scanning, is likely to result in unnecessary delay and is not recommended. [1.11.16]	
A patient who presents with symptoms suggestive of brain or CNS cancer should be referred to an appropriate specialist, depending on local arrangements. [1.12.1]	Replaced by: Consider an urgent direct access MRI scan of the brain (within 2 weeks) to assess for brain or central nervous system cancer in adults with progressive, sub-acute loss of central neurological function. **[new 2015]** Consider a very urgent referral (for an appointment within 48 hours) for suspected brain or central nervous system cancer in children and young people with newly abnormal cerebellar or other central neurological function. **[new 2015]**
If a primary healthcare professional has concerns about the interpretation of a patient's symptoms and/or signs, a discussion with a local specialist should be considered. If rapid access to scanning is available, this investigation should also be considered as an alternative. [1.12.2]	
In patients with new, unexplained headaches or neurological symptoms, the primary healthcare professional should undertake a neurological examination guided by the symptoms, but including examination for papilloedema. The absence of papilloedema does not exclude the possibility of a brain tumour. [1.12.3]	
In any patient with symptoms related to the CNS (including progressive neurological deficit, new-onset seizures, headaches, mental changes, cranial nerve palsy, unilateral sensorineural deafness) in whom a brain tumour is suspected, an urgent referral should be made. The development of new signs related to the CNS should be considered as potential indications for referral. [1.12.4]	
In patients with headaches of recent	

onset accompanied by either features suggestive of raised intracranial pressure (for example, vomiting, drowsiness, posture-related headache, headache with pulse-synchronous tinnitus) or other focal or non-focal neurological symptoms (for example, blackout, change in personality or memory), an urgent referral should be made. [1.12.5]	
In patients with unexplained headaches of recent onset, present for at least 1 month but not accompanied by features suggestive of raised intracranial pressure (see recommendation 1.12.5), discussion with a local specialist or referral (usually non-urgent) should be considered. [1.12.6]	
In patients with a new, qualitatively different unexplained headache that becomes progressively severe, an urgent referral should be made. [1.12.7]	
Re-assessment and re-examination is required if the patient does not progress according to expectations. [1.12.8]	
A detailed history should be taken from the patient and an eyewitness to the event if possible, to determine whether or not a seizure is likely to have occurred. [1.12.9]	
In patients presenting with a seizure, a physical examination (including cardiac, neurological, mental state) and developmental assessment, where appropriate, should be carried out. [1.12.10]	
In any patient with suspected recent-onset seizures, an urgent referral to a neurologist should be made. [1.12.11]	
In patients with rapid progression of:	

• subacute focal neurological deficit • unexplained cognitive impairment, behavioural disturbance, or slowness or a combination of these • personality changes confirmed by a witness (for example, a carer, friend or a family member) and for which there is no reasonable explanation even in the absence of the other symptoms and signs of a brain tumour an urgent referral to an appropriate specialist should be considered. [1.12.12]	
In patients previously diagnosed with any cancer an urgent referral should be made if the patient develops any of the following symptoms: • recent-onset seizure • progressive neurological deficit • persistent headaches • new mental or cognitive changes • new neurological signs. [1.12.13]	
A patient who presents with symptoms suggesting bone cancer or sarcoma should be referred to a team specialising in the management of bone cancer and sarcoma, or to a recognised bone cancer centre, depending on local arrangements. [1.13.1]	Replaced by: Consider an urgent direct access X-ray (within 2 weeks) to assess for bone sarcoma in children and young people with unexplained bone swelling or pain. **[new 2015]** Consider a suspected cancer pathway referral (for an appointment within 2 weeks) for people if an X-ray suggests the possibility of bone sarcoma. **[new 2015]** Consider an urgent direct access ultrasound scan (within 2 weeks) to assess for soft tissue sarcoma in people with an unexplained lump that is increasing in size. **[new 2015]**
If a primary healthcare professional has concerns about the interpretation of a patient's symptoms and/or signs, a discussion with the local specialist should be considered. [1.13.2]	Consider a suspected cancer pathway referral (for an appointment within 2 weeks) for people if they have ultrasound scan findings that are suggestive of soft tissue sarcoma or if ultrasound findings are uncertain and clinical concern persists. **[new 2015]**
Patients with increasing, unexplained or persistent bone pain or tenderness, particularly pain at rest (and especially if not in the joint), or an unexplained limp should be investigated by the primary healthcare professional urgently. The nature of the investigations will vary according to the patient's age and	

