

Managing Post-Treatment Care in Colorectal Cancer



RACGP Activity ID: 914028



ACRRM Activity ID: 33995

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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: Psychosocial care**' (<https://app.magicapp.org/#/guideline/noPKwE/section/Lwr715>).

Colorectal (bowel) cancer (CRC) continues to have considerable burden on Australians, with **97,754 years of healthy life lost due to CRC in 2022**. Patients report on some of the limitations associated with their care post-CRC treatment, including feeling isolated and unequipped as they continue their journey adapting to life post-cancer. In addition to a perceived barrier to contacting specialist clinicians for support, patients perceive that GPs have insufficient expertise in dealing with post-CRC treatment needs.

Resources provided to CRC patients in the immediate post-treatment period generally relate to reducing the risk of recurrence and **may not specifically focus on supportive care and the management of short- and long-term treatment effects**. CRC is a highly specialised area requiring allied health professionals such as dietitians and pelvic floor therapists. Healthcare providers with expertise in managing CRC-treatment effects could **offer context-specific strategies to promote functional recovery**.

Using existing tools to support quality outcomes, GPs can play a greater role in coordinating post-treatment care and connecting patients with appropriate support. Please reflect on your practice to **complete the table below** regarding the roles that specialist support services and professional networks can provide to CRC patients:

Role	Do you have the following services in your referral network? (Yes/No)	Describe the perceived/actual barriers to access (e.g. cost, distance, language, etc.)
Exercise physiologist	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Stomal therapy nurse	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Pelvic floor therapist	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Dietitian	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Psychologist	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Fertility specialist	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Social worker	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Occupational therapist	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Patient support organisation	<input type="checkbox"/> Yes <input type="checkbox"/> No	

PREDISPOSING QUESTIONS

Please answer these questions before undertaking this audit.

1. In general, how familiar do you consider yourself to be with the healthcare providers who have knowledge in CRC (e.g. psychologists with expertise in cancer survivorship) in your geographical area?

Very familiar Somewhat familiar Neutral Not very familiar Not familiar

2. When seeing patients who are in the post-treatment stage of CRC, how often do you provide education about post-treatment care?

Always Most of the time Sometimes Occasionally Never

3. How accessible do you consider yourself to be with respect to your rapport with your post-treatment CRC patients?

Very accessible Somewhat accessible Neutral Not very accessible Not accessible

4. CRC survivors report poorer physical function, depression and health-related quality of life than the general population, with specific unmet needs related to sexual dysfunction, fatigue, pain, and bowel control.

How familiar do you consider yourself to be with the psychosocial impacts unique to younger patient cohorts (i.e., patients in the post-treatment stage of early onset CRC)?

Very familiar Somewhat familiar Neutral Not very familiar Not familiar

5. How familiar are you with CRC and its treatment?

Very familiar Somewhat familiar Neutral Not very familiar Not familiar

The learning outcomes of this program have been developed to support your discussions with patients/ carers who are being or have been treated for CRC.

LEARNING OUTCOMES

Identify specialist and allied health services which support post-treatment CRC patients.

Describe the physical, mental and social impacts of post-treatment CRC, including any perceived barriers to care.

Create practice-based systems for recalls to address subsequent management of post-treatment CRC patients.

CASE FINDING ACTIVITY

Use your practice systems and processes to access patient data for one patient diagnosed with CRC. You may select a patient who is receiving ongoing treatment for CRC or has completed treatment and is in remission for CRC.

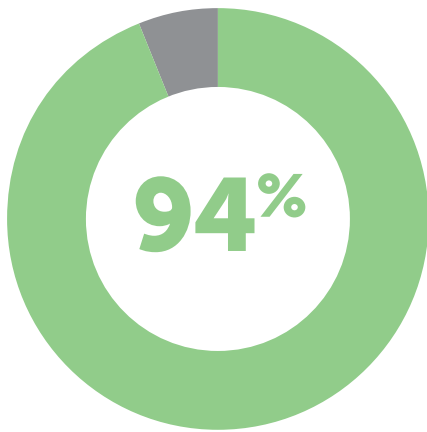
PATIENT CONSULTATION NOTES

Record your interactions with the patient you selected for the audit, considering their general medical care, psychosocial support and any preventative advice provided.

