THE LONDON
# Clinician

THE LONDON CLINIC

MEDICAL NEWS AND INSIGHTS FROM LONDON'S LEADING INDEPENDENT HOSPITAL

WINTER 2020

## Oncology special

# COMMONLY MISSED CANCERS

**Prof Siwan Thomas-Gibson and Mr Alastair Fry discuss two of the most commonly missed cancers**

**Dr Waseem Bakkour: putting the spotlight on dermatology**

**Case Notes**

SUPRASELLAR MENINGIOMA WITH MR PETER BULLOCK

IN THIS ISSUE

# IN THIS Issue



# Welcome
## FROM THE EDITOR

### Welcome to the second issue of The London Clinician.

We had some great feedback on our first edition and are delighted to share our latest one focused on Oncology.

COVID-19 is undoubtedly one of the biggest healthcare challenges we've faced and we know that the late presentation of cancers as a consequence of this, is at the forefront of many clinicians' and patients' minds. With figures around missed cancer diagnoses during the pandemic period emerging, it feels pertinent to include advice on identifying symptoms of commonly missed cancers from some of our leading consultants in this issue.

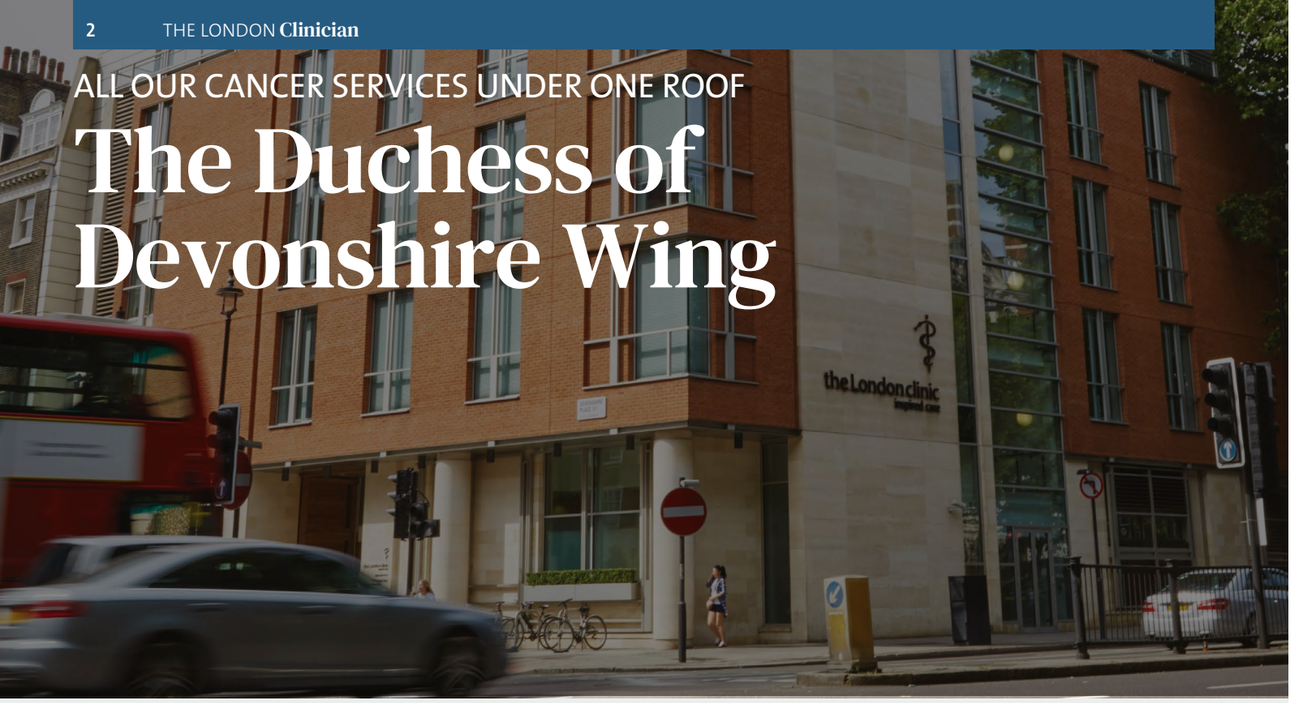
Cancer services make up the heart of The London Clinic and we see it as an absolute privilege that patients choose us to provide their care. Our service to patients doesn't stop with diagnosis and treatment, but continues through our responsibility to support both them and their loved ones through rehabilitation and palliative care, as needed. Committed to investing in the fight against cancer through innovative treatment options, we're proud of the many positive stories of recovery and are humbled to have been awarded the Macmillan Quality Environment Mark.

In this edition, as we share how we ensure holistic care is accessible to all patients, it would be criminal not to give mention to our Head Chef. He is extremely passionate about nutrition for cancer patients... teaching their families to cook more nutritious (whilst delicious!) dishes has become a regular feature in The London Clinic kitchen.

This issue's 'Case Notes' feature a patient's battle with recurring brain tumours and the use of innovative treatment options within her care plan. Read on for a dedicated 'Your Questions Answered' spread and a visual guide to skin cancers, amongst other articles... all consultant-led.

This wealth of content means we've stretched to a few extra pages this time – I really hope you enjoy reading it. Please keep your feedback and ideas coming to: **editor@thelondonclinic.co.uk**.

**SUKHY JAGDEV**
Head of Clinician Relationships




ALL OUR CANCER SERVICES UNDER ONE ROOF

# The Duchess of Devonshire Wing

**Opened by Her Majesty the Queen in 2010, our cancer unit is the largest private cancer hospital to be built in London in the last 25 years.**

This state-of-the-art facility brings all our cancer services under one roof and is led by an expert multidisciplinary team of clinical nurse specialists, physiotherapists, counsellors, dieticians and world leading oncology physicians and surgeons.

The team continually progresses their knowledge and understanding of the field by pioneering new technologies and participating in research that aims to deliver the treatments of the future.

As you will discover in this oncology special, our care does not stop once a patient has undergone a procedure or received a course of treatment. We are proud to offer a bespoke 'Moving On' programme of services to support patient recovery. For those facing life-threatening illness we provide a comfortable setting for palliative care that is free to patients who have undergone treatment at The London Clinic.

"We deliver a world-class service with a holistic approach to patient care," says The London Clinic's Medical Director and consultant surgeon, Mr Satya Bhattacharya. "By making sure that patients' needs are taken care of, and simplifying their experience by providing most services on-site, we aim to take away some of the anxiety around cancer and help patients to get the best outcomes from their treatment."

## Innovations and accolades

### Excellent...

**GRADED AS 'EXCELLENT' IN 2019** in our first Macmillan Quality Environment Mark (MQEM) assessment.

### The largest...

**STEM CELL COLLECTION CENTRE IN EUROPE**, collecting and storing stem cell and bone marrow samples until needed by cancer patients worldwide.

