1. Care map information
This pathway was developed based on the Cancer Council 2016 Optimal care pathway for people with colorectal cancer

2. Resources for patients, families and carers

**Australian Cancer Survivorship Centre**
Has general and tumour-specific information, primarily focussed on the post-treatment survivorship phase
Telephone: +61 3 9656 5207

**Beyond Blue**
Information on depression, anxiety and related disorders, available treatment and support services
Telephone: 1300 22 4636

**Bowel Cancer Australia**
Information about bowel cancer prevention, diagnosis and treatment

**Cancer Australia**
Information on cancer prevention, screening, diagnosis, treatment and supportive care for Australians affected by cancer, and their families and carers
Telephone: 1800 624 973

**Cancer Council Victoria**
A confidential telephone support service for people affected by cancer providing information on treatment, cancer support groups and other community resources
Telephone: 13 11 20 (Monday to Friday, 8.30am – 5.30pm)

**Care Search: Palliative Care Knowledge Network**
Information for patients and carers on living with illness, practical advice on how to care, and finding services
Telephone: (08) 7221 8233

**National Bowel Cancer Screening Program**
Information about the national screening program

**Optimal Care pathways Resources**
- [Patient information](#)
- [Quick reference guide](#)
- [Optimal Care Pathway for people with colorectal cancer](#)

3. Resources for health professionals

**Australian Cancer Trials**
Information on the latest clinical trials in cancer care, including trials that are recruiting new Participants

**Cancer Australia**
Information for health professionals including guidelines, cancer guides, reports, fact sheets, DVDs, posters and pamphlets

**Cancer Council Australia**
Information on prevention, research, treatment and support provided by Australia’s peak independent cancer authority

**EviQ**
Clinical information resource providing health professionals with current evidence based, peer maintained, best practice cancer treatment protocols and information relevant to the Australian clinical environment

**National Health and Medical Research Council**
Information on clinical practice guidelines, cancer prevention and treatment

**Optimal Care pathways Resources**
- Patient information
- Quick reference guide
- Optimal Care Pathway for people with colorectal cancer

### 4. Aboriginal & Torres Strait Islander Health

The burden of cancer is higher in the Australian Indigenous population (AIHW 2014). Survival also significantly decreases as remoteness increases, unlike the survival rates of non-Indigenous Australians. Aboriginal and Torres Strait Islander people in Australia have high rates of certain lifestyle risk factors including tobacco smoking, higher alcohol consumption, poor diet and low levels of physical activity (Cancer Australia 2013). The high prevalence of these risk factors is believed to be a significant contributing factor to the patterns of cancer incidence and mortality rates in this population group (Robotin et al. 2008).

In caring for Aboriginal and Torres Strait Islander people diagnosed with cancer, the current gap in survivorship is a significant issue. The following approaches are recommended to improve survivorship outcomes (Cancer Australia 2013):

- Raise awareness of risk factors and deliver key cancer messages.
- Develop evidence-based information and resources for community and health professionals.
- Provide training for Aboriginal and Torres Strait Islander health workers and develop training resources.
- Increase understanding of barriers to care and support.
- Encourage and fund research.
- Improve knowledge within the community to act on cancer risk and symptoms.
- Improve the capacity of Aboriginal and Torres Strait Islander health workers to provide cancer care and support to their communities.
- Improve system responsiveness to cultural needs.
- Improve our understanding of care gaps through data monitoring and targeted priority research.

### 5. Prevention

Recommendations for preventing colorectal cancer include:
- 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
6. Risk factors & screening

Based on family history, people can be placed into one of three categories of relative risk of developing colorectal cancer. Age is an independent risk factor for colorectal cancer, with the incidence increasing significantly after the age of 50 years.

