Colorectal Clinic - **Admin**

Pink Forms

These are how the hospital gets paid, and how the patient gets their follow up appointment. If they go missing we lose lots of money and it creates a big admin headache. We get paid a lot extra for extra procedures, but only if your record you do them on the pink form.

- tick all procedures you have done (proctoscopy, haemorrhoids, wound attention)
- tick on the front for the outcome
- tell the patient to give the form in at the front of the hospital on leaving
- any forms left behind by the patient should be handed in to the admin office behind OPD 4.

Follow ups

The more we can reduce follow ups the fewer patients there will be to see in clinic and the easier clinic will become! Try to cover everything at the initial appointment, arrange tests as required, and not bring patients back for results.

No follow up appointment:

- for endoscopy results – the endoscopist should give these to patient at end of procedure.
- for blood test results – add these to your clinic letter as an addendum when you approve it.
- post treatment cancer patients for surveillance - refer to Martina Cussack (CNS)
- patients who need onward referral if symptoms do not settle (GP can usually refer)
- you don't know what to do (ask someone)!

Telephone clinic appointment:

- for imaging results
- biopsy results from endoscopy (if non-concerning for malignancy)

Face to face follow up:

- if re-examination needed (eg wound problems, or to complete a rectal examination post fissure treatment).
- If need non-verbal cues for difficult consultation (bad news, complaints etc.)

F8 Referrals

F8 referrals are for suspected cancer. They must be seen within 2 weeks of referral, and the patient must start treatment for any discovered cancer within 62 days of referral.

- Order any tests (imaging, endoscopy) as F8 so that we can meet the target
- If you can exclude cancer without further tests then state in your letter that you are taking the patient off the F8 pathway due to non-concerning symptoms. Order any subsequent tests as routine.

Theatre Bookings

- Fill out the complete green TCI form, including the back to determine if patient requires pre-assessment. Request "MRSA Screen" on ICE. Give stickers and form to patient to take to the clinic nurse outside your room.
- Must be discussed with a consultant who will countersign the form
- Complete the consent form in clinic.

Letters – These must be signed off electronically within 5 days of the clinic. Check on day 3/4.

DNAs – Give a new appointment to F8 referrals on 1st DNA (write to GP and discharge on 2nd). Otherwise only a give a follow up appointment if there is a clinical risk.

Clinical

These are generic guidelines only and will not apply for every patient. If in doubt then ask.

F8 referrals – which test

The following are suggestions for the ideal situation. Some patients may not be suitable for some or any investigations (eg. if in renal failure or serious co-morbidities). Book these tests as F8.

- **Iron deficiency anaemia** (confirm it really is iron deficient) needs OGD, and whole colon examination[1] (unless gastric cancer or coeliac disease is confirmed on OGD).
- **Change in bowel habit to diarrhoea** needs whole colon examination[1] and TFTs/Coeliac on blood tests.
- **Fresh rectal bleeding** usually needs a flexible sigmoidoscopy unless the patient is <40 with no risk factors and a peri-anal cause is seen on proctoscopy[2].
- **Constipation** is rarely a presenting complaint of cancer, except where there is obstruction. If suggestion of imminent obstruction consider plain CT first as bowel prep is unsafe. If acute and not previously investigated, or any other concerning features may still need whole colon examination[1]. Discuss if unsure.
- **Weight loss** is usually best investigated with plain CT chest/abdo/pelvis. Consider blood tests for other systemic causes depending on history/examination findings (TFTs, Coeliac screen, HIV etc.)
- **Abdominal pain** is usually only a feature of T4 colorectal cancer invading adjacent structures – this can usually be seen on CT. Many patients with pain have IBS, or have retroperitoneal pathology (pancreatic, renal etc). Avoid colonoscopy as it is usually not helpful, and investigate with CT if concerned.

Procedures

This is a suggestion of which tests/procedures to consider. If you think banding or proctoscopy is appropriate but you are not competent doing it alone then get someone to join you.

Proctoscopy: Carry out in all patients with perianal symptoms, or rectal bleeding.

Injection/Banding of haemorrhoids: Consider only if haemorrhoids present, symptomatic (bleeding/prolapse, not for pain), and patient wishes them treated. Avoid treating haemorrhoids that do not trouble the patient – you can only make things worse!

Rigid Sigmoidoscopy: We do not do this routinely – if it is indicated then so is a flexible sigmoidoscopy which is what you should book. Main use is to confirm height of a rectal tumour, or to biopsy a newly recognised rectal mass.

Endoscopy Requests

- For F8 / urgent requests please select this box at the bottom of the form
- For Flexi sig ensure Phosphate Enema is signed for on the form
- For Colonoscopy sign for Picolax (cheaper) or Moviprep (safer if renal impairment)
- Think "What happens next if the test is normal?" It usually is! Ideally they should be discharged.
  - Write "Discharge if normal" on the form or someone will book them back in to clinic.
  - If they need haemorrhoids treating do this before endoscopy so they don't need to return afterwards
  - Document any plan in your clinic letter (eg. "GP to start loperamide if endoscopy normal")

1. Whole Colon Examination This can either by CT pneumocolon or Colonoscopy. We have limited CT pneumocolon availability so try to use this only for patients who cannot have colonoscopy due to frailty, or because of previous failures. Plain CT with IV contrast is an option for frail patients who will not tolerate the bowel prep for CT pneumocolon. It will usually see large or obstructing cancers, and can be useful where there is significant suspicion and a diagnosis will help to plan palliation. If booked as the only test then the discussion in clinic should cover that this is not a perfect test and that we are using it as a compromise because it is safer.**2.** Remember c.40% of patients with bowel cancer also have incidental haemorrhoids.