Community HealthPathways North Cumbria

Colorectal Symptoms

Assessment

1. History – ask about:
   - rectal bleeding .

     Rectal bleeding

     - Sinister bleeding – includes blood coating or blood mixed with the stool, dark blood, clots, or mucus.
     - Outlet or anal bleeding:
       - Includes bright red blood on the toilet paper or passed after the motion.
       - Anal or rectal pain strongly suggests outlet bleeding.

   - altered bowel habit .

     Altered bowel habit

     Looser or more frequent bowel motions for more than 6 weeks are of more concern than constipation.

     Consider causes:

     - Recent change in diet, medication, or lifestyle
     - Overseas travel
     - Infective causes
     - Post-cholecystectomy

   - weight loss .

     Weight loss

     - Weight loss is clinically relevant if more than 5% of body weight is lost over 6 to 12 months, although smaller losses may be important in frail elderly people. [1]
     - Associated loss of appetite.

   - abdominal pain.

- personal history of colorectal cancer.
- family history of colorectal cancer. See also British Society of Gastroenterology – Family History Surveillance .
- medications, e.g. nonsteroidal anti-inflammatory drugs (NSAIDs), anticoagulants, antiplatelets, proton pump inhibitors (PPIs).

2. Examination:
   - Check for abdominal and rectal masses.
   - Perform a rectal examination.
3. Assess for 2-week wait symptom criteria for colorectal cancer .

> **2-week wait symptom criteria for colorectal cancer**
>
> - Abdominal, rectal, anal mass or ulceration.
> - Rectal bleeding in association with unexplained:
> - abdominal pain.
> - change in bowel habit.
> - weight loss.
> - iron deficiency anaemia. IDA is defined as haemoglobin less than 130 g/L for men or less than 115 g/L for women and low MCV, low MCH, or low ferritin. [2] Consider iron deficiency may also be present if ferritin is between 23 to 75 microgram/L in the presence of systemic inflammation, e.g. elevated CRP.
> - Rectal bleeding in a patient older than 50 years.
> - A patient:
> - older than 40 years with unexplained weight loss with abdominal pain.
> - with high-risk iron deficiency anaemia (IDA) – Defined as all men with IDA, women older than 50 years, or women who are older than 40 years and are non-menstruating.

4. Investigation – do not request CT colonography in primary care.
   - Arrange FBC, ferritin , B12, folate, LFT, urea and electrolytes .

> **Urea and electrolytes**
>
> When requesting urea and electrolytes, the laboratory will automatically test:
>
> - Sodium
> - Potassium – blood sample must be spun down or analysed within 6 hours of collecting, or the lab will omit potassium analysis
> - Urea
> - Creatinine
> - eGFR

Ferritin

- Iron studies (serum iron, serum transferrin and transferrin saturation) are not a first-line test for iron deficiency.
- Ferritin is the most useful test to measure iron deficiency, but a normal ferritin dose not exclude iron deficiency in the context of systemic inflammation.
- Serum iron is a negative acute phase reactant, i.e. serum iron may be low in patients with inflammation as well as in iron deficiency. The serum transferrin level will typically be high (or high-normal) in iron deficiency but low (or low-normal) in inflammation.
- Where interpretation of results is unclear, seek non-acute haematology advice.

- If diarrhoea or loose motions, arrange CRP, stool culture, thyroid function tests (TFTs), and tissue transglutaminase (tTG).
- Consider faecal calprotectin to help exclude inflammatory bowel disease (IBD).

Faecal calprotectin

- Faecal calprotectin is a useful but expensive stool test.
- For diarrhoea, it is now seen as a first line test to help exclude inflammatory bowel disease (IBD): [3]
  - Faecal calprotectin is a marker of intestinal mucosal inflammation that can be useful in differentiating between inflammatory bowel disease (IBD) and irritable bowel syndrome (IBS) in symptomatic patients.
  - In IBD, levels correlate with disease activity, and a concentration less than 50 microgram/g is considered to be a good negative predictor (published negative predictive values 70 to 90%). The best value of this test in general practice is a negative result, which effectively excludes a diagnosis of IBD in young patients presenting with diarrhoea.
  - For patients with known inflammatory bowel disease in remission, faecal calprotectin greater than 50 microgram/g is associated with an increased risk of relapse over the next 12 months.

- If iron deficiency anaemia, arrange coeliac serology (tissue transglutaminase (tTG) antibodies) and urine dipstick to exclude other causes.

Tissue transglutaminase (tTG) antibodies

Advise the patient to include gluten in their diet for 4 to 6 weeks for the test results to be accurate, e.g. at least 4 slices of gluten-containing bread or equivalent each day.

A patient with a co-existing IgA deficiency will have a false-negative IgA tTG result. The laboratory will automatically check for IgA deficiency. If the patient is IgA deficient, then IgG tTG will be measured.

- If unexplained change in bowel habit in women, check CA125.

- If bowel cancer is suspected, arrange a faecal immunochemical test (FIT).
- Do not arrange carcinoembryonic antigen (CEA) .

> **Carcinoembryonic antigen (CEA)**
>
> - CEA is a tumour marker for monitoring disease progression.
> - It cannot be relied on for diagnosis inclusion or exclusion.

Management

1. Request 2-week wait colorectal surgery assessment if the patient :
   - meets 2-week wait symptom criteria for colorectal cancer .
   - has other symptoms and a positive FIT result.

   The patient may be offered direct to test colonoscopy or CT unless a clinic option is chosen. Check performance status and co-morbidities and discuss with patient before selecting option.

2. Manage any other causes:
   - Anal fissures
   - Haemorrhoids
   - Irritable bowel syndrome
   - Inflammatory bowel disease
   - Medications, e.g. metformin, proton pump inhibitors (PPIs), anticoagulants, antiplatelets, NSAIDs.
   - If a mass may be due to faecal loading, give laxatives and reassess in a few days.
3. If FIT is negative, safety net and follow up in primary care. If persistent or troublesome symptoms, consider requesting routine gastroenterology assessment, routine colorectal surgery assessment, or colorectal surgery advice.

Request

- Request 2-week wait colorectal surgery assessment if patient has:
  - 2-week wait symptom criteria for colorectal cancer .
  - other symptoms and a positive FIT result.
- If FIT is negative and persistent or troublesome symptoms, consider requesting routine gastroenterology assessment, routine colorectal surgery assessment, or colorectal surgery advice.

Information

For health professionals

Education

North Cumbria HealthPathways – Continuing Professional Development

Further information

NHS Northern Cancer Alliance – GI and Colorectal

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SOURCES

References

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PAGE INFORMATION

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