or if her social circumstances/medical
comorbidities change?
There are also other advantages in
sending ‘unsolicited mail’ to our patients
that Dr Greenhalgh overlooks. For example,
such offers of screening, even if they are
declined, can serve to remind infrequent
attenders of the existence of their GP and
encourage attendance for other problems.

Dr Greenhalgh refers to a few of her
patients ‘who have negative attitudes
towards proactive care’ and one patient
in particular who felt that ‘her biometric
data in the absence of symptoms are
none of anyone’s business’.1 Surely it
is our role as primary care clinicians to
challenge attitudes of this sort and, so far
as it is reasonable, encourage all patients
to participate willingly and actively in taking
responsibility for their long-term health,
rather than allowing a select few to opt out
of health checks on a default basis.

Zain Bamber,
GP Locum, Harrow, London.
E-mail: zapbaz@doctors.org.uk

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Symptoms and risk
factors to identify
people with suspected
cancer in primary care

Julia Hippisley-Cox and her team have
made great progress in their continuing
process of helping GPs estimate a patient’s
risk of cancer.1,2 I do suggest caution in
the use of their current QCancer® risk
calculators3,4 for three reasons though.

First, the risk calculators don’t as
yet include important data such as the
doctor’s clinical examination findings or
recent negative results of screening by
mammography, cervical smears, and
colonoscopy.

Second, predictive values of symptoms,
signs, and test results (indicators) depend
on the context in which the data were
collected.5 Predictive values for indicators in
the QCancer risk calculators were derived
and validated using coded data recorded
during general practice consultations.

These predictive values therefore don’t
necessarily apply to data recorded by
patients themselves or by doctors on
checklists, nor to uncoded indicators. This
isn’t made clear to members of the public
visiting the QCancer website who are
told: ‘You can use this calculator to work
out your risk of having a cancer as yet
undiagnosed by answering some simple
questions’.3,4 Nor is it made clear to doctors
who are told that ‘the template would
then help structured data entry of other
related symptoms including significant
negative findings and the results generated
automatically’.1,2

Third, a digital risk score replacing or
accompanying the traditional analogue
clinical note will have unpredictable, perhaps
undesirable, consequences. Diagnosis and
risk assessment are improved by looking at
the clinical information available from
different angles. These calculators provide
an additional perspective. How clear a view
they give us is questionable.

Wilfrid Treasure,
Whalsay Health Centre, Symbister,
Whalsay, Shetland, ZE2 9AE.
E-mail: wt treasure@gmail.com

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Authors’ response

Thank you for the opportunity to respond to
Dr Wilfred Treasure’s letter regarding our
two papers.2,3 The QCancer® algorithms are
an evolving set of risk algorithms to quantify
the risk of a previously undiagnosed cancer.
They are intended to support clinical decision
making and we are currently carrying out a
pilot to inform how best to implement them.
The algorithms currently combine multiple
risk factors and symptoms to give a global
risk of cancer and risks of individual cancer
types. Dr Treasure is correct in saying that
the QCancer algorithms do not currently
include results of clinical examinations; it’s
possible these could be added in a future
version of the tool should the relevant data
be coded in the clinical record. However, as
we say in the paper, QCancer is intended
for use in a primary healthcare setting to
help doctors assess which patients to send
for investigations such as colonoscopy.
Therefore the tool does not include the
results of colonoscopy or other diagnostic
tests as that is not the purpose of the tool.

In response to Dr Treasure’s second
point we agree that the predictive values
are based on data recorded during general
practice consultations. The information on
the QCancer website states the following
‘This website is primarily intended for
doctors and nurses working in general
practice and for academics who are interest
in the underlying research. Patients are
welcome to read this information and use
the calculator together with their doctor
so that any symptoms or concerns can be
addressed within a healthcare setting. All
medical decisions need to be taken by a
patient in consultation with their doctor.
QCancer works out the risk of a patient
having a current but as yet undiagnosed
cancer-taking account of their risk factors
and current symptoms. It does not give a
diagnosis of cancer, but a risk’.

The paper offers possibilities on how
QCancer can be implemented into clinical
settings as Dr Treasure points out. The
paper is not a detailed guide on the
implementation but does offer several
possibilities including the use of structured
templates. Such templates are already
commonly used to assist in data entry
across a wide range of clinical areas
including risk-assessment tools and their
use is likely to improve the ascertainment
and recording of positive and negative
symptoms over time. This will enhance
both the medical record in its primary
purpose but also future updates of the
QCancer tool.

Julia Hippisley-Cox,
University of Nottingham, Division
of Primary Care, 13th Floor, Tower Building,
Nottingham, NG2 7RD.
E-mail: juliahippisleycox@gmail.com
Carol Coupland,