You don’t need a colonoscopy or do you?

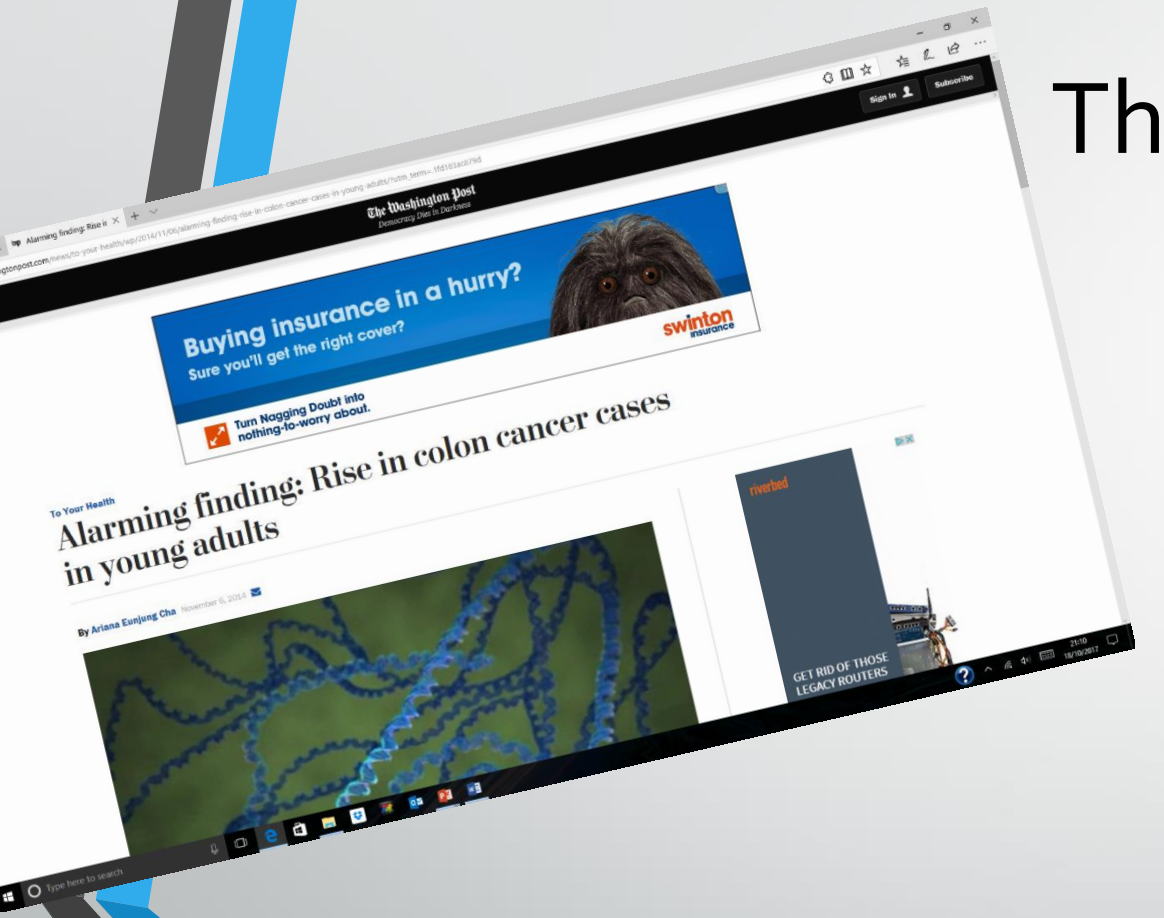
General & Colorectal Updates – October 2017

Denzil May

Consultant General & Colorectal Surgeon

Duchy Hospital & RCHT.

The Headlines



The Headlines

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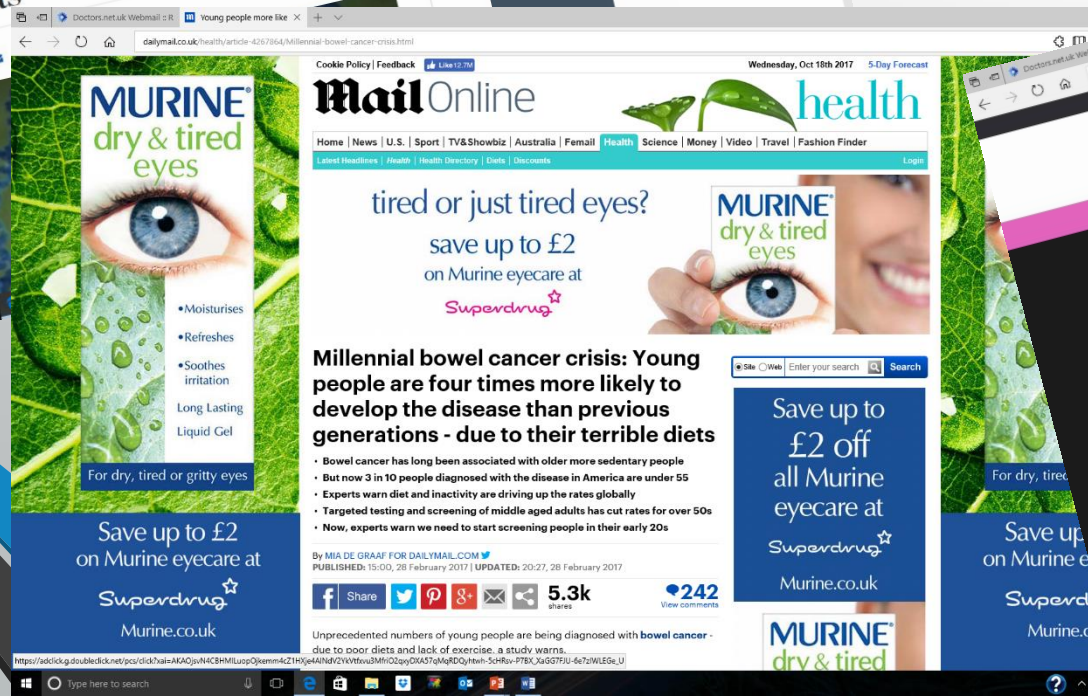


