Colorectal Cancer - Suspected

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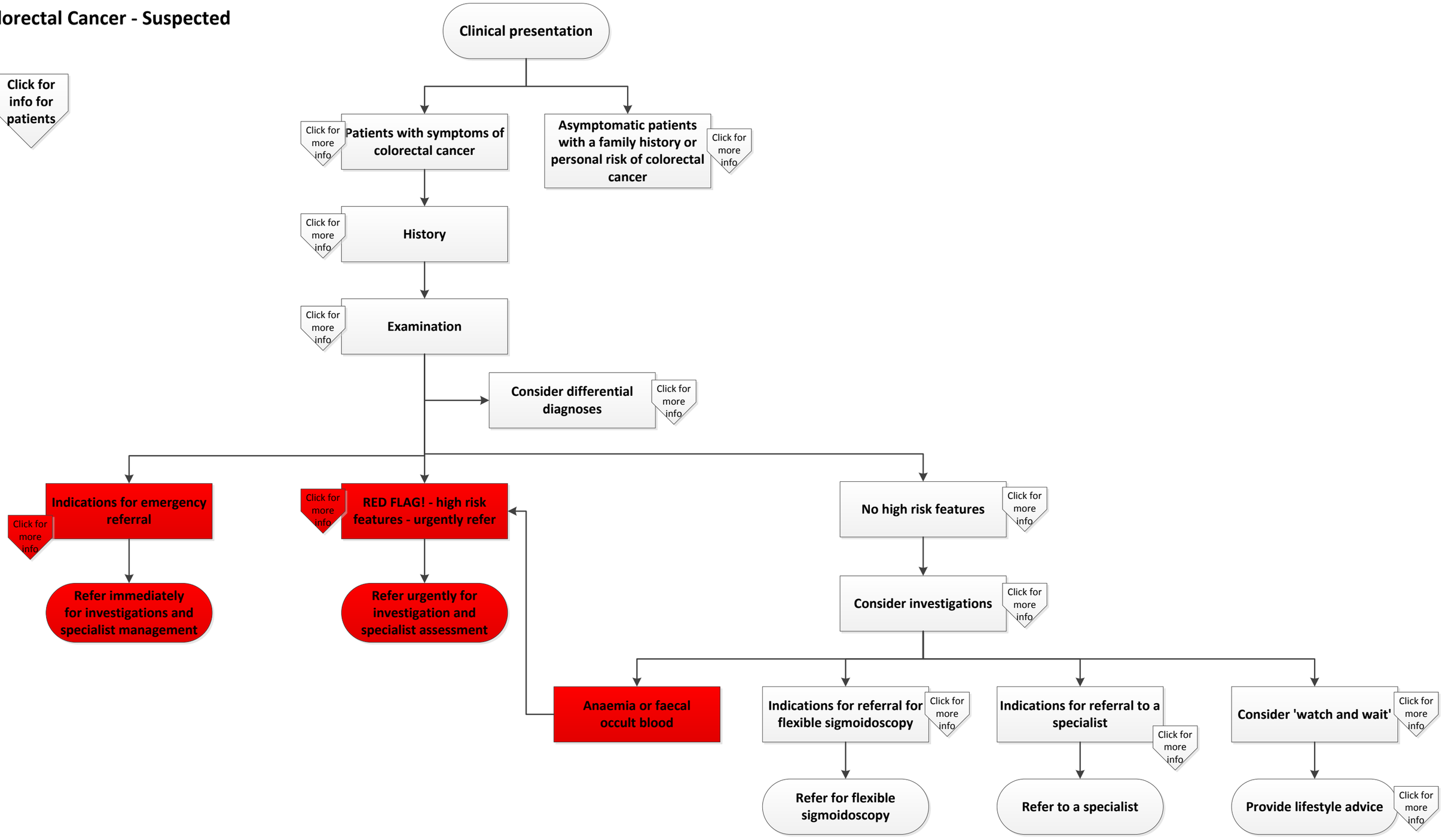

