Colorectal Symptoms & Suspected Colorectal Cancer

Oncology > Oncology > Colorectal Cancer

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1 Care map information

Quick info:

The aims of this pathway are to:

- explain risk assessment (high, moderate and low) to referrer
- aid prompt diagnosis of colorectal cancer for patients presenting with 'high' or 'moderate' risk symptoms
- avoid inappropriate use of colonoscopy, faecal occult blood tests (FOBs) and faecal calprotectin (FCP)
- direct referral of patients to the most appropriate service
- help referrers provide adequate information for prioritisation or use accepted indications to make a referral with all required information
- support referrers to 'treat and review' patients with 'low risk' symptoms, who are not unduly anxious
- the 'symptom' pathways are only suitable if 'rectal bleeding', 'altered bowel habit' or 'iron deficiency' is present

Incidence:

In 2008, colorectal cancer was the second most common cancer registered and the second most common cause of death in New Zealand accounting for 14% of all cancer registrations and 15% of all deaths from cancer [1]. Men have considerably higher rates of rectal cancer [2]. Each year between 2500 and 3000 New Zealanders will be diagnosed with colorectal cancer and between 1,100 and 1,200 will die as a result of colorectal cancer [1].

In 2008, colorectal cancer was the fourth most commonly registered cancer and third most common cause of death from cancer for Maori compared to non-Maori where colorectal cancer was the second most commonly registered cancer and cause of death from cancer.

References


2 Information resources for patients and carers

Quick info:

Resources for patients and carers:
- colonoscopy - a patients guide
- beat bowel cancer - tests
- Colorectal Surgical Society of Australia and New Zealand
- Cancer Society - bowel cancer

3 Information resources for clinicians

Quick info:

Resources for clinicians:
- National Referral Criteria for Direct Access Outpatient Colonoscopy
- Category 2 Family History
- Category 3 Family History
- guideline for the Management of Iron Deficiency Anaemia
- management of early colorectal cancer
- management of early colorectal cancer

4 Updates to this care map

Quick info:

Date of publication: ????.

For further information on contributors and references please see the care map’s Provenance.
5 Hauora Maori

Quick info:
As a practitioner you will work with Maori whanau/families. Each Maori whanau is diverse with their own set of values and beliefs, inherited, practised and passed down from generation to generation.

There are some important things that you should be mindful of when working with Maori individuals and their whanau from a holistic approach to working in a Whanau ora or family / whanau centred way.

Key enablers that you should be aware of when working with Maori whanau/families are:
- building relationships and gaining trust
- effective communication with whanau /families
- understanding and involving whanau/ families in the treatment planning and care management
- practical things to be mindful of when working with Maori whanau so that you do not breech Tikanga/Principles and practices that are important in Te Ao Maori/the Maori world

Common terms and definitions are noted here.

6 Pasifika

Quick info:
Our pasifika community:
- is a diverse and dynamic population
  - more than 22 nations represented in New Zealand
  - each with their own unique culture, language, history, and health status
  - share many similarities which we have shared with you here in order to help you work with pasifika patients more effectively

The main Pacific nations in New Zealand are
- Samoa, Cook Islands, Fiji, Tonga, Niue, Tokelau and Tuvalu

Acknowledging The FonoFale Model (pasifika mode of health) when working with pasifika peoples and families.

Acknowledging general pacific guidelines when working with pasifika peoples and families:
- cultural protocols and greetings
- building relationships with your pacific patients
- involving family support, involving religion, during assessments and in the hospital
- home visits
- pasifika phrasebook

7 Colorectal symptoms raising suspicion of cancer

Quick info:
The incidence of colorectal cancer increases substantially with increasing age. Ninety percent of colorectal cancers are diagnosed in patients age >50.

