Colorectal Cancer Diagnosis Pathway Map

Version 2018.03

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Pathway Map Considerations

- For more information on the Diagnostic Assessment Program (DAP) refer to the Organizational Standards for DAPs.
- 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, HealthCare Connect, 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-Centered Care Guideline.
- Hyperlinks are used throughout the pathway map to provide information about relevant CCO tools, resources and guidance documents.
- The term ‘health care provider’, used throughout the pathway map, includes primary care providers and specialists, nurse practitioners, and emergency physicians.
- 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.

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. The pathway map is intended to be used for informational purposes only. The pathway map is not intended to constitute or be a substitute for medical advice and should not be relied upon in any such regard. Further, all pathway maps are subject to clinical judgment and actual practice patterns may not follow the proposed steps set out in the pathway map. In the situation where the reader is not a healthcare provider, the reader should always consult a healthcare provider if he/she has any questions regarding the information set out in the pathway map. The information in the pathway map does not create a physician-patient relationship between Cancer Care Ontario (CCO) and the reader.

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Note: Guidelines indicated in red are currently undergoing development or review.

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Assessment for Symptomatic Patients

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Symptomatic Patients

Visit to Primary Care Provider

Patient presenting with one or more of the following signs or symptoms:
- Palpable rectal or abdominal mass
- Iron deficiency anemia
- Rectal bleeding
- Change in bowel habits
- Unexplained weight loss
- Abdominal discomfort
- Perianal symptoms

Focused History
- Age and sex
- Rectal bleeding
- Change in bowel habits
- Unexplained weight loss
- Abdominal discomfort
- Perianal symptoms
- Symptoms of anemia
- Personal history of colorectal polyps or IBD, or family history of first-degree relative with CRC

Focused Physical Exam and Test
- Digital rectal exam
- Abdominal examination
- Iron deficiency anemia
- Weight
- Complete blood count

Status

Yes

No

Proceed to Page 4

Semi-urgent

For all other unexplained signs and symptoms that do not meet criteria for an urgent or semi-urgent referral

Level of Suspicion

Resolution of Signs and/or Symptoms (within 4-6 weeks)

EBS #24-1

EBS #24-1

EBS #24-1

EBS #24-1

EBS #24-1

EBS #24-1

Endoscopist

Screen for psychosocial needs, and assessment and management of symptoms. Click here for more information about symptom assessment and management tools

Consider the introduction of palliative care, early and across the cancer journey Click here for more information about palliative care

1 Urgent referral to a specialist competent in endoscopy or to a CRC DAP within 24 hours. Expect a consultation within 2 weeks and definitive diagnostic workup completed within 4 weeks of referral. Refer to EBS #24-1

2 Semi-urgent referral to a specialist competent in endoscopy or to a CRC DAP within 24 hours. Expect a consultation within 4 weeks and definitive diagnostic workup completed within 8 weeks of referral. Refer to EBS #24-1

3 Development of standardized entry and transfer of care criteria are currently underway.

A

Proceed to Page 4

B

Proceed to Page 4

1 Proceed to Screening Pathway Map (Page 3)

R

Urgent

R

Semi-urgent

R

Proceed to Page 4

R

EBS #24-1
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From Screening Pathway Map (Page 3)

From Page 3

Complete colonoscopy

No mass or polyp

Incomplete colonoscopy

Lesion with a low suspicion for cancer

Pathology

Results

Lesion with a high suspicion for cancer (biopsy +/- tattooing)

R

Surgeon

Appropriate completion of bowel examination:

Repeat Colonoscopy with biopsy, polypectomy and/or tattooing as appropriate

EBS #15-5

Quality Management Program for Colonoscopy and Quality-Based Procedures Clinical Handbook for GI Endoscopy

Appropriate treatment

Non-neoplastic

Malignant

Dysplastic

EBS #15-5

Quality Management Program for Colonoscopy and Quality-Based Procedures Clinical Handbook for GI Endoscopy

Screening Pathway Map (Page 3)

Quality Management Program for Colonoscopy and Quality-Based Procedures Clinical Handbook for GI Endoscopy

EBS #24-1

Consider referral to a specialist endoscopist. Refer to EBS #24-1

Screening Pathway Map (Page 4)

Quality Management Program for Colonoscopy and Quality-Based Procedures Clinical Handbook for GI Endoscopy

CT Colonography (If not available, consider double contrast barium enema)

From Screening Pathway Map (Page 4)

From Page 3

Colonoscopy with biopsy, polypectomy and/or tattooing as appropriate

EBS #15-5

Quality Management Program for Colonoscopy and Quality-Based Procedures Clinical Handbook for GI Endoscopy

# Development of standardized entry and transfer of care criteria are currently underway.

# The appropriate treatment of a non-neoplastic lesion is at the discretion of the treating physician.

# Consider referral to a specialist endoscopist. Refer to EBS #24-1
Lesion with a Low Suspicion for Cancer

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Endoscopically Resectable?

- Yes
  - Non-neoplastic
    - Pathology
    - Results
  - Yes
    - Appropriate Treatment
  - No or Uncertain (biopsy +/- tattooing)
    - Pathology
    - Results
  - Dysplastic/ precursor lesion and completely excised
    - Second Endoscopist
    - Endoscopically Resectable?
      - Yes
        - Colonoscopy with biopsy, polypectomy and/or tattooing as appropriate
        - Surgeon
      - No
        - Malignant
          - Secondary Pathology Review
          - Individualized Care Plan
  - Dysplastic/ precursor lesion and incompletely excised
    - Second Endoscopist
    - Endoscopically Resectable?
      - Yes
        - Colonoscopy with biopsy, polypectomy and/or tattooing as appropriate
        - Surgeon
      - No
        - Malignant
          - Secondary Pathology Review
          - Individualized Care Plan

- No
  - Non-neoplastic
    - Appropriate Treatment
  - Dysplastic/ precursor lesion
    - Second Endoscopist
    - Endoscopically Resectable?
      - Yes
        - Colonoscopy with biopsy, polypectomy and/or tattooing as appropriate
        - Surgeon
      - No
        - Malignant
          - Secondary Pathology Review
          - Individualized Care Plan

- Malignant
  - Secondary Pathology Review
  - Individualized Care Plan

2 Development of standardized entry and transfer of care criteria are currently underway.

4 The appropriate treatment of a non-neoplastic lesion is at the discretion of the treating physician.

6 For more information on the classification and reporting of colorectal polyps refer to the Pathological Reporting of Colorectal Polyps: Pan-Canadian Consensus Guidelines

7 sessile serrated adenoma/ polyp (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

8 A secondary pathology review should be considered for malignant polyps (adenomas containing early invasive adenocarcinoma). Refer to ES #22-2-2

Screen for psychosocial needs, and assessment and management of symptoms. Click here for more information about symptom assessment and management tools

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*The choice of CT chest or chest X-ray should be consistent with the modality used for postoperative surveillance. For more information, refer to EBS #17-8*