

1 **Suspected Cancer:**

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

4

5 **Update of clinical guideline 27**

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9 **Appendix F: Evidence review**

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15 Developed for NICE by the National Collaborating Centre for Cancer

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1 This document is an update of the Evidence Review which accompanies NICE clinical guideline 27
2 (published June 2005) and will replace it.

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4 Evidence has been reviewed on the recognition and management of suspected cancer in children,
5 young people and adults. New evidence which has been included as part of this update is highlighted
6 in **peach**. You are invited to comment on this evidence only. Appendix J contains content from the
7 2005 Evidence Review which is being deleted as it has been updated.

8

9 The original NICE guideline and supporting documents are available from
10 <http://www.nice.org.uk/guidance/CG27>

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PATIENT INFORMATION**Review question:**

What are the information needs of: 1) patients who are referred for suspected cancer and their carers/families, and 2) patients who are being monitored (for suspected cancer) in primary care and their carers/families?

Results**Literature search**

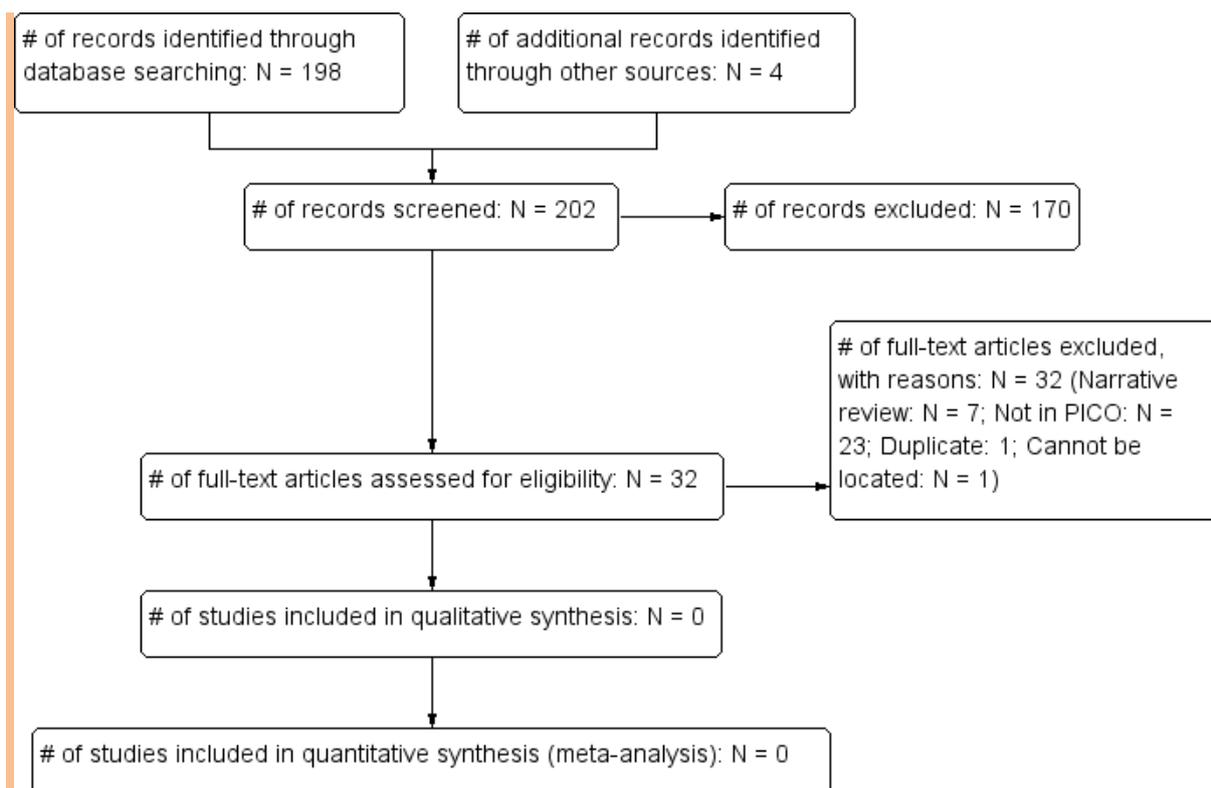
Database name	Dates Covered	No of references found	No of references retrieved	Finish date of search
<i>Medline</i>	1980-2013	1575	93	11/07/2013
<i>Premedline</i>	1980-2013	95	3	11/07/2013
<i>Embase</i>	1980-2013	799	33	09/09/2013
<i>Cochrane Library</i>	1980-2013	874	0	09/09/2013
<i>Psychinfo</i>	1980-2013	133	3	09/09/2013
<i>Web of Science (SCI & SSCI) and ISI Proceedings</i>	1980-2013	38	0	09/09/2013
<i>Websites etc</i>			18	09/09/2013

Total References retrieved (after de-duplication): 142

Update Search

Database name	Dates Covered	No of references found	No of references retrieved	Finish date of search
<i>Medline</i>	2013-27/082014	70	24	27/082014
<i>Premedline</i>	2013-27/082014	89	22	27/082014
<i>Embase</i>	2013-27/082014	125	31	27/082014
<i>Cochrane Library</i>	2013-27/082014	279	1	27/082014
<i>Psychinfo</i>	2013-27/082014	22	7	27/082014
<i>Web of Science (SCI & SSCI) and ISI Proceedings</i>	2013-27/082014	4	1	27/082014

Total References retrieved (after de-duplication): 56



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4 **Study results**

5 No evidence was found pertaining to the information needs of primary care patients who are
 6 referred for suspected cancer and their carers/families, or of patients who are being monitored (for
 7 suspected cancer) in primary care and their carers/families.

8

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10 **Included studies**

11 None

12

13 **Excluded studies (with reason)**

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20 PATIENT PARTICIPATION Cancer Care Focus Group at Caen Medical Centre. 2013.

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SAFETY-NETTING**Review question:**

What safety-netting strategies are effective in primary care for patients being monitored for suspected cancer?

Results**Literature search**

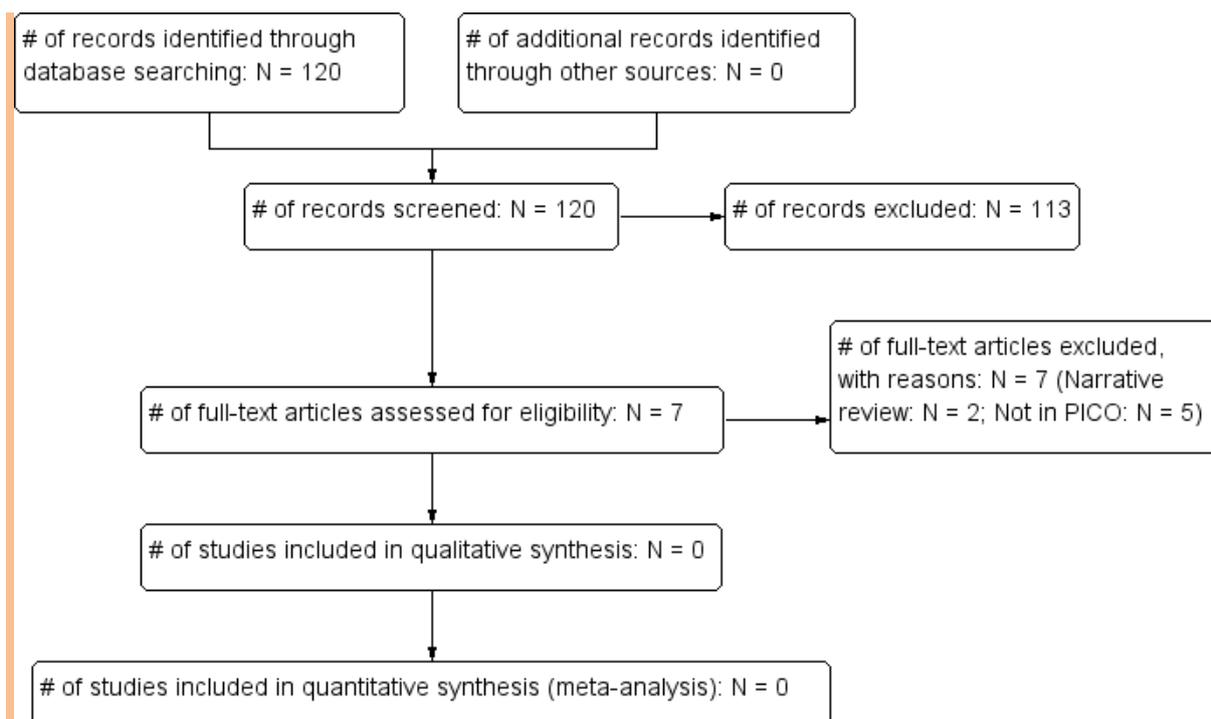
Database name	Dates Covered	No of references found	No of references retrieved	Finish date of search
<i>Medline</i>	1980-2013	362	51	03/07/2013
<i>Premedline</i>	1980-2013	79	9	04/07/2013
<i>Embase</i>	1980-2013	548	21	04/07/2013
<i>Cochrane Library</i>	1980-2013	27	1	04/07/2013
<i>Psychinfo</i>	1980-2013	35	3	04/07/2013
<i>Web of Science (SCI & SSCI) and ISI Proceedings</i>	1980-2013	567	8	04/07/2013
<i>Websites, Cancer networks</i>			12	08/07/2013

Total References retrieved (after de-duplication): 85

Update Search

Database name	Dates Covered	No of references found	No of references retrieved	Finish date of search
<i>Medline</i>	2013-27/08/2014	49	5	27/08/2014
<i>Premedline</i>	2013-27/08/2014	67	5	27/08/2014
<i>Embase</i>	2013-27/08/2014	98	10	27/08/2014
<i>Cochrane Library</i>	2013-27/08/2014	4	0	27/08/2014
<i>Psychinfo</i>	2013-27/08/2014	13	3	27/08/2014
<i>Web of Science (SCI & SSCI) and ISI Proceedings</i>	2013-27/08/2014	132	24	27/08/2014
<i>Websites, Cancer networks</i>			7	27/08/2014

Total References retrieved (after de-duplication): 35



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4 **Study results**

5 No evidence was found pertaining to the effectiveness of any safety-netting strategies in primary
6 care for patients being monitored for suspected cancer.

7

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LUNG AND PLEURAL CANCERS

LUNG CANCER

Review question:

What is the risk of lung cancer in patients presenting in primary care with symptom(s)?

Results

Literature search

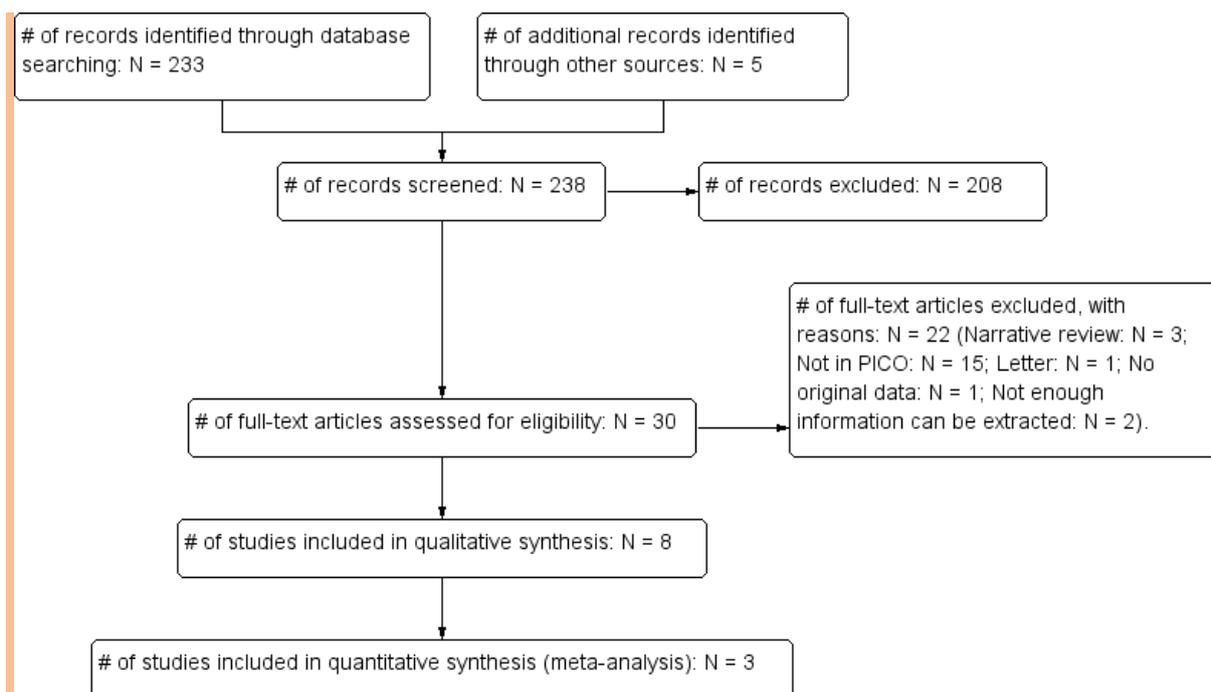
Database name	Dates Covered	No of references found	No of references retrieved	Finish date of search
<i>Medline</i>	All-2012	1520	57	06/02/2013
<i>Premedline</i>	All-2012	19	3	06/02/2013
<i>Embase</i>	All-2012	4958	100	12/02/2013
<i>Cochrane Library</i>	All-2012	419	3	12/02/2013
<i>Psychinfo</i>	All-2012	21	3	12/02/2013
<i>Web of Science (SCI & SSCI) and ISI Proceedings</i>	All-2012	784	65	13/02/2013
Database name	Dates Covered	No of references found	No of references retrieved	Finish date of search

Total References retrieved (after de-duplication): 208

Update Search

Database name	Dates Covered	No of references found	No of references retrieved	Finish date of search
<i>Medline</i>	2013-19/08/2014	109	2	19/08/2014
<i>Premedline</i>	2013-19/08/2014	195	9	19/08/2014
<i>Embase</i>	2013-19/08/2014	298	13	19/08/2014
<i>Cochrane Library</i>	2013-19/08/2014	140	0	19/08/2014
<i>Web of Science (SCI & SSCI) and ISI Proceedings</i>	2013-19/08/2014	178	6	19/08/2014

Total References retrieved (after de-duplication): 25



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Risk of bias in the included studies

The risk of bias and applicability concerns are summarised per study in the figure below. The main bias and validity issues to note are that patient sampling was not based on a consecutive or random series of patients in a number of the studies, some of which were also not conducted in a population directly relevant to the current question. Studies employing non-consecutive/random sampling are at high risk of bias because, for example, case-control studies have been shown to be associated with inflated test accuracy parameters compared to designs that incorporate random or consecutive patient selection. Studies conducted in other settings than UK-based primary care are only applicable to the extent that the study populations and settings are comparable to a UK GP population as defined for the current purposes. Other bias and applicability threats to the results concern missing data, symptom coding and specification as well as suboptimal reference standard.

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	Risk of Bias				Applicability Concerns		
	Patient Selection	Index Test	Reference Standard	Flow and Timing	Patient Selection	Index Test	Reference Standard
Deyo (1988)	?	+	?	+	-	+	+
Hallissey (1990)	+	+	+	+	?	+	+
Hamilton (2005)	-	+	+	+	+	+	+
Hippisley-Cox (2011)	+	+	+	-	+	+	+
Iyen-Omofoman (2013)_deri	-	+	+	+	+	+	+
Iyen-Omofoman (2013)_vali	+	+	+	+	+	+	+
Jones (2007)	+	+	+	+	+	+	+
Muris (1995)	-	+	+	+	-	-	+
Oudega (2006)	+	+	+	+	?	+	+

- High
 ? Unclear
 + Low

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Study results

Table 1: Lung cancer: Meta-analyses

Studies included	Symptom(s)	Patient group	Positive predictive value, % (95% CI)
Jones (2007, at 6 months), Hippisley-Cox (2011), Iyen-Omofoman (2013)	Haemoptysis	All patients (N = 14516)	3.51 (1.61-7.5)
Jones (2007, at 3 years), Hippisley-Cox (2011), Iyen-Omofoman (2013)	Haemoptysis	All patients (N = 14516)	3.83 (1.66-8.62)

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Please note that the data from Hamilton (2005) are not included in these meta-analyses due to the case-control design of the study. These data are instead reported in the second table below.

Table 2: Lung cancer: Individual positive predictive values from the meta-analyses

Studies included	Symptom(s)	Patient group	Positive predictive value, % (95% CI)
Hippisley-Cox (2011)	Haemoptysis	All patients (N = 7861)	6.4 (5.9-7)
Iyen-Omofoman (2013)	Haemoptysis	All patients (N = 1843)	1.3 (0.9-2)
Jones (2007, at 6 months),	Haemoptysis	All patients (N =4822)	4.8 (4.2-5.5)

Jones (2007, at 3 years),	Haemoptysis	All patients (N = 4822)	6.3 (6-7)
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Table 3: Lung cancer: Additional results reported by the individual papers: Single symptoms

Study	Symptom(s)	Patient group	Positive predictive value, % (95% CI)
Deyo (1988)	Back pain	All included patients	0.05 (0.003-0.3) 1/1975
Muris (1995)	Non-acute abdominal complaints	All included patients	0.2 (0.04-0.9) 2/933
Oudega (2006)	Deep vein thrombosis	All included patients	0.7 (0.2-2.2) 3/430
Hallissey (1990)	Dyspepsia	All patients	0.3 (0.1-0.6) 8/2585
Jones (2007)	Haemoptysis	Men (all ages) at 6 months	5.8 (5-6.7)
Jones (2007)	Haemoptysis	Men (all ages) at 3 years	7.5 (6.6-8.5)
Jones (2007)	Haemoptysis	Men < 45 years at 3 years	0.21 (0.03-7.55)
Jones (2007)	Haemoptysis	Men 45-54 years at 3 years	1.65 (0.67-3.37)
Jones (2007)	Haemoptysis	Men 55-64 years at 3 years	8.37 (6.12-11.1)
Jones (2007)	Haemoptysis	Men 65-74 years at 3 years	14.86 (12-18.1)
Jones (2007)	Haemoptysis	Men 75-84 years at 3 years	17.05 (13.5-21.1)
Jones (2007)	Haemoptysis	Men ≥ 85 years at 3 years	20.43 (12.8-30.1) 19/93
Jones (2007)	Haemoptysis	Women (all ages) at 6 months	3.3 (2.6-4.3)
Jones (2007)	Haemoptysis	Women (all ages) at 3 years	4.3 (3.4-5.3)
Jones (2007)	Haemoptysis	Women < 45 years at 3 years	0.36 (0.04-1.3)
Jones (2007)	Haemoptysis	Women 45-54 years at 3 years	1.84 (0.6-4.24)
Jones (2007)	Haemoptysis	Women 55-64 years at 3 years	4.12 (2.32-6.71)
Jones (2007)	Haemoptysis	Women 65-74 years at 3 years	8.38 (5.73-11.8)
Jones (2007)	Haemoptysis	Women 75-84 years at 3 years	10.47 (7.01-14.9)
Jones (2007)	Haemoptysis	Women ≥ 85 years at 3 years	2.6 (0.32-9.07) 2/77
Hamilton (2005)	Haemoptysis	All included patients	2.4 (1.4-4.1)
Hamilton (2005)	Haemoptysis	All smokers	4.5 (NR)
Hamilton (2005)	Haemoptysis (reported twice)	All included patients	17 (NR)

Hamilton (2005)	Haemoptysis (reported twice)	All smokers	12 (NR)
Hamilton (2005)	Haemoptysis	Patients \geq 70 years	7.1 (NR)
Hamilton (2005)	Cough	All included patients	0.4 (0.3-0.5)
Hamilton (2005)	Cough	All smokers	0.9 (NR)
Hamilton (2005)	Cough (reported twice)	All included patients	0.58 (0.4-0.8)
Hamilton (2005)	Cough (reported twice)	All smokers	1.3 (NR)
Iyen-Omofoman (2013)	Haemoptysis 4-12 months prior to diagnosis	Derivation cohort	Cases: 247/12074 Controls: 125/120731
Iyen-Omofoman (2013)	Haemoptysis 13-24 months prior to diagnosis	Derivation cohort	Cases: 133/12074 Controls: 191/120731
Hamilton (2005)	Cough (reported 3 times)	All included patients	0.77 (0.54-1.1)
Iyen-Omofoman (2013)	Cough	Validation cohort	0.24 (0.2-0.3)
Iyen-Omofoman (2013)	Cough 4-12 months prior to diagnosis	Derivation cohort	Cases: 1938/12074 Controls: 7088/120731
Iyen-Omofoman (2013)	Cough 13-24 months prior to diagnosis	Derivation cohort	Cases: 1774/12074 Controls: 9087/120731
Iyen-Omofoman (2013)	Voice hoarseness	Validation cohort	0.17 (0.08-0.3)
Iyen-Omofoman (2013)	Voice hoarseness 4-12 months prior to diagnosis	Derivation cohort	Cases: 66/12074 Controls: 219/120731
Iyen-Omofoman (2013)	Voice hoarseness 13-24 months prior to diagnosis	Derivation cohort	Cases: 56/12074 Controls: 326/120731
Hamilton (2005)	Fatigue	All included patients	0.43 (0.3-0.6)
Hamilton (2005)	Fatigue	All smokers	0.8 (NR)
Hamilton (2005)	Fatigue (reported twice)	All included patients	0.57 (0.4-0.9)
Hamilton (2005)	Fatigue (reported twice)	All smokers	1.2 (NR)
Hamilton (2005)	Dyspnoea	All included patients	0.66 (0.5-0.8)
Hamilton (2005)	Dyspnoea	All smokers	1.2 (NR)
Hamilton (2005)	Dyspnoea (reported twice)	All included patients	0.88 (NR)
Hamilton (2005)	Dyspnoea (reported twice)	All smokers	1.5 (NR)
Iyen-Omofoman (2013)	Dyspnoea	Validation cohort	0.51 (0.5-0.6)
Iyen-Omofoman (2013)	Dyspnoea 4-12 months prior to diagnosis	Derivation cohort	Cases: 1091/12074 Controls: 2479/120731
Iyen-Omofoman (2013)	Dyspnoea 13-24 months prior to diagnosis	Derivation cohort	Cases: 992/12074 Controls: 3047/120731
Hamilton (2005)	Chest pain	All included patients	0.82 (0.6-1.1)

Hamilton (2005)	Chest pain	All smokers	1.3 (NR)
Hamilton (2005)	Chest pain (reported twice)	All included patients	0.95 (0.7-1.4)
Hamilton (2005)	Chest pain (reported twice)	All smokers	1.4 (NR)
Iyen-Omofoman (2013)	Chest/shoulder pain	Validation cohort	0.18 (0.15-0.21)
Iyen-Omofoman (2013)	Chest/shoulder pain 4-12 months prior to diagnosis	Derivation cohort	Cases: 1002/12074 Controls: 4880/120731
Iyen-Omofoman (2013)	Chest/shoulder pain 13-24 months prior to diagnosis	Derivation cohort	Cases: 959/12074 Controls: 6540/120731
Hamilton (2005)	Weight loss	All included patients	1.1 (0.8-1.6)
Hamilton (2005)	Weight loss	All smokers	2.1 (NR)
Hamilton (2005)	Weight loss (reported twice)	All included patients	1.2 (0.7-2.3)
Hamilton (2005)	Weight loss (reported twice)	All smokers	1.7 (NR)
Iyen-Omofoman (2013)	Weight loss	Validation cohort	0.34 (0.23-0.5)
Iyen-Omofoman (2013)	Weight loss 4-12 months prior to diagnosis	Derivation cohort	Cases: 197/12074 Controls: 323/120731
Iyen-Omofoman (2013)	Weight loss 13-24 months prior to diagnosis	Derivation cohort	Cases: 139/12074 Controls: 416/120731
Hamilton (2005)	Appetite loss	All included patients	0.87 (0.6-1.3)
Hamilton (2005)	Appetite loss	All smokers	1.8 (NR)
Hamilton (2005)	Appetite loss	Patients 40-69 years	1.1 (NR)
Hamilton (2005)	Appetite loss (reported twice)	All included patients	1.7 (NR)
Hamilton (2005)	Appetite loss (reported twice)	All smokers	2.7 (NR)
Iyen-Omofoman (2013)	Constipation 4-12 months prior to diagnosis	Derivation cohort	Cases: 423/12074 Controls: 1469/120731
Iyen-Omofoman (2013)	Constipation 13-24 months prior to diagnosis	Derivation cohort	Cases: 421/12074 Controls: 1848/120731
Hamilton (2005)	Thrombocytosis	All included patients	1.6 (0.8-3.1)
Hamilton (2005)	Thrombocytosis	All smokers	4.2 (NR)
Hamilton (2005)	Thrombocytosis	Patients 40-69 years	3 (NR)
Hamilton (2005)	Abnormal spirometry	All included patients	1.6 (0.9-2.9)
Hamilton (2005)	Abnormal spirometry	All smokers	4 (NR)
Hamilton (2005)	Abnormal spirometry	Patients ≥ 70 years	4.1 (NR)
Hamilton (2005) also reports that the PPVs for all the variables reported for this study apart from thrombocytosis were higher for patients aged ≥ 70 years than patients aged 40-69 years. In patients aged ≥ 70 years the PPVs ranged from 0.9-2.2% apart from for haemoptysis and abnormal spirometry (see separate entry)			

Iyen-Omofoman (2013)	Depressive disorders 4-12 months prior to diagnosis	Derivation cohort	Cases: 365/12074 Controls: 3365/120731
Iyen-Omofoman (2013)	Depressive disorders 13-24 months prior to diagnosis	Derivation cohort	Cases: 449/12074 Controls: 4705/120731
Iyen-Omofoman (2013)	Upper respiratory tract infections 4-12 months prior to diagnosis	Derivation cohort	Cases: 426/12074 Controls: 3082/120731
Iyen-Omofoman (2013)	Upper respiratory tract infections 13-24 months prior to diagnosis	Derivation cohort	Cases: 497/12074 Controls: 4274/120731
Iyen-Omofoman (2013)	Lower respiratory tract infections 4-12 months prior to diagnosis	Derivation cohort	Cases: 516/12074 Controls: 1585/120731
Iyen-Omofoman (2013)	Lower respiratory tract infections 13-24 months prior to diagnosis	Derivation cohort	Cases: 566/12074 Controls: 2218/120731
Iyen-Omofoman (2013)	Non-specific chest infections 4-12 months prior to diagnosis	Derivation cohort	Cases: 1398/12074 Controls: 4350/120731
Iyen-Omofoman (2013)	Non-specific chest infections 13-24 months prior to diagnosis	Derivation cohort	Cases: 1356/12074 Controls: 5856/120731
Iyen-Omofoman (2013)	Chronic obstructive pulmonary disease 4-12 months prior to diagnosis	Derivation cohort	Cases: 978/12074 Controls: 1349/120731
Iyen-Omofoman (2013)	Chronic obstructive pulmonary disease 13-24 months prior to diagnosis	Derivation cohort	Cases: 1024/12074 Controls: 1553/120731
Iyen-Omofoman (2013)	Outcome of blood tests 4-12 months prior to diagnosis	Derivation cohort	
	No blood test record		Cases: 6406/12074 Controls: 84997/120731
	Test without results		Cases: 5431/12074 Controls: 34295/120731
	Abnormal		Cases: 107/12074 Controls: 528/120731
	Normal		Cases: 130/12074 Controls: 911/120731
Iyen-Omofoman (2013)	Outcome of blood tests 13-24 months prior to diagnosis	Derivation cohort	
	No blood test record		Cases: 6136/12074

			Controls: 79446/120731
	Test without results		Cases: 5632/12074 Controls: 39255/120731
	Abnormal		Cases: 127/12074 Controls: 752/120731
	Normal		Cases: 179/12074 Controls: 1278/120731
Iyen-Omofoman (2013)	Number of GP consultations 4-12 months prior to diagnosis	Derivation cohort	
	0-10		Cases: 4316/12074 Controls: 77720/120731
	11-20		Cases: 4373/12074 Controls: 29327/120731
	≥21		Cases: 3385/12074 Controls: 13684/120731
Iyen-Omofoman (2013)	Number of GP consultations 13-24 months prior to diagnosis	Derivation cohort	
	0-10		Cases: 3491/12074 Controls: 64881/120731
	11-20		Cases: 3492/12074 Controls: 29296/120731
	≥21		Cases: 5091/12074 Controls: 26554/120731

1 NR = Not reported, TP = true positives, FP = false positives. Please note the calculations of the
 2 positive predictive values differ between the studies with Deyo (1988), Hippisley-Cox (2011), Jones
 3 (2007), Iyen-Omofoman (2013), Muris (1995) and Oudega (2003) using $(TP)/(TP+FP)$ and Hamilton
 4 (2005) using Bayesian statistics due to the case-control design of this study.
 5

6 **Table 4: Lung cancer: Additional results reported by the individual papers: Pairs of**
 7 **signs/symptoms**

Hippisley-Cox (2011)	Haemoptysis + current/ex-smoking	Patients ≥ 40 years	9.7 (8.9-10.7)
Hamilton (2005)	Haemoptysis + cough	All included patients	2 (1.1-3.5)
Hamilton (2005)	Haemoptysis + cough	All smokers	3.9 (NR)
Hamilton (2005)	Haemoptysis + fatigue	All included patients	3.3 (NR)
Hamilton (2005)	Haemoptysis + fatigue	All smokers	6.1 (NR)

Hamilton (2005)	Haemoptysis + dyspnoea	All included patients	4.9 (NR)
Hamilton (2005)	Haemoptysis + dyspnoea	All smokers	6.9 (NR)
Hamilton (2005)	Haemoptysis + chest pain	All included patients	5 (NR)
Hamilton (2005)	Haemoptysis + chest pain	All smokers	4.1 (NR)
Hamilton (2005)	Haemoptysis + weight loss	All included patients	9.2 (NR)
Hamilton (2005)	Haemoptysis + weight loss	All smokers	*
Hamilton (2005)	Haemoptysis + appetite loss	All included patients	> 10 (NR)
Hamilton (2005)	Haemoptysis + appetite loss	All smokers	*
Hamilton (2005)	Haemoptysis + thrombocytosis	All included patients	> 10 (NR)
Hamilton (2005)	Haemoptysis + thrombocytosis	All smokers	NR
Hamilton (2005)	Haemoptysis + abnormal spirometry	All included patients	> 10 (NR)
Hamilton (2005)	Haemoptysis + abnormal spirometry	All smokers	*
Hamilton (2005)	Fatigue + cough	All included patients	0.63 (0.5-0.9)
Hamilton (2005)	Fatigue + cough	All smokers	1 (NR)
Hamilton (2005)	Fatigue + dyspnoea	All included patients	0.89 (0.6-?)
Hamilton (2005)	Fatigue + dyspnoea	All smokers	1.4 (NR)
Hamilton (2005)	Fatigue + chest pain	All included patients	0.84 (0.5-1.3)
Hamilton (2005)	Fatigue + chest pain	All smokers	1.3 (NR)
Hamilton (2005)	Fatigue + weight loss	All included patients	1 (0.6-1.7)
Hamilton (2005)	Fatigue + weight loss	All smokers	2 (NR)
Hamilton (2005)	Fatigue + appetite loss	All included patients	1.2 (0.7-2.1)
Hamilton (2005)	Fatigue + appetite loss	All smokers	2.3 (NR)
Hamilton (2005)	Fatigue + thrombocytosis	All included patients	1.8 (NR)
Hamilton (2005)	Fatigue + thrombocytosis	All smokers	2.4 (NR)
Hamilton (2005)	Fatigue + abnormal spirometry	All included patients	4 (NR)
Hamilton (2005)	Fatigue + abnormal spirometry	All smokers	>10 (NR)
Hamilton (2005)	Cough + dyspnoea	All included patients	0.79 (0.6-1)
Hamilton (2005)	Cough + dyspnoea	All smokers	1.4 (NR)
Hamilton (2005)	Cough + chest pain	All included patients	0.76 (0.6-1)
Hamilton (2005)	Cough + chest pain	All smokers	0.9 (NR)
Hamilton (2005)	Cough + weight loss	All included patients	1.8 (1.1-2.9)
Hamilton (2005)	Cough + weight loss	All smokers	2.3 (NR)
Hamilton (2005)	Cough + appetite loss	All included patients	1.6 (0.9-2.7)
Hamilton (2005)	Cough + appetite loss	All smokers	2.8 (NR)
Hamilton (2005)	Cough + thrombocytosis	All included patients	2 (1.1-3.5)
Hamilton (2005)	Cough + thrombocytosis	All smokers	6.5 (NR)

Hamilton (2005)	Cough + abnormal spirometry	All included patients	1.2 (0.6-2.6)
Hamilton (2005)	Cough + abnormal spirometry	All smokers	3.6 (NR)
Hamilton (2005)	Dyspnoea + chest pain	All included patients	1.2 (0.9-1.8)
Hamilton (2005)	Dyspnoea + chest pain	All smokers	2.2 (NR)
Hamilton (2005)	Dyspnoea + weight loss	All included patients	2 (1.2-3.8)
Hamilton (2005)	Dyspnoea + weight loss	All smokers	3.1 (NR)
Hamilton (2005)	Dyspnoea + appetite loss	All included patients	2 (1.2-3.8)
Hamilton (2005)	Dyspnoea + appetite loss	All smokers	5.5 (NR)
Hamilton (2005)	Dyspnoea + thrombocytosis	All included patients	2 (NR)
Hamilton (2005)	Dyspnoea + thrombocytosis	All smokers	2.4 (NR)
Hamilton (2005)	Dyspnoea + abnormal spirometry	All included patients	2.3 (NR)
Hamilton (2005)	Dyspnoea + abnormal spirometry	All smokers	>10 (NR)
Hamilton (2005)	Chest pain + weight loss	All included patients	1.8 (1-3.4)
Hamilton (2005)	Chest pain + weight loss	All smokers	4.4 (NR)
Hamilton (2005)	Chest pain + appetite loss	All included patients	1.8 (0.9-3.9)
Hamilton (2005)	Chest pain + appetite loss	All smokers	7.6 (NR)
Hamilton (2005)	Chest pain + thrombocytosis	All included patients	2 (NR)
Hamilton (2005)	Chest pain + thrombocytosis	All smokers	>10 (NR)
Hamilton (2005)	Chest pain + abnormal spirometry	All included patients	1.4 (NR)
Hamilton (2005)	Chest pain + abnormal spirometry	All smokers	>10 (NR)
Hamilton (2005)	Weight loss + appetite loss	All included patients	2.3 (1.2-4.4)
Hamilton (2005)	Weight loss + appetite loss	All smokers	5 (NR)
Hamilton (2005)	Weight loss + thrombocytosis	All included patients	6.1 (NR)
Hamilton (2005)	Weight loss + thrombocytosis	All smokers	>10 (NR)
Hamilton (2005)	Weight loss + abnormal spirometry	All included patients	1.5 (NR)
Hamilton (2005)	Weight loss + abnormal spirometry	All smokers	>10 (NR)
Hamilton (2005)	Appetite loss + thrombocytosis	All included patients	0.9 (NR)
Hamilton (2005)	Appetite loss + thrombocytosis	All smokers	*

Hamilton (2005)	Appetite loss + abnormal spirometry	All included patients	2.7 (NR)
Hamilton (2005)	Appetite loss + abnormal spirometry	All smokers	*
Hamilton (2005)	Thrombocytosis + abnormal spirometry	All included patients	3.6 (NR)
Hamilton (2005)	Thrombocytosis + abnormal spirometry	All smokers	NR

1 TP = true positives, FP = false positives, NR = Not reported. * "The original study was not able to
2 calculate figures for these boxes, but they are almost certainly worthy of a red shade [2 week wait
3 referral]", * effectively means >2%. Please note the calculations of the positive predictive values
4 differ between the studies with Hippisley-Cox (2011) using (TP)/(TP+FP) and Hamilton (2005) using
5 Bayesian statistics due to the case-control design of this study.
6

7 Evidence statement(s):

8 Haemoptysis (4 studies, N = 15998) presenting in a primary care setting is associated with overall
9 positive predictive values of 2.4-17% for lung cancer, which tended to increase with age in men and
10 women (1 study, N = 4822). The studies were associated with 0-1 bias or applicability concern (see
11 also Tables 1-3).
12

13 Single symptoms other than haemoptysis presenting in a primary care setting is associated with
14 overall positive predictive values from 0.05% (for back pain) to 1.6% (for abnormal spirometry and
15 thrombocytosis) for lung cancer (6 studies, N = 1833698), and with positive predictive values
16 from 0.9% (for cough) to 4.2% (for thrombocytosis) for smokers for lung cancer (1 study, N = 1482).
17 The studies were associated with 1-3 bias or applicability concerns (see also Table 3).
18

19 Two symptoms presenting in combination in a primary care setting were associated with overall
20 positive predictive values from 0.63% (for fatigue and cough) to > 10% (for haemoptysis with
21 appetite loss, abnormal spirometry or thrombocytosis) for lung cancer (2 studies, N = 6030), and
22 with positive predictive values from 0.9% (for chest pain and cough) to > 10% (for abnormal
23 spirometry with fatigue, dyspnoea, chest pain or loss of weight, and for thrombocytosis with chest
24 pain or loss of weight) for smokers for lung cancer (1 study, N = 1482). The studies were each
25 associated with 1 bias concern (see also Table 4).
26

27 Evidence tables

28 Deyo (1988)

PATIENT SELECTION	
A. risk of bias	
Patient sampling	Prospective consecutive? patient series
Was a consecutive or random sample of patients enrolled?	Unclear
Was a case-control design avoided?	Yes
Did the study avoid inappropriate exclusions?	Yes (probably)
Could the selection of patients have introduced bias?	Unclear risk
B. Concerns regarding applicability	
Patient characteristics and setting	N = 1975, mean (SD; range) age = 39.5 (15.4; 15-86) years, 62% females. 54% of the patients were seeking medical care for back pain for the first time and 76% of the patients had had back pain for < 3 months. 3% had a history of

	back pain surgery. Maximal back pain in the low back (84%) or in the upper back (16%). <u>Inclusion criteria</u> : Patients who sought treatment between March 1982 and September 1984 in the walk-in clinic of a public hospital where virtually all patients are self-referred. In each case back pain was part of the chief complaint. <u>Exclusion criteria</u> : Neck pain. <u>Clinical setting</u> : Walk-in clinic of a public hospital; this clinic is a source of primary care for indigent persons in a county in the USA with a population of approximately 1 million.
Are there concerns that the included patients and setting do not match the review question?	High concern
INDEX TEST	
A. Risk of bias	
Index test	Back pain; not further specified.
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes
Could the conduct or interpretation of the index test have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the index test, its conduct, or interpretation differ from the review question?	Low concern
REFERENCE STANDARD	
A. risk of bias	
Reference standard(s)	The reference standard consisted of a search on each patient name in the institutional tumour registry \geq 6 months after the index visit. The registry included every patient with a histological diagnosis of cancer made in the authors' hospital system regardless of site of care. The authors point out that "while this method might fail to identify cancer patients who sought care elsewhere, it is likely that most patients sought follow-up for a particular illness at the same facility.
Is the reference standard likely to correctly classify the target condition?	Unclear
Were the reference standard results interpreted without knowledge of the results of the index tests?	No (but all patients had a positive index test)
Could the reference standard, its conduct, or its interpretation have introduced bias?	Unclear risk
B. Concerns regarding applicability	
Are there concerns that the target condition as defined by the reference standard does not match the question?	Low concern
FLOW AND TIMING	
A. risk of bias	
Flow and timing	All the patients are accounted for in the results.
Was there an appropriate interval between index test and reference standard?	Yes (probably)
Did all patients receive the same reference standard?	Yes

Were all patients included in the analysis?	Yes
Could the patient flow have introduced bias?	Low risk
NOTES	It is a concern that some patients with cancer might have been missed due to the choice of reference standard because this would result in an underestimation of the positive predictive value. 38/1975 patients were found in the tumour registry. Of those 38, 13 patients had tumours that were probable causes of back pain, and 4 of these 13 patients already had a diagnosis of cancer at presentation. The 9/1975 patients who had undiagnosed cancer that the back pain could be attributed to had: Lymphoma (NOS; 2), cancer of unknown primary (1), prostate cancer (1), retroperitoneal liposarcoma (1), lung cancer (1), renal cell (1), multiple myeloma (1), mucinous adenocarcinoma (of gallbladder?; 1)
1	
2	
Hallissey (1990)	
PATIENT SELECTION	
A. risk of bias	
Patient sampling	Propective consecutive patient series from a group of 10 general practices in England.
Was a consecutive or random sample of patients enrolled?	Yes
Was a case-control design avoided?	Yes
Did the study avoid inappropriate exclusions?	Yes
Could the selection of patients have introduced bias?	Low risk
B. Concerns regarding applicability	
Patient characteristics and setting	N = 2585 aged > 40 years. No other information reported. The patient group was equally divided between new patients with dyspepsia, old patients with uninvestigated dyspepsia, and old patients with investigated dyspepsia. <u>Inclusion criteria:</u> All patients over 40 years making their first attendance during the study period (4 years and 9 months) with any degree of dyspepsia <u>Exclusion criteria:</u> None listed. <u>Clinical setting:</u> Primary care, England.
Are there concerns that the included patients and setting do not match the review question?	Unclear concern
INDEX TEST	
A. Risk of bias	
Index test	Dyspepsia of any degree
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes
Could the conduct or interpretation of the index test have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the index test, its conduct, or interpretation differ from the review question?	Low concern
REFERENCE STANDARD	
A. risk of bias	
Reference standard(s)	Upper gastrointestinal endoscopy within 4 weeks and follow up.
Is the reference standard likely to correctly classify the	Yes

target condition?	
Were the reference standard results interpreted without knowledge of the results of the index tests?	No
Could the reference standard, its conduct, or its interpretation have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the target condition as defined by the reference standard does not match the question?	Low concern
FLOW AND TIMING	
A. risk of bias	
Flow and timing	2659 patients were seen and 2585 attended for investigation
Was there an appropriate interval between index test and reference standard?	Yes
Did all patients receive the same reference standard?	Yes
Were all patients included in the analysis?	Yes
Could the patient flow have introduced bias?	Low risk
NOTES	Malignancy was detected in 115 patients: Gastric adenocarcinoma (57), gastric lymphoma (1; added to the gastric adenocarcinoma data in the PPV), oesophageal cancer (15), colorectal (14), pancreatic (6), bronchial (8), prostatic (2), duodenal (1, also added to the gastric carcinoma data in the PPV), liver (1), gall bladder (1), carcinoid (1), uterine (1), leukaemia (1), circinomatosis of unknown primary (7).
1	
2	Hamilton (2005)
PATIENT SELECTION	
A. risk of bias	
Patient sampling	Population-based matched case-control study involving all 21 general practices in Exeter, Devon, UK.
Was a consecutive or random sample of patients enrolled?	No
Was a case-control design avoided?	No
Did the study avoid inappropriate exclusions?	Yes
<i>For diagnostic case-control studies:</i> Attempts were made within the design or analysis to balance the comparison groups for potential confounders?	Yes
<i>For diagnostic case-control studies:</i> The groups were comparable at baseline, including all major confounding and prognostic factors?	Yes
Could the selection of patients have introduced bias?	High risk
B. Concerns regarding applicability	
Patient characteristics and setting	<u>Cases:</u> N = 247 (170 males/77 females), age at diagnosis: < 60 years: N = 35, 60-69 years: N = 60, 70-79 years: N = 118, 80+ years: N = 34. <u>Controls:</u> N = 1235 (850 males/385 females), age at diagnosis: < 60 years: N = 178, 60-69 years: N = 310, 70-79 years: N = 575, 80+ years: N = 174. <u>Inclusion criteria:</u>

	<p>Cases: All patients aged ≥ 40 years with a primary lung cancer, diagnosed from 1998 to 2002, were identified from the cancer registry at the Royal Devon and Exeter Hospital combined with computerised searches at every practice in Devon to identify any cases missing from the cancer register.</p> <p>Controls: Five controls were matched to each case on sex, general practice, and age. Controls were eligible if they were alive at the time of diagnosis of their case.</p> <p><u>Exclusion criteria:</u> Cases and controls: Unobtainable records; no consultations in the 2 years before diagnosis; previous lung cancer; or residence outside Exeter at the time of diagnosis.</p> <p><u>Clinical setting:</u> Primary care, UK.</p>
Are there concerns that the included patients and setting do not match the review question?	Low concern
INDEX TEST	
<u>A. Risk of bias</u>	
Index test	Anonymised photocopies of the full primary care records for 2 years before diagnosis were coded (blinded to case/control status) for all entries using the International Classification of Primary Care-2. Additional codes were created to incorporate all possible clinical features. Only variables occurring in $\geq 2.5\%$ of cases or controls were analysed.
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes
<i>For diagnostic case-control studies:</i> Investigators were kept 'blind' to other important confounding and prognostic factors?	Yes
Could the conduct or interpretation of the index test have introduced bias?	Low risk
<u>B. Concerns regarding applicability</u>	
Are there concerns that the index test, its conduct, or interpretation differ from the review question?	Low concern
REFERENCE STANDARD	
<u>A. risk of bias</u>	
Reference standard(s)	Lung cancer diagnosis in the cancer registry at the Royal Devon and Exeter Hospital or practice notes.
Is the reference standard likely to correctly classify the target condition?	Yes
Were the reference standard results interpreted without knowledge of the results of the index tests?	Unclear
Could the reference standard, its conduct, or its interpretation have introduced bias?	Low risk
<u>B. Concerns regarding applicability</u>	
Are there concerns that the target condition as defined by the reference standard does not match the question?	Low concern
FLOW AND TIMING	
<u>A. risk of bias</u>	
Flow and timing	All the patients are accounted for.
Was there an appropriate interval between index test and	Yes

reference standard?	
Did all patients receive the same reference standard?	Yes
Were all patients included in the analysis?	Yes
Could the patient flow have introduced bias?	Low risk
NOTES	
1	
2	Hippisley-Cox (2011)
PATIENT SELECTION	
A. risk of bias	
Patient sampling	Prospective patient series using patients in the QResearch database (version 30).
Was a consecutive or random sample of patients enrolled?	Yes
Was a case-control design avoided?	Yes
Did the study avoid inappropriate exclusions?	Yes
Could the selection of patients have introduced bias?	Low risk
B. Concerns regarding applicability	
Patient characteristics and setting	<p>A total of 1267151 patients were identified from 189 practices (632522 males, 634629 females), mean (SD) age = 49.6 (14.8) years, mean (SD) Townsend score = -0.1 (3.6).</p> <p><u>Current symptoms and symptoms in the preceding year:</u> Current haemoptysis (N = 8010), current appetite loss (N = 6303), current weight loss (N = 17355), cough in the last year (N = 30298), dyspnoea in the last year (N = 5887), tiredness in the last year (N = 12854), hoarseness (N = 966), haemoglobin recoded in the last year (N = 189945), haemoglobin < 11 g/dl in the last year (N = 8010). Incident cases of lung cancer during the 2-year follow up period: N = 2196.</p> <p><u>Inclusion criteria:</u> All practices in England and Wales that had been using their Egton Medical Information Systems (EMIS) computer system for ≥ 1 year were included. Two-thirds of practices were randomly allocated to the derivation dataset and the remaining practices were allocated to the validation dataset. An open cohort of patients aged 30–84 years was identified, drawn from patients registered with practices between 1 January 2000 and 30 September 2010. Entry to the cohort was defined as the latest of the study start date (1 January 2000) and 12 months after the patient registered with the practice, ensuring that all patients had ≥ 12 months' registration prior to study entry. For patients with haemoptysis, appetite loss, or weight loss, the entry date was the date of the first consultation with the symptom within the study period. <i>The relevant data for the present purposes is only available for the validation cohort, therefore only information pertaining to these patients will be reported.</i></p> <p><u>Exclusion criteria:</u> Patients without a postcode-related Townsend score, patients with a history of lung cancer at baseline, and patients with a recorded 'red-flag' (see "Definition of symptom" below) symptom in the 12 months prior to the study entry date.</p> <p><u>Clinical setting:</u> Primary care</p>
Are there concerns that the included patients and setting do not match the review question?	Low concern

INDEX TEST	
A. Risk of bias	
Index test	'Red-flag' symptoms were defined as symptoms that might alarm the patient and also indicate the presence of lung cancer; that is, symptoms of haemoptysis, loss of appetite, or weight loss.
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes
Could the conduct or interpretation of the index test have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the index test, its conduct, or interpretation differ from the review question?	Low concern
REFERENCE STANDARD	
A. risk of bias	
Reference standard(s)	Lung tract cancer during the 2 years after study entry, recorded either on the patient's GP record using the relevant UK diagnostic Read Codes, or their linked Office for National Statistics cause-of-death record, using the relevant ICD-9 codes or ICD-10 diagnostic codes.
Is the reference standard likely to correctly classify the target condition?	Yes
Were the reference standard results interpreted without knowledge of the results of the index tests?	Unclear
Could the reference standard, its conduct, or its interpretation have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the target condition as defined by the reference standard does not match the question?	Low concern
FLOW AND TIMING	
A. risk of bias	
Flow and timing	The numbers of patients in the validation cohort reported in text/Table 5 do not correspond to those reported in Table 1, both on terms of total numbers of patients (1243329/1342329 versus 1267151) and number of patients with haemoptysis (7861 v 8010). The missing data does not appear to include any of the cancer cases, but it is unclear what the effect of the missing data is on the PPVs as clearly some of the false positives are missing.
Was there an appropriate interval between index test and reference standard?	Yes
Did all patients receive the same reference standard?	Yes
Were all patients included in the analysis?	No
Could the patient flow have introduced bias?	High risk
NOTES	
1	
2 Iyen-Omofoman (2013)	
PATIENT SELECTION	
A. risk of bias	
Patient sampling	Case-control study using The Health Improvement Network (THIN) database, which had data from 446 UK general practices with a total of

	8.2 million patients.
Was a consecutive or random sample of patients enrolled?	No
Was a case-control design avoided?	No (for derivation cohort) Yes (for validation cohort)
Did the study avoid inappropriate exclusions?	Yes
<i>For diagnostic case-control studies:</i> Attempts were made within the design or analysis to balance the comparison groups for potential confounders?	Yes
<i>For diagnostic case-control studies:</i> The groups were comparable at baseline, including all major confounding and prognostic factors?	Yes
Could the selection of patients have introduced bias?	High risk (for derivation cohort) Low risk (for validation cohort)
B. Concerns regarding applicability	
Patient characteristics and setting	<p><u>Cases:</u> N = 12074 (7154 males/4920 females), age at diagnosis: 40-45 years: N = 95, 45-50 years: N = 220, 50-55 years: N = 469, 55-60 years: N = 896, 60-65 years: N = 1488, 65-70 years: N = 1750, 70-75 years: N = 2212, 75-80 years: N = 2305, > 80 years: N = 2639.</p> <p><u>Controls:</u> N = 120731 (58034 males/62697 females), age at diagnosis (of cases): 40-45 years: N = 18969, 45-50 years: N = 16756, 50-55 years: N = 15963, 55-60 years: N = 15439, 60-65 years: N = 13475, 65-70 years: N = 11201, 70-75 years: N = 9940, 75-80 years: N = 8191, > 80 years: N = 10797.</p> <p><u>Validation cohort:</u> N = 1826293 (886994 males/939299 females). Age: Not reported. Incident cases of lung cancer during the 1-year follow up: N = 1728.</p> <p><u>Inclusion criteria:</u> Cases: All incident cases of lung cancer diagnosed between 1 January 2000 and 28 July 2009 in patients aged \geq 40 years. Controls: Ten randomly selected controls aged \geq 40 years with \geq 1 year of active records were matched to each case on general practice. Validation cohort: All THIN patients aged > 39 years, free from lung cancer on 29 July 2009, and \geq 1 year general practice follow up.</p> <p><u>Exclusion criteria:</u> Cases: Patients with < 1 year of active records prior to their first diagnosis of lung cancer.</p> <p><u>Clinical setting:</u> Primary care, UK.</p>
Are there concerns that the included patients and setting do not match the review question?	Low concern
INDEX TEST	
A. Risk of bias	
Index test	Cough, chest/shoulder pain, dyspnoea, weight loss, hoarseness, upper and lower respiratory tract infections, non-specific chest infections, constipation, depressive disorders, and chronic obstructive pulmonary disease (COPD), recorded over the 2-year period before lung cancer diagnosis.
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes
<i>For diagnostic case-control studies:</i>	Yes

Investigators were kept 'blind' to other important confounding and prognostic factors?	
Could the conduct or interpretation of the index test have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the index test, its conduct, or interpretation differ from the review question?	Low concern
REFERENCE STANDARD	
A. risk of bias	
Reference standard(s)	Lung cancer diagnosis in THIN database
Is the reference standard likely to correctly classify the target condition?	Yes
Were the reference standard results interpreted without knowledge of the results of the index tests?	Unclear
Could the reference standard, its conduct, or its interpretation have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the target condition as defined by the reference standard does not match the question?	Low concern
FLOW AND TIMING	
A. risk of bias	
Flow and timing	All the patients are accounted for.
Was there an appropriate interval between index test and reference standard?	Yes
Did all patients receive the same reference standard?	Yes
Were all patients included in the analysis?	Yes
Could the patient flow have introduced bias?	Low risk
NOTES	
1	
2 Jones (2007)	
PATIENT SELECTION	
A. risk of bias	
Patient sampling	Retrospective consecutive patient series using patients in the UK's General Practice Research Database.
Was a consecutive or random sample of patients enrolled?	Yes
Was a case-control design avoided?	Yes
Did the study avoid inappropriate exclusions?	Yes
Could the selection of patients have introduced bias?	Low risk
B. Concerns regarding applicability	
Patient characteristics and setting	A total of 923605 patients were identified, of whom 762325 were aged ≥ 15 years. Number of first occurrences in patients with no previous diagnosis of cancer: Haematuria: N = 11138, mean (SD) age at first symptom = 58.5 (18.9) years. Patients excluded due to incomplete dates for their first symptom: N = 30. Sex (of final sample): 6385 males, 4723 females.

	<p><u>Haemoptysis</u>: N = 4822, mean (SD) age at first symptom = 61.6 (18) years. Patients excluded due to incomplete dates for their first symptom: N = 10. Sex (of final sample): 2930 males, 1882 females.</p> <p><u>Dysphagia</u>: N = 6003, mean (SD) age at first symptom = 54.5 (19.4) years. Patients excluded due to incomplete dates for their first symptom: N = 4. Sex (of final sample): 2628 males, 3371 females.</p> <p><u>Rectal bleeding</u>: N = 15314, mean (SD) age at first symptom = 52.5 (18.8) years. Patients excluded due to incomplete dates for their first symptom: N = 25. Sex (of final sample): 7523 males, 7766 females.</p> <p><u>Inclusion criteria</u>: All patients from 128 general practices that provided data of a sufficient standard from 1 January 1994 to 31 December 2000 and which provided exclusively Read coded data, who were aged between 15 and 100 years, whose first ever recorded occurrence of each alarm symptom (haematuria, haemoptysis, dysphagia, or rectal bleeding) was after 31 December 1994 and who had not previously been diagnosed as having any cancer.</p> <p><u>Exclusion criteria</u>: Patients whose date of first symptom or first relevant diagnosis of cancer was before 1 January 1995 and patients with a diagnosis of any other cancer than the ones of interest before the date of the first recorded symptom or before the index cancer diagnosis date if the related symptom was not recorded.</p> <p><u>Clinical setting</u>: Primary care</p>
Are there concerns that the included patients and setting do not match the review question?	Low concern
INDEX TEST	
A. Risk of bias	
Index test	Identification of all patients who ever had symptoms recorded for haematuria, haemoptysis, dysphagia, or rectal bleeding.
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes
Could the conduct or interpretation of the index test have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the index test, its conduct, or interpretation differ from the review question?	Low concern
REFERENCE STANDARD	
A. risk of bias	
Reference standard(s)	<p>Cancer code in the UK's General Practice Research Database:</p> <p><u>Haematuria</u>: Urinary tract neoplasms, including neoplasms of the urethra, bladder, ureter, and kidney but excluding neoplasms of the prostate and other reproductive organs.</p> <p><u>Haemoptysis</u>: Respiratory tract neoplasms.</p> <p><u>Dysphagia</u>: Oesophageal neoplasms.</p> <p><u>Rectal bleeding</u>: Colorectal neoplasms.</p>
Is the reference standard likely to correctly classify the target condition?	Yes
Were the reference standard results interpreted without knowledge of the results of the index tests?	Unclear (but all patients had a positive index test)
Could the reference standard, its conduct, or its	Low risk

interpretation have introduced bias?		
B. Concerns regarding applicability		
Are there concerns that the target condition as defined by the reference standard does not match the question?		Low concern
FLOW AND TIMING		
A. risk of bias		
Flow and timing	All patients are accounted for in the results	
Was there an appropriate interval between index test and reference standard?	Unclear	
Did all patients receive the same reference standard?	Yes	
Were all patients included in the analysis?	Yes	
Could the patient flow have introduced bias?		Low risk
NOTES	<p>Diagnoses of cancer were most often made in the first three months after the onset of alarm symptoms; very few diagnoses of cancer were made later than three years after symptom onset. In the 4th and 5th years of study, the small number of observed occurrences of cancer was similar to the number expected from background incidence rates.</p> <p>Secondary analyses evaluating whether the incidence of neoplasms other than those prespecified was increased after the occurrence of alarm symptoms showed for:</p> <p><u>Haematuria</u>: Inclusion of cancers of the reproductive organs yielded 21 additional cancers in women and 158 cancers in men, mostly cancers of the prostate. Inclusion of these cancers in the analysis would give a positive predictive value of 3.9% in women and 9.9% in men.</p> <p><u>Dysphagia</u>: Inclusion of gastric cancers yielded 17 additional cancer diagnoses in women and 30 in men. Inclusion of these cancers gave positive predictive values of 5.2% in women and 6.9% in men.</p> <p><i>Estimates based on the pre-specified cancers may be thus conservative for these symptoms.</i></p> <p><u>Haemoptysis</u>: Extension of the diagnostic criteria yielded 6 additional cancers.</p> <p><u>Rectal bleeding</u>: Extension of the diagnostic criteria yielded 2 additional cancers.</p>	
1		
2	Muris (1995)	
PATIENT SELECTION		
A. risk of bias		
Patient sampling	Prospective patient series from 80/460 general practitioners in Limburg (The Netherlands)	
Was a consecutive or random sample of patients enrolled?	No	
Was a case-control design avoided?	Yes	
Did the study avoid inappropriate exclusions?	Unclear	
Could the selection of patients have introduced bias?		High risk
B. Concerns regarding applicability		
Patient characteristics and setting	N = 933; 335 males, 598 females; age range = 18-75, aged > 30 years: N = 712, aged > 40 years: N = 517, aged > 60 years: N = 171.	

	<p><u>Inclusion criteria:</u> Patients who in 1989 consulted one of the participating GPs for new abdominal complaints lasting ≥ 2 weeks and with whom the GPs had a diagnostic problem.</p> <p><u>Exclusion criteria:</u> None listed.</p> <p><u>Clinical setting:</u> GPs in The Netherlands</p>
Are there concerns that the included patients and setting do not match the review question?	High concern
INDEX TEST	
A. Risk of bias	
Index test	New abdominal complaints lasting ≥ 2 weeks. Not further specified.
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes
Could the conduct or interpretation of the index test have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the index test, its conduct, or interpretation differ from the review question?	High concern
REFERENCE STANDARD	
A. risk of bias	
Reference standard(s)	Follow up for ≥ 12 months (mean = 18 months).
Is the reference standard likely to correctly classify the target condition?	Yes
Were the reference standard results interpreted without knowledge of the results of the index tests?	No
Could the reference standard, its conduct, or its interpretation have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the target condition as defined by the reference standard does not match the question?	Low concern
FLOW AND TIMING	
A. risk of bias	
Flow and timing	All patients appear to be accounted for
Was there an appropriate interval between index test and reference standard?	Unclear
Did all patients receive the same reference standard?	Yes
Were all patients included in the analysis?	Yes
Could the patient flow have introduced bias?	Low risk
NOTES	Other cancers diagnosed in these patients were: Stomach (2/933), pancreas (2/933), trachea/bronchus/lung (2/933), kidney (1/933), cervix (1/933), other cancer of the female genital system (2/933), and other and unspecified sites (2/933).
1	
2	Oudega (2006)
PATIENT SELECTION	
A. risk of bias	
Patient sampling	Prospective study of all primary care physicians (N = 50) within a

	catchment area (ca 130000 inhabitants) of a non-teaching hospital in The Netherlands.
Was a consecutive or random sample of patients enrolled?	Yes
Was a case-control design avoided?	Yes
Did the study avoid inappropriate exclusions?	Yes
Could the selection of patients have introduced bias?	Low risk
B. Concerns regarding applicability	
Patient characteristics and setting	N = 430; 162 males, 268 females; mean age (SD) = 60.7 (18.2) years. <u>Inclusion criteria:</u> Consecutive patients who consulted their GP between January 1996 and July 2002 and who, after investigation (not referral) was confirmed to have deep vein thrombosis. <u>Exclusion criteria:</u> Patients with a known malignancy or a malignancy detected within 2 weeks of deep vein thrombosis diagnosis. <u>Clinical setting:</u> Primary care, The Netherlands.
Are there concerns that the included patients and setting do not match the review question?	Unclear concern
INDEX TEST	
A. Risk of bias	
Index test	Deep vein thrombosis (suspicion based on painful swollen leg \leq 30 days). Patients were classified as having secondary deep vein thrombosis if \geq 1 of the following risk factors for deep vein thrombosis were present: Recent surgery, prolonged immobilisation, use of oral contraceptives or hormonal replacement therapy. If no risk factors were present patients were classified as having idiopathic deep vein thrombosis.
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes
Could the conduct or interpretation of the index test have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the index test, its conduct, or interpretation differ from the review question?	Low concern
REFERENCE STANDARD	
A. risk of bias	
Reference standard(s)	2 years follow up.
Is the reference standard likely to correctly classify the target condition?	Yes
Were the reference standard results interpreted without knowledge of the results of the index tests?	No
Could the reference standard, its conduct, or its interpretation have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the target condition as defined by the reference standard does not match the question?	Low concern
FLOW AND TIMING	
A. risk of bias	

Flow and timing	All patients appear to be accounted for
Was there an appropriate interval between index test and reference standard?	Yes
Did all patients receive the same reference standard?	Yes
Were all patients included in the analysis?	Yes
Could the patient flow have introduced bias?	Low risk
NOTES	In total N = 19 had cancer: 3 colorectal, 5 urogenital (not further subgrouped), 4 breast, 3 lung and 4 other. The urogenital data is added to the renal cancer evidence review.

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46
47
48 **Review question:**

1 Which investigations of symptoms of suspected lung cancer should be done with clinical
2 responsibility retained by primary care?

3 **Results**

4 **Literature search**

5

Database name	Dates Covered	No of references found	No of references retrieved	Finish date of search
<i>Medline</i>	1980-2013	958	180	28/02/2013
<i>Premedline</i>	1980-2013	136	25	28/02/2013
<i>Embase</i>	1980-2013	1481	339	06/03/2013
<i>Cochrane Library</i>	1980-2013	175	2	06/03/2013
<i>Psychinfo</i>	1980-2013	14	4	06/03/2013
<i>Web of Science (SCI & SSCI) and ISI Proceedings</i>	1980-2013	224	26	06/03/2013

6 Total References retrieved (after de-duplication): 487

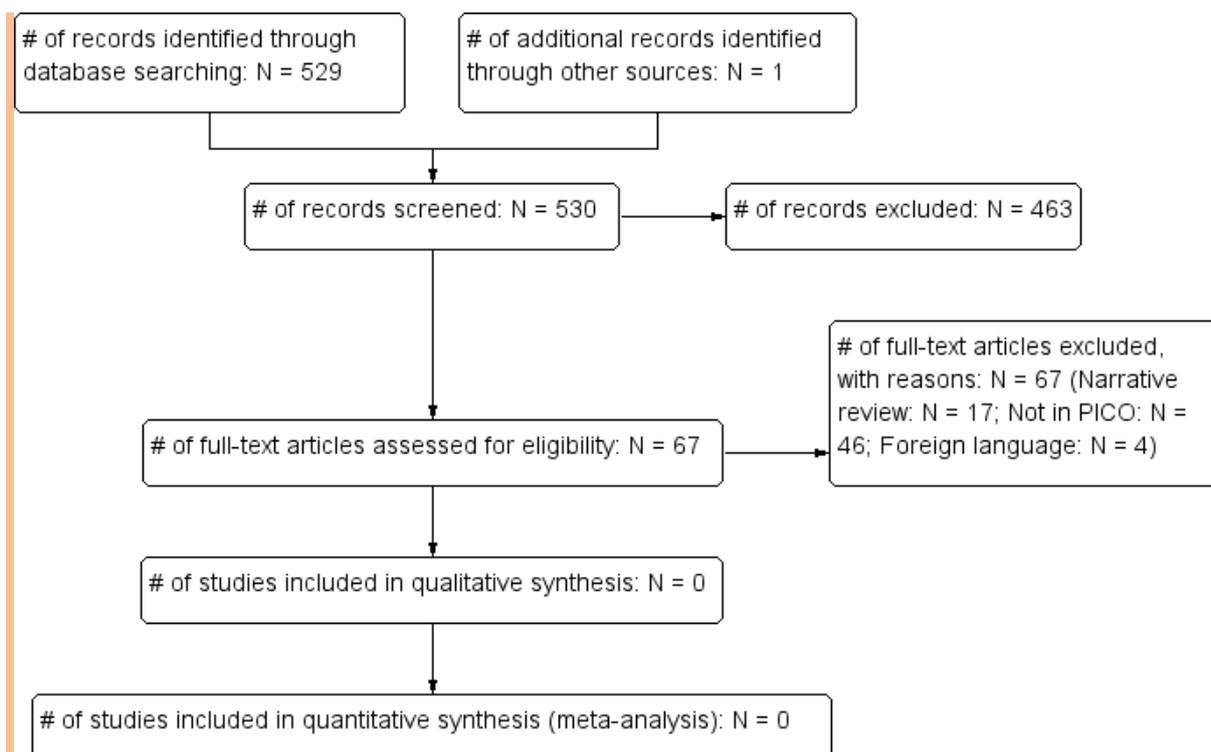
7

8 **Update Search**

Database name	Dates Covered	No of references found	No of references retrieved	Finish date of search
<i>Medline</i>	2013-19/08/2014	105	6	19/08/2014
<i>Premedline</i>	2013-19/08/2014	133	14	19/08/2014
<i>Embase</i>	2013-19/08/2014	164	31	19/08/2014
<i>Cochrane Library</i>	2013-19/08/2014	70	0	19/08/2014
<i>Web of Science (SCI & SSCI) and ISI Proceedings</i>	2013-19/08/2014	47	3	19/08/2014

9 Total References retrieved (after de-duplication): 42

10



1

2 **Study results**

3 No evidence was identified pertaining to the diagnostic accuracy of chest x-ray, CT, sputum cytology,
 4 or bronchoscopy in patients with suspected lung cancer where the clinical responsibility was
 5 retained by primary care.

6

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28 admitted to the oncology unit with increasing dyspnea. He reported symptoms that included
29 shortness of breath, difficulty sleeping, and a lack of appetite. The patient's physician ordered
30 supplemental oxygen and scheduled diagnostic imaging examinations, laboratory tests, and a
31 possible bronchoscopy. The morning after admission, the patient experienced significantly
32 increased dyspnea. The stress-management nurse realized that the sensation of breathlessness
33 was creating panic, which increased anxiety and the need for oxygen, worsening the dyspnea.
34 The stress-management nurse coached the patient in a structured relaxation technique as a tool
35 to help him learn to control and regulate his breathing. Over time the response was positive, as
36 reported by the patient and validated by the oncology nurse. Although dyspnea is a complex
37 symptom that varies among patients, nonpharmacologic interventions to promote relaxation and
38 provide instruction in breathing control may reduce stress and increase the ease and
39 effectiveness of respiration and gas exchange. Nurses should be familiar with simple stress
40 management approaches, such as relaxation breathing, to assist an anxious patient with
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25 Reprint: Not in File
26 Abstract: Screening is not a test but a process. This distinction matters. Findings on radiographic
27 screening lead to a diagnostic workup. Once a diagnosis is made, the process dictates the choice
28 of treatment. Each of the steps in a screening algorithm is a medical decision in which the
29 physician, acting as the patient's advocate, weighs benefits and risks. Physicians caring for people
30 who are susceptible to lung cancer face four conflicting factors: the demand from the public to
31 act, the need to consider cost-effectiveness and social responsibility, the need for scientific
32 knowledge, and the lack of definitive evidence. One of the inherent weaknesses of any single
33 radiographic or biomarker test for lung cancer is the inability to provide unequivocal information
34 about the biology of a tumor - that is, its growth pattern and how it will respond to therapy. We
35 are making solid progress in combining CT scanning with sputum analysis, fluorescence
36 bronchoscopy, and analysis of pulmonary fluids, exhaled gases, and blood by genomic,
37 proteomic, and immunologic methods. Routine clinical applications of these methods, however,
38 are not available. These technological wonders require extensive validation and proof that
39 markers alone or in combination are sufficiently specific for the detection and diagnosis of lung
40 cancer. (PsycINFO Database Record (c) 2012 APA, all rights reserved)
41 Notes: DB - PsycINFO
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44
45

MESOTHELIOMA**Review question:**

What is the risk of mesothelioma in patients presenting in primary care with symptom(s)?

Results**Literature search**

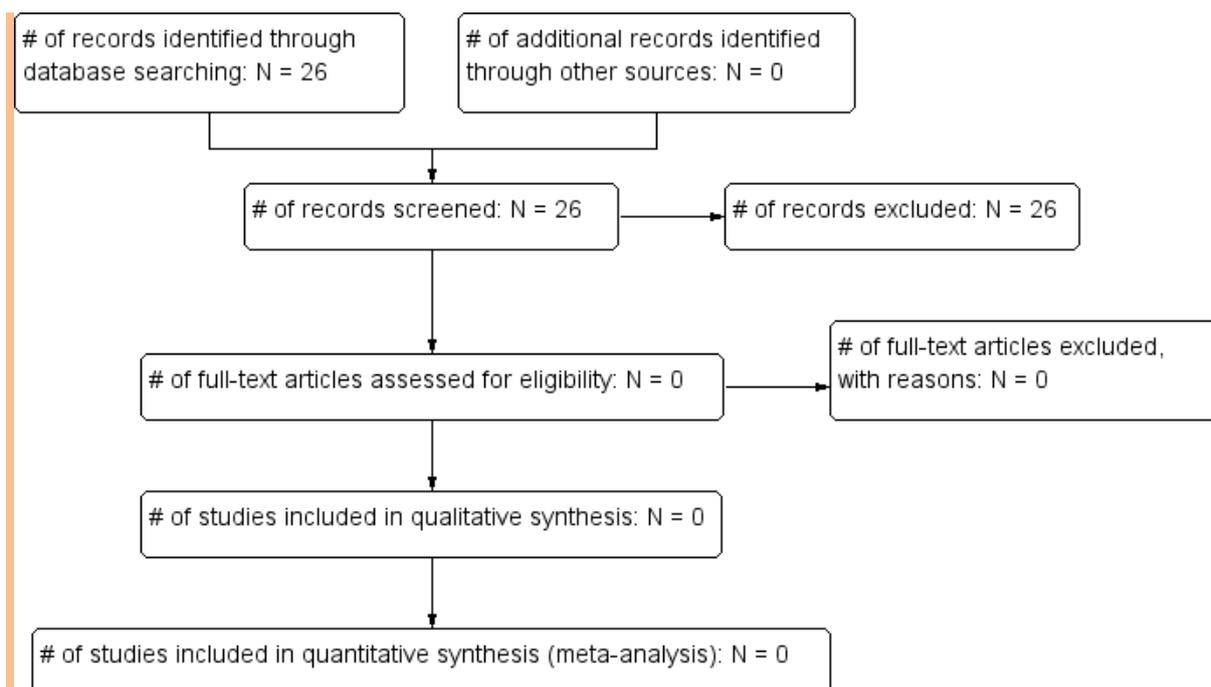
Database name	Dates Covered	No of references found	No of references retrieved	Finish date of search
<i>Medline</i>	1980-2013	185	6	22/04/2013
<i>Premedline</i>	1980-2013	4	0	22/04/2013
<i>Embase</i>	1980-2013	301	15	22/04/2013
<i>Cochrane Library</i>	1980-2013	17	0	22/04/2013
<i>Psychinfo</i>	1980-2013	2	0	22/04/2013
<i>Web of Science (SCI & SSCI) and ISI Proceedings</i>	1980-2013	81	3	22/04/2013

Total References retrieved (after de-duplication): 21

Update Search

Database name	Dates Covered	No of references found	No of references retrieved	Finish date of search
<i>Medline</i>	4/2013-20/08/2014	120	0	20/08/2014
<i>Premedline</i>	4/2013-20/08/2014	22	2	20/08/2014
<i>Embase</i>	4/2013-20/08/2014	37	2	20/08/2014
<i>Cochrane Library</i>	4/2013-20/08/2014	4	0	20/08/2014
<i>Web of Science (SCI & SSCI) and ISI Proceedings</i>	4/2013-20/08/2014	27	3	20/08/2014

Total References retrieved (after de-duplication): 5



1

2 **Study results**

3 No evidence was identified.

4 **References**

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6 None

7

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 35 Narrative review

38 Review question:

39 Which investigations of symptoms of suspected mesothelioma should be done with clinical
 40 responsibility retained by primary care?

42 Results

43 Literature search

Database name	Dates Covered	No of references found	No of references retrieved	Finish date of search
Medline	1980-2013	118	27	14/05/2013
Premedline	1980-2013	13	4	14/05/2013
Embase	1980-2013	169	53	14/05/2013
Cochrane Library	1980-2013	12	0	14/05/2013

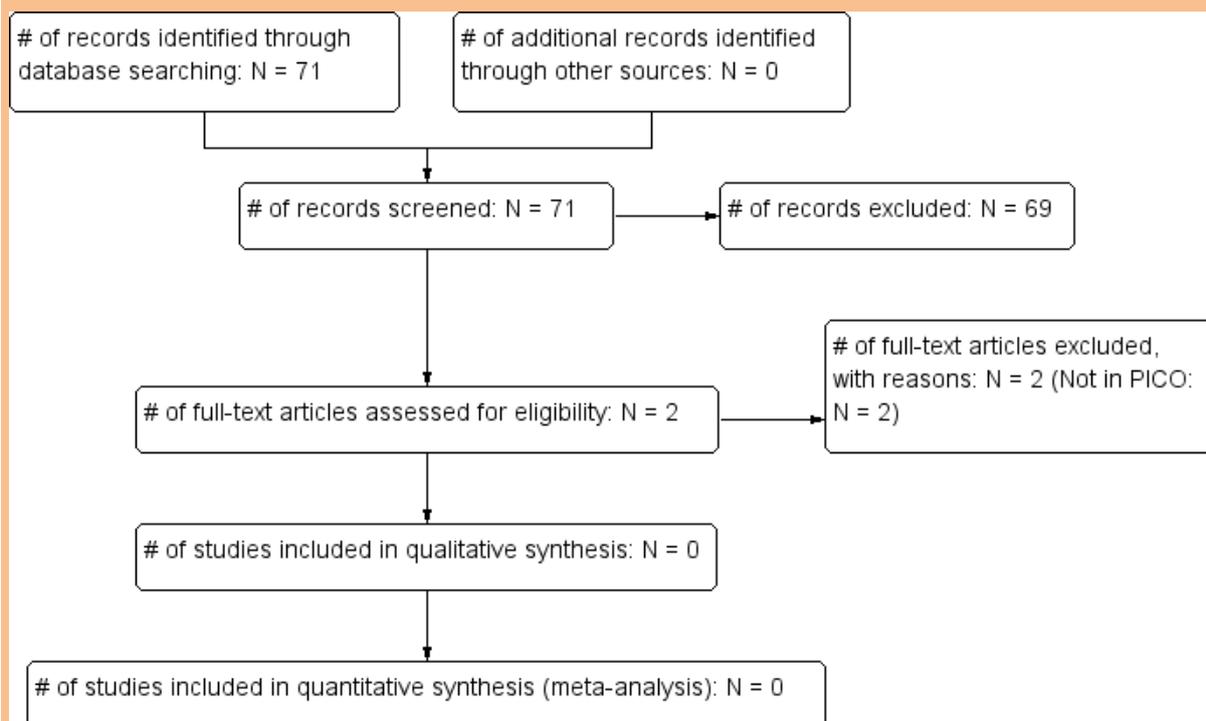
Psychinfo	1980-2013	1	0	14/05/2013
Web of Science (SCI & SSCI) and ISI Proceedings	1980-2013	24	0	14/05/2013

1 Total References retrieved (after de-duplication): 63

2
3 **Update Search**

Database name	Dates Covered	No of references found	No of references retrieved	Finish date of search
<i>Medline</i>	5/2013-20/08/2014	7	0	20/08/2014
<i>Premedline</i>	5/2013-20/08/2014	17	3	20/08/2014
<i>Embase</i>	5/2013-20/08/2014	37	4	20/08/2014
<i>Cochrane Library</i>	5/2013-20/08/2014	4	0	20/08/2014
<i>Web of Science (SCI & SSCI) and ISI Proceedings</i>	5/2013-20/08/2014	6	1	20/08/2014

4 Total References retrieved (after de-duplication): 8



6
7 **Study results**

8 No evidence was identified pertaining to the diagnostic accuracy of chest x-ray, CT, abdominal x-ray,
9 or ultrasound in patients with suspected mesothelioma where the clinical responsibility was retained
10 by primary care.

11
12 **References**

13 **Included studies**

14 None

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2 **Excluded studies (with excl reason)**
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UPPER GASTRO-INTESTINAL TRACT CANCERS

OESOPHAGEAL

Review question:

What is the risk of oesophageal cancer in patients presenting in primary care with symptom(s)?

Results

Literature search

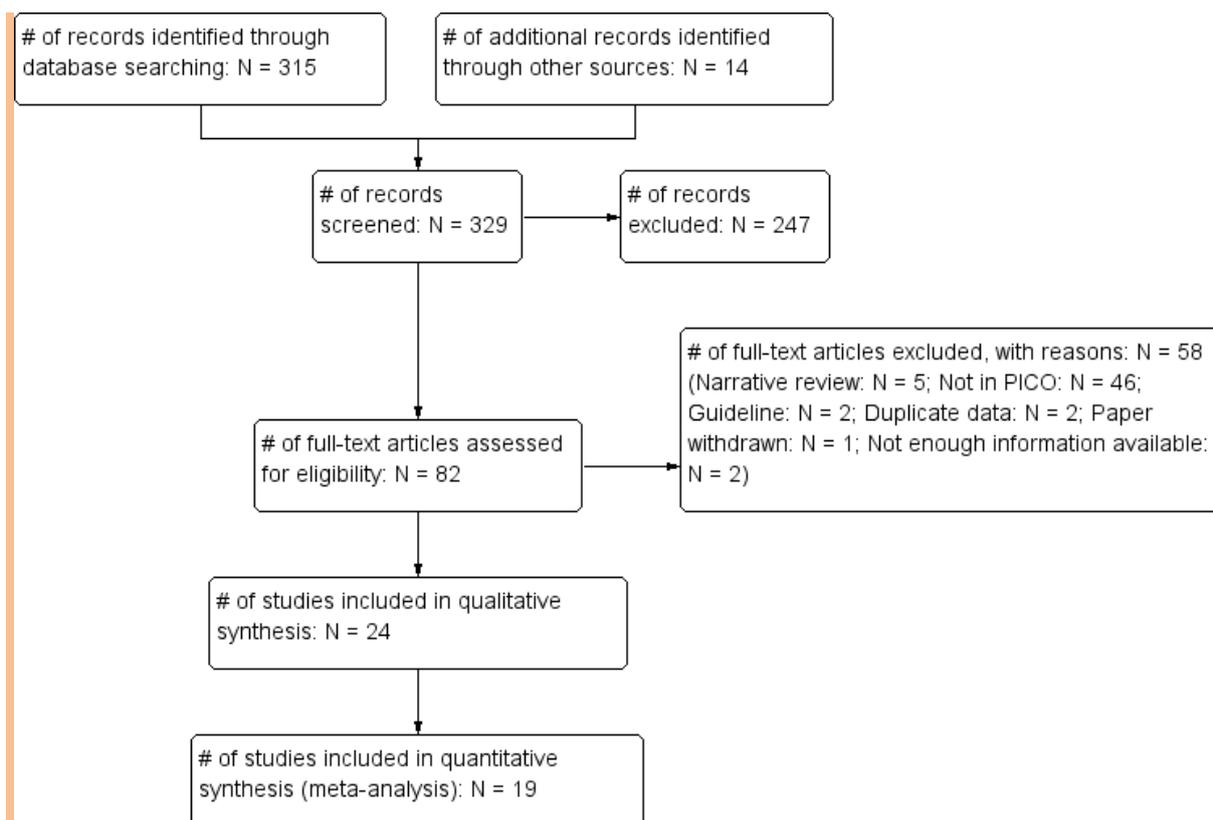
Database name	Dates Covered	No of references found	No of references retrieved	Finish date of search
<i>Medline</i>	All-2012	1593	122	08/05/2013
<i>Premedline</i>	All-2012	72	17	08/05/2013
<i>Embase</i>	All-2012	1831	182	09/05/2013
<i>Cochrane Library</i>	All-2012	483	5	10/05/2013
<i>Psychinfo</i>	All-2012	6	2	08/05/2013
<i>Web of Science (SCI & SSCI) and ISI Proceedings</i>	All-2012	480	56	10/05/2013

Total References retrieved (after de-duplication): 294

Update Search

Database name	Dates Covered	No of references found	No of references retrieved	Finish date of search
<i>Medline</i>	5/2013-20/08/2014	429	8	20/08/2014
<i>Premedline</i>	5/2013-20/08/2014	76	1	20/08/2014
<i>Embase</i>	5/2013-20/08/2014	458	11	20/08/2014
<i>Cochrane Library</i>	5/2013-20/08/2014	31	0	20/08/2014
<i>Web of Science (SCI & SSCI) and ISI Proceedings</i>	5/2013-20/08/2014	112	8	20/08/2014

Total References retrieved (after de-duplication): 21



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Risk of bias in the included studies

The risk of bias and applicability concerns are summarised per study in the figure below. The main bias and validity issues to note relates to patient selection and applicability with some studies employing non-consecutive patient sampling, e.g., case-control designs (which has been shown to be associated with inflated test accuracy parameters compared to designs that incorporate random or consecutive patient selection), and others being conducted in setting that may not directly translate to UK-based primary care. The other main issues of concern relates to missing data (and the concern that this may not be missing at random) and under specification of symptoms and reference standards, which makes it difficult to ascertain their applicability and/or validity. The evidence base is also limited by the fact that some of the positive predictive value estimates are based on low numbers of patients and a number of the studies do not provide different estimates for stomach nad oesophageal cancer, but only provide one estimate for these cancers combined.

