GUIDELINE FOR
SUSPECTED CANCER REFERRAL
in the State of Qatar
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This document is a best practice guide intended to assist in the timely recognition and appropriate referral of patients with suspected cancer symptoms in the State of Qatar compiled by the Ministry of Public Health (MOPH) and based on guidelines from the National Institute for Health and Care Excellence (NICE), Hamad Medical Corporation (HMC), the National Comprehensive Cancer Network (NCCN), and the London Cancer Alliance (LCA) Clinical Network.

This guideline is subject to ongoing review on a 12 monthly basis.
1. **Introduction**

Cancer is a leading cause of death globally, with number of new cases expected to rise by about 70% over the next 2 decades.\(^1\)\(^-\)\(^4\) Cancers figure among the leading causes of morbidity and mortality worldwide, with approximately 14 million new cases and 8.2 million cancer related deaths in 2012.\(^4\) Worldwide statistics show that among men, the five most common sites of cancer diagnosed in 2012 were lung, prostate, colorectum, stomach, and liver cancer; and that among women, the five most common sites diagnosed were breast, colorectum, lung, cervix, and stomach cancer.\(^4\)

Cancer has an enormous impact on the people affected by it and those close to them. In Qatar, a total of 1421 malignant and 47 in situ cancer cases were reported in 2014.\(^3\) The five most common cancers in Qatar in 2014, were breast cancer (17.4 percent), colorectal cancer (10.6 percent), prostate cancer (6.5 percent), lymphoma (6.5 percent), leukaemia (5.7 percent) and lung cancer (5 percent).\(^3\) Each cancer has different presenting features, though they sometimes overlap. Around one third of cancer incidence are due to the five leading behavioural and dietary risks: high body mass index, low fruit and vegetable intake, lack of physical activity, tobacco use, and alcohol use. Early prevention and detection is known to reduce the risk of mortality with cancers.

Childhood cancers - a term most commonly used to designate cancers that arise in children before the age of 15 years - are rare, representing between 0.5% and 4.6% of all cancers. Overall incidence rates vary between 50 and 200 per million children across the world.\(^1\)\(^,\)\(^4\)

1.1 **Purpose of the Guideline**

This guideline is intended to aid the recognition and selection for referral in primary care and private care for people of all ages, who may have cancer within the State of Qatar and to assist clinical staff to provide appropriate/timely referral and support for all people with suspected cancer.
1.2 **End Users of the Guideline – Professional Groups**

This guideline aims to help providers understand what symptoms may suggest cancer in a patient. It is relevant to all healthcare professionals (physicians, nurses, allied health professionals, others) who come into contact with patients with suspected cancer.

It is also expected that this guideline will be of value to those involved in clinical governance in primary, secondary, tertiary care and private healthcare to help ensure that arrangements are in place to deliver appropriate referral and care to this group of patients.

1.3 **Target Areas**

This guideline is intended as a reference for the following public or private providers: primary, secondary and within the State of Qatar.
2. General Principles of Care

• A person presenting with symptoms and/or signs suggestive of cancer requires urgent investigation, which may include referral to a specialist team.

• A person presenting with symptoms and/or signs suggestive of cancer should be assessed through a detailed history and examination, irrespective of the presence of risk factors.

• An explanation needs to be given to people who are being referred with suspected cancer that they are being referred to a cancer service.

• The information given to people with suspected cancer and their families and/or carers should cover:
  o where the person is being referred to.
  o how long they will have to wait for the appointment.
  o how to obtain further information about the type of cancer suspected or help before
  o the specialist appointment (check www.ncp.qa).
  o what to expect from the service the person will be attending.
  o what type of tests may be carried out, and what will happen during diagnostic procedures.
  o how long it will take to get a diagnosis or test results.
  o whether they can take someone with them to the appointment.
  o who to contact if they do not receive confirmation of an appointment.

• Healthcare professionals should pay careful attention to caregiver reports of a child’s symptoms. When cancer is suspected in a child, discuss the referral decision and information to be given to the child with the parents or carers (and the child if appropriate).