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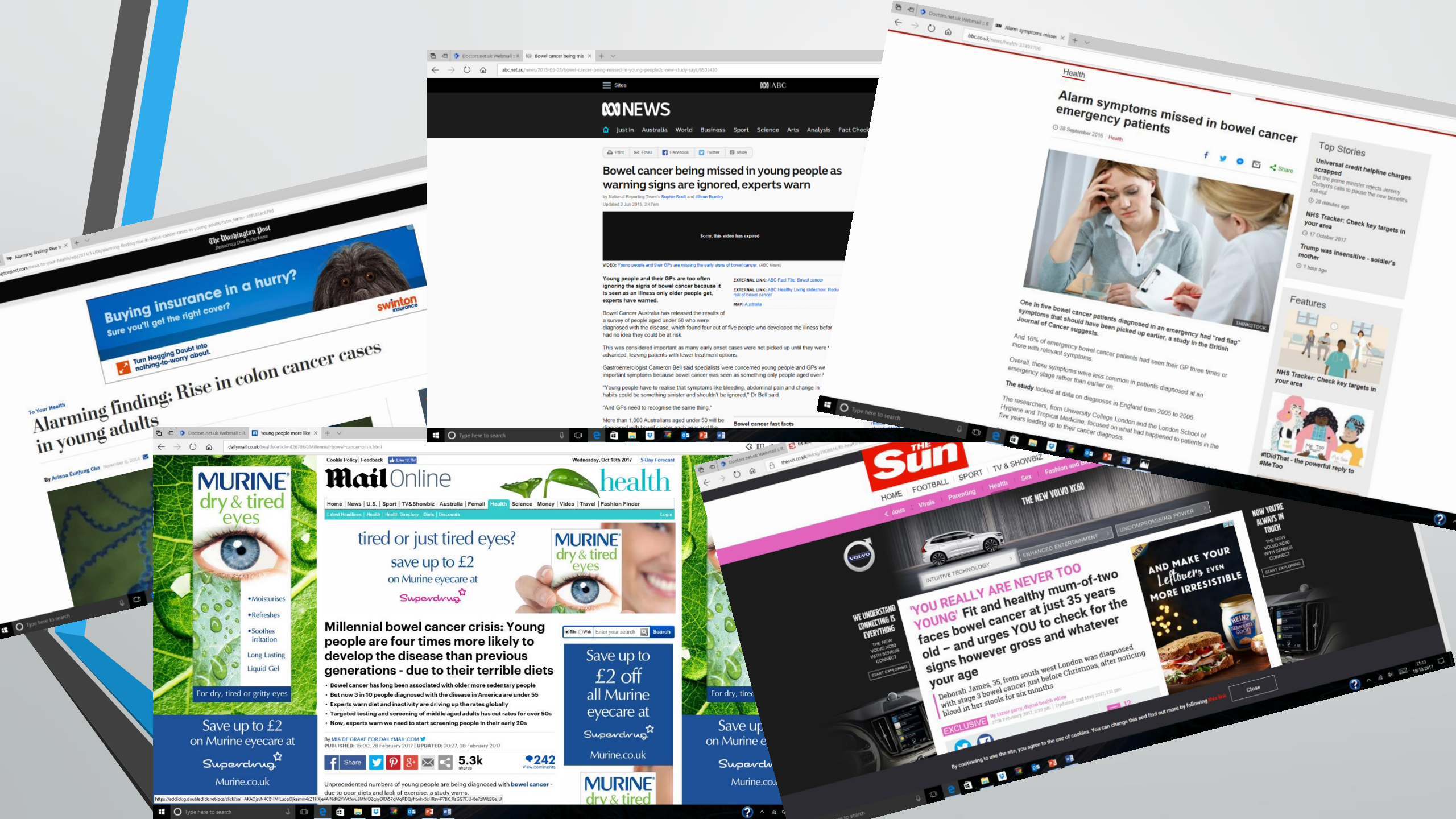
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Bowel cancer fast facts
Alarm symptoms missed in bowel cancer emergency patients
Health
One in five bowel cancer patients diagnosed in an emergency had "red flag" symptoms that should have been picked up earlier, a study in the British Journal of Cancer suggests.
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Bowel cancer has long been associated with older more sedentary people
But now 3 in 10 people diagnosed with the disease in America are under 55
Experts warn diet and inactivity are driving up the rates globally
Targeted testing and screening of middle aged adults has cut rates for over 50s
Now, experts warn we need to start screening people in their early 20s
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cancerresearchuk.org/about-us/cancer-news/press-release/2016-09-28-1-in-5-emergency-bowel-cancer-patients-had-symptoms-before-diagnosis

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1 in 5 emergency bowel cancer patients had symptoms before diagnosis

Category: Press release | 28 September 2016 | Cancer Research UK

Around one in five bowel cancer patients diagnosed after an emergency presentation have displayed at least one cancer 'alarm symptom' in the year leading up to their diagnosis, according to a Cancer Research UK-funded study published in the British Journal of Cancer.

