NHSGGC Webinar Wednesday 26th August 2020

Impact of COVID 19: Colorectal Pathway Recovery Plan

Q&A

Questions were responded to by a panel including:

- **Dr Douglas Rigg, Lead GP for Cancer NHSGGC**
- **Dr Jack Winter, Consultant Gastroenterologist NHSGGC**
- **Mr Andrew Renwick, Consultant General Surgeon NHSGGC (Clyde)**
- **Mr Paul Witherspoon, Consultant General Surgeon NHSGGC (South)**
- **Mr Graham Mackay Consultant General Surgeon NHSGGC (North)**

General

Q: Where can I get a copy of the new pathway?
A: Please see attached link for the new pathway here.

Q: Would it be worth getting people with no qFIT result in category 4 to do a qFIT whilst they are waiting?
A: We have been doing that - but unfortunately only a minority of patients have returned the test. From primary care perspective and if clinician/patient concern then repeat qFiT after 6 weeks would be appropriate or discussion with consultant colleagues.

Q: Is there a generic email address to seek advice or discuss a referral with a colorectal surgeon or gastroenterologist if required?
A: There isn't a generic email for the whole of GGC at present. The collaborative group did discuss having Consultant Connect for access to advice and this remains under discussion. It is however available at some sites through Consultant Connect (RAH, QEUH). The service isn't currently running at GRI but the colorectal team there are happy to receive questions through contact by either email or their secretaries.

Referral

Q: Can you clarify if persistent rectal bleeding and a negative repeat qFIT at 6 weeks should be a USoC colorectal referral?
A: A repeated negative qFIT but persistent rectal bleeding is urgent (not USoC) to colorectal. Usually patients will be seen at a nurse led clinic to evaluate risk and further exclude a local issue such as piles or a fissure.

Only if a patient has a positive qFIT and age > 40 should you send a USoC colorectal referral.

Q: In the very frail, elderly group who are not fit enough to tolerate a scope, is there any merit in referring them at all as I assume treatment options would be very limited if not non-existent? Is it reasonable to refer purely to get a diagnosis?
A: In general there is value for some frail, elderly patients being referred to allow certainty and prognostication. This depends on the patients wishes, the index of suspicion and can usually be done through radiological imaging (CT) rather than endoscopy. Where uncertainty affects quality of life, knowledge of diagnosis/prognosis can be useful. If the patient does want referral, it's worth putting this detail on the referral. They would probably be seen in clinic first.

The mechanics of qFIT

Q: How important is the action of scraping the qFIT stick along the length of a stool as opposed to dipping the end in?
A: As long as there is stool on the picker it should get a result, the scraping just ensures a representative sample.

Q: What is the usual turnaround time for qFIT?
A: Biochemistry reduced frequency of testing during the peak of the pandemic but they are now back to running tests every day. You should have a result back within 48-72hrs. The sample needs to be analysed within 7 days of the sample being taken.

Q: How does qFIT work if a patient has known piles?
A: If you are confident that the patient just has piles then treat as such. However, if you are uncertain then qFIT is helpful. Piles cause fresh bleeding and qFIT detects a degraded globin protein from old blood lying in the colon so is often negative in piles, which purely bleed on physical contact.

Q: Can you clarify why qFIT is required if a patient has overt rectal bleeding?
A: Rectal bleeding is not a strong and specific risk factor for colorectal cancer whereas qFIT is far more sensitive and specific.

Patient non-compliance with qFIT

Q: What happens if a qFIT result isn't received from a patient who has been referred?
A: If you have a very high suspicion it is USoC then it is OK to send the referral as long as qFIT is checked too and the result is pending. However, the patient will not be vetted until qFIT and FBC are available. The patient will be contacted at 2 weeks if no qFIT result is received. If we can't get hold of the patient directly we will contact the practice to alert them.
If a patient has low risk symptoms and you are checking qFIT to be thorough, please wait until the qFIT result is available and then refer urgently/USoC if qFIT is high. We always look for qFIT 400s who have not been referred on a monthly basis and contact practices.

