

# Early Diagnosis of Colorectal Conditions

Delays in the diagnosis of colorectal conditions is a growing cause of concern. These materials, developed by the Task Force on Early Diagnosis of Colorectal Conditions, were developed for three reasons:

1. To improve the quality of care of persons with colorectal conditions
2. To promote a consistent approach among various specialties, and
3. To reduce malpractice lawsuits for failure-to-diagnose.

We estimate that use of this protocol will prevent two out of three lawsuits for failure-to-diagnose colorectal cancer.

This packet, developed for use by primary care physicians, includes the following materials:

- Diagnostic Protocol: Early Diagnosis of Colorectal Conditions
- Notes
- Patient Handout: Understanding Your Lower Bowel Symptoms
- Improving Follow-up of Patients with Colorectal Conditions
- Avoiding Colorectal Cancer Lawsuits: Seven Reasons Why Doctors Get Sued

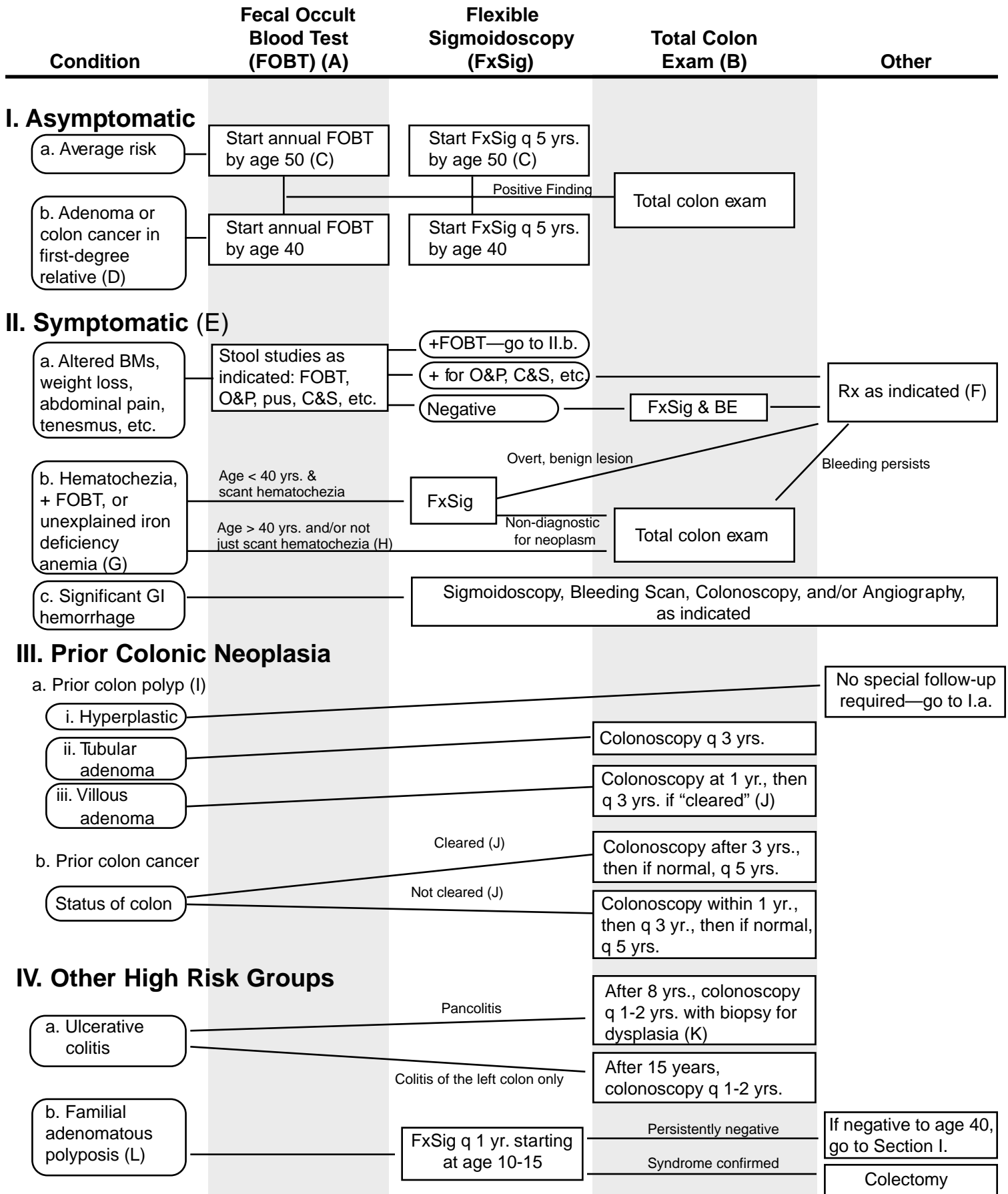
This protocol is intended to be a guideline and should not be considered a standard of care. We encourage you to adapt the protocol and accompanying materials according to your clinical judgment and organizational policies. When you do adapt the protocol, document your reasoning in the chart. These materials are not proprietary, and may be reproduced and used by any individual or organization, provided proper credit is given.

