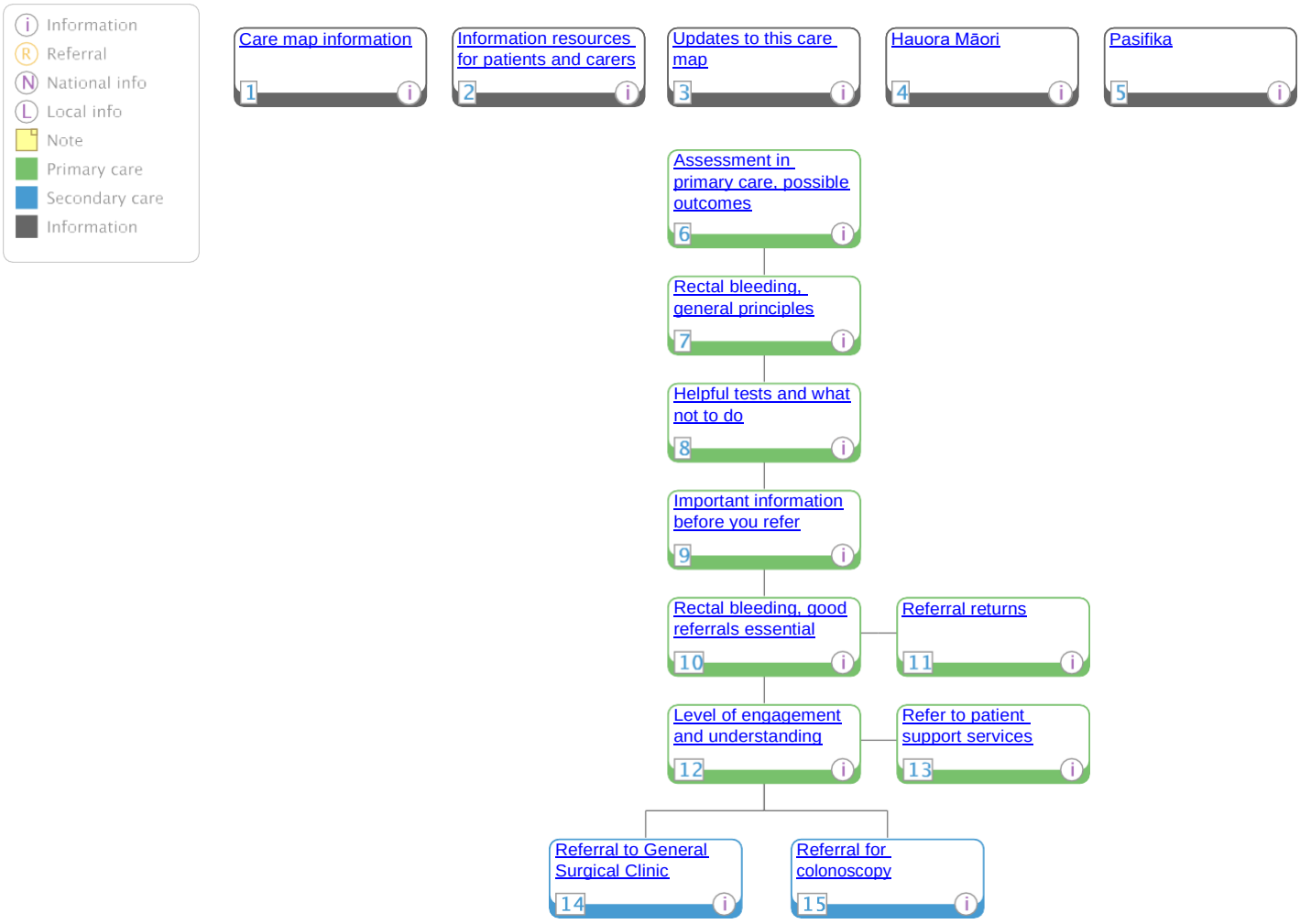
Rectal Bleeding

Oncology > Oncology > Colorectal Symptoms and Suspected Colorectal Cancer



1.Care map information

In scope:

- This is intended for the stable outpatient with overt lower gastrointestinal bleeding

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

6. Assessment in primary care, possible outcomes

This section does not apply to melaena, large volume acute gastrointestinal haemorrhage, or occult bleeding (iron deficiency anaemia). It is intended for the stable outpatient with overt lower gastrointestinal bleeding.

Rectal Bleeding - Assessment in Primary Care - Possible Outcomes:

- history, examination, +/- treatment, and EITHER:
  - **review in Primary Care**, OR
  - r**eferral to General Surgical Clinic**, OR
  - referral to ga**stroenterology/Endoscopy Service** for colonoscopy (or CT colonography in some cases)

7. Rectal bleeding, general principles

Rectal Bleeding - general principles:

- rectal bleeding is most commonly due to benign causes
- '**outlet'** bleeding is fresh/bright red blood - limited to the toilet tissue, or in the bowl but separate from the stool
- **'non-outlet'** bleeding is 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 prolapse 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 to General Surgical Clinic
- 'outlet' bleeding over one or a few days that does not recur within 6 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
- overt rectal bleeding from colorectal cancer is likely to be persistent (>4 weeks) and unlikely to cease spontaneously
- these last two points explain the emphasis on 'persistent bleeding (>4 weeks)' in our referral guidelines. They also explain why it is usually more difficult (and less efficient) for specialists to prioritise referrals, if patients are referred within a few days or weeks of a first presentation with rectal bleeding. The incidence of colorectal cancer increases substantially with increasing age. Ninety percent of colorectal cancers are diagnosed in patients (³ 50). This explains the age (³ 50) criteria, in referral guidelines
- **all patients with rectal bleeding should have a digital rectal examination**

8. Helpful tests and what not to do

Helpful tests and what not to do:

- 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, **do 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 calprotecton (FCP) should **NOT** be ordered for acute (<4 weeks) or persistent (>4 weeks) rectal bleeding, or acute onset diarrhoea (<6 weeks)
- if the patient has an accepted indication for colonoscopy, do not collect stool samples for FOBs or calprotecton
- do **NOT** refer to both Gastroenterology/Endoscopy Clinic **AND** General Surgical Clinic.

