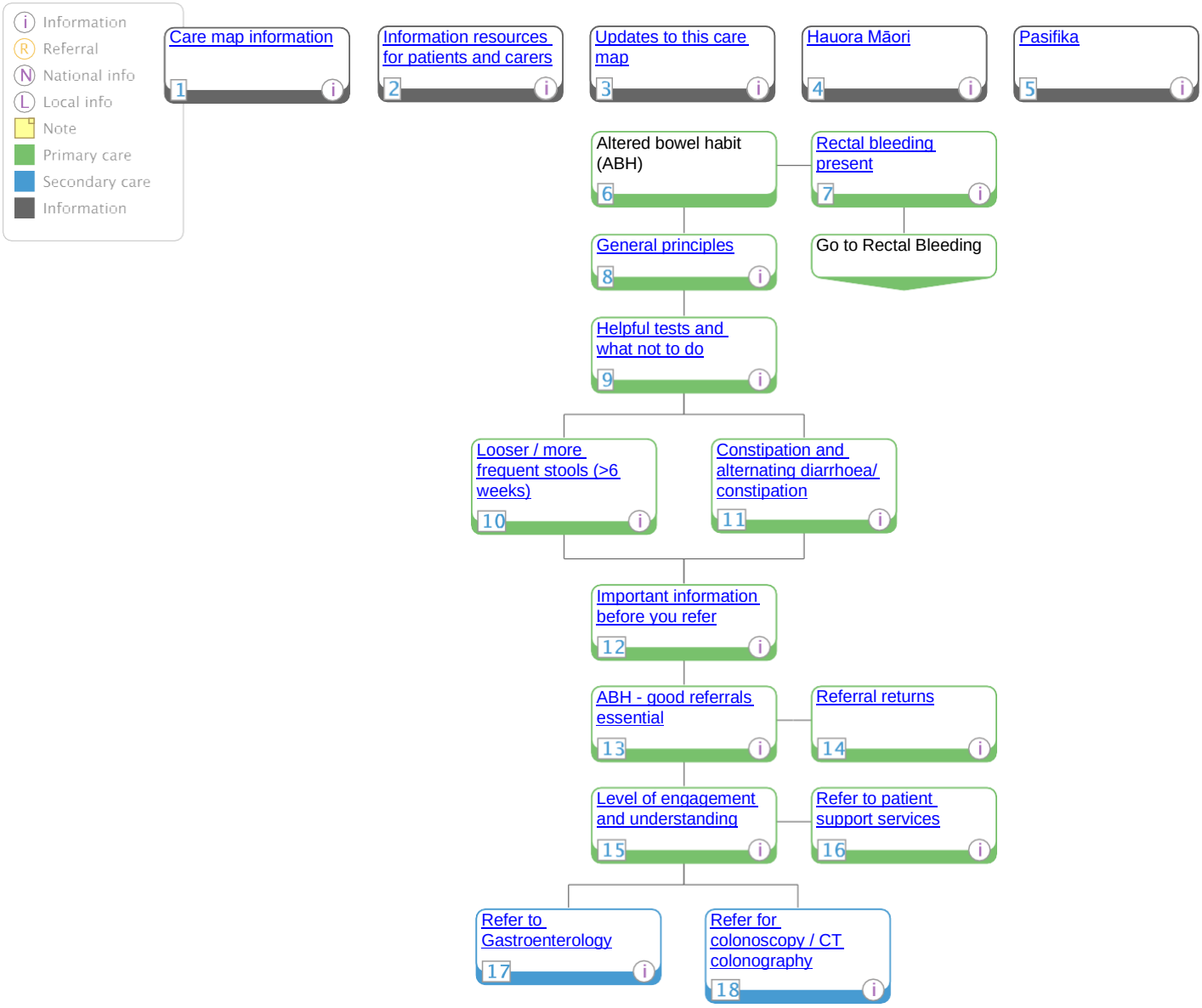
Altered Bowel Habit

Oncology > Oncology > Colorectal Symptoms and Suspected Colorectal Cancer



1.Care map information

In scope:

- Altered bowel habit

Out of scope:

- this section does not apply to melaena, large volume acute gastrointestinal haemorrhage, or occult bleeding (iron deficiency anaemia)
- secondary care treatment

Faster Cancer Treatment Programme (FCT)

Achieving the Ministry of Health's 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.

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.

