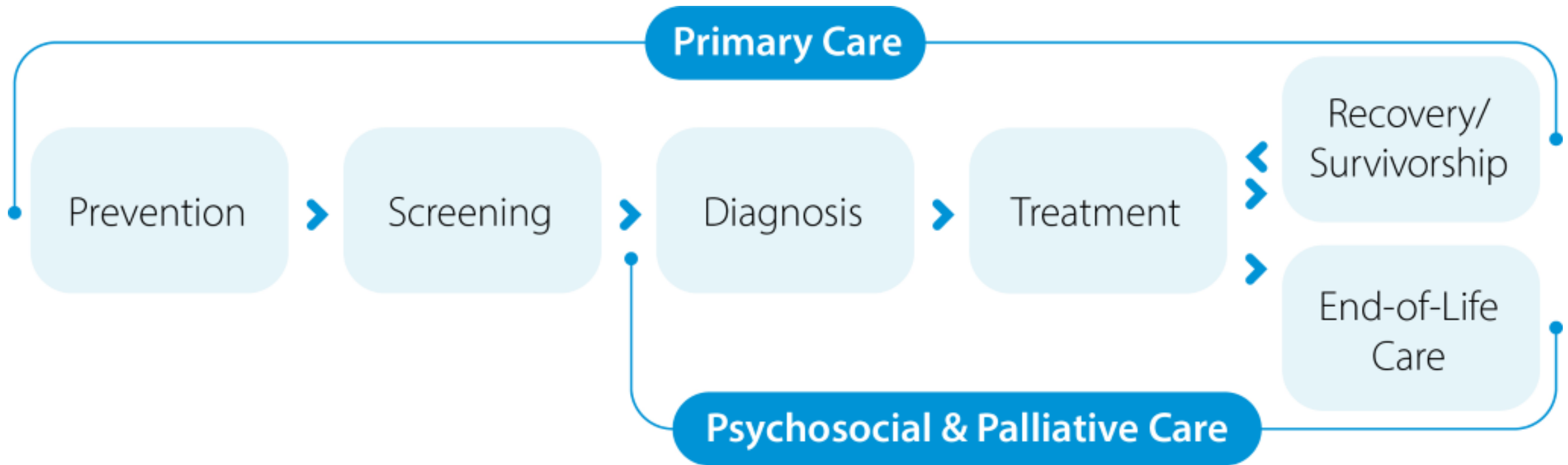


# Colorectal Cancer Diagnosis Pathway Map

Version 2023.06



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**Ontario Health**  
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


















## Target Population

Patients with abnormal screen test results, or signs and symptoms of colorectal cancer.

## Pathway Map Considerations

- The pathway map is only intended for primary adenocarcinoma. Familial cancers (Lynch/non-Lynch) and cancers in the settings of inflammatory bowel disease are handled differently.
- Primary care providers play an important role in the cancer journey and should be informed of relevant tests and consultations. Ongoing care with a primary care provider is assumed to be part of the pathway map. For patients who do not have a primary care provider, [Health811](#) is a government resource that helps patients find a doctor or nurse practitioner.
- Throughout the pathway map, a shared decision-making model should be implemented to enable and encourage patients to play an active role in the management of their care. For more information see [Person-Centred Care Guideline](#) and [EBS #19-2 Provider-Patient Communication](#).\*
- Hyperlinks are used throughout the pathway map to provide information about relevant Ontario Health (Cancer Care Ontario) tools, resources and guidance documents.
- The term 'health care provider', used throughout the pathway map, includes primary care providers and specialists, e.g. family doctors, nurse practitioners, and emergency physicians.
- Multidisciplinary Cancer Conferences (MCCs) may be considered for all phases of the pathway map. For more information on Multidisciplinary Cancer Conferences, visit [MCC Tools](#).
- For more information on wait time prioritization, visit [Surgery](#).
- Clinical trials should be considered for all phases of the pathway map.
- Sexual health should be considered throughout the care continuum. Healthcare providers should discuss sexual health with patients before, during and after treatment as part of informed decision-making and symptom management. See [Psychosocial Oncology Guidelines Resources](#).
- Before initiating gonadotoxic therapy (e.g. surgery, systemic, radiation), healthcare providers should discuss potential effects on fertility with patients and arrange referral to a fertility specialist if appropriate. See [Ontario Fertility Program](#).
- Psychosocial oncology (PSO) is the interprofessional specialty concerned with understanding and treating the social, practical, psychological, emotional, spiritual and functional needs and quality-of-life impact that cancer has on patients and their families. Psychosocial care should be considered an integral and standardized part of cancer care for patients and their families at all stages of the illness trajectory. For more information, visit [EBS #19-3](#).\*

## Pathway Map Legend

Colour Guide	Shape Guide	Line Guide
 Primary Care	 Intervention	 Required
 Palliative Care	 Decision or assessment point	 Possible
 Pathology	 Patient (disease) characteristics	
 Surgery	 Consultation with specialist	
 Radiation Oncology	 Exit pathway	
 Medical Oncology	 Off page reference	
 Radiology	 Referral	
 Multidisciplinary Cancer Conference (MCC)		
 Psychosocial Oncology (PSO)		
 Endoscopy		
 Organized Diagnostic Assessment		

## Pathway Map Disclaimer

This pathway map is a resource that provides an overview of the treatment that an individual in the Ontario cancer system may receive.

