BEYOND A GUT FEELING

Driving Investigations for Colorectal Cancer

RACGP CPD Approved Activity

Educational Activities	Measuring Outcomes	Reviewing Performance
1 hours	4 hours	4 hours

RACGP Activity ID: 919365

ACRRM CPD ACCREDITED ACTIVITY 2023-2025

ACRRM Activity ID: TBD

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Bowel Cancer AUSTRALIA

This educational activity was developed by Lateral Connections at the request of and with funding from Bowel Cancer Australia

Date of preparation: July 2024

INTRODUCTORY EXERCISE

This program has been developed based on the recommendations in the National Health and Medical Research Council (NHMRC) endorsed **'Clinical practice guidelines for the prevention, early detection and management of colorectal cancer: The symptomatic patient' (https://app.magicapp.org/#/guideline/noPKwE/section/LrveBW).**

Colorectal (bowel) cancer (CRC) continues to have considerable burden on Australians, with **97,754 years of healthy life lost due to CRC in 2022.** Further to this, the incidence of early-onset colorectal cancer (EOCRC) is increasing globally, with CRC being the **deadliest cancer for Australians aged 25 to 44.**

Approximately **75% of bowel cancers are diagnosed symptomatically.** GPs play a key role in managing patient presentations, screening for CRC and referring patients for further investigation. It is recommended that individuals experiencing any symptoms of CRC (including **blood in stool, blood in toilet bowl, changes in appearance or consistency of stool, abdominal pain, unexpected weight loss, fatigue,** etc.,) consult their general practitioner for appropriate investigation. Patients should be encouraged to discuss any symptoms with their GP or healthcare professional, even if they may consider them related to other conditions or lifestyle factors (including haemorrhoids, food intolerances or some medications).

Review the **'Clinical practice guidelines for the prevention, early detection and management of colorectal cancer: Consensus-based colonoscopy triage categories' (https://app.magicapp.org/#/guideline/noPKwE/section/Ea0DlP)** and identify the appropriate colonoscopy triage category (tick the relevant box):

Altered bowel habit for more than 6 weeks, 40–60 years old and no other GI symptoms	☐ Category 1 ☐ Category 2 ☐ Category 3 ☐ Category 4
Anaemia and all of: • **No GI symptoms** • **Negative immunochemical faecal blood test (iFOBT)** • **No likely non-GI cause identified**	☐ Category 1 ☐ Category 2 ☐ Category 3 ☐ Category 4
Unexplained abdominal pain and any one of: • **Rectal bleeding** • **Unexplained weight loss** • **Positive iFOBT**	☐ Category 1 ☐ Category 2 ☐ Category 3 ☐ Category 4

PREDISPOSING QUESTIONS

Please answer these questions before undertaking this audit.

1. **How familiar do you consider yourself to be with the red-flag symptoms for colorectal cancer (CRC)?**

   ☐ Very familiar ☐ Somewhat familiar ☐ Neutral ☐ Not very familiar ☐ Not familiar

2. **When seeing patients presenting with symptoms potentially suggestive of CRC, how often do you provide them with written educational materials?**

   ☐ Always ☐ Most of the time ☐ Sometimes ☐ Occasionally ☐ Never

3. **How familiar do you consider yourself to be with the recommendations for screening and diagnostic procedures for CRC?**

   ☐ Very familiar ☐ Somewhat familiar ☐ Neutral ☐ Not very familiar ☐ Not familiar

4. **How accessible do you consider yourself to be with respect to your rapport with patients who may be experiencing gastrointestinal signs and symptoms?**

   ☐ Very accessible ☐ Somewhat accessible ☐ Neutral ☐ Not very accessible ☐ Not accessible

5. **How familiar do you consider yourself to be with the baseline risk factors for CRC?**

   ☐ Very familiar ☐ Somewhat familiar ☐ Neutral ☐ Not very familiar ☐ Not familiar

6. **Approximately one quarter of EOCRC patients present with rectal bleeding.**

   ☐ True ☐ False

LEARNING OUTCOMES & AUDIT OUTLINE

The learning outcomes of this program have been developed to support your discussions with patients presenting with signs and symptoms potentially associated with colorectal cancer.

LEARNING OUTCOMES

Identify signs and symptoms potentially associated with colorectal cancer (CRC).

Apply the consensus-based colonoscopy triage categories in practice.

Create practice-based systems for recalls to support timely diagnosis and continuity of care.

CASE FINDING ACTIVITY

Use your practice systems and processes to access patient data for **three patients** presenting with signs and symptoms potentially associated with CRC.