Most patients with colorectal cancer will present with:
- rectal bleeding (with or separate from the faeces)
- colorectal cancer presenting with altered bowel habit, is most likely to cause “looser and/or more frequent stools
- changes in bowel habit, such as:
  - increased frequency of defaecation
  - looser stools
- constipation and alternating constipation/diarrhoea are uncommon presentations of colorectal cancer
- non-specific symptoms, e.g. tiredness due to undetected blood loss
- most (80 - 90%) symptomatic colorectal cancers present with rectal bleeding, altered bowel habit or iron deficiency anaemia - alone or in combination
- other presentations of colorectal cancer include:
• symptoms of metastatic disease
• acute or intermittent intestinal obstruction (may present as intermittent pain and nausea/vomiting, worse after eating)
• abdominal or rectal mass

Other presenting complaints include:
• feeling of bloatedness
• weight loss (usually weight loss is a late symptom associated with metastatic disease or other complications - consider other causes)
• malaise
• mucus in the faeces

NB: these however are non-specific and can be related to multiple other pathologies. Alternative explanations should be sought where these are the predominant symptom without evidence of rectal bleeding, changes in bowel habit, anaemia or other associated risk factors for colorectal cancer.

Patients with cancers proximal to the sigmoid colon may present with:
• intestinal obstruction
• iron deficiency anaemia – defined as both haemoglobin and ferritin below the reference range for age and gender
• abdominal mass

8 History

Quick info:

Ask patient about:
• onset and duration of symptoms, e.g:
  • rectal bleeding
  • changes in bowel habit
• risk factors, e.g:
  • inflammatory bowel disease (IBD)
  • personal history of adenomatous polyps
  • personal history of colorectal cancer
  • diet
  • drugs
  • smoking
• systemic symptoms, e.g:
  • weight loss
  • anorexia
  • fatigue
• positive family history of colorectal cancer

Equity:
• Maori patients have poorer survival rates for colorectal cancer. Consider early referral in this group
• ask all of your patients if they smoke
• tobacco use is the single most preventable cause of disease, disability and death in New Zealand. Maori smoking prevalence is over double of non-Maori prevalence. Give all of your patients who smoke, brief advice to quit and nicotine replacement therapy (NRT). If you have no NRT on hand, a prescription or Quit card will suffice. There is no need to assess readiness to quit. Give an NRT prescription or Quit card to all patients. Ask permission to refer each patient for cessation support either with a community based provider or to Quitline. Tobacco control should also be discussed with the patient's household and family members
• offer and refer your Maori patients for socioeconomic support

9 Consider differential diagnoses
Quick info:
Differential diagnoses include:
- inflammatory bowel disease (IBD):
  - Crohn's disease
  - ulcerative colitis
- irritable bowel syndrome (IBS): must not have bleeding
- haemorrhoids
- benign polyps
- non-pathological constipation or faecal incontinence
- infective colitis
- coeliac disease
- medication-related, e.g. erythromycin use
- anal cancer

10 Examination

Quick info:
**Examination:**
- assess patient for:
  - weight loss
  - signs of cachexia
  - anaemia:
    - all patients with unexplained iron deficiency anaemia should be referred for endoscopic investigation of upper and lower gastrointestinal tract
    - menstruation is the commonest cause of iron deficiency anaemia in women - for women aged less than 55 years a menstrual history should be obtained prior to referral. Coeliac disease and urinary loss should also be excluded
  - abdominal distension
  - palpable abdominal mass
  - palpable lymph nodes
  - signs of obstruction or acute abdomen
  - where signs of malnutrition are present, complete a validated nutrition screening tool, e.g. Malnutrition Universal Screening Tool (MUST)
- digital rectal examination (DRE), if the patient:
  - has reported a history of rectal bleeding
  - is age 40 years or older
  - has persistent symptoms
  - has symptoms suspicious of colorectal cancer
  - if CT colonography is planned, all patients must have a DRE documented, as CT colonoscopy can miss low rectal and anal lesions
  - vaginal examination
  - assessment of the presence of a palpable rectal mass (if there is uncertainty regarding the mass, the patient should be re-examined after treatment with laxatives)

11 Rectal bleeding

Quick info:
**Rectal Bleeding**
**General Principles:**
- rectal bleeding is most commonly due to benign causes