	Risk of Bias				Applicability Concerns		
	Patient Selection	Index Test	Reference Standard	Flow and Timing	Patient Selection	Index Test	Reference Standard
Brignoli (1997)	?	+	-	+	?	+	+
Collins (2012)	+	+	+	+	+	+	+
Droogendijk (2011)	+	+	+	?	?	+	+
Duggan (2008)	?	+	+	+	+	+	+
Edenholm (1985)	?	+	+	-	?	+	+
Esfandyari (2002)	+	+	+	+	-	+	+
Farrus Palou (2000)	+	+	?	-	?	+	?
Hallissey (1990)	+	+	+	+	?	+	+
Hansen (1998)	+	+	+	?	?	+	+
Heikkinen (1995)	+	+	+	+	?	+	+
Hippisley-Cox (2011)	+	+	+	?	+	+	+
Jaskiewicz (1991)	?	+	+	+	?	?	+
Jones (2007)	+	+	+	+	+	+	+
Kagevi (1989)	+	+	+	+	?	+	+
Mahadeva (1998)	?	+	+	+	-	+	+
Meineche-Schmidt (2002)	+	+	+	+	?	+	+
Muris (1993)	+	+	+	+	?	?	+
Møllmann (1981)	+	+	?	-	?	+	+
Stapley (2013)	-	+	+	+	+	+	+
Stellon (1997)	+	+	+	+	+	+	+
Thomson (2003)	?	+	+	+	?	+	+
Tosetti (2010)	-	+	?	+	-	-	+
Vakil (2009)	?	+	+	+	+	+	+
Yates (2004)	+	+	+	+	?	+	+

- High
 ? Unclear
 + Low

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Study results

Table 1: Oesophageal cancer: Meta-analyses

Studies included	Symptom(s)	Patient group	Positive predictive value, % (95% CI)

Collins (2012) Hippisley-Cox (2011) Møllmann (1981)	Abdominal pain	All patients N = 3389979	0.23 (0.14-0.36)
Collins (2012) Droogendijk (2011) Farrus Palou (2000) Hippisley-Cox (2011) Stellon (1997) Yates (2004)	Anaemia	All patients N = 3375342	0.94 (0.54-1.64)
Brignoli (1997) Duggan (2008) Edenholm (1985) Hallissey (1990) Hansen (1998) Heikkinen (1995) Jaskiewicz (1991) Kagevi (1989) Meineche-Schmidt (2002) Thomson (2003) Vakil (2009)	Dyspepsia	All patients N = 11403	0.25 (0.13-0.5)
Collins (2012) Esfandyari (2002) Hippisley-Cox (2011) Jones (2007) at 6 months	Dysphagia	All patients N = 4136936	4.96 (3.49-7.01)
Collins (2012) Esfandyari (2002) Hippisley-Cox (2011) Jones (2007) at 3 years	Dysphagia	All patients N = 4136936	5.11 (3.7-7.01)

1 Please note that the data from Stapley (2013) are not included in these meta-analyses due to the
2 case-control design of the study, and the data from Mahadeva (1998) is not included due to the
3 limited and different age range of the population. These data are instead reported in the table below
4 entitled "Additional results reported by the individual papers: Single symptoms". When the number
5 of studies was < 3, the data were not meta-analysed, but presented for the individual studies
6 instead.

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Table 2: Oesophageal cancer: Individual positive predictive values from the meta-analyses

Study	Symptom(s)	Patient group	PPVs % (95% CI); prevalence
Collins (2012)	Abdominal pain	All patients	0.2 (0.2-0.2) 437/246998
Hippisley-Cox (2011)	Abdominal pain	All patients	0.3 (0.3-0.4) 309/91627
Møllmann (1981)	Upper abdominal pain > 2 weeks	All patients	0 (0-0.8) 0/577
Collins (2012)	Anaemia	All patients	0.6 (0.5-0.8) 116/18355
Droogendijk (2011)	Anaemia	All patients	0.35 (0.02-2.2) 1/287

Farrus Palou (2000)	Anaemia	All patients	0 (0-7.7) 0/58
Hippisley-Cox (2011)	Anaemia	All patients	1.1 (1-1.4) 119/10349
Stellon (1997)	Anaemia	All patients (N = 26)	0 (0-16) 0/26
Yates (2004)	Anaemia	All patients	2.55 (1.35-4.66) 11/431 has UGI cancer: No distinction made between the different kinds
Brignoli (1997)	Dyspepsia	All patients	0 (0-0.58) 0/828
Duggan (2008)	Dyspepsia	All patients	0.27 (0.05-1.1) 2/753
Edenholm (1985)	Persisten epigastric pain/ulcer-like dyspepsia	All patients who received an UGI endoscopy	0.61 (0.03-3.8) 1/165
Hallissey (1990)	Dyspepsia	All patients	0.58 (0.33-0.98) 15/2585
Hansen (1998)	Dyspepsia	All patients	1 (0.4-2.2) 6/612
Heikkinen (1995)	Dyspepsia	All patients	0.5 (0.09-2) 2/400
Jaskiewicz (1991)	Dyspepsia	All included patients	0 (0-0.8) 0/585
Kagevi (1989)	Dyspepsia	All included patients	0 (0-2.7) 0/172
Meineche-Schmidt (2002)	Dyspepsia	All patients	0.54 (0.25-1.1) 8/1491
Thomson (2003)	Dyspepsia	All patients	0.1 (0.01-0.6) 1/1040
Vakil (2009)	Dyspepsia without alarm symptoms	All included patients	0.1 (0.03-0.35) 3/2741
Collins (2012)	Dysphagia	All patients	4.2 (3.9-4.5) 810/19237
Esfandyari (2002)	Dysphagia	All patients	6 (2.5-13.1) 6/100
Hippisley-Cox (2011)	Dysphagia	All patients	7.8 (7.1-8.5) 434/5590
Jones (2007)	Dysphagia	All patients at 6 months	3.47 (3-4) 208/5999
Jones (2007)	Dysphagia	All patients at 3 years	3.85 (3.38-4.38) 231/5999

1

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Table 3: Oesophageal cancer: Additional results reported by the individual papers: Single symptoms

Study	Symptom(s)	Patient group	Positive predictive value, % (95% CI)
Tosetti (2010)	Upper gastro-intestinal symptoms without	All patients	0.36 (0.02-2.3) 1/275

	alarming features		
Muris (1993)	Non-acute abdominal complaints	All patients	0 (0-0.8) 0/578
Collins (2012)	Abdominal pain	Women	0.1 (0.1-0.1) 139/144266
		Men	0.3 (0.3-0.3) 298/102732
Stapley (2013)	Abdominal pain	Patients ≥ 55 years	0.3 (0.2-0.3)
Stapley (2013)	Epigastric pain	Patients ≥ 55 years	0.9 (0.8-1)
Collins (2012)	Anaemia	Women	0.4 (0.3-0.5) 49/13792
		Men	1.5 (1.1-1.9) 67/4563
Møllmann (1981)	Anaemia	Males	0 (0-44) 0/7
Stapley (2013)	Low haemoglobin	Patients ≥ 55 years	0.2 (0.2-109)
Stapley (2013)	Dyspepsia	Patients ≥ 55 years	0.7 (0.6-0.7)
Stapley (2013)	Dyspepsia (reported ≥ twice)	Patients ≥ 55 years	1.2 (1-1.5)
Vakil (2009)	Dyspepsia without alarm symptoms	Patients ≥ 45 years old	0.18 (0.03-0.71) 2/1127
		Patients ≥ 50 years old	0.24 (0.04-1) 2/829
		Patients ≥ 55 years old	0.18 (0.01-1.16) 1/554
		Patients ≥ 60 years old	0.3 (0.02-2) 1/323
Hansen (1998)	Ulcer-like dyspepsia	All patients	0.6 (0.03-3.9) 1/161
Hansen (1998)	Dysmotility-like dyspepsia	All patients	0 (0-2.9) 0/163
Hansen (1998)	Reflux-like dyspepsia	All patients	1.16 (0.2-4.6) 2/173
Hansen (1998)	Unclassifiable dyspepsia	All patients	0.9 (0.05-5.8) 1/107
Mahadeva (2008)	Dyspepsia	All patients (they were aged 18-45 years)	0 (0-1.1) 0/432
Collins (2012)	Dysphagia	Women	2.5 (2.2-2.8) 262/10391
		Men	6.2 (5.7-6.7) 548/8846
Jones	Dysphagia	Men (all ages) at 6 months	5.3 (4.4-6.2) 138/2628
		Men (all ages) at 3 years	5.7 (4.9-6.7) 150/2628
		Men < 45 years at 3 years	0.21 (0-1.15) 1/482
		Men 45-54 years at 3 years	4.03 (2.36-6.37) 17/422
		Men 55-64 years at 3	5.98 (4.1-8.39)

		years	31/518
		Men 65-74 years at 3 years	9.03 (6.82-11.7) 52/576
		Men 75-84 years at 3 years	7.14 (5-9.84) 34/476
		Men ≥ 85 years at 3 years	9.74 (5.55-15.6) 15/154
Jones	Dysphagia	Women (all ages) at 6 months	2.1 (1.6-2.6) 70/3371
		Women (all ages) at 3 years	2.4 (1.9-3) 81/3371
		Women < 45 years at 3 years	0.16 (0-0.86) 1/642
		Women 45-54 years at 3 years	0.58 (0.12-1.68) 3/520
		Women 55-64 years at 3 years	1.92 (0.92-3.49) 10/522
		Women 65-74 years at 3 years	3.79 (2.47-5.55) 25/659
		Women 75-84 years at 3 years	4.03 (2.65-5.85) 26/645
		Women ≥ 85 years at 3 years	4.18 (2.41-6.7) 16/383
Stapley (2013)	Dysphagia	Patients ≥ 55 years	4.8 (4.3-5.9)
Stapley (2013)	Dysphagia (reported ≥ twice)	Patients ≥ 55 years	5.5 (4.2-7.9)
Collins (2012)	Appetite loss	All patients	0.6 (0.5-0.9) 37/5838
		Women	0.4 (0.2-0.7) 12/3317
		Men	1 (0.7-1.5) 25/2521
Hippisley-Cox (2011)	Appetite loss	All patients	1.1 (0.8-1.5) 35/3391
Møllmann (1981)	Weight loss and/or anorexia	All patients	0 (0-8.9) 0/50
Collins (2012)	Weight loss	All patients	0.8 (0.7-0.9) 218/28403
		Women	0.6 (0.4-0.7) 86/15465
		Men	1 (0.9-1.2) 132/12938
Hippisley-Cox (2011)	Weight loss	All patients	1.2 (1-1.4) 107/9170
Stapley (2013)	Weight loss	Patients ≥ 55 years	0.9 (0.7-1)
Collins (2012)	Haematemesis	All patients	1 (0.8-1.2) 110/10792
		Women	0.5 (0.3-0.7) 22/4630
		Men	1.4 (1.2-1.8)

			88/6162
Hippisley-Cox (2011)	Haematemesis	All patients	2.3 (1.9-2.7) 101/4477
Stapley (2013)	Constipation	Patients ≥ 55 years	0.2 (0.2-0.2)
Stapley (2013)	Chest pain	Patients ≥ 55 years	0.2 (0.2-0.2)
Stapley (2013)	Reflux	Patients ≥ 55 years	0.6 (0.6-0.7)
Møllmann (1981)	Nausea and/or vomiting > 2 weeks	All patients	0 (0-12.3) 0/35
Stapley (2013)	Nausea/vomiting	Patients ≥ 55 years	0.6 (0.5-0.7)
Stapley (2013)	Nausea/vomiting reported ≥ twice	Patients ≥ 55 years	1 (0.8-1.2)
Stapley (2013)	Raised platelets	Patients ≥ 55 years	0.5 (0.4-0.5)
Stapley (2013) reported that all PPVs for symptom combinations in patients < 55 years were < 1%, and that the highest PPV in this age group was for dysphagia, 0.8 (0.4-1.5)%			
Møllmann (1981)	Gastrointestinal bleeding	All patients	0 (0-32) 0/11

1 Please note:
2 - The calculations of the positive predictive values differ between all the other included studies using
3 (TP)/(TP+FP) and Stapley (2013) using other statistics due to the case-control design of these studies.
4 NR = Not reported.

5
6 Table 4: Oesophageal cancer: Additional results reported by the individual papers: Symptom
7 combinations

Study	Symptom(s)	Patient group	Positive predictive value, % (95% CI)
Meineche-Schmidt (2002)	Dyspepsia and jaundice	All patients	0 (0-48.32) 0/6
Meineche-Schmidt (2002)	Dyspepsia and black stools	All patients	0.91 (0.05-5.69) 1/110
Meineche-Schmidt (2002)	Dyspepsia and bloody stools	All patients	0.76 (0.04-4.81) 1/131
Stapley (2013)	Dysphagia and chest pain	Patients ≥ 55 years	5.8 (3.5-10.8)
Stapley (2013)	Dysphagia and loss of weight	Patients ≥ 55 years	9.2 (4.4-22.7)
Stapley (2013)	Dysphagia and abdominal pain	Patients ≥ 55 years	6.5 (3.5-13.5)
Stapley (2013)	Dysphagia and epigastric pain	Patients ≥ 55 years	9.3 (NR)
Stapley (2013)	Dysphagia and reflux	Patients ≥ 55 years	5 (3.3-8.4)
Stapley (2013)	Dysphagia and low haemoglobin	Patients ≥ 55 years	4.6 (3.4-6.6)
Stapley (2013)	Dysphagia and nausea/vomiting	Patients ≥ 55 years	7.3 (4.4-13.9)
Meineche-Schmidt (2002)	Dyspepsia and dysphagia	All patients	1.4 (0.04-4.36) 3/215
Stapley (2013)	Dysphagia and dyspepsia	Patients ≥ 55 years	9.8 (5.7-20.2)

Stapley (2013)	Dysphagia and raised platelets	Patients ≥ 55 years	6.1 (3.2-13.2)
Stapley (2013)	Dyspepsia and chest pain	Patients ≥ 55 years	0.7 (0.5-0.9)
Stapley (2013)	Dyspepsia and abdominal pain	Patients ≥ 55 years	1 (0.7-1.3)
Stapley (2013)	Dyspepsia and epigastric pain	Patients ≥ 55 years	1.4 (1-2)
Stapley (2013)	Dyspepsia and nausea/vomiting	Patients ≥ 55 years	1.3 (0.9-1.8)
Stapley (2013)	Dyspepsia and reflux	Patients ≥ 55 years	0.9 (0.7-1.2)
Meineche-Schmidt (2002)	Dyspepsia and weight loss	All patients	1.37 (0.35-4.28) 3/219
Stapley (2013)	Dyspepsia and loss of weight	Patients ≥ 55 years	2.1 (1.3-3.5)
Stapley (2013)	Dyspepsia and raised platelets	Patients ≥ 55 years	1.4 (0.9-2.2)
Meineche-Schmidt (2002)	Dyspepsia and anaemia	All patients	0 (0-11.71) 0/37
Stapley (2013)	Dyspepsia and low haemoglobin	Patients ≥ 55 years	1 (0.8-1.3)
Stapley (2013)	Constipation and chest pain	Patients ≥ 55 years	0.4 (0.3-0.5)
Stapley (2013)	Constipation and loss of weight	Patients ≥ 55 years	1.1 (0.8-1.7)
Stapley (2013)	Constipation and abdominal pain	Patients ≥ 55 years	0.4 (0.3-0.5)
Stapley (2013)	Constipation and epigastric pain	Patients ≥ 55 years	1.4 (0.8-2.3)
Stapley (2013)	Constipation and reflux	Patients ≥ 55 years	0.7 (0.5-1.1)
Stapley (2013)	Constipation and low haemoglobin	Patients ≥ 55 years	0.4 (0.4-0.5)
Stapley (2013)	Constipation and nausea/vomiting	Patients ≥ 55 years	0.6 (0.4-0.7)
Stapley (2013)	Constipation and dyspepsia	Patients ≥ 55 years	0.8 (0.6-1.1)
Stapley (2013)	Constipation and dysphagia	Patients ≥ 55 years	4.2 (2.7-7.2)
Stapley (2013)	Constipation and raised platelets	Patients ≥ 55 years	0.9 (0.6-1.4)
Stapley (2013)	Abdominal pain and chest pain	Patients ≥ 55 years	0.3 (0.3-0.4)
Stapley (2013)	Abdominal pain and epigastric pain	Patients ≥ 55 years	0.9 (0.7-1.2)
Stapley (2013)	Abdominal pain and reflux	Patients ≥ 55 years	0.6 (0.5-0.9)
Stapley (2013)	Abdominal pain and weight loss	Patients ≥ 55 years	1.4 (0.9-2.2)
Møllmann (1981)	Upper abdominal pain > 2 weeks and nausea	All patients	0 (0-1.6) 0/293

	and/or vomiting > 2 weeks		
Stapley (2013)	Abdominal pain and nausea/vomiting	Patients ≥ 55 years	0.7 (0.5-0.9)
Stapley (2013)	Abdominal pain and low haemoglobin	Patients ≥ 55 years	0.5 (0.4-0.6)
Stapley (2013)	Abdominal pain and raised platelets	Patients ≥ 55 years	0.8 (0.6-1.1)
Møllmann (1981)	Upper abdominal pain > 2 weeks and gastrointestinal bleeding	All patients	0 (0-21) 0/19
Møllmann (1981)	Upper abdominal pain > 2 weeks and nausea/vomiting > 2 weeks and gastrointestinal bleeding	All patients	0 (0-44) 0/7
Møllmann (1981)	Upper abdominal pain > 2 weeks and nausea/vomiting > 2 weeks and weight loss/anorexia	All patients	0 (0-4) 0/116
Møllmann (1981)	Upper abdominal pain > 2 weeks and weight loss/anorexia and gastrointestinal bleeding	All patients	0 (0-20) 0/5
Møllmann (1981)	Upper abdominal pain > 2 weeks and weight loss/anorexia	All patients	0 (0-4.7) 0/98
Stapley (2013)	Chest pain and epigastric pain	Patients ≥ 55 years	0.9 (0.6-1.4)
Stapley (2013)	Chest pain and reflux	Patients ≥ 55 years	0.6 (0.5-0.9)
Stapley (2013)	Chest pain and weight loss	Patients ≥ 55 years	1.1 (0.7-1.8)
Stapley (2013)	Chest pain and nausea/vomiting	Patients ≥ 55 years	0.6 (0.4-0.8)
Stapley (2013)	Chest pain and low haemoglobin	Patients ≥ 55 years	0.3 (0.3-0.4)
Stapley (2013)	Chest pain and raised platelets	Patients ≥ 55 years	0.8 (0.6-1.2)
Stapley (2013)	Epigastric pain and reflux	Patients ≥ 55 years	1.5 (1-2.4)
Stapley (2013)	Epigastric pain and weight loss	Patients ≥ 55 years	4.2 (1.8-11)
Stapley (2013)	Epigastric pain and low haemoglobin	Patients ≥ 55 years	1.6 (1.1-2.2)
Stapley (2013)	Reflux and loss of weight	Patients ≥ 55 years	3.1 (1.5-6.7)
Stapley (2013)	Reflux and low haemoglobin	Patients ≥ 55 years	0.9 (0.7-1.2)
Stapley (2013)	Weight loss and low haemoglobin	Patients ≥ 55 years	1 (0.8-1.3)
Møllmann (1981)	Weight loss/anorexia	All patients	0 (0-80)

	and gastrointestinal bleeding		0/2
Møllmann (1981)	Weight loss/anorexia and gastrointestinal bleeding and nausea/vomiting > 2 week	All patients	0 (0-80) 0/2
Møllmann (1981)	Weight loss/anorexia and nausea/vomiting > 2 week	All patients	0 (0-16.6) 0/25
Stapley (2013)	Nausea/vomiting and weight loss	Patients ≥ 55 years	2.8 (1.7-4.8)
Stapley (2013)	Nausea/vomiting and epigastric pain	Patients ≥ 55 years	1.3 (0.9-2)
Stapley (2013)	Nausea/vomiting and reflux	Patients ≥ 55 years	2.3 (1.5-3.5)
Stapley (2013)	Nausea/vomiting and low haemoglobin	Patients ≥ 55 years	0.9 (0.7-1.1)
Stapley (2013)	Reflux and raised platelets	Patients ≥ 55 years	1.6 (0.9-2.9)
Stapley (2013)	Weight loss and raised platelets	Patients ≥ 55 years	1.8 (1.1-3)
Stapley (2013)	Nausea/vomiting and raised platelets	Patients ≥ 55 years	1.4 (1-2.1)
Stapley (2013)	Epigastric pain and raised platelets	Patients ≥ 55 years	1.9 (1-3.8)
Stapley (2013)	Low haemoglobin and raised platelets	Patients ≥ 55 years	0.6 (0.6-0.7)
Møllmann (1981)	Any of the inclusion symptoms + previous dyspepsia	All patients	0 (0-0.62) 0/773
Møllmann (1981)	Any of the inclusion symptoms + no previous dyspepsia	All patients	0 (0-0.91) 0/524
Møllmann (1981)	Any of the inclusion symptoms + unchanged previous dyspepsia	All patients	0 (0-1.2) 0/407
Møllmann (1981)	Any of the inclusion symptoms + no previous or changed dyspepsia	All patients	0 (0-0.54) 0/890
Møllmann (1981)	Any of the inclusion symptoms + pain provoked by meals	All patients	0 (0-1.8) 0/257
Møllmann (1981)	Any of the inclusion symptoms + no pain provoked by meals	All patients	0 (0-0.52) 0/924
Møllmann (1981)	Any of the inclusion symptoms + relief of pain by meals	All patients	0 (0-0.7) 0/488
Møllmann (1981)	Any of the inclusion symptoms + no pain	All patients	0 (0-2.8) 0/687

	relief by meals		
Møllmann (1981)	Any of the inclusion symptoms + irritable bowel syndrome	All patients	0 (0-2.8) 0/167
Møllmann (1981)	Any of the inclusion symptoms + no irritable bowel syndrome	All patients	0 (0-0.42) 0/1129

1 Please note:

2 - The calculations of the positive predictive values differ between the all the other included studies
3 using (TP)/(TP+FP) and Stapley (2013) using other statistics due to the case-control design of these
4 studies. NR = not reported.

6 Evidence statement(s):

7 Abdominal pain (4 studies, N = 3416339) presenting in a primary care setting is associated with an
8 overall positive predictive value of up to 0.3% for oesophageal cancer. The studies were associated
9 with 0-3 bias or applicability concerns (see also Tables 1-3).

10 Anaemia (8 studies, N = 3417170) presenting in a primary care setting is associated with an overall
11 positive predictive value of up to 0.94% for oesophageal cancer. The studies were associated with 0-
12 4 bias or applicability concern (see also Tables 1-3).

13 Dyspepsia (13 studies, N = 52183) presenting in a primary care setting is associated with an overall
14 positive predictive value of up to 1.2% for oesophageal cancer. The studies were associated with 1-3
15 bias or applicability concerns (see also Tables 1-3).

16 Dysphagia (5 studies, N = 4177284) presenting in a primary care setting is associated with an overall
17 positive predictive value of up to 5.5% for oesophageal cancer. All the studies were associated with
18 0-1 bias or applicability concerns (see also Tables 1-3).

19 Other single symptoms (6 studies, N = 3417192) presenting in a primary care setting are associated
20 with an overall positive predictive values for oesophageal cancer up to 2.3% (for haematemesis).
21 The studies were associated with 0-4 bias or applicability concerns (see also Table 3).

22 Two or more symptom presenting in combination (3 studies, N = 43319) in a primary care setting are
23 associated with overall positive predictive values for oesophageal cancer up to to 9.8% (for
24 dysphagia and dyspepsia). The studies were associated with 1-3 bias or applicability concerns (see
25 also Table 4).

32 Evidence tables

33 Brignoli (1997)

PATIENT SELECTION	
A. risk of bias	
Patient sampling	Prospective patient series from Switzerland.
Was a consecutive or random sample of patients enrolled?	Unclear
Was a case-control design avoided?	Yes
Did the study avoid inappropriate exclusions?	Unclear
Could the selection of patients have introduced bias?	Unclear risk
B. Concerns regarding applicability	

Patient characteristics and setting	N = 828; 329 men, 499 women; mean (SD) age = 41-42 (15-16) years. <u>Inclusion criteria</u> : "Adult patients with epigastric complaints were admitted to the multicentre [omega]-project if their symptoms persisted for over 1 month and their clinical history and appearance did not suggest an organic disorder (i.e. absence of alarm features, such as gastrointestinal blood loss, palpable tumour mass, massive weight loss, etc.). The studies were conducted by general practitioners acting as primary care physicians." <u>Exclusion criteria</u> : None listed <u>Clinical setting</u> : Primary care, Switzerland	
Are there concerns that the included patients and setting do not match the review question?		Unclear concern
INDEX TEST		
A. Risk of bias		
Index test	Epigastric complaints (dyspepsia)	
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes	
Could the conduct or interpretation of the index test have introduced bias?	Low risk	
B. Concerns regarding applicability		
Are there concerns that the index test, its conduct, or interpretation differ from the review question?		Low concern
REFERENCE STANDARD		
A. risk of bias		
Reference standard(s)	Endoscopy and 84-day follow up.	
Is the reference standard likely to correctly classify the target condition?	No	
Were the reference standard results interpreted without knowledge of the results of the index tests?	No	
Could the reference standard, its conduct, or its interpretation have introduced bias?	High risk	
B. Concerns regarding applicability		
Are there concerns that the target condition as defined by the reference standard does not match the question?		Low concern
FLOW AND TIMING		
A. risk of bias		
Flow and timing	All patients are accounted for	
Was there an appropriate interval between index test and reference standard?	Yes	
Did all patients receive the same reference standard?	Yes	
Were all patients included in the analysis?	Yes	
Could the patient flow have introduced bias?	Low risk	
NOTES	3 patients had gastric cancer, 0 patients had oesophageal cancer, and 2 patients had cancer outside the digestive tract.	

1

2

Collins (2012)

PATIENT SELECTION	
A. risk of bias	
Patient sampling	Retrospective patient series using the THIN database.
Was a consecutive or random sample of patients enrolled?	Yes
Was a case-control design avoided?	Yes
Did the study avoid inappropriate exclusions?	Yes
Could the selection of patients have introduced bias?	Low risk
B. Concerns regarding applicability	
Patient characteristics and setting	<p>A total of 2135540 patients were identified from 364 practices.</p> <p><u>Symptoms:</u> Dysphagia (N = 19237; 8846 men, 10391 women), abdominal pain (N = 246998; 102732 men, 144266 women), appetite loss (N = 5838; 2521 men, 3317 women), weight loss (N = 28403; 12938 men, 15465 women), haematemesis (N = 10792; 6162 men, 4630 women), anaemia (N = 18355; 4563 men, 13792 women).</p> <p><u>Incident cases of gastro-oesophageal cancer during the 2-year follow up period:</u> N = 1766 (1184 men, 582 women; 32% gastric cancer, 68% oesophageal cancer).</p> <p><u>Inclusion criteria:</u> Patients aged 30–84 years and registered with practices between 1 January 2000 and 30 June 2008. Entry to the cohort was defined as the latest of the study start date; the date the patient registered with the practice; and for those patients with red flag symptoms (see below), the date of the first recorded onset within the study period.</p> <p><u>Exclusion criteria:</u> Patients with a prior diagnosis of gastro-oesophageal cancer, registration with the general practice < 12 months, or with invalid dates.</p> <p><u>Clinical setting:</u> Primary care, UK</p>
Are there concerns that the included patients and setting do not match the review question?	Low concern
INDEX TEST	
A. Risk of bias	
Index test	'Red-flag' symptoms: Haematemesis, dysphagia, loss of appetite, weight loss, anaemia, and abdominal pain.
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes
Could the conduct or interpretation of the index test have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the index test, its conduct, or interpretation differ from the review question?	Low concern
REFERENCE STANDARD	
A. risk of bias	
Reference standard(s)	2-year follow up
Is the reference standard likely to correctly classify the target condition?	Yes

Were the reference standard results interpreted without knowledge of the results of the index tests?	Unclear
Could the reference standard, its conduct, or its interpretation have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the target condition as defined by the reference standard does not match the question?	Low concern
FLOW AND TIMING	
A. risk of bias	
Flow and timing	All patients seem to be accounted for
Was there an appropriate interval between index test and reference standard?	Yes
Did all patients receive the same reference standard?	Yes
Were all patients included in the analysis?	Yes
Could the patient flow have introduced bias?	Low risk
NOTES	The study did not distinguish between gastric and oesophageal cancer
1	
2	Droogendijk (2011)
PATIENT SELECTION	
A. risk of bias	
Patient sampling	Retrospective peripheral hospital laboratory database study serving 265 GPs in Dordrecht (Holland).
Was a consecutive or random sample of patients enrolled?	Yes
Was a case-control design avoided?	Yes
Did the study avoid inappropriate exclusions?	Yes
Could the selection of patients have introduced bias?	Low risk
B. Concerns regarding applicability	
Patient characteristics and setting	N = 287; 129 men, 158 women; median (range) age = 70 (19-87) years. <u>Inclusion criteria:</u> All women aged > 50 years and all men aged ≥ 18 years who between January 2004 and December 2005 were diagnosed with iron-deficiency anaemia (haemoglobin < 13.7 g/dl in men and < 12.1 g/dl in women, and a serum ferritin level < 25 µg/l for men and < 20 µg/l for women). <u>Exclusion criteria:</u> Patients with a known history of iron-deficiency anaemia in the previous 2 years, a history of gastrointestinal malignancy or congenital haemoglobinopathy. <u>Clinical setting:</u> GPs in Holland
Are there concerns that the included patients and setting do not match the review question?	Unclear concern
INDEX TEST	
A. Risk of bias	
Index test	New onset iron-deficiency anaemia (haemoglobin < 13.7 g/dl in men and < 12.1 g/dl in women, and a serum ferritin level < 25 µg/l for men and < 20 µg/l for women).
Were the index test results interpreted without knowledge	Yes

of the results of the reference standard?	
Could the conduct or interpretation of the index test have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the index test, its conduct, or interpretation differ from the review question?	Low concern
REFERENCE STANDARD	
A. risk of bias	
Reference standard(s)	Endoscopy and 12-month follow up.
Is the reference standard likely to correctly classify the target condition?	Yes
Were the reference standard results interpreted without knowledge of the results of the index tests?	No
Could the reference standard, its conduct, or its interpretation have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the target condition as defined by the reference standard does not match the question?	Low concern
FLOW AND TIMING	
A. risk of bias	
Flow and timing	It is unclear if all patients are accounted for
Was there an appropriate interval between index test and reference standard?	Unclear
Did all patients receive the same reference standard?	Unclear
Were all patients included in the analysis?	Unclear
Could the patient flow have introduced bias?	Unclear risk
NOTES	In addition to the 24 patients with colorectal cancer, 3 patients had gastric cancer, 1 patient had oesophageal cancer and 1 patient had locally invasive endometrial cancer.
1	
2 Duggan (2008)	
PATIENT SELECTION	
A. risk of bias	
Patient sampling	Prospective patient series from 43 GP practices in the UK.
Was a consecutive or random sample of patients enrolled?	No
Was a case-control design avoided?	Yes
Did the study avoid inappropriate exclusions?	Yes
Could the selection of patients have introduced bias?	Unclear risk
B. Concerns regarding applicability	
Patient characteristics and setting	N = 762; 411 men, 351 women; mean (range) age = 42 (18-73) years. <u>Inclusion criteria:</u> Patients aged 18-70 with dyspepsia thought by the GP to arise from the upper GI tract and of sufficient severity to justify empirical treatment with an H ₂ antagonist or PPI. <u>Exclusion criteria:</u> Patients thought to be unfit for investigation, with alarm

	symptoms suggestive of malignancy (dysphagia, weight loss > 5 g, anaemia, haematemesis, melaena or jaundice), previous radiological or endoscopic diagnosis of peptic ulcer disease or reflux oesophagitis, investigation for dyspepsia in the previous 5 years with either procedure or symptom onset within 6 months of commencement of NSAID therapy, previous H. pylori eradication therapy or more than 3 prescriptions for acid suppression therapy in the previous 6 months. <u>Clinical setting</u> : Primary care, UK
Are there concerns that the included patients and setting do not match the review question?	Low concern
INDEX TEST	
A. Risk of bias	
Index test	Dyspepsia
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes
Could the conduct or interpretation of the index test have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the index test, its conduct, or interpretation differ from the review question?	Low concern
REFERENCE STANDARD	
A. risk of bias	
Reference standard(s)	Endoscopy and 1-2-year follow up.
Is the reference standard likely to correctly classify the target condition?	Yes
Were the reference standard results interpreted without knowledge of the results of the index tests?	No
Could the reference standard, its conduct, or its interpretation have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the target condition as defined by the reference standard does not match the question?	Low concern
FLOW AND TIMING	
A. risk of bias	
Flow and timing	At 12-month follow up GP data were available for 753/762.
Was there an appropriate interval between index test and reference standard?	Yes
Did all patients receive the same reference standard?	Yes
Were all patients included in the analysis?	Yes
Could the patient flow have introduced bias?	Low risk
NOTES	2 patients had gastric cancer, 2 patients had oesophageal cancer (the authors report that these patients should not have been included as they had a history of dysphagia).
1	
2	Edenholm (1985)
PATIENT SELECTION	

A. risk of bias	
Patient sampling	Prospective patient series from the Distric General Clinic in Huskvarna, Sweden.
Was a consecutive or random sample of patients enrolled?	Unclear
Was a case-control design avoided?	Yes
Did the study avoid inappropriate exclusions?	Unclear
Could the selection of patients have introduced bias?	Unclear risk
B. Concerns regarding applicability	
Patient characteristics and setting	N = 187; 96 men, 91 women; mean/median (range) age = 44 (17-80) years. <u>Inclusion criteria:</u> Patients who between November 1982 and June 1984 called on the clinic because of abdominal pain and who were diagnosed by the general practitioner as having ulcer-like dyspepsia. The criterion used was persistent epigastric pain. Most patients also had additional symptoms such as acid regurgitation, nausea, belching or vomiting. <u>Exclusion criteria:</u> None listed <u>Clinical setting:</u> GPs in Sweden
Are there concerns that the included patients and setting do not match the review question?	Unclear concern
INDEX TEST	
A. Risk of bias	
Index test	Ulcer-like dyspepsia. The criterion used was persistent epigastric pain.
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes
Could the conduct or interpretation of the index test have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the index test, its conduct, or interpretation differ from the review question?	Low concern
REFERENCE STANDARD	
A. risk of bias	
Reference standard(s)	UGI endoscopy
Is the reference standard likely to correctly classify the target condition?	Yes
Were the reference standard results interpreted without knowledge of the results of the index tests?	No
Could the reference standard, its conduct, or its interpretation have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the target condition as defined by the reference standard does not match the question?	Low concern
FLOW AND TIMING	
A. risk of bias	
Flow and timing	20/187 patients declined endoscopy and it was unsuccessful in a further 2 patients. Thus the PPV is likely to be an over-estimate, calculated as 2/165.
Was there an appropriate interval between index test and	Yes probably

reference standard?	
Did all patients receive the same reference standard?	Yes
Were all patients included in the analysis?	No
Could the patient flow have introduced bias?	High risk
NOTES	There were a total of 3 cancers confirmed in the 165 patients who received UGI endoscopy: 1 oesophageal cancer, 1 stomach cancer, and 1 cancer of the duodenum, the latter of which was included with the stomach cancer
1	
2	Esfandiyari (2002)
PATIENT SELECTION	
A. risk of bias	
Patient sampling	Prospective/retrospective? patient series from USA
Was a consecutive or random sample of patients enrolled?	Yes
Was a case-control design avoided?	Yes
Did the study avoid inappropriate exclusions?	Yes
Could the selection of patients have introduced bias?	Low risk
B. Concerns regarding applicability	
Patient characteristics and setting	N = 100; 49 men, 51 women; mean (SE) age = 64 (2) years. <u>Inclusion criteria</u> : Patients with new onset dysphagia without a prior work up who were evaluated at the Cleveland Clinic Foundation outpatient clinic by their primary care physician. <u>Exclusion criteria</u> : Neurological disease, oropharyngeal dysphagia or previous gastric or oesophageal surgery, and patients without a final diagnosis explaining their dysphagia. <u>Clinical setting</u> : Primary care outpatient clinic, USA.
Are there concerns that the included patients and setting do not match the review question?	High concern
INDEX TEST	
A. Risk of bias	
Index test	New onset dysphagia
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes
Could the conduct or interpretation of the index test have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the index test, its conduct, or interpretation differ from the review question?	Low concern
REFERENCE STANDARD	
A. risk of bias	
Reference standard(s)	Completed clinical and diagnostic testing after an initial barium swallow/upper GI endoscopy.
Is the reference standard likely to correctly classify the target condition?	Yes
Were the reference standard results interpreted without knowledge of the results of the index tests?	No
Could the reference standard, its conduct, or its	Low risk

interpretation have introduced bias?		
B. Concerns regarding applicability		
Are there concerns that the target condition as defined by the reference standard does not match the question?		Low concern
FLOW AND TIMING		
A. risk of bias		
Flow and timing	All patients are accounted for	
Was there an appropriate interval between index test and reference standard?	Yes	
Did all patients receive the same reference standard?	Yes	
Were all patients included in the analysis?	Yes	
Could the patient flow have introduced bias?		Low risk
NOTES	6 patients had malignancy, but the type of malignancy was not further specified	
1		
2 Farrus Palou (2000)		
PATIENT SELECTION		
A. risk of bias		
Patient sampling	Retrospective consecutive patient series from urban general practice covering a population of 24000.	
Was a consecutive or random sample of patients enrolled?	Yes	
Was a case-control design avoided?	Yes	
Did the study avoid inappropriate exclusions?	Yes	
Could the selection of patients have introduced bias?		Low risk
B. Concerns regarding applicability		
Patient characteristics and setting	<p>N = 87 of whom the data from 29 were unavailable as no etiological diagnosis was found (due to patient refusal of further investigation [?; 8], lost to follow up [7], patient deterioration rendering them unsuitable for further investigation [14]); of the remaining 58 patients there were 14 males, 44 females; mean? (SD?) age = 54.26 (19.95) years.</p> <p><u>Inclusion criteria:</u> Patients aged > 14 years who attended the health centre between 1 October 1995 and 31 September 1996 who were found to have new onset (previously unknown) anaemia (haemoglobin < 13 g/dl for men and 12 g/dl for women).</p> <p><u>Exclusion criteria:</u> Pregnant women.</p> <p><u>Clinical setting:</u> Spanish GP</p>	
Are there concerns that the included patients and setting do not match the review question?		Unclear concern
INDEX TEST		
A. Risk of bias		
Index test	Anaemia (haemoglobin < 13 g/dl for men and 12 g/dl for women)	
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes	
Could the conduct or interpretation of the index test have introduced bias?		Low risk

B. Concerns regarding applicability		
Are there concerns that the index test, its conduct, or interpretation differ from the review question?		Low concern
REFERENCE STANDARD		
A. risk of bias		
Reference standard(s)	Follow up I think	
Is the reference standard likely to correctly classify the target condition?		Unclear
Were the reference standard results interpreted without knowledge of the results of the index tests?		No
Could the reference standard, its conduct, or its interpretation have introduced bias?		Unclear risk
B. Concerns regarding applicability		
Are there concerns that the target condition as defined by the reference standard does not match the question?		Unclear concern
FLOW AND TIMING		
A. risk of bias		
Flow and timing	No diagnosis available for 29/87 patients	
Was there an appropriate interval between index test and reference standard?		Unclear
Did all patients receive the same reference standard?		Yes
Were all patients included in the analysis?		No
Could the patient flow have introduced bias?		High risk
NOTES	This paper is published in Spanish. One patient had gastric cancer, 2 patients had colon cancer.	
1		
2	Hallissey (1990)	
PATIENT SELECTION		
A. risk of bias		
Patient sampling	Propective consecutive patient series from a group of 10 general practices in England.	
Was a consecutive or random sample of patients enrolled?		Yes
Was a case-control design avoided?		Yes
Did the study avoid inappropriate exclusions?		Yes
Could the selection of patients have introduced bias?		Low risk
B. Concerns regarding applicability		
Patient characteristics and setting	N = 2585 aged > 40 years. No other information reported. The patient group was equally divided between new patients with dyspepsia, old patients with uninvestigated dyspepsia, and old patients with investigated dyspepsia. <u>Inclusion criteria:</u> All patients over 40 years making their first attendance during the study period (4 years and 9 months) with any degree of dyspepsia <u>Exclusion criteria:</u> None listed. <u>Clinical setting:</u> Primary care, England.	
Are there concerns that the included patients and setting		Unclear concern

do not match the review question?		
INDEX TEST		
A. Risk of bias		
Index test	Dyspepsia of any degree	
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes	
Could the conduct or interpretation of the index test have introduced bias?	Low risk	
B. Concerns regarding applicability		
Are there concerns that the index test, its conduct, or interpretation differ from the review question?	Low concern	
REFERENCE STANDARD		
A. risk of bias		
Reference standard(s)	Upper gastrointestinal endoscopy within 4 weeks and follow up.	
Is the reference standard likely to correctly classify the target condition?	Yes	
Were the reference standard results interpreted without knowledge of the results of the index tests?	No	
Could the reference standard, its conduct, or its interpretation have introduced bias?	Low risk	
B. Concerns regarding applicability		
Are there concerns that the target condition as defined by the reference standard does not match the question?	Low concern	
FLOW AND TIMING		
A. risk of bias		
Flow and timing	2659 patients were seen and 2585 attended for investigation	
Was there an appropriate interval between index test and reference standard?	Yes	
Did all patients receive the same reference standard?	Yes	
Were all patients included in the analysis?	Yes	
Could the patient flow have introduced bias?	Low risk	
NOTES	Malignancy was detected in 115 patients: Gastric adenocarcinoma (57), gastric lymphoma (1; added to the gastric adenocarcinoma data in the PPV), oesophageal cancer (15), colorectal (14), pancreatic (6), bronchial (8), prostatic (2), duodenal (1, also added to the gastric carcinoma data in the PPV), liver (1), gall bladder (1), carcinoid (1), uterine (1), leukaemia (1), carcinomatosis of unknown primary (7).	
1		
2	Hansen (1998)	
PATIENT SELECTION		
A. risk of bias		
Patient sampling	Prospective patient series from general an open-access endoscopy clinic in Denmark.	
Was a consecutive or random sample of patients enrolled?	Yes	
Was a case-control design avoided?	Yes	

Did the study avoid inappropriate exclusions?	Yes
Could the selection of patients have introduced bias?	Low risk
B. Concerns regarding applicability	
Patient characteristics and setting	N = 612 from 66 GPs; 288 males / 324 females; mean age (SD) = 47 (16.8) years. <u>Inclusion criteria:</u> "All general practitioners (n = 108) in the city of Odense (population, 170,000) were invited to participate in the study. GPs were asked to refer all patients who consulted them with dyspepsia, regardless of the severity of the symptoms. To obtain compliance with this request the participating GPs were sent numerous reminders. Because of a limited endoscopy capacity not all GPs took part in the study at the same time." Study period was 11 March 1991-27 March 1992. <u>Exclusion criteria:</u> Aged < 18 years, signs of UGI bleeding, abdominal emergency, jaundice, previous surgery in the UGI tract except for closure of an ulcer, supposed acute bacterial or viral infection, pregnancy, or endoscopy contraindicated. <u>Clinical setting:</u> GPs in Denmark
Are there concerns that the included patients and setting do not match the review question?	Unclear concern
INDEX TEST	
A. Risk of bias	
Index test	Epigastric or retrosternal pain or discomfort, with or without heartburn, nausea, vomiting, and any other symptom considered to be referable to the proximal alimentary tract.
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes
Could the conduct or interpretation of the index test have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the index test, its conduct, or interpretation differ from the review question?	Low concern
REFERENCE STANDARD	
A. risk of bias	
Reference standard(s)	Endoscopy within 1 week of referral and follow up
Is the reference standard likely to correctly classify the target condition?	Yes
Were the reference standard results interpreted without knowledge of the results of the index tests?	No
Could the reference standard, its conduct, or its interpretation have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the target condition as defined by the reference standard does not match the question?	Low concern
FLOW AND TIMING	
A. risk of bias	
Flow and timing	56 eligible patients declined participation. These patients were older than

	the study group (mean age = 52 years versus 47 years) and they were characterised by a shorter dyspepsia history (median duration = 1 month, range = 4 days to 35 years versus 2 months, range = 4 days to 14 years). Fewer of the non-participating patients had had a previous endoscopy or UGI radiography (22% versus 43%, but identical proportions of the patients had an ulcer history (11% versus 14%).
Was there an appropriate interval between index test and reference standard?	Yes
Did all patients receive the same reference standard?	Yes
Were all patients included in the analysis?	No
Could the patient flow have introduced bias?	Unclear risk
NOTES	There were a total of 4 cancers histologically confirmed in the study. No subclassification of the cancers reported. Follow up of the 364 patients with normal endoscopy revealed missing date in 5% of the cases and 1 lymphoma and 1 rectal carcinoma. These 6 cancers (NOS) are included in the overall PPV for dyspepsia.
1	
2	Heikkinen (1995)
PATIENT SELECTION	
A. risk of bias	
Patient sampling	Consecutive patient series from 11 GPs (from 3 rural health centres) and from the catchment area of 6 physicians in the health centre of an urban area (population [individuals > 14 years old] of study area = 24600) in Finland.
Was a consecutive or random sample of patients enrolled?	Yes
Was a case-control design avoided?	Yes
Did the study avoid inappropriate exclusions?	Yes
Could the selection of patients have introduced bias?	Low risk
B. Concerns regarding applicability	
Patient characteristics and setting	N = 400; 152 males, 248 females; 77% were > 44 years. <u>Inclusion criteria:</u> Consecutive patients who consulted their GP from January 11th 1993 to January 12 th 1994 for dyspepsia (defined as upper abdominal or retrosternal pain, discomfort, heartburn, nausea, vomiting, or other symptoms considered to be referable to the proximal alimentary tract). <u>Exclusion criteria:</u> Patients with symptoms of an acute condition within the abdomen or who had had an upper intestinal endoscopy performed within the last 3 months or aged < 15 years <u>Clinical setting:</u> Primary care, Finland.
Are there concerns that the included patients and setting do not match the review question?	Unclear concern
INDEX TEST	
A. Risk of bias	
Index test	Dyspepsia (defined as upper abdominal or retrosternal pain, discomfort, heartburn, nausea, vomiting, or other symptoms considered to be referable to the proximal alimentary tract).
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes

Could the conduct or interpretation of the index test have introduced bias?		Low risk
B. Concerns regarding applicability		
Are there concerns that the index test, its conduct, or interpretation differ from the review question?		Low concern
REFERENCE STANDARD		
A. risk of bias		
Reference standard(s)	Upper gastrointestinal endoscopy, upper abdominal ultrasound, more detailed interview, blood count, serum screening (creatinine, alkaline phosphatase, alanine aminotransferase, amylase, and C-reactive protein), lactose intolerance test, and follow up of ≥ 1 month.	
Is the reference standard likely to correctly classify the target condition?		Yes
Were the reference standard results interpreted without knowledge of the results of the index tests?		No
Could the reference standard, its conduct, or its interpretation have introduced bias?		Low risk
B. Concerns regarding applicability		
Are there concerns that the target condition as defined by the reference standard does not match the question?		Low concern
FLOW AND TIMING		
A. risk of bias		
Flow and timing	All patients appear to be accounted for	
Was there an appropriate interval between index test and reference standard?		Yes
Did all patients receive the same reference standard?		Yes
Were all patients included in the analysis?		Yes
Could the patient flow have introduced bias?		Low risk
NOTES	In total N = 9 had cancer: 0 colorectal, 2 oesophageal and 7 stomach (of which 3 were lymphomas of the MALT type (Mucosa-associated lymphoid tissue)).	
1		
2 Hippisley-Cox (2011)		
PATIENT SELECTION		
A. risk of bias		
Patient sampling	Prospective patient series using patients in the QResearch database (version 30).	
Was a consecutive or random sample of patients enrolled?		Yes
Was a case-control design avoided?		Yes
Did the study avoid inappropriate exclusions?		Yes
Could the selection of patients have introduced bias?		Low risk
B. Concerns regarding applicability		
Patient characteristics and setting	A total of 1238971 patients were identified from 189 practices (621478 males, 617493 females), mean (SD) age = 50.1 (15) years, mean (SD) Townsend score = -0.2 (3.6). Symptoms: Current dysphagia (N = 8165), current haematemesis (N = 7119), current	

	<p>abdominal pain (N = 126161), current appetite loss (N = 6133), current weight loss (N = 5377), tiredness in the last year (N = 14119), haemoglobin recorded in the last year (N = 12638, haemoglobin < 11 g/dl in the last year (N = 218862).</p> <p><u>Incident cases of gastro-oesophageal cancer during the 2-year follow up period:</u> N = 1343 (776 oesophageal and 567 gastric).</p> <p><u>Inclusion criteria:</u> All practices in England and Wales that had been using their Egton Medical Information Systems (EMIS) computer system for ≥ a year were included. Two-thirds of practices were randomly allocated to the derivation dataset and the remaining practices were allocated to the validation dataset. An open cohort of patients aged 30–84 years was identified, drawn from patients registered with practices between 1 January 2000 and 30 September 2010. Entry to the cohort was defined as the latest of the study start date (1 January 2000); 12 months after the patient registered with the practice; and for those patients with red flag symptoms (see below), the date of the first recorded onset within the study period. <i>The relevant data for the present purposes is only available for the validation cohort, therefore only information pertaining to these patients will be reported.</i></p> <p><u>Exclusion criteria:</u> Patients without a postcode-related Townsend score, patients with a history of gastro-oesophageal cancer at baseline, and patients with a recorded 'red-flag' symptom in the 12 months prior to the study entry date.</p> <p><u>Clinical setting:</u> Primary care, UK</p>
Are there concerns that the included patients and setting do not match the review question?	Low concern
INDEX TEST	
A. Risk of bias	
Index test	'Red-flag' symptoms: Incident dysphagia, haematemesis, loss of appetite, weight loss, anaemia, and abdominal pain.
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes
Could the conduct or interpretation of the index test have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the index test, its conduct, or interpretation differ from the review question?	Low concern
REFERENCE STANDARD	
A. risk of bias	
Reference standard(s)	2-year follow up
Is the reference standard likely to correctly classify the target condition?	Yes
Were the reference standard results interpreted without knowledge of the results of the index tests?	Unclear
Could the reference standard, its conduct, or its interpretation have introduced bias?	Low risk
B. Concerns regarding applicability	

Are there concerns that the target condition as defined by the reference standard does not match the question?		Low concern
FLOW AND TIMING		
A. risk of bias		
Flow and timing	A total of 1342329 patients were initially identified of whom 103358 patients were excluded for the following reasons: No recorded Townsend score (N = 70847), history of gastro-oesophageal cancer (N = 538), and \geq one 'red flag' symptom recorded in the 12 months prior to study entry (N = 31973), leaving 1238971 patients. However, data is presented for 963040/1238971 patients for all symptoms. The missing data does not appear to include any of the cancer cases, but it is unclear whether some of the missing data includes symptomatic patients, i.e., false positives.	
Was there an appropriate interval between index test and reference standard?	Yes	
Did all patients receive the same reference standard?	Yes	
Were all patients included in the analysis?	No	
Could the patient flow have introduced bias?	Unclear risk	
NOTES	Results not presented separately for gastric and oesophageal cancer	
1		
2	Jaskiewicz (1991)	
PATIENT SELECTION		
A. risk of bias		
Patient sampling	Patient series from a program aimed at screening patients with chronic gastric complaints for gastric carcinoma in the South and North-Western Cape Province of South Africa.	
Was a consecutive or random sample of patients enrolled?	Unclear	
Was a case-control design avoided?	Yes	
Did the study avoid inappropriate exclusions?	Unclear	
Could the selection of patients have introduced bias?	Unclear risk	
B. Concerns regarding applicability		
Patient characteristics and setting	<p>N = 585, 355 males, 230 females; mean (range) age males = 45.1 (19-87) years, mean (range) age females = 47.2 (19-87) years.</p> <p><u>Inclusion criteria</u>: "participants who were treated for dyspeptic complaints such as epigastric pain, heartburn, post-prandial pain and bloating, vomiting or nausea with a duration of at least 3 months. Patients represented various areas in the south-and north-western Cape province including Namaqualand, and formed part of a programme aimed at screening patients with chronic gastric complaints for gastric carcinoma."</p> <p><u>Exclusion criteria</u>: None listed</p> <p><u>Clinical setting</u>: Unclear, South Africa.</p>	
Are there concerns that the included patients and setting do not match the review question?	Unclear concern	
INDEX TEST		
A. Risk of bias		
Index test	Unspecified dyspepsia (dyspeptic complaints such as epigastric pain, heartburn, post-prandial pain and bloating, vomiting or nausea with a duration of at least 3 months).	

Were the index test results interpreted without knowledge of the results of the reference standard?	Yes
Could the conduct or interpretation of the index test have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the index test, its conduct, or interpretation differ from the review question?	Unclear concern
REFERENCE STANDARD	
A. risk of bias	
Reference standard(s)	Endoscopy
Is the reference standard likely to correctly classify the target condition?	Yes
Were the reference standard results interpreted without knowledge of the results of the index tests?	No
Could the reference standard, its conduct, or its interpretation have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the target condition as defined by the reference standard does not match the question?	Low concern
FLOW AND TIMING	
A. risk of bias	
Flow and timing	All patients appear to be accounted for
Was there an appropriate interval between index test and reference standard?	Yes
Did all patients receive the same reference standard?	Yes
Were all patients included in the analysis?	Yes
Could the patient flow have introduced bias?	Low risk
NOTES	In total N = 16 had gastric cancer. No oesophageal cancers reported
1	
2	Jones (2007)
PATIENT SELECTION	
A. risk of bias	
Patient sampling	Retrospective consecutive patient series using patients in the UK's General Practice Research Database.
Was a consecutive or random sample of patients enrolled?	Yes
Was a case-control design avoided?	Yes
Did the study avoid inappropriate exclusions?	Yes
Could the selection of patients have introduced bias?	Low risk
B. Concerns regarding applicability	
Patient characteristics and setting	A total of 923605 patients were identified, of whom 762325 were aged ≥ 15 years. Number of first occurrences in patients with no previous diagnosis of cancer: Haematuria: N = 11138, mean (SD) age at first symptom = 58.5 (18.9) years. Patients excluded due to incomplete dates for their first symptom: N = 30. Sex (of final sample): 6385 males, 4723 females.

	<p>Haemoptysis: N = 4822, mean (SD) age at first symptom = 61.6 (18) years. Patients excluded due to incomplete dates for their first symptom: N = 10. Sex (of final sample): 2930 males, 1882 females.</p> <p>Dysphagia: N = 6003, mean (SD) age at first symptom = 54.5 (19.4) years. Patients excluded due to incomplete dates for their first symptom: N = 4. Sex (of final sample): 2628 males, 3371 females.</p> <p>Rectal bleeding: N = 15314, mean (SD) age at first symptom = 52.5 (18.8) years. Patients excluded due to incomplete dates for their first symptom: N = 25. Sex (of final sample): 7523 males, 7766 females.</p> <p>Inclusion criteria: All patients from 128 general practices that provided data of a sufficient standard from 1 January 1994 to 31 December 2000 and which provided exclusively Read coded data, who were aged between 15 and 100 years, whose first ever recorded occurrence of each alarm symptom (haematuria, haemoptysis, dysphagia, or rectal bleeding) was after 31 December 1994 and who had not previously been diagnosed as having any cancer.</p> <p>Exclusion criteria: Patients whose date of first symptom or first relevant diagnosis of cancer was before 1 January 1995 and patients with a diagnosis of any other cancer than the ones of interest before the date of the first recorded symptom or before the index cancer diagnosis date if the related symptom was not recorded.</p> <p>Clinical setting: Primary care</p>
Are there concerns that the included patients and setting do not match the review question?	Low concern
INDEX TEST	
A. Risk of bias	
Index test	Identification of all patients who ever had symptoms recorded for haematuria, haemoptysis, dysphagia, or rectal bleeding.
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes
Could the conduct or interpretation of the index test have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the index test, its conduct, or interpretation differ from the review question?	Low concern
REFERENCE STANDARD	
A. risk of bias	
Reference standard(s)	<p>Cancer code in the UK's General Practice Research Database:</p> <p>Haematuria: Urinary tract neoplasms, including neoplasms of the urethra, bladder, ureter, and kidney but excluding neoplasms of the prostate and other reproductive organs.</p> <p>Haemoptysis: Respiratory tract neoplasms.</p> <p>Dysphagia: Oesophageal neoplasms.</p> <p>Rectal bleeding: Colorectal neoplasms.</p>
Is the reference standard likely to correctly classify the target condition?	Yes
Were the reference standard results interpreted without knowledge of the results of the index tests?	Unclear (but all patients had a positive index test)

Could the reference standard, its conduct, or its interpretation have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the target condition as defined by the reference standard does not match the question?	Low concern
FLOW AND TIMING	
A. risk of bias	
Flow and timing	All patients are accounted for in the results.
Was there an appropriate interval between index test and reference standard?	Unclear
Did all patients receive the same reference standard?	Yes
Were all patients included in the analysis?	Yes
Could the patient flow have introduced bias?	Low risk
NOTES	<p>Diagnoses of cancer were most often made in the first three months after the onset of alarm symptoms; very few diagnoses of cancer were made later than three years after symptom onset. In the 4th and 5th years of study, the small number of observed occurrences of cancer was similar to the number expected from background incidence rates.</p> <p>Secondary analyses evaluating whether the incidence of neoplasms other than those prespecified was increased after the occurrence of alarm symptoms showed for:</p> <p><u>Haematuria</u>: Inclusion of cancers of the reproductive organs yielded 21 additional cancers in women and 158 cancers in men, mostly cancers of the prostate. Inclusion of these cancers in the analysis would give a positive predictive value of 3.9% in women and 9.9% in men.</p> <p><u>Dysphagia</u>: Inclusion of gastric cancers yielded 17 additional cancer diagnoses in women and 30 in men. Inclusion of these cancers gave positive predictive values of 5.2% in women [reported in the paper, however, the numbers reported do not match up and I think the PPV is instead 2.91%; 98/3371] and 6.9% in men.</p> <p><i>Estimates based on the pre-specified cancers may be thus conservative for these symptoms.</i></p> <p><u>Haemoptysis</u>: Extension of the diagnostic criteria yielded 6 additional cancers.</p> <p><u>Rectal bleeding</u>: Extension of the diagnostic criteria yielded 2 additional cancers.</p>
1	
2	Kagevi (1989)
PATIENT SELECTION	
A. risk of bias	
Patient sampling	Propective consecutive patient series from a primary care centre in Sweden.
Was a consecutive or random sample of patients enrolled?	Yes
Was a case-control design avoided?	Yes
Did the study avoid inappropriate exclusions?	Yes
Could the selection of patients have introduced bias?	Low risk
B. Concerns regarding applicability	

Patient characteristics and setting	N = 172; 88 men, 84 women; mean (SD) age = 43 (16) years. <u>Inclusion criteria:</u> "All patients visiting the medical center with complaints referable to the digestive tract were considered for inclusion. Even when the patient consulted the primary care center because of another complaint and coincidentally mentioned gastrointestinal problem, the patient was considered for inclusion. The patient's gastrointestinal problem could have been reported in connection with an earlier visit at the primary care center." <u>Exclusion criteria:</u> Patients with jaundice, gastrointestinal bleeding or acute abdominal pain were excluded and so were patients judged to have a non-gastro-enterologic cause of their symptoms (gynaecologic problems, spondylosis deformans, etc), patients aged < 16 years and patients unwilling to participate. <u>Clinical setting:</u> Primary care Center, Sweden.
Are there concerns that the included patients and setting do not match the review question?	Unclear concern
INDEX TEST	
A. Risk of bias	
Index test	Dyspepsia defined as any pain, discomfort, or other symptoms referable to the digestive tract \geq 2 weeks. Symptoms could be intermittent or continuous.
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes
Could the conduct or interpretation of the index test have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the index test, its conduct, or interpretation differ from the review question?	Low concern
REFERENCE STANDARD	
A. risk of bias	
Reference standard(s)	Esophagogastroduodenoscopy within 1 week and 6 month follow up.
Is the reference standard likely to correctly classify the target condition?	Yes
Were the reference standard results interpreted without knowledge of the results of the index tests?	No
Could the reference standard, its conduct, or its interpretation have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the target condition as defined by the reference standard does not match the question?	Low concern
FLOW AND TIMING	
A. risk of bias	
Flow and timing	13/185 patients were excluded as they did not want to have an endoscopy
Was there an appropriate interval between index test and reference standard?	Yes
Did all patients receive the same reference standard?	Yes
Were all patients included in the analysis?	Yes
Could the patient flow have introduced bias?	Low risk

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NOTES	2 patients had gastric cancer, 0 patients had oesophageal cancer.	
Mahadeva (2008)		
PATIENT SELECTION		
A. risk of bias		
Patient sampling	Prospective patient series from the Primary Care Clinics of the University of Malaya in Malaysia	
Was a consecutive or random sample of patients enrolled?	Unclear	
Was a case-control design avoided?	Yes	
Did the study avoid inappropriate exclusions?	Unclear	
Could the selection of patients have introduced bias?	Unclear risk	
B. Concerns regarding applicability		
Patient characteristics and setting	<p>N = 432; 198 males/234 females; mean ages (SDs) = 30-31 (8) years.</p> <p><u>Inclusion criteria</u>: "All patients were recruited from the Primary Care Clinics of the University of Malaya, which provide a regular service to the local community. Patients aged ≤ 45 years presenting with uninvestigated dyspepsia were invited to participate in the study", which ran from January 2004 until October 2005.</p> <p><u>Exclusion criteria</u>: Age > 45 or < 18 years; symptoms of weight loss, progressive dysphagia or those suggestive of anaemia; pregnancy; previous H pylori testing; any contra-indication to to endoscopy or sedation; failure to turn up for initial test ; and on regular doses of non-steroidal anti-inflammatory drugs.</p> <p><u>Clinical setting</u>: Primary care clinic, Malaysia</p>	
Are there concerns that the included patients and setting do not match the review question?	High concern	
INDEX TEST		
A. Risk of bias		
Index test	Uninvestigated dyspepsia. Dyspepsia defined as predominant upper abdominal discomfort for > 4 weeks, with any associated symptoms, including heart burn and regurgitation.	
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes	
Could the conduct or interpretation of the index test have introduced bias?	Low risk	
B. Concerns regarding applicability		
Are there concerns that the index test, its conduct, or interpretation differ from the review question?	Low concern	
REFERENCE STANDARD		
A. risk of bias		
Reference standard(s)	Follow up ± upper endoscopy (oesophagogastroduodenoscopy)	
Is the reference standard likely to correctly classify the target condition?	Yes	
Were the reference standard results interpreted without knowledge of the results of the index tests?	No	
Could the reference standard, its conduct, or its	Low risk	

interpretation have introduced bias?		
B. Concerns regarding applicability		
Are there concerns that the target condition as defined by the reference standard does not match the question?		Low concern
FLOW AND TIMING		
A. risk of bias		
Flow and timing	39/471 eligible patients were excluded from the study for the following reasons: 34/39 patients declined to participate, 3/39 became pregnant before the test, 1/39 emigrated from the country and 1/39 had missing data.	
Was there an appropriate interval between index test and reference standard?	Yes	
Did all patients receive the same reference standard?	Yes	
Were all patients included in the analysis?	Yes	
Could the patient flow have introduced bias?	Low risk	
NOTES	One patient was found to have cancer, which was metastatic pancreatic cancer. No oesophageal or gastric cancers were reported.	
1		
2 Meineche-Schmidt (2002)		
PATIENT SELECTION		
A. risk of bias		
Patient sampling	Consecutive patient series from 82 GPs in Denmark.	
Was a consecutive or random sample of patients enrolled?	Yes	
Was a case-control design avoided?	Yes	
Did the study avoid inappropriate exclusions?	Yes	
Could the selection of patients have introduced bias?	Low risk	
B. Concerns regarding applicability		
Patient characteristics and setting	N = 1491; 688 males, 803 females; age groups: 18-37 years: N = 377; 38-50 years: N = 369; 51-64 years: N = 338; 65- years: N = 402. <u>Inclusion criteria:</u> Consecutive patients who consulted their GP between June 1991 and May 1993 for dyspepsia (defined as pain or discomfort in the abdomen judged by the GP to be related to the gastrointestinal tract). <u>Exclusion criteria:</u> None listed. <u>Clinical setting:</u> Primary care, Denmark.	
Are there concerns that the included patients and setting do not match the review question?	Unclear concern	
INDEX TEST		
A. Risk of bias		
Index test	Dyspepsia (defined as pain or discomfort in the abdomen judged by the GP to be related to the gastrointestinal tract).	
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes	
Could the conduct or interpretation of the index test have introduced bias?	Low risk	
B. Concerns regarding applicability		
Are there concerns that the index test, its conduct, or	Low concern	

interpretation differ from the review question?		
REFERENCE STANDARD		
A. risk of bias		
Reference standard(s)	18 months-3 years and 10 months follow up.	
Is the reference standard likely to correctly classify the target condition?	Yes	
Were the reference standard results interpreted without knowledge of the results of the index tests?	No	
Could the reference standard, its conduct, or its interpretation have introduced bias?	Low risk	
B. Concerns regarding applicability		
Are there concerns that the target condition as defined by the reference standard does not match the question?	Low concern	
FLOW AND TIMING		
A. risk of bias		
Flow and timing	All patients appear to be accounted for	
Was there an appropriate interval between index test and reference standard?	Yes	
Did all patients receive the same reference standard?	Yes	
Were all patients included in the analysis?	Yes	
Could the patient flow have introduced bias?	Low risk	
NOTES	In total N = 31 had cancer: 17 colorectal, 8 gastro-oesophageal (no subgroup analyses presented for these patients) and 6 other.	
1		
2 Muris (1993)		
PATIENT SELECTION		
A. risk of bias		
Patient sampling	Prospective consecutive patient series from 11 general practitioners in Maastricht (Holland)	
Was a consecutive or random sample of patients enrolled?	Yes	
Was a case-control design avoided?	Yes	
Did the study avoid inappropriate exclusions?	Unclear	
Could the selection of patients have introduced bias?	Low risk	
B. Concerns regarding applicability		
Patient characteristics and setting	N = 578; 212 males, 342 females; age groups: 18-39 years: N = 295; 40-49 years: N = 80; 50-59 years: N = 91; 60-75 years: N = 88. <u>Inclusion criteria:</u> Patients who during a 3-month period consulted one of the participating GPs for abdominal complaints. <u>Exclusion criteria:</u> Patients aged < 18 years and patients with a condition necessitating immediate referral or admission to hospital. <u>Clinical setting:</u> GPs in Holland	
Are there concerns that the included patients and setting do not match the review question?	Unclear concern	
INDEX TEST		

A. Risk of bias	
Index test	Abdominal complaints. Not further specified, but the authors do report that the duration of pain before the patient presented for the first time for the evaluation of abdominal pain varied from some days to more than 1 year.
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes
Could the conduct or interpretation of the index test have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the index test, its conduct, or interpretation differ from the review question?	Unclear concern
REFERENCE STANDARD	
A. risk of bias	
Reference standard(s)	Follow up for 15 months.
Is the reference standard likely to correctly classify the target condition?	Yes
Were the reference standard results interpreted without knowledge of the results of the index tests?	No
Could the reference standard, its conduct, or its interpretation have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the target condition as defined by the reference standard does not match the question?	Low concern
FLOW AND TIMING	
A. risk of bias	
Flow and timing	All patients appear to be accounted for
Was there an appropriate interval between index test and reference standard?	Unclear
Did all patients receive the same reference standard?	Yes
Were all patients included in the analysis?	Yes
Could the patient flow have introduced bias?	Low risk
NOTES	Although not explicitly stated by the authors it is implied that the patients included were those presenting with the abdominal complaint for the first time.
1	
2 Møllmann (1981)	
PATIENT SELECTION	
A. risk of bias	
Patient sampling	Prospective patient series from an open-access gastroscopy clinic in Denmark.
Was a consecutive or random sample of patients enrolled?	Yes
Was a case-control design avoided?	Yes
Did the study avoid inappropriate exclusions?	Yes
Could the selection of patients have introduced bias?	Low risk
B. Concerns regarding applicability	

Patient characteristics and setting	N = 1480; gender not reported; 40-44 years: N = 144; 45-49 years: N = 186; 50-69 years: N = 882; 70-74 years: N = 130; 75-79 years: N = 83; 80-89 years N = 47; 90- years: N = 8. <u>Inclusion criteria:</u> All patients who, for a 2-year period, presented to their GP with (any of) the following symptoms were referred to the open access gastroscopy clinic: Upper abdominal pain > 2 weeks, nausea and/or vomiting > 2 weeks, weight loss and/or anorexia, gastrointestinal bleeding, and anaemia (i.e., Hb < 80%). <u>Exclusion criteria:</u> Patients who had been examined for any of the above symptoms within the last 6 months. <u>Clinical setting:</u> GPs in Denmark
Are there concerns that the included patients and setting do not match the review question?	Unclear concern
INDEX TEST	
A. Risk of bias	
Index test	Upper abdominal pain > 2 weeks, nausea and/or vomiting > 2 weeks, weight loss and/or anorexia, gastrointestinal bleeding, and anaemia (i.e., Hb < 80%).
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes
Could the conduct or interpretation of the index test have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the index test, its conduct, or interpretation differ from the review question?	Low concern
REFERENCE STANDARD	
A. risk of bias	
Reference standard(s)	2-stage process: Gastroscopy with photography, using a gastroscope, performed with only local anaesthesia of the pharynx. If this investigation disclosed abnormal conditions, the next stage was gastroscopy, possibly with biopsy, using diazepam sedation.
Is the reference standard likely to correctly classify the target condition?	Unclear
Were the reference standard results interpreted without knowledge of the results of the index tests?	No
Could the reference standard, its conduct, or its interpretation have introduced bias?	Unclear risk
B. Concerns regarding applicability	
Are there concerns that the target condition as defined by the reference standard does not match the question?	Low concern
FLOW AND TIMING	
A. risk of bias	
Flow and timing	177/1480 patients declined endoscopy, 2/1480 did not show up for endoscopy, and it was unsuccessful in a further 24 patients, leaving 1277 patients. However, the paper reports that only 1273 had primary endoscopy, and then reports the results for between 1181 and 1297 patients.
Was there an appropriate interval between index test and reference standard?	Yes probably

Did all patients receive the same reference standard?	Yes
Were all patients included in the analysis?	No
Could the patient flow have introduced bias?	High risk
NOTES	There were a total of 18 gastric cancers confirmed in the study. No oesophageal cancers were reported. This research was published in 2 papers.
Stapley (2013)	
PATIENT SELECTION	
A. risk of bias	
Patient sampling	Matched case-control study using patients in the UK's General Practice Research Database (GPRD).
Was a consecutive or random sample of patients enrolled?	No
Was a case-control design avoided?	No
Did the study avoid inappropriate exclusions?	Yes
<i>For diagnostic case-control studies:</i> Attempts were made within the design or analysis to balance the comparison groups for potential confounders?	Yes
<i>For diagnostic case-control studies:</i> The groups were comparable at baseline, including all major confounding and prognostic factors?	Yes
Could the selection of patients have introduced bias?	High risk
B. Concerns regarding applicability	
Patient characteristics and setting	<p><u>Cases:</u> <u>Oesophageal cancer cases:</u> N = 4854, 3174 males / 1680 females; aged 40-54 years: N = 387; 55-69 years: N = 1712; 70-84 years: N = 2230; ≥ 85 years: N = 532. <u>Gastric cancer cases:</u> N = 2617, 1625 males / 992 females; aged 40-54 years: N = 130; 55-69 years: N = 671; 70-84 years: N = 1437; ≥ 85 years: N = 382. Median number of consultations (all cases) = 26 (IQR = 15-42)</p> <p><u>Controls:</u> <u>Oesophageal cancer controls:</u> N = 21506, gender not reported; aged 40-54 years: N = 1539; 55-69 years: N = 7473; 70-84 years: N = 10296; ≥ 85 years: N = 2198. <u>Gastric cancer controls:</u> N = 11371, gender not reported; aged 40-54 years: N = 497; 55-69 years: N = 2887; 70-84 years: N = 6431; ≥ 85 years: N = 1556. Median number of consultations (all controls) = 15 (IQR = 7-28)</p> <p><u>Inclusion criteria:</u> Cases: Patients with a record of one of 42 (18 oesophageal, 24 gastric) GPRD tumour diagnostic codes between January 2000 and December 2009 inclusive, aged ≥ 40 years, with min. 1 year of data before diagnosis. The first instance of a oesophago-gastric cancer code was assigned the data of diagnosis/index date. Controls: Up to 5 controls were matched to cases on sex, general practice, and to 1 year of age of the case. The index date was the index date of the matched case.</p>

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	<p><u>Exclusion criteria:</u> Oesophago-gastric cancer (controls), no consultations in the year before diagnosis.</p> <p><u>Clinical setting:</u> Primary care, UK</p>
Are there concerns that the included patients and setting do not match the review question?	Low concern
INDEX TEST	
A. Risk of bias	
Index test	<p>All symptoms, physical signs or abnormal investigations compiled from the oesophago-gastric cancer literature were studied, and supplemented by literature from relevant cancer websites. The GPRD's code list has many synonyms for for similar symptoms, often including additional description such as severity or duration. These synonyms were identified and merged. The dyspepsia variable merged codes with either the word 'dyspepsia' or 'indigestion'; the reflux variable included 'regurgitation' as well as 'reflux'; the variable 'epigastric pain' required a precise anatomical description, whereas the variable 'abdominal pain' incorporated all other abdominal pain variables without a precise anatomical description. Occurrences of these features in the year before the index date were identified. Features were only retained for further study if they occurred in $\geq 5\%$ of cases or controls. For laboratory tests, the local laboratory range was used to identify abnormal results. Patients without a test were considered to be the same status as those with a normal result. All hepatic enzyme results were merged into a composite variable, deemed abnormal if any enzyme was raised; similarly, abnormal erythrocyte sedimentation rate, plasma viscosity and C-reactive protein were collated into a single variable called raised inflammatory markers. All codes for fractures were also identified, as a test for any recording bias between cases and controls (making the assumption that the fracture rate would be approximately equal).</p>
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes
<i>For diagnostic case-control studies:</i> Investigators were kept 'blind' to other important confounding and prognostic factors?	Yes
Could the conduct or interpretation of the index test have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the index test, its conduct, or interpretation differ from the review question?	Low concern
REFERENCE STANDARD	
A. risk of bias	
Reference standard(s)	Oesophago-gastric cancer code in the UK's General Practice Research Database.
Is the reference standard likely to correctly classify the target condition?	Yes
Were the reference standard results interpreted without knowledge of the results of the index tests?	Unclear
Could the reference standard, its conduct, or its interpretation have introduced bias?	Low risk
B. Concerns regarding applicability	

Are there concerns that the target condition as defined by the reference standard does not match the question?		Low concern
FLOW AND TIMING		
A. risk of bias		
Flow and timing	A total of 45356 patients were identified, 37699 controls and 7657 cases. Of the controls the following exclusions were applied: Already used as a case (N = 252), case excluded (N = 808), duplicate control (N = 427) and no data in year pre-index date (N = 3335). Of the cases the following exclusions were applied: No controls (N = 17), OG cancer diagnosis before 2000 (N = 28), case already used as case (for other O/G cancer: N = 131) and case with metastatic cancer (N = 10).	
Was there an appropriate interval between index test and reference standard?		Yes
Did all patients receive the same reference standard?		Yes
Were all patients included in the analysis?		Yes
Could the patient flow have introduced bias?		Low risk
NOTES	Results are not split for oesophageal cancer and gastric cancer.	
Stellon (1997)		
PATIENT SELECTION		
A. risk of bias		
Patient sampling	Prospective? consecutive patient series from semi-rural UK general practice with a patient list between 2400-3400 during the study period.	
Was a consecutive or random sample of patients enrolled?		Yes
Was a case-control design avoided?		Yes
Did the study avoid inappropriate exclusions?		Yes
Could the selection of patients have introduced bias?		Low risk
B. Concerns regarding applicability		
Patient characteristics and setting	N = 26; 5 males, 21 females; age range = 51-87 years. <u>Inclusion criteria:</u> All patients aged > 50 years found to have iron deficiency anaemia between January 1989 and March 1994. <u>Exclusion criteria:</u> None listed. <u>Clinical setting:</u> UK GP	
Are there concerns that the included patients and setting do not match the review question?		Low concern
INDEX TEST		
A. Risk of bias		
Index test	Iron deficiency anaemia (< 12 g/dl haemoglobin and/or mean corpuscular volume < 80 fl with ferritin ≤ 16 ng/l)	
Were the index test results interpreted without knowledge of the results of the reference standard?		Yes
Could the conduct or interpretation of the index test have introduced bias?		Low risk
B. Concerns regarding applicability		
Are there concerns that the index test, its conduct, or interpretation differ from the review question?		Low concern

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REFERENCE STANDARD	
A. risk of bias	
Reference standard(s)	Follow up during 5 year study period.
Is the reference standard likely to correctly classify the target condition?	Yes
Were the reference standard results interpreted without knowledge of the results of the index tests?	No
Could the reference standard, its conduct, or its interpretation have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the target condition as defined by the reference standard does not match the question?	Low concern
FLOW AND TIMING	
A. risk of bias	
Flow and timing	All patients appear to be accounted for
Was there an appropriate interval between index test and reference standard?	Yes
Did all patients receive the same reference standard?	Yes
Were all patients included in the analysis?	Yes
Could the patient flow have introduced bias?	Low risk
NOTES	
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2 Thomson (2003)	
PATIENT SELECTION	
A. risk of bias	
Patient sampling	Propective patient series from a group of 49 family physician practices in Canada.
Was a consecutive or random sample of patients enrolled?	Unclear
Was a case-control design avoided?	Yes
Did the study avoid inappropriate exclusions?	Unclear
Could the selection of patients have introduced bias?	Unclear risk
B. Concerns regarding applicability	
Patient characteristics and setting	N = 1040, 520 males / 520 females; mean (range) age =45.6 (18-84) years. <u>Inclusion criteria:</u> Patients ≥ 18 years with a primary complaint of ≥ 3 months intermittent or continuous dyspepsia. Patients could not have used proton pump inhibitors within 30 days or prokinetics or prescription H ₂ -receptor antagonists (H ₂ RAS) within 14 days of enrolment. <u>Exclusion criteria:</u> Heartburn or acid regurgitation as their sole symptom; documented history of upper GI pathology/surgery; clinical investigation of dyspepsia by endoscopy or radiology in the previous 6 months or more than twice in the past 10 years; H. pylori eradication treatment in the previous 6 months; irritable bowel syndrome as assessed by the presence of ≥ manning criteria; or severe concurrent disease. <u>Clinical setting:</u> Family physician practice, Canada.

