Colorectal cancer: are we any good?

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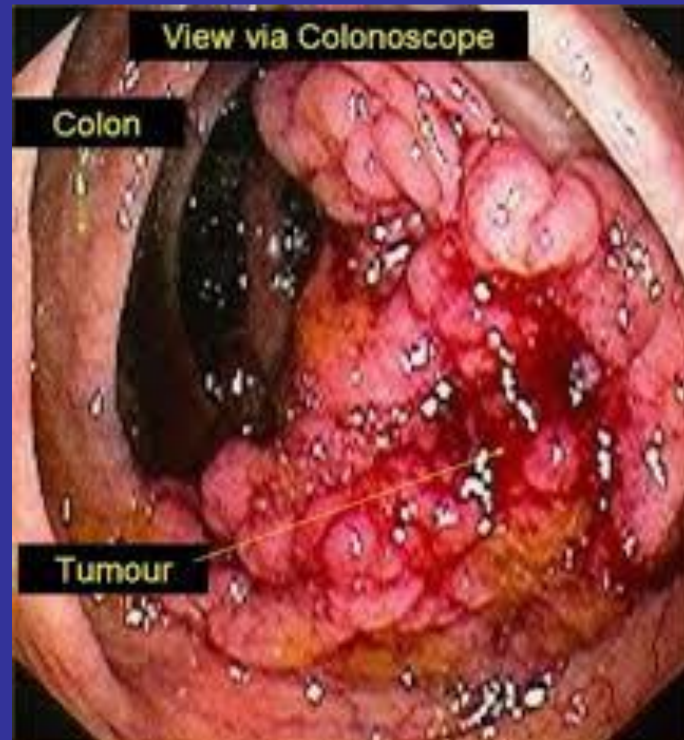
Private Consultations: BMI Hendon, BMI Cavell and HCA Wellington

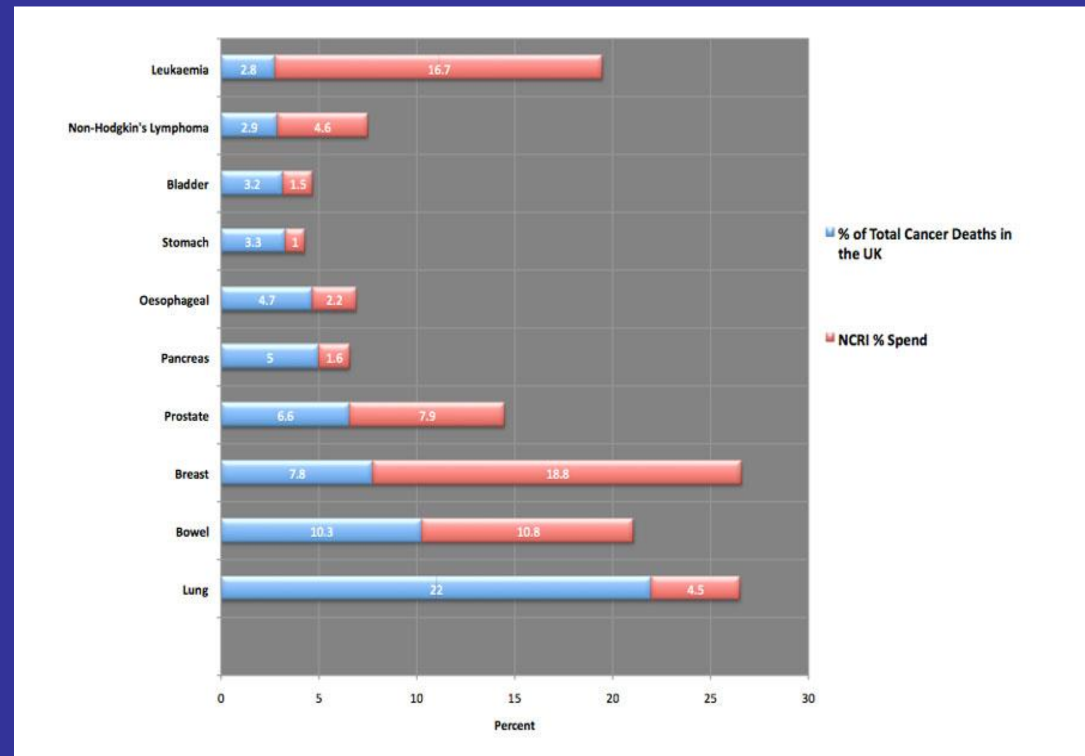
The next 45 minutes...

- Colorectal Cancer
- The problem
- Potential solutions!



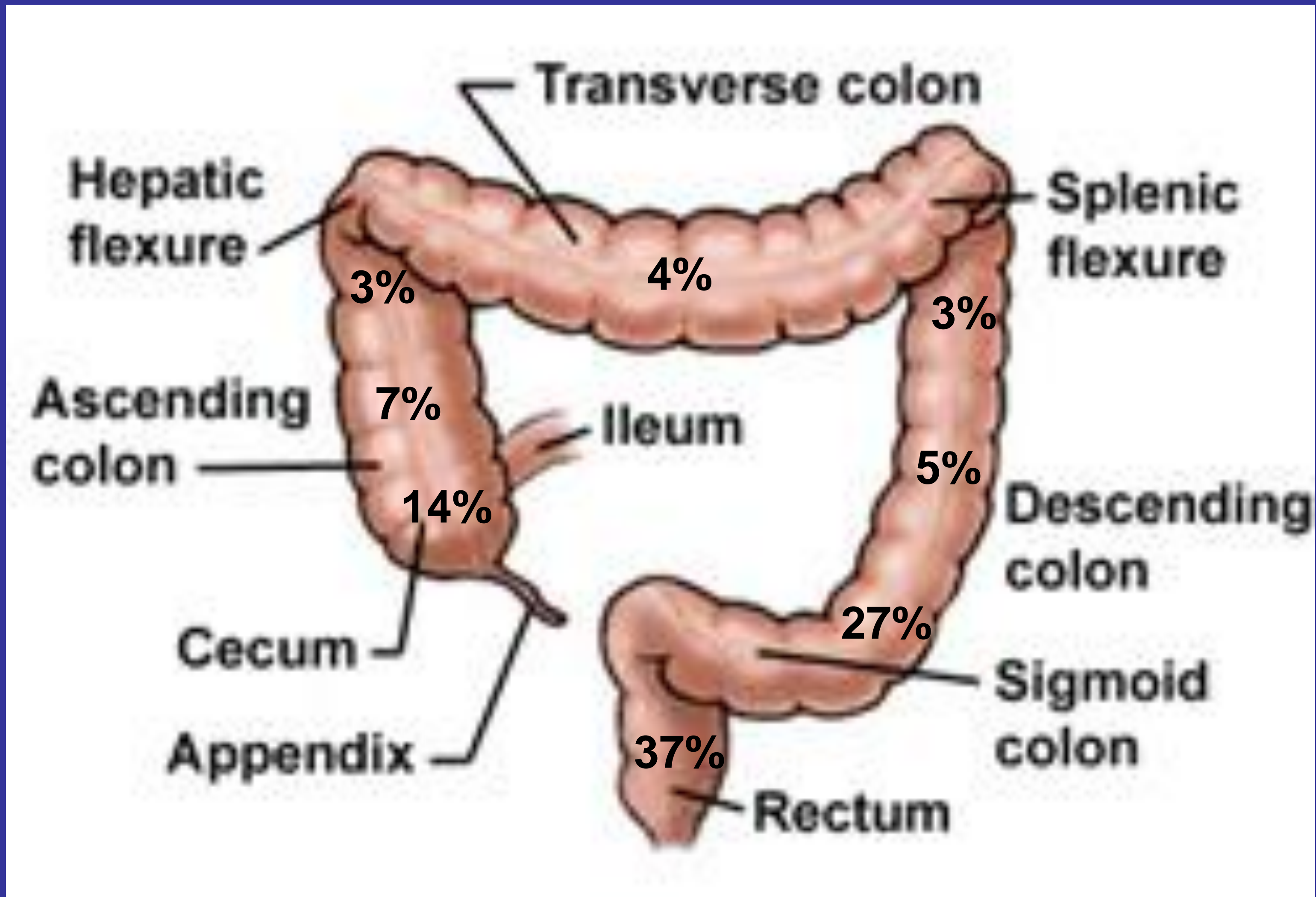
Colorectal Cancer

- 2nd most common cause cancer death
- 35,000 new cases/year
- 16-20,000 deaths
- 5 year survival 50%
  - (20% in 1970's)