• Adult and paediatric healthcare teams should work jointly to provide assessment and services to young people with suspected cancer.

• Provide information that is appropriate for the person in terms of language, ability and culture, recognizing the potential for different cultural meanings associated with the possibility of cancer.

• Have information available in a variety of formats on both local and national sources of information and support for people who are being referred with suspected cancer.
• When referring a person with suspected cancer to a specialist service, assess their need for continuing support while waiting for their referral appointment. This should include inviting the person to contact their healthcare professional again if they have more concerns or questions before they see a specialist.

• If the person has additional support needs because of their personal circumstances, inform the specialist at HMC (with the person’s agreement).

• Ensure local arrangements are in place to identify people who miss their appointments so that they can be followed up.

• Include all appropriate information in the urgent referral correspondence.

• Once the decision to refer has been made, make sure that the referral is made immediately. Use local referral proformas if these are in use. It is expected that the suspected cancer referral pathway is followed.

• Treatment and care should take into account individual needs and preferences.

• Patients should have the opportunity to make informed decisions about their care and treatment, in partnership with their healthcare professionals.
REFERRAL GUIDELINES AND PATIENT PATHWAY
3. **Referral Guidelines and Patient Pathway**

Patients are referred to the various cancer specialist teams from the following providers:

- Primary Healthcare Centres (PHCC) by using the Urgent Suspected Cancer (USC) form or through routine referral.
- Internal HMC referrals from other consultants within HMC.
- Other cancer multi-disciplinary teams (MDTs)
- Private providers.
- Clinicians whose patients are returning to Qatar following treatment overseas.

Patients referred to the specialist cancer services should be seen in a specialist clinic by a clinician who has been designated as privileged for this specialty.

### 3.1 The Urgent Suspected Cancer (USC) Form

The USC form for adults and children is completed for urgent referrals to Hamad Medical Corporation (HMC) if a patient presents with one or any combination of the signs or symptoms listed in Chapter 4. This form can be downloaded from the National Cancer Program (NCP) website at www.ncp.qa

### 3.2 Management of Referrals in HMC

I. Referrals of all new cancer patients using the USC form and internal referrals within HMC are managed by the Referral Management Office (RMO).

Any provider who wishes to refer a patient to cancer services at HMC using an urgent suspicion of cancer referral form should complete the USC form and phone the request through to the RMO and then send the USC form to the RMO.

The **RMO** contact details are as follows:

- Telephone: +974 40250116
- Fax: +974 44398975
- Email: suspectedcancer@hamad.qa
II. Referrals from all providers for discussion and/or opinion at the HMC MDT for patients with a confirmed or suspected diagnosis of cancer is managed by the MDT coordinator.

The MDT coordinators can be contacted on:

<table>
<thead>
<tr>
<th>MDT</th>
<th>Coordinator</th>
<th>Contact details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast Cancer MDT</td>
<td><a href="mailto:afigueroa@hamad.qa">afigueroa@hamad.qa</a></td>
<td>Telephone: +974 55231962/44398106 Fax: +974 40151082</td>
</tr>
<tr>
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<td>Gastrointestinal Cancer MDT covering Upper and lower GI</td>
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<td>Telephone: +974 55250112/66825686 Office: +974 44398105</td>
</tr>
<tr>
<td>Gynaecological Cancer MDT covering cervical, endometrial, ovarian cancers</td>
<td><a href="mailto:rpadilla@hamad.qa">rpadilla@hamad.qa</a></td>
<td>Telephone: +974 55825053 Fax: +974 40151082</td>
</tr>
<tr>
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<td>(+974) 3387 8464</td>
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<tr>
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</tr>
<tr>
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</tr>
<tr>
<td>Thyroid Cancer MDT</td>
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<td>Telephone: +974 55629907</td>
</tr>
<tr>
<td>Neuro-oncology MDT</td>
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<td>Telephone: +974 55629907</td>
</tr>
<tr>
<td>Palliative Care MDT (The referral to this MDT is from within HMC)</td>
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<td>Telephone: +974 33203541</td>
</tr>
<tr>
<td>Paediatric MDT</td>
<td><a href="mailto:rpadilla@hamad.qa">rpadilla@hamad.qa</a></td>
<td>Telephone: +974 55825053 Fax: +974 40151082</td>
</tr>
<tr>
<td>Lung/Thoracic Cancer MDT</td>
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<td>Telephone: +974 66721662 Fax: +974 40151082</td>
</tr>
</tbody>
</table>