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This project is supported by educational grants from FPIC, Jacksonville, FL, and Frontier Healthcare, Bedford Hills, NY. If you have further questions, please contact Edward E. Bartlett, PhD, Coordinator, Early Diagnosis Steering Committee, P.O. Box 1404, Rockville, MD 20849. Telephone 301-670-1964, Internet [eba@intr.net](mailto:eba@intr.net).

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Letters in parentheses refer to Notes



# Notes

**A.** Hemoccult II (and similar guaiac-based testing) is ideally done on three successive stools. To minimize false-negative and false-positive results, proper dietary preparation is essential (see diet instructions on test kit). For this reason, the physician should avoid a random FOBT test done incidental to a routine physical exam. Because colonic bleeding is often intermittent, a single positive FOBT is considered a positive result.

Rehydration will increase both false positive and false negative results. The sensitivity is probably about 30-50% and specificity about 97%. HemoQuant, a fluorescent assay based on hemoglobin-derived porphyrin, in the study has a higher reported sensitivity (40-60%) but is more complex and may not add practical value.

**B.** Total colon examination may be accomplished using one of two approaches:

1. Colonoscopy *or*
  2. Flexible Sigmoidoscopy (Fxsig) plus Barium Enema (usually double contrast exam).
- Barium Enema (BE) and colonoscopy are complementary exams. If one procedure is not diagnostic, either reprep and repeat for a satisfactory exam or go to the alternative exam, especially if clinical suspicion is high. If colonoscopy is incomplete or anatomically infeasible, consider BE. If BE was done first and was negative, but signs or symptoms persist, colonoscopy is indicated.

**C.** Specialty guidelines vary greatly. Physicians are encouraged to study the available recommendations and modify their practice along the guidelines appropriate to their specialty.

**D.** Some recommend colonoscopy q 5 years as an alternative to FOBT or Flex Sig screening. Consider colonoscopy every 3-5 years starting at age 40 if two or more relatives were diagnosed with colonic neoplasia before age 55.

**E.** A high risk family history may indicate a more aggressive approach.

**F.** In symptomatic patients, a physician needs to follow through on these symptoms as indicated (e.g., weight loss may require thyroid profile, test of digestion or absorption if diarrhea present, upper tract exams, etc.). If symptoms persist and remain unexplained, colonoscopy may ultimately be required.

**G.** Unexplained Iron Deficiency Anemia--any male without documented cause (e.g., a multi-gallon blood donor with records) or post-menopausal female (natural or surgical menopause) requires investigation for GI tract source of iron

**H.** Use clinical judgment for isolated or scant hematochezia.

**I.** Colonoscopy is considered the standard for follow-up of colon polyps and colon cancer. Hyperplastic polyps are not precancerous and follow-up is not required. Adenomas or tubular adenomas are precancerous and the risk varies. If only a single, small lesion is found initially, the risk is low. If the polyps are large and numerous (six or more, all one cm. or greater in diameter), the risk is substantial. Villous or tubovillous adenomas pose the highest risk and follow-up is usually necessary at one year.

**J.** A colon has been "cleared" if the exam was complete to the cecum and the prep was adequate to allow the mucosa to be well-seen, and if there were no polyps or sessile masses left at the end of the procedure.

