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## Guidance to Investigating Non-Specific Abdominal Pain (FIT <10ug/g) in the Rapid Diagnostic Centre

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The assessment and diagnosis of patients with abdominal pain is often challenging, and factors that contribute to this include a broad differential diagnosis and occasionally a negative diagnostic work-up <sup>(1)</sup>. Patients presenting to their GP with new and vague abdominal pain for four weeks or more can be referred to a Rapid Diagnostic Centre (RDC), as set out in 2019/20 Implementation Specification for RDCs <sup>(2)</sup>. Vague abdominal symptoms can be a presenting symptom of malignancy <sup>(3, 4)</sup> and Phase II ACE pilots have demonstrated the value of a vague symptom pathway in the investigation of non-specific abdominal pain <sup>(5)</sup>.

Patients that meet a more appropriate tumour specific pathway should be triaged and directed away from the Rapid Diagnostic Centre <sup>(2)</sup> in order to avoid delays in diagnosis. Therefore, it is imperative to review key filter function tests upon referral, such as a quantitative Faecal Immunochemical Test (qFIT) and blood results. Every effort should be made to communicate the importance of up-front testing of filter-function tests within primary care.

The following document sets out a guidance to clinicians working within the Rapid Diagnostic Centre about what to consider when investigating a patient presenting with non-specific abdominal pain (FIT <10ug/g).

### History

Although challenging, a detailed history can provide key information to target further investigation <sup>(6)</sup>. It is often useful to consider a system-based approach to the history; it is therefore useful to consider:

- Site, onset, character and radiation of the pain, alongside any relevant triggers and chronicity.
- GI: red-flag symptoms suggestive of upper or lower GI malignancy; symptoms suggestive of a malabsorptive process (eg abdominal bloating, steatorrhoea, weight loss); appetite loss, early satiety or symptoms suggestive of delayed gastric emptying
- Liver: the presence of symptoms suggestive of liver pathology, such as RUQ pain, jaundice or signs/symptoms in keeping with decompensation (ascites, easy bruising, encephalopathy, peripheral oedema); risk factors for Hepatitis and HIV
- Urinary: red flag symptoms in keeping with bladder or renal cancer.
- Gynaecology: pregnancy, PV discharge, PMB, pelvic pain, menstrual irregularities
- Travel History
- Constitutional symptoms: fevers, night sweats, weight loss, lethargy
- The finding of new lumps and bumps
- A review of symptoms related to infection or inflammatory/autoimmune process.
- Review for potential risk factor for malignancy for example smoking history, occupational history, family history
- A thorough psychosocial history

## Examination

If a face-to-face appointment is offered to the patient, it is often useful to conduct a full system abdominal examination.

## Investigations

A variety of tests are available to further investigate the presentation of non-specific abdominal pain. A thorough history and examination can help focus testing in order to most appropriately and efficiently investigate the patient and referring GP's concerns. The following sets out a list of tests to consider, but one must consider what is most appropriate for the patient that has presented to the RDC, as well as what has already been performed in primary care, rather than using a scatter-gun approach to investigation.

### **Bloods:**

1. FBC, renal profile, liver function tests, PSA, CA125, haematinics (ferritin, B12, serum folate), IgA anti-TTG and inflammatory markers (CRP/ESR).
2. Include an extended liver screen if clinically indicated
3. LDH if lymphoproliferative disorder is a differential diagnosis
4. Serum tumour markers may be useful in certain conditions, but their use in the diagnostic phase is contested. Elevated tumour markers may correlate with either malignant or benign conditions, and they can complement radiological, clinical and pathological evidence but should not be used in isolation <sup>(7)</sup>. Additionally, they are of limited diagnostic value in non-site specific symptoms and can lead to inappropriate testing <sup>(8)</sup>. It has even been suggested that levels of serum abdominal tumour markers, (such as CA19-9, CEA, AFP and CA125), have not been significantly elevated in early upper GI malignancies <sup>(9)</sup>. However, as part of the diagnostic work-up, one may consider the use of serum tumour markers if the suspicion of malignancy is high, in addition to directed imaging and MDT discussion.

**Urinalysis:** dipstick, MSU, HCG if appropriate (this may also be raised in HCG producing testicular cancers <sup>(10)</sup>). Urine cytology may be suitable as an assistant method in the diagnosis of bladder cancer by combining it with other diagnostic methods with higher levels of sensitivity <sup>(11)</sup>.

**Stool:** review the qFIT result from the GP. Consider sending faecal MCS / calprotectin / H Pylori if clinically indicated. A faecal elastase test is helpful in the diagnostic work-up of patients with suspected pancreatic exocrine insufficiency <sup>(12)</sup>. Other tests for the investigation of chronic diarrhoea can be led by Gastroenterology, including hydrogen breath-test, SehCAT and endoscopy <sup>(13)</sup>.

### **Imaging:**

An erect Chest Xray or plain abdominal film are indicated in more acute pathology, where obstruction or perforation is suspected, and are not first line in the investigation of malignancy.

Consider CT abdomen and pelvis with contrast in patients where there is a suspicion of intra-abdominal malignancy. A CT colonography provides a degree of assessment for luminal pathology, as well as extra-colonic disease and may be appropriate when a colonoscopy is unlikely to be tolerated.

Ultrasound abdomen is a helpful modality to investigate intra-abdominal pathology, particularly liver, gallbladder and renal tract, and can be used first line where malignancy is not suspected. Ultrasound evaluation of enlarged palpable lymph nodes is also useful, and opportunistic FNA may be a possibility.

### **Endoscopy:**

Direct endoscopic evaluation of the upper and lower GI tract is preferable in patients presenting with clear GI red flag symptoms, or with the concurrent finding of iron deficiency anaemia.

If cancer has been found on imaging, a plan for biopsy should be made for histological assessment. If cancer has not been found, consider referral to the Gastroenterology team for further assessment.

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*Written by Dr A Gill (GPSI Oncology, RM Partners NSS RDC Clinical Lead)*