GP Referral Pathway for Suspected Colorectal Cancer

Colorectal cancer is the second most common cancer in men and women in Ireland. Over 2,500 cases are diagnosed each year; 1,500 men and 1,000 women. It accounts for 12.2% of all invasive cancers diagnosed and for 11.8% of cancer deaths. The median age at diagnosis is 70-74 years; more than 90% are over 50 years at diagnosis. 60% of patients are diagnosed at a late stage. The risk of developing colorectal cancer up to age 74 is 5% in males and 3% in females. The 5-year survival rate is 62.6%. (Data source National Cancer Registry, 2017).

Lifestyle risk factors for colorectal cancer include obesity, alcohol, diet high in fat, red/processed meat and low in fibre, sedentary lifestyle, cigarette smoking. HPV is a risk factor for anal cancer. Patients with longstanding ulcerative colitis and Crohn's disease are at higher risk of colorectal cancer. Participation in Bowel Screen is recommended.

The aim of this pathway is to guide GPs as to which patients with clinical features of suspected colorectal cancer should be referred directly to endoscopy or for an urgent clinical review to a colorectal surgeon or a gastroenterologist.

Good Practice Points:

- Prior to referral, all patients require a full blood count (FBC) but imaging is not required.
- Tumour markers are of no diagnostic benefit for colorectal cancer.
- A negative digital rectal examination (DRE) does not rule out the need to refer.
- A main cause of iron deficiency anaemia (IDA) in people <55 years is coeliac disease.
- Patients should be informed that they are being referred for colonoscopy.
- Patients referred direct to endoscopy should be considered fit to tolerate the procedure.
- For patients who had a previous colonoscopy, please indicate findings.

Direct referral for endoscopy is generally NOT applicable for the following:

- Diarrhoea (less than 6 weeks).
- Constipation as a single symptom.
- Abdominal pain in the absence of altered bowel habit.
- Anal symptoms such as prolapsed piles, rectal prolapse, anal fissure.
- Low ferritin in patients >50 years but with a normal haemoglobin (should still consider the need for endoscopy, particularly in males).
- A young person presenting with bloody diarrhoea. This usually requires an urgent referral to Gastroenterology Service with possible Inflammatory Bowel Disease.

Suitable for Direct Referral to Endoscopy

Age ≥ 60

Persistent rectal bleeding*

OR

Change in bowel habit for > 6 weeks

OR

Unexplained significant weight loss in combination with other symptoms suggestive of colorectal cancer

Age ≥ 40

With rectal bleeding

AND

Change in bowel habit for > 6 weeks

Age <40

With unexplained rectal bleeding AND/OR change in bowel habit

AND

A family history¥ of colorectal OR inflammatory bowel disease

Refer for **Unexplained Iron Deficiency Anaemia,** i.e. considered on the basis of history and clinical examination in primary care not to be related to other sources of blood loss.

Male (any age) ≤11g/100ml;
Female (non-menstruating) ≤10g/100ml

Include a Ferritin level where iron deficiency anaemia is the sole indication for referral.

Colonoscopy referrals triaged as urgent will be offered an appointment within four weeks where possible; routine referrals will be seen within about 13 weeks. All referrals should include details of previous endoscopy examinations and relevant past medical history and recent FBC.

* Persistent rectal bleeding is defined as lasting > 6 weeks and requires an urgent referral.

¥ A significant family history within this context includes:

- One 1st degree relative (i.e. sibling, parent or child) diagnosed with colorectal cancer under the age of 50.
- Two or more relatives with colorectal or endometrial cancer. One of these should be a 1st degree relative of the patient and they should be first degree relatives of each other.
- A family history of colorectal cancer syndrome such as Lynch Syndrome or polyposis.

Require Referral Direct to Colorectal OPD (Not suitable for Direct to Endoscopy)

- Palpable abdominal mass
- Palpable rectal mass
- Anal mass
- Anal ulceration

- Suspected colorectal cancer on abdominal/ pelvic imaging +/ - metastatic disease, e.g. as incidental findings, should not be referred for endoscopy. The patient requires assessment at OPD, followed by discussion at a colorectal multi disciplinary team (MDT).
- A suspicion of colorectal cancer in any patient otherwise not fitting criteria for direct referral to endoscopy.
- **Patients with suspected bowel obstruction or perforation require urgent referral to an Emergency Department.**