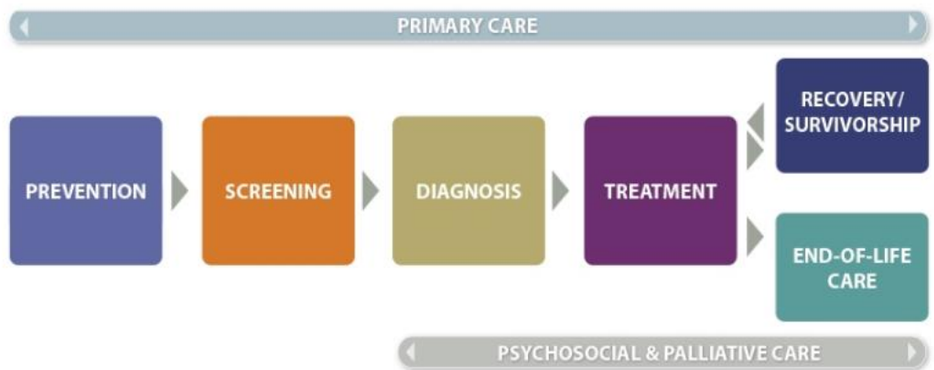
Colorectal Cancer Diagnosis Pathway Map

Version 2020.01



Disclaimer

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 Ontario Health (Cancer Care Ontario) and the reader.

Ontario Health
Cancer Care Ontario

Pathway Map Considerations

- For more information on Organized Diagnostic Assessment refer to the **Organizational Standards**
- 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, **Health Care 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 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, 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 Legend

Colour Guide

- Primary Care
- Endoscopy
- Palliative Care
- Pathology
- Organized Diagnostic Assessment
- Surgery
- Radiation Oncology
- Medical Oncology
- Radiology
- Multidisciplinary Cancer Conference (MCC)
- Psychosocial Oncology (PSO)

Shape Guide

- Intervention
- Decision or assessment point
- Patient (disease) characteristics
- Consultation with specialist
- Exit pathway
- Off-page reference (or)
- Patient/ Provider interaction
- R — Referral
- W — Wait time indicator time point

Line Guide

- Required
- Possible

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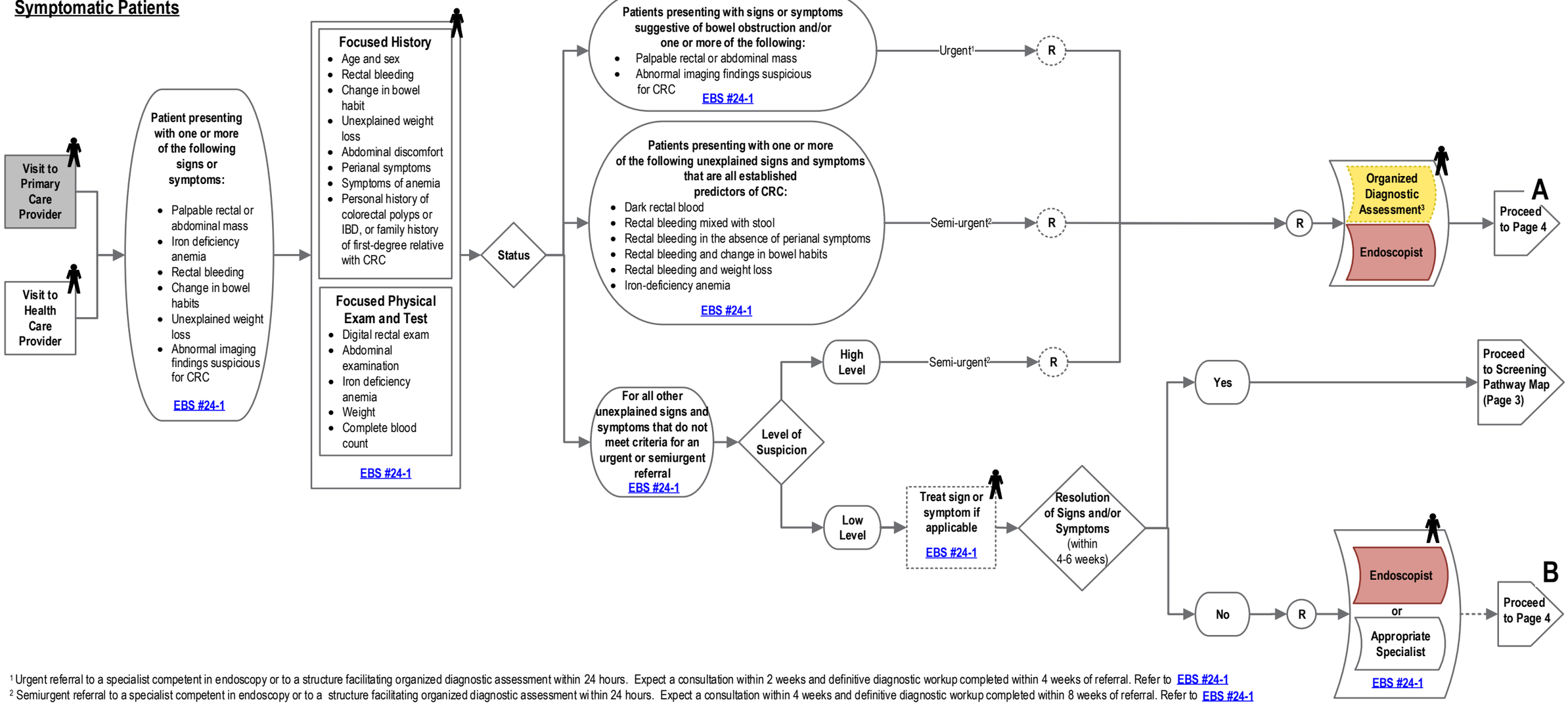
Screen for psychosocial needs, and assessment and management of symptoms. Click here for more information about symptom assessment and management tools

