

# The Management of Colorectal Cancer

## Pathway of Care

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## 1.0 Introduction and purpose

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The purpose of these guidelines for patients diagnosed and treated for colorectal cancer in the Kent & Medway Cancer Collaborative (KMCC) is to describe the process for ensuring that all Colorectal Cancer cases diagnosed within the KMCC region are managed by the designated Colorectal Cancer MDTs, achieving a coordinated seamless patient pathway in accordance with the best possible evidence based practice and to facilitate advancement in the specialty in the field of colorectal cancer management.

### Notes:

- The Tumour Site Specific Group (TSSG) is responsible for agreeing all of the guidance
- The TSSG should include patient/carer members on the development of the pathway
- The purpose of the document is to provide a framework for the management of patients with suspected/confirmed colorectal cancer
- The overall management details are largely reflected in the updated flow charts
- Oncology treatments are located in the “Oncology Treatment for Colorectal Cancers” document developed by the standing Non-Surgical Oncology Sub Group of the Colorectal TSSG
- Information on MDT “functioning” is confined to the MDT Operational Policies based on the TSSG agreed “High Level Operational Policy” which is located on the KMCC website: <http://kmcc.nhs.uk/tumour-sites/tumour-site-specific-information/colorectal-tssg/>

## 2.0 Scope

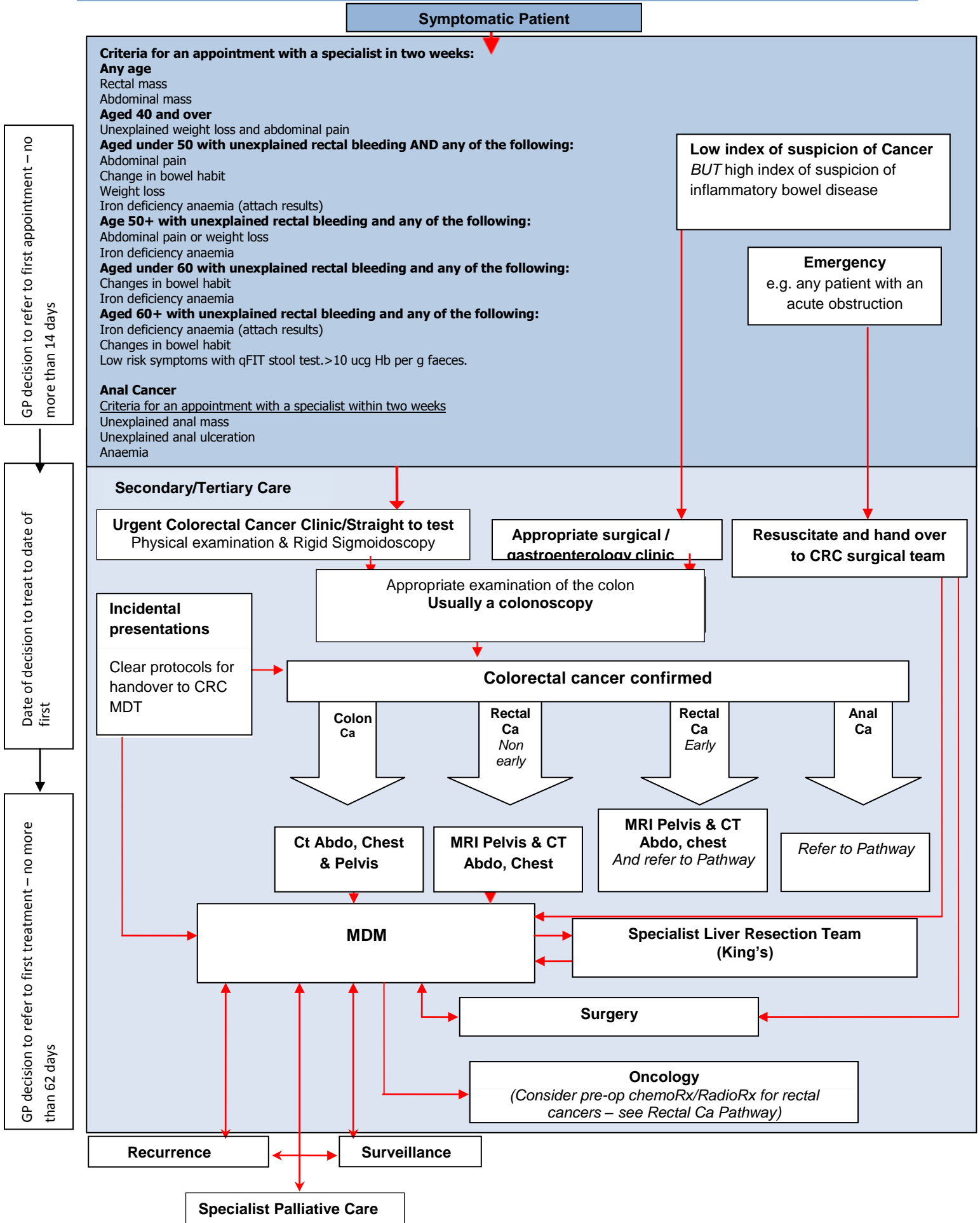
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This Standard Operating Procedure (SOP) applies to all cases and suspected cases of Colorectal Cancer within the KMCC region. The KMCC colorectal cancer specification of delivery of care requires all Trusts within Kent & Medway (K&M) to adopt an agreed policy for the delivery of care. The policy relates to the expected pathway of care / treatment regimes for patients diagnosed with bowel cancer.

