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Clinical Prioritisation of Imaging Examinations

1. BACKGROUND

Throughout the COVID19 pandemic, Diagnostic Imaging services have continued to provide services for all emergency, inpatient and clinically urgent patients, including those under an urgent suspicion of cancer.

Due to changes in physical distancing and enhanced infection prevention and control measures – including social distancing and PPE, the volume of imaging tests that can be carried out has unavoidably decreased.

2. KEY AIMS

This Guidance outlines a standardised national process for the clinical prioritisation of patients who have been referred for a diagnostic imaging test.

This document has been develop to support demand, ensuring those of most clinical urgency have their imaging carried out first.

This Framework should be implemented at local specialty level ensuring that patients are categorised appropriately.

3. CATEGORISATION OF IMAGING EXAMINATIONS

The below categorisation broadly mirrors that set out in the Clinical Prioritisation Framework for Supporting Elective Care, with priority levels from 1 to 3:

Priority level 1 — can wait up to 2 weeks

Priority level 2 — can wait up to 6 weeks (or as planned for cancer surveillance)

Priority level 3 — can wait more than six weeks

Referrals waiting over 12 weeks will be subject to regular reviews and communication with the patients.

4. PRIORITY LEVELS EXPLAINED

Priority level 1

This priority level would include imaging referrals for:

- Inpatient requiring a diagnostic imaging test.
- Urgent suspicion of cancer (USOC) patients, who require urgent imaging
- Examinations to diagnose and/or alter treatment for significant disease or injury where delay is likely to result in: risk to function; worsening disability; or worsening pain.

- Patients on an active cancer pathway, where imaging is high priority.

Priority Level 2

- This priority level would include routine imaging referrals with no urgent flags, excluding those in priority 3 level.
- Patients undergoing surveillance after cancer treatment, where imaging is high priority but likely to be non-urgent (planned scans)

Priority Level 3

This priority level would include routine imaging referrals for examinations to diagnose and/or alter treatment for disease or injury where delay is unlikely to result in risk to function, worsening disability or worsening pain.

5. APPLICATION OF THE PRIORITISATION PROCESS

- Upon receipt of the referral, the imaging department will vet and assign a priority category, using the suggestions in the tables below for reference, taking into account the urgency category allocated by the referrer. The categories within the enclosed tables are not exhaustive and a degree of clinical judgment will be required regarding interpretation and the assignment of a prioritisation category depending on the individual clinical history.
- Priority 1 and 2 scans will be booked as soon as possible within the noted timescales in order of priority or, in the case of planned treatment follow up, according to the scheduled date.
- When Priority 2 patients have waited longer than 12 weeks, a letter to the patient and referrer, explaining the wait and informing them of when their appointment will take place, will be issued.
- When Priority level 3 patients have waited longer than 12 weeks, their referral will be reviewed by the imaging department, followed by a letter to the patient and referrer, explaining the wait. This review process will be an administrative one, ensuring that there is no duplicate request and that the investigation has not already been performed as an inpatient. Consultation may be required with radiologists or referrers at this point.
- There will be a review of priority 3 referrals every subsequent three months followed by communication with patients until capacity issues have resolved or the waiting time falls below 12 weeks.

ANNEX

Imaging Clinical Prioritisation – Clinical Categories

The following tables outline suggestions regarding which examinations should be included within each Priority Level. These suggestions are split by modality and should form the basis of a Clinical Prioritisation framework for vetting Radiologists or Radiographers.

Priority 1			Priority 2		Priority 3
USOC	Cancer Pathway	Urgent	Routine	Cancer Surveillance	Non-Urgent Non-Cancer
Examinations for patients where there is significant concern of cancer.	Examinations for patients on an active cancer pathway, where imaging is high priority including assessment of treatment response.	Examinations to diagnose and/or alter treatment for significant disease or injury where delay is likely to result in: risk to function; worsening disability; or worsening pain.	Examinations which do not fall into any of the other priority levels.	Examinations for patients undergoing surveillance after cancer treatment	Examinations to diagnose and/or alter treatment for disease or injury where delay is unlikely to result in: risk to function; worsening disability; or worsening pain.

Imaging Clinical Prioritisation – CT Categories

	Priority 1			Priority 2		Priority 3
	USOC	**Cancer Pathway**	**Urgent**	**Routine Non-Cancer**	**Cancer Surveillance**	**Non-Urgent Non-Cancer**
Neurology	USOC Primary staging	Tumour treatment assessment	First seizure Infection FU	Recurrent seizures Aneurysms and AVM FU JC positive Headache	Routine surveillance	
ENT	USOC Primary staging	Tumour treatment assessment	Suspected infection Stridor Assessment of epistaxis Unilateral sinonasal lesions	Throat pain (no red flags) Sinus infection/polyps 4D CT for parathyroid Cholesteatoma	Routine surveillance	SCC dehiscence
Respiratory	USOC Primary staging	Tumour treatment assessment		ILD to determine treatment	Routine surveillance First nodule FU scan	2nd or subsequent nodule FU scan ILD FU
GI/HPB	USOC Primary staging	Tumour treatment assessment	Symptomatic IBD	Non-severe weight loss, CIBH Pancreatitis FU Cirrhosis staging	Routine surveillance	New diagnosis of diabetes
Urology	USOC Primary staging	Tumour treatment assessment	CT IVU for new haematuria or hydronephrosis Initial assessment of complex renal cyst	Bosniak cyst surveillance Adrenal characterisation	Routine surveillance	CT for stone burden CT IVU for anatomy Adrenal nodule FU