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

Symptomatic Patients



[1] 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

[2] Semiurgent 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

[3] Evaluation of patients with a high suspicion of colorectal cancer may be performed within structures facilitating organized diagnostic assessment.

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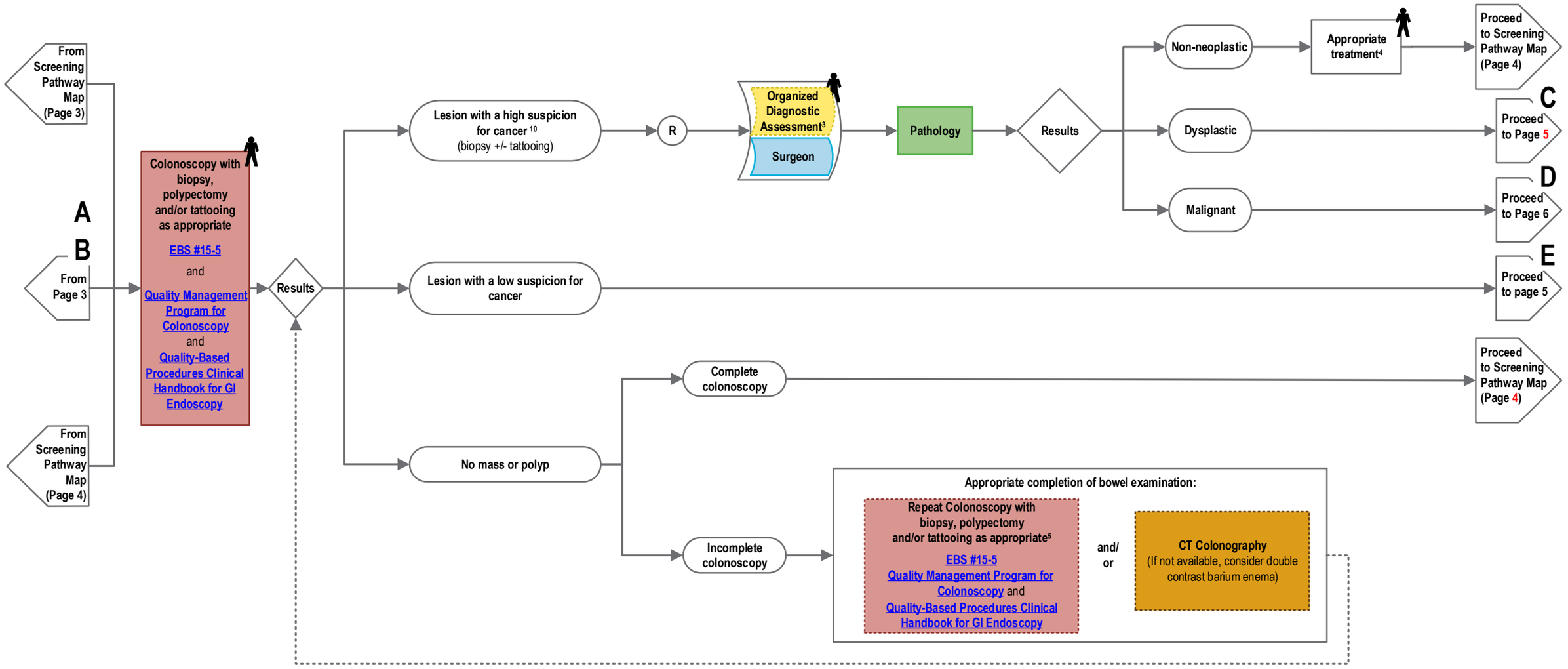