The study found that 'red flag' symptoms were much more common in patients who were diagnosed via non-emergency routes, and that patients diagnosed as an emergency often did not display these symptoms strongly associated with bowel cancer.

It's lack of these 'red flag' symptoms in many patients diagnosed as an emergency that makes it much more difficult for GPs to diagnose the cancer early.

"This research shows the difficulties in diagnosing patients who are not showing typical symptoms of bowel cancer." - *Dr Julie Sharp*

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Bowel (colorectal) cancer news

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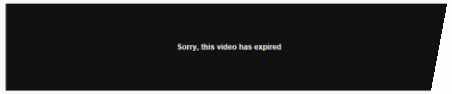
Bowel cancer being missed in young people as warning signs are ignored, experts warn

by National Reporting Team's Sophie Scott and Alison Branley

Updated 2 Jun 2015, 2:47am



VIDEO: Young people and their GPs are missing the early signs of bowel cancer. (ABC News)

Young people and their GPs are too often ignoring the signs of bowel cancer because it is seen as an illness only older people get, experts have warned.

EXTERNAL LINK: ABC Fact File: Bowel cancer

EXTERNAL LINK: ABC Healthy Living slideshow: Redu risk of bowel cancer

MAP: Australia

Bowel Cancer Australia has released the results of a survey of people aged under 50 who were diagnosed with the disease, which found four out of five people who developed the illness befor had no idea they could be at risk.

This was considered important as many early onset cases were not picked up until they were advanced, leaving patients with fewer treatment options.

Gastroenterologist Cameron Bell said specialists were concerned young people and GPs we important symptoms because bowel cancer was seen as something only people aged over

"Young people have to realise that symptoms like bleeding, abdominal pain and change in habits could be something sinister and shouldn't be ignored," Dr Bell said.

"And GPs need to recognise the same thing."

More than 1,000 Australians aged under 50 will be

Bowel cancer fast facts

Health

Alarm symptoms missed in bowel cancer emergency patients

28 September 2016 | Health

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One in five bowel cancer patients diagnosed in an emergency had "red flag" symptoms that should have been picked up earlier, a study in the British Journal of Cancer suggests.

And 16% of emergency bowel cancer patients had seen their GP three times or more with relevant symptoms.

Overall, these symptoms were less common in patients diagnosed at an emergency stage rather than earlier on.

The study looked at data on diagnoses in England from 2005 to 2006.

The researchers, from University College London and the London School of Hygiene and Tropical Medicine, focused on what had happened to patients in the five years leading up to their cancer diagnosis.

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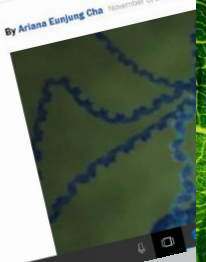
Alarming finding: Rise in colon cancer in young adults

By Ariana Eunjung Cha November 6, 2014



dailymail.co.uk/health/article-4267864/Millennial-bowel-cancer-crisis.html

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Millennial bowel cancer crisis: Young people are four times more likely to develop the disease than previous generations - due to their terrible diets

- **Bowel cancer has long been associated with older more sedentary people**
- **But now 3 in 10 people diagnosed with the disease in America are under 55**
- **Experts warn diet and inactivity are driving up the rates globally**
- **Targeted testing and screening of middle aged adults has cut rates for over 50s**
- **Now, experts warn we need to start screening people in their early 20s**

By MIA DE GRAAF FOR DAILYMAIL.COM

PUBLISHED: 15:00, 28 February 2017 | UPDATED: 20:27, 28 February 2017

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Unprecedented numbers of young people are being diagnosed with **bowel cancer** - due to poor diets and lack of exercise, a study warns.

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THE Sun

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'YOU REALLY ARE NEVER TOO YOUNG' Fit and healthy mum-of-two faces bowel cancer at just 35 years old – and urges YOU to check for the signs however gross and whatever your age

Deborah James, 35, from south west London was diagnosed with stage 3 bowel cancer just before Christmas, after noticing blood in her stools for six months

EXCLUSIVE By Lizzie parry, digital health editor 27th February 2017, 2:39 pm | Updated: 2nd May 2017, 1:11 pm

Aims for today

- What are the alarm symptoms?
  - Cancer vs colitis vs self limiting benign disease.
- Indications for referral
- Indications for colonoscopy?
- Listen to a patient and her journey
  - Review the evidence with reference to her story

Background

- Colorectal symptoms are common (1 in 12 GP consultations)
- Young patients (<50 years); other diagnoses considered first
- Average no. appointments before referral; 5
- Average time to diagnosis; 9 months
- Sex divide; females longer to diagnosis than males.