Back to pathway

Patients with symptoms of colorectal cancer

The most common presenting symptoms of bowel cancer are:

- rectal bleeding
- a change in bowel habit
- unexplained new onset anaemia

Other symptoms include:

- general or localised abdominal pain
- weight loss
- nausea
- anorexia
- weakness

Sigmoid cancers commonly present with:

- rectal bleeding:
  - NB: rectal bleeding occurs without anal symptoms in over 60% of patients with cancer
- changes in bowel habit, usually with:
  - increased frequency of defaecation; and/or
  - looser stools

Cancers proximal to the sigmoid colon:

- are more likely to present as:
  - emergencies with intestinal obstruction – most common emergency presentation
  - iron deficiency anaemia, with or without symptoms
- only a small number of patients will present to outpatient departments without iron deficiency anaemia and/or abdominal mass

Back to pathway

Asymptomatic patients with a family history or personal risk of colorectal cancer

Colonoscopic and/or genetic screening and surveillance of asymptomatic patients may be appropriate:

- in patients who are part of a high risk group, such as:
  - hereditary nonpolyposis colorectal cancer (HNPCC)
  - familial adenomatous polyposis (FAP)
  - MYH associated polyposis (MAP)
  - juvenile polyposis syndrome (JPS)
  - Peutz-Jeghers syndrome (PJS)
- in patients with a family history and/or personal risk factors for colorectal cancer
- as part of NHS bowel cancer screening programme (BCSP)

Back to pathway

History

Ask patient about:

- onset and duration of symptoms
- presence of perianal symptoms
- risk factors, e.g.**:**
  - inflammatory bowel disease (IBD)
  - diet - red meat, low fibre
  - smoking
  - alcohol
  - being overweight
  - individuals who rarely exercise
- red flag symptoms or signs:
  - weight loss
  - change in bowel habit, especially diarrhoea or increased frequency
  - symptoms suggestive of anaemia, e.g.:
    - lethargy
    - tiredness
    - shortness of breath
  - abdominal or rectal mass
- family history of colorectal cancer

Back to pathway

Examination

Abdominal examination:

- examine for abdominal mass:
- it is likely that a right sided mass will be of greater diagnostic value than left sided in view of a higher prevalence of a palpable sigmoid colon
- if there is uncertainty about the cause of an abdominal mass, the patient should be treated with laxatives and re-examined to establish whether the mass is persistent before referral

Digital rectal examination (DRE):

- examine for:
  - fissure
  - rectal mass:
    - there is a palpable rectal mass in 40-80% of patients with rectal cancer
  - constipation with faecal overflow
- may be deferred if the patient:
  - presents with rectal bleeding, and is young, has a strong history for haemorrhoids and is in a low risk group:
    - e.g. young patient with a short duration of symptoms and/or in whom review is planned
    - defer DRE to second presentation
  - is being referred due to initial presentation – DRE is desirable but may not be necessary
- if patient is to remain in primary care, DRE is required to definitively attribute rectal bleeding symptoms to benign causes

Vaginal examination:

- should be performed as part of the assessment of suspected rectal cancer in women

Assess patient for signs of:

- obstruction
- peritonitis
- perforation
- life threatening bleeding

Back to pathway

Consider differential diagnoses

Consider the following differential diagnoses:

- IBS:
  - rare as a first time presentation after age 50 years but is a common condition that presents with abdominal pain
- gastrointestinal cancer
- non-pathological constipation or faecal incontinence
- coeliac disease
- medication-related, e.g. erythromycin use
- other causes of rectal bleeding:
  - haemorrhoids
  - anal fissure
  - diverticular disease
  - inflammatory bowel disease (IBD)
  - colonic polyps
  - radiation proctitis
  - infectious gastroenteritis
  - angiodysplasia
  - ischaemic colitis
  - solitary rectal ulcer
  - anal cancer
  - sexually transmitted diseases
  - anorectal trauma

NB: Patients < 30 years are more likely to have haemorrhoids, anal fissures, or IBD, whereas patients > 50 years with rectal bleeding are at a higher risk of colorectal cancer