PATIENT CONSULTATION NOTES

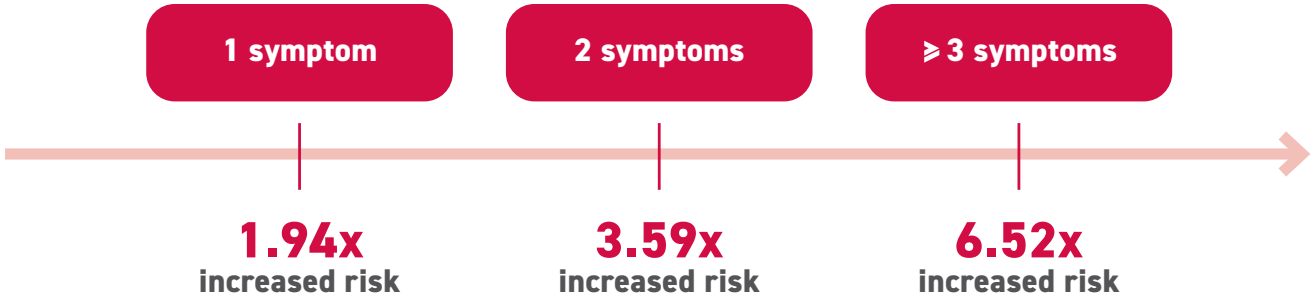
Record your interactions with these patients you selected for the audit, considering their general medical care, recommendations and referrals, and any preventative advice provided.

Investigate symptoms early to optimise outcomes

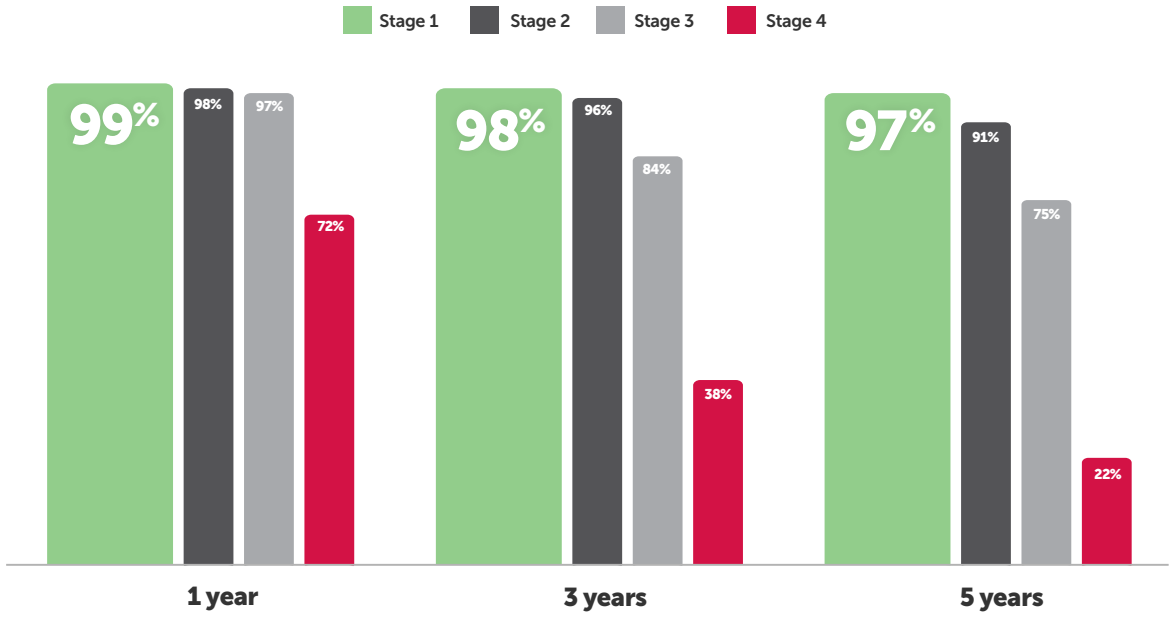
A recent study found that over a third of patients with CRC had taken more than 3 months from developing symptoms to seeing a hospital specialist.[1] There are four **red-flag symptoms associated with an increased risk** of early-onset colorectal cancer (EOCRC):[2]

- Abdominal pain
- Rectal bleeding
- Diarrhoea
- Iron deficiency anaemia

Patients with these symptoms were associated with increased risk of EOCRC ($p < 0.001$):[3]



Patients presenting later with more advanced stages of disease can be more challenging to treat, whilst nearly all colorectal cancer cases can be treated successfully when detected early: relative survival in patients <50 years old was as high as 99% for patients diagnosed at Stage 1.[4]



In addition, the existing government-funded screening program contributes to reducing morbidity and mortality from CRC in Australia through early detection.[5] **GPs are important stakeholders in educating people on the need to screen** for CRC from age 40.

