Optimal care pathway for people with colorectal cancer

Quick reference guide

Please note that not all patients will follow every step of this pathway:

**Step 1**
**Prevention and early detection**

**Prevention:**
- Eating a healthy diet, including plenty of vegetables, fruit and whole grains while minimising intake of red meat and processed meat
- Maintaining a healthy body weight
- Exercising regularly
- Avoiding or limiting alcohol intake
- Not smoking.

**Early detection:**
- Average risk
- No personal history of colorectal cancer, adenoma or chronic inflammatory bowel disease, or
- No more than one close relative diagnosed at age 55 or older.

**Screening recommendations:**
- If over 50 years, screen every two years using a faecal occult blood test (FOBT)
- Participation in the National Bowel Cancer Screening Program recommended if eligible.

**Increased or high risk – refer to the colorectal optimal care pathway for screening recommendations.**

**Step 2**
**Presentation, initial investigations and referral**

The following signs and symptoms should be investigated:
- Positive FOBT
- Passage of blood with or without mucus in the faeces
- Unexplained iron deficiency anaemia
- Change in bowel habit (loose stools or constipation)
- Undiagnosed abdominal pain
- Unexplained rectal or abdominal mass
- Unexplained weight loss
- The presence of multiple signs and symptoms.

**Positive screening test: All patients with a positive FOBT should be referred for a colonoscopy within four weeks.**

**Initial investigations include:**
- Physical examination
- Digital rectal examination
- Blood tests including iron studies.

Test results should be provided to the patient within one week.

**Referral:** If symptoms suggest cancer, the patient should be referred for a colonoscopy within four weeks.

**Communication – lead clinician to:**
- Explain to the patient/carer who they are being referred to and why
- Support the patient/carer while waiting for specialist appointments.

**Step 3**
**Diagnosis, staging and treatment planning**

**Diagnosis and staging:**
- For colon cancer
  - Computed tomography (CT) scan of the chest, abdomen and pelvis
  - Whole-body fluoro-deoxyglucose positron emission tomography (FDG PET) (if suspected limited metastatic disease)
- For rectal cancer:
  - CT scan of chest, abdomen and pelvis
  - Local staging with magnetic resonance imaging (MRI) and/or endoscopic rectal ultrasound

**Treatment planning:** All newly diagnosed patients should be discussed by a multidisciplinary team. Patients with rectal cancer should be discussed prior to surgery.

**Research and clinical trials:** Consider enrolment where available and appropriate.

**Communication – lead clinician to:**
- Discuss a timeframe for diagnosis and treatment with the patient/carer
- Explain the role of the multidisciplinary team in treatment planning and ongoing care
- Provide appropriate information or refer to support services as required.

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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.
Cancer survivors should be provided with the following to guide care after initial treatment.

Treatment summary (provided to the patient, carer and general practitioner) outlining:
• diagnostic tests performed and results
• tumour characteristics
• type and date of treatment(s)
• interventions and treatment plans from other health professionals
• supportive care services provided.

Follow-up care plan (provide a copy to patient/carer and general practitioner) outlining:
• medical follow-up required (tests, ongoing surveillance)
• care plans for managing the late effects of treatment
• a process for rapid re-entry to medical services for suspected recurrence.

Communication – lead clinician to:
• discuss treatment options with the patient/carer including the intent of treatment as well as risks and benefits
• discuss advance care planning with the patient/carer where appropriate
• discuss the treatment plan with the patient’s general practitioner.

Radiation therapy may benefit people with:
• high-risk rectal cancer for whom adjuvant preoperative (or less commonly post-operative) radiation therapy is recommended
• symptomatic non-resectable locally advanced cancer who may benefit from radiation with palliative intent.

Chemotherapy or drug therapy may benefit people with:
• a high risk of relapse
• locally advanced rectal cancer, treated with neoadjuvant chemo-radiation
• 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.

Communication – lead clinician to:
• explain the treatment summary and follow-up care plan to the patient/carer
• inform the patient/carer about secondary prevention and healthy living
• discuss the follow-up care plan with the patient’s general practitioner.

This work is available at: www.cancer.org.au/ocp