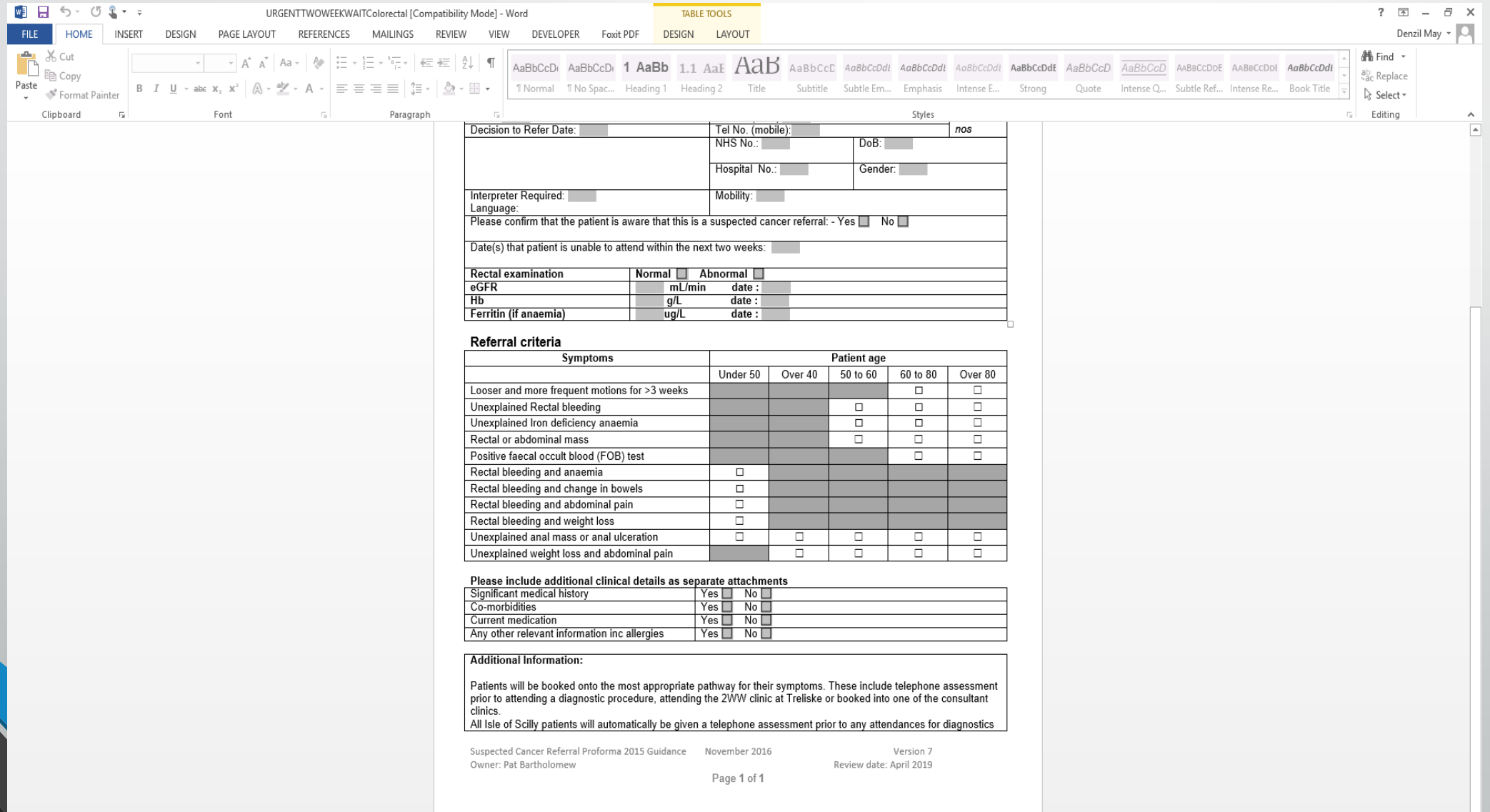
Colorectal Symptoms

- Rectal bleeding
- Change in bowel habit
- Rectal mucous
- Tenesmus
- Anaemia (iron deficient)
- Abdominal pain
- Anal pain / anal discomfort
- Weight loss
- Family history
- Anal pain

Suspected Colorectal Cancer Referral Criteria

Referral criteria
40 - 60 yrs old with persistent (> 6 weeks) rectal bleeding and a change to looser / more frequent stools
60 yrs or over with persistent (> 6 weeks) rectal bleeding (in absence of anal symptoms) and / or change to looser / more frequent stools
Definite intraluminal (not pelvic) mass on rectal examination irrespective of age
Definite palpable right sided abdominal mass (probably involving large bowel) irrespective of age
Other
Unexplained iron deficiency anaemia (Hb =< 11g/dl in men and =< 10g/dl in non menstruating women)

Suspected colorectal cancer referral April 2017



URGENTTWOWEEKWAITColorectal [Compatibility Mode] - Word

Decision to Refer Date:	Tel No. (mobile): nos
	NHS No.: DoB:
	Hospital No.: Gender:
Interpreter Required: Language:	Mobility:
Please confirm that the patient is aware that this is a suspected cancer referral: - Yes ☐ No ☐	
Date(s) that patient is unable to attend within the next two weeks:	

