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CANCER SERVICE OR HEALTH SERVICE?

Impact of the cancer referral threshold

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We read with interest the article by Rammya Mathew and the associated correspondence.¹⁻³

Over the past decade the number of urgent suspected cancer referrals in England has approximately doubled.⁴ Despite this, and the establishment in 2015 of a 3% risk of a cancer diagnosis threshold for referral,⁵ the corresponding rate of cancer diagnosed through these pathways only steadily reduced from 11% in 2009-10 to 7% in 2019-20. So, despite increasing numbers of referrals, the overall proportion of cancer diagnosis following urgent referral remains above twice that recommended.⁴

The proportion of cancer diagnosed through emergency presentation has reduced (from around 24% in 2006 to around 18% in 2018), with a corresponding increase in the proportion diagnosed through urgent referral pathways (about 25% to about 40%). In contrast, however, the proportion of all cancers diagnosed at stage 1 or 2 has not perceptibly changed (54.2% in 2013 and 54.5% in 2019). The article cited by Mathew also shows similar proportions of early stage diagnosis in 2014 and 2018.⁶

Overall, 10 year survival rates have doubled from around 25% in adults in 1970-71 to around 50% in 2010-2011 and continued to improve year on year to 2021.⁷⁻⁹ These improvements in survival, in the context of minimally observed changes in early stage diagnoses, are more likely explained by improvements in treatments for cancer rather than significantly earlier diagnosis or lead time bias.

Delays in cancer diagnosis impact outcome.¹⁰ Therefore, while earlier diagnosis may not be the main reason for improvements in survival, refining and recommending a universal threshold for cancer referral remains important. Although observed variations remain in the diagnosis rate, stage at diagnosis, and survival across cancer sites, defining a consistent referral threshold for suspected cancer has provided a common target to reduce inequality, improve experience, and promote standards, which could be also applied to other areas of health.

Competing interests: RIC is a member of the NICE NG101 Early and locally advanced breast cancer: diagnosis and management update committee, a trustee of the Association of Breast Surgery (ABS), and chair of the ABS Academic and Research Committee. RIC declares institutional research support from SECA and Astra Zeneca. TG is a member of the clinical advisory panel for Cancer Research UK, the audit advisory committee for the National Audit of Primary Breast Cancer, and the academic and research committee for the Association of Breast Surgery. This correspondence represents the personal opinions of the authors.

Full response at: www.bmj.com/content/381/bmj.p1382/rr-2.

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