The policy covers the following:

- Access
- Initial Assessment
- Investigations
- Colorectal cancer multidisciplinary meeting (MDM)
- Surgical and non-surgical treatment
- Recurrent disease
- Follow up

### 3.0 Pathway Overview



## 4.0 Referral Pathway

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### 4.1 General Principles

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- KMCC Colorectal Teams will function in accordance with the principles set out in the Colorectal High Level Operational Policy and the flow charts outlining the care pathways reflect this approach to care.
- Any KMCC Secondary Care NHS colorectal cancer service or clinic must be provided or lead by a clinician who:
  - Is a member of a recognised KMCC Colorectal Cancer MDT and attends MDMs at least to levels (2/3<sup>rd</sup>) specified in the Quality Measures
  - Is a member of the KMCC Colorectal Cancer TSSG and attends at least 75% of Colorectal Cancer TSSG meetings in any 2 year period
- The management of early rectal cancers, anal cancers and liver metastases will be in accordance with the agreements set out in the High Level Operational Policy for Colorectal Cancer.
- Patients will be offered a Key Worker and should expect to receive clinical and supportive care of the highest standards at all stages along the Pathway of Care.
- All patients should be considered for entry into an approved clinical trial.
- Patients should be referred under the two-week rule according to the agreed referral criteria detailed in the pathways set out on page 5.
- Patients should always be managed appropriately in accordance with their performance status.
- Patients will be seen in rapid access colorectal cancer clinics and investigated, which can have several outcomes. Flexible sigmoidoscopy is regarded as a helpful primary investigation. For those patients in whom whole colon visualisation is warranted, colonoscopy and biopsy will be the gold standard diagnostic tool and will be arranged for appropriate patients. For patients with poor performance status CT Colonography, if available, is a suitable alternative investigation. For patients with very poor performance status, CT chest, liver and abdomen alone may access the appropriate diagnostic tool.
- As a matter of principle for those patients where colonoscopy is not completed (patient discomfort, clinical/technical reasons), patients should wherever possible be offered same day CT Colonography, accepting that logistically this may be difficult to organise.
- Patients, after colonoscopic biopsies, (CT Colonography) will need to attend a results clinic. Ideally the histology should be available within 7 working days unless additional immunochemical staining is required. This should be reviewed by the multidisciplinary team before the patient attends so that the need for staging and appropriate treatments has already been discussed.
- Where the primary investigation reveals a suspected colon cancer the first staging investigation should be CT chest, liver and abdomen. Where the primary investigation reveals a rectal or anal cancer an MRI pelvis and CT chest and liver will be required. These staging examinations should be carried out as soon as possible after the primary investigation and do not require MDT discussion to trigger a request.
- As there are several different treatment options for the spectrum (including early rectal / anal) of colorectal cancer a full discussion should take place about these, after any necessary staging investigations have been carried out, involving the relevant specialists and the patient before a definitive decision is made.
- Where patients fall into the Children's & Young Peoples age group an appropriate referral will be made.
- This pathway will be revised by the K&M Colorectal Cancer TSSG as and when appropriate