Rectal examination	**Normal** ☐ **Abnormal** ☐
eGFR	**mL/min date :**
Hb	**g/L date :**
Ferritin (if anaemia)	**ug/L date :**

Referral criteria

Symptoms	**Patient age**				
	Under 50	Over 40	50 to 60	60 to 80	Over 80
Looser and more frequent motions for >3 weeks				☐	☐
Unexplained Rectal bleeding			☐	☐	☐
Unexplained Iron deficiency anaemia			☐	☐	☐
Rectal or abdominal mass			☐	☐	☐
Positive faecal occult blood (FOB) test				☐	☐
Rectal bleeding and anaemia	☐				
Rectal bleeding and change in bowels	☐				
Rectal bleeding and abdominal pain	☐				
Rectal bleeding and weight loss	☐				
Unexplained anal mass or anal ulceration	☐	☐	☐	☐	☐
Unexplained weight loss and abdominal pain		☐	☐	☐	☐

Please include additional clinical details as separate attachments

Significant medical history	Yes ☐ No ☐
Co-morbidities	Yes ☐ No ☐
Current medication	Yes ☐ No ☐
Any other relevant information inc allergies	Yes ☐ No ☐

Additional Information:

Patients will be booked onto the most appropriate pathway for their symptoms. These include telephone assessment prior to attending a diagnostic procedure, attending the 2WW clinic at Treliske or booked into one of the consultant clinics.
All Isle of Scilly patients will automatically be given a telephone assessment prior to any attendances for diagnostics

IBD vs Cancer

- Both share similar symptoms
  - Probably best to consider the diagnoses together & investigate early
- Crohn's typically present at ages 33 to 45 years
- UC typically 5-10 years later than Crohn's
- Cancer much more common >60, but over 2500 cases per year in UK in <50
- Delayed diagnosis common

Patient’s Story

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Research

Clinical features of bowel disease in patients aged <50 years in primary care: a large case-control study

Sally A Stapley, Greg P Rubin, Deborah Alsina, Elizabeth A Shephard, Matthew D Rutter and William T Hamilton

Br J Gen Pract 27 March 2017; bjgp17X690425. DOI: https://doi.org/10.3399/bjgp17X690425

Abstract

Background Incidences of colorectal cancer (CRC) and inflammatory bowel disease (IBD) are increasing in those aged <50 years.

Aim To identify and quantify clinical features in primary care of CRC/IBD in those aged <50 years. This study considered the two conditions together and aimed to determine which younger patients, presenting in primary care with symptoms, would benefit from investigation for potentially serious colorectal disease.

Their methods

- Case control study
- 700 practices included
- Cases of IBD / CRC vs case controls January 2000 to December 2013
- Features (symptoms, signs, investigations) recorded
- Power calculation done for sample size
- 12,000 cases, vs 36,000 controls

PPVs (95% CI) for colorectal cancer (CRC) or inflammatory bowel disease (IBD) in males and females aged 18–49 years for individual risk markers and for pairs of risk markers in combination.

Rectal bleeding	Change in bowel habit	Diarrhoea	Abdominal pain	Low mean red cell volume	Raised white cell count	Raised platelets	Abnormal liver function	Low haemoglobin	Raised inflammatory markers	
1.2 (1.1 to 1.4)	1.0 (0.8 to 1.3)	0.5 (0.5 to 0.6)	0.2 (0.2 to 0.2)	0.4 (0.3 to 0.4)	0.3 (0.3 to 0.3)	0.8 (0.7 to 0.9)	0.1 (0.1 to 0.1)	0.3 (0.3 to 0.3)	0.5 (0.5 to 0.6)	PPV as a single symptom
2.4 (1.9 to 3.2)	2.0 (0.9 to 4.4)	3.7 (2.2 to 6.3)	1.5 (1.1 to 2.2)	3.2 (1.3 to 7.4)	2.7 (1.3 to 5.3)	5.3 (-)	1.7 (1.0 to 2.7)	3.3 (1.7 to 6.2)	5.2 (2.9 to 9.1)	Rectal bleeding
	3.3 (1.6 to 6.9)	1.4 (0.8 to 2.5)	1.0 (0.6 to 1.6)	5.5 (-)	2.1 (-)	3.1 (-)	1.0 (0.5 to 1.9)	9.6 (-)	2.1 (1.1 to 3.9)	Change in bowel habit
		1.5 (1.2 to 1.9)	0.9 (0.7 to 1.1)	2.1 (1.3 to 3.5)	2.8 (1.9 to 4.2)	6.9 (3.7 to 13)	1.1 (0.8 to 1.5)	2.1 (1.5 to 3.1)	2.8 (2.0 to 3.7)	Diarrhoea
			0.4 (0.4 to 0.5)	1.0 (0.7 to 1.4)	0.7 (0.6 to 0.9)	2.7 (1.8 to 4.0)	0.3 (0.3 to 0.4)	0.8 (0.6 to 1.0)	1.2 (1.0 to 1.5)	Abdominal pain
					0.9 (0.7 to 1.3)	1.3 (1.0 to 1.8)	0.4 (0.3 to 0.6)	0.6 (0.5 to 0.7)	1.7 (1.2 to 2.3)	Low mean red cell volume
						1.3 (1.0 to 1.7)	0.4 (0.3 to 0.5)	0.5 (0.4 to 0.6)	1.0 (0.8 to 1.2)	Raised white cell count
							1.0 (0.7 to 1.4)	1.2 (0.9 to 1.5)	2.0 (1.5 to 2.6)	Raised platelets
								0.5 (0.4 to 0.6)	0.5 (0.4 to 0.6)	Abnormal liver function
									1.4 (1.1 to 1.7)	Low haemoglobin