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• 'outlet' bleeding is fresh/bright red blood – limited to the toilet tissue, or in the bowl but separate from the stool
• 'non-outlet' or 'colonic' bleeding old/dark red blood, and/or blood mixed in with the stool
• 'persistent' bleeding means bleeding on at least two days per week over four consecutive weeks
• 'recurrent' means bleeding that is not persistent, but two or more episodes over four or more weeks
• rectal bleeding with anal symptoms, and an external visible cause, such as prolapsed piles, rectal prolapsed and anal fissures, are low risk for colorectal cancer
• rectal bleeding associated with hard stools, straining to pass stool, or dripping blood into the toilet bowl suggest an anal cause.
  A bulking agent, local treatment and review in a few weeks, is appropriate. If bleeding persists, refer for consideration of flexible sigmoidoscopy and consideration of haemorrhoid banding
• 'outlet' bleeding over one or a few days that does not recur within six months, even without anal symptoms, or identified anal cause, is very likely due to a benign cause
• patients who are not unduly anxious, do not require referral to secondary care for a single episode or a few episodes over a few days of ‘outlet’ bleeding without anal symptoms. It is reasonable to review these patients in a few weeks, or advise them to report further bleeding or additional symptoms - consider referral if bleeding has been persistent (>4 weeks)
• overt rectal bleeding from colorectal cancer is likely to be persistent (>4 weeks) and unlikely to cease spontaneously

Diagnostic Investigations:
• check CBC and ferritin for all patients age ≥50 years with rectal bleeding, and those aged <50 years with heavy or persistent bleeding
• if referring a patient with rectal bleeding for colonoscopy, arrange bloods for CBC, ferritin, CRP and creatinine (the results can be checked at time of prioritisation and need not delay the referral being sent)
• faecal occult blood (FOBs) and calprotectin (FCP) should NOT be ordered for acute (<4 weeks) or persistent (>4 weeks) rectal bleeding, or acute onset diarrhea (<6 weeks)
• if the patient has an accepted indication for colonoscopy, do not collect stool samples for FOBs or calprotectin

Patients to refer for lower GI investigations including direct access colonoscopy:
• unexplained rectal bleeding (benign anal causes treated or excluded) with iron deficiency anaemia (haemoglobin below the local reference range) - refer for urgent colonoscopy
• unexplained rectal bleeding (benign anal causes treated or excluded) aged ≥50 years - refer for non-urgent colonoscopy
• rectal bleeding aged less than 50 years (normal haemoglobin) - consider FSA or flexible sigmoidoscopy if no anal cause

12 Altered bowel habit

Quick info:
General Principles:
• colorectal cancer presenting with altered bowel habit, is most likely to cause ‘looser and/or more frequent stools’
• constipation or alternating constipation/diarrhoea are uncommon presentations of colorectal cancer
Diagnostic Investigations:
• patients age <50, with looser and/or more frequent stools >6 weeks, should have the results of CBC, ferritin, CRP, and Coeliac abs (TTG/DGP) included in the referral. If inflammatory bowel disease is strongly suspected, refer directly for colonoscopy. If CRP is normal and the suspicion of IBD is low discuss with a a specialist prior to requesting faecal calprotectin. A low faecal calprotectin (<50) makes IBD unlikely, if elevated >150 IBD should be suspected and a colonoscopy requested. Results between 50-150 are ambiguous and hard to interpret
• patients age ≥50, with looser and/or more frequent stools >6 weeks, should have CBC, ferritin, CRP, creatinine and Celiac abs (TTG/DGP) requested, but referral for colonoscopy should not be delayed. Results can be checked at time of prioritisation.
  FOBs and FCP should not be ordered for these patients
• faecal occult blood tests (FOBs) and faecal calprotectin (FCP) should not be collected on patients who meet criteria for colonoscopy referral

Looser/more frequent stools (>6 weeks):
• a persistent (>6 weeks) change to “looser and/or more frequent” stool, without rectal bleeding, age ≥50, is ‘moderate risk’ for colorectal cancer – particularly if new (< 1 year), and is accepted indication for direct access colonoscopy (<6 week priority)
• faecal occult blood tests (FOBs) and faecal calprotectin (FCP) should not be collected on patients who meet criteria for colonoscopy referral
• acute onset diarrhoea <6 weeks duration is not accepted as an indication for FSA or colonoscopy. Check stool cultures for infectious cause and review in 4-6 weeks to check symptoms have resolved