## 5.0 Process and Terminology

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### 5.1 Tumours

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- Cancer of the colon
- Cancers of rectum, “early” and “non-early”
- Cancers of the anus
- Liver metastases from a colorectal primary

### 5.2 Referral guidelines and process

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#### 5.2.1 Basis of prioritisation

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The following protocol outlines the priority that should be given to the different types of clinical presentation for investigation of large bowel problems. The clinical presentations are in accordance with the National Referral Guidelines for Suspected Cancer as reflected in the KMCC Urgent Suspected Cancer Referral Proforma.

**General practitioners should not make referrals to named clinicians but to teams.**

#### 5.2.2 Referral of patients with symptoms of colorectal pathology but at low risk of cancer

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It is recommended in patients having a normal abdominal and rectal examination and haemoglobin estimation that the following symptoms be used to identify patients at very low risk of bowel cancer:

- Rectal bleeding with anal symptoms (itching, discomfort, soreness, lump, prolapse and pain).
- Transient changes in bowel habit, particularly to harder stools and/or decreased frequency of defaecation.
- Abdominal pain as a single symptom without other high-risk symptoms and signs, an iron deficiency anaemia, or intestinal obstruction.
- Weight loss in the absence of higher risk symptoms unless rapid and profound.

Patients with these symptoms can be initially safely managed in primary care by careful "treat, watch-and-wait" strategies and reviewed after 3 months. However, if symptoms persist or recur when off all treatment and:

- Remain low risk – refer routinely using Choose & Book or a letter.
- Remain in the low risk category but are worrying / severe – refer using Choose & Book or a letter, requesting an appointment as soon as possible.
- Change to higher risk – refer urgently to clinic using the Network 2ww proforma.

All KMCC reporting pathologists follow The Royal College of Pathologists Histopathology Reporting on Cancers guidelines – a copy of which is available through the KMCC website:-

<http://kmcc.nhs.uk/tumour-sites/sub-groups-or-cross-cutting-groups/pathology-group/>

### 5.2.3 The rapid access route

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General practitioners are encouraged to refer patients with a high index of suspicion of cancer as a matter of urgency.

***High index of suspicion of cancer:***

**Any age**

Rectal mass

Abdominal mass

**Aged 40 and over**

Unexplained weight loss and abdominal pain

**Aged under 50 with unexplained rectal bleeding AND any of the following:**

Abdominal pain

Change in bowel habit

Weight loss

Iron deficiency anaemia (attach results)

**Age 50+ with unexplained rectal bleeding and any of the following:**

Abdominal pain or weight loss

Iron deficiency anaemia

**Aged under 60 with unexplained rectal bleeding and any of the following:**

Changes in bowel habit

Iron deficiency anaemia

**Aged 60+ with unexplained rectal bleeding and any of the following:**

Iron deficiency anaemia (attach results)

Changes in bowel habit

Anaemia

**Anal Cancer**

Criteria for an appointment with a specialist within two weeks

Unexplained anal mass

Unexplained anal ulceration

General practitioners should:

- Provide information on:
  - Family history (including 1<sup>st</sup> and 2<sup>nd</sup> degree relatives with cancer, FAP & HNPCC)
  - History of GI disease (Inflammatory bowel disease)
  - Current medication
- Forward the results of all recent investigations:
  - Barium enema / colonoscopy results
  - FBC results + renal function

**Note:** General practitioners are encouraged to make referrals using the appropriate referral proforma for patients in whom there is a high index of suspicion cancer.