Patients should be encouraged to discuss any symptoms with their GP or other healthcare professional, even if they may consider them related to other conditions or lifestyle factors (including haemorrhoids, food intolerances or some medications). GPs should consider full blood count, iron studies and iFOBT as part of their assessment of patients in primary care.

Handling objections

iFOBT are available through pharmacies at a low cost to patients. Patients generally consider iFOBT to be non-invasive and are willing to participate when informed. Patients view GPs as a key first contact and a credible source of advice. A recent study showed a **17% increase in iFOBT screening uptake by patients eligible for the NBCSP following active recommendation from their GP.**[6]

Patients may share concerns about colonoscopy-related complications or harms. GPs should reassure patients regardless of age that the potential reduction in mortality from screening outweighs the risk of colonoscopy-related harms.[7]

GPs should explain to patients that even those who have **'low risk but not no risk'** symptoms may still be at risk of CRC. If colonoscopy is not conducted (either due to not meeting criteria, or due to patient hesitancy), patients should be reviewed by their GP and reconsider the need for investigation following any changing or new signs or symptoms.[8]

Risk reduction

Australian data shows that more than half of CRC burden in 2018 was attributable to the **combined impact of modifiable risk factors.**[9] GPs can educate, guide and support patients to make behavioural changes to reduce their CRC risk.[10]

Healthy lifestyle is associated with lower CRC incidence. An integration of healthy lifestyle with endoscopic screening may substantially enhance prevention for CRC, compared to endoscopic screening alone.[11]

Normal body weight

Meeting at least 3 dietary suggestions

Daily vigorous exercise

None-to-moderate alcohol intake

No or low smoking history

The benefit in risk reduction was **incremental for each additional healthy lifestyle factor.**

Risk reduction through lifestyle has ongoing benefit for patients who are diagnosed with CRC. For both early and late-onset CRC patients, those with poorer baseline health-related quality of life have poorer cancer outcomes.[12]

References: 1. Lacey K, et al. Med J Aust 2016 Jul 18;205(2):66-71 **2.** Fritz C, et al. J Natl Cancer Inst. 2023;115(8):909-916. **3.** Alese, OB, et al. Am Soc Clin Oncol Educ Book (2023) 43:e389574. **4.** National Cancer Control Indicators. Relative survival by stage at diagnosis (colorectal cancer). Available at https://ncci.canceraustralia.gov.au/outcomes/relative-survival-rate/relative-survival-stage-diagnosis-colorectal-cancer. **5.** Australian Institute of Health & Welfare. National Bowel Cancer Screening Program monitoring report 2023. Available at https://www.aihw.gov.au/reports/cancer-screening/nbcsp-monitoring-2023/summary. **6.** McIntosh JG, et al. Br J Gen Pract. 2024;74(741):e275-e282. **7.** Ko CW, Sonnenberg A. Gastroenterology. 2005;129(4):1163-1170. **8.** Cancer Council Australia. Clinical practice guidelines for the prevention, early detection and management of colorectal cancer: Signs & symptoms predictive of CRC. September 2023. Available at https://app.magicapp.org/#/guideline/noPKwE/section/j96wpN. **9.** Australian Institute of Health & Welfare. Australian Burden of Disease Study: Methods and supplementary material 2018. Available at https://www.aihw.gov.au/reports/burden-of-disease/abds-methods-supplementary-material-2018/contents/about. **10.** RACGP Guidelines for preventative activities in general practice. 9th edition. **11.** Wang K, et al. PLoS Med. 2021;18(2):e1003522. **12.** Downing A, et al. J Clin Oncol. 2015;33(6):616-624).

RECORD OF PATIENT INTERACTIONS

Complete this audit for **three patients presenting with signs and symptoms potentially associated with CRC.**

You may select patients who are presenting for the first time or are a follow-up visit requiring further investigation.

Record your interactions with these patients you selected for the audit.

ENSURE THAT YOUR NOTES HERE ARE DE-IDENTIFIED AND UNIDENTIFIABLE.

PATIENT 1

Describe the signs and symptoms that the patient presented with. Were any of these symptoms considered red-flag symptoms for CRC?

What alternative aetiologies were considered and/or investigated?

List the patient's relevant medical history and any predisposing factors (e.g. Lynch syndrome, family history) that could increase this patient's risk of CRC. Were these discussed with the patient during your interaction?