Gynae	USOC Primary staging	Tumour treatment assessment			Routine surveillance	
MSK	USOC Primary staging	Tumour treatment assessment	Acute trauma where imaging alters management Infection	Assess fracture healing	Routine surveillance	Leg length Prosthesis position
Vascular			Critical or acute limb ischaemia Carotid stenosis assessment for endarterectomy	EVAR or other graft follow up Acute vasculitis		Thoracic outlet syndrome Stable claudication Low risk chest pain (CT coronary artery)

Imaging Clinical Prioritisation – MRI Categories

	Priority 1			Priority 2		Priority 3
	USOC	**Cancer Pathway**	**Urgent**	**Routine Non-Cancer**	**Cancer Surveillance**	**Non-Urgent Non-Cancer**
Neurology	USOC Primary staging	Tumour treatment assessment	MS relapse requiring treatment First seizure Infection FU	MS monitoring on biological Recurrent seizures Aneurysms and AVM FU JC positive Cervical myelopathy MND?	Routine surveillance	MS routine monitoring Radiculopathy
ENT	USOC Primary staging	Tumour treatment assessment	Suspected infection Unilateral sinonasal lesions	Throat pain (no red flags) Cholesteatoma	Routine surveillance	Tinnitus SDHB screening
GI/HPB	USOC Primary staging	Tumour treatment assessment	Liver lesion characterisation MRCP with biliary ductal dilatation Symptomatic SB Crohn's Fistula – unwell Cirrhosis staging	MRCP without biliary dilatation Initial pancreatic cyst assessment	Routine surveillance	Pancreatic cyst follow-up Hernia Fistula – not unwell Hernia Dynamic pelvis
Urology	USOC Primary staging	Tumour treatment assessment	Initial assessment of complex renal cyst	Bosniak cyst surveillance Adrenal characterisation	Routine surveillance	Chronic pelvic/testicular pain Urethral diverticulum

Gynaecology	USOC Primary staging	Tumour treatment assessment	Adnexal lesion characterisation PMB (failed hysteroscopy)	Endometriosis or pelvic pain	Routine surveillance	Dysfunctional uterine bleeding (smear up to date) Mullerian Duct Anomalies Mesh assessment Fibroid assessment Urethral diverticulum
MSK	USOC Primary staging	Tumour treatment assessment	Acute trauma where imaging alters management Infection/acute joint Cord compression/cauda equina Locked knee	Chronic trauma/cuff tears in surgical candidates Severe synovitis which will alter management	Routine surveillance	OA/degenerative disease Non-surgical candidates for joint assessment Tendinopathy Screening for inflammatory spondyloarthritis
Vascular			Critical or acute limb ischaemia for surgery Carotid stenosis assessment for endarterectomy	Acute vasculitis		Thoracic outlet syndrome Stable claudication

Imaging Clinical Prioritisation –Ultrasound Categories

	Priority 1			Priority 2		Priority 3
	USOC	Cancer Pathway	Urgent	Routine	Surveillance	Non-Urgent Non-Cancer
UROLOGY	Testicular lump		Visible haematuria Hydronephrosis	Renal stones Non visible haematuria	RCC	Chronic pelvic/testicular pain
ENT	Neck lump with red flag suspicion of malignancy Lesion biopsy	Urgent neck lump		New thyroid lumps (low index of suspicion) Thyroid pathology follow up parathyroid		Lipoma Sebaceous cyst Thyroglossal duct cyst
MSK	Assessment or biopsy of lump suspicious for malignancy		Trauma requiring urgent surgery eg finger tendon, Achilles Aspiration for infection if not possible clinically	Chronic trauma/cuff tears in surgical candidates Severe synovitis which will alter management		Hernia Bakers cyst Lipoma Non suspicious lumps Nerve assessment tendinopathy
GI/GENERAL	Targeted liver biopsy	Targeted liver biopsy	DVT	Non targeted liver biopsy US abdo - ? gallstones Deranged LFTs? cause AAA	HCC Liver US in melanoma	GB polyp surveillance
GYNAE	Ovarian/uterine mass	Postmenopausal bleeding		Bloating and normal Ca-125 Ovarian cyst follow up		PCOS Ovaries for infertility
Vascular			Carotid Doppler for stroke	Aneurysm follow up		Varicose vein assessment / vein aping for routine procedures.