

**Audit Template**

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| **Audit Title:**  Thames Audit on Tumour Marker Service Provision | |
| **Lead Auditor:**  Peter West | **Audit date(s):**  23rd May 2018 |
| Please indicate if **Local / Regional / National Audit**  Please indicate which hospital & location or region  Regional | **Report Author:**  Name: Peter West  Email: peterwest@nhs.net |
| **Aims of the Audit:**  To ascertain the current tumour marker service being provided by laboratories within the Thames Region | |
| **Audit Method and Outcome(s):** Questionnaire sent to laboratories within the Region   1. As expected, most of the more routine tumour markers were assayed on site. 2. Very few laboratories provided a guideline for the appropriate use of tumour markers and when they did exist, Clinical Scientists had an input into their production. 3. Very few laboratories had performed a local audit of their tumour marker service. 4. Most laboratories routinely reviewed their tumour marker requests and as expected these tended to be for those tests referred to another laboratory for analysis. 5. The main reasons for rejecting a request were an inappropriate request and no clinical details given. 6. Most laboratories received tumour marker requests from their Accident and Emergency department and stated their reasons for either accepting or rejecting such requests. 7. All those laboratories who received requests for tumour markers from primary care accepted requests other than PSA. 8. There was some variation as to the availability of tumour markers between laboratories. 9. There was some variation as to how laboratories responded to an urgent request for tumour markers. 10. Most laboratories analysed tumour markers in fluids other than serum or plasma and there was some variation as to what markers were offered and in what fluids. 11. Most laboratories had not validated their method for the measurement of such fluids and some did mention this o their laboratory report. 12. Most laboratories quoted reference ranges for their tumour markers and age-related reference ranges for PSA. 13. Most laboratories did not comment on their laboratory report that reference ranges for tumour markers are not well defined and should be used for guidance purposes only. 14. Most laboratories did not state the method used to measure the tumour marker. 15. Equal numbers of laboratories did or did not comment on their laboratory report regarding the specificity of tumour markers. 16. Most laboratories did not comment on their laboratory report that measurement of tumour markers is not recommended in patients with vague symptoms when the population likelihood of cancer is low and most that tumour markers can be elevated in a variety of non-malignant conditions. 17. Most laboratories did not produce cumulative reports for tumour markers. 18. Most laboratories telephoned tumour marker results and there was some variation as to which markers were telephoned and when. 19. Most laboratories did not have minimum re-test intervals for requesting tumour markers. 20. Most laboratories had not been involved in organising and presenting talks on the appropriate use of tumour markers to clinical and other health professional staff. 21. Most laboratories did not issue recommendations regarding when to collect blood for PSA. 22. As expected, most laboratories had seen a large increase in requests for CA125 since the 2011 NICE guideline for ovarian cancer. 23. There was some variation as to the analyser used to measure tumour markers. | |
| **Audit Recommendations / Standards:**   1. Laboratories should wherever possible adopt local guidelines for non-specialists for the most appropriate use of tumour markers and these should be based on nationally or internationally developed evidence-based guidelines. 2. Laboratories should regularly audit their tumour marker service in order to review the requesting pattern and use. 3. Clinical Scientists should demand manage the service to ensure that only the most appropriate requests are processed, in particular those sent to another laboratory for assay. 4. The only requests that should be processed from primary care are PSA in males, CA125 in females and where the GP is following up a patient being treated by a secondary care physician. 5. Where tumour markers are measured in fluids, the report should state that the method has not been validated if this is the case. 6. Laboratories should state the relevant reference range of the tumour marker on the report and emphasise that these are not well defined and only to be used a guidance, that a value below or above the quoted reference range does not exclude or imply the presence of a tumour, that benign conditions may cause a rise, some transient in serum tumour marker levels that may lead to an incorrect interpretation and that factors such as lifestyle, medication and medical intervention can also influence the results and where possible state their method as results from different methods are not necessarily comparable. 7. Tumour marker results should always be interpreted in the context of all available clinical and laboratory information. 8. Laboratories should advise users of the service of factors that can affect the interpretation of tumour marker measurements such a UTI and catheterisation prior to a PSA measurement and that samples are collected at the correct time after a particular procedure such as digital rectal examination. 9. Laboratories should provide guidance on the appropriate frequency of tumour marker measurements eg:by recommending minimum re-test intervals. 10. Requests for tumour markers from Accident and Emergency should be discouraged wherever possible as these are often requested in a patient with vague symptoms. The possible exception would be in a known cancer patient under the care of a secondary care physician. | |
| **Please indicate to whom and when audit presented &/or circulated&/or published:**  Findings presented at the Thames Audit meeting on 23rd May 2018 | |
| **Audit recommendations / standards ratified by … and when:**  Ratified at the Thames Audit meeting of 23rd May 2018 | |
| **Date of audit report:** 7th June 2018 | |
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