South East London Integrated Care System

Primary Care Pathology Prioritisation Guidance

Updated 25 July 2024

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Purpose

This document summarises the clinical guidance for pathology testing in primary care in response to the Synnovis cyber attack which occurred on 03/06/2024. It has been jointly developed with the acute Trusts, the S.E. London Cancer Alliance, Children & Young People, Maternity and Urgent & Emergency Care clinical leads. This document is subject to change as the incident is evolving on a daily basis. We will share changes as soon as we are able.

Please refer to the SEL Medicines Optimisation Team recommendations on monitoring medications for primary care on the webpage for primary care here.

This document does not supplant clinical judgement based on patients' background, medical history and clinical presentation. It cannot provide specific guidance on all clinical scenarios in General Practice.

It is intended to highlight evidence-based, best practice recommendations.

Please considering using other resources available including: *Advice & Guidance*, *Consultant Connect* or consider safety netting lower risk patients* pending changes in pathology capacity.

Record that a test is delayed using the Ardens *'SEL test delay protocol and template'

General principles

CHECK IF RECENT BLOODS HAVE BEEN DONE AND DO NOT REPEAT

ONLY ORDER THOSE BLOODS THAT ARE CONSIDERED NECESSARY FOR MANAGEMENT – DO NOT ADD ON A TEST THAT WOULD BE A "NICE TO KNOW"

CHECK THE GUIDANCE ON KEY PRIMARY CARE MINIMUM RETESTING GUIDANCE

National Minimum Retesting Intervals in Pathology Guidance, Royal College of Pathologists (March 2021)

Considerations

TEST SMARTER

Don't tick all the boxes: Order only what is necessary and reduce risk of

- Over medicalising
- Workload burden
- Carbon footprint of pathology service

Reduce duplication: check no recent bloods have been done (e.g. check London Care Record)

Support the team: senior clinical support for new and junior team members, ARRS roles to manage uncertainty without need for multiple tests

Use the guidelines IMOC, CESEL, NICE to support safe care

BALANCE

- Managing your backlog using the *'SEL test delay protocol and template'*
- Dealing with ongoing demand

PRIORITISE

Excluding important pathology e.g. in patients presenting with new polyarthralgia
Possible new specific diagnoses i.e. heart failure, thyroid disease
Monitoring long term conditions i.e. diabetes and hypertension – consider prioritising:

- Poor control
- High risk
- Those not reviewed in over 12 months

Medicines optimisation/safety

Please refer to the specific IMOC guidance on medicines monitoring

- Anything urgent and critical to be prioritised first.
- People who require tests before starting new medicines where previous bloods cannot provide this information.
- People who require tests for dose titrations to optimise long term conditions.
- People who are overdue tests using the interim drug monitoring guidance for high-risk medications, including medication monitoring assessed by the Care Quality Commission (CQC).
- Gradual return to standard monitoring frequency for all medications– starting with those most overdue who are higher risk, e.g.:
  - Patients with multimorbidity, polypharmacy
  - Older / frail adults
  - Children and young people

Definitions

Critical has been defined as requiring an investigation that is critical to inform **immediate required treatment** which cannot be determined without the investigation(s) e.g. **within 0-24 hours**.

Urgent has been defined as requiring an investigation that is essential to inform **short-term treatment** which cannot be determined or safely administered without the investigation(s) eg **3-4 days**

Important has been defined as required for safe clinical management e.g. **within 1 week**

Routine has been defined as required for appropriate **ongoing** clinical management but can be reasonably deferred e.g. within **1- 3 months**.

These are examples/indicative time-frames which do not supplant clinical judgement based on patients' background, medical history and clinical presentation.

It is not intended to be prescriptive or give specific guidance on all clinical scenarios in General Practice.

Critical/Urgent Scenarios

Requiring investigation(s) that is/are critical to inform immediate required treatment which cannot be determined without the investigation e.g. within 0-24 hours

	Pathway	Pathology requirements	High risk groups	
Critical	Life threatening clinical presentation	Disease and complication management including interventions	All patients	Use **emergency** care pathways – A&E, SDEC etc. If sending to emergency care pathways do not take bloods/sample(s)
Urgent / Critical	Preventing emergency attendance and admission	Disease and complication management potential in the community but require diagnostic e.g. renal function, CRP, FBC	All patients	Use **urgent** pathology pathway (i.e. mutual aid provision)
Critical	Immunosuppressed patients who are clinically unwell/sepsis		All patients with immunosuppression	Use **emergency** care pathways

Renal profile

Critical/Urgent/Important	Routine*
Concerns about acute kidney injury Consider: 1. Baseline renal function 2. Medications Repeat within 24 hours if possible or if concerned admit to ED	LTC reviews for patients who are stable
Clinical concern re hypo- or hyperkalaemia - see here	Please refer to the SEL Medicines Optimisation Team's recommendations on monitoring medications
Possible hyponatraemia – see here (e.g. polydipsia, polyuria)	
Concerns about deteriorating kidney function	