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While care has been taken in the preparation of the information contained in the pathway map, such information is provided on an "as-is" basis, without any representation, warranty, or condition, whether express, or implied, statutory or otherwise, as to the information's quality, accuracy, currency, completeness, or reliability.

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This pathway map may not reflect all the available scientific research and is not intended as an exhaustive resource. Ontario Health (Cancer Care Ontario) and its content providers assume no responsibility for omissions or incomplete information in this pathway map. It is possible that other relevant scientific findings may have been reported since completion of this pathway map. This pathway map may be superseded by an updated pathway map on the same topic.

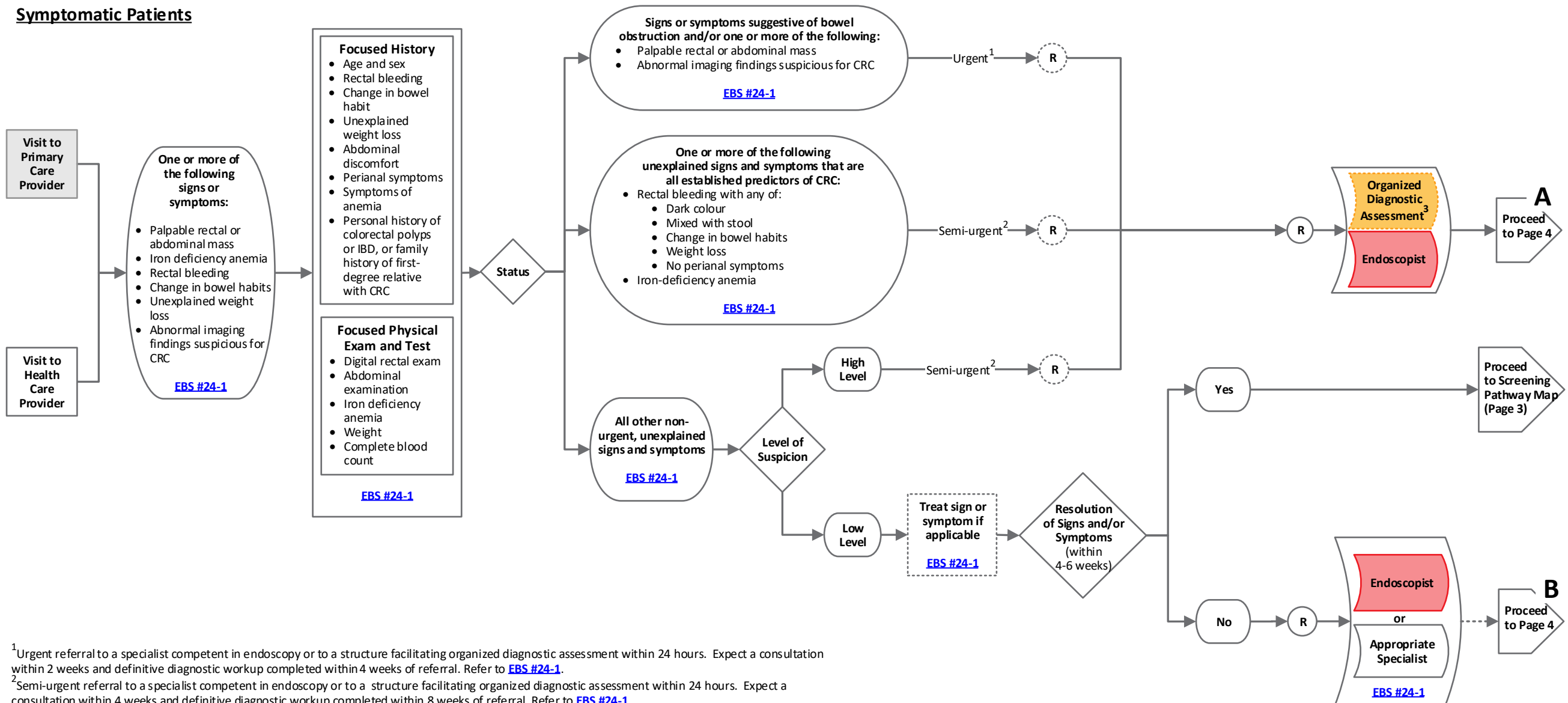
\* **Note. EBS #19-2 and EBS #19-3** are older than 3 years and are currently listed as 'For Education and Information Purposes'. This means that the recommendations will no longer be maintained but may still be useful for academic or other information purposes.