Cancer Research UK 2008

Natural history



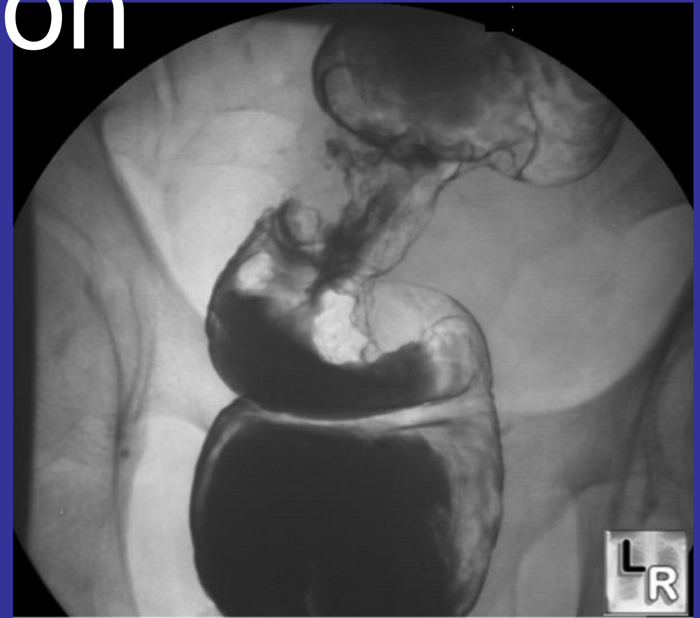
- Majority arise from adenomas
- Spread
  - Directly: into any surrounding structure
  - Lymphatic
  - Blood-borne: 37% have liver mets at time of surgery. Overall 50% will get liver mets. 10% lung mets

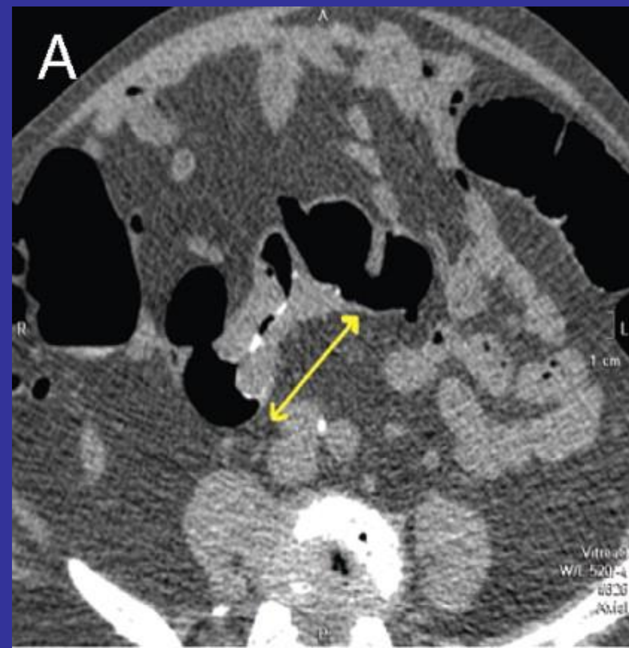
Aetiology

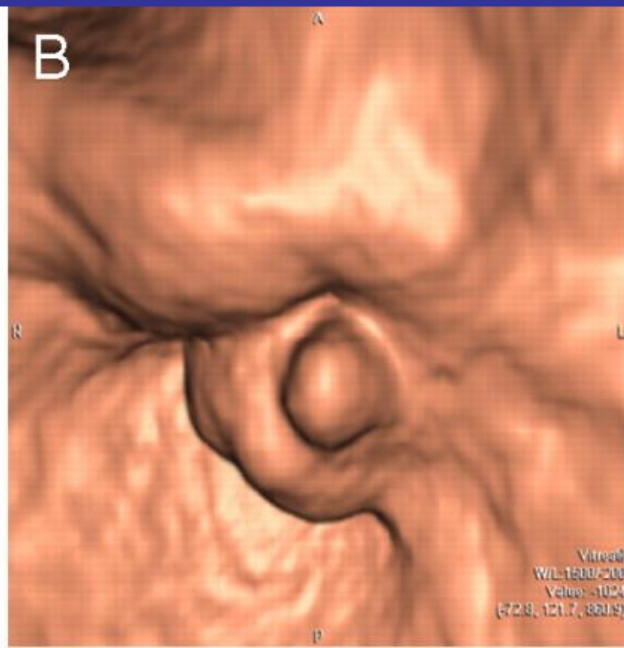
- World Cancer Research Fund
  - ↓risk: exercise, fibre, calcium, garlic, pulses
  - ↑risk: obesity, red meat, alcohol, animal fat, sugar, smoking
- Predisposing factors
  - Long-standing IBD
  - Previous gastric surgery

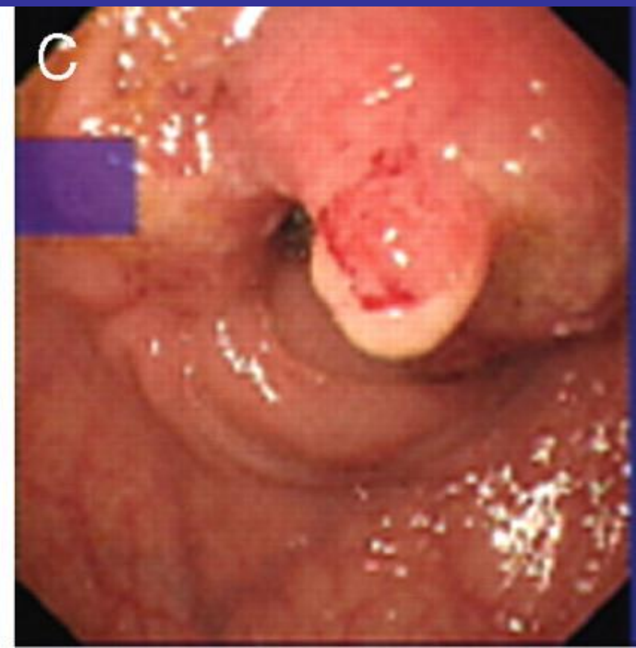
Investigation

- Barium Enema out dated
- CT VC polyps from 6mm
- Colonoscopy









Treatment

- Surgery
- Pre-op DXT for rectal cancer
- Post op chemo if advanced disease
- Liver resection where possible

Prognosis

- Dukes A 90% 5yr survival
- Dukes B 60% 5yr survival

This alone is an argument for early diagnosis

- Dukes C (node positive) 30% 5yr survival
- Liver mets : Few survive 1 yr unless has liver resection (40% 5yr survival)

Houston...we have a problem....

- Poor cancer outcomes
- Poor uptake of screening
- Delays at all points in diagnostic and treatment pathways

Survival

- 1 yr survival as measure of late diagnosis
- 5 yr survival as measure of quality of treatment

How do we compare?