Describe any primary prevention measures (dietary and lifestyle strategies or chemopreventative agents) which have been adopted by this patient. Did you recommend any additional dietary and lifestyle strategies to reduce CRC risk?

RECORD OF PATIENT INTERACTIONS (CONTINUED)

PATIENT 1 (CONTINUED)

What recommendations or referrals did you make for this patient? Describe how and when will recall be conducted.

Was the patient indicated for colonoscopy?

☐ Yes ☐ No

If yes, what category was your referral? *Hint: you may wish to refer to 'Clinical practice guidelines for the prevention, early detection and management of colorectal cancer: Consensus-based colonoscopy triage categories'* **(https://app.magicapp.org/#/guideline/noPKwE/section/EaODlP).**

Did patient costs associated with diagnostic tests/procedures enter the discussion? Were costs considered a barrier to referral? Expand on how you handled the discussion on cost.

Reflect on ways in which you communicated with the patient to not alarm them of suspected potential cancer.

PATIENT 1 (CONTINUED)

Evidence suggests that written materials are considered helpful by patients. Were any written resources provided to the patient and/or carer?

☐ Yes ☐ No

If yes, what written resources were provided?

What was the outcome of the diagnostic test(s)? Please state if not yet available.

If the patient was aged under 50 at presentation, reflect on what aspects of your discussion differed to a similar presentation in older patient cohorts? Conversely, if the patient was aged over 50, how would you have adapted your discussion to a younger patient?

Delayed CRC diagnosis is associated with poorer clinical outcomes. Reflect on ways in which your interaction with the patient facilitated timely investigations. Could this have been improved?

☐ Yes ☐ No

If yes, how?

RECORD OF PATIENT INTERACTIONS

Complete this audit for **three patients presenting with signs and symptoms potentially associated with CRC.**

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Record your interactions with these patients you selected for the audit.

ENSURE THAT YOUR NOTES HERE ARE DE-IDENTIFIED AND UNIDENTIFIABLE.

PATIENT 2

Describe the signs and symptoms that the patient presented with. Were any of these symptoms considered red-flag symptoms for CRC?

What alternative aetiologies were considered and/or investigated?

List the patient's relevant medical history and any predisposing factors (e.g. Lynch syndrome, family history) that could increase this patient's risk of CRC. Were these discussed with the patient during your interaction?

Describe any primary prevention measures (dietary and lifestyle strategies or chemopreventative agents) which have been adopted by this patient. Did you recommend any additional dietary and lifestyle strategies to reduce CRC risk?

PATIENT 2 (CONTINUED)

What recommendations or referrals did you make for this patient? Describe how and when will recall be conducted.

Was the patient indicated for colonoscopy?

☐ Yes ☐ No

If yes, what category was your referral? *Hint: you may wish to refer to 'Clinical practice guidelines for the prevention, early detection and management of colorectal cancer: Consensus-based colonoscopy triage categories'* **(https://app.magicapp.org/#/guideline/noPKwE/section/EaODlP).**

Did patient costs associated with diagnostic tests/procedures enter the discussion? Were costs considered a barrier to referral? Expand on how you handled the discussion on cost.

Reflect on ways in which you communicated with the patient to not alarm them of suspected potential cancer.

PATIENT 2 (CONTINUED)

Evidence suggests that written materials are considered helpful by patients. Were any written resources provided to the patient and/or carer?

☐ Yes ☐ No

If yes, what written resources were provided?

What was the outcome of the diagnostic test(s)? Please state if not yet available.

If the patient was aged under 50 at presentation, reflect on what aspects of your discussion differed to a similar presentation in older patient cohorts? Conversely, if the patient was aged over 50, how would you have adapted your discussion to a younger patient?

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RECORD OF PATIENT INTERACTIONS

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Record your interactions with these patients you selected for the audit.

ENSURE THAT YOUR NOTES HERE ARE DE-IDENTIFIED AND UNIDENTIFIABLE.

PATIENT 3

Describe the signs and symptoms that the patient presented with. Were any of these symptoms considered red-flag symptoms for CRC?

What alternative aetiologies were considered and/or investigated?

List the patient's relevant medical history and any predisposing factors (e.g. Lynch syndrome, family history) that could increase this patient's risk of CRC. Were these discussed with the patient during your interaction?

Describe any primary prevention measures (dietary and lifestyle strategies or chemopreventative agents) which have been adopted by this patient. Did you recommend any additional dietary and lifestyle strategies to reduce CRC risk?

