Colorectal Cancer Safety Netting in Primary Care

Background

Many patients present to primary care with bowel and/or abdominal symptoms. NICE provides guidance about which patients we should be investigating and referring - NG12 and DG30.

However, there is a growing body of evidence regarding the use of **FIT** (Faecal Immunochemical Test) as a valid and reliable triage tool for colorectal cancer, better than any symptoms. This presents a significant opportunity to spare patients unnecessary colonoscopies and ensure that the most urgent patients are investigated most quickly.

In July 2022 the British Society of Gastroenterology (BSG) and the Association of Coloproctology of Great Britain & Ireland (ACPGBI) published a NICE accredited joint guideline on use of FIT in symptomatic patients. NHSE letters to Primary Care in October 2022 asked for the recommendations in the BSG/ACPGBI guidance to be implemented in full, including the requirement that patients with a FIT <10, with normal full blood count and no ongoing clinical concerns are not referred on a LGI urgent pathway but instead managed in primary care or referred on an alternative pathway.

What is changing in Wessex?

In line with the evidence, from 9th January 2023, the colorectal cancer pathways are changing throughout Wessex:

1. **The two week wait referral form has been updated**
- The new form is in line with national guidance making FIT ≥ 10 the main referral criterion unless the patient has an unexplained abdominal, rectal or anal mass/ulceration.
- Patients with new IDA should be considered for urgent referral and investigations regardless of FIT result. Please refer to details of your local IDA service (where available)
- The new form retains the ability for referral where there is concern about colorectal cancer even if FIT < 10 or patient is unable or unwilling to do a FIT test, or the result is delayed.

2. **Provision of a secondary care FIT < 10 pathway**
- This is a pathway that primary care can refer into for patients with NG12 symptoms but who have FIT <10, where the GP is not happy to safety net in primary care.

What is the risk of FIT < 10 missing colorectal cancer in patients without abdominal, rectal or anal masses/ ulceration?

As with any other test, how well FIT performs depends on the overall risk of colorectal cancer of the individual patient.
Patients with NG12 symptoms have a colorectal cancer risk of around 3%.

Patients with DG30 symptoms have a colorectal cancer risk of around 1%.
FIT <10 can potentially fail to pick up 10% of colorectal cancers.

Therefore in NG12 patients (including those with rectal bleeding) a single FIT < 10 may miss 0.3% of patients with colorectal cancer.
In DG30 patients, FIT <10 may miss 0.1% of patients with colorectal cancer.

Additionally evidence shows that NG12 patients with 2 FIT <10 have a 0.04% risk of colorectal cancer.

Important to remember

1. **Bowel screening -** uses FIT but at a different threshold (120 not 10). **Do not rely on a negative bowel screening test in a symptomatic patient.**
2. **Don't forget that patients with abdominal/ bowel symptoms and FIT < 10 may have cancer of another site** e.g. ovary, pancreas. Remember to consider the Rapid Investigation Service for non-specific symptoms where there is concern about cancer
3. **FIT does risk assess patients with rectal bleeding**

When will primary care need to safety net for possible colorectal cancer?

1. **When patients present with symptoms that could be colorectal cancer (**NG12 and DG30**)**.
   Primary Care now needs to take a full history and examination including rectal examination and arrange blood tests (FBC, U&Es) and FIT test before deciding whether the patient needs two week wait referral, FIT < 10 pathway referral or Primary Care safety netting. Systems need to be in place to safety net receipt of the FIT test and blood results
2. **When a FIT ≥ 10 result is received.**
   Primary Care will need to contact the patient, make a two week wait referral and ensure the patient attends.
3. **When a FIT < 10 result is received on a patient with NG12 symptoms.**
   Primary Care will need to decide with the patient whether to refer on the FIT < 10 pathway or to manage the patient in primary care with repeat FBC and FIT test at 8 weeks. Safety netting needs to be in place to ensure the tests are done and that the patient knows when and who to contact if symptoms are changing. If repeat FIT ≥ 10 contact patient and refer on two week wait.
4. **When a FIT <10 result is received on a patient with DG30 symptoms.**
   Primary Care needs to inform the patient and provide information about when to seek help if symptoms are not settling or are getting worse.

Suggestions for safety netting colorectal cancer in primary care

1. **When a FIT test has been requested**
   - Code FIT test requested in the notes (tick box in Ardens Symptoms analyser) and run a practice report regularly looking for patients where no result has been received within 14 days

- Use of scheduled task as a reminder to look for the results- this could be by the individual clinician, cancer care coordinator or specific admin team
- Use of AccuRx to prompt patient to do the tests

2. When a FIT ≥ 10 result has been received

- A report can be run regularly by the practice looking for patients with FIT ≥ 10 who have not been referred via two week wait.
- A report can be run by the practice to identify patients referred via two week wait where no correspondence has been received from the hospital 4 weeks after referral.
- Use of scheduled tasks by the clinician, Cancer Care Coordinator or specific administrative team to ensure patient has attended.
- Use of AccuRx to check patient attendance.

3. When a FIT < 10 result is received on a patient with NG12 symptoms

- Primary Care will need to make contact with the patient to decide whether to refer on FIT < 10 pathway or to arrange follow up FIT test and FBC in primary care.
- Primary Care also needs to consider whether the patient may have symptoms/ signs of a non-GI cancer and act as clinically appropriate.
- A scheduled task at 6 weeks could be set up by the clinician, cancer care coordinator or specific admin team to remind the patient to have the necessary repeat testing and further task set to ensure results received.
- AccuRx could be used to remind the patient to have the tests done and scheduled task to check results received.
- All patients should receive information about when to seek help.

4. FIT < 10 result received on a patient with DG30 symptoms

- Primary Care needs to let the patient know the result, consider whether the patient has any symptoms/ signs suggestive of a non-GI cancer acting as clinically appropriate. Provide the patient with information about when to seek further medical advice if symptoms worsen/ don't settle.