Are there concerns that the included patients and setting do not match the review question?	Unclear concern
INDEX TEST	
A. Risk of bias	
Index test	Dyspepsia defined as symptom complex of epigastric pain/discomfort in association with other upper GI symptoms, including heartburn and acid regurgitation.
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes
Could the conduct or interpretation of the index test have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the index test, its conduct, or interpretation differ from the review question?	Low concern
REFERENCE STANDARD	
A. risk of bias	
Reference standard(s)	Upper gastrointestinal endoscopy within 10 days and 6-months follow up.
Is the reference standard likely to correctly classify the target condition?	Yes
Were the reference standard results interpreted without knowledge of the results of the index tests?	No
Could the reference standard, its conduct, or its interpretation have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the target condition as defined by the reference standard does not match the question?	Low concern
FLOW AND TIMING	
A. risk of bias	
Flow and timing	All patients are accounted for. 1100/1171 enrolled patients consented to endoscopy, but 60/1100 did not received endoscopy (eligibility criteria not fulfilled [27], lost to follow up [3], withdrew consent [9], non-compliant with the protocol [1], endoscopy-intolerable [2], other [18]).
Was there an appropriate interval between index test and reference standard?	Yes
Did all patients receive the same reference standard?	Yes
Were all patients included in the analysis?	Yes
Could the patient flow have introduced bias?	Low risk
NOTES	Malignancy was detected in 2 patients: Gastric (MALToma; 1), oesophageal cancer (1).
1	
2 Tosetti (2010)	
PATIENT SELECTION	
A. risk of bias	
Patient sampling	Prospective patient series from 63 general practitioners in Italy
Was a consecutive or random sample of patients enrolled?	Unclear

Was a case-control design avoided?	Yes
Did the study avoid inappropriate exclusions?	Unclear
Could the selection of patients have introduced bias?	High risk
<u>B. Concerns regarding applicability</u>	
Patient characteristics and setting	N = 275; 124 males, 151 females; median age (range) = 46 (18-92) years. Symptoms: Epigastric pain (72%), prolonged digestion (51.6%), heartburn (49.1%), epigastric postprandial fullness (45.5%), epigastric distension (41.5%), nausea (38.5%), acid regurgitation (34.5%), belching (28.7%), early satiety (20.7%). <u>Inclusion criteria</u> : "Each GP enrolled in the survey patients who, over a three-month period, presented with UGI [upper gastro-intestinal] symptoms at the first onset without alarming features." <u>Exclusion criteria</u> : "Patients with either previous or recurrent complaints or previously investigated for UGI symptoms were not included". <u>Clinical setting</u> : GPs in Italy
Are there concerns that the included patients and setting do not match the review question?	High concern
INDEX TEST	
<u>A. Risk of bias</u>	
Index test	New onset UGI symptoms without alarming features. Not further specified.
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes
Could the conduct or interpretation of the index test have introduced bias?	Low risk
<u>B. Concerns regarding applicability</u>	
Are there concerns that the index test, its conduct, or interpretation differ from the review question?	High concern
REFERENCE STANDARD	
<u>A. risk of bias</u>	
Reference standard(s)	1-year follow up.
Is the reference standard likely to correctly classify the target condition?	Unclear
Were the reference standard results interpreted without knowledge of the results of the index tests?	No
Could the reference standard, its conduct, or its interpretation have introduced bias?	Unclear risk
<u>B. Concerns regarding applicability</u>	
Are there concerns that the target condition as defined by the reference standard does not match the question?	Low concern
FLOW AND TIMING	
<u>A. risk of bias</u>	
Flow and timing	All patients appear to be accounted for
Was there an appropriate interval between index test and reference standard?	Unclear
Did all patients receive the same reference standard?	Yes

Were all patients included in the analysis?	Yes
Could the patient flow have introduced bias?	Low risk
NOTES	Cancers diagnosed in these patients were: Pancreas (1/275), and oesophageal (1/275).
1	
2	Vakil (2009)
PATIENT SELECTION	
A. risk of bias	
Patient sampling	Prospective patient series
Was a consecutive or random sample of patients enrolled?	Unclear
Was a case-control design avoided?	Yes
Did the study avoid inappropriate exclusions?	Yes (probably)
Could the selection of patients have introduced bias?	Unclear risk
B. Concerns regarding applicability	
Patient characteristics and setting	<p>N = 2741, mean (range) age = not reported (not reported) years, numbers of females/males: Not reported.</p> <p><u>Inclusion criteria:</u> Patients aged 18-70 years who met Rome II criteria for dyspepsia (intermittent or continuous pain or burning centered in the upper abdomen for ≥ 3 months).</p> <p><u>Exclusion criteria:</u> Past diagnosis of gastro-oesophageal reflux disease, predominant symptom of heartburn or regurgitation, history of heartburn or regurgitation > 2 days/week, treatment > 2 days/week with non-steroidal anti-inflammatory drugs or cyclooxygenase-2 selective inhibitors or aspirin (except for cardiovascular prophylaxis at doses ≤ 325 mg/day), concurrent alarm features (e.g., dysphagia, recurrent vomiting, unexplained anaemia, gastro-intestinal bleeding), H pylori eradication treatment within 12 months, maintenance therapy with either a proton pump or an H2-receptor antagonist within 6 months.</p> <p><u>Clinical setting:</u> The study was conducted in 190 primary care health centers in 17 countries (Argentina, Belgium, Brazil, Canada, Denmark, France, Germany, Greece, Iceland, Italy, Norway, Romania, Singapore, South Africa, Spain, Sweden, Switzerland). Patients were recruited from primary care clinics where flyers publicising the study were placed and the primary care physicians recruited patients presenting to their offices with dyspepsia [random or consecutive sampling unlikely].</p>
Are there concerns that the included patients and setting do not match the review question?	Low concern
INDEX TEST	
A. Risk of bias	
Index test	Dyspepsia/ intermittent or continuous pain or burning centered in the upper abdomen for ≥ 3 months. Symptoms were evaluated using a scale validated in a number of languages
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes
Could the conduct or interpretation of the index test have introduced bias?	Low risk
B. Concerns regarding applicability	

Are there concerns that the index test, its conduct, or interpretation differ from the review question?		Low concern
REFERENCE STANDARD		
A. risk of bias		
Reference standard(s)	All patients received outpatient endoscopy	
Is the reference standard likely to correctly classify the target condition?	Yes	
Were the reference standard results interpreted without knowledge of the results of the index tests?	No (but all patients had a positive index test)	
Could the reference standard, its conduct, or its interpretation have introduced bias?	Low risk	
B. Concerns regarding applicability		
Are there concerns that the target condition as defined by the reference standard does not match the question?	Low concern	
FLOW AND TIMING		
A. risk of bias		
Flow and timing	All the patients are accounted for in the results.	
Was there an appropriate interval between index test and reference standard?	Yes (probably)	
Did all patients receive the same reference standard?	Yes	
Were all patients included in the analysis?	Yes	
Could the patient flow have introduced bias?	Low risk	
NOTES	Supported by AstraZeneca R&D Sweden. The authors state that "The sponsor did not play any role in the calculations or in the writing of the manuscript". Six patients had cancer: 3 oesophagus and 3 stomach.	
1		
2	Yates (2004)	
PATIENT SELECTION		
A. risk of bias		
Patient sampling	Retrospective database study using the laboratory databases of two district general hospitals including all the general practices using these laboratories.	
Was a consecutive or random sample of patients enrolled?	Yes	
Was a case-control design avoided?	Yes	
Did the study avoid inappropriate exclusions?	Yes	
Could the selection of patients have introduced bias?	Low risk	
B. Concerns regarding applicability		
Patient characteristics and setting	N = 431; 154 males, 277 females; median age (inter-quartile range) = 75 (65-81) years. <u>Inclusion criteria:</u> All female patients aged > 50 years and male patients aged > 20, with haemoglobin concentrations ≤ 110 g/l (women) or ≤ 120 g/l (men), and mean cell volume < 82 fl (district 1) or 78 fl (district 2), and red cell count ≤ 5.5 x 10 ¹² /l between June 1997 and May 1998. <u>Exclusion criteria:</u> History of anaemia within previous 12 months, known	

	haematological abnormalities (e.g., haemoglobinopathy), unavailable notes at follow up. <i>That is, patients with a history of cancer were not excluded.</i> Clinical setting: UK GP
Are there concerns that the included patients and setting do not match the review question?	Unclear concern
INDEX TEST	
A. Risk of bias	
Index test	Iron deficiency anaemia (haemoglobin concentrations ≤ 110 g/l (women) or ≤ 120 g/l (men), and mean cell volume < 82 fl (district 1) or 78 fl (district 2), and red cell count $\leq 5.5 \times 10^{12}/l$)
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes
Could the conduct or interpretation of the index test have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the index test, its conduct, or interpretation differ from the review question?	Low concern
REFERENCE STANDARD	
A. risk of bias	
Reference standard(s)	Minimum 3 years follow up.
Is the reference standard likely to correctly classify the target condition?	Yes
Were the reference standard results interpreted without knowledge of the results of the index tests?	No
Could the reference standard, its conduct, or its interpretation have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the target condition as defined by the reference standard does not match the question?	Low concern
FLOW AND TIMING	
A. risk of bias	
Flow and timing	All patients appear to be accounted for
Was there an appropriate interval between index test and reference standard?	Yes
Did all patients receive the same reference standard?	Yes
Were all patients included in the analysis?	Yes
Could the patient flow have introduced bias?	Low risk
NOTES	In total N = 48 had gastrointestinal cancer (11 upper, 2 small bowel and 35 lower, including recurrent tumours) and N = 23 had non-gastrointestinal cancers, but the study only reports the type of some of these cancers (3 lung + 1 lung tumour secondary to a previous breast tumour, 1 ovary, 2 bladder, 1 Hodgkin's, 1 Non-Hodgkin's, 1 endometrial sarcoma, 1 lymphoma, 1 endometrial) and has therefore not been added to the evidence reviews for the non-gastrointestinal cancers. The paper considers both the lower gastrointestinal cancers and the small bowel cancers as colorectal cancer and in order to present subgroup analyses by gender I have maintained this grouping and not added this paper to the evidence review for small intestine.

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Review question:

Which investigations of symptoms of suspected oesophageal cancer should be done with clinical responsibility retained by primary care?

Results

Literature search

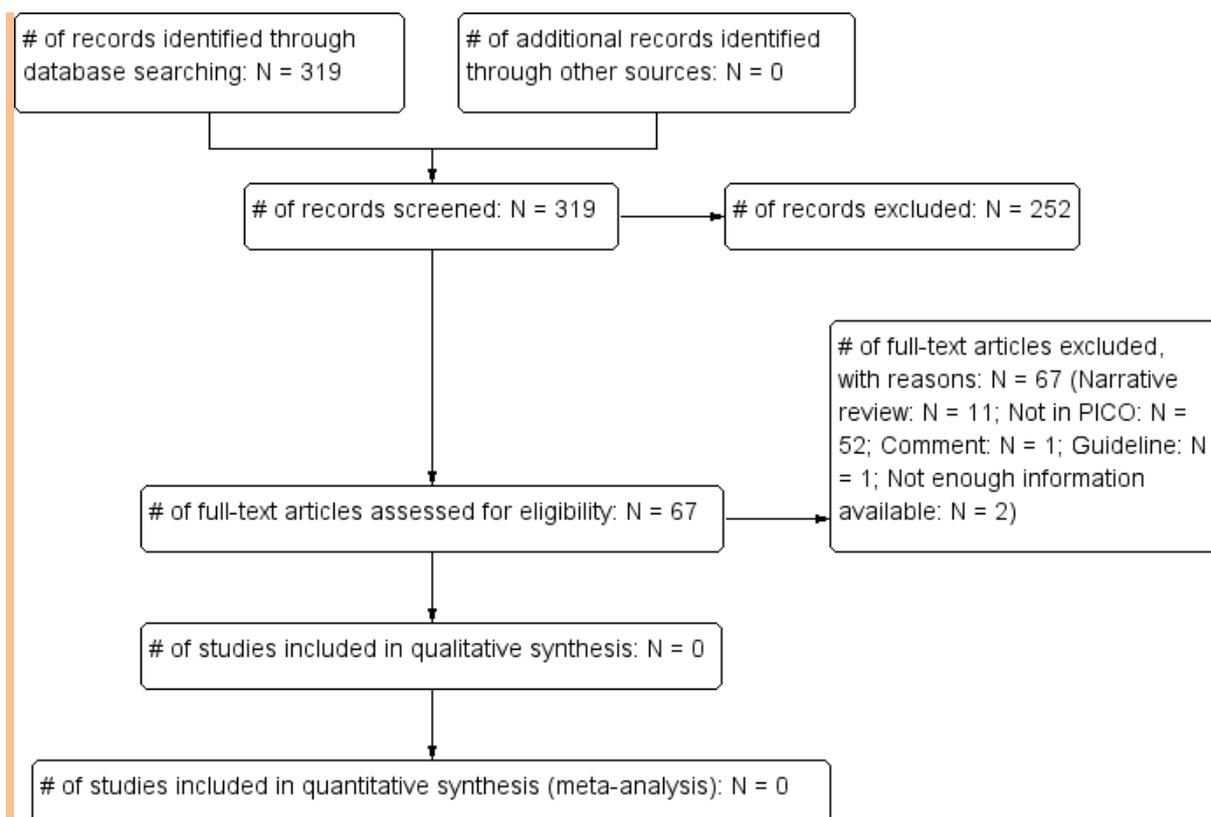
Database name	Dates Covered	No of references found	No of references retrieved	Finish date of search
<i>Medline</i>	1980-2013	339	136	04/06/2013
<i>Premedline</i>	1980-2013	46	16	04/06/2013
<i>Embase</i>	1980-2013	675	142	05/06/2013
<i>Cochrane Library</i>	1980-2013	29	7	05/06/2013
<i>Psychinfo</i>	1980-2013	1	0	05/06/2013
<i>Web of Science (SCI & SSCI) and ISI Proceedings</i>	1980-2013	176	45	05/06/2013

Total References retrieved (after de-duplication): 294

Update Search

Database name	Dates Covered	No of references found	No of references retrieved	Finish date of search
<i>Medline</i>	5/2013-20/08/2014	9	0	20/08/2014
<i>Premedline</i>	5/2013-20/08/2014	73	19	20/08/2014
<i>Embase</i>	5/2013-20/08/2014	34	10	20/08/2014
<i>Cochrane Library</i>	5/2013-20/08/2014	4	1	20/08/2014
<i>Web of Science (SCI & SSCI) and ISI Proceedings</i>	5/2013-20/08/2014	28	4	20/08/2014

Total References retrieved (after de-duplication): 25



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Study results

No evidence was identified pertaining to the diagnostic accuracy of upper gastrointestinal endoscopy, barium swallow or chest x-ray in patients with suspected oesophageal cancer where the clinical responsibility was retained by primary care.

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None

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38 Boccu, C., Bonoldi, E., Bottona, E., Bozzola, L., Canizzaro, R., Canzonieri, V., Caroli, A., Carta, A.,
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40 C., Donisi, P. M., Franceschi, M., Furlanetto, A., Germana, B., Grassi, S. A., Macor, V., Marcon, V.,
41 Marin, R., Meggiato, T., Melina, V., Menghi, A., Milan, R., Militello, C., Molena, D., Monica, F.,
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43 F., Pozzato, F., Ronzani, G., Rugge, M., Saggiaro, A., Stracca-Pansa, V., Togni, R., Valiante, F. &
44 Vianello, F. (2001) Prevalence of intestinal metaplasia in the distal oesophagus, oesophagogastric
45 junction and gastric cardia in symptomatic patients in north-east Italy: a prospective, descriptive
46 survey. The Italian Ulcer Study Group "GISU". *Digestive & Liver Disease*, 33: 316-321.
47 Not in PICO
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49 neoplasia. - *Journal of Digestive Diseases*, 15: 217-223.
50 Narrative review
51

PANCREATIC CANCER**Review question:**

What is the risk of pancreatic cancer in patients presenting in primary care with symptom(s)?

Results**Literature search**

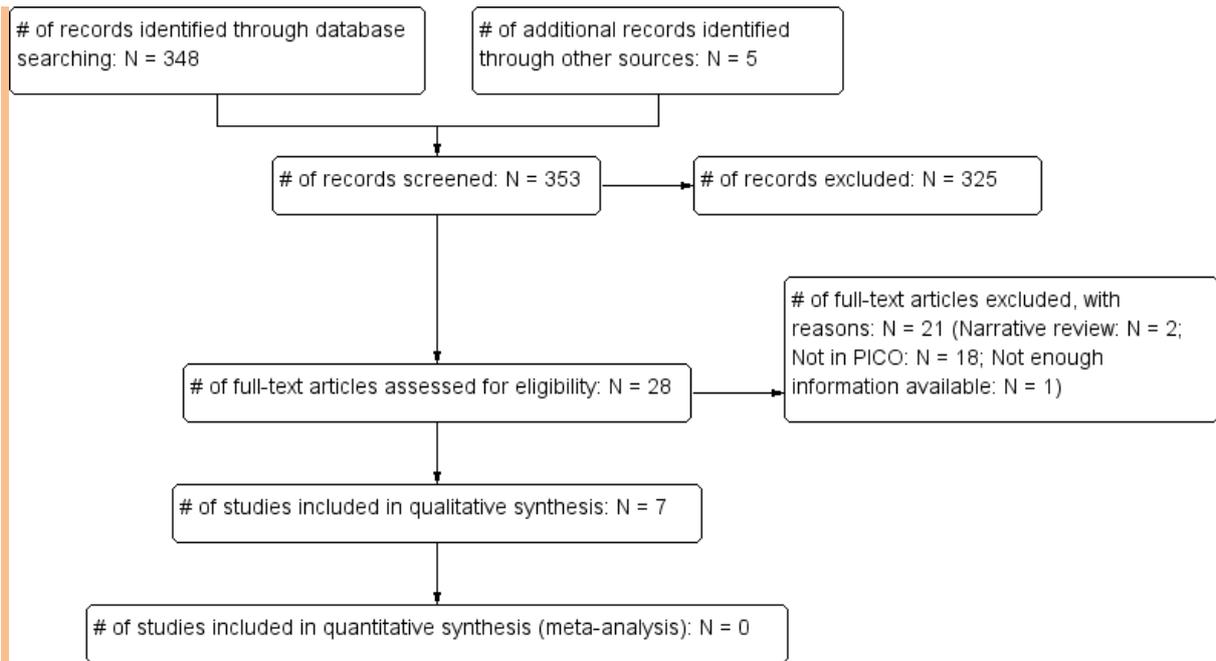
Database name	Dates Covered	No of references found	No of references retrieved	Finish date of search
<i>Medline</i>	All-2012	973	152	31/05/2013
<i>Premedline</i>	All-2012	130	19	31/05/2013
<i>Embase</i>	All-2012	1396	245	07/06/2013
<i>Cochrane Library</i>	All-2012	191	0	07/06/2013
<i>Psychinfo</i>	All-2012	29	6	31/05/2013
<i>Web of Science (SCI & SSCI) and ISI Proceedings</i>	All-2012	368	35	10/06/2013

Total References retrieved (after de-duplication): 331

Update Search

Database name	Dates Covered	No of references found	No of references retrieved	Finish date of search
<i>Medline</i>	5/2013-20/08/2014	48	2	20/08/2014
<i>Premedline</i>	5/2013-20/08/2014	90	4	20/08/2014
<i>Embase</i>	5/2013-20/08/2014	151	11	20/08/2014
<i>Cochrane Library</i>	5/2013-20/08/2014	60	0	20/08/2014
<i>Web of Science (SCI & SSCI) and ISI Proceedings</i>	5/2013-20/08/2014	55	2	20/08/2014

Total References retrieved (after de-duplication): 17



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Risk of bias in the included studies

The risk of bias and applicability concerns are summarised per study in the figure below. The main bias and applicability concerns to note in terms of patient selection were that this was not clearly consecutive or random in four of the studies, with three of these studies conducted in a setting that is not clearly directly representative of UK-based primary care. The other bias and applicability concerns to note include missing data, population with restricted age range, short follow up and underspecified presenting symptoms. These issues should all be born in mind when evaluating the evidence.

	<u>Risk of Bias</u>				<u>Applicability Concerns</u>		
	Patient Selection	Index Test	Reference Standard	Flow and Timing	Patient Selection	Index Test	Reference Standard
Collins (2013)	+	+	+	+	+	+	+
Hallissey (1990)	+	+	+	+	?	+	+
Hippisley-Cox (2012)	+	+	+	-	+	+	+
Mahadeva (2008)	?	+	+	+	-	+	+
Muris (1995)	-	+	+	+	-	-	+
Stapley (2012)	-	+	+	+	+	+	+
Tosetti (2010)	-	+	?	+	-	-	+

- High
 ? Unclear
 + Low

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3**Study results**

Table 1: Pancreatic cancer: Single symptoms

Study	Symptom(s)	Patient group	Positive predictive value % (95% CI)
Collins (2013)	Abdominal pain	All patients	0.14 (0.12-0.15)
		Women	0.1 (0.09-0.12)
		Men	0.19 (0.16-0.22)
Hippisley-Cox (2012)	Abdominal pain	All patients	0.3 (0.3-0.4)
Stapley (2012)	Abdominal pain	All patients	0.2 (0.19-0.22)
Stapley (2012)	Abdominal pain	Patients ≥ 60 years	0.3 (0.3-0.4)
Stapley (2012)	Abdominal pain (attended ≥ twice)	Patients ≥ 60 years	1 (0.8-1.2)
Hallissey (1990)	Dyspepsia	All patients	0.23 (0.09-0.53) 6/2585
Mahadeva (2008)	Dyspepsia	All patients (they were aged 18-45 years)	0.23 (0.01-1.49) 1/432
Hippisley-Cox (2012)	Abdominal distension	All patients	0.3 (0.1-0.5)
Collins (2013)	Abdominal distension	Women	0.16 (0.07-0.34)
Muris (1995)	Non-acute abdominal complaints	All patients	0.21 (0.04-0.86) 2/933
Hippisley-Cox (2012)	Dysphagia	All patients	0.2 (0.1-0.4)
Collins (2013)	Dysphagia	Men	0.1 (0.05-0.19)
Collins (2013)	Appetite loss	All patients	0.39 (0.26-0.59)
		Women	0.32 (0.17-0.59)
		Men	0.49 (0.27-0.86)
Hippisley-Cox (2012)	Appetite loss	All patients	0.8 (0.5-1.2)
Collins (2013)	Weight loss	All patients	0.28 (0.22-0.35)
		Women	0.16 (0.11-0.24)
		Men	0.42 (0.32-0.54)
Hippisley-Cox (2012)	Weight loss	All patients	0.6 (0.5-0.8)
Stapley (2012)	Weight loss	All patients	0.44 (0.36-0.55)
Stapley (2012)	Weight loss	Patients ≥ 60 years	0.8 (0.7-1)
Stapley (2012)	Nausea/vomiting	All patients	0.19 (0.17-0.21)
Stapley (2012)	Nausea/vomiting	Patients ≥ 60 years	0.3 (0.3-0.4)
Stapley (2012)	Back pain	All patients	0.06 (0.05-0.07)
Stapley (2012)	Back pain	Patients ≥ 60 years	0.1 (0.1-0.1)
Stapley (2012)	Back pain (attended ≥ twice)	Patients ≥ 60 years	0.2 (0.1-0.2)
Stapley (2012)	Constipation	All patients	0.1 (0.09-0.11)
Stapley (2012)	Constipation	Patients ≥ 60 years	0.2 (0.2-0.2)
Collins (2013)	Constipation	Males	0.21 (0.11-0.38)
Stapley (2012)	Diarrhoea	All patients	0.09 (0.08-0.11)
Stapley (2012)	Diarrhoea	Patients ≥ 60 years	0.2 (0.2-0.2)
Stapley (2012)	Malaise	All patients	0.12 (0.1-0.15)
Stapley (2012)	Malaise	Patients ≥ 60 years	0.2 (0.2-0.3)
Stapley (2012)	Jaundice	All patients	12.9 (7.89-27.1)
Stapley (2012)	Jaundice	Patients ≥ 60 years	21.6 (14-52)
Stapley (2012)	Jaundice (attended ≥ twice)	Patients ≥ 60 years	31.6 (NR)

Stapley (2012)	New-onset diabetes	All patients	0.09 (0.08-0.1)
Stapley (2012)	New-onset diabetes	Patients ≥ 60 years	0.2 (0.2-0.2)
Tosetti (2010)	Upper gastro-intestinal symptoms without alarming features	All patients	0.36 (0.02-2.33) 1/275
Stapley (2012)	Abnormal liver function	All patients	0.16 (0.15-0.17)
Stapley (2012)	Low haemoglobin	All patients	0.1 (0.09-0.11)
Stapley (2012)	Raised inflammatory markers	All patients	0.16 (0.15-0.17)
Stapley (2012)	The authors report that in patients ≥ 70 years the PPVs for most symptoms were 1.5-4.5 times higher than in patients < 70 years.		

1 Stapley (2012) calculated the positive predictive values using Bayesian statistics. Meta-analyses are
2 not undertaken as the Stapley data cannot be included due to the case-control design of the study.
3 NR = not reported.

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Table 2: Pancreatic cancer: Symptom combinations

Study	Symptom(s)	Patient group	Positive predictive value % (95% CI)
Stapley (2012)	Abdominal pain and back pain	Patients ≥ 60 years	0.4 (0.3-0.5)
Stapley (2012)	Abdominal pain and constipation	Patients ≥ 60 years	0.5 (0.4-0.7)
Stapley (2012)	Abdominal pain and malaise	Patients ≥ 60 years	0.6 (0.4-0.8)
Stapley (2012)	Abdominal pain and diarrhoea	Patients ≥ 60 years	0.4 (0.3-0.5)
Stapley (2012)	Abdominal pain and nausea/vomiting	Patients ≥ 60 years	0.9 (0.7-1.2)
Stapley (2012)	Abdominal pain and loss of weight	Patients ≥ 60 years	2.5 (1.5-4.4)
Stapley (2012)	Abdominal pain and new onset diabetes	Patients ≥ 60 years	0.9 (0.7-1.1)
Stapley (2012)	Abdominal pain and jaundice	Patients ≥ 60 years	15 (NR)
Stapley (2012)	Back pain and constipation	Patients ≥ 60 years	0.3 (0.2-0.4)
Stapley (2012)	Back pain and malaise	Patients ≥ 60 years	0.3 (0.2-0.6)
Stapley (2012)	Back pain and diarrhoea	Patients ≥ 60 years	0.2 (0.1-0.3)
Stapley (2012)	Back pain and nausea/vomiting	Patients ≥ 60 years	0.3 (0.2-0.5)
Stapley (2012)	Back pain and loss of weight	Patients ≥ 60 years	2 (1-4.3)
Stapley (2012)	Back pain and new onset diabetes	Patients ≥ 60 years	0.3 (0.2-0.4)
Stapley (2012)	Back pain and jaundice	Patients ≥ 60 years	8.9 (NR)
Stapley (2012)	Diarrhoea and constipation	Patients ≥ 60 years	0.2 (0.1-0.3)
Stapley (2012)	Diarrhoea and malaise	Patients ≥ 60 years	0.3 (0.1-0.5)
Stapley (2012)	Diarrhoea and nausea/vomiting	Patients ≥ 60 years	0.2 (0.2-0.3)

Stapley (2012)	Diarrhoea and loss of weight	Patients \geq 60 years	2.7 (NR)
Stapley (2012)	Diarrhoea and new onset diabetes	Patients \geq 60 years	0.4 (0.3-0.5)
Stapley (2012)	Diarrhoea and jaundice	Patients \geq 60 years	> 10*
Stapley (2012)	Constipation and malaise	Patients \geq 60 years	0.3 (0.2-0.5)
Stapley (2012)	Nausea/vomiting and malaise	Patients \geq 60 years	0.5 (0.3-0.8)
Stapley (2012)	Constipation and weight loss	Patients \geq 60 years	1.5 (0.8-3)
Stapley (2012)	Constipation and nausea/vomiting	Patients \geq 60 years	0.6 (0.4-0.8)
Stapley (2012)	Nausea/vomiting and weight loss	Patients \geq 60 years	2.2 (1.1-4.6)
Stapley (2012)	Weight loss and new onset diabetes	Patients \geq 60 years	1.6 (1-2.9)
Stapley (2012)	New onset diabetes and jaundice	Patients \geq 60 years	22.3 (NR)
Stapley (2012)	Constipation and new onset diabetes	Patients \geq 60 years	0.4 (0.3-0.6)
Stapley (2012)	Malaise and new onset diabetes	Patients \geq 60 years	0.5 (0.3-0.9)
Stapley (2012)	Nausea/vomiting and new onset diabetes	Patients \geq 60 years	0.7 (0.5-1)
Stapley (2012)	Weight loss and malaise	Patients \geq 60 years	0.9 (0.4-2.1)
Stapley (2012)	Jaundice and nausea/vomiting	Patients \geq 60 years	14.6 (NR)
Stapley (2012)	Jaundice and constipation	Patients \geq 60 years	>10*
Stapley (2012)	Jaundice and malaise	Patients \geq 60 years	>10*
Stapley (2012)	Jaundice and weight loss	Patients \geq 60 years	>10*

1 Stapley (2012) calculated the positive predictive values using Bayesian statistics. NR = not reported.
2 * > 40 cases and 0 controls had these symptoms.

3

4 **Evidence statement(s):**

5 For pancreatic cancer the positive predictive values of single symptoms (7 studies, N = 3146347)
6 presenting in primary care ranged from 0.06% (for back pain) to 21.6% (for jaundice). The included
7 studies were associated with 0-4 bias/applicability concerns (see also Table 1).

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9 For pancreatic cancer the positive predictive values of symptom combinations (1 study, N = 20094)
10 presenting in primary care ranged from 0.2% (for diarrhoea in combination with either constipation,
11 nausea/vomiting or back pain) to 22.3% (for new onset diabetes combined with jaundice). The
12 included study was associated with 1 bias concern (see also Table 2).

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14 **Evidence tables**

15 **Collins (2013)**

PATIENT SELECTION

A. risk of bias	
Patient sampling	Retrospective patient series using the THIN database.
Was a consecutive or random sample of patients enrolled?	Yes
Was a case-control design avoided?	Yes
Did the study avoid inappropriate exclusions?	Yes
Could the selection of patients have introduced bias?	Low risk
B. Concerns regarding applicability	
Patient characteristics and setting	<p>A total of 2150322 patients were identified from 364 practices.</p> <p><u>Symptoms:</u> Dysphagia (men only: N = 9326), abdominal pain (N = 255058; 106768 men, 148290 women), appetite loss (N = 6102; 2658 men, 3444 women), weight loss (N = 29464; 13484 men, 15980 women), abdominal distension (women only: N = 4457), constipation (men only, N = 5326).</p> <p><u>Incident cases of pancreatic cancer during the 2-year follow up period:</u> N = 618 (331 men, 287 women).</p> <p><u>Inclusion criteria:</u> Patients aged 30–84 years and registered with practices between 1 January 2000 and 30 June 2008. Entry to the cohort was defined as the latest of the study start date; the date the patient registered with the practice; and for those patients with red flag symptoms (see below), the date of the first recorded onset within the study period.</p> <p><u>Exclusion criteria:</u> Patients with a prior diagnosis of pancreatic cancer, registration < 12 months with the general practice, or invalid dates.</p> <p><u>Clinical setting:</u> Primary care, UK</p>
Are there concerns that the included patients and setting do not match the review question?	Low concern
INDEX TEST	
A. Risk of bias	
Index test	'Red-flag' symptoms: Dysphagia (men only), loss of appetite, weight loss, abdominal pain, abdominal distension (women only), and constipation (men only).
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes
Could the conduct or interpretation of the index test have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the index test, its conduct, or interpretation differ from the review question?	Low concern
REFERENCE STANDARD	
A. risk of bias	
Reference standard(s)	2-year follow up
Is the reference standard likely to correctly classify the target condition?	Yes
Were the reference standard results interpreted without knowledge of the results of the index tests?	Unclear
Could the reference standard, its conduct, or its interpretation have introduced bias?	Low risk

B. Concerns regarding applicability		
Are there concerns that the target condition as defined by the reference standard does not match the question?		Low concern
FLOW AND TIMING		
A. risk of bias		
Flow and timing	All patients seem to be accounted for	
Was there an appropriate interval between index test and reference standard?		Yes
Did all patients receive the same reference standard?		Yes
Were all patients included in the analysis?		Yes
Could the patient flow have introduced bias?		Low risk
NOTES		
1		
2 Hallissey (1990)		
PATIENT SELECTION		
A. risk of bias		
Patient sampling	Prospective consecutive patient series from a group of 10 general practices in England.	
Was a consecutive or random sample of patients enrolled?		Yes
Was a case-control design avoided?		Yes
Did the study avoid inappropriate exclusions?		Yes
Could the selection of patients have introduced bias?		Low risk
B. Concerns regarding applicability		
Patient characteristics and setting	N = 2585 aged > 40 years. No other information reported. The patient group was equally divided between new patients with dyspepsia, old patients with uninvestigated dyspepsia, and old patients with investigated dyspepsia. <u>Inclusion criteria:</u> All patients over 40 years making their first attendance during the study period (4 years and 9 months) with any degree of dyspepsia <u>Exclusion criteria:</u> None listed. <u>Clinical setting:</u> Primary care, England.	
Are there concerns that the included patients and setting do not match the review question?		Unclear concern
INDEX TEST		
A. Risk of bias		
Index test	Dyspepsia of any degree	
Were the index test results interpreted without knowledge of the results of the reference standard?		Yes
Could the conduct or interpretation of the index test have introduced bias?		Low risk
B. Concerns regarding applicability		
Are there concerns that the index test, its conduct, or interpretation differ from the review question?		Low concern
REFERENCE STANDARD		
A. risk of bias		
Reference standard(s)	Upper gastrointestinal endoscopy within 4 weeks and follow up.	

Is the reference standard likely to correctly classify the target condition?	Yes
Were the reference standard results interpreted without knowledge of the results of the index tests?	No
Could the reference standard, its conduct, or its interpretation have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the target condition as defined by the reference standard does not match the question?	Low concern
FLOW AND TIMING	
A. risk of bias	
Flow and timing	2659 patients were seen and 2585 attended for investigation
Was there an appropriate interval between index test and reference standard?	Yes
Did all patients receive the same reference standard?	Yes
Were all patients included in the analysis?	Yes
Could the patient flow have introduced bias?	Low risk
NOTES	Malignancy was detected in 115 patients: Gastric adenocarcinoma (57), gastric lymphoma (1; added to the gastric adenocarcinoma data in the PPV), oesophageal cancer (15), colorectal (14), pancreatic (6), bronchial (8), prostatic (2), duodenal (1, also added to the gastric carcinoma data in the PPV), liver (1), gall bladder (1), carcinoid (1), uterine (1), leukaemia (1), carcinomatosis of unknown primary (7).
1	
2	Hippisley-Cox (2012)
PATIENT SELECTION	
A. risk of bias	
Patient sampling	Prospective patient series using patients in the QResearch database (version 30).
Was a consecutive or random sample of patients enrolled?	Yes
Was a case-control design avoided?	Yes
Did the study avoid inappropriate exclusions?	Yes
Could the selection of patients have introduced bias?	Low risk
B. Concerns regarding applicability	
Patient characteristics and setting	A total of 1243740 patients were identified from 189 practices (624352 males, 619388 females), mean (SD) age = 50.1 (14.9) years, mean (SD) Townsend score = -0.2 (3.6). Current symptoms and symptoms in the preceding year: Current dysphagia (N = 8507), current abdominal pain (N = 129924), current abdominal distension (N = 4929), current appetite loss (N = 5567), current weight loss (N = 14686), constipation in the last year (N = 8476), diarrhoea in the last year (N = 12233), tiredness in the last year (N = 12688), itching in the last year (N = 1454), haemoglobin recoded in the last year (N = 214497), haemoglobin < 11 g/dl in the last year (N = 16172). Incident cases of pancreatic cancer during the 2-year follow up period: N = 781.

	<p>Inclusion criteria: All practices in England and Wales that had been using their Egton Medical Information Systems (EMIS) computer system for \geq a year were included. Two-thirds of practices were randomly allocated to the derivation dataset and the remaining practices were allocated to the validation dataset. An open cohort of patients aged 30–84 years was identified, drawn from patients registered with practices between 1 January 2000 and 30 September 2010. Entry to the cohort was defined as the latest of the study start date (1 January 2000) and 12 months after the patient registered with the practice, ensuring that all patients had \geq 12 months' registration prior to study entry. For patients with incident haematuria, appetite loss, weight loss, or abdominal pain, the entry date was the date of the first consultation with the symptom within the study period. <i>The relevant data for the present purposes is only available for the validation cohort, therefore only information pertaining to these patients will be reported.</i></p> <p>Exclusion criteria: Patients without a postcode-related Townsend score, patients with a history of pancreatic cancer at baseline, and patients with a recorded 'red-flag' (see "Definition of symptom" below) symptom in the 12 months prior to the study entry date.</p> <p>Clinical setting: Primary care</p>
Are there concerns that the included patients and setting do not match the review question?	Low concern
INDEX TEST	
A. Risk of bias	
Index test	'Red-flag' symptoms were defined as symptoms that might alarm the patient and also indicate the presence of pancreatic cancer; that is, symptoms of dysphagia, loss of appetite, weight loss, abdominal distension or abdominal pain.
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes
Could the conduct or interpretation of the index test have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the index test, its conduct, or interpretation differ from the review question?	Low concern
REFERENCE STANDARD	
A. risk of bias	
Reference standard(s)	Pancreatic cancer, which was defined as incident diagnosis of pancreatic cancer during the 2 years after study entry, recorded either on the patient's GP record using the relevant UK diagnostic Read Codes, or their linked Office for National Statistics cause-of-death record, using the relevant ICD-9 code (157) or ICD-10 diagnostic codes (C25).
Is the reference standard likely to correctly classify the target condition?	Yes
Were the reference standard results interpreted without knowledge of the results of the index tests?	Unclear
Could the reference standard, its conduct, or its interpretation have introduced bias?	Low risk
B. Concerns regarding applicability	

Are there concerns that the target condition as defined by the reference standard does not match the question?		Low concern
FLOW AND TIMING		
A. risk of bias		
Flow and timing	A total of 1342329 patients were initially identified of whom 98589 patients were excluded for the following reasons: No recorded Townsend score (N = 70847), history of pancreatic cancer (N = 96), and \geq one 'red flag' symptom recorded in the 12 months prior to study entry (N = 27646), leaving 1243740 patients. However, data is presented for 971706 / 1243740 patients. The missing data does not appear to include any of the cancer cases, but it is unclear whether some of the missing data includes symptomatic patients, i.e., false positives.	
Was there an appropriate interval between index test and reference standard?	Yes	
Did all patients receive the same reference standard?	Yes	
Were all patients included in the analysis?	No	
Could the patient flow have introduced bias?	High risk	
NOTES		
1 2 Mahadeva (2008)		
PATIENT SELECTION		
A. risk of bias		
Patient sampling	Prospective patient series from the Primary Care Clinics of the University of Malaya in Malaysia	
Was a consecutive or random sample of patients enrolled?	Unclear	
Was a case-control design avoided?	Yes	
Did the study avoid inappropriate exclusions?	Unclear	
Could the selection of patients have introduced bias?	Unclear risk	
B. Concerns regarding applicability		
Patient characteristics and setting	N = 432; 198 males/234 females; mean ages (SDs) = 30-31 (8) years. <u>Inclusion criteria</u> : "All patients were recruited from the Primary Care Clinics of the University of Malaya, which provide a regular service to the local community. Patients aged \leq 45 years presenting with uninvestigated dyspepsia were invited to participate in the study", which ran from January 2004 until October 2005. <u>Exclusion criteria</u> : Age > 45 or < 18 years; symptoms of weight loss, progressive dysphagia or those suggestive of anaemia; pregnancy; previous H pylori testing; any contra-indication to endoscopy or sedation; failure to turn up for initial test ; and on regular doses of non-steroidal anti-inflammatory drugs. <u>Clinical setting</u> : Primary care clinic, Malaysia	
Are there concerns that the included patients and setting do not match the review question?	High concern	
INDEX TEST		
A. Risk of bias		
Index test	Uninvestigated dyspepsia. Dyspepsia defined as predominant upper abdominal discomfort for > 4 weeks, with any associated symptoms,	

	including heart burn and regurgitation.	
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes	
Could the conduct or interpretation of the index test have introduced bias?	Low risk	
B. Concerns regarding applicability		
Are there concerns that the index test, its conduct, or interpretation differ from the review question?	Low concern	
REFERENCE STANDARD		
A. risk of bias		
Reference standard(s)	Follow up ± upper endoscopy (oesophagogastroduodenoscopy)	
Is the reference standard likely to correctly classify the target condition?	Yes	
Were the reference standard results interpreted without knowledge of the results of the index tests?	No	
Could the reference standard, its conduct, or its interpretation have introduced bias?	Low risk	
B. Concerns regarding applicability		
Are there concerns that the target condition as defined by the reference standard does not match the question?	Low concern	
FLOW AND TIMING		
A. risk of bias		
Flow and timing	39/471 eligible patients were excluded from the study for the following reasons: 34/39 patients declined to participate, 3/39 became pregnant before the test, 1/39 emigrated from the country and 1/39 had missing data.	
Was there an appropriate interval between index test and reference standard?	Yes	
Did all patients receive the same reference standard?	Yes	
Were all patients included in the analysis?	Yes	
Could the patient flow have introduced bias?	Low risk	
NOTES	One patient was found to have cancer, which was metastatic pancreatic cancer. No oesophageal or gastric cancers were reported.	
1		
2	Muris (1995)	
PATIENT SELECTION		
A. risk of bias		
Patient sampling	Prospective patient series from 80/460 general practitioners in Limburg (Holland)	
Was a consecutive or random sample of patients enrolled?	No	
Was a case-control design avoided?	Yes	
Did the study avoid inappropriate exclusions?	Unclear	
Could the selection of patients have introduced bias?	High risk	
B. Concerns regarding applicability		
Patient characteristics and	N = 933; 335 males, 598 females; age range = 18-75, aged > 30 years: N = 712, aged > 40 years: N = 517, aged > 60 years: N = 171.	

setting	Inclusion criteria: Patients who in 1989 consulted one of the participating GPs for new abdominal complaints lasting ≥ 2 weeks and with whom the GPs had a diagnostic problem. Exclusion criteria: None listed. Clinical setting: GPs in Holland
Are there concerns that the included patients and setting do not match the review question?	High concern
INDEX TEST	
A. Risk of bias	
Index test	New abdominal complaints lasting ≥ 2 weeks. Not further specified.
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes
Could the conduct or interpretation of the index test have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the index test, its conduct, or interpretation differ from the review question?	High concern
REFERENCE STANDARD	
A. risk of bias	
Reference standard(s)	Follow up for ≥ 12 months (mean = 18 months).
Is the reference standard likely to correctly classify the target condition?	Yes
Were the reference standard results interpreted without knowledge of the results of the index tests?	No
Could the reference standard, its conduct, or its interpretation have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the target condition as defined by the reference standard does not match the question?	Low concern
FLOW AND TIMING	
A. risk of bias	
Flow and timing	All patients appear to be accounted for
Was there an appropriate interval between index test and reference standard?	Unclear
Did all patients receive the same reference standard?	Yes
Were all patients included in the analysis?	Yes
Could the patient flow have introduced bias?	Low risk
NOTES	Cancers diagnosed in these patients were: Stomach (2/933), pancreas (2/933), trachea/bronchus/lung (2/933), kidney (1/933), colorectal (4/933), cervix (1/933), other cancer of the female genital system (2/933), and other and unspecified sites (2/933).
1	
2	Stapley (2012)
PATIENT SELECTION	
A. risk of bias	

Patient sampling	Matched case-control study using patients in the UK's General Practice Research Database (GPRD).	
Was a consecutive or random sample of patients enrolled?	No	
Was a case-control design avoided?	No	
Did the study avoid inappropriate exclusions?	Yes	
<i>For diagnostic case-control studies:</i> Attempts were made within the design or analysis to balance the comparison groups for potential confounders?	Yes	
<i>For diagnostic case-control studies:</i> The groups were comparable at baseline, including all major confounding and prognostic factors?	Yes	
Could the selection of patients have introduced bias?	High risk	
B. Concerns regarding applicability		
Patient characteristics and setting	<p><u>Cases:</u> N = 3635, 1743 males / 1892 females; median number of consultations = 18 (IQR = 11-27); aged 40-49 years: N = 107; 50-59 years: N = 529; 60-69 years: N = 829; 70-79 years: N = 1212; ≥ 80 years: N = 958; UK.</p> <p><u>Controls:</u> N = 16459, gender not reported; median number of consultations = 9 (IQR = 4-15); aged 40-49 years: N = 422; 50-59 years: N = 2239; 60-69 years: N = 3755; 70-79 years: N = 5702; ≥ 80 years: N = 4341; UK.</p> <p><u>Inclusion criteria:</u> Cases: Patients with a record of one of 25 GPRD pancreatic cancer codes between January 2000 and December 2009 inclusive, aged ≥ 40 years, with min. 1 year of data before diagnosis. The first instance of a pancreatic cancer code was assigned the data of diagnosis/index date. Controls: Up to 5 controls were matched to cases on sex, general practice, and to 1 year of age of the case. The index date was the index date of the matched case.</p> <p><u>Exclusion criteria:</u> Pancreatic cancer (controls), no consultations in the year before diagnosis.</p> <p><u>Clinical setting:</u> Primary care</p>	
Are there concerns that the included patients and setting do not match the review question?	Low concern	
INDEX TEST		
A. Risk of bias		
Index test	<p>All symptoms, physical signs or abnormal investigations compiled from the pancreatic cancer literature were studied, and supplemented by discussion with two pancreatic cancer charities. Libraries of codes relating to these were collated. All codes for fractures were also identified, as a test for any recording bias between cases and controls (making the assumption that the fracture rate would be approximately equal). Occurrences of these features in the year before the index date were identified. Features were only retained for further study if they occurred in ≥5% of cases or controls. Repeat attendances with the same symptom were also retained if the subsequent consultation also occurred in ≥5% of cases or controls. New-onset diabetes was defined as a code for diabetes, or a random blood glucose above the local laboratory's normal range, without similar codes more than 1 year before the index date. For laboratory tests, patients without a test were</p>	

	considered to be the same status as those with a normal result, making our binary variable abnormal result/ no abnormal result. Abnormal liver function was defined as any liver enzyme above the normal range, and raised inflammatory markers as either abnormal erythrocyte sedimentation rate or C-reactive protein, as there were too few plasma viscosity results.
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes
<i>For diagnostic case-control studies:</i> Investigators were kept 'blind' to other important confounding and prognostic factors?	Yes
Could the conduct or interpretation of the index test have introduced bias?	Low risk
<u>B. Concerns regarding applicability</u>	
Are there concerns that the index test, its conduct, or interpretation differ from the review question?	Low concern
REFERENCE STANDARD	
<u>A. risk of bias</u>	
Reference standard(s)	Pancreatic cancer code in the UK's General Practice Research Database.
Is the reference standard likely to correctly classify the target condition?	Yes
Were the reference standard results interpreted without knowledge of the results of the index tests?	Unclear
Could the reference standard, its conduct, or its interpretation have introduced bias?	Low risk
<u>B. Concerns regarding applicability</u>	
Are there concerns that the target condition as defined by the reference standard does not match the question?	Low concern
FLOW AND TIMING	
<u>A. risk of bias</u>	
Flow and timing	A total of 21624 patients were identified, 17977 controls and 3647 cases. Of the controls the following exclusions were applied: pancreatic cancer (N = 64), case excluded (N = 40), and no data in year pre-index date (N = 1414). Of the cases the following exclusions were applied: No controls (N = 2), and cancer not of pancreatic origin (N = 10).
Was there an appropriate interval between index test and reference standard?	Yes
Did all patients receive the same reference standard?	Yes
Were all patients included in the analysis?	Yes
Could the patient flow have introduced bias?	Low risk
NOTES	
1	
2	Tosetti (2010)
PATIENT SELECTION	
<u>A. risk of bias</u>	
Patient sampling	Prospective patient series from 63 general practitioners in Italy
Was a consecutive or random sample of patients enrolled?	Unclear

Was a case-control design avoided?	Yes
Did the study avoid inappropriate exclusions?	Unclear
Could the selection of patients have introduced bias?	High risk
<u>B. Concerns regarding applicability</u>	
Patient characteristics and setting	N = 275; 124 males, 151 females; median age (range) = 46 (18-92) years. Symptoms: Epigastric pain (72%), prolonged digestion (51.6%), heartburn (49.1%), epigastric postprandial fullness (45.5%), epigastric distension (41.5%), nausea (38.5%), acid regurgitation (34.5%), belching (28.7%), early satiety (20.7%). <u>Inclusion criteria</u> : "Each GP enrolled in the survey patients who, over a three-month period, presented with UGI [upper gastro-intestinal] symptoms at the first onset without alarming features." <u>Exclusion criteria</u> : "Patients with either previous or recurrent complaints or previously investigated for UGI symptoms were not included". <u>Clinical setting</u> : GPs in Italy
Are there concerns that the included patients and setting do not match the review question?	High concern
INDEX TEST	
<u>A. Risk of bias</u>	
Index test	New onset UGI symptoms without alarming features. Not further specified.
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes
Could the conduct or interpretation of the index test have introduced bias?	Low risk
<u>B. Concerns regarding applicability</u>	
Are there concerns that the index test, its conduct, or interpretation differ from the review question?	High concern
REFERENCE STANDARD	
<u>A. risk of bias</u>	
Reference standard(s)	1-year follow up.
Is the reference standard likely to correctly classify the target condition?	Unclear
Were the reference standard results interpreted without knowledge of the results of the index tests?	No
Could the reference standard, its conduct, or its interpretation have introduced bias?	Unclear risk
<u>B. Concerns regarding applicability</u>	
Are there concerns that the target condition as defined by the reference standard does not match the question?	Low concern
FLOW AND TIMING	
<u>A. risk of bias</u>	
Flow and timing	All patients appear to be accounted for
Was there an appropriate interval between index test and reference standard?	Unclear
Did all patients receive the same reference standard?	Yes

Were all patients included in the analysis?	Yes
Could the patient flow have introduced bias?	Low risk
NOTES	Cancers diagnosed in these patients were: Pancreas (1/275), and oesophageal (1/275).

1

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24

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Review question:

Which investigations of symptoms of suspected pancreatic cancer should be done with clinical responsibility retained by primary care?

Results

Literature search

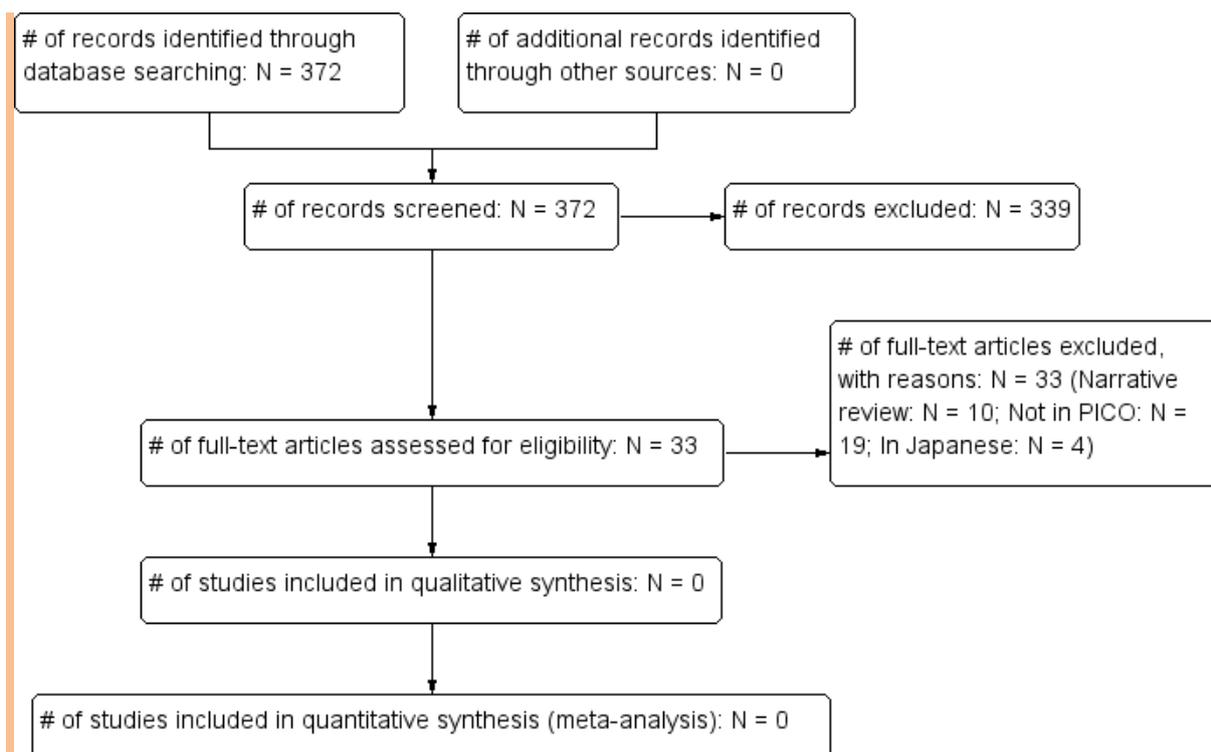
Database name	Dates Covered	No of references found	No of references retrieved	Finish date of search
<i>Medline</i>	1980-2013	951	257	14/06/2013
<i>Premedline</i>	1980-2013	81	3	14/06/2013
<i>Embase</i>	1980-2013	1407	132	14/06/2013
<i>Cochrane Library</i>	1980-2013	67	12	14/06/2013
<i>Psychinfo</i>	1980-2013	1	0	14/06/2013
<i>Web of Science (SCI & SSCI) and ISI Proceedings</i>	1980-2013	42	10	14/06/2013

Total References retrieved (after de-duplication): 339

Update Search

Database name	Dates Covered	No of references found	No of references retrieved	Finish date of search
<i>Medline</i>	6/2013-20/08/2014	42	12	20/08/2014
<i>Premedline</i>	6/2013-20/08/2014	93	16	20/08/2014
<i>Embase</i>	6/2013-20/08/2014	24	6	20/08/2014
<i>Cochrane Library</i>	6/2013-20/08/2014	9	1	20/08/2014
<i>Web of Science (SCI & SSCI) and ISI Proceedings</i>	6/2013-20/08/2014	4	2	20/08/2014

Total References retrieved (after de-duplication): 33



1

2 **Study results**

3 No evidence was identified pertaining to the diagnostic accuracy of CT scan, ultrasound, MRI, CEA,
 4 Beta hCG or tumour markers CA19-9 and CA72-4 in patients with suspected pancreatic cancer where
 5 the clinical responsibility was retained by primary care.

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STOMACH CANCER**Review question:**

What is the risk of stomach cancer in patients presenting in primary care with symptom(s)?

Results**Literature search**

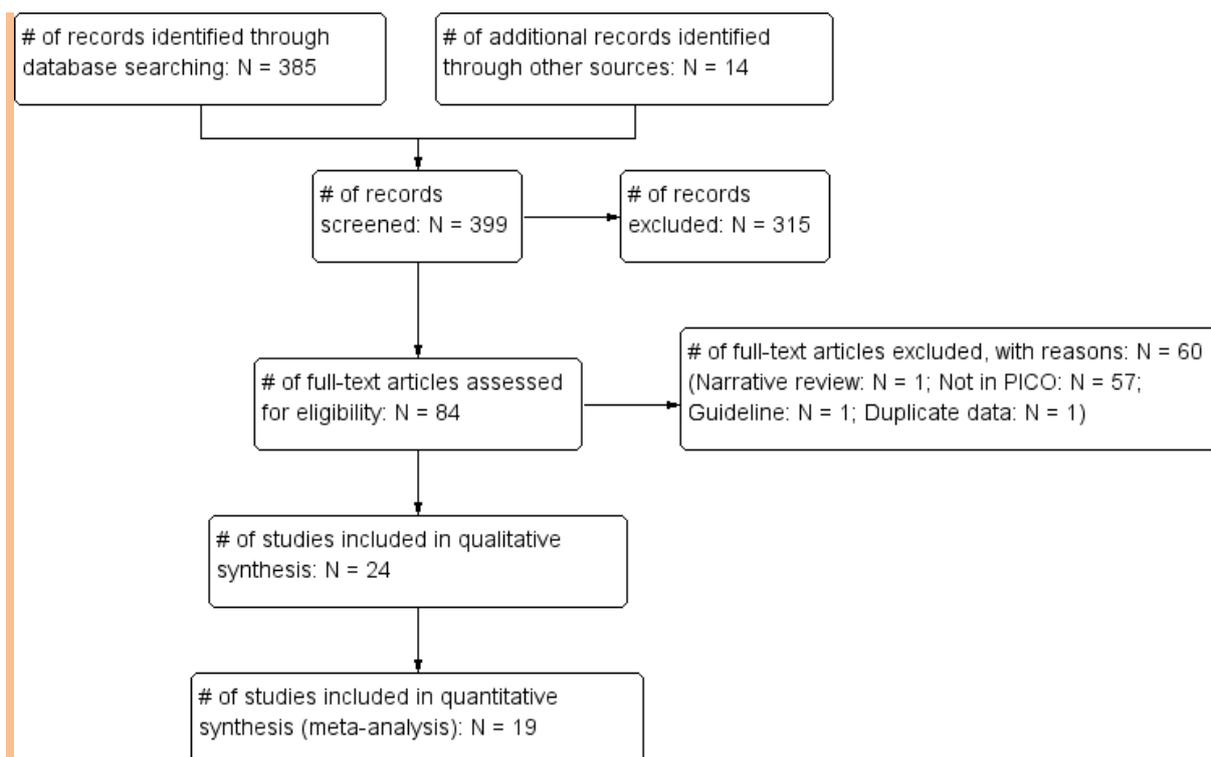
Database name	Dates Covered	No of references found	No of references retrieved	Finish date of search
Medline	All-2012	965	199	20/05/2013
Premedline	All-2012	108	33	21/05/2013
Embase	All-2012	1500	227	24/05/2013
Cochrane Library	All-2012	215	0	28/05/2013
Psychinfo	All-2012	13	2	21/05/2013
Web of Science (SCI & SSCI) and ISI Proceedings	All-2012	436	58	28/05/2013

Total References retrieved (after de-duplication): 369

Update Search

Database name	Dates Covered	No of references found	No of references retrieved	Finish date of search
<i>Medline</i>	5/2013-26/08/2014	43	5	26/08/2014
<i>Premedline</i>	5/2013-26/08/2014	82	10	26/08/2014
<i>Embase</i>	5/2013-26/08/2014	109	5	26/08/2014
<i>Cochrane Library</i>	5/2013-26/08/2014	88	0	26/08/2014
<i>Web of Science (SCI & SSCI) and ISI Proceedings</i>	5/2013-26/08/2014	101	0	26/08/2014

Total References retrieved (after de-duplication): 16



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Risk of bias in the included studies

The risk of bias and applicability concerns are summarised per study in the figure below. The main bias and validity issues to note relates to patient selection and applicability with some studies employing non-consecutive patient sampling, e.g., case-control designs (which has been shown to be associated with inflated test accuracy parameters compared to designs that incorporate random or consecutive patient selection), and others being conducted in a setting that may not directly translate to UK-based primary care. The other main issues of concern relates to missing data (and the concern that this may not be missing at random) and under specification of symptoms and reference standards, which makes it difficult to ascertain their applicability and/or validity. The evidence base is also limited by the fact that some of the positive predictive value estimates are based on low numbers of patients and a number of the studies do not provide different estimates for stomach and oesophageal cancer, but only provide one estimate for these cancers combined.

	Risk of Bias				Applicability Concerns		
	Patient Selection	Index Test	Reference Standard	Flow and Timing	Patient Selection	Index Test	Reference Standard
Brignoli (1997)	?	+	-	+	?	+	+
Collins (2012)	+	+	+	+	+	+	+
Droogendijk (2011)	+	+	+	?	?	+	+
Duggan (2008)	?	+	+	+	+	+	+
Edenholm (1985)	?	+	+	-	?	+	+
Esfandyari (2002)	+	+	+	+	-	+	+
Farrus Palou (2000)	+	+	?	-	?	+	?
Hallissey (1990)	+	+	+	+	?	+	+
Hansen (1998)	+	+	+	?	?	+	+
Heikkinen (1995)	+	+	+	+	?	+	+
Hippisley-Cox (2011)	+	+	+	?	+	+	+
Jaskiewicz (1991)	?	+	+	+	?	?	+
Jones (2007)	+	+	+	+	+	+	+
Kagevi (1989)	+	+	+	+	?	+	+
Mahadeva (1998)	?	+	+	+	-	+	+
Meineche-Schmidt (2002)	+	+	+	+	?	+	+
Muris (1993)	+	+	+	+	?	?	+
Møllmann (1981)	+	+	?	-	?	+	+
Stapley (2013)	-	+	+	+	+	+	+
Stellon (1997)	+	+	+	+	+	+	+
Thomson (2003)	?	+	+	+	?	+	+
Tosetti (2010)	-	+	?	+	-	-	+
Vakil (2009)	?	+	+	+	+	+	+
Yates (2004)	+	+	+	+	?	+	+

- High
 ? Unclear
 + Low

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Study results

Table 1: Stomach cancer: Meta-analyses

Studies included	Symptom(s)	Patient group	Positive predictive value, % (95% CI)

Collins (2012) Hippisley-Cox (2011) Møllmann (1981)	Abdominal pain	All patients N = 3389979	0.34 (0.16-0.71)
Collins (2012) Droogendijk (2011) Farrus Palou (2000) Hippisley-Cox (2011) Stellon (1997) Yates (2004)	Anaemia	All patients N = 3375342	1.09 (0.67-1.77)
Brignoli (1997) Duggan (2008) Edenholm (1985) Hallissey (1990) Hansen (1998) Heikkinen (1995) Jaskiewicz (1991) Kagevi (1989) Meineche-Schmidt (2002) Thomson (2003) Vakil (2009)	Dyspepsia	All patients N = 11403	0.65 (0.33-1.3)
Collins (2012) Esfandyari (2002) Hippisley-Cox (2011) Jones (2007)	Dysphagia	All patients N = 4136936	3.6 (1.58-8.01)

1 Please note that the data from Stapley (2013) are not included in these meta-analyses due to the
2 case-control design of the study, and the data from Mahadeva (1998) is not included due to the
3 limited and different age range of the population. These data are instead reported in the table below
4 entitled "Additional results reported by the individual papers: Single symptoms". When the number
5 of studies was < 3, the data were not meta-analysed, but presented for the individual studies
6 instead.

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Table 2: Stomach cancer: Individual positive predictive values from the meta-analyses

Study	Symptom(s)	Patient group	PPVs % (95% CI); prevalence
Collins (2012)	Abdominal pain	All patients	0.2 (0.2-0.2) 437/246998
Hippisley-Cox (2011)	Abdominal pain	All patients	0.3 (0.3-0.4) 309/91627
Møllmann (1981)	Upper abdominal pain > 2 weeks	All patients	1 (0.4-2.4) 6/577
Collins (2012)	Anaemia	All patients	0.6 (0.5-0.8) 116/18355
Droogendijk (2011)	Anaemia	All patients	1.04 (0.27-3.28) 3/287
Farrus Palou (2000)	Anaemia	All patients	1.7 (0.09-10.5) 1/58
Hippisley-Cox (2011)	Anaemia	All patients	1.1 (1-1.4) 119/10349
Stellon (1997)	Anaemia	All patients (N = 26)	0 (0-16)

			0/26
Yates (2004)	Anaemia	All patients	2.55 (1.35-4.66) 11/431 has UGI cancer: No distinction made between the different kinds
Brignoli (1997)	Dyspepsia	All patients	0.4 (0.09-1.14) 3/828
Duggan (2008)	Dyspepsia	All patients	0.27 (0.05-1.1) 2/753
Edenholm (1985)	Persisten epigastric pain/ulcer-like dyspepsia	All patients who received an UGI endoscopy	1.2 (0.21-4.77) 2/165
Hallissey (1990)	Dyspepsia	All patients	2.28 (1.76-3) 59/2585
Hansen (1998)	Dyspepsia	All patients	1 (0.4-2.2) 6/612
Heikkinen (1995)	Dyspepsia	All patients	1.75 (0.8-3.7) 7/400
Jaskiewicz (1991)	Dyspepsia	All included patients	2.7 (1.6-4.5) 16/585
Kagevi (1989)	Dyspepsia	All included patients	1.16 (0.2-4.6) 2/172
Meineche-Schmidt (2002)	Dyspepsia	All patients	0.54 (0.25-1.1) 8/1491
Thomson (2003)	Dyspepsia	All patients	0.1 (0.01-0.6) 1/1040
Vakil (2009)	Dyspepsia without alarm symptoms	All included patients	0.1 (0.03-0.35) 3/2741
Collins (2012)	Dysphagia	All patients	4.2 (3.9-4.5) 810/19237
Esfandyari (2002)	Dysphagia	All patients	6 (2.5-13.1) 6/100
Hippisley-Cox (2011)	Dysphagia	All patients	7.8 (7.1-8.5) 434/5590
Jones (2007)	Dysphagia	All patients	0.78 (0.58-1.05) 47/5999

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Table 3: Stomach cancer: Additional results reported by the individual papers: Single symptoms

Study	Symptom(s)	Patient group	Positive predictive value, % (95% CI)
Tosetti (2010)	Upper gastro-intestinal symptoms without alarming features	All patients	0 (0-1.7) 0/275
Muris (1993)	Non-acute abdominal complaints	All patients	0 (0-0.8) 0/578
Collins (2012)	Abdominal pain	Women	0.1 (0.1-0.1) 139/144266
		Men	0.3 (0.3-0.3) 298/102732

Stapley (2013)	Abdominal pain	Patients ≥ 55 years	0.3 (0.2-0.3)
Stapley (2013)	Epigastric pain	Patients ≥ 55 years	0.9 (0.8-1)
Collins (2012)	Anaemia	Women	0.4 (0.3-0.5) 49/13792
		Men	1.5 (1.1-1.9) 67/4563
Møllmann (1981)	Anaemia	Men	0 (0-44) 0/7
Stapley (2013)	Low haemoglobin	Patients ≥ 55 years	0.2 (0.2-109)
Jaskiewicz (1991)	Dyspepsia	Males	3.4 (1.8-6) 12/355
		Females	1.7 (0.6-4.7) 4/230
Stapley (2013)	Dyspepsia	Patients ≥ 55 years	0.7 (0.6-0.7)
Stapley (2013)	Dyspepsia (reported ≥ twice)	Patients ≥ 55 years	1.2 (1-1.5)
Vakil (2009)	Dyspepsia without alarm symptoms	Patients ≥ 45 years old	0.27 (0.07-0.84) 3/1127
		Patients ≥ 50 years old	0.36 (0.09-1.15) 3/829
		Patients ≥ 55 years old	0 (0-0.86) 0/554
		Patients ≥ 60 years old	0 (0-1.47) 0/323
Hansen (1998)	Ulcer-like dyspepsia	All patients	0.6 (0.03-3.9) 1/161
Hansen (1998)	Dysmotility-like dyspepsia	All patients	0 (0-2.9) 0/163
Hansen (1998)	Reflux-like dyspepsia	All patients	1.16 (0.2-4.6) 2/173
Hansen (1998)	Unclassifiable dyspepsia	All patients	0.9 (0.05-5.8) 1/107
Mahadeva (2008)	Dyspepsia	All patients (they were aged 18-45 years)	0 (0-1.1) 0/432
Collins (2012)	Dysphagia	Women	2.5 (2.2-2.8) 262/10391
		Men	6.2 (5.7-6.7) 548/8846
Jones (2007)	Dysphagia	Women	0.5 (0.3-0.8) 17/3371
		Men	1.14 (0.79-1.65) 30/2628
Stapley (2013)	Dysphagia	Patients ≥ 55 years	4.8 (4.3-5.9)
Stapley (2013)	Dysphagia (reported ≥ twice)	Patients ≥ 55 years	5.5 (4.2-7.9)
Collins (2012)	Appetite loss	All patients	0.6 (0.5-0.9) 37/5838
		Women	0.4 (0.2-0.7) 12/3317
		Men	1 (0.7-1.5)

			25/2521
Hippisley-Cox (2011)	Appetite loss	All patients	1.1 (0.8-1.5) 35/3391
Møllmann (1981)	Weight loss and/or anorexia	All patients	2 (0.1-12) 1/50
Collins (2012)	Weight loss	All patients	0.8 (0.7-0.9) 218/28403
		Women	0.6 (0.4-0.7) 86/15465
		Men	1 (0.9-1.2) 132/12938
Hippisley-Cox (2011)	Weight loss	All patients	1.2 (1-1.4) 107/9170
Stapley (2013)	Weight loss	Patients ≥ 55 years	0.9 (0.7-1)
Collins (2012)	Haematemesis	All patients	1 (0.8-1.2) 110/10792
		Women	0.5 (0.3-0.7) 22/4630
		Men	1.4 (1.2-1.8) 88/6162
Hippisley-Cox (2011)	Haematemesis	All patients	2.3 (1.9-2.7) 101/4477
Stapley (2013)	Constipation	Patients ≥ 55 years	0.2 (0.2-0.2)
Stapley (2013)	Chest pain	Patients ≥ 55 years	0.2 (0.2-0.2)
Stapley (2013)	Reflux	Patients ≥ 55 years	0.6 (0.6-0.7)
Møllmann (1981)	Nausea and/or vomiting > 2 weeks	All patients	0 (0-12.3) 0/35
Stapley (2013)	Nausea/vomiting	Patients ≥ 55 years	0.6 (0.5-0.7)
Stapley (2013)	Nausea/vomiting reported ≥ twice	Patients ≥ 55 years	1 (0.8-1.2)
Stapley (2013)	Raised platelets	Patients ≥ 55 years	0.5 (0.4-0.5)
Stapley (2013) reported that all PPVs for symptom combinations in patients < 55 years were < 1%, and that the highest PPV in this age group was for dysphagia, 0.8 (0.4-1.5)%			
Møllmann (1981)	Gastrointestinal bleeding	All patients	0 (0-32) 0/11

1 Please note:
2 - The calculations of the positive predictive values differ between all the other included studies using
3 (TP)/(TP+FP) and Stapley (2013) using other statistics due to the case-control design of these studies.
4 NR = Not reported.

5

6 Table 4: Stomach cancer: Additional results reported by the individual papers: Symptom
7 combinations

Study	Symptom(s)	Patient group	Positive predictive value, % (95% CI)
Meineche-Schmidt (2002)	Dyspepsia and jaundice	All patients	0 (0-48.32) 0/6
Meineche-Schmidt (2002)	Dyspepsia and black stools	All patients	0.91 (0.05-5.69) 1/110
Meineche-Schmidt	Dyspepsia and bloody	All patients	0.76 (0.04-4.81)

(2002)	stools		1/131
Stapley (2013)	Dysphagia and chest pain	Patients ≥ 55 years	5.8 (3.5-10.8)
Stapley (2013)	Dysphagia and loss of weight	Patients ≥ 55 years	9.2 (4.4-22.7)
Stapley (2013)	Dysphagia and abdominal pain	Patients ≥ 55 years	6.5 (3.5-13.5)
Stapley (2013)	Dysphagia and epigastric pain	Patients ≥ 55 years	9.3 (NR)
Stapley (2013)	Dysphagia and reflux	Patients ≥ 55 years	5 (3.3-8.4)
Stapley (2013)	Dysphagia and low haemoglobin	Patients ≥ 55 years	4.6 (3.4-6.6)
Stapley (2013)	Dysphagia and nausea/vomiting	Patients ≥ 55 years	7.3 (4.4-13.9)
Meineche-Schmidt (2002)	Dyspepsia and dysphagia	All patients	1.4 (0.04-4.36) 3/215
Stapley (2013)	Dysphagia and dyspepsia	Patients ≥ 55 years	9.8 (5.7-20.2)
Stapley (2013)	Dysphagia and raised platelets	Patients ≥ 55 years	6.1 (3.2-13.2)
Stapley (2013)	Dyspepsia and chest pain	Patients ≥ 55 years	0.7 (0.5-0.9)
Stapley (2013)	Dyspepsia and abdominal pain	Patients ≥ 55 years	1 (0.7-1.3)
Stapley (2013)	Dyspepsia and epigastric pain	Patients ≥ 55 years	1.4 (1-2)
Stapley (2013)	Dyspepsia and nausea/vomiting	Patients ≥ 55 years	1.3 (0.9-1.8)
Stapley (2013)	Dyspepsia and reflux	Patients ≥ 55 years	0.9 (0.7-1.2)
Meineche-Schmidt (2002)	Dyspepsia and weight loss	All patients	1.37 (0.35-4.28) 3/219
Stapley (2013)	Dyspepsia and loss of weight	Patients ≥ 55 years	2.1 (1.3-3.5)
Stapley (2013)	Dyspepsia and raised platelets	Patients ≥ 55 years	1.4 (0.9-2.2)
Meineche-Schmidt (2002)	Dyspepsia and anaemia	All patients	0 (0-11.71) 0/37
Stapley (2013)	Dyspepsia and low haemoglobin	Patients ≥ 55 years	1 (0.8-1.3)
Stapley (2013)	Constipation and chest pain	Patients ≥ 55 years	0.4 (0.3-0.5)
Stapley (2013)	Constipation and loss of weight	Patients ≥ 55 years	1.1 (0.8-1.7)
Stapley (2013)	Constipation and abdominal pain	Patients ≥ 55 years	0.4 (0.3-0.5)
Stapley (2013)	Constipation and epigastric pain	Patients ≥ 55 years	1.4 (0.8-2.3)
Stapley (2013)	Constipation and reflux	Patients ≥ 55 years	0.7 (0.5-1.1)

Stapley (2013)	Constipation and low haemoglobin	Patients ≥ 55 years	0.4 (0.4-0.5)
Stapley (2013)	Constipation and nausea/vomiting	Patients ≥ 55 years	0.6 (0.4-0.7)
Stapley (2013)	Constipation and dyspepsia	Patients ≥ 55 years	0.8 (0.6-1.1)
Stapley (2013)	Constipation and dysphagia	Patients ≥ 55 years	4.2 (2.7-7.2)
Stapley (2013)	Constipation and raised platelets	Patients ≥ 55 years	0.9 (0.6-1.4)
Stapley (2013)	Abdominal pain and chest pain	Patients ≥ 55 years	0.3 (0.3-0.4)
Stapley (2013)	Abdominal pain and epigastric pain	Patients ≥ 55 years	0.9 (0.7-1.2)
Stapley (2013)	Abdominal pain and reflux	Patients ≥ 55 years	0.6 (0.5-0.9)
Stapley (2013)	Abdominal pain and weight loss	Patients ≥ 55 years	1.4 (0.9-2.2)
Møllmann (1981)	Upper abdominal pain > 2 weeks and nausea and/or vomiting > 2 weeks	All patients	0.7 (0.12-2.7) 2/293
Stapley (2013)	Abdominal pain and nausea/vomiting	Patients ≥ 55 years	0.7 (0.5-0.9)
Stapley (2013)	Abdominal pain and low haemoglobin	Patients ≥ 55 years	0.5 (0.4-0.6)
Stapley (2013)	Abdominal pain and raised platelets	Patients ≥ 55 years	0.8 (0.6-1.1)
Møllmann (1981)	Upper abdominal pain > 2 weeks and gastrointestinal bleeding	All patients	0 (0-21) 0/19
Møllmann (1981)	Upper abdominal pain > 2 weeks and nausea/vomiting > 2 weeks and gastrointestinal bleeding	All patients	0 (0-44) 0/7
Møllmann (1981)	Upper abdominal pain > 2 weeks and nausea/vomiting > 2 weeks and weight loss/anorexia	All patients	5.2 (2.1-11.4) 6/116
Møllmann (1981)	Upper abdominal pain > 2 weeks and weight loss/anorexia and gastrointestinal bleeding	All patients	20 (1.1-70) 1/5
Møllmann (1981)	Upper abdominal pain > 2 weeks and weight loss/anorexia	All patients	2 (0.4-7.9) 2/98
Stapley (2013)	Chest pain and epigastric pain	Patients ≥ 55 years	0.9 (0.6-1.4)
Stapley (2013)	Chest pain and reflux	Patients ≥ 55 years	0.6 (0.5-0.9)

Stapley (2013)	Chest pain and weight loss	Patients \geq 55 years	1.1 (0.7-1.8)
Stapley (2013)	Chest pain and nausea/vomiting	Patients \geq 55 years	0.6 (0.4-0.8)
Stapley (2013)	Chest pain and low haemoglobin	Patients \geq 55 years	0.3 (0.3-0.4)
Stapley (2013)	Chest pain and raised platelets	Patients \geq 55 years	0.8 (0.6-1.2)
Stapley (2013)	Epigastric pain and reflux	Patients \geq 55 years	1.5 (1-2.4)
Stapley (2013)	Epigastric pain and weight loss	Patients \geq 55 years	4.2 (1.8-11)
Stapley (2013)	Epigastric pain and low haemoglobin	Patients \geq 55 years	1.6 (1.1-2.2)
Stapley (2013)	Reflux and loss of weight	Patients \geq 55 years	3.1 (1.5-6.7)
Stapley (2013)	Reflux and low haemoglobin	Patients \geq 55 years	0.9 (0.7-1.2)
Stapley (2013)	Weight loss and low haemoglobin	Patients \geq 55 years	1 (0.8-1.3)
Møllmann (1981)	Weight loss/anorexia and gastrointestinal bleeding	All patients	0 (0-80) 0/2
Møllmann (1981)	Weight loss/anorexia and gastrointestinal bleeding and nausea/vomiting > 2 week	All patients	0 (0-80) 0/2
Møllmann (1981)	Weight loss/anorexia and nausea/vomiting > 2 week	All patients	0 (0-16.6) 0/25
Stapley (2013)	Nausea/vomiting and weight loss	Patients \geq 55 years	2.8 (1.7-4.8)
Stapley (2013)	Nausea/vomiting and epigastric pain	Patients \geq 55 years	1.3 (0.9-2)
Stapley (2013)	Nausea/vomiting and reflux	Patients \geq 55 years	2.3 (1.5-3.5)
Stapley (2013)	Nausea/vomiting and low haemoglobin	Patients \geq 55 years	0.9 (0.7-1.1)
Stapley (2013)	Reflux and raised platelets	Patients \geq 55 years	1.6 (0.9-2.9)
Stapley (2013)	Weight loss and raised platelets	Patients \geq 55 years	1.8 (1.1-3)
Stapley (2013)	Nausea/vomiting and raised platelets	Patients \geq 55 years	1.4 (1-2.1)
Stapley (2013)	Epigastric pain and raised platelets	Patients \geq 55 years	1.9 (1-3.8)
Stapley (2013)	Low haemoglobin and raised platelets	Patients \geq 55 years	0.6 (0.6-0.7)
Møllmann (1981)	Any of the inclusion symptoms + previous dyspepsia	All patients	0.9 (0.4-1.9) 7/773

Møllmann (1981)	Any of the inclusion symptoms + no previous dyspepsia	All patients	2.1 (1.1-3.8) 11/524
Møllmann (1981)	Any of the inclusion symptoms + unchanged previous dyspepsia	All patients	1.2 (0.5-3) 5/407
Møllmann (1981)	Any of the inclusion symptoms + no previous or changed dyspepsia	All patients	1.5 (0.8-2.6) 13/890
Møllmann (1981)	Any of the inclusion symptoms + pain provoked by meals	All patients	2.3 (1.5-3) 6/257
Møllmann (1981)	Any of the inclusion symptoms + no pain provoked by meals	All patients	1.1 (0.6-2.1) 10/924
Møllmann (1981)	Any of the inclusion symptoms + relief of pain by meals	All patients	1.2 (0.5-2.8) 6/488
Møllmann (1981)	Any of the inclusion symptoms + no pain relief by meals	All patients	1.5 (0.7-2.8) 10/687
Møllmann (1981)	Any of the inclusion symptoms + irritable bowel syndrome	All patients	1.2 (0.2-4.7) 2/167
Møllmann (1981)	Any of the inclusion symptoms + no irritable bowel syndrome	All patients	1.4 (0.8-2.3) 16/1129

1 Please note:

2 - The calculations of the positive predictive values differ between the all the other included studies
3 using (TP)/(TP+FP) and Stapley (2013) using other statistics due to the case-control design of these
4 studies. NR = not reported.

5
6 **Evidence statement(s):**

7 Abdominal pain (4 studies, N = 3416339) presenting in a primary care setting is associated with an
8 overall positive predictive value of up to 0.34% for stomach cancer. The studies were associated with
9 0-3 bias or applicability concerns (see also Tables 1-3).

10
11 Anaemia (8 studies, N = 3417170) presenting in a primary care setting is associated with an overall
12 positive predictive value of up to 1.09% for stomach cancer. The studies were associated with 0-4
13 bias or applicability concern (see also Tables 1-3).

14
15 Dyspepsia (13 studies, N = 52183) presenting in a primary care setting is associated with an overall
16 positive predictive value of up to 1.2% for stomach cancer. The studies were associated with 1-3 bias
17 or applicability concerns (see also Tables 1-3).

18
19 Dysphagia (5 studies, N = 4177284) presenting in a primary care setting is associated with an overall
20 positive predictive value of up to 5.5% for stomach cancer. All the studies were associated with 0-1
21 bias or applicability concerns (see also Tables 1-3).

1 Other single symptoms (6 studies, N = 3417192) presenting in a primary care setting are associated
 2 with an overall positive predictive values for stomach cancer up to 2.3% (for haematemesis). The
 3 studies were associated with 0-4 bias or applicability concerns (see also Table 3).

4
 5 Two or more symptom presenting in combination (3 studies, N = 43319) in a primary care setting are
 6 associated with overall positive predictive values for stomach cancer ranging from 0% (dyspepsia
 7 with jaundice or anaemia, for 'gastrointestinal bleeding and nausea/vomiting and upper abdominal
 8 pain', and for 'gastrointestinal bleeding and anorexia/weightloss' with or without nausea/vomiting)
 9 to 20% (for 'upper abdominal pain and weight loss/anorexia and gastrointestinal bleeding'), but
 10 some of these positive predictive values were based on bvery low numbers of patients. The studies
 11 were associated with 1-3 bias or applicability concerns (see also Table 4).

12 Evidence tables

14 Brignoli (1997)

PATIENT SELECTION	
A. risk of bias	
Patient sampling	Prospective patient series from Switzerland.
Was a consecutive or random sample of patients enrolled?	Unclear
Was a case-control design avoided?	Yes
Did the study avoid inappropriate exclusions?	Unclear
Could the selection of patients have introduced bias?	Unclear risk
B. Concerns regarding applicability	
Patient characteristics and setting	N = 828; 329 men, 499 women; mean (SD) age = 41-42 (15-16) years. Inclusion criteria: "Adult patients with epigastric complaints were admitted to the multicentre [omega]-project if their symptoms persisted for over 1 month and their clinical history and appearance did not suggest an organic disorder (i.e. absence of alarm features, such as gastrointestinal blood loss, palpable tumour mass, massive weight loss, etc.). The studies were conducted by general practitioners acting as primary care physicians." Exclusion criteria: None listed Clinical setting: Primary care, Switzerland
Are there concerns that the included patients and setting do not match the review question?	Unclear concern
INDEX TEST	
A. Risk of bias	
Index test	Epigastric complaints (dyspepsia)
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes
Could the conduct or interpretation of the index test have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the index test, its conduct, or interpretation differ from the review question?	Low concern
REFERENCE STANDARD	
A. risk of bias	
Reference	Endoscopy and 84-day follow up.

standard(s)	
Is the reference standard likely to correctly classify the target condition?	No
Were the reference standard results interpreted without knowledge of the results of the index tests?	No
Could the reference standard, its conduct, or its interpretation have introduced bias?	High risk
B. Concerns regarding applicability	
Are there concerns that the target condition as defined by the reference standard does not match the question?	Low concern
FLOW AND TIMING	
A. risk of bias	
Flow and timing	All patients are accounted for
Was there an appropriate interval between index test and reference standard?	Yes
Did all patients receive the same reference standard?	Yes
Were all patients included in the analysis?	Yes
Could the patient flow have introduced bias?	Low risk
NOTES	3 patients had gastric cancer, 0 patients had oesophageal cancer, and 2 patients had cancer outside the digestive tract.
1	
2	Collins (2012)
PATIENT SELECTION	
A. risk of bias	
Patient sampling	Retrospective patient series using the THIN database.
Was a consecutive or random sample of patients enrolled?	Yes
Was a case-control design avoided?	Yes
Did the study avoid inappropriate exclusions?	Yes
Could the selection of patients have introduced bias?	Low risk
B. Concerns regarding applicability	
Patient characteristics and setting	A total of 2135540 patients were identified from 364 practices. <u>Symptoms:</u> Dysphagia (N = 19237; 8846 men, 10391 women), abdominal pain (N = 246998; 102732 men, 144266 women), appetite loss (N = 5838; 2521 men, 3317 women), weight loss (N = 28403; 12938 men, 15465 women), haematemesis (N = 10792; 6162 men, 4630 women), anaemia (N = 18355; 4563 men, 13792 women). <u>Incident cases of gastro-oesophageal cancer during the 2-year follow up period:</u> N = 1766 (1184 men, 582 women; 32% gastric cancer, 68% oesophageal cancer). <u>Inclusion criteria:</u> Patients aged 30–84 years and registered with practices between 1 January 2000 and 30 June 2008. Entry to the cohort was defined as the latest of the study start date; the date the patient registered with the practice; and for those patients with red flag symptoms (see below), the date of the first recorded onset within the study period.