- International comparisons show that UK has poorer survival from cancer in general than comparable Western countries (Coleman 2010)
- Much of that difference is explained by mortality in the first 3 months following diagnosis (Morris 2011)

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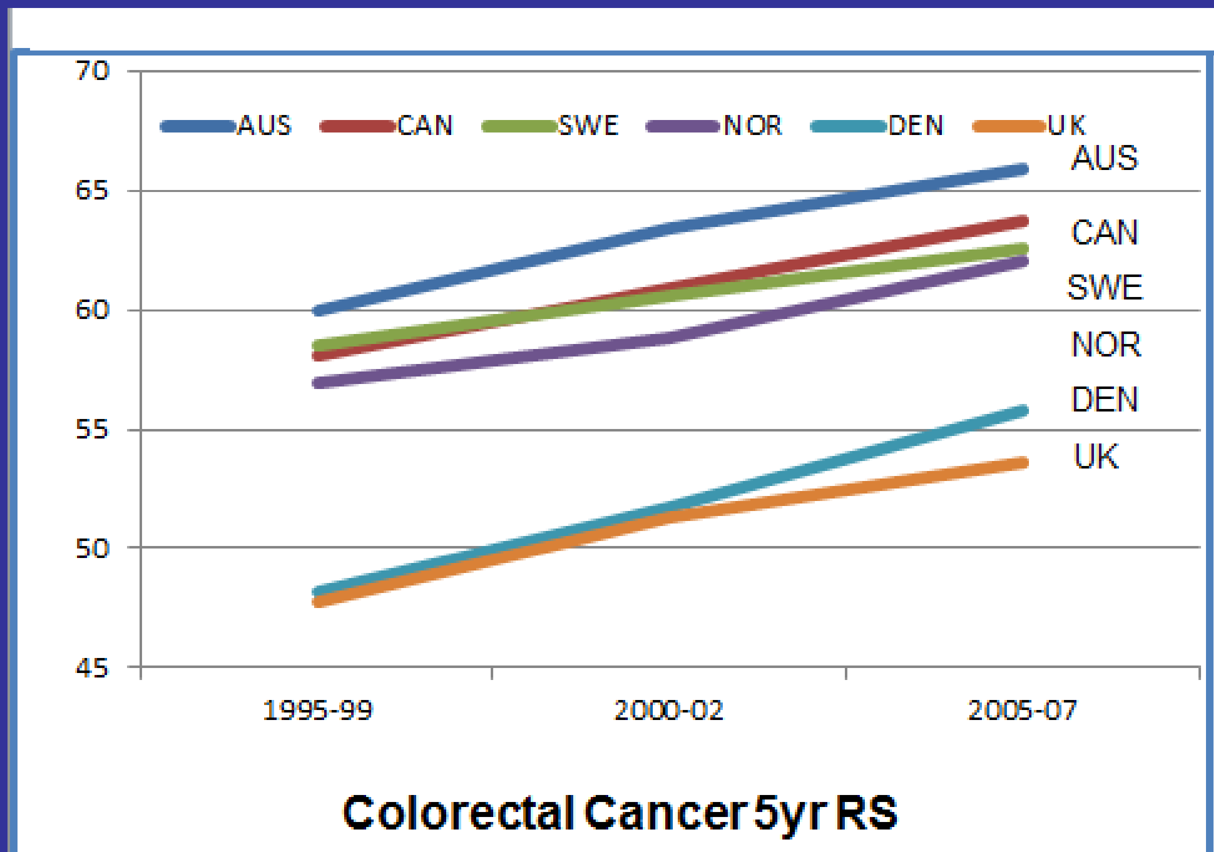
ICBP: 5 year relative survival: Coleman et al, *Lancet* 2011



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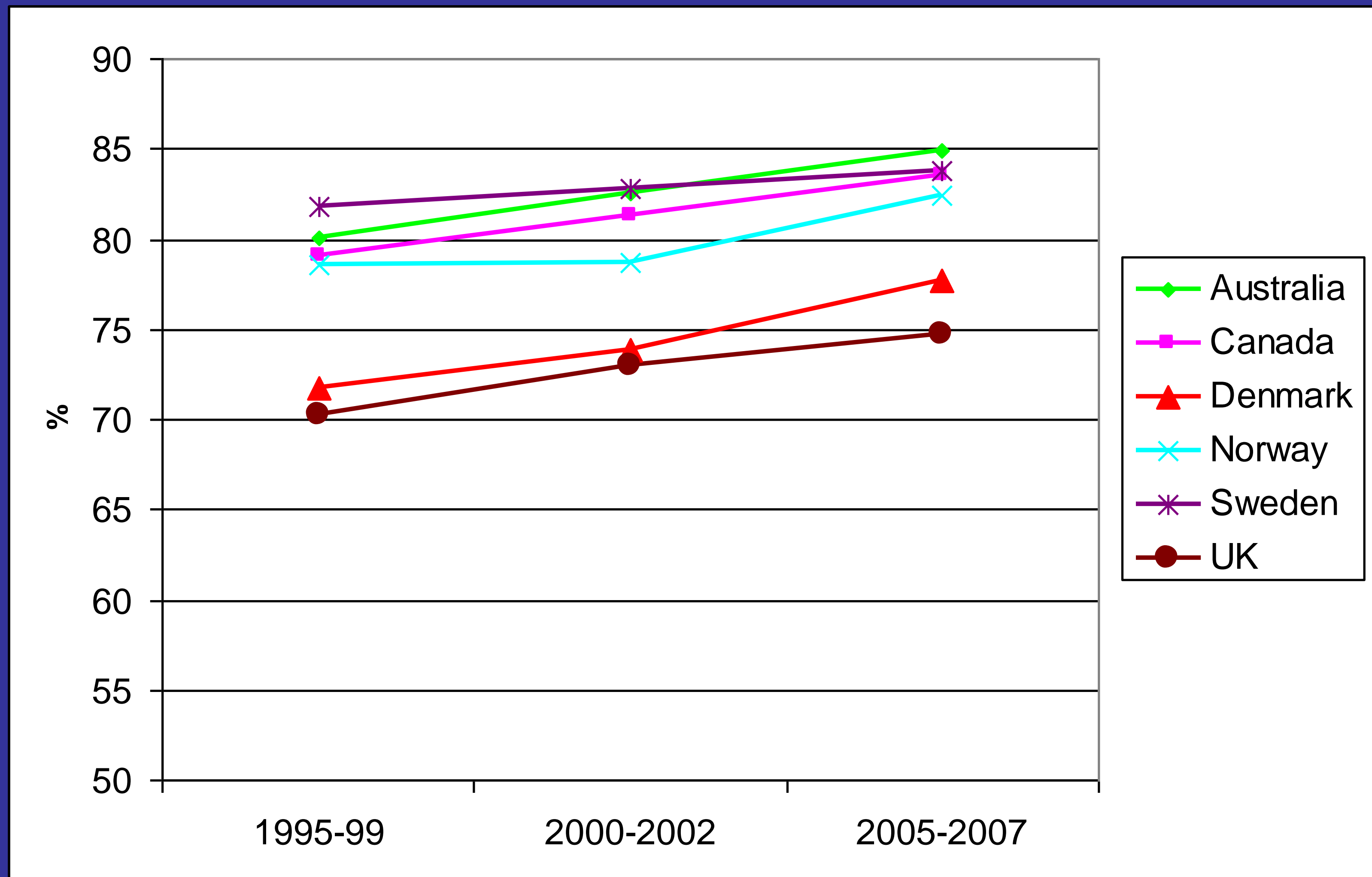
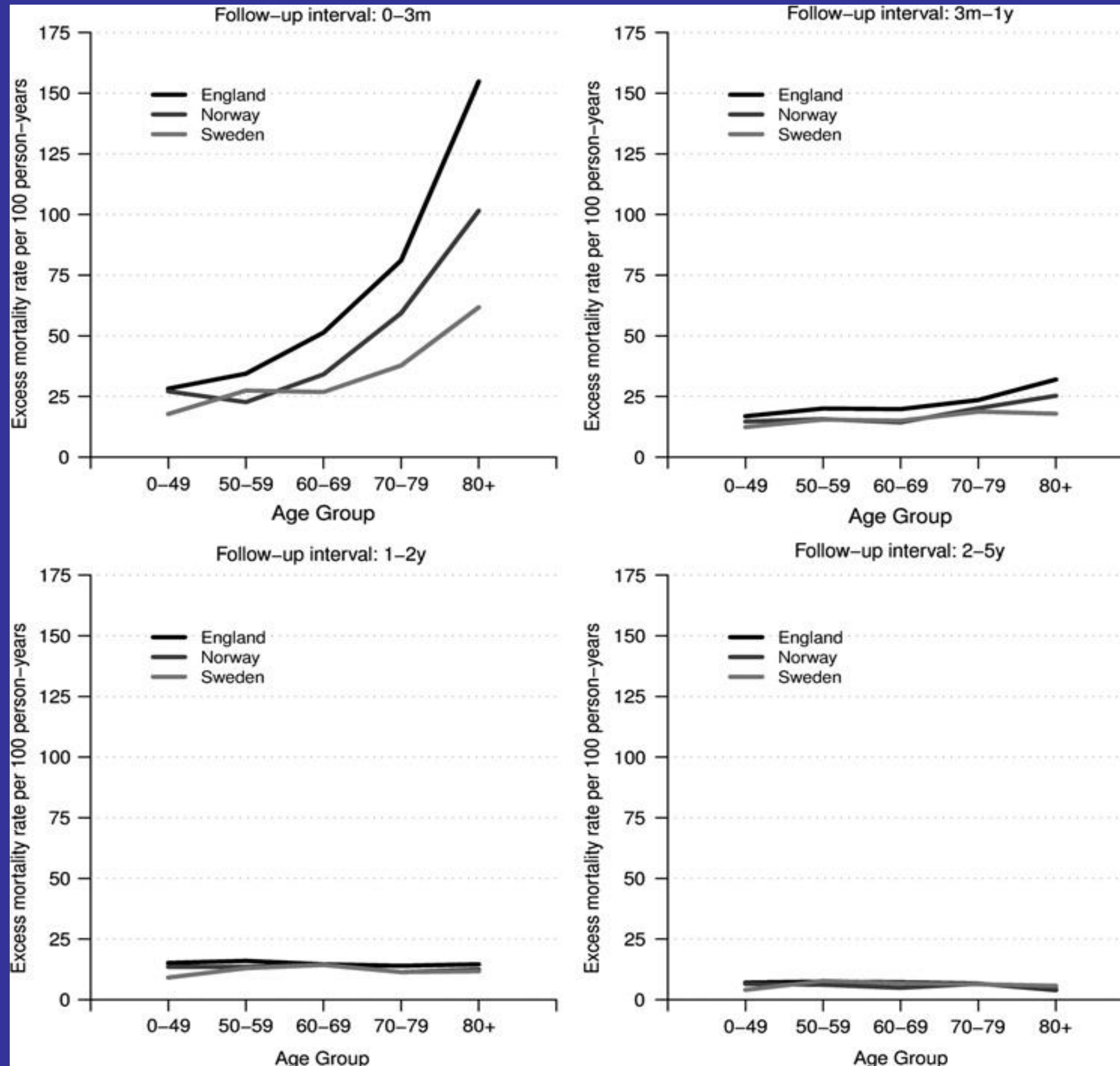
One year survival from colorectal cancer, international comparisons Coleman, 2010