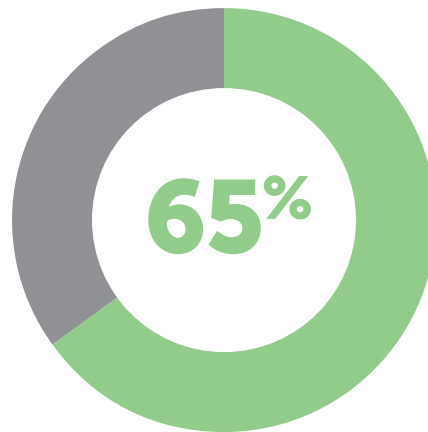
Survivorship in colorectal (bowel) cancer (CRC)

CRC survivors report poorer **physical function, depression** and **health-related quality of life** than the general population, with specific unmet needs related to sexual dysfunction, fatigue, pain and bowel control.¹ Later stage diagnosis is associated with poorer patient outcomes.^{2,3} Patients diagnosed with **earlier staging** may require lower intensity treatments and experience less severe post-treatment effects.

Post-treatment effects are common in people who have CRC. Common physical challenges include bowel issues, including frequent bowel movements or inability to defer. Impaired physical functioning is ongoing:²



94% of patients
experience some form
of bowel dysfunction at
12 months post-treatment



65% of patients
experience some form
of bowel dysfunction at
3 years post-treatment

Patients who have received stomas face additional challenges.

There is a unique cross-section between patient-specific cancer characteristics, treatment, post-treatment effects and overall health-related quality of life. Factors associated with **increased risk of developing depression** among people with CRC include:⁴

Radiotherapy

**Poor physical,
cognitive or social
functioning**

**Difficulties with
personal care and
communication**

Post-treatment in primary care: assumptions and gaps

Many recommendations and resources, including those coordinated or provided by specialists, focus on reducing CRC recurrence. GPs can coordinate ongoing monitoring through examination, colonoscopy or other diagnostic tests at follow-up. However, post-treatment care must be tailored to ensure best patient outcomes; people with cancer continue to experience **high levels of unmet need for psychosocial care**.⁵ Early onset CRC is associated with psychosocial **impacts unique to younger cohorts**, specifically exercise, self-image and relationships, and fertility.⁶

Most CRC patients report that their GP played a minimal role in managing their cancer post-treatment.¹ However, GPs self-report that they feel they may not be provided with sufficient information to best support the patient at the point of transition back to primary care.⁷

GPs report that their role in post-treatment CRC management involves interpreting complex medical terminology, explaining risk and providing guidance.⁷ Several trials have shown that cancer survivors can be safely and effectively managed by GPs.⁸

The GP is well placed to coordinate long-term follow-up by **acting as central care coordinator** and advocating for the patient. Key strategies which can be adopted by GPs include:

- Allow the patient to speak and drive interactions based on their self-identified needs
- Use a structured follow-up approach to prevent breakdowns in communication at the points of transitions of care
- Provide the right information at the right time: repeating patient education post-CRC treatment may be necessary
- Leverage existing frameworks such as a GP Management Plan (GPMP) or mental health treatment plan

GPs educate, guide and support patients to make behavioural changes⁹

Cancer survivors are a vulnerable group with increased risk of comorbid chronic conditions. **Up to two thirds of cancer survivors report ongoing unmet health needs**. Contemporary models of cancer care recognise the importance of managing comorbidities, due to their adverse impact on cancer survival.^{10,11}

Patients view GPs as a key first contact and a credible source of preventative advice. Follow-up should address healthy lifestyle behaviours including **maintaining a healthy diet, engaging in regular exercise, smoking cessation and limiting alcohol intake**. These behaviours are associated with improved quality of life and **decreased risk of cancer recurrence**.



CRC runs in some families due to inherited genetic mutations, including Lynch syndrome and familial adenomatous polyposis. GPs can refer patients to a genetics service after discussion with the patient.

References: 1. Rutherford C, et al. Support Care Cancer. 2023;31(5):255. 2. Ju A, et al. Iran J Colorectal Res. 2021;9(4):125-43. 3. Alese, OB, et al. Am Soc Clin Oncol Educ Book (2023) 43:e389574. 4. Gray NM, et al. Support Care Cancer 2014 Feb;22(2):307-14. 5. Sanson-Fisher R, et al. Cancer 2000 Jan 1;88(1):226-37. 6. Khoo AM, et al. Cancer Med. 2022;11(7):1688-1700. 7. Harris MF, et al. Aust Fam Physician. 2012;41(11):899-902. 8. Emery JD, et al. Nat Rev Clin Oncol. 2014;11(1):38-48. 9. RACGP Guidelines for preventative activities in general practice. 9th edition. 10. RACGP Position Statement: Cancer Survivorship Shared Care. May 2024. Available at <https://www.racgp.org.au/FSDEDEV/media/documents/Advocacy/RACGP-Position-statement-Cancer-survivorship-May-2024.pdf>. Accessed June 2024. 11. Sarfati D, et al. BMC Cancer. 2009;9:116.

RECORD OF PATIENT INTERACTION

Complete this audit for one patient:

Complete this audit for one patient who has been diagnosed with CRC. You may select a patient who is receiving ongoing treatment for CRC or has completed treatment and is in remission for CRC.