<table>
<thead>
<tr>
<th>Risk Factors</th>
<th>Screening</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Slightly above risk</strong></td>
<td></td>
</tr>
<tr>
<td>• no personal history of colorectal cancer, colorectal adenomas or chronic inflammatory bowel disease and no confirmed close family history of colorectal cancer</td>
<td>• Screening using an FOBT is recommended every two years for all people over the age of 50.</td>
</tr>
<tr>
<td>• one first-degree relative (parent, sibling, child) or second-degree relative (aunt, uncle, niece, nephew, grandparent, grandchild) with colorectal cancer diagnosed at age 55 or older, or</td>
<td>• Timely and full examination of the large bowel by colonoscopy is recommended for people who have a positive FOBT.</td>
</tr>
<tr>
<td>• two relatives diagnosed with bowel cancer at age 55 or older but on different sides of the family.</td>
<td>• If eligible, participation in the National Bowel Cancer Screening Program is recommended.</td>
</tr>
<tr>
<td><strong>Moderately increased risk</strong></td>
<td></td>
</tr>
<tr>
<td>• one first-degree relative with colorectal cancer diagnosed before the age of 55 or</td>
<td>• Offer colonoscopy every five years starting at 50 years. Alternatively, offer it at an age 10 years younger than the age of first diagnosis of colorectal cancer in the family, whichever comes first.</td>
</tr>
<tr>
<td>• two first- or one first- and second-degree relative(s) on the same side of the family diagnosed with colorectal cancer at any age</td>
<td>• Consider offering an FOBT in the intervening years. People should be informed that a positive test will require further investigation (NHMRC 2005).</td>
</tr>
<tr>
<td><strong>Potentially HIGH risk</strong></td>
<td></td>
</tr>
<tr>
<td>• three or more first-degree relatives or a combination of first- and second-degree relatives on the same side of the family with colorectal cancer</td>
<td>• Consider referral to a familial cancer service for further risk assessment and possible genetic testing.</td>
</tr>
<tr>
<td>• two or more first- or second-degree relatives on the same side of the family diagnosed with colorectal cancer plus any of the following high-risk features</td>
<td>• Refer to a bowel cancer specialist to plan appropriate surveillance and management.</td>
</tr>
<tr>
<td>• multiple colorectal cancers in a family member</td>
<td></td>
</tr>
<tr>
<td>• colorectal cancer before the age of 50 years</td>
<td></td>
</tr>
<tr>
<td>• a hereditary non-polyposis colorectal cancer (HNPCC)-related cancer</td>
<td></td>
</tr>
<tr>
<td>• at least one first-degree or second-degree relative with a large number of adenomas throughout the large bowel (suspected familial adenomatous polyposis (FAP)), or</td>
<td></td>
</tr>
</tbody>
</table>
being a member of a family in which a gene mutation that confers a high risk of bowel cancer has been identified.

General practitioners and primary care nurses should educate patients and encourage them to participate in the screening appropriate to the individual’s level of risk.

7. Signs & symptoms

Based on family history, people can be placed into one of the three categories of relative risk of developing colorectal cancer. Age is an independent risk factor for colorectal cancer, with the incidence increasing significantly after the age of 50 years.

General practitioners and primary care nurses should educate patients and encourage them to participate in the screening and appropriate to the individual’s level of risk.

The following signs and symptoms should be investigated:
- positive FOBT
- passage of blood with or without mucus in faeces
- unexplained iron deficiency anaemia
- change in bowel habit, especially a recent one (loose stools or constipation)
- undiagnosed abdominal pain
- unexplained rectal or abdominal mass
- unexplained weight loss (ACN 2005).

The presence of multiple signs and symptoms, particularly in combination with other underlying risk factors, indicates an increased risk of colorectal cancer.

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

8. Initial investigations

Investigations prior to referral should include:
- physical examination
- digital rectal examination
- full blood examination including iron studies

Note: a negative result from an FOBT does not exclude cancer.

A detailed family history should be obtained from patients presenting with colorectal cancer symptoms.
9. Colonoscopy
All patients referred for colonoscopy should be seen by a clinician or surgeon accredited in colonoscopy by the Conjoint Committee of the Royal Australasian College of Surgeons, Royal Australasian College of Physicians or Gastroenterological Society of Australia.

For private endoscopy/colonoscopy refer to National Human Services Directory

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

10. Specialist referral
Referral for suspected colorectal cancer should incorporate appropriate documentation sent with the patient including:

- a letter that includes important psychosocial history and relevant past history, family history, current medications and allergies
- results of current clinical investigations (imaging and pathology reports)
- results of all prior relevant investigations
- notification if an interpreter service is required.

If access is via online referral, a lack of a hard copy (of results) should not delay referral. If a pathological (or endoscopic) diagnosis has been made, the patient should be referred to a general or colorectal surgeon affiliated with (or with access to) a multidisciplinary team (and multidisciplinary team meeting). Some early cancers can be managed by endoscope alone without surgical consultation but should also be considered by a multidisciplinary team.

Guidelines for screening colonoscopy – refer to NH&MRC guidelines (currently under review)

11. Colorectal Specialist

PUBLIC HOSPITAL CLINICS
ALFRED HEALTH
Colorectal & General Surgery Clinic
Advice: Contact Colorectal Fellow via switch on (03) 9076 2000 to discuss confirmed colorectal patients for urgent referral
Fax: (03) 9076 6938
Head of Unit: Mr Roger Wale
Referral guidelines: Colorectal Surgery

MONASH HEALTH
Colorectal Surgery Clinic
Advice: Phone Colorectal Cancer Coordinator for urgent cancer referrals 0466 300 228 or Colorectal Surgical Fellow via switch (03) 9554 1000
Fax: (03) 9594 2273
Head of Unit: Mr William Teoh
Referral guidelines

PENINSULA HEALTH
No outpatient’s clinic for newly diagnosed patients
Refer to National Human Services Directory for colorectal specialist listing

