

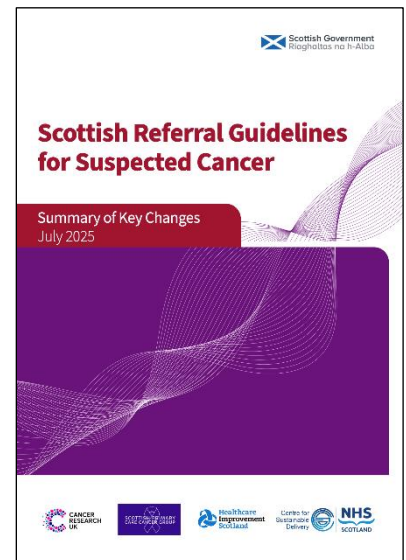


Keeping you updated with **Lothian Referral Guidelines**- for previous e-Bulletin issues see [RefNews](#)

Lead Referral Advisor – Becky Cheesbrough

Welcome to this special “bumper” edition of the e-bulletin. Over the last six months, the RefHelp team has been working closely with our Secondary Care colleagues to implement the updated **Scottish Referral Guidelines for Suspected Cancer (SRG)**, published in 2025. This work has led to the creation of several new RefHelp pages, updates to many existing pages, and multiple changes to SciGateway referral forms and pathways.

In this e-bulletin, we summarise the most important changes and outline the new and updated referral pathways in Lothian. We have also produced a webinar—with special guest Lorna Porteous, Primary Care Cancer Lead for NHS Lothian—which provides an overview of the SRG and recent pathway changes. You can watch it here: [srg_refhelp | Videos & Movies on Vimeo](#)



You can access the full SRG here: [Scottish Referral Guidelines for Suspected Cancer 2025](#), and a useful summary of the key changes here: [Scottish Cancer Referral Guidelines Review](#)

To support awareness and implementation of the SRG, the Scottish Government’s Detect Cancer Earlier (DCE) Programme, and NHS Education for Scotland, have partnered with GatewayC to provide a dedicated Scottish Referral Guidelines area. Various resources include bitesize videos, learning modules and a podcast coming soon.

[Scottish referral guidelines for suspected cancer - GatewayC](#)



Thrombocytosis and Cancer

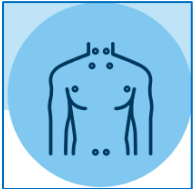
The commonest causes of a persistent, unexplained thrombocytosis (platelets $>400 \times 10^9/l$) are reactive. Myeloproliferative disorders are relatively rare.

However, there are significant associations with cancer generally. In people aged ≥ 40 with a new thrombocytosis, the SRG reports **a cohort study showing higher all-cancer incidence of 11.6% in men and 6.2% in women (cf controls of 4.1% / 2.2% respectively)**. ***This well exceeds the threshold for referral for malignancy, and the risks are even higher with a raised ALP.***

There are specific associations with the **LEGO-C** cancers which need to be actively considered: **L**ung, **E**ndometrial, **G**astric, **O**esophageal & **C**olorectal.

Top Tips for thrombocytosis:

- Significant reactive thrombocytosis can take 6-8 weeks to settle - consider other differentials: chronic inflammatory conditions; iron deficiency; polycythaemia. If there are no red flags, tests may need to be repeated to ensure that they settle.
- Thorough history and examination including scrutiny for LEGO-C cancers
- Where there are no tumour-specific symptoms arrange a USOC chest X-ray
- And arrange further tests if you have a 'gut feeling' of something more serious wrong, including consideration for Chest - Abdo - Pelvis imaging.



Haematological Cancers

We have a new suite of RefHelp pages on haematological cancers. The individual pages provide more detail, but some headlines are:

- They are generally more common in older age, with the majority diagnosed in those over 60, the exception being Hodgkin's lymphoma (almost half diagnosed under 40)
- Remember the 'B symptoms too' - weight loss, fever, or drenching night sweats - but they have a wide differential too
- [Leukaemia](#) - acute leukaemia presents with pancytopenia due to bone marrow failure and needs emergency (same day) referral. The chronic leukaemias develop more gradually: Chronic Myeloid Leukaemia also warrants urgent haematological discussion; Chronic Lymphocytic Leukaemia is often an incidental finding
- [Lymphoma](#) - hepatomegaly and/or splenomegaly are common, but lymphadenopathy is a strong feature: 95% of people with Hodgkin's Lymphoma present with lymph node involvement. *Don't forget to consider HIV too!*
- [Myeloma](#) can be more tricky, with non-specific symptoms in the early stages. The new myeloma page suggests a risk assessment to consider the level of investigation based on the clinical scenario and any red flags. The page also has advice about Monoclonal Gammopathy of Undetermined Significance (MGUS).