	<p><u>Exclusion criteria:</u> Patients with a prior diagnosis of gastro-oesophageal cancer, registration with the general practice < 12 months, or with invalid dates.</p> <p><u>Clinical setting:</u> Primary care, UK</p>
Are there concerns that the included patients and setting do not match the review question?	Low concern
INDEX TEST	
A. Risk of bias	
Index test	'Red-flag' symptoms: Haematemesis, dysphagia, loss of appetite, weight loss, anaemia, and abdominal pain.
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes
Could the conduct or interpretation of the index test have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the index test, its conduct, or interpretation differ from the review question?	Low concern
REFERENCE STANDARD	
A. risk of bias	
Reference standard(s)	2-year follow up
Is the reference standard likely to correctly classify the target condition?	Yes
Were the reference standard results interpreted without knowledge of the results of the index tests?	Unclear
Could the reference standard, its conduct, or its interpretation have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the target condition as defined by the reference standard does not match the question?	Low concern
FLOW AND TIMING	
A. risk of bias	
Flow and timing	All patients seem to be accounted for
Was there an appropriate interval between index test and reference standard?	Yes
Did all patients receive the same reference standard?	Yes
Were all patients included in the analysis?	Yes
Could the patient flow have introduced bias?	Low risk
NOTES	
1	
2	Droogendijk (2011)
PATIENT SELECTION	
A. risk of bias	
Patient sampling	Retrospective peripheral hospital laboratory database study serving 265 GPs in Dordrecht (Holland).
Was a consecutive or random sample of patients enrolled?	Yes

Was a case-control design avoided?	Yes
Did the study avoid inappropriate exclusions?	Yes
Could the selection of patients have introduced bias?	Low risk
B. Concerns regarding applicability	
Patient characteristics and setting	N = 287; 129 men, 158 women; median (range) age = 70 (19-87) years. <u>Inclusion criteria:</u> All women aged > 50 years and all men aged ≥ 18 years who between January 2004 and December 2005 were diagnosed with iron-deficiency anaemia (haemoglobin < 13.7 g/dl in men and < 12.1 g/dl in women, and a serum ferritin level < 25 µg/l for men and < 20 µg/l for women). <u>Exclusion criteria:</u> Patients with a known history of iron-deficiency anaemia in the previous 2 years, a history of gastrointestinal malignancy or congenital haemoglobinopathy. <u>Clinical setting:</u> GPs in Holland
Are there concerns that the included patients and setting do not match the review question?	Unclear concern
INDEX TEST	
A. Risk of bias	
Index test	New onset iron-deficiency anaemia (haemoglobin < 13.7 g/dl in men and < 12.1 g/dl in women, and a serum ferritin level < 25 µg/l for men and < 20 µg/l for women).
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes
Could the conduct or interpretation of the index test have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the index test, its conduct, or interpretation differ from the review question?	Low concern
REFERENCE STANDARD	
A. risk of bias	
Reference standard(s)	Endoscopy and 12-month follow up.
Is the reference standard likely to correctly classify the target condition?	Yes
Were the reference standard results interpreted without knowledge of the results of the index tests?	No
Could the reference standard, its conduct, or its interpretation have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the target condition as defined by the reference standard does not match the question?	Low concern
FLOW AND TIMING	
A. risk of bias	
Flow and timing	It is unclear if all patients are accounted for
Was there an appropriate interval between index test and reference standard?	Unclear

Did all patients receive the same reference standard?	Unclear
Were all patients included in the analysis?	Unclear
Could the patient flow have introduced bias?	Unclear risk
NOTES	In addition to the 24 patients with colorectal cancer, 3 patients had gastric cancer, 1 patient had oesophageal cancer and 1 patient had locally invasive endometrial cancer.
1	
2	Duggan (2008)
PATIENT SELECTION	
A. risk of bias	
Patient sampling	Prospective patient series from 43 GP practices in the UK.
Was a consecutive or random sample of patients enrolled?	No
Was a case-control design avoided?	Yes
Did the study avoid inappropriate exclusions?	Yes
Could the selection of patients have introduced bias?	Unclear risk
B. Concerns regarding applicability	
Patient characteristics and setting	N = 762; 411 men, 351 women; mean (range) age = 42 (18-73) years. <u>Inclusion criteria:</u> Patients aged 18-70 with dyspepsia thought by the GP to arise from the upper GI tract and of sufficient severity to justify empirical treatment with an H ₂ antagonist or PPI. <u>Exclusion criteria:</u> Patients thought to be unfit for investigation, with alarm symptoms suggestive of malignancy (dysphagia, weight loss > 5 g, anaemia, haematemesis, melaena or jaundice), previous radiological or endoscopic diagnosis of peptic ulcer disease or reflux oesophagitis, investigation for dyspepsia in the previous 5 years with either procedure or symptom onset within 6 months of commencement of NSAID therapy, previous H. pylori eradication therapy or more than 3 prescriptions for acid suppression therapy in the previous 6 months. <u>Clinical setting:</u> Primary care, UK
Are there concerns that the included patients and setting do not match the review question?	Low concern
INDEX TEST	
A. Risk of bias	
Index test	Dyspepsia
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes
Could the conduct or interpretation of the index test have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the index test, its conduct, or interpretation differ from the review question?	Low concern
REFERENCE STANDARD	
A. risk of bias	
Reference standard(s)	Endoscopy and 1-2-year follow up.
Is the reference standard likely to correctly classify the	Yes

target condition?	
Were the reference standard results interpreted without knowledge of the results of the index tests?	No
Could the reference standard, its conduct, or its interpretation have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the target condition as defined by the reference standard does not match the question?	Low concern
FLOW AND TIMING	
A. risk of bias	
Flow and timing	At 12-month follow up GP data were available for 753/762.
Was there an appropriate interval between index test and reference standard?	Yes
Did all patients receive the same reference standard?	Yes
Were all patients included in the analysis?	Yes
Could the patient flow have introduced bias?	Low risk
NOTES	2 patients had gastric cancer, 2 patients had oesophageal cancer (the authors report that these patients should not have been included as they had a history of dysphagia).
1	
2 Edenholm (1985)	
PATIENT SELECTION	
A. risk of bias	
Patient sampling	Prospective patient series from the Distric General Clinic in Huskvarna, Sweden.
Was a consecutive or random sample of patients enrolled?	Unclear
Was a case-control design avoided?	Yes
Did the study avoid inappropriate exclusions?	Unclear
Could the selection of patients have introduced bias?	Unclear risk
B. Concerns regarding applicability	
Patient characteristics and setting	N = 187; 96 men, 91 women; mean/median (range) age = 44 (17-80) years. <u>Inclusion criteria:</u> Patients who between November 1982 and June 1984 called on the clinic because of abdominal pain and who were diagnosed by the general practitioner as having ulcer-like dyspepsia. The criterion used was persistent epigastric pain. Most patients also had additional symptoms such as acid regurgitation, nausea, belching or vomiting. <u>Exclusion criteria:</u> None listed <u>Clinical setting:</u> GPs in Sweden
Are there concerns that the included patients and setting do not match the review question?	Unclear concern
INDEX TEST	
A. Risk of bias	
Index test	Ulcer-like dyspepsia. The criterion used was persistent epigastric pain.
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes

Could the conduct or interpretation of the index test have introduced bias?		Low risk
B. Concerns regarding applicability		
Are there concerns that the index test, its conduct, or interpretation differ from the review question?		Low concern
REFERENCE STANDARD		
A. risk of bias		
Reference standard(s)	UGI endoscopy	
Is the reference standard likely to correctly classify the target condition?		Yes
Were the reference standard results interpreted without knowledge of the results of the index tests?		No
Could the reference standard, its conduct, or its interpretation have introduced bias?		Low risk
B. Concerns regarding applicability		
Are there concerns that the target condition as defined by the reference standard does not match the question?		Low concern
FLOW AND TIMING		
A. risk of bias		
Flow and timing	20/187 patients declined endoscopy and it was unsuccessful in a further 2 patients. Thus the PPV is likely to be an over-estimate, calculated as 2/165.	
Was there an appropriate interval between index test and reference standard?		Yes probably
Did all patients receive the same reference standard?		Yes
Were all patients included in the analysis?		No
Could the patient flow have introduced bias?		High risk
NOTES	There were a total of 3 cancers confirmed in the 165 patients who received UGI endoscopy: 1 oesophageal cancer, 1 stomach cancer, and 1 cancer of the duodenum, the latter of which was included with the stomach cancer	
1		
2 Esfandiyari (2002)		
PATIENT SELECTION		
A. risk of bias		
Patient sampling	Prospective/retrospective? patient series from USA	
Was a consecutive or random sample of patients enrolled?		Yes
Was a case-control design avoided?		Yes
Did the study avoid inappropriate exclusions?		Yes
Could the selection of patients have introduced bias?		Low risk
B. Concerns regarding applicability		
Patient characteristics and setting	N = 100; 49 men, 51 women; mean (SE) age = 64 (2) years. <u>Inclusion criteria:</u> Patients with new onset dysphagia without a prior work up who were evaluated at the Cleveland Clinic Foundation outpatient clinic by their primary care physician. <u>Exclusion criteria:</u> Neurological disease, oropharyngeal dysphagia or previous	

	gastric or oesophageal surgery, and patients without a final diagnosis explaining their dysphagia. Clinical setting: Primary care outpatient clinic, USA.	
Are there concerns that the included patients and setting do not match the review question?		High concern
INDEX TEST		
A. Risk of bias		
Index test	New onset dysphagia	
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes	
Could the conduct or interpretation of the index test have introduced bias?	Low risk	
B. Concerns regarding applicability		
Are there concerns that the index test, its conduct, or interpretation differ from the review question?		Low concern
REFERENCE STANDARD		
A. risk of bias		
Reference standard(s)	Completed clinical and diagnostic testing after an initial barium swallow/upper GI endoscopy.	
Is the reference standard likely to correctly classify the target condition?	Yes	
Were the reference standard results interpreted without knowledge of the results of the index tests?	No	
Could the reference standard, its conduct, or its interpretation have introduced bias?	Low risk	
B. Concerns regarding applicability		
Are there concerns that the target condition as defined by the reference standard does not match the question?		Low concern
FLOW AND TIMING		
A. risk of bias		
Flow and timing	All patients are accounted for	
Was there an appropriate interval between index test and reference standard?	Yes	
Did all patients receive the same reference standard?	Yes	
Were all patients included in the analysis?	Yes	
Could the patient flow have introduced bias?	Low risk	
NOTES	6 patients had malignancy, but the type of malignancy was not further specified	
1		
2	Farrus Palou (2000)	
PATIENT SELECTION		
A. risk of bias		
Patient sampling	Retrospective consecutive patient series from urban general practice covering a population of 24000.	
Was a consecutive or random sample of patients enrolled?	Yes	
Was a case-control design avoided?	Yes	

Did the study avoid inappropriate exclusions?	Yes
Could the selection of patients have introduced bias?	Low risk
B. Concerns regarding applicability	
Patient characteristics and setting	N = 87 of whom the data from 29 were unavailable as no etiological diagnosis was found (due to patient refusal of further investigation [?; 8], lost to follow up [7], patient deterioration rendering them unsuitable for further investigation [14]); of the remaining 58 patients there were 14 males, 44 females; mean? (SD?) age = 54.26 (19.95) years. <u>Inclusion criteria:</u> Patients aged > 14 years who attended the health centre between 1 October 1995 and 31 September 1996 who were found to have new onset (previously unknown) anaemia (haemoglobin < 13 g/dl for men and 12 g/dl for women). <u>Exclusion criteria:</u> Pregnant women. <u>Clinical setting:</u> Spanish GP
Are there concerns that the included patients and setting do not match the review question?	Unclear concern
INDEX TEST	
A. Risk of bias	
Index test	Anaemia (haemoglobin < 13 g/dl for men and 12 g/dl for women)
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes
Could the conduct or interpretation of the index test have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the index test, its conduct, or interpretation differ from the review question?	Low concern
REFERENCE STANDARD	
A. risk of bias	
Reference standard(s)	Follow up I think
Is the reference standard likely to correctly classify the target condition?	Unclear
Were the reference standard results interpreted without knowledge of the results of the index tests?	No
Could the reference standard, its conduct, or its interpretation have introduced bias?	Unclear risk
B. Concerns regarding applicability	
Are there concerns that the target condition as defined by the reference standard does not match the question?	Unclear concern
FLOW AND TIMING	
A. risk of bias	
Flow and timing	No diagnosis available for 29/87 patients
Was there an appropriate interval between index test and reference standard?	Unclear
Did all patients receive the same reference standard?	Yes
Were all patients included in the analysis?	No

Could the patient flow have introduced bias?		High risk
NOTES	This paper is published in Spanish. One patient had gastric cancer, 2 patients had colon cancer.	
1		
2	Hallissey (1990)	
PATIENT SELECTION		
A. risk of bias		
Patient sampling	Propective consecutive patient series from a group of 10 general practices in England.	
Was a consecutive or random sample of patients enrolled?	Yes	
Was a case-control design avoided?	Yes	
Did the study avoid inappropriate exclusions?	Yes	
Could the selection of patients have introduced bias?		Low risk
B. Concerns regarding applicability		
Patient characteristics and setting	N = 2585 aged > 40 years. No other information reported. The patient group was equally divided between new patients with dyspepsia, old patients with uninvestigated dyspepsia, and old patients with investigated dyspepsia. <u>Inclusion criteria:</u> All patients over 40 years making their first attendance during the study period (4 years and 9 months) with any degree of dyspepsia <u>Exclusion criteria:</u> None listed. <u>Clinical setting:</u> Primary care, England.	
Are there concerns that the included patients and setting do not match the review question?		Unclear concern
INDEX TEST		
A. Risk of bias		
Index test	Dyspepsia of any degree	
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes	
Could the conduct or interpretation of the index test have introduced bias?		Low risk
B. Concerns regarding applicability		
Are there concerns that the index test, its conduct, or interpretation differ from the review question?		Low concern
REFERENCE STANDARD		
A. risk of bias		
Reference standard(s)	Upper gastrointestinal endoscopy within 4 weeks and follow up.	
Is the reference standard likely to correctly classify the target condition?	Yes	
Were the reference standard results interpreted without knowledge of the results of the index tests?	No	
Could the reference standard, its conduct, or its interpretation have introduced bias?		Low risk
B. Concerns regarding applicability		
Are there concerns that the target condition as defined by the reference standard does not match the question?		Low concern

FLOW AND TIMING	
A. risk of bias	
Flow and timing	2659 patients were seen and 2585 attended for investigation
Was there an appropriate interval between index test and reference standard?	Yes
Did all patients receive the same reference standard?	Yes
Were all patients included in the analysis?	Yes
Could the patient flow have introduced bias?	Low risk
NOTES	Malignancy was detected in 115 patients: Gastric adenocarcinoma (57), gastric lymphoma (1; added to the gastric adenocarcinoma data in the PPV), oesophageal cancer (15), colorectal (14), pancreatic (6), bronchial (8), prostatic (2), duodenal (1, also added to the gastric carcinoma data in the PPV), liver (1), gall bladder (1), carcinoid (1), uterine (1), leukaemia (1), cirrhomatosis of unknown primary (7).
1	
2	Hansen (1998)
PATIENT SELECTION	
A. risk of bias	
Patient sampling	Prospective patient series from general an open-access endoscopy clinic in Denmark.
Was a consecutive or random sample of patients enrolled?	Yes
Was a case-control design avoided?	Yes
Did the study avoid inappropriate exclusions?	Yes
Could the selection of patients have introduced bias?	Low risk
B. Concerns regarding applicability	
Patient characteristics and setting	N = 612 from 66 GPs; 288 males / 324 females; mean age (SD) = 47 (16.8) years. <u>Inclusion criteria:</u> "All general practitioners (n = 108) in the city of Odense (population, 170,000) were invited to participate in the study. GPs were asked to refer all patients who consulted them with dyspepsia, regardless of the severity of the symptoms. To obtain compliance with this request the participating GPs were sent numerous reminders. Because of a limited endoscopy capacity not all GPs took part in the study at the same time." Study period was 11 March 1991-27 March 1992. <u>Exclusion criteria:</u> Aged < 18 years, signs of UGI bleeding, abdominal emergency, jaundice, previous surgery in the UGI tract except for closure of an ulcer, supposed acute bacterial or viral infection, pregnancy, or endoscopy contraindicated. <u>Clinical setting:</u> GPs in Denmark
Are there concerns that the included patients and setting do not match the review question?	Unclear concern
INDEX TEST	
A. Risk of bias	
Index test	Epigastric or retrosternal pain or discomfort, with or without heartburn, nausea, vomiting, and any other symptom considered to be referable to the proximal alimentary tract.
Were the index test results interpreted without knowledge	Yes

of the results of the reference standard?		
Could the conduct or interpretation of the index test have introduced bias?		Low risk
B. Concerns regarding applicability		
Are there concerns that the index test, its conduct, or interpretation differ from the review question?		Low concern
REFERENCE STANDARD		
A. risk of bias		
Reference standard(s)	Endoscopy within 1 week of referral and follow up	
Is the reference standard likely to correctly classify the target condition?		Yes
Were the reference standard results interpreted without knowledge of the results of the index tests?		No
Could the reference standard, its conduct, or its interpretation have introduced bias?		Low risk
B. Concerns regarding applicability		
Are there concerns that the target condition as defined by the reference standard does not match the question?		Low concern
FLOW AND TIMING		
A. risk of bias		
Flow and timing	56 eligible patients declined participation. These patients were older than the study group (mean age = 52 years versus 47 years) and they were characterised by a shorter dyspepsia history (median duration = 1 month, range = 4 days to 35 years versus 2 months, range = 4 days to 14 years). Fewer of the non-participating patients had had a previous endoscopy or UGI radiography (22% versus 43%, but identical proportions of the patients had an ulcer history (11% versus 14%).	
Was there an appropriate interval between index test and reference standard?		Yes
Did all patients receive the same reference standard?		Yes
Were all patients included in the analysis?		No
Could the patient flow have introduced bias?		Unclear risk
NOTES	There were a total of 4 cancers histologically confirmed in the study. No subclassification of the cancers reported. Follow up of the 364 patients with normal endoscopy revealed missing data in 5% of the cases and 1 lymphoma and 1 rectal carcinoma. These 6 cancers (NOS) are included in the overall PPV for dyspepsia.	
1		
2 Heikkinen (1995)		
PATIENT SELECTION		
A. risk of bias		
Patient sampling	Consecutive patient series from 11 GPs (from 3 rural health centres) and from the catchment area of 6 physicians in the health centre of an urban area (population [individuals > 14 years old] of study area = 24600) in Finland.	
Was a consecutive or random sample of patients enrolled?		Yes

Was a case-control design avoided?	Yes
Did the study avoid inappropriate exclusions?	Yes
Could the selection of patients have introduced bias?	Low risk
B. Concerns regarding applicability	
Patient characteristics and setting	N = 400; 152 males, 248 females; 77% were > 44 years. <u>Inclusion criteria:</u> Consecutive patients who consulted their GP from January 11th 1993 to January 12 th 1994 for dyspepsia (defined as upper abdominal or retrosternal pain, discomfort, heartburn, nausea, vomiting, or other symptoms considered to be referable to the proximal alimentary tract). <u>Exclusion criteria:</u> Patients with symptoms of an acute condition within the abdomen or who had had an upper intestinal endoscopy performed within the last 3 months or aged < 15 years <u>Clinical setting:</u> Primary care, Finland.
Are there concerns that the included patients and setting do not match the review question?	Unclear concern
INDEX TEST	
A. Risk of bias	
Index test	Dyspepsia (defined as upper abdominal or retrosternal pain, discomfort, heartburn, nausea, vomiting, or other symptoms considered to be referable to the proximal alimentary tract).
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes
Could the conduct or interpretation of the index test have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the index test, its conduct, or interpretation differ from the review question?	Low concern
REFERENCE STANDARD	
A. risk of bias	
Reference standard(s)	Upper gastrointestinal endoscopy, upper abdominal ultrasound, more detailed interview, blood count, serum screening (creatinine, alkaline phosphatase, alanine aminotransferase, amylase, and C-reactive protein), lactose intolerance test, and follow up of ≥ 1 month.
Is the reference standard likely to correctly classify the target condition?	Yes
Were the reference standard results interpreted without knowledge of the results of the index tests?	No
Could the reference standard, its conduct, or its interpretation have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the target condition as defined by the reference standard does not match the question?	Low concern
FLOW AND TIMING	
A. risk of bias	
Flow and timing	All patients appear to be accounted for
Was there an appropriate interval between index test and	Yes

reference standard?	
Did all patients receive the same reference standard?	Yes
Were all patients included in the analysis?	Yes
Could the patient flow have introduced bias?	Low risk
NOTES	In total N = 9 had cancer: 0 colorectal, 2 oesophageal and 7 stomach (of which 3 were lymphomas of the MALT type (Mucosa-associated lymphoid tissue)).
1	
2	Hippisley-Cox (2011)
PATIENT SELECTION	
A. risk of bias	
Patient sampling	Prospective patient series using patients in the QResearch database (version 30).
Was a consecutive or random sample of patients enrolled?	Yes
Was a case-control design avoided?	Yes
Did the study avoid inappropriate exclusions?	Yes
Could the selection of patients have introduced bias?	Low risk
B. Concerns regarding applicability	
Patient characteristics and setting	<p>A total of 1238971 patients were identified from 189 practices (621478 males, 617493 females), mean (SD) age = 50.1 (15) years, mean (SD) Townsend score = -0.2 (3.6).</p> <p><u>Symptoms:</u> Current dysphagia (N = 8165), current haematemesis (N = 7119), current abdominal pain (N = 126161), current appetite loss (N = 6133), current weight loss (N = 5377), tiredness in the last year (N = 14119), haemoglobin recorded in the last year (N = 12638, haemoglobin < 11 g/dl in the last year (N = 218862).</p> <p><u>Incident cases of colorectal cancer during the 2-year follow up period:</u> N = 1343 (776 oesophageal and 567 gastric).</p> <p><u>Inclusion criteria:</u> All practices in England and Wales that had been using their Egton Medical Information Systems (EMIS) computer system for ≥ a year were included. Two-thirds of practices were randomly allocated to the derivation dataset and the remaining practices were allocated to the validation dataset. An open cohort of patients aged 30–84 years was identified, drawn from patients registered with practices between 1 January 2000 and 30 September 2010. Entry to the cohort was defined as the latest of the study start date (1 January 2000); 12 months after the patient registered with the practice; and for those patients with red flag symptoms (see below), the date of the first recorded onset within the study period. <i>The relevant data for the present purposes is only available for the validation cohort, therefore only information pertaining to these patients will be reported.</i></p> <p><u>Exclusion criteria:</u> Patients without a postcode-related Townsend score, patients with a history of gastro-oesophageal cancer at baseline, and patients with a recorded 'red-flag' symptom in the 12 months prior to the study entry date.</p> <p><u>Clinical setting:</u> Primary care, UK</p>
Are there concerns that the included patients and setting do not match the review question?	Low concern

INDEX TEST	
A. Risk of bias	
Index test	'Red-flag' symptoms: Incident dysphagia, haematemesis, loss of appetite, weight loss, anaemia, and abdominal pain.
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes
Could the conduct or interpretation of the index test have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the index test, its conduct, or interpretation differ from the review question?	Low concern
REFERENCE STANDARD	
A. risk of bias	
Reference standard(s)	2-year follow up
Is the reference standard likely to correctly classify the target condition?	Yes
Were the reference standard results interpreted without knowledge of the results of the index tests?	Unclear
Could the reference standard, its conduct, or its interpretation have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the target condition as defined by the reference standard does not match the question?	Low concern
FLOW AND TIMING	
A. risk of bias	
Flow and timing	A total of 1342329 patients were initially identified of whom 103358 patients were excluded for the following reasons: No recorded Townsend score (N = 70847), history of gastro-oesophageal cancer (N = 538), and \geq one 'red flag' symptom recorded in the 12 months prior to study entry (N = 31973), leaving 1238971 patients. However, data is presented for 963040/1238971 patients for all symptoms. The missing data does not appear to include any of the cancer cases, but it is unclear whether some of the missing data includes symptomatic patients, i.e., false positives.
Was there an appropriate interval between index test and reference standard?	Yes
Did all patients receive the same reference standard?	Yes
Were all patients included in the analysis?	No
Could the patient flow have introduced bias?	Unclear risk
NOTES	Results not presented separately for gastric and oesophageal cancer
1	
2	Jaskiewicz (1991)
PATIENT SELECTION	
A. risk of bias	
Patient sampling	Patient series from a program aimed at screening patients with chronic gastric complaints for gastric carcinoma in the South and North-Western Cape Province of South Africa.

Was a consecutive or random sample of patients enrolled?	Unclear
Was a case-control design avoided?	Yes
Did the study avoid inappropriate exclusions?	Unclear
Could the selection of patients have introduced bias?	Unclear risk
<u>B. Concerns regarding applicability</u>	
Patient characteristics and setting	N = 585, 355 males, 230 females; mean (range) age males = 45.1 (19-87) years, mean (range) age females = 47.2 (19-87) years. <u>Inclusion criteria:</u> "participants who were treated for dyspeptic complaints such as epigastric pain, heartburn, post-prandial pain and bloating, vomiting or nausea with a duration of at least 3 months. Patients represented various areas in the south-and north-western Cape province including Namaqualand, and formed part of a programme aimed at screening patients with chronic gastric complaints for gastric caecinoma." <u>Exclusion criteria:</u> None listed <u>Clinical setting:</u> Unclear, South Africa.
Are there concerns that the included patients and setting do not match the review question?	Unclear concern
INDEX TEST	
<u>A. Risk of bias</u>	
Index test	Unspecified dyspepsia (dyspeptic complaints such as epigastric pain, heartburn, post-prandial pain and bloating, vomiting or nausea with a duration of at least 3 months).
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes
Could the conduct or interpretation of the index test have introduced bias?	Low risk
<u>B. Concerns regarding applicability</u>	
Are there concerns that the index test, its conduct, or interpretation differ from the review question?	Unclear concern
REFERENCE STANDARD	
<u>A. risk of bias</u>	
Reference standard(s)	Endoscopy
Is the reference standard likely to correctly classify the target condition?	Yes
Were the reference standard results interpreted without knowledge of the results of the index tests?	No
Could the reference standard, its conduct, or its interpretation have introduced bias?	Low risk
<u>B. Concerns regarding applicability</u>	
Are there concerns that the target condition as defined by the reference standard does not match the question?	Low concern
FLOW AND TIMING	
<u>A. risk of bias</u>	
Flow and timing	All patients appear to be accounted for
Was there an appropriate interval between index test and	Yes

reference standard?	
Did all patients receive the same reference standard?	Yes
Were all patients included in the analysis?	Yes
Could the patient flow have introduced bias?	Low risk
NOTES	In total N = 16 had gastric cancer. No oesophageal cancers reported
1	
2	Jones (2007)
PATIENT SELECTION	
A. risk of bias	
Patient sampling	Retrospective consecutive patient series using patients in the UK's General Practice Research Database.
Was a consecutive or random sample of patients enrolled?	Yes
Was a case-control design avoided?	Yes
Did the study avoid inappropriate exclusions?	Yes
Could the selection of patients have introduced bias?	Low risk
B. Concerns regarding applicability	
Patient characteristics and setting	<p>A total of 923605 patients were identified, of whom 762325 were aged ≥ 15 years.</p> <p><u>Number of first occurrences in patients with no previous diagnosis of cancer:</u></p> <p><u>Haematuria:</u> N = 11138, mean (SD) age at first symptom = 58.5 (18.9) years. Patients excluded due to incomplete dates for their first symptom: N = 30. Sex (of final sample): 6385 males, 4723 females.</p> <p><u>Haemoptysis:</u> N = 4822, mean (SD) age at first symptom = 61.6 (18) years. Patients excluded due to incomplete dates for their first symptom: N = 10. Sex (of final sample): 2930 males, 1882 females.</p> <p><u>Dysphagia:</u> N = 6003, mean (SD) age at first symptom = 54.5 (19.4) years. Patients excluded due to incomplete dates for their first symptom: N = 4. Sex (of final sample): 2628 males, 3371 females.</p> <p><u>Rectal bleeding:</u> N = 15314, mean (SD) age at first symptom = 52.5 (18.8) years. Patients excluded due to incomplete dates for their first symptom: N = 25. Sex (of final sample): 7523 males, 7766 females.</p> <p><u>Inclusion criteria:</u> All patients from 128 general practices that provided data of a sufficient standard from 1 January 1994 to 31 December 2000 and which provided exclusively Read coded data, who were aged between 15 and 100 years, whose first ever recorded occurrence of each alarm symptom (haematuria, haemoptysis, dysphagia, or rectal bleeding) was after 31 December 1994 and who had not previously been diagnosed as having any cancer.</p> <p><u>Exclusion criteria:</u> Patients whose date of first symptom or first relevant diagnosis of cancer was before 1 January 1995 and patients with a diagnosis of any other cancer than the ones of interest before the date of the first recorded symptom or before the index cancer diagnosis date if the related symptom was not recorded.</p> <p><u>Clinical setting:</u> Primary care</p>
Are there concerns that the included patients and setting do not match the review question?	Low concern
INDEX TEST	

A. Risk of bias	
Index test	Identification of all patients who ever had symptoms recorded for haematuria, haemoptysis, dysphagia, or rectal bleeding.
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes
Could the conduct or interpretation of the index test have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the index test, its conduct, or interpretation differ from the review question?	Low concern
REFERENCE STANDARD	
A. risk of bias	
Reference standard(s)	Cancer code in the UK's General Practice Research Database: <u>Haematuria</u> : Urinary tract neoplasms, including neoplasms of the urethra, bladder, ureter, and kidney but excluding neoplasms of the prostate and other reproductive organs. <u>Haemoptysis</u> : Respiratory tract neoplasms. <u>Dysphagia</u> : Oesophageal neoplasms. <u>Rectal bleeding</u> : Colorectal neoplasms.
Is the reference standard likely to correctly classify the target condition?	Yes
Were the reference standard results interpreted without knowledge of the results of the index tests?	Unclear (but all patients had a positive index test)
Could the reference standard, its conduct, or its interpretation have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the target condition as defined by the reference standard does not match the question?	Low concern
FLOW AND TIMING	
A. risk of bias	
Flow and timing	All patients are accounted for in the results.
Was there an appropriate interval between index test and reference standard?	Unclear
Did all patients receive the same reference standard?	Yes
Were all patients included in the analysis?	Yes
Could the patient flow have introduced bias?	Low risk
NOTES	Diagnoses of cancer were most often made in the first three months after the onset of alarm symptoms; very few diagnoses of cancer were made later than three years after symptom onset. In the 4th and 5th years of study, the small number of observed occurrences of cancer was similar to the number expected from background incidence rates. Secondary analyses evaluating whether the incidence of neoplasms other than those prespecified was increased after the occurrence of alarm symptoms showed for: <u>Haematuria</u> : Inclusion of cancers of the reproductive organs yielded 21 additional cancers in women and 158 cancers in men, mostly cancers of the prostate. Inclusion of these cancers in the analysis would give a positive predictive value of 3.9% in women and 9.9% in men.

	<p><u>Dysphagia</u>: Inclusion of gastric cancers yielded 17 additional cancer diagnoses in women and 30 in men. Inclusion of these cancers gave positive predictive values of 5.2% in women [reported in the paper, however, the numbers reported do not match up and I think the PPV is instead 2.91%; 98/3371] and 6.9% in men.</p> <p><i>Estimates based on the pre-specified cancers may be thus conservative for these symptoms.</i></p> <p><u>Haemoptysis</u>: Extension of the diagnostic criteria yielded 6 additional cancers.</p> <p><u>Rectal bleeding</u>: Extension of the diagnostic criteria yielded 2 additional cancers.</p>
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Kagevi (1989)**PATIENT SELECTION****A. risk of bias**

Patient sampling	Propective consecutive patient series from a primary care centre in Sweden.
Was a consecutive or random sample of patients enrolled?	Yes
Was a case-control design avoided?	Yes
Did the study avoid inappropriate exclusions?	Yes
Could the selection of patients have introduced bias?	Low risk

B. Concerns regarding applicability

Patient characteristics and setting	<p>N = 172; 88 men, 84 women; mean (SD) age = 43 (16) years.</p> <p><u>Inclusion criteria</u>: "All patients visiting the medical center with complaints referable to the digestive tract were considered for inclusion. Even when the patient consulted the primary care center because of another complaint and coincidentally mentioned gastrointestinal problem, the patient was considered for inclusion. The patient's gastrointestinal problem could have been reported in connection with an earlier visit at the primary care center."</p> <p><u>Exclusion criteria</u>: Patients with jaundice, gastrointestinal bleeding or acute abdominal pain were excluded and so were patients judged to have a non-gastro-enterologic cause of their symptoms (gynaecologic problems, spondylosis deformans, etc), patients aged < 16 years and patients unwilling to participate.</p> <p><u>Clinical setting</u>: Primary care Center, Sweden.</p>
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Are there concerns that the included patients and setting do not match the review question?	Unclear concern
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INDEX TEST**A. Risk of bias**

Index test	Dyspepsia defined as any pain, discomfort, or other symptoms referable to the digestive tract \geq 2 weeks. Symptoms could be intermittent or continuous.
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes
Could the conduct or interpretation of the index test have introduced bias?	Low risk

B. Concerns regarding applicability

Are there concerns that the index test, its conduct, or interpretation differ from the review question?	Low concern
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REFERENCE STANDARD	
A. risk of bias	
Reference standard(s)	Esophagogastroduodenoscopy within 1 week and 6 month follow up.
Is the reference standard likely to correctly classify the target condition?	Yes
Were the reference standard results interpreted without knowledge of the results of the index tests?	No
Could the reference standard, its conduct, or its interpretation have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the target condition as defined by the reference standard does not match the question?	Low concern
FLOW AND TIMING	
A. risk of bias	
Flow and timing	13/185 patients were excluded as they did not want to have an endoscopy
Was there an appropriate interval between index test and reference standard?	Yes
Did all patients receive the same reference standard?	Yes
Were all patients included in the analysis?	Yes
Could the patient flow have introduced bias?	Low risk
NOTES	2 patients had gastric cancer, 0 patients had oesophageal cancer.
1	
2 Mahadeva (2008)	
PATIENT SELECTION	
A. risk of bias	
Patient sampling	Prospective patient series from the Primary Care Clinics of the University of Malaya in Malaysia
Was a consecutive or random sample of patients enrolled?	Unclear
Was a case-control design avoided?	Yes
Did the study avoid inappropriate exclusions?	Unclear
Could the selection of patients have introduced bias?	Unclear risk
B. Concerns regarding applicability	
Patient characteristics and setting	N = 432; 198 males/234 females; mean ages (SDs) = 30-31 (8) years. <u>Inclusion criteria:</u> "All patients were recruited from the Primary Care Clinics of the University of Malaya, which provide a regular service to the local community. Patients aged ≤ 45 years presenting with uninvestigated dyspepsia were invited to participate in the study", which ran from January 2004 until October 2005. <u>Exclusion criteria:</u> Age > 45 or < 18 years; symptoms of weight loss, progressive dysphagia or those suggestive of anaemia; pregnancy; previous H pylori testing; any contra-indication to endoscopy or sedation; failure to turn up for initial test ; and on regular doses of non-steroidal anti-inflammatory drugs. <u>Clinical setting:</u> Primary care clinic, Malaysia

Are there concerns that the included patients and setting do not match the review question?		High concern
INDEX TEST		
A. Risk of bias		
Index test	Uninvestigated dyspepsia. Dyspepsia defined as predominant upper abdominal discomfort for > 4 weeks, with any associated symptoms, including heart burn and regurgitation.	
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes	
Could the conduct or interpretation of the index test have introduced bias?	Low risk	
B. Concerns regarding applicability		
Are there concerns that the index test, its conduct, or interpretation differ from the review question?	Low concern	
REFERENCE STANDARD		
A. risk of bias		
Reference standard(s)	Follow up ± upper endoscopy (oesophagogastroduodenoscopy)	
Is the reference standard likely to correctly classify the target condition?	Yes	
Were the reference standard results interpreted without knowledge of the results of the index tests?	No	
Could the reference standard, its conduct, or its interpretation have introduced bias?	Low risk	
B. Concerns regarding applicability		
Are there concerns that the target condition as defined by the reference standard does not match the question?	Low concern	
FLOW AND TIMING		
A. risk of bias		
Flow and timing	39/471 eligible patients were excluded from the study for the following reasons: 34/39 patients declined to participate, 3/39 became pregnant before the test, 1/39 emigrated from the country and 1/39 had missing data.	
Was there an appropriate interval between index test and reference standard?	Yes	
Did all patients receive the same reference standard?	Yes	
Were all patients included in the analysis?	Yes	
Could the patient flow have introduced bias?	Low risk	
NOTES	One patient was found to have cancer, which was metastatic pancreatic cancer. No oesophageal or gastric cancers were reported.	
1		
2	Meineche-Schmidt (2002)	
PATIENT SELECTION		
A. risk of bias		
Patient sampling	Consecutive patient series from 82 GPs in Denmark.	
Was a consecutive or random sample of patients enrolled?	Yes	
Was a case-control design avoided?	Yes	

Did the study avoid inappropriate exclusions?	Yes
Could the selection of patients have introduced bias?	Low risk
B. Concerns regarding applicability	
Patient characteristics and setting	N = 1491; 688 males, 803 females; age groups: 18-37 years: N = 377; 38-50 years: N = 369; 51-64 years: N = 338; 65- years: N = 402. <u>Inclusion criteria</u> : Consecutive patients who consulted their GP between June 1991 and May 1993 for dyspepsia (defined as pain or discomfort in the abdomen judged by the GP to be related to the gastrointestinal tract). <u>Exclusion criteria</u> : None listed. <u>Clinical setting</u> : Primary care, Denmark.
Are there concerns that the included patients and setting do not match the review question?	Unclear concern
INDEX TEST	
A. Risk of bias	
Index test	Dyspepsia (defined as pain or discomfort in the abdomen judged by the GP to be related to the gastrointestinal tract).
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes
Could the conduct or interpretation of the index test have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the index test, its conduct, or interpretation differ from the review question?	Low concern
REFERENCE STANDARD	
A. risk of bias	
Reference standard(s)	18 months-3 years and 10 months follow up.
Is the reference standard likely to correctly classify the target condition?	Yes
Were the reference standard results interpreted without knowledge of the results of the index tests?	No
Could the reference standard, its conduct, or its interpretation have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the target condition as defined by the reference standard does not match the question?	Low concern
FLOW AND TIMING	
A. risk of bias	
Flow and timing	All patients appear to be accounted for
Was there an appropriate interval between index test and reference standard?	Yes
Did all patients receive the same reference standard?	Yes
Were all patients included in the analysis?	Yes
Could the patient flow have introduced bias?	Low risk
NOTES	In total N = 31 had cancer: 17 colorectal, 8 gastro-oesophageal (no subgroup analyses presented for these patients) and 6 other.

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Muris (1993)	
PATIENT SELECTION	
A. risk of bias	
Patient sampling	Prospective consecutive patient series from 11 general practitioners in Maastricht (Holland)
Was a consecutive or random sample of patients enrolled?	Yes
Was a case-control design avoided?	Yes
Did the study avoid inappropriate exclusions?	Unclear
Could the selection of patients have introduced bias?	Low risk
B. Concerns regarding applicability	
Patient characteristics and setting	N = 578; 212 males, 342 females; age groups: 18-39 years: N = 295; 40-49 years: N = 80; 50-59 years: N = 91; 60-75 years: N = 88. <u>Inclusion criteria:</u> Patients who during a 3-month period consulted one of the participating GPs for abdominal complaints. <u>Exclusion criteria:</u> Patients aged < 18 years and patients with a condition necessitating immediate referral or admission to hospital. <u>Clinical setting:</u> GPs in Holland
Are there concerns that the included patients and setting do not match the review question?	Unclear concern
INDEX TEST	
A. Risk of bias	
Index test	Abdominal complaints. Not further specified, but the authors do report that the duration of pain before the patient presented for the first time for the evaluation of abdominal pain varied from some days to more than 1 year.
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes
Could the conduct or interpretation of the index test have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the index test, its conduct, or interpretation differ from the review question?	Unclear concern
REFERENCE STANDARD	
A. risk of bias	
Reference standard(s)	Follow up for 15 months.
Is the reference standard likely to correctly classify the target condition?	Yes
Were the reference standard results interpreted without knowledge of the results of the index tests?	No
Could the reference standard, its conduct, or its interpretation have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the target condition as defined by the reference standard does not match the question?	Low concern
FLOW AND TIMING	

A. risk of bias		
Flow and timing	All patients appear to be accounted for	
Was there an appropriate interval between index test and reference standard?	Unclear	
Did all patients receive the same reference standard?	Yes	
Were all patients included in the analysis?	Yes	
Could the patient flow have introduced bias?	Low risk	
NOTES	Although not explicitly stated by the authors it is implied that the patients included were those presenting with the abdominal complaint for the first time.	
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Møllmann (1981)		
PATIENT SELECTION		
A. risk of bias		
Patient sampling	Prospective patient series from an open-access gastroscopy clinic in Denmark.	
Was a consecutive or random sample of patients enrolled?	Yes	
Was a case-control design avoided?	Yes	
Did the study avoid inappropriate exclusions?	Yes	
Could the selection of patients have introduced bias?	Low risk	
B. Concerns regarding applicability		
Patient characteristics and setting	<p>N = 1480; gender not reported; 40-44 years: N = 144; 45-49 years: N = 186; 50-69 years: N = 882; 70-74 years: N = 130; 75-79 years: N = 83; 80-89 years N = 47; 90- years: N = 8.</p> <p><u>Inclusion criteria:</u> All patients who, for a 2-year period, presented to their GP with (any of) the following symptoms were referred to the open access gastroscopy clinic: Upper abdominal pain > 2 weeks, nausea and/or vomiting > 2 weeks, weight loss and/or anorexia, gastrointestinal bleeding, and anaemia (i.e., Hb < 80%).</p> <p><u>Exclusion criteria:</u> Patients who had been examined for any of the above symptoms within the last 6 months.</p> <p><u>Clinical setting:</u> GPs in Denmark</p>	
Are there concerns that the included patients and setting do not match the review question?	Unclear concern	
INDEX TEST		
A. Risk of bias		
Index test	Upper abdominal pain > 2 weeks, nausea and/or vomiting > 2 weeks, weight loss and/or anorexia, gastrointestinal bleeding, and anaemia (i.e., Hb < 80%).	
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes	
Could the conduct or interpretation of the index test have introduced bias?	Low risk	
B. Concerns regarding applicability		
Are there concerns that the index test, its conduct, or interpretation differ from the review question?	Low concern	
REFERENCE STANDARD		
A. risk of bias		

Reference standard(s)	2-stage process: Gastroscopy with photography, using a gastrocamera, performed with only local anaesthesia of the pharynx. If this investigation disclosed abnormal conditions, the next stage was gastroscopy, possibly with biopsy, using diazepam sedation.	
Is the reference standard likely to correctly classify the target condition?	Unclear	
Were the reference standard results interpreted without knowledge of the results of the index tests?	No	
Could the reference standard, its conduct, or its interpretation have introduced bias?	Unclear risk	
B. Concerns regarding applicability		
Are there concerns that the target condition as defined by the reference standard does not match the question?	Low concern	
FLOW AND TIMING		
A. risk of bias		
Flow and timing	177/1480 patients declined endoscopy, 2/1480 did not show up for endoscopy, and it was unsuccessful in a further 24 patients, leaving 1277 patients. However, the paper reports that only 1273 had primary endoscopy, and then reports the results for between 1181 and 1297 patients.	
Was there an appropriate interval between index test and reference standard?	Yes probably	
Did all patients receive the same reference standard?	Yes	
Were all patients included in the analysis?	No	
Could the patient flow have introduced bias?	High risk	
NOTES	There were a total of 18 gastric cancers confirmed in the study. No oesophageal cancers were reported. This research was published in 2 papers.	
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2	Stapley (2013)	
PATIENT SELECTION		
A. risk of bias		
Patient sampling	Matched case-control study using patients in the UK's General Practice Research Database (GPRD).	
Was a consecutive or random sample of patients enrolled?	No	
Was a case-control design avoided?	No	
Did the study avoid inappropriate exclusions?	Yes	
<i>For diagnostic case-control studies:</i> Attempts were made within the design or analysis to balance the comparison groups for potential confounders?	Yes	
<i>For diagnostic case-control studies:</i> The groups were comparable at baseline, including all major confounding and prognostic factors?	Yes	
Could the selection of patients have introduced bias?	High risk	
B. Concerns regarding applicability		
Patient characteristics and setting	Cases: Oesophageal cancer cases: N = 4854, 3174 males / 1680 females; aged 40-54 years: N = 387; 55-69	

	<p>years: N = 1712; 70-84 years: N = 2230; ≥ 85 years: N = 532.</p> <p><u>Gastric cancer cases:</u> N = 2617, 1625 males / 992 females; aged 40-54 years: N = 130; 55-69 years: N = 671; 70-84 years: N = 1437; ≥ 85 years: N = 382. Median number of consultations (all cases) = 26 (IQR = 15-42)</p> <p><u>Controls:</u> <u>Oesophageal cancer controls:</u> N = 21506, gender not reported; aged 40-54 years: N = 1539; 55-69 years: N = 7473; 70-84 years: N = 10296; ≥ 85 years: N = 2198. <u>Gastric cancer controls:</u> N = 11371, gender not reported; aged 40-54 years: N = 497; 55-69 years: N = 2887; 70-84 years: N = 6431; ≥ 85 years: N = 1556. Median number of consultations (all controls) = 15 (IQR = 7-28)</p> <p><u>Inclusion criteria:</u> Cases: Patients with a record of one of 42 (18 oesophageal, 24 gastric) GPRD tumour diagnostic codes between January 2000 and December 2009 inclusive, aged ≥ 40 years, with min. 1 year of data before diagnosis. The first instance of a oesophago-gastric cancer code was assigned the data of diagnosis/index date. Controls: Up to 5 controls were matched to cases on sex, general practice, and to 1 year of age of the case. The index date was the index date of the matched case. <u>Exclusion criteria:</u> Oesophago-gastric cancer (controls), no consultations in the year before diagnosis. <u>Clinical setting:</u> Primary care, UK</p>
<p>Are there concerns that the included patients and setting do not match the review question?</p>	<p>Low concern</p>
<p>INDEX TEST</p>	
<p>A. Risk of bias</p>	
<p>Index test</p>	<p>All symptoms, physical signs or abnormal investigations compiled from the oesophago-gastric cancer literature were studied, and supplemented by literature from relevant cancer websites. The GPRD's code list has many synonyms for for similar symptoms, often including additional description such as severity or duration. These synonyms were identified and merged. The dyspepsia variable merged codes with either the word 'dyspepsia' or 'indigestion'; the reflux variable included 'regurgitation' as well as 'reflux'; the variable 'epigastric pain' required a precise anatomical description, whereas the variable 'abdominal pain' incorporated all other abdominal pain variables without a precise anatomical description. Occurrences of these features in the year before the index date were identified. Features were only retained for further study if they occurred in ≥5% of cases or controls. For laboratory tests, the local laboratory range was used to identify abnormal results. Patients without a test were considered to be the same status as those with a normal result. All hepatic enzyme results were merged into a composite variable, deemed abnormal if any enzyme was raised; similarly, abnormal erythrocyte sedimentation rate, plasma viscosity and C-reactive protein were collated into a single variable called raised inflammatory markers. All codes for fractures were also identified, as a test for any recording bias between cases and controls (making the assumption that the fracture rate would be approximately equal).</p>

Were the index test results interpreted without knowledge of the results of the reference standard?	Yes
<i>For diagnostic case-control studies:</i> Investigators were kept 'blind' to other important confounding and prognostic factors?	Yes
Could the conduct or interpretation of the index test have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the index test, its conduct, or interpretation differ from the review question?	Low concern
REFERENCE STANDARD	
A. risk of bias	
Reference standard(s)	Oesophago-gastric cancer code in the UK's General Practice Research Database.
Is the reference standard likely to correctly classify the target condition?	Yes
Were the reference standard results interpreted without knowledge of the results of the index tests?	Unclear
Could the reference standard, its conduct, or its interpretation have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the target condition as defined by the reference standard does not match the question?	Low concern
FLOW AND TIMING	
A. risk of bias	
Flow and timing	A total of 45356 patients were identified, 37699 controls and 7657 cases. Of the controls the following exclusions were applied: Already used as a case (N = 252), case excluded (N = 808), duplicate control (N = 427) and no data in year pre-index date (N = 3335). Of the cases the following exclusions were applied: No controls (N = 17), OG cancer diagnosis before 2000 (N = 28), case already used as case (for other O/G cancer: N = 131) and case with metastatic cancer (N = 10).
Was there an appropriate interval between index test and reference standard?	Yes
Did all patients receive the same reference standard?	Yes
Were all patients included in the analysis?	Yes
Could the patient flow have introduced bias?	Low risk
NOTES	Results are not split for oesophageal cancer and gastric cancer.
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Stellon (1997)	
PATIENT SELECTION	
A. risk of bias	
Patient sampling	Prospective? consecutive patient series from semi-rural UK general practice with a patient list between 2400-3400 during the study period.
Was a consecutive or random sample of patients enrolled?	Yes
Was a case-control design avoided?	Yes

Did the study avoid inappropriate exclusions?	Yes
Could the selection of patients have introduced bias?	Low risk
B. Concerns regarding applicability	
Patient characteristics and setting	N = 26; 5 males, 21 females; age range = 51-87 years. <u>Inclusion criteria:</u> All patients aged > 50 years found to have iron deficiency anaemia between January 1989 and March 1994. <u>Exclusion criteria:</u> None listed. <u>Clinical setting:</u> UK GP
Are there concerns that the included patients and setting do not match the review question?	Low concern
INDEX TEST	
A. Risk of bias	
Index test	Iron deficiency anaemia (< 12 g/dl haemoglobin and/or mean corpuscular volume < 80 fl with ferritin ≤ 16 ng/l)
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes
Could the conduct or interpretation of the index test have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the index test, its conduct, or interpretation differ from the review question?	Low concern
REFERENCE STANDARD	
A. risk of bias	
Reference standard(s)	Follow up during 5 year study period.
Is the reference standard likely to correctly classify the target condition?	Yes
Were the reference standard results interpreted without knowledge of the results of the index tests?	No
Could the reference standard, its conduct, or its interpretation have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the target condition as defined by the reference standard does not match the question?	Low concern
FLOW AND TIMING	
A. risk of bias	
Flow and timing	All patients appear to be accounted for
Was there an appropriate interval between index test and reference standard?	Yes
Did all patients receive the same reference standard?	Yes
Were all patients included in the analysis?	Yes
Could the patient flow have introduced bias?	Low risk
NOTES	
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2	Thomson (2003)

PATIENT SELECTION	
A. risk of bias	
Patient sampling	Propective patient series from a group of 49 family physician practices in Canada.
Was a consecutive or random sample of patients enrolled?	Unclear
Was a case-control design avoided?	Yes
Did the study avoid inappropriate exclusions?	Unclear
Could the selection of patients have introduced bias?	Unclear risk
B. Concerns regarding applicability	
Patient characteristics and setting	N = 1040, 520 males / 520 females; mean (range) age =45.6 (18-84) years. <u>Inclusion criteria:</u> Patients ≥ 18 years with a primary complaint of ≥ 3 months intermittent or continuous dyspepsia. Patients could not have used proton pump inhibitors within 30 days or prokinetics or prescription H ₂ -receptor antagonists (H ₂ RAS) within 14 days of enrolment. <u>Exclusion criteria:</u> Heartburn or acid regurgitation as their sole symptom; documented history of upper GI pathology/surgery; clinical investigation of dyspepsia by endoscopy or radiology in the previous 6 months or more than twice in the past 10 years; H. pylori eradication treatment in the previous 6 months; irritable bowel syndrome as assessed by the presence of ≥ manning criteria; or severe concurrent disease. <u>Clinical setting:</u> Family physician practice, Canada.
Are there concerns that the included patients and setting do not match the review question?	Unclear concern
INDEX TEST	
A. Risk of bias	
Index test	Dyspepsia defined as symptom complex of epigastric pain/discomfort in association with other upper GI symptoms, including heartburn and acid regurgitation.
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes
Could the conduct or interpretation of the index test have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the index test, its conduct, or interpretation differ from the review question?	Low concern
REFERENCE STANDARD	
A. risk of bias	
Reference standard(s)	Upper gastrointestinal endoscopy within 10 days and 6-months follow up.
Is the reference standard likely to correctly classify the target condition?	Yes
Were the reference standard results interpreted without knowledge of the results of the index tests?	No
Could the reference standard, its conduct, or its interpretation have introduced bias?	Low risk
B. Concerns regarding applicability	

Are there concerns that the target condition as defined by the reference standard does not match the question?		Low concern
FLOW AND TIMING		
A. risk of bias		
Flow and timing	All patients are accounted for. 1100/1171 enrolled patients consented to endoscopy, but 60/1100 did not received endoscopy (eligibility criteria not fulfilled [27], lost to follow up [3], withdrew consent [9], non-compliant with the protocol [1], endoscopy-intolerable [2], other [18]).	
Was there an appropriate interval between index test and reference standard?		Yes
Did all patients receive the same reference standard?		Yes
Were all patients included in the analysis?		Yes
Could the patient flow have introduced bias?		Low risk
NOTES	Malignancy was detected in 2 patients: Gastric (MALToma; 1), oesophageal cancer (1).	
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2 Tosetti (2010)		
PATIENT SELECTION		
A. risk of bias		
Patient sampling	Prospective patient series from 63 general practitioners in Italy	
Was a consecutive or random sample of patients enrolled?		Unclear
Was a case-control design avoided?		Yes
Did the study avoid inappropriate exclusions?		Unclear
Could the selection of patients have introduced bias?		High risk
B. Concerns regarding applicability		
Patient characteristics and setting	N = 275; 124 males, 151 females; median age (range) = 46 (18-92) years. Symptoms: Epigastric pain (72%), prolonged digestion (51.6%), heartburn (49.1%), epigastric postprandial fullness (45.5%), epigastric distension (41.5%), nausea (38.5%), acid regurgitation (34.5%), belching (28.7%), early satiety (20.7%). <u>Inclusion criteria</u> : "Each GP enrolled in the survey patients who, over a three-month period, presented with UGI [upper gastro-intestinal] symptoms at the first onset without alarming features." <u>Exclusion criteria</u> : "Patients with either previous or recurrent complaints or previously investigated for UGI symptoms were not included". <u>Clinical setting</u> : GPs in Italy	
Are there concerns that the included patients and setting do not match the review question?		High concern
INDEX TEST		
A. Risk of bias		
Index test	New onset UGI symptoms without alarming features. Not further specified.	
Were the index test results interpreted without knowledge of the results of the reference standard?		Yes
Could the conduct or interpretation of the index test have introduced bias?		Low risk
B. Concerns regarding applicability		

Are there concerns that the index test, its conduct, or interpretation differ from the review question?		High concern
REFERENCE STANDARD		
A. risk of bias		
Reference standard(s)	1-year follow up.	
Is the reference standard likely to correctly classify the target condition?		Unclear
Were the reference standard results interpreted without knowledge of the results of the index tests?		No
Could the reference standard, its conduct, or its interpretation have introduced bias?		Unclear risk
B. Concerns regarding applicability		
Are there concerns that the target condition as defined by the reference standard does not match the question?		Low concern
FLOW AND TIMING		
A. risk of bias		
Flow and timing	All patients appear to be accounted for	
Was there an appropriate interval between index test and reference standard?		Unclear
Did all patients receive the same reference standard?		Yes
Were all patients included in the analysis?		Yes
Could the patient flow have introduced bias?		Low risk
NOTES	Cancers diagnosed in these patients were: Pancreas (1/275), and oesophageal (1/275).	
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2	Vakil (2009)	
PATIENT SELECTION		
A. risk of bias		
Patient sampling	Prospective patient series	
Was a consecutive or random sample of patients enrolled?		Unclear
Was a case-control design avoided?		Yes
Did the study avoid inappropriate exclusions?		Yes (probably)
Could the selection of patients have introduced bias?		Unclear risk
B. Concerns regarding applicability		
Patient characteristics and setting	N = 2741, mean (range) age = not reported (not reported) years, numbers of females/males: Not reported. <u>Inclusion criteria:</u> Patients aged 18-70 years who met Rome II criteria for dyspepsia (intermittent or continuous pain or burning centered in the upper abdomen for ≥ 3 months). <u>Exclusion criteria:</u> Past diagnosis of gastro-oesophageal reflux disease, predominant symptom of heartburn or regurgitation, history of heartburn or regurgitation > 2 days/week, treatment > 2 days/week with non-steroidal anti-inflammatory drugs or cyclooxygenase-2 selective inhibitors or aspirin (except for cardiovascular prophylaxis at doses ≤ 325 mg/day), concurrent alarm features (e.g., dysphagia, recurrent vomiting, unexplained anaemia,	

	gastro-intestinal bleeding), H pylori eradication treatment within 12 months, maintenance therapy with either a proton pump or an H2-receptor antagonist within 6 months. <u>Clinical setting</u> : The study was conducted in 190 primary care health centers in 17 countries (Argentina, Belgium, Brazil, Canada, Denmark, France, Germany, Greece, Iceland, Italy, Norway, Romania, Singapore, South Africa, Spain, Sweden, Switzerland). Patients were recruited from primary care clinics where flyers publicising the study were placed and the primary care physicians recruited patients presenting to their offices with dyspepsia [random or consecutive sampling unlikely].
Are there concerns that the included patients and setting do not match the review question?	Low concern
INDEX TEST	
A. Risk of bias	
Index test	Dyspepsia/ intermittent or continuous pain or burning centered in the upper abdomen for ≥ 3 months. Symptoms were evaluated using a scale validated in a number of languages
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes
Could the conduct or interpretation of the index test have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the index test, its conduct, or interpretation differ from the review question?	Low concern
REFERENCE STANDARD	
A. risk of bias	
Reference standard(s)	All patients received outpatient endoscopy
Is the reference standard likely to correctly classify the target condition?	Yes
Were the reference standard results interpreted without knowledge of the results of the index tests?	No (but all patients had a positive index test)
Could the reference standard, its conduct, or its interpretation have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the target condition as defined by the reference standard does not match the question?	Low concern
FLOW AND TIMING	
A. risk of bias	
Flow and timing	All the patients are accounted for in the results.
Was there an appropriate interval between index test and reference standard?	Yes (probably)
Did all patients receive the same reference standard?	Yes
Were all patients included in the analysis?	Yes
Could the patient flow have introduced bias?	Low risk
NOTES	Supported by AstraZeneca R&D Sweden. The authors state that "The sponsor did not play any role in the calculations or in the writing of the manuscript".

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	Six patients had cancer: 3 Oesophagus and 3 stomach.
Yates (2004)	
PATIENT SELECTION	
A. risk of bias	
Patient sampling	Retrospective database study using the laboratory databases of two district general hospitals including all the general practices using these laboratories.
Was a consecutive or random sample of patients enrolled?	Yes
Was a case-control design avoided?	Yes
Did the study avoid inappropriate exclusions?	Yes
Could the selection of patients have introduced bias?	Low risk
B. Concerns regarding applicability	
Patient characteristics and setting	N = 431; 154 males, 277 females; median age (inter-quartile range) = 75 (65-81) years. <u>Inclusion criteria:</u> All female patients aged > 50 years and male patients aged > 20, with haemoglobin concentrations ≤ 110 g/l (women) or ≤ 120 g/l (men), and mean cell volume < 82 fl (district 1) or 78 fl (district 2), and red cell count ≤ 5.5 x 10 ¹² /l between June 1997 and May 1998. <u>Exclusion criteria:</u> History of anaemia within previous 12 months, known haematological abnormalities (e.g., haemoglobinopathy), unavailable notes at follow up. <i>That is, patients with a history of cancer were not excluded.</i> <u>Clinical setting:</u> UK GP
Are there concerns that the included patients and setting do not match the review question?	Unclear concern
INDEX TEST	
A. Risk of bias	
Index test	Iron deficiency anaemia (haemoglobin concentrations ≤ 110 g/l (women) or ≤ 120 g/l (men), and mean cell volume < 82 fl (district 1) or 78 fl (district 2), and red cell count ≤ 5.5 x 10 ¹² /l)
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes
Could the conduct or interpretation of the index test have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the index test, its conduct, or interpretation differ from the review question?	Low concern
REFERENCE STANDARD	
A. risk of bias	
Reference standard(s)	Minimum 3 years follow up.
Is the reference standard likely to correctly classify the target condition?	Yes
Were the reference standard results interpreted without knowledge of the results of the index tests?	No
Could the reference standard, its conduct, or its interpretation have introduced bias?	Low risk

B. Concerns regarding applicability	
Are there concerns that the target condition as defined by the reference standard does not match the question?	Low concern
FLOW AND TIMING	
A. risk of bias	
Flow and timing	All patients appear to be accounted for
Was there an appropriate interval between index test and reference standard?	Yes
Did all patients receive the same reference standard?	Yes
Were all patients included in the analysis?	Yes
Could the patient flow have introduced bias?	Low risk
NOTES	In total N = 48 had gastrointestinal cancer (11 upper, 2 small bowel and 35 lower, including recurrent tumours) and N = 23 had non-gastrointestinal cancers, but the study only reports the type of some of these cancers (3 lung + 1 lung tumour secondary to a previous breast tumour, 1 ovary, 2 bladder, 1 Hodgkin's, 1 Non-Hodgkin's, 1 endometrial sarcoma, 1 lymphoma, 1 endometrial) and has therefore not been added to the evidence reviews for the non-gastrointestinal cancers. The paper considers both the lower gastrointestinal cancers and the small bowel cancers as colorectal cancer and in order to present subgroup analyses by gender I have maintained this grouping and not added this paper to the evidence review for small intestine.

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36 Review question:

37 Which investigations of symptoms of suspected stomach cancer should be done with clinical
38 responsibility retained by primary care?

40 Results

41 Literature search

Database name	Dates Covered	No of references found	No of references retrieved	Finish date of search
<i>Medline</i>	1980-2013	2648	137	23/05/2013
<i>Premedline</i>	1980-2013	143	20	23/05/2013
<i>Embase</i>	1980-2013	3279	120	23/05/2013
<i>Cochrane Library</i>	1980-2013	151	7	23/05/2013
<i>Psychinfo</i>	1980-2013	1	0	23/05/2013
<i>Web of Science (SCI &</i>	1980-2013	147	34	23/05/2013

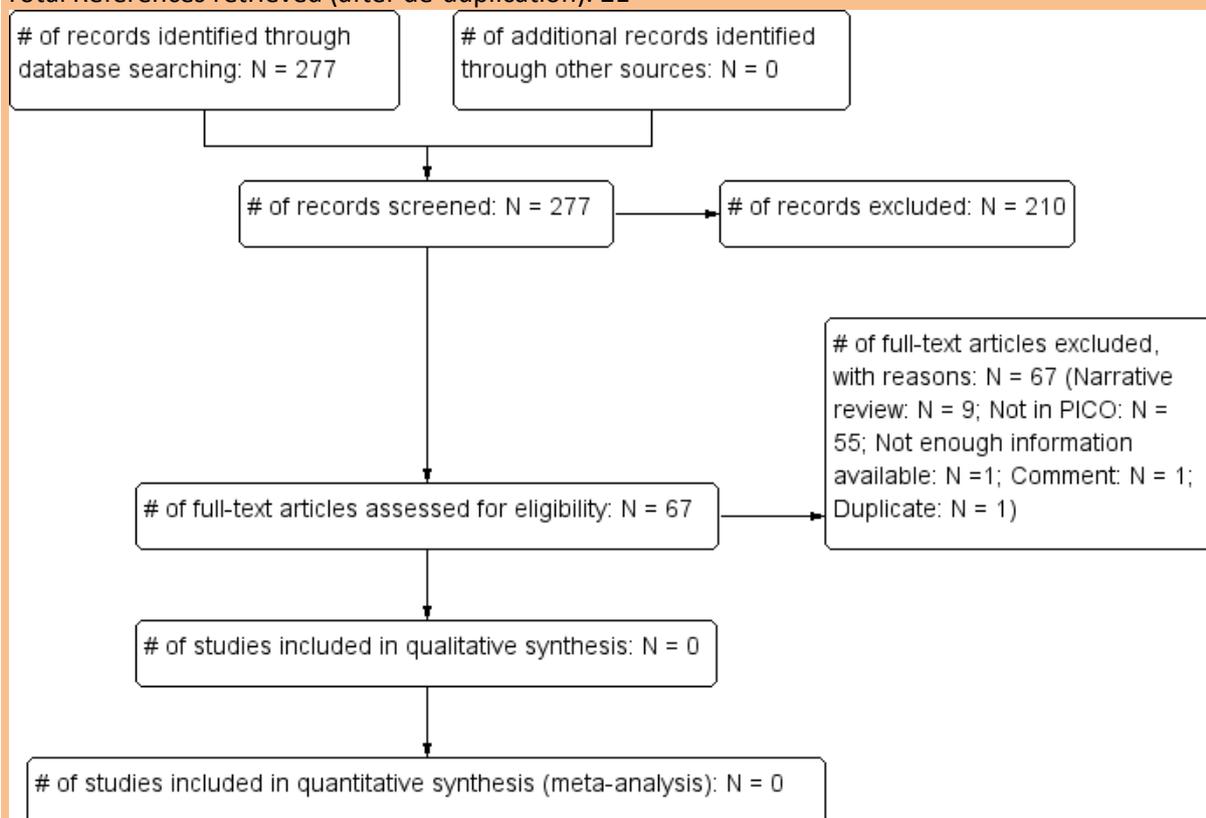
SSCI) and ISI Proceedings				
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1 Total References retrieved (after de-duplication): 256

2 **Update Search**

Database name	Dates Covered	No of references found	No of references retrieved	Finish date of search
Medline	5/2013-26/08/2014	17	4	26/08/2014
Premedline	5/2013-26/08/2014	109	8	26/08/2014
Embase	5/2013-26/08/2014	65	14	26/08/2014
Cochrane Library	5/2013-26/08/2014	54	0	26/08/2014
Web of Science (SCI & SSCI) and ISI Proceedings	5/2013-26/08/2014	13	0	26/08/2014

3 Total References retrieved (after de-duplication): 21



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5
6
7 **Study results**

8 No evidence was identified pertaining to the diagnostic accuracy of upper gastrointestinal
9 endoscopy, barium meal or abdominal ultrasound in patients with suspected stomach cancer where
10 the clinical responsibility was retained by primary care.

11
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SMALL INTESTINAL CANCER**Review question:**

What is the risk of small intestine cancer in patients presenting in primary care with symptom(s)?

Results**Literature search**

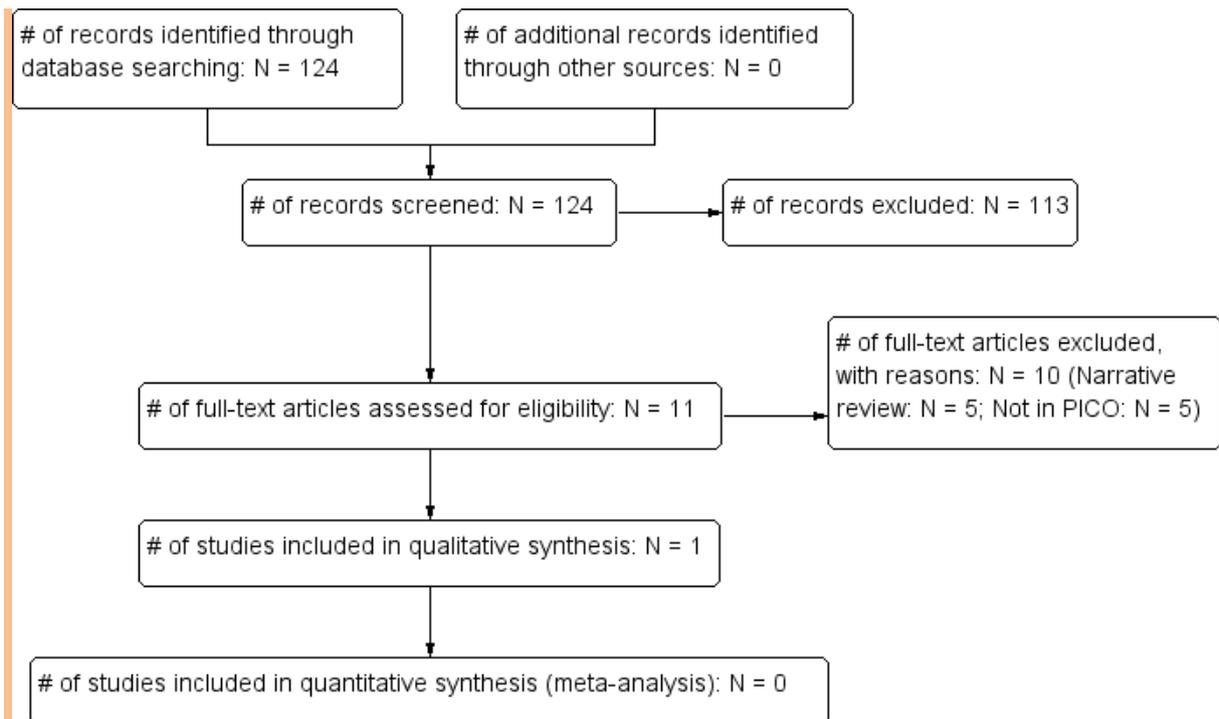
Database name	Dates Covered	No of references found	No of references retrieved	Finish date of search
<i>Medline</i>	All-2012	344	68	29/10/2012
<i>Premedline</i>	All-2012	2	1	29/10/2012
<i>Embase</i>	All-2012	398	53	01/11/2012
<i>Cochrane Library</i>	All-2012	172	0	01/11/2012
<i>Psychinfo</i>	All-2012	0	0	01/11/2012
<i>Web of Science (SCI & SSCI) and ISI Proceedings</i>	All-2012	211	3	01/11/2012
<i>Biomed Central</i>	All-2012	217	5	05/11/2012

Total References retrieved (after de-duplication): 117

Update Search

Database name	Dates Covered	No of references found	No of references retrieved	Finish date of search
<i>Medline</i>	11/2012-26/08/2014	25	2	26/08/2014
<i>Premedline</i>	11/2012-26/08/2014	4	3	26/08/2014
<i>Embase</i>	11/2012-26/08/2014	40	2	26/08/2014
<i>Cochrane Library</i>	11/2012-26/08/2014	155	0	26/08/2014
<i>Web of Science (SCI & SSCI) and ISI Proceedings</i>	11/2012-26/08/2014	23	0	26/08/2014

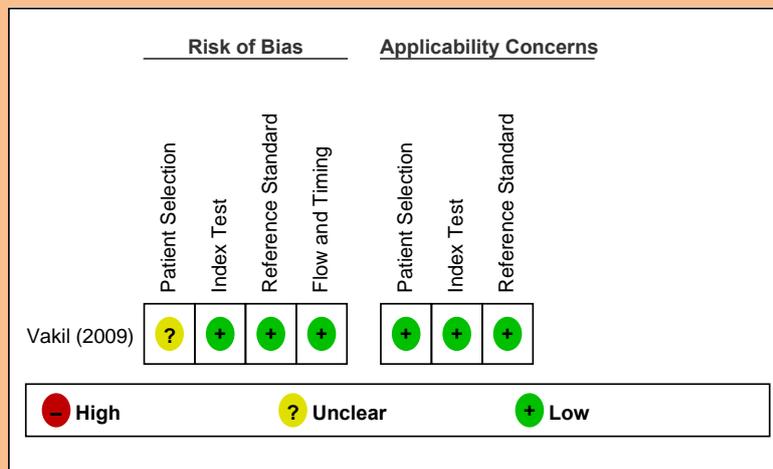
Total References retrieved (after de-duplication): 7



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Risk of bias in the included studies

The risk of bias and applicability concerns are summarised for the included study in the figure below. The main issue to note is that the patient recruitment method is unclear and that the study patients may therefore not be directly representative of an unselected symptomatic population of patients presenting to the UK-based GP.



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Study results

Table 1: Small intestinal cancer: Study results.

Study	Symptom(s)	Patient group	PPVs % (95% CI); prevalence
Vakil (2009)	Dyspepsia without alarm symptoms	All included patients	0.2 (0.09-0.5) 6/2741 Cancer:

			Oesophagus: N = 3 Stomach: N = 3
Vakil (2009)	Dyspepsia without alarm symptoms	Patients ≥ 45 years old	0.4 (0.2-1.1) 5/1127 Cancer: Oesophagus: N = 2 Stomach: N = 3
Vakil (2009)	Dyspepsia without alarm symptoms	Patients ≥ 50 years old	0.6 (0.2-1.5) 5/829 Cancer: Oesophagus: N = 2 Stomach: N = 3
Vakil (2009)	Dyspepsia without alarm symptoms	Patients ≥ 55 years old	0.2 (0.009-1.2) 1/554 Cancer: Oesophagus: N = 1 Stomach: N = 0
Vakil (2009)	Dyspepsia without alarm symptoms	Patients ≥ 60 years old	0.3 (0.02-2) 1/323 Cancer: Oesophagus: N = 1 Stomach: N = 0

1 TP = True positives, FP = False positives.

2

3 **Evidence statement(s):**

4 Dyspepsia without accompanying alarm features (1 study, N = 2741) presenting in a primary care
5 setting do not appear to confer an increased risk of small intestine cancer, although the study
6 population is probably not directly representative of the typical unselected symptomatic UK GP
7 population (see also Table 1).

8

9 **Evidence tables**

10 **Vakil (2009)**

PATIENT SELECTION	
A. risk of bias	
Patient sampling	Prospective patient series
Was a consecutive or random sample of patients enrolled?	Unclear
Was a case-control design avoided?	Yes
Did the study avoid inappropriate exclusions?	Yes (probably)
Could the selection of patients have introduced bias?	Unclear risk
B. Concerns regarding applicability	
Patient characteristics and setting	N = 2741, mean (range) age = not reported (not reported) years, numbers of females/males: Not reported. <u>Inclusion criteria:</u> Patients aged 18-70 years who met Rome II criteria for dyspepsia (intermittent or continuous pain or burning centered in the upper abdomen for ≥ 3 months). <u>Exclusion criteria:</u> Past diagnosis of gastro-oesophageal reflux disease,

	<p>predominant symptom of heartburn or regurgitation, history of heartburn or regurgitation > 2 days/week, treatment > 2 days/week with non-steroidal anti-inflammatory drugs or cyclooxygenase-2 selective inhibitors or aspirin (except for cardiovascular prophylaxis at doses ≤ 325 mg/day), concurrent alarm features (e.g., dysphagia, recurrent vomiting, unexplained anaemia, gastro-intestinal bleeding), H pylori eradication treatment within 12 months, maintenance therapy with either a proton pump or an H2-receptor antagonist within 6 months.</p> <p><u>Clinical setting:</u> The study was conducted in 190 primary care health centers in 17 countries (Argentina, Belgium, Brazil, Canada, Denmark, France, Germany, Greece, Iceland, Italy, Norway, Romania, Singapore, South Africa, Spain, Sweden, Switzerland). Patients were recruited from primary care clinics where flyers publicising the study were placed and the primary care physicians recruited patients presenting to their offices with dyspepsia [random or consecutive sampling unlikely].</p>
Are there concerns that the included patients and setting do not match the review question?	Low concern
INDEX TEST	
A. Risk of bias	
Index test	Dyspepsia/ intermittent or continuous pain or burning centered in the upper abdomen for ≥ 3 months. Symptoms were evaluated using a scale validated in a number of languages
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes
Could the conduct or interpretation of the index test have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the index test, its conduct, or interpretation differ from the review question?	Low concern
REFERENCE STANDARD	
A. risk of bias	
Reference standard(s)	All patients received outpatient endoscopy
Is the reference standard likely to correctly classify the target condition?	Yes
Were the reference standard results interpreted without knowledge of the results of the index tests?	No (but all patients had a positive index test)
Could the reference standard, its conduct, or its interpretation have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the target condition as defined by the reference standard does not match the question?	Low concern
FLOW AND TIMING	
A. risk of bias	
Flow and timing	All the patients are accounted for in the results.
Was there an appropriate interval between index test and reference standard?	Yes (probably)

Did all patients receive the same reference standard?	Yes
Were all patients included in the analysis?	Yes
Could the patient flow have introduced bias?	Low risk
NOTES	Supported by AstraZeneca R&D Sweden. The authors state that “The sponsor did not play any role in the calculations or in the writing of the manuscript”.

1

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Review question:

25 Which investigations of symptoms of suspected small intestine cancer should be done with clinical
 26 responsibility retained by primary care?

Results**Literature search**

Database name	Dates Covered	No of references found	No of references retrieved	Finish date of search
<i>Medline</i>	1980-2013	299	59	03/06/2013
<i>Premedline</i>	1980-2013	15	10	03/06/2013
<i>Embase</i>	1980-2013	114	48	03/06/2013
<i>Cochrane Library</i>	1980-2013	79	0	03/06/2013
<i>Psychinfo</i>	1980-2013	0	0	03/06/2013
<i>Web of Science (SCI & SSCI) and ISI Proceedings</i>	1980-2013	27	6	03/06/2013

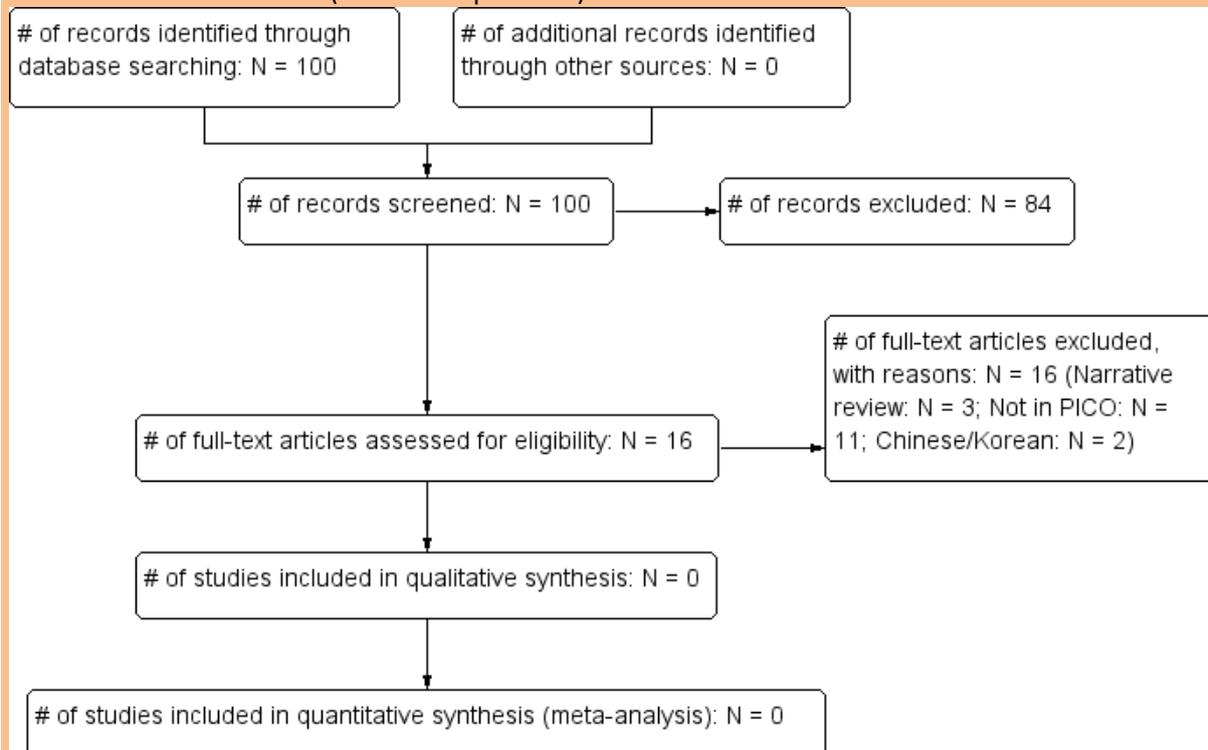
29 Total References retrieved (after de-duplication): 95

Update Search

Database name	Dates Covered	No of references found	No of references retrieved	Finish date of search
<i>Medline</i>	6/2013- 26/08/2014	14	0	26/08/2014
<i>Premedline</i>	6/2013- 26/08/2014	37	4	26/08/2014
<i>Embase</i>	6/2013- 26/08/2014	15	1	26/08/2014

Cochrane Library	6/2013-26/08/2014	12	0	26/08/2014
Web of Science (SCI & SSCI) and ISI Proceedings	6/2013-26/08/2014	1	1	26/08/2014

1 Total References retrieved (after de-duplication): 5



2

3 **Study results**

4 No evidence was identified pertaining to the diagnostic accuracy of CT scan, barium follow
 5 through or capsule endoscopy in patients with suspected small intestine cancer where the
 6 clinical responsibility was retained by primary care.

7

8 **References**

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10 None

11

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8

GALL BLADDER CANCER**Review question:**

What is the risk of gall bladder cancer in patients presenting in primary care with symptom(s)?

