Reviewer's report

Title: The effects of the Two-Week Rule on NHS colorectal cancer diagnostic services: A literature review

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Reviewer: michael thompson

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General

The review should make clear that the basis for the introduction of the 2-week clinics was that all patients ‘suspected by their GPs’ of having bowel cancer should be seen within two weeks. The Cancer and Primary Care Working Group, [a DoH group of GPs] decided that the word ‘suspected’ should not be based on a ‘hunch’, but on ‘predictive values of symptoms’, and recommended that the Association of Coloproctology of Great Britain and Ireland and the British Society of Gastroenterology together with GPs, develop guidelines to help GPs identify patients at higher risk of cancer.

This meant that not all patients presenting with the symptoms of bowel cancer would be eligible for the 2-week standard i.e. 10-15% would still be diagnosed in routine clinics.

The Guidelines were therefore designed to capture up to 90% of symptomatic patients currently referred to Outpatients. The Guidelines were not designed to identify patients needing ‘urgent admission’.

In reviews of this sort it is important to determine therefore what denominator is used when calculating the success of the Guidelines, whether this should be:

- as a percentage of the total number of patients, including emergencies
- as a percentage of those referred to Outpatients
- as a percentage of eligible patients with higher risk symptoms referred to Outpatients

It is difficult to establish what standard (percentage of correctly referred cancers) one should expect using the third denominator. It might be predicted that a lot of patients present through other routes if they have other severe and important co-morbidities, such as senile dementia, heart and chest conditions, alcoholism etc at the time of referral.
There is a need to identify why cancer patients, who would have been eligible for the 2-week clinic i.e. had higher risk symptoms, were referred elsewhere. [Reference1]

When the third denominator was used (? only one study measured this) [Reference 2] 46% of eligible patients for the 2-week clinics were so referred. It may be that it is only reasonable to expect for example 60-70% of eligible patients to be referred in this way.

It is also important not to confuse, as in the first paragraph of the ‘Discussion’, the 90% target specified in the Department of Health Guidelines, (the overall sensitivity of the Guidelines) with the colorectal detection rate of ‘only 10.3%’, which is the predictive value of the Guidelines. A more objective view of the success of the Guidelines would be to compare the overall predictive value of the Guidelines for cancer as determined in the 2-week clinic with that achieved in non-fast track routine clinics, as determined in only one of the reviewed references [Reference 2] where the diagnostic yield of cancer in non-2-week clinics was 2.2%.

The aims of the Guidelines were in fact to achieve a predictive value of 10% [Reference 3] and this misunderstanding of the Guidelines should be corrected throughout the article.

The ‘new’ Guidelines published by NICE in June 2005 are word for word virtually identical with the original Guidelines, other than the age threshold for criterion 1, which now has an age threshold of over the age 40, whereas before there was no age threshold.

It is incorrect therefore to assume that the new NICE Guidelines will by themselves achieve any improvement in the number of cancer patients that are captured nor in the predictive values of patients presenting with symptoms and signs of an iron deficiency anaemia, as determined by the Guidelines.

It is true however that there is great room for improvement, and ways should be sought to try and improve the effectiveness of these clinics. More hard data is needed to determine what standards we should aim for.

It would also be helpful to the readers if the authors could be more specific in what they are suggesting both in the conclusions of the abstract and in the final paragraph of the Paper on page 9, when they recommend that the TWC should be “officially evaluated by an independent group to determine whether there is any subsequent increase in the colorectal cancer detection rate to accompany the desired increase in GP referral time to make the TWR worthwhile”.

It would also be useful if they could suggest precisely how GPs could be helped not to refer
inappropriate patients to the 2-week clinic.

Overall I think this is an excellent review of all the available literature, it is timely and will be of value to the readers.

Their conclusions are broadly correct, and I think it is a useful exercise to bring all these studies together. The article could be considerably improved by paying more close attention to the original aims of the Guidelines and to clearly differentiate between their overall sensitivity and their predictive value and what standard they feel we should be aiming for and how this might be achieved.

References


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Declaration of competing interests:

I declare that I have no competing interesting.