The referral should be made by a faxed referral letter or copy of HMC’s completed MDT referral proforma. Any relevant imaging and pathology (both report and blocks where possible) should be made available for review as part of the MDT discussion.
The MDT will agree the next steps for the patient and the appropriate appointment will be made. The patient pathway coordinator will take responsibility for facilitating access to the required service.

The outcome of the discussion at the MDT will be uploaded onto the EMR viewer which will enable the referring physician (PHCC or HMC) to review the proposed plan of care. Other referring providers will be communicated with in a mutually agreed format.

### 3.3 The Patient Referral Pathway in Qatar

The following diagram (Figure 1) presents an overview of a cancer patient referral pathway in the State of Qatar.

#### Significant Timelines in the Patient Referral Pathway

I. **Referral to Specialist Clinic:**
   - Those referred using the USC form should be seen **within 48 hours of referral**.

II. **Time to Definitive Diagnosis:**
   - Once a patient is seen, **a definitive diagnosis should be reached in 14 days** using a combination of imaging, pathology and physical examinations. This applies to any patient seen in a specialist clinic and found to have a diagnosis of cancer, regardless of the referral route. Diagnosis must be confirmed at the multidisciplinary team (MDT) meeting.

III. **Time to Treatment:**
   - There must be no more **than 14 days between the date of confirmed diagnosis at MDT and the date of first definitive treatment**. This applies to any patient, with a confirmed diagnosis of cancer, regardless of the referral route.
Urgent Suspicion of Cancer

Refer to/within HMC using Urgent Suspected Cancer (USC) form

Referral received by Referral Management Office (RMO)

Patient seen in a specialist clinic **within 48 hours of referral**

Clinical examination and diagnostic investigations carried out

Benign: patient discharged from cancer services

Cancer?

Yes/Maybe

Refer to MDT coordinator at HMC

Definitive diagnosis **within 14 days of appointment**

MDT discussion and management plan decided

Management plan decided with patient

First definitive treatment **within 14 days of diagnosis**

Referral back to MDT if indicated
RECOMMENDATIONS ORGANISED BY SITE OF CANCER
4. **Recommendations Organised by Site of Cancer**

The recommendations in this guideline have been organised to help healthcare professionals in the State of Qatar find the relevant information easily. This section includes the recommendations for referral organised by the site of suspected cancer.

People should be referred using the urgent suspected cancer pathway referral (for an appointment with a specialist within 48 hours) if they present with certain symptoms and signs listed in the cancer sites below. Criteria for referral within 14 days is also listed for some cancer sites.

4.1 **Breast Cancer**

- New, discrete lump in the breast or axilla (with or without pain).
- Altered breast contour/dimpling
- Persistent asymmetrical nodularity/thickening
- Breast abscess/inflammation not responsive to one course of antibiotics
- Bloodstained, persistent/troublesome nipple discharge
- Recent nipple retraction/distortion or eczema suspected Paget’s disease
- Abnormal Mammogram (BIRADS 4 or more)

4.2 **Upper Gastrointestinal Cancers (Oesophageal, Gastric Cancers)**

- Persistent dysphagia
- Persistent vomiting
- Epigastric mass
- Progressive unexplained unintentional weight loss
- Chronic gastrointestinal (GI) bleeding.
- Unexplained iron deficiency anaemia*
- Positive occult blood in stool.
- Patients aged over 55 years with unexplained persistent recent onset dyspepsia (>6-8 weeks).

