

Colorectal Symptoms - Suspected Colorectal Cancer

[Disclaimer](#)

This pathway is for symptomatic patients. see also [National Bowel Cancer Screening Program \(NBCSP\)](#).

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Background

About colorectal symptoms

In Australia approximately 75% of bowel cancers are diagnosed in symptomatic patients. Effective implementation of the National Bowel Cancer Screening Program (NBCSP) may help reduce this percentage through detection of bowel cancer in asymptomatic patients.

Single symptoms alone are not strong predictors, but suspicion of colorectal cancer increases with the combination of symptoms, in particular if a symptom is associated with any of the following four critical factors:

- Positive immunochemical faecal occult blood test (iFOBT)
- Anaemia
- Rectal bleeding
- Aged ≥ 60 years

Assessment

1. Take a history to elicit concerning symptoms that require further investigation:

- History of positive faecal occult blood test
- Rectal symptoms including **bleeding**, tenesmus

Rectal bleeding

- *Outlet pattern* – includes bright red blood passed after motion or on paper. Consider haemorrhoids, anal fissures.
- *Higher in colon* – includes blood mixed with the stool, dark blood, clots, or mucus. More likely to be due to bowel cancer.
- Unexplained [iron deficiency anaemia](#)
- Change in bowel habit > 6 weeks especially a recent one (loose stools or constipation)
- Undiagnosed abdominal pain
- Unexplained weight loss
- Unexplained rectal or abdominal mass

2. Assess risk factors for bowel cancer, asking about:

- **gastrointestinal history.**

Gastrointestinal history

- Previous [colorectal cancer](#)
- Colonic adenoma
- [Inflammatory bowel disease.](#)
- **previous procedures** – colonoscopy, abdominal or anal procedure.

Previous procedures

- *Date, findings, and histology (if available)*
- *A history of recent complete high quality colonoscopy in last 2 years may mean further colonoscopy is not needed.*

- family history:
 - **family history of bowel cancer.**

Family history of bowel cancer

<i>Risk category</i>	<i>Family history</i>
<i>Risk category 1</i> Near average risk (95 to 98% of the population)	<ul style="list-style-type: none"> • No first or second degree relatives with CRC • One first-degree relative diagnosed with CRC at age > 55 years • One first degree relative and one second degree relative with CRC at age > 55 years
<i>Risk category 2</i> Moderate risk (3 to 6 fold increased risk compared to average population) (2 to 5% of the population)	<ul style="list-style-type: none"> • One first degree relative diagnosed with CRC at age < 55 years • Two first degree relatives diagnosed with CRC at any age • One first degree relative and at least 2 second degree relatives diagnosed with CRC at any age
<i>Risk category 3 (7 to 10 fold increased risk compared to average population)</i> High risk (< 1% if the population)	<ul style="list-style-type: none"> • 3 or more first degree or second degree relatives with CRC, with at least one diagnosed at age < 55 years • 3 or more first degree relatives

See Cancer Council Australia – [Colorectal Cancer Risk According to Family History](#).

- **High risk familial syndromes**

High risk familial syndromes

Patients with the following familial syndromes have a genetic predisposition to colorectal cancers.

- **high risk familial syndromes.**
 - Attenuated FAP (AFAP)
 - Cowden syndrome
 - Familial adenomatous polyposis (FAP)
 - Juvenile polyposis syndrome
 - Lynch syndrome – previously hereditary nonpolyposis colorectal cancer (HNPCC). Lynch syndrome related cancers include:
 - Biliary tract
 - Brain
 - Colorectal
 - Endometrial
 - Ovarian
 - Small bowel
 - Stomach
 - Urinary tract
 - MUTYH associated polyposis (MAP)
 - NTHL1 associated polyposis (NAP)

- Peutz Jeghers syndrome
 - Polymerase proofreading associated polyposis (PPAP)
 - Serrated polyposis syndrome (previously hyperplastic polyposis)
- **high probability of having a high-risk familial syndrome**

Factors indicating high probability of a high-risk familial syndrome³

Risk categories 2 and 3 specifically exclude patients with:

- a relative confirmed as carrying a pathogenic mutation in a gene associated with a high-risk familial syndrome, where the patient has not been tested.
- a relative with multiple colorectal cancers.
- a relative with familial adenomatous polyposis.
- at least 3 first degree or 2 degree relatives with a Lynch syndrome related cancer (endometrial, ovarian, stomach, small bowel, urothelial, biliary tract, brain) with at least 1 diagnosed before age 55 years.

See Cancer Council Australia – [High-risk Familial Syndromes](#).

2. Consider **medical history**.

Medical history

- Significant bleeding risk – coagulopathy, oral anticoagulant, and/or anti-platelet therapy (specify on referral).
- A chronic comorbid condition (e.g., ischaemic heart disease (IHD), congestive heart failure (CHF), COPD, chronic kidney disease (CKD), diabetes) that has implications for anaesthesia or sedation.

3. Perform **examination**.

Examination

- Check:
 - vital signs and record current weight and BMI.
 - for signs of anaemia e.g., pale conjunctivae, palmar crease pallor.
 - for jaundice e.g., scleral icterus.
- Palpate abdomen for signs of an abdominal mass or organomegaly e.g., enlarged liver.
- Examine the perineum and anus looking for haemorrhoids, anal fissure, or ulceration.
- Perform a digital rectal examination (DRE) to check for any palpable rectal masses.