Back to pathway

Indications for emergency referral

An emergency referral should be made if colorectal cancer is suspected and the patient has any of the following:

- large bowel obstruction – most common
- life-threatening bleeding
- perforation
- peritonitis

Emergency presentations are associated with a higher operative mortality:

- perforation is an indication for emergency surgery
- large bowel obstruction can be managed with urgent surgery
- life threatening bleeding is now best managed with radiological intervention and embolisation, with surgery as a last resort

Back to pathway

RED FLAG! - high risk features - urgently refer

Urgent referral (2 week wait) for <u>colorectal</u> cancer is indicated in the following circumstances:

- aged ≥ 40 years with rectal bleeding AND change in bowel habit
- aged ≥ 40 years with unexplained weight loss and abdominal pain:
  - an urgent CT scan needs to be performed within 2 weeks: refer even if normal if ongoing concerns of malignancy
- aged ≥ 50 years with unexplained rectal bleeding
- aged ≥ 60 years AND changes in bowel habit
- rectal or abdominal mass upon examination
- aged < 50 years with rectal bleeding, and any of the following unexplained symptoms or findings:
  - abdominal pain
  - change in bowel habit
  - weight loss
  - iron-deficiency anaemia
- aged ≥ 50 years AND iron-deficiency anaemia (≤11g men, ≤10g non-menstruating women)
  - suggest coeliac testing in addition to FBC and eGFR
- tests show occult blood in their faeces - testing is indicated for adults without rectal bleeding who:
  - are ≥ 50 years with unexplained:
    - abdominal pain; or
    - weight loss
  - NB: see 'Consider investigations'box

Urgent referral (2 week wait) for <u>anal</u> cancer should be considered in the following circumstances:

- aged ≥ 60 years and unexplained anal mass or unexplained anal ulceration:

NB: if a pelvic mass is palpated outside the bowel, refer urgently to a urologist or gynaecologist

Review by a Regional Clinical Genetics Service is recommended for accurate risk assessment if this is the principal indication for referral for investigation.

The need for further investigation should be triggered in patients with persistent or unexplained symptoms, and those with intractable pain preventing proper clinical assessment

Back to pathway

No high risk features

Patients with high risk features should be referred urgently (2-week wait) - see 'RED FLAG!' box.
Features indicating a lower risk of colorectal cancer include:

- rectal bleeding with anal symptoms
- rectal bleeding with an external visible cause, such as:
  - prolapsed piles
  - rectal prolapse
  - anal fissures
- transient change in bowel habit for less than 6 weeks – especially if decreased frequency of defaecation and harder stools
- abdominal pain without:
  - iron deficiency anaemia
  - palpable abdominal mass
  - higher risk symptoms, e.g. loss of appetite causing weight loss
  - evidence of intestinal obstruction

Back to pathway

Consider investigations

All symptomatic patients should have a full blood count:

- evaluate haemoglobin (Hb), mean corpuscular volume (MCV), and mean corpuscular haemoglobin (MCH)
  - consider urgent referral of patients of any age with iron deficiency anaemia for gastroscopy or specialist review
- other blood tests will only be necessary if there are other features in the history, e.g. unexplained weight loss

A faecal occult blood test should be offered to adults without rectal bleeding who:

- are ≥ 50 years with unexplained:
  - abdominal pain; or
  - weight loss
- are < 60 years with:
  - changes in their bowel habit; or
  - iron deficiency anaemia
- are ≥ 60 years and have anaemia even in the absence of iron-deficiency
- NB: be aware of the possibility of false negative results for tests for occult blood in faeces

Faecal calprotectin:

- consider as a screening tool for inflammatory bowel disease (IBD) in younger low risk patients
- has a high positive predictive value (PPV) for IBD

Scopes:

- flexible sigmoidoscopy may be performed to rule out serious pathology
- proctoscopy:
  - may be used by some primary care clinicians as a screening tool for patients with rectal bleeding
  - should not be used as a substitute for flexible sigmoidoscopy

