RM Partners
West London Cancer Alliance

Hosted by The Royal Marsden NHS Foundation Trust

Urology Suspected Cancer Pathways: Primary Care Education

February 2023
Version 7

Working in partnership, ***we will achieve world class cancer outcomes*** *for the population we serve*

Urology Cancer: Facts

- 25% of all surgical referrals to hospital are for urological conditions, and urology makes up one tenth 10% of GP consultations (https://www.baus.org.uk/patients/information/default.aspx)
- Around 52,300 men are diagnosed with prostate cancer in the UK each year - it is the most common cancer in men in the UK.
- Around 10,300 people are diagnosed with bladder cancer in the UK every year - it' is the 11th most common cancer in the UK
- Around 13,300 kidney cancers are diagnosed in the UK each year – it is the 7th most common cancer in the UK
- Cancer of the penis is very rare - around 700 men are diagnosed each year in the UK
- Although testicular cancer is rare, it is the most common cancer in men aged between 15 and 49 – In the UK, 2,400 men are diagnosed with testicular cancer each year.

Reference: About Cancer | Cancer Research UK

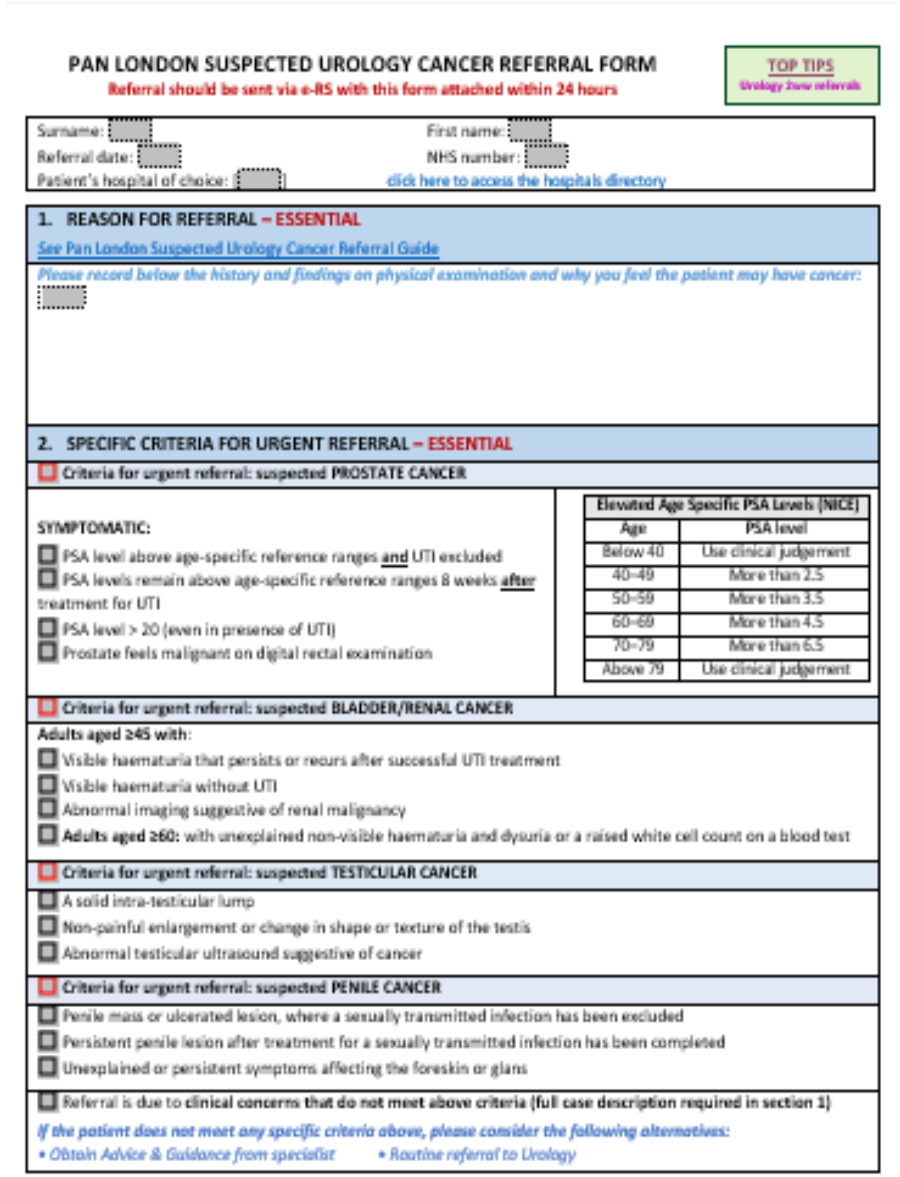
Faster Diagnosis Standard (FDS)

What is it?	What will it do?	Who it applies to?	Which Pathways?
Diagnosis or exclusion of cancer within 28 days from the date of referral request received.	• Improve clinical outcomes by expediting diagnosis of cancer • Reduce patient and carer anxiety by ruling out cancer quickly	All Trusts measured against 75% FDS standard	• GP Suspect cancer (2ww) • GP Breast symptoms • Cancer Screening Programme

How GPs can Support the Achievement of FDS:

- ✓ Appropriate **direct access tests** done
- ✓ Patient **informed** they are on an **urgent pathway**, of **possible cancer** diagnosis and **MUST** attend. This could be at any of the Trust sites.
- ✓ Check with patient they are **able to attend** one or more appointments within 28 days from referral (holidays)
- ✓ Ensure **patient details are correct** on GP system (details will also be used in referral)
- ✓ Give sufficient clinical details e.g. **reason for referral**, **medical history** and **patient ability** to undertake telephone assessment for straight to test pathways including spoken language and patient mobility.
- ✓ Make **referrals via eRs**, and ensure referrals are attached in a **timely manner** to enable secondary care triage within 24 hours of request received.

