

with or without the provision of safety equipment, can increase the use of safety equipment and improve safety behaviours in the short term, but the effect on unintentional injury is less clear.<sup>15</sup> Many of the trials included in these reviews were conducted in the US, limiting the generalisability of their findings to the UK. In addition, reviews have highlighted the lack of high quality randomised controlled trials with adequate power and sufficient follow up periods.<sup>16</sup>

Kendrick *et al* have focused their attention on reducing the use of baby walkers for this cluster randomised trial in primary care. The injury risk associated with the use of baby walkers is not new, and has been identified as an international problem that crosses cultural divides.<sup>17–19</sup> This paper is the first published trial to assess the effectiveness of providing education regarding baby walkers in a primary care setting. The authors conclude that an educational package delivered by midwives and health visitors can be effective in reducing baby walker possession and use. PCTs should take note of this study and include baby walker education in their injury prevention strategy.

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# NICE suspected cancer guidelines

The National Institute for Health and Clinical Excellence (NICE) *Referral Guidelines for Suspected Cancer*<sup>1</sup> are the update of those issued by the Department of Health guidelines of 2000,<sup>2</sup> which were usually referred to as the '2-week wait' guidelines.

These guidelines are different in nature to the large majority of guidelines that NICE produces as they are not for a specific condition, for example schizophrenia or epilepsy. These guidelines are about the referral of patients with suspected cancer. Since early diagnosis is a priority, the large majority of patients will not actually have

cancer. The diagnosis of advanced cancer is easy, and the guidelines relating to this can appear patronising, but the challenge is to detect cancers early. The positive predictive value of rectal bleeding for colorectal cancer is less than 1 in 1000 in the community, 1 in 50 in general practice and 1 in 3 of those referred to hospital by GPs.<sup>3</sup> The guidelines cover 12 different cancer groups, and these are very different diseases. In the case of symptomatic breast cancer, over 90% of women have a breast lump at presentation and survival is 77% at 5 years, while with lung cancer, only 5% present with a 'typical' symptom of

haemoptysis, and only 6% survive 5 years.

The new guidelines have been produced within a timescale that has allowed a rigorous examination of the evidence. They have been produced by a multidisciplinary team with patient representation. GPs and primary care clinicians have outnumbered the specialists. The guidelines are divided into 11 major cancer groups with a further section on children's cancers. Each section contains differences from the Department of Health guideline, for example the melanoma advice now includes a 7-point weighted checklist. The

guidelines include advice on appropriate watching and waiting in general practice for patients who do not need immediate referral and appropriate and inappropriate investigations are identified for all cancers. There is now advice on patient support and information needed at the time of diagnosis. There is also a section on communication at this sensitive time, and information throughout the document from more of a patient perspective.

Despite the differences with the previous guideline, most of the symptoms triggering urgent referral are similar to those produced by a consensus of experts for the Department of Health guideline. The reason for this is that there is not a great deal of evidence on the diagnosis of cancer in primary care. The timescale of the NICE guideline did not allow the results of the commissioned study into how the Department of Health guidelines fared to be incorporated. However, it is unlikely that significant changes would have been made, since conclusions were difficult to draw from the study due to the unsystematic nature of most of the audits available.

The framework chosen by NICE followed that of the Department of Health and was based on tumour groups. This is a sensible way to approach the problem if one is a secondary care specialist. In general practice, patients present with symptoms. These symptoms do not neatly fall into tumour groups, and indeed often do not suggest cancer at all. The GP has to take the major step of realising that there is a possible cancer diagnosis, before consulting the guidelines.

A solution to this is to base the guidelines on the symptoms that present to GPs. The advantage of this approach is that the guideline will be useful before the stage that the cancer diagnosis has been thought about. A guideline for patients presenting with tiredness was produced. A very small proportion of tired patients will have cancer, but as result of such a guideline, the patients with psychological or psychosocial problems, anaemia, diabetes, thyroid disorder and so on, may get an earlier diagnosis in general practice. A major advantage of basing the guideline on symptoms, is that this can be incorporated into a mentoring system in

the practice's clinical computer system. The GP would be prompted to think about cancer where it wasn't otherwise an obvious possibility.

GP education is clearly a complex adaptive process, and a single technology will not be used in the same, or indeed any or useful, way by GPs. Some will skim the guidelines for new information and never refer to them again. Others may use them regularly for reference. Some will become aware of the new features in reviews, ranging from those in this Journal to those in the medical newspapers. Some will use the guidelines as result of using urgent cancer referral proformas.

Guideline production is an iterative process, and one of the outcomes of this is to point out the need for further research. There is still very little prospective evidence concerning the presentation of common symptoms in primary care. There is little research on clusters of symptoms and clues that the GP comes across on a daily basis, despite calls for this. The majority of evidence is from retrospective studies of cancer patients. It may be worth looking at whether some clinicians are particularly good at diagnosing cancer and, if so, what information they use.

Guidelines are only part of the solution to earlier cancer diagnosis by GPs. We know that we operate in a complex adaptive system and we do not expect that a single tool, however accurate, will be adequate. The basic currency of the guideline is the symptom. GPs will know that by the time the patient arrives at the hospital, the symptoms have been established by negotiation with the GP. The symptoms often started as a narrative, from which many symptoms or groups of symptoms could have been chosen for further elaboration. Since there is not a single symptom that can not presage a cancer, then the generalist role of the GP, using high level communication skills, is vital. We know that consultation length determines the success with which important elements of care are performed.<sup>4</sup> We know that in the case of bowel cancer, a detailed history involving a long list of questions gives much greater accuracy than use of existing guidelines.<sup>5</sup> The limitations of guidelines emphasise the importance of the generalist

skills of GPs, with adequate IT support and enough time to reach a diagnosis.

There are three possible outcomes from using the guidelines. There can be an urgent cancer referral, a non-urgent referral or continuing care by the GP. The government's moves to cut the waiting time for non-urgent outpatient appointments may remove part of the value of the guideline, but the correct decision in relation to non-referral will still be informed by this and future guidelines.

GPs, while being aware of the limitations of guidelines, should welcome the referral guidelines for suspected cancer as a step in the evolutionary process of improving cancer diagnosis.

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#### Competing interest

Membership of guideline development group.

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