Head & Neck Cancers

The main presenting features of ENT cancers remain unchanged: they are commoner in men (2:1) and have strong associations with age, smoking, tobacco chewing and alcohol. However, there are some new areas of emphasis in the [Head, Neck and](#)

[Thyroid section](#) of the cancer referral guidelines:

- Socioeconomic deprivation is a significant risk factor, as is drug use (especially opioids and cannabis)
- People from more deprived areas, ethnic minority groups, the elderly and those with multiple comorbidities present later and have poorer outcomes
- HPV as a risk needs to be considered, especially in young people (age 30-40).

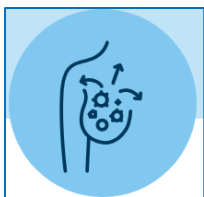
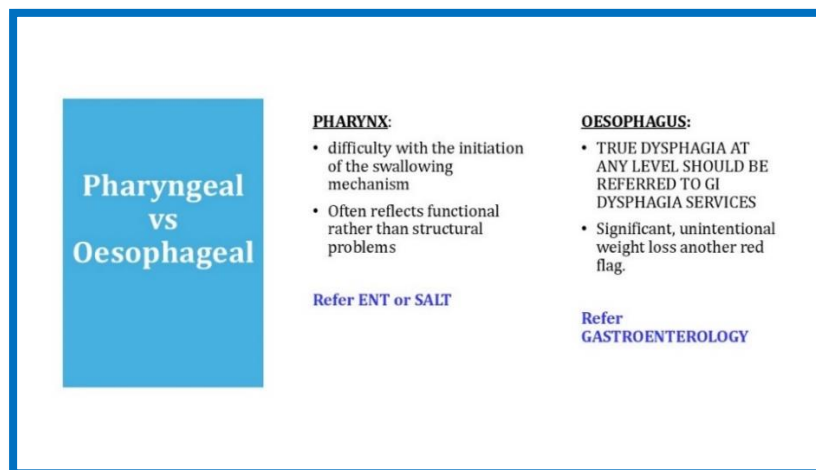
Full details are on the [Neck Lump and Throat Cancer Risk Assessment](#) page. The commoner presentations requiring a USOC referral are unexplained, persistent symptoms lasting more than 3

weeks and include: constant hoarseness in those aged 35 years or over; constant unilateral throat pain (not simply FOSSIT), pain on swallowing (odynophagia) and tonsillar ulcers or masses – whenever they present.

ENT Top Tips:

- Hoarseness needs to be *constant* as well as *persistent* i.e. the voice is never normal
- The [Head and Neck Cancer Risk Calculator](#) is no longer recommended for Primary Care, but the symptoms it reflects are still relevant and remain on the SCI Gateway protocol
- Stridor needs a same day discussion with on-call ENT
- Remember that suspicious oral lesions should always be referred to OMFS and never to Oral Medicine or Oral Surgery
- Most FOSSIT is benign and, in the first instance, only older patients with progressive symptoms or those with associated red flags need a USOC referral. Persistent symptoms (especially in older people) may warrant referral but rarely as a USOC.
- Thyroid nodules should be referred directly *without* a scan – the specialist team will arrange that subsequently.

