Early diagnosis of cancer

What is the current situation?

Early diagnosis rates	Variation between cancer types	Why does this matter?
• For the 13 cancers where this is measured, 58.7% diagnosed stage 1/2 (England) – 2.7% ↑ on pre-pandemic levels. • Still only 38% of cancer diagnoses made by suspected cancer pathway.	• Breast/skin cancers have highest early diagnosis rates; pancreas, lung and ovary have the lowest.	• ↑ range of treatment options. • ↑ survival rates.

Why is cancer sometimes diagnosed late?

Patient factors	Clinician factors	System factors
• Lack of symptom awareness. • Cultural concerns about what might happen next, or fear of what symptoms may represent. • Previous negative experiences with healthcare. • Not returning if symptoms persist/worsen, because reassured by initial normal tests.	• Lack of recognition that many cancers don't present with 'red flags' (at least 1/3 present with non-specific symptoms). • Being reassured by no abnormal findings on examination. • Rare cancers may not be recognised. • Unconscious bias – not thinking of cancer in e.g. a young adult.	• General lack of resources in primary/secondary care. • Lack of availability of interpreters at time → communication issues. • Lack of safety-netting so test results not actioned. • Lack of continuity of care due to resource issues.

What can we do to improve this, within the resources available to us

Clinical issues	Consultation skills	Systems factors
• Patient seen multiple times with no clear diagnosis – rethink, consider involving a colleague. • Trust your intuition – shown to have a good predictive value for cancer diagnosis. • ↑ platelets, calcium, LFTs or inflammatory markers and ↓ Hb all have >1% positive predictive value for cancer – don't ignore even in absence of worrying symptoms. • Don't let a single negative test reassure you e.g. 20% of women with ↑Ca125 and no ovarian cancer have cancer elsewhere. • Be aware of NICE guidance on suspected cancer and referral pathways for worrying but non-specific symptoms.	• Use interpreter when needed. • Ask direct questions to capture/exclude red flag symptoms if not volunteered. • Convert to face to face if remote consultations aren't making progress. • Be aware that patients may not be able to speak freely on remote consultations (e.g. domestic abuse/coercion). • If reassuring patient, encourage them to come back if symptoms change/worsen.	• Ensure that there is easy access to face to face appointments if triage is phone/online. • Commissioners should ensure easy access to a rapid diagnostic centre or other pathway for cancer concern which doesn't fit an existing suspected cancer pathway. • Consider use of risk assessment tools e.g. QCancer, C The Signs and PPV tools (in resources section of course) as well as cancer mind maps. • Automate safety-netting systems to 'close the loop'. • Ensure well-organised and resourced systems for picking up recurrences (e.g. PSA screening post prostate cancer). • Consider taking part in the National Cancer Diagnosis Audit, to improve future care.