### The world's first...

**PRIVATE HOSPITAL** to pilot Proximie augmented reality technology, during a robotic prostate cancer operation.

### The only...

**PRIVATE HOSPITAL IN LONDON** offering adaptive radiotherapy for bladder cancer cases.

### CAR-T

**ONE OF THE FEW UK HOSPITALS** offering chimeric antigen receptor T-cell (CAR-T) therapy and the highly specialised CyberKnife robotic radiotherapy treatment system.

### IORT

**THE ONLY UK SITE TO OFFER INTRA-OPERATIVE RADIOTHERAPY (IORT)** for the aggressive brain cancer glioblastoma multiforme (GBM).

HOME



SPOTLIGHT ON

# Dermatological cancers

SKIN CANCER INCIDENCE HAS BEEN ON THE RISE CONSISTENTLY OVER THE PAST DECADE.

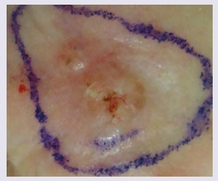
Early detection is the key to successful management and a good outcome. It is therefore imperative for clinicians in general practice to familiarise themselves with the 'red flag' signs of common skin cancers and refer for an expert opinion and a biopsy where appropriate.

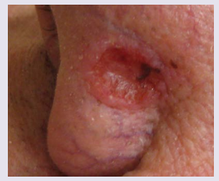
Whilst typical presentations of common skin cancers are relatively easy to recognise, atypical presentations and rarer types of skin cancer can be challenging. The safest way to approach skin lesions when the diagnosis is unclear is to refer for expert dermatology opinion, especially when there is a history of a new lesion or a change in an existing lesion.

**Here, I discuss some common examples:**

**DR WASEEM BAKKOUR,**
Consultant Dermatologist and Dermatological Surgeon, The London Clinic and University College London Hospital

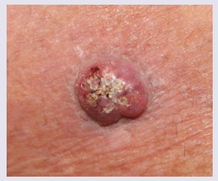
## BASAL CELL CARCINOMA (BCC)

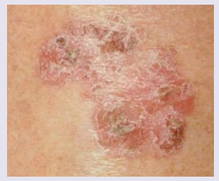




Basal cell carcinoma (BCC) often presents as a slowly growing pearly nodule that commonly ulcerates, scabs and bleeds. A rarer morphoeic type can present like a white scar that feels hard and sclerotic to touch. When suspected, these should be referred for a biopsy and excision. This should include using Mohs surgery which allows 99% accurate removal and check, followed by reconstruction on the same day. This is the gold standard treatment worldwide for head and neck BCCs.

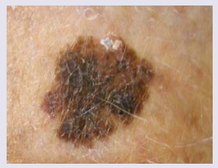
## BOWEN'S DISEASE

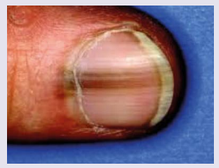


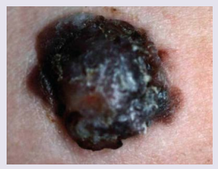


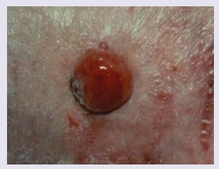
Bowen's disease is squamous cell carcinoma in-situ confined to the epidermis and usually presents as an erythematous scaly plaque. On the other hand, a full-blown squamous cell carcinoma usually presents as an erythematous nodule that grows rapidly within weeks. It usually has a central crust, can ulcerate and bleed and is often painful. Both of these should be referred for an urgent biopsy and excision, including Mohs surgery where appropriate.

## MELANOMAS









Melanomas arise on normal skin in the majority of cases (75%), usually as an irregular shaped pigmented lesion with an irregular outline, multiple shades of black, brown, blue and grey colours, and relatively rapid change. They can then progress into a nodule. In about 25% of cases they present as a change in a pre-existing mole with a history of change in size, shape and/or colour. Rarely, melanomas can be amelanotic, presenting as a friable erythematous nodule. Lastly, they can arise from the nail matrix as a longitudinal streak affecting the nail. If melanoma is suspected, an urgent referral should be made. In general, any new pigmented lesion or a change in a pre-existing mole warrants an expert assessment unless the referring clinician is confident the lesion is benign, such as in the case of sebbhoreic keratosis.

**Amisha Thobhani has been coming to The London Clinic since 2005 when she was first diagnosed with a suprasellar meningioma. Her surgeon, Mr Peter Bullock, has been by her side for over 15 years, providing treatment and support for Amisha's first and two subsequent tumours. In this case study they give us their perspectives on living with and treating meningiomas.**

*Case notes*

# BRAIN TUMOURS

## AMISHA'S PERSPECTIVE...

**I was diagnosed by chance with a suprasellar meningioma in 2005.** I had been having occasional headaches for years and the vision in my right eye had gradually blurred, but I put this down to long periods working at computer screens. I didn't consult my GP, but I did see an optician and was advised to wear glasses for screen use and have regular check-ups. It was at a check-up that a new optician noticed something abnormal behind my retina. She referred me to a specialist at Moorfields Eye Hospital who then sent me to The London Clinic. As soon as the ophthalmologist had checked my eyes, I was sent for an MRI scan, and shortly after I was told I had a suprasellar meningioma on my optic nerve. Two days later I met Mr Bullock and I have been under his care ever since.

**Unfortunately, this was only my first brain tumour.** I had a nine-hour craniotomy to remove this tumour and spent 15 days in hospital. Meningiomas can recur, so regular scans are part of your follow-up and in 2010 another tumour was identified, this time in the occipital lobe of my brain. It quickly doubled in size so I underwent a further craniotomy to remove it. No one expected to find a third tumour but, in 2015, a growth recurred at the site of my original tumour. This time invasive surgery was deemed too dangerous so I was given CyberKnife radiotherapy to shrink the tumour. I have now been living with this tumour for five years and it is currently stable.

**Removing the tumour is not the end of the story.** Recovery from brain surgery is long and difficult. I have had to learn to live with partial blindness, as a result of tumour damage to my optic nerve and, at times, I have been debilitated with brain fatigue. This type of fatigue is specific to brain injury patients and can last for years. It is an invisible illness; on the outside we all look fine but no one sees the emotional trauma on the inside such as feeling lost and helpless, mood swings, depression, memory loss, exhaustion and personality changes.

This also takes its toll on family and friends. I had only been married two years when I was first diagnosed and it turned our lives upside down. And, just over a year after my first tumour was removed, I gave birth to twins! I could not have coped without the support of my family who have been amazing throughout.

**My journey would have been a struggle without the Hillingdon Brain Tumour and Injury Group.** The support group I joined was a place full of hope where I could be myself. It gave me an opportunity to meet other people who had been through similar experiences and to whom I could relate. I didn't want to burden my family and friends with constant complaints but here I didn't have to stay strong and could be honest about my feelings with others who could understand and not judge.

