

Specialty guides for patient management during the coronavirus pandemic

Clinical guide for triaging patients with suspected colorectal cancer

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This guide, produced with acknowledgement to British Society of Gastroenterology, sets out the process providers should adopt to prioritise and triage patients with suspected colorectal cancer (CRC) during the coronavirus pandemic.

Patients will continue to present with symptoms that may be due to CRC and a level of service provision must be maintained to support them and to prevent them presenting to A&E.

- **Local prioritisation arrangements** should ensure that there is a single, clinician-managed route to urgent care for patients on both screening and symptomatic lists requiring this.
- **Investigations** may be required in others but not immediately; they should be appropriately held in a fail-safe process until normal/full service provision resumes.
- **National advice** has already been issued on the [management of 2WW referrals for cancer](#).
- **Local systems** should continue to manage referrals in line with NG12 and this additional advice wherever possible.
- **Patients requiring endoscopy services:** Guidance on management has been published [here](#).

Prioritisation and triage of symptomatic patients referred on a 2WW pathway

To support appropriate referral from primary care, trusts should consider:

- **Providing GPs** with specialist telephone advice and guidance before formal referral
- **Direct telephone consultations** between patients and specialists.
- **Clinicians may prioritise referrals** using:
 - Patient-reported symptoms together with
 - Blood test results (full blood count, ferritin, U&E and CRP) and
 - FIT (faecal immunochemical test)

These can help clinicians prioritise referrals requiring urgent colonoscopy or CT (CTC/plain CT) where these services are available.

Clinical teams will need to develop a triage process that reflects their local endoscopy and imaging capacity, including capacity from non-acute and independent sector provider sites.

Clinical guidance

The published evidence is that, in the absence of iron-deficiency anaemia, a palpable abdominal mass, rectal bleeding or obstructive symptoms, a FIT $<10\mu\text{g/g}$ has a negative predictive value (NPV) for CRC of $>95\%$. While the NPV and positive predictive value (PPV) of a FIT $10\text{--}100\mu\text{g/g}$ are unknown, preliminary data (supported by data from NHS England FIT pioneers sites) shows that in people with symptoms a FIT $>100\mu\text{g/g}$ is associated with a 1 in 4 chance of CRC.

Patients should therefore be prioritised for further investigation according to the following triage process:

1. Top priority patients for urgent endoscopy or CT (CTC or plain CT):

- *Early signs of a large bowel obstruction*, eg lower abdominal pain and distension
- *Other NG12-specified symptoms and a FIT $>100\mu\text{g/g}$* , and who have not had a colonoscopy in the previous three years
- *Symptoms deemed by specialist GI surgeons/gastroenterologists* at the point of triage to merit urgent intervention.

2. Second-order priority patients to be placed on an endoscopy waiting list:

- *NG12-specified symptoms and a FIT $10\text{--}100\mu\text{g/g}$*

- *Other NG12-specified symptoms and a FIT >100µg/g, and who have had a colonoscopy requiring no further investigation in the previous three years.*

3. Third-order priority patients to be safety-netted on a patient tracking list:

- *NG12-specified symptoms and a FIT <10µg/g.*

Patients should **not** be discharged from the pathway on the basis of a FIT result alone, except by existing FIT pioneer service evaluation sites that were piloting the use of FIT before the COVID-19 outbreak.

Vulnerable patients

Vulnerable patients who meet the referral criteria but have been advised to self-isolate for 12 weeks should be prioritised by specialist telephone advice.

Decisions about further investigation for this group must consider the risk of COVID-19 infection.

Participants identified as FIT positive in the Bowel Cancer Screening Programme (BCSP)

Reduced service provision may mean that some BCSP participants with a positive FIT result develop symptoms while waiting for their diagnostic test. Their symptoms should be assessed during remote appointments with specialist screening practitioners and/or accredited screening colonoscopists, and they should be prioritised as above for further investigation, with consideration of the risk of COVID-19 infection.

Service provision

Colonoscopy should only be performed for patients with the most urgent need, ie where CT colonography or plain CT is not a viable option, and when a biopsy is required. As such, Cancer Alliances will need to ensure all MDT centres have access to cold imaging facilities.

Plain CT scans of chest, abdomen and pelvis may be performed for the most urgent cases, eg where obstructive symptoms are elicited.

Patients presenting with rectal bleeding and a rectal mass should be offered a flexible sigmoidoscopy.

Cancer alliances will need to adapt to respond to the quickly changing situation on the ground. Any plans put in place must have the flexibility to respond to changing demand and capacity resulting from the COVID-19 outbreak. As demand reduces, resources should be allocated to process patients with the highest risk and most clinical need.

Safety netting

Patients who do not require immediate investigation should be held on a patient tracking list (PTL) managed by MDT co-ordinators, for further management at a later date. The timing of progressing these patients through further diagnostic testing should be discussed on a regular basis with local system leads in order to mitigate against avoidable delays.

Appropriate safety netting should be put in place for these patients, to allow for a further clinical assessment should their symptoms worsen. Any MDT recommendations and shared decision-making with patients at variance with pre-pandemic pathways should be recorded.

Patients for whom further investigation is deferred should be reassured that:

- their FIT result indicates that further tests are needed but cancer is unlikely
- the coronavirus pandemic means their appointment for further tests will be booked at a later date. This is because of concern over their safety due to the current risk of COVID-19 infection.

Safety instructions for staff

Patients who are invited for any procedure (urgent colonoscopy, CT colonography or plain CT) should be advised that they must cancel their appointments and self-isolate if they have any potential COVID-19 symptoms.

Before any patient is admitted for their procedure, enquiries should be made to confirm that they are symptom free. Where possible, they should be asked to self-isolate for seven days before admission.

Where possible, COVID-19-free facilities should be established, with patients screened for carriage of SARS-CoV-2 before endoscopy.

Staff providing or supporting any endoscopy procedures will need to be provided with appropriate personal protective equipment (PPE) according to PHE advice. This will also reduce patients' risk of nosocomial infection.

Experts from the Health and Safety Executive and Public Health England have carried out a rapid review of the evidence supporting the use of PPE in healthcare and in the context of COVID-19. This [guidance](#) recommends the use of FFP3 respirators when caring for patients in areas where high-risk aerosol generating procedures are performed.