9. 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%)

10. Rectal bleeding, good referrals essential

Good referrals with adequate detail are essential to determine the most appropriate prioritisation - review in primary care, General Surgical Clinic, or Colonoscopy/Flexible sigmoidoscopy.

Referrals with minimal detail such as:

- "please see this patient with rectal bleeding" or
- "please see this patient with rectal bleeding and altered bowel habit" or
- "please see this patient with rectal bleeding and a strong family history of bowel cancer"

are inadequate for determining which service or investigation in secondary care, if any, is most appropriate, or what priority should be given.

Inadequate referrals may be returned.

Referrals for rectal bleeding should contain detail about:

- 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; *use the format: number of episodes, over number of days/weeks/months, and 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 with detail (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 of colo-rectal cancer(s) – with detail - relationship(s) to patient (and each other), age at diagnosis – e.g. father 55, paternal uncle 65
- additionally, if referring for colonoscopy, CBC, ferritin, CRP and creatinine are useful

11. Referral returns

Referrals may be returned if:

- inadequate information is provided - refer to 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)

12. Level of engagement and understanding

Assess the patient's 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

13. 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 Oncology:

- we can support you and your family/whanau 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

14. Referral to General Surgical Clinic

Referral to General Surgical Clinic:

- 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 steriod) 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
- recurrent (>4 weeks), but no persistent (>4 weeks) 'outlet' bleeding, age ≥50 years, **AND no response to empirical treament (2 weeks)** - bulking agent/softener and haemorrhoid suppositories

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

15. Referral for colonoscopy

Referral Criteria for Direct Access Outpatient Colonoscopy or CT Colonography

Accepted criteria for urgent (<2 weeks priority) colonoscopy *(high suspicion of cancer):*

- rectal tumour - palpable or visible, on rectal examination (*this excludes internal or external anal tags - refer to the General Surgical Clinic)*
- known or suspected colorectal cancer on imaging
- persistent (>4weeks) and unexplained rectal bleeding (benign anal causes treated or excluded) with altered bowel habit (ABH)

– looser/more frequent > 6 weeks, age ≥50

- persistent (>4weeks) and unexplained rectal bleeding (benign anal causes treated or excluded) with iron deficiency (low ferritin) anaemia (Hb <125 g/L men, <115 g/L women)

Accepted criteria for routine (<6 weeks priority) colonoscopy:

CT colonography may be arranged in some cases:

- persistent (>4weeks), unexplained PR bleeding (benign anal causes treated or excluded) with altered bowel habit (ABH) – looser/more frequent >6 weeks, age <50 (<6 week priority)
- unexplained "non-outlet" (blood mixed with stool/dark blood) PR bleeding (benign anal causes treated or excluded), age ≥50 (<6 week priority)
- persistent (>4weeks), unexplained "non-outlet" type (blood mixed with stool/ dark blood) PR bleeding (benign anal causes treated or excluded), age <50 (<6 week priority)
- persistent (>4 weeks) "outlet" bleeding, no anal cause found (primary care), age ≥50, and no response to two weeks empirical treatment with bulking agent and haemorrhoid suppositories *('recurrent/non-persistent' 'outlet' bleeding not accepted; give empirical treatment - bulking agent and haemorrhoid suppositories and refer to General Surgical Clinic)*
- persistent (>4weeks), unexplained PR bleeding (benign anal causes treated or excluded) and NZGC Category 2 Family History and age ≥40, or NZGC Category 3 Family History and age ≥25 (<6 week priority)
- persistent (>4 weeks) rectal bleeding, and proctitis on rectal examination (<6 week priority)
- 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)
- unexplained iron deficiency (low ferritin) anaemia (Hb <125 g/L men, <115 g/L post menopausal women) (<6 week priority)
- specialist suspected Inflammatory Bowel disease (or FSA arranged) (<6 week priority)
- imaging reveals polyp >5mm (<6 week priority)
- rectal polyp ≥5mm - palpable on DRE, or visible on sigmoidoscopy. (<6 week priority) *This excludes internal anal tags – refer to General Surgical Clinic*
- (+) FOB (Human Haemoglobin), age ≥50, and 'low risk' ABH >6 weeks (constipation, or alternating diarrhoea/constipation), or asymptomatic patients– average risk, or NZGG Category 1 family History, *not collected on a bloody sample or <6 weeks after acute onset diarrhoea*

Moderate risk indications for direct access colonoscopy

Indications considered for colonoscopy or CT colonography:

- iron deficiency (ferritin <20) without anaemia, age ≥50 men, postmenopausal women ≥50

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 colongraphy:

- patients 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

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

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.

Contributors

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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.