clinical features. * In older people metastases, myeloma or lymphoma, as well as sarcoma, should be considered. [1.13.3]	
A patient with a suspected spontaneous fracture should be referred for an immediate X-ray. [1.13.4]	
If an X-ray indicates that bone cancer is a possibility, an urgent referral should be made. [1.13.5]	
If the X-ray is normal but symptoms persist, the patient should be followed up and/or a repeat X-ray or bone function tests or a referral requested. [1.13.6]	
In patients presenting with a palpable lump, an urgent referral for suspicion of soft tissue sarcoma should be made if the lump is: • greater than about 5 cm in diameter • deep to fascia, fixed or immobile • painful • increasing in size • a recurrence after previous excision. If there is any doubt about the need for referral, discussion with a local specialist should be undertaken. [1.13.7]	
If a patient has HIV disease, Kaposi's sarcoma should be considered and a referral made if this is suspected. [1.13.8]	
Children and young people who present with symptoms and signs of cancer should be referred to a paediatrician or a specialist children's cancer service, if appropriate. [1.14.1]	Replaced by: Consider very urgent referral (for an appointment within 48 hours) for specialist assessment for neuroblastoma in children with a palpable abdominal mass or unexplained enlarged abdominal organ. **[new 2015]** Consider urgent referral (for an appointment within 2 weeks) for ophthalmological assessment for retinoblastoma in children with an absent red reflex. **[new 2015]**

	Consider very urgent referral (for an appointment within 48 hours) for specialist assessment for Wilm's tumour in children with a palpable abdominal mass or unexplained enlarged abdominal organ. **[new 2015]** Consider very urgent referral (for an appointment within 48 hours) for specialist assessment for Wilm's tumour in children with unexplained visible haematuria. **[new 2015]** Take into account the insight and knowledge of parents and carers when considering making a referral for suspected cancer in a child or young person. Consider referral for children if their parent or carer has persistent concern or anxiety about the child's symptoms, even if the symptoms are most likely to have a benign cause. **[2015]**
Childhood cancer is rare and may present initially with symptoms and signs associated with common conditions. Therefore, in the case of a child or young person presenting several times (for example, three or more times) with the same problem, but with no clear diagnosis, urgent referral should be made. [1.14.2]	Replaced by: Consider very urgent referral (for an appointment within 48 hours) for specialist assessment for neuroblastoma in children with a palpable abdominal mass or unexplained enlarged abdominal organ. **[new 2015]** Consider urgent referral (for an appointment within 2 weeks) for ophthalmological assessment for retinoblastoma in children with an absent red reflex. **[new 2015]** Consider very urgent referral (for an appointment within 48 hours) for specialist assessment for Wilm's tumour in children with a palpable abdominal mass or unexplained enlarged abdominal organ. **[new 2015]** Consider very urgent referral (for an appointment within 48 hours) for specialist assessment for Wilm's tumour in children with unexplained visible haematuria. **[new 2015]** Take into account the insight and knowledge of parents and carers when considering making a referral for suspected cancer in a child or young person. Consider referral for children if their parent or carer has persistent concern or anxiety about the child's symptoms, even if the symptoms are most likely to have a benign cause. **[2015]**
The parent is usually the best observer of the child's or young person's symptoms. The primary healthcare professional should take note of parental insight and knowledge when considering urgent referral. [1.14.3]	
Persistent parental anxiety should be a sufficient reason for referral of a child or young person, even when the primary healthcare professional considers that the symptoms are most likely to have a benign cause. [1.14.4]	
Persistent back pain in a child or young person can be a symptom of cancer and is indication for an examination, investigation with a full blood count and blood film, and consideration of referral. [1.14.5]	
There are associations between Down's syndrome and leukaemia, between neurofibromatosis and CNS tumours, and between other rare	

syndromes and some cancers. The primary healthcare professional should be alert to the potential significance of unexplained symptoms in children or young people with such syndromes. [1.14.6]	
The primary healthcare professional should convey information to the parents and child/young person about the reason for referral and which service the child/young person is being referred to so that they know what to do and what will happen next. [1.14.7]	
The primary healthcare professional should establish good communication with the parents and child/young person in order to develop the supportive relationship that will be required during the further management if the child/young person is found to have cancer. [1.14.8]	
Leukaemia usually presents with a relatively short history of weeks rather than months. The presence of one or more of the following symptoms and signs requires investigation with full blood count and blood film: • pallor • fatigue • unexplained irritability • unexplained fever • persistent or recurrent upper respiratory tract infections • generalised lymphadenopathy • persistent or unexplained bone pain • unexplained bruising. If the blood film or full blood count indicates leukaemia then an urgent referral should be made. [1.14.9]	Replaced by: Offer a very urgent full blood count (within 48 hours) to assess for leukaemia in children and young people with any of the following symptoms: • pallor • persistent fatigue • unexplained fever • unexplained persistent infection • generalised lymphadenopathy • persistent or unexplained bone pain • unexplained bruising • unexplained bleeding. **[new 2015]**
The presence of either of the following signs in a child or young person requires immediate referral: • unexplained petechiae • hepatosplenomegaly [1.14.10]	

