Optimal care pathway for people with colorectal cancer

Quick reference guide

The optimal care pathways describe the standard of care that should be available to all cancer patients treated in Australia. The pathways support patients and carers, health systems, health professionals and services, and encourage consistent optimal treatment and supportive care at each stage of a patient's journey. Seven key principles underpin the guidance provided in the pathways: patient-centred care; safe and quality care; multidisciplinary care; supportive care; care coordination; communication; and research and clinical trials.

This quick reference guide provides a summary of the *Optimal care pathway for people with colorectal cancer.*

Please note that not all patients will follow every step of the pathway.

Support: Assess supportive care needs at every step of the pathway and refer to appropriate health professionals or organisations.

Step 1: Prevention and early detection

Prevention

Recommendations for reducing the risk of colorectal cancer include:

- completing the National Bowel Cancer Screening Program (NBCSP) at-home bowel cancer screening test every two years if aged 45–74 years
- eating a healthy diet, including sufficient vegetables, fruit, whole grains, dietary fibre and dairy products while minimising intake of red, barbequed, grilled and processed meat
- maintaining a healthy body weight
- undertaking regular physical activity
- not smoking.

Consider aspirin (100-300mg per day) as a prevention measure for people who are 45-70 years of including those at an average risk of colorectal cancer, in conjunction with other comorbidities.

Early detection

The NBCSP invites people from 45 to 74 years (at average risk and asymptomatic) to screen for bowel cancer using an immunochemical faecal occult blood test (iFOBT), a free, simple test at home.

For people aged 40-44 years, and people aged 75-85 years who are fit and healthy, who request screening after a discussion with their health care professional about the benefits and potential harms of testing, health care professionals could consider offering an iFOBT every two years, outside the NBCSP.

Screening recommendations

- Category 1 (near average risk) patients: iFOBT is recommended every 2 years between 45 and 74 years. If the iFOBT test is positive, the person should undergo a high-quality diagnostic colonoscopy.
- Category 2 (moderately increased risk) patients: colonoscopy should be offered every 5 years starting at 10 years younger than the earliest age of diagnosis of colorectal cancer in a first-degree relative or age 50, whichever is earlier, to age 74.
- Category 3 (high risk) patients: colonoscopy should be offered every 5 years starting at 10 years younger than the earliest age of diagnosis of colorectal cancer in a first-degree relative or age 40, whichever is earlier, to age 74.

Refer to the colorectal cancer optimal care pathway for more about the risk categories.

Checklist

- ❑ Individual risk of developing cancer assessed
- ❑ Education on screening recommendations appropriate to the patient's risk
- ❑ Encourage NBCSP iFOBT to eligible patients
- ❑ Recent weight changes discussed and weight recorded
- ❑ Alcohol intake discussed and recorded and support for reducing alcohol consumption offered if appropriate
- ❑ Smoking status discussed and recorded and brief smoking cessation advice offered to smokers
- ❑ Physical activity recorded
- ❑ Referral to a dietitian, physiotherapist or exercise physiologist considered
- ❑ Education on being sun smart considered

Step 2: Presentation, initial investigations and referral

Signs and symptoms included in the tables below are based on best available evidence on how patients may present to their general practitioner (GP) with colorectal cancer.

Signs and symptoms

Patients presenting to their GP with the following signs and symptoms should be investigated. Symptoms have been categorised by higher, moderate and lower risk, underpinned by primary care evidence. See referral and safety netting section for more detail on appropriate next steps.

Checklist

- ❑ Signs, symptoms and iFOBT recorded
- ❑ Supportive care needs assessment recorded and required referrals to allied health services actioned

SECOND EDITION

Australian Government
Cancer Australia

Cancer Council

Step 2: Presentation, initial investigations and referral continued

Higher-risk signs and symptoms About 3-5 out of 100 people with one of these symptoms are likely to have colorectal cancer	Abdominal or rectal mass Rectal bleeding Unexplained anaemia
Moderate-risk signs and symptoms About 1-2 out of 100 people with one of these symptoms are likely to have colorectal cancer	Abdominal pain, tenderness or bloating Change in bowel habit Constipation Raised platelets* Unexplained weight loss
Lower-risk signs and symptoms Less than one out of 100 people with one of these symptoms is likely to have colorectal cancer	Diarrhoea Dyspepsia Loss of appetite

* A raised platelet count of >400 x10^9/L is recognised as a predictor of undiagnosed cancer in primary care, linked to an increased risk of lung, colorectal, gastric, oesophageal, pancreatic, ovarian, uterine, bladder and kidney cancer.