PATIENT 3 (CONTINUED)

What recommendations or referrals did you make for this patient? Describe how and when will recall be conducted.

Was the patient indicated for colonoscopy?

☐ Yes ☐ No

If yes, what category was your referral? *Hint: you may wish to refer to 'Clinical practice guidelines for the prevention, early detection and management of colorectal cancer: Consensus-based colonoscopy triage categories'* **(https://app.magicapp.org/#/guideline/noPKwE/section/EaODlP).**

Did patient costs associated with diagnostic tests/procedures enter the discussion? Were costs considered a barrier to referral? Expand on how you handled the discussion on cost.

Reflect on ways in which you communicated with the patient to not alarm them of suspected potential cancer.

PATIENT 3 (CONTINUED)

Evidence suggests that written materials are considered helpful by patients. Were any written resources provided to the patient and/or carer?

☐ Yes ☐ No

If yes, what written resources were provided?

What was the outcome of the diagnostic test(s)? Please state if not yet available.

If the patient was aged under 50 at presentation, reflect on what aspects of your discussion differed to a similar presentation in older patient cohorts? Conversely, if the patient was aged over 50, how would you have adapted your discussion to a younger patient?

Delayed CRC diagnosis is associated with poorer clinical outcomes. Reflect on ways in which your interaction with the patient facilitated timely investigations. Could this have been improved?

☐ Yes ☐ No

If yes, how?

REINFORCING ACTIVITY

Please answer these questions after undertaking this audit.

1. **In future, when seeing patients presenting with signs and symptoms potentially associated with CRC, how often will you consider referral for colonoscopy based on triage categories?**

   ☐ Always ☐ Most of the time ☐ Sometimes ☐ Occasionally ☐ Never

2. **Having completed this activity, how familiar are you in your knowledge of the red-flag symptoms for CRC?**

   ☐ Very familiar ☐ Somewhat familiar ☐ Neutral ☐ Not very familiar ☐ Not familiar

3. **Having completed this activity, how confident are you in your ability to address hesitancy or objections from patients related to screening via iFOBT or colonscopy?**

   ☐ Very confident ☐ Somewhat confident ☐ Neutral ☐ Not very confident ☐ Not confident

4. **Having completed this activity, how often will you provide written education about lifestyle changes to patients?**

   ☐ Always ☐ Most of the time ☐ Sometimes ☐ Occasionally ☐ Never

5. **Having completed this activity, how confident are you in your ability to adapt your approach to handling patient presentations in younger cohorts, compared to older patients? (i.e. based on age of the patient)**

   ☐ Very confident ☐ Somewhat confident ☐ Neutral ☐ Not very confident ☐ Not confident

CLOSING REFLECTION

Outline how you can actively create systems to recall patients who have been referred for further investigation.

Consider any patients previously treated by you who presented with similar signs and symptoms, but you did not consider potential CRC. How would you consider handling these patients differently?

The National Bowel Cancer Screening Program (NBCSP) recommends routine screening for people without symptoms from age 45. What are the barriers to eligible people without symptoms participating in screening?

Practical implementation: List opportunistic ways in which you can increase uptake by eligible people without symptoms to screen for CRC (i.e. participate in the National Bowel Cancer Screening Program from age 45).

Where to go for more information

Bowel Cancer Australia Helpline 1800 727 336 during business hours, Monday to Friday.

Australian Dietary Guidelines

http://www.eatforhealth.gov.au

EVALUATION OF PROGRAM

Please rate to what degree the learning outcomes of the program were met:

Identify signs and symptoms potentially associated with colorectal cancer (CRC).	Not met ☐	Partially met ☐	Entirely met ☐
Apply the consensus-based colonoscopy triage categories in practice.	Not met ☐	Partially met ☐	Entirely met ☐
Create practice-based systems for recalls to support timely diagnosis and continuity of care.	Not met ☐	Partially met ☐	Entirely met ☐

Please rate to what degree this CPD activity met your expectation about:

Content: Current, contemporary, evidence-based, and relevant to general practice	Not met ☐	Partially met ☐	Entirely met ☐
Delivery: Engaging/interactive, e.g., with opportunity for questions and feedback.	Not met ☐	Partially met ☐	Entirely met ☐

Comments:

Would you likely recommend this CPD activity to a colleague?

☐ Yes ☐ No Why?

Would you likely change anything in your practice as a result of this CPD activity?

☐ Yes ☐ No Why?

EVALUATION OF PROGRAM

General comments and feedback:

Quality improvement is an integral component of the RACGP CPD Program. If you have a concern about the quality of this activity, please submit your feedback online to your local RACGP office.

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