Sally A Stapley et al. Br J Gen Pract
doi:10.3399/bjgp17X690425

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PPVs (95% CI) for colorectal cancer (CRC) in males and females aged 18–49 years for individual risk markers and for pairs of risk markers in combination.

Rectal bleeding	Rectal mass	Change in bowel habit	Constipation	Diarrhoea	Abdominal pain	Nausea and/or vomiting	Low haemoglobin	Raised inflammatory markers	Low mean red cell volume	
0.4 (0.3 to 0.6)	0.6 (0.3 to 1.1)	0.5 (0.2 to 1.0)	0.1 (0.1 to 0.2)	0.1 (0.1 to 0.1)	0.1 (0.1 to 0.1)	0.1 (0.1 to 0.1)	0.1 (0.1 to 0.1)	0.1 (0.1 to 0.1)	0.1 (0.1 to 0.2)	PPV as a single symptom
1.8 (-)	17 (-)	0.3 (-)	5.8 (-)	0.4 (-)	0.4 (-)	1.3 (-)	13 (-)	1.4 (-)	8.0 (-)	Rectal bleeding
	5.6 (-)	6.3 (-)	6.1 (-)	5.1 (-)	7.0 (-)	1.3 (-)	5.6 (-)	7.0 (-)	2.9 (-)	Rectal mass
		1.2 (-)	0.3 (-)	6.1 (-)	0.3 (-)	0.3 (-)	5.1 (-)	0.4 (-)	2.1 (-)	Change in bowel habit
			0.3 (0.1 to 0.7)	1.8 (-)	0.3 (0.1 to 0.6)	0.5 (-)	0.4 (-)	1.0 (-)	5.1 (-)	Constipation
				0.1 (0.1 to 0.2)	0.2 (0.1 to 0.3)	0.1 (-)	0.4 (-)	0.3 (0.1 to 0.6)	0.7 (-)	Diarrhoea
					0.2 (0.1 to 0.3)	0.1 (0.1 to 0.3)	0.5 (0.3 to 1.2)	0.3 (0.2 to 0.6)	0.7 (-)	Abdominal pain
						0.1 (0.1 to 0.2)	0.3 (-)	0.2 (-)	0.2 (-)	Nausea and/or vomiting
								0.4 (0.2 to 0.6)	0.2 (0.2 to 0.4)	Low haemoglobin
									0.4 (0.2 to 0.7)	Raised inflammatory markers

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PPVs (95% CI) for inflammatory bowel disease (IBD) in males and females aged 18–49 years for individual risk markers and for pairs of risk markers in combination.

