# Optimal care pathway for people with colorectal cancer

## Quick reference guide

**Please note that not all patients will follow every step of this pathway:**

Support: Assess supportive care needs at every step of the pathway and refer to appropriate health professionals or organisations.

### Step 1

**Prevention and early detection**

**Prevention:**

- eating a healthy diet, including plenty of vegetables, fruit and whole grains while minimising intake of red meat and processed meat
- maintaining a healthy body weight
- exercising regularly
- avoiding or limiting alcohol intake
- not smoking.

**Early detection:**

- Average risk
- No personal history of colorectal cancer, adenoma or chronic inflammatory bowel disease, or
- No more than one close relative diagnosed at age 55 or older.

**Screening recommendations:**

- If over 50 years, screen every two years using a faecal occult blood test (FOBT)
- Participation in the National Bowel Cancer Screening Program recommended if eligible.

**Increased or high risk – refer to the colorectal optimal care pathway for screening recommendations.**

### Step 2

**Presentation, initial investigations and referral**

**The following signs and symptoms should be investigated:**

- positive FOBT
- passage of blood with or without mucus in the faeces
- unexplained iron deficiency anaemia
- change in bowel habit (loose stools or constipation)
- undiagnosed abdominal pain
- unexplained rectal or abdominal mass
- unexplained weight loss
- the presence of multiple signs and symptoms.

**Positive screening test: All patients with a positive FOBT should be referred for a colonoscopy within four weeks.**

**Initial investigations include:**

- physical examination
- digital rectal examination
- blood tests including iron studies.

Test results should be provided to the patient within one week.

**Referral:** If symptoms suggest cancer, the patient should be referred for a colonoscopy within four weeks.

**Communication – lead clinician to:**[1]

- explain to the patient/carer who they are being referred to and why
- support the patient/carer while waiting for specialist appointments.

### Step 3

**Diagnosis, staging and treatment planning**

**Diagnosis and staging:**

- For colon cancer
  - Computed tomography (CT) scan of the chest, abdomen and pelvis
  - Whole-body fluoro-deoxyglucose positron emission tomography (FDG PET) (if suspected limited metastatic disease)
- For rectal cancer:
  - CT scan of chest, abdomen and pelvis
  - Local staging with magnetic resonance imaging (MRI) and/or endoscopic rectal ultrasound

**Treatment planning:** All newly diagnosed patients should be discussed by a multidisciplinary team. Patients with rectal cancer should be discussed prior to surgery.

**Research and clinical trials:** Consider enrolment where available and appropriate.

**Communication – lead clinician to:**

- discuss a timeframe for diagnosis and treatment with the patient/carer
- explain the role of the multidisciplinary team in treatment planning and ongoing care
- provide appropriate information or refer to support services as required.

1 Lead clinician – the clinician who is responsible for managing patient care.
The lead clinician may change over time depending on the stage of the care pathway and where care is being provided.

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## Step 4

**Treatment:**

Establish intent of treatment:

- curative
- anti-cancer therapy to improve quality of life and/or longevity without expectation of cure
- symptom palliation.

**Surgery:**

- Surgery is frequently recommended for patients with colorectal cancer.
- Surgeons should have adequate qualifications and expertise, especially those undertaking rectal surgery.

**Radiation therapy may benefit people with:**

- high-risk rectal cancer for whom adjuvant preoperative (or less commonly post-operative) radiation therapy is recommended
- symptomatic non-resectable locally advanced cancer who may benefit from radiation with palliative intent.

**Chemotherapy or drug therapy may benefit people with:**

- a high risk of relapse
- locally advanced rectal cancer, treated with neoadjuvant chemo-radiation
- non-resectable locally advanced or metastatic disease.

**Palliative care:** Early referral to palliative care can improve quality of life and in some cases survival. Referral should be based on need, not prognosis.

**Communication – lead clinician to:**

- discuss treatment options with the patient/carer including the intent of treatment as well as risks and benefits
- discuss advance care planning with the patient/carer where appropriate
- discuss the treatment plan with the patient's general practitioner.

For detailed information see http://www.nhmrc.gov.au/guidelines/publications/cp106

## Step 5

**Care after initial treatment and recovery**

Cancer survivors should be provided with the following to guide care after initial treatment.

**Treatment summary (provided to the patient, carer and general practitioner) outlining:**

- diagnostic tests performed and results
- tumour characteristics
- type and date of treatment(s)
- interventions and treatment plans from other health professionals
- supportive care services provided.

**Follow-up care plan (provide a copy to patient/carer and general practitioner) outlining:**

- medical follow-up required (tests, ongoing surveillance)
- care plans for managing the late effects of treatment
- a process for rapid re-entry to medical services for suspected recurrence.

**Communication – lead clinician to:**

- explain the treatment summary and follow-up care plan to the patient/carer
- inform the patient/carer about secondary prevention and healthy living
- discuss the follow-up care plan with the patient's general practitioner.

## Step 6

**Managing recurrent, residual and metastatic disease**

**Detection:** Most residual or recurrent disease will be detected via routine follow-up or by the patient presenting with symptoms.

**Treatment:** Where possible, refer the patient to the original multidisciplinary team. Treatment will depend on the location and extent of disease, previous management and patient preferences.

**Palliative care:** Early referral to palliative care can improve quality of life and in some cases survival. Referral should be based on need, not prognosis.

**Communication – lead clinician to:**

- explain the treatment intent, likely outcomes and side effects to the patient/carer.

## Step 7

**End-of-life care**

**Palliative care:** Consider referral to palliative care if not already involved. Ensure that an advance care plan is in place.

**Communication – lead clinician to:**

- be open about the prognosis and discuss palliative care options with the patient
- establish transition plans to ensure the patient's needs and goals are addressed in the appropriate environment.

Visit www.cancerpathways.org.au for consumer friendly guides. Visit www.cancer.org.au/OCP for the full clinical version and instructions on how to import these guides into your GP software.