2. Information resources for patients and carers

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. Updates to this care map

Date of publication: September 2016

Date of republication: August 2017

This pathway was reviewed and no changes to the pathway were necessary.
See provenance certificate for a list of references.

4. Hauora Māori

NB: *Māori are 30 percent less likely than non-Māori to get bowel cancer but once diagnosed are 30 percent more likely to die from bowel cancer[1]*

Māori are a diverse people, it is vital practitioners offer culturally appropriate care when working with Māori patients and their

family/whānau. It is important for practitioners to have a baseline understanding of the issues surrounding Māori health.

This knowledge can be actualised by (not in any order of priority):

- acknowledging Te Whare Tapa Wha (Māori model of health) when working with family/whānau
- asking Māori patients if they would like their family/whānau or significant others to be involved in assessment and treatment
- kanohi ki te kanohi (face to face interaction and communication
- ask about any particular cultural beliefs they or their family/whānau have that might impact on assessment and treatment of a particular health issue
- consider importance of whakawhanautanga (making meaningful connections) with their patient and their family/whānau
- knowledge of Whānau Ora, Te Ara Whānau Ora and referring to Whānau Ora Navigators where appropriate
- having a historical overview of legislation that has impacted on Māori well-being

Consider barriers to effective care:
Factors that could stop the patient from getting further tests or treatment:

- health literacy:
  - understanding medical terminology, use laymen terms
  - english as second language
- locality and geographic access to health and hospital services (travel)
- socio-economic factors including source of income (work commitments and responsibilities)
- complexity of cancer care pathway not knowing when or where to go next
- family/whānau and social network dynamics
- family/whānau support, family history
- family/whānau obligations including dependents
- family/whānau, hapu and iwi obligations
- community engagement and obligations or responsibilities

5. Pasifika

NB: *Pacific and Asian New Zealanders have substantially lower incidence and mortality from bowel cancer than other New Zealanders [2]*

Our community is a diverse and dynamic population:

- there are more than 22 nations represented in New Zealand
- main pacific nations are Samoa, Cook Islands, Fiji, Tonga, Niue, Tokelau and Tuvalu
- each have their own unique culture, language, history and health status
- there are some similarities i.e. cultural protocols

Acknowledging general pacific guidelines when working with pacific people and families:

- cultural protocols and greetings
- building relationships with your pasifika patients
- involving family support, involving religion, during assessments and in the hospital
- home visits

Click here to download the Pacific Cultural Guidelines (Central PHO) 6MB file.

Consider barriers to effective care:
Factors that could stop the patient from getting further tests or treatment:

- complexity of cancer care pathway not knowing when or where to go next

- health literacy:
  - understanding medical terminology, use laymen terms
  - english as second language
- locality and geographic access to health and hospital services (travel)
- socio-economic factors including source of income (work commitments, responsibilities)
- family and social network dynamics
- any religious beliefs, support, family history
- family obligations including dependents
- community engagement and obligations or responsibilities

7. Rectal bleeding present

If rectal bleeding is present follow Rectal Bleeding Pathway.

8. General principles

General principles:

- the incidence of colorectal cancer increases substantially with increasing age. Ninety percent of colorectal cancers are diagnosed in patients age ³50. This explains the age (³50) criteria, in referral guidelines
- 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

9. Helpful tests and what not to do

Helpful tests and what not to do:

- 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. Patients with normal CRP, should have the result of faecal calprotectin (FCP) included in the referral
- 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 calprotecton (FCP) should **NOT** be collected on patients who meet criteria for colonoscopy referral

10. Looser/more frequent stools (>6 weeks)

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 calprotecton (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 Gastroenterology Clinic or colonoscopy

11. Constipation and alternating diarrhoea/constipation

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 extra-colonic imaging)
- faecal occult blood tests (FOBs) are reasonable, for 'low risk' ABH *(opinion of author)*, and if positive, patients should be referred for colonoscopy (<6 weeks priority)
- *NB. 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. 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
- for patients with 'low risk' ABH, particularly if long-standing, or intermittent, or non-progressive, 'treat and review' is appropriate care

12. Important information before you refer

In referring a patient for colonoscopy the referrer should:

- inform the patient about the procedure
- ensure the patient is 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 co-morbidities or advanced malignancy (generally referral implies they are well enough to tolerate further treatment)
- if the patient has had a colonoscopy in the preceding five years, ensure there is a clear indication to repeat the procedure (the 'miss' rates of lesions >1cm following a well performed colonoscopy is approximately 6%)

13. ABH – good referrals essential

Good referrals with adequate detail are essential to determine the most appropriate prioritisation: review in primary care, Gastroenterology Clinic, or colonoscopy / CT colongraphy.