**Constipation and alternating diarrhoea/constipation:**

• constipation (less frequent or harder stools) "is very low risk for colorectal cancer, and as a sole symptom, is not an accepted indication for colonoscopy

• alternating bowel habit (alternating diarrhoea and constipation) "is 'low risk' for colorectal cancer

• minimal unexplained weight loss (<2.5%) is non-specific, but warrants review. ‘Low risk’ ABH with moderate (5-10%) or marked (>10%) weight loss warrants referral (CT colonography may be preferred, as it provides some degree of extra-colonic imaging). If >10% weight loss alone is the predominant symptom, consider contrast CT or upper GI investigations in the first instance

• an isolated positive faecal occult blood test (FOB) in the absence of other symptoms is currently not an accepted indication for lower GI investigations outside the context of the Bowel Screening Programme. Ordering FOB is discouraged except on discussion with a specialist

• NB. if FOB is tested after discussion with a specialist, Guaiac (+), Human Haemoglobin (-) is a negative result

• for patients with ‘Constipation’ or ‘Alternating bowel habit’, abdominal pain - without evidence of obstruction, bloating, incomplete emptying, ‘thin’ stools, and rectal mucus, are not alarm symptoms and are considered ‘low risk’. These patients should be prescribed a bulking agent (e.g Konsyl D) and at least one other laxative to try, and reviewed in 4-6 weeks. If concern persists after an appropriate trial of fibre, consider referral for CT colonography or flexible sigmoidoscopy

• for patients with ‘low risk’ ABH, particularly if long-standing, or intermittent, or non-progressive, ‘treat and review’ is appropriate care

• for patients with ‘low risk’ ABH (i.e. who do not have rectal bleeding or looser/more frequent stool), those >80 and those with significant comorbidities, CT colonography is a reasonable and appropriate alternative to colonoscopy. If CT colonoscopy is requested, ensure rectal examination findings are documented on the referral, as the low rectum and anal canal can be obscured by the colonography balloon leading to low lesions being missed

**13 Iron deficiency anaemia**

**Quick info:**

**General Principles:**

• anaemia is defined as a haemoglobin < 125 g/L in men, and < 115 g/L in women

• iron deficiency anaemia is diagnosed by the combination of low haemoglobin and low ferritin

• a low ferritin (<20 men, <30 women) is the most specific indicator of iron deficiency

• low ‘serum iron’, and low ‘iron saturation’ are non-specific, and not accepted as indicators of iron deficiency, if ferritin is normal

• microcytosis (MCV) and low mean cell haemoglobin (MCH) are suggestive of, but not specific for iron deficiency. A ferritin is needed

• an otherwise low ferritin may be elevated to a low-normal range (30-60) if inflammation (acute or chronic) or renal impairment is present. Iron deficiency is unlikely if ferritin is > 100. Serum creatinine and CRP are needed in such cases

• in unclear cases of iron deficiency, iron deficiency can be proven if there is a significant increment in haemoglobin with iron replacement

• anaemia that is NOT due to iron deficiency does NOT warrant upper or lower GI endoscopies, unless there are GI symptoms that warrant endoscopy in their own right

• unexplained iron deficiency (low ferritin) anaemia (Hb < 125 g/L men, < 115 g/L post menopausal women) is a good indication (moderate risk) for colonoscopy (and gastroscopy) (≤6 week priority)

• all patients with IDA should be screened for Coeliac Disease with TTG/DGP abs, unless there is a clear history of upper or lower GI bleeding. Do not request IgA levels, or endomysial antibodies

• premenopausal women with IDA should be screened for coeliac disease, but upper and lower GI endoscopies are not indicated in women < 50, except those with symptoms suggestive of GI disease, or those with a strong family history of CRC (NZGC Category 2 or 3 Family History)

• faecal occult blood tests (FOBs) and faecal calprotectin (FCP) should not be collected except on the advice of a specialist

• isolated low ferritin without anaemia in men >50 and post menopausal women should be closely monitored for development of IDA or other symptoms suggestive of GI tract pathology. Clinical review and repeat blood tests should be planned and the patient referred promptly should symptoms develop

**Diagnostic Investigations:**

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14 Symptoms suspected to be due to anal cause