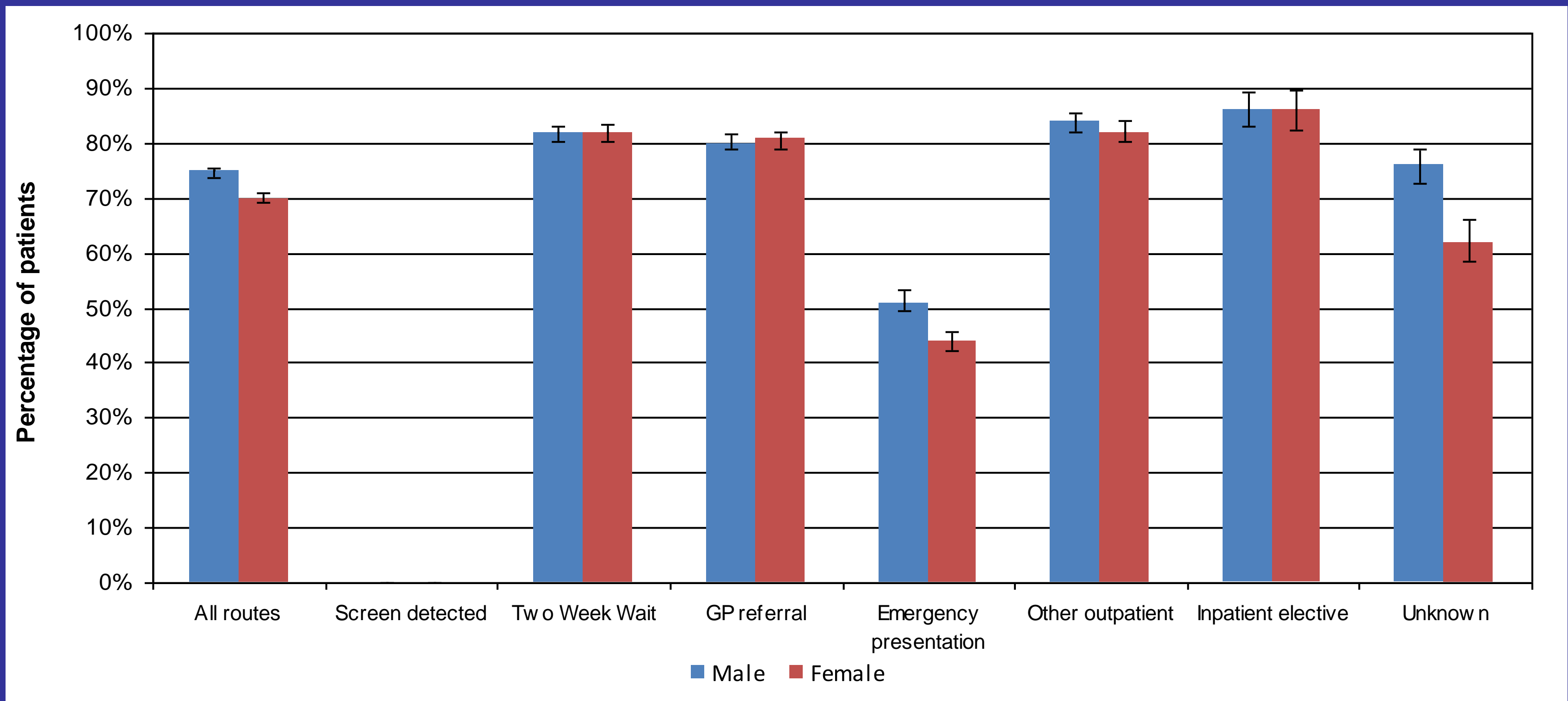
Excess deaths in people with colon cancer by age at diagnosis and follow up time **(Morris 2011)**



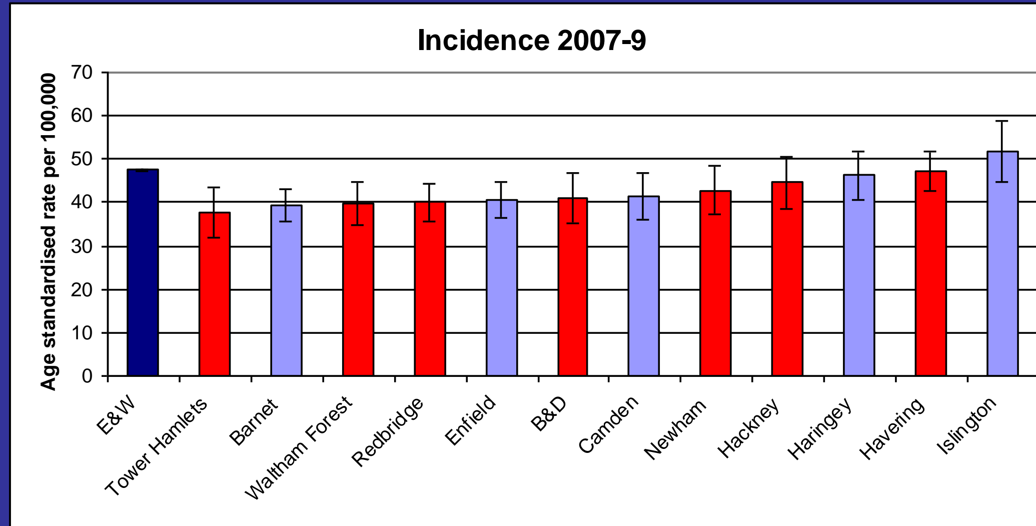
One year survival by route of presentation

