



Be Clear on Cancer: Regional abdominal symptoms campaign, 2017

Caveats: This summary presents the results of the metric on emergency presentations. This is one of a series of metric summaries that will be produced for this campaign, each focusing on a different metric. A comprehensive interpretation about the campaign is not included here as this requires a full evaluation of all the metrics. The full evaluation of each campaign is published as a final report incorporating the results of all the metrics. These metrics should not be considered in isolation.

Emergency presentations

The campaign

The regional abdominal symptoms campaign ran from 9 February to 31 March 2017 in the East and West Midlands.

The core campaign message was:

'Don't ignore the warning signs. If you've been suffering from tummy troubles such as diarrhoea, bloating, discomfort or anything else that just doesn't feel right for 3 weeks or more, it could be a sign of cancer. Finding it early makes it more treatable. Tell your doctor'.

Metric: Emergency presentations

The Hospital Episode Statistics (HES) derived emergency presentation metric is calculated from inpatient data and uses the methodology set out in the cancer outcomes metric specification.¹ It measures the proportion of people with oesophageal, stomach, lower gastrointestinal (GI), pancreatic, ovarian or renal cancers who first presented as an emergency.

Data were extracted for persons admitted between July 2015 and June 2017 in the East and West Midlands with a primary diagnosis of oesophageal (ICD10 C15), stomach (C16), lower GI (C18-20), pancreatic (C25), ovarian (C56-57) or renal (C64) cancer. Numbers do not include persons diagnosed via other routes. For example, outpatient or general practice settings.

Key message

The regional abdominal symptoms campaign appears to have had no impact on the proportion of relevant abdominal cancers diagnosed through emergency presentation.

¹ Public Health England. Indicator Specification: Proportion of cancer admissions diagnosed for the first time via emergency presentation. 2015.

For each month, the proportion was calculated as the number of first inpatient admissions for oesophageal, stomach, lower GI, pancreatic, ovarian and/or renal cancer presenting through an emergency route, divided by the total number of first inpatient admissions for those cancers, multiplied by 100. Binomial confidence intervals were calculated using the Wilson score method.

Results are presented comparing the periods July 2015 to June 2016 and July 2016 to June 2017. The impact of the campaign was assessed by comparing the proportion of relevant abdominal cancers diagnosed through emergency presentation for the campaign period plus 2 months post campaign, from February to May 2017, with the same months in 2016. In addition to a year-on-year comparison, results for the regional pilot area (East and West Midlands) were also compared with those for a control area (South East).

Cancer sites were analysed separately, and also grouped together as abdominal cancers. The analysis also considers 2 separate age-groups; those aged 50 and over and all ages combined.

Results

For all ages combined, there were 11,388 persons admitted with a relevant abdominal cancer diagnosis in 2016-17, 2,842 of whom presented through emergency presentation. In 2015-16, there were 11,335 and 2,913 respectively.

For the East and West Midlands there were no significant differences in the proportions of patients with a relevant abdominal cancer diagnosis who first presented via emergency presentation in February to May 2017 compared with the same months in 2016 (Figure 1). The proportions of patients with a relevant abdominal cancer diagnosis who first presented via emergency presentation during the regional campaign period plus 2 months were 24% in February, 25% in March, 25% in April and 23% in May 2017 compared with 24%, 27%, 25% and 26% for the same 4 months in 2016.

For those aged 50 and over, there were 10,614 persons admitted with a relevant abdominal cancer diagnosis in 2016-17, 2,688 of whom presented through emergency presentation. In 2015-16, there were 10,529 and 2,718 respectively. Results for those aged 50 and over were very similar to all ages combined.

By individual cancer site, there were no significant differences in the monthly proportion of patients diagnosed with oesophageal, stomach, lower GI, pancreatic, ovarian or renal cancers through emergency presentation during February to May 2017 compared with February to May 2016.

For all ages combined, there were no significant differences in the monthly proportions of patients diagnosed with a relevant abdominal cancer through emergency presentation during February to May 2017 between the East and West Midlands and the control area (South East) (Figure 2). The proportions of patients with a relevant abdominal cancer diagnosis who first presented via emergency presentation during the regional campaign period plus 2 months in the South East were 22% in February, 25% in March, 28% in April and 26% in May 2017.

Figure 1: Proportion of emergency presentations and 95% confidence intervals for relevant abdominal cancers, East and West Midlands, all ages combined, 2015-16 and 2016-17.