Quick info:
The following symptoms trigger referral to General Surgical Clinic or flexible sigmoidoscopy for further investigation:

- rectal bleeding due to suspected malignant anal lesions, symptomatic anal tags, and anal polyps
- persistent, heavy or frequent recurrent bleeding due to identified benign anal causes AND unresponsive to first line treatment (stool softener/diet and/or haemorrhoid cream/suppositories (topical anaesthetic and steroid) and/or nitrate paste as appropriate:
  - haemorrhoids
  - anal fissure
  - anal/rectal prolapse
- persistent or recurrent outlet bleeding with anal symptoms (any age), without identified anal cause, AND unresponsive to empirical treatment (4 weeks) - bulking agent/softener and haemorrhoid cream/suppositories
- persistent (>4 weeks) or frequently recurrent outlet bleeding, no anal cause found (primary care), age >50 years, normal haemoglobin, AND no response to empirical treatment (2 weeks) - bulking agent/softener and haemorrhoid suppositories

16 Symptoms suspected to be due to anal cause

Quick info:
Refer patient to the General Surgical Clinic if their symptoms are due to or are suspected to be due to:

- rectocele
- anorectal prolapse
- anal sphincter incompetence
- anal stenosis
AND whose symptoms remain significant despite a trial of bulking agent, or laxatives.

21 High risk indications for direct access colonoscopy

Quick info:
National Referral Criteria for Direct Access Outpatient Colonoscopy:

Accepted criteria for urgent (<2 week priority) colonoscopy:

- known or suspected colorectal cancer (on imaging, or palpable, or visible on rectal examination), for pre-operative procedure to rule out synchronous pathology
- unexplained rectal bleeding (benign anal causes treated or excluded) with iron deficiency anaemia (haemoglobin and ferritin below the local reference range)
- altered bowel habit (looser and/or more frequent) >6 weeks duration plus unexplained rectal bleeding (benign anal causes treated or excluded) aged ≥ 50 years

22 Moderate risk indications for direct access colonoscopy

Quick info:
National Referral Criteria for Direct Access Outpatient Colonoscopy:

• all patients with IDA should be screened for Coeliac Disease with TTG/DGP abs, unless there is a clear history of upper or lower GI bleeding. Do not request IgA levels, or endomysial antibodies
• premenopausal women with IDA should be screened for coeliac disease, but upper and lower GI endoscopies are not indicated in women < 50, except those with symptoms suggestive of GI disease, or those with a strong family history of CRC (NZGC Category 2 or 3 Family History)
• faecal occult blood tests (FOBs) and faecal calprotectin (FCP) should not be collected except on the advice of a specialist

• faecal occult blood tests (FOBs) and faecal calprotectin (FCP) should not be collected except on the advice of a specialist
Accepted criteria for non-urgent (<6 weeks priority) colonoscopy:

- altered bowel habit (looser and/or more frequent) > six weeks duration, aged ≥ 50 years
- altered bowel habit (looser and/or more frequent) > six weeks duration plus unexplained rectal bleeding (benign anal causes treated or excluded), aged 40 - 50 years
- unexplained rectal bleeding (benign anal causes treated or excluded) aged ≥ 50 years
- unexplained iron deficiency anaemia (haemoglobin and ferritin below local reference range)

- Category 2 Family History plus one or more of altered bowel habit (looser and/or more frequent) > six weeks duration plus unexplained rectal bleeding (benign and anal causes treated or excluded), aged ≥ 40 years
- Category 3 Family History plus one or more of altered bowel habit (looser and/or more frequent) > six weeks duration plus unexplained rectal bleeding (benign and anal causes treated or excluded), aged ≥ 25 years
- suspected/assessment inflammatory bowel disease (consider FSA)
- imaging reveals polyp > 5mm

23 Low risk symptoms not accepted for direct access colonoscopy

Quick info:
National Referral Criteria for Direct Access Outpatient Colonoscopy:
The following are not accepted as indications for direct access colonoscopy:

- acute diarrhoea < six weeks duration - likely infectious aetiology and self-limited
- rectal bleeding aged less than 50 years (normal haemoglobin) - consider FSA or flexible sigmoidoscopy if no anal cause
- irritable bowel syndrome (may require specialist assessment)
- constipation as a single symptom
- uncomplicated computed tomography (CT) proven diverticulitis without suspicious radiological features
- abdominal pain alone without any 'six week category' features
- decreased ferritin aged < 50 years with normal haemoglobin
- abdominal mass - refer for appropriate imaging
- metastatic adenocarcinoma unknown primary - 6% is due to colorectal cancer (CRC) and in the absence of clinical, radiological, or tumour marker evidence of CRC, colonoscopy is not indicated

25 Assess patient's suitability to undergo colonoscopy

Quick info:
In referring a patient for colonoscopy, the referrer should:

- inform the patient about the procedure and ensure they are willing to undergo the procedure
- consider the ability of the patient to tolerate both the bowel preparation and the procedure
- consider whether the patient being referred will benefit if they are frail, have multiple comorbidities or advanced malignancy (generally referral implies they are well enough to tolerate further treatment)
- if the patient has had a colonoscopy or CT colonography in the preceding five years, ensure there is a clear indication to repeat the procedure (the 'miss' rate of lesions > 1cm following a well performed colonoscopy is approximately six percent)
- if there is a clear indication for lower GI investigations but looser/more frequent stools or bleeding are not the predominant symptoms, and the patient is >80 or has comorbidities increasing the risk of colonoscopy, consider CT colonography +/- flexible sigmoidoscopy in the first instance. All patients referred for CT colonography should have a rectal examination done and findings documented in the referral, as low rectal and anal lesions can be obscured by the colonography balloon resulting in missed lesions

26 Consider referral to a colorectal specialist if symptoms persist

Quick info:
Review in 3 - 6 months. Consider referral to colorectal specialist if the patient experiences persistent symptoms.
28 Patient not suitable or declines further investigation

Quick info:
See Advance Care Planning Pathway.

30 Referral for lower GI investigations including direct access colonoscopy

Quick info:
Good referrals with adequate detail are essential to determine the most appropriate prioritisation (direct access colonoscopy / CT colonography).

Use the Colonoscopy advanced referral form in Medtech.

All referrals need to include:
1. detailed personal history and findings of examinations including previous surgery, previous endoscopies, abdominal imaging, and any relevant investigations/examinations, BMI
2. details of family colorectal cancer, including which relative/s, what cancer types and at what age
3. blood tests as described below (e.g. CBC, ferritin, CRP, creatinine and Celiac abs (TTG/DGP), LFTs, U&Es
4. list of current medications

Rectal Bleeding:
Please include the following information when referring the patient for lower GI investigations:

• type and quantity e.g: fresh blood, on the toilet tissue and in the bowl, but separate from the stool, < tsp
• duration and frequency of rectal bleeding:
  • number of episodes
  • number of days/weeks/months
  • when the last bleeding occurred: e.g.: three episodes over two days, 10 days ago
• presence or absence of associated anal symptoms
• presence or absence of a change in bowel habit:
  • looser/more frequent >6 weeks; or other)
  • and/or description of general bowel habit (stool form, frequency, variable form or frequency, straining, incomplete emptying, bloating etc)
• digital rectal examination (DRE) findings
• whether the patient has had a colonoscopy, especially within the preceding 5 years - including where, indication and findings
• presence or absence of family history or colorectal cancer(s) – with detail - relationship(s) to patient (and each other), age at diagnosis – e.g father 55, paternal uncle 65 etc
• additionally, if referring for colonoscopy, CBC, ferritin, CRP and creatinine are useful

Altered Bowel Habit:
Please include the following information when referring the patient for lower GI investigations:

• the type, and duration of change: e.g looser and more frequent stools, 2 months, OR Constipation, 1 year, OR alternating diarrhoea/constipation, 6 months
• whether the altered bowel habit is persistent OR intermittent
• referrals for ‘looser and/or more frequent stools’ should give detail about: the onset of the change: gradual or sudden; the prior stool form and frequency, and the current stool form and frequency e.g from 1-2x/day, formed stool, to 4-5x/day loose stool with urgency
• patients age <50, with looser and/or more frequent stools > 6 weeks, should have the results of CBC, ferritin, CRP, and Coeliac abs (TTG/DGP) included in the referral. If inflammatory bowel disease is strongly suspected, refer directly for colonoscopy. If CRP is normal and the suspicion of IBD is low discuss with a a specialist prior to requesting faecal calprotectin. A low faecal calprotectin (<50) makes IBD unlikely, if elevated >150 IBD should be suspected and a colonoscopy requested. Results between 50-150 are ambiguous and hard to interpret
• patients age ≥ 50, with looser and/or more frequent stools >6 weeks, should have CBC, ferritin, CRP, creatinine and Celiac abs (TTG/DGP) requested, but referral for colonoscopy should not be delayed. Results can be checked at time of prioritisation. FOBs and FCP should not be ordered for these patients

Iron Deficiency Anaemia:

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• unexplained iron deficiency (low ferritin) anaemia (Hb < 125 g/L men, < 115 g/L post menopausal women) is a good indication (moderate risk) for colonoscopy (and gastroscopy) (<6 week priority)
• premenopausal women with IDA should be screened for coeliac disease, but upper and lower GI endoscopies are not indicated in women < 50, except those with symptoms suggestive of GI disease, or those with a strong family history of CRC (NZGC Category 2 or 3 Family History)
• isolated low ferritin without anaemia in men >50 and post menopausal women should be closely monitored for development of IDA or other symptoms suggestive of GI tract pathology. Clinical review and repeat blood tests should be planned and the patient referred promptly should symptoms develop
Refer to the Guideline for the Management of Iron Deficiency Anaemia for further information.
Overview
This document describes the provenance of Whanganui Regions Colorectal Cancer Pathways. The localised pathways were last updated in February 2016.

The purpose of implementing cancer pathways in our District as part of the Priority Cancer Pathways Implementation Project is to:

- Reduce barriers so that all people with cancer are able to access the same quality care within the same timeframes, irrespective of their ethnicity, gender, locality or socio-economic status
- Achieve the faster cancer treatment (FCT) health target – 85% of patient receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks by July 2016, increasing to 90% by June 2017
- Implementing the national tumour standards of service provision, developed as part of the FCT programme, to support the delivery of standardised quality care for all people with cancer
- Improving equity along the cancer pathway
- Clarify expectations across providers
- Improve communications and follow up care for cancer patients

To cite this pathway, use the following format:

Editorial methodology
This care map has been based on a Map of Medicine Care Map developed according to the Map of Medicine editorial methodology. The content of the Map of Medicine care map is based on high quality guidelines and practice-based knowledge provided by contributors with front-line clinical experience (see contributors section of this document). This localised version of the evidence-based, practice informed care map has been peer-reviewed by the WDHB and WRHN Collaborative Clinical Directors and Leaders Forum and with stakeholder groups.

Consumer engagement
Development of the Whanganui Collaborative Clinical Pathways focuses on person-centred care and an experience based co-design approach where consumers are invited to consult with the Health Promoter / Community Developer (who sits on each pathway working group). Consumers are asked prior if possible, or if not at the very start of the pathway process to share their experiences to assist in designing services that work for them and their families, critiquing and feeding back on suitable consumer information and resources which can then be incorporated into the pathways. Feedback obtained ensures we address consumer challenges and needs within the pathway and provide suitable services, information and resources for consumers. Additional information on patient centred care is provided by following this link and experience based co-design of health care services at http://www.kingsfund.org.uk/projects/ebcd.

References


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The following individuals have contributed to this local care map:

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- Wiremu MacFrater, Māori Clinical Representative, Whanganui DHB
- Jess Long (Project Director, Collaborative Clinical Pathways, MidCentral DHB)

Disclaimers
CCP Leadership Team, Whanganui.

It is not the function of the CCP Leadership Team to substitute for the role of the clinician, but to support the clinician in enabling access to know-how and knowledge. Users of the Map of Medicine are therefore urged to use their own professional judgement to ensure that the patient receives the best possible care. Whilst reasonable efforts have been made to ensure the accuracy of the information on this online clinical knowledge resource, we cannot guarantee its correctness and completeness. The information on the Map of Medicine is subject to change and we cannot guarantee that it is up-to-date.