Scottish Parliament Cross Party Group on Cancer Research UK

19th March 2019, 17.30-19.30

1) Welcome

Anas Sarwar (The chair) opened the meeting and welcomed the attendees and speakers. The Chair noted the sessions focus on the refresh of the Scottish Cancer Referral Guidelines and the new FIT bowel screening test.

2) Minutes of the Last Meeting

The Minutes of the previous meeting of the Cross Party Group on Cancer on 16th January 2019 were approved by the group without amendments.

3) The Chair then welcomed Dr Peter Hutchison (PH) to discuss the refresh of the Scottish Cancer Referral Guidelines

PH began the presentation with a case study of a patient presenting to a GP with no significant history, that is currently presenting continuous bloating for 8 weeks or so, occasional loose bowels and slight weight loss. He discussed the possible responses to the case, highlighting that good practice would be to test blood and refer for pelvic ultrasound scan.

He continued by noting that the refreshed Scottish Cancer referral guidelines (SCRG) more closely align with NICE guidelines. However, PG noted that the NICE guidelines are often difficult to follow with many variations based on age and the refreshed SCRG were developed to provide a referral/treatment route which can be more easily followed and ensure good practice. He also stated that the reviewed guidelines hope to remove discrepancies between England and Scotland, but noted that NICE's 3% threshold was not used strictly in all cases.

The guidelines were reviewed as a response to the Scottish Primary Care Cancer Group (SPCCG), who identified a need for a review of certain cancers (lung, breast, lower GI, upper GI, urological, head and neck, brain and CNS, and children, teenagers and young adults). The process of the review included a literature review from Healthcare Improvement Scotland (HIS); a Steering Group involving the Scottish Government, HIS, SCPPG and Macmillan; followed by the involvement of cancer specific groups including, primary and secondary care clinicians, third sector and the Scottish Government.

PH then discussed the implementation of SCRG following their publication in January 2019. He identified the ways in which the guidelines can be accessed which includes: online via www.cancerreferral.scot.nhs.uk, a wall chart, Quick Reference Guide, SCI-Gateway referral protocols and an app for smartphones and tablets.

Subsequent peer reviews were then discussed noting the valuable feedback that was given, particularly within Gastroenterology where collaboration with gastroenterologists allowed for improvements.

He also discussed the inclusion of guidance on realistic medicine into the SCRG and the emphasis on patient-centred care. As well as the provision of the Cancer Research UK's Scotland-specific "your urgent referral explained" leaflet. He also noted the changing roles in primary care and that a range of professionals now see patients including: advance nurse practitioners, practice nurses, pharmacists, dentists, optometrists, NHS 24, A&E and secondary care clinicians. He noted the need to engage with all these groups as well as those involved in signposting – such as reception staff – as well as the need to engage with secondary care.

He also discussed the inclusion of fitness rating (ECOG/WHO) in the referral document and the need to incorporate the new SCRG in Scotland's SCI-Gateway referral protocols. He also highlighted that the guidelines emphasise a cancer referral as an opportunity for primary care practitioners to promote healthy choices (smoking cessation/exercise/national screening programmes etc.)

The presentation concluded by explaining the inclusion of thrombocytosis as a strong risk marker for cancer. Which, for both men and women, when presented warrants investigation to identify associated cancers such as lung, endometrium, gastric, oesophageal and colorectal.

AS thanked the speaker and provided an opportunity for questions.

Heather Goodare asked whether the age guidance for breast cancer had been lowered. PH noted that the guideline has been improved and women will now be referred at >30.

Lorraine Sloan (Macmillan) thanked PH for his work on chairing the refresh.

Larraine Dallas (Roy Castle) then asked what the health promotion information looks like in the SCRG. PH noted that in the guideline, for brevity, it only states that if you're seeing someone with suspected cancer and/or is presenting symptoms this is the time to begin health promotion.

Joe Woollcott (Brain Tumour Research) asked about epilepsy misdiagnosis in brain cancer and PH answered that the SCRG uses the HeadSmart campaign guidelines, that are suitable for both children and adults, adopting changes to both old and new epilepsy as well as other issues such as papilledema. Finally PH was asked whether optometrists will be provided with the guidelines. He stated that optometrists can access the guidelines online but have not currently been sent a copy directly.

b) The Chair then welcomed Professor Robert Steele (RS) to discuss FIT in the Scottish Bowel Screening Programme

RS started by thanking PH raising his interest in using the reviewed Scottish Cancer Referral Guidelines for health promotion and would like to see screening used as a similar opportunity.

He began the talk by explaining the term 'screening' stating that it is the act of proactively offering a test to a group of people who do not have the symptoms of the condition in question with a view to improving the outcomes associated with that condition. He continued by stating both the positive and negative impacts of screening, explaining that the programme has allowed early detection of bowel cancer, however, the risks associated with unnecessary colonoscopy as the result of a false negative can be harmful, as well as the unintended impact of a negative result giving people false reassurance of health in some cases. RS emphasised the need for a balance between the benefits of screening with the potential harms cause to people with and without disease.