Results**Literature search**

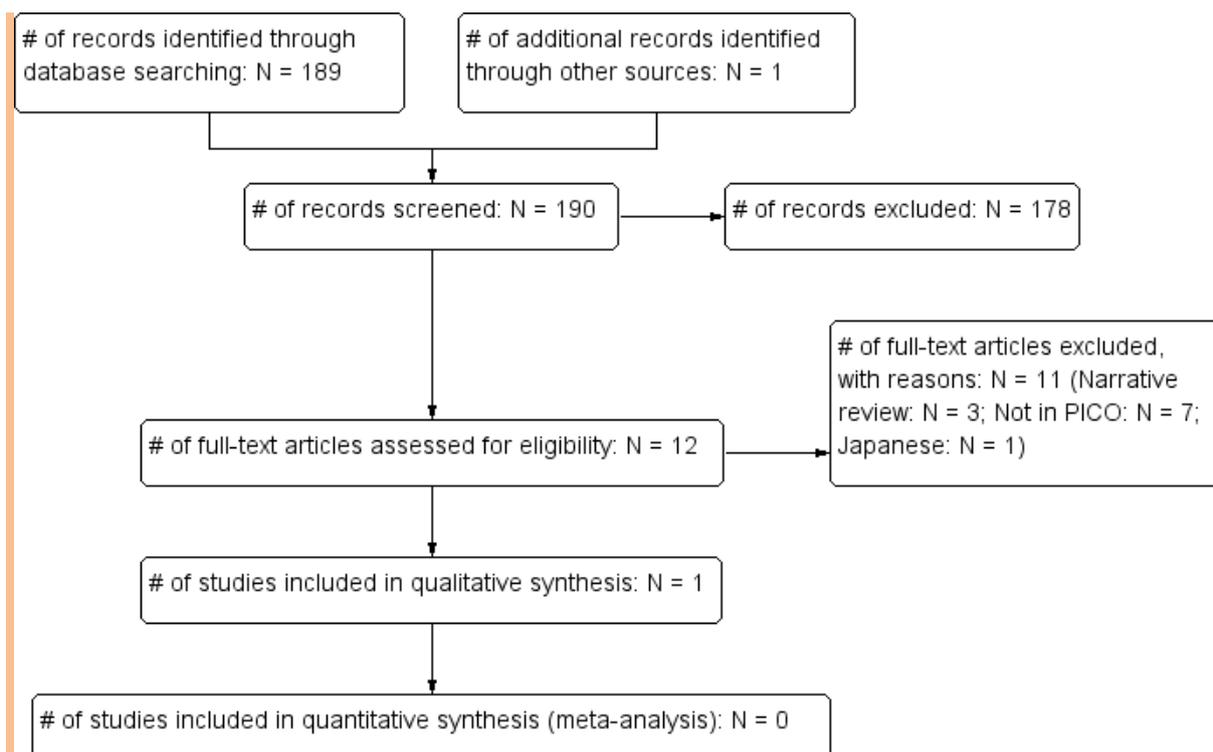
Database name	Dates Covered	No of references found	No of references retrieved	Finish date of search
<i>Medline</i>	All-2012	691	113	05/11/2012
<i>Premedline</i>	All-2012	24	6	05/11/2012
<i>Embase</i>	All-2012	1010	94	07/11/2012
<i>Cochrane Library</i>	All-2012	160	0	07/11/2012
<i>Psychinfo</i>	All-2012	1	1	05/11/2012
<i>Web of Science (SCI & SSCI) and ISI Proceedings</i>	All-2012	75	7	07/11/2012
<i>Biomed Central</i>	All-2012	82	0	07/11/2012

Total References retrieved (after de-duplication): 182

Update Search

Database name	Dates Covered	No of references found	No of references retrieved	Finish date of search
<i>Medline</i>	11/2012-26/08/2014	35	1	26/08/2014
<i>Premedline</i>	11/2012-26/08/2014	59	2	26/08/2014
<i>Embase</i>	11/2012-26/08/2014	200	4	26/08/2014
<i>Cochrane Library</i>	11/2012-26/08/2014	38	0	26/08/2014
<i>Web of Science (SCI & SSCI) and ISI Proceedings</i>	11/2012-26/08/2014	20	0	26/08/2014

Total References retrieved (after de-duplication): 7



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Risk of bias in the included studies

The risk of bias and applicability concerns are summarised for the included study in the figure below. The main issue to note is that the patient sample may not be directly applicable to the current question.

	Risk of Bias				Applicability Concerns		
	Patient Selection	Index Test	Reference Standard	Flow and Timing	Patient Selection	Index Test	Reference Standard
Hallissey (1990)	+	+	+	+	?	+	+

● High	● Unclear	● Low
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Study results

Table 1: Gall bladder cancer: Positive predictive values for gall bladder cancer

Study	Symptom(s)	Patient group	Positive predictive value (95% CI)
Hallissey (1990)	Dyspepsia	All patients	0.04 (0.002-0.3) 1/2585

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8**Evidence statement(s):**

The positive predictive value of having gall bladder cancer was 0.04% (for dyspepsia) for patients aged > 40 years (1 study, N = 2585). The included study was associated with 1 applicability concern (see also Table 1).

Evidence tables**Hallissey (1990)**

PATIENT SELECTION	
A. risk of bias	
Patient sampling	Propective consecutive patient series from a group of 10 general practices in England.
Was a consecutive or random sample of patients enrolled?	Yes
Was a case-control design avoided?	Yes
Did the study avoid inappropriate exclusions?	Yes
Could the selection of patients have introduced bias?	Low risk
B. Concerns regarding applicability	
Patient characteristics and setting	N = 2585 aged > 40 years. No other information reported. The patient group was equally divided between new patients with dyspepsia, old patients with uninvestigated dyspepsia, and old patients with investigated dyspepsia. <u>Inclusion criteria:</u> All patients over 40 years making their first attendance during the study period (4 years and 9 months) with any degree of dyspepsia <u>Exclusion criteria:</u> None listed. <u>Clinical setting:</u> Primary care, England.
Are there concerns that the included patients and setting do not match the review question?	Unclear concern
INDEX TEST	
A. Risk of bias	
Index test	Dyspepsia of any degree
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes
Could the conduct or interpretation of the index test have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the index test, its conduct, or interpretation differ from the review question?	Low concern
REFERENCE STANDARD	
A. risk of bias	
Reference standard(s)	Upper gastrointestinal endoscopy within 4 weeks and follow up.
Is the reference standard likely to correctly classify the target condition?	Yes
Were the reference standard results interpreted without knowledge of the results of the index tests?	No
Could the reference standard, its conduct, or its	Low risk

interpretation have introduced bias?		
B. Concerns regarding applicability		
Are there concerns that the target condition as defined by the reference standard does not match the question?		Low concern
FLOW AND TIMING		
A. risk of bias		
Flow and timing	2659 patients were seen and 2585 attended for investigation	
Was there an appropriate interval between index test and reference standard?	Yes	
Did all patients receive the same reference standard?	Yes	
Were all patients included in the analysis?	Yes	
Could the patient flow have introduced bias?		Low risk
NOTES	Malignancy was detected in 115 patients: Gastric adenocarcinoma (57), gastric lymphoma (1; added to the gastric adenocarcinoma data in the PPV), oesophageal cancer (15), colorectal (14), pancreatic (6), bronchial (8), prostatic (2), duodenal (1, also added to the gastric carcinoma data in the PPV), liver (1), gall bladder (1), carcinoid (1), uterine (1), leukaemia (1), cirrinomatosis of unknown primary (7).	

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27 Review question:

28 Which investigations of symptoms of suspected gall bladder cancer should be done with clinical
29 responsibility retained by primary care?

30 Results

31 Literature search

Database name	Dates Covered	No of references found	No of references retrieved	Finish date of search
<i>Medline</i>	1980-2013	348	100	08/05/2013
<i>Premedline</i>	1980-2013	19	4	08/05/2013
<i>Embase</i>	1980-2013	509	69	09/05/2013
<i>Cochrane Library</i>	1980-2013	31	0	09/05/2013
<i>Psychinfo</i>	1980-2013	0	0	09/05/2013
<i>Web of Science (SCI & SSCI) and ISI Proceedings</i>	1980-2013	21	5	09/05/2013

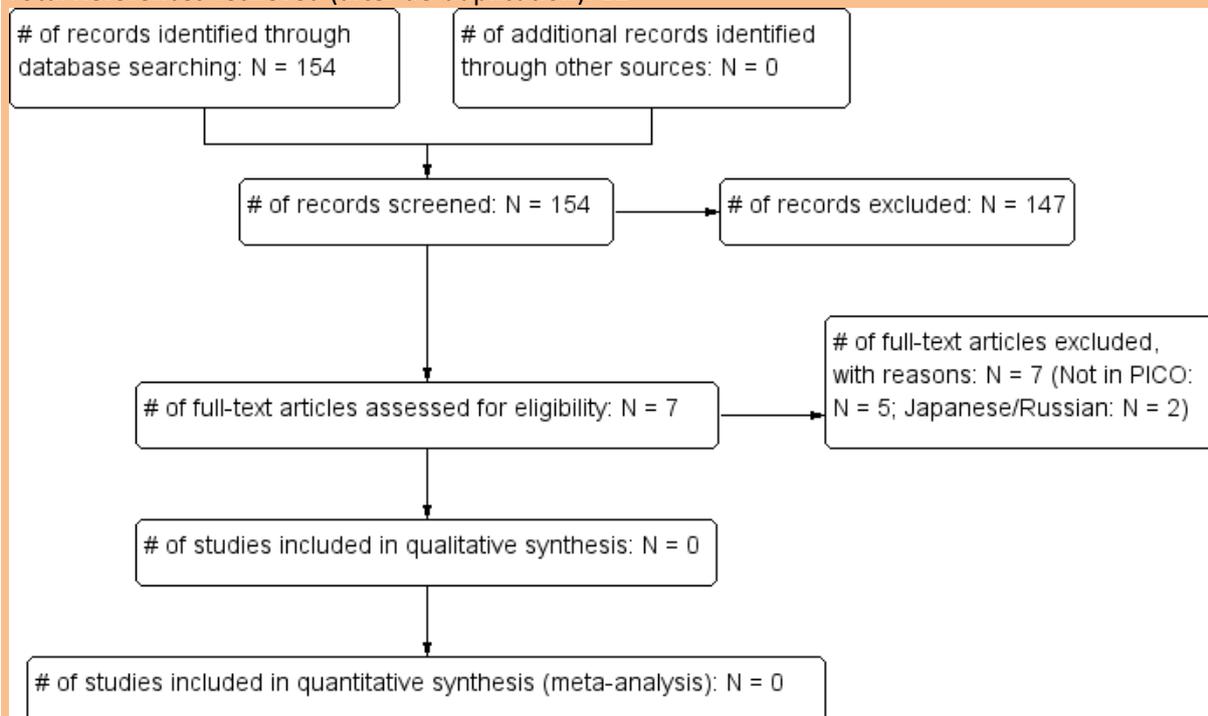
32 Total References retrieved (after de-duplication): 142

34 Update Search

Database name	Dates Covered	No of references found	No of references retrieved	Finish date of search
<i>Medline</i>	5/2013-26/08/2014	9	0	26/08/2014
<i>Premedline</i>	5/2013-26/08/2014	16	3	26/08/2014

Embase	5/2013-26/08/2014	75	11	26/08/2014
Cochrane Library	5/2013-26/08/2014	34	0	26/08/2014
Web of Science (SCI & SSCI) and ISI Proceedings	5/2013-26/08/2014	9	0	26/08/2014

1 Total References retrieved (after de-duplication): 12



2

3 **Study results**

4 No evidence was identified pertaining to the diagnostic accuracy of CT scan, ultrasound, liver
 5 function tests or tumour marker CA19-9 in patients with suspected gall bladder cancer where the
 6 clinical responsibility was retained by primary care.

7

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11

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LIVER CANCER**Review question:**

What is the risk of liver cancer in patients presenting in primary care with symptom(s)?

Results**Literature search**

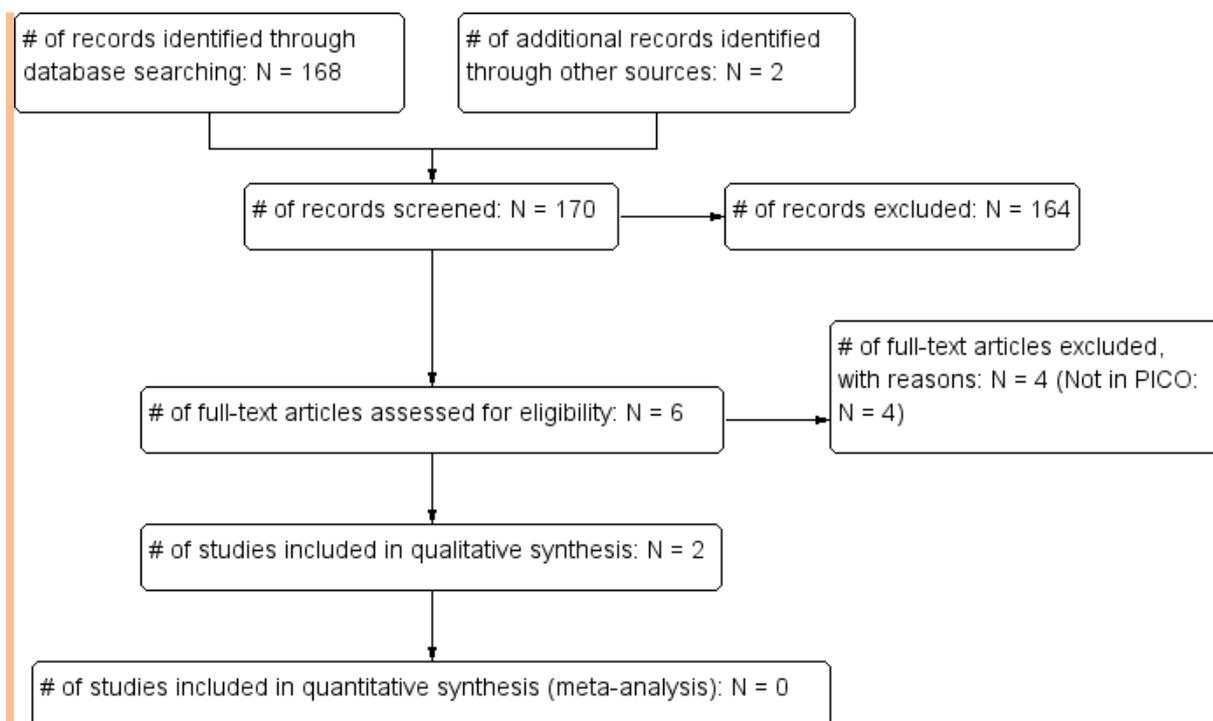
Database name	Dates Covered	No of references found	No of references retrieved	Finish date of search
<i>Medline</i>	All-2012	1073	71	30/04/2013
<i>Premedline</i>	All-2012	155	9	01/05/2013
<i>Embase</i>	All-2012	1305	93	02/05/2013
<i>Cochrane Library</i>	All-2012	459	0	03/05/2013
<i>Psychinfo</i>	All-2012	20	2	30/04/2013
<i>Web of Science (SCI & SSCI) and ISI Proceedings</i>	All-2012	771	31	03/05/2013

Total References retrieved (after de-duplication): 164

Update Search

Database name	Dates Covered	No of references found	No of references retrieved	Finish date of search
<i>Medline</i>	5/2013-19/08/2014	28	1	19/08/2014
<i>Premedline</i>	5/2013-19/08/2014	101	2	19/08/2014
<i>Embase</i>	5/2013-19/08/2014	163	2	19/08/2014
<i>Cochrane Library</i>	5/2013-19/08/2014	202	0	19/08/2014
<i>Web of Science (SCI & SSCI) and ISI Proceedings</i>	5/2013-19/08/2014	139	0	19/08/2014

Total References retrieved (after de-duplication): 4



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Study results

Risk of bias in the included studies

The risk of bias and applicability concerns are summarised for the included studies in the figure below. In one of the included studies, the main issue to note is that the population in the study comprises a mix of 'old' and 'new' investigated or uninvestigated symptoms, and it is unclear how directly applicable this sample is to the current question. In the other included study, it is unclear whether the patient selection was consecutive. This study also used a sub-optimal reference standard and was also subject to varying degrees of missing data; all of which challenges the validity of the reported results.

	Risk of Bias				Applicability Concerns		
	Patient Selection	Index Test	Reference Standard	Flow and Timing	Patient Selection	Index Test	Reference Standard
Hallissey (1990)	+	+	+	+	?	+	+
Lilford (2013)	?	+	?	-	+	+	+

● High	● Unclear	● Low
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Study results

Table 1: Liver cancer: Single symptoms

Study	Symptom(s)	Patient group	Positive predictive value % (95% CI)
Hallissey (1990)	Dyspepsia	All patients	0.04 (0.002-0.25) 1/2585
Lilford (2013)	LFT: Abnormal alanine aminotransferase	All patients	0.46 (0.08-1.8) 2/438
Lilford (2013)	LFT: Abnormal aspartate aminotransferase	All patients	0.39 (0.02-2.5) 1/255
Lilford (2013)	LFT: Abnormal γ -glutamyltransferase	All patients	0.92 (0.43-1.9) 8/867
Lilford (2013)	LFT: Abnormal bilirubin	All patients	0 (0-3.2) 0/148
Lilford (2013)	LFT: Abnormal alkaline phosphatase	All patients	1.59 (0.41-4.9) 3/189
Lilford (2013)	LFT: Abnormal albumin	All patients	0 (0-14) 0/30
Lilford (2013)	LFT: Abnormal globulin	All patients	0 (0-8.1) 0/55
Lilford (2013)	LFT: Abnormal total protein	All patients	0 (0-4.7) 0/97

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Evidence statement(s):

The positive predictive value for liver cancer ranged from 0% (for abnormal bilirubin/ albumin/ globulin/ total [hepatic] protein) to 1.59% (for abnormal alkaline phosphatase; 2 studies, N = 3875) presenting in primary care was 0.04%. The included studies were associated with 1-3 bias/applicability concerns (see also Table 1).

Evidence tables

Hallissey (1990)

PATIENT SELECTION	
A. risk of bias	
Patient sampling	Prospective consecutive patient series from a group of 10 general practices in England.
Was a consecutive or random sample of patients enrolled?	Yes
Was a case-control design avoided?	Yes
Did the study avoid inappropriate exclusions?	Yes
Could the selection of patients have introduced bias?	Low risk
B. Concerns regarding applicability	
Patient characteristics and setting	N = 2585 aged > 40 years. No other information reported. The patient group was equally divided between new patients with dyspepsia, old patients with uninvestigated dyspepsia, and old patients with investigated dyspepsia. <u>Inclusion criteria:</u> All patients over 40 years making their first attendance during the study period (4 years and 9 months) with any degree of dyspepsia <u>Exclusion criteria:</u> None listed. <u>Clinical setting:</u> Primary care, England.

Are there concerns that the included patients and setting do not match the review question?	Unclear concern
INDEX TEST	
A. Risk of bias	
Index test	Dyspepsia of any degree
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes
Could the conduct or interpretation of the index test have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the index test, its conduct, or interpretation differ from the review question?	Low concern
REFERENCE STANDARD	
A. risk of bias	
Reference standard(s)	Upper gastrointestinal endoscopy within 4 weeks and follow up.
Is the reference standard likely to correctly classify the target condition?	Yes
Were the reference standard results interpreted without knowledge of the results of the index tests?	No
Could the reference standard, its conduct, or its interpretation have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the target condition as defined by the reference standard does not match the question?	Low concern
FLOW AND TIMING	
A. risk of bias	
Flow and timing	2659 patients were seen and 2585 attended for investigation
Was there an appropriate interval between index test and reference standard?	Yes
Did all patients receive the same reference standard?	Yes
Were all patients included in the analysis?	Yes
Could the patient flow have introduced bias?	Low risk
NOTES	Malignancy was detected in 115 patients: Gastric adenocarcinoma (57), gastric lymphoma (1; added to the gastric adenocarcinoma data in the PPV), oesophageal cancer (15), colorectal (14), pancreatic (6), bronchial (8), prostatic (2), duodenal (1, also added to the gastric carcinoma data in the PPV), liver (1), gall bladder (1), carcinoid (1), uterine (1), leukaemia (1), carcinomatosis of unknown primary (7).
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2	Lilford (2013)
PATIENT SELECTION	
A. risk of bias	
Patient sampling	Prospective UK study of patients with an abnormal LFT panel across eight primary care practices in Birmingham and three in the Lambeth area of London, UK.
Was a consecutive or random sample of patients enrolled?	Unclear

Was a case-control design avoided?	Yes
Did the study avoid inappropriate exclusions?	Unclear
Could the selection of patients have introduced bias?	Unclear risk
B. Concerns regarding applicability	
Patient characteristics and setting	N = 1290; 724 males / 566 females; aged ≤ 34 years: N = 106; 35-44 years: N = 165; 45-54 years: N = 240; 55-64 years: N = 325; 65-74 years: N = 273; 75+ years: N = 181. Reason for testing: Signs and symptoms: N = 406; chronic disease review: N = 884; alcohol at follow up (unit/week): 0: N = 547; 1-14: N = 352; 15-29: N = 153; 30-49: N = 122; 50-99: N = 84; 100+: N = 24; not known: N = 8. <u>Inclusion criteria:</u> Primary care patients without obvious or pre-existing liver disease, and one or more of the eight analytes in an index LFT panel was abnormal. Recruitment took place from 2005 to 2008. Eligible patients were invited to join the study and attend a first follow-up session. <u>Exclusion criteria:</u> None listed. <u>Clinical setting:</u> Primary care, England.
Are there concerns that the included patients and setting do not match the review question?	Low concern
INDEX TEST	
A. Risk of bias	
Index test	“The index panel comprised: alanine aminotransferase (ALT), aspartate aminotransferase (AST), γ-glutamyltransferase (GGT), bilirubin (Bili), alkaline phosphatase (ALP), albumin (Alb), globulin (Glob), and total protein (Tprot). Analyte abnormality was determined using standard laboratory reference ranges, which are routinely adjusted for age and gender where appropriate.” The measurement of these was repeated at a first follow up session (taking place a median of 30 days post-first LFT measures (IQR 21-51 days).
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes
Could the conduct or interpretation of the index test have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the index test, its conduct, or interpretation differ from the review question?	Low concern
REFERENCE STANDARD	
A. risk of bias	
Reference standard(s)	Diagnosis of any tumours of the hepatobiliary system based on ultrasound of the upper abdomen + exclusion of other hepatic diseases and hepatologist’s opinion along with follow up.
Is the reference standard likely to correctly classify the target condition?	Unclear
Were the reference standard results interpreted without knowledge of the results of the index tests?	No
Could the reference standard, its conduct, or its interpretation have introduced bias?	Unclear risk
B. Concerns regarding applicability	
Are there concerns that the target condition as defined	Low concern

by the reference standard does not match the question?		
FLOW AND TIMING		
A. risk of bias		
Flow and timing	The authors report the results both for the initial testing (that identified the patients in the first place) and for the follow up session (a median of 30 days later). The results reported here are limited to the former, which across the panel of 8 LFTs varied between 977 and 1278 of the included 1290.	
Was there an appropriate interval between index test and reference standard?		Yes
Did all patients receive the same reference standard?		Yes
Were all patients included in the analysis?		No
Could the patient flow have introduced bias?		Unclear risk
NOTES		

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1 **Review question:**

2 Which investigations of symptoms of suspected liver cancer should be done with clinical
3 responsibility retained by primary care?

4 **Results**5 **Literature search**

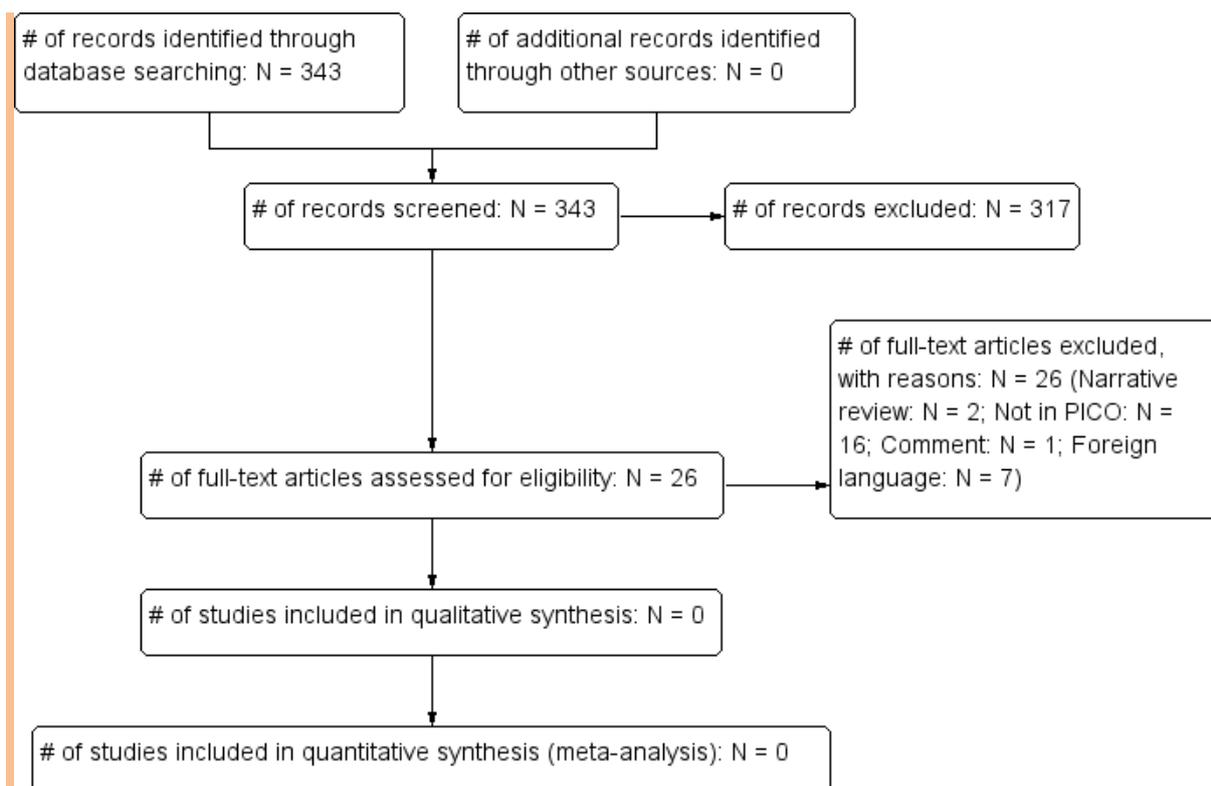
Database name	Dates Covered	No of references found	No of references retrieved	Finish date of search
<i>Medline</i>	1980-2013	992	190	21/05/2013
<i>Premedline</i>	1980-2013	75	19	22/05/2013
<i>Embase</i>	1980-2013	1742	176	22/05/2013
<i>Cochrane Library</i>	1980-2013	182	2	22/05/2013
<i>Psychinfo</i>	1980-2013	1	0	22/05/2013
<i>Web of Science (SCI & SSCI) and ISI Proceedings</i>	1980-2013	108	10	22/05/2013

6 Total References retrieved (after de-duplication): 329

7
8 **Update Search**

Database name	Dates Covered	No of references found	No of references retrieved	Finish date of search
<i>Medline</i>	5/2013-19/08/2014	23	2	19/08/2014
<i>Premedline</i>	5/2013-19/08/2014	73	5	19/08/2014
<i>Embase</i>	5/2013-19/08/2014	70	5	19/08/2014
<i>Cochrane Library</i>	5/2013-19/08/2014	92	0	19/08/2014
<i>Web of Science (SCI & SSCI) and ISI Proceedings</i>	5/2013-19/08/2014	25	4	19/08/2014

9 Total References retrieved (after de-duplication): 14
10



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2 **Study results**

3 No evidence was identified pertaining to the diagnostic accuracy of ultrasound, CT, MRI or alpha feta
 4 protein in patients with suspected liver cancer where the clinical responsibility was retained by
 5 primary care.
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LOWER GASTRO-INTESTINAL TRACT CANCERS**COLORECTAL CANCER****Review question:**

What is the risk of colorectal cancer in patients presenting in primary care with symptom(s)?

Results**Literature search**

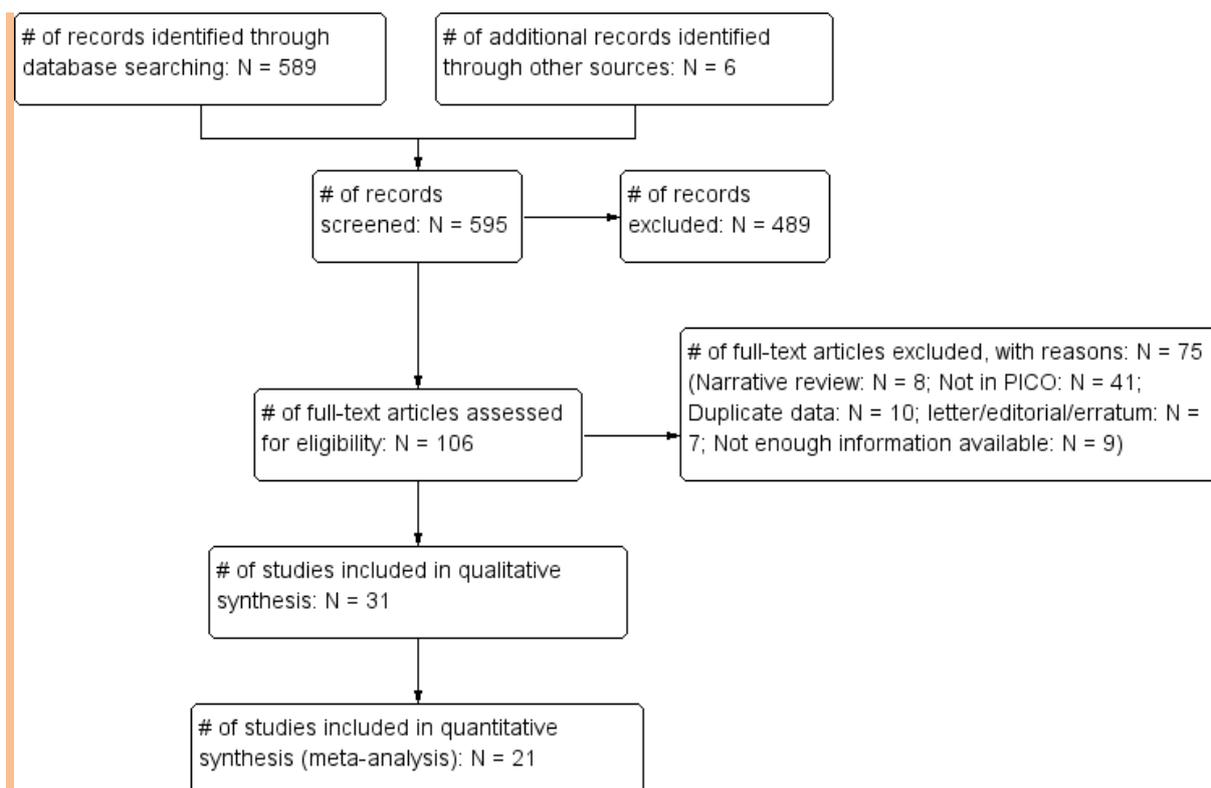
Database name	Dates Covered	No of references found	No of references retrieved	Finish date of search
<i>Medline</i>	All - 2012	3575	329	10/08/2012
<i>Premedline</i>	All - 2012	16	12	11/07/2012
<i>Embase</i>	All - 2012	4169	279	18/07/2012
<i>Cochrane Library</i>	All - 2012	725	5	18/07/2012
<i>Psychinfo</i>	All - 2012	12	4	18/07/2012
<i>Web of Science (SCI & SSCI) and ISI Proceedings</i>	All - 2012	1207	53	18/07/2012
<i>Biomed Central</i>	All - 2012	1680	1	18/07/2012

Total References retrieved (after de-duplication): 519

Update Search

Database name	Dates Covered	No of references found	No of references retrieved	Finish date of search
<i>Medline</i>	7/2012-13/08/2014	172	24	13/08/2014
<i>Premedline</i>	7/2012-13/08/2014	98	20	13/08/2014
<i>Embase</i>	7/2012-13/08/2014	655	31	13/08/2014
<i>Cochrane Library</i>	7/2012-13/08/2014	23	0	13/08/2014
<i>Web of Science (SCI & SSCI) and ISI Proceedings</i>	7/2012-13/08/2014	297	3	13/08/2014

Total References retrieved (after de-duplication): 70



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Risk of bias in the included studies

The risk of bias and applicability concerns are summarised per study in the figure below. The main bias and validity issues to note relates to patient selection and applicability with some studies employing non-consecutive patient sampling, e.g., case-control designs (which has been shown to be associated with inflated test accuracy parameters compared to designs that incorporate random or consecutive patient selection), and others being conducted in setting or with patients that may not directly translate to the current question and UK-based primary care. The other main issues of concern relates to missing data (and the concern that this may not be missing at random) and under specification of symptoms and reference standards, which makes it difficult to ascertain their applicability and/or validity.

	Risk of Bias				Applicability Concerns		
	Patient Selection	Index Test	Reference Standard	Flow and Timing	Patient Selection	Index Test	Reference Standard
Bellentani (1990)	+	+	+	+	?	?	+
Collins (2012)	+	+	+	+	+	+	+
Droogendijk (2011)	+	+	+	?	?	+	+
Du Toit (2006)	+	+	+	+	+	+	+
Ellis (2005)	?	+	+	+	+	+	+
Farrus Palou (2000)	+	+	?	-	?	+	?
Fijten (1995)	+	+	?	?	?	+	+
Hallissey (1990)	+	+	+	+	?	+	+
Hamilton (2005)	-	+	+	+	+	+	+
Hamilton (2008)	-	+	+	?	+	+	+
Hamilton (2009)	-	+	+	+	+	+	+
Heikkinen (1995)	+	+	+	+	?	+	+
Heintze (2005)	-	+	+	-	+	+	+
Helfand (1997)	+	+	+	+	-	+	+
Hippisley-Cox (2012)	+	+	+	+	+	+	+
Jones (2007)	+	+	+	+	+	+	+
Lawrenson (2006)	+	+	+	+	+	+	+
Lucas (1996)	+	+	+	+	?	+	+
Mant (1989)	+	+	+	+	?	+	+
Meineche-Schmidt (2002)	+	+	+	+	?	+	+
Metcalf (1996)	+	+	+	+	+	+	+
Muris (1993)	+	+	+	+	?	?	+
Muris (1995)	-	+	+	+	-	-	+
Nørrelund (1996)	?	+	+	+	+	+	+
Oudega (2006)	+	+	+	+	?	+	+
Panzuto (2003)	-	+	+	?	?	+	+
Parker (2007)	+	+	+	+	+	+	+
Robertson (2006)	+	+	+	+	+	+	+
Stellon (1997)	+	+	+	+	+	+	+
Wauters (2000)	?	+	+	+	?	+	+
Yates (2004)	+	+	+	+	?	+	+

- High
 ? Unclear
 + Low

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4**Study results**

Table 1: Colorectal cancer: Meta-analyses

Studies included	Symptom(s)	Patient group	Positive predictive value, % (95% CI)
Collins (2012) Du Toit (2006) Ellis (2005) Fijten (1995) Heintze (2005) Helfand (1997) Hippisley-Cox (2012) Jones (2007, at 6 months) Mant (1989) Metcalf (1996) Nørrelund (1996) Panzuto (2003) Parker (2007) Robertson (2006) Wauters (2000)	Rectal bleeding	All patients N = 132701	4.79 (3.37-6.77)
		Without Heintze (2005) and Panzuto (2003) N = 132187	4.41 (3.1-6.28)
Collins (2012) Du Toit (2006) Ellis (2005) Fijten (1995) Heintze (2005) Helfand (1997) Hippisley-Cox (2012) Jones (2007, at 3 years) Mant (1989) Metcalf (1996) Nørrelund (1996) Panzuto (2003) Parker (2007) Robertson (2006) Wauters (2000)	Rectal bleeding	All patients N = 132701	4.88 (3.48-6.79)
		Without Heintze (2005) and Panzuto (2003) N = 132187	4.5 (3.2-6.3)
Collins (2012) Bellentani (1990) Hippisley-Cox (2012) Panzuto (2003)	Abdominal pain	All patients N = 371703	2.04 (0.53-7.55)
		Without Panzuto (2003) N = 371480	1.02 (0.38-2.69)
Collins (2012) Droogendijk (2011) Farrus Palou (2000) Hippisley-Cox (2012) Lucas (1996) Panzuto (2003) Stellon (1997) Yates (2004)	Anaemia	All patients N = 35949	5.87 (2.64-12.)
		Without Panzuto (2003) N = 35880	4.09 (2.24-7.34)

Collins (2012) Hippisley-Cox (2012) Panzuto (2003)	Weight loss	All patients N = 42338	3 (0.32-22.89)
		Collins (2012) N = 28289	0.8 (0.7-0.9)
		Hippisley-Cox (2012) N = 14007	0.8 (0.7-0.9)
Hallissey (1990) Heikkinen (1995) Meineche-Schmidt (2002)	Dyspepsia	All patients N = 4476	0.6 (0.27-1.35)

1 Please note that the data from Hamilton (2005, 2008, 2009) are not included in these meta-analyses
2 due to the case-control design of the studies. These data are instead reported in the table below. In
3 addition, sensitivity analyses were conducted where the studies with a high risk of patient selection
4 bias were excluded. When the number of studies was < 3, the data were not meta-analysed, but
5 presented for the individual studies instead.

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Table 2: Colorectal cancer: Individual positive predictive values from the meta-analyses

Studies included	Symptom(s)	Patient group	Positive predictive value, % (95% CI)
Collins (2012)	Rectal bleeding	All patients (N = 56234)	2.4 (2.3-2.6)
Du Toit (2006)	Rectal bleeding	All patients (N = 265)	5.7 (3.3-9.4)
Ellis (2005),	Rectal bleeding	All patients (N = 319)	3.4 (1.8-6.3)
Fijten (1995),	Rectal bleeding	All patients (N = 269)	3.3 (1.6-6.5)
Heintze (2005)	Rectal bleeding	All patients (N = 400)	4.3 (2.6-6.9)
Helfand (1997)	Rectal bleeding	All patients (N = 201)	6.5 (3.6-11.1)
Hippisley-Cox (2012)	Rectal bleeding	All patients (N = 28952)	2.9 (2.7-3.1)
Jones (2007, at 6 months)	Rectal bleeding	All patients (N = 15289)	1.7 (1.5-1.9)
Jones (2007, at 3 years)	Rectal bleeding	All patients (N = 15289)	2.2 (2-2.5)
Mant (1989)	Rectal bleeding	All patients (N = 145)	11.7 (7.2-18.4)
Metcalf (1996)	Rectal bleeding	All patients (N = 99)	8.1 (3.8-15.8)
Nørrelund (1996)	Rectal bleeding	All patients (N = 417)	13.7 (10.6-17.4)
Panzuto (2003)	Rectal bleeding	All patients (N = 114)	15.8 (9.9-24.1)
Parker (2007)	Rectal bleeding	All patients (N = 29007)	2.2 (2.1-2.4)
Robertson (2006)	Rectal bleeding	All patients (N = 604)	3.6 (2.4-5.6)
Wauters (2000)	Rectal bleeding	All patients (N = 386)	7 (4.7-10.1)
Bellentani (1990)	Abdominal pain	All patients (N = 254)	3.9 (2-7.3)
Collins (2012)	Abdominal pain	All patients (N = 245989)	0.5 (0.5-0.5)
Hippisley-Cox (2012)	Abdominal pain	All patients (N = 125237)	0.7 (0.6-0.7)
Panzuto (2003)	Abdominal pain	All patients (N = 223)	13.5 (9.4-18.8)
Collins (2012)	Anaemia	All patients (N = 18125)	1.7 (1.5-1.9)
Droogendijk (2011)	Anaemia	All patients (N = 287)	8.4 (5.5-12.3)
Farrus Palou (2000)	Anaemia	All patients (N = 58)	3.4 (0.6-13)
Hippisley-Cox (2012)	Anaemia	All patients (N = 16823)	1.5 (1.3-1.7)
Lucas (1996)	Anaemia	All patients (N = 130)	6.9 (3.4-13.1)
Panzuto (2003)	Anaemia	All patients (N = 69)	40.6 (29.1-53.1)
Stellon (1997)	Anaemia	All patients (N = 26)	7.7 (1.3-26.6)

Yates (2004)	Anaemia	All patients (N = 431)	8.6 (6.2-11.7)
Collins (2012)	Weight loss	All patients (N = 28289)	0.8 (0.7-0.9)
Hippisley-Cox (2012)	Weight loss	All patients (N = 14007)	0.8 (0.7-0.9)
Panzuto (2003)	Weight loss	All patients (N = 42)	35.7 (22-52)
Hallissey (1990)	Dyspepsia	All patients	0.5 (0.3-0.9) 14/2585
Heikkinen (1995)	Dyspepsia	All patients	0/400
Meineche-Schmidt (2002)	Dyspepsia	All patients	1.14 (0.7-1.9)

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Table 3: Colorectal cancer: Additional results reported by the individual papers: Individual symptoms

Study	Symptom(s)	Patient group	Positive predictive value, % (95% CI)
Hamilton (2005)	Rectal bleeding (reported once)	All patients	2.4 (1.9-3.2) Cases: 148/349 Controls: 73/1744
Hamilton (2005)	Rectal bleeding (reported twice)	All patients	6.8 (NR)
Hamilton (2005)	Constipation (reported once)	All patients	0.42 (0.3-0.5) Cases: 91/349 Controls: 258/1744
Hamilton (2005)	Constipation (reported twice)	All patients	0.81 (0.5-1.3)
Panzuto (2003)	Constipation	All patients	15.7 (10.2-23.2) 21/134
Hamilton (2005)	Diarrhoea (reported once)	All patients	0.94 (0.7-1.1) Cases: 132/349 Controls: 171/1744
Panzuto (2003)	Diarrhoea	All patients	11.8 (6.1-21)
Hamilton (2005)	Diarrhoea (reported twice)	All patients	1.5 (1-2.2)
Panzuto (2003)	Bloating	All patients	13.2 (8.6-19.5) 22/167
Panzuto (2003)	Change in bowel habit	All patients	14 (6.7-26.3) 8/57
Hamilton (2005)	Loss of weight (reported once)	All patients	1.2 (0.9-1.6) Cases: 94/349 Controls: 92/1744
Hamilton (2005)	Loss of weight (reported twice)	All patients	1.4 (0.8-2.6)
Collins (2012)	Loss of appetite	All patients	0.8 (0.6-1.1)
Hippisley-Cox (2012)	Loss of appetite	All patients	0.9 (0.6-1.2)
Hamilton (2005)	Abdominal pain (reported once)	All patients	1.1 (0.9-1.3) Cases: 148/349 Controls: 163/1744
Hamilton (2005)	Abdominal pain (reported twice)	All patients	3 (1.8-5.2)
Hamilton (2005)	Abdominal tenderness (reported once)	All patients	1.1 (0.8-1.5) Cases: 62/349 Controls: 67/1744

Muris (1993)	Non-acute abdominal complaints	All patients	0.52 (0.1-1.6)
Muris (1995)	Non-acute abdominal complaints	All patients	0.43 (0.1-1.2)
Hamilton (2005)	Abnormal rectal exam (reported once)	All patients	1.5 (1-2.2) Cases: 51/349 Controls: 14/1744
Hamilton (2005)	Haemoglobin 10-13 g dl ⁻¹ (reported once)	All patients	0.97 (0.8-1.3)
Hamilton (2008)	Haemoglobin 10-12.9 g dl ⁻¹	All patients	0.3 (0.2-0.3)
Hamilton (2005)	Haemoglobin < 10 g dl ⁻¹ (reported once)	All patients	2.3 (1.6-3.1)
Hamilton (2008)	Haemoglobin < 9.9 g dl ⁻¹	All patients	2 (1.7-2.3)
Hamilton (2005)	Haemoglobin 12-12.9 g dl ⁻¹	All patients	Cases: 17/349 Controls: 20/1744
Hamilton (2005)	Haemoglobin 10-11.9 g dl ⁻¹	All patients	Cases: 38/349 Controls: 49/1744
Hamilton (2005)	Haemoglobin < 10 g dl ⁻¹	All patients	Cases: 40/349 Controls: 21/1744
Hamilton (2005)	Positive faecal occult blood	All patients	Cases: 31/79 Controls: 5/47
Hamilton (2005)	Blood sugar > 10 mmol l ⁻¹	All patients	Cases: 25/349 Controls: 39/1744
Oudega (2006)	Deep vein thrombosis	All patients	0.7 (0.2-2.2) 3/430
Hamilton (2005)	History of diabetes	All patients	Cases: 37/349 Controls: 119/1744

1 Please note:

2 - Lawrenson (2006) calculated the positive predictive values of colorectal cancer being diagnosed
3 within 12 months of initial symptoms per 100 patients presenting by using Kaplan-Maier curves, and
4 it is unclear how and if these calculations differ from those of the other studies.

5 - The calculations of the positive predictive values differ between the remaining studies using
6 (TP)/(TP+FP) and Hamilton (2005, 2008, 2009) using other statistics due to the case-control design of
7 these studies. NR = Not reported.

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9 Table 4: Colorectal cancer: Additional results reported by the individual papers: Rectal bleeding with
10 other symptoms/signs

Study	Symptom(s)	Patient group	Positive predictive value, % (95% CI)
Hamilton (2005)	Rectal bleeding and constipation	All patients	2.4 (1.4-4.4)
Metcalfe (1996)	Rectal bleeding and constipation	All patients	2.6 (0.1-15.1) 1/39
Hamilton (2005)	Rectal bleeding and diarrhoea	All patients	3.4 (2.1-6)
Metcalfe (1996)	Rectal bleeding and diarrhoea	All patients	7.4 (1.3-25.8) 2/27
Hamilton (2005)	Rectal bleeding and abdominal tenderness	All patients	4.5 (NR)

Hamilton (2005)	Rectal bleeding and abnormal rectal exam	All patients	8.5 (NR)
Wauters (2000)	Rectal bleeding and fatigue	All patients	7.1 (??)
Hamilton (2005)	Rectal bleeding and haemoglobin 10-13 g dl ⁻¹	All patients	3.6 (NR)
Hamilton (2005)	Rectal bleeding and haemoglobin < 10 g dl ⁻¹	All patients	3.2 (NR)
Ellis (2005)	Rectal bleeding and change in bowel habit	Patients with flexible sigmoidoscopy/ questionnaire data	9.2 (4.9-16.3) 11/119
Mant (1989)	Rectal bleeding and change in bowel habit	All patients	11 (NR)
Metcalfe (1996)	Rectal bleeding and change in bowel habit	All patients	10.3 (3.3-25.2) 4/39
Nørrelund (1996)	New onset or changed pattern rectal bleeding and change in bowel habit	All patients	26.85 (19-36.4) 29/108
Nørrelund (1996)	New onset or changed pattern rectal bleeding and uncertain change in bowel habit	All patients	25 (8.3-52.6) 4/16
Nørrelund (1996)	New onset or changed pattern rectal bleeding and no change in bowel habit	All patients	8.75 (5.6-13.2)
Ellis (2005)	Rectal bleeding and no change in bowel habit	Patients with flexible sigmoidoscopy/ questionnaire data	0 0/147
Mant (1989)	Rectal bleeding and no change in bowel habit	All patients	11 (NR)
Ellis (2005)	Rectal bleeding and change in bowel habit (loose ± frequent)	Patients with flexible sigmoidoscopy/ questionnaire data	12 (6.2-21.5) 10/83
Robertson (2006)	Rectal bleeding and increased frequency/loose motions	All patients	4.8 (2.7-8.3)
Robertson (2006)	Rectal bleeding and no 'increased frequency/loose motions'	All patients	2.8 (1.4-5.5)
Ellis (2005)	Rectal bleeding and change in bowel habit (hard ± infrequent)	Patients with flexible sigmoidoscopy/ questionnaire data	2.8 (0.1-16.2) 1/36
Ellis (2005)	Rectal bleeding and no perianal symptoms	Patients with flexible sigmoidoscopy/ questionnaire data	11.1 (5-22.2) 7/63
Ellis (2005)	Rectal bleeding and perianal symptoms	Patients with flexible sigmoidoscopy/	1.97 (0.6-5.3) 4/203

		questionnaire data	
Mant (1989)	Rectal bleeding and feeling of incomplete evacuation of rectum	All patients	12 (NR)
Mant (1989)	Rectal bleeding and no feeling of incomplete evacuation of rectum	All patients	11 (NR)
Mant (1989)	Rectal bleeding and pain on defecation	All patients	7 (NR)
Mant (1989)	Rectal bleeding and no pain on defecation	All patients	12 (NR)
Wauters (2000)	Rectal bleeding and spasm	All patients	5.4 (2-11.4)
Nørrelund (1996)	New onset or changed pattern rectal bleeding and discomfort	All patients	16.67 (10.1-26) 16/96
Nørrelund (1996)	New onset or changed pattern rectal bleeding and uncertain discomfort	All patients	23.08 (9.8-44.1) 6/26
Nørrelund (1996)	New onset or changed pattern rectal bleeding and no discomfort	All patients	13.22 (9.3-18.3)
Ellis (2005)	Rectal bleeding and change in bowel habit and abdominal pain	Patients with flexible sigmoidoscopy/ questionnaire data	9 (3.7-19.1) 6/67
Ellis (2005)	Rectal bleeding and change in bowel habit and no abdominal pain	Patients with flexible sigmoidoscopy/ questionnaire data	9.6 (3.6-21.8) 5/52
Ellis (2005)	Rectal bleeding: Dark blood	Patients with flexible sigmoidoscopy/ questionnaire data	9.7 (2.5-26.9) 3/31
Mant (1989)	Rectal bleeding: Dark blood	All patients	19 (NR)
Robertson (2006)	Rectal bleeding: Dark blood	All patients	7.4 (3.7-14)
Metcalf (1996)	Rectal bleeding: Dark red blood loss	All patients	9.7 (2.5-26.9) 3/31
Robertson (2006)	Rectal bleeding: No/not dark blood	All patients	2.7 (1.5-4.7)
Ellis (2005)	Rectal bleeding: Bright blood	Patients with flexible sigmoidoscopy/ questionnaire data	4 (1.9-8.1) 8/199
Mant (1989)	Rectal bleeding: Bright blood	All patients	10 (NR)
Metcalf (1996)	Rectal bleeding: Bright red blood loss	All patients	8.6 (3.5-18.4) 6/70
Ellis (2005)	Rectal bleeding: Blood on paper only	Patients with flexible sigmoidoscopy/ questionnaire data	2.4 (0.4-9.4) 2/82
Mant (1989)	Rectal bleeding:	All patients	9 (NR)

	Blood seen on paper		
Metcalf (1996)	Rectal bleeding: Blood only on paper	All patients	8.3 (1.5-28.5) 2/24
Mant (1989)	Rectal bleeding: Blood seen in toilet bowl	All patients	14 (NR)
Ellis (2005)	Rectal bleeding: Blood in pan and on paper	Patients with flexible sigmoidoscopy/questionnaire data	4.9 (2.4-9.4) 9/184
Mant (1989)	Rectal bleeding: Blood seen on paper and in toilet bowl	All patients	11 (NR)
Ellis (2005)	Rectal bleeding: Large volume of blood	Patients with flexible sigmoidoscopy/questionnaire data	1.3 (0.07-7.8) 1/79
Ellis (2005)	Rectal bleeding: Small volume of blood	Patients with flexible sigmoidoscopy/questionnaire data	5.3 (2.7-9.9) 10/187
Ellis (2005)	Rectal bleeding: First time	Patients with flexible sigmoidoscopy/questionnaire data	4.7 (1.7-11.2) 5/106
Nørrelund (1996)	Rectal bleeding: New onset	All patients	14.24 (10.7-18.7) 45/316
Ellis (2005)	Rectal bleeding: Not first time	Patients with flexible sigmoidoscopy/questionnaire data	3.8 (1.5-8.3) 6/160
Nørrelund (1996)	Rectal bleeding: Not first time, unchanged bleeding pattern	All patients	4.4 (0.8-16.4) 2/45
Nørrelund (1996)	Rectal bleeding: Not first time, changed bleeding pattern	All patients	18.75 (9.4-33.1) 9/48
Fijten (1995)	Rectal bleeding: Blood on stool or mixed with only	All patients	7 (NR) Total positives N = 54
Fijten (1995)	Rectal bleeding: Blood mixed with stool only	All patients	14 (NR) Total positives N = 14
Mant (1989)	Rectal bleeding: Blood seen mixed with faeces	All patients	21 (NR)
Metcalf (1996)	Rectal bleeding: Blood mixed with stool	All patients	10.9 (4.1-24.4) 5/46
Ellis (2005)	Rectal bleeding: Blood mixed with the stool	Patients with flexible sigmoidoscopy/questionnaire data	3 (0.2-17.5) 1/33
Robertson (2006)	Rectal bleeding: Blood mixed with stool	All patients	5.4 (3.3-8.7)
Fijten (1995)	Rectal bleeding: Others or combinations apart from "blood on stool or mixed with stool	All patients	1 (NR) Total positives N = 122

	only"		
Robertson (2006)	Rectal bleeding: Dark blood and blood mixed with stool	All patients	10.2 (5.1-19) 9/88
Robertson (2006)	Rectal bleeding: Not 'dark blood and blood mixed with stool'	All patients	2.5 (1.4-4.4)
Robertson (2006)	Rectal bleeding: Blood neither dark nor mixed with stool	All patients	1.9 (0.7-4.7)
Robertson (2006)	Rectal bleeding: Not 'blood neither dark nor mixed with stool'	All patients	4.9 (3-7.9)
Fijten (1995)	Rectal bleeding: Unknown how blood was seen	All patients	7 (NR) Total positives N = 54
Ellis (2005)	Rectal bleeding: Blood not mixed with the stool	Patients with flexible sigmoidoscopy/ questionnaire data	4.3 (2.2-8) 10/233
Robertson (2006)	Rectal bleeding: Blood not mixed with stool	All patients	1.7 (0.6-4.2)
Mant (1989)	Rectal bleeding: Blood seen separate from faeces	All patients	7 (NR)
Metcalf (1996)	Rectal bleeding and associated slime	All patients	10.7 (2.8-29.4) 3/28
Fijten (1995)	Rectal bleeding and nausea	All patients	2 (NR) Total positives N = 68
Fijten (1995)	Rectal bleeding and abdominal pain	All patients	2 (NR) Total positives N = 135
Hamilton (2005)	Rectal bleeding and abdominal pain	All patients	3.1 (1.9-5.3)
Mant (1989)	Rectal bleeding and abdominal pain	All patients	9 (NR)
Metcalf (1996)	Rectal bleeding and abdominal pain	All patients	7.1 (1.9-20.6) 3/42
Robertson (2006)	Rectal bleeding and abdominal pain	All patients	1.7 (0.6-4.6)
Nørrelund (1996)	New onset or changed pattern rectal bleeding and abdominal pain	All patients	23.33 (15.3-33.7) 21/90
Meineche-Schmidt (2002)	Rectal bleeding and dyspepsia	All patients	2.6 (1.1-5.9) 6/227
Meineche-Schmidt (2002)	Rectal bleeding (visible blood in stools only) and dyspepsia	All patients	4 (1.5-9.6) 5/124
Nørrelund (1996)	New onset or changed pattern rectal bleeding and uncertain abdominal pain	All patients	22.22 (3.9-59.8) 2/9

Mant (1989)	Rectal bleeding and no abdominal pain	All patients	12 (NR)
Robertson (2006)	Rectal bleeding and no abdominal pain	All patients	4.5 (2.7-7.3)
Nørrelund (1996)	New onset or changed pattern rectal bleeding and no abdominal pain	All patients	11.7 (8.2-16.3)
Fijten (1995)	Rectal bleeding and decreased appetite	All patients	2 (NR) Total positives N = 42
Fijten (1995)	Rectal bleeding and pain at night	All patients	0 (0-8.9) Total positives N = 50
Wauters (2000)	Rectal bleeding and pain	All patients	0 (0-10.2)
Fijten (1995)	Rectal bleeding and weight loss	All patients	10 (NR) Total positives N = 42
Hamilton (2005)	Rectal bleeding and weight loss	All patients	4.7 (NR)
Robertson (2006)	Rectal bleeding and weight loss	All patients	4.8 (1.3-14.4) 3/62
Mant (1989)	Rectal bleeding and weight loss	All patients	13 (NR)
Metcalf (1996)	Rectal bleeding and weight loss	All patients	13.3 (2.3-41.6) 2/15
Nørrelund (1996)	New onset or changed pattern rectal bleeding and weight loss	All patients	22.73 (12-38.2) 10/44
Wauters (2000)	Rectal bleeding and weight loss	All patients	16 (4.5-36.1)
Nørrelund (1996)	New onset or changed pattern rectal bleeding and uncertain weight loss	All patients	28.57 (9.6-58) 4/14
Mant (1989)	Rectal bleeding and no weight loss	All patients	11 (NR)
Robertson (2006)	Rectal bleeding and no weight loss	All patients	3.6 (2.2-5.6)
Nørrelund (1996)	New onset or changed pattern rectal bleeding and no weight loss	All patients	13.07 (9.6-17.5)
Fijten (1995)	Rectal bleeding and pale conjunctivae	All patients	17 (NR) Total positives N = 6
Mant (1989)	Rectal bleeding and nongastrointestinal symptoms	All patients	5 (NR)
Mant (1989)	Rectal bleeding and no nongastrointestinal symptoms	All patients	12 (NR)
Fijten (1995)	Rectal bleeding and perianal eczema	All patients	18 (NR) Total positives N = 17
Mant (1989)	Rectal bleeding and anal itch	All patients	3 (NR)
Mant (1989)	Rectal bleeding and no	All patients	14 (NR)

	anal itch		
Fijten (1995)	Rectal bleeding and haemorrhoid on rectal palpation	All patients	10 (NR) Total positives N = 20 (but out of 208, not 269)
Mant (1989)	Rectal bleeding and haemorrhoids identified by GP	All patients	5 (NR)
Robertson (2006)	Rectal bleeding and haemorrhoids	All patients	3.1 (1.6-5.9)
Robertson (2006)	Rectal bleeding and haemorrhoids and bright red blood not mixed with stools	All patients	1.9 (0.5-5.8)
Robertson (2006)	Rectal bleeding and haemorrhoids and no other symptoms except bright non-mixed bleeding	All patients	3.3 (0.9-10.1) 3/90
Mant (1989)	Rectal bleeding and no haemorrhoids identified by GP	All patients	17 (NR)
Robertson (2006)	Rectal bleeding and no haemorrhoids	All patients	4.6 (2.4-8.3)
Robertson (2006)	Rectal bleeding and no 'haemorrhoids and bright red blood not mixed with stools'	All patients	4.5 (2.8-7.2)
Robertson (2006)	Rectal bleeding and no 'haemorrhoids and no other symptoms except bright non-mixed bleeding'	All patients	3.8 (2.4-6.1)
Fijten (1995)	Rectal bleeding and tumour on rectal palpation	All patients	100 (NR) Total positives N = 1 (but out of 208, not 269)
Wauters (2000)	Rectal bleeding and palpable tumour	All patients	31.5 (12.5-56.5)
Mant (1989)	Rectal bleeding and anal protrusion noticed by patient	All patients	3 (NR)
Mant (1989)	Rectal bleeding and no anal protrusion noticed by patient	All patients	13 (NR)
Fijten (1995)	Rectal bleeding and abnormal prostate on rectal palpation	All patients	50 (NR) Total positive N = 2 (but out of 208, not 269)
Fijten (1995)	Rectal bleeding and previous history of rectal	All patients	0 (0-4.8) Total positives N = 96

	bleeding		
Mant (1989)	Rectal bleeding and first degree relative with colorectal cancer	All patients	10 (NR)
Mant (1989)	Rectal bleeding and no first degree relative with colorectal cancer	All patients	11 (NR)
Metcalf (1996)	Rectal bleeding and family history of bowel cancer	All patients	0 (0-40.2) 0/8
Fijten (1995)	Rectal bleeding and family history of abdominal disease	All patients	0 (0-5.5) Total positives N = 83
Robertson (2006)	Rectal bleeding and history of irritable bowel syndrome	All patients	0 (0-4.8) 0/96
Robertson (2006)	Rectal bleeding and no history of irritable bowel syndrome	All patients	4.4 (2.8-6.7)
Robertson (2006)	Rectal bleeding and history of diverticular disease	All patients	0 (0-12.6) 0/34
Robertson (2006)	Rectal bleeding and no history of diverticular disease	All patients	3.9 (2.5-6)
Fijten (1995)	Rectal bleeding and abnormal proctoscopy	All patients	0 (0-14.1) Total positives N = 30 (but out of 45, not 269)
Robertson (2006)	Rectal bleeding and deprivation category (deprivation category 1 = least deprived, deprivation category 7 = most deprived)	Deprivation category 1	4.1 (1.1-12.2) 3/74
		Deprivation category 2	3.4 (1.1-8.9) 4/119
		Deprivation category 3	2.6 (0.8-6.9) 4/155
		Deprivation category 4	5.8 (2.7-11.6) 8/137
		Deprivation category 5	0/53 (0-8.4)
		Deprivation category 6	0/25 (0-16.6)
		Deprivation category 7	5.3 (0.3-28.1) 1/19

1 Please note:
 2 - The calculations of the positive predictive values differ between the remaining studies using
 3 (TP)/(TP+FP) and Hamilton (2005, 2008, 2009) using other statistics due to the case-control design of
 4 these studies. NR = Not reported.
 5

6 Table 5: Colorectal cancer: Additional results reported by the individual papers: Other symptom
 7 combinations

Study	Symptom(s)	Patient group	Positive predictive value, % (95% CI)
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Hamilton (2005)	Constipation and diarrhoea	All patients	1.1 (0.6-1.8)
Hamilton (2005)	Constipation and loss of weight	All patients	3 (1.7-5.4)
Hamilton (2005)	Constipation and abdominal pain	All patients	1.5 (1-2.2)
Hamilton (2005)	Constipation and abdominal tenderness	All patients	1.7 (0.9-3.4)
Hamilton (2005)	Constipation and abnormal rectal exam	All patients	2.6 (NR)
Hamilton (2005)	Constipation and haemoglobin 10-13 g dl ⁻¹	All patients	1.2 (0.6-2.7)
Hamilton (2005)	Constipation and haemoglobin < 10 g dl ⁻¹	All patients	2.6 (NR)
Hamilton (2005)	Diarrhoea and loss of weight	All patients	3.1 (1.8-5.5)
Hamilton (2005)	Diarrhoea and abdominal pain	All patients	1.9 (1.4-2.7)
Hamilton (2005)	Diarrhoea and abdominal tenderness	All patients	2.4 (1.3-4.8)
Hamilton (2005)	Diarrhoea and abnormal rectal exam	All patients	11 (NR)
Hamilton (2005)	Diarrhoea and haemoglobin 10-13 g dl ⁻¹	All patients	2.2 (1.2-4.3)
Hamilton (2005)	Diarrhoea and haemoglobin < 10 g dl ⁻¹	All patients	2.9 (NR)
Hamilton (2005)	Abdominal pain and loss of weight	All patients	3.4 (2.1-6)
Hamilton (2005)	Abdominal pain and abdominal tenderness	All patients	1.4 (0.3-2.2)
Hamilton (2005)	Abdominal pain and abnormal rectal exam	All patients	3.3 (NR)
Hamilton (2005)	Abdominal pain and haemoglobin 10-13 g dl ⁻¹	All patients	2.2 (1.1-4.5)
Hamilton (2005)	Abdominal pain and haemoglobin < 10 g dl ⁻¹	All patients	6.9 (NR)
Hamilton (2005)	Abdominal tenderness and loss of weight	All patients	6.4 (NR)
Hamilton (2005)	Abdominal tenderness and abnormal rectal exam	All patients	5.8 (NR)
Hamilton (2005)	Abdominal tenderness and haemoglobin 10-13 g dl ⁻¹	All patients	2.7 (NR)
Hamilton (2005)	Abdominal tenderness and haemoglobin < 10 g dl ⁻¹	All patients	>10 (NR) (no controls had this pair of symptoms)
Hamilton (2005)	Loss of weight and abnormal rectal exam	All patients	7.4 (NR)
Hamilton (2005)	Loss of weight and haemoglobin 10-13 g dl ⁻¹	All patients	1.3 (0.7-2.6)

Hamilton (2005)	Loss of weight and haemoglobin < 10 g dl ⁻¹	All patients	4.7 (NR)
Meineche-Schmidt (2002)	Dyspepsia and anaemia	All patients	13.51 (5-29.57) 5/37
Meineche-Schmidt (2002)	Dyspepsia and dysphagia	All patients	0 (0-2.2) 0/215
Meineche-Schmidt (2002)	Dyspepsia and jaundice	All patients	0 (0-48.32) 0/6
Meineche-Schmidt (2002)	Dyspepsia and weight loss	All patients	1.37 (0.35-4.28) 3/219

1 Please note:
2 - The calculations of the positive predictive values differ between the remaining studies using
3 (TP)/(TP+FP) and Hamilton (2005, 2008, 2009) using other statistics due to the case-control design of
4 these studies. NR = not reported.
5

6 Table 6: Colorectal cancer: Additional results reported by the individual papers: Age

Study	Symptom(s)	Patient group	Positive predictive value, % (95% CI)
Du Toit (2006)	Rectal bleeding	Patients 45-54 years	3.9 (NR)
		Patients 55-64 years	1.3 (NR)
		Patients 65-74 years	9.5 (NR)
		Patients ≥ 75 years	7.9 (NR)
Ellis (2005)	Rectal bleeding and aged ≥ 60 years	Patients with flexible sigmoidoscopy/ questionnaire data	5.2 (2.4-10.3) 8/155
	Rectal bleeding and aged ≤ 59 years		1.8 (0.5-5.7) 3/164
Fijten (1995)	Rectal bleeding	Patients 18-59 years	0.4 (0.03-2.8) 1/229
		Patients 60-75 years	20 (9.6-36.1) 8/40
Nørrelund (1996)	New onset or changed pattern rectal bleeding	Patients 40-69 years	7.87 (5-12.1)
		Patients 70-79 years	34.12 (24.4-45.3)
		Patients 80+ years	20 (7.6-41.3)
Hamilton (2005)	Rectal bleeding	Patients 40-69 years	1.4 (NR)
		Patients ≥ 70 years	4.8 (NR)
Heintze (2005)	Rectal bleeding	Patients < 50 years	2/≤153*
		Patients ≥ 50 years	15/≤268*
Mant (1989)	Rectal bleeding	Patients 40-60 years	8 (NR)
		Patients > 60 years	16 (NR)
Parker (2007)	Rectal bleeding	Patients 25-34 years	0.1 3/4717
		Patients 35-44 years	0.3 17/5301
		Patients 45-54 years	1.5 (1.2-1.8)
		Patients 55-64 years	2.8 (2.3-3.3)
		Patients 65-74 years	4.3 (3.7-5)
		Patients 75-84 years	5.5 (4.7-6.3)
Robertson (2006)	Rectal bleeding	Patients < 50 years	3.7 (2.8-4.8)
			1.1 (0.3-3.5)

		Patients 50-69 years	4.8 (2.6-8.7)
		Patients ≥ 70 years	7.5 (3.5-14.6)
Wauters (2000)	Rectal bleeding	Patients < 50 years	0.7 (0-4.9)
		Patients 50-59 years	1.7 (0-9.4) 1/57
		Patients 60-69 years	11.2 (5-21) 8/71
		Patients 70-79 50 years	21.2 (12-33) 14/66
		Patients ≥ 80 years	5.8 (1.2-16.2) 3/51
Nørrelund (1996)	New onset or changed pattern rectal bleeding and change in bowel habit	Patients 40-69 years	16.13 (8.4-28.1) 10/62
		Patients 70-79 years	42.5 (27.4-59) 17/40
		Patients 80+ years	33.3 (6-75.9) 2/6
Nørrelund (1996)	New onset or changed pattern rectal bleeding and uncertain change in bowel habit	Patients 40-69 years	18.18 (3.2-52.2) 2/11
		Patients 70-79 years	66.7 (12.5-98.2) 2/3
		Patients 80+ years	0 (0-80.2) 0/2
Nørrelund (1996)	New onset or changed pattern rectal bleeding and no change in bowel habit	Patients 40-69 years	4.42 (2.1-8.8) 8/181
		Patients 70-79 years	23.81 (12.6-39.8) 10/42
		Patients 80+ years	17.65 (4.7-44.2) 3/17
Hamilton (2005)	Abdominal pain	Patients 40-69 years	0.65 (NR)
		Patients ≥ 70 years	2 (NR)
Hamilton (2005)	Diarrhoea	Patients 40-69 years	0.63 (NR)
		Patients ≥ 70 years	1.7 (NR)
Hamilton (2005)	Constipation	Patients 40-69 years	0.2 (NR)
		Patients ≥ 70 years	1.3 (NR)
Hamilton (2005)	Weight loss	Patients 40-69 years	0.74 (NR)
		Patients ≥ 70 years	2.5 (NR)

1 *Data missing from 22/422 patients, but it is unclear which of the age subgroups the missing data
2 belongs to.

3 Please note:

4 - Lawrenson (2006) calculated the positive predictive values of colorectal cancer being diagnosed
5 within 12 months of initial symptoms per 100 patients presenting by using Kaplan-Maier curves, and
6 it is unclear how and if these calculations differ from those of the other studies.

7 - The calculations of the positive predictive values differ between the remaining studies using
8 (TP)/(TP+FP) and Hamilton (2005, 2008, 2009) using other statistics due to the case-control design of
9 these studies.

10 Table 7: Colorectal cancer: Additional results reported by the individual papers: Men

Study	Symptom(s)	Patient group	Positive predictive value, % (95% CI)
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Collins (2012)	Rectal bleeding	Men 30-84 years	2.8 (2.6-3)
Jones (2007)	Rectal bleeding at 6 months	Men (all ages)	1.8 (1.5-2.2)
Fijten (1995)	Rectal bleeding	Men (all ages)	5.9 (2.6-12.3) 7/118
Jones (2007)	Rectal bleeding at 3 years	Men (all ages)	2.4 (2.1-2.8)
Mant (1989)	Rectal bleeding	Men ≥ 40 years	9 (NR)
Nørrelund (1996)	New onset or changed pattern rectal bleeding	Men ≥ 40 years	17.26 (12-24)
Robertson (2006)	Rectal bleeding	Men (all ages)	4.8 (2.7-8.2)
Jones (2007)	Rectal bleeding at 3 years	Men < 45 years	0.07 (0.01-0.27)
		Men 45-54 years	1.56 (1-2.31)
		Men 55-64 years	3.38 (2.47-4.51)
		Men 65-74 years	4.8 (3.65-6.17)
		Men 75-84 years	7.74 (5.78-10.1)
Hamilton (2009)	Rectal bleeding at 2 years (read off graph)	Men ≥ 85 years	5.1 (2.23-9.79)
		Men < 60 years	0.5 (0.3-0.7)
		Men 60-69 years	2.4 (1.8-3.2)
		Men 70-79 years	3.5 (2.8-4.6)
Lawrenson (2006)	Rectal bleeding	Men ≥ 80 years	4.5 (3.3-5.9)
		Men 40-49 years	0.92 (NR)
		Men 50-59 years	2.75 (NR)
		Men 60-69 years	5.99 (NR)
		Men 70-79 years	7.69 (NR)
Helfand (1007)	Rectal bleeding	Men 80-89 years	9.13 (NR)
		Men < 50 years	0 (0-7.7) 0/58
Collins (2012)	Change in bowel habit	Men 30-84 years	2.9 (2.2-3.9)
Hippisley-Cox (2012)	Change in bowel habit	Men 30-84 years	2.8 (1.8-4.2)
Hamilton (2009)	Change in bowel habit (read off graph)	Men < 60 years	1.1 (0.6-2.4)
		Men 60-69 years	3 (2.1-4.2)
		Men 70-79 years	4.2 (3.2-5.4)
		Men ≥ 80 years	3.9 (2.8-5.6)
Lawrenson (2006)	Change in bowel habit	Men ≥ 80 years	3.9 (2.8-5.6)
		Men 40-49 years	0.89 (NR)
		Men 50-59 years	4.07 (NR)
		Men 60-69 years	6.89 (NR)
		Men 70-79 years	8.48 (NR)
Collins (2012)	Abdominal pain	Men 80-89 years	7.73 (NR)
		Men 30-84 years	0.6 (0.6-0.7)
Hamilton (2009)	Abdominal pain (read off graph)	Men < 60 years	0.15 (0.1-0.15)
		Men 60-69 years	0.9 (0.7-1)
		Men 70-79 years	1.1 (0.9-1.3)
		Men ≥ 80 years	1.2 (1-1.5)
Hamilton (2009)	Diarrhoea (read off graph)	Men < 60 years	0.1 (0.1-0.1)
		Men 60-69 years	0.9 (0.7-1.1)
		Men 70-79 years	1.3 (1.1-1.5)
		Men ≥ 80 years	1.2 (1-1.5)
Hamilton (2009)	Constipation (read off graph)	Men < 60 years	0.2 (0.2-0.2)
		Men 60-69 years	0.8 (0.6-0.9)

		Men 70-79 years	0.8 (0.7-0.9)
		Men ≥ 80 years	0.7 (0.6-0.8)
Collins (2012)	Appetite loss	Men 30-84 years	1 (0.6-1.5)
Collins (2012)	Weight loss	Men 30-84 years	1 (0.8-1.1)
Hamilton (2009)	Weight loss 5-10% (read off graph)	Men aged < 60 years	0.1 (0.05-0.2)
		Men aged 60-69 years	0.3 (0.2-0.4)
		Men aged 70-79 years	0.7 (0.5-0.8)
		Men aged ≥ 80 years	0.5 (0.3-0.8)
Hamilton (2009)	Weight loss ≥ 10% (read off graph)	Men < 60 years	0.2 (0.1-0.3)
		Men 60-69 years	0.7 (0.4-0.9)
		Men 70-79 years	1.5 (1.2-1.8)
		Men ≥ 80 years	0.8 (0.6-1.4)
Hamilton (2008)	Haemoglobin ≥ 13 g dl ⁻¹	Men 30-59 years	0.1 (0.1-0.1)
		Men 60-69 years	0.3 (0.3-0.3)
		Men 70-79 years	0.4 (0.3-0.4)
		Men ≥ 80 years	0.4 (0.3-0.5)
Hamilton (2008)	Haemoglobin 12-12.9 g dl ⁻¹	Men 30-59 years	0.2 (0.1-0.3)
		Men 60-69 years	0.7 (0.5-1)
		Men 70-79 years	1 (0.7-1.2)
		Men ≥ 80 years	0.6 (0.5-0.8)
Hamilton (2008)	Haemoglobin 11-11.9 g dl ⁻¹	Men 30-59 years	0.8 (0.2-2.9)
		Men 60-69 years	1.4 (0.9-2.3)
		Men 70-79 years	1.5 (1.2-2)
		Men ≥ 80 years	1 (0.8-1.4)
Hamilton (2008)	Haemoglobin 10-10.9 g dl ⁻¹	Men 30-59 years	0.8 (0.3-2.2)
		Men 60-69 years	2.3 (1.1-4.8)
		Men 70-79 years	3.2 (2.2-4.8)
		Men ≥ 80 years	1.6 (1.1-2.2)
Hamilton (2008)	Haemoglobin 9-9.9 g dl ⁻¹	Men 30-59 years	1.4 (0.2-10)
		Men 60-69 years	7.2 (2.9-17)
		Men 70-79 years	4 (2.5-6.3)
		Men ≥ 80 years	6 (3.4-10)
Hamilton (2008)	Haemoglobin < 9 g dl ⁻¹	Men 30-59 years	1.3 (0.4-4.3)
		Men 60-69 years	7.6 (3.4-16)
		Men 70-79 years	8.8 (5.4-14)
		Men ≥ 80 years	6.8 (4.2-11)
Hamilton (2008)	Haemoglobin ≥ 13 g dl ⁻¹ + indicators of iron deficiency**	Men 60-69 years	1.4 (0.6-3.6)
		Men 70-79 years	1.7 (0.9-3.1)
		Men ≥ 80 years	1.4 (0.6-3.1)
Hamilton (2008)	Haemoglobin 12-12.9 g dl ⁻¹ + indicators of iron deficiency**	Men 60-69 years	1.8 (0.7-4.2)
		Men 70-79 years	3.9 (1.8-8.5)
		Men ≥ 80 years	1.5 (0.5-4.2)
Hamilton (2008)	Haemoglobin 11-11.9 g dl ⁻¹ + indicators of iron deficiency**	Men 60-69 years	6.5 (2-19)
		Men 70-79 years	4.1 (2.1-8)
		Men ≥ 80 years	4 (1.6-9.3)
Hamilton (2008)	Haemoglobin 10-10.9 g dl ⁻¹ + indicators of iron deficiency**	Men 60-69 years	5.5 (1.2-21)
		Men 70-79 years	14 (5.9-29)
		Men ≥ 80 years	8.2 (3.7-17)
Hamilton (2008)	Haemoglobin 9-9.9 g dl ⁻¹ + indicators of iron	Men 60-69 years	12 (3.1-37)
		Men 70-79 years	16 (6.3-35)

	deficiency**	Men ≥ 80 years	31 (5.6-77)
Hamilton (2008)	Haemoglobin < 9 g dl ⁻¹ + indicators of iron deficiency**	Men 60-69 years	>5 (30 cases, 0 controls)
		Men 70-79 years	18 (8.7-34)
		Men ≥ 80 years	15 (7.3-28)
Hamilton (2008)	Haemoglobin < 11 g dl ⁻¹ + indicators of iron deficiency	Men > 60 years	13.3 (9.7-18)
Collins (2012)	Anaemia	Men 30-84 years	3 (2.5-3.6)
Yates (2004)	Anaemia	Men > 20 years	18.2 (12.6-25.4)
Lawrenson (2006)	Anaemia	Men 40-49 years	1.07 (NR)
		Men 50-59 years	1.86 (NR)
		Men 60-69 years	3.02 (NR)
		Men 70-79 years	3.38 (NR)
		Men 80-89 years	2.98 (NR)

**For the 30-59 years group 64 cases, but only 11 controls had markers of iron deficiency making meaningful analysis impossible.

Please note:

- Lawrenson (2006) calculated the positive predictive values of colorectal cancer being diagnosed within 12 months of initial symptoms per 100 patients presenting by using Kaplan-Maier curves, and it is unclear how and if these calculations differ from those of the other studies.

- The calculations of the positive predictive values differ between the remaining studies using (TP)/(TP+FP) and Hamilton (2005, 2008, 2009) using other statistics due to the case-control design of these studies. NP = Not reported.

Table 8: Colorectal cancer: Additional results reported by the individual papers: Women

Study	Symptom(s)	Patient group	Positive predictive value, % (95% CI)
Collins (2012)	Rectal bleeding	Women 30-84 years	2.1 (1.9-2.2)
Jones (2007)	Rectal bleeding at 6 months	Women (all ages)	1.5 (1.3-1.8)
Fijten (1995)	Rectal bleeding	Women (all ages)	1.3 (0.2-5.2) 2/151
Jones (2007)	Rectal bleeding at 3 years	Women (all ages)	2 (1.7-2.3)
Mant (1989)	Rectal bleeding	Women ≥ 40 years	13 (NR)
Nørrelund (1996)	New onset or changed pattern rectal bleeding	Women ≥ 40 years	12.76 (8.6-18.4)
Robertson (2006)	Rectal bleeding	Women (all ages)	2.7 (1.3-5.3)
Jones (2007)	Rectal bleeding at 3 years	Women < 45 years	0.22 (0.08-0.47)
		Women 45-54 years	0.63 (0.27-1.24)
		Women 55-64 years	2.75 (1.9-3.84)
		Women 65-74 years	2.42 (1.62-3.48)
		Women 75-84 years	7.2 (5.63-9.06)
Hamilton (2009)	Rectal bleeding at 2 years (read off graph)	Women < 60 years	0.4 (0.3-0.5)
		Women 60-69 years	2.1 (1.4-3.1)
		Women 70-79 years	2.2 (1.7-2.9)
		Women ≥ 80 years	2.9 (2.1-3.8)

Lawrenson (2006)	Rectal bleeding	Women 40-49 years	0.87 (NR)
		Women 50-59 years	2.16 (NR)
		Women 60-69 years	3.5 (NR)
		Women 70-79 years	4.61 (NR)
		Women 80-89 years	4.89 (NR)
Hamilton (2009)	Change in bowel habit (read off graph)	Women < 60 years	0.4 (0.3-0.5)
		Women 60-69 years	1.3 (0.8-1.9)
		Women 70-79 years	1.5 (1.1-1.9)
		Women ≥ 80 years	1.9 (1.3-2.7)
Lawrenson (2006)	Change in bowel habit	Women 40-49 years	0.64 (NR)
		Women 50-59 years	1.64 (NR)
		Women 60-69 years	2.42 (NR)
		Women 70-79 years	3.25 (NR)
		Women 80-89 years	4.09 (NR)
Collins (2012)	Abdominal pain	Women 30-84 years	0.4 (0.4-0.5)
Hamilton (2009)	Abdominal pain (read off graph)	Women < 60 years	0.01 (0.1-0.1)
		Women 60-69 years	0.4 (0.35-0.5)
		Women 70-79 years	0.7 (0.6-0.75)
		Women ≥ 80 years	0.9 (0.8-1)
Hamilton (2009)	Diarrhoea (read off graph)	Women < 60 years	0.01 (0.1-0.1)
		Women 60-69 years	0.35 (0.25-0.4)
		Women 70-79 years	0.5 (0.4-0.6)
		Women ≥ 80 years	0.7 (0.6-0.8)
Hamilton (2009)	Constipation (read off graph)	Women < 60 years	0.1 (0.1-0.1)
		Women 60-69 years	0.5 (0.4-0.6)
		Women 70-79 years	0.5 (0.4-0.6)
		Women aged ≥ 80 years	0.5 (0.4-0.6)
Collins (2012)	Appetite loss	Women 30-84 years	0.6 (0.4-1)
Collins (2012)	Weight loss	Women 30-84 years	0.6 (0.5-0.7)
Hamilton (2009)	Weight loss 5-10% (read off graph)	Women < 60 years	0.05 (0.05-0.05)
		Women 60-69 years	0.2 (0.1-0.3)
		Women 70-79 years	0.4 (0.3-0.6)
		Women ≥ 80 years	0.4 (0.3-0.6)
Hamilton (2009)	Weight loss ≥ 10% (read off graph)	Women < 60 years	0.06 (0.06-0.08)
		Women 60-69 years	0.5 (0.3-0.7)
		Women 70-79 years	0.8 (0.6-1.1)
		Women ≥ 80 years	0.8 (0.6-1.1)
Hamilton (2008)	Haemoglobin ≥ 13 g dl ⁻¹	Women 30-59 years	0 (0-0)
		Women 60-69 years	0.1 (0.1-0.2)
		Women 70-79 years	0.2 (0.2-0.2)
		Women ≥ 80 years	0.2 (0.2-0.3)
Hamilton (2008)	Haemoglobin 12-12.9 g dl ⁻¹	Women 30-59 years	0.0 (0.0-0.1)
		Women 60-69 years	0.2 (0.1-0.2)
		Women 70-79 years	0.3 (0.3-0.4)
		Women ≥ 80 years	0.3 (0.2-0.4)
Hamilton (2008)	Haemoglobin 11-11.9 g dl ⁻¹	Women 30-59 years	0.1 (0.1-0.2)
		Women 60-69 years	0.4 (0.3-0.6)
		Women 70-79 years	0.5 (0.4-0.6)
		Women ≥ 80 years	0.6 (0.5-0.8)

Hamilton (2008)	Haemoglobin 10-10.9 g dl ⁻¹	Women 30-59 years	0.4 (0.2-0.8)
		Women 60-69 years	1.2 (0.7-2)
		Women 70-79 years	1.9 (1.4-2.6)
		Women ≥ 80 years	1.2 (0.9-1.5)
Hamilton (2008)	Haemoglobin 9-9.9 g dl ⁻¹	Women 30-59 years	0.3 (0.1-0.6)
		Women 60-69 years	2.7 (1.2-5.9)
		Women 70-79 years	3.6 (2.1-6)
		Women ≥ 80 years	2.2 (1.5-3.1)
Hamilton (2008)	Haemoglobin < 9 g dl ⁻¹	Women 30-59 years	0.9 (0.3-2.9)
		Women 60-69 years	>5 (41 cases, 0 controls)
		Women 70-79 years	8.6 (5.4-14)
		Women ≥ 80 years	7.1 (4.5-11)
Hamilton (2008)	Haemoglobin ≥ 13 g dl ⁻¹ + indicators of iron deficiency	Women 30-59 years	0.1 (0-0.3)
		Women 60-69 years	2.9 (0.6-12)
		Women 70-79 years	0.4 (0.2-1.1)
		Women ≥ 80 years	0.8 (0.3-1.8)
Hamilton (2008)	Haemoglobin 12-12.9 g dl ⁻¹ + indicators of iron deficiency	Women 30-59 years	0.1 (0.0-0.3)
		Women 60-69 years	0.1 (0.0-0.8)
		Women 70-79 years	0.8 (0.4-1.7)
		Women ≥ 80 years	1.5 (0.5-4.2)
Hamilton (2008)	Haemoglobin 11-11.9 g dl ⁻¹ + indicators of iron deficiency	Women 30-59 years	0.2 (0.1-0.4)
		Women 60-69 years	1.5 (0.7-3.3)
		Women 70-79 years	2.1 (1.1-4)
		Women ≥ 80 years	3.6 (2-6.5)
Hamilton (2008)	Haemoglobin 10-10.9 g dl ⁻¹ + indicators of iron deficiency	Women 30-59 years	0.6 (0.2-2.1)
		Women 60-69 years	2.4 (1-5.7)
		Women 70-79 years	5.9 (3-11)
		Women ≥ 80 years	2.5 (1.5-4.1)
Hamilton (2008)	Haemoglobin 9-9.9 g dl ⁻¹ + indicators of iron deficiency	Women 30-59 years	0.3 (0.1-0.8)
		Women 60-69 years	3.5 (1.1-11)
		Women 70-79 years	8.6 (3.8-18)
		Women ≥ 80 years	5.7 (3-11)
Hamilton (2008)	Haemoglobin < 9 g dl ⁻¹ + indicators of iron deficiency	Women 30-59 years	0.6 (0.2-2.2)
		Women 60-69 years	>5 (36 cases, 0 controls)
		Women 70-79 years	10 (5.2-19)
		Women ≥ 80 years	10 (5.6-17)
Hamilton (2008)	Haemoglobin < 10 g dl ⁻¹	Women > 60 years	7.7 (5.7-11)
Collins (2012)	Anaemia	Women 30-84 years	1.3 (1.1-1.5)
Yates (2004)	Anaemia	Women > 50 years	3.2 (1.6-6.3)
Lawrenson (2006)	Anaemia	Women 40-49 years	0.08 (NR)
		Women 50-59 years	0.56 (NR)
		Women 60-69 years	1.38 (NR)
		Women 70-79 years	1.99 (NR)
		Women 80-89 years	2.01 (NR)

1 Please note:

2 - Lawrenson (2006) calculated the positive predictive values of colorectal cancer being diagnosed
3 within 12 months of initial symptoms per 100 patients presenting by using Kaplan-Maier curves, and
4 it is unclear how and if these calculations differ from those of the other studies.