And a reminder that true dysphagia should be referred to Gastroenterology:



Breast Cancer

For the vast majority of patients presenting with Breast symptoms and signs, the SRGSC25 update will not change how they are referred, but there are a few key changes that it's helpful to be aware of:

- There is now new guidance on referring patients with a new breast lump and the patient is **under the age of 30 years**. These patients can be referred as a USOC referral when in addition to the breast lump the patient **“also has other suspicious features such as an axillary lump, nipple or skin changes or a significant family history of breast cancer.”**
- There is now guidance on referring patients with a “new unexplained axillary lump” and RefHelp has a new page dedicated to [Axillary Symptoms](#)
- With the updating of this section of RefHelp we have updated our page on [Breast Disease in Men](#) and there is now a new SCI Gateway protocol that can be used for referring men to the Breast

Unit. This has been introduced to help guide referrers regarding the information that should be included when referring for this group of patients, and it also aims to help with effective eTriage by secondary care. It is important to note that **Referrals to the Breast Unit for men with USOC priority will continue to be triaged in the same way and to the same timescale as USOC referrals to the Breast Unit for women are triaged.**

- There is also a new page on [Breast Cancer](#) which brings together a number of areas of guidance that can be helpful when caring for patients with a Breast Cancer diagnosis. In particular there is new guidance on **Bone Health in Breast Cancer**. Following this algorithm will largely be carried out by the Breast Team, until the patient is discharged from the service, however GPs may find it helpful to know what the Breast Unit processes are if issues relating to Bone Health in Breast Cancer are raised by patients, and they may find it useful to know when they are being asked to take over prescribing of bisphosphonates or have treatment holidays from bisphosphonates, why this is being advised. **The Breast Cancer page is a new page, and if you feel that there is an area that it would be helpful for this page to cover that we haven't addressed, please do get in touch via the [Contact Us](#) options on RefHelp.**



Iron Deficiency Anaemia - GI Referral Route

The new guidelines give a **clear definition of Iron Deficiency anaemia**, that is used when referring patients with **unexplained iron deficiency anaemia in the absence of GI symptoms**. The definition is: Low haemoglobin in the presence of either:

- Low ferritin <30 mcg/L (best diagnostic marker)
OR
- Low serum iron in the presence of transferrin >3.0

The lower limit of normal of Ferritin in NHS Lothian was previously below this level and so for patients with a Ferritin level of between 20 and 29, the results would not have been in bold / clearly identifiable on the lab results. As a result, the **lower limit of normal for Ferritin in NHS Lothian has been changed to 30 to mcg/L for all adult patients**. It's hoped that this change will make it easier for referrers who are arranging preliminary bloods with a view to referring patients along this pathway.



Weight Loss

The SRG has given clearer guidance as to what is meant by the term **weight loss** when referring via USOC pathways. The guidance states:

- Weight loss is unintentional
- Weight loss is greater than 5% or more of body weight.

There is also a helpful acknowledgment that "it is not always possible for primary care to verify a patient's weight loss through recorded weights. This is particularly relevant for those without access to scales at home. Therefore, it is acceptable to include a strong clinical suspicion of weight loss, such as dropping dress sizes or needing a tighter hole on a belt." This new and clearer definition has been incorporated into guidance on a number of RefHelp pages including: [Urgent Suspected Upper GI Cancer](#), [MOE Weight Loss Guidance](#) and [CT for suspected cancer with no clinically obvious primary](#).



GP Access to CT for Suspected Cancer (No Clinically Obvious Primary)

The GP Access to CT for Suspected Cancer (No Clinically Obvious Primary) pathway is intended for patients presenting with non-specific symptoms or signs where malignancy is suspected, most commonly unexplained weight loss.

Referral for **CT chest/abdomen/pelvis** should only be made **after a thorough clinical assessment**, as outlined in the [Primary Care Management section of RefHelp](#).

Referrals are accepted for patients with **new, unexplained symptoms**, including:

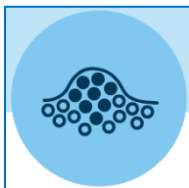
- **Weight loss $\geq 5\%$ over 3 months**
- **Loss of appetite, fatigue, nausea, malaise, or bloating** for ≥ 4 weeks
- **Unexplained or progressive pain (including bone pain)** for ≥ 4 weeks

Earlier referral may be appropriate where there is **strong clinical suspicion of malignancy**.



