Guidelines for the Management of Colorectal Emergencies and for the Unexpected Diagnosis of Colorectal Cancer in Adults 2012
Version Control

This is a controlled document please destroy all previous versions on receipt of a new version.

Date Approved: June 2012  Review Date: June 2014

<table>
<thead>
<tr>
<th>Version</th>
<th>Date Issued</th>
<th>Review Date</th>
<th>Brief Summary of Change</th>
<th>Owner’s Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.0</td>
<td>October 2007</td>
<td>October 2007</td>
<td>Draft Guideline</td>
<td>Colorectal NSSG</td>
</tr>
<tr>
<td>1.1</td>
<td>October 2007</td>
<td>January 2008</td>
<td>Draft guidelines updated following consultation</td>
<td>Colorectal NSSG</td>
</tr>
<tr>
<td>1.2</td>
<td>January 2008</td>
<td>May 2010</td>
<td>Final Guideline</td>
<td>Colorectal NSSG</td>
</tr>
<tr>
<td>1.3</td>
<td>May 2010</td>
<td>December 2010</td>
<td>Updated following 2010 guideline review by NSSG</td>
<td>Colorectal NSSG</td>
</tr>
<tr>
<td>1.4</td>
<td>December 2010</td>
<td>May 2011</td>
<td>Amendments made to NSSG guidelines</td>
<td>Colorectal NSSG</td>
</tr>
<tr>
<td>1.5</td>
<td>Reissued May 2011</td>
<td>June 2012</td>
<td>Clarification of wording requested by Zonal Team for Peer Review</td>
<td>Colorectal NSSG</td>
</tr>
<tr>
<td>1.6</td>
<td>June 2012</td>
<td>June 2014</td>
<td>Main guidelines reviewed</td>
<td>Colorectal CEG</td>
</tr>
</tbody>
</table>

NEYHCA (Cancer) adheres to the Colorectal Clinical Expert Group (CEG) Guidelines which incorporates NICE Guidance. For the latest version of these guidelines please see the NEYHCA (Cancer) website. Please press control and click on the links below

http://www.hyccn.nhs.uk/NetworkGuidelinesAndPublications/ColorectalNSSG.htm

Signature Sheet

Agreement of the NEYHCA (Cancer) Colorectal CEG Emergency & Unexpected Diagnosis Guidelines

These guidelines have been agreed by:

<table>
<thead>
<tr>
<th>Title</th>
<th>Name</th>
<th>Date Agreed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chair of the Colorectal CEG</td>
<td>Mr James Gunn</td>
<td>June 2012</td>
</tr>
<tr>
<td>MDT Leads</td>
<td>HEYHT Mr Gunn</td>
<td>June 2012</td>
</tr>
<tr>
<td></td>
<td>NLGHFT Mr Pearson (Mr Sasapu from September 2012)</td>
<td>June 2012</td>
</tr>
<tr>
<td></td>
<td>NLGHFT Mr Ahmad</td>
<td>June 2012</td>
</tr>
<tr>
<td></td>
<td>SNEYHT Miss McNaught</td>
<td>June 2012</td>
</tr>
<tr>
<td>Chair, NEYHCA Board / NEYHCA Cancer Management Group</td>
<td>Mrs Allison Cooke</td>
<td>July 2012</td>
</tr>
<tr>
<td>The Colorectal CEG have agreed these guidelines</td>
<td></td>
<td>June 2012</td>
</tr>
</tbody>
</table>
Contents

Version Control ........................................................................................................................................ 2
Signature Sheet......................................................................................................................................... 2
Contents .................................................................................................................................................. 3

1. Scope of the Guideline ........................................................................................................................ 4
2. Emergency Admissions ..................................................................................................................... 4
3. Emergency Admissions Pathway ....................................................................................................... 5
4. Colorectal Stenting ............................................................................................................................ 6
5. Unsuspected Diagnosis of Colorectal Cancer .................................................................................. 6
   5.1 When an unsuspected colorectal cancer is detected on an endoscopic investigation ............. 6
   5.2 When an unsuspected colorectal cancer is detected on a radiological or pathological investigation ................................................................................................................................. 7
   5.3 When a clinical members of a team is informed that a patient under their care has, or is likely to have colorectal cancer ................................................................. 7
   5.4 Unexpected diagnosis of metastatic or recurrent colorectal cancer .......................................... 7
   5.5 The Colorectal MDT .................................................................................................................... 7

Appendix (i) MDT Meeting Timetable & Contact Information............................................................. 8
1. Scope of the Guideline

The Colorectal Clinical Expert Group has developed this document to provide a guideline for how to manage those adult patients admitted as a colorectal emergency with large bowel obstruction potentially due to colorectal cancer and how to managed patients who have an unexpected diagnosis of colorectal cancer.

This guideline applies both within & outside of normal working hours.