**The London Clinic has been like a home away from home.** What differentiates The London Clinic is that everyone from the cleaning staff to the medical team are so welcoming and attentive. I also owe a debt of gratitude to Mr Bullock; he is a brilliant surgeon and a wonderfully kind and supportive person who has been a calm and reassuring presence throughout my treatment. My surgeries have given me a second chance at life; allowing me to be a wife, a daughter, a sister, and a mother, and demonstrating that you can overcome adversity and trauma by being positive and having faith.

### MORE INFORMATION

To find out more about treatments at The London Clinic

thelondonclinic.co.uk/treatments

If you would like to talk to us about a patient referral, please contact our Enquiries Team on

020 7935 4444





## SUPRASELLAR MENINGIOMA FACTS

- Meningiomas are the most common type of benign brain tumour diagnosed in the UK
- They tend to occur in middle-aged and older people and are more common in women than in men
- Suprasellar meningiomas occur at the base of the skull near the pituitary gland and optic nerves

## MR BULLOCK'S PERSPECTIVE...

**MR PETER BULLOCK,**
Consultant Neurosurgeon
at The London Clinic.

**From a fairly typical presentation, Amisha's meningioma developed into quite a challenging case.** Amisha presented with headaches and vision problems and, as is often the case, was referred by an optician who spotted a reduced visual field during an eye exam. Having looked at the MRI brain scan, we could see that her tumour was at a critical size and location; 4cm in diameter, growing up from the floor of the skull and wrapping around the carotid artery and optic nerve.

Surgery is the principle treatment for meningiomas and being young, fit and without other health issues, Amisha was a good candidate for craniotomy. However, brain surgery is a major undertaking and it is important to be very clear with patients about the risks involved and the recovery process.

**The majority of people who are treated for meningioma have a grade 1, slow growing tumour, have a good prognosis with surgery and are unlikely to require any further treatment.** A minority of patients have small asymptomatic tumours that do not require any treatment; and they will remain asymptomatic for life. Grade 2 or atypical tumours, have an increased risk of recurring and therefore require closer follow up. Rarely, meningiomas can be malignant, grade 3, and will require a combination of treatments. As recurrence is a possibility for all grades of meningioma, patients should be monitored with regular scans, for a minimum of five years following treatment. It was as a result of this monitoring that we discovered Amisha's second and third tumours (both grade 1).

**Neurosurgical techniques and technologies such as intraoperative navigation and endoscopy have progressed rapidly since Amisha was first diagnosed.** We were concerned about managing Amisha's third tumour with more invasive surgery and were fortunate that the CyberKnife was available at The London Clinic. This innovative technology uses X-ray imaging to focus narrow beams of radiation precisely on the tumour target thus minimising damage to surrounding healthy tissue. Using the CyberKnife we managed to shrink her tumour and it has remained stable since.

**Advances in molecular genetics are providing a deeper understanding across the whole range of brain tumours and helping to shape the future treatments of all tumours, including meningiomas.** Amisha has a marvellous positive attitude and this has been crucial in getting her through some tough times. But, the potential recurrence of tumours is often an underlying anxiety for meningioma patients. By investigating the genetics of families and the tumour cells we extract during surgery, we gain further insights into the natural history of brain tumours. New classifications are being defined with more precise tumour grades that allow us to optimise treatment strategies and give our patients the best possible outcomes.

**Meningiomas are slow growing and can be asymptomatic for years making them challenging to diagnose early.** It is only when the tumour becomes larger and exerts pressure on the brain that people begin to notice changes to their sight, hearing, personality or balance. Headaches are a late symptom of slow growing brain tumours, but headaches are one of the most common complaints of patients attending GP appointments, and it is not appropriate to send everyone for a brain scan. However, there are red flags to look out for such as; patients who describe new, severe progressive headaches; someone experiencing migraines for the first time in later life or being woken by headache.

**The London Clinic's Neuro-Oncology multidisciplinary team is happy to give advice.** We meet regularly as a team to discuss referrals and advise on cases that have been sent in by GPs and Consultants. As with most tumours, the sooner we can treat meningiomas the better. So if you have any concerns or questions, please ask the team.

HOME



DO NOT LET ASSUMPTIONS DELAY DIAGNOSIS

# Hepatobiliary cancers

MR SATYA BHATTACHARYA

Consultant General and Hepatobiliary Surgeon, The London Clinic

**Patients with acute pain in the upper abdomen rising towards the chest are usually, and quite correctly, directed to A&E.**

However, if a cardiac event is ruled out, they are often discharged with a diagnosis of acid reflux and are put on a proton pump inhibitor (PPI), with no investigation into possible hepatobiliary pathology.

"Even if symptoms recur, patients may return to A&E several times before further tests are requested," says Mr Satya Bhattacharya, Medical Director of The London Clinic. "There's a significant number of patients who encounter delays in diagnosis," Mr Bhattacharya says. "Some may be given an endoscopy, with ultrasound as an afterthought. But as ultrasound is less invasive, it should probably precede an endoscopy. The problem may be a common one such as gallstones, easily picked up on ultrasound, and very treatable. However, less often, persistent symptoms could suggest a malignancy. So, it's important that scan findings are interpreted in conjunction with liver function tests (LFTs)."

"If LFTs are abnormal, yet the gallbladder appears pristine, there may be a more sinister cause for the patient's symptoms," he adds. "In these cases, you should definitely do an MRI or CT scan to find out why the patient has abnormal liver test results without any gallstones. Painless obstructive jaundice is another warning sign to look out for."

Biliary cancer can occur in people of all ages; Mr Bhattacharya has seen it in patients aged from 30 to 80 years plus. It is more common in people with hereditary conditions such as primary sclerosing cholangitis, which can trigger bile duct cancer.

> If cancer is found, surgery is the best option. 'Get it out'
>
> SAYS MR BHATTACHARYA

If cancer is found, surgery is the preferred option, if it is feasible. "The surgeon's aim is always to get the cancer out in its entirety," says Mr Bhattacharya. "The nature and extent of the operation depends on the location of the growth – whether it is in the gall bladder or in the bile duct, and if the latter, within or outside the liver. Chemotherapy such as gemcitabine and cisplatin may shrink it but will not cure it." He stresses that, as with every malignancy, if biliary cancer is suspected it is important to act quickly. "Earlier diagnosis leads to better prognosis." If the cancer cannot be removed, the bile duct can be kept open with stenting. Mr Bhattacharya says: "It is the blockage in the biliary system and the infection that follows, that often kills the patient."