*Unexplained iron deficiency anaemia means unrelated to other sources of blood loss, for example, heavy menstrual bleeding, non-steroidal anti-inflammatory drug treatment or blood dyscrasia.
4.3 Lower Gastrointestinal Cancers (Colorectal and Anal Cancers)

- A man of any age with unexplained iron deficiency anaemia and a haemoglobin level of 11g/dL or below.
- A non-menstruating woman with unexplained iron deficiency anaemia and a haemoglobin level of 10g/dL or below.
- Patients aged 40 years and over with:
  - Rectal bleeding and change in bowel habit which is defined as change to loose stools and/or increased or decreased frequency of defecation persisting for 2 weeks or more
  - Rectal bleeding persisting 2 weeks or more without change in bowel habit, as defined above, or anal symptoms.
- Change in bowel habit, as defined above, for 2 weeks or more.
- Palpable rectal mass.
- Abdominal mass consistent with involvement of the large bowel.
- Progressive unintentional weight loss.
- Unexplained anal mass or unexplained anal ulceration.
- Strong family history of bowel cancer, one or more 1st degree or two or more 2nd degree relatives.

4.4 Gynaecological Cancers:

4.4.1 Cervical, Endometrial and Ovarian Cancers

Criteria for using the USC form:

- Post-menopausal bleeding
- Abnormal high grade cervical smear such as
  - HSIL (High-grade squamous intraepithelial lesion),
  - ASC-H (Atypical Squamous Cells, Cannot Rule Out High-Grade Squamous Intra-epithelial Lesion),
  - AGC (atypical glandular cells)
• Suspicious mass
• Suspicious imaging
• Radiological findings strongly suspicious of invasive malignancy
• Ovarian mass with risk of malignancy index (RMI) >200
• Ovarian mass with family history of breast and ovarian cancer.

Criteria for referral within 14 days for further evaluation in the gynaecology clinic:

• LSIL (Low-grade squamous intraepithelial lesion)
• Irregular bleeding in a woman on hormone replacement therapy (HRT) or in peri-menopausal patient
• Purulent vaginal discharge
• Bloodstained vaginal discharge
• RMI 100 - 200
• Inter-menstrual bleeding
• Post-coital bleeding
• Persistent abdominal distension/bloating
• Abdominal/pelvic pain
• Feeling full quickly (early satiety) and/or having difficulty eating (loss of appetite).

4.5 Urological Cancers:

4.5.1 Bladder and Renal Cancers

• Renal mass
• Painless haematuria
  ○ Macroscopic (any age)
  ○ Microscopic (>50 years)

4.5.2 Testicular Cancer

• Testicular mass or swelling.
4.5.3 Prostate Cancer Referral

- Abnormal Digital Rectal Examination (DRE)
- High Risk Patients with PSA above 20 e.g. positive family history, African American descent and symptomatic patients with life expectancy >10years.
- Elevated age-specific prostate-specific antigen (PSA).

<table>
<thead>
<tr>
<th>Age Range</th>
<th>African Americans</th>
<th>Asians</th>
<th>Whites</th>
</tr>
</thead>
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<tr>
<td>40-49 years</td>
<td>0 - 2.0 ng/ml</td>
<td>0 - 2.0 ng/ml</td>
<td>0-2.5ng/ml</td>
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<tr>
<td>50-59 years</td>
<td>0 - 4.0 ng/ml</td>
<td>0 - 3.0 ng/ml</td>
<td>0 - 3.5 ng/ml</td>
</tr>
<tr>
<td>60-69 years</td>
<td>0 - 4.5 ng/ml</td>
<td>0 - 4.0 ng/ml</td>
<td>0 - 4.5 ng/ml</td>
</tr>
<tr>
<td>70-79 years</td>
<td>0 - 5.5 ng/ml</td>
<td>0 - 5.0 ng/ml</td>
<td>0 - 6.5 ng/ml</td>
</tr>
</tbody>
</table>

- A high PSA and with any unexplained symptoms (e.g. bone pain, lower back pain).