Record that a test is delayed using the Ardens *'SEL test delay protocol and template'

HYPERKALAEMIA

https://ukkidney.org/sites/renal.org/files/FINAL%20VERSION%20-%20UKKA%20CLINICAL%20PRACTICE%20GUIDELINE%20-%20MANAGEMENT%20OF%20HYPERKALAEMIA%20IN%20ADULTS%20-%20191223.pdf

- Mild — serum potassium concentration **5.5 - 5.9** mmol/l
- Moderate — serum potassium concentration **6.0-6.4** mmol/L
- Severe — serum potassium concentration **≥ 6.5** mmol/L

Mild hyperkalaemia (K^+ ≥ 5.5 mmol/l): Withhold relevant medication(s), modify dietary factors; repeat test within 3 days or as soon as it is feasible (urgent/important)

Moderate hyperkalaemia (K^+ 6.0 – 6.4 mmol/l): Repeat serum K^+ within 1 day of first detection (urgent) however if clinically concerned discuss with acute medical team/SDEC (critical)

Severe hyperkalaemia (K^+ ≥ 6.5 mmol/l): if detected in the community – admit for immediate assessment and treatment via ED (critical)

HYPONATRAEMIA (NICE 2020)

- **Mild** — serum sodium concentration **130–135 mmol/L**
- **Moderate** — serum sodium concentration **125–129 mmol/L**
- **Severe** — serum sodium concentration **≤125 mmol/L**

Acute — duration of less than 48 hours
Chronic — duration of 48 hours or more

Asymptomatic, **mild** hyponatraemia: The underlying cause of hyponatraemia should be sought in primary care (if possible and appropriate) (important)

Asymptomatic, moderate, hyponatraemia: Specialist advice from SDEC/acute medical team should be sought regarding the need for admission or referral (urgent)

Severe or **symptomatic** hyponatraemia: Admission to ED/SDEC (critical)

*If a person has an acute illness that may be contributing to the hyponatraemia, treat this, consider withholding relevant medication(s) during this time

Liver function tests	
Urgent/Important	**Routine**
• Acute jaundice • Possible liver failure e.g. ascites	• Monitoring of patients with long-term but stable liver conditions • Please refer to the IMOC guide re Statins

Full blood count	
Urgent/Important	**Routine**
• High risk anaemia e.g. severe menorrhagia, severe haemorrhoids, melaena • Possible haematological malignancy • Possible ITP – discuss with Haematology on-call	• To exclude anaemia in lower risk clinical scenarios • Monitoring/follow up of platelet count over 100

Other tests

	Urgent/Important	Routine*
Urate	Make a clinical diagnosis of acute gout and treat accordingly, if possible Test if no/poor response to empirical treatment	Monitoring of effectiveness of allopurinol - delay
Ferritin, iron studies	Severely deficient and symptomatic – consider urgent pathology pathway (repeat or if concerned, discuss with SDEC	If MCV reduced recently (e.g. within last 3 months) or clinical signs/symptoms present, treat as iron deficiency
B12, Folate	Neurologically symptomatic patient with possible severe B12 deficiency	Post supplement checks e.g. B12 injections or oral supplements
D-Dimer	Refer to ED or SDEC services if VTE considered and/or patient symptomatic/unwell	N/A

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Other tests

	Urgent/Important	Routine*
CRP, ESR	If suspicious temporal arteritis consider CRP or ESR	For diagnosis of inflammatory conditions
Vitamin D	Confirmation of rickets in a child If clinical suspicion high treat	Routine monitoring of patients at risk of nutritional deficiency e.g. parenteral feeding, post bariatric surgery
Bone profile	Acute hypercalcaemia or hypocalcaemia	Routine monitoring of hyperparathyroidism
Thyroid profile	Acute thyrotoxicosis /thyroid storm - consider emergency pathways	Routine monitoring of hyper or hypothyroidism
HbA1c	If undiagnosed or poorly-controlled diabetes	Monitoring of stable T2DM or NDH
Allergy testing	Not urgent; defer	Possible IgE mediated allergies