4. Arrange **investigations**.

Investigations

- Arrange FBE, LFT, electrolytes, urea, and creatinine (EUC), iron studies
- Depending on symptoms, consider:
 - **coeliac serology**, CRP, ESR, TFTs

Coeliac disease serology

- Transglutaminase-IgA (tTG-IgA), and
- Deamidated gliadin peptide-IgG (DGP-IgG)

These antibody tests are now the current accepted tests for coeliac disease and in practice both tests have > 85% sensitivity and > 90% specificity. See Australian Journal of General Practice – [Interpreting Tests for Coeliac Disease: Tips, Pitfalls and Updates](#).

- faecal investigations such as stool culture or **faecal calprotectin**

Faecal calprotectin

Faecal calprotectin is a:

- recommended test, but not yet funded by the MBS.
 - sensitive, non-invasive marker of intestinal inflammation, and can be useful in the following settings:
 - Differentiating between those with and without current inflammation in the lower gut needing further evaluation.
 - Distinguishing between people with IBS and IBD. Can cost between \$80 to \$100 – but easier than a colonoscopy. Particularly useful for rural patients where access to colonoscopy can involve travel and extended waiting times.
 - It is used to monitor IBD patients on therapy to determine whether there is current disease activity and risk of relapse, response to treatment.
 - There is potential for false positive results in infectious diarrhoea in the absence of IBD. Therefore do not use where diarrhoea is present for < 6 weeks.
 - It is not useful when there is PR bleeding from any cause as it will be high.
- Consider immunochemical faecal occult blood test (iFOBT) if not already performed:
- Not indicated if rectal bleeding.
 - If positive, indicates need for further evaluation (a critical factor of suspected colorectal cancer).
 - If negative, does not rule out bowel cancer.
- Consider imaging (CT or ultrasound abdomen or pelvis) if palpable abdominal or pelvic mass on examination.

Management

1. Arrange [colonoscopy referral](#) or [urgent or routine colorectal surgery referral](#) if rectal bleeding in patients aged ≥ 40 years with:
 - unintended weight loss ($\geq 5\%$ of body weight in previous 6 months).
 - abdominal or rectal mass.
 - recent change in bowel habits.

- patient or family history of bowel cancer (first-degree relative aged < 55 years).
 - iron deficiency that persists despite correction of potential causative factors.
2. For asymptomatic patients:
 - If positive IFOBT, arrange [colonoscopy referral](#) – see [National Bowel Cancer Screening Program \(NBCSP\)](#).
 - If **high risk familial syndromes**, arrange [genetic assessment](#).
 3. Continue to review and monitor patients with symptoms suggestive of colorectal cancer during the waiting period for diagnostic colonoscopy.
 - Advise patients to report any new colorectal symptoms lasting > 6 weeks.
 - If the patient's status changes, facilitate more urgent specialist referral.
 4. Offer support and further information to patients and their families about testing and management of suspected colorectal cancer, including:
 - Cancer Council Australia [helpline](#) 13-11-20 for expert practical and emotional support.
 - Cancer Council Victoria – [Diagnosing Bowel Cancer](#).
 - Optimal Care Pathways – [Bowel Cancer: What to Expect](#)
 5. For further information, see Cancer Australia – [Optimal Care Pathway for People with Colorectal Cancer](#).

Referral

- Arrange [colonoscopy referral](#) or [urgent or routine colorectal surgery referral](#) if rectal bleeding in patients aged ≥ 40 years with:
 - unintended weight loss ($\geq 5\%$ of body weight in previous 6 months).
 - abdominal or rectal mass.
 - recent change in bowel habits.
 - patient or family history of bowel cancer (first-degree relative aged < 55 years).
 - iron deficiency that persists despite correction of potential causative factors.
- If **high risk familial syndromes**, arrange [genetic assessment](#).

Information

For health professionals

Further information

- Cancer Council Australia – [Guidelines for Colorectal Cancer Screening: Family History](#)
- Cancer Council Victoria:
 - [Optimal Care Pathway for People with Colorectal Cancer](#)
 - [Optimal Care Pathway for People with Colorectal Cancer: Quick Reference Guide](#)
- Cancer Guidelines Wiki – [Clinical Practice Guidelines for Surveillance Colonoscopy](#)
- Victorian Department of Health and Human Services – [Colonoscopy Categorisation Guidelines 2017](#)

For patients

- Better Health Channel:
 - [Bowel Cancer](#)
 - [Bowel Cancer Screening](#)
 - [Bowel Preparation](#)
 - [Colonoscopy](#)
 - [Flexible Sigmoidoscopy](#)
- Cancer Council Australia – [Bowel Cancer: What to Expect](#)
- Cancer Council Victoria:
 - [Diagnosing Bowel Cancer](#)
 - [Helpline](#)
- Gastroenterological Society of Australia – [Colonoscopy](#)

References

1. [Colonoscopy categorisation guidelines 2017](#). Victoria, Australia: Victorian Department of Health and Human Services; 2017.
2. Cancer Guidelines Wiki. Australia: Cancer Council Australia; [Clinical practice guidelines for the prevention, early detection and management of colorectal cancer: Introduction: High-risk familial syndromes](#). 2017. [cited 2017 Dec 12].
3. Cancer Guidelines Wiki. Australia: Cancer Council Australia; [Colorectal cancer risk according to family history](#). 2017. [cited 2018 Jan 20].

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- Geary R, Barclay M, Florkowski C, George P. [Faecal Calprotectin: the case for a novel non-invasive way of assessing intestinal inflammation](#). New Zealand Medical Journal. 2005.
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