Direct Access Colonoscopy Service (DACS) – Homerton University Hospital

Reasons behind setting up this service:

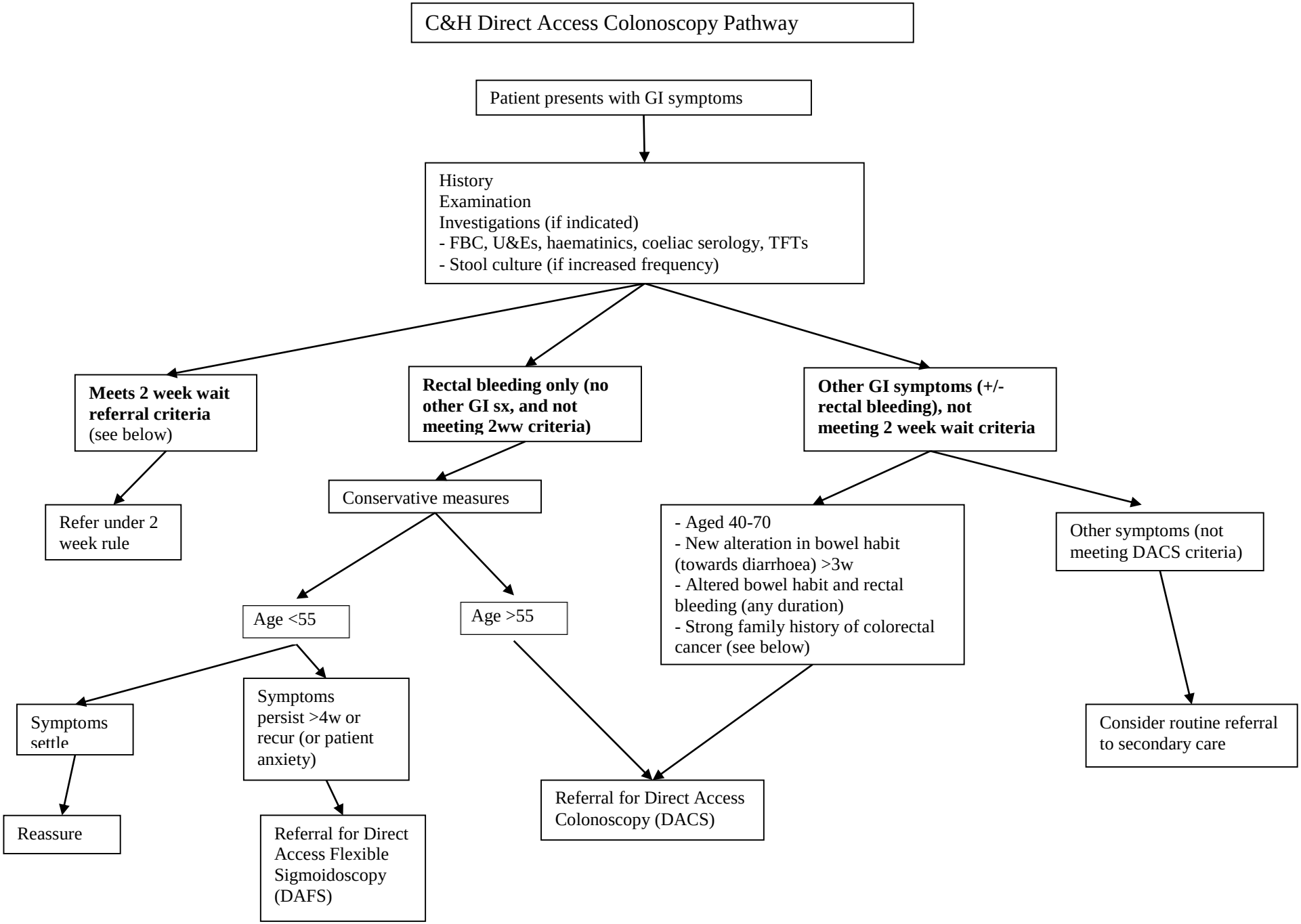
- Bowel cancer is the UK's second biggest cancer killer and the fourth most common cancer.
- Colorectal symptoms are common in the population, and the majority of patients with symptoms do not have colorectal cancer
- Nationally, only 6.4% of 2ww referrals lead to a cancer diagnosis
- At the Homerton, the 2012/13 data showed that of the colorectal cancers diagnosed
    - 35% were via a 2ww referral
    - 28% were via an A&E presentation
    - The remaining 37% were via routine referrals
- Survival rates are better when diagnosed at an earlier stage
- City & Hackney have a high proportion of patients who present at Stage 4

New 2ww criteria for Suspected Colorectal Cancer:

- Rectal bleeding with change of bowel habit* of ≥ 3 weeks duration (age 40 and over)
- ctal bleeding without change in bowel habit with no obvious cause ≥ 3 weeks duration (age 50 years and over)
- Change of bowel habit with tendency towards looser stools persisting for 3 weeks or more without bleeding (age 50 years and over)
- Abdominal mass thought to be large bowel cancer (any age)
- Palpable rectal mass (any age)
- Males of any age with Hb ≤ 11g/100ml; Ferritin ≤30 mg/dL; MCV ≤ 79 iron deficiency picture
- Non menstruating female with Hb ≤ 10g/100ml; Ferritin ≤30 mg/dL; MCV ≤ 79 iron deficiency picture
- Other high clinical suspicion of colorectal cancer