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Microbiology

	Urgent/Important	Routine
MSU	Where results will help to guide/change clinical management in the next 3-4 days e.g. treatment failure, children and elderly adults, high risk of systemic infection/sepsis	• Consider treating empirically if clinical suspicion is high +/- suggestive urinalysis results • Consider using previous MSU results in the first instance before sending another sample • Consider delaying MSU for investigation of LUTs i.e. where using MSU to exclude infection*
Wound swabs	Where results will help to guide/change clinical management in the next 3-4 days e.g. treatment failure, children and elderly adults, high risk of systemic infection/sepsis	• Consider treating empirically according to clinical picture, symptoms and signs • Consider using previous wound swab culture result in the first instance before sending another sample
Mycology	None are considered urgent	These should be delayed*
Chlamydia/other uro-genital swabs	If patient is unwell and acute pelvic inflammatory disease is suspected, please consider referring to local sexual health clinics or the Emergency Department	• If patient is asymptomatic, please consider signposting them to the Sexual Health London (e-service) to obtain a home testing kit (except for Greenwich – see below) • If you are concerned your patient may have an STI but they are not acutely unwell, please consider signposting them to the Sexual Health London (e-service) to obtain a home testing kit or to local sexual health clinics • Greenwich has an in-house e-service for home testing kits: https://www.greenwichsexualhealth.org/home_sti_kits/

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Cellular Pathology

	Status/Advice
Cervical smear	Normal service; Can continue as usual
Semen Analysis	Normal service. Please email completed Synnovis semen analysis forms to synnovis.semenanalysis@nhs.net (i.e. not via tQuest). Refer to Pages 2-4 for instructions to patients.
Histopathology (e.g. for minor surgery)	Details on how to generate a request will be confirmed soon

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Please indicate that your test requests are **urgent** on the request forms

NHS South East London

Cancer pathways		
Gynaecology	Endometrial	No routine bloods required; abnormal USS
	Ovarian	Ca-125 helpful but not essential; consider urgent USS
	Vulval & other	No routine bloods required; based on clinical findings only
	Cervical	
Head & Neck	No routine bloods required; based on clinical findings only	
Respiratory	Normal CXR or nodule on CXR – non-contrast CT is ok therefore renal profile not strictly necessary	
	Otherwise: direct CT which will need renal profile *within the last 6 months*	
Dermatology	No routine bloods required; based on clinical findings only	
Upper GI	Refer based on red flags; if renal profile ≤ 3 months ago then can consider straight-to-test endoscopy/CT pathway	
Lower GI	FIT testing is available and is **crucial** for appropriate triage of patients being referred on the Urgent Lower GI Pathway unless there is anal/rectal mass or ulceration, or if the patient has a suspected cancer on endoscopy or imaging	
Rapid Diagnostic Centres	If clinical suspicion high, request imaging (CXR, USS), perform urinalysis, FIT test. Review with results	

Please indicate that your test requests are **urgent** on the request forms

Cancer Pathways		
Urology	Prostate	Difficult without a PSA. As in COVID, safety net the patient and prioritise PSA when this becomes available* If strong clinical suspicion and/or significant risk factors present (i.e. family history, ethnicity) then refer
	Bladder/renal	Frank haematuria with no signs/symptoms/WCC on urinalysis
	Testicular	No routine bloods required; based on clinical presentation or suspicious USS
	Penile	
Haematology/Oncology	Leukaemia	If patient clinically unwell +/- high clinical suspicion, please refer via the **emergency** pathway, or discussion with haematology Urgent blood test based on clinical presentation (*refer to 2ww form on which tests)
	Lymphoma	
	Myeloma	
Brain & CNS	No routine bloods required; based on clinical findings only. Direct CT possible if renal profile done in last 6m	
Breast	No routine bloods required; based on clinical presentation	
Sarcoma	No routine bloods required; based on clinical presentation and/or imaging results	
Ophthalmology	No routine bloods required; based on clinical presentation and/or imaging results	

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Paediatrics and Maternity

Paediatrics

- Request important bloods via borough-specific CYP phlebotomy pathway(s)
- Request important CYP pathology (bloods, MSU, wab) as clinically applicable according to previous slides
- Seek specialist advice via Consultant Connect if you are unsure on whether a test is required

Maternity

- Request urgent/important pathology as above slide
- If uncertain, please discuss and/or manage with midwifery, antenatal or obstetric teams

Urgent: Essential to inform short-term treatment which cannot be determined or safely administered without the investigation(s) e.g. 3-4 days
Important: required for safe clinical management e.g. within 1 week

Routine Virology & Immunology

Virology *High risk groups*

Paediatrics

- Request important bloods via borough-specific CYP phlebotomy pathway(s)
- Seek specialist advice via Consultant Connect if you are unsure on whether a virology test is required

Maternity

- Seek specialist advice via Consultant Connect if you are unsure on whether a test is required
- If uncertain discuss and/or manage with midwifery, antenatal or obstetric teams

In other groups, please discuss with secondary care teams if unsure (A&G, Consultant Connect)

Immunology

- If in doubt, discuss with specialist colleagues: Call or email Synnovis Customer Services to link up; consider using Advice & Guidance

Routine is defined as required for appropriate ongoing clinical management but can be reasonably deferred e.g. within 1- 3 months. If a test can be delayed, record that a test is delayed using the Ardens *'SEL test delay protocol and template'*

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END