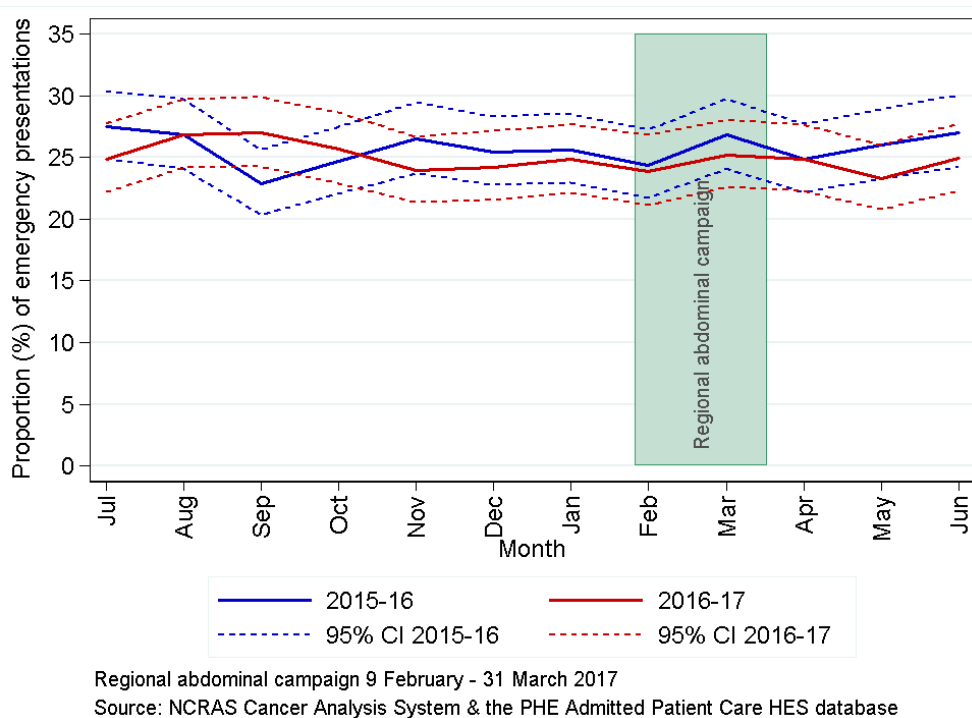
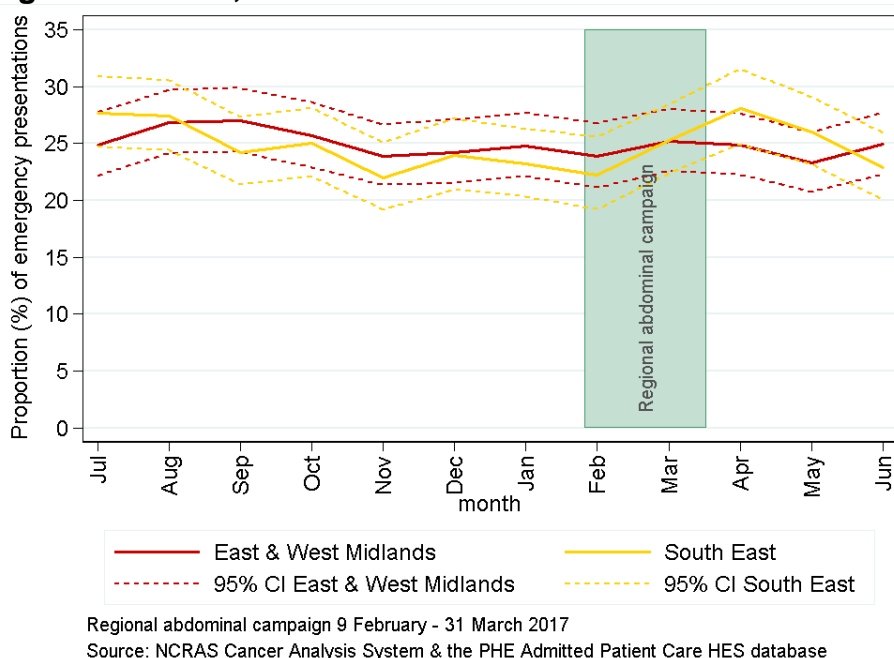


Figure 2: Proportion of emergency presentations and 95% confidence intervals for oesophageal cancer, East and West Midlands, and control area (South East), all ages combined, 2016-17.



Conclusions

The regional abdominal campaign appears to have had no impact on the proportion of relevant abdominal cancers diagnosed through emergency presentation, for those aged 50 and over or for all ages combined.

Other metrics being evaluated include the Cancer Waiting Times referrals, conversion and detection rate, numbers of cancers diagnosed, stage at diagnosis and one-year survival.

Considerations

In general, cancer incidence is increasing which may have an impact on trends over time for this and other metrics. So the results must be considered with these underlying trends in mind.

Where the results are statistically significant there is some evidence for an impact of the campaign. Although underlying trends and other external factors (for example other awareness activities, changing referral guidance) may also affect the results.

Campaigns are more likely to have a greater impact on metrics relating to patient behaviour (for example symptom awareness and GP attendance with relevant symptoms) and use of the healthcare system (for example urgent GP referrals for suspected cancer), compared to disease metrics (for example incidence, stage at diagnosis, and survival).

Find out more about Be Clear on Cancer at:

www.ncin.org.uk/be_clear_on_cancer

www.nhs.uk/be-clear-on-cancer/