General practitioners should be actively discouraged from requesting barium enemas on patients in whom there is a high index of suspicion of cancer.



## 5.3 Other risk factors

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- Offer patients with ulcerative colitis a follow-up plan agreed with a specialist in an effort to detect colorectal cancer in this high-risk group
- There is insufficient evidence to suggest that a positive family history of colorectal cancer can be used to assist in the decision about referral of a symptomatic patient

Choose and Book referrals for patients with large bowel problems will be evaluated by a surgeon or gastroenterologist who is a member of the colorectal MDT and if there is cause for concern the urgency of the referral will be raised and the patient booked accordingly.

Patients will be notified in accordance with the relevant Trust policy.

## 5.4 Emergency referrals

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### 5.4.1 Within normal working hours

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Patients who present as emergencies within normal working hours should always be managed by designated Bowel Cancer teams.

### 5.4.2 Outside normal working hours

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Patients who present as emergencies outside normal working hours should, if possible, be managed by designated Bowel Cancer teams.

Acute colonic pseudo-obstruction should be excluded.

When out of hours cover is provided by a non-colorectal team, patients should, if clinically appropriate, be resuscitated and referred to the designated Bowel Cancer team at the earliest opportunity.

Where the patient's condition dictates that emergency surgery is the only option, this should be carried out by the "on-call" team, who should then refer the patient to the designated colorectal team at the earliest opportunity.

#### Right sided lesions:

Primary resection & ileo-colic anastomosis is the favoured option.

#### Obstructing left sided lesions:

Primary resection either as a Hartmann's procedure or a primary resection and anastomosis are recommended. The latter may be after segmental resection and on-table lavage or as a sub-total colectomy and ileo-rectal anastomosis.

#### Stoma formation:

Should be carried out in the patient's best interest only and not due to the lack of experience of surgical staff. Except in debilitated patients not fit for major resection, simple defunctioning stoma formation for obstructing left sided lesions is not recommended.