**This guideline applies to the following organisations**
- Hull & East Yorkshire Hospitals NHS Trust
- Northern Lincolnshire & Goole Hospitals NHS Foundation Trust
- Scarborough & North East Yorkshire Healthcare NHS Trust

**This guideline is aimed at**
- All Colorectal Surgeons
- All Upper GI Surgeons
- All Surgeons on the Surgical “Take” Rota
- All Gynaecologists
- All Physicians on the Medical “Take” Rota
- All Radiologists
- All Pathologists

2. Emergency Admissions

20% of colorectal cancer patients present through emergency admission usually with intestinal obstruction. These patients are often frail and elderly and peri-operative mortality is higher among this group so surgery in these patients should ideally occur during the day and by specialist surgeons and anaesthetists, (unless dealing with a perforation is necessary).

If it is practical and possible to do so colorectal cases admitted as emergencies should be stabilised and await treatment during the next working day with surgery being performed under the care of a core surgical MDT member, unless delay is life threatening, where the surgeon on call will attend.

If a core member is not available, the patient will be transferred to a hospital with a core MDT member if appropriate.

**ANY** Colorectal Cancer emergency following initial life saving management must be referred to the appropriate colorectal MDT for review and subsequent management.

When managing patients with a bowel obstruction, consideration should be given to the ACPGBI 2007 position statement on the Management of Malignant Large Bowel Obstruction, with particular regard to peri-operative management. This applies both within and outside normal working hours.

Consideration should also be given as to whether the patient is suitable for entry into the CREST RCT for Stenting.
The NEYHCA (Cancer) Colorectal CEG have considered the options for emergency surgery and have made the following recommendations:

- If it is practical and possible the surgery should be performed by a core surgical member of a colorectal MDT. If a patient is treated by a member of the general surgical on-call team then the MDT should be notified of the treatment and the patient should be discussed at the next available MDT.

- If it is practical and possible to do so there should be consultant to consultant discussion between the on-call surgical consultant and a core surgical member of the colorectal on-call team prior to treatment.

- All patients whether managed by a member of the Colorectal MDT or a member of the general surgical on-call team should be discussed at the next available MDT meeting to discuss and agree further management.

The Guidelines for the Management of Colorectal Emergencies and for the Unexpected Diagnosis of Colorectal Cancer in Adults are hosted electronically and can be accessed via the following weblink:

http://www.hyccn.nhs.uk/NetworkGuidelinesAndPublications/ColorectalNSSG.htm

3. Emergency Admissions Pathway

*If it is practical and possible surgery should be performed by a core surgical member of a colorectal MDT. If a patient is treated by a member of the general surgical on-call team then the MDT should be notified of the treatment and the patient should be discussed at the next available MDT.

** A stenting service should be available for the management of lower bowel obstructions for each MDT and there should be named personnel agreed by the CEG to perform colonic stents (see next section).
4. Colorectal Stenting

There should be a colorectal stenting service available to each MDT within NEYHCA (Cancer). The practice of colorectal stenting should be restricted by those agreed by the CEG as competent in this practice.

In patients with large bowel obstruction the insertion of an expanding stent is an acceptable treatment option where there is adequate local expertise. Stenting may be used either for palliation or as a bridge to surgery (ACGBI, 2007)

Consideration should be given as to whether the patient is suitable for entry into the CREST RCT.

The personnel agreed by the CEG as competent at colorectal stenting are listed below

- Hull & East Yorkshire Hospitals NHS Trust
  Dr James Cast, Consultant Radiologist

- Northern Lincolnshire & Goole Hospitals NHS Foundation Trust
  Mr S. Ahmad, Consultant Colorectal Surgeon (covering both MDTs at Grimsby and Scunthorpe)

- Scarborough & North East Yorkshire Healthcare NHS Trust
  Dr Ian Renwick, Consultant Radiologist

5. Unsuspected Diagnosis of Colorectal Cancer

The section applies to new diagnosis / distant or local recurrence / metastatic colorectal cancer.

A diagnosis of colorectal cancer can only be established by histology, or in the absence of tissue diagnosis, by evaluating all available evidence at the Local Colorectal MDT. Endoscopy is the preferred means of establishing a diagnosis of colorectal cancer.

This outlines the process by which the person generating the request is notified of the diagnosis.

It excludes

- All patients referred with the “urgent, suspicious of cancer”, fast-track arrangements
- All patients where examination has been requested in conjunction with a known or suspected malignancy
- All patients remain the clinical responsibility of the consultant or GP requesting the investigation until the referral is received by a colorectal MDT. The Consultant or GP requesting the investigation is responsible for communicating to the patient the results of the investigation (including suspicion / confirmation of cancer) and the onward referral to the Colorectal MDT.

5.1 When an unsuspected colorectal cancer is detected on an endoscopic investigation.

When an Endoscopist identifies an abnormality via endoscopic examination as a cancer and the examination does not fall into either of the above categories the endoscopist is responsible for

- Identifying the biopsy samples for urgent processing by the pathology department
- Urgently informing the referring clinician of the suspected diagnosis
- Informing the MDT co-ordinator of the patient’s details to enable tracking of the patient.
5.2 When an unsuspected colorectal cancer is detected on a radiological or pathological investigation.