Lymphadenopathy is more frequently benign in younger children but urgent referral is advised if one or more of the following characteristics are present, particularly if there is no evidence of local infection: • lymph nodes are non-tender, firm or hard • lymph nodes are greater than 2 cm in size • lymph nodes are progressively enlarging • other features of general ill-health, fever or weight loss • the axillary nodes are involved (in the absence of local infection or dermatitis) • the supraclavicular nodes are involved. [1.14.11]	Replaced by: Consider a suspected cancer pathway referral (for an appointment within 2 weeks) for non-Hodgkin's lymphoma in people presenting with unexplained lymphadenopathy or splenomegaly. When considering referral, take into account any associated symptoms, particularly fever, night sweats, shortness of breath, pruritus or weight loss. **[new 2015]** Consider a suspected cancer pathway referral (for an appointment within 2 weeks) for Hodgkin's lymphoma in people presenting with unexplained lymphadenopathy. When considering referral, take into account any associated symptoms, particularly fever, night sweats, shortness of breath, pruritus, weight loss or alcohol-induced lymph node pain. **[new 2015]**
The presence of hepatosplenomegaly requires immediate referral. [1.14.12]	
Shortness of breath is a symptom that can indicate chest involvement but may be confused with other conditions such as asthma. Shortness of breath in association with the above signs (recommendation 1.14.11), particularly if not responding to bronchodilators, is an indication for urgent referral. [1.14.13]	
A child or young person with a mediastinal or hilar mass on chest X-ray should be referred immediately. [1.14.14]	
Persistent headache in a child or young person requires a neurological examination by the primary healthcare professional. An urgent referral should be made if the primary healthcare professional is unable to undertake an adequate examination. [1.14.15]	Replaced by: Consider a suspected cancer pathway referral (for an appointment within 2 weeks) for thyroid cancer in people with an unexplained thyroid lump. **[new 2015]** Consider a very urgent referral (for an appointment within 48 hours) for suspected brain or central nervous system cancer in children and young people with newly abnormal cerebellar or other central neurological function. **[new 2015]**
Headache and vomiting that cause early morning waking or occur on waking are classical signs of raised intracranial pressure, and an immediate referral should be made.	

[1.14.16]	
The presence of any of the following neurological symptoms and signs should prompt urgent or immediate referral: • new-onset seizures • cranial nerve abnormalities • visual disturbances • gait abnormalities • motor or sensory signs • unexplained deteriorating school performance or developmental milestones • unexplained behavioural and/or mood changes. [1.14.17]	
A child or young person with a reduced level of consciousness requires emergency admission.[1.14.18]	
In children aged younger than 2 years, any of the following symptoms may suggest a CNS tumour, and referral (a indicated below) is required. • Immediate referral: − new-onset seizures − bulging fontanelle − extensor attacks − persistent vomiting. • Urgent referral: − abnormal increase in head size − arrest or regression of motor development − altered behaviour − abnormal eye movements − lack of visual following − poor feeding/failure to thrive. • Urgency contingent on other factors: − squint. [1.14.19]	
Most children and young people with neuroblastoma have symptoms of	Replaced by:

metastatic disease which may be general in nature (malaise, pallor, bone pain, irritability, fever or respiratory symptoms), and may resemble those of acute leukaemia. The presence of any of the following symptoms and signs requires investigation with a full blood count: • persistent or unexplained bone pain (and X-ray) • pallor • fatigue • unexplained irritability • unexplained fever • persistent or recurrent upper respiratory tract infections • generalised lymphadenopathy • unexplained bruising. [1.14.20]	Consider very urgent referral (for an appointment within 48 hours) for specialist assessment for neuroblastoma in children with a palpable abdominal mass or unexplained enlarged abdominal organ. **[new 2015]**
Other symptoms which should raise concern about neuroblastoma and prompt urgent referral include: • proptosis • unexplained back pain • leg weakness • unexplained urinary retention. [1.14.21]	
In children or young people with symptoms that could be explained by neuroblastoma, an abdominal examination (and/or urgent abdominal ultrasound) should be undertaken, and a chest X-ray and full blood count considered. If any mass is identified, an urgent referral should be made. [1.14.22]	
Infants aged younger than 1 year may have localised abdominal or thoracic masses, and in infants younger than 6 months of age, there may also be rapidly progressive intra-abdominal disease. Some babies may present with skin nodules. If any such mass is identified, an immediate referral should be made. [1.14.23]	
Wilms' tumour most commonly presents with a painless abdominal mass. Persistent or progressive abdominal distension should prompt abdominal examination, and if a	Replaced by: Consider very urgent referral (for an appointment within 48 hours) for specialist assessment for Wilm's tumour in children with a palpable abdominal mass or unexplained