Rectal bleeding	Change in bowel habit	Diarrhoea	Abdominal pain	Low mean red cell volume	Raised white cell count	Raised platelets	Abnormal liver function	Low haemoglobin	Raised inflammatory markers	
0.8 (0.7 to 1.0)	0.7 (0.5 to 0.9)	0.4 (0.4 to 0.4)	0.1 (0.1 to 0.2)	0.2 (0.2 to 0.3)	0.2 (0.2 to 0.2)	0.6 (0.5 to 0.7)	0.1 (0.1 to 0.1)	0.2 (0.2 to 0.2)	0.4 (0.3 to 0.4)	PPV as a single symptom
1.5 (1.1 to 2.0)	1.7 (-)	2.9 (1.6 to 5.1)	1.1 (0.7 to 1.7)	1.8 (0.7 to 4.3)	1.7 (0.8 to 3.4)	3.3 (-)	1.2 (0.7 to 2.0)	1.9 (1.0 to 3.6)	3.6 (2.0 to 6.6)	Rectal bleeding
		0.9 (0.5 to 1.5)	0.6 (0.4 to 1.1)	3.3 (-)	1.2 (-)	1.8 (-)	0.6 (0.3 to 1.3)	5.6 (-)	1.6 (0.8 to 3.2)	Change in bowel habit
		1.2 (1.0 to 1.5)	0.7 (0.6 to 0.9)	1.5 (0.9 to 2.5)	2.2 (1.4 to 3.4)	5.2 (2.6 to 10)	0.8 (0.6 to 1.1)	1.5 (1.0 to 2.3)	2.3 (1.6 to 3.1)	Diarrhoea
			0.3 (0.2 to 0.3)	0.7 (0.5 to 1.1)	0.6 (0.4 to 0.7)	1.9 (1.2 to 2.9)	0.2 (0.2 to 0.3)	0.5 (0.4 to 0.7)	0.9 (0.7 to 1.2)	Abdominal pain
					0.6 (0.4 to 0.9)	1.0 (0.7 to 1.5)	0.3 (0.2 to 0.4)	0.4 (0.3 to 0.4)	1.1 (0.8 to 1.6)	Low mean red cell volume
						1.0 (0.7 to 1.3)	0.3 (0.2 to 0.4)	0.3 (0.3 to 0.4)	0.8 (0.6 to 0.9)	Raised white cell count
							0.8 (0.6 to 1.2)	1.0 (0.7 to 1.3)	1.7 (1.2 to 2.3)	Raised platelets
								0.3 (0.2 to 0.4)	0.4 (0.3 to 0.5)	Abnormal liver function
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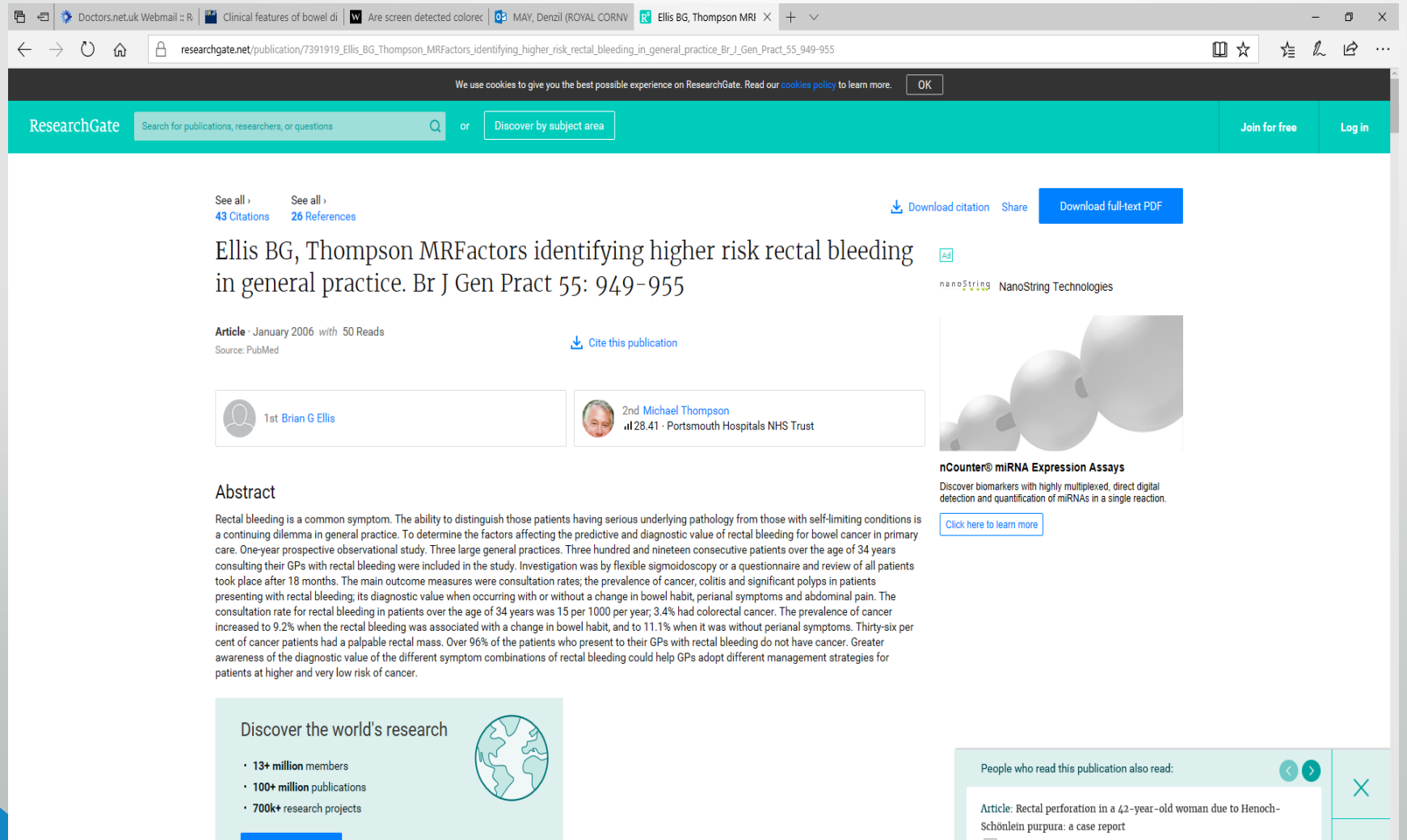
Other evidence in the literature



Other evidence in the literature

researchgate.net/publication/7391919_Ellis_BG_Thompson_MRFactors_identifying_higher_risk_rectal_bleeding_in_general_practice_Br_J_Gen_Pract_55_949-955

Table 1. The diagnostic value of symptom combinations and the characteristics of rectal bleeding for colorectal cancer in primary care.