Cancer of Unknown Primary (CUP)

The [Cancer of Unknown Primary \(CUP\) pathway](#) is intended for patients whose **CT CAP** demonstrates advanced or metastatic malignancy, where the primary site remains unclear following initial clinical assessment. The pathway may also be appropriate for patients with suspicious findings on other imaging modalities (e.g. ultrasound or MRI) who have not yet undergone CT. In cases of clinical deterioration or urgency, referral to the CUP team should be made concurrently with CT imaging, without awaiting results. Patients under active follow-up for a previous invasive cancer should be referred back to their oncology team via SCI Gateway.



Suspected Bone/Soft Tissue Tumour

Patients presenting with **unexplained bone pain \pm tenderness** that is **persistent or worsening for ≥ 6 weeks**, particularly if **nocturnal, present at rest, or interfering with activities of daily living**, should undergo an **urgent USOC X-ray of the relevant area** to exclude a bone tumour.

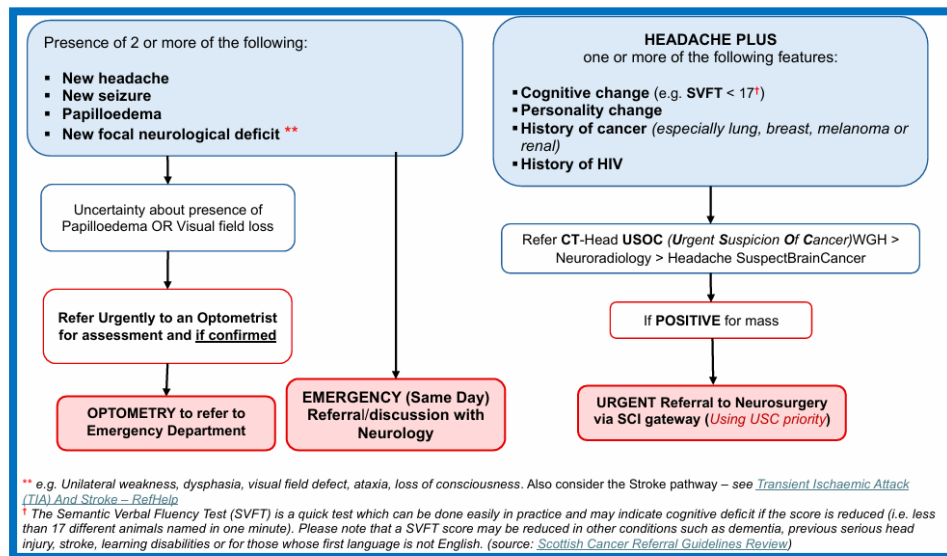
If imaging is suggestive of a tumour, an **urgent onward referral to the sarcoma service** should be made. See [Suspected Bone Tumour – RefHelp](#). The presence of a **soft tissue mass** with one or more of the following features should raise suspicion of sarcoma and prompt USOC referral to the sarcoma service ([Suspected Soft Tissue Tumour – RefHelp](#)):

- Size ≥ 5 cm (unless clearly long-standing; refer to lipoma guidance)
- Deep, tethered, fixed, or immobile
- Rapid enlargement over weeks to months
- Firm or irregular consistency
- Fungation
- Occurrence within a previous surgical site or radiotherapy field



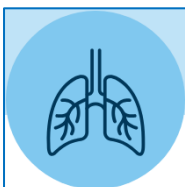
Brain and CNS Tumours (incl. Headache PLUS)

The [Brain and CNS Tumours \(incl. Headache PLUS\) pathway](#) replaces the previous *Headache Suspicious of Cancer* pathway. Patients with headache and concern for CNS malignancy, plus one or more of the following, should be referred via SCI Gateway as USOC: cognitive or personality change, history of cancer (particularly lung, breast, melanoma, or renal), or HIV. Patients with new headache accompanied by seizure, papilloedema, or focal neurological deficit require same-day discussion with Neurology. Responsibility for actioning imaging results lies with the referring GP. If malignancy is suspected, refer to Neurosurgery (RIE) via SCI Gateway using USOC priority.



Oncology

The [Oncology](#) section on RefHelp has been updated including a new page on [Post Radiotherapy Skin Care for Breast Cancer Patients – RefHelp](#). This section provides guidance on various aspects of cancer treatment. Patients receiving, or within 6 weeks of, cancer treatment should be advised to contact the **Cancer Treatment Helpline (CTH)** for treatment-related concerns. This is an NHS 24 call-handling service and does not provide specialist advice. Patients already assessed in Primary Care should not be redirected to the CTH and should instead be discussed directly with Acute Oncology (WGH).