**K.** For severe dysplasia, consider repeat colonoscopy with biopsy vs. colectomy.

**L.** Familial adenomatous polyposis--an autosomal dominant trait that leads to adenomatous colon polyps and inevitably colon cancer. Genetic testing and counseling should be considered. Refer to standard textbooks or appropriate specialists regarding details of diagnosis and management of other rare syndromes:

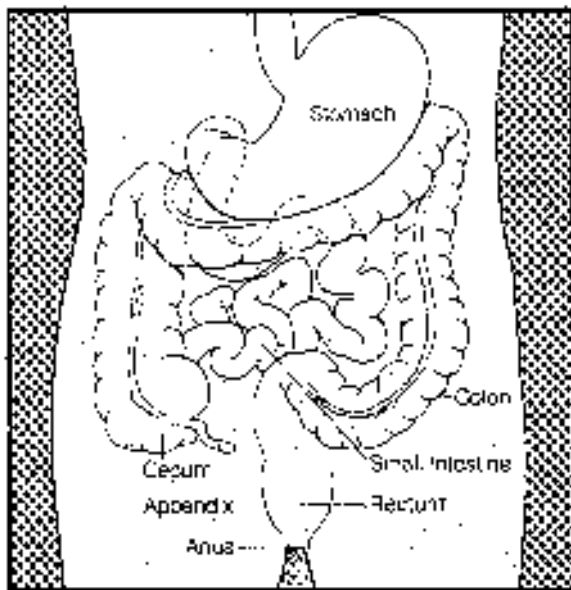
- Gardner's Syndrome--also an autosomal dominant disorder, produces adenomas of the colon, stomach, and peri-ampullary area, in addition to osteomas of the mandible, skull, and long bones and a variety of other benign tumors.
- Turcot's Syndrome--thought to be a recessive autosomal disorder with familial colonic polyposis and cancer as well as malignant brain tumors.
- Cancer Family Syndrome--includes members without colonic polyposis but with colon, female genital tract, and other cancers.
- Hereditary site-specific nonpolyposis colon cancer syndromes--also inherited disorders, but with the cancer in the same location within the colon (e.g., ascending colon) in successive generations.

## Understanding Your Lower Bowel Symptoms

Lower bowel symptoms--such as bleeding from your rectum, diarrhea, constipation, belly pain, or changes in the number of daily bowel movements--are common. Most bowel symptoms are not cancer, but only a careful evaluation can tell for sure. This handout explains how your doctor will evaluate your bowel symptoms.

### A look inside your lower

**bowel** Your lower bowel is a long, coiled, tubelike organ that twists and turns from the rectum to the small intestine--see diagram. The large bowel, also called the large intestine, is about 5-6 feet long. The purpose of the colon is to remove water from digested food. The remaining material, solid waste called "stool," moves through the colon to the rectum and leaves the body through the anus.



### What could be causing the bowel symptoms?

Reaching a diagnosis is often difficult because the symptoms may be vague and the exact cause can be located anywhere along the small or large intestines.

These are some of the conditions the doctor will be considering:

- Bleeding from the small intestines
- Hemorrhoids
- Diverticulitis
- Colitis (Ulcerative or Crohn's)
- Irritable Bowel Syndrome
- Polyps
- Cancer

### Could it be cancer?

Your doctor may need to consider the possibility of colorectal cancer. Risk factors for colorectal cancer include family history of polyps or cancer, being over 40 years old, history of breast cancer, or ulcerative colitis.

Colorectal cancer comes from pea-sized growths called "polyps." The polyps usually do not cause any symptoms, and do not always turn into cancer. We try to remove polyps whenever we see them. Like other forms of cancer, early detection improves the chances of survival.

### How does the doctor evaluate my symptoms?

Your doctor will evaluate your condition by asking you questions about your health history, doing a physical examination, and running certain tests. These are the tests that we can use:

- *Fecal occult blood test (FOBT)*

The patient places a stool specimen on a special card, which is examined for hidden blood. Most persons who have hidden blood do not necessarily have cancer.