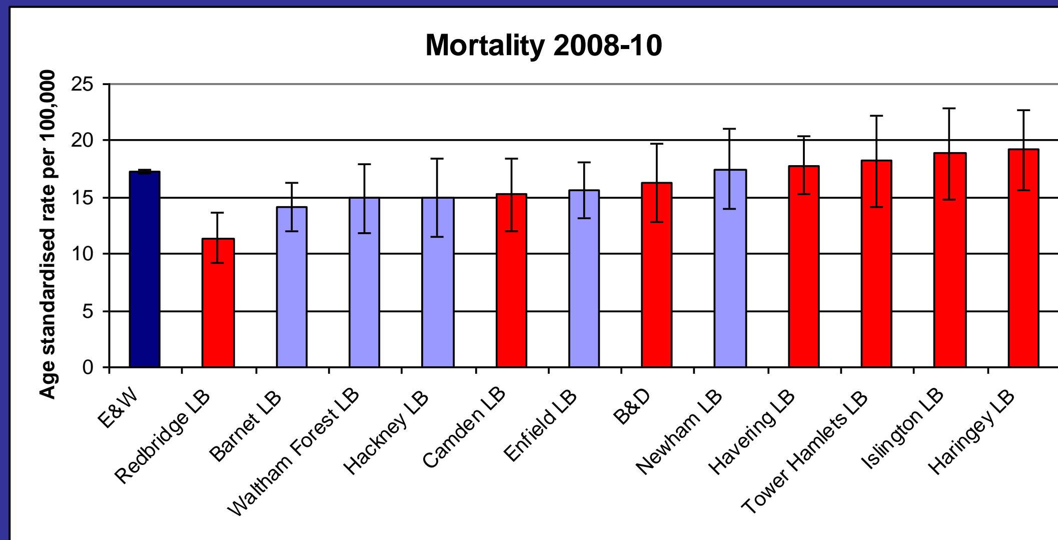
(Routes to Diagnosis Report 2010, NCIN)

- **25%** patients present via emergency route
  (23% men, 28% women)