1 - The calculations of the positive predictive values differ between the remaining studies using
2 (TP)/(TP+FP) and Hamilton (2005, 2008, 2009) using other statistics due to the case-control design of
3 these studies. NR = Not reported
4

5 **Evidence statement(s):**

6 Rectal bleeding (16 studies, N = 134794) presenting in a primary care setting is associated with an
7 overall positive predictive value of up to 4.88% for colorectal cancer, which tended to increase with
8 age (10 studies, N = 33874) both in men (3 studies, N = 103846) and in women (3 studies, N =
9 103846). All the studies were associated with ≤ 2 bias or applicability concerns (see also Tables 1-3,
10 6-8).

11
12 Abdominal pain (5 studies, N = 373796) presenting in a primary care setting is associated with an
13 overall positive predictive value of up to 2.04% for colorectal cancer, which tended to increase with
14 age (1 study, N = 2093) both in men (1 study, N = 43791) and in women (1 study, N = 43791). All the
15 studies were associated with ≤ 2 bias or applicability concerns (see also Tables 1-3, 6-8).

16
17 Anaemia (10 studies, N = 89550) presenting in a primary care setting is associated with an overall
18 positive predictive value of up to 5.87% for colorectal cancer, which tended to increase with age (1
19 study, N = 2093) both in men (2 studies, N = 118672) and in women (2 studies, N = 118672). Seven of
20 the studies were associated with ≤ 2 bias or applicability concern, while the remaining two studies
21 were associated with 3 and 4 bias or applicability concerns, respectively (see also Tables 1-3, 7-8).

22
23 Constipation (2 studies, N = 2373) presenting in a primary care setting is associated with an overall
24 positive predictive value of up to 15.7% for colorectal cancer in a very small study (N = 280) in
25 selected patients that contrasts with the estimates of 0.42-0.81% reported by another study (N =
26 2093) that also showed that the positive predictive values increase with age, which seems to be the
27 case for both men (1 study, N = 43791) and for women (1 study, N = 43791). All the studies were
28 associated with ≤ 3 bias or applicability concerns (see also Tables 3, 6-8).

29
30 Diarrhoea (2 studies, N = 2373) presenting in a primary care setting is associated with an overall
31 positive predictive value of up to 11.8% for colorectal cancer in a very small study (N = 280) in
32 selected patients that contrasts with the estimates of 0.94-1.5% reported by another study (N =
33 2093) that also showed that the positive predictive values increase with age, which seems to be the
34 case for both men (1 study, N = 43791) and for women (1 study, N = 43791). All the studies were
35 associated with ≤ 3 bias or applicability concerns (see also Tables 3, 6-8).

36
37 Change in bowel habit (3 studies, N = 621601) presenting in a primary care setting is associated with
38 an overall positive predictive value of up to 14% for colorectal cancer in a very small study (N = 280)
39 in selected patients that contrasts with the estimates of 2.8% and 2.9% reported by two other
40 studies in men only (N = 621321). The positive predictive values of change in bowel habit for
41 colorectal cancer also appears to increase with age in men (2 studies, N = 71315) and in women (2
42 studies, N = 71315). All the studies were associated with ≤ 3 bias or applicability concerns (see also
43 Tables 3, 7-8).

44
45 Weight loss (4 studies, N = 44431) presenting in a primary care setting is associated with an overall
46 positive predictive value of up to 3% for colorectal cancer which tended to increase with age (1
47 study, N = 2093) both in men (1 study, N = 43791) and in women (1 study, N = 43791). All the studies
48 were associated with ≤ 3 bias or applicability concerns (see also Tables 1-3, 6-8).

1 Dyspepsia (3 studies, N = 4476) presenting in a primary care setting is associated with an overall
 2 positive predictive value of 0.6% for colorectal cancer. All the studies were associated with 1
 3 applicability concerns (see also Table 3).

4
 5 Other single symptoms (8 studies, N = 1245637) presenting in a primary care setting are associated
 6 with overall positive predictive values of up to 13.2% for colorectal cancer, but this estimate comes
 7 from a small study (N = 280) of selected patients and may therefore be inflated. All the studies were
 8 associated with ≤ 3 bias or applicability concerns (see also Table 3).

9
 10 Rectal bleeding presenting with other symptoms (9 studies, N = 5770) in a primary care setting are
 11 associated with overall positive predictive values ranging from 0-100%, but many of these estimates
 12 are artificially inflated due to small numbers of patients in the calculations. All the studies were
 13 associated with ≤ 2 bias or applicability concerns (see also Table 4).

14
 15 Other symptom combinations (2 studies, N = 3494) presenting in a primary care setting are
 16 associated with overall positive predictive values for colorectal cancer ranging from 0% for dyspepsia
 17 with dysphagia or jaundice to 13.51% for dyspepsia and anaemia. Both studies were associated with
 18 1 bias/applicability concern (see also Table 5).

19 Evidence tables

20 Bellentani (1990)

21 PATIENT SELECTION	
A. risk of bias	
Patient sampling	Prospective consecutive patient series
Was a consecutive or random sample of patients enrolled?	Yes
Was a case-control design avoided?	Yes
Did the study avoid inappropriate exclusions?	Yes
Could the selection of patients have introduced bias?	Low risk
B. Concerns regarding applicability	
Patient characteristics and setting	<p>N = 254 (103 males/151 females); mean (SD) age of patients = Not reported; N = 140 were studied in primary care, N = 114 were referred to the gastroenterology services. It is unclear from the publication whether the patients who were referred to secondary care were a subset of "254 consecutive patients who presented to their GP during the study period for chronic abdominal pain" or whether they are recruited directly from secondary care (see Inclusion criteria).</p> <p><u>Inclusion criteria:</u> All consecutive patients consulting 14 GPs of the local health district, taking care of 14000 citizens, or referred to the outpatient clinic of the Gastroenterology Unit, either complaining of recurrent abdominal pain or having intestinal problems (as judged by the GP), between January 1987 and March 1988.</p> <p><u>Exclusion criteria:</u> Patients with acute abdomen, acute gastroenteritis or a clear cut diagnosis of upper gastrointestinal tract disease (gastritis, oesophagitis, peptic ulcer, or dyspepsia).</p> <p><u>Clinical setting:</u> Primary/secondary care, Italy.</p>
Are there concerns that the included patients and setting do not match the review question?	Unclear concern

INDEX TEST	
A. Risk of bias	
Index test	Recurrent abdominal pain or intestinal problems (as judged by the GP; not further specified)
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes
Could the conduct or interpretation of the index test have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the index test, its conduct, or interpretation differ from the review question?	Unclear concern
REFERENCE STANDARD	
A. risk of bias	
Reference standard(s)	Double-contrast barium enema or colonoscopy no more than 2 months after the enrolment in the study.
Is the reference standard likely to correctly classify the target condition?	Yes
Were the reference standard results interpreted without knowledge of the results of the index tests?	Unclear (but all patients had a positive index test)
Could the reference standard, its conduct, or its interpretation have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the target condition as defined by the reference standard does not match the question?	Low concern
FLOW AND TIMING	
A. risk of bias	
Flow and timing	All patients are accounted for in the results but the number of true negatives and false negatives could not be ascertained from the reported results.
Was there an appropriate interval between index test and reference standard?	Yes
Did all patients receive the same reference standard?	Yes
Were all patients included in the analysis?	Yes
Could the patient flow have introduced bias?	Low risk
NOTES	
1	
2 Collins (2012)	
PATIENT SELECTION	
A. risk of bias	
Patient sampling	Retrospective patient series using the THIN database.
Was a consecutive or random sample of patients enrolled?	Yes
Was a case-control design avoided?	Yes
Did the study avoid inappropriate exclusions?	Yes
Could the selection of patients have introduced bias?	Low risk
B. Concerns regarding applicability	
Patient	A total of 2135540 patients were identified from 364 practices.

characteristics and setting	<p>Symptoms: Rectal bleeding (N = 56234; 28423 men, 27811 women), abdominal pain (N = 245989; 102192 men, 143797 women), appetite loss (N = 5776; 2481 men, 3295 women), weight loss (N = 28289; 12891 men, 15398 women), anaemia (N = 18125; 4466 men, 13659 women), change in bowel habit (men only, N = 1670).</p> <p>Incident cases of colorectal cancer during the 2-year follow up period: N = 3712 (2036 men, 1676 women).</p> <p>Inclusion criteria: Patients aged 30–84 years and registered with practices between 1 January 2000 and 30 June 2008. Entry to the cohort was defined as the latest of the study start date; the date the patient registered with the practice; and for those patients with red flag symptoms (see below), the date of the first recorded onset within the study period.</p> <p>Exclusion criteria: Patients without a postcode-related Townsend score, patients with a history of colorectal cancer at baseline, and patients with a recorded 'red-flag' symptom in the 12 months prior to the study entry date.</p> <p>Clinical setting: Primary care, UK</p>
Are there concerns that the included patients and setting do not match the review question?	Low concern
INDEX TEST	
A. Risk of bias	
Index test	'Red-flag' symptoms: Rectal bleeding, loss of appetite, weight loss, abdominal pain, change in bowel habit (men only), and anaemia.
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes
Could the conduct or interpretation of the index test have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the index test, its conduct, or interpretation differ from the review question?	Low concern
REFERENCE STANDARD	
A. risk of bias	
Reference standard(s)	2-year follow up
Is the reference standard likely to correctly classify the target condition?	Yes
Were the reference standard results interpreted without knowledge of the results of the index tests?	Unclear
Could the reference standard, its conduct, or its interpretation have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the target condition as defined by the reference standard does not match the question?	Low concern
FLOW AND TIMING	
A. risk of bias	
Flow and timing	All patients seem to be accounted for
Was there an appropriate interval between index test and	Yes

reference standard?	
Did all patients receive the same reference standard?	Yes
Were all patients included in the analysis?	Yes
Could the patient flow have introduced bias?	Low risk
NOTES	The is <i>very large, if not complete, overlap</i> of the data used in this study with those used in Hamilton (2008 [for anaemia], 2009)
1	
2	
Droogendijk (2011)	
PATIENT SELECTION	
A. risk of bias	
Patient sampling	Retrospective peripheral hospital laboratory database study serving 265 GPs in Dordrecht (Holland).
Was a consecutive or random sample of patients enrolled?	Yes
Was a case-control design avoided?	Yes
Did the study avoid inappropriate exclusions?	Yes
Could the selection of patients have introduced bias?	Low risk
B. Concerns regarding applicability	
Patient characteristics and setting	N = 287; 129 men, 158 women; median (range) age = 70 (19-87) years. <u>Inclusion criteria:</u> All women aged > 50 years and all men aged ≥ 18 years who between January 2004 and December 2005 were diagnosed with iron-deficiency anaemia (haemoglobin < 13.7 g/dl in men and < 12.1 g/dl in women, and a serum ferritin level < 25 µg/l for men and < 20 µg/l for women). <u>Exclusion criteria:</u> Patients with a known history of iron-deficiency anaemia in the previous 2 years, a history of gastrointestinal malignancy or congenital haemoglobinopathy. <u>Clinical setting:</u> GPs in Holland
Are there concerns that the included patients and setting do not match the review question?	Unclear concern
INDEX TEST	
A. Risk of bias	
Index test	New onset iron-deficiency anaemia (haemoglobin < 13.7 g/dl in men and < 12.1 g/dl in women, and a serum ferritin level < 25 µg/l for men and < 20 µg/l for women).
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes
Could the conduct or interpretation of the index test have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the index test, its conduct, or interpretation differ from the review question?	Low concern
REFERENCE STANDARD	
A. risk of bias	
Reference standard(s)	Endoscopy and 12-month follow up.
Is the reference standard likely to correctly classify the target condition?	Yes

Were the reference standard results interpreted without knowledge of the results of the index tests?	No
Could the reference standard, its conduct, or its interpretation have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the target condition as defined by the reference standard does not match the question?	Low concern
FLOW AND TIMING	
A. risk of bias	
Flow and timing	It is unclear if all patients are accounted for
Was there an appropriate interval between index test and reference standard?	Unclear
Did all patients receive the same reference standard?	Unclear
Were all patients included in the analysis?	Unclear
Could the patient flow have introduced bias?	Unclear risk
NOTES	In addition to the 24 patients with colorectal cancer, 3 patients had gastric cancer, 1 patient had oesophageal cancer and 1 patient had locally invasive endometrial cancer.
1	
2	Du Toit (2006)
PATIENT SELECTION	
A. risk of bias	
Patient sampling	10-year prospective consecutive patient sample from a rural UK GP practice (four doctors and 1 registrar; mean list size 4426 patients over the decade).
Was a consecutive or random sample of patients enrolled?	Yes
Was a case-control design avoided?	Yes
Did the study avoid inappropriate exclusions?	Yes
Could the selection of patients have introduced bias?	Low risk
B. Concerns regarding applicability	
Patient characteristics and setting	N = 265; age: 45-54 years: N = 51; 55-64 years: N = 75; 65-74 years: N = 63; ≥ 75 years: N = 76. <u>Inclusion criteria:</u> Patients aged ≥ 45 years reporting new onset rectal bleeding with or without diarrhoea, during a 10-year period. <u>Exclusion criteria:</u> None listed <u>Clinical setting:</u> Primary care, UK.
Are there concerns that the included patients and setting do not match the review question?	Low concern
INDEX TEST	
A. Risk of bias	
Index test	New onset rectal bleeding
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes
Could the conduct or interpretation of the index test have introduced bias?	Low risk

B. Concerns regarding applicability	
Are there concerns that the index test, its conduct, or interpretation differ from the review question?	Low concern
REFERENCE STANDARD	
A. risk of bias	
Reference standard(s)	Rigid sigmoidoscopy with barium enema or flexible sigmoidoscopy or colonoscopy.
Is the reference standard likely to correctly classify the target condition?	Yes
Were the reference standard results interpreted without knowledge of the results of the index tests?	No
Could the reference standard, its conduct, or its interpretation have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the target condition as defined by the reference standard does not match the question?	Low concern
FLOW AND TIMING	
A. risk of bias	
Flow and timing	All patients appear to be accounted for
Was there an appropriate interval between index test and reference standard?	Unclear
Did all patients receive the same reference standard?	Yes
Were all patients included in the analysis?	Yes
Could the patient flow have introduced bias?	Low risk
NOTES	13/265 patients had adenoma and 15/265 had colorectal cancer. 2/15 patients with cancer and 4/13 patients with adenoma had diarrhoea.
1	
2 Ellis (2005)	
PATIENT SELECTION	
A. risk of bias	
Patient sampling	Prospective patient series from 19 GPs in 3 practices (1 in each of the following: market town/rural community, suburban area and inner-city).
Was a consecutive or random sample of patients enrolled?	No
Was a case-control design avoided?	Yes
Did the study avoid inappropriate exclusions?	Unclear
Could the selection of patients have introduced bias?	Unclear risk
B. Concerns regarding applicability	
Patient characteristics and setting	N = 319 (143 males/176 females); mean (range) age of male patients = 56 (35-84) years, mean (range) age of female patients = 62 (35-84) years. Patients accepting a flexible sigmoidoscopy: 219/319; patients filling out questionnaire: 47/319; patients declining both sigmoidoscopy and questionnaire: 57/319. 61/219 patients had either a barium-enema (37) or a colonoscopy (24). Inclusion criteria: GPs were asked to identify patients (aged > 34 years)

	whose primary complaint was rectal bleeding and those with other lower gastrointestinal symptoms who, on questioning, also had rectal bleeding. The patients were asked if they were willing to fill out a postal questionnaire and/or accept a flexible sigmoidoscopy. <u>Exclusion criteria:</u> None listed. <u>Clinical setting:</u> Primary care, UK.
Are there concerns that the included patients and setting do not match the review question?	Low concern
INDEX TEST	
A. Risk of bias	
Index test	Rectal bleeding
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes
Could the conduct or interpretation of the index test have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the index test, its conduct, or interpretation differ from the review question?	Low concern
REFERENCE STANDARD	
A. risk of bias	
Reference standard(s)	Flexible sigmoidoscopy/barium enema/colonoscopy and follow up
Is the reference standard likely to correctly classify the target condition?	Yes
Were the reference standard results interpreted without knowledge of the results of the index tests?	Unclear (but all patients had a positive index test)
Could the reference standard, its conduct, or its interpretation have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the target condition as defined by the reference standard does not match the question?	Low concern
FLOW AND TIMING	
A. risk of bias	
Flow and timing	All patients are accounted for and included in the results for rectal bleeding alone. However, for the analyses based on other symptoms presenting with rectal bleeding only those patients who received flexible sigmoidoscopy (N = 219) or who filled in a patient questionnaire (N = 47) were included.
Was there an appropriate interval between index test and reference standard?	Yes
Did all patients receive the same reference standard?	No
Were all patients included in the analysis?	Yes
Could the patient flow have introduced bias?	Low risk
NOTES	
1	
2	Farrus Palou (2000)
PATIENT SELECTION	

A. risk of bias	
Patient sampling	Retrospective consecutive patient series from urban general practice covering a population of 24000.
Was a consecutive or random sample of patients enrolled?	Yes
Was a case-control design avoided?	Yes
Did the study avoid inappropriate exclusions?	Yes
Could the selection of patients have introduced bias?	Low risk
B. Concerns regarding applicability	
Patient characteristics and setting	<p>N = 87 of whom the data from 29 were unavailable as no etiological diagnosis was found (due to patient refusal of further investigation [?; 8], lost to follow up [7], patient deterioration rendering them unsuitable for further investigation [14]); of the remaining 58 patients there were 14 males, 44 females; mean? (SD?) age = 54.26 (19.95) years.</p> <p><u>Inclusion criteria:</u> Patients aged > 14 years who attended the health centre between 1 October 1995 and 31 September 1996 who were found to have new onset (previously unknown) anaemia (haemoglobin < 13 g/dl for men and 12 g/dl for women).</p> <p><u>Exclusion criteria:</u> Pregnant women.</p> <p><u>Clinical setting:</u> Spanish GP</p>
Are there concerns that the included patients and setting do not match the review question?	Unclear concern
INDEX TEST	
A. Risk of bias	
Index test	Anaemia (haemoglobin < 13 g/dl for men and 12 g/dl for women)
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes
Could the conduct or interpretation of the index test have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the index test, its conduct, or interpretation differ from the review question?	Low concern
REFERENCE STANDARD	
A. risk of bias	
Reference standard(s)	Follow up I think
Is the reference standard likely to correctly classify the target condition?	Unclear
Were the reference standard results interpreted without knowledge of the results of the index tests?	No
Could the reference standard, its conduct, or its interpretation have introduced bias?	Unclear risk
B. Concerns regarding applicability	
Are there concerns that the target condition as defined by the reference standard does not match the question?	Unclear concern
FLOW AND TIMING	
A. risk of bias	

Flow and timing	No diagnosis available for 29/87 patients
Was there an appropriate interval between index test and reference standard?	Unclear
Did all patients receive the same reference standard?	Yes
Were all patients included in the analysis?	No
Could the patient flow have introduced bias?	High risk
NOTES	This paper is published in Spanish
1	
2	Fijten (1995)
PATIENT SELECTION	
A. risk of bias	
Patient sampling	Prospective consecutive patient series
Was a consecutive or random sample of patients enrolled?	Yes
Was a case-control design avoided?	Yes
Did the study avoid inappropriate exclusions?	Yes
Could the selection of patients have introduced bias?	Low risk
B. Concerns regarding applicability	
Patient characteristics and setting	<p>N = 269 (118 males/151 females), mean (SD, range) age = 42 (15, 18-75). Mean (SD) follow up time = 20 (5) months. For 51% rectal bleeding was the main reason for the encounter, and 49% had another reason (e.g., abdominal complaints), but blood loss per rectum was seen and mentioned by the patients. N = 8 used anticoagulants.</p> <p><u>Inclusion criteria:</u> From September 1988 to April 1990, patients with rectal bleeding were recruited by 83 GPs in Limburg, with an average duration of participation of 11 months per doctor. Patients were included when overt rectal bleeding was the reason for encounter or when there was a history of recent (within the previous three months) rectal blood loss visible for the patient.</p> <p><u>Exclusion criteria:</u> Aged below 18 or above 75 years, pregnancy, urgent admission to hospital (for, e.g., a massive bleeding or acute abdominal pain), and if follow-up data were not available.</p> <p><u>Clinical setting:</u> Primary care, Netherlands</p>
Are there concerns that the included patients and setting do not match the review question?	Unclear concern
INDEX TEST	
A. Risk of bias	
Index test	Rectal bleeding
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes
Could the conduct or interpretation of the index test have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the index test, its conduct, or interpretation differ from the review question?	Low concern
REFERENCE STANDARD	
A. risk of bias	

Reference standard(s)	Follow up for min 1 year.	
Is the reference standard likely to correctly classify the target condition?	Yes	
Were the reference standard results interpreted without knowledge of the results of the index tests?	Yes	
Could the reference standard, its conduct, or its interpretation have introduced bias?	Low risk	
<u>B. Concerns regarding applicability</u>		
Are there concerns that the target condition as defined by the reference standard does not match the question?	Low concern	
FLOW AND TIMING		
<u>A. risk of bias</u>		
Flow and timing	A total of 290 patients were recruited, however 21/290 were excluded as they were lost to follow-up (moved to an unknown destination).	
Was there an appropriate interval between index test and reference standard?	Unclear	
Did all patients receive the same reference standard?	Yes	
Were all patients included in the analysis?	Yes	
Could the patient flow have introduced bias?	Unclear risk	
NOTES		
1		
2	Hallissey (1990)	
PATIENT SELECTION		
<u>A. risk of bias</u>		
Patient sampling	Propective consecutive patient series from a group of 10 general practices in England.	
Was a consecutive or random sample of patients enrolled?	Yes	
Was a case-control design avoided?	Yes	
Did the study avoid inappropriate exclusions?	Yes	
Could the selection of patients have introduced bias?	Low risk	
<u>B. Concerns regarding applicability</u>		
Patient characteristics and setting	N = 2585 aged > 40 years. No other information reported. The patient group was equally divided between new patients with dyspepsia, old patients with uninvestigated dyspepsia, and old patients with investigated dyspepsia. <u>Inclusion criteria:</u> All patients over 40 years making their first attendance during the study period (4 years and 9 months) with any degree of dyspepsia <u>Exclusion criteria:</u> None listed. <u>Clinical setting:</u> Primary care, England.	
Are there concerns that the included patients and setting do not match the review question?	Unclear concern	
INDEX TEST		
<u>A. Risk of bias</u>		
Index test	Dyspepsia of any degree	
Were the index test results interpreted without knowledge	Yes	

of the results of the reference standard?	
Could the conduct or interpretation of the index test have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the index test, its conduct, or interpretation differ from the review question?	Low concern
REFERENCE STANDARD	
A. risk of bias	
Reference standard(s)	Upper gastrointestinal endoscopy within 4 weeks and follow up.
Is the reference standard likely to correctly classify the target condition?	Yes
Were the reference standard results interpreted without knowledge of the results of the index tests?	No
Could the reference standard, its conduct, or its interpretation have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the target condition as defined by the reference standard does not match the question?	Low concern
FLOW AND TIMING	
A. risk of bias	
Flow and timing	2659 patients were seen and 2585 attended for investigation
Was there an appropriate interval between index test and reference standard?	Yes
Did all patients receive the same reference standard?	Yes
Were all patients included in the analysis?	Yes
Could the patient flow have introduced bias?	Low risk
NOTES	Malignancy was detected in 115 patients: Gastric adenocarcinoma (57), gastric lymphoma (1; added to the gastric adenocarcinoma data in the PPV), oesophageal cancer (15), colorectal (14), pancreatic (6), bronchial (8), prostatic (2), duodenal (1, also added to the gastric carcinoma data in the PPV), liver (1), gall bladder (1), carcinoid (1), uterine (1), leukaemia (1), circinomatosis of unknown primary (7).
1	
2	Hamilton (2005)
PATIENT SELECTION	
A. risk of bias	
Patient sampling	Population-based matched case-control study involving all 21 general practices in Exeter, Devon, UK.
Was a consecutive or random sample of patients enrolled?	No
Was a case-control design avoided?	No
Did the study avoid inappropriate exclusions?	Yes
<i>For diagnostic case-control studies:</i> Attempts were made within the design or analysis to balance the comparison groups for potential confounders?	Yes
<i>For diagnostic case-control studies:</i> The groups were comparable at baseline, including all	Yes

major confounding and prognostic factors?	
Could the selection of patients have introduced bias?	High risk
<u>B. Concerns regarding applicability</u>	
Patient characteristics and setting	<p><u>Cases:</u> N = 349 (177 males/172 females), age at diagnosis: < 60 years: N = 45, 60-69 years: N = 97, 70-79 years: N = 113, 80+ years: N = 94. 210/349 had tumours at or distal to the splenic flexure, and 126/349 had tumours proximal to the splenic flexure, the remaining 13/349 has tumours in multiple or unknown sites. Duke's staging was known for 305/349: 170/305 were Duke's A or B, and 135/305 were Duke's C or D.</p> <p><u>Controls:</u> N = 1744 (885 males/859 females), age at diagnosis: < 60 years: N = 225, 60-69 years: N = 487, 70-79 years: N = 555, 80+ years: N = 477.</p> <p><u>Inclusion criteria:</u> Cases: All patients aged \geq 40 years with a primary colorectal cancer, diagnosed from 1998 to 2002, were identified from the cancer registry at the Royal Devon and Exeter Hospital combined with computerised searches at every practice in Devon to identify any cases missing from the cancer register. Controls: Five controls were matched to each case on sex, general practice, and age (to 1-year bands if possible, increased in 1-year multiples to a maximum of 5 years). Controls were eligible if they were alive at the time of diagnosis of their case.</p> <p><u>Exclusion criteria:</u> Cases and controls: Unobtainable records; no consultations in the 2 years before diagnosis; previous colorectal cancer; or residence outside Exeter at the time of diagnosis.</p> <p><u>Clinical setting:</u> Primary care, UK.</p>
Are there concerns that the included patients and setting do not match the review question?	Low concern
INDEX TEST	
<u>A. Risk of bias</u>	
Index test	Anonymised photocopies of the full primary care records for 2 years before diagnosis were coded (blinded to case/control status) for all entries using the International Classification of Primary Care-2. Additional codes were created to incorporate all possible clinical features. Only variables occurring in \geq 2.5% of cases or controls were analysed.
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes
<i>For diagnostic case-control studies:</i> Investigators were kept 'blind' to other important confounding and prognostic factors?	Yes
Could the conduct or interpretation of the index test have introduced bias?	Low risk
<u>B. Concerns regarding applicability</u>	
Are there concerns that the index test, its conduct, or interpretation differ from the review question?	Low concern
REFERENCE STANDARD	

A. risk of bias	
Reference standard(s)	Colorectal cancer diagnosis in the cancer registry at the Royal Devon and Exeter Hospital or practice notes.
Is the reference standard likely to correctly classify the target condition?	Yes
Were the reference standard results interpreted without knowledge of the results of the index tests?	Unclear
Could the reference standard, its conduct, or its interpretation have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the target condition as defined by the reference standard does not match the question?	Low concern
FLOW AND TIMING	
A. risk of bias	
Flow and timing	All the patients are accounted for.
Was there an appropriate interval between index test and reference standard?	Yes
Did all patients receive the same reference standard?	Yes
Were all patients included in the analysis?	Yes
Could the patient flow have introduced bias?	Low risk
NOTES	
1	
2 Hamilton (2008)	
PATIENT SELECTION	
A. risk of bias	
Patient sampling	Matched case-control study using patients in the Health Improvement Network (THIN), which uploads electronic medical records from GP practices using the VISION computer system. The records contain patient characteristics, all consultations, diagnoses, and primary care investigations. The database has 2.2 million currently active patients in over 300 practices; 4.7 million patients when historical data are included. Laboratory results have been transmitted electronically to most practices from the year 2000.
Was a consecutive or random sample of patients enrolled?	No
Was a case-control design avoided?	No
Did the study avoid inappropriate exclusions?	Yes
<i>For diagnostic case-control studies:</i> Attempts were made within the design or analysis to balance the comparison groups for potential confounders?	Yes
<i>For diagnostic case-control studies:</i> The groups were comparable at baseline, including all major confounding and prognostic factors?	Yes
Could the selection of patients have introduced bias?	High risk
B. Concerns regarding applicability	
Patient characteristics and setting	Cases: 6442 cases of colorectal cancer (3421 men, 3021 women) of whom 3183 cases (1604 males, 1579 females) had a haemoglobin value measured in the

	<p>year before the index date. Age of patients with a haemoglobin estimation: 30-59 years: N = 489; 60-69 years: N = 748; 70-79: N = 1085; 80+ years: N = 861. The haemoglobin results were taken in a median (interquartile range) of 62 (28- 122) days before the index date. A mean cell volume (MVC) result was available in 2951 cases of which 764 results showed microcytosis. Ferritin results were available for 723 and 353 of these were low.</p> <p>Haemoglobin > 12.9 g dl⁻¹: Men/women (N = 805/459); Haemoglobin 12-12.9 g dl⁻¹: Men/women (N = 203/289) Haemoglobin 11-11.9 g dl⁻¹: Men/women (N = 171/238) Haemoglobin 10-10.9 g dl⁻¹: Men/women (N = 129/226) Haemoglobin 9-9.9 g dl⁻¹: Men/women (N = 118/146) Haemoglobin < 9 g dl⁻¹: Men/women (N = 178/221)</p> <p><u>Controls:</u> 45066 matched controls were available, of whom 10514 controls (5223 males, 5291 females) had a haemoglobin value measured in the year before the index date. Age of patients with a haemoglobin estimation: 30-59 years: N = 1158; 60-69 years: N = 2215; 70-79: N = 3823; 80+ years: N = 3318. Haemoglobin results were taken in a median (interquartile range) of 134 (59-235) days before the index date. AN MVC result was available in 9648 controls of which 210 results showed microcytosis. Ferritin results were available for 825 and 129 of these were low.</p> <p>Haemoglobin > 12.9 g dl⁻¹: Men/women (N = 4131/2992); Haemoglobin 12-12.9 g dl⁻¹: Men/women (N = 572/1337) Haemoglobin 11-11.9 g dl⁻¹: Men/women (N = 293/616) Haemoglobin 10-10.9 g dl⁻¹: Men/women (N = 131/225) Haemoglobin 9-9.9 g dl⁻¹: Men/women (N = 49/85) Haemoglobin < 9 g dl⁻¹: Men/women (N = 47/36)</p> <p><u>Inclusion criteria:</u> Cases: All patients with colorectal cancer were identified, who were aged 30 years or older, and diagnosed between January 2000 and July 2006. All participants had at least 2 years of electronic records prior to the date of diagnosis of the case (the index date). Controls: Up to seven controls were randomly selected for each case, using a computerised random numbers sequence. Controls were free from colorectal cancer and were matched for practice, sex, and age. Where possible controls were born in the same year as cases, if none were available within 1 year of the cases, the range was expanded to 2 years, continuing to a maximum of 5 years. All participants had at least 2 years of electronic records prior to the date of diagnosis of the case (the index date).</p> <p><u>Exclusion criteria:</u> None listed. <u>Clinical setting:</u> Primary care, UK.</p>
Are there concerns that the included patients and setting do not match the review question?	Low concern
INDEX TEST	
A. Risk of bias	
Index test	Haemoglobin results were taken in the year before the index dates were studied. If more than one haemoglobin measurement had been taken, the final value was used for analysis. MCV and ferritin results for the same year were also collated. Microcytosis was defined as an MCV < 80.0 fl, and a low ferritin as < 20 ng ml ⁻¹ .

Were the index test results interpreted without knowledge of the results of the reference standard?	Yes
<i>For diagnostic case-control studies:</i> Investigators were kept 'blind' to other important confounding and prognostic factors?	Yes
Could the conduct or interpretation of the index test have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the index test, its conduct, or interpretation differ from the review question?	Low concern
REFERENCE STANDARD	
A. risk of bias	
Reference standard(s)	Colorectal cancer code in the THIN database.
Is the reference standard likely to correctly classify the target condition?	Yes
Were the reference standard results interpreted without knowledge of the results of the index tests?	Unclear
Could the reference standard, its conduct, or its interpretation have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the target condition as defined by the reference standard does not match the question?	Low concern
FLOW AND TIMING	
A. risk of bias	
Flow and timing	The MVC and ferritin data was not available for all included cases and controls, which may bias the results reported for the combined haemoglobin + iron deficiency estimates.
Was there an appropriate interval between index test and reference standard?	Yes
Did all patients receive the same reference standard?	Yes
Were all patients included in the analysis?	No
Could the patient flow have introduced bias?	Unclear risk
NOTES	The is <i>very large, if not complete, overlap</i> of the data used in this study with those used in Collins (2012) and Hamilton (2009)
1	
2	Hamilton (2009)
PATIENT SELECTION	
A. risk of bias	
Patient sampling	Matched case-control study using patients in the Health Improvement Network (THIN), which uploads electronic medical records from GP practices using the VISION computer system. The records contain patient characteristics, all consultations, diagnoses, and primary care investigations. The database has 2.2 million currently active patients in over 300 practices; 4.7 million patients when historical data are included. Laboratory results have been transmitted electronically to most practices from the year 2000.

Was a consecutive or random sample of patients enrolled?	No
Was a case-control design avoided?	No
Did the study avoid inappropriate exclusions?	Yes
<i>For diagnostic case-control studies:</i> Attempts were made within the design or analysis to balance the comparison groups for potential confounders?	Yes
<i>For diagnostic case-control studies:</i> The groups were comparable at baseline, including all major confounding and prognostic factors?	Yes
Could the selection of patients have introduced bias?	High risk
B. Concerns regarding applicability	
Patient characteristics and setting	<p><u>Cases:</u> 5477 cases of colorectal cancer from 317 practices (2911 men, 2566 women); median (inter-quartile range) age at diagnosis: 72 (63-79) years. Constipation: N = 1477/27%; Diarrhoea: N = 988/18%; Change in bowel habit: N = 615/11.2%; Rectal bleeding: N = 853/15.6%; Weight loss 5-9.9%: N = 210/3.8%; Weight loss \geq 10%: N = 351/6.4%; Abdominal pain: N = 1629/29.7%; Haemoglobin $<$ 12 g dl⁻¹: N = 1424/26%; Mean red cell volume $<$ 80 fl: N = 363/6.6%; Irritable bowel syndrome: N = 135/2.5%; Diabetes: N = 626/11.4%; Obesity: N = 510/9.3%.</p> <p><u>Controls:</u> 38314 matched controls (with only seven very elderly cases having fewer than seven controls available). 36925 (96.4%) controls were matched to the same year of birth, and 1150 to the adjoining year, leaving only 239 controls 2 to 5 years different in age. Constipation: N = 4051/10.6%; Diarrhoea: N = 2171/5.7%; Change in bowel habit: N = 375/1%; Rectal bleeding: N = 460/1.2%; Weight loss 5-9.9%: N = 852/2.2%; Weight loss \geq 10%: N = 678/1.8%; Abdominal pain: N = 3121/8.1%; Haemoglobin $<$ 12 g dl⁻¹: N = 1803/4.7%; Mean red cell volume $<$ 80 fl: N = 923/2.4%; Irritable bowel syndrome: N = 325/0.8%; Diabetes: N = 3679/9.6%; Obesity: N = 3510/9.2%.</p> <p><u>Inclusion criteria:</u> Cases: All patients with colorectal cancer were identified, who were aged 30 years or older, and diagnosed between January 2001 and July 2006. All participants had at least 2 years of electronic records prior to the date of diagnosis of the case (the index date). Controls: Up to seven controls were randomly selected for each case, using a computerised random numbers sequence. Controls were free from colorectal cancer and were matched for practice, sex, and age. Where possible controls were born in the same year as cases, if none were available within 1 year of the cases, the range was expanded to 2 years, continuing to a maximum of 5 years. All participants had at least 2 years of electronic records prior to the date of diagnosis of the case (the index date).</p> <p><u>Exclusion criteria:</u> None listed. <u>Clinical setting:</u> Primary care, UK.</p>
Are there concerns that the included patients and setting do not match the review question?	Low concern
INDEX TEST	
A. Risk of bias	

Index test	From a review of the literature, 23 candidate variables (features) were identified, either a symptom, or an abnormal primary care investigation, or a predisposing risk marker such as obesity. Codes for irritable bowel syndrome as a potential misdiagnosis were also identified. For some symptoms the availability of data on related prescriptions were also used, for example, prescriptions for antidiarrhoeals and laxatives were obtained as possible surrogates for the relevant symptoms, and similarly antispasmodic drugs for irritable bowel syndrome. Features were designated as new if there were no similar symptoms or prescriptions observed previously in the 2 years before the index date. Weight loss was calculated from the change between the last recorded weight and the highest weight in the previous 2 years, separated into two categories: $\geq 10\%$ weight loss or 5-10% weight loss. Patients were assigned to their maximum weight loss category. Obesity was defined as a body mass index > 30 kg/m ² within 2 years of the index date. Diabetes was considered to be present if it had ever been diagnosed. < 2.5% cases or controls had an abnormal rectal examination (15 cases, 2 controls), abdominal masses (86 cases, 19 controls), a positive FOB (7 cases, 2 controls), or thrombo-embolism (24 cases, 74 controls), and these features were therefore not analysed any further.
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes
<i>For diagnostic case-control studies:</i> Investigators were kept 'blind' to other important confounding and prognostic factors?	Yes
Could the conduct or interpretation of the index test have introduced bias?	Low risk
<u>B. Concerns regarding applicability</u>	
Are there concerns that the index test, its conduct, or interpretation differ from the review question?	Low concern
REFERENCE STANDARD	
<u>A. risk of bias</u>	
Reference standard(s)	Colorectal cancer code in the THIN database.
Is the reference standard likely to correctly classify the target condition?	Yes
Were the reference standard results interpreted without knowledge of the results of the index tests?	Unclear
Could the reference standard, its conduct, or its interpretation have introduced bias?	Low risk
<u>B. Concerns regarding applicability</u>	
Are there concerns that the target condition as defined by the reference standard does not match the question?	Low concern
FLOW AND TIMING	
<u>A. risk of bias</u>	
Flow and timing	All the participants are accounted for in the results.
Was there an appropriate interval between index test and reference standard?	Yes
Did all patients receive the same reference standard?	Yes

Were all patients included in the analysis?	Yes
Could the patient flow have introduced bias?	Low risk
NOTES	The is very large, if not complete, overlap of the data used in this study with those used in Collins (2012) and Hamilton (2008, for anaemia)
1	
2	
Heikkinen (1995)	
PATIENT SELECTION	
A. risk of bias	
Patient sampling	Consecutive patient series from 11 GPs (from 3 rural health centres) and from the catchment area of 6 physicians in the health centre of an urban area (population [individuals > 14 years old] of study area = 24600) in Finland.
Was a consecutive or random sample of patients enrolled?	Yes
Was a case-control design avoided?	Yes
Did the study avoid inappropriate exclusions?	Yes
Could the selection of patients have introduced bias?	Low risk
B. Concerns regarding applicability	
Patient characteristics and setting	N = 400; 152 males, 248 females; 77% were > 44 years. <u>Inclusion criteria:</u> Consecutive patients who consulted their GP from January 11th 1993 to January 12 th 1994 for dyspepsia (defined as upper abdominal or retrosternal pain, discomfort, heartburn, nausea, vomiting, or other symptoms considered to be referable to the proximal alimentary tract). <u>Exclusion criteria:</u> Patients with symptoms of an acute condition within the abdomen or who had had an upper intestinal endoscopy performed within the last 3 months or aged < 15 years <u>Clinical setting:</u> Primary care, Finland.
Are there concerns that the included patients and setting do not match the review question?	Unclear concern
INDEX TEST	
A. Risk of bias	
Index test	Dyspepsia (defined as upper abdominal or retrosternal pain, discomfort, heartburn, nausea, vomiting, or other symptoms considered to be referable to the proximal alimentary tract).
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes
Could the conduct or interpretation of the index test have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the index test, its conduct, or interpretation differ from the review question?	Low concern
REFERENCE STANDARD	
A. risk of bias	
Reference standard(s)	Upper gastrointestinal endoscopy, upper abdominal ultrasound, more detailed interview, blood count, serum screening (creatinine, alkaline phosphatase, alanine aminotransferase, amylase, and C-reactive protein), lactose intolerance test, and follow up of ≥ 1 month.
Is the reference standard likely to correctly classify the	Yes

target condition?	
Were the reference standard results interpreted without knowledge of the results of the index tests?	No
Could the reference standard, its conduct, or its interpretation have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the target condition as defined by the reference standard does not match the question?	Low concern
FLOW AND TIMING	
A. risk of bias	
Flow and timing	All patients appear to be accounted for
Was there an appropriate interval between index test and reference standard?	Yes
Did all patients receive the same reference standard?	Yes
Were all patients included in the analysis?	Yes
Could the patient flow have introduced bias?	Low risk
NOTES	In total N = 9 had cancer: 0 colorectal, 2 oesophageal and 7 stomach (of which 3 were lymphomas of the MALT type (Mucosa-associated lymphoid tissue)).
1	
2	Heintze (2005)
PATIENT SELECTION	
A. risk of bias	
Patient sampling	Prospective patient series
Was a consecutive or random sample of patients enrolled?	No
Was a case-control design avoided?	Yes
Did the study avoid inappropriate exclusions?	Unclear
Could the selection of patients have introduced bias?	High risk
B. Concerns regarding applicability	
Patient characteristics and setting	N = 422 (222 males/199 females); aged < 50 years: N = 153, aged ≥ 50 years: N = 268. The most common accompanying symptoms associated with rectal bleeding were: Abdominal pain > 3 weeks (N = 97), change in bowel habit > 3 weeks (N = 73), anaemia (N = 23), and weight loss (N = 13). <u>Inclusion criteria</u> : Patients aged ≥ 15 years presenting with ≥ 1 bowel symptom to one of the participating 116 GP. The present analyses only included patients who presented with the first sign of rectal bleeding and associated symptoms, but without any pre-existing bowel diseases. <u>Exclusion criteria</u> : ≤ minimum level of data entry for each patient by the participating physician. <u>Clinical setting</u> : Primary care, Germany.
Are there concerns that the included patients and setting do not match the review question?	Low concern
INDEX TEST	
A. Risk of bias	
Index test	Rectal bleeding, abdominal pain > 3 weeks, change in bowel habit > 3 weeks,

	anaemia, and weight loss.	
Were the index test results interpreted without knowledge of the results of the reference standard?		Yes
Could the conduct or interpretation of the index test have introduced bias?		Low risk
B. Concerns regarding applicability		
Are there concerns that the index test, its conduct, or interpretation differ from the review question?		Low concern
REFERENCE STANDARD		
A. risk of bias		
Reference standard(s)	A number of different diagnostic investigations, although some patients did not undergo any, - their explanatory notes were examined instead	
Is the reference standard likely to correctly classify the target condition?		Unclear
Were the reference standard results interpreted without knowledge of the results of the index tests?		Unclear (but all patients had a positive index test)
Could the reference standard, its conduct, or its interpretation have introduced bias?		Low risk
B. Concerns regarding applicability		
Are there concerns that the target condition as defined by the reference standard does not match the question?		Low concern
FLOW AND TIMING		
A. risk of bias		
Flow and timing	93 patients did not undergo any investigations, and in 22/93 the course of disease and the diagnostics could not be assessed with the data provided in the explanatory notes. The results are therefore only reported for the 400 patients for whom the data are known	
Was there an appropriate interval between index test and reference standard?		Yes
Did all patients receive the same reference standard?		No
Were all patients included in the analysis?		No
Could the patient flow have introduced bias?		High risk
NOTES	Over the course of 1 year, 2239 patients with chronic bowel symptoms and diseases were registered by 116 participating GPs. 24/116 GPs withdrew from the study before study completion (due to personal reasons (12) or lack of cooperation (10)), leaving 1696 patients registered by 94 GPs of whom 1584 met the minimum requirements for inclusion. 422/1584 patients presented with rectal bleeding.	
1		
2	Helfand (1997)	
PATIENT SELECTION		
A. risk of bias		
Patient sampling	Prospective consecutive patient series from the walk-in and general medical clinics of the Veterans Affairs Medical Center, Palo Alto, California.	
Was a consecutive or random sample of patients enrolled?		Yes
Was a case-control design avoided?		Yes

Did the study avoid inappropriate exclusions?	Yes
Could the selection of patients have introduced bias?	Low risk
B. Concerns regarding applicability	
Patient characteristics and setting	<p>N = 201; 200 males, 1 female; mean ages (SD; 3 values given based on final diagnostic category): “None” (N = 49) = 53.8 (15.4) years; “anorectal” (N = 104) = 54.6 (13.6) years; “serious” (N = 48) = 58.3 (11.3) years.</p> <p><u>Inclusion criteria:</u> Patients who between January 1981 and October 1983 presented to the walk-in and general medical clinics of the Veterans Affairs Medical Center, Palo Alto, California were given a questionnaire after by the nursing personnel after their vital signs had been measured. Patients who according to their answers had experienced rectal bleeding within the last 3 months and not sought medical attention for it were invited to take part in the study.</p> <p><u>Exclusion criteria:</u> Patients with no data available at 6 and 12 months follow up.</p> <p><u>Clinical setting:</u> Walk-in and general medical clinics of the Veterans Affairs Medical Center, Palo Alto, California</p>
Are there concerns that the included patients and setting do not match the review question?	High concern
INDEX TEST	
A. Risk of bias	
Index test	New onset (within 3-months) rectal bleeding (blood in stool or on toilet paper)
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes
Could the conduct or interpretation of the index test have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the index test, its conduct, or interpretation differ from the review question?	Low concern
REFERENCE STANDARD	
A. risk of bias	
Reference standard(s)	Follow up 6-12 months and examination of medical records 8-10 years after study entry.
Is the reference standard likely to correctly classify the target condition?	Yes
Were the reference standard results interpreted without knowledge of the results of the index tests?	No
Could the reference standard, its conduct, or its interpretation have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the target condition as defined by the reference standard does not match the question?	Low concern
FLOW AND TIMING	
A. risk of bias	
Flow and timing	All patients appear to be accounted for

Was there an appropriate interval between index test and reference standard?	Unclear
Did all patients receive the same reference standard?	Yes
Were all patients included in the analysis?	Yes
Could the patient flow have introduced bias?	Low risk
NOTES	The authors mention that between 2 and 10 years after study entry 3 patients developed colorectal cancer. These patients do not appear to be included as true positives.
1	
2	Hippisley-Cox (2012)
PATIENT SELECTION	
A. risk of bias	
Patient sampling	Prospective patient series using patients in the QResearch database (version 30).
Was a consecutive or random sample of patients enrolled?	Yes
Was a case-control design avoided?	Yes
Did the study avoid inappropriate exclusions?	Yes
Could the selection of patients have introduced bias?	Low risk
B. Concerns regarding applicability	
Patient characteristics and setting	<p>A total of 1236601 patients were identified from 189 practices (620240 males, 616361 females), mean (SD) age = 50.1 (14.9) years, mean (SD) Townsend score = -0.2 (3.6).</p> <p><u>Symptoms:</u> Current rectal bleeding (N = 29118), current abdominal pain (N = 125816), current appetite loss (N = 5358), current weight loss (N = 14065), recent change in bowel habit (N = 1821).</p> <p><u>Incident cases of colorectal cancer during the 2-year follow up period:</u> N = 2603 (1562 colon and 1041 rectum).</p> <p><u>Inclusion criteria:</u> All practices in England and Wales that had been using their Egton Medical Information Systems (EMIS) computer system for \geq a year were included. Two-thirds of practices were randomly allocated to the derivation dataset and the remaining practices were allocated to the validation dataset. An open cohort of patients aged 30–84 years was identified, drawn from patients registered with practices between 1 January 2000 and 30 September 2010. Entry to the cohort was defined as the latest of the study start date (1 January 2000); 12 months after the patient registered with the practice; and for those patients with red flag symptoms (see below), the date of the first recorded onset within the study period. <i>The relevant data for the present purposes is only available for the validation cohort, therefore only information pertaining to these patients will be reported.</i></p> <p><u>Exclusion criteria:</u> Patients without a postcode-related Townsend score, patients with a history of colorectal cancer at baseline, and patients with a recorded 'red-flag' symptom in the 12 months prior to the study entry date.</p> <p><u>Clinical setting:</u> Primary care, UK</p>
Are there concerns that the included patients and setting do not match the review question?	Low concern
INDEX TEST	
A. Risk of bias	

Index test	'Red-flag' symptoms: First onset rectal bleeding, first onset loss of appetite, first onset weight loss, first onset abdominal pain, first onset change in bowel habit (in the past 12 months), and anaemia (recorded haemoglobin < 11 g/dl in the past 12 months).
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes
Could the conduct or interpretation of the index test have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the index test, its conduct, or interpretation differ from the review question?	Low concern
REFERENCE STANDARD	
A. risk of bias	
Reference standard(s)	2-year follow up
Is the reference standard likely to correctly classify the target condition?	Yes
Were the reference standard results interpreted without knowledge of the results of the index tests?	Unclear
Could the reference standard, its conduct, or its interpretation have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the target condition as defined by the reference standard does not match the question?	Low concern
FLOW AND TIMING	
A. risk of bias	
Flow and timing	A total of 1342329 patients were initially identified of whom 105728 patients were excluded for the following reasons: No recorded Townsend score (N = 70847), history of colorectal cancer (N = 2908), and ≥ one 'red flag' symptom recorded in the 12 months prior to study entry (N = 31973), leaving 1236601 patients. However, data is presented for 1235547/1236601 patients for all symptoms apart from change in bowel habit, which is only presented for 619651/620240 of the male patients. The missing data does not appear to include any of the cancer cases (although this cannot be ascertained for change in bowel habit), but it is unclear whether some of the missing data includes symptomatic patients, i.e., false positives.
Was there an appropriate interval between index test and reference standard?	Yes
Did all patients receive the same reference standard?	Yes
Were all patients included in the analysis?	No
Could the patient flow have introduced bias?	Low risk
NOTES	Please note there is some overlap between this patient sample and that of Parker (2007)
1	
2	Jones (2007)
PATIENT SELECTION	
A. risk of bias	

Patient sampling	Retrospective consecutive patient series using patients in the UK's General Practice Research Database.
Was a consecutive or random sample of patients enrolled?	Yes
Was a case-control design avoided?	Yes
Did the study avoid inappropriate exclusions?	Yes
Could the selection of patients have introduced bias?	Low risk
B. Concerns regarding applicability	
Patient characteristics and setting	<p>A total of 923605 patients were identified, of whom 762325 were aged ≥ 15 years.</p> <p>Number of first occurrences in patients with no previous diagnosis of cancer:</p> <p><u>Haematuria</u>: N = 11138, mean (SD) age at first symptom = 58.5 (18.9) years. Patients excluded due to incomplete dates for their first symptom: N = 30. Sex (of final sample): 6385 males, 4723 females.</p> <p><u>Haemoptysis</u>: N = 4822, mean (SD) age at first symptom = 61.6 (18) years. Patients excluded due to incomplete dates for their first symptom: N = 10. Sex (of final sample): 2930 males, 1882 females.</p> <p><u>Dysphagia</u>: N = 6003, mean (SD) age at first symptom = 54.5 (19.4) years. Patients excluded due to incomplete dates for their first symptom: N = 4. Sex (of final sample): 2628 males, 3371 females.</p> <p><u>Rectal bleeding</u>: N = 15314, mean (SD) age at first symptom = 52.5 (18.8) years. Patients excluded due to incomplete dates for their first symptom: N = 25. Sex (of final sample): 7523 males, 7766 females.</p> <p><u>Inclusion criteria</u>: All patients from 128 general practices that provided data of a sufficient standard from 1 January 1994 to 31 December 2000 and which provided exclusively Read coded data, who were aged between 15 and 100 years, whose first ever recorded occurrence of each alarm symptom (haematuria, haemoptysis, dysphagia, or rectal bleeding) was after 31 December 1994 and who had not previously been diagnosed as having any cancer.</p> <p><u>Exclusion criteria</u>: Patients whose date of first symptom or first relevant diagnosis of cancer was before 1 January 1995 and patients with a diagnosis of any other cancer than the ones of interest before the date of the first recorded symptom or before the index cancer diagnosis date if the related symptom was not recorded.</p> <p><u>Clinical setting</u>: Primary care</p>
Are there concerns that the included patients and setting do not match the review question?	Low concern
INDEX TEST	
A. Risk of bias	
Index test	Identification of all patients who ever had symptoms recorded for haematuria, haemoptysis, dysphagia, or rectal bleeding.
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes
Could the conduct or interpretation of the index test have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the index test, its conduct, or interpretation differ from the review question?	Low concern

REFERENCE STANDARD	
A. risk of bias	
Reference standard(s)	Cancer code in the UK's General Practice Research Database: <u>Haematuria</u> : Urinary tract neoplasms, including neoplasms of the urethra, bladder, ureter, and kidney but excluding neoplasms of the prostate and other reproductive organs. <u>Haemoptysis</u> : Respiratory tract neoplasms. <u>Dysphagia</u> : Oesophageal neoplasms. <u>Rectal bleeding</u> : Colorectal neoplasms.
Is the reference standard likely to correctly classify the target condition?	Yes
Were the reference standard results interpreted without knowledge of the results of the index tests?	Unclear (but all patients had a positive index test)
Could the reference standard, its conduct, or its interpretation have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the target condition as defined by the reference standard does not match the question?	Low concern
FLOW AND TIMING	
A. risk of bias	
Flow and timing	All patients are accounted for in the results.
Was there an appropriate interval between index test and reference standard?	Unclear
Did all patients receive the same reference standard?	Yes
Were all patients included in the analysis?	Yes
Could the patient flow have introduced bias?	Low risk
NOTES	<p>Diagnoses of cancer were most often made in the first three months after the onset of alarm symptoms; very few diagnoses of cancer were made later than three years after symptom onset. In the 4th and 5th years of study, the small number of observed occurrences of cancer was similar to the number expected from background incidence rates.</p> <p>Secondary analyses evaluating whether the incidence of neoplasms other than those prespecified was increased after the occurrence of alarm symptoms showed for:</p> <p><u>Haematuria</u>: Inclusion of cancers of the reproductive organs yielded 21 additional cancers in women and 158 cancers in men, mostly cancers of the prostate. Inclusion of these cancers in the analysis would give a positive predictive value of 3.9% in women and 9.9% in men.</p> <p><u>Dysphagia</u>: Inclusion of gastric cancers yielded 17 additional cancer diagnoses in women and 30 in men. Inclusion of these cancers gave positive predictive values of 5.2% in women and 6.9% in men.</p> <p><i>Estimates based on the pre-specified cancers may be thus conservative for these symptoms.</i></p> <p><u>Haemoptysis</u>: Extension of the diagnostic criteria yielded 6 additional cancers.</p> <p><u>Rectal bleeding</u>: Extension of the diagnostic criteria yielded 2 additional cancers.</p>

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Lawrenson (2006)	
PATIENT SELECTION	
A. risk of bias	
Patient sampling	Database study using patients from a sample of UK practices contributing data to the General Practice Research Database.
Was a consecutive or random sample of patients enrolled?	Yes
Was a case-control design avoided?	Yes
Did the study avoid inappropriate exclusions?	Yes
Could the selection of patients have introduced bias?	Low risk
B. Concerns regarding applicability	
Patient characteristics and setting	<p>Anaemia cases: N = 67164 (18896 males, 48268 females) Changes in bowel habit cases: N = 27524 (10934 males, 16590 females) Rectal bleeding cases: N = 44741 (21472 males, 23269 females) Colorectal cancer cases: N = 9143</p> <p><u>Inclusion criteria:</u> All patients aged 40-89 years presenting to their GP between 1 January 1992 and 31 December 1999 with new symptoms of anaemia, change in bowel habit or rectal bleeding, who had ≥ 1 year of data. <u>Exclusion criteria:</u> Patients with colorectal cancer, or a diagnosis of colorectal cancer within 1 year of presentation. <u>Clinical setting:</u> Primary care, UK.</p>
Are there concerns that the included patients and setting do not match the review question?	Low concern
INDEX TEST	
A. Risk of bias	
Index test	Anaemia, change in bowel habit or rectal bleeding as identified by their diagnostic codes
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes
Could the conduct or interpretation of the index test have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the index test, its conduct, or interpretation differ from the review question?	Low concern
REFERENCE STANDARD	
A. risk of bias	
Reference standard(s)	Follow up from presenting symptom until diagnosis of colorectal cancer, death or the end of the patient record.
Is the reference standard likely to correctly classify the target condition?	Yes
Were the reference standard results interpreted without knowledge of the results of the index tests?	No
Could the reference standard, its conduct, or its interpretation have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the target condition as defined by the reference standard does not match the question?	Low concern

FLOW AND TIMING	
A. risk of bias	
Flow and timing	All patients appear to be accounted for
Was there an appropriate interval between index test and reference standard?	Yes
Did all patients receive the same reference standard?	Yes
Were all patients included in the analysis?	Yes (probably)
Could the patient flow have introduced bias?	Low risk
NOTES	The authors state that the positive predictive values were derived from Kaplan-Maier curves constructed for men and women for each symptom cohort in 10-year age bands and report the positive predictive values of colorectal cancer being diagnosed within 12 months of initial symptoms per 100 patients presenting. It is unclear to me why this method was chosen over just calculating the values by dividing the true positives by the total positives and how and if these calculations differ from those of the other studies. The raw data is not presented and these data can therefore not be included in the meta-analysis.
1	
2 Lucas (1996)	
PATIENT SELECTION	
A. risk of bias	
Patient sampling	Retrospective laboratory database (recording all full blood counts analysed in the district) study from one UK health district (population 290000).
Was a consecutive or random sample of patients enrolled?	Yes
Was a case-control design avoided?	Yes
Did the study avoid inappropriate exclusions?	Yes
Could the selection of patients have introduced bias?	Low risk
B. Concerns regarding applicability	
Patient characteristics and setting	N = 130 of whom 21 were clearly attributable to non-gastrointestinal disease (e.g., urinary tract bleeding, uterine/respiratory/surgical blood loss and sideroblastic anaemia). In the remaining 109 patients with a presumed gastrointestinal cause N = 29 were aged < 65 years, N = 51 were aged 65-79 years and N = 29 were aged > 80 years. <u>Inclusion criteria:</u> Women aged > 50 years and all men who between October 1991 and March 1992 were found to have probable iron-deficiency anaemia (haemoglobin < 11 g/dl in women and < 12 g/dl in men, and men cell volume < 83 fl) where the date of the first abnormal full blood count fell either within or 3 months prior to the study period and where there had been no other episode of anaemia within the previous 2 years. <u>Exclusion criteria:</u> None listed. <u>Clinical setting:</u> UK primary and beyond
Are there concerns that the included patients and setting do not match the review question?	Unclear concern
INDEX TEST	
A. Risk of bias	
Index test	New onset iron-deficiency anaemia. Hypochronic microcytic anaemia was

	presumed to be due to iron-deficiency anaemia unless proven otherwise through appropriate investigation.
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes
Could the conduct or interpretation of the index test have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the index test, its conduct, or interpretation differ from the review question?	Low concern
REFERENCE STANDARD	
A. risk of bias	
Reference standard(s)	Follow up using hospital and general practice records until 18 months after study period finish.
Is the reference standard likely to correctly classify the target condition?	Yes
Were the reference standard results interpreted without knowledge of the results of the index tests?	No
Could the reference standard, its conduct, or its interpretation have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the target condition as defined by the reference standard does not match the question?	Low concern
FLOW AND TIMING	
A. risk of bias	
Flow and timing	All patients appear to be accounted for
Was there an appropriate interval between index test and reference standard?	Yes
Did all patients receive the same reference standard?	Yes
Were all patients included in the analysis?	Yes
Could the patient flow have introduced bias?	Low risk
NOTES	In addition to the 9 patients with colorectal cancer, 5 patients had gastric cancer.
1	
2	Mant (1989)
PATIENT SELECTION	
A. risk of bias	
Patient sampling	Prospective consecutive patient series from 58 general practitioners in New South Wales, Australia.
Was a consecutive or random sample of patients enrolled?	Yes
Was a case-control design avoided?	Yes
Did the study avoid inappropriate exclusions?	Yes
Could the selection of patients have introduced bias?	Low risk
B. Concerns regarding applicability	
Patient characteristics and setting	N = 145; 77 males, 68 females; mean age (SD, range) = 57.7 (11.9, 40-95) years.

	<p><u>Inclusion criteria:</u> All patients aged ≥ 40 years who consulted the GP with rectal bleeding.</p> <p><u>Exclusion criteria:</u> Patients (1) for whom it was considered that their age or general medical condition precluded colonoscopy, (2) who were known to have inflammatory bowel disease, colorectal cancer or polyposis coli, (3) with a coagulation defect or haemalogic disorder, (4) where the bleeding was melanic, or (5) who refused investigation.</p> <p><u>Clinical setting:</u> General practice in New South Wales, Australia.</p>
Are there concerns that the included patients and setting do not match the review question?	Unclear concern
INDEX TEST	
A. Risk of bias	
Index test	New onset (within 6-months) rectal bleeding (blood in stool or on toilet paper)
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes
Could the conduct or interpretation of the index test have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the index test, its conduct, or interpretation differ from the review question?	Low concern
REFERENCE STANDARD	
A. risk of bias	
Reference standard(s)	Flexible sigmoidoscopy and air-contrast barium enema \pm colonoscopy
Is the reference standard likely to correctly classify the target condition?	Yes
Were the reference standard results interpreted without knowledge of the results of the index tests?	No
Could the reference standard, its conduct, or its interpretation have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the target condition as defined by the reference standard does not match the question?	Low concern
FLOW AND TIMING	
A. risk of bias	
Flow and timing	All patients appear to be accounted for
Was there an appropriate interval between index test and reference standard?	Yes (probably)
Did all patients receive the same reference standard?	Yes
Were all patients included in the analysis?	Yes
Could the patient flow have introduced bias?	Low risk
NOTES	In addition to the 15 patients with colorectal cancer, 1 patient had anal cancer and 1 patient had lymphoma of the ascending colon. Both of these are included in the meta-analyses, but only the lymphoma patient is included in the subgroup analyses reported by the authors.

1

Meineche-Schmidt (2002)	
PATIENT SELECTION	
A. risk of bias	
Patient sampling	Consecutive patient series from 82 GPs in Denmark.
Was a consecutive or random sample of patients enrolled?	Yes
Was a case-control design avoided?	Yes
Did the study avoid inappropriate exclusions?	Yes
Could the selection of patients have introduced bias?	Low risk
B. Concerns regarding applicability	
Patient characteristics and setting	N = 1491; 688 males, 803 females; age groups: 18-37 years: N = 377; 38-50 years: N = 369; 51-64 years: N = 338; 65- years: N = 402. <u>Inclusion criteria:</u> Consecutive patients who consulted their GP between June 1991 and May 1993 for dyspepsia (defined as pain or discomfort in the abdomen judged by the GP to be related to the gastrointestinal tract). <u>Exclusion criteria:</u> None listed. <u>Clinical setting:</u> Primary care, Denmark.
Are there concerns that the included patients and setting do not match the review question?	Unclear concern
INDEX TEST	
A. Risk of bias	
Index test	Dyspepsia (defined as pain or discomfort in the abdomen judged by the GP to be related to the gastrointestinal tract).
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes
Could the conduct or interpretation of the index test have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the index test, its conduct, or interpretation differ from the review question?	Low concern
REFERENCE STANDARD	
A. risk of bias	
Reference standard(s)	18 months-3 years and 10 months follow up.
Is the reference standard likely to correctly classify the target condition?	Yes
Were the reference standard results interpreted without knowledge of the results of the index tests?	No
Could the reference standard, its conduct, or its interpretation have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the target condition as defined by the reference standard does not match the question?	Low concern
FLOW AND TIMING	
A. risk of bias	
Flow and timing	All patients appear to be accounted for

Was there an appropriate interval between index test and reference standard?	Yes
Did all patients receive the same reference standard?	Yes
Were all patients included in the analysis?	Yes
Could the patient flow have introduced bias?	Low risk
NOTES	In total N = 31 had cancer: 17 colorectal, 8 gastro-oesophageal (no subgroup analyses presented for these patients) and 6 other.
1	
2	Metcalf (1996)
PATIENT SELECTION	
A. risk of bias	
Patient sampling	Prospective consecutive patient sample from UK GPs.
Was a consecutive or random sample of patients enrolled?	Yes
Was a case-control design avoided?	Yes
Did the study avoid inappropriate exclusions?	Unclear
Could the selection of patients have introduced bias?	Low risk
B. Concerns regarding applicability	
Patient characteristics and setting	N = 99, 42 males, 57 females; median age (range) = 58 (40-86) years. <u>Inclusion criteria:</u> Patients aged > 40 years presenting with rectal bleeding of recent onset (< 1 year). <u>Exclusion criteria:</u> Patients refusing colonoscopy. <u>Clinical setting:</u> Primary care, UK
Are there concerns that the included patients and setting do not match the review question?	Low concern
INDEX TEST	
A. Risk of bias	
Index test	Recent onset (< 1 year) rectal bleeding
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes
Could the conduct or interpretation of the index test have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the index test, its conduct, or interpretation differ from the review question?	Low concern
REFERENCE STANDARD	
A. risk of bias	
Reference standard(s)	Colonoscopy ± barium enema
Is the reference standard likely to correctly classify the target condition?	Yes
Were the reference standard results interpreted without knowledge of the results of the index tests?	No
Could the reference standard, its conduct, or its interpretation have introduced bias?	Low risk
B. Concerns regarding applicability	

Are there concerns that the target condition as defined by the reference standard does not match the question?		Low concern
FLOW AND TIMING		
A. risk of bias		
Flow and timing	All patients appear to be accounted for	
Was there an appropriate interval between index test and reference standard?	Yes	
Did all patients receive the same reference standard?	Yes	
Were all patients included in the analysis?	Yes	
Could the patient flow have introduced bias?		Low risk
NOTES		
1		
2	Muris (1993)	
PATIENT SELECTION		
A. risk of bias		
Patient sampling	Prospective consecutive patient series from 11 general practitioners in Maastricht (Holland)	
Was a consecutive or random sample of patients enrolled?	Yes	
Was a case-control design avoided?	Yes	
Did the study avoid inappropriate exclusions?	Unclear	
Could the selection of patients have introduced bias?		Low risk
B. Concerns regarding applicability		
Patient characteristics and setting	<p>N = 578; 212 males, 342 females; age groups: 18-39 years: N = 295; 40-49 years: N = 80; 50-59 years: N = 91; 60-75 years: N = 88.</p> <p><u>Inclusion criteria:</u> Patients who during a 3-month period consulted one of the participating GPs for abdominal complaints.</p> <p><u>Exclusion criteria:</u> Patients aged < 18 years and patients with a condition necessitating immediate referral or admission to hospital.</p> <p><u>Clinical setting:</u> GPs in Holland</p>	
Are there concerns that the included patients and setting do not match the review question?		Unclear concern
INDEX TEST		
A. Risk of bias		
Index test	Abdominal complaints. Not further specified, but the authors do report that the duration of pain before the patient presented for the first time for the evaluation of abdominal pain varied from some days to more than 1 year.	
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes	
Could the conduct or interpretation of the index test have introduced bias?		Low risk
B. Concerns regarding applicability		
Are there concerns that the index test, its conduct, or interpretation differ from the review question?		Unclear concern
REFERENCE STANDARD		
A. risk of bias		
Reference	Follow up for 15 months.	

standard(s)	
Is the reference standard likely to correctly classify the target condition?	Yes
Were the reference standard results interpreted without knowledge of the results of the index tests?	No
Could the reference standard, its conduct, or its interpretation have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the target condition as defined by the reference standard does not match the question?	Low concern
FLOW AND TIMING	
A. risk of bias	
Flow and timing	All patients appear to be accounted for
Was there an appropriate interval between index test and reference standard?	Unclear
Did all patients receive the same reference standard?	Yes
Were all patients included in the analysis?	Yes
Could the patient flow have introduced bias?	Low risk
NOTES	Although not explicitly stated by the authors it is implied that the patients included were those presenting with the abdominal complaint for the first time.
1	
2	
Muris (1995)	
PATIENT SELECTION	
A. risk of bias	
Patient sampling	Prospective patient series from 80/460 general practitioners in Limburg (Holland)
Was a consecutive or random sample of patients enrolled?	No
Was a case-control design avoided?	Yes
Did the study avoid inappropriate exclusions?	Unclear
Could the selection of patients have introduced bias?	High risk
B. Concerns regarding applicability	
Patient characteristics and setting	N = 933; 335 males, 598 females; age range = 18-75, aged > 30 years: N = 712, aged > 40 years: N = 517, aged > 60 years: N = 171. Inclusion criteria: Patients who in 1989 consulted one of the participating GPs for new abdominal complaints lasting \geq 2 weeks and with whom the GPs had a diagnostic problem. Exclusion criteria: None listed. Clinical setting: GPs in Holland
Are there concerns that the included patients and setting do not match the review question?	High concern
INDEX TEST	
A. Risk of bias	
Index test	New abdominal complaints lasting \geq 2 weeks. Not further specified.
Were the index test results interpreted without knowledge	Yes

of the results of the reference standard?	
Could the conduct or interpretation of the index test have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the index test, its conduct, or interpretation differ from the review question?	High concern
REFERENCE STANDARD	
A. risk of bias	
Reference standard(s)	Follow up for ≥ 12 months (mean = 18 months).
Is the reference standard likely to correctly classify the target condition?	Yes
Were the reference standard results interpreted without knowledge of the results of the index tests?	No
Could the reference standard, its conduct, or its interpretation have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the target condition as defined by the reference standard does not match the question?	Low concern
FLOW AND TIMING	
A. risk of bias	
Flow and timing	All patients appear to be accounted for
Was there an appropriate interval between index test and reference standard?	Unclear
Did all patients receive the same reference standard?	Yes
Were all patients included in the analysis?	Yes
Could the patient flow have introduced bias?	Low risk
NOTES	Other cancers diagnosed in these patients were: Stomach (2/933), pancreas (2/933), trachea/bronchus/lung (2/933), kidney (1/933), cervix (1/933), other cancer of the female genital system (2/933), and other and unspecified sites (2/933).
1	
2	Nørrelund (1996)
PATIENT SELECTION	
A. risk of bias	
Patient sampling	Prospective patient sample from GPs in Denmark.
Was a consecutive or random sample of patients enrolled?	Yes
Was a case-control design avoided?	Yes
Did the study avoid inappropriate exclusions?	Unclear
Could the selection of patients have introduced bias?	Unclear risk
B. Concerns regarding applicability	
Patient characteristics and setting	N = 417, but no demographic data reported for 45 patients who presented with similar rectal bleeding patterns to previously experienced rectal bleeding or for 8 patients with non-reported rectal bleeding pattern. The characteristics for the 364 patients with new onset or changed pattern rectal bleeding are as follows: 168 males, 196 females; age groups: 40-69 years: N =

	254; 70-79 years: N = 85; 80+ years: N = 25. <u>Inclusion criteria</u> : Patients aged ≥ 40 years who between August 1989 and October 1992 presented to the participating GPs with rectal bleeding. <u>Exclusion criteria</u> : Known inflammatory bowel disease, colonic polyps, polyposis coli, colorectal cancer, predisposition to haemorrhage, and melaena stool. <u>Clinical setting</u> : Primary care, Denmark
Are there concerns that the included patients and setting do not match the review question?	Low concern
INDEX TEST	
A. Risk of bias	
Index test	Rectal bleeding subclassified into: First episode (within 6-months) rectal bleeding (blood in/on stool, in the toilet or on toilet paper), change in rectal bleeding pattern, and no change in rectal bleeding pattern
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes
Could the conduct or interpretation of the index test have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the index test, its conduct, or interpretation differ from the review question?	Low concern
REFERENCE STANDARD	
A. risk of bias	
Reference standard(s)	Follow up (range = 22-57 months)
Is the reference standard likely to correctly classify the target condition?	Yes
Were the reference standard results interpreted without knowledge of the results of the index tests?	No
Could the reference standard, its conduct, or its interpretation have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the target condition as defined by the reference standard does not match the question?	Low concern
FLOW AND TIMING	
A. risk of bias	
Flow and timing	All patients appear to be accounted for
Was there an appropriate interval between index test and reference standard?	Yes
Did all patients receive the same reference standard?	Yes
Were all patients included in the analysis?	Yes
Could the patient flow have introduced bias?	Low risk
NOTES	
1	
2	Oudega (2006)
PATIENT SELECTION	

A. risk of bias	
Patient sampling	Prospective study of all primary care physicians (N = 50) within a catchment area (ca 130000 inhabitants) of a non-teaching hospital in Holland.
Was a consecutive or random sample of patients enrolled?	Yes
Was a case-control design avoided?	Yes
Did the study avoid inappropriate exclusions?	Yes
Could the selection of patients have introduced bias?	Low risk
B. Concerns regarding applicability	
Patient characteristics and setting	N = 430; 162 males, 268 females; mean age (SD) = 60.7 (18.2) years. <u>Inclusion criteria</u> : Consecutive patients who consulted their GP between January 1996 and July 2002 and who, after investigation (not referral) was confirmed to have deep vein thrombosis. <u>Exclusion criteria</u> : Patients with a known malignancy or a malignancy detected within 2 weeks of deep vein thrombosis diagnosis. <u>Clinical setting</u> : Primary care, Holland.
Are there concerns that the included patients and setting do not match the review question?	Unclear concern
INDEX TEST	
A. Risk of bias	
Index test	Deep vein thrombosis (suspicion based on painful swollen leg \leq 30 days). Patients were classified as having secondary deep vein thrombosis if \geq 1 of the following risk factors for deep vein thrombosis were present: Recent surgery, prolonged immobilisation, use of oral contraceptives or hormonal replacement therapy. If no risk factors were present patients were classified as having idiopathic deep vein thrombosis.
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes
Could the conduct or interpretation of the index test have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the index test, its conduct, or interpretation differ from the review question?	Low concern
REFERENCE STANDARD	
A. risk of bias	
Reference standard(s)	2 years follow up.
Is the reference standard likely to correctly classify the target condition?	Yes
Were the reference standard results interpreted without knowledge of the results of the index tests?	No
Could the reference standard, its conduct, or its interpretation have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the target condition as defined by the reference standard does not match the question?	Low concern

FLOW AND TIMING		
A. risk of bias		
Flow and timing	All patients appear to be accounted for	
Was there an appropriate interval between index test and reference standard?	Yes	
Did all patients receive the same reference standard?	Yes	
Were all patients included in the analysis?	Yes	
Could the patient flow have introduced bias?		Low risk
NOTES	In total N = 19 had cancer: 3 colorectal, 5 urogenital (not further subgrouped), 4 breast, 3 lung and 4 other. The urogenital data is added to the renal cancer evidence review.	
1		
2	Panzuto (2003)	
PATIENT SELECTION		
A. risk of bias		
Patient sampling	Prospective 8-week study of patients presenting to 159 primary care physicians (approximately 63600 patient visits during the study period in total) in Italy.	
Was a consecutive or random sample of patients enrolled?	No	
Was a case-control design avoided?	Yes	
Did the study avoid inappropriate exclusions?	Unclear	
Could the selection of patients have introduced bias?		High risk
B. Concerns regarding applicability		
Patient characteristics and setting	<p>N = 280; 120 males, 160 females; median age (range) = 61 (18-87) years.</p> <p><u>Inclusion criteria:</u> Consecutive patients who consulted their GP "with symptoms considered suspicious for the presence of a colon disease to rule out the presence of colorectal cancer" and who were investigated with a colonoscopy or double-contrast barium enema [The decision of how (colonoscopy or double-contrast barium enema) and when to investigate the colon was made only by the physicians on the basis of the clinical evaluation during the visit].</p> <p><u>Exclusion criteria:</u> Patients with previous diagnoses of colorectal disorders or a recent large bowel examination.</p> <p><u>Clinical setting:</u> Primary care, Italy.</p>	
Are there concerns that the included patients and setting do not match the review question?		Unclear concern
INDEX TEST		
A. Risk of bias		
Index test	Abdominal pain, bloating, constipation, rectal bleeding, diarrhoea, iron-deficiency anaemia (haemoglobin levels < 14 g/dl for males and < 12 g/dl for females, in the presence of ferritin < 30 µg/l and a median corpuscular value < 80 fl), change in bowel habits (onset of diarrhoea or constipation or altered stool in the previous 3 months) and weight loss (decrease of ≥ 3 kg in the 3 months prior to the visit).	
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes	
Could the conduct or interpretation of the index test		Low risk

have introduced bias?		
B. Concerns regarding applicability		
Are there concerns that the index test, its conduct, or interpretation differ from the review question?		Low concern
REFERENCE STANDARD		
A. risk of bias		
Reference standard(s)	Histology	
Is the reference standard likely to correctly classify the target condition?		Yes
Were the reference standard results interpreted without knowledge of the results of the index tests?		No
Could the reference standard, its conduct, or its interpretation have introduced bias?		Low risk
B. Concerns regarding applicability		
Are there concerns that the target condition as defined by the reference standard does not match the question?		Low concern
FLOW AND TIMING		
A. risk of bias		
Flow and timing	56/332 patients were excluded due to lack of mandatory fields (age, sex, clinical history, presenting symptoms and procedure results) in the database (N = 35) or violation of exclusion criteria (N = 18)	
Was there an appropriate interval between index test and reference standard?		Yes
Did all patients receive the same reference standard?		Yes
Were all patients included in the analysis?		No
Could the patient flow have introduced bias?		Unclear risk
NOTES		
1		
2 Parker (2007)		
PATIENT SELECTION		
A. risk of bias		
Patient sampling	Prospective patient series using patients in the QResearch database.	
Was a consecutive or random sample of patients enrolled?		Yes
Was a case-control design avoided?		Yes
Did the study avoid inappropriate exclusions?		Yes
Could the selection of patients have introduced bias?		Low risk
B. Concerns regarding applicability		
Patient characteristics and setting	<p>Rectal bleeding: N = 29007 (13931, males, 15076 females); median age (inter-quartile range) = 54 (40-69) years.</p> <p>Post-menopausal bleeding: N = 10122 (10122 females); median age (inter-quartile range) = 58 (54-67) years.</p> <p><u>Inclusion criteria:</u></p> <p>All practices in England and Wales that had been using their Egton Medical Information Systems (EMIS) computer system before 1 April 1998 and had complete data up to 1 April 2005. Patients were included if they were</p>	

	<p>registered with an eligible practice at any time between 1 April 1998 and 31 March 2003, had been registered with the practice for ≥ 12 months and had a first-ever consultation for rectal bleeding and were aged ≥ 25 years, or post-menopausal bleeding and were aged ≥ 40 years, between 1 April 1998 and 31 March 2003.</p> <p><u>Exclusion criteria:</u> Previous record of colorectal cancer (for patients presenting with rectal bleeding) and endometrial cancer (for patients presenting with post-menopausal bleeding)</p> <p><u>Clinical setting:</u> Primary care, UK</p>
Are there concerns that the included patients and setting do not match the review question?	Low concern
INDEX TEST	
A. Risk of bias	
Index test	First ever presentation of rectal bleeding, first ever presentation of post-menopausal bleeding.
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes
Could the conduct or interpretation of the index test have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the index test, its conduct, or interpretation differ from the review question?	Low concern
REFERENCE STANDARD	
A. risk of bias	
Reference standard(s)	2-year follow up
Is the reference standard likely to correctly classify the target condition?	Yes
Were the reference standard results interpreted without knowledge of the results of the index tests?	Unclear
Could the reference standard, its conduct, or its interpretation have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the target condition as defined by the reference standard does not match the question?	Low concern
FLOW AND TIMING	
A. risk of bias	
Flow and timing	All patients appear to be accounted for
Was there an appropriate interval between index test and reference standard?	Yes
Did all patients receive the same reference standard?	Yes
Were all patients included in the analysis?	Yes
Could the patient flow have introduced bias?	Low risk
NOTES	Please note there is some overlap between this patient sample and that of Hippisley-Cox (2012).