PETER MACCALLUM CANCER CENTRE
12. Diagnosis & 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 and magnetic resonance imaging (MRI) and/or endoscopic rectal ultrasound
Consider enrolment in clinical trials where appropriate

13. Supportive care
Screening, assessment and referral to appropriate health professionals is required to meet the identified needs of an individual, their carer and family.
Supportive care in cancer refers to the following five domains:
• physical needs
• psychosocial needs
• social needs
• information needs
• spiritual needs

An individualised clinical assessment is required to meet the identified needs of an individual, their carer and family; referral should be as required.
In addition to common issues identified, specific needs that may arise at this time include:
• treatment for physical symptoms such as pain, fatigue and altered bowel function
• help with the emotional distress of dealing with a potential cancer diagnosis, anxiety/depression, interpersonal problems, stress and adjustments difficulties
• pre-surgical education with a stomal therapist wherever a diversion of permanent stoma is possible
• pre-surgical referral to a psycho oncologist for support over body image expectations associated with surgical treatment
• appropriate information for people from culturally and linguistically diverse backgrounds

The general practitioner should:
• provide the patient with information that clearly describes who they are being referred to, the reason for referral, and expected timeframes for specialist appointments
• support the patient while waiting for the specialist appointment.

14. Management & planning
Ideally, all newly diagnosed patients should be discussed at a multidisciplinary team meeting. The level of discussion may vary depending on both clinical and psychosocial factors.
Multidisciplinary discussion for patients with rectal cancer should take place before surgery because multimodality neoadjuvant therapy is often considered optimal care.

15. GP participation in MDT

GPs are invited to participate in the MDT meeting. It is an opportunity to discuss the case with the lead clinician. After the meeting, GPs will receive a letter from the MDT within a week which provides details on their patient’s treatment plan.

- Alfred Health MDM - Wednesday 11.30am-12noon
- Monash Health MDM - Friday 7.30am - 9am
- Peninsula Health MDM - Alternate Fridays 1pm - 2pm

16. Treatment

The intent of treatment can be defined as one of the following:
- curative
- anti-cancer therapy to improve quality of life and/or longevity without expectation of cure
- symptom palliation.

The morbidity and risks of treatment need to be balanced against the potential benefits. The lead clinician should discuss treatment intent and prognosis with the patient and care prior to beginning treatment.

If appropriate, advance care planning should be initiated with patients at this stage as there can be multiple benefits such as ensuring a person’s preferences are known and respected after the loss of decision-making capacity.

17. Supportive care

Screening with a validated screening tool (such as the National Comprehensive Cancer Network distress thermometer and problem checklist), assessment and referral to appropriate health professionals or organisations is required to meet the needs of individual patients, their carers and families.

Specific needs that may arise at this time include:
- physical symptoms such as pain, weight loss, fatigue and altered bowel function
- gastrointestinal symptoms (such as nausea, vomiting, mucositis and loss of appetite) as a result of chemotherapy treatment, requiring optimal symptom control with medication and referral to a dietitian if dietary intake is affected
- assistance with managing complex medication regimens, multiple medications, assessment of side-effects and assistance with difficulties swallowing medications – referral to a pharmacist may be required
- decline in mobility and/or functional status as a result of treatment
- emotional and psychological issues including, but not limited to, body image concerns, coping with stomas, fatigue, quitting smoking, traumatic experiences, existential anxiety, treatment phobias, anxiety/depression, interpersonal problems and sexuality concerns
- potential isolation from normal support networks, particularly for rural patients who are staying away from home for treatment
- financial issues related to loss of income and additional expenses as a result of illness and/or treatment
- legal issues (including advance care planning, appointing a power of attorney, and completing a will)
- the need for appropriate information for people from culturally and linguistically diverse backgrounds.
18. Care & surveillance after initial treatment

After completion of initial treatment, patients should be provided with a treatment summary and follow up care plan including a comprehensive list of issues identified by all members of the multidisciplinary team. Transition from acute to primary or community care will vary depending on the type and stage of cancer and needs to be planned. In some cases, people will require ongoing, hospital-based care.

19. Management of recurrent disease

Most residual or recurrent disease will be detected via routine follow-up or by the patient presenting with symptoms. Where possible, refer patient to the original multidisciplinary team. Treatment will depend on the location and extent of the disease, previous management and patient preferences.

20. Disease progression

In managing people with colorectal cancer, treatment programs have recently become more complex, with more chemotherapy and major surgical programs being offered to patients with potentially curable recurrent cancer; however, therapy may be focused on disease control or palliation, based on the extent of disease and the patient’s general health, preferences and values.

Treatment may include surgery, radiation therapy and/or drug therapy.

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

21. Palliative planning & management

Early referral to palliative care can improve the quality of life for people with cancer and in some cases may be associated with survival benefits. This is particularly true for poor prognosis cancers. Ensure carers and families receive information, support and guidance regarding their role according to their needs and wishes.

The patient and carer should be encouraged to develop an advance care plan.