Signs, symptoms and symptom combinations

Presenting to general practice with a combination of signs and symptoms may increase a patient's risk of having colorectal cancer. This table demonstrates the single symptoms associated with colorectal cancer, and how the risk changes when presenting with more than one symptom. The same risk categories have been used, with an additional category highlighting symptom combinations that increase the risk of colorectal cancer to above 5%. Symptoms have been categorised by higher, moderate and lower risk, underpinned by primary care evidence.

	Single symptoms	Symptom combinations
Highest-risk symptom combinations About 5-10 out of 100 people presenting with this symptom combination are likely to have colorectal cancer	N/A	• Rectal bleeding with any of the following: – abdominal pain – change in bowel habit – diarrhoea – unexplained weight loss or a repeat presentation of rectal bleeding • Unexplained weight loss with either: – abdominal tenderness – unexplained anaemia
Higher-risk symptoms About 3-5 out of 100 people with these symptoms or combinations are likely to have colorectal cancer	Abdominal or rectal mass Rectal bleeding Unexplained anaemia	• Abdominal pain with either: – raised platelets – unexplained anaemia • Abdominal tenderness with rectal bleeding • Repeat presentations of either: – abdominal pain – unexplained weight loss • Unexplained weight loss with either: – abdominal pain – constipation
Moderate-risk symptoms About 1-2 out of 100 people with these symptoms or combinations are likely to have colorectal cancer	Abdominal pain, tenderness or bloating Change in bowel habit Constipation Raised platelets Unexplained weight loss	• Change in bowel habit, constipation or diarrhoea with either: – abdominal pain – abdominal tenderness • Dyspepsia with: – unexplained weight loss
Lower-risk symptoms Less than one person out of 100 with one of these symptoms is likely to have colorectal cancer	Diarrhoea Dyspepsia Loss of appetite	

Support: Assess supportive care needs at every step of the pathway and refer to appropriate health professionals or organisations.

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Step 2: Presentation, initial investigations and referral continued

While the evidence to support the recommendations was generated primarily in populations aged over 40, the incidence of colorectal cancer is increasing in younger people. The risk of an undiagnosed cancer increases with age for all signs and symptoms.

Underlying risk factors outlined in Step 1 (e.g., family history) should be considered in the presence of signs and symptoms of colorectal cancer, although they are unlikely to alter the risk of an undiagnosed cancer significantly.

The National Bowel Cancer Screening Program (NBCSP) is for detection of colorectal cancer in asymptomatic people. In the NBCSP, about 4 out of 100 asymptomatic people with a positive immunochemical faecal occult blood test (iFOBT) would have colorectal cancer. An additional 11 out of 100 with a positive iFOBT would have an advanced adenoma.

Initial investigations include

- Detailed history including family history
- Physical examination
- Digital rectal examination
- Full blood count and serum ferritin (if not already performed)
- iFOBT

An iFOBT is a useful triaging tool for symptomatic patients in general practice.

Out of 1000 patients with a moderate-risk symptom (e.g., abdominal pain, weight loss, change in bowel habit), and a **negative** iFOBT, about 2-3 (0.2-0.3%) will be diagnosed with colorectal cancer in the next year. For patients with a **positive** iFOBT, about 80-100 (8-10%) will have colorectal cancer. In symptomatic patients, a single iFOBT is appropriate (rather than two samples used in the NBCSP) and can be ordered through the Medicare Benefits Schedule (MBS) (outside of the NBCSP) at any age for symptomatic patients.

Referral and safety netting

Patients with higher- and highest-risk symptoms and symptom combinations should be referred promptly for a colonoscopy. For patients with low-to-moderate-risk symptoms, further investigation to identify an underlying cause is appropriate. All patients should be provided with safety-netting advice, including a planned timeframe for follow-up that is agreed with the patient, and the need for patient-initiated follow-up if new symptoms develop, if symptoms persist or worsen, or if the patient has further concerns.

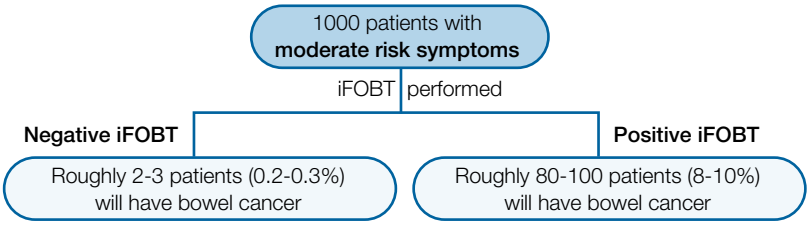
Referral options

At the referral stage, the patient's GP or other referring doctor should advise the patient about their options for referral, waiting periods, expertise, if there are likely to be out-of-pocket costs and the range of services available. This will enable patients to make an informed choice of specialist and health service.