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### Symptomatic Patients



<sup>1</sup>Urgent referral to a specialist competent in endoscopy or to a structure facilitating organized diagnostic assessment within 24 hours. Expect a consultation within 2 weeks and definitive diagnostic workup completed within 4 weeks of referral. Refer to [EBS #24-1](#).

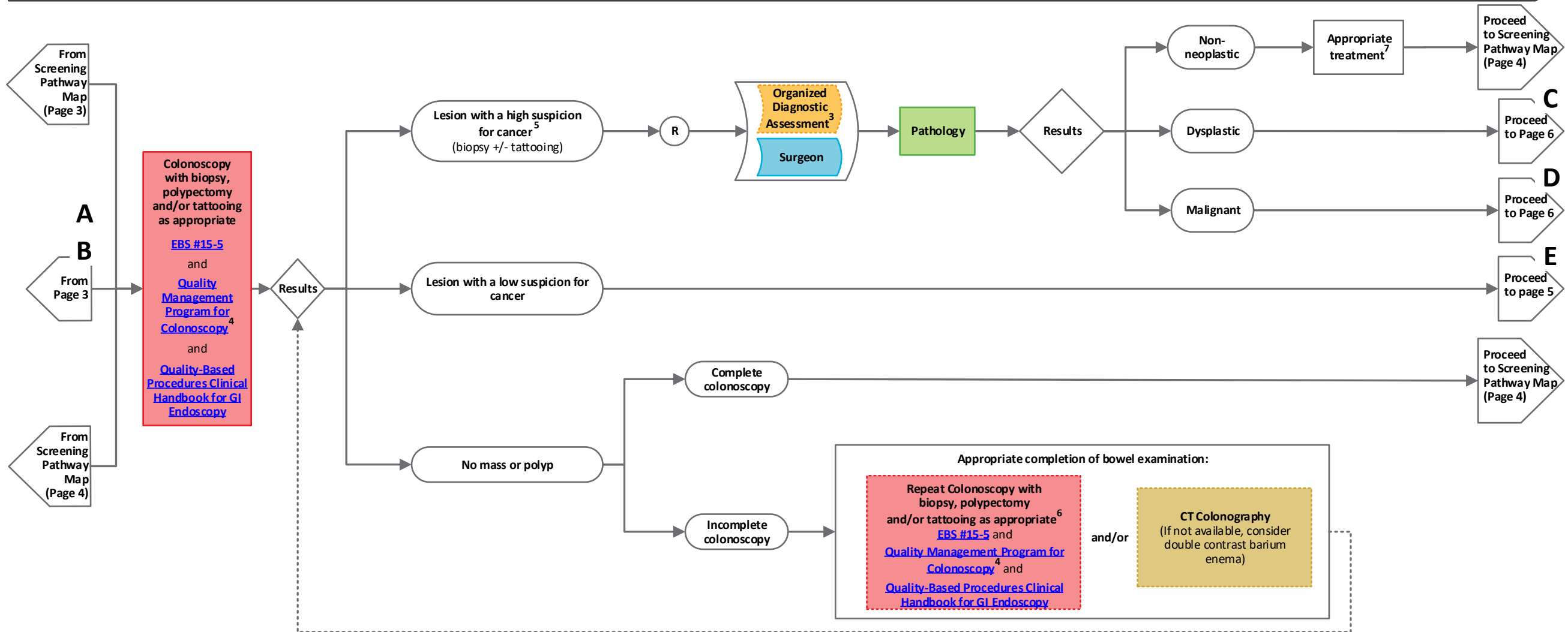
<sup>2</sup>Semi-urgent referral to a specialist competent in endoscopy or to a structure facilitating organized diagnostic assessment within 24 hours. Expect a consultation within 4 weeks and definitive diagnostic workup completed within 8 weeks of referral. Refer to [EBS #24-1](#).

<sup>3</sup>Evaluation of patients with a high suspicion of colorectal cancer may be performed within structures facilitating organized diagnostic assessment.

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<sup>3</sup>Evaluation of patients with a high suspicion of colorectal cancer may be performed within structures facilitating organized diagnostic assessment.

<sup>4</sup>Quality Management Program for Colonoscopy, pages 28 and 29.

<sup>5</sup>Referral should be made for any lesions with a high suspicion for cancer regardless of inconclusive or negative biopsy result for cancer.

<sup>6</sup>Consider referral to a specialist endoscopist. Refer to [EBS #24-1](#).

<sup>7</sup>The appropriate treatment of a non-neoplastic lesion is at the discretion of the treating physician.