Lung Cancer

Lung Cancer outcomes remain poor in Scotland (amongst the worst in Europe) and is the most common cause of cancer death in Scotland. Data shows 46% of lung cancers are diagnosed at stage 4!

The recent SRG changes are outlined below:

- Refer all patients with haemoptysis for CXR **AND** a USOC referral to Respiratory **simultaneously** (i.e. do not wait for CXR result)
- CXRs should **not** reassure clinicians if patients have concerning symptoms and are at risk of lung cancer (i.e. smoking history or previous asbestos exposure).

- Patients with the following symptoms no longer require to have had symptoms for 6 weeks. If CXR is negative but any ongoing symptoms as below present, refer as USOC to Respiratory:
 - Smokers or those exposed to asbestos:
 - Breathlessness with weight loss or appetite loss
 - Chest pain with weight loss, appetite loss or thrombocytosis
 - Weight loss and appetite loss together *
 - In all people:
 - Weight loss and thrombocytosis together *
- * GP Access to CT for Suspected Cancer pathway may be a suitable alternative for this symptom combination especially in the absence of respiratory symptoms or a smoking history
- Other changes
 - 2 symptoms to request x-rays in non-smokers (rather than 1)
 - Hoarseness clarified as persistent (rather than coming and going)
 - Refer for CXR if LRTI persists following X2 courses of antibiotics
 - Further emphasis on thrombocytosis (Lung Cancer is one of the Lego-C cancers which are particularly associated with a raised platelet count)

For detailed information please see updated Lung Cancer page: [Lung Cancer – RefHelp](#)



Prostate Cancer

Prostate Cancer is the most common cancer in men in Scotland

What's changed?

- Age for testing is now specified i.e. >50 or >45 with risk factors (Family History, BRCA gene, Black Men)
- Age related PSA cut off ranges for referral have changed – see RefHelp page for details
- Guidance on managing and repeating PSA for patients with a suspected benign or spurious cause for a raised PSA has been updated. See RefHelp page for details

PSA testing in asymptomatic patients

[Prostate specific antigen testing: summary guidance for GPs - GOV.UK](#) This supports clinicians to give balanced information to men without symptoms of prostate disease who ask about a PSA test.

PSA testing in older men:

In men aged 80 years or over, prostate cancer is commonly found but may not be clinically significant. It is recommended that PSA testing should be reserved for men aged 80 years or over in the following scenarios:

- Clinical features suggestive of metastatic prostate cancer (e.g. new significant bone pain, unexplained weight loss or unexplained anaemia)
- The man wants a PSA test after shared decision-making.
- The potential benefits of diagnosing and treating prostate cancer are greater in those with a good functional status and a longer life expectancy (10 plus years).

For more details refer to [Raised PSA – RefHelp](#)

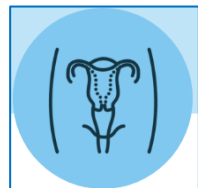
Penile Conditions

New page on different penile conditions including those that require USOC referral and those that can be managed safely and effectively in Primary Care. Please see: [Penile Conditions – RefHelp](#)



Urology

[Visible Haematuria – RefHelp](#), [Non-Visible Haematuria – RefHelp](#) and [Haematospermia – RefHelp](#) have all been updated to reflect the latest SRG. Check them out!



Gynaecology

Over recent years, referrals for PMB have increased significantly, largely due to the growing number of women using HRT. Differentiating “true PMB” from unscheduled bleeding related to HRT can be challenging.

To support decision-making, RefHelp now provides **separate pages** for:

- **Post-Menopausal Bleeding** [Post Menopausal Bleeding \(No HRT\) – RefHelp](#), and
- **Unscheduled Bleeding on HRT** [Unscheduled Bleeding on HRT – RefHelp](#)

Each includes flowcharts to help identify which women require investigation. Corresponding separate Sci Gateway referral forms are also now in place to request pelvic ultrasound scans for the two groups.

A new **troubleshooting guide for bleeding on HRT**, developed by the Gynaecology and Sexual Health teams, is also available to support management in Primary Care.