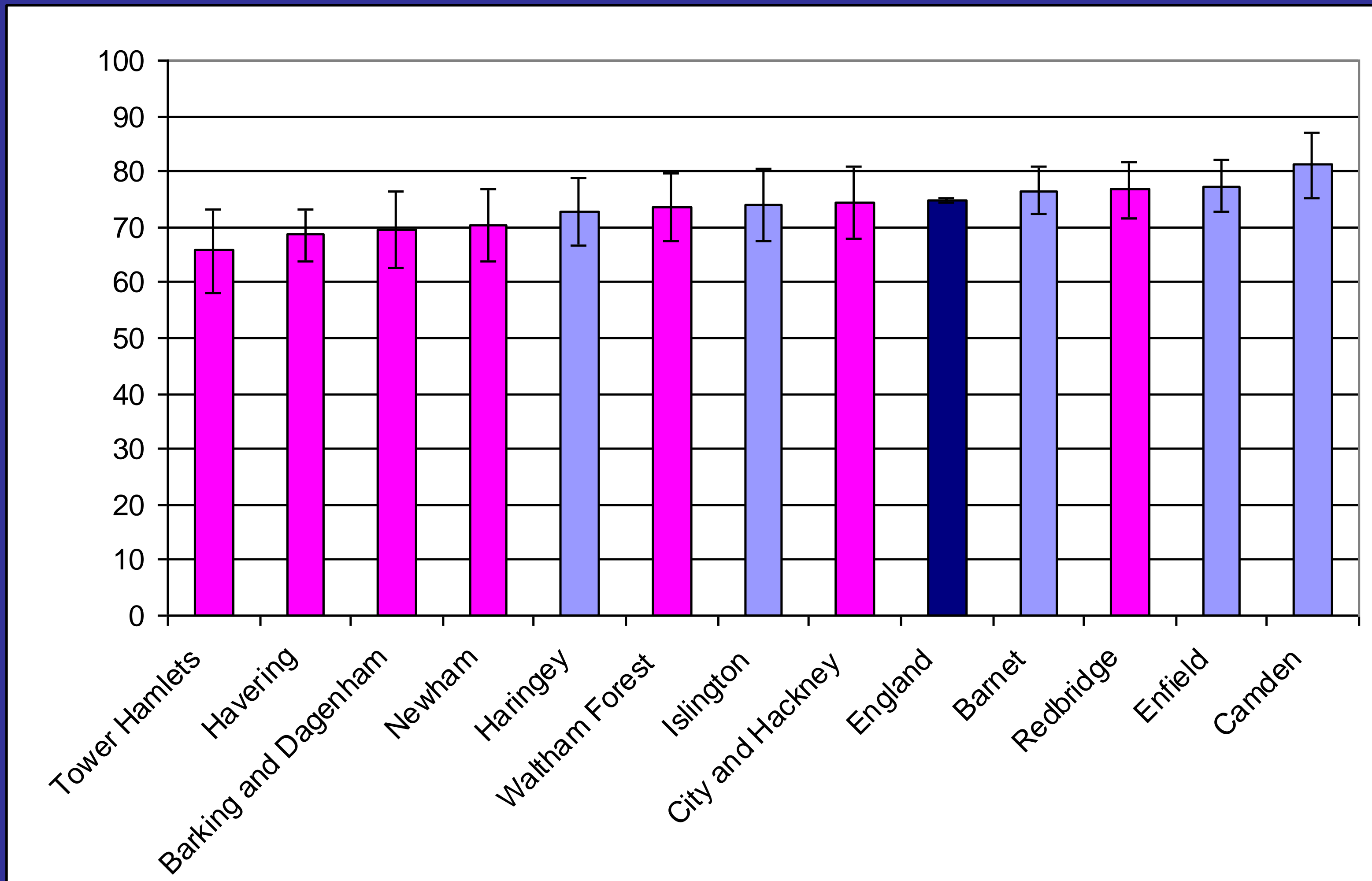


Incidence and Mortality from colorectal cancer, NEL and NCL

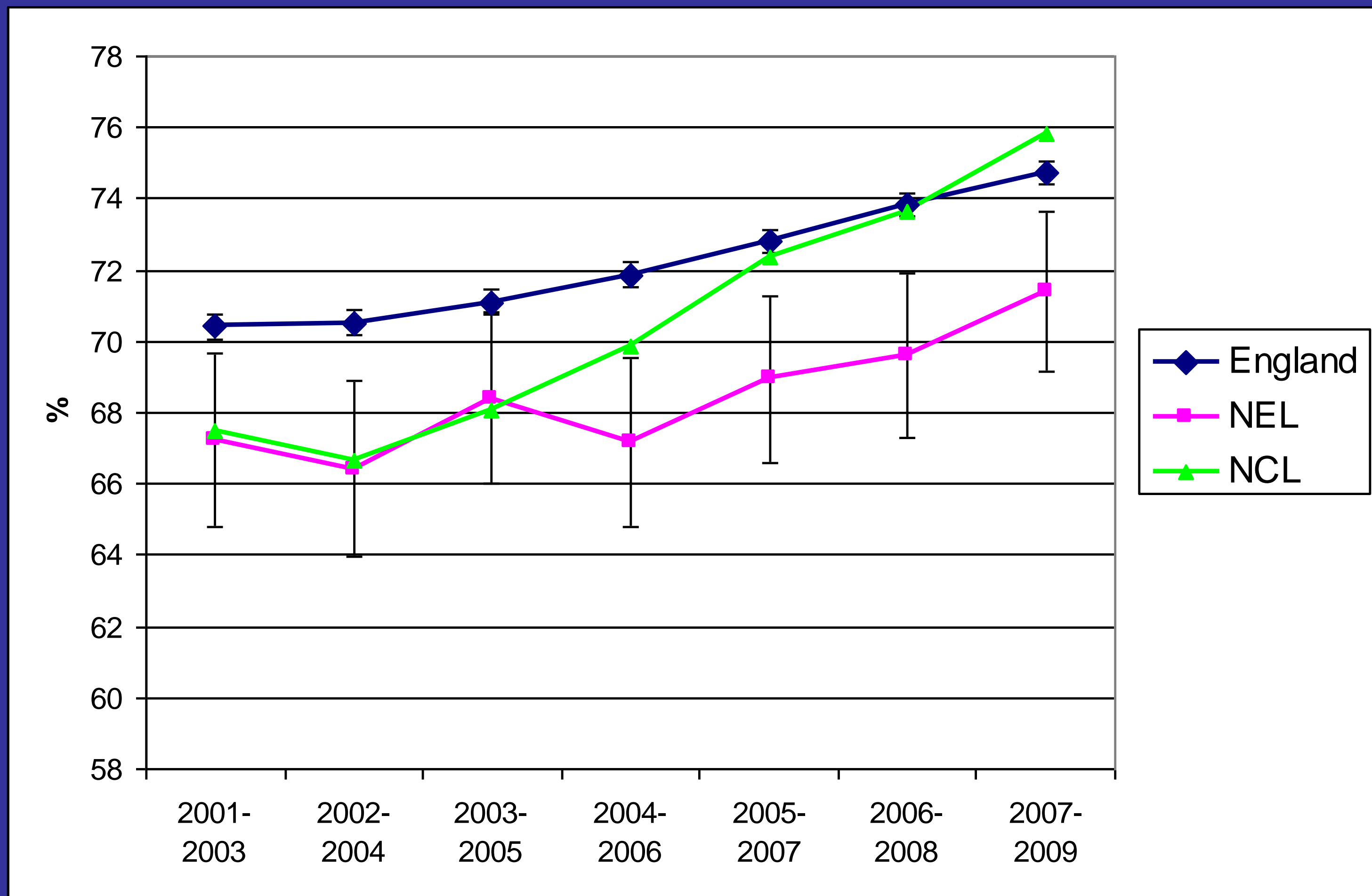




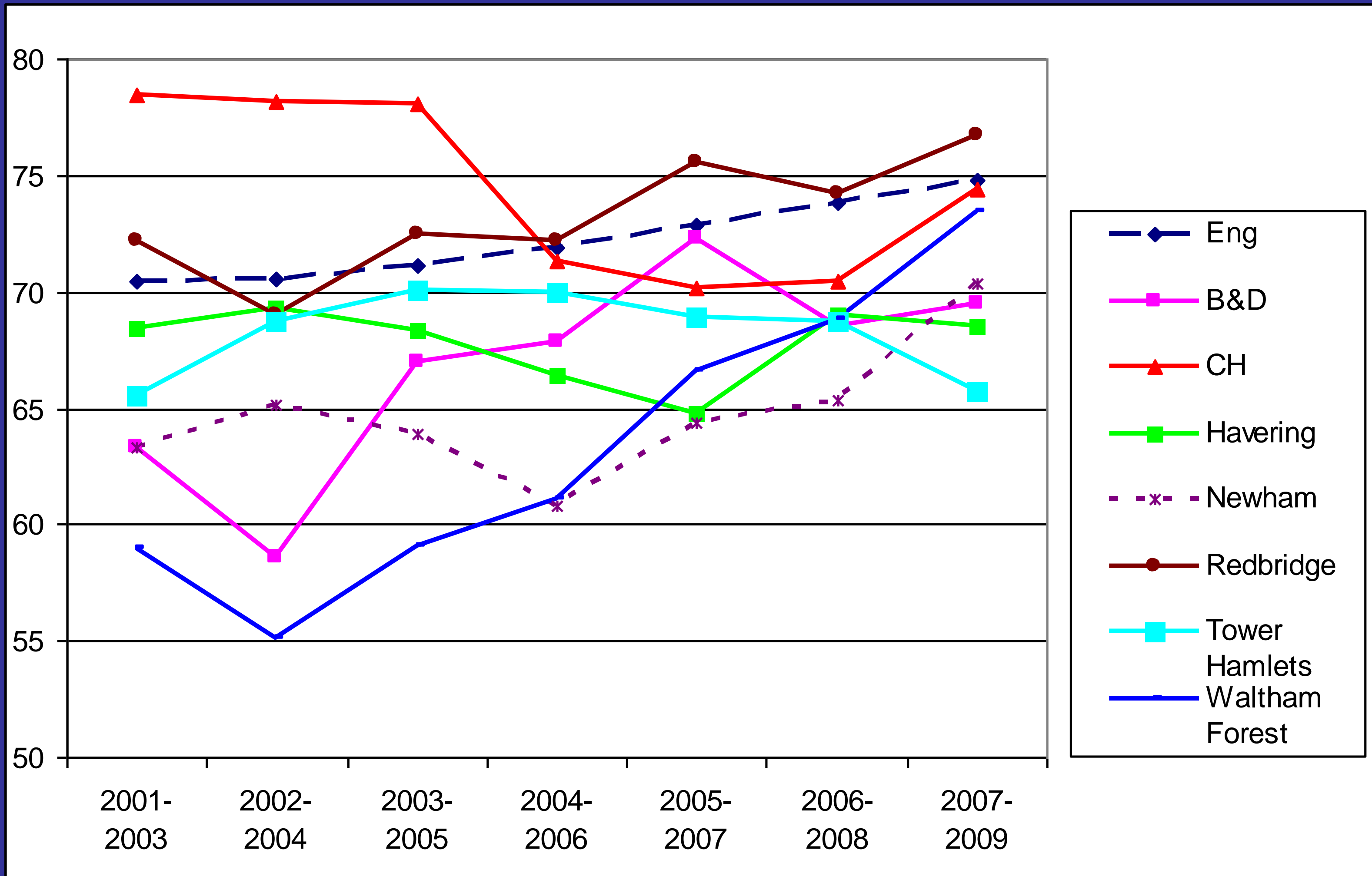
One year survival from colorectal cancer, 2007-9, NEL, NCL



Trends in 1 yr survival from colorectal cancer, NEL and NCL



Trends in 1 yr survival from colorectal cancer, NEL PCTs



Reasons for poor 1 yr survival – late diagnosis

- Late presentation
  - lack of awareness of symptoms
  - perceived barriers to Primary Care
  - low uptake of bowel screening

- Delays in Primary Care
  - referral delays

- Delays in secondary care
  - diagnostic delays
  - pathway delays

Factors affecting delay 1

- Late presentation: patient awareness
  - <20% of people recall 'change in bowel habit' as symptom (National CAM survey, 2009)

- Barriers
  - 25% perceived barriers to going to GP (NEL)