**Mr Bhattacharya has more than 20 years' experience as a consultant general surgeon with a special interest in hepatobiliary surgery.**

He has undertaken extensive research into pancreatic and liver cancer, and has written more than 50 papers, book chapters and reviews. As well as his role as Medical Director of The London Clinic, Mr Bhattacharya is an honorary consultant surgeon at the Barts Health NHS Trust

## GALLBLADDER POLYPS

**These are generally benign and are often an incidental finding on ultrasound. But they too can indicate early cancer. Mr Bhattacharya suggests looking for these warning signs when polyps have been identified:**

- The patient is over 60 years
- Stones are present
- There are symptoms – most polyps do not cause symptoms
- A solitary polyp – multiple polyps are more likely to be benign
- Size greater than one centimetre
- It is a sessile polyp, without a stalk

Removal of the gallbladder is the only option if you encounter the majority of these warning signs," says Mr Bhattacharya. "If you are only ticking one or two boxes, monitor and suggest another ultrasound in six to 12 months."

# Your QUESTIONS ANSWERED

**Oncology is a diverse field covering multiple diseases with multiple challenges in diagnosis and treatment. With so many potential topics to cover, we undertook some research, asking for your help to identify the burning questions that trouble GPs.**

**Some common themes came up, several of which focused on patient presentations, diagnostics and monitoring. In this 'Question and Answer' piece, we have taken some of the topics that featured most often and have enlisted the help of some of The London Clinic's leading consultants to give you their expert opinions.**

"We are fortunate to have some of the country's top oncologists and surgeons working with us at The London Clinic. They bring a wealth of specialist knowledge across all aspects of cancer diagnosis and treatment." Says Lina Patel, The London Clinic's Head of Cancer Services. "Sharing our medical knowledge and expertise for the benefit of the wider healthcare community is also an intrinsic part of The London Clinic's mission. As a team we are always happy to provide advice and counsel that may benefit patient outcomes."



**MR THOMAS IND,**
Consultant Gynaecological Surgeon,
The London Clinic and Head of Gynaecological Oncology,
The Royal Marsden Hospital

## Detecting and diagnosing endometrial cancer

**Endometrial cancer is the fourth most common cancer affecting women in the UK.**

As its incidence is increasing in line with rising obesity and our growing, aging population, GPs are likely to see more cases in their surgeries.

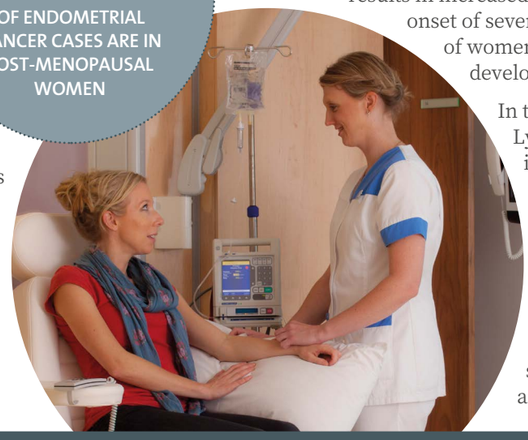
### WHAT PROPORTION OF WOMEN WITH IRREGULAR MENSTRUAL BLEEDING ARE LIKELY TO HAVE ENDOMETRIAL CANCER?

Irregular bleeding is a common complaint and relatively few women reporting these symptoms will develop endometrial cancer. Approximately 9% of post-menopausal women who see a doctor for bleeding are later diagnosed with endometrial cancer and the percentage falls greatly for pre-menopausal women.

However, 80% of endometrial cancer cases are in post-menopausal women and in this group 90% report bleeding before their diagnosis. Detected early, there is a good prognosis but in its later stages endometrial cancer is largely incurable, so any persistent, abnormal bleeding in women over 40 years merits further investigation.

**80%**

OF ENDOMETRIAL CANCER CASES ARE IN POST-MENOPAUSAL WOMEN



### HOW SENSITIVE IS ENDOMETRIAL BIOPSY FOR EXCLUDING ENDOMETRIAL CANCER?

On its own, an endometrial biopsy is not a conclusive test. It samples approximately 1% of the surface of the endometrium so may miss cancerous cells. However, combined with an ultrasound to determine if there is any endometrial thickening, the two provide a reasonable indication of the absence of cancer.

For a more conclusive result, hysteroscopy is the gold standard. There has been significant progress in this field in recent years with the development of smaller and more effective instruments. Some centres, including The London Clinic, are now able to offer hysteroscopy as an out-patient appointment as an alternative to the traditional day-case procedure under sedation. Using a small gauge hysteroscope, tissue samples and photographs of the endometrium can be taken in as little as 30 minutes, causing minimal disruption to a patient's day.

### IS THERE A ROLE FOR GENETIC TESTING?

Genetic testing does have a role in confirmed cases of endometrial cancer. Around 5% of cases of endometrial cancer develop as a result of Lynch syndrome; a hereditary disorder caused by genetic defects in one or more DNA mismatch repair genes. Lynch syndrome results in increased risk of and earlier onset of several types of cancer; 71% of women affected will go on to develop endometrial cancer.

In the case of a positive Lynch syndrome test, it is then important to confirm whether the disorder is present in a woman's primary relatives (parent, sibling or child) and to offer investigation or monitoring for signs of cancer, as appropriate.

## What do I need to look out for when examining a sinister neck lump?

**MR PAUL STIMPSON,**
Consultant ENT/Head and Neck Surgeon,
The London Clinic and University College Hospital London

**The neck contains complex anatomy and the list of possible differential diagnoses for neck lumps is very long.**

Neck lumps are common and many will resolve without treatment. However, they may also be the presenting feature of life-threatening diseases. Keeping the following tips in mind can be useful when examining a patient.

**1. Keep it simple! Expose the neck and have a really good look with a headlamp.** Are there any obvious asymmetries, scars or skin changes? Ask the patient to point to the area of concern – is there a definite lump or is there a feeling of a lump on the inside?

**2. Consider the site of the lump.** What structures exist within that area of the neck? Think in layers; is the lump in the skin, subcutaneous tissues or fat? Is it deeper and associated with blood vessels or nerves? Could it be muscular, a lymph node, or something else?

In the case of thyroid swellings, asking the patient to swallow may emphasise the lesion and a midline lump may move with tongue protrusion in the case of a thyroglossal cyst.

**3. Feel the lump from behind the patient, using two hands.** Consider the size and consistency, surface and texture. Are there multiple lumps? Red flags to watch for in a malignancy typically include a hard mass which is often deep and feels fixed to surrounding structures. It may be painful, but not always.

**4. In some cases, the exact nature of the lump may not be immediately obvious.** Patients should be referred on if there are any concerns regarding a possible malignancy.

At The London Clinic we provide a rapid access head and neck clinic. Patients can access state-of-the-art on-site imaging including ultrasound (with cytology), CT, MRI and PET scanning, often with results given during the same clinic visit. Definitive treatments are then offered based on the knowledge and expertise of the entire head and neck multidisciplinary team.

**DR JOHN COSTELLO,**
Consultant Respiratory Medicine Physician, The London Clinic

# Pulmonary nodules

**A solitary pulmonary nodule is discovered on 0.2% of chest X-rays and up to 50% of CT thorax scans.**

Whilst the radiological discovery of a lung nodule may be lifesaving for some patients, for others it is a cause of worry. In both cases it will require careful, ongoing management to establish the cause, and to help the patient through an anxious time.