1

2

Robertson (2006)

PATIENT SELECTION	
A. risk of bias	
Patient sampling	Prospective consecutive patient sample from UK GPs.
Was a consecutive or random sample of patients enrolled?	Yes
Was a case-control design avoided?	Yes
Did the study avoid inappropriate exclusions?	Unclear
Could the selection of patients have introduced bias?	Low risk
B. Concerns regarding applicability	
Patient characteristics and setting	N = 604, 273 males, 331 females; median age (range) = 52 (18-97) years. <u>Inclusion criteria</u> : Patients who between September 1996 and June 1999 presented to the participating GPs with rectal bleeding. <u>Exclusion criteria</u> : Patients with ulcerative colitis, current warfarin treatment or missing data for the kind of bleeding. <u>Clinical setting</u> : Primary care, UK
Are there concerns that the included patients and setting do not match the review question?	Low concern
INDEX TEST	
A. Risk of bias	
Index test	Rectal bleeding
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes
Could the conduct or interpretation of the index test have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the index test, its conduct, or interpretation differ from the review question?	Low concern
REFERENCE STANDARD	
A. risk of bias	
Reference standard(s)	Follow up (min 4 years)
Is the reference standard likely to correctly classify the target condition?	Yes
Were the reference standard results interpreted without knowledge of the results of the index tests?	No
Could the reference standard, its conduct, or its interpretation have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the target condition as defined by the reference standard does not match the question?	Low concern
FLOW AND TIMING	
A. risk of bias	
Flow and timing	All patients appear to be accounted for
Was there an appropriate interval between index test and reference standard?	Yes
Did all patients receive the same reference standard?	Yes

Were all patients included in the analysis?	Yes
Could the patient flow have introduced bias?	Low risk
NOTES	Deprivation categories were allocated to participants by mapping their postcodes with national deprivation categories (septiles) derived from the Carstairs scores generated by MIMAS at Manchester University using 1991 census data.
1	
2	Stellon (1997)
PATIENT SELECTION	
A. risk of bias	
Patient sampling	Prospective? consecutive patient series from semi-rural UK general practice with a patient list between 2400-3400 during the study period.
Was a consecutive or random sample of patients enrolled?	Yes
Was a case-control design avoided?	Yes
Did the study avoid inappropriate exclusions?	Yes
Could the selection of patients have introduced bias?	Low risk
B. Concerns regarding applicability	
Patient characteristics and setting	N = 26; 5 males, 21 females; age range = 51-87 years. <u>Inclusion criteria:</u> All patients aged > 50 years found to have iron deficiency anaemia between January 1989 and March 1994. <u>Exclusion criteria:</u> None listed. <u>Clinical setting:</u> UK GP
Are there concerns that the included patients and setting do not match the review question?	Low concern
INDEX TEST	
A. Risk of bias	
Index test	Iron deficiency anaemia (< 12 g/dl haemoglobin and/or mean corpuscular volume < 80 fl with ferritin ≤ 16 ng/l)
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes
Could the conduct or interpretation of the index test have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the index test, its conduct, or interpretation differ from the review question?	Low concern
REFERENCE STANDARD	
A. risk of bias	
Reference standard(s)	Follow up during 5 year study period.
Is the reference standard likely to correctly classify the target condition?	Yes
Were the reference standard results interpreted without knowledge of the results of the index tests?	No
Could the reference standard, its conduct, or its interpretation have introduced bias?	Low risk

B. Concerns regarding applicability		
Are there concerns that the target condition as defined by the reference standard does not match the question?		Low concern
FLOW AND TIMING		
A. risk of bias		
Flow and timing	All patients appear to be accounted for	
Was there an appropriate interval between index test and reference standard?		Yes
Did all patients receive the same reference standard?		Yes
Were all patients included in the analysis?		Yes
Could the patient flow have introduced bias?		Low risk
NOTES		
1		
2 Wauters (2000)		
PATIENT SELECTION		
A. risk of bias		
Patient sampling	Prospective study of a network of sentinel Belgian general practices (covering 1% of the Belgian population) registering epidemiological data.	
Was a consecutive or random sample of patients enrolled?		Unclear
Was a case-control design avoided?		Yes
Did the study avoid inappropriate exclusions?		Unclear
Could the selection of patients have introduced bias?		Unclear risk
B. Concerns regarding applicability		
Patient characteristics and setting	N = 386; gender distribution not reported; age groups: < 50 years: N = 141; 50-59 years: N = 57; 60-69 years: N = 71; 70-79 years: N = 66; ≥ 80 years: N = 51. Inclusion criteria: All patients who in 1993-4 presented with rectal bleeding. Exclusion criteria: None listed. Clinical setting: GPs in Belgium	
Are there concerns that the included patients and setting do not match the review question?		Unclear concern
INDEX TEST		
A. Risk of bias		
Index test	Rectal bleeding (any blood of rectal origin on stool, underwear or toilet paper irrespective of duration)	
Were the index test results interpreted without knowledge of the results of the reference standard?		Yes
Could the conduct or interpretation of the index test have introduced bias?		Low risk
B. Concerns regarding applicability		
Are there concerns that the index test, its conduct, or interpretation differ from the review question?		Low concern
REFERENCE STANDARD		
A. risk of bias		
Reference	18-30 months follow up.	

standard(s)	
Is the reference standard likely to correctly classify the target condition?	Yes
Were the reference standard results interpreted without knowledge of the results of the index tests?	No
Could the reference standard, its conduct, or its interpretation have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the target condition as defined by the reference standard does not match the question?	Low concern
FLOW AND TIMING	
A. risk of bias	
Flow and timing	All patients appear to be accounted for
Was there an appropriate interval between index test and reference standard?	Yes
Did all patients receive the same reference standard?	Yes
Were all patients included in the analysis?	Yes (probably)
Could the patient flow have introduced bias?	Low risk
NOTES	
1	
2 Yates (2004)	
PATIENT SELECTION	
A. risk of bias	
Patient sampling	Retrospective database study using the laboratory databases of two district general hospitals including all the general practices using these laboratories.
Was a consecutive or random sample of patients enrolled?	Yes
Was a case-control design avoided?	Yes
Did the study avoid inappropriate exclusions?	Yes
Could the selection of patients have introduced bias?	Low risk
B. Concerns regarding applicability	
Patient characteristics and setting	N = 431; 154 males, 277 females; median age (inter-quartile range) = 75 (65-81) years. <u>Inclusion criteria:</u> All female patients aged > 50 years and male patients aged > 20, with haemoglobin concentrations ≤ 110 g/l (women) or ≤ 120 g/l (men), and mean cell volume < 82 fl (district 1) or 78 fl (district 2), and red cell count ≤ 5.5 x 10 ¹² /l between June 1997 and May 1998. <u>Exclusion criteria:</u> History of anaemia within previous 12 months, known haematological abnormalities (e.g., haemoglobinopathy), unavailable notes at follow up. <i>That is, patients with a history of cancer were not excluded.</i> <u>Clinical setting:</u> UK GP
Are there concerns that the included patients and setting do not match the review question?	Unclear concern
INDEX TEST	
A. Risk of bias	

Index test	Iron deficiency anaemia (haemoglobin concentrations ≤ 110 g/l (women) or ≤ 120 g/l (men), and mean cell volume < 82 fl (district 1) or 78 fl (district 2), and red cell count $\leq 5.5 \times 10^{12}$ /l)
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes
Could the conduct or interpretation of the index test have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the index test, its conduct, or interpretation differ from the review question?	Low concern
REFERENCE STANDARD	
A. risk of bias	
Reference standard(s)	Minimum 3 years follow up.
Is the reference standard likely to correctly classify the target condition?	Yes
Were the reference standard results interpreted without knowledge of the results of the index tests?	No
Could the reference standard, its conduct, or its interpretation have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the target condition as defined by the reference standard does not match the question?	Low concern
FLOW AND TIMING	
A. risk of bias	
Flow and timing	All patients appear to be accounted for
Was there an appropriate interval between index test and reference standard?	Yes
Did all patients receive the same reference standard?	Yes
Were all patients included in the analysis?	Yes
Could the patient flow have introduced bias?	Low risk
NOTES	In total N = 48 had gastrointestinal cancer (11 upper, 2 small bowel and 35 lower, including recurrent tumours) and N = 23 had non-gastrointestinal cancers, but the study only reports the type of some of these cancers (3 lung + 1 lung tumour secondary to a previous breast tumour, 1 ovary, 2 bladder, 1 Hodgkin's, 1 Non-Hodgkin's, 1 endometrial sarcoma, 1 lymphoma, 1 endometrial) and has therefore not been added to the evidence reviews for the non-gastrointestinal cancers. The paper considers both the lower gastrointestinal cancers and the small bowel cancers as colorectal cancer and in order to present subgroup analyses by gender I have maintained this grouping and not added this paper to the evidence review for small intestine.

1

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Not relevant; cancer patients, not symptomatic primary care patients

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Not relevant; cancer patients, not symptomatic primary care patients

Review question:

Which investigations of symptoms of suspected colorectal cancer should be done with clinical responsibility retained by primary care?

Results

Literature search

Database name	Dates Covered	No of references found	No of references retrieved	Finish date of search
<i>Medline</i>	1980-2013	1321	136	10/01/2013
<i>Premedline</i>	1980-2013	35	4	14/01/2013
<i>Embase</i>	1980-2013	896	132	14/01/2013
<i>Cochrane Library</i>	1980-2013	116	3	14/01/2013
<i>Psychinfo</i>	1980-2013	4	1	14/01/2012
<i>Web of Science (SCI & SSCI) and ISI Proceedings</i>	1980-2013	79	21	14/01/2013
<i>Biomed Central</i>	1980-2013	68	0	14/01/2013

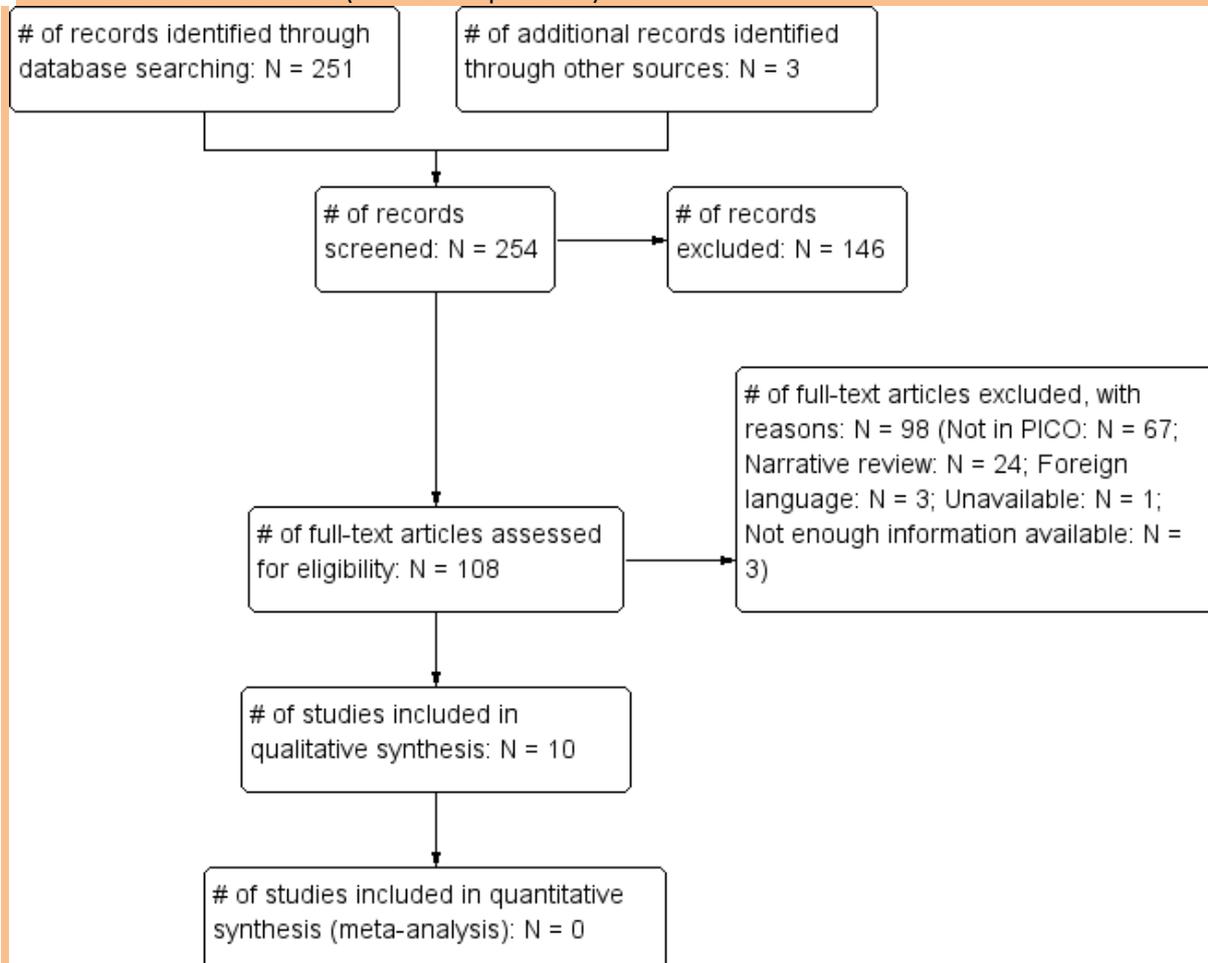
Total References retrieved (after de-duplication): 226

Update Search

Database name	Dates Covered	No of references found	No of references retrieved	Finish date of search
<i>Medline</i>	2013-13/08/2014	48	9	13/08/2014
<i>Premedline</i>	2013-13/08/2014	37	4	13/08/2014
<i>Embase</i>	2013-	131	26	13/08/2014

	13/08/2014			
Cochrane Library	2013-13/08/2014	15	1	13/08/2014
Web of Science (SCI & SSCI) and ISI Proceedings	2013-13/08/2014	118	1	13/08/2014

1 Total References retrieved (after de-duplication): 25



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Risk of bias in the included studies

The risk of bias and applicability concerns are summarised per study in the figure below. The studies were associated with a number of bias and validity issues. Two of the main issues to note relate to the patient selection methods employed and study settings, some of which were not clearly consecutive or random (and may therefore bias the results) or clearly transferable to UK-based primary care. Other issues of concern relate to missing data (and the concern that this may not be missing at random) and sub-optimal reference standards, which may both influence the results to an unknown extent.

	Risk of Bias				Applicability Concerns		
	Patient Selection	Index Test	Reference Standard	Flow and Timing	Patient Selection	Index Test	Reference Standard
Fijten (1995)	+	+	+	-	?	+	+
Gillberg (2012)	+	+	+	+	?	+	+
Glaser (1989)	?	+	-	-	-	+	-
Jensen (1993)	+	+	?	+	?	+	+
Kalra (1988)	+	+	-	-	?	+	-
Kok (2012)	?	+	?	?	?	+	?
Leicester (1984)	?	+	-	-	+	+	-
Niv (1992)	+	+	-	-	?	+	+
Steine (1993)	+	+	+	+	?	+	+
Stellon (1997)_BE	+	+	+	-	+	+	+
Stellon (1997)_FOB	+	+	+	-	+	+	+
Stellon (1997)_FS	+	+	+	+	+	+	+

	High		Unclear		Low
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Study results

Table 1: Colorectal cancer: Faecal occult blood

Study	Test	Prevalence	Sensitivity	Specificity	Other results (95% CI)
Fijten (1995)	Faecal occult blood (Haemoccult)	5/225	50%	82%	Positive predictive value = 5% Negative predictive value = 99% False negativity rate = 50% 95% CI cannot be calculated as 2-by-2 table could not be extracted
Gillberg (2012)	Faecal occult blood (Haemoccult II)	161/8928	75%	87%	TP = 120 FN = 41 TN = 7585 FP = 1182 Positive predictive value = 9.2% (7.7-11) False negativity rate = 25%
Jensen (1993)	Faecal occult blood	5/149	60%	79%	TP = 3 FN = 2 TN = 114 FP = 30

	(Hemoccult II)				Positive predictive value = 9.1% (2.4-25.5) False negativity rate = 40%
Kok (2012)	Faecal occult blood (Clearview One Step immune-chemical)	19/386	84%	76%	Data only available for N = 376 TP = 16 FN = 3 TN = 270 FP = 87 Positive predictive value = 15.5% (9.4-24.3) False negativity rate = 16%
Leicester (1984)	Faecal occult blood (Haemoccult)	4 cancers in 25 positive results out of 161 tests	56%	Not reported	Positive predictive value = 16% False negativity rate = 44% 95% CI cannot be calculated as 2-by2 table could not be extracted
Stellon (1997)	Faecal occult blood (Haemoccult)	1/22	0%	76%	TP = 0 FN = 1 TN = 16 FP = 5 Positive predictive value = 0% (0-54) False negativity rate = 100%

1 The data were not meta-analysed due to concerns about excessive heterogeneity (see forest plots
2 below), differences in the tests employed and missing data. TP = true positives, FP = false positives,
3 TN = true negatives, FN = false negatives. See forest plots below for the 95% CI for sensitivity and
4 specificity.
5

6 Table 2: Colorectal cancer: Sigmoidoscopy

Study	Test	Prevalence	Sensitivity (95% CI)	Specificity (95% CI)	Other results (95% CI)
Glaser (1989)	Rigid sigmoidoscopy	7/351	37.5% (10.2-74.1)	100% (98.6-100)	TP = 3 FN = 5 TN = 343 FP = 0 Positive predictive value = 100% (31-100) False negativity rate = 62.5%
Jensen (1993)	Rectosigmoidoscopy	5/149	40% (7.3-83)	100% (96.8-100)	TP = 2 FN = 3 TN = 144 FP = 0 Positive predictive value = 100% (19.8-100) False negativity rate = 60%
Kalra (1988)	Fibre-sigmoidoscopy	64 cancers in 216 abnormal findings in 541 patients	Not reported	Not reported	- Fibresigmoidoscopy unsuccessful in 31/541 patients - 4 cancers missed by fibresigmoidoscopy Positive predictive value = 29.6% 95% CI cannot be calculated as 2-by2 table could not be extracted
Niv (1992)	Flexible sigmoidoscopy	5/255	Not reported	Not reported	TP = 4 FN = ≥ 1 TN = ? FP = 0 Positive predictive value = 100% (39.6-100) False negativity rate = cannot be ascertained as negative cases did not

					appear to be followed up
Stellon (1997)	Flexible sigmoidoscopy	2/26	0% (0-80.2)	100% (82.8-100)	TP = 0 FN = 2 TN = 24 FP = 0 Positive predictive value = 0% False negativity rate = 100%

1 The data were not meta-analysed due to concerns about differences in the tests employed and
 2 missing data. TP = true positives, FP = false positives, TN = true negatives, FN = false negatives.

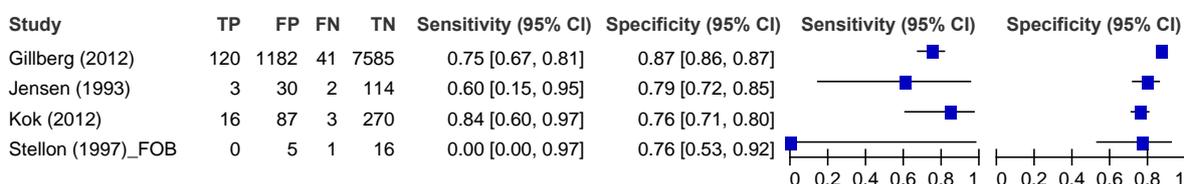
4 Table 3: Colorectal cancer: Double-contrast barium enema

Study	Test	Prevalence	Sensitivity	Specificity	Other results
Jensen (1993)	Double-contrast barium enema	5/149	60%	100%	TP = 3 FN = 2 TN = 144 FP = 0 Positive predictive value = 100% (31-100) False negativity rate = 40%
Steine (1993)	Double-contrast barium enema	8/189	100%	98%	TP = 8 FN = 0 TN = 177 FP = 4 False negativity rate = 0% Positive predictive value = 66.7% (35.4-88.7) 1 patient with anal cancer was not examined
Stellon (1997)	Double-contrast barium enema	2/22	50%	100%	TP = 1 FN = 1 TN = 20 FP = 0 Positive predictive value = 100% (54.6-100) False negativity rate = 50%

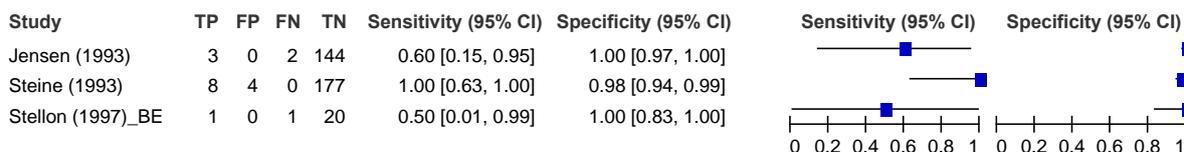
5 The data were not meta-analysed due to concerns about excessive heterogeneity (see forest plot
 6 below). TP = true positives, FP = false positives, TN = true negatives, FN = false negatives. See forest
 7 plots below for the 95% CI for sensitivity and specificity.

10 Forests plots

Faecal occult blood



Double-contrast barium enema



11

1 No evidence was found for colonoscopy, CT-colonoscopy/colonography, CT, and CEA.
2

3 Evidence statement(s):

4 Faecal occult blood (6 studies, N = 9871) conducted in symptomatic patients presenting in a primary
5 care setting is associated with sensitivities that ranged from 0-84%, specificities that ranged from 76-
6 87%, positive predictive values that ranged from 0-16%, and false negativity rates that ranged from
7 16-100% for colorectal cancer. All the studies were associated with 1-5 bias or applicability concerns
8 (see also Table 1).
9

10 Sigmoidoscopy (5 studies, N = 1322) conducted in symptomatic patients presenting in a primary care
11 setting is associated with sensitivities that ranged from 0-40%, specificities of up to 100%, positive
12 predictive values that ranged from 0-100%, and false negativity rates that ranged from 60-100% for
13 colorectal cancer. All the studies were associated with 0-5 bias or applicability concerns (see also
14 Table 2).
15

16 Double-contrast barium enema (3 studies, N = 360) conducted in symptomatic patients presenting in a
17 primary care setting is associated with sensitivities that ranged from 50-100%, specificities that
18 ranged from 98-100%, positive predictive values that ranged from 66.7-100%, and false negativity
19 rates that ranged from 0-50% for colorectal cancer. All the studies were associated with ≤ 2 bias or
20 applicability concerns (see also Table 3).
21

22 Evidence tables

23 Fijten (1995)

PATIENT SELECTION	
A. risk of bias	
Patient sampling	Prospective consecutive patient series
Was a consecutive or random sample of patients enrolled?	Yes
Was a case-control design avoided?	Yes
Did the study avoid inappropriate exclusions?	Yes
Could the selection of patients have introduced bias?	Low risk
B. Concerns regarding applicability	
Patient characteristics and setting	<p>N = 269 (118 males/151 females), mean (SD, range) age = 42 (15, 18-75). Mean (SD) follow up time = 20 (5) months. For 51% rectal bleeding was the main reason for the encounter, and 49% had another reason (e.g., abdominal complaints), but blood loss per rectum was seen and mentioned by the patients. N = 8 used anticoagulants.</p> <p><u>Inclusion criteria:</u> From September 1988 to April 1990, patients with rectal bleeding were recruited by 83 GPs in Limburg, with an average duration of participation of 11 months per doctor. Patients were included when overt rectal bleeding was the reason for encounter or when there was a history of recent (within the previous three months) rectal blood loss visible for the patient.</p> <p><u>Exclusion criteria:</u> Aged below 18 or above 75 years, pregnancy, urgent admission to hospital (for, e.g., a massive bleeding or acute abdominal pain), and if follow-up data were not available.</p> <p><u>Clinical setting:</u> Primary care, Netherlands</p>

Are there concerns that the included patients and setting do not match the review question?		Unclear concern
INDEX TEST		
A. Risk of bias		
Index test	Faecal occult blood (Haemoccult test, 3 X, with a diet low of peroxidase and free of red meat); ≥ 1 positive out of 3 regarded as a positive result	
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes	
Could the conduct or interpretation of the index test have introduced bias?	Low risk	
B. Concerns regarding applicability		
Are there concerns that the index test, its conduct, or interpretation differ from the review question?	Low concern	
REFERENCE STANDARD		
A. risk of bias		
Reference standard(s)	Follow up for min 1 year.	
Is the reference standard likely to correctly classify the target condition?	Yes	
Were the reference standard results interpreted without knowledge of the results of the index tests?	No	
Could the reference standard, its conduct, or its interpretation have introduced bias?	Low risk	
B. Concerns regarding applicability		
Are there concerns that the target condition as defined by the reference standard does not match the question?	Low concern	
FLOW AND TIMING		
A. risk of bias		
Flow and timing	A total of 290 patients were recruited, however 21/290 were excluded as they were lost to follow-up (moved to an unknown destination) and the haeoccult test data were available for 225/269 included patients. 5/225 patients had cancer (9/269 patients had cancer in the whole included sample) which means that almost half of the cancer patients were not included in the test data calculations.	
Was there an appropriate interval between index test and reference standard?	Unclear	
Did all patients receive the same reference standard?	Yes	
Were all patients included in the analysis?	No	
Could the patient flow have introduced bias?	High risk	
NOTES	2-by-2 table cannot be extracted	
1		
2 Gillberg (2012)		
PATIENT SELECTION		
A. risk of bias		
Patient sampling	Database study covering 20 public primary care centres and a few private centres in Sörmland County (population 265000), Sweden.	
Was a consecutive or random sample of patients enrolled?	Yes	

Was a case-control design avoided?	Yes
Did the study avoid inappropriate exclusions?	Yes
Could the selection of patients have introduced bias?	Low risk
B. Concerns regarding applicability	
Patient characteristics and setting	N = 8928 (3481 males/5447 females), age groups: 0-10: N = 100; 11-20: N = 304; 21-30: N = 619; 31-40: N = 820; 41-50: N = 1103; 51-60: N = 1458; 61-70: N = 1550; 71-80: N = 1876; 81-90: N = 1006; 90+: N = 92. <u>Inclusion criteria:</u> All patients who between 2000-2005 had undergone faecal occult blood testing in one of the participating primary care centres. <u>Exclusion criteria:</u> Repeat faecal occult blood testing for the same individual. <u>Clinical setting:</u> Primary care, Sweden.
Are there concerns that the included patients and setting do not match the review question?	Unclear concern
INDEX TEST	
A. Risk of bias	
Index test	Faecal occult blood (Haemoccult II test, 3 X; samples not rehydrated; read at the GP centre); ≥ 1 positive out of 3 regarded as a positive result
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes
Could the conduct or interpretation of the index test have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the index test, its conduct, or interpretation differ from the review question?	Low concern
REFERENCE STANDARD	
A. risk of bias	
Reference standard(s)	Follow up using the Swedish Cancer Registry; diagnosis of cancer within 2 years of faecal occult blood test
Is the reference standard likely to correctly classify the target condition?	Yes
Were the reference standard results interpreted without knowledge of the results of the index tests?	No
Could the reference standard, its conduct, or its interpretation have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the target condition as defined by the reference standard does not match the question?	Low concern
FLOW AND TIMING	
A. risk of bias	
Flow and timing	A total of 9048 patients were recruited, however 104 patients were excluded as they had adenoma (984), colorectal cancer diagnosis > 2 years after faecal occult blood test (19), or refused further investigation (1), which leaves 8944 patients as opposed to the 8928 included in the study. It is unclear what happened to the missing 16 patients.
Was there an appropriate interval between index test and reference standard?	Yes

Did all patients receive the same reference standard?	Yes
Were all patients included in the analysis?	No
Could the patient flow have introduced bias?	Low risk
NOTES	
1	
2	
Glaser (1989)	
PATIENT SELECTION	
A. risk of bias	
Patient sampling	Retrospective patient series from a private family practice
Was a consecutive or random sample of patients enrolled?	Unclear
Was a case-control design avoided?	Yes
Did the study avoid inappropriate exclusions?	Unclear
Could the selection of patients have introduced bias?	Unclear risk
B. Concerns regarding applicability	
Patient characteristics and setting	N = 351; 149 males, 202 females; mean age = 57.9 years. <u>Inclusion criteria:</u> Patients who received a diagnostic sigmoidoscopy for a variety of clinical problems (e.g., rectal bleeding, abdominal pain or cramps, anaemia, change in bowel habits, hernia, constipation, proctalgia, weight loss, diarrhoea, pruritis ani, positive results of faecal occult blood test, rectal mass, palpable abdominal mass, condyloma, unusual flatulence, other) in which colorectal cancer or other significant disease was suspected in the author's private family practice between 1977 and 1986. <u>Exclusion criteria:</u> None listed. <u>Clinical setting:</u> Canadian private family practice
Are there concerns that the included patients and setting do not match the review question?	High concern
INDEX TEST	
A. Risk of bias	
Index test	Rigid sigmoidoscopy
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes
Could the conduct or interpretation of the index test have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the index test, its conduct, or interpretation differ from the review question?	Low concern
REFERENCE STANDARD	
A. risk of bias	
Reference standard(s)	Barium enema or colonoscopy
Is the reference standard likely to correctly classify the target condition?	Unclear
Were the reference standard results interpreted without knowledge of the results of the index tests?	No
Could the reference standard, its conduct, or its interpretation have introduced bias?	High risk

B. Concerns regarding applicability		
Are there concerns that the target condition as defined by the reference standard does not match the question?		High concern
FLOW AND TIMING		
A. risk of bias		
Flow and timing	All the patients appear to be accounted for	
Was there an appropriate interval between index test and reference standard?	Unclear	
Did all patients receive the same reference standard?	No	
Were all patients included in the analysis?	Yes	
Could the patient flow have introduced bias?	High risk	
NOTES		
1 2 Jensen (1993)		
PATIENT SELECTION		
A. risk of bias		
Patient sampling	Prospective? consecutive patient series from the Department of Radiology at Varberg Hospital, Sweden.	
Was a consecutive or random sample of patients enrolled?	Yes	
Was a case-control design avoided?	Yes	
Did the study avoid inappropriate exclusions?	Yes	
Could the selection of patients have introduced bias?	Low risk	
B. Concerns regarding applicability		
Patient characteristics and setting	N = 149; 63 males, 86 females; mean age (range) = 64 (52-74) years. <u>Inclusion criteria:</u> All patients referred with symptoms of colorectal disease by general practitioners to the Department of Radiology, Varberg Hospital, Sweden, for a double-contrast enema. <u>Exclusion criteria:</u> None listed. <u>Clinical setting:</u> Swedish department of radiology.	
Are there concerns that the included patients and setting do not match the review question?	Unclear concern	
INDEX TEST		
A. Risk of bias		
Index test	Faecal occult blood on 3 separate samples using the Hemoccult II test (≥ 1 positive test indicate a positive result); 60-cm rectosigmoidoscopy; double-contrast barium enema	
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes	
Could the conduct or interpretation of the index test have introduced bias?	Low risk	
B. Concerns regarding applicability		
Are there concerns that the index test, its conduct, or interpretation differ from the review question?	Low concern	
REFERENCE STANDARD		
A. risk of bias		

Reference standard(s)	3-5 year follow up in the local cancer register.	
Is the reference standard likely to correctly classify the target condition?	Unclear	
Were the reference standard results interpreted without knowledge of the results of the index tests?	No	
Could the reference standard, its conduct, or its interpretation have introduced bias?	Unclear risk	
B. Concerns regarding applicability		
Are there concerns that the target condition as defined by the reference standard does not match the question?	Low concern	
FLOW AND TIMING		
A. risk of bias		
Flow and timing	All patients appear to be accounted for	
Was there an appropriate interval between index test and reference standard?	Yes	
Did all patients receive the same reference standard?	Yes	
Were all patients included in the analysis? All test	Yes	
Could the patient flow have introduced bias? All tests	Low risk	
NOTES		
1 2 Kalra (1988)		
PATIENT SELECTION		
A. risk of bias		
Patient sampling	Retrospective consecutive patients who were referred for open access fibresigmoidoscopy in the UK.	
Was a consecutive or random sample of patients enrolled?	Yes	
Was a case-control design avoided?	Yes	
Did the study avoid inappropriate exclusions?	Yes	
Could the selection of patients have introduced bias?	Low risk	
B. Concerns regarding applicability		
Patient characteristics and setting	<p>N = 541; male:female ratio = 35:65. Abdominal pain was the commonest cause of open access referral followed by diarrhoea, rectal bleeding and constipation.</p> <p><u>Inclusion criteria:</u> All patients referred for fibresigmoidoscopy for the first time during 1982-6. Open access referrals were defined as patients seen for the first time during the procedure and in whom no examination or investigations had previously been undertaken.</p> <p><u>Exclusion criteria:</u> Hospital inpatients, patients attending the outpatient department for colorectal symptoms in whom results of other investigations were available.</p> <p><u>Clinical setting:</u> UK open access fibresigmoidoscopy clinic</p>	
Are there concerns that the included patients and setting do not match the review question?	Unclear concern	
INDEX TEST		

A. Risk of bias	
Index test	Fibresigmoidoscopy (examination was deemed as a failure if in the absence of disease the rectosigmoid junction could not be negotiated).
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes
Could the conduct or interpretation of the index test have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the index test, its conduct, or interpretation differ from the review question?	Low concern
REFERENCE STANDARD	
A. risk of bias	
Reference standard(s)	Follow up and some barium enema/colonoscopy studies
Is the reference standard likely to correctly classify the target condition?	Unclear
Were the reference standard results interpreted without knowledge of the results of the index tests?	No
Could the reference standard, its conduct, or its interpretation have introduced bias?	High risk
B. Concerns regarding applicability	
Are there concerns that the target condition as defined by the reference standard does not match the question?	High concern
FLOW AND TIMING	
A. risk of bias	
Flow and timing	
Was there an appropriate interval between index test and reference standard?	Unclear
Did all patients receive the same reference standard?	No
Were all patients included in the analysis?	Unclear
Could the patient flow have introduced bias?	High risk
NOTES	2-by-2 cannot be extracted.
1	
2	Kok (2012)
PATIENT SELECTION	
A. risk of bias	
Patient sampling	Data from the CEDAR (Cost-effectiveness of a decision rule for abdominal complaints in primary care) study, an ongoing, prospective, cross-sectional, diagnostic study in 170 general practices in 2 regions (central and south) of Holland.
Was a consecutive or random sample of patients enrolled?	Unclear
Was a case-control design avoided?	Yes
Did the study avoid inappropriate exclusions?	Unclear
Could the selection of patients have introduced bias?	Unclear risk
B. Concerns regarding applicability	
Patient	N = 8928 (3481 males/5447 females), age groups: 0-10: N = 100; 11-20: N =

characteristics and setting	304; 21-30: N = 619; 31-40: N = 820; 41-50: N = 1103; 51-60: N = 1458; 61-70: N = 1550; 71-80: N = 1876; 81-90: N = 1006; 90+: N = 92. <u>Inclusion criteria:</u> Patients who between July 2009 – January 2011 consulted their GP for persistent (≥ 2 weeks) lower-abdomen complaints who also experienced ≥ 1 of the following: Rectal bleeding, altered defecation pattern, abdominal pain, fever, diarrhoea, weight loss, sudden onset in the elderly, or findings at physical examination suggestive of organic bowel disease (palpable abdominal or rectal mass). <u>Exclusion criteria:</u> Patients aged < 18 years, unable to give informed consent, previously diagnosed with organic bowel disease, or positive on triple faeces test (testing for intestinal parasites) not requiring endoscopy. <u>Clinical setting:</u> Primary care, Holland.
Are there concerns that the included patients and setting do not match the review question?	Unclear concern
INDEX TEST	
A. Risk of bias	
Index test	Faecal occult blood test (Clearview One Step immunochemical point of care test).
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes
Could the conduct or interpretation of the index test have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the index test, its conduct, or interpretation differ from the review question?	Low concern
REFERENCE STANDARD	
A. risk of bias	
Reference standard(s)	Colonoscopy (N = 351)/sigmoidoscopy (N = 21; other bowel examinations in N = 10)) with biopsies if required according to routine clinical practice + 3 month follow-up for all patients with an inconclusive colonoscopy/sigmoidoscopy.
Is the reference standard likely to correctly classify the target condition?	Unclear
Were the reference standard results interpreted without knowledge of the results of the index tests?	No
Could the reference standard, its conduct, or its interpretation have introduced bias?	Unclear risk
B. Concerns regarding applicability	
Are there concerns that the target condition as defined by the reference standard does not match the question?	Unclear concern
FLOW AND TIMING	
A. risk of bias	
Flow and timing	Data only available for 376/386 included patients.
Was there an appropriate interval between index test and reference standard?	Unclear
Did all patients receive the same reference standard?	Yes
Were all patients included in the analysis?	No

Could the patient flow have introduced bias?		Unclear risk
NOTES		
1		
2	Leicester (1984)	
PATIENT SELECTION		
A. risk of bias		
Patient sampling	Prospective random selection of consecutive? patients from UK general practice.	
Was a consecutive or random sample of patients enrolled?	Yes probably	
Was a case-control design avoided?	Yes	
Did the study avoid inappropriate exclusions?	Unclear	
Could the selection of patients have introduced bias?		Unclear risk
B. Concerns regarding applicability		
Patient characteristics and setting	<p>N = 315; 121 males, 194 females; mean age (SD) = 58.2 (13.9) years, who were then randomly allocated to haemoccult testing or control. 161 patients (99.4%) in the haemoccult group complied with the testing and 24 tested positive.</p> <p><u>Inclusion criteria:</u> Patients aged > 40 years presenting in general practice with any abdominal or bowel complaints.</p> <p><u>Exclusion criteria:</u> None listed.</p> <p><u>Clinical setting:</u> UK GP</p>	
Are there concerns that the included patients and setting do not match the review question?		Low concern
INDEX TEST		
A. Risk of bias		
Index test	Haemoccult testing	
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes	
Could the conduct or interpretation of the index test have introduced bias?		Low risk
B. Concerns regarding applicability		
Are there concerns that the index test, its conduct, or interpretation differ from the review question?		Low concern
REFERENCE STANDARD		
A. risk of bias		
Reference standard(s)	<p>Patients with a negative haemoccult test were managed conventionally by their GP including specialist referral, if appropriate. Patients with a positive haemoccult test underwent flexible sigmoidoscopy and double-contrast barium enema at the earliest opportunity, followed by urgent outpatient appointment and colonoscopy where indicated.</p>	
Is the reference standard likely to correctly classify the target condition?	Unclear	
Were the reference standard results interpreted without knowledge of the results of the index tests?	No	
Could the reference standard, its conduct, or its interpretation have introduced bias?		High risk

B. Concerns regarding applicability		
Are there concerns that the target condition as defined by the reference standard does not match the question?		High concern
FLOW AND TIMING		
A. risk of bias		
Flow and timing		
Was there an appropriate interval between index test and reference standard?		Unclear
Did all patients receive the same reference standard?		No
Were all patients included in the analysis?		Unclear
Could the patient flow have introduced bias?		High risk
NOTES	Published as abstract only. 2-by-2 table cannot be extracted	
1		
2	Niv (1992)	
PATIENT SELECTION		
A. risk of bias		
Patient sampling	Retrospective consecutive patient series from an open-access flexible sigmoidoscopy outpatient clinic in Israel.	
Was a consecutive or random sample of patients enrolled?		Yes
Was a case-control design avoided?		Yes
Did the study avoid inappropriate exclusions?		Yes
Could the selection of patients have introduced bias?		Low risk
B. Concerns regarding applicability		
Patient characteristics and setting	<p>N = 255; 123 males, 132 females; mean age (range) = 54 (10-90) years. The patients were referred with the following indications: Change in bowel habit (N = 103), rectal bleeding (N = 107), abdominal pain (N = 45), anaemia (3%), weight loss (N = 15), Fx colon cancer (N = 26), positive faecal occult blood test (N = 26), "post polyp." (N = 11).</p> <p><u>Inclusion criteria:</u> All patients referred for open-access flexible sigmoidoscopy by general practitioners.</p> <p><u>Exclusion criteria:</u> Bad state of health, referral error.</p> <p><u>Clinical setting:</u> Israeli open-access flexible sigmoidoscopy outpatient clinic.</p>	
Are there concerns that the included patients and setting do not match the review question?		Unclear concern
INDEX TEST		
A. Risk of bias		
Index test	Flexible sigmoidoscopy	
Were the index test results interpreted without knowledge of the results of the reference standard?		Yes
Could the conduct or interpretation of the index test have introduced bias?		Low risk
B. Concerns regarding applicability		
Are there concerns that the index test, its conduct, or interpretation differ from the review question?		Low concern
REFERENCE STANDARD		
A. risk of bias		

Reference standard(s)	When a polyp or cancer was found, the patient was referred for total colonoscopy. Negative results did not appear to be followed up.	
Is the reference standard likely to correctly classify the target condition?	No	
Were the reference standard results interpreted without knowledge of the results of the index tests?	No	
Could the reference standard, its conduct, or its interpretation have introduced bias?	High risk	
<u>B. Concerns regarding applicability</u>		
Are there concerns that the target condition as defined by the reference standard does not match the question?	Low concern	
FLOW AND TIMING		
<u>A. risk of bias</u>		
Flow and timing	As the negative results did not appear to be followed up, the false negative rate cannot be ascertained	
Was there an appropriate interval between index test and reference standard?	Unclear	
Did all patients receive the same reference standard?	No	
Were all patients included in the analysis?	No	
Could the patient flow have introduced bias? All tests	High risk	
NOTES		
1		
2 Steine (1993)		
PATIENT SELECTION		
<u>A. risk of bias</u>		
Patient sampling	Retrospective randomly selected patient series from the Central Roentgen Institute in Oslo, Norway.	
Was a consecutive or random sample of patients enrolled?	Yes	
Was a case-control design avoided?	Yes	
Did the study avoid inappropriate exclusions?	Yes	
Could the selection of patients have introduced bias?	Low risk	
<u>B. Concerns regarding applicability</u>		
Patient characteristics and setting	N = 190; age range = 45-79 years. <u>Inclusion criteria</u> : Random sample (9%) of patients referred by GPs for double-contrast barium enema at the Central Roentgen Institute. <u>Exclusion criteria</u> : Patients not aged 45-79. <u>Clinical setting</u> : Norwegian roentgen institute.	
Are there concerns that the included patients and setting do not match the review question?	Unclear concern	
INDEX TEST		
<u>A. Risk of bias</u>		
Index test	Double-contrast barium enema	
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes	
Could the conduct or interpretation of the index test	Low risk	

have introduced bias?		
B. Concerns regarding applicability		
Are there concerns that the index test, its conduct, or interpretation differ from the review question?		Low concern
REFERENCE STANDARD		
A. risk of bias		
Reference standard(s)	Colonoscopy (with histology)	
Is the reference standard likely to correctly classify the target condition?		Yes
Were the reference standard results interpreted without knowledge of the results of the index tests?		Yes
Could the reference standard, its conduct, or its interpretation have introduced bias?		Low risk
B. Concerns regarding applicability		
Are there concerns that the target condition as defined by the reference standard does not match the question?		Low concern
FLOW AND TIMING		
A. risk of bias		
Flow and timing	All patients are accounted for	
Was there an appropriate interval between index test and reference standard?		Unclear
Did all patients receive the same reference standard?		Yes
Were all patients included in the analysis?		Yes
Could the patient flow have introduced bias? All tests		Low risk
NOTES	One patient with anal cancer was not examined	
1		
2	Stellon (1997)	
PATIENT SELECTION		
A. risk of bias		
Patient sampling	Prospective? consecutive patient series from semi-rural UK general practice with a patient list between 2400-3400 during the study period.	
Was a consecutive or random sample of patients enrolled?		Yes
Was a case-control design avoided?		Yes
Did the study avoid inappropriate exclusions?		Yes
Could the selection of patients have introduced bias?		Low risk
B. Concerns regarding applicability		
Patient characteristics and setting	N = 26; 5 males, 21 females; age range = 51-87 years. <u>Inclusion criteria:</u> All patients aged > 50 years found to have iron deficiency anaemia (< 12 g/dl haemoglobin and/or mean corpuscular volume < 80 fl with ferritin ≤ 16 ng/l) between January 1989 and March 1994. <u>Exclusion criteria:</u> None listed. <u>Clinical setting:</u> UK GP	
Are there concerns that the included patients and setting		Low concern

do not match the review question?		
INDEX TEST		
A. Risk of bias		
Index test	Faecal occult blood on 3 separate samples using the haemocult test; flexible sigmoidoscopy; double-contrast barium enema	
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes	
Could the conduct or interpretation of the index test have introduced bias?	Low risk	
B. Concerns regarding applicability		
Are there concerns that the index test, its conduct, or interpretation differ from the review question?	Low concern	
REFERENCE STANDARD		
A. risk of bias		
Reference standard(s)	Follow up during 5 year study period.	
Is the reference standard likely to correctly classify the target condition?	Yes	
Were the reference standard results interpreted without knowledge of the results of the index tests?	No	
Could the reference standard, its conduct, or its interpretation have introduced bias?	Low risk	
B. Concerns regarding applicability		
Are there concerns that the target condition as defined by the reference standard does not match the question?	Low concern	
FLOW AND TIMING		
A. risk of bias		
Flow and timing	22/26 patients received the faecal occult blood test (FOB); 22/26 patients received double contrast barium enema (BE); 26/26 patients received the flexible sigmoidoscopy (FS).	
Was there an appropriate interval between index test and reference standard?	Yes	
Did all patients receive the same reference standard?	Yes	
Were all patients included in the analysis? FOB	No	
Were all patients included in the analysis? BE	No	
Were all patients included in the analysis? FS	Yes	
Could the patient flow have introduced bias? FOB	High risk	
Could the patient flow have introduced bias? BE	High risk	
Could the patient flow have introduced bias? FS	Low risk	
NOTES		

1

2 **References**3 **Included studies**

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ANAL CANCER**Review question:**

What is the risk of anal cancer in patients presenting in primary care with symptom(s)?

Results**Literature search**

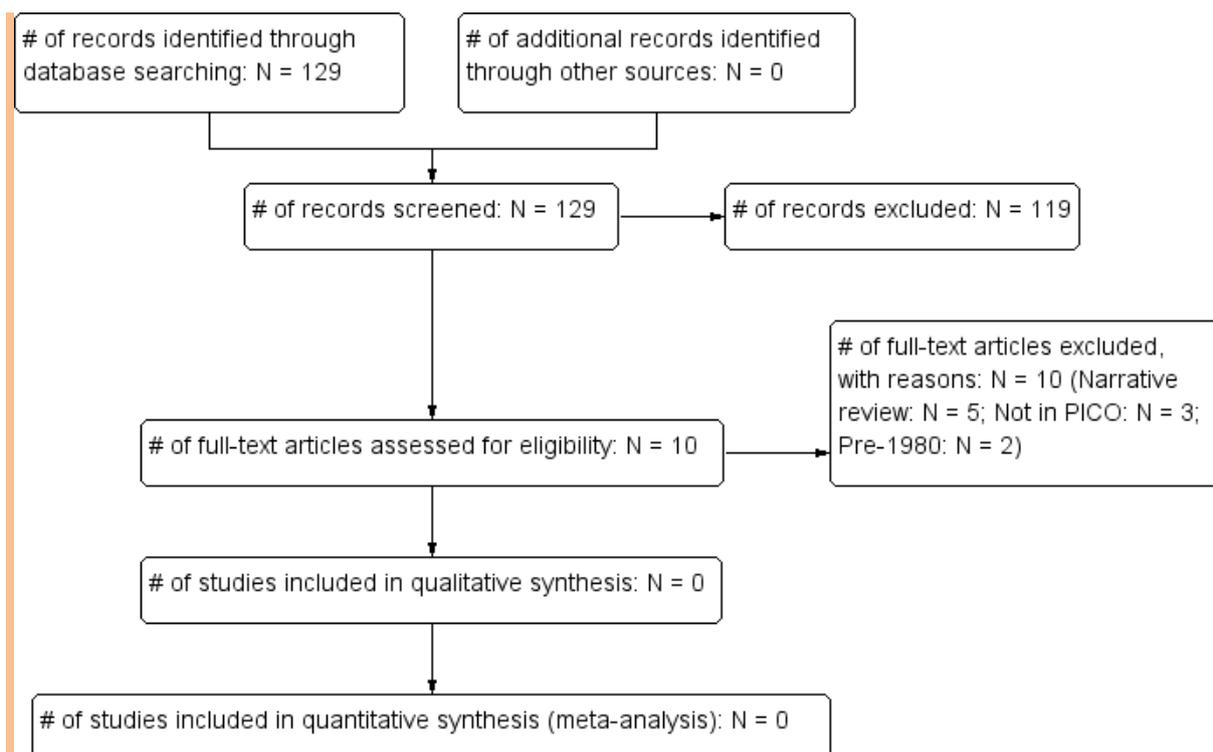
Database name	Dates Covered	No of references found	No of references retrieved	Finish date of search
<i>Medline</i>	All-2012	217	99	04/09/2012
<i>Premedline</i>	All-2012	8	1	04/09/2012
<i>Embase</i>	All-2012	264	61	04/09/2012
<i>Cochrane Library</i>	All-2012	132	2	12/09/2012
<i>Psychinfo</i>	All-2012	6	0	12/09/2012
<i>Web of Science (SCI & SSCI) and ISI Proceedings</i>	All-2012	85	11	12/09/2012
<i>Biomed Central</i>	All-2012	2	0	12/09/2012

Total References retrieved (after de-duplication): 128

Update Search

Database name	Dates Covered	No of references found	No of references retrieved	Finish date of search
<i>Medline</i>	9/2012-26/08/2014	7	0	26/08/2014
<i>Premedline</i>	9/2012-26/08/2014	38	0	26/08/2014
<i>Embase</i>	9/2012-26/08/2014	61	1	26/08/2014
<i>Cochrane Library</i>	9/2012-26/08/2014	58	0	26/08/2014
<i>Web of Science (SCI & SSCI) and ISI Proceedings</i>	9/2012-26/08/2014	27	0	26/08/2014

Total References retrieved (after de-duplication): 1



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Study results

No evidence was found.

Included studies

None

Excluded studies (with excl reason)

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Review question:

43 Which investigations of symptoms of suspected anal cancer should be done with clinical
 44 responsibility retained by primary care?
 45

Results

Literature search

Database name	Dates Covered	No of references	No of references	Finish date of
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		found	retrieved	search
Medline	1980-2013	146	19	11/06/2013
Premedline	1980-2013	19	2	11/06/2013
Embase	1980-2013	196	29	12/06/2013
Cochrane Library	1980-2013	57	0	12/06/2013
Psychinfo	1980-2013	5	0	11/06/2013
Web of Science (SCI & SSCI) and ISI Proceedings	1980-2013	93	9	13/06/2013

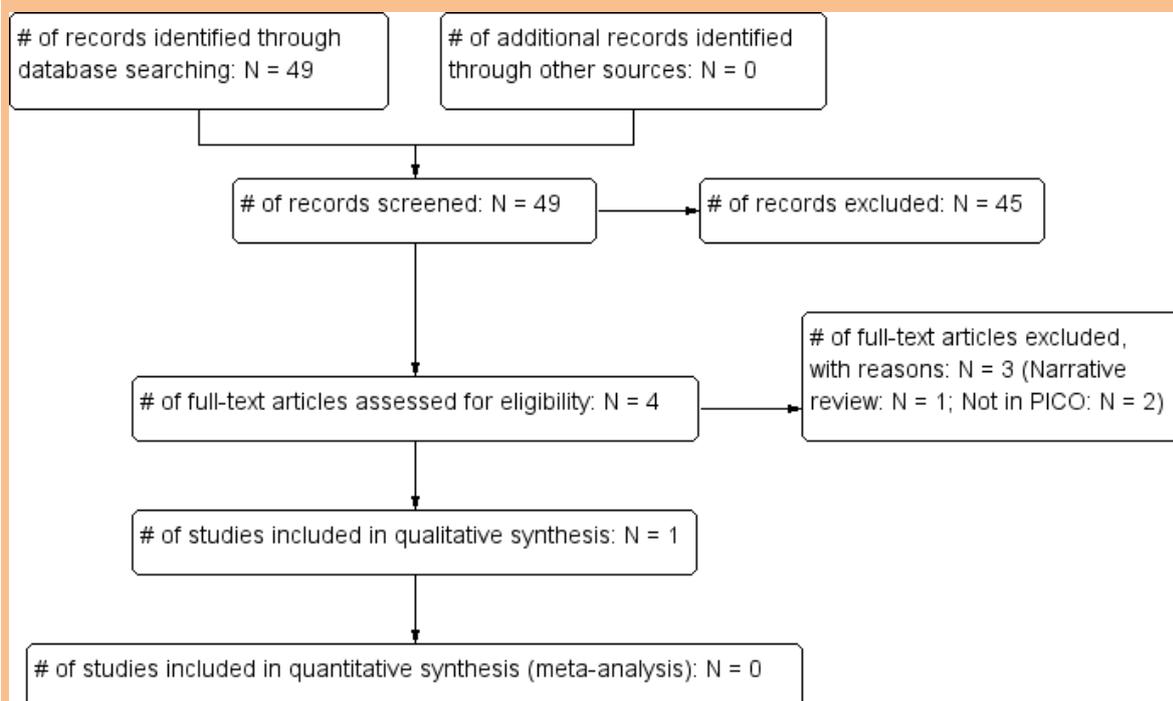
1 Total References retrieved (after de-duplication): 44

2
3

Update Search

Database name	Dates Covered	No of references found	No of references retrieved	Finish date of search
Medline	6/2013-26/08/2014	5	0	26/08/2014
Premedline	6/2013-26/08/2014	13	1	26/08/2014
Embase	6/2013-26/08/2014	38	4	26/08/2014
Cochrane Library	6/2013-26/08/2014	12	0	26/08/2014
Web of Science (SCI & SSCI) and ISI Proceedings	6/2013-26/08/2014	12	0	26/08/2014

4 Total References retrieved (after de-duplication): 5



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Risk of bias in the included studies

The risk of bias and applicability concerns are summarised per study in the figure below. The only included study was associated with a number of bias and validity issues, with the main concerns

1 relating to whether the results are representative of those of UK-based primary care practice and
 2 the fact that negative sigmoidoscopy results were not verified or followed up.
 3

	Risk of Bias				Applicability Concerns		
	Patient Selection	Index Test	Reference Standard	Flow and Timing	Patient Selection	Index Test	Reference Standard
Niv (1992)	+	+	-	-	?	+	+

⊖ High	⊛ Unclear	⊕ Low
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Study results

Table 1: Anal cancer: Sigmoidoscopy

Study	Test	Prevalence	Sensitivity (95% CI)	Specificity (95% CI)	Other results (95% CI)
Niv (1992)	Flexible sigmoidoscopy	5/255	Not reported	Not reported	TP = 4 FN = ≥ 1 TN = ? FP = 0 Positive predictive value = 100% (39.6-100) False negativity rate = cannot be ascertained as negative cases did not appear to be followed up

10 TP = true positives, FP = false positives, TN = true negatives, FN = false negatives.

11
12 No evidence was found for proctoscopy.

13

14 **Evidence statement(s):**

15 Sigmoidoscopy (1 study, N = 255) conducted in symptomatic patients presenting in a primary care
 16 setting is associated with a positive predictive values of 100%. The included study was associated
 17 with 3 bias/applicability concerns (see also Table 1).
 18

19 **Evidence tables**

20 **Niv (1992)**

PATIENT SELECTION	
A. risk of bias	
Patient sampling	Retrospective consecutive patient series from an open-access flexible sigmoidoscopy outpatient clinic in Israel.
Was a consecutive or random sample of patients enrolled?	Yes
Was a case-control design avoided?	Yes

Did the study avoid inappropriate exclusions?	Yes
Could the selection of patients have introduced bias?	Low risk
B. Concerns regarding applicability	
Patient characteristics and setting	N = 255; 123 males, 132 females; mean age (range) = 54 (10-90) years. The patients were referred with the following indications: Change in bowel habit (N = 103), rectal bleeding (N = 107), abdominal pain (N = 45), anaemia (3%), weight loss (N = 15), Fx colon cancer (N = 26), positive faecal occult blood test (N = 26), "post polyp." (N = 11). <u>Inclusion criteria:</u> All patients referred for open-access flexible sigmoidoscopy by general practitioners. <u>Exclusion criteria:</u> Bad state of health, referral error. <u>Clinical setting:</u> Israeli open-access flexible sigmoidoscopy outpatient clinic.
Are there concerns that the included patients and setting do not match the review question?	Unclear concern
INDEX TEST	
A. Risk of bias	
Index test	Flexible sigmoidoscopy
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes
Could the conduct or interpretation of the index test have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the index test, its conduct, or interpretation differ from the review question?	Low concern
REFERENCE STANDARD	
A. risk of bias	
Reference standard(s)	When a polyp or cancer was found, the patient was referred for total colonoscopy. Negative results did not appear to be followed up.
Is the reference standard likely to correctly classify the target condition?	No
Were the reference standard results interpreted without knowledge of the results of the index tests?	No
Could the reference standard, its conduct, or its interpretation have introduced bias?	High risk
B. Concerns regarding applicability	
Are there concerns that the target condition as defined by the reference standard does not match the question?	Low concern
FLOW AND TIMING	
A. risk of bias	
Flow and timing	As the negative results did not appear to be followed up, the false negative rate cannot be ascertained
Was there an appropriate interval between index test and reference standard?	Unclear
Did all patients receive the same reference standard?	No
Were all patients included in the analysis?	No
Could the patient flow have introduced bias? All tests	High risk

NOTES

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BREAST CANCER**Review question:**

What is the risk of breast cancer in patients presenting in primary care with symptom(s)?

Results**Literature search**

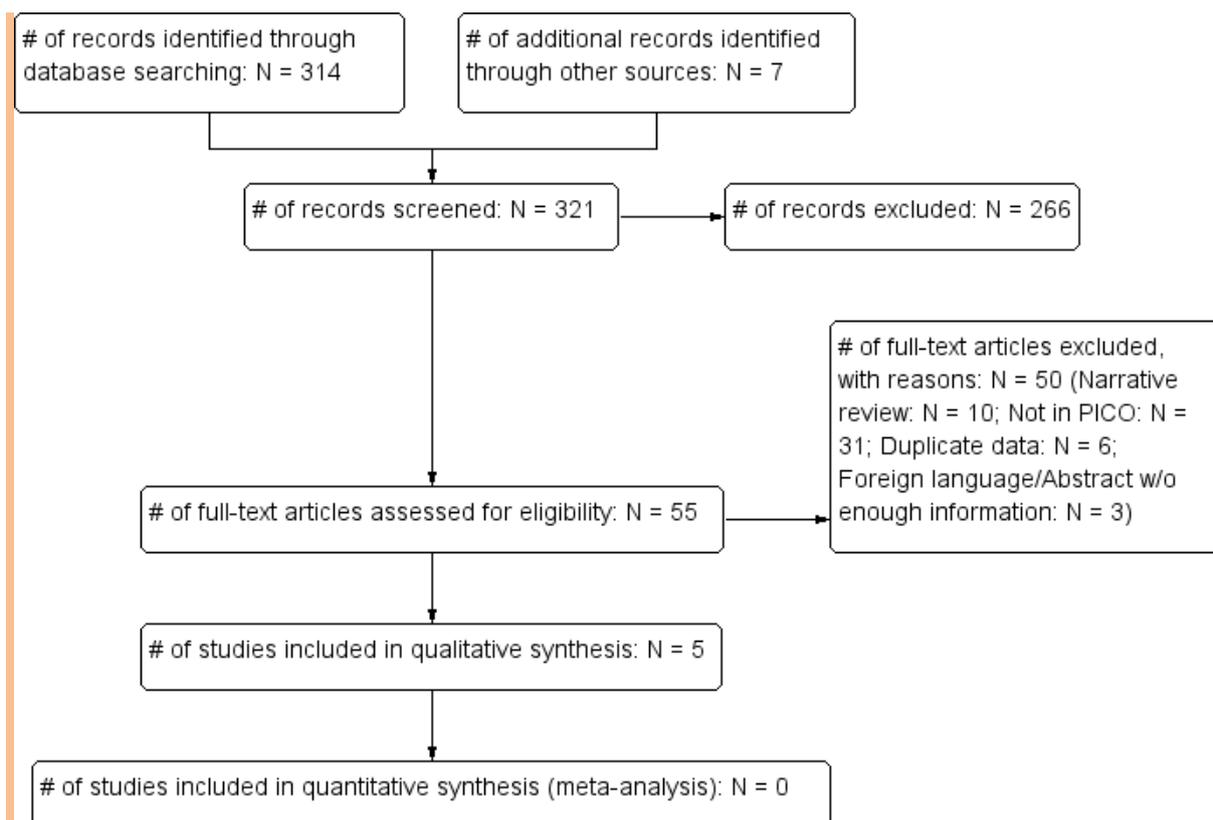
Database name	Dates Covered	No of references found	No of references retrieved	Finish date of search
<i>Medline</i>	1980-4/2013	1361	122	22/04/2013
<i>Premedline</i>	1980-4/2013	275	24	23/04/2013
<i>Embase</i>	1980-4/2013	1776	151	25/04/2013
<i>Cochrane Library</i>	1980-4/2013	426	4	25/04/2013
<i>Psychinfo</i>	1980-4/2013	385	23	23/04/2013
<i>Web of Science (SCI & SSCI) and ISI Proceedings</i>	1980-4/2013	1541	84	26/04/2013

Total References retrieved (after de-duplication): 284

Update Search

Database name	Dates Covered	No of references found	No of references retrieved	Finish date of search
<i>Medline</i>	4/2013-12/08/2014	145	9	12/08/2014
<i>Premedline</i>	4/2013-12/08/2014	172	11	12/08/2014
<i>Embase</i>	4/2013-12/08/2014	578	13	12/08/2014
<i>Cochrane Library</i>	4/2013-12/08/2014	138	0	12/08/2014
<i>Web of Science (SCI & SSCI) and ISI Proceedings</i>	4/2013-12/08/2014	95	2	12/08/2014

Total References retrieved (after de-duplication): 30



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Risk of bias in the included studies

The risk of bias and applicability concerns are summarised per study in the figure below. The main issues to note is that 3/5 studies employed samples of patients that are not directly representative of an unselected symptomatic population of patients presenting to the UK-based GP and a fourth study employed a case-control design which has been shown to inflate the test accuracy characteristics. However, the statistical analyses employed by the authors may have gone some way in counteracting this influence. Two of the studies also employed reference standards that are subject to an unclear risk of bias, one study only reported episode-(not patient)based analyses, which seems to result in overestimation of the PPVs, and one study had a large amount of missing data; all of which must be born in mind when evaluating the evidence contributed by these studies.

	Risk of Bias				Applicability Concerns		
	Patient Selection	Index Test	Reference Standard	Flow and Timing	Patient Selection	Index Test	Reference Standard
Barton (1999)	+	+	?	+	?	+	+
Eberl (2008)	+	+	?	+	?	+	+
McCowan (2011)	+	+	+	-	+	+	+
Oudega (2006)	+	+	+	+	?	+	+
Walker (2014)	-	+	+	+	+	+	+

- High	? Unclear	+ Low
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Study results

Table 1: Breast cancer: Single symptoms

Study	Symptom(s)	Patient group	Positive predictive value (95% CI)% Prevalence
Barton (1999) <i>Episode-based analysis</i>	Breast pain	Women aged 40-79 years	1.8 (0.6-4.9) 4/221 episodes in 372 women
Eberl (2008)	Breast pain	Women aged <25 – 75+ years	0.9 (0.5-1.7) 11/1191
McCowan (2011)	Breast pain	Women aged 25- >80 years	5.9 (1-21.1) 2/34
Walker (2014)	Breast pain	Women aged 40-49 years	0.17 (0.16-0.17)
Walker (2014)	Breast pain	Women aged 50-59 years	0.8 (0.52-1.2)
Walker (2014)	Breast pain	Women aged 60-69 years	1.2 (0.73-2)
Walker (2014)	Breast pain	Women aged 70+ years	2.8 (1.4-5.4)
Barton (1999) <i>Episode-based analysis</i>	Breast mass	Women aged 40-79 years	10.7 (6.9-16.1) 21/196 episodes in 372 women
Eberl (2008)	Breast lump/mass	Women aged <25 – 75+ years	8.1 (6.3-10.4) 60/741
Walker (2014)	Breast lump	Women aged 40-49 years	4.8 (3.6-5.4)
Walker (2014)	Breast lump	Women aged 50-59 years	8.5 (6.7-11)
Walker (2014)	Breast lump	Women aged 60-69 years	25 (17-36)

Walker (2014)	Breast lump	Women aged 70+ years	48 (35-61)
McCowan (2011)	Discrete breast lump	Women aged 25- >80 years	10 (3.7-22.6) 5/50
McCowan (2011)	Discrete breast lump < 2 cm	Women aged 25- >80 years	7.7 (0.4-37.9) 1/13
McCowan (2011)	Discrete breast lump ≥ 2 cm	Women aged 25- >80 years	14.3 (2.5-43.8) 2/14
McCowan (2011)	Discrete breast lump: Round, oblong mass	Women aged 25- >80 years	25 (4.5-64.4) 2/8
McCowan (2011)	Discrete breast lump: Irregular in shape	Women aged 25- >80 years	0 (0-69) 0/3
McCowan (2011)	Discrete breast lump: Mobile	Women aged 25- >80 years	12.5 (2.2-40) 2/16
McCowan (2011)	Discrete breast lump: Tethered to skin or chest wall	Women aged 25- >80 years	40 (7.3-83) 2/5
McCowan (2011)	Discrete breast lump: Smooth texture	Women aged 25- >80 years	18.2 (3.2-52.2) 2/11
McCowan (2011)	Discrete breast lump: Irregular texture	Women aged 25- >80 years	33.3 (6-75.9) 2/6
McCowan (2011)	Discrete breast lump: Spongy texture	Women aged 25- >80 years	0 (0-94.5) 0/1
Walker (2014)	Nipple discharge	Women aged 40-49 years	1.2 (NR)
Walker (2014)	Nipple discharge	Women aged 50-59 years	2.1 (0.81-5.1)
Walker (2014)	Nipple discharge	Women aged 60-69 years	2.3 (NR)
Walker (2014)	Nipple discharge	Women aged 70+ years	23 (NR)
McCowan (2011)	Nipple discharge	Women aged 25- >80 years	0 (0-37.1) 0/9
McCowan (2011)	Nipple discharge: Bloodstained	Women aged 25- >80 years	0 (0-53.7) 0/5
McCowan (2011)	Nipple discharge: Persistent	Women aged 25- >80 years	0 (0-43.9) 0/7
Barton (1999) <i>Episode-based analysis</i>	Skin or nipple change	Women aged 40-79 years	3 (0.5-11.3) 2/67 episodes in 372 women
Eberl (2008)	Nipple complaint	Women aged <25 – 75+ years	1.9 (0.6-5.1) 4/210
McCowan (2011)	Nipple eczema	Women aged 25- >80 years	0 (0-94.3) 0/1
McCowan (2011)	Nipple retraction	Women aged 25- >80 years	0 (0-53.7) 0/5
Walker (2014)	Nipple retraction	Women aged 40-49 years	NR (NR) 4 cases, 0 controls
Walker (2014)	Nipple retraction	Women aged 50-59 years	2.6 (NR)
Walker (2014)	Nipple retraction	Women aged 60-69 years	3.4 (NR)

Walker (2014)	Nipple retraction	Women aged 70+ years	12 (NR)
Barton (1999) <i>Episode-based analysis</i>	Breast lumpiness	Women aged 40-79 years	2.6 (0.1-15.4) 1/38 episodes in 372 women
McCowan (2011)	Breast thickening	Women aged 25- >80 years	11.1 (0.6-49.3) 1/9
McCowan (2011)	Breast abscess	Women aged 25- >80 years	0 (0-94.3) 0/1
Barton (1999) <i>Episode-based analysis</i>	Other breast symptom	Women aged 40-79 years	0 (0-43.9) 0/7 episodes in 372 women
Eberl (2008)	Other breast complaint	Women aged <25 – 75+ years	1.7 (0.7-3.8) 6/361
McCowan (2011)	Other breast symptom (skin nodules, general nodularity)	Women aged 25- >80 years	25 (1.3-78.1) 1/4
McCowan (2011)	Lymphadenopathy	Women aged 25- >80 years	40 (7.3-83) 2/5
Oudega (2006)	Deep vein thrombosis	All patients	0.93 (0.3-2.53) 4/430

1 CI = Confidence interval. Please note the calculations of the positive predictive values differ between
2 the studies with Barton (1999), Eberl (2008), McCowan (2011) and Oudega (2006) using (TP)/(TP+FP)
3 and Walker (2014) using Bayesian statistics due to the case-control design of this study. No meta-
4 analyses were performed as there were not enough studies for this analysis to be performed with
5 both Barton (1999) and Walker (2014) being ineligible for inclusion due to the episode-based
6 analysis and case-control design, respectively.
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Table 2: Breast cancer: Symptom combinations

Study	Symptom(s)	Patient group	Positive predictive value (95% CI)%
Barton (1999) <i>Episode-based analysis</i>	Breast pain (reported twice in an episode??)	Women aged 40-79 years	1.2 (0.2-4.7)* 2/169 episodes in 372 women
Barton (1999) <i>Episode-based analysis</i>	Breast mass (reported twice in an episode??)	Women aged 40-79 years	10.7 (6.5-16.8)* 17/159 episodes in 372 women
Barton (1999) <i>Episode-based analysis</i>	Skin or nipple change (reported twice in an episode??)	Women aged 40-79 years	2 (0.1-11.8)* 1/51 episodes in 372 women
Barton (1999) <i>Episode-based analysis</i>	Breast lumpiness (reported twice in an episode??)	Women aged 40-79 years	4 (0.2-22.3)* 1/25 episodes in 372 women
Barton (1999) <i>Episode-based analysis</i>	Breast pain and breast mass	Women aged 40-79 years	6.5 (1.1-22.8) 2/31 episodes in 372 women
Walker (2014)	Breast lump and breast pain	Women aged 40-49 years	4.9 (NR)
Walker (2014)	Breast lump and breast pain	Women aged 50-59 years	5.7 (NR)
Walker (2014)	Breast lump and breast	Women aged 60-69 years	6.5 (NR)

	pain	years	
Walker (2014)	Breast lump and breast pain	Women aged 70+ years	> 5 (NR)
Barton (1999) <i>Episode-based analysis</i>	Breast pain and skin or nipple change	Women aged 40-79 years	0 (0-26.8) 0/14 episodes in 372 women
Barton (1999) <i>Episode-based analysis</i>	Breast pain and breast lumpiness	Women aged 40-79 years	0 (0-43.9) 0/7 episodes in 372 women
Barton (1999) <i>Episode-based analysis</i>	Breast mass and skin or nipple change	Women aged 40-79 years	100 (5.5-100) 1/1 episodes in 372 women
Barton (1999) <i>Episode-based analysis</i>	Breast mass and breast lumpiness	Women aged 40-79 years	20 (10.5-70.1) 1/5 episodes in 372 women
Barton (1999) <i>Episode-based analysis</i>	Skin or nipple change and breast lumpiness	Women aged 40-79 years	0 (0-94.5) 0/1 episodes in 372 women

1 CI = Confidence interval. Please note the calculations of the positive predictive values differ between
 2 the studies with Barton (1999) using (TP)/(TP+FP) and Walker (2014) using Bayesian statistics due to
 3 the case-control design of this study. * These results are presented in a table (Table 5) entitled
 4 "Breast Cancer Diagnosis According to Combinations of Symptoms", it is however unclear what they
 5 reflect: Since they are similar, but not identical to those presented as single symptoms, they cannot
 6 be that; also, since only 56 women had 2 episodes and 35 women had 3 or more episodes, these
 7 results cannot represent a repeat presentation of the same symptom across episodes; which leaves
 8 repeat presentations of these symptoms within episodes as an option. However, that is not clearly
 9 reported either in the paper, so it cannot be confirmed what exactly these results reflect.

10
 11 **Evidence statement(s):**

12 The positive predictive values for breast cancer of single symptoms presenting in a primary care
 13 setting ranged from 0% (for an 'irregularly shaped discrete breast lump', a 'breast lump with a
 14 spongy texture', nipple discharge, nipple eczema, nipple retraction, breast abscess, 'other breast
 15 symptom') to 48% (for breast lump in women aged 70+ years; 5 studies, N = 24269), but these
 16 extreme PPVs were based on small patient/episode numbers. The studies were subject to 1-2 bias or
 17 applicability concerns (see also Table 1).

18
 19 The positive predictive values for breast cancer of symptom pairs presenting in a primary care
 20 setting ranged from 0% (for breast lumpiness with 'skin or nipple change' or breast pain, and for
 21 breast pain with 'skin or nipple change') to 100% (for breast mass and 'skin or nipple change'; 2
 22 studies, N = 21239), but these extreme PPVs were based on small patient/episode numbers. The
 23 studies were subject to 1-2 bias/applicability concerns (see also Table 2).

24
 25
 26 **Evidence tables**

27 **Barton (1999)**

PATIENT SELECTION	
A. risk of bias	
Patient sampling	Retrospective cohort study at a large health maintenance organisation (HMO).