Communication

The GP's responsibilities include:

- explaining to the patient and/or carer who they are being referred to and why
- supporting the patient and/or carer while waiting for specialist appointments
- informing the patient and/ or carer that they can contact Cancer Council on 13 11 20 for additional support.



Checklist continued

- ❑ Patient notified of support services such as Cancer Council 13 11 20
- ❑ Referral options discussed with the patient and/or carer including cost implications

Timeframe

Test results should be provided to the patient **within 1 week** of testing. If symptoms suggest colorectal cancer, patients should be referred and colonoscopy completed **within 4 weeks**. Patients should see a surgeon **within 2 weeks** of GP referral following a positive diagnosis of colorectal cancer via colonoscopy.

Support: Assess supportive care needs at every step of the pathway and refer to appropriate health professionals or organisations.

Step 3: Diagnosis, staging and treatment planning

Diagnosis and staging

For colon and rectal cancer:

- CT scan of the chest, abdomen and pelvis
- MRI liver
- PET-CT.

For rectal cancer:

- endorectal ultrasound.

Genetic testing

Up to 5% of colorectal cancers are specifically inherited (familial adenomatous polyposis and lynch syndrome) and up to 25% may have some form of inherited component.

Find out more about colorectal cancer genetic testing <https://wiki.cancer.org.au/australia/Guidelines:Colorectal_cancer/High-risk_familial_syndromes>.

Treatment planning

The multidisciplinary team should discuss all newly diagnosed patients **within 2 weeks** of diagnosis and staging.

Some cases of colorectal cancer present as emergencies and require appropriate acute care followed by management from a multidisciplinary team.

Research and clinical trials

Consider enrolment where available and appropriate. Search for a trial <www.australiancancertrials.gov.au>.

Communication

The lead clinician's[1] responsibilities include:

- discussing a timeframe for diagnosis and treatment options with the patient and/or carer
- explaining the role of the multidisciplinary team in treatment planning and ongoing care
- encouraging discussion about the diagnosis, prognosis, advance care planning and palliative care while clarifying the patient's wishes, needs, beliefs and expectations, and their ability to comprehend the communication
- providing appropriate information and referral to support services as required
- communicating with the patient's GP about the diagnosis, treatment plan and recommendations from multidisciplinary meetings (MDMs).

Checklist

- ❑ Diagnosis confirmed
- ❑ Full histology obtained
- ❑ Performance status and comorbidities measured and recorded
- ❑ Patient discussed at an MDM and decisions provided to the patient and/or carer
- ❑ Clinical trial enrolment considered
- ❑ Supportive care needs assessment completed and recorded, and referrals to allied health services actioned as required
- ❑ Patient referred to support services (such as Cancer Council) as required
- ❑ Treatment costs discussed with the patient and/or carer

Timeframe

Investigations should be completed **within 2 weeks.**

1 Lead clinician – the clinician who is responsible for managing patient care.
The lead clinician may change over time depending on the stage of the care pathway and where care is being provided.

Support: Assess supportive care needs at every step of the pathway and refer to appropriate health professionals or organisations.

Step 4: Treatment

Establish intent of treatment

- Curative
- Anti-cancer therapy to improve quality of life and/or longevity without expectation of cure
- Symptom palliation.

Surgery

- Surgery is recommended for many patients with colorectal cancer.
- Surgeons should have adequate qualifications and expertise, especially those undertaking rectal surgery.

Radiation therapy

- Neoadjuvant radiation therapy is recommended for those with high-risk rectal cancer.
- Radiation therapy may be given with palliative intent in symptomatic, non-resectable, locally advanced colorectal cancer.
- Radiation therapy may be suitable for patients with colon cancer where the tumour has penetrated a fixed structure.

Systemic therapy

Systemic therapy may be beneficial for patients with:

- a high risk of relapse and who may benefit from adjuvant therapy
- locally advanced (high-risk) rectal cancer, treated with chemoradiation therapy
- non-resectable, locally advanced or metastatic disease.