Record your interactions with this patient you selected for the audit.

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

What age group was the selected patient when they were diagnosed with CRC?

Under 30 30-49 50-64 65+

Data suggests that recall post-discharge from hospital would be beneficial to discuss ongoing problems or new issues that arose due to treatment and/or the cancer. In identifying this patient, did you recall the patient ?

Yes No

Describe your discussion with the patient or carer. Which physical, mental or social treatment effects were discussed?

Describe the nature of the interaction, including any formal assessment tools used. What resources did you turn to?

Evidence suggests that written materials are considered helpful by patients and repeating patient education post-CRC treatment may be necessary. Were any written resources provided to the patient and/or carer?

Yes No

If yes, what written resources were provided?

RECORD OF PATIENT INTERACTION (CONTINUED)

Identify the short-, medium- and long-term care goals for this patient. *E.g. short-term: managing nausea from chemotherapy; long-term: managing altered bowel habits sufficiently to return to work.*

Short-term:

Medium-term:

Long-term:

Is a GP Management Plan (GPMP) in place for this patient?

Yes No

If no, why not?

Did you refer the patient to any specialist or allied health service?

Yes No

Expand on the type of service suggested. Was expertise in managing CRC-treatment effects considered when selecting a healthcare provider?

RECORD OF PATIENT INTERACTION (CONTINUED)

Did costs associated with the services enter the discussion?

Yes No

Expand on how you handled the discussion on cost, including if costs were a barrier to referral.

If the patient was an early-onset CRC patient (aged under 50 at diagnosis), what aspects of your discussion differed to a similar presentation in older CRC patient cohorts?

Conversely, if the patient was aged over 50 at diagnosis, how would you have adapted your discussion to suit a younger patient?



REINFORCING ACTIVITY

Outline how you can actively create systems to recall patients in the post-treatment stage of CRC (i.e., using a GP Management Plan)?

List opportunistic ways in which you can identify and support CRC patients in managing post-treatment effects.
Hint: You may wish to consider patient support organisations, online support groups, or other patient-led initiatives.

What are the barriers to referring patients to specialist and allied health services?

How will you ensure your referral network of appropriate specialist or other support services is kept up to date?

CLOSING REFLECTION

Please answer these questions after undertaking this audit.

1. In future, when seeing patients in the post-treatment stage of CRC, how often will you opportunistically ask about their physical, mental and social post-treatment effects?

Always Most of the time Sometimes Occasionally Never

2. Having completed this activity, how familiar are you in your knowledge of the different types of post-treatment effects which impact patients with CRC?

Very familiar Somewhat familiar Neutral Not very familiar Not familiar

3. Having completed this activity, how confident are you in your ability to make referrals to healthcare providers with knowledge in CRC (e.g. psychologists with expertise in cancer survivorship) in your geographical area?

Very confident Somewhat confident Neutral Not very confident Not confident

4. Having completed this activity, how often will you provide written education about post-treatment CRC care 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 post-treatment effects to younger and older CRC patient cohorts? (i.e. based on age of the patient)

Very confident Somewhat confident Neutral Not very confident Not confident

Where to go for more information

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

Cancer Survivorship Shared Care Position Statement (RACGP)

<https://www.racgp.org.au/advocacy/position-statements/view-all-position-statements/clinical-and-practice-management/cancer-shared-care>

Factsheet: Improving care and support for cancer survivors (ACSC)

<https://www.petermac.org/component/edocman/acsc-factsheet-improvingcareandsupportforsurvivors/viewdocument/123?Itemid=0>

Factsheet: Follow-up of survivors of colorectal cancer (ACSC)

<https://www.petermac.org/component/edocman/acsc-hpfactsheet-colorectalcancer/viewdocument/128?Itemid=0>

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 specialist and allied health services which support post-treatment colorectal cancer (CRC) patients.	Not met <input type="checkbox"/>	Partially met <input type="checkbox"/>	Entirely met <input type="checkbox"/>
Describe the physical, mental and social impacts of post-treatment CRC, including any perceived barriers to care.	Not met <input type="checkbox"/>	Partially met <input type="checkbox"/>	Entirely met <input type="checkbox"/>
Create practice-based systems for recalls to address subsequent management of post-treatment CRC patients.	Not met <input type="checkbox"/>	Partially met <input type="checkbox"/>	Entirely met <input type="checkbox"/>

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

Content: Current, contemporary, evidence-based, and relevant to general practice	Not met <input type="checkbox"/>	Partially met <input type="checkbox"/>	Entirely met <input type="checkbox"/>
Delivery: Engaging/interactive, e.g., with opportunity for questions and feedback.	Not met <input type="checkbox"/>	Partially met <input type="checkbox"/>	Entirely met <input type="checkbox"/>

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?

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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