## WHEN SHOULD WE BE CONCERNED ABOUT PULMONARY NODULES?

A nodule is a rounded or oval lesion <30mm in diameter. If the lesion is <6mm it is very likely to be benign and will not require follow up unless there are specific risk factors; if the patient is a smoker (or stopped in the past 15 years), is over 50 years, has a history of a previous malignancy or occupational exposure. However, larger nodules are of more concern and a diameter of 3cm or greater is suggestive of malignancy. Overall, only around 2% of incidentally discovered lung nodules (on CT) are malignant.

**2%**

OF INCIDENTALLY DISCOVERED LUNG NODULES ON CT ARE MALIGNANT

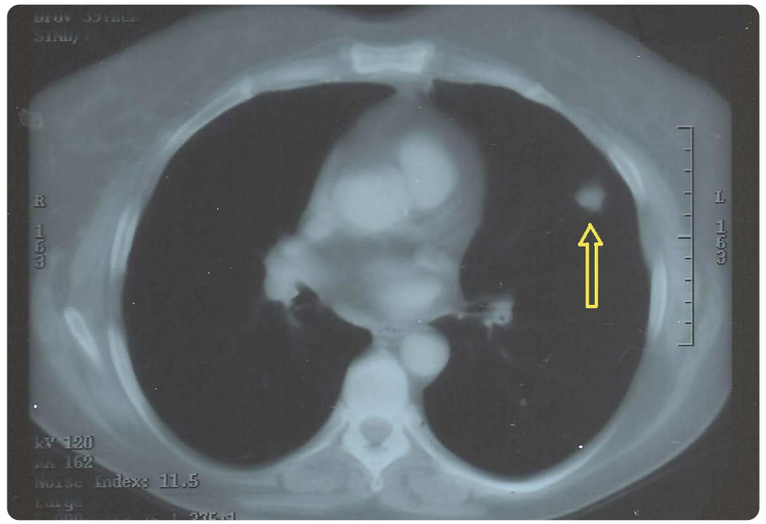
The characteristics of the nodule are critical and will provide an indication of whether further investigation or treatment is required. Spiculated or lobulated lesions are more likely to be malignant and those with ground glass, part solid and thick walled appearances need surveillance. In general, calcification is reassuring, but not always indicative of a benign lesion.

## HOW AND WHEN SHOULD PULMONARY NODULES BE MONITORED?

Benign pulmonary nodules are most commonly small scars from previous infection, for example tuberculosis or fungal infection, but many other non-malignant lesions such as benign tumours (hamartoma) or arteriovenous malformation can present this way. So, judicious reassurance on low risk may be given to younger (<40 yrs), non-smoking patients with lesions that have benign characteristics.

> “Benign pulmonary nodules are most commonly small scars from previous infection.”

For high risk patients with larger, more suspicious lesions, the British Thoracic Society Guidelines or Fleischner Society Guidelines provide clear pathways for surveillance. These pathways involve CT and sometimes PET CT imaging at defined intervals to measure growth and change, in order to make informed decisions about when and how to intervene with biopsy or removal. Low dose screening for early lung cancer in at risk groups has now been shown to significantly reduce mortality by detection of early malignant lesions.






**MR TIM BRIGGS,**
Consultant Urologist, The London Clinic and University College London Hospital

# Understanding haematuria

**Haematuria is usually classified as non-visible (microscopic) or visible (macroscopic or frank). Everybody loses some red blood cells from the kidney every day but this should only be a trace on a dipstick, or 1-3 red cells on microscopy. Apart from this, obey the rule ‘always take haematuria seriously’ and you won’t go far wrong.**

## HAEMATURIA – COULD IT BE BLADDER OR RENAL CANCER?

It may be either, but blood in the urine doesn’t always mean cancer. Being over 50 years, male and a smoker will increase the risk but only about 35% of people with visible haematuria will have something significant; with non-visible haematuria it is much less. For the remainder, haematuria usually has a benign cause such as renal kidney disease, renal or ureteric stones and infections. It can also occur in patients with previously treated prostate disease, such as after a prostate resection or after radiotherapy for pelvic cancer treatment. Diseases such as diabetes and hypertension along with protein in the urine make renal disease more likely.

## WHAT’S THE IDEAL PATHWAY FOR MANAGING HAEMATURIA TO ENSURE CANCER ISN’T MISSED?

First, ask the patient to provide a mid-stream urine sample to confirm blood is present or to make sure there isn’t an infection. Blood at the beginning of the urine stream is most likely from the urethra, throughout the stream – from the bladder, kidneys or ureters. Blood at the end of the stream may be from the bladder neck or prostate.

Whilst dipstick testing is as sensitive as microscopy it has more false positive results. In microscopic haematuria, patients should then be referred for ultrasound of the kidney, ureter and bladder and in patients over 40 years they should also have a flexible cystoscopy. In visible haematuria, a CT intravenous urogram (CT–IVU) should be requested, followed by a cystoscopy.

**35%**

OF PEOPLE WITH HAEMATURIA WILL HAVE SOMETHING SIGNIFICANT

## HOW SENSITIVE IS ULTRASOUND IN EXCLUDING THESE CANCERS?

It is good at picking up renal lesions but not particularly good at looking at the ureter, which is why, when there is visible haematuria, we do a CT–IVU. This test can miss small mucosal changes in the bladder though which is why it should be followed with a cystoscopy.

None of these tests will be 100% accurate but put the three together and you increase the chance of detecting any abnormalities.

**MR SENTHIL NATHAN,**
Consultant Urologist, The London Clinic and Consultant Urologist and Honorary Clinical Senior Lecturer, University College Hospital

# Understanding PSA

**Prostate specific antigen (PSA) has been controversial as a tumour marker for prostate cancer. It is a very useful test, but background knowledge is mandatory in understanding its relevance.**

## IS PSA SPECIFIC?

PSA is neither specific to the prostate nor statistically specific to diagnose prostate cancer. Although the majority of PSA is secreted by the prostate, it has also been found in other tissues in both sexes. PSA has a low specificity for diagnosing cancer at 25% with advocated cut off levels.

Increased PSA can be caused by urinary tract infections, urethral instrumentations, rectal examinations, following sexual intercourse, and any trauma to the perineum and prostate including prolonged cycling. Even having dogs and horses at home can cause a false elevation!

## HOW EFFECTIVE IS SERUM PSA AS A TUMOUR MARKER FOR PROSTATE CANCER?

Serum PSA has a high sensitivity for prostate cancer at 85%. If you have 100 men with prostate cancer, serum PSA will be raised in 85%. It should also be noted that the remaining 15% could have cancer with a false negative serum PSA estimation so a digital rectal examination is advised to check for clinically palpable malignant disease.

