**Cancer Staging**

**Descriptor:**

Appropriate imagjng staging of common cancers.

**Background:**

Imaging staging protocols for cancer care are well established for the diagnosis and staging of malignancy with the intention of speeding up examination times, avoiding unnecessary radiation, ensuring optimal image quality and comparable examinations for follow up.

This audit is generic and can be used for any of the common cancers. The audit will confirm that the imaging protocol for the cancer is being adhered to.

## The Cycle

**The standard:**

All patients referred with the diagnosis, or the provisional diagnosis, of a common cancer will be imaged according to RCR guidelines [1] or locally agreed Cancer Network guidelines, unless specifically excluded in the medical notes or radiology report.

**Target:**

100%

## Assess local practice

**Indicators:**

Percentage of examinations for staging of a common cancer complying with the RCR guidelines or Cancer Network guidelines.

**Data items to be collected:**

Identify consecutive staging examinations for a common cancer (for example breast, lung, colorectal, prostate, gynae, lymphoma) from appropriate Cancer Multidisciplinary Meeting patient list.

Record for each examination whether or not it complied with the RCR or Cancer Network guidelines in respect of:

• the areas examined;

• the imaging protocol;

• the use of intravenous contrast medium

If the guidelines were not followed was a reason given in the report or patient's notes MDT record for the deviation. Allowable exceptions being contraindications to the scan, for example: MRI pelvis indicated for staging of endometrial cancer but patient has Non MRI compatible pacemaker.

**Suggested number:**

Retrospective review of the staging examinations of 30 consecutive patients with one type of cancer.

**Suggestions for change if target not met:**

Ensure local policy is to stage all common cancers according to the RCR or Cancer Network guidelines and is agreed at the relevant MDT policy meeting.

Circulate and discuss the policy with all consultant radiologists involved in imaging these patients.

Have protocols available in CT/MRI/ Ultrasound/PET/Nuclear Medicine and when justifying requests.

All radiographic staff to understand and to use the protocols routinely (unless a patient is specifically excluded).

Repeat date for commencing the next audit: six months following changes.

**Resources:**

MDT records to identify cases.

Radiologist to review the images.

**References:**

1. Royal College of Radiologists. BFCR(14)2.  [Recommendations for Cross-Sectional Imaging in Cancer Management Second Edition](http://www.rcr.ac.uk/recommendations-cross-sectional-imaging-cancer-management-second-edition)

**Editor's comments:**

Clinical governance places an emphasis on protocols and care pathways in order to achieve best practice and consistency of examination. Reasons for not using the local protocols need to be made explicit within the medical record.

The results of this completed audit would be a valuable addition to the folder for revalidation (eg, of the consultant in charge of CT or MRI and those of her/his colleagues involved as lead for the MDT or the clinical decision processes, of patients with a common cancer).

**Submitted by:**

Taken from Clinical Audit in Radiology 100+ recipes RCR 1996, updated by J Parikh

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