Strategies to try to improve the stage at diagnosis:

- Public Health approaches and awareness campaigns
- National Screening programmes
    - Bowel Cancer Screening Programme
        - Aged 60-75 FOB tests
        - Colonoscopy if FOB positive
    - Bowelscope
        - One-off Flexi Sig at age 55 – aim to start at HUH Jan 2015
- Approaches to change GPs referral behaviour
    - Change to 2ww criteria (see right)
    - Direct access diagnostic testing


C&H Direct Access Colonoscopy Pathway
Patient presents with GI symptoms
History
Examination
Investigations (if indicated)
- FBC, U&Es, haematinics, coeliac serology, TFTs
- Stool culture (if increased frequency)
Meets 2 week wait referral criteria (see below)
Rectal bleeding only (no other GI sx, and not meeting 2ww criteria)
Other GI symptoms (+/- rectal bleeding), not meeting 2 week wait criteria
Refer under 2 week rule
Conservative measures
- Aged 40-70
- New alteration in bowel habit (towards diarrhoea) >3w
- Altered bowel habit and rectal bleeding (any duration)
- Strong family history of colorectal cancer (see below)
Other symptoms (not meeting DACS criteria)
Age <55
Age >55
Symptoms settle
Symptoms persist >4w or recur (or patient anxiety)
Consider routine referral to secondary care
Reassure
Referral for Direct Access Flexible Sigmoidoscopy (DAFS)
Referral for Direct Access Colonoscopy (DACS)

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Direct Access Flexible Sigmoidoscopy (DAFS)

- Patients aged 18-55 with rectal bleeding (and no CIBH)
- Treat with conservative measures for 4w (see C&H rectal bleeding pathway 2013)
- Refer if symptoms persist >4w or if patient anxiety

Direct Access Colonoscopy

Referral criteria:

- Aged 40-70

One of:

- New alteration in bowel habit (towards diarrhoea) >3w
- Altered bowel habit and rectal bleeding (any duration)
- Rectal bleeding alone if aged >55
- Strong family history of colorectal cancer (colonoscopy recommended at age 50-55 if asymptomatic) – see BSG website: 'Colonoscopy in High Risk groups' for more information
    - CRC in 1 FDR aged <50y
    - CRC in 2 FDR of any age

Note some overlap with new 2ww criteria – recommend refer to 2ww pathway if high suspicion; DACS is for cases of low clinical concern

Exclusion Criteria:

- Mental health problems or dementia (if wouldn't tolerate procedure/prep/consent)
- Recent MI or CVA within 8w
- eGFR <30
- Obesity (weight >135kg)
- Had full colonoscopy within last 2y

Medical Considerations (* refer to colorectal or gastroenterology clinic for assessment if uncertainty over fitness)

- U&Es within last 3m preferable
    - essential if comorbidities (CKD, DM, CVD)
- Medications to consider:
    - Iron tablets – stop 7d before
    - Aspirin – ok to continue
    - Clopidogrel / warfarin – safe to stop 10d before? (refer to clinic if not able to stop)
    - Diabetics on insulin: get advice from diabetes centre

A. THE GP CONSULTATION
Patients being considered for referral to DACS (note that the referral form includes this checklist)

1) Refer for DACS appointment – directly bookable through Choose and Book
Under Diagnostic Endoscopy – Colonoscopy – Homerton

2) Print and give patient the Patient Information Leaflet on Colonoscopy
Found on City and Hackney CCG website and on Homerton website
- highlight need for dietary changes in 48hrs prior to procedure and timing of taking bowel prep

3) Prescribe Moviprep 2 sachets and give to patient (instructions on when to take found on patient information leaflet)

4) Complete City and Hackney DACS Referral Form
ESSENTIAL – REFERRALS WILL BE REJECTED UNLESS REFERRAL FORM COMPLETED (as this acts as checklist that all above measures have been done)

5) Advise patient that they need to have an adult available to accompany them home
PREFERABLE – UNABLE TO RECEIVE SEDATION UNLESS ESCORT AVAILABLE

B. ON THE DAY OF THE PROCEDURE
- Patient attends for procedure at or before appointment time (with relative available to accompany them home after sedation)
- Admitted by nursing staff, observations, get changed
- Brief history and consent form by Endoscopist
- Procedure with sedation

- Detailed report to GP, patient and hospital notes

C. AFTER THE PROCEDURE
- All patients discharged back to GP care, except if diagnosis of:
  - colorectal cancer (added to lower GI MDM)
  - IBD (referred to Gastro clinic)
  - adenomatous polyps (to be removed at the time and added to polyp surveillance (1, 3 or 5year time)
  - if biopsies taken, results to be reviewed in a paper clinic 2-3 weeks later and communicated to GP and patient and appropriate action taken

References:
1) Primary Care Cancer Audit – Greater Midlands Cancer Network – March 2010
2) Eur J Cancer Clin Oncol. 1986 Feb;22(2):157-61. Colorectal cancer: incidence, delay in diagnosis and stage of disease. Robinson E, Mohilever J, Zidan J, Sapir D.