

**FAQs for the UHB URGENT CANCER REFERRAL FORM FOR SUSPECTED UROLOGICAL CANCERS April 2024**

1. ***Is it mandatory to perform a digital rectal examination (DRE) in a patient with a raised PSA who we are planning to refer?***

The latest evidence from GIRFT (“Getting It Right First Time”) mentions that there is no need for mandatory DRE. However, if high clinical suspicion especially with risk factors (e.g. positive family history, black ethnicity), consider DRE even if PSA normal.

1. ***Can I make a referral if the DRE is abnormal (e.g. hard nodular prostate or abnormal feeling prostate) even if the PSA is “normal”?***

15% of patients with a “normal” PSA may have prostate cancer. Thus the referral pathway allows a patient with an abnormal DRE to be referred.

1. ***DRE reveals a smooth enlarged prostate. PSA is normal. What do I do?***

This is more likely to be due to BPH (Benign Prostatic Hypertrophy). Please review symptoms and manage with lifestyle measures and/or medication. You could use IPSS (International Prostate Symptom Score) questionnaire to monitor symptoms. Please consider routine referral to urology if limited response to medical treatment for 3 months and/or patient requesting surgical options.

1. ***Why do we need to perform a urine dipstick/MSU even if the patient has no clinical symptoms suggestive of a urinary tract infection (UTI) for suspected prostate and bladder cancer referrals?***

A large number of patients with a raised PSA go straight to test (mpMRI) without a further clinical consultation. PSA levels can be falsely elevated due to a UTI. UTIs may be asymptomatic (bacteriuria) and a urine dipstick/MSU helps to identify these cases. Both symptomatic and asymptomatic UTIs can adversely affect the results of investigations (e.g.) mpMRI scan. This means that patients will then end up having more invasive tests (e.g. biopsies) which were not really necessary. Therefore all patients should have a urine dipstick/MSU prior to referral with a raised PSA.

If the PSA is >30 then refer using the two week referral form regardless of potential UTI as these men will not have an MRI as their first investigation; a CT and bone scan will be offered.

For suspected Bladder cancer, a UTI needs to be excluded (using a urine dipstick or MSU) regardless of whether the patient has symptoms of a UTI since this can contribute to the presence of visible or non-visible haematuria. *This is mandatory when referring for suspected Bladder cancer as the form may be returned without this information.*

 For recurrent UTI associated with visible or non-visible haematuria (in spite of treatment with oral antibiotics), please refer using the 2 week referral form.

1. ***What happens if the patient has an abnormal urine dipstick/MSU and/or clinical symptoms suggestive of UTI?***

Please assess the patient clinically and treat for a UTI in the presence of symptoms and/or abnormal MSU. For suspected prostate cancer referrals, please repeat the PSA blood test again in 1 month and refer via 2ww pathway if PSA still raised. For suspected bladder cancer referrals, please review and repeat urine dipstick/MSU in 2 weeks after completing antibiotics- if haematuria settled, wait/see with safety-netting advice; if haematuria still present, refer via the (2ww) urgent cancer referral pathway.

1. ***MSU shows sterile pyuria (raised WCC in urine) with no growth. What do I do?***

For suspected prostate cancer, in the presence of UTI symptoms, treat for a UTI and repeat the MSU and PSA in 1 month. If sterile pyuria persists, request a sterile pyuria culture and refer if the PSA is still raised. In case of suspected bladder cancer, in the presence of UTI symptoms, treat for UTI and repeat urine dipstick/MSU in 2 weeks. If asymptomatic and normal urine dipstick/MSU, wait/see with safety-netting advice. If still abnormal (raised WCC with non-visible haematuria, age > 60), refer via 2ww pathway (otherwise, urology advice and guidance).

1. ***Why is the guidance different for the above 80s?***

Evidence shows that there is a risk of over-diagnosing prostate cancer and over-treating prostate cancer in men above 80. Above 80, the prevalence of prostate cancer is high but the proportion of cancers which are clinically significant is low. For many patients, it will not cause symptoms in their lifetime or impact life expectancy. Investigations and treatments may expose the patient to additional risks and cause more anxiety. Individuals would need to have a further life expectancy of at least 10 years to benefit from radical treatment for localised prostate cancer.

1. ***So what should I do for the over 80s?***

There is limited benefit for screening for prostate cancer above 80. Lower Urinary Tract Symptoms (LUTS) can be suggestive of BPH rather than prostate cancer. Prostate cancer may be more of an incidental finding. It is thus important to make a clinical assessment and have a discussion with the patient/family regarding the pros and cons of PSA testing. The referral thresholds and guidance are different (see form) in the above 80s for these reasons.

1. ***My patient had an ultrasound scan/CT/MRI for another reason. The report mentions a suspicious lesion (e.g. on prostate/kidney/bladder) with possibility of cancer and/or the radiologist is concerned. What do I do?***

As primary care is having more direct access to diagnostics, we may come across this more often. To take this into account, we have added an additional referral criteria that over-rides the symptoms as below

“Abnormal radiological findings suggestive of urological malignancy”

Please do not use this referral criteria for likely benign conditions such as a smooth enlarged prostate or simple renal cysts.

1. ***My patient does not meet the (2ww) urgent cancer referral criteria as his PSA and DRE are normal. I am still concerned. What should I do?***

Please use the urology advice and guidance service in such cases to help with further management.

1. ***What are the reasons why my referral may be returned?***

The following will result in your referral being returned:

1. Patient demographics not on the form to identify the patient (Name, DOB).
2. Missing PSA value (on the form) for suspected prostate cancer referrals.
3. Creatinine and eGFR not included within 3 months of the referral date OR “bloods have been requested box” not ticked.
4. UTI excluded box not ticked for suspected Bladder cancer
5. Suspected recurrence of prostate cancer whether the patient is under urology or has been discharged (transfer of care document should be followed and the patient referred via urgent urology referral instead).
6. Suspected recurrence of cancer for kidney, penile, bladder, or same testis; if the patient is still under urology and had not been discharged.
7. If there is radiological evidence of a suspected urological cancer but the imaging result has not been attached. It is vital the hospital is aware where and when the imaging took place and what the result is.
8. Updated form not used after 01/09/24
9. ***I have a patient with severe frailty and/or in a care home. I am concerned about possibility of cancer. He/she is likely to struggle to attend out-patient clinic and/or tolerate further investigations/treatment. Should I refer purely to get a diagnosis?***

Please assess each individual case and discuss the pros and cons of investigations, treatment, how their frailty may affect their ability to tolerate investigations/treatment and what would be in their best interests. A discussion with the patient and family may allow the patient to be managed conservatively in a supportive way in the community if appropriate.