4.6 Head and Neck Cancers

- Persistent unexplained hoarseness for more than 4 weeks.
- Unexplained ulceration of the oral mucosa persisting for more than 2 weeks.
- Oral swellings persisting for more than 2 weeks.
- All red or red and white patches of the oral mucosa persisting more than 3 weeks
- Unilateral nasal obstruction, particularly when associated with purulent/bloody discharge persisting for more than 3 weeks.
- Dysphagia persisting for more than 3 weeks
- Painless mass in the neck persisting for more than 3 weeks.
- Unexplained sensory or motor deficits in the cranial, maxillo facial domain.
- Orbital extra global masses and lesions.
- Tooth mobility that cannot be otherwise explained persisting for more than 3 weeks.
• Unexplained unilateral hearing loss in an adult.

• Any pathological change in the skin of the face or the Head and Neck area suspicious of malignancy. (Dermatology or head and neck Referral)

4.7 **Thyroid Cancer**

Thyroid carcinoma most commonly manifests as a painless, palpable, solitary thyroid nodule. Patients or clinicians discover most of these nodules during routine palpation of the neck. Refer urgently persons with unexplained thyroid lump AND:

• Rapid nodular growth

• Core nodules most likely to be malignant in patients older than 60 years and in patients younger than 30 years

• Usually painless (non-tender to palpation); sudden onset of pain more strongly associated with benign disease (e.g., haemorrhage into a benign cyst, sub-acute viral thyroiditis)

• Hard and fixed nodules

• Family history of endocrine tumour

• Voice changes

• Cervical lymphadenopathy

4.8 **Lung/Thoracic Cancer**

A patient with the following symptoms should be sent by the referring clinician for an urgent chest x-ray:

• Haemoptysis

• Persistent hoarseness of voice

• Unexplained shortness of breath

• Unexplained persistent chest pain

• Chronic cough for more than 8 weeks

• Persistent or recurring chest infection

• Unexplained weight loss or loss of appetite.
And/or

• Physical examination shows:
  o finger clubbing
  o supra-clavicular lymphadenopathy or cervical lymphadenopathy.
  o Signs of superior vena cava obstruction

The above symptoms should be considered particularly urgent if they are smokers or ex-smokers aged 40 years and above. Also consider any history of asbestos exposure.

**Urgent Suspected Cancer Referral for Lung Mass**

Patients should be referred using the USC form when they have an abnormal chest x-ray suggestive of lung cancer irrespective of the symptoms including

• Lung nodule
• Mass
• Pleural effusion
• Hilar adenopathy
• Consolidation.

**These patients should be referred for lung cancer pre-diagnosis pulmonary assessment.**
5. References


3. Qatar National Cancer Registry. Available at qncr@moph.gov.qa


6. The Guideline Development Group (GDG)

The suspected cancer referral guidelines have been produced with the assistance of a multidisciplinary group of clinicians to provide a comprehensive overview of the suspected cancer patient’s journey from referral to timely diagnosis and treatment.

The guideline development process was supported by staff from Hamad Medical Corporation (HMC), Primary Health Care Corporation (PHCC), and Ministry of Public Health (MOPH). The draft of the guideline was prepared in partnership by HMC, PHCC and SCH staff. This draft was then discussed and agreed with the cancer performance working group of the ministry and the cancer specific multidisciplinary teams in HMC and subsequently forwarded to all stakeholders for consultation.

Following the consultation period, staff from MOPH finalized the recommendations and the final document was sent to the National Cancer Committee (NCC) for approval. On receipt of the NCC approval, publication and dissemination occurred in the state of Qatar.

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Mrs Fiona Bonas                  Director, National Cancer Program
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Updating the Guideline

One year after publication of the guideline, the guideline development group will review the guideline to determine whether the evidence base has progressed significantly to alter the guideline recommendations and warrant an early update.

Disclaimer

The GDG assumes that healthcare professionals will use clinical judgment, knowledge and expertise when deciding whether it is appropriate to apply these guidelines. The recommendations cited here are a guide and may not be appropriate for use in all situations. The decision to adopt any of the recommendations cited here must be made by the practitioner in light of individual patient circumstances, the wishes of the patient and clinical expertise.

The MOPH disclaims any responsibility for damages arising out of the use or non-use of these guidelines and the literature used in support of these guidelines.