**85%**

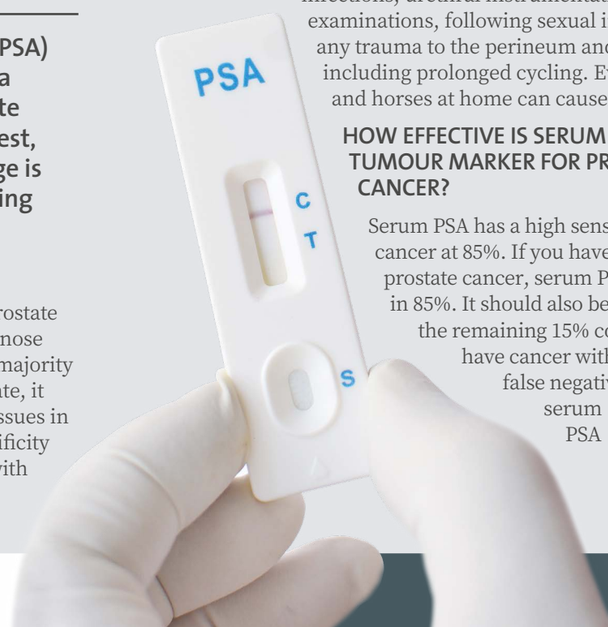
SERUM PSA HAS A HIGH SENSITIVITY FOR PROSTATE CANCER

## HOW CAN WE IMPROVE THE SPECIFICITY OF SERUM PSA ESTIMATION?

Age-specific PSA, especially in young men, increases specificity from 25% to around 35%. Using the ratio of free PSA to total PSA can improve the specificity to 40% in the absence of infection.

PSA density can increase specificity up to 80% but requires serum PSA and the prostate volume estimation from either a transrectal ultrasound or MRI scan.

PSA kinetics, monitoring PSA over time, can also provide a useful indication of a potential malignancy; an increase of 0.75 µg/ml per year or a doubling time of under 36 months indicates significant chance of having cancer.




HOME

**Recent headlines have covered the negative impact of COVID-19 on cancer referrals, diagnostic testing and the reluctance of many people to visit their healthcare providers. Cancer charities are concerned about a backlog of people with undiagnosed cancer and how treatment delays will affect their long-term outcomes.**

**As people regain confidence in coming back to their GPs, extra vigilance will be needed to ensure that potential cancer symptoms are identified and people receive timely testing and treatment. However, some cancers can be harder to identify than others and symptoms may be overlooked as they overlap other less threatening conditions. In this article, two of The London Clinic's top consultants provide examples of some commonly missed cancers and highlight the key symptoms and patterns to help identify them.**

**22%**

**of the 356,000 people diagnosed with cancer each year were only picked up at A&E**

# COMMONLY MISSED CANCERS

**Cancer survival rates are now at their HIGHEST EVER**






## PROFESSOR SIWAN THOMAS-GIBSON

Consultant Gastroenterologist and Specialist Endoscopist, The London Clinic and St Mark's National Bowel Hospital London and Professor of Practice in Gastrointestinal Endoscopy at Imperial College London


## Cancers of the Upper and Lower Gastrointestinal Tract (GI)

**The challenge with identifying these types of cancers is that patients commonly present with vague symptoms that overlap with other less grave gastrointestinal (GI) conditions.** Often the most disturbing and indicative symptoms do not occur until the cancer progresses. It is therefore important to be able to recognise the early warning signs for GI cancers to ensure they are investigated thoroughly, as often an early diagnosis will lead to much better outcomes.

Whilst most of us are familiar with the below red flag symptoms, it is worth knowing that 21% of bowel cancer patients see their doctor more than three times before they receive a referral:

**SYMPTOMS INCLUDE**

- Unexplained abdominal pain
- Weight loss
- Fatigue (which may be due to anaemia)
- Blood in stools
- Change in bowel habit.

**21%**

**of bowel cancer patients see their doctor more than three times before they receive a referral**

Persistent problems with any of these symptoms should be investigated. This is also relevant in patients under 50 yrs, who may not historically have been seen as 'at risk,' but for whom bowel cancer incidence is now increasing.

Cancers of the upper GI tract are more of a challenge to diagnose as there is no simple screening test. Symptoms can overlap those above with the addition of reflux which may indicate an oesophageal problem.

Faecal immunochemical tests (FIT) may be a first step in investigating patients for lower GI cancers. With all suspected GI cancers, diagnosis is best confirmed with an endoscopy (colonoscopy or gastroscopy) or a CT scan. A timely colonoscopy can catch pre-cancerous lesions or cancers in their early stages.

At The London Clinic we are fortunate to have a world-class, JAG* accredited endoscopy suite and one of the largest independent specialist GI centres. Our close team of experienced professionals includes some of the world's leading endoscopists and radiologists, reassuring our patients that they will receive the very highest levels of care in our hands.

*Royal College of Physicians Joint Advisory Group on Gastrointestinal Endoscopy


## MR ALASTAIR FRY

Consultant Oral and Maxillofacial Surgeon The London Clinic and Chair of the Head and Neck Team at Guy's Hospital


## Commonly Missed Head and Neck Cancers

**Some head and neck cancers can be tricky to spot because they have innocuous symptoms that can be overlooked.**
In the upper jaw, maxillary sinus cancers often present late; there is an air space into which the cancers can grow and they can get quite large before you notice any symptoms. In the oropharynx, you may not be able to see anything, but cancers can cause a lump in the neck or pain on swallowing which people pick up on.

The biggest pitfall with oral cancers is that people often present to their GP with something that looks like a tooth infection. These types of symptoms can be commonly treated with a course of antibiotics. In the case of cancer, however, this will not make them go away. Anyone with a persistent change in the mouth, lasting more than two weeks, needs to be referred. Red flags to look for are tooth and gum infections that do not resolve with antibiotics, swollen gums, loose teeth, altered sensation or numbness in the gum or jaw, or a lump in the mouth.

Lately, I am seeing many cancers of the jaw. Dentists are key in identifying and referring people with mouth cancers. Unfortunately, with the cancellation or delay in appointments due to the COVID-19 pandemic, this has not been happening. Early identification dramatically improves outcomes – there is a 95% cure rate if we spot these cancers early, but this falls to 50% when they present in the advanced stages. We all need to be extra vigilant, especially whilst the pandemic is still impacting healthcare services.

Dysplasias can provide an early warning system for mouth cancers. These are precancerous lesions that typically appear as white, red or mixed patches in the mouth that may or may not be painful. They offer a window of opportunity to stop the development of mouth cancer by early removal. Once confirmed by biopsy, any abnormal cells can be lasered off in a relatively simple procedure.