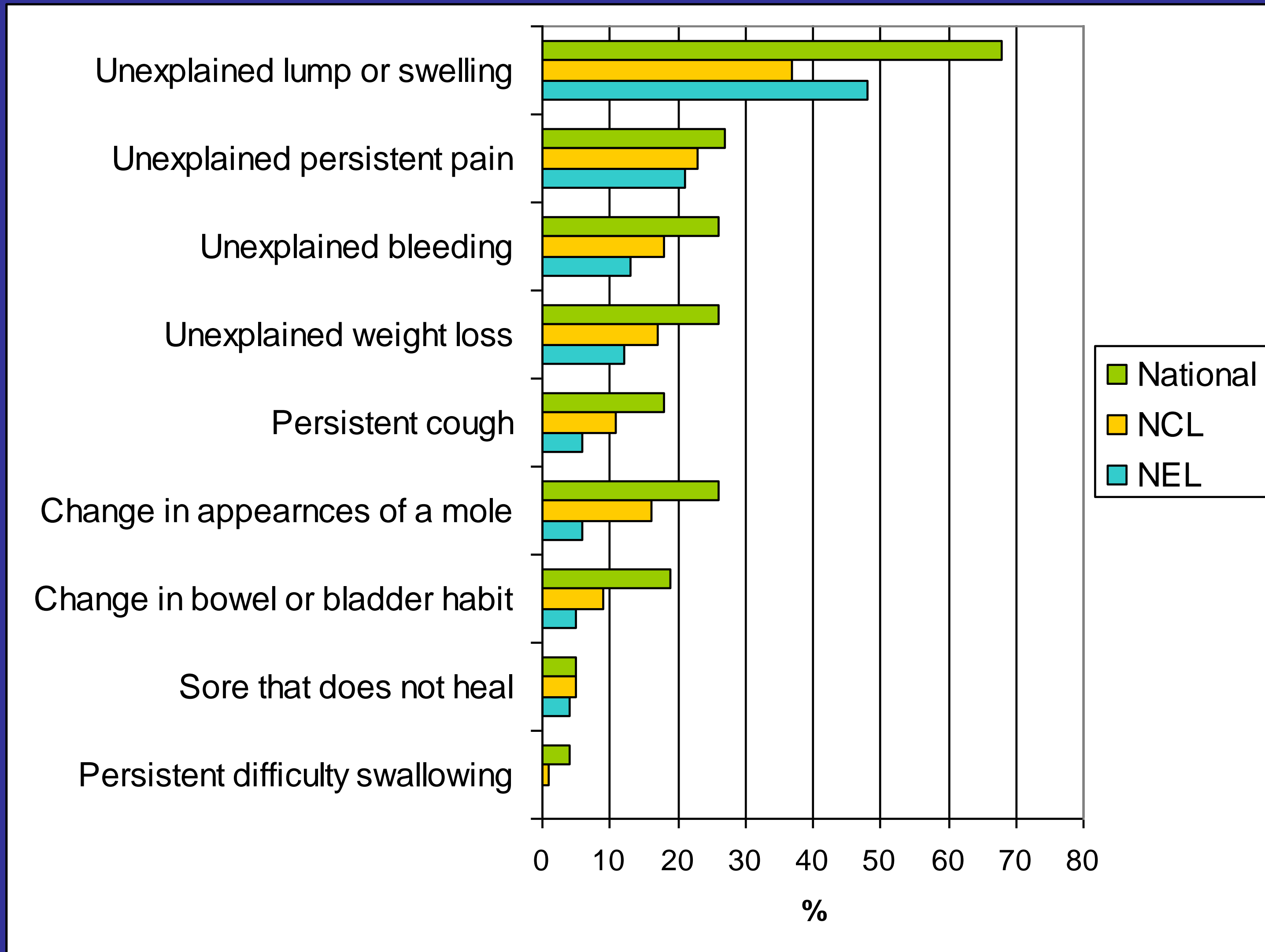
    5-21% (NCL)

    eg. difficulty getting appointment, communication

Unprompted recall of cancer symptoms

% of respondents in NEL, NCL and national survey*

(*Robb, BJC 2009)



Factors affecting delay

- Primary Care delays
  - 44% referred urgently in NEL 2011/12 (CWT)
    46% NCL (GP Audit)
  - 28% referred as routine referral in NEL
    14% in NCL (GP Audit 2010)
  - 25% present through emergency route
    (NCIN, 2010)
  - 22% presented 3 or more times to GP
    (NCL GP Audit)
  - 21% have metastatic disease at diagnosis
    (NCL GP Audit 2010)

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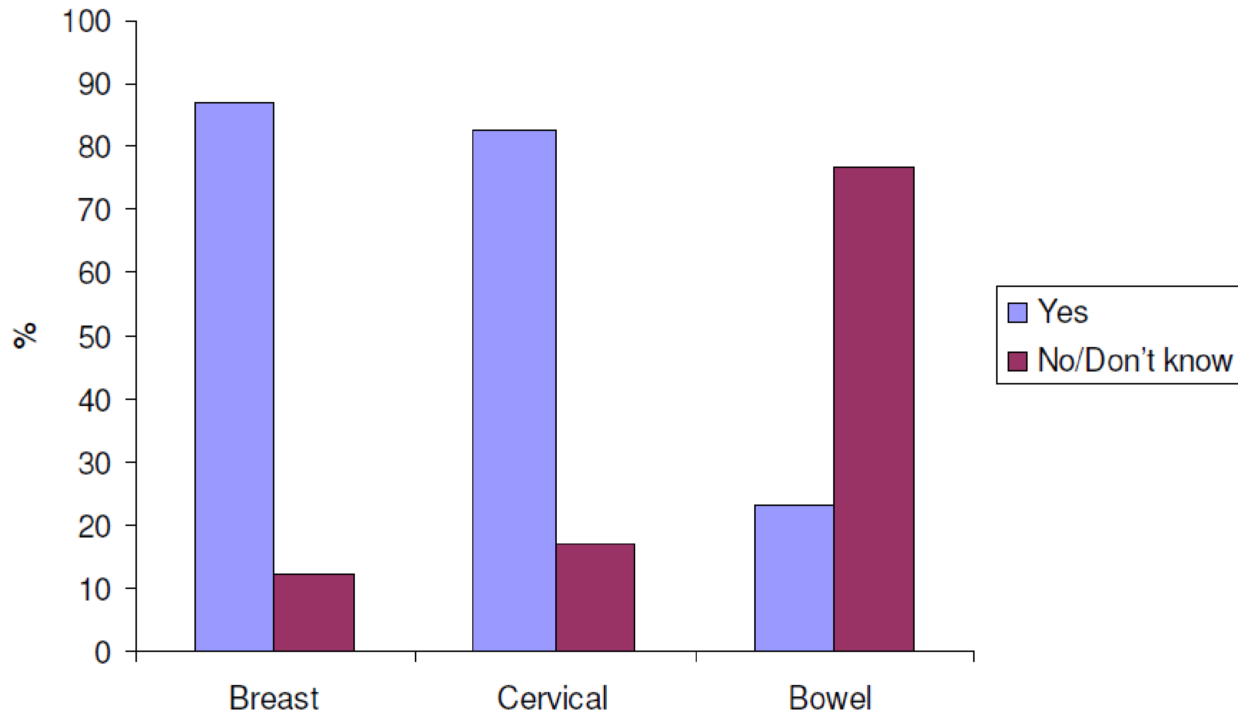

(Source: UCL, *Public awareness of cancer in Britain*)

