

CHAPTER 5 THE PATIENT WITH SYMPTOMS

There are three main sets of symptoms and signs that raise the possibility of Colorectal Cancer. They are:

- rectal bleeding
- bowel or abdominal symptoms
- iron deficiency anaemia

This chapter provides guidance on how these signs and symptoms might be approached, with the goal of reducing morbidity and mortality from Colorectal Cancer.

5.1 The patient with rectal bleeding bowel, or abdominal symptoms

The principal relevant symptoms include:

- bleeding from the rectum, with or separate from the faeces, which should be appropriately investigated regardless of age,
- symptoms of anaemia, (haemoglobin less than 10g/100ml in postmenopausal women)
- a change in bowel habit, especially a recent one and towards loose stools,
- abdominal pain, especially if of recent onset.

Other symptoms may be the presenting complaint such as bloating, loss of weight, malaise or mucus in the faeces (see Chapter 13 for urgent Colorectal Cancer presentation). While each of these symptoms can be associated with more common and relatively benign conditions such as irritable bowel syndrome or haemorrhoids, it should not be assumed too readily that this is the case.¹ Age over 40 years, and recent onset of symptoms (say within the past 6–12 months) should raise concern for colorectal cancer. Although uncommon, Colorectal Cancer can occur below the age of 40 and persistent symptoms in younger people demand full investigations. In addition, the presence of any risk factors for Colorectal Cancer should also raise the level of suspicion.

Risk factors for Colorectal Cancer

The principal risk factors for Colorectal Cancer are:

- age >40 years
- a personal history of Colorectal Cancer or adenoma
- a family history of Colorectal Cancer, adenoma or gynaecological cancer
- a personal history of inflammatory bowel disease.²

See Table 3.1 for a summary of the absolute risk of colorectal cancer by age and time interval.

Rectal bleeding is the most important symptom. It is not always possible to be certain from the patient's description of the bleeding that it necessarily originates from a simple lesion such as haemorrhoids, rather than a colorectal adenoma or cancer. Indeed, haemorrhoids may coexist with colorectal neoplasia.

An Australian survey has shown that a high proportion of adults never examine their stools, the toilet paper, or the toilet bowl adequately to be able to identify whether blood is present.³ Prompt medical attention for rectal bleeding facilitates diagnosis of Colorectal Cancer.³

Rectal bleeding requires investigation, especially when it is of recent onset (within the previous 6–12 months).

People over 40 years of age should be encouraged to look for blood with their bowel motions on a regular basis.

5.1.1 Investigation

Investigation must be tailored to the circumstances. Recent onset of symptoms in a patient over 40 years of age raises the index of suspicion for Colorectal Cancer and investigation is important in this situation.

In all patients, a thorough examination of the anus, rectum and colon should be performed including digital rectal examination. Proctosigmoidoscopy is recommended, as this enables haemorrhoids to be more easily identified. However, failure of symptoms to settle should lead to full colonoscopic examination⁴⁻⁹ barium enema or CT Colonography, which is becoming preferred to barium enema (see Sections 8.1.3, 8.1.4 and 8.1.5). This in spite of evidence that the prevalence of Colorectal Cancer in patients with colonic symptoms who have no evidence of bleeding ‘is low and is comparative with the prevalence in an asymptomatic population’.¹⁰

Complete colonoscopy has been shown in a two-cohort study to exhibit a high level of accuracy. A cohort of 8 486 patients had a clear colonoscopy. Of these, 496 had repeat studies with an average of 3.1 years follow up. Subsequent malignancy was observed in 0.6%.⁴ This degree of accuracy can be achieved very safely in diagnostic colonoscopy.⁵

It should also be recognised that with flexible sigmoidoscopy, colonoscopy and double contrast barium enema it is possible to miss a cancer during the examination. Should there be a deficiency of ‘correlation between clinical and investigational findings’, the matter should be carefully reviewed.¹¹

What investigations need to be included?

Guidelines — Investigation	Level of evidence	Practice recommendation	Refs
In symptomatic patients aged over 40 years, referral to a specialist should be considered and consideration of full examination of the colon with colonoscopy is recommended.	III-3	Equivocal	4-8

5.2 The patient with iron deficiency anaemia

There is always a cause for iron deficiency and, in non-menstruating patients, gastrointestinal bleeding is the most common cause.⁷ It is usually occult. In non-menstruating patients over 40, Colorectal Cancer is a common pathology.⁸

It is important to confirm iron deficiency before embarking on gastrointestinal investigation. An isolated low serum ferritin is not adequate evidence,⁷ and it needs to be confirmed by microcytosis or low iron saturation and other abnormalities in iron studies.

Investigation of patients with iron deficiency must include full colonic evaluation. Colonoscopy is preferred, as lesions such as angiodysplasia are not recognisable by radiology. If colonoscopy is incomplete or unavailable, a double contrast barium enema is required⁸, or CT Colonography

considered (see 8.1.5). Double contrast barium enema has a known false-negative perception error which has been shown to be effectively reduced if the images are submitted to multiple radiologists for reading¹¹ (see Section 8.1.4).

References

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