**RENE MAREE,**
Advanced Physiotherapy Practitioner

**KAROLINA WOJCIK,**
Senior Physiotherapist

**MARTA OLIVEIRA,**
Senior Physiotherapist

# Physiotherapy

## SUPPORTING PATIENTS THROUGH CANCER SURGERY AT THE LONDON CLINIC

Physiotherapy plays an integral part in most cancer surgeries, supporting patients both pre and post-operatively to optimise their physical health and achieve the best outcomes from their procedures. For these reasons, physiotherapy is an important element within the holistic package of care provided by The London Clinic and has helped many of our patients on their road to recovery.

**The benefits of pre-operative physical exercise are well documented.** In fact, the Royal College of Anaesthetists recommends regular cardiovascular physical activity prior to all surgeries. Evidence also suggests that structured exercise therapy, as part of a prehabilitation programme for patients undergoing major abdominal surgery and the resection of non-small cell lung tumours, results in a significant reduction in post-operative pulmonary complications.

At The London Clinic, the Physiotherapy team offers comprehensive pre-admission assessment to patients due to have cancer surgery. This includes advice and education around preparing for surgery, a tailored exercise programme and inspiratory muscle training depending on the type of surgery the patient is having. Examples include the provision of pelvic floor exercises and practical advice on how to avoid straining post-operatively for patients who are due to have radical prostatectomy or gynaecological cancer surgery. For patients who are due hepatobiliary, colorectal, oesophagogastric or thoracic surgery, we will educate them around early mobilisation post-operatively, chest expansion exercises and airway clearance techniques.

**Physiotherapy plays an essential role in helping our patients get back to their best health post-surgery.** Enhanced recovery programmes have been shown to speed up patient recovery after elective major or complex surgery; typically resulting in less time in hospital and a faster return to normal activity compared with traditional recovery.

Physiotherapists are essential in enhanced recovery programmes. The goal is always to optimise patient mobility, increase strength and activity levels, and to overall improve their quality of life.

The number of post-operative physiotherapy sessions will be tailored to each patient's requirements and preferences. Post-surgical patients routinely receive two treatment sessions daily during their hospital stay. This may include respiratory physiotherapy, indicated to manage post-operative pulmonary complications. For example, for patients with suppressed diaphragmatic movement, reduced chest expansion, atelectasis and difficulties in clearing secretions. Respiratory physiotherapy is also available as an on-call service overnight.

Physiotherapy will often also address the post-operative consequences some patients experience, such as reduced range of movement and strength, swelling, pain and reduced mobility.

**Our collaborative approach means our patients receive a consistently high standard of care.** We are an expert on-site team providing care within state-of-the-art facilities. This enables us to offer patients a continuity of care that goes above and beyond expectations.

Our patients are normally reviewed within 24 hours of surgery, or if indicated, as soon as a couple of hours after surgery. Thanks to the physiotherapy pre-admission assessment service, we are aware of all scheduled theatre admissions and can anticipate when a patient might need early intervention. We can then ensure the appropriate skill mix of treating therapists is available.

Close working between our inpatient and outpatient physiotherapy teams maintains the continuity of care for our patients beyond discharge. We offer a wide range of treatments to aid recovery following cancer surgery and improve patient well-being. Services are provided within our own treatment rooms, fully equipped inpatient and outpatient gyms, or aquatic therapy pool and include: specialist men's and women's health services; aquatic therapy; respiratory physiotherapy; specialist musculoskeletal physiotherapy; acupuncture; cancer rehabilitation and a lymphoedema service.

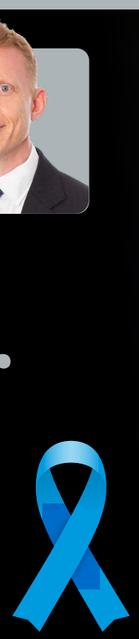
HOME



**MR OLIVER WARREN,**
Consultant Colorectal Surgeon, The London Clinic and Chelsea and Westminster Hospital, and Honorary Clinical Senior Lecturer, Department of Surgery and Cancer, Imperial College London

## FIT FOR PURPOSE

# Testing for Colorectal Cancer



Bowel symptoms are very common in primary care, so any tool that helps triage the need for referral or further investigation is worthy of attention. Faecal immunochemical testing (FIT) is one such tool and a useful addition to the diagnostic armamentarium.

**FIT is a high-precision, non-invasive test for detecting blood degradation products in the stool.** It has all but replaced the guaiac-based faecal occult blood test (gFOBT). Only one stool sample is needed, compared to three in FOBT, making it more acceptable to patients.

FIT has been widely used as a screening tool in asymptomatic people in the UK since around 2017 but, increasingly, studies have focused on its role in symptomatic patients.

The test carries a high sensitivity and specificity for the detection of colorectal cancer for results above 10 micrograms Hb/g faeces. The overall accuracy of FIT for colorectal cancer is 95%. For every 100 tests carried out to assess whether the patient has bowel cancer, the result will be correct on all but five occasions and these will either be false positive or false negative tests. The false positives are not too worrisome – patients go on to have a colonoscopy and are reassured. But false negatives are something we all fear as we then miss the cancer.

**95%**

THE OVERALL ACCURACY OF FIT TESTING FOR COLORECTAL CANCER

The cut-off level for 'negative' varies according to whether the patient is being screened (asymptomatic) or is symptomatic, where the test is being used to guide the need for further investigations.

The likelihood of a FIT-negative, asymptomatic individual having colorectal cancer is very low, hence the test's use as a national screening tool. The likelihood of a symptomatic patient with a negative FIT test having bowel cancer is in the order of 0.5-1%, depending on the severity of symptoms and other factors, particularly age.

In a 'low-risk' patient – someone under 40 years with either no red-flag symptoms or only one – a negative result is fairly reassuring that the cause is not bowel cancer. Where any concern remains, a colonoscopy is still the gold standard of care.

Rectal bleeding is the most common first presenting complaint of rectal cancer. A FIT test in this population has no benefit – consider it positive and refer the patient. I believe all patients with rectal bleeding need at least a flexible sigmoidoscopy and, more commonly, a full colonoscopy. This diagnostic aspect can often be combined with a therapeutic intervention for the most common causes of rectal bleeding – haemorrhoids and fissure-in-ano – if conservative therapies have failed.

FIT should not be compared to colonoscopy. FIT simply indicates the presence of blood, while colonoscopy offers the chance to visualise, biopsy and deliver therapy. We know that in at least 25% of people over 50 years who have a colonoscopy we will find and remove at least one polyp. We also know that removing polyps lessens a patient's likelihood of being diagnosed with, and dying of, bowel cancer. So the finding – or not – of polyps allows us to risk stratify a patient's requirement for future colonoscopy and their likelihood of developing bowel cancer.

**The palliative care team offers a range of services, free of charge to those who have undergone treatment at The London Clinic, to bring comfort and support to patients facing life-threatening illness and their families.**

CHRISTINA WATKINS
Lead Symptom Control & Palliative Care Clinical Nurse Specialist, The London Clinic

## MAKING A DIFFERENCE WITH

# Palliative care

The vision of the Palliative Care team at The London Clinic is to provide the highest quality end-of-life care to those accessing its services, whatever their diagnosis, irrespective of their ability to pay.