Clinical scenarios

Q: With faecal calprotectin not being available during the pandemic, is there a role for qFIT as a potential screening tool for identifying younger patients with possible inflammatory bowel disease who present in primary care?
A: Yes - absolutely. It is very helpful in the diagnosis of ulcerative colitis however not so good in isolated small bowel Crohn's disease but this is less common.

Q: Douglas Rigg was mainly talking about colorectal cancer; am I correct in thinking that the pathway is for any new colorectal symptoms - so also if IBD is suspected rather than cancer?
A: Yes, you are right. This relates to ANY new lower GI symptoms. The outcome is slightly different though as IBD patients tend to be younger and so if age <40, urgent referral to gastroenterology would be recommended instead of USoC to colorectal services.

Q: If you are worried about IBD, should you check qFIT and a faecal calprotectin? I have been told by the lab that calprotectin can be done if you state that the patient has possible IBD.
A: Yes - it would help in organising referrals. Routine faecal calprotectin has been available on a routine basis since 17th August.

Q: I have a patient with asymptomatic iron deficiency anaemia. They are not keen for investigation and my plan had been to prescribe oral iron and repeat FBC iron studies in 6 weeks. I presume qFIT would be useful in order to risk stratify and encourage the patient to accept referral on basis of risk?
A: Absolutely - there is increasing evidence for using qFiT in patients with asymptomatic iron deficiency anaemia.

Q: Where do patients go to receive their pre-colonoscopy covid test?
A: Presently this is being done by the endoscopy staff in the main at the local hospital but this may change as time goes on.

Q: Is it possible to do qFIT in patients with diarrhoeal symptoms or do we need to investigate in other ways such as faecal calprotectin, FBC etc?
A: It is possible, patients need to be very generous with toilet paper covering the toilet bowl to ensure the stool does not become wet. This is covered in the patient information leaflets which will be updated and online but will also be included in distribution of new sample kits to practices.
qFIT in patients with diarrhoea should be our the first-line investigation. FBC should be checked in all patients and falecl calprotectin can give additional information where IBD is suspected. However, qFIT and FBC are as good as calprotectin for ulcerative colitis. It is not so good in small bowel Crohn's and it does not pick up microscopic colitis - hence we will still scope some patients with severe diarrhoea and negative qFIT as we have good treatments.

Q: Are patients with upper GI symptoms still being directed to pancreatic imaging if upper GI endoscopy is negative?
A: Upper GI guidance is if USoC concerns and endoscopy is negative, you should proceed to CT.

Patients on surveillance

Q: What is happening with people who get regular colonoscopy monitoring for higher risk of bowel cancer e.g. FAP (familial adenomatous polyposis)?
A: If they have a very high risk, such as HNPCC (hereditary nonpolyposis colorectal cancer) or MUTYH-associated polyposis, they will be prioritised to have a scope in a timely fashion - usually every 2 years. We do not want to delay this but will try to get a qFIT too to see if this is helpful. If there is a weaker family cancer history and the patient only needs scoped every 5 years then their surveillance is currently paused, as it is for polyp and IBD surveillance.

Q: We often have to re-refer patients on surveillance (family history, polyp surveillance etc) who have been lost to follow up. Do these patients need qFIT (they look like category 4 patients)?
A: You are right - these patients sit on surveillance recall lists which are paused. For polyp surveillance, the national guidance was reviewed last year and tightened up, with far fewer needing surveillance and the intervals lengthening. If they have no symptoms, you don't need to check qFIT. Many of these patients would have their surveillance intervals lengthened or discontinued anyway, regardless of COVID-19. We have just obtained funding to undertake a large review of surveillance lists and reconfigure follow up. It may help us to expedite a referral if lost to follow up.

Colon capsule

Q: What has been the feedback from patients about the oral colon capsule pill? Is there any information on experiences in comparison with colonoscopy?
A: Still very early to provide evidence yet. Reports from Highland are positive but the prep is rather arduous.