For most women, the pelvic ultrasound result will determine whether onward referral to Gynaecology is needed. However, please note two important exceptions:

Women who are **currently taking or have ever taken Tamoxifen**, and those with **high-risk genetics (such as Lynch/Cowden Syndrome)**, should be referred to Gynaecology as USOC **at the same time** as their ultrasound request.



Dermatology

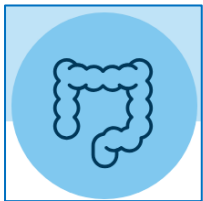
A key update in Dermatology is that, in addition to suspected melanomas, **all suspected Squamous Cell Carcinomas (SCC)** and **high-risk Basal Cell Carcinomas (BCC)** should now be referred as **USOC**.

There are new, dedicated RefHelp pages for:

- Melanoma [Melanoma – RefHelp](#)
- SCC [Squamous Cell Carcinoma – RefHelp](#)
- BCC [Basal Cell Carcinoma – RefHelp](#)

which describe clinical features suspicious for these lesions and aid in clinical assessment. Each has a corresponding SciGateway USOC form to support consistent referral.

The SRG recommend photographs should be sent with referrals to allow accurate and timely triage which, in turn, increases efficiency of care for patients with skin cancer. Photos can be taken via the Consultant Connect app [Using the Consultant Connect App – RefHelp](#), the Outlook method or can be ones taken by the patient, providing they are in focus and clear [Attaching photos to referrals – RefHelp](#). If there are technical issues which mean that photos can't be taken in Primary Care, then the Dermatology dept has provided an Exception Pathway whereby patients can be referred via Sci Gateway to have photos taken at Lauriston Buildings. Details are available here: [Photo Exception Pathway – RefHelp](#)



Colorectal

All patients with suspected Colorectal Cancer should be referred directly to the **Colorectal Department**, rather than Gastroenterology. This is done via the dedicated USOC form in SciGateway. Patients will continue to be triaged and asked to provide two separate stool samples for qFIT testing, with results used to guide further investigation.

The main exception is patients presenting with an **anorectal mass**. These patients will be seen directly in clinic. A **PR examination in Primary Care remains essential** in identifying these cases and ensuring they are managed appropriately.

Thank you

I just want to say a sincere thank you to everyone for their hard work, support, and collaboration throughout this project. It's been a genuinely team-led effort, and I'm incredibly grateful for the time, thought, and energy that everyone has contributed.

The graphic displays the 'Ref Talks Schedule 2026' with the NHS Lothian logo. It lists the following topics and dates:

Date	Month	Topic
23	Apr	Functional Neurological Disorder
25	May	Sleep Pathways
24	Jun	Cardiology
28	Sep	Dermatology
29	Oct	Screen Time in CYP
30	Nov	Lower GI Pathways

<https://apps.nhslothian.scot/refhelp/education/reftalks/>

A huge thank you to our Referrals Advisors — **Jane Burnett, David Millar, Mo Alshaikly, and Catriona Morton**. And to all our Secondary Care colleagues who have contributed.

Thanks also to **Lorna Porteous**, our NHS Lothian Primary Care Cancer Lead, for her guidance and support throughout.

I'd also like to recognise the rest of the RefHelp team who keep the "behind-the-scenes" work moving smoothly and are invaluable— **Aparna Amanna, Maria Mazoy Saavedra, and Keren Tipton**.

And finally, a thank you to the **Medical Photography team** for your help with the webinar. Your input always makes us look more “polished” and is hugely appreciated.

A big thank you to all our colleagues who have participated in RefHelp’s impact survey. For those who haven’t yet, please do give us your valuable feedback via the link below or QR code.

[Impact Survey 2026 - Primary Care – Fill out form](#)

[Impact Survey 2026 - Secondary Care – Fill out form](#)

Best Wishes, Becky



Contributors to this issue were:

Dr Becky Cheesbrough, Dr Catriona Morton, Dr Jane Burnett, Dr Mohammad Alshaikly, Dr David R Millar, Aparna Amanna & Maria Mazoy Saavedra. Thank you to all who have supported the development and content of the RefHelp website.

Was this useful and interesting? We would love to hear your feedback or suggestions for future updates and content!

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