The report should be treated as ‘urgent’ – the mechanism will vary between hospitals dependent upon the departmental operating policies and technology, e.g. voice recognition. The report will then be fast-tracked to the referring clinician – e.g. via fax, e-mail or the integrated electronic patient record.

A copy of the report should be sent to the appropriate MDT co-ordinator (Appendix 1). Depending upon the referrer and hospital infrastructure the relevant imaging, pathology or endoscopy report should, if possible, be made available to the appropriate MDT lead clinician (Appendix i).

It should be remembered that the referring clinician has a responsibility to ensure the report is acted upon.

5.3 When a clinical members of a team is informed that a patient under their care has, or is likely to have colorectal cancer.

The clinician is responsible for making an urgent referral of the patient on to the local colorectal cancer MDT via a named core member of the colorectal cancer MDT. The referral should be made within one working day of the diagnosis being made.

5.4 Unexpected diagnosis of metastatic or recurrent colorectal cancer.

If the diagnosis is made via radiological, pathological or endoscopic investigation the same processes as listed above should be followed and the patient referred rapidly to the Local Colorectal MD for discussion regarding management and treatment options.

5.5 The Colorectal MDT

The Colorectal Cancer MDT will

- Inform the patient of their diagnosis (if patient is not already aware)
- Discuss and evaluate the most appropriate treatment options
- Inform the GP within one working day of the patient’s diagnosis
- Allocate a key worker to the patient

The full colorectal cancer pathway is available in the NEYHCA (Cancer) Guidelines for the Management of Adult Patients with Colorectal Cancers version 3.6 June 2012
<table>
<thead>
<tr>
<th>Trust</th>
<th>Hull and East Yorkshire Hospitals NHS Trust (SMDT)</th>
<th>Scarborough and North East Yorkshire NHS Trust (LMDT)</th>
<th>Northern Lincolnshire and Goole Foundation NHS Trust (LMDT) x 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Location</td>
<td>Castle Hill Hospital</td>
<td>Scarborough General Hospital</td>
<td>Via video conferencing between Diana, Princess of Wales Hospital Grimsby and Scunthorpe General Hospital (&amp; Hull from w/c 9/2/9)</td>
</tr>
<tr>
<td>Arrangements for Specialist Care</td>
<td>HEHYT</td>
<td>HEYHT</td>
<td>HEYHT</td>
</tr>
<tr>
<td>Urgent Referral Fax</td>
<td>CHH / HRI: 01482 675505</td>
<td>SGH / Bridlington: 01724 342423</td>
<td>DPOW: 01472 302450 / SGH: 01472 387704</td>
</tr>
<tr>
<td>Day (weekly)</td>
<td>Thursday</td>
<td>Thursday</td>
<td>DPOW Wednesday / SGH Thursday</td>
</tr>
<tr>
<td>Time</td>
<td>8.00</td>
<td>9.00 – 10.00</td>
<td>830 - 1000</td>
</tr>
<tr>
<td>Lead Clinician / Phone Numbers</td>
<td>Mr. James Gunn / Sec: Claire Acey / Tel: 01482 672412 / 01482 622331 / Ms Mandie Bulmer / Ms Judy East / Bleep Switchboard 01482 875875</td>
<td>Miss Clare McNaught / Sec: Verity Darrell / Tel: 01723 342598 / Fax: 01723 342 471 / Ms Amanda Rowe / Ms Jean Campbell / Bleep Switchboard 01723 368111</td>
<td>Mr. Kishore Sasapu / Sec: Jayne Dannatt / Tel: 01472 875688 / Fax: 01472 875527 / Ms Carol Owen / Ms Louise Smith / Bleep Switchboard 01472 874111 / Ms Stacy Kirby / Ms Jill Doyle / Tel: 01723 385175 / Ext 3558 / Fax 01482 622375 / Tel: 01482 624345</td>
</tr>
<tr>
<td>CNSs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referring PCT / Population Approx Total Population</td>
<td>Hull Teaching PCT 262,400 East Riding of Yorkshire 337,000 Total 599,400</td>
<td>North Yorkshire &amp; York (old Scarborough, Whitby &amp; Ryedale) 162,000</td>
<td>North Lincolnshire: 157,200 North East Lincolnshire: 158,500 Total: 315,700</td>
</tr>
<tr>
<td>MDT Co-ordinators</td>
<td>Karolina Malewska / Angie Thompson / Tel: 01482 875875 Ext 3558 / Rebecca Sample / Tel: 01482 622375 / Fax 01482 624345</td>
<td>Ms Alison Meads / Tel: 01723 385175 / Fax 01723 385229</td>
<td>Ms Stacy Kirby / Ms Jill Doyle / Tel: 01472 875528 / Ext 7328 / Fax 01472 875527</td>
</tr>
<tr>
<td>Co-ordinators</td>
<td>Patient Trackers</td>
<td>Data Administrators</td>
<td></td>
</tr>
</tbody>
</table>