Urology Suspected Cancer Referral Form



PAN LONDON SUSPECTED UROLOGY CANCER REFERRAL FORM

Referral should be sent via e-RS with this form attached within 24 hours

TOP TIPS
Urology 2ww referrals

Surname: First name:
Referral date: NHS number:
Patient's hospital of choice: click here to access the hospitals directory

1. REASON FOR REFERRAL – ESSENTIAL

See Pan London Suspected Urology Cancer Referral Guide

Please record below the history and findings on physical examination and why you feel the patient may have cancer:

2. SPECIFIC CRITERIA FOR URGENT REFERRAL – ESSENTIAL

☐ **Criteria for urgent referral: suspected PROSTATE CANCER**

SYMPTOMATIC:
- ☐ PSA level above age-specific reference ranges **and** UTI excluded
- ☐ PSA levels remain above age-specific reference ranges 8 weeks **after** treatment for UTI
- ☐ PSA level > 20 (even in presence of UTI)
- ☐ Prostate feels malignant on digital rectal examination

Elevated Age Specific PSA Levels (NICE)	
Age	PSA level
Below 40	Use clinical judgement
40–49	More than 2.5
50–59	More than 3.5
60–69	More than 4.5
70–79	More than 6.5
Above 79	Use clinical judgement

☐ **Criteria for urgent referral: suspected BLADDER/RENAL CANCER**

Adults aged ≥45 with:
- ☐ Visible haematuria that persists or recurs after successful UTI treatment
- ☐ Visible haematuria without UTI
- ☐ Abnormal imaging suggestive of renal malignancy
- ☐ **Adults aged ≥60:** with unexplained non-visible haematuria and dysuria or a raised white cell count on a blood test

☐ **Criteria for urgent referral: suspected TESTICULAR CANCER**
- ☐ A solid intra-testicular lump
- ☐ Non-painful enlargement or change in shape or texture of the testis
- ☐ Abnormal testicular ultrasound suggestive of cancer

☐ **Criteria for urgent referral: suspected PENILE CANCER**
- ☐ Penile mass or ulcerated lesion, where a sexually transmitted infection has been excluded
- ☐ Persistent penile lesion after treatment for a sexually transmitted infection has been completed
- ☐ Unexplained or persistent symptoms affecting the foreskin or glans

☐ Referral is due to **clinical concerns that do not meet above criteria (full case description required in section 1)**

If the patient does not meet any specific criteria above, please consider the following alternatives:
- *Obtain Advice & Guidance from specialist*
- *Routine referral to Urology*

3. INVESTIGATIONS AND ACTIONS TO BE COMPLETED PRIOR TO REFERRAL – ESSENTIAL

GPs should arrange direct access investigations/ tests before referral, unless unavailable. Please confirm:

PROSTATE CANCER:	☐ Digital Rectal Examination	☐ PSA, U&Es/eGFR within previous 3 months
	☐ Urine dipstick + MSU within previous 3 months	
BLADDER CANCER:	☐ FBC/U&Es/eGFR within previous 3 months	☐ Ultrasound for non-visible haematuria
RENAL CANCER:	☐ Ultrasound	☐ FBC/U&Es blood tests within previous 3 months
TESTICULAR:	☐ Ultrasound	

4. INFORMATION FOR HOSPITAL ASSESSMENT – ESSENTIAL

WHO Performance status
- ☐ 0 Fully active
- ☐ 1 Restricted physically but ambulatory and able to carry out light work
- ☐ 2 Ambulatory more than 50% of waking hours; able to carry out self-care
- ☐ 3 Limited self-care; confined to bed or chair more than 50% of waking hours
- ☐ 4 Completely disabled; cannot carry out any self-care. The patient is totally confined to bed or chair

Is the patient contraindicated for MRI (e.g. implanted device, claustrophobic)? Yes ☐ No ☐

Other access needs - *please detail per the selected options in the field below*

Is patient suitable for a telephone assessment consultation? Yes ☐ No ☐

- ☐ Interpreter required If Yes, Language:
- ☐ Transport required
- ☐ Wheelchair access required
- ☐ Cognitive impairment including dementia
- ☐ Learning disability (see London LD contacts)
- ☐ Mental health issues that may impact on engagement
- ☐ SMI

Details of access needs and reasonable adjustments:

5. ADDITIONAL IMPORTANT CLINICAL INFORMATION

Past history of cancer:
Relevant family history of cancer:
Safeguarding concerns:
Other relevant information about patient's circumstances:
Patient referred/previously investigated for similar symptoms at other hospital/service?
☐ No ☐ Yes, please give details:

- ☐ I have discussed the **possible diagnosis of cancer** with the patient (Patient Information Resources)
- ☐ I have advised the patient to **prioritise this appointment & confirmed they'll be available within the next 14 days.**
- ☐ The patient has been advised that the hospital care **may contact them by telephone**
- ☐ Patient added to the practice **safety-netting system** and practice will review by DDMMYY *(manual entry)*

6. REFERRER DETAILS

Usual GP name:	Referring clinician:
Practice code:	Practice address:
Practice name:	Email:
Main Tel:	Practice bypass number: *(manual entry)*

7. PATIENT DETAILS

Surname:	First name:
NHS number:	Title:

Relevant tests: PSA, U&Es/eGFR blood tests **within previous 3 months**

Ensures patient is aware of possible diagnosis of cancer and that that they should prioritise appointments and be available within the **next 14 days.**

V6 02/02 /2023

Urology Cancer: General Top Tips for Primary Care

GPs must ensure patient is **aware of possible diagnosis of cancer** and that that they should prioritise **appointments within the next 14 days**.

Refer using the Pan London Suspected Cancer Referral form, and attach the referral via eRs in a timely manner (within 4 hours of request being made, but no later than 24) to enable efficient secondary care triage: [Pan-London suspected cancer referral forms - Healthy London Partnership Partnership]

Include **family history** and **frailty information** on the referral, as this helps direct patients to the most appropriate assessment. Smoking status, and referring patients onto smoking cessation service is beneficial, given that smoking is a key risk factor for urological cancers.

Undertake necessary investigations prior to referral:

- *Prostate*:- Blood tests (PSA, U&Es/eGFR within 3 months), DRE examination where appropriate and urine dipstick (+ MSU result if dipstick +ve) within 3 months
- *Bladder:*- Blood tests (FBC, U&Es/eGFR within 3 months) and ultrasound scan for non-visible haematuria
- *Renal/Kidney*:- Blood tests (FBC, U&Es/eGFR within 3 months) and ultrasound scan
- *Testicular:*- Blood tests (FBC, U&E's, Beta HCG, AFP, LDH) and ultrasound scan

Prostate Cancer

Prostate Cancer: Risks & Symptoms

- Ensure all clinicians are aware of the increased risk factors of Prostate Cancer, which are:
  - **Age** - mainly affects men aged 50 or over (risk increases with age)
  - **Ethnicity** – Black men (particularly those aged 45 or over)
  - **Family history** – two and a half times more likely to get prostate cancer if father or brother has had it. Patients are at higher risk of developing prostate cancer if their father/brother received diagnosis before the age of 60 and/or if their mother has had breast cancer.