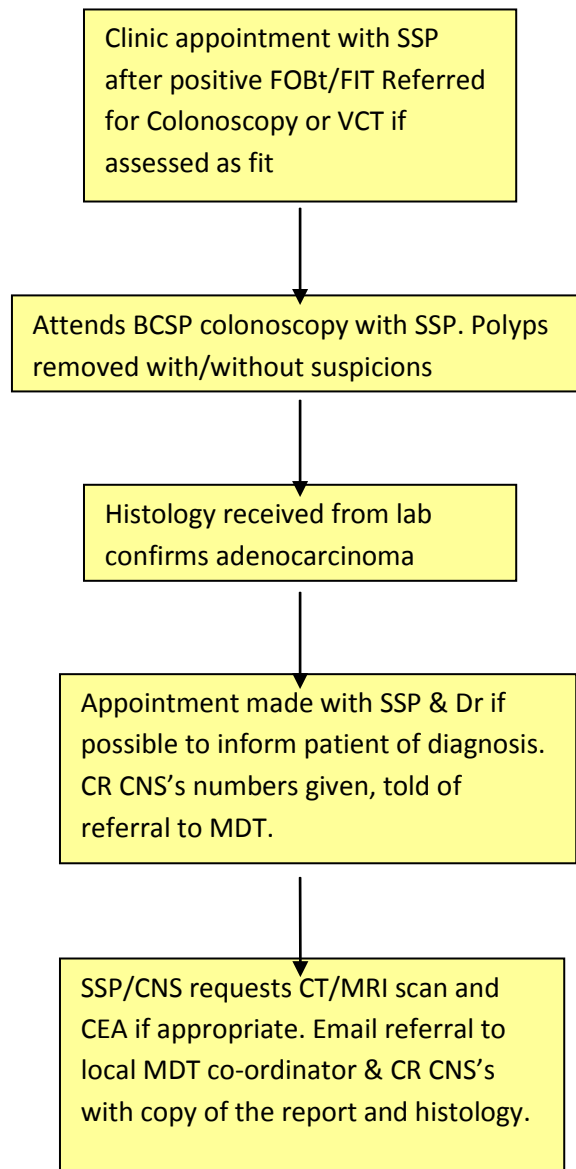
## 5.5 Bowel Cancer Screening

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### 5.5.1 Unsuspected Cancer Referrals

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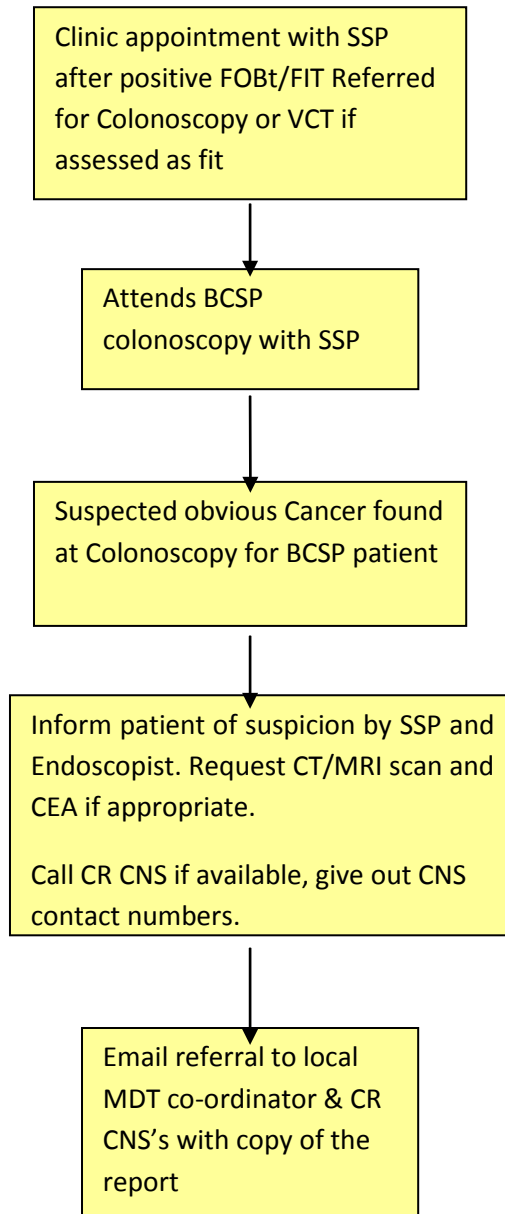
Referral to local Multi-Disciplinary Teams when Unsuspected Cancer is detected:



### 5.5.2 Referral when Cancer is suspected

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Referral to local Multi-Disciplinary Teams when Cancer suspected:



## 5.6 Referral Policy

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The TSSG agreed, in consultation with the MDTs, a policy governing onward referral from the colorectal diagnostic service when a diagnosis is made of either malignant disease or non-malignant disease, and specifies as follows:

- The procedure to be followed;
- The personnel responsible for making onward referral;
- The contact points for the MDTs;
- The points in the process and personnel responsible for informing the patient and the GP of the diagnosis;
- An intention to inform the GP of a diagnosis of malignancy by the following working day after the patient has been informed

**Note:** Contacts are provided in the CRC High Level Operational Policy – please follow the link: <http://kmcc.nhs.uk/tumour-sites/sub-groups-or-cross-cutting-groups/pathology-group/>

Patients who have been referred to non-Bowel Cancer teams, either as routine outpatients or as non-cancer emergencies, and who are subsequently diagnosed with Bowel Cancer, should be referred to the Bowel Cancer team at the earliest opportunity.

This category includes patients, with a low index of suspicion of cancer, initially referred to inflammatory bowel or rectal bleeding clinics.