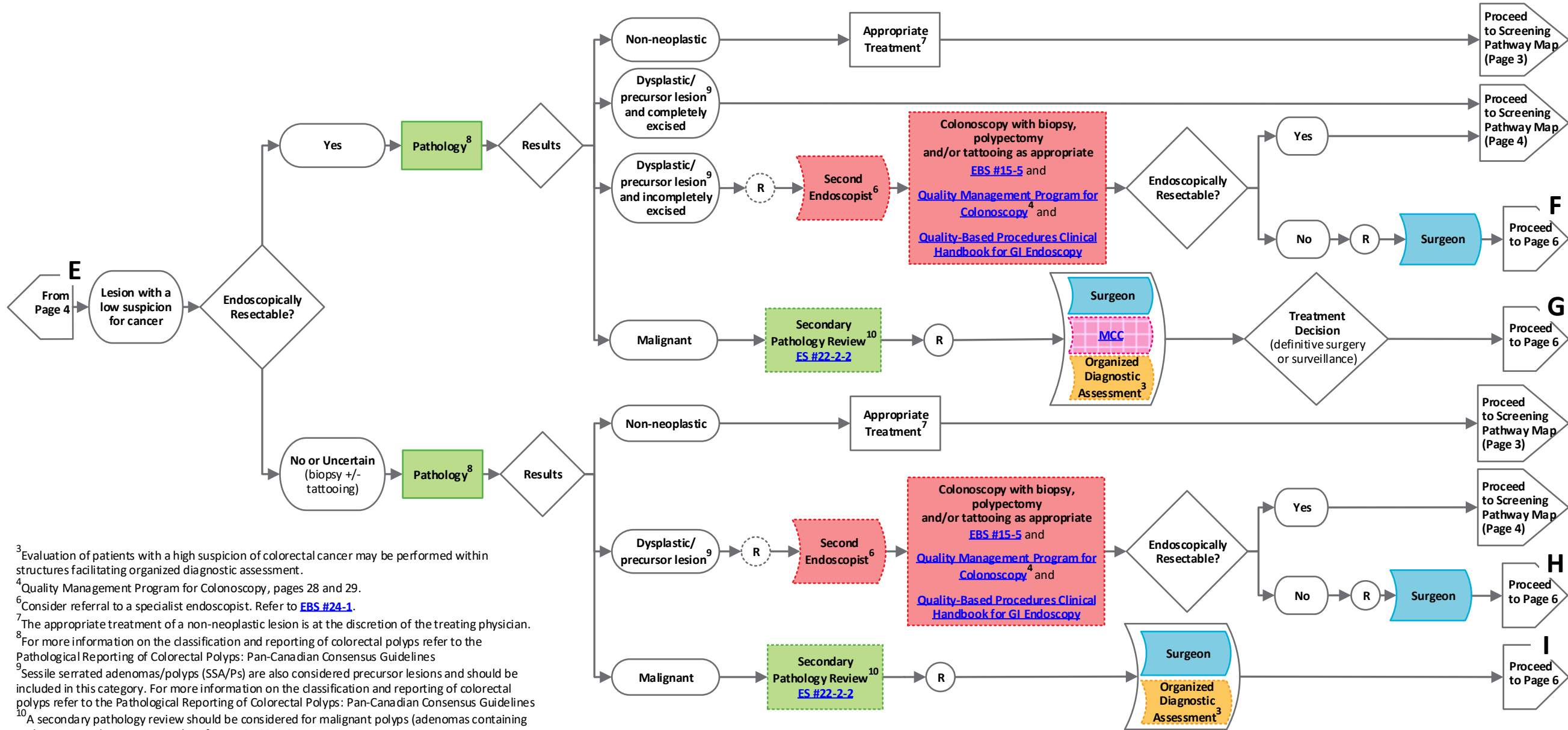
# Colorectal Cancer Diagnosis Pathway Map

## Lesion with a Low Suspicion for Cancer

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<sup>6</sup>Consider referral to a specialist endoscopist. Refer to [EBS #24-1](#).

<sup>7</sup>The appropriate treatment of a non-neoplastic lesion is at the discretion of the treating physician.

<sup>8</sup>For more information on the classification and reporting of colorectal polyps refer to the Pathological Reporting of Colorectal Polyps: Pan-Canadian Consensus Guidelines

<sup>9</sup>Sessile serrated adenomas/polyps (SSA/Ps) are also considered precursor lesions and should be included in this category. For more information on the classification and reporting of colorectal polyps refer to the Pathological Reporting of Colorectal Polyps: Pan-Canadian Consensus Guidelines

<sup>10</sup>A secondary pathology review should be considered for malignant polyps (adenomas containing early invasive adenocarcinomas). Refer to [ES #22-2-2](#).

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