A SYMPTOM AND RISK FACTOR QUESTIONNAIRE ACCURATELY PREDICTS UPPER GASTROINTESTINAL CANCER

INTRODUCTION
Waiting times for endoscopy are rising rapidly following the COVID-19 pandemic. In addition, cancers may be missed as patients are placed on routine waiting lists but not monitored. Some hospitals use the Edinburgh Dysphagia Score to assess and prioritise patients for investigation. This offers a sensitivity of 98.4% and specificity of 9.3% to detect malignancy in patients presenting with dysphagia. However, it is not designed for detecting gastric cancer. We aimed to create a more accurate screening questionnaire as an aid to triaging referrals.

METHODS
Patients were recruited as part of the Saliva to Prevent a more accurate screening questionnaire as an aid to triaging referrals. 

RESULTS
20 features were found to be important and reproducible. They included age, sex, dysphagia, odynophagia, early satiety, weight loss, duration of chest pain and regurgitation, frequency of acid taste in the mouth, a previous history of smoking, cancer or psychological disorders, current anxiety level and frequency of vegetable intake. The area under the receiver operator curve to detect cancer was 0.83. 50% of cancers scored greater than 85 whereas 50% of normals scored less than 25. At a cut-off score of 10, sensitivity was 97.7% with specificity 26.8% to detect cancer (figure).

CONCLUSIONS
We have created a simple, reproducible risk score to identify patients at high and low risk of upper GI cancer. It performs better than previous scores but now needs testing in the real world. It might be usable to both upgrade routine patients to urgent endoscopy and remove patients at very low risk from waiting lists, thereby helping to prioritise patients with a greater clinical need and reducing the endoscopic backlog.

REFERENCE