This category includes patients with metastatic and/or recurrent disease.

The consultant (any surgeon, any physician, any A&E consultant or radiologist) responsible for the care of the patient at the time the diagnosis of cancer is made should be the individual responsible for making the appropriate referral. If not these individuals then Local MDTs should agree with Trust Lead Cancer Clinicians and/or the Trust Medical Director who will be responsible.

It is also “this” consultant who is responsible for ensuring that patients (and their carers) receive appropriate information at this stage in their journey. If it is appropriate that patients are given a potential/confirmed diagnosis of cancer at this stage, this should be undertaken in accordance with the local policy on giving “bad news”. Whilst it the responsibility of the “diagnosing” consultant to ensure that appropriate information is given to the patient BEFORE they are handed over to another team, they may wish to delegate this to an appropriate member of the Bowel Cancer MDT. This may be the Clinical Nurse Specialist. Under NO circumstances should the “giving of bad news” be delegated to junior staff that have not received appropriate training and been deemed competent to undertake this task sensitively.

The responsibilities agreed with Trust Lead Cancer Clinicians and/or Trust Medical Directors must be clearly outlined in Local MDT Operational Policies.

Local MDT Operational Polices must specify the appropriate contact details and be responsible for ensuring the information is kept up to date.

Trust Lead Cancer Clinicians and /or Trust Medical Directors should be responsible for making sure that all of the relevant teams (including any team responsible for out of hours “on call takes”) are aware of this policy.

Trust Bowel Cancer MDT Lead Clinicians should be responsible for making sure that Trust Lead Cancer Clinicians and Trust Medical Directors are aware of this policy. This includes ensuring that any updates (such as changes to contact details) are promptly disseminated to Trust Lead Cancer Clinicians and Trust Medical Directors for onward dissemination.

**Note:** Please cross reference with the relevant section of the CRC High Level Operational Policy <http://kmcc.nhs.uk/tumour-sites/sub-groups-or-cross-cutting-groups/pathology-group/>

## 5.7 Local specialist clinic (& reference to Local Diagnostic Service)

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Patients referred under the 2-week criteria should be seen within 2-weeks of referral.

The Local Specialist Clinic should be managed by members of the local specialist Bowel Cancer multi-disciplinary team.

Clinical assessment of performance status should be undertaken to ensure that patients can be managed effectively and safely.

Abdominal examination, PR and flexible sigmoidoscopy should be undertaken before embarking on any “next steps”.

Where whole colon visualisation is required and unless contraindicated on clinical grounds, colonoscopy should always be the investigation of choice to exclude/confirm a diagnosis of colorectal cancer.

Where colonoscopy is contraindicated, wherever possible it should be replaced by CT Colonography (and if not available barium enema):

- Where CT Colonography is employed, and because rectal tumours can be missed where the balloon is placed to insufflate the bowel, it should always be supplemented with PR examination sigmoidoscopy (a rigid sigmoidoscopy should suffice in this situation).

If for technical reasons (or patient discomfort which cannot be managed by simple analgesic therapy) the initial colonoscopy is not completed (i.e. the caecum is not visualised), the examination of entire colon should be completed/CT Colonography. Under these circumstances, wherever possible, the supplementary CT Colonography should be ideally undertaken on the same day as the initial incomplete colonoscopy to save patients the ordeal of further bowel preparations. The named core member of the MDT responsible for the diagnostic service should liaise with the radiological service to agree a pathway to facilitate same day CT Colonography following incomplete colonoscopy wherever possible.