Referrals with minimal detail such as "Please see this patient with altered bowel habit" are inadequate for prioritisation. Inadequate referrals may be returned, further referral with more detail is welcome.

Referrals for altered bowel habit should contain detail about:

- the type, and duration of change: e.g. *looser and more frequent stools, 2 months, OR constipation 1year, OR alternating diarrhoea/constipation 6 months* and 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. Patients with normal CRP, should have the result of faecal calprotectin (FCP) included in the referral
- 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

14. Referral returns

Referrals may be returned if:

- inadequate information is provided - refer to "ABH - good referrals essential good referrals essential" node
- symptoms that are reported are low risk and don't qualify for direct access colonoscopy

- the patient will not benefit as they are frail, have multiple co-morbidities or advanced malignancy (generally referral implies that the patient is well enough to tolerate further treatment)

15. Level of engagement and understanding

Assess the patients level of understanding and engagement in medical care. Consider patient choice and general state of health before proceeding:

- patient is terminal or elderly and frail
- has significant comorbidities
- may not tolerate any sort of treatment
- may not want to pursue further diagnostic testing
- hearing impairment
- cultural background and belief systems
- anxiety or extreme emotional intensity

Consider barriers to effective care:

Factors that could stop the patient from getting further tests or treatment:

- health literacy:
  - english as second language
  - understanding medical terminology, use laymen terms
  - what happens next
- locality and geographic access to health and hospital services (travel)
- socio-economic factors including source of income (work commitments and responsibilities)
- complexity of cancer care pathway not knowing when or where to go next
- family / whanau and social network dynamics
- family / whanau support, family history

Language Line (Nationwide):

An over-the-phone interpreting service:

- Phone: **0800 656 656**
- Hours: Monday to Friday, 9am to 6pm, and Saturday 9am to 2pm.
- Website: www.languageline.govt.nz

16. Refer to patient support services

1. Māori Cancer Coordinators:

Cancer Coordinator will work across the cancer control continuum for Māori, either before or at the diagnosis of cancer who require ongoing support in the community.

The service will include:

- supporting clients and their whānau to cancer services
- improving the level of communication and facilitate increased knowledge/information cancer
- supporting Māori community development initiatives for cancer
- improve the delivery of health promotion and education about cancer
- support cancer service coordination for the diagnosed patient and their whanau

Best Care (Whakapai Hauora) Charitable Trust:

- Palmerston North City area

- Phone: (06) 353 6385
- Te Runanaga O Raukawa Inc:
- Horowhenua/Otaki area
- Phone: (06) 368 8678

Rangitane o Tamaki nui a Rua:

- Tararua area
- Phone: (06) 374 6860
- Te Wakahuia Manawatu Trust:
- Manawatu and Feilding areas
- Phone: (06) 357 3400

Central PHO - Te Tihi - Whānau Ora Navigation Service:

- Patient referral form
- email: referrals@tetihi.org.nz
- Contact Kaiwhakataki/Service Manager
- Phone: (06) 354 9107 ext 233

Palmerston North Hospital - Pae Ora Māori Health Services:

- Te Pae Ora Ruahine Ki Tararua
- Patient referral form
- Phone: (06) 350 8210
- Fax: (06) 350 8158

2. Pasifika Health Service:

The Pasifika Health Service is a service provided free of charge for all Pasifika people living in Manawatu, Horowhenua, Tararua and Otaki who have long term conditions. Further information about the service and referral form.

Palmerston North Office:

- Central PHO 575 Main Street, Palmerston North
- Phone: (06) 354 9107 ext 218
- email: pasifikahealth@centralpho.org.nz

Horowhenua Health Centre:

- 62 Liverpool Street, Levin
- Phone: (06) 367 6433
- email:pasifikahealth@centralpho.org.nz

3.Social Work Service:

- we can support you and your family/wh#nau as you come to terms with your diagnosis and the impact it may have in your day-to-day life, now and in the future
- more information about the service

4. Community Cancer Nurses:

- we are Registered Nurses
- we work with individuals, families/whanau and caregivers
- we offer a flexible, individual focused service
- we walk the whole journey with you and your families

