Guidance for investigating colorectal symptoms in primary care including IDA, Faecal Immunochemical Test (FIT) and Faecal Calprotectin.

based on NICE NG12/DG30 and York FC pathway and BSG guidance

Please note that this guidance does not replace clinical judgement and should be used in conjunction with the clinical assessment and opinion of the responsible doctor(s)
Clinical advice for the commissioning of the whole bowel cancer pathway — November 2017, National Colorectal Cancer Clinical Expert group.

• ‘Patients should be referred when high risk symptoms are present for three weeks before referral is made, in line with the advice given by Public Health England awareness campaigns’

• We interpret this to mean abdominal pain and change of bowel habit – not rectal bleeding or anaemia or weight loss
New or persistent lower GI symptoms or abdominal pain for > 3 weeks

Unexplained weight loss

Rectal bleeding

2WW Criteria or High risk confirmed IDA (Men, non-menstruating women >40y, women >50y)

Non-2WW

>50Y

2x Platelets >450 6 weeks apart

<50Y

Possible IBD/IBS

Offer faecal calprotectin test Repeat after 4 weeks if 100-250

Unexplained confirmed medium risk IDA or clinical suspicion of colorectal cancer

Safety netting in primary care Consider advice and guidance or routine referral for persistent or troublesome symptoms

<100

100-250

>250

Likely IBS Manage in Primary Care

Routine GI referral

Urgent not 2WW referral

Routine GI referral

Offer FIT consider CT if weight loss sx

Northern Cancer Alliance Colorectal Symptoms Assessment Pathway
Patients with bowel symptoms/high risk anaemia for urgent (2ww) referral

- Any age with rectal bleeding
- Age 50+ with rectal bleeding
- Age <50 with rectal bleeding plus 1 of:
  - abdo pain
  - change of bowel habit
  - weight loss
  - iron deficiency anaemia

- Age <50 with rectal bleeding
- Age 50+ with abdominal mass or
- Age 40+ with abdo pain and weight loss
- Age 60+ with unexplained change of bowel habit (exclude drug causes and infections first where appropriate)

- FIT positive

- High risk IDA (please offer urinalysis and TTG as well)
  - All men with confirmed IDA with low ferritin and Hb<130
  - Women – age >50 with confirmed IDA and Hb<115 (irrespective of menopause exclude drug causes and infections)
  - Women age 40-50 who are post-menopausal or non-menstruating (e.g. Mirena) with confirmed IDA with low ferritin and Hb<115

Consider offering urgent 2ww colorectal referral for gastroscopy and colonoscopy or clinic depending on frailty / patient preference

Consider offering urgent 2ww colorectal referral for colonoscopy or clinic depending on frailty / patient preference
Patients with symptoms that do not fulfil 2WW but may require routine referral for endoscopic tests – please refer by letter via electronic referral system

Age<60 with significant watery diarrhoea (Bristol stool type 6 or 7) that impacts on patient’s life for >3-6/52 (drug and infectious causes excluded) (people 60 and older with unexplained change of bowel habit qualify for 2ww colonoscopy)

Consider routine referral for colonoscopy to rule out microscopic colitis

Age<50 with unexplained rectal bleeding alone (people with rectal bleeding plus abdo pain or diarrhoea or anaemia qualify for 2ww referral)

Consider routine referral to colorectal team (but may not be necessary in younger people, people with single occurrence, when there is confirmed fissure or piles or when not the presenting symptom)
Medium risk lower GI symptoms

**Age 50+** with either of:
- **Unexplained** persistent abdominal pain alone
- **Unexplained documented** weight loss alone

Consider wide range of diagnoses – consider offering FiT or routine clinic and/or CT abdomen and pelvis

<table>
<thead>
<tr>
<th>FiT negative</th>
<th>FiT positive</th>
<th>FiT positive</th>
<th>FiT negative</th>
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**Age 50-59** with unexplained change in bowel habit
**Age 50+** – vague or chronic bowel symptoms of uncertain significance for >3/52
**Age <50** suspicion of lower GI cancer
Persistent raised platelets >450/dl (at least 2 recorded at least 6 weeks apart)

Consider offering FiT to identify people needing 2WW referral

If patients does not submit FiT within two weeks of request – review in primary care

If FiT –ve, consider other urgent / 2ww pathways as appropriate
Exclude ovarian cancer in women

If FiT +ve, consider 2WW colorectal referral for clinic or straight to test depending on frailty

If FiT –ve bowel cancer is unlikely. Actively monitor for any new red flags
If still concerned, refer as routine to gastroenterology.
Collaborating to improve cancer care

Low risk patients:
Age <50 with unexplained change in bowel habit +/- abdo pain for >3/52 – consider check Hb and coeliac antibodies
Faecal Calprotectin (FC) is considered the more appropriate test in people under 50 instead of FIT

IBS suspected - based on ABC (abdo pain, bloating and/or change of bowel habit)
No further investigations usually needed

Monitor and manage symptomatically using IBS pathway. If FC<50 and age<50 99% confidence of IBS
https://cks.nice.org.uk/irritable-bowel-syndrome#!scenario

Inflammatory Bowel Disease suspected*** - check faecal calprotectin (FC) and Hb

FC 100-250 – repeat test
 FC<100 - Including repeat <100
Offer routine referral for colonoscopy or clinic

FC >250
Urgent non-2WW referral

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*** - any patient with symptoms suggestive of fulminant colitis should be admitted or seen in OPC clinic urgently
Anaemia – IDA (medium and low risk), isolated low ferritin and unproven IDA

\[ \text{IDA} = \text{HB} < 130g/\text{L} \ (\text{MEN}), \ 115g/\text{L} \ (\text{Women}) \ \text{AND} \]

confirmed by local definition which may include: Ferritin < 15 or Ferritin < 30 and low MCV or Ferritin <30 and low transferrin. Please refer to local lab guidance.

**Medium risk Anaemia:** also check tTG and urinalysis):

- Menstruating women <50 with confirmed IDA
  - Without rectal bleeding
  - Menstruation, diet or blood donation unlikely to be the cause
- Over 60 Yr with unexplained anaemia without confirmed iron deficiency

**Low risk IDA or isolated low ferritin (also offer tTG and urinalysis)**

- Menstruating women <50 without rectal bleeding and when menstruation, diet or blood donation is likely as the cause for either an isolated low ferritin or IDA
- People with low ferritin but normal Hb

Offer FIT test in primary care

**FiT positive**

If patient does not submit FiT in 2/52, review in primary care

**FiT negative**

Treat with iron + active monitoring. Monitor ferritin and Hb and if anaemia recurs 3 months after normalising, consider routine referral to IDA clinic/ Gastroenterology. Check FIT if this has not already been done

Offer 2WW referral for bidirectional endoscopy.
Anaemia – IDA (medium and low risk), isolated low ferritin and unproven IDA

IDA = HB < 130g/ L (MEN), 115g/ L (Women) AND confirmed by local definition which may include: Ferritin < 15 or Ferritin < 30 and low MCV or Ferritin <30 and low transferrin. Please refer to local lab guidance.

**Medium risk Anaemia:** also check tTG and urinalysis:
- Menstruating women <50 with confirmed IDA
  - Without rectal bleeding
  - Menstruation, diet or blood donation unlikely to be the cause

**Over 60 Yr with unexplained anaemia without confirmed iron deficiency**

**Low risk IDA (also offer tTG and urinalysis)**
- Menstruating women <50 without rectal bleeding and when menstruation, diet or blood donation is likely as the cause for IDA

**Isolated low ferritin without anaemia (also offer tTG and urinalysis)**
- >50y – consider FIT if any suspicion of LGI cancer
- <50y – FIT not needed

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**Offer FIT test in primary care**

**FiT positive**
- If patient does not submit FiT in 2/52, review in primary care

**FiT negative**
- Treat with iron + active monitoring. Monitor ferritin and Hb and if anaemia recurs 3 months after normalising, consider routine referral to IDA clinic/Gastroenterology. Check FIT if this has not already been done

**Offer 2WW referral for bidirectional endoscopy.**
• New or persistent lower GI symptoms or abdominal pain for > 3 weeks
• Unexplained weight loss
• Rectal bleeding

2WW Criteria or High risk confirmed IDA (Men and non-menstruating women >40y women >50y)

Non-2WW

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2x Platelets >450 6 weeks apart

Unexplained confirmed medium risk IDA or clinical suspicion of colorectal cancer

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Possible IBD/ IBS

<=100

100-250

>250

Safety netting in primary care Consider advice and guidance or routine referral for persistent or troublesome symptoms

Likely IBS Manage in Primary Care

Routine GI referral

Urgent not 2WW referral

Northern Cancer Alliance Colorectal Symptoms Assessment Pathway

Safety netting in primary care Consider advice and guidance or routine referral for persistent or troublesome symptoms

Northern Cancer Alliance
Notes:
1. FiT is 85-90% sensitive for bowel cancer (at lower end of estimate in anaemic patients) and 80% specific at a cut off of 10µ/gm faeces

2. Confirmed IDA may include: **IDA = HB < 130g/ L (MEN) , 115g/ L (Women) AND Ferritin < 15 or Ferritin < 50 and low MCV or Ferritin <50 and low transferrin.** There may be local differences in definition please consult local labs.

2. Pre-menopausal women have low risk of colorectal cancer or GI causes of anaemia and most need no testing at all. Risk increases between age 40 and 50. Menstruating women younger than 40 with anaemia and no rectal bleeding should rarely need GI anaemia pathway.

3. Young people (<50), and blood donors with low ferritin alone and normal Hb are extremely unlikely to have GI cause and may need no testing or just TtG. Older ones may be offered FiT. There is no NICE recommendation on low ferritin with a normal Hb.

4. For the low risk patients with anaemia and negative FiT, watchful waiting should be purposeful - it generally requires treatment with adequate oral iron for at least three months to ensure that Hb comes back into normal range and iron stores are filled. It is suggested that the patient has repeat ferritin and Hb at 3 and 6 months after adequate treatment. Recurrent IDA is often due to inadequate treatment. If anaemia recurs or does not resolve despite adequate treatment, then consider referral to gastroenterology to consider bidirectional endoscopy.

5. Patients >50 with rectal bleeding qualify for 2ww referral irrespective of anaemia.

6. CT colonography is an acceptable means of ruling out bowel cancer as an alternative to colonoscopy and may be offered as an option form straight to test triage.

7. Urgent 2ww OPA is preferable to direct access endoscopy if age >80 or major organ dysfunction/frailty or patient wishes.

8. Calprotectin should not be used for diagnosis in people >50 – use FiT instead (Calprotectin can be used in monitoring known IBD in older patients).

9. This pathway takes into account all NICE guidance + Commissioning advice and Letter from NHC Cancer team and the York faecal calprotectin pathway.

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Acknowledgements

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• **Dr John Painter** Gastroenterologist Sunderland Royal Hospital NHS Trust. NCA Upper GI Cancer Clinical Lead
• **NCA Colorectal EAG members**
• **NCA Cancer in the Community Group members**

• Enquiries to:
• **Dr Katie Elliott** NCA Primary Care Clinical Lead [katieelliott@nhs.net](mailto:katieelliott@nhs.net)

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