The MDT may agree that under clearly defined circumstances, a local arrangement for “straight to test” is appropriate. These circumstances must be very clearly set out in the Local Operational Policy and made known to those administrators responsible for managing referrals. For example:

- Patients must be known to have good performance status
- Patients must be able to comply with the necessary bowel prep

**Note:** The responsibility for overseeing the diagnostic phase of the pathway must lie with that core member of the MDT agreed as the Lead for the Diagnostic Service. Please cross reference with the relevant section in the CRC High Level Operational Policy <http://kmcc.nhs.uk/tumour-sites/sub-groups-or-cross-cutting-groups/pathology-group/>

### 5.7.1 Further investigations

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Patients diagnosed with Bowel Cancer other than rectal cancer that are considered potentially fit enough to undergo active intervention should be referred for:

- CT Chest
- CT Abdomen
- CT Pelvis

Patients with rectal cancer should be referred for:

- CT Chest
- CT Liver & abdomen
- MRI pelvis
- ERUS (for patients with suspected T1 tumours of the rectum)

**Note:** For further information on imaging – please refer to KMCC Imaging Guidance available on the KMCC website:-

<http://kmcc.nhs.uk/tumour-sites/sub-groups-or-cross-cutting-groups/diagnostics-group/>

## 5.8 Patients who do NOT have a diagnosis of colorectal cancer

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- In general patients referred to the Bowel Cancer Team and who do NOT have a diagnosis of cancer should promptly be referred back to the GP who should be provided with as much diagnostic information as is available; this should certainly include the results of any endoscopic, radiological, physical and cellular pathology investigations undertaken.
- Patients who do not have a diagnosis of cancer but do require an urgent referral to an appropriate team should be discussed urgently with the GP and agreement reached on how the “new” referral is achieved.
- MDTs should describe in their Operational Policies how patients who are found not to have colorectal cancers are managed. MDTs should ensure that Locality Groups are signed up to the arrangements for the ongoing management for this cohort of patients.
- MDTs should also specify the individual with overall responsibility for managing this cohort of patients. The specified individual should be named in the Operational Policy.

## 6.0 Patients with colorectal cancer

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### 6.1 DUKES’ STAGE A: (Stage 1) T1/2, N0, M0

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Patients with Dukes’ stage A disease have a high probability of cure with surgery alone.

### 6.2 DUKES’ STAGE B: (Stage 2) T3/4, N0, M0

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Patients with Dukes’ stage B disease have a good probability of cure but may benefit significantly from adjuvant chemotherapy

Patients who are considered fit enough for chemotherapy at MDM should be referred to an oncologist for a discussion on the potential benefits of treatment taking into account risk factors within the Dukes’ B spectrum.

### 6.3 DUKES' STAGE C: (Stage 3) Any T, N1-2, M0

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Patients with Dukes' stage C disease have a significant risk of recurrence with surgery alone and should be referred for adjuvant chemotherapy taking into account patient preference and co-morbidity.

Whilst the benefit from adjuvant chemotherapy in this group is established, the risk of recurrence remains significant and patients should be considered for entry into clinical trials attempting to improve the benefits of adjuvant treatment.

### 6.4 DUKES' STAGE D: (modified) (Stage 4)

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Patients with potentially resectable metastatic disease should be considered for chemotherapy and metastatectomy.

Patients unsuitable for resection of their metastases should be considered for palliative chemotherapy taking into account patient preference, co-morbidity and performance status. Whilst the benefits of palliative chemotherapy are confirmed, they are modest and patients should be entered in to clinical trials attempting to improve the benefits of treatment.

All patients with advanced disease should be offered the support of the palliative care team.

## 7.0 Surgical process

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### 7.1 Patients with potentially resectable liver metastasis

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Bowel Cancer patients who develop liver metastasis should be discussed at the MDM and considered for resection/

A designated specialist team agreed by the Colorectal TSSG should carry out all resections for liver metastasis.

There should be clear referral/communication guidelines between the local specialist team and the specialist team providing liver resection.

The agreed Liver Resection Service for Kent and Medway is at King's College Hospital. Kent and Medway patients should normally be referred to King's for this service.

Where patients express a personal preference, then on an individual named patient basis and in agreement with the relevant CCG, the following providers are known to be IOG compliant in the delivery of a Liver Resection Service: King's, St. Bart's and the London, and Guildford. All such providers