Was a consecutive or random sample of patients enrolled?	Yes
Was a case-control design avoided?	Yes
Did the study avoid inappropriate exclusions?	Yes (probably)
Could the selection of patients have introduced bias?	Low risk
B. Concerns regarding applicability	
Patient characteristics and setting	<p>372 women presented with breast symptoms in 539 separate episodes; although most women had only 1 breast-symptom episode, 56 women presented twice and 35 women presented three or more times. Total number of episodes = 539, consisting of 221 for pain, 196 for mass, 67 for skin or nipple change, 38 for lumpiness, 7 for other, and 69 episodes where no specific symptom was documented. 23/372 women had breast cancer. 24/539 episodes lead to a diagnosis of breast cancer.</p> <p><u>Inclusion criteria:</u> "Female HMO members with automated medical records were eligible. We selected a cohort of 2400 women who were continuously enrolled in the HMO from 1 July 1983 through 30 June 1995. Women 40 to 69 years of age as of 1 July 1983 were sampled in a random, age-stratified manner to include 1200 women in the age group 40 to 49, 600 women in the age group 50 to 59 years, and 600 women in the age group 60 to 69 years." "Information on all breast-related encounters between 1 July 1983 and 30 June 1993 was collected from a computerized medical record". "The reason for each visit was determined to be screening (unrelated to any previously recognized breast abnormality or symptom) or diagnostic (to investigate an abnormality noted by the patient, by the clinician at an earlier examination or on previous mammography). This study reports on diagnostic visits related to patient symptoms."</p> <p><u>Exclusion criteria:</u> Women with insurance coverage in addition to that of the HMO during the study period (N = 1), had breast cancer before 1 July 1983 (N = 4), or had reduction mammoplasty or prophylactic mastectomy before or during the study period (N = 11).</p> <p><u>Clinical setting:</u> Health maintenance organisation, USA.</p>
Are there concerns that the included patients and setting do not match the review question?	Unclear concern
INDEX TEST	
A. Risk of bias	
Index test	<p>Patient symptoms were classified as follows:</p> <ol style="list-style-type: none"> 1) Mass (a single lump or nodule) 2) Pain (a report of pain or tenderness in either breast or bilaterally) 3) Skin or nipple change (including nipple discharge) 4) Multiple lumps or nodules (often described by patients as "lumpiness" and by clinicians as "fibrocystic" or "diffuse cystic change") 5) Other symptoms (such as increasing size of breast) <p>Physical examination findings were recorded by using the same five categories. More than one symptom/finding could be documented.</p> <p>"We defined a breast-symptom episode as the initial patient visit and all subsequent related visits and evaluations; a woman could have more than one episode during the 10-year study. We defined a new episode as beginning with a breast-symptom visit more than 6 months after the end of any previous episode. We considered a breast-symptom visit within 6</p>

	months of a previous episode to be the beginning of a new episode when the symptom was in the contralateral breast.”	
Were the index test results interpreted without knowledge of the results of the reference standard?		Unclear
Could the conduct or interpretation of the index test have introduced bias?		Low risk
B. Concerns regarding applicability		
Are there concerns that the index test, its conduct, or interpretation differ from the review question?		Low concern
REFERENCE STANDARD		
A. risk of bias		
Reference standard(s)	<p>“Breast cancer outcomes were determined for all women from 1 July 1983 to 30 June 1994 to ensure adequate time for follow-up of all breast-symptom episodes. To determine outcomes, we reviewed the computerized medical records and the HMO’s tumor registry for diagnoses of breast cancer.”</p> <p>Given that the time between symptom and diagnosis could be 10 years according to the study methodology, cancer may not always be the cause of the symptom, and the authors only report that the median (range) time to diagnosis from the <i>last</i> breast-symptom episode was 36 days (1-155) days, but not the corresponding data for the first symptom, which, I believe is still included in the analyses.</p>	
Is the reference standard likely to correctly classify the target condition?		Unclear
Were the reference standard results interpreted without knowledge of the results of the index tests?		No (but all patients had a positive index test)
Could the reference standard, its conduct, or its interpretation have introduced bias?		Unclear risk
B. Concerns regarding applicability		
Are there concerns that the target condition as defined by the reference standard does not match the question?		Low concern
FLOW AND TIMING		
A. risk of bias		
Flow and timing	It appears that all patients are accounted for, but the results reported are not patient-based, but rather episode-based.	
Was there an appropriate interval between index test and reference standard?		Yes (probably)
Did all patients receive the same reference standard?		Yes
Were all patients included in the analysis?		Yes
Could the patient flow have introduced bias?		Low risk
NOTES	<p>The episode-based analysis undertaken in this paper makes the results less comparable with other results presented for this guideline than would otherwise have been the case, and the net result of this type of analysis may be an underestimation of the PPVs.</p> <p>It is unclear whether the patients included span the ages of 40-69 years or 40-79 years, as reported in the inclusion criteria and discussion, and in Table 1, respectively.</p>	

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Eberl (2008)	
PATIENT SELECTION	
A. risk of bias	
Patient sampling	Retrospective patient series using the Transition Project database.
Was a consecutive or random sample of patients enrolled?	Yes
Was a case-control design avoided?	Yes
Did the study avoid inappropriate exclusions?	Yes (probably)
Could the selection of patients have introduced bias?	Low risk
B. Concerns regarding applicability	
Patient characteristics and setting	<p>N = 2503 females, aged from below 25 to above 65 years who had the following breast-related symptoms: Breast lump/mass (N = 741), breast pain (N = 1191), nipple complaint (N = 210), and other breast complaint (N = 361). 81/2503 patients had breast cancer.</p> <p><u>Inclusion criteria:</u> Patients with breast-related encounters in the Transition Project “Between 1985 and 2003, the Transition Project in the Netherlands comprehensively and prospectively coded office visits to family physicians based on the <i>International Classification of Primary Care (ICPC)</i>. The term <i>encounter</i> is synonymous with an office visit in the United States. For the Transition Project, 58 Dutch family physicians routinely coded data on reasons for encounter, diagnoses, and interventions for all episodes of care they provided between 1985 and 2003. Given that each patient in the Netherlands must register with a family practice office, clinic-based participation is reflective of the broader population-based health care system. Only visits to physicians participating in the Dutch Transition project are contained in the study database; visits to nurse-practitioners and physician’s assistants were not included.”</p> <p><u>Exclusion criteria:</u> None reported.</p> <p><u>Clinical setting:</u> Dutch primary care.</p>
Are there concerns that the included patients and setting do not match the review question?	Unclear concern
INDEX TEST	
A. Risk of bias	
Index test	“Breast symptoms include specific complaints, such as breast lump/mass, breast pain or tenderness, and nipple discharge; however, it is clear that women also come to physicians with fear of breast cancer and anxiety regarding their family history and risk of cancer. Fear of breast cancer is considered a unique reason for encounter in the Transition Project.”
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes
Could the conduct or interpretation of the index test have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the index test, its conduct, or interpretation differ from the review question?	Low concern
REFERENCE STANDARD	
A. risk of bias	
Reference standard(s)	“A final diagnosis of benign (absence of neoplasm) vs malignant (including ductal carcinoma in situ, lobular carcinoma in situ, and histologic atypical)

	disease was assigned to each breast-related reason for encounter,” “Participating family physicians completed all coding for their patients; no cancer registry match was performed.”
Is the reference standard likely to correctly classify the target condition?	Unclear
Were the reference standard results interpreted without knowledge of the results of the index tests?	No (but all patients had a positive index test)
Could the reference standard, its conduct, or its interpretation have introduced bias?	Unclear risk
B. Concerns regarding applicability	
Are there concerns that the target condition as defined by the reference standard does not match the question?	Low concern
FLOW AND TIMING	
A. risk of bias	
Flow and timing	All the patients are accounted for in the results.
Was there an appropriate interval between index test and reference standard?	Yes (probably)
Did all patients receive the same reference standard?	Yes
Were all patients included in the analysis?	Yes
Could the patient flow have introduced bias?	Low risk
NOTES	Although it does not explicitly stated that women with pre-existing breast cancer were excluded, even if they consulted with a breast-related episode, it appears that they were.
1	
2	McCowan (2011)
PATIENT SELECTION	
A. risk of bias	
Patient sampling	Prospective patient series from 11 UK-based general practices.
Was a consecutive or random sample of patients enrolled?	Yes
Was a case-control design avoided?	Yes
Did the study avoid inappropriate exclusions?	Yes
Could the selection of patients have introduced bias?	Low risk
B. Concerns regarding applicability	
Patient characteristics and setting	97 women, aged: 25-39 years: N = 28; 40-49 years: N = 31; 50-59 years: N = 14; 60-69 years: N = 11; 70-79 years: N = 10; ≥ 80 years: N = 3; Past history: Any breast problems: N = 60; previous clinic attendance: N = 43; breast cancer: N = 3; breast lump: N = 37; breast abscess: N = 9; breast pain: N = 41. <u>Inclusion criteria:</u> “11 participating general practices in the region agreed to recruit all women who attended for an initial consultation regarding symptomatic breast problems between January 2006 and June 2007.” <u>Exclusion criteria:</u> “Patients were excluded if the consultation was related to issues around cosmetic surgery or breastfeeding problems.” <u>Clinical setting:</u> Primary care, UK
Are there concerns that the included patients and setting do not match the review question?	Low concern

INDEX TEST	
A. Risk of bias	
Index test	Symptomatic breast problems
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes
Could the conduct or interpretation of the index test have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the index test, its conduct, or interpretation differ from the review question?	Low concern
REFERENCE STANDARD	
A. risk of bias	
Reference standard(s)	“All patients in the two cohorts were traced for a diagnosis of breast cancer using the regional prospective cancer audit in the year following their initial consultation. This audit identifies all diagnosed breast cancers to allow reporting on the standards of care against national targets and is the basis of cancer registry returns.”
Is the reference standard likely to correctly classify the target condition?	Yes
Were the reference standard results interpreted without knowledge of the results of the index tests?	Unclear
Could the reference standard, its conduct, or its interpretation have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the target condition as defined by the reference standard does not match the question?	Low concern
FLOW AND TIMING	
A. risk of bias	
Flow and timing	All patients appears to be accounted for, but only 97/202 eligible patients took part (mainly due to lack of telephone contact details being available/correct; 16/118 contacted patients declined participation and 5/118 contact patients failed to return the written consent).
Was there an appropriate interval between index test and reference standard?	Yes
Did all patients receive the same reference standard?	Yes
Were all patients included in the analysis?	No
Could the patient flow have introduced bias?	High risk (missing data as per above)
NOTES	
1	
2 Oudega (2006)	
PATIENT SELECTION	
A. risk of bias	
Patient sampling	Prospective study of all primary care physicians (N = 50) within a catchment area (ca 130000 inhabitants) of a non-teaching hospital in Holland.
Was a consecutive or random sample of patients enrolled?	Yes

Was a case-control design avoided?	Yes
Did the study avoid inappropriate exclusions?	Yes
Could the selection of patients have introduced bias?	Low risk
B. Concerns regarding applicability	
Patient characteristics and setting	N = 430; 162 males, 268 females; mean age (SD) = 60.7 (18.2) years. <u>Inclusion criteria:</u> Consecutive patients who consulted their GP between January 1996 and July 2002 and who, after investigation (not referral) was confirmed to have deep vein thrombosis. <u>Exclusion criteria:</u> Patients with a known malignancy or a malignancy detected within 2 weeks of deep vein thrombosis diagnosis. <u>Clinical setting:</u> Primary care, Holland.
Are there concerns that the included patients and setting do not match the review question?	Unclear concern
INDEX TEST	
A. Risk of bias	
Index test	Deep vein thrombosis (suspicion based on painful swollen leg \leq 30 days). Patients were classified as having secondary deep vein thrombosis if \geq 1 of the following risk factors for deep vein thrombosis were present: Recent surgery, prolonged immobilisation, use of oral contraceptives or hormonal replacement therapy. If no risk factors were present patients were classified as having idiopathic deep vein thrombosis.
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes
Could the conduct or interpretation of the index test have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the index test, its conduct, or interpretation differ from the review question?	Low concern
REFERENCE STANDARD	
A. risk of bias	
Reference standard(s)	2 years follow up.
Is the reference standard likely to correctly classify the target condition?	Yes
Were the reference standard results interpreted without knowledge of the results of the index tests?	No
Could the reference standard, its conduct, or its interpretation have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the target condition as defined by the reference standard does not match the question?	Low concern
FLOW AND TIMING	
A. risk of bias	
Flow and timing	All patients appear to be accounted for
Was there an appropriate interval between index test and reference standard?	Yes

Did all patients receive the same reference standard?	Yes
Were all patients included in the analysis?	Yes
Could the patient flow have introduced bias?	Low risk
NOTES	In total N = 19 had cancer: 3 colorectal, 5 urogenital (not further subgrouped), 4 breast, 3 lung and 4 other. The urogenital data is added to the renal cancer evidence review.
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2	
Walker (2014)	
PATIENT SELECTION	
A. risk of bias	
Patient sampling	Matched case-control study using patients in the UK's Clinical Practice Research Database (CPRD).
Was a consecutive or random sample of patients enrolled?	No
Was a case-control design avoided?	No
Did the study avoid inappropriate exclusions?	Yes
<i>For diagnostic case-control studies:</i> Attempts were made within the design or analysis to balance the comparison groups for potential confounders?	Yes
<i>For diagnostic case-control studies:</i> The groups were comparable at baseline, including all major confounding and prognostic factors?	Yes
Could the selection of patients have introduced bias?	High risk
B. Concerns regarding applicability	
Patient characteristics and setting	<p><u>Cases:</u> 3994 women, median age at diagnosis = 63 (IQR = 55-74) years; median number of consultations: in the year before index = 9 (IQR = 5-15), in 6 months before index = 9 (IOR = 4-16); UK.</p> <p><u>Controls:</u> 16873 women; median number of consultations: in the year before index = 7 (IQR = 4-13), in 6 months before index = 6 (IOR = 2-12); UK.</p> <p><u>Inclusion criteria:</u> Cases: Women aged ≥ 40 years with one of 56 identified breast tumour diagnostic codes in the CPRD between 1 January 2000 and 31 December 2009, with min. 1 year of data before diagnosis. The first instance of a breast cancer code was assigned the data of diagnosis/index date. Controls: 5 randomly selected controls matched on sex, general practice, and to 1 year of age of the case. The index date was the index date of the matched case.</p> <p><u>Exclusion criteria:</u> Males diagnosed with breast cancer, ill-defined medcodes giving multiple sites of cancer; skin cancer of the breast; cases with a mastectomy, chemotherapy or radiotherapy medcode > 90 days before the index date (as this strongly suggested that the index date was wrong); controls diagnosed with breast cancer (or having a mastectomy) before the index date; and women with no consultations in the year before diagnosis.</p> <p><u>Clinical setting:</u> UK primary care</p>
Are there concerns that the included patients and setting do not match the review question?	Low concern
INDEX TEST	

A. Risk of bias	
Index test	All symptoms, signs or abnormal investigations previously recorded in the breast cancer literature and cancer charity websites were studied. "The CPRD stores clinical information in just over 100,000 medcodes, each describing a facet of primary care, such as a symptom. There are several codes for each symptom, differing usually in a qualifier such as duration or severity, so generally containing more information than a specific Read code. All the codes pertaining to individual symptoms were collated into single symptom libraries." "Occurrences of symptoms in the year before the index date were identified. Features were only retained in the study if they occurred in $\geq 1\%$ of the cases or controls (this was invariably cases). We assembled a list of plausible laboratory abnormalities <i>a priori</i> using the literature and our clinical knowledge (WH, CH). We also identified all abnormal laboratory results in the year before the index date, using the local laboratory's normal range, which is supplied with the data. We considered women without a test to be equivalent to those with a normal result. Some abnormal tests were grouped: abnormal liver function was defined as the presence of any liver enzyme above the normal range. The variable 'raised inflammatory markers' was defined as a raised erythrocyte sedimentation rate, C-reactive protein or plasma viscosity. These simplifications were necessary as different localities in the UK contributing to the CPRD have different tests available."
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes
<i>For diagnostic case-control studies:</i> Investigators were kept 'blind' to other important confounding and prognostic factors?	Yes
Could the conduct or interpretation of the index test have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the index test, its conduct, or interpretation differ from the review question?	Low concern
REFERENCE STANDARD	
A. risk of bias	
Reference standard(s)	One of 56 identified breast tumour diagnostic codes in the CPRD.
Is the reference standard likely to correctly classify the target condition?	Yes
Were the reference standard results interpreted without knowledge of the results of the index tests?	Unclear
Could the reference standard, its conduct, or its interpretation have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the target condition as defined by the reference standard does not match the question?	Low concern
FLOW AND TIMING	
A. risk of bias	
Flow and timing	A total of 26162 women were identified, 21755 controls and 4407 cases. Of the controls the following exclusions were applied: Mastectomy medcode before index date of case (N = 564), breast cancer before the index date of

	the case (N = 380), no GP consultations in the year before the index date of the case (N = 2238), and controls of excluded cases (N = 1700). Of the cases the following exclusions were applied: Males (N = 51), ill-defined codes giving multiple sites of cancer (N = 52), skin cancers in breast (N = 18), cancers in sites other than breast (N = 2), medcodes > 3 months pre-index of mastectomy (N = 150) or chemotherapy./radiotherapy (N = 45), no GP consultations in the year before the index date of case (N = 89), and no controls (N = 6).
Was there an appropriate interval between index test and reference standard?	Yes
Did all patients receive the same reference standard?	Yes
Were all patients included in the analysis?	Yes
Could the patient flow have introduced bias?	Low risk
NOTES	23 symptoms and 22 abnormal test results were considered initially. The proportion of patients with a recorded fracture did not differ between cases (1.8%) and controls (1.6%).

1

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In Chinese, and almost certainly not primary care

Review question:

Which investigations of symptoms of suspected breast cancer should be done with clinical responsibility retained by primary care?

Results

Literature search

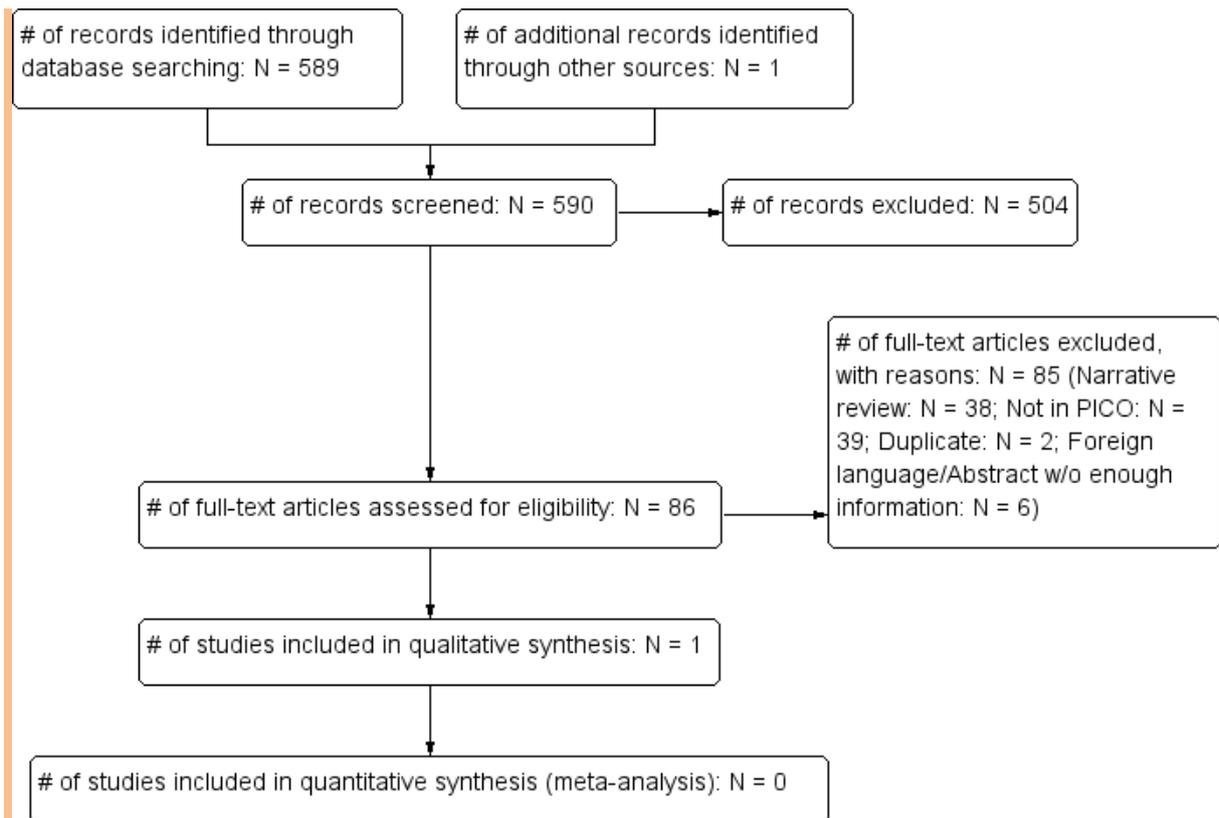
Database name	Dates Covered	No of references found	No of references retrieved	Finish date of search
<i>Medline</i>	1980-4/2013	1663	326	24/04/2013
<i>Premedline</i>	1980-4/2013	350	45	24/04/2013
<i>Embase</i>	1980-4/2013	1509	290	25/04/2013
<i>Cochrane Library</i>	1980-4/2013	274	22	25/04/2013
<i>Psychinfo</i>	1980-4/2013	67	4	24/04/2013
<i>Web of Science (SCI & SSCI) and ISI Proceedings</i>	1980-4/2013	164	14	25/04/2013

Total References retrieved (after de-duplication): 553

Update Search

Database name	Dates Covered	No of references found	No of references retrieved	Finish date of search
<i>Medline</i>	4/2013-12/08/014	349	17	12/08/014
<i>Premedline</i>	4/2013-12/08/014	180	11	12/08/014
<i>Embase</i>	4/2013-12/08/014	137	11	12/08/014
<i>Cochrane Library</i>	4/2013-12/08/014	77	0	12/08/014
<i>Web of Science (SCI & SSCI) and ISI Proceedings</i>	4/2013-12/08/014	16	0	12/08/014

Total References retrieved (after de-duplication): 36



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Risk of bias in the included studies

The risk of bias and applicability concerns are summarised for the included study in the figure below. The study was associated with a number of bias and validity issues. The following issues compromise the validity and applicability of this study, (1) only about half of the patient population were patients relevant to the current question, to the extent that Dutch primary care is comparable to UK-based primary care, and no subgroup analyses were presented for this group of patients, (2) the results of the ultrasound scan was interpreted non-blinded to the results of the mammography and clinical examination, which biases the accuracy of the outcome measures study, most likely upwards, and (3) the time span between the index test and reference standard is unclear and the results are therefore compromised to an unknown extent.

	<u>Risk of Bias</u>				<u>Applicability Concerns</u>		
	Patient Selection	Index Test	Reference Standard	Flow and Timing	Patient Selection	Index Test	Reference Standard
Flobbe (2003)	+	?	+	?	-	?	+

- High	? Unclear	+ Low
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Study results

1 Table 1: Breast cancer: Study results

Study	Test	Prevalence	Sensitivity (95% CI) %	Specificity (95% CI) %	Other results (95% CI)
Flobbe (2003)	Mammography	129/3835 breasts 127/2020 patients	82.9 (75.1-88.8)	91.9 (90.9-92.7)	TP = 107 FN = 22 TN = 3405 FP = 301 Positive predictive value = 26.2 (22.1-30.8)% Negative predictive value = 99.4 (99-99.6)% False negativity rate = 17.1%
Flobbe (2003)	Ultrasound	129/3835 breasts 127/2020 patients	87.6 (80.4-92.5)%	95.5 (94.8-96.1)%	TP = 113 FN = 16 <i>TN = 3556 FP = 167 These values from the paper are wrong as the total of negatives should be 3706 and not 3723 as is the case here. This means that apart from the sensitivity and false negativity rate, the remaining results for ultrasound should be interpreted with extreme caution.</i> Positive predictive value = 40.4 (34.6-46.4) % Negative predictive value = 99.6 (99.3-99.7)% False negativity rate = 12.4%

2 TP = true positives, FP = false positives, TN = true negatives, FN = false negatives.

3

4 No evidence was found for FNA.

5 **Evidence statement(s):**

6 Mammography (1 study, N = 2020 patients/ 3835 breasts) is associated with a sensitivity of 82.9%, a
7 specificity of 91.9%, a positive predictive value of 26.2%, and a false negativity rate of 17.1% for
8 breast cancer. Ultrasound (1 study, N = 2020 patients/ 3835 breasts) is associated with a sensitivity
9 of 87.6%, a specificity of 95.5%, a positive predictive value of 40.4%, and a false negativity rate of
10 12.4% for breast cancer. The study was associated with 4 bias or applicability concerns (see also
11 Table 1).

12 **Evidence tables**

13 **Flobbe (2003)**

PATIENT SELECTION	
A. risk of bias	
Patient sampling	Prospectiveconsecutive patient series
Was a consecutive or random sample of patients enrolled?	Yes
Was a case-control design avoided?	Yes
Did the study avoid inappropriate exclusions?	Yes
Could the selection of patients have introduced bias?	Low risk

B. Concerns regarding applicability	
Patient characteristics and setting	<p>N = 2020 (20 males/2000 females), mean (range) age = 50.2 (16.8-90.3) years; Referred by: GP (N = 1044), surgeons (N = 712), other specialists (N = 264); Indications for referral: Palpable breast lump (N = 470), other breast symptoms, such as pain or skin or nipple abnormalities (N = 486), follow up of prior breast malignancy (N = 438), follow up of prior benign breast disease (N = 152), mammography abnormalities detected at screening (N = 144), family history of breast cancer (N = 234), patient anxiety (N = 13), other asymptomatic reasons (N = 83).</p> <p><i>The results are only reported for breasts as the unit of analysis, not patients: There were 3835 breasts examined in 2020 patients, with 129 malignancies found in 127 patients (2 bilateral breast cancers).</i></p> <p><u>Inclusion criteria:</u> "Between October 1, 1999, and August 1, 2000, all consecutive patients referred to our radiology department for diagnostic breast imaging underwent additional US after a CE [clinical examination] and MAM [mammography]".</p> <p><u>Exclusion criteria:</u> When ultrasound could not be performed because of logistic reasons or when no informed consent was given.</p> <p><u>Clinical setting:</u> Unclear, the Netherlands</p>
Are there concerns that the included patients and setting do not match the review question?	High concern
INDEX TEST	
A. Risk of bias	
Index test	Bilateral clinical performed while the patient was in standing and sitting positions, followed by mammography (standard craniocaudal and mediolateral oblique examination; Siemens Mammomat-2 unit/Kodak Min-R film screen combination) followed by whole-breast ultrasound (model ATL5000, 12.5-MHz linear array transducer; Philips Medical Systems, Best, the Netherlands) both scored on a scale from 1-5 with increasing suggestion of malignancy (1 and 2 defined as negative results and 3-5 defined as positive results). All examinations were performed and interpreted with full knowledge of prior test results.
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes
Could the conduct or interpretation of the index test have introduced bias?	Unclear risk
B. Concerns regarding applicability	
Are there concerns that the index test, its conduct, or interpretation differ from the review question?	Unclear concern
REFERENCE STANDARD	
A. risk of bias	
Reference standard(s)	Pathologic results of core needle biopsy, excision biopsy and other surgical interventions during a follow up of 12 months. An additional 2 months were added, accounting for administrative routing of test results at the end of the follow up period. Pathologic results were retrieved from the hospital pathology department and the Dutch Network and National Database for Pathology, to which all Dutch hospital pathology departments are linked. Breast cancer status was considered negative when non pathologic condition was reported in either system.

Is the reference standard likely to correctly classify the target condition?	Yes
Were the reference standard results interpreted without knowledge of the results of the index tests?	Unclear
Could the reference standard, its conduct, or its interpretation have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the target condition as defined by the reference standard does not match the question?	Low concern
FLOW AND TIMING	
A. risk of bias	
Flow and timing	Of the 2720 scheduled imaging examinations, 112 were cancelled and 84 were excluded from the study due to earlier inclusion. 279 did not receive the additional ultrasound for logistical reasons, and 255 refused consent. The patients excluded from the study had a comparable prevalence of breast cancer, age distribution, reason for referral, and imaging interpretation.
Was there an appropriate interval between index test and reference standard?	Unclear
Did all patients receive the same reference standard?	Yes
Were all patients included in the analysis?	Yes
Could the patient flow have introduced bias?	Unclear risk
NOTES	

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25
26

GYNAECOLOGICAL CANCERS**ENDOMETRIAL CANCER****Review question:**

What is the risk of endometrial cancer in patients presenting in primary care with symptom(s)?

Results**Literature search**

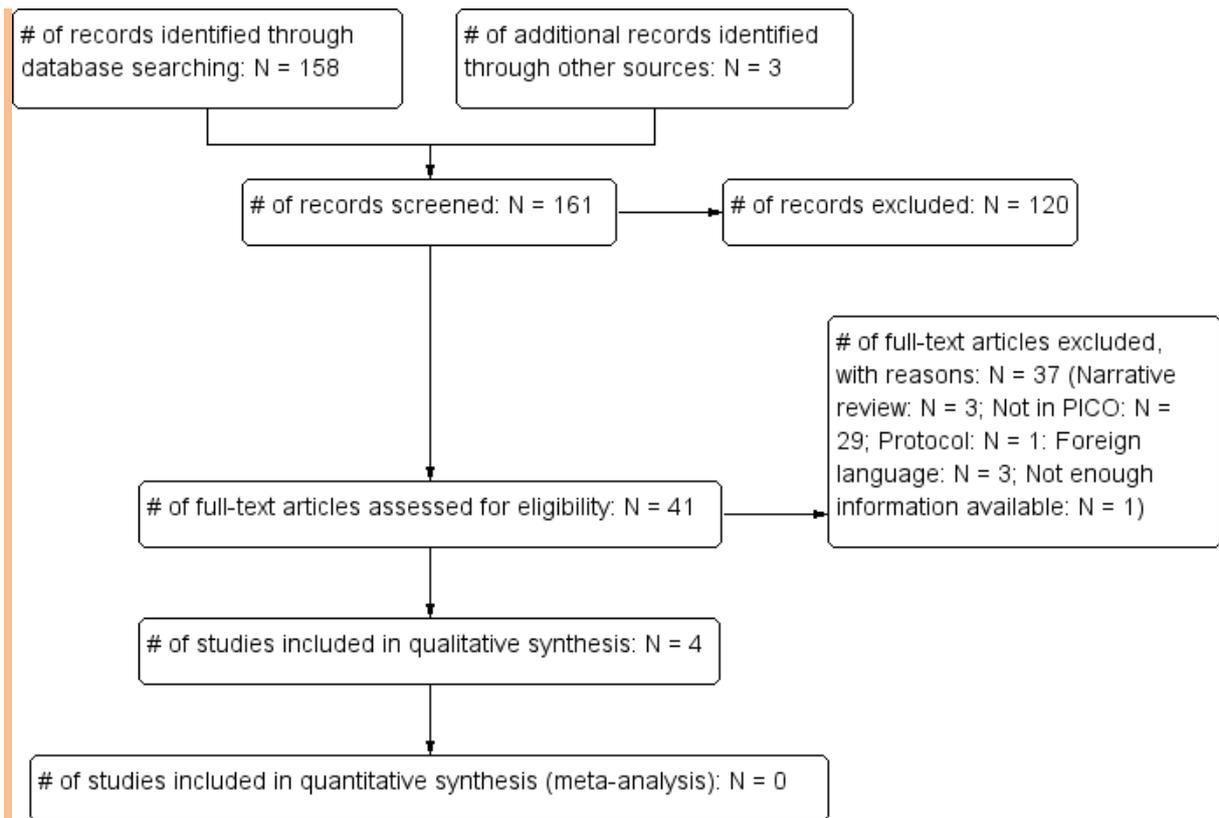
Database name	Dates Covered	No of references found	No of references retrieved	Finish date of search
<i>Medline</i>	All-2012	849	63	12/04/2013
<i>Premedline</i>	All-2012	24	3	12/04/2013
<i>Embase</i>	All-2012	2855	111	15/04/2013
<i>Cochrane Library</i>	All-2012	565	3	15/04/2013
<i>Psychinfo</i>	All-2012	5	0	12/04/2013
<i>Web of Science (SCI & SSCI) and ISI Proceedings</i>	All-2012	259	9	16/04/2013

Total References retrieved (after de-duplication): 144

Update Search

Database name	Dates Covered	No of references found	No of references retrieved	Finish date of search
<i>Medline</i>	4/2013-13/08/2014	41	2	13/08/2014
<i>Premedline</i>	4/2013-13/08/2014	32	7	13/08/2014
<i>Embase</i>	4/2013-13/08/2014	196	6	13/08/2014
<i>Cochrane Library</i>	4/2013-13/08/2014	81	0	13/08/2014
<i>Web of Science (SCI & SSCI) and ISI Proceedings</i>	4/2013-13/08/2014	14	1	13/08/2014

Total References retrieved (after de-duplication): 14



Risk of bias in the included studies

The risk of bias and applicability concerns are summarised for the included studies in the figure below. The main issues to note are that one of the studies was conducted in a Dutch primary care setting, which may limit the applicability of the result to UK primary care and this study may also not have accounted for all the patients. Moreover, another study employed a case-control design which has been shown to inflate the test accuracy characteristics. However, the statistical analyses employed by the authors of the study may have gone some way in counteracting this influence. Finally, the population in one of the studies comprises a mix of 'old' and 'new' investigated or uninvestigated symptoms, and it is unclear how directly applicable this sample is to the current question.

	Risk of Bias				Applicability Concerns		
	Patient Selection	Index Test	Reference Standard	Flow and Timing	Patient Selection	Index Test	Reference Standard
Droogendijk (2011)	+	+	+	?	?	+	+
Hallisey (1990)	+	+	+	+	?	+	+
Parker (2007)	+	+	+	+	+	+	+
Walker (2013)	-	+	+	+	+	+	+

⊖ High	⊛ Unclear	⊕ Low
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Study results

Table 1: Endometrial cancer: Single symptoms

Study	Symptom(s)	Patient group	Positive predictive value % (95% CI)
Walker (2013)	Abdominal pain (first presentation to GP)	Women ≥ 55 years	0.1 (0.1-0.1)
Walker (2013)	Abdominal pain (repeated symptom)	Women ≥ 55 years	0.2 (0.1-0.1) <i>As reported, but CI is not correct</i>
Hallissey (1990)	Dyspepsia	All patients	0.04 (0.002-0.25) 1/2585
Walker (2013)	Haematuria (first presentation to GP)	Women ≥ 55 years	0.7 (0.5-1)
Walker (2013)	Vaginal discharge (first presentation to GP)	Women ≥ 55 years	1.1 (0.8-1.5)
Parker (2007)	Post-menopausal bleeding	All women	1.7 (1.4-2)
		Women 40-44 years	0 (0-5.9) 0/77
		Women 45-54 years	0.3 (0.2-0.7)
		Women 55-64 years	1.1 (0.9-1.5)
		Women 65-74 years	3.1 (2.4-4.1)
		Women 75-84 years	5.4 (4-7.2)
Walker (2013)	Post-menopausal bleeding (first presentation to GP)	Women ≥ 55 years	4 (3.2-5.2)
Walker (2013)	Post-menopausal bleeding (repeated symptom)	Women ≥ 55 years	9.6 (6.2-17.8)
Droogendijk	Anaemia	All women	0.63 (0.03-4.01) 1/158
Walker (2013)	Low haemoglobin (test)	Women ≥ 55 years	0.1 (0.1-0.1)
Walker (2013)	High platelets (test)	Women ≥ 55 years	0.1 (0.1-0.1)
Walker (2013)	High glucose (test)	Women ≥ 55 years	0.1 (0.1-0.2)

Walker (2013) calculated the positive predictive values using Bayesian statistics.

Table 2: Endometrial cancer: Symptom combinations

Study	Symptom(s)	Patient group	Positive predictive value % (95% CI)
Walker (2013)	Post-menopausal bleeding + haematuria	Women ≥ 55 years	9.1 (NR)
Walker (2013)	Post-menopausal bleeding + vaginal discharge	Women ≥ 55 years	8.3 (NR)
Walker (2013)	Post-menopausal bleeding + abdominal pain	Women ≥ 55 years	2.9 (1.6-5.7)

Walker (2013)	Post-menopausal bleeding + low haemoglobin (test)	Women ≥ 55 years	6.4 (NR)
Walker (2013)	Post-menopausal bleeding + high platelets (test)	Women ≥ 55 years	5.4 (3.1-10.2)
Walker (2013)	Post-menopausal bleeding + high glucose (test)	Women ≥ 55 years	3.4 (1.3-9.5)
Walker (2013)	Abdominal pain + haematuria	Women ≥ 55 years	0.7 (NR)
Walker (2013)	Abdominal pain + vaginal discharge	Women ≥ 55 years	0.5 (0.2-1.3)
Walker (2013)	Abdominal pain + low haemoglobin (test)	Women ≥ 55 years	0.2 (0.1-0.4)
Walker (2013)	Abdominal pain + high platelets (test)	Women ≥ 55 years	0.1 (0.1-0.2)
Walker (2013)	Abdominal pain + high glucose (test)	Women ≥ 55 years	0.3 (0.1-0.5)
Walker (2013)	Vaginal discharge + haematuria	Women ≥ 55 years	2.2 (NR)
Walker (2013)	Vaginal discharge + low haemoglobin (test)	Women ≥ 55 years	0.6 (NR)
Walker (2013)	Vaginal discharge + high platelets (test)	Women ≥ 55 years	1.4 (NR)
Walker (2013)	Vaginal discharge + high glucose (test)	Women ≥ 55 years	0.6 (NR)
Walker (2013)	Haematuria + low haemoglobin (test)	Women ≥ 55 years	2.7 (NR)
Walker (2013)	Haematuria + high platelets (test)	Women ≥ 55 years	1.9 (NR)
Walker (2013)	Haematuria + high glucose (test)	Women ≥ 55 years	1.1 (NR)
Walker (2013)	Low haemoglobin (test) + high glucose (test)	Women ≥ 55 years	0.2 (0.1-0.2)
Walker (2013)	Low haemoglobin (test) + high platelets (test)	Women ≥ 55 years	0.1 (0.1-0.2)
Walker (2013)	High platelets (test) + high glucose (test)	Women ≥ 55 years	0.1 (0.1-0.2)

1 Walker (2013) calculated the positive predictive values using Bayesian statistics. NR = not reported.

2

3 **Evidence statement(s):**

4 For uterine cancer the positive predictive values of single symptoms (4 studies, N = 25134)
5 presenting in primary care ranged from 0% (for post-menopausal bleeding in women aged 40-44
6 years) to 9.6% (for repeated post-menopausal bleeding). The included studies were associated with
7 0-2 bias/applicability concerns (see also Table 1).

8

9 For uterine cancer the positive predictive values of symptom combinations (1 study, N = 12269)
10 presenting in primary care ranged from 0.1% (for high platelets in combination with either

1 abdominal pain, low haemoglobin or high glucose) to 9.1% (for post-menopausal bleeding combined
2 with haematuria). The included study was associated with 1 bias concern (see also Table 2).

3

4 **Evidence tables**5 **Droogendijk (2011)**

PATIENT SELECTION	
A. risk of bias	
Patient sampling	Retrospective peripheral hospital laboratory database study serving 265 GPs in Dordrecht (Holland).
Was a consecutive or random sample of patients enrolled?	Yes
Was a case-control design avoided?	Yes
Did the study avoid inappropriate exclusions?	Yes
Could the selection of patients have introduced bias?	Low risk
B. Concerns regarding applicability	
Patient characteristics and setting	N = 287; 129 men, 158 women; median (range) age = 70 (19-87) years. <u>Inclusion criteria</u> : All women aged > 50 years and all men aged ≥ 18 years who between January 2004 and December 2005 were diagnosed with iron-deficiency anaemia (haemoglobin < 13.7 g/dl in men and < 12.1 g/dl in women, and a serum ferritin level < 25 µg/l for men and < 20 µg/l for women). <u>Exclusion criteria</u> : Patients with a known history of iron-deficiency anaemia in the previous 2 years, a history of gastrointestinal malignancy or congenital haemoglobinopathy. <u>Clinical setting</u> : GPs in Holland
Are there concerns that the included patients and setting do not match the review question?	Unclear concern
INDEX TEST	
A. Risk of bias	
Index test	New onset iron-deficiency anaemia (haemoglobin < 13.7 g/dl in men and < 12.1 g/dl in women, and a serum ferritin level < 25 µg/l for men and < 20 µg/l for women).
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes
Could the conduct or interpretation of the index test have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the index test, its conduct, or interpretation differ from the review question?	Low concern
REFERENCE STANDARD	
A. risk of bias	
Reference standard(s)	Endoscopy and 12-month follow up.
Is the reference standard likely to correctly classify the target condition?	Yes
Were the reference standard results interpreted without knowledge of the results of the index tests?	No

Could the reference standard, its conduct, or its interpretation have introduced bias?		Low risk
B. Concerns regarding applicability		
Are there concerns that the target condition as defined by the reference standard does not match the question?		Low concern
FLOW AND TIMING		
A. risk of bias		
Flow and timing	It is unclear if all patients are accounted for	
Was there an appropriate interval between index test and reference standard?	Unclear	
Did all patients receive the same reference standard?	Unclear	
Were all patients included in the analysis?	Unclear	
Could the patient flow have introduced bias?		Unclear risk
NOTES	In addition to the 24 patients with colorectal cancer, 3 patients had gastric cancer, 1 patient had oesophageal cancer and 1 patient had locally invasive endometrial cancer.	
1		
2	Hallissey (1990)	
PATIENT SELECTION		
A. risk of bias		
Patient sampling	Prospective consecutive patient series from a group of 10 general practices in England.	
Was a consecutive or random sample of patients enrolled?	Yes	
Was a case-control design avoided?	Yes	
Did the study avoid inappropriate exclusions?	Yes	
Could the selection of patients have introduced bias?		Low risk
B. Concerns regarding applicability		
Patient characteristics and setting	N = 2585 aged > 40 years. No other information reported. The patient group was equally divided between new patients with dyspepsia, old patients with uninvestigated dyspepsia, and old patients with investigated dyspepsia. <u>Inclusion criteria:</u> All patients over 40 years making their first attendance during the study period (4 years and 9 months) with any degree of dyspepsia <u>Exclusion criteria:</u> None listed. <u>Clinical setting:</u> Primary care, England.	
Are there concerns that the included patients and setting do not match the review question?		Unclear concern
INDEX TEST		
A. Risk of bias		
Index test	Dyspepsia of any degree	
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes	
Could the conduct or interpretation of the index test have introduced bias?		Low risk
B. Concerns regarding applicability		
Are there concerns that the index test, its conduct, or		Low concern

interpretation differ from the review question?		
REFERENCE STANDARD		
A. risk of bias		
Reference standard(s)	Upper gastrointestinal endoscopy within 4 weeks and follow up.	
Is the reference standard likely to correctly classify the target condition?	Yes	
Were the reference standard results interpreted without knowledge of the results of the index tests?	No	
Could the reference standard, its conduct, or its interpretation have introduced bias?	Low risk	
B. Concerns regarding applicability		
Are there concerns that the target condition as defined by the reference standard does not match the question?	Low concern	
FLOW AND TIMING		
A. risk of bias		
Flow and timing	2659 patients were seen and 2585 attended for investigation	
Was there an appropriate interval between index test and reference standard?	Yes	
Did all patients receive the same reference standard?	Yes	
Were all patients included in the analysis?	Yes	
Could the patient flow have introduced bias?	Low risk	
NOTES	Malignancy was detected in 115 patients: Gastric adenocarcinoma (57), gastric lymphoma (1; added to the gastric adenocarcinoma data in the PPV), oesophageal cancer (15), colorectal (14), pancreatic (6), bronchial (8), prostatic (2), duodenal (1, also added to the gastric carcinoma data in the PPV), liver (1), gall bladder (1), carcinoid (1), uterine (1), leukaemia (1), carcinomatosis of unknown primary (7).	
1		
2	Parker (2007)	
PATIENT SELECTION		
A. risk of bias		
Patient sampling	Prospective patient series using patients in the QResearch database.	
Was a consecutive or random sample of patients enrolled?	Yes	
Was a case-control design avoided?	Yes	
Did the study avoid inappropriate exclusions?	Yes	
Could the selection of patients have introduced bias?	Low risk	
B. Concerns regarding applicability		
Patient characteristics and setting	Rectal bleeding: N = 29007 (13931, males, 15076 females); median age (inter-quartile range) = 54 (40-69) years. Post-menopausal bleeding: N = 10122 (10122 females); median age (inter-quartile range) = 58 (54-67) years. <u>Inclusion criteria:</u> All practices in England and Wales that had been using their Egton Medical Information Systems (EMIS) computer system before 1 April 1998 and had complete data up to 1 April 2005. Patients were included if they were registered with an eligible practice at any time between 1 April 1998 and 31	

	March 2003, had been registered with the practice for ≥ 12 months and had a first-ever consultation for rectal bleeding and were aged ≥ 25 years, or post-menopausal bleeding and were aged ≥ 40 years, between 1 April 1998 and 31 March 2003. <u>Exclusion criteria:</u> Previous record of colorectal cancer (for patients presenting with rectal bleeding) and endometrial cancer (for patients presenting with post-menopausal bleeding) <u>Clinical setting:</u> Primary care, UK
Are there concerns that the included patients and setting do not match the review question?	Low concern
INDEX TEST	
A. Risk of bias	
Index test	First ever presentation of rectal bleeding, first ever presentation of post-menopausal bleeding.
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes
Could the conduct or interpretation of the index test have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the index test, its conduct, or interpretation differ from the review question?	Low concern
REFERENCE STANDARD	
A. risk of bias	
Reference standard(s)	2-year follow up (relevant cancer for rectal bleeding was colorectal cancer; relevant cancer for post-menopausal bleeding was endometrial cancer).
Is the reference standard likely to correctly classify the target condition?	Yes
Were the reference standard results interpreted without knowledge of the results of the index tests?	Unclear
Could the reference standard, its conduct, or its interpretation have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the target condition as defined by the reference standard does not match the question?	Low concern
FLOW AND TIMING	
A. risk of bias	
Flow and timing	All patients appear to be accounted for
Was there an appropriate interval between index test and reference standard?	Yes
Did all patients receive the same reference standard?	Yes
Were all patients included in the analysis?	Yes
Could the patient flow have introduced bias?	Low risk
NOTES	
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2	Walker (2013)
PATIENT SELECTION	
A. risk of bias	

Patient sampling	Matched case-control study using patients in the UK's General Practice Research Database (GPRD).
Was a consecutive or random sample of patients enrolled?	No
Was a case-control design avoided?	No
Did the study avoid inappropriate exclusions?	Yes
<i>For diagnostic case-control studies:</i> Attempts were made within the design or analysis to balance the comparison groups for potential confounders?	Yes
<i>For diagnostic case-control studies:</i> The groups were comparable at baseline, including all major confounding and prognostic factors?	Yes
Could the selection of patients have introduced bias?	High risk
B. Concerns regarding applicability	
Patient characteristics and setting	<p><u>Cases:</u> N = 2732; median number of consultations in the year before the index date = 14 (IQR = 9-21); median number of consultations in the 6 months before the index date = 9 (IQR = 6-14); median age at diagnosis = 67 (IQR = 59-75); UK.</p> <p><u>Controls:</u> N = 9537; median number of consultations in the year before the index date = 8 (IQR = 4-14); median number of consultations in the 6 months before the index date = 4 (IQR = 2-8); UK.</p> <p><u>Inclusion criteria:</u> Cases: A list of 30 uterine tumour diagnostic codes was collated from the GPRD master code library, all mapping to Read Codes within the B43..00 tree for uterine cancer. Codes relating to cervical cancer were omitted. All women aged ≥40 years with one of these codes, diagnosed between 1 January 2000 and 31 December 2009, were identified. The date of the first cancer code in the records was taken to be the date of diagnosis; this was labelled the index date. Controls: For each case, five controls, matched to the case by year of birth, sex, and practice, were randomly selected, using a computer-generated sequence. The matched controls were assigned the index date of their case.</p> <p><u>Exclusion criteria:</u> The following exclusion criteria were applied: Cases with <1 year of data meeting GPRD quality standards before the first diagnostic code; leiomyosarcoma (the GPRD had ascribed all leiomyosarcomas to uterine origin: as there are several possible sites for leiomyosarcomas, all were excluded); diagnosis before 1 January 2000; controls diagnosed with uterine cancer before the index date; metastatic cancer from a non-uterine primary cancer; women with a recorded hysterectomy before the index date; and women with no consultations in the year before the index date. Women with a hysterectomy recorded >3 months before their first uterine cancer code were also excluded, as the date of diagnosis was unreliable; if the discrepancy was <3 months, the index date was taken to be the date of the hysterectomy.</p> <p><u>Clinical setting:</u> Primary care UK</p>
Are there concerns that the included patients and setting	Low concern

do not match the review question?		
INDEX TEST		
A. Risk of bias		
Index test	All symptoms, signs or abnormal investigations previously recorded in the uterine cancer literature and cancer charity websites were studied. Libraries of codes relating to these were collated. All codes for fractures were also identified, as a test for any recording bias between cases and controls (making the assumption that the fracture rate would be approximately equal). Occurrences of these features in the year before the index date were identified. Features were only retained for further study if they occurred in $\geq 2\%$ of cases or controls. A list of plausible laboratory abnormalities was assembled a priori, using the literature and the authors' clinical knowledge. All abnormal laboratory results in the year before the index date were also identified, using the local laboratory's normal range, which is supplied with the data. Women without a test were considered to be equivalent to those with a normal result. Some abnormal tests were grouped: abnormal liver function was defined as the presence of any liver enzyme above the normal range. The variable 'raised inflammatory markers' was defined as a raised erythrocyte sedimentation rate, C-reactive protein, or plasma viscosity. These simplifications were necessary, as different localities in the UK contributing to the GPRD have different tests available.	
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes	
<i>For diagnostic case-control studies:</i> Investigators were kept 'blind' to other important confounding and prognostic factors?	Yes	
Could the conduct or interpretation of the index test have introduced bias?	Low risk	
B. Concerns regarding applicability		
Are there concerns that the index test, its conduct, or interpretation differ from the review question?	Low concern	
REFERENCE STANDARD		
A. risk of bias		
Reference standard(s)	Uterine cancer code in the UK's General Practice Research Database.	
Is the reference standard likely to correctly classify the target condition?	Yes	
Were the reference standard results interpreted without knowledge of the results of the index tests?	Unclear	
Could the reference standard, its conduct, or its interpretation have introduced bias?	Low risk	
B. Concerns regarding applicability		
Are there concerns that the target condition as defined by the reference standard does not match the question?	Low concern	
FLOW AND TIMING		
A. risk of bias		
Flow and timing	A total of 18841 patients were identified, 15675 controls and 3166 cases. Of the controls the following exclusions were applied: Uterine cancer before	

	index date of case (N = 41), hysterectomy before index date of case (N = 2732), case excluded (N = 2074) and no data in year pre-index date (N = 1291). Of the cases the following exclusions were applied: No controls (N = 13), sarcoma (N = 251), metastatic cancer (N = 3), and hysterectomy recorded > 3 months prior to cancer index date (N = 167).
Was there an appropriate interval between index test and reference standard?	Yes
Did all patients receive the same reference standard?	Yes
Were all patients included in the analysis?	Yes
Could the patient flow have introduced bias?	Low risk
NOTES	One subgroup analysis examined women aged ≥55 years, as a proxy for being postmenopausal, and for this analysis all abnormal menstrual bleeding variables were categorised as postmenopausal bleeding.

1

2 **References**3 **Included studies**

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- 13 Walker, S., Hyde, C. & Hamilton, W. (2013) Risk of uterine cancer in symptomatic women in primary
14 care: case-control study using electronic records. *British Journal of General Practice*, 63: 643-648.

15

16 **Excluded studies (with reason)**

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18 [Dutch]. *Huisarts en Wetenschap*, 51: March.
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- 20 (2004) Endometrial cancer. Better odds with early detection. *Mayo Clinic Health Letter*, 22: 4-5.
21 Narrative review
- 22 Achillarre, M. T., Ceci, O., Mangiatordi, G., Pinto, L., Laera, A., Chiarulli, E. & Bettocchi, S. (2010) Is
23 Office Hysteroscopy always necessary after endometrial ultrasound evaluation in
24 postmenopausal women? *Journal of Minimally Invasive Gynecology. Conference: 39th Global*
25 *Congress of Minimally Invasive Gynecology, AAGL 2010 Las Vegas, NV United States. Conference*
26 *Start: 20101108 Conference End: 20101112. Conference Publication: (var.pagings)*, 17: November-
27 December.
28 Not in PICO
- 29 Aedo, O. (2012) New techniques for the diagnosis of endometrial and ovarian pathology.
30 *Cytopathology. Conference: 37th European Congress of Cytopathology Dubrovnik-Cavtat*
31 *Croatia. Conference Start: 20120930 Conference End: 20121003. Conference Publication:*
32 *(var.pagings)*, 23: October.
33 Narrative review
- 34 Ajao, M., Vachon, T. & Snyder, P. (2013) Ovarian dysgerminoma: a case report and literature review.
35 *Military Medicine*, 178: e954-e955.
36 Not in PICO

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2 in Saudi patients with postmenopausal bleeding. *Saudi Medical Journal*, 25: 857-861.
3 Not in PICO
- 4 Albers, J. R., Hull, S. K. & Wesley, R. M. (2004) Abnormal uterine bleeding. [Review] [45 refs].
5 *American Family Physician*, 69: 1915-1926.
6 Narrative review
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8 hysteroscopies in the management of abnormal uterine bleeding. *Gynaecological Endoscopy*, 8.
9 Not in PICO (secondary care)
- 10 Apgar, B. S. & Newkirk, G. R. (1997) Office procedures. Endometrial biopsy. *Primary care*, 24: Jun.
11 Narrative review
- 12 Aslam, N., Oniah, M., Gaber, M. & Hollingworth, J. (2012) An audit of one stop post menopausal
13 bleeding (PMB) clinic, do we need to change the endometrial thickness (ET) cut-off of 4MM?
14 *International Journal of Gynecology and Obstetrics.Conference: 20th FIGO World Congress of*
15 *Gynecology and Obstetrics Rome Italy.Conference Start: 20121007 Conference End:*
16 *20121012.Conference Publication: (var.pagings)*, 119: October.
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20 Not in PICO
- 21 Bachet, W., Brunner, P., Dodenhof, J. D. J. & Strobel, E. (1983) The diagnostic accuracy of
22 endometrial cytology with prevical. [German]. *Geburtshilfe und Frauenheilkunde*, 43.
23 Not in PICO
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Review question:

Which investigations of symptoms of suspected endometrial cancer should be done with clinical responsibility retained by primary care?

Results**Literature search**

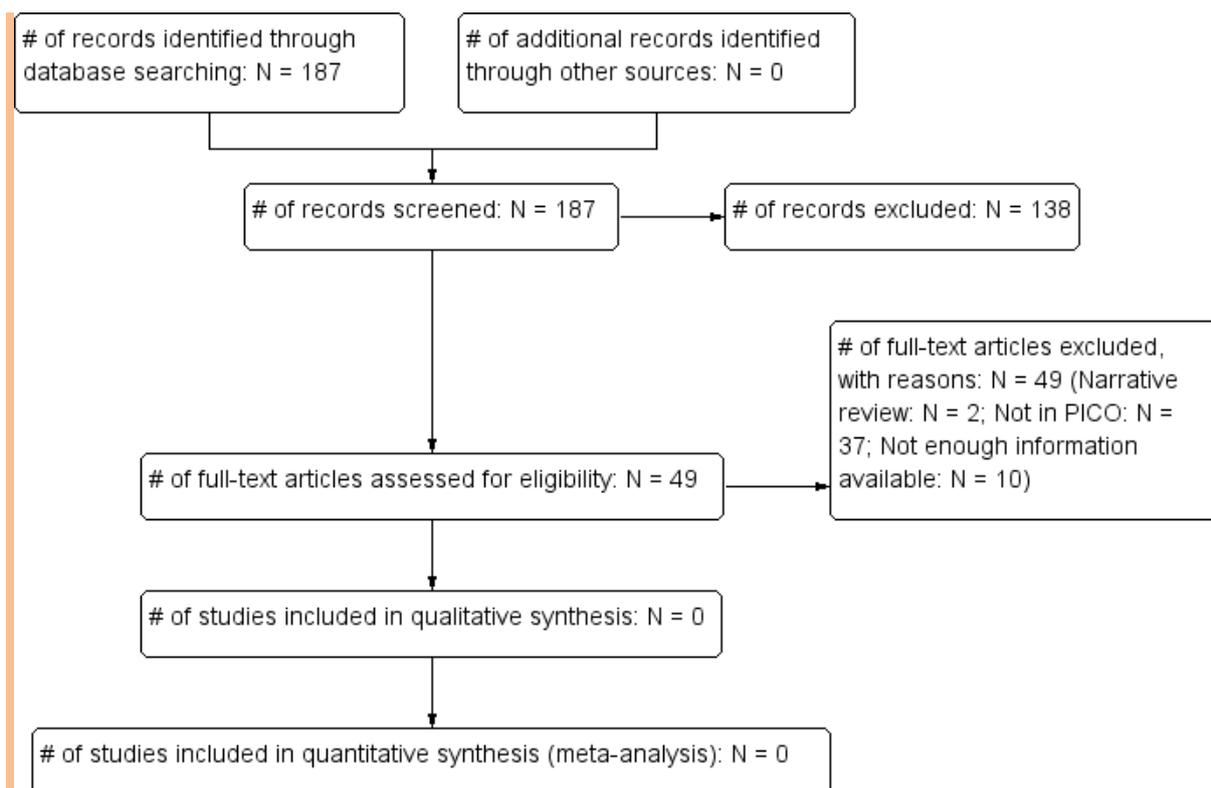
Database name	Dates Covered	No of references found	No of references retrieved	Finish date of search
<i>Medline</i>	1980-2013	1107	80	19/06/2013
<i>Premedline</i>	1980-2013	66	6	19/06/2013
<i>Embase</i>	1980-2013	2720	101	20/06/2013
<i>Cochrane Library</i>	1980-2013	145	8	20/06/2013
<i>Psychinfo</i>	1980-2013	3	1	19/06/2013
<i>Web of Science (SCI & SSCI) and ISI Proceedings</i>	1980-2013	57	16	20/06/2013

Total References retrieved (after de-duplication): 181

Update Search

Database name	Dates Covered	No of references found	No of references retrieved	Finish date of search
<i>Medline</i>	6/2013-13/08/2014	10	1	13/08/2014
<i>Premedline</i>	6/2013-13/08/2014	51	4	13/08/2014
<i>Embase</i>	6/2013-13/08/2014	45	4	13/08/2014
<i>Cochrane Library</i>	6/2013-13/08/2014	78	0	13/08/2014
<i>Web of Science (SCI & SSCI) and ISI Proceedings</i>	6/2013-13/08/2014	7	0	13/08/2014

Total References retrieved (after de-duplication): 6



1

2 **Study results**

3 No evidence was identified pertaining to the diagnostic accuracy of transvaginal/abdominal
 4 ultrasound, pipelle sampling, CA125 or hysteroscopy in patients with suspected endometrial cancer
 5 where the clinical responsibility was retained by primary care.
 6

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13 Method: Retrospective chart review was completed of all endometrial biopsies performed on
14 women attending a dedicated gynaecology clinic for women with intellectual disability over an 8-
15 year period. A fine calibre disposable suction curette was utilized. Results: Of the 64 women
16 sampled, adequate tissue for pathological diagnosis was obtained in 84%. Of the 35 with post-
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19 sampling can be successfully performed on an outpatient basis in women with intellectual
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22 reserved) (journal abstract)
23 Notes: DB - PsycINFO
24 AN - Peer Reviewed Journal: 2008-01714-011
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CERVICAL CANCER**Review question:**

What is the risk of cervical cancer in patients presenting in primary care with symptom(s)?

Results**Literature search**

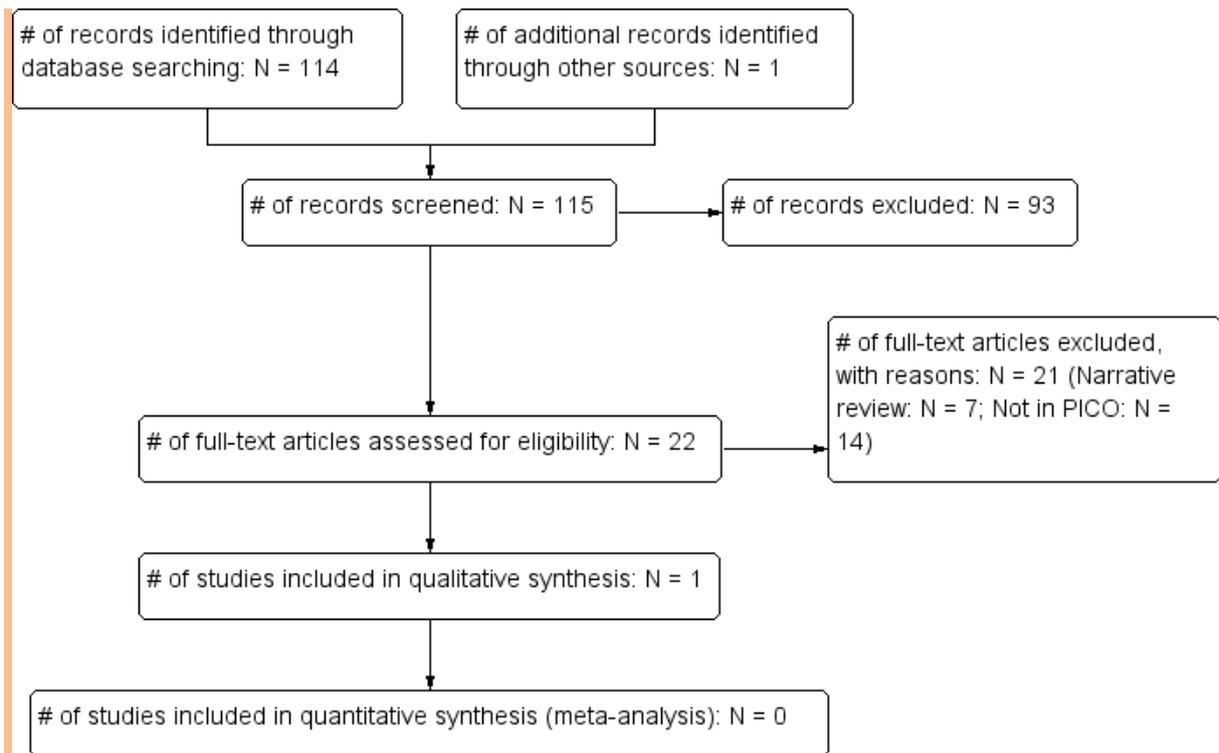
Database name	Dates Covered	No of references found	No of references retrieved	Finish date of search
<i>Medline</i>	All-2012	1076	34	17/04/2013
<i>Premedline</i>	All-2012	42	5	18/04/2013
<i>Embase</i>	All-2012	1532	44	18/04/2013
<i>Cochrane Library</i>	All-2012	529	3	19/04/2013
<i>Psychinfo</i>	All-2012	31	2	18/04/2013
<i>Web of Science (SCI & SSCI) and ISI Proceedings</i>	All-2012	539	16	19/04/2013

Total References retrieved (after de-duplication): 96

Update Search

Database name	Dates Covered	No of references found	No of references retrieved	Finish date of search
<i>Medline</i>	4/2013-13/08/2014	166	4	13/08/2014
<i>Premedline</i>	4/2013-13/08/2014	56	5	13/08/2014
<i>Embase</i>	4/2013-13/08/2014	315	9	13/08/2014
<i>Cochrane Library</i>	4/2013-13/08/2014	99	0	13/08/2014
<i>Web of Science (SCI & SSCI) and ISI Proceedings</i>	4/2013-13/08/2014	20	2	13/08/2014

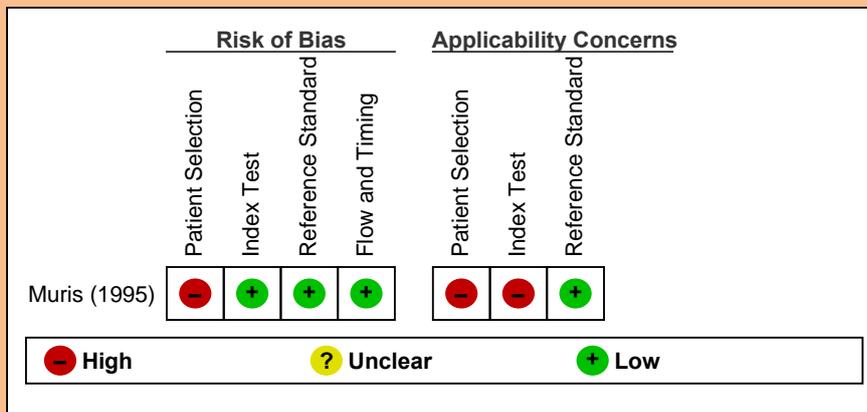
Total References retrieved (after de-duplication): 18



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Risk of bias in the included studies

The risk of bias and applicability concerns are summarised for the included study in the figure below. The main issues to note are that the study results are compromised by both the non-consecutive/non-random patient selection as well as by the under-specification of the symptom under investigation and the setting, which may not be directly applicable to UK-based primary care.



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Study results

Table 1: Cervical cancer: Single symptoms

Study	Symptom(s)	Patient group	Positive predictive value % (95% CI)
Muris (1995)	Non-acute abdominal complaints	All women	0.5 (0.1-1.6) 3/598: 1 cervix, 2 other cancer of the female genital

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8**Evidence statement(s):**

Non-acute abdominal complaints presenting in primary care do not appear to be associated with an increased risk of cervical cancer (PPV = 0.5%; 1 study, N = 598). The included study was associated with 3 bias/applicability concerns (see also Table 1).

Evidence tables**Muris (1995)**

PATIENT SELECTION	
A. risk of bias	
Patient sampling	Prospective patient series from 80/460 general practitioners in Limburg (Holland)
Was a consecutive or random sample of patients enrolled?	No
Was a case-control design avoided?	Yes
Did the study avoid inappropriate exclusions?	Unclear
Could the selection of patients have introduced bias?	High risk
B. Concerns regarding applicability	
Patient characteristics and setting	N = 933; 335 males, 598 females; age range = 18-75, aged > 30 years: N = 712, aged > 40 years: N = 517, aged > 60 years: N = 171. <u>Inclusion criteria:</u> Patients who in 1989 consulted one of the participating GPs for new abdominal complaints lasting ≥ 2 weeks and with whom the GPs had a diagnostic problem. <u>Exclusion criteria:</u> None listed. <u>Clinical setting:</u> GPs in Holland
Are there concerns that the included patients and setting do not match the review question?	High concern
INDEX TEST	
A. Risk of bias	
Index test	New abdominal complaints lasting ≥ 2 weeks. Not further specified.
Were the index test results interpreted without knowledge of the results of the reference standard?	Yes
Could the conduct or interpretation of the index test have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the index test, its conduct, or interpretation differ from the review question?	High concern
REFERENCE STANDARD	
A. risk of bias	
Reference standard(s)	Follow up for ≥ 12 months (mean = 18 months).
Is the reference standard likely to correctly classify the target condition?	Yes
Were the reference standard results interpreted without knowledge of the results of the index tests?	No

Could the reference standard, its conduct, or its interpretation have introduced bias?	Low risk
B. Concerns regarding applicability	
Are there concerns that the target condition as defined by the reference standard does not match the question?	Low concern
FLOW AND TIMING	
A. risk of bias	
Flow and timing	All patients appear to be accounted for
Was there an appropriate interval between index test and reference standard?	Unclear
Did all patients receive the same reference standard?	Yes
Were all patients included in the analysis?	Yes
Could the patient flow have introduced bias?	Low risk
NOTES	Other cancers diagnosed in these patients were: Stomach (2/933), pancreas (2/933), trachea/bronchus/lung (2/933), kidney (1/933), colorectal (4/933), and other and unspecified sites (2/933).

1

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Review question:

41 Which investigations of symptoms of suspected cervix cancer should be done with clinical
42 responsibility retained by primary care?
43

Results**Literature search**

Database name	Dates Covered	No of references found	No of references retrieved	Finish date of search
<i>Medline</i>	1980-2013	917	138	10/06/2013
<i>Premedline</i>	1980-2013	158	6	10/06/2013
<i>Embase</i>	1980-2013	2221	114	11/06/2013

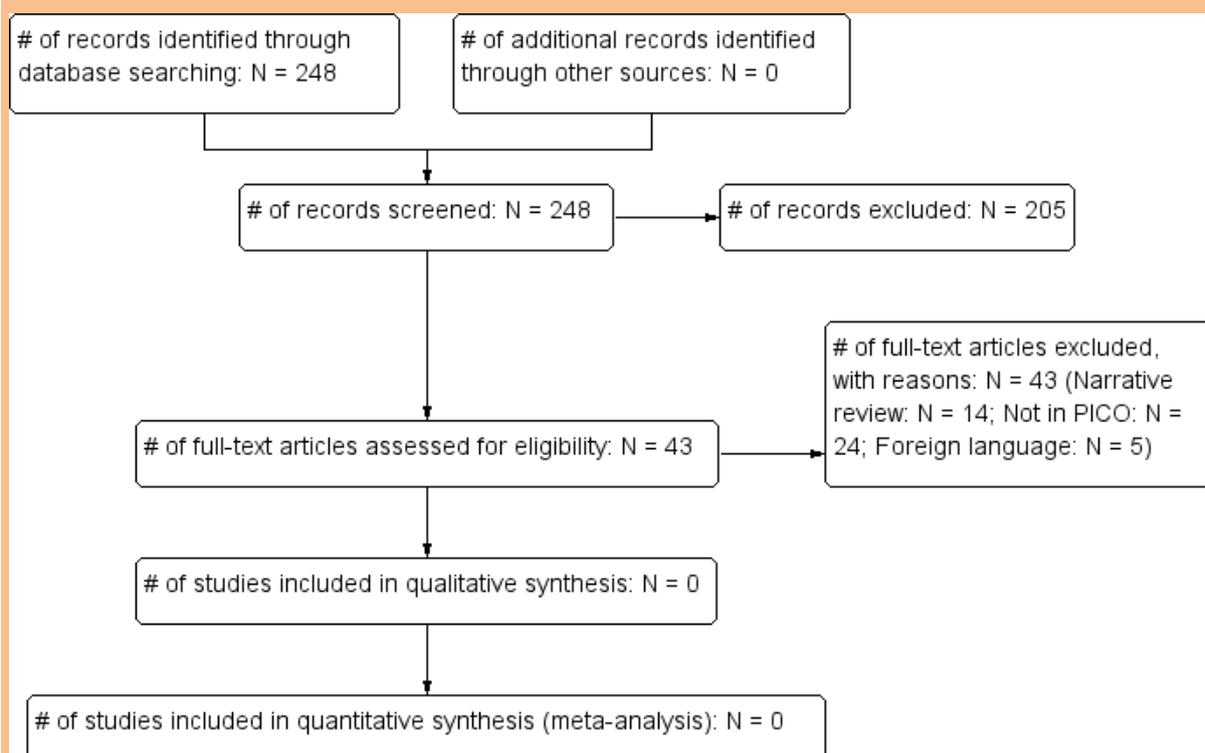
Cochrane Library	1980-2013	275	18	11/06/2013
Psychinfo	1980-2013	8	1	11/06/2013
Web of Science (SCI & SSCI) and ISI Proceedings	1980-2013	108	12	11/06/2013

1 Total References retrieved (after de-duplication): 245

2
3 **Update Search**

Database name	Dates Covered	No of references found	No of references retrieved	Finish date of search
Medline	6/2013-13/08/2014	170	2	13/08/2014
Premedline	6/2013-13/08/2014	44	1	13/08/2014
Embase	6/2013-13/08/2014	32	0	13/08/2014
Cochrane Library	6/2013-13/08/2014	34	0	13/08/2014
Web of Science (SCI & SSCI) and ISI Proceedings	6/2013-13/08/2014	15	0	13/08/2014

4 Total References retrieved (after de-duplication): 3



7
8 **Study results**

9 No evidence was identified pertaining to the diagnostic accuracy of cervical smear in patients with
10 suspected cervix cancer where the clinical responsibility was retained by primary care.

11
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3	
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18 Ref ID: 145
19 Reprint: Not in File
20 Abstract: Examined breast self-examination (BSE) practices and cervical cancer Pap smear testing
21 in female physicians. 284 female physicians (aged 24-67 yrs) residing in Norway completed
22 questionnaires. Results show that 30.6% of Ss performed BSE at least once monthly; 54.6% of Ss
23 had a Pap smear test once every 3rd yr at least. BSE was never practiced among 19.2% of the
24 physicians: primary cited reasons for this included forgetting, membership in a low risk group, or
25 having no symptoms of disease. 16.2% of Ss had never undergone routine Pap smears, claiming
26 that they were in a low risk group, they had no symptoms of disease, they had a problem in
27 finding a physician to attend, or they forgot. Compared with 738 Norwegian females, a subgroup
28 of 135 physicians (aged 35-49 yrs) practiced BSE monthly or more often compared with other
29 university educated women. However, a significantly lower percentage of the physicians had Pap
30 smear tests every 3rd yr or more frequently. (PsycINFO Database Record (c) 2012 APA, all rights
31 reserved)
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33 AN - Peer Reviewed Journal: 2000-14380-006
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VULVAL CANCER**Review question:**

What is the risk of vulval cancer in patients presenting in primary care with symptom(s)?

Results**Literature search**

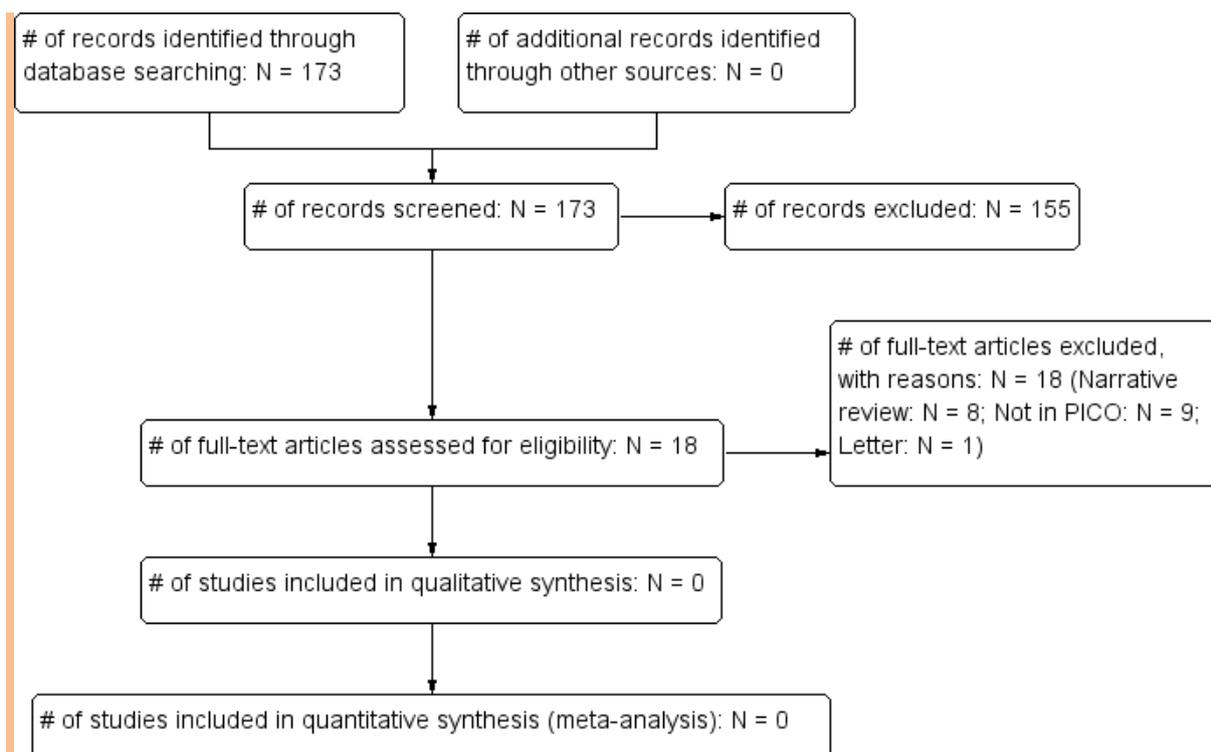
Database name	Dates Covered	No of references found	No of references retrieved	Finish date of search
<i>Medline</i>	All-2012	373	93	27/09/2012
<i>Premedline</i>	All-2012	9	2	27/09/2012
<i>Embase</i>	All-2012	474	125	01/10/2012
<i>Cochrane Library</i>	All-2012	23	0	27/09/2012
<i>Psychinfo</i>	All-2012	0	0	27/09/2012
<i>Web of Science (SCI & SSCI) and ISI Proceedings</i>	All-2012	3	2	27/09/2012
<i>Biomed Central</i>	All-2012	73	2	27/09/2012

Total References retrieved (after de-duplication): 167

Update Search

Database name	Dates Covered	No of references found	No of references retrieved	Finish date of search
<i>Medline</i>	9/2012-27/08/2014	42	0	27/08/2014
<i>Premedline</i>	9/2012-27/08/2014	36	4	27/08/2014
<i>Embase</i>	9/2012-27/08/2014	56	3	27/08/2014
<i>Cochrane Library</i>	9/2012-27/08/2014	17	0	27/08/2014
<i>Web of Science (SCI & SSCI) and ISI Proceedings</i>	9/2012-27/08/2014	8	0	27/08/2014

Total References retrieved (after de-duplication): 6



1

2 **Study results**

3 No evidence was identified.

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27 Review question:

28 Which investigations of symptoms of suspected vulval cancer should be done with clinical
29 responsibility retained by primary care?

31 Results

32 Literature search

Database name	Dates Covered	No of references found	No of references retrieved	Finish date of search
<i>Medline</i>	1980-2013	196	37	06/06/2013
<i>Premedline</i>	1980-2013	17	1	06/06/2013
<i>Embase</i>	1980-2013	212	57	06/06/2013
<i>Cochrane Library</i>	1980-2013	24	1	06/06/2013
<i>Psychinfo</i>	1980-2013	1	0	06/06/2013
<i>Web of Science (SCI & SSCI) and ISI Proceedings</i>	1980-2013	25	5	06/06/2013

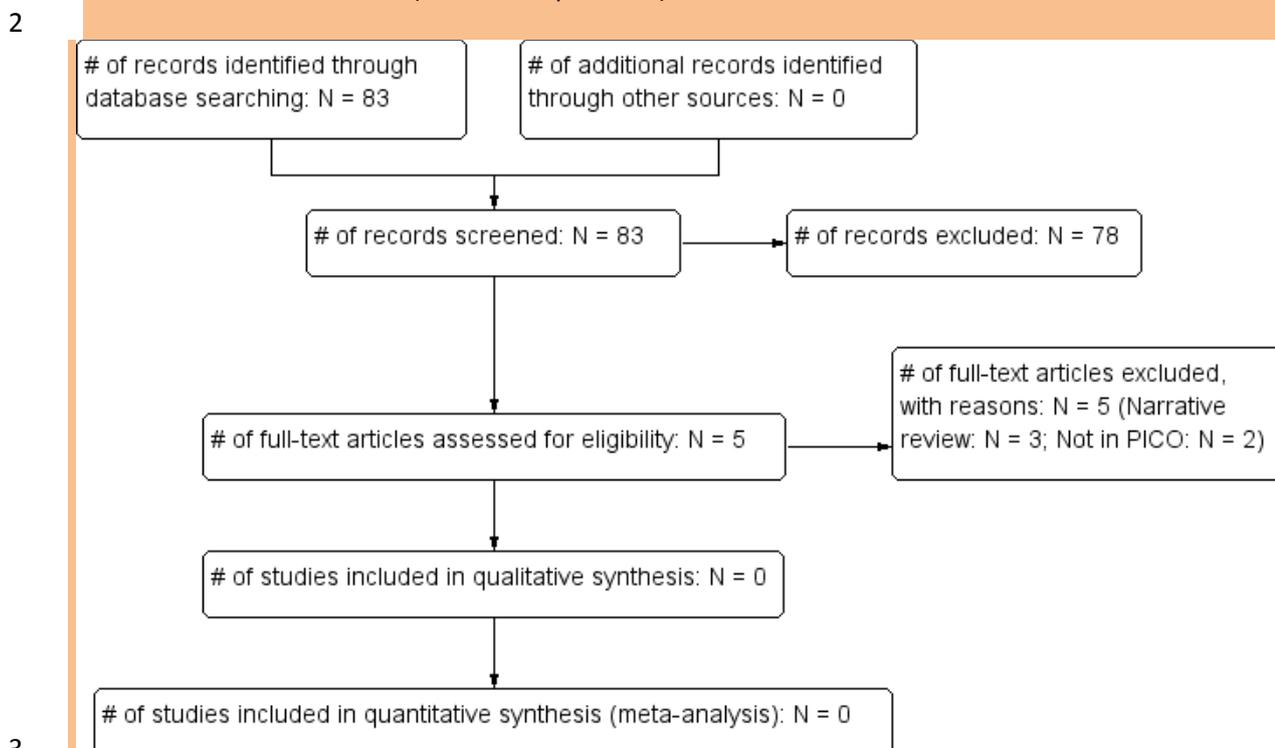
33 Total References retrieved (after de-duplication): 77

35 Update Search

Database name	Dates Covered	No of references found	No of references retrieved	Finish date of search
<i>Medline</i>	6/2013- 27/08/2014	5	0	27/08/2014
<i>Premedline</i>	6/2013- 27/08/2014	24	6	27/08/2014

Embase	6/2013-27/08/2014	30	1	27/08/2014
Cochrane Library	6/2013-27/08/2014	12	1	27/08/2014
Web of Science (SCI & SSCI) and ISI Proceedings	6/2013-27/08/2014	5	0	27/08/2014

1 Total References retrieved (after de-duplication): 6



4 **Study results**

5 No evidence was identified pertaining to the diagnostic accuracy of biopsy in patients with suspected
6 vulvar cancer where the clinical responsibility was retained by primary care.

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VAGINA CANCER**Review question:**

What is the risk of vagina cancer in patients presenting in primary care with symptom(s)?

Results**Literature search**

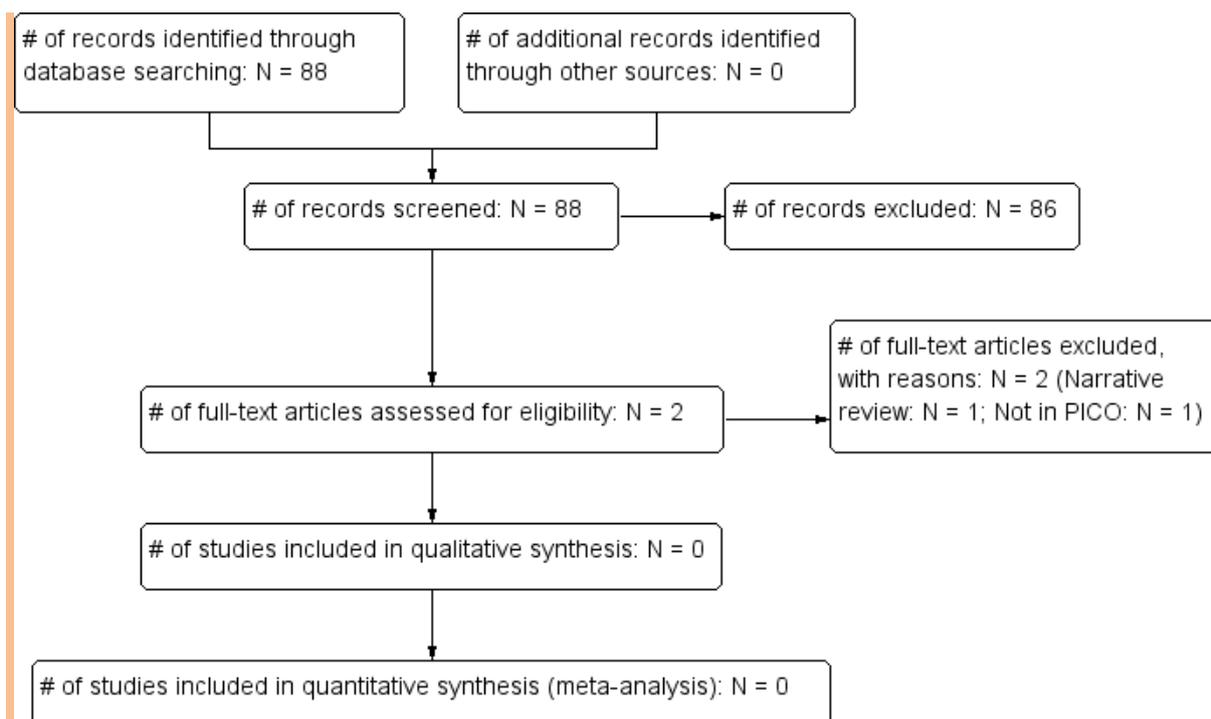
Database name	Dates Covered	No of references found	No of references retrieved	Finish date of search
<i>Medline</i>	All-2012	248	50	24/09/2012
<i>Premedline</i>	All-2012	6	2	24/09/2012
<i>Embase</i>	All-2012	293	54	27/09/2012
<i>Cochrane Library</i>	All-2012	83	0	24/09/2012
<i>Psychinfo</i>	All-2012	3	0	24/09/2012
<i>Web of Science (SCI & SSCI) and ISI Proceedings</i>	All-2012	4	1	27/09/2012
<i>Biomed Central</i>	All-2012	108	2	27/09/2012

Total References retrieved (after de-duplication): 83

Update Search

Database name	Dates Covered	No of references found	No of references retrieved	Finish date of search
<i>Medline</i>	9/2012-27/08/2014	8	1	27/08/2014
<i>Premedline</i>	9/2012-27/08/2014	20	1	27/08/2014
<i>Embase</i>	9/2012-27/08/2014	36	2	27/08/2014
<i>Cochrane Library</i>	9/2012-27/08/2014	99	0	27/08/2014
<i>Web of Science (SCI & SSCI) and ISI Proceedings</i>	9/2012-27/08/2014	32	2	27/08/2014

Total References retrieved (after de-duplication): 5



1

2 **Study results**

3 No evidence was identified.

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Review question:

48 Which investigations of symptoms of suspected vaginal cancer should be done with clinical
 49 responsibility retained by primary care?

50

1 **Results**

2 **Literature search**

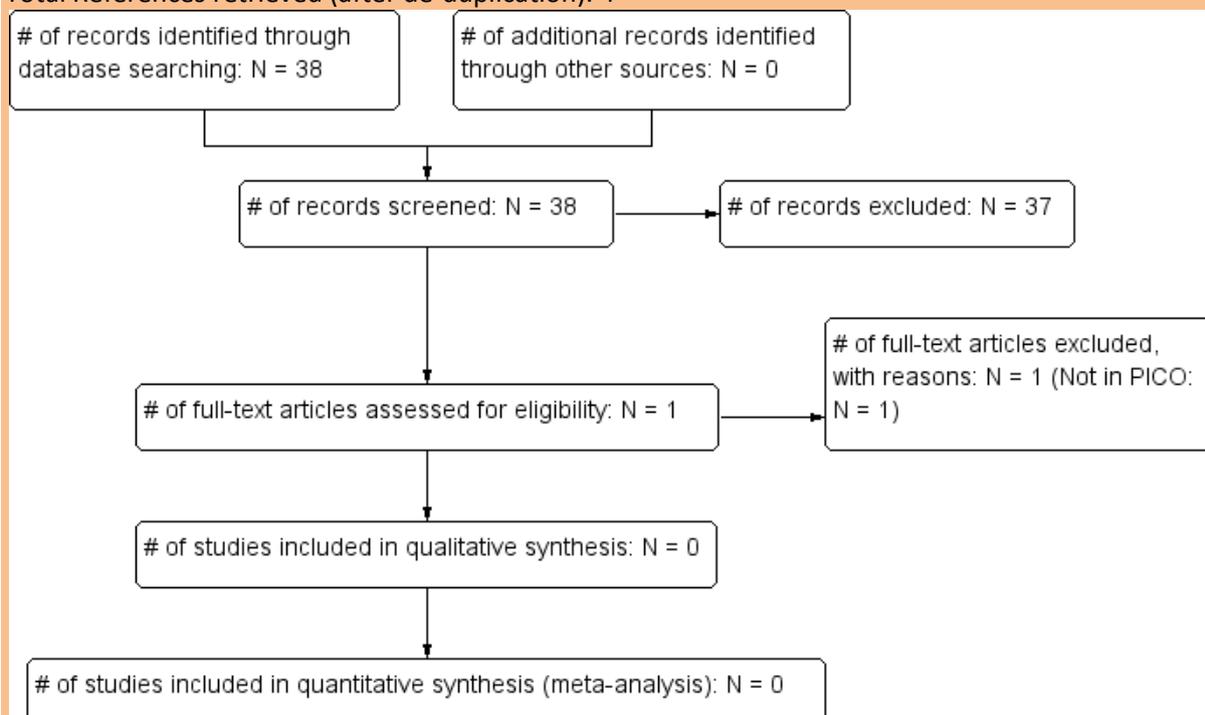
Database name	Dates Covered	No of references found	No of references retrieved	Finish date of search
<i>Medline</i>	1980-2013	151	16	05/06/2013
<i>Premedline</i>	1980-2013	10	1	05/06/2013
<i>Embase</i>	1980-2013	142	10	05/06/2013
<i>Cochrane Library</i>	1980-2013	104	0	05/06/2013
<i>Psychinfo</i>	1980-2013	4	0	05/06/2013
<i>Web of Science (SCI & SSCI) and ISI Proceedings</i>	1980-2013	76	8	05/06/2013

3 Total References retrieved (after de-duplication): 34

5 **Update Search**

Database name	Dates Covered	No of references found	No of references retrieved	Finish date of search
<i>Medline</i>	6/2013-27/08/2014	6	0	27/08/2014
<i>Premedline</i>	6/2013-27/08/2014	10	0	27/08/2014
<i>Embase</i>	6/2013-27/08/2014	18	2	27/08/2014
<i>Cochrane Library</i>	6/2013-27/08/2014	75	0	27/08/2014
<i>Web of Science (SCI & SSCI) and ISI Proceedings</i>	6/2013-27/08/2014	19	2	27/08/2014

6 Total References retrieved (after de-duplication): 4



8 **Study results**

1 No evidence was identified pertaining to the diagnostic accuracy of tests in patients with suspected
2 vaginal cancer where the clinical responsibility was retained by primary care.

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