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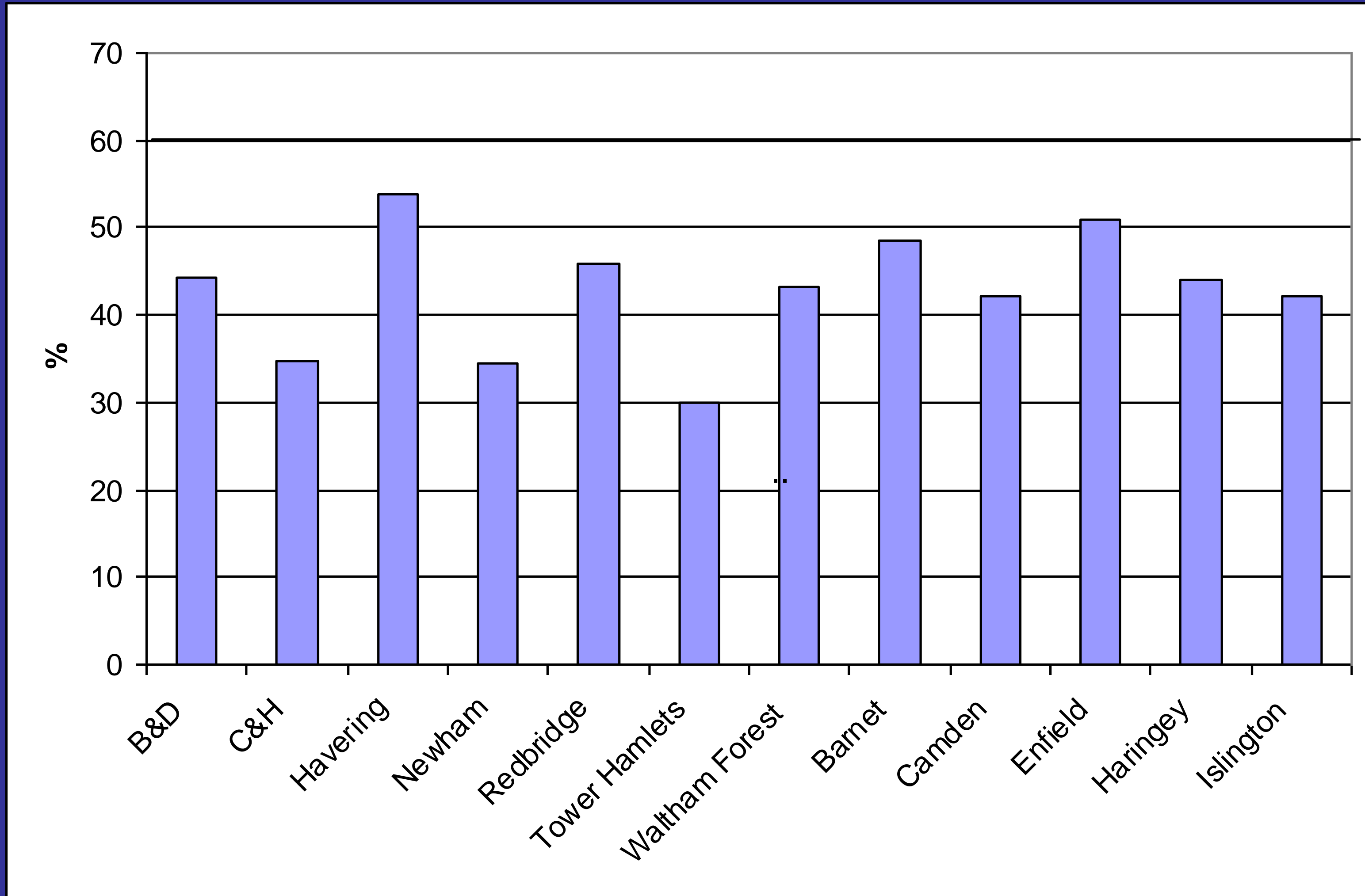
Screening uptake



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Our priorities

- Driving participation in screening
- Optimising the diagnostic pathway
- Enhancing follow-up

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Driving participation in screening

Increase awareness

- Approximately 20% of our target group are aware of screening. (Source: UCL, *Public awareness of cancer in Britain*)
- Increase awareness of free phone number for people over 70/75 to opt in.
- Media campaigns

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Incentivisation and performance management of GPs

- In Scotland, the 6% increase in participation in bowel screening was linked to the introduction of SQOF points for GPs. (Source: Dr David Linden Health Delivery Directorate Scottish Government)
- Why not switch focus of performance management ***from* cervical screening *to* bowel**?

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Simple, intuitive flagging system for GPs

- Introduction of a **virtual 'Post-It'** note on patient records to identify to GP patients eligible for screening.

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Early adoption of flexible sigmoidoscopy for patients at age 55 (BowelScope)

"Flexi sig is a safe and practical test and, when offered only once between ages 55 and 64 years, confers a substantial and long-lasting benefit."

[Atkin, W. *The Lancet*, Volume 375, Issue 9726, 1624 - 1633, 2010]

QE & South Tyneside
West Kent & Medway
Norwich
St Marks
Wolverhampton
Guildford

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Optimising the diagnostic pathway

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Proposed diagnostic pathways

- Patients referred into a one stop diagnostic service eg: Multi-disciplinary diagnostic centres
- Lower threshold for referral (new NICE guidance)

NICE GUIDELINES

- aged 40 years and over with unexplained weight loss <u>and</u> abdominal pain
- aged 50 years and over with unexplained rectal bleeding
- aged 60 years and over with IDA or CIBH, or FOB positive
- abdo or rectal mass

NICE GUIDELINES: FOB's

- aged 50 years and over with unexplained abdominal pain or weight loss
- aged under 60 years with CIBH or with IDA
- aged 60 years and over with anaemia even in the absence of iron deficiency.

NICE GUIDELINES

- Consider a 2WW referral in adults aged *under 50* with rectal bleeding <u>and</u> any of the following symptoms or findings:

- abdominal pain
- CIBH
- weight loss or IDA

Everyone!

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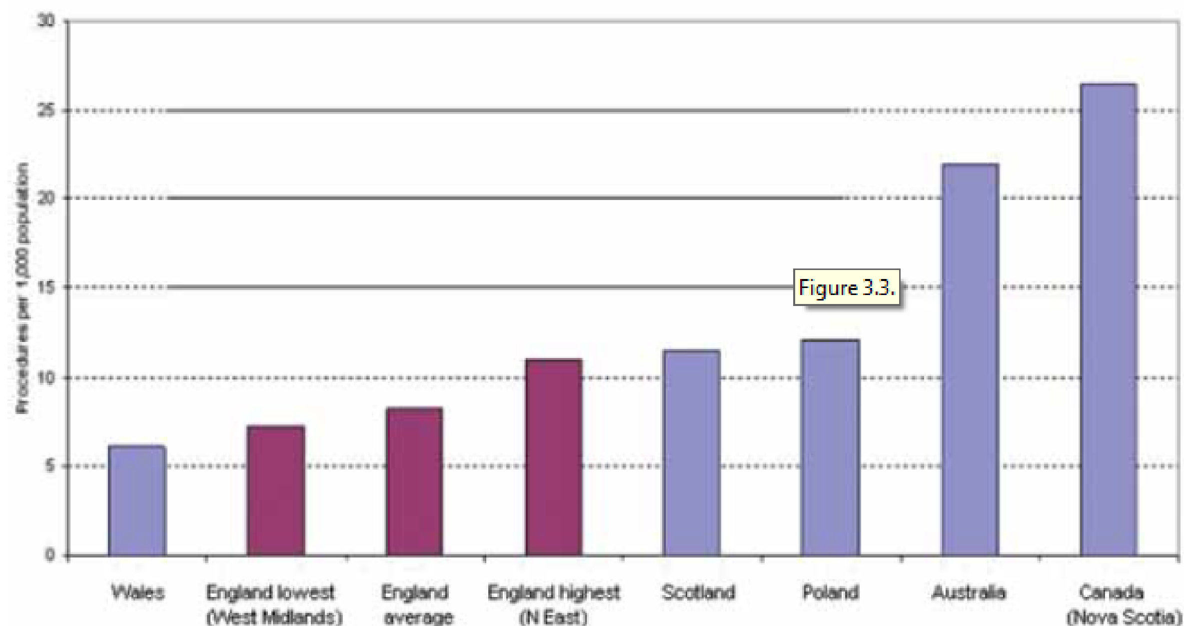
Figure 3.3. International comparisons – crude colonoscopy rates per 1,000 in 2010/11



The advantages of a *definitive diagnosis*

- Safer than working with presumed diagnosis
- Opportunity to tailor treatment to the patient
- Promote self care for benign conditions / fewer visits to GP

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Enhancing follow-up

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'Virtual' follow-up

- For patients at low risk of recurrence or metastatic disease.
- Access to nurses/doctors when needed
- CEA blood tests, CT scans and colonoscopy booked via diary programme and results relayed to patient and GP
- Broomfield Hospital have used this approach for a decade

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Advantages

- Patient satisfaction
- Better data collection
- Patients seen quickly when they need to be seen
- Potential cost saving (invested in diagnosis)

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Summary

- Bowel cancer common and curable if caught early
- National strategies being worked on to improve delivery of cancer services in UK
- As GP's, be vigilant and encourage uptake in screening and early referral