[3] Evaluation of patients with a high suspicion of colorectal cancer may be performed within structures facilitating organized diagnostic assessment.

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

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

[10] Referral should be made for any lesions with a high suspicion for cancer regardless of inconclusive or negative biopsy result for cancer

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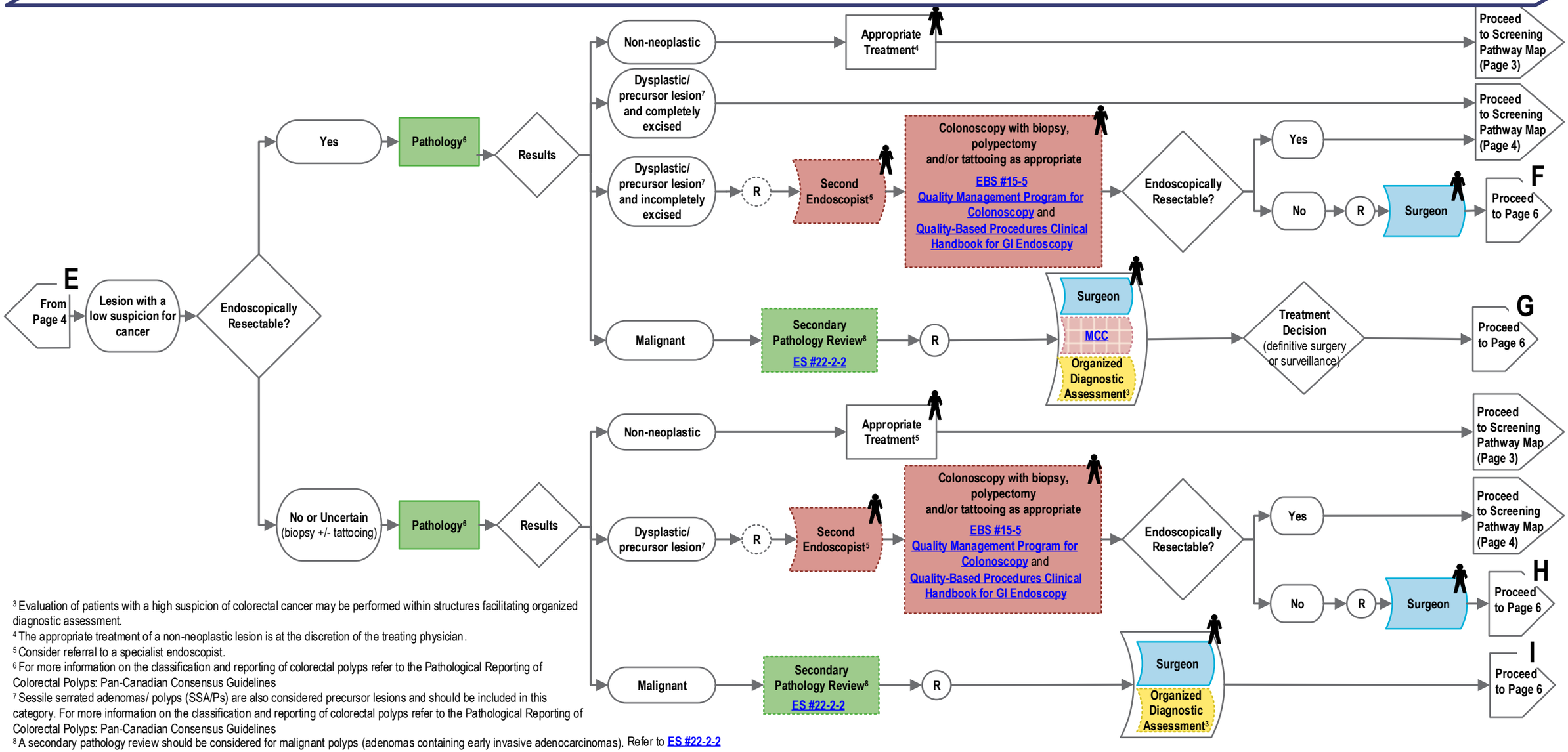

[3] Evaluation of patients with a high suspicion of colorectal cancer may be performed within structures facilitating organized diagnostic assessment.