The following are not recommended to aid diagnosis in patients with rectal bleeding:

- tumour markers, e.g. CEA
- faecal occult blood testing

Back to pathway

Indications for referral for flexible sigmoidoscopy

Direct access flexible-sigmoidoscopy:

- should be considered for low risk patients with rectal bleeding who are concerned about colorectal malignancy
- is the investigation of choice for patients < 45 years with persistent rectal bleeding who:
  - are concerned about pathology apart from haemorrhoids; or
  - have received treatment for haemorrhoids and still have persistent bleeding
- NB: some patients with rectal bleeding should be referred urgently to specialist care for further investigation:
  - see 'RED FLAG!' box

Access to flexible-sigmoidoscopy varies depending on local services and capacity for patients:

- the Department of Health recommends considering direct referral for flexible-sigmoidoscopy, or to a one-stop clinic (where available) for patients not meeting criteria for urgent referral and:
  - ≥ 40 years with unexplained rectal bleeding for at least 6 weeks

Back to pathway

Indications for referral to a specialist

Patients with high risk features should be referred urgently (2-week wait) - see 'RED FLAG!' box.

Consider referral to a specialist if the patient:

- ≥ 40 years with a change in bowel habit to loose or more frequent stools for at least 6 weeks:
  - ≥ 60 years with a change in bowel habit, refer urgently (2-week wait)
- > 40 years with:
  - abdominal pain and no clear cause; or
  - weight loss; or
  - constipation
- has multiple or repeated symptoms
- has unexplained iron deficiency anaemia:
  - also consider urgent referral for gastroscopy

Consider referring patients on an urgent basis to a normal clinic if they have persistent low-risk features but there are other worrying factors, such as:

- positive family history:
  - NB: review of patient by a regional clinical genetic service is recommended for accuracy of risk assessment if family history is the principal indication for referral

Back to pathway

Consider 'watch and wait'

Patients who are low risk with rectal bleeding:

- and who are not overly anxious may be managed with a 'watch and wait' approach:
  - SIGN recommend a watch and wait strategy in patients who are < 40 years with low risk/transient features
- but who are concerned about colorectal malignancy should be considered for direct access flexible sigmoidoscopy

Safety netting:

- arrange review for patients with any symptom that is associated with an increased risk of cancer but who do not meet the criteria for referral or other investigative action
- the review may be:
  - planned within an agreed time frame
  - patient initiated if:
    - new symptoms develop; or
    - they continue to be concerned; or
    - their symptoms recur, persist, or worsen

Back to pathway

Provide lifestyle advice

Provide patients with advice on lifestyle changes to prevent the development of colorectal cancer:

- weight:
  - maintain a BMI close to the lower end of the normal range
- diet:
  - eat at least five portions (400g or 14oz) of non-starchy vegetables and fruits each day
  - eat relatively unprocessed cereal with every meal
  - keep consumption of red meat to less than 500g (18oz) per week
  - avoid processed meat
  - NB: nutrition support should be considered for those who are malnourished or at risk of malnutrition
- alcohol – limit the number of drinks consumed to no more than:
  - 2 drinks (4 units) per day for men
  - one drink (2 units) per day for women
- exercise:
  - physical activity of at least moderate intensity (equivalent to brisk walking) for at least 30 minutes for 5 days per week is recommended
- smoking cessation

Back to pathway

Information for Patients

Understanding Bowel Cancer from Beating Bowel Cancer: https://www.beatingbowelcancer.org/understanding-bowel-cancer/

Bowel cancer from Cancer Research UK: http://www.cancerresearchuk.org/about-cancer/bowel-cancer

Understanding Bowel Cancer from Macmillan: http://www.macmillan.org.uk/information-and-support/bowel-cancer

Screening for Bowel (Colorectal) Cancer from Patient Info UK: https://patient.info/health/screening-for-bowel-colorectal-cancer

Treating Rectal Cancer from Macmillan: http://www.macmillan.org.uk/information-and-support/bowel-cancer/rectal/treating/