Though always an important element of the care offered by The London Clinic, the dedicated, palliative care service offered today was established seven years ago by myself and another clinical nurse specialist (CNS). Since then the team has expanded to include two part-time CNSs, an end-of-life care facilitator and a consultant in palliative medicine. We see patients face-to-face, six days a week Monday through to Saturday, and a member of the team is available out of hours and on Sundays for advice. Having a salaried consultant, who is readily available to offer help and advice, makes a big difference to our team and the care we are able to provide to our patients and their loved ones.

Our team is based in the Duchess of Devonshire Wing, but we provide services to patients in their own private rooms throughout the hospital. Our service is comparable to hospice care and patients also benefit from being in a hospital setting; if required, interventions or scans can all be arranged quickly without the need for ambulance transport or to wait for an appointment.

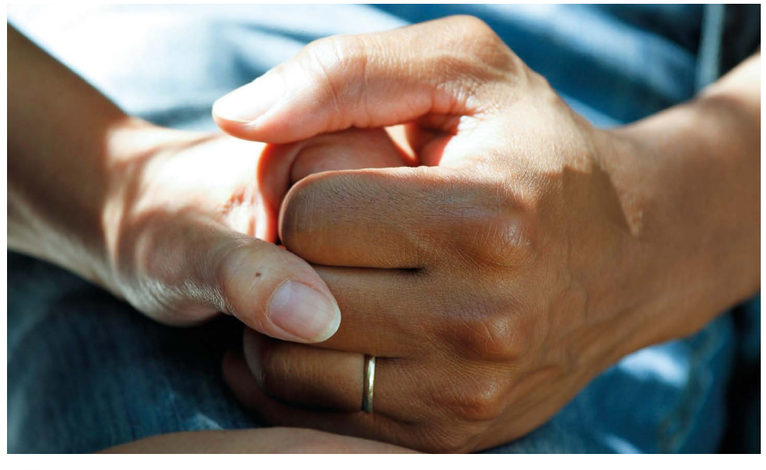
The team is guided by the World Health Organisation definition of palliative care. This emphasises a holistic approach to advancing illness, where any physical, psychosocial or spiritual need the patient may experience is acknowledged and addressed. The prevention and relief of pain and suffering are key. To meet those aims, we offer a range of services including complex symptom management and end of life care, emotional support and financial advice for patients and families; specialist counselling; as well as family bereavement support.

> “At The London Clinic, we believe that palliative care is everyone’s responsibility. So, although the service is there to provide expertise, members of our palliative care team work closely with other teams across the hospital.”

At The London Clinic, we believe that palliative care is everyone’s responsibility. So, although the service is there to provide expertise, members of our palliative care team work closely with other teams across the hospital. Our end of life facilitator plays a significant role in helping teams through a patient’s final illness, while everyone on the ward, including catering and domestic staff, are trained both to support patients and to cope with their own bereavement.

Most patients seen by the palliative care service are already in the care of a consultant at The London Clinic. Many of those referred have cancer, though doctors and clinical nurse specialists from other medical specialities can also refer patients with other life-limiting illnesses. We sometimes see patients immediately after cancer diagnosis, if they are experiencing many symptoms such as excessive pain and nausea. But most are further into their treatment journey when, as well as symptom management, we will also offer help with the side effects of chemotherapy and radiotherapy.

Our service has not been untouched by the COVID-19 pandemic, but we always endeavour to support our patients and their families to the best of our abilities. We are pleased to have been able to provide virtual counselling for those who have needed it, while patients have continued to have the option open to them of having a relative or close family member with them in the last few days of life.







# OUR Events

Our onsite educational events went virtual earlier this year as a result of the COVID-19 pandemic.

We have had a great response to the new format and we were delighted that so many of you were able to take advantage of the varied programme of seminars, workshops and Q&A sessions on offer.

We plan to continue to support you with online content and are proud to present our upcoming programme of events, alongside further information on how to reserve your place.

## UPCOMING EVENTS 2021

### JANUARY

**TUESDAY 12TH** 12.30
**Respiratory**
The COVID-19 Chest

**WEDNESDAY 20TH** 12.30
**Breast Surgery**
Lumps and Bumps

**THURSDAY 28TH** 12.30
**Orthopaedics – Shoulder**
Management of Shoulder Problems in General Practice and Key Tips for Virtual Examinations

### FEBRUARY

**TUESDAY 2ND** 12.30
**Colorectal Surgery**
Update on Chronic Diarrhoea

**WEDNESDAY 10TH** 12.30
**Gynaecology**
Polycystic Ovaries

> “The talk was really informative and helpful. It covered some really important topics and I felt that I learnt a lot.

**THURSDAY 18TH** 12.30
**Care of The Elderly**
COVID-19 and The Elderly Examinations

**TUESDAY 23RD** 12.30
**Orthopaedics – Spine**
Disc Prolapse and Tips for Virtual Examinations

### MARCH

**WEDNESDAY 3RD** 12.30
**Women’s Health**
HRT and Menopause

**THURSDAY 11TH** 12.30
**Cancer**
Bowel Cancer

**WEDNESDAY 17TH** 12.30
**Ophthalmology**
COVID-19 and Telemedicine

**TUESDAY 23RD** 12.30
**Orthopaedics – Hip & Knee**
Managing Hip and Knee Pain in Young Adults

> “Today’s webinar – brilliant – keep them coming!

## THE LONDON CLINIC ONLINE EVENTS JULY TO OCTOBER 2020

**520** attendees

**55HRS** of free virtual education for GPs and AHPs

**35** consultant speakers

**15HRS** of free virtual education sessions delivered directly to GP & AHP practices

To reserve your free place on one or all of our events, or to arrange a virtual education session for your practice, please:
**EMAIL** gpliaison@thelondonclinic.co.uk **CALL**: 07841 049744 or 07525 836277


THE
LONDON
CLINIC
WORLD-CLASS BREAST CANCER SPECIALISTS
"Being in safe hands is everything. The London Clinic follows the same MDT approach to breast cancer treatment as the NHS, with specialists working collaboratively for the best patient outcomes. As an international leader in cancer care, we provide rapid access to the latest technology, leading consultants and nursing teams."
Mr Gerald P H Gui
Consultant Breast Surgeon MS FRCS FRCS(Ed)
The London Clinic
The Royal Marsden NHS Foundation Trust
The London Clinic is the UK's largest independent charitable hospital, operating from the heart of Harley Street. Our cancer centre offers patients quick access to the best possible diagnostics, treatment and surgery for all forms of cancers, including breast cancer.
To book an appointment with one of our renowned breast specialists, call us on +44 (0)20 8108 9500 or visit thelondonclinic.co.uk/breastservices to discover more.
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