Upper GI

Oesophageal Cancer

PLEASE REFER TO THE DIRECT ACCESS GASTROSCOPY SERVICE FOR SUSPECTED CANCER
2 Week Direct Access Gastroscopy (SEPARATE 2WW FORM)

If an upper GI cancer is identified at gastroscopy, the patient will be automatically discussed at the Upper GI Cancer Multidisciplinary Team meeting and managed appropriately.

☐ Dysphagia

(Consider direct referral for barium swallow, rather than gastroscopy, where **dysphagia is above suprasternal notch**. For direct access barium swallow, please use the Suspected Upper Gastrointestinal Tract Cancer Referral form)

☐ Aged 55 and over with weight loss **and** any of the following

☐ Reflux ☐ Upper abdominal pain ☐ Dyspepsia

☐ Highly suspicious of oesophageal cancer but patient is unfit or unwilling to undergo a gastroscopy.
Reason for referring to clinic rather than direct access gastroscopy

Gall bladder cancer

☐ Ultrasound indicates gall bladder cancer

(MANDATORY) ALL PATIENTS MUST HAVE GFR (renal function) within 6 weeks, as they are likely to need a contract CT scan before review.

Liver cancer

☐ Ultrasound indicates liver cancer

(MANDATORY) ALL PATIENTS MUST HAVE GFR (renal function) within 6 weeks, as they are likely to need a contract CT.

Pancreatic cancer

☐ Over 40 with jaundice;

(MANDATORY) ALL PATIENTS MUST HAVE GFR (renal function) within 6 weeks,

☐ ultrasound indicates pancreatic cancer.

(MANDATORY) ALL PATIENTS MUST HAVE GFR (renal function) within 6 weeks,

☐ CT indicates pancreatic cancer

Clinical findings

☐ upper abdominal mass consistent with stomach cancer

☐ Aged 60 and over with weight loss **and** any of the following:

☐ diarrhoea ☐ abdominal pain ☐ Vomiting ☐ New-onset diabetes

☐ back pain ☐ nausea ☐ Constipation