He then highlighted the need for caution in interpreting screening data due to the existence of potential bias. Firstly, through lead-time bias, where disease is detected earlier through screening and even if treatment isn't successful, it gives the false impression that screening has extended cancer survival. Secondly, through length bias, where symptoms can present between screening and are therefore missed. Thirdly, volunteer bias where screening tests and results are influenced by the population which choose to participate who are often more likely to be more health conscious.

He then noted that bowel screening was first introduced in 2007 with the gFOBT test and discussed bowel screening age differences in the UK, mentioning that Scotland screens between 50-74 compared with the rest of the UK which screens between age 60-74. RS noted the impact of the test in improving the early detection of bowel cancer. Increasing the cancers diagnosed at the earliest

stage from 8% to 48% and reducing the proportion detected at the latest stage from 25% to just 1%. He also highlighted the ability of bowel screening to prevent cancer by detecting adenoma's which often develop into tumours and can be removed before cancer occurs.

RS then discussed the impact of bowel screening on the incidence rate of bowel cancer. After its introduction, there was a quick peak (likely due to early detection) directly after the roll out of screening but since these has been a relatively steady decrease in the incidence rate. By comparison, the <50 cohort has seen an increased incidence rate in this time and while this is still at a low incidence, RS highlighted the potential links to lifestyle changes.

The new FIT test was then compared to the gFOBT test. RS stated that the gFOBT test was not specific for human haemoglobin, meaning that false positives could happen through diet, and that the test needed three samples. He compared this to the new FIT test which is specific to human haemoglobin, only requires one sample and is quantitative. He noted that in the development of the FIT test the quantitative nature of the test means that the sensitivity, how many cancers are detected, and specificity, how many false positives are found, of the test needed to be balanced. Following pilots, RS stated the FIT sensitivity was set at 80µgHb/g; to be comparable the sensitivity of the previous gFOBT test.

He then discussed FITs impact on uptake. FIT has increased the uptake of bowel screening in men and women across all levels of deprivation. Greater uptake is also more evident from people from more deprived areas and in men who have been typically less likely to participate in screening. He noted FIT at the 80µgHb/g has been more sensitive than previously thought, with a 3.2% sensitivity rate, rather than the expected 2%. However, he stated that at the 2% sensitivity, 20% of the bowel cancers detected by FIT would have been missed, as well as almost 40% of adenomas. RS emphasised that this increased sensitivity has benefitted both the detection of cancer as well as the prevention of cancer through the detection of adenomas.

RS concluded by discussing the challenges faced by the endoscopy workforce. The increase detection of adenomas and tumours has led to a 100% increase in colonoscopies, however, that the introduction of FIT hasn't led to an increase in people waiting for colonoscopy significantly above the increase that was happening before its introduction. RS also referenced that ongoing research into the uses of the quantitative nature of FIT, looking at whether differential sensitivities can be used based on age and gender, and whether screening intervals can be adjusted based on previous results. He also highlighted the potential use of FIT as a rule out test for people with bowel cancer symptoms.

The chair then asked about the impact of symptomatic FIT use on the colonoscopy workforce and how we can deal with the increased waiting lists for colonoscopy. RS stated that it is important to separate screening and non-screening FIT and that symptomatic FIT would free up colonoscopy resource by ruling out some with symptoms. He also stated that an increased colonoscopy workforce would help the waiting times and he hopes that the endoscopy action plan goes some way to address this.

Peter Hastie (Macmillan) asked whether there is any information about the impact of the FIT test on participation rates people doing the test continually. RS stated that the vast majority do screening all the time, some don't ever participate and then a small portion dip in and out. RS noted that 8-9% of people who never took part in screening previously are now participating following the introduction of FIT.

4) A.O.B

AS provided an update on the Cancer Strategy Inquiry report and stated that that Cabinet Secretary for health and Sport, Jeane Freeman, has responded to the report in writing and will, following invitation from the co-convenors, attend the next CPG in June to address the report and answer members' questions.

Chris Walden from Bloodwise noted the rejection of CAR-T for adults with blood cancer in Scotland by the SMC, but had been approved by NICE and asked whether the CPG would consider a future meeting on this issue. AS said the Montgomery Review was a topic on which they wanted to hold a future meeting.

5) AS closed the meeting. Next meeting 17.30-19.00, Wed 12th June 2019.

Group Members

Member
Anas Sarwar MSP
Dr Peter Hutchison
Prof Bob Steele
Cancer Research UK
Brain Tumour Research
SHAAP
Bloodwise
Macmillan Cancer Support
Roy Castle Lung Cancer Foundation
Ochre: Oesophageal Cancer Charity
Pancreatic Cancer UK
Friends of the Meadows & B.L
Finlay Carson MSP
Beatson Cancer Charity
MASSCOT
Scottish Cancer Foundation
Abbvie
Bowel Cancer UK
Breast Cancer Now
Cancer Support Scotland
Pancreatic Cancer Scotland
Breast Cancer Care
Circle of Comfort
Heather Goodare
Scottish Cancer Foundation