mass is found an immediate referral be made. If the child or young person is uncooperative and abdominal examination is not possible, referral for an urgent abdominal ultrasound should be considered. [1.14.24]	enlarged abdominal organ. **[new 2015]** Consider very urgent referral (for an appointment within 48 hours) for specialist assessment for Wilm's tumour in children with unexplained visible haematuria. **[new 2015]**
Haematuria in a child or young person, although a rarer presentation of a Wilms' tumour, merits urgent referral. [1.14.25]	
A soft tissue sarcoma should be suspected and an urgent referral should be made for a child or young person with an unexplained mass at almost any site that has one or more of the following features. The mass is: • deep to the fascia • non-tender • progressively enlarging • associated with a regional lymph node that is enlarging • greater than 2 cm in diameter. [1.14.26]	Replaced by: Consider an urgent direct access ultrasound scan (within 2 weeks) to assess for soft tissue sarcoma in people with an unexplained lump that is increasing in size. **[new 2015]** Consider a suspected cancer pathway referral (for an appointment within 2 weeks) for people if they have ultrasound scan findings that are suggestive of soft tissue sarcoma or if ultrasound findings are uncertain and clinical concern persists. **[new 2015]**
A soft tissue mass in an unusual location may give rise to misleading local and persistent unexplained symptoms and signs, and the possibility of sarcoma should be considered. These symptoms and signs include: • head and neck sarcomas: − proptosis − persistent unexplained unilateral nasal obstruction with or without discharge and/or bleeding − aural polyps/discharge • genitourinary tract: − urinary retention − scrotal swelling − bloodstained vaginal discharge. [1.14.27]	
Limbs are the most common site for bone tumours, especially around the	Replaced by:

knee in the case of osteosarcoma. Persistent localised bone pain and/or swelling requires an X-ray. If a bone tumour is suspected, an urgent referral should be made. [1.14.28]	Consider an urgent direct access X-ray (within 2 weeks) to assess for bone sarcoma in children and young people with unexplained bone swelling or pain. **[new 2015]** Consider a suspected cancer pathway referral (for an appointment within 2 weeks) for people if an X-ray suggests the possibility of bone sarcoma. **[new 2015]**
History of an injury should not be assumed to exclude the possibility of a bone sarcoma. [1.14.29]	
Rest pain, back pain and unexplained limp may all point to a bone tumour and require discussion with a paediatrician, referral or X-ray. [1.14.30]	
In a child with a white pupillary reflex (leukocoria) noted by the parents, identified in photographs or found on examination, an urgent referral should be made. The primary healthcare professional should pay careful attention to the report by a parent of noticing an odd appearance in their child's eye. [1.14.31]	Replaced by: Consider urgent referral (for an appointment within 2 weeks) for ophthalmological assessment for retinoblastoma in children with an absent red reflex. **[new 2015]**
A child with a new squint or change in visual acuity should be referred. If cancer is suspected, referral should be urgent, but otherwise referral should be non-urgent. [1.14.32]	
A family history of retinoblastoma should alert the primary healthcare professional to the possibility of retinoblastoma in a child who presents with visual problems. Offspring of a parent who has had retinoblastoma, or siblings of an affected child, should undergo screening soon after birth. [1.14.33]	
When cancer is suspected in children and young people, imaging is often required. This may be best performed by a paediatrician, following urgent or immediate referral by the primary healthcare professional. [1.14.34]	Replaced by: Consider very urgent referral (for an appointment within 48 hours) for specialist assessment for neuroblastoma in children with a palpable abdominal mass or unexplained enlarged abdominal organ. **[new 2015]** Consider urgent referral (for an appointment within 2 weeks) for ophthalmological assessment for retinoblastoma in children with an absent red reflex. **[new 2015]**
The presence of any of the following symptoms and signs requires	

investigation with full blood count: • pallor • fatigue • irritability • unexplained fever • persistent or recurrent upper respiratory tract infections • generalised lymphadenopathy • persistent or unexplained bone pain (and X-ray) • unexplained bruising. [1.14.35]	Consider very urgent referral (for an appointment within 48 hours) for specialist assessment for Wilm's tumour in children with a palpable abdominal mass or unexplained enlarged abdominal organ. **[new 2015]** Consider very urgent referral (for an appointment within 48 hours) for specialist assessment for Wilm's tumour in children with unexplained visible haematuria. **[new 2015]**

Changes to recommendation wording for clarification only (no change to meaning)

Recommendation numbers in current guideline	Comment
All recommendations labelled **[2005].**	Recommendations have been edited into the direct style (in line with current NICE style for recommendations in clinical guidelines) where possible. Yellow highlighting has not been applied to these changes.