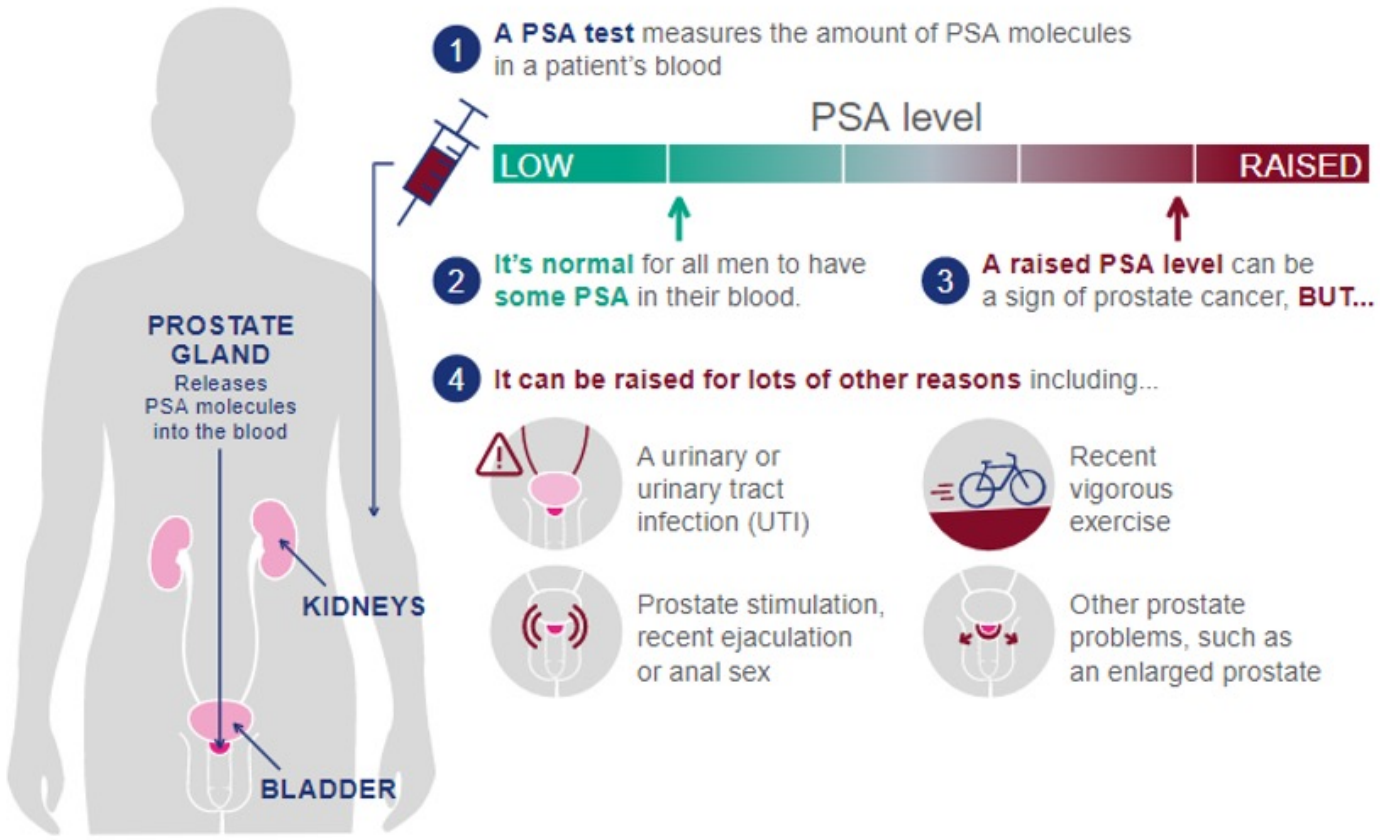
See links to 'check your risk' and 'Embarrassed' video on the Prostate Cancer: Resources page.

- Consider a prostate-specific antigen (PSA) test and digital rectal examination to assess for prostate cancer in people with:
  - ➢any lower urinary tract symptoms, such as nocturia, urinary frequency, hesitancy, urgency or retention ***or***
  - ➢erectile dysfunction ***or***
  - ➢visible haematuria.

- A 2ww suspected cancer referral should be made if:
  - ➢if prostate feels malignant on digital rectal examination
  - ➢if their PSA levels are above the indicated threshold for their age

Elevated Age Specific PSA Levels (NICE)	
Age	**PSA level**
Below 40	Use clinical judgement
40–49	More than 2.5
50–59	More than 3.5
60–69	More than 4.5
70–79	More than 6.5
Above 79	Use clinical judgement

Prostate Cancer: PSA Testing



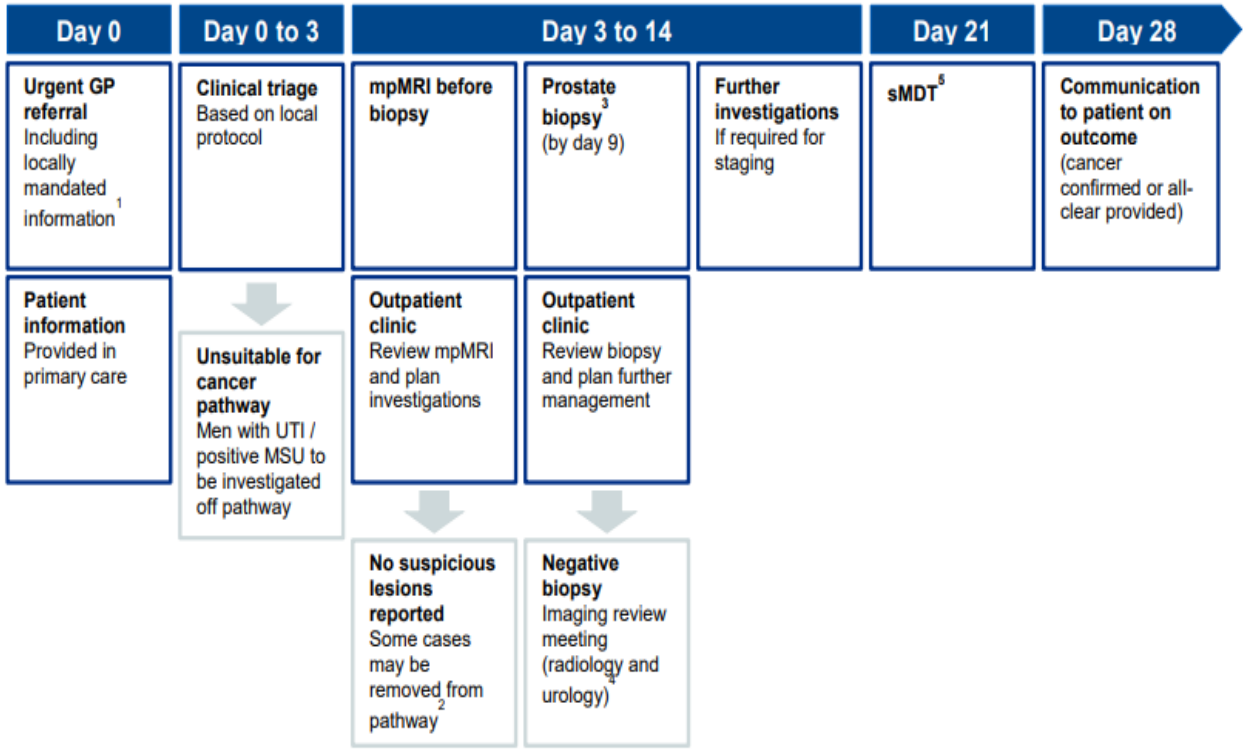
In the absence of symptoms, GPs should discuss the pros and cons of PSA tests with the patient. If a subsequent PSA test result shows raised PSA levels, the GP should use their clinical judgement to consider whether a referral is appropriate.