- we provide a free service
- more information and contact details

5. Cancer Nurse Coordinators Central Region:

- cancer nurse coordinators can improve the experience for patients including:
  - their family and whanau, with cancer or suspected cancer
  - they also help improve overall access and timeliness of access to diagnostic and treatment services for patients with cancer
  - contacts list for the Central Region Cancer Nurse Coordinators

6. Cancer Society:

- for support services phone the cancer information nurses on the Cancer Information Helpline 0800 226 237
- or visit their website

7. Central Region Cancer Services Directory:

- provides a directory to multiple cancer services throughout the central region including Horowhenua, Manawatu, Whanganui and Hawke's Bay

17. Refer to Gastroenterology

Refer to Gastroenterology Service:

- patients whose symptoms are due to or suspected to be due to rectocele, anorectal prolapse, anal sphincter incompetence, or anal stenosis, and whose symptoms remain significant despite a trial of bulking agent, or laxatives should be referred to **General Surgical Clinic**
- all other patients should be referred to Gastroenterology/Endoscopy service

NB: Annote *'High Suspicion of Cancer'* to aide triaging as part of the Ministry of Health's Faster Cancer Treatment Target.

18. Refer for colonoscopy/CT colonography

Referral Criteria for Direct Access Outpatient Colonoscopy or CT Colonography

Accepted criteria for routine (>6 weeks priority) colonoscopy:
CT colonography may be arranged in some cases:

- altered bowel habit (looser/ more frequent) > 6 weeks, age ≥50 (<6 week priority)
- altered bowel habit (looser/ more frequent) > 6 weeks duration and NZGC Category 2 Family History and age ≥40, or NZGC Category 3 Family History and age ≥25 (<6 week priority)
- specialist suspected Inflammatory Bowel disease (or FSA arranged) (<6 week priority)
- 'low risk' ABH >6 weeks (constipation, or alternating diarrhoea/constipation), age ≥50, and a (+) FOB, *not collected on a bloody sample or <6 weeks after acute onset diarrhoea*
- asymptomatic patients, age ≥50 years, average risk or category 1 family history, and (+) FOB, *not collected on a bloody sample or <6 weeks after acute onset diarrhoea*

Moderate risk indications for direct access colonoscopy

Indications accepted for CT colonography:

- patients with 'low risk' altered bowel habit (constipation, or alternating diarrhoea/constipation), AND unexplained weight loss (≥5%). CT colonography preferred as it provides extra-colonic imaging

Indications considered for CT colonography: (this will be a hyperlink to the form)

- patients ≥50 years with 'low risk' altered bowel habit, or abdominal symptoms (*pain, bloating, incomplete emptying*) who after treatment and review report no improvement or progression of symptoms, or are unduly anxious

Indications not accepted for colonoscopy or CT colonography:

- for patients with unexplained marked weight loss (>10%), without any GI symptoms, a CT body is a better first investigation than GI endoscopies or CT colonography - Refer to General Medical Clinic, not Gastroenterology/Endoscopy, and not General Surgical Clinic
- a (+)FOB, in asymptomatic patients, age <50, will not be accepted for publicly funded colonoscopy or CT colonography; DO NOT ORDER THESE
- patients ≤50 years with 'low risk' altered bowel habit, or abdominal symptoms (*pain, bloating, incomplete emptying*) who after treatment and review report no improvement or progression of symptoms or are unduly anxious - these patients may receive a clinic appointment as resources allow.

Colorectal Cancer

Provenance Certificate

Overview | Editorial methodology | References | Contributors | Disclaimers

Overview

This document describes the provenance of MidCentral Regions Colorectal Cancer Pathways. The localised pathways were last updated in July 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 bowel cancer 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:

Map of Medicine – /Oncology / Oncology / Colorectal Cancer – MidCentral view.

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 MidCentral Region Collaborative Clinical Directors, Leaders Forum and with stakeholder groups.

References

1	Ministry of Health. (2008). Cancer: New registrations and deaths 2008. Wellington: Ministry of Health
2	Blakely, T., Shaw, C., Atkinson, J., Tobias, M., Bastiampillai, N., Sloane, K et al. Cancer trends: Trends in incidence by ethnic and socioeconomic group, New Zealand 1981-2004. Wellington, New Zealand: Ministry of Health.
3	Central Cancer Network (CNN) Regional Bowel Cancer Workplan 2014.

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Disclaimers

CCP Leadership Team, MidCentral.

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.