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

[5] Consider referral to a specialist endoscopist.

[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 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

[8] 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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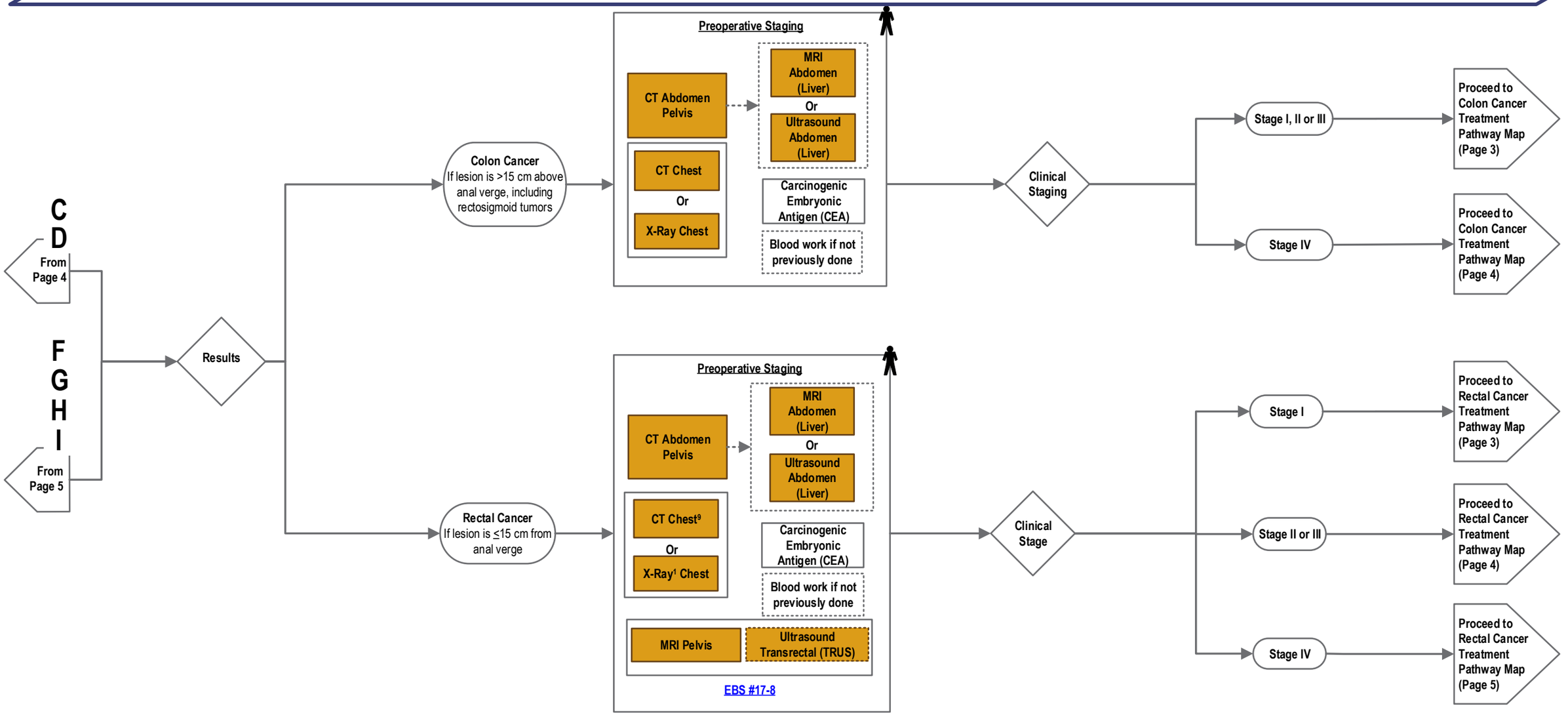

[9] The choice of CT chest or chest X-ray should be consistent with the modality used for postoperative surveillance. For more information, refer to EBS #17-8