Referral for patients with suspected bowel cancer

The following questions can be used as discussion points for peer groups or self-reflection of practice. The questions for this peer group discussion relate to referral of patients with features suggestive of bowel cancer.

It is strongly recommended that the following article is read before considering the questions.

"Referral for patients with features suggestive of bowel cancer" available from: **www.bpac.org.nz/2020/bowel-cancer.aspx**

Bowel cancer is one of the most common causes of cancer death in New Zealand. New Zealand also has a high proportion of people (26%) who are diagnosed with bowel cancer after presentation with bowel-related symptoms at an emergency department and there is evidence that this is associated with poorer outcomes.

Bowel cancer incidence and mortality in New Zealand is high compared to other countries, and people of Māori and Pacific ethnicities have worse outcomes. People of Māori or Pacific ethnicity:

- Tend to have more advanced disease at diagnosis
- Are more likely to be diagnosed after presenting to an emergency department
- Are more likely to live in socioeconomically deprived neighbourhoods
- Have higher rates of co-morbidity

These factors all contribute to worse survival statistics but do not fully explain the differences in bowel cancer outcomes. A lack of access to healthcare at all levels and reduced quality of care may also be contributing factors. There have been reports of wide variation between district health boards (DHBs) in New Zealand in the diagnosis and treatment of bowel cancer.

The Ministry of Health and National Bowel Cancer Working Group have developed a number of initiatives which aim to reduce the impact of bowel cancer in New Zealand, to ensure consistency of care throughout the country and to address the associated disparities in diagnosis and treatment for people of Māori or Pacific ethnicity.

The updated guidance and criteria allows general practitioners to refer patients directly for outpatient bowel investigation. Patients can be referred directly for colonoscopy or Computed Tomography (CT) colonography (i.e. without first seeing a gastroenterologist or general surgeon) if they have symptoms and signs suggestive of bowel cancer and meet the referral criteria.

For patients who do not meet the direct referral criteria, including atypical presentations, referral to a gastroenterologist or general surgeon may remain an appropriate action. Referrals for colonoscopy or CT colonography after a positive screening test through the National Bowel Screening Programme are not covered by these criteria and there is a separate referral pathway and funding stream.

Key symptoms and signs that may suggest a diagnosis of bowel cancer include rectal bleeding, changes in bowel habit, weight loss and iron deficiency anaemia. The majority of these symptoms have a low positive predictive value (≤ 5%) for detecting colorectal cancer. Therefore, to establish whether symptomatic patients meet the criteria for direct access, in most cases, a combination of symptoms and signs along with laboratory investigations are required. Patients with unexplained rectal bleeding, a change in bowel habit where the motions are looser and/or more frequent lasting more than six weeks, iron deficiency anaemia and risk factors such as the patient's age and family history are prioritised. Age and family history also have an impact on the likelihood of cancer and whether patients will meet the referral criteria.

It is thought that in the majority of cases, patients who do not meet the criteria for direct access will not have bowel cancer, however, these patients should continue to be monitored regularly, e.g. two to three month intervals, with assessment of symptoms, repeat clinical examination, a check of weight and investigation of haemoglobin and ferritin levels. In some patients, symptoms may persist (and therefore meet the six-week criteria) or worsen (e.g. they become anaemic due to ongoing blood loss) and they may then become eligible for direct access referral at a subsequent appointment. "Safety netting" in the form of active follow-up or placement of a recall to prompt reassessment is recommended, particularly for young patients and patients who may not book a further appointment or do not report changes in symptoms.

The updated referral criteria make no changes to the way acutely unwell patients should be managed. Patients who are unwell, e.g. with significant bleeding, suspected perforation or acute large bowel obstruction should be referred directly to secondary care for acute assessment or admission.

Asymptomatic patients who have a family history of bowel cancer indicating a moderate to high increase in risk can also be offered direct access surveillance colonoscopy.

The updated guidance and full criteria are available on the Ministry of Health website (**https://www.health.govt.nz/publication/referral-criteria-direct-access-outpatient-colonoscopy-or-computed-tomography-colonography**) and are also outlined on the regional Health Pathways websites.

Questions to consider:

1. The Ministry of Health and National Bowel Cancer Working Group have developed a number of initiatives with the aim of ensuring consistency of care. One of these is the updated referral criteria for direct access investigations. Prior to reading this article were you aware of the criteria and that clinicians in primary care were able to refer via this pathway? Have you applied the referral criteria within your practice? If so, do you think it streamlined the process for the patient?
2. People of Māori or Pacific ethnicity have worse outcomes than people of other ethnicities following a diagnosis of bowel cancer. A number of reasons have been put forward to explain this disparity, primarily lower socioeconomic background and higher rates of co-morbidity. In your experience, do you feel that there are other factors that may be contributing to this difference in outcomes? How could these factors be addressed in your practice?
3. Key symptoms and signs that may suggest a diagnosis of bowel cancer include rectal bleeding, changes in bowel habit, weight loss and iron deficiency anaemia; how confident are you in differentiating other potential causes for these features such as haemorrhoids, irritable bowel syndrome and diverticulitis?
4. If you have a patient who does not currently meet the referral criteria for direct access, what processes do you have in place to ensure that they are reviewed in an appropriate time frame, i.e. what safety netting strategies do you use? In your opinion, how much of the responsibility for follow-up should be placed on the patient rather than the clinician?
5. Asymptomatic patients with a significant family history of bowel cancer can also be referred using the criteria. Regularly updating family history is therefore required to allow accurate categorisation of family history. Do you regularly and consistently enquire about and document family history? If not, do you feel that this would be a good strategy to put in place?
6. If the patient meets the criteria for direct access investigation, you need to consider whether they will be able to tolerate the bowel preparation and the procedure itself. Factors to be considered when making this decision include the patient's co-morbidities, level of frailty and prescribed medicines, e.g. anticoagulants, insulin. In you experience, do you find people generally cope well with the bowel preparation? What practical advice do you give people to help them with this?