Symptoms	Numbers	Predictive value	Likelihood ratio (95% CI)	Sensitivity	Specificity
Bleeding and CIBH	11/119	9.2	2.361 (2.046 to 2.725)	100	55
Bleeding and no CIBH	0/147	0			
Bleeding and CIBH (loose +/- frequent)	10/83	12.1	1.345[a] (1.071 to 1.689)	91	32
Bleeding and CIBH (hard +/- infrequent)	1/36	2.8			
Bleeding and no perianal symptoms	7/63	11.1	2.898 (1.752 to 4.792)	64	78
Bleeding and perianal symptoms	4/203	1.97			
Bleeding, CIBH and abdominal pain	6/67	9	0.966[a] (0.549 to 1.697)	55	44
Bleeding, CIBH and no abdominal pain	5/52	9.6			
Dark blood	3/31	9.7	2.133 (0.765 to 5.946)	27	87
Bright blood	8/199	4			
Aged ≥60 years	8/155	5.2	1.524 (1.042 to 2.229)	73	52
Aged ≤59	3/164	1.8			
Blood on paper only	2/82	2.4	0.580 (0.163 to 2.057)	18	69
Blood in pan and on paper	9/184	4.9			
Large volume of blood	1/79	1.3	0.297 (0.045 to 1.944)	9	69
Small volume of blood	10/187	5.3			
First time rectal bleeding	5/106	4.7	1.148 (0.590 to 2.231)	45	60
Not first time bleeding	6/160	3.8			
Blood mixed with the stool	1/33	3	0.724 (0.109 to 4.827)	9	87
Blood not mixed with the stool	10/233	4.3			

Total cancers in study: 11/319 = 3.4%. Diagnostic yield for cancer in patients sigmoidoscoped: 11/219 = 5%. Pre-test probability or positive predictive value of rectal bleeding in cancer for patients answering questionnaire or sigmoidoscoped: 11/266, 4.1% [95% CI = 2.1 to 7.3]). [a]Likelihood ratio derived using only patients with rectal bleeding and a change in bowel habit using pre-test probability of 9.2%. CIBH = change in bowel habit.

Table 2. The diagnostic value of symptom combinations and the characteristics of proctocolitis in primary care.

Symptoms	Numbers	Predictive value	Likelihood ratio (95% CI)	Sensitivity	Specificity
Bleeding and CIBH	5/119	4.2	1.901 (1.295 to 2.789)	83	56
Bleeding and no CIBH	1/147	0.7			
Bleeding and CIBH (loose +/- frequent)	5/83	6.0	1.207 (0.827 to 1.763)	83	31
Bleeding and CIBH (hard +/- infrequent)	1/36	2.8			
Bleeding and no perianal symptoms	6/63	9.5	4.561 (3.626 to 5.737)	100	76.3
Bleeding and perianal symptoms	0/203	0			
Bleeding, CIBH and abdominal pain	1/67	1.5	0.355 (0.061 to 2.061)	20	42
Bleeding, CIBH and no abdominal pain	4/52	7.7			
Dark blood	1/31	3.2	1.5 (0.252 to 8.934)	20	86
Bright blood	4/199	2			

Total proctocolitis in study: 6/319, 1.9%. Diagnostic yield for proctocolitis in patients sigmoidoscoped: 16/219, 2.7% [95% CI = 1.1 to 6.1]). CIBH = change in bowel habit.

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ectal bleeding could help GPs adopt different management strategies for

Summary of the literature

- Younger patients with GI symptoms difficult diagnostic problem
- Most will have functional disorder or non serious disease
- Faecal calprotectin (level >50µg/g) sensitive & specific for IBD 93 & 94% against IBS.
- Faecal calprotectin no help in CRC vs IBS
- NICE CG61
  - Risk >3% should have colonoscopy
  - Risk 1-3% IBD can be excluded by normal faecal calprotectin
  - Risk <1% managed expectantly
  - Patient progress monitored and referred if not as expected

Other Indications for a colonoscopy (asymptomatic patients)

- Surveillance
  - Polyps
  - Post cancer resection
  - Colitis
- Family history
- Screening (Bowel Scope & National Bowel Cancer Screening Programme)
- Following acute appendicitis in age >50
- Following first presentation diverticulitis (flexible sigmoidoscopy)

Surveillance

- Polyps
  - As per BSG guidelines
    - Low Risk – 5 years
    - Intermediate risk – 3 years
    - High Risk – 1 year
- Post cancer resection
  - Colonoscopy at 1 year post resection
  - Colonoscopy at 3 years post resection
  - Then polyp guidelines

- Colitis
  - High risk – annual
    - PSC
    - Stricture or dysplasia last 5 years
    - Extensive colitis with severe inflammation
    - First degree relative with CRC <50 years
  - Intermediate risk – 2-3 yearly
    - Extensive colitis, with mild to moderate inflammation
    - Inflammatory polyps
    - First degree relative with CRC > 50 years
  - Low risk – 5 yearly

Family History

- Low Risk Group
  - No personal history CRC
  - One first degree relative with CRC >45 years
- Moderate Risk Group
  - One first degree relative with CRC <45 years
  - Two first degree relatives with CRC at any age (except if meet criteria for high risk)
- High Risk Group
  - HNPCC / Lynch syndrome
  - FAP
  - POLE syndrome

Discussion / Questions?

Summary indications for GI investigation

- Combination symptoms with >3% risk warrant urgent referral
- Hard symptoms – Consider referral for specialist opinion
  - Bloods for WCC, CRP, platelets, LFTs, haematinics.
- Soft symptoms – Referral if doesn't settle as expected
  - Bloods for WCC, CRP, platelets, LFTs, haematinics
  - Except personal or family history of IBD or CRC – refer.
- Family History
  - Moderate or high risk – specialist opinion