Palliative care

Early referral to palliative care can improve quality of life and in some cases survival. Referral should be based on need, not prognosis. For more, visit the Palliative Care Australia website <www.palliativecare.org.au>.

Communication

The lead clinician and team's responsibilities include:

- discussing treatment options with the patient and/or carer including the intent of treatment as well as risks and benefits
- discussing advance care planning with the patient and/or carer where appropriate
- communicating the treatment plan to the patient's GP
- helping patients to find appropriate support for exercise programs where appropriate to improve treatment outcomes.

Checklist

- ❑ Intent of treatment established
- ❑ Risks and benefits of treatments discussed with the patient and/or carer
- ❑ Treatment plan discussed with the patient and/or carer
- ❑ Treatment plan provided to the patient's GP
- ❑ Treating specialist has adequate qualifications, experience and expertise
- ❑ Supportive care needs assessment completed and recorded, and referrals to allied health services actioned as required
- ❑ Early referral to palliative care considered
- ❑ Advance care planning discussed with the patient and/or carer

Timeframe

Surgery conducted **within 5 weeks** of investigations and MDM if no neoadjuvant therapy is required for patients with colorectal cancer.

Surgery conducted **8–12 weeks** after neoadjuvant therapy for patients with rectal cancer.

Neoadjuvant radiation and **neoadjuvant chemotherapy** should begin **within 3 weeks** of the MDM.

Adjuvant chemotherapy should begin **within 8 weeks** of surgery.

Support: Assess supportive care needs at every step of the pathway and refer to appropriate health professionals or organisations.

Step 5: Care after initial treatment and recovery

Provide a treatment and follow-up summary to the patient, carer and GP outlining:

- the diagnosis, including tests performed and results
- tumour characteristics
- treatment received (types and date)
- current toxicities (severity, management and expected outcomes)
- interventions and treatment plans from other health professionals
- potential long-term and late effects of treatment and care of these
- supportive care services provided
- a follow-up schedule, including tests required and timing
- contact information for key healthcare providers who can offer support for lifestyle modification
- a process for rapid re-entry to medical services for suspected recurrence.

Communication

The lead clinician's responsibilities include:

- explaining the treatment summary and follow-up care plan to the patient and/or carer
- informing the patient and/or carer about secondary prevention and healthy living
- discussing the follow-up care plan with the patient's GP.

Checklist

- ❑ Treatment and follow-up summary provided to the patient and/or carer and the patient's GP
- ❑ Supportive care needs assessment completed and recorded, and referrals to allied health services actioned as required
- ❑ Patient-reported outcome measures recorded

Step 6: Managing recurrent, residual or metastatic disease

Detection

Most recurrent disease will be detected via routine follow-up or by the patient presenting with symptoms.

Treatment

Evaluate each patient for whether referral to the original multidisciplinary team is appropriate. Treatment will depend on the location and extent of disease, previous management and the patient's preferences.

Advance care planning

Advance care planning is important for all patients but especially those with advanced disease. It allows them to plan for their future health and personal care by thinking about their values and preferences. This can guide future treatment if the patient is unable to speak for themselves.

Survivorship and palliative care

Survivorship and palliative care should be addressed and offered early. Early referral to palliative care can improve quality of life and in some cases survival. Referral should be based on need, not prognosis.

Communication

The lead clinician and team's responsibilities include:

- explaining the treatment intent, likely outcomes and side effects to the patient and/or carer and the patient's GP.

Checklist

- ❑ Treatment intent, likely outcomes and side effects explained to the patient and/or carer and the patient's GP
- ❑ Supportive care needs assessment completed and recorded, and referrals to allied health services actioned as required
- ❑ Advance care planning discussed with the patient and/or carer
- ❑ Patient referred to palliative care if appropriate
- ❑ Routine follow-up visits scheduled

Step 7: End-of-life care

Palliative care

Consider a referral to palliative care. Ensure an advance care directive is in place.

Communication

The lead clinician's responsibilities include:

- being open about the prognosis and discussing palliative care options with the patient
- establishing transition plans to ensure the patient's needs and goals are considered in the appropriate environment.

Checklist

- ❑ Supportive care needs assessment completed and recorded, and referrals to allied health services actioned as required
- ❑ Patient referred to palliative care
- ❑ Advance care directive in place

Visit our guides to best cancer care webpage <www.cancercareguides.org.au> for consumer guides. Visit our OCP webpage <www.cancer.org.au/OCP> for the optimal care pathway and instructions on how to import these guides into your GP software.

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