**Remote Consulting (For Lessons of the Week)**

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Here are some more tips on remote consulting which colleagues have shared during courses which have been run around the region and have been collated.

Please note - there will be exceptions to every rule, trust your instincts, and if something doesn’t feel right, it probably isn’t right.

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***7. Could I be missing a cancer?***

Lots has been written about missing cancers due to the increase in remote consulting - but remember, we have always sadly missed some cancers even following a face to face, so some general themes and tips may help minimise the impact of the on-going restrictions we are all working under.

A number of cancers have been discovered following a series of remote consultations and in retrospect maybe there were some clues, including:

**1. The old 3 strikes and you're out rule** - I know this has saved my bacon on numerous occasions - if a patient contacts you about. a problem that has not been resolved after 3 consultations. (remote or otherwise) then it is worth giving some consideration to whether a F2F or a referral ( by 2ww if criteria met) is a good idea (or at least investigate to prompt a further consideration of risk, for example a FIT test?)

**2. Do all symptoms carry the same weight?** (if you pardon the pun)

* unintentional weight loss
* persistent vomiting
* painless jaundice

have a much higher predictive value of being related to serious pathology or cancer than others eg itching around a mole.

When a patient persistently mentions a symptom, ask yourself if checking the 2ww form for that symptom / department would help reassure you or add weight to the fact that a referral might be appropriate? Would phoning a friend help (discussing with one of your practice colleagues or consultant connect)?

**3. Listen to the ideas, concerns and expectations** - both of the caller and any sensible concerned others - annoyingly they have a habit of being right.

**4. Some haematological markers** may suggest malignancy - look for a subtle drop in Hb or ferritin or persistently elevated platelets / ESR.

**5. What about the art of note keeping and 'storytelling'** - so that the next clinician has as good an idea as possible of the thinking that preceded their contact. Try to convey a sense of a plan and acknowledgement of results that may be slightly off, or symptoms that have recurred, otherwise it is all too easy to miss those subtle clues when coming into a series of telephone consultations.

Imagine talking to Beryl, age 78 who has had repeated UTIs, some with haematuria. Would you be surprised if in the end bladder cancer was the final diagnosis? Would NICE or 2ww guidelines suggest that further investigation was appropriate? And at what stage? Be aware of colluding with a patient who is trying to talk you out of arranging an invasive investigation and downplaying their symptoms “it’s just a bit of bleeding doc” (think wellness bias).

Remember, you don’t need to video if the phone call is good enough but for vague symptoms consider whether video or F2F is needed. In essence, it’s about walking that horrible tightrope between risks of Covid versus missing cancers.

And time is always on our side in primary care, do they need referring NOW, or could we review in a month? If their weight was steady in one to two months down the line would that reassure you that “masterly non-intervention” was appropriate? And in the meanwhile, safety netting is your “get out of jail free card” when there is uncertainty - so use it.

All symptoms are equal, to paraphrase George Orwell, but we all know that when it comes to the predictive value of symptoms in cancer diagnosis, some are more equal than others.