confusing information while seeking to imply that there is abuse by GPs of the referral system. Primary care personnel, like those in secondary care, are under increasing pressure to investigate/refer patients partly fuelled by public concern about cancer and from the risk of litigation. Coupled with this is the considerable uncertainty with which primary care physicians have to work.

Referral guidelines are there to identify the majority of patients with cancer. There will always be patients who fall outside guidelines but who are a source of concern in primary care and who, nevertheless, need to be seen urgently. It is this group in whom it is vital to mark the referral letter as 'urgent' or even to speak to the relevant consultant prior to dispatch of the letter. It is imperative that hospital personnel look at work patterns and lobby for increase in resources while supporting a reasonable and safe shift from secondary to primary care. Patient education should remain an integral part of any scheme to improve the care of patients with cancer.²

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AUTHORS' RESPONSE

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We agree that when a two-week referral proforma is used there is an obligation on the part of the hospital clinician to see the patient within two weeks of the receipt of the referral. We also agree that the GP needs to use the referral form appropriately and acknowledge Dr Menon's views about the need to increase resources.

However, we do have concerns that despite the fact that basal cell carcinomas (BCCs) are not included as a cancer for the UK Department of Health statistics, 9 of the 58 urgent referrals were for patients who the GP suspected a BCC. The GPs may be disregarding guidelines on clinical grounds, due to pressure from the patient or from lack of

experience. We agree with Dr Menon that, in the case of a patient requiring an urgent referral who falls outside the guidelines, it is prudent to speak to the relevant consultant surgeon or give clarification in the referral letter.

We acknowledge that the accuracy of diagnosis for non-malignant conditions is 93%; however, of the 58 urgent referrals, there were only two patients with lesions that come under the skin cancer guidelines, which is an accuracy of only 3%. Unfortunately, 3% of the non-urgent referrals also had lesions that come under the skin cancer guidelines. This may be just an unfortunate set of referrals but the large proportion of urgent referrals (28%) does represent a significant workload for the secondary carers and may also be indicative of insufficient exposure to skin diseases within the training of GPs.

Our second concern is how to prioritise the patients whose referral letter, which is either marked as routine or has no priority specified and is not faxed through the normal urgent referral route, indicates no history or examination, only the patient's concern regarding a 'mole' and could it be 'melanoma'? We agree that if there is a question of malignant melanoma then the request for urgency is superfluous. However, when such a referral is specified as routine, or is not sent through the urgent route, it would be useful to know that the GP, in fact, has a low index of suspicion and the referral is for a second opinion to allay the patient's worry. In the previous system, a referral with a concerning history, examination or proposed diagnosis would have been seen urgently. In the current system, where does the responsibility lie if a patient has a delayed diagnosis of malignant melanoma because the appointment is given as routine, even though the history is suspicious but the GP marks the referral as routine?

We disagree that the information provided was contradictory; however, we can understand that some of the tables may appear confusing initially. For example, there is a total of 192 rather than 204 when comparing the referral letter's diagnosis because 12 had insufficient information to infer a benign or malignant suspicion. There is also a variation in totals when comparing 'malignancy' with appropriate urgent referrals because of the exclusion of BCC for the urgent referrals.

We have not sought to imply that GPs abuse the referral system but to highlight the inconsistencies that easily arise with the current system of referrals. Indeed, we have tried to highlight that, in our experience, while there is a need for more detailed information in the referral letter, the prognostic stage for melanoma patients at diagnosis is unaltered since the introduction of the 2-weeks wait.

We are pleased that our paper has stimulated some much-needed debate and, therefore, has clearly contributed to the evaluation of the rapid referral scheme for suspected cancer.