- *Sigmoidoscopy*

We pass a long, thin tube up your rectum to actually see the inside of your rectum. The tube carries a tiny light and camera lens. We can see problems that occur within the first two feet of the colon (remember the colon is 5-6 feet long).

- *Barium enema*

We give you an enema of a white liquid that shows up on an X-ray. We rotate your body so any polyps are outlined by the X-ray. A barium enema, when done with sigmoidoscopy, is considered as good as colonoscopy.

- *Colonoscopy*

Similar to sigmoidoscopy, but the tube is long enough to reach the entire length of the colon. With colonoscopy, the doctor can also take out a small piece of tissue for a biopsy, or actually remove suspicious polyps. The patient receives medication to feel more comfortable.

These tests have very few complications. Each test has its own drawbacks and limitations. The skill of the examiner is also important:

- Several tests require you to follow a special preparation diet: FOBT, barium enema, and colonoscopy.
- For several procedures, the bowel is first cleaned out by an enema or laxative solution.
- With sigmoidoscopy and colonoscopy it may be hard to find

polyps or other problems that fall behind the folds of the colon or near the anus.

- A barium enema usually cannot see polyps smaller than the size of a pea.

- The tests might seem embarrassing, but most patients say the thought of the exam is worse than the experience itself.

### **What about screening tests?**

The American Cancer Society and many other organizations now recommend that people who are 50 years of age and not in a high risk group begin receiving a fecal occult blood test and digital rectal exam every year, and sigmoidoscopy every five years.

There are other recommendations, however. To decide what is right for you, talk it over with your doctor.

### **A final word...**

Colorectal symptoms can be bothersome and embarrassing. Some symptoms arise from two different conditions that happen to be affecting the colon at the same time. Because no test is perfect, the doctor may need to repeat certain tests. You will need to work closely with your doctor. Feel free to ask questions.

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## Improving Follow-Up of Patients with Colorectal Conditions

The diagnosis of colorectal symptoms typically requires multiple visits with different physicians. Thus, effective tracking methods are necessary to assure follow-up. These suggestions may help:

- Explain to the patient the importance of a shared responsibility—the patient needs to keep appointments and monitor symptoms.
- Patients should be advised of the results of all diagnostic studies, including negative findings, for a rule-out cancer diagnosis.
- Diagnostic reports should not be filed in the chart until the physician has reviewed and initialed them.
- When you send the patient for a consultation or diagnostic test, have your assistant call to schedule the appointment before the patient leaves. Fax the referral form and other pertinent documents. Schedule a repeat visit for about one week after the consultant's visit, to allow time for the report to be received.
- If authorization is needed from the managed care organization, go ahead and schedule the consultation visit or procedure anyway. If the MCO denies your request, advise the patient to obtain the consultation or test anyway, even at their own expense.
- If the patient misses an appointment, call to reschedule. If you cannot reach the patient in one or two calls, send a letter. If the patient repeatedly misses visits, you may need to discharge the patient from your practice.
- Establish a “tickler” system, such as:
  - A log sheet listing blood work/specimens sent out. The log sheet is reviewed weekly to identify missing reports.
  - Health flowsheet that indicates due dates for screening procedure.
  - A computerized reminder system that generates monthly follow-up reports, such as the one shown below:

ACCOUNT	GUARANTOR INFORMATION	TELEPHONES	PATIENT NAME	DCC	LAST V.	DUE DT.	REASON FOR RECALL
000001451	Joe Macy 18709 Old River Rd. Jacksonville, FL 32251	323-5555	Joe Macy	5	09/92	09/93	colon recall 1 yr.
000001317	John Smith 16092 Michell Dr. Jacksonville, FL 32335	624-9999	John Smith	5	01/96	12/96	colon 1 yr. recall
000005358	Thomas Brown 7012 Dancy Street Jacksonville, FL 32502	838-2323	Anne Brown	1	01/96	12/96	colon 1 yr. recall
000008410	Larry Luck RT 4 Box 2239 Palatka, FL 33277	382-1111	Larry Luck	3	04/96	12/96	colon 1 yr. recall
000003595	George Jones PO Box 1622 McClenny, FL 32134	729-0528 631-3782	Janet Jones	3	12/95	12/96	RTO recall