Reference: PSA testing and Prostate Cancer NHS leaflet

- PSA levels can be raised in a number of conditions, such as a urinary infection, an enlarged prostate, prostatitis or prostate cancer
- Most men have a PSA level less than 3ng/ml.
- Before a PSA test, men should not have:
  - an active urinary infection or within previous 6 weeks
  - ejaculated in previous 48 hours
  - exercised vigorously, for example cycling in the previous 48 hours
  - had a urological intervention such as prostate biopsy in previous 6 weeks
- When taking blood for PSA testing:
  - ensure the specimen will reach laboratory in time for the serum to be separated within 16 hours
  - send samples to an ISO accredited laboratory
  - repeat the test if not taken in ideal circumstances

Rapid Access to Prostate Imaging and Diagnosis (RAPID) Pathway

- **'Straight to Test' model,** ensuring patients are in the 'right place, first time' for faster diagnostics
- **Investigations that must be undertaken prior to referral**
  - Blood tests (PSA, U&Es/eGFR within 3 months)
  - DRE examination where appropriate
  - Urine dipstick (+ MSU result if dipstick +ve) within 3 months
- Referral requests are made via eRs (**referral must be attached** to the request for triage within 4 hours – this is key for triage)
- Referring clinicians MUST ensure patient is **aware of possible diagnosis of cancer** and that that they should prioritise **appointments within the next 28 days**.
- Triage generally happens within **24-72 hours** (excluded: UTI, AUR, claustrophobic, metalwork)
- IPSS: FR + RV
- All patients are booked to an initial telephone consultation – ***important to indicate on the referral if the patient is unsuitable for telephone assessment.(e.g. hard of hearing)***
- Patients will generally have an MRI scan, then +/- prostate biopsy, before a diagnosis is made (either cancer or ruling out of cancer). Biopsies are all trans perineal (anticoagulants stopped).



Reference: Suspected cancer: recognition and referral (nice.org.uk)

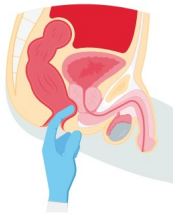
Prostate Cancer: Top Tips for Primary Care

Age-specific prostate-specific antigen (PSA) – if PSA level is above the specific age range refer on a suspected cancer pathway. Clinical judgement should be used to manage asymptomatic men and those aged under 50 years who are considered to have a higher risk

Ethnicity – incidence of prostate cancer is higher in black men.

Family history– important to ask about family history (particularly prostate or breast cancer) when assessing prostatic symptoms or considering a PSA test.

Exclude UTIs – UTIs Urinary tract infections can falsely elevate a patient's PSA levels. If a PSA level is marginally elevated then repeat test in 6-8 weeks after treatment of UTI, before referring.



Digital Rectal Examination (DRE) – if prostate feels abnormal on examination, refer on a suspected cancer pathway, regardless of PSA result.

Red flag symptoms - Symptoms of metastatic disease include sudden onset urinary incontinence, faecal incontinence and loss of power in the lower limbs, which could indicated metastatic spinal cord compression. *These patients require emergency admission to hospital (via A&E).*

Prostate Cancer: Resources

www.embarrassedfilm.org | A SIR STEVE MCQUEEN FILM Raising awareness of prostate cancer within the black community

Check your risk in 30 seconds | Prostate Cancer UK

PSA testing and Prostate Cancer NHS leaflet

Resources for health professionals available from Prostate Cancer UK

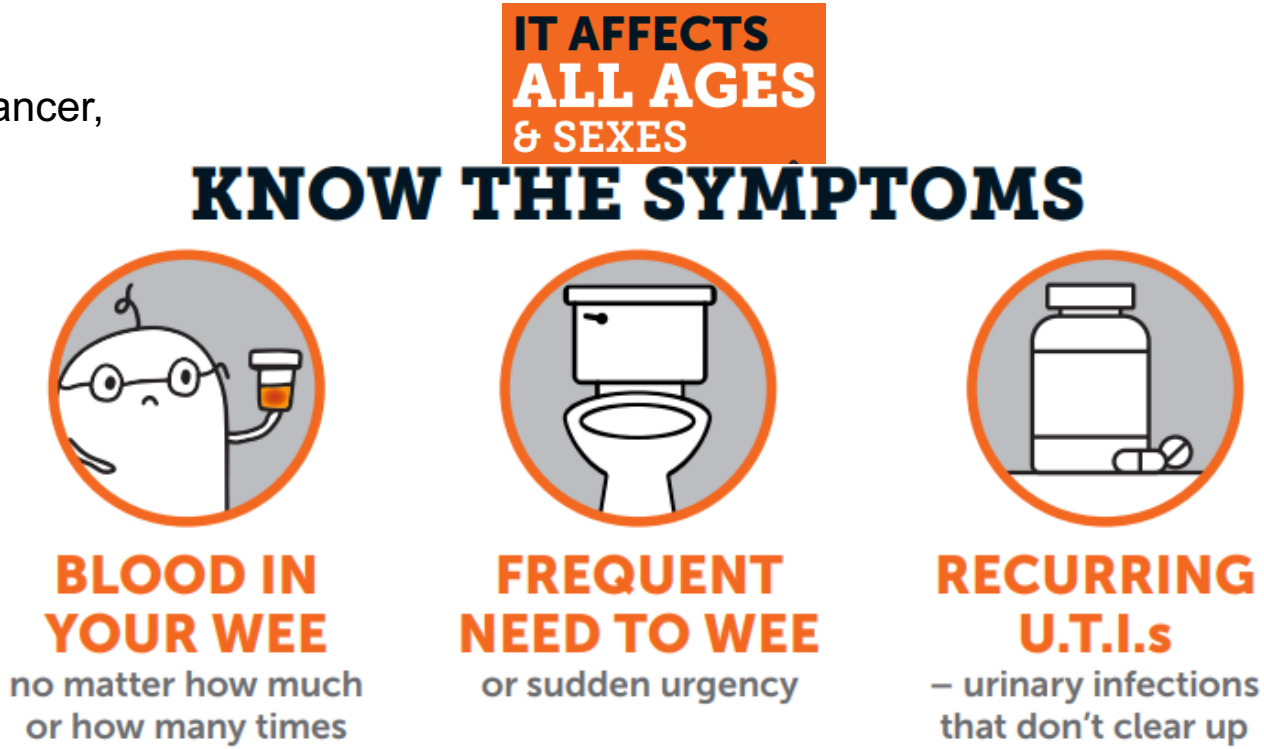
Macmillan Ten Top Tips for Prostate Cancer

English-Patient-information-for-urgent-referrals.pdf (healthylondon.org)

Bladder Cancer

Bladder Cancer: Risks & Symptoms

- Ensure all clinicians are aware of the risk factors of Bladder Cancer, which are:
  - Smoking
  - Infections and long lasting bladder irritation
  - Chemicals at work e.g. Arylamines, Polycyclic aromatic hydrocarbons
  - Having bladder cancer before
  - Family history
  - Other medical conditions e.g. Systemic sclerosis, Kidney transplant



- Main symptom of bladder cancer is **blood in your urine -** this can either be visible or found on checking urine with a dip test
- *Other symptoms could include:*
  - **passing urine very often** (frequency)
  - **passing urine very suddenly** (urgency)
  - **pain or a burning sensation when passing urine**

These symptoms can also be caused by a UTI, ***so UTI needs to be ruled out first.***

Reference: Downloads | Fight Bladder Cancer

Bladder Cancer: Risks & Symptoms

- Refer using a suspected cancer pathway referral for bladder cancer if:
    - Adults aged ≥45 with UNEXPLAINED visible haematuria without urinary tract infection
    - Adults aged ≥45 with visible haematuria that persists or recurs after successful treatment of urinary tract infection
    - Adults aged ≥60 with UNEXPLAINED non-visible haematuria and either dysuria or a raised white cell count
- Non-visible haematuria under age 40 is more likely to indicate glomerular disease than malignancy - In the absence of symptoms, follow NICE CKD guidelines: https://www.nice.org.uk/guidance/ng203/chapter/Recommendations
- GPs should consider *non-urgent* referral for bladder cancer in people aged ≥60 with recurrent or persistent UNEXPLAINED urinary tract infection.

- 'Non-visible' haematuria is determined by dipstick urinalysis of a fresh urine sample:
    - ➢ Dipstick testing rather than urine microscopy is recommended and trace haematuria is not significant – regard and record this as negative; the test should be repeated twice.
    - ➢ Intercourse, exercise and menses can all give spurious positive results

Reference: Downloads | Fight Bladder Cancer

Bladder Cancer: Research

IDENTIFY study

- Collected data on the incidence of urological tract cancer in 824 patients (491 men and 333 women) referred with haematuria in 2016, from 7 hospitals in the South of England.

- Results:
  - 301 (36.5%) patients had non-visible haematuria (NVH); 523 (63.5%) had visible haematuria (VH).
  - All cystoscopy and ultrasound as first line investigations, and a mixture of CT, intravenous urogram and ureterorenoscopy as second line.
  - Overall **prevalence of urological malignancy was 12.2%** (10.4% bladder, 0.6% ureteric/renal TCC, 1.2% renal); which was 16.4% of the VH group and 5.0% of the NVH group.
  - **85% of malignancies presented with VH**.
  - Differences in prevalence existed in sex and age groups - Bladder cancer was found in 5 patients >45 years, 4 of whom presented with VH. A higher percentage of patients with malignancy had a smoking history vs. non-smokers.
  - 95.5% of all malignancies were diagnosed following an abnormal flexible cystoscopy and/or USS alone. 1 renal malignancy and 4 upper tract TCCs that were diagnosed with second line investigations, had a normal USS.

- Conclusion: majority of malignancies were diagnosed following abnormal first line investigations (USS for upper tract imaging). Patients with **malignancy** were more likely to have a **smoking history** and present with **visible haematuria**.

Reference: The IDENTIFY study: the investigation and detection of urological neoplasia in patients referred with suspected urinary tract cancer - a multicentre observational study - PubMed (nih.gov)

Bladder Cancer: Best Practice Timed Diagnostic Pathways

- **'Straight to Test' model,** ensuring patients are in the 'right place, first time' for faster diagnostics
- **Investigations that must be undertaken prior to referral**
  - Blood tests (FBC, U&Es/eGFR within 3 months)
  - Ultrasound for non-visible haematuria
  - Referral to smoking cessation advised
- Referral requests are made via eRs (**referral must be attached** to the request for triage within 4 hours – this is key for triage)
- Referring clinicians MUST ensure patient is **aware of possible diagnosis of cancer** and that that they should prioritise **appointments within the next 28 days**.
- Triage generally happens within **24-72 hours**
- Patients may have an initial telephone consultation – ***important to indicate on the referral if the patient is unsuitable for telephone assessment (e.g. hard of hearing).***
- Patients will have the most appropriate diagnostic test depending on triage outcome.
  - For non-visible haematuria, patients will generally have an ultrasound scan, then +/- flexible cystoscopy
  - For visible haematuria patients will generally have an CT scan, then +/- flexible cystoscopy
- Patients with a suspicion of cancer at diagnostic test, will go on to have a Trans urethral removal of bladder tumour (TURBT)

Reference: Suspected cancer: recognition and referral (nice.org.uk)

Bladder Cancer: Top Tips for Primary Care

Visible Haematuria always needs to be explained – it may indicate malignancy anywhere in the renal tract or possibly female genital system, but especially the bladder. Refer on a suspected cancer pathway,, along with blood tests (FBC, U&Es/eGFR within 3 months).

Patients with haematuria who do not meet NICE criteria for suspected cancer referral – patients with haematuria who do not meet the NICE criteria for an urgent suspected cancer referral, such as aged ≥60 years with unexplained non-visible haematuria and either dysuria or a raised white cell count OR ≥45 years for visible haematuria, should still be investigated thoroughly - *this does not need to be via an urgent suspected cancer referral.*

Persistent asymptomatic non-visible haematuria (diagnosed when 2 out of 3 dipstick tests are positive over 6-8 weeks) requires a *routine urological* investigation in the over 40s. Trace haematuria should be regarded and recorded as negative.

Non-visible haematuria under age 40 - more likely to indicate glomerular disease than malignancy. In the absence of symptoms, follow NICE CKD guidelines (https://www.nice.org.uk/guidance/ng203/chapter/Recommendations). Cola coloured urine, younger patient and red cell casts all suggest a renal cause and indicate the need for a referral to nephrology

Smoking Cessation – discuss smoking as a key risk factor, advise patient to stop smoking, and refer onto smoking cessation services

Family history/previous bladder cancer– important to ask about family history (particularly bladder cancer), and if patient has had a previous

NICE suspected cancer guidelines – suggests considerations of prostate cancer in men with visible haematuria (perform DRE and request PSA level) and endometrial cancer in women over 55 with visible haematuria with vaginal discharge or low Hb, thrombocytosis or high blood sugar (request USS of pelvis).

Bladder Cancer: Resources

Support for you | Fight Bladder Cancer

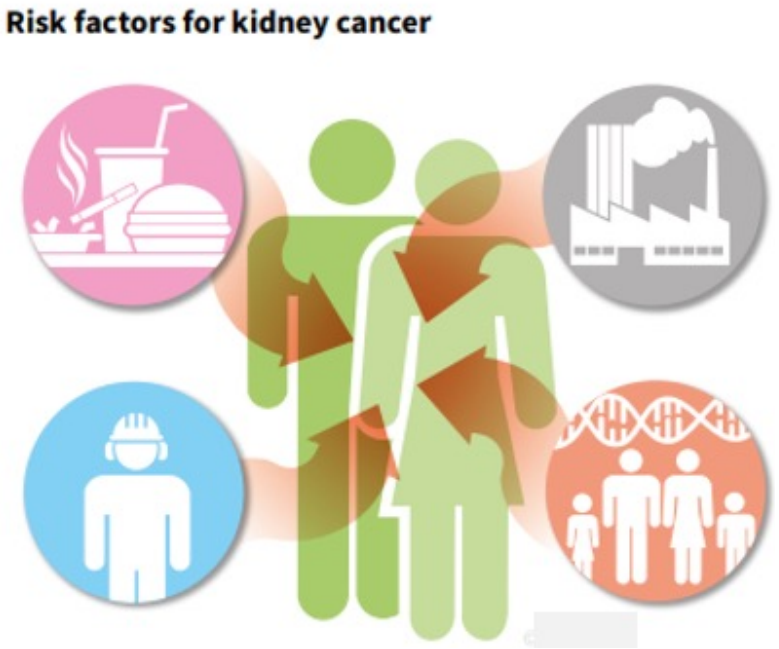
ten-tips-haematuria-tcm9-300202 (macmillan.org.uk)

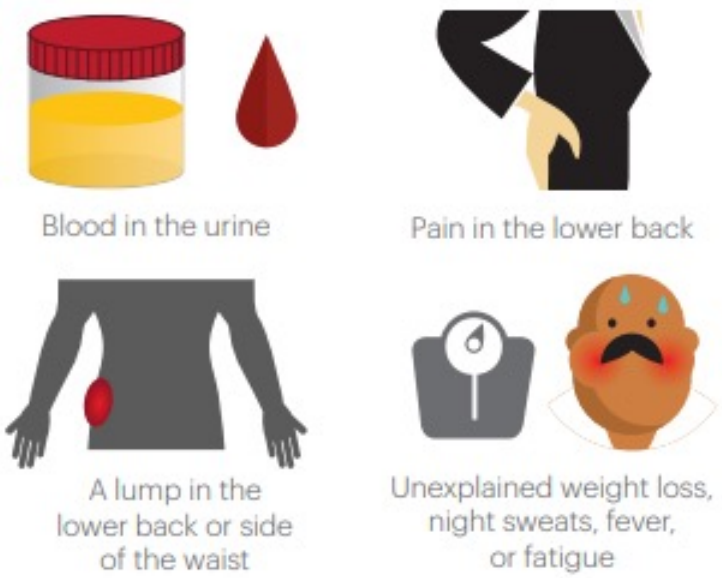
English-Patient-information-for-urgent-referrals.pdf (healthylondon.org)

Renal/Kidney Cancer

Renal Cancer: Risks & Symptoms

- Ensure all clinicians are aware of the risk factors of Renal/Kidney Cancer, which are**:**
    - **Age & Gender** - most common in >60 years old, and more common in men
    - **Life style factors** – e.g. high BMI, smoking
    - **Certain medical conditions and treatments** – e.g. high blood pressure, kidney disease, thyroid cancer and diabetes (type 1)
    - **Inherited conditions** – e.g. family history of renal cancer and faulty genes inherited conditions

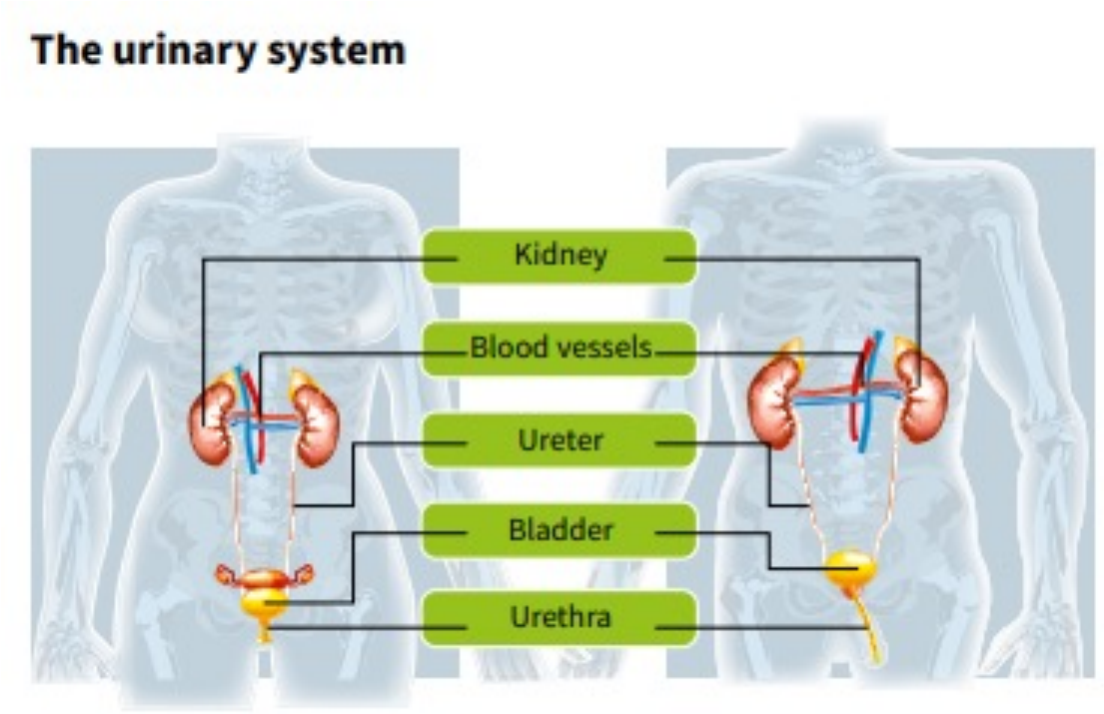




- Most people who are diagnosed with kidney cancer do not have any symptoms and the cancer is found ‘incidentally’. When symptoms occur, these could include:
    - **blood in the urine** – most common symptom
    - a **lump or mass in the kidney** area
    - a **pain in your back on one side** (below the ribs) that won't go away
    - **Unexplained weight loss, fever**, very **heavy sweating** and **tiredness**

Reference: Kidney-Cancer-Basics-AKC.pdf (actionkidneycancer.org)

Renal Cancer: Risks & Symptoms



- Refer using a suspected cancer pathway referral for bladder cancer if:
  - Adults aged ≥45 with UNEXPLAINED visible haematuria without urinary tract infection
  - Adults aged ≥45 with visible haematuria that persists or recurs after successful treatment of urinary tract infection
  - Abnormal ultrasound suggestive of renal cancer

Reference: Kidney-Cancer-Basics-AKC.pdf (actionkidneycancer.org)

Renal/Kidney Cancer: Best Practice Timed Diagnostic Pathways

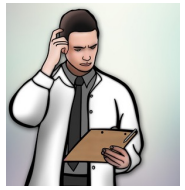
- **'Straight to Test' model,** ensuring patients are in the 'right place, first time' for faster diagnostics
- **Investigations that must be undertaken prior to referral**
  - Blood tests (FBC, U&Es/eGFR within 3 months)
  - Ultrasound
- Referral requests are made via eRs (**referral must be attached** to the request for triage within 4 hours – this is key for triage)
- Referring clinicians MUST ensure patient is **aware of possible diagnosis of cancer** and that that they should prioritise **appointments within the next 28 days**.
- Triage generally happens within **24-72 hours**
- Some patients are booked to an initial telephone consultation – ***important to indicate on the referral if the patient is unsuitable for telephone assessment.(e.g. hard of hearing)***
- Patients will have the most appropriate diagnostic test depending on triage outcome.
  - For non-visible haematuria, patients will generally have an ultrasound scan, then +/- flexible cystoscopy
  - For visible haematuria patients will generally have an CT scan, then +/- flexible cystoscopy
  - For renal mass, patients will generally have CT Scan
- Patients with a suspicion of cancer at diagnostic test, will go on to have a CT/Ultrasound guided renal biopsy.

Reference: Suspected cancer: recognition and referral (nice.org.uk)

Renal Cancer: Top Tips for Primary Care

Visible Haematuria always needs to be explained – it may indicate malignancy anywhere in the renal tract or possibly female genital system, but especially the bladder. Refer on a suspected cancer pathway, along with blood tests (FBC, U&Es/eGFR within 3 months)

Non-visible haematuria under age 40 - more likely to indicate glomerular disease than malignancy. In the absence of symptoms, follow NICE CKD guidelines (https://www.nice.org.uk/guidance/ng203/chapter/Recommendations). Cola coloured urine, younger patient and red cell casts all suggest a renal cause and indicate the need for a referral to nephrology



Most renal cancers are found incidentally, usually on an unrelated scan (for e.g. when investigating gallstones). Refer on a suspected cancer pathway, along with blood tests (FBC, U&Es/eGFR within 3 months)

Renal Cancer: Resources

Kidney-Cancer-Basics-AKC.pdf (actionkidneycancer.org)

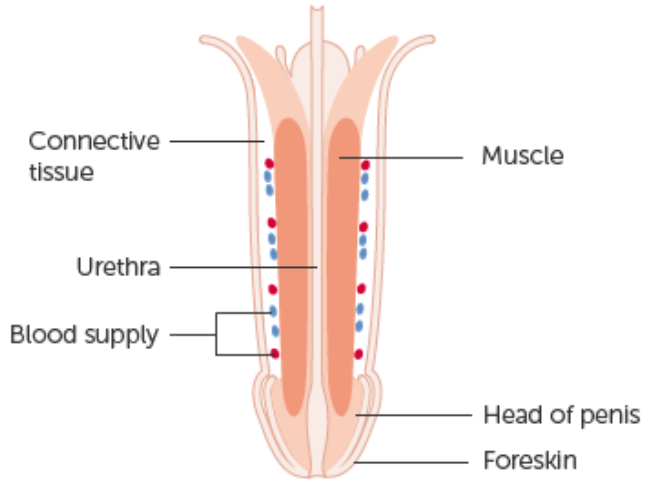
Clinician Tools | National Kidney Foundation

English-Patient-information-for-urgent-referrals.pdf (healthylondon.org)

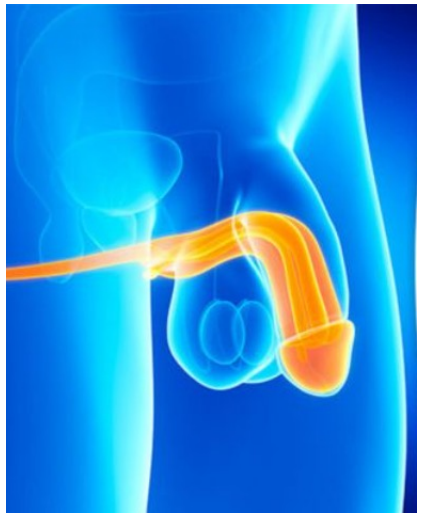
Penile Cancer

Penile Cancer: Risks & Symptoms

- The most common symptom of penile cancer is a **growth,** an **ulcer** or a **rash** on the penis. Symptoms of penile cancer include:
    - **a growth or sore on the penis** that doesn't heal within 4 weeks
    - **bleeding from the penis,** including from under the foreskin
    - **foul smelling discharge** - this is a less common cause of penile cancer
    - **a rash on the penis**
    - **difficulty in drawing back your foreskin** (phimosis)
    - **changes to the colour of the penis or foreskin.**



- Ensure all clinicians are aware of the risk factors of Penile Cancer, which are**:**
    - **Human papilloma virus** (HPV)
    - Age – more common in **men aged 50 or over**
    - Having a **weakened immune system**
    - **Uncircumcised** men
    - **Psoriasis** treatment
    - **Smoking**



Refer on a suspected penile cancer pathway if:

- Patient has a **penile mass** or **ulcerated lesion,** when a **STI has been excluded** as a cause
- Patient has a **persistent penile lesion after treatment for a STI** has been completed.
- Patient has **unexplained** or **persistent symptoms** affecting the **foreskin or glans**

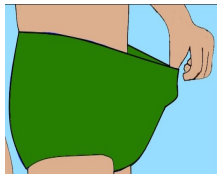
Penile Cancer: Best Practice Timed Diagnostic Pathways

- **'Straight to Test' model,** ensuring patients are in the 'right place, first time' for faster diagnostics
- Referral requests are made via eRs (**referral must be attached** to the request for triage within 4 hours – this is key for triage)
- Referring clinicians MUST ensure patient is **aware of possible diagnosis of cancer** and that that they should prioritise **appointments within the next 28 days**.
- Triage generally happens within **24-72 hours**
- Patients are initially seen in an outpatient consultation, and will go onto have a penile biopsy.

The supraregional treatment centre for penile cancer within West London is St George's University Hospitals NHS Foundation Trust

Reference: Suspected cancer: recognition and referral (nice.org.uk)

Penile Cancer: Top Tips for Primary Care



A new rash on the penis that does not resolve in 4 weeks should be urgently investigated for penile cancer. Refer on a suspected cancer pathway.

A growth on the penis, should be urgently investigated for penile cancer. Refer on a suspected cancer pathway.

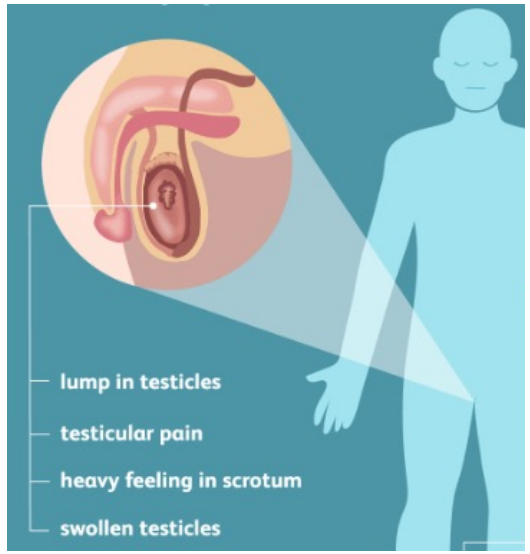
Penile Cancer: Resources

- English-Patient-information-for-urgent-referrals.pdf (healthylondon.org)
- Orchid | Fighting Male Cancer (orchid-cancer.org.uk)

Testicular Cancer

Testicular Cancer: Risks & Symptoms

- The most common symptom of testicular cancer is a **lump** or **swelling** in the testicle. Symptoms of testicular cancer include:
  - a **lump** or **swelling** in part of **one testicle**
  - a **testicle** that **gets bigger**
  - a **heavy scrotum**
  - **discomfort** or **pain** in your **testicle** or **scrotum**



- Ensure all clinicians are aware of the risk factors of testicular cancer, which are:
  - **Undescended testicles** (cryptorchidism)
  - **Abnormal cells** in the testicle (germ cell neoplasia in situ)
  - **Family history** - brothers or sons of men who have had testicular cancer have an increased risk
  - **Previous testicular cancer**
  - **Abnormality of the penis** and **urethra** (hypospadias)
  - **HIV/Aids**
  - **Ethnicity** – Caucasian men in the UK have a higher risk than men from other ethnic groups

- Refer on a suspected testicular cancer pathway if:
  - Patient has a **solid intra-testicular lump**
  - if patients has a **non-painful enlargement** or **change in shape or texture** of the testis
  - **abnormal testicular ultrasound** suggestive of cancer

Testicular Cancer: Best Practice Timed Diagnostic Pathways

- **'Straight to Test' model,** ensuring patients are in the 'right place, first time' for faster diagnostics
- **Investigations that must be undertaken prior to referral**
  - Blood tests for FBC, U&E's, Beta HCG, AFP, LDH
  - Testicular Ultrasound Scan
- Referral requests are made via eRs (**referral must be attached** to the request for triage within 4 hours – this is key for triage)
- Referring clinicians MUST ensure patient is **aware of possible diagnosis of cancer** and that that they should prioritise **appointments within the next 21 days**.
- Triage generally happens within **24-72 hours**
- Patients are initially seen in a one-stop outpatient consultation, usually undergoing an ultrasound scan on the same day.

RARE CANCER = FASTER PATHWAY
(21 days NOT 28 days)

The supraregional treatment centre for testicular cancer within West London is St George's University Hospitals NHS Foundation Trust

Reference: Suspected cancer: recognition and referral (nice.org.uk)

Testicular Cancer: Top Tips for Primary Care

Any lump within the testicle, in the absence of obvious epididymo-orchitis, should be urgently investigated. Refer on a suspected cancer pathway, along with blood tests (FBC, U&E's, Beta HCG, AFP, LDH) along with a concurrent USS

Consider a direct access ultrasound scan in men with unexplained or persistent testicular pain, where no lump is present.

Testicular Cancer: Resources

- English-Patient-information-for-urgent-referrals.pdf (healthylondon.org)
- Orchid | Fighting Male Cancer (orchid-cancer.org.uk)