Colorectal cancer

This resource has been developed as part of the Implementing PAthways for Cancer Early Diagnosis (I-PACED) project supported by the Victorian Government. It aims to increase GP awareness about critical primary care points as outlined in the colorectal cancer Optimal Care Pathway – a nationally endorsed resource.

Summary statistics
- In Victoria 2018, there were 2,141 new cases of colorectal cancer in males and 1,801 new cases in females.
- The five-year survival for people with colorectal cancer is 69%.

Prevention
- Promote eating a healthy diet, including plenty of vegetables, fruit and whole grains while minimising intake of red meat and processed meat.
- Exercising regularly.
- Maintaining a healthy body weight.
- Avoiding or limiting alcohol intake.
- Avoiding smoking.
- Low dose aspirin (100–300 mg per day) should be actively considered as chemoprevention for all people aged 50–70 years.
  - Overall use of aspirin results in fewer deaths and incidents from colorectal cancer, heart attack and stroke, however there is increased risk of bleeding from the stomach and gut, which is greater in men than women.
  - Aspirin is recommended for at least 2.5 years, commencing at age 50 to 70 years.

Screening Recommendations

For average risk:
- If over 50 years, screen every 2 years using a faecal occult blood test (FOBT), until 74 years of age.
- Encourage participation in the National Bowel Cancer Screening Program for eligible patients.

Assessment of symptomatic patient
- Physical examination including digital rectal examination.
- Assess risk of cancer based on signs, symptoms and initial tests (see Figure 1):
  - Initial tests: FBC, Iron + FOBT.
  - Recent onset of symptoms in patients >40yrs should be viewed with a higher degree of suspicion.
  - Colonoscopy within 28 days if positive FOBT or symptoms suggest CRC.

Figure 1: Is colonoscopy the right screening test?

Outcomes for average risk population, without symptoms

- 100,000 people have a FOBT
- 92,700 test negative
- Colonoscopy
- 260 have bowel cancer
- 46 have bowel cancer
- 12 die from bowel cancer
- 7 die from bowel cancer
- 19 deaths
- 10 bleeds
- 5 perforations

- 100,000 people have no screening
- 7,300 test positive
- 291 have bowel cancer
- 15 have bowel cancer
- 13 die from bowel cancer
- 60 die from bowel cancer
- 23 deaths
- 140 bleeds
- 68 perforations

References:
Figure 2: Expected frequency tree\textsuperscript{3}
Showing the effects of aspirin on the incidence events and mortality, over 10 years of taking aspirin, for at least five years in Australian women aged 50-70 years

Figure 3: Expected frequency tree\textsuperscript{3}
Showing the effects of aspirin on the incidence events and mortality, over 10 years of taking aspirin, for at least five years in Australian men aged 50-70 years

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Figure 4: **Australian guidelines for colorectal cancer screening by family history, 2017.**

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>AGE OF UNAFFECTED PATIENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>25 30 35 40 45 50 55 60 65 70 75 80</td>
</tr>
<tr>
<td>No FDR / SDR with CRC</td>
<td>iFOBT EVERY 2YRS</td>
</tr>
<tr>
<td>One FDR / one FDR &amp; one SDR with CRC diagnosed at 55 or over (consider iFOBT from age 45 years)</td>
<td>LIFETIME RISK 5-15%</td>
</tr>
<tr>
<td>RR 0.9 - 2</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>One FDR with CRC diagnosed before age 55 years</td>
</tr>
<tr>
<td>Two FDR / one FDR and at least two SDR diagnosed with CRC at any age</td>
<td>LIFETIME RISK 15-30%</td>
</tr>
<tr>
<td>RR 3 - 6</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>At least three FDR diagnosed with CRC at any age</td>
</tr>
<tr>
<td>At least three FDR or SDR with CRC, with at least one before age 55</td>
<td>LIFETIME RISK 30-40%</td>
</tr>
<tr>
<td>RR 7 - 10*</td>
<td></td>
</tr>
<tr>
<td>SUSPECTED OR KNOWN MUTATION</td>
<td>COLONOSCOPY EVERY 5 YRS</td>
</tr>
<tr>
<td>For Lynch syndrome, screening from age 25 or 5 years younger than the youngest affected family member if less than 30 yrs. Recommendations vary for other syndromes</td>
<td></td>
</tr>
<tr>
<td>AUSTRALIAN POPULATION</td>
<td>COLONOSCOPY EVERY 1 - 2 YRS</td>
</tr>
<tr>
<td>LIFETIME RISK 5% 7%</td>
<td></td>
</tr>
</tbody>
</table>

**Risk over the next 10 years**

<table>
<thead>
<tr>
<th>WOMEN</th>
<th>MEN</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 in 1390</td>
<td>1 in 1350</td>
</tr>
<tr>
<td>1 in 370</td>
<td>1 in 303</td>
</tr>
<tr>
<td>1 in 125</td>
<td>1 in 87</td>
</tr>
<tr>
<td>1 in 57</td>
<td>1 in 36</td>
</tr>
</tbody>
</table>

The Optimal Care Pathways were developed through consultation with a wide range of expert multidisciplinary teams, peak health organisations, consumers and carers. They are nationally endorsed by the National Cancer Expert Reference Group, Cancer Australia and Cancer Council Australia.

For more information on the Optimal Care Pathways please refer to www.cancervic.org.au/for-health-professionals/optimal-care-pathways

### Referral pathways

- Prior to referral, discuss the cost implications to enable patients to make an informed decision regarding their choice of specialist and health service, including out of pocket costs: for example, radiological tests and specialist appointments.
- Refer to the 2017 Colonoscopy guidelines on information from GP referrals used to determine urgency at: www2.health.vic.gov.au/about/publications/policiesandguidelines/colonoscopy-categorisation-guidelines
- For information about colorectal cancer specialists, see bowlcanceraustralia.org/find-a-specialist

Local referral process and proformas can be found at:

To gain access to your local HealthPathways visit https://vtphna.org.au/care-pathways-and-referral/ or equivalent care pathways site.

### Patient resource checklist

- Explain to patient/carer why these test are being performed, what the next steps are and who they are being referred to and why.
- For additional practical and emotional support, encourage patients to call Cancer Council 13 11 20 to speak with an experienced oncology nurse or visit www.cancervic.org.au for more information about colorectal cancer.
- For translator assistance call TIS on 13 14 50
- Download the “What to expect – Colorectal cancer” guide at www.cancerpathways.org.au
- Bowel Cancer Australia – for free information packs, support and resources, visit bowlcanceraustralia.org or freecall 1800 555 494

### Reference:


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**Figure 5: Risk assessment tool**

<table>
<thead>
<tr>
<th>Constipation</th>
<th>Diarrhoea</th>
<th>Rectal bleeding</th>
<th>Weight loss</th>
<th>Abdominal pain</th>
<th>Abnormal tenderness</th>
<th>Abnormal rectal exam</th>
<th>Haemoglobin 10-13 g/dL</th>
<th>Haemoglobin &lt; 10 g/dL</th>
<th>PPV as a single symptom</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.4</td>
<td>0.9</td>
<td>2.4</td>
<td>1.2</td>
<td>1.1</td>
<td>1.1</td>
<td>1.5</td>
<td>0.9</td>
<td>2.3</td>
<td>PPV as a single symptom</td>
</tr>
<tr>
<td>0.8*</td>
<td>1.1</td>
<td>2.4</td>
<td>3.0</td>
<td>1.5</td>
<td>1.7</td>
<td>2.6</td>
<td>1.2</td>
<td>2.6</td>
<td>Constipation</td>
</tr>
<tr>
<td></td>
<td>1.5*</td>
<td>3.4</td>
<td>3.1</td>
<td>1.9</td>
<td>2.4</td>
<td>11</td>
<td>2.2</td>
<td>2.9</td>
<td>Diarrhoea</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4.7</td>
<td>3.1</td>
<td>4.5</td>
<td>8.5</td>
<td>3.6</td>
<td>3.2</td>
<td>3.2</td>
<td>Rectal bleeding</td>
</tr>
<tr>
<td></td>
<td></td>
<td>6.8*</td>
<td>3.4</td>
<td>6.4</td>
<td>7.4</td>
<td>1.3</td>
<td>4.7</td>
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<td></td>
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<td>3.0*</td>
<td>1.4</td>
<td>3.3</td>
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<td>6.9</td>
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<td>Abdominal pain</td>
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<td></td>
<td></td>
<td></td>
<td>1.7*</td>
<td>5.8</td>
<td>2.7</td>
<td>&gt;10</td>
<td></td>
<td>Abdominal tenderness</td>
</tr>
</tbody>
</table>

Probability of cancer

- <1%
- 1-2%
- 2-5%
- >5%

*Second presentation

**Figure 5** shows the probability of colorectal cancer for individual symptoms and pairs of symptoms, including second presentation* of same symptom. For example, the probability of colorectal cancer for rectal bleeding alone is 2.4%, but rectal bleeding combined with an abnormal rectal exam increases the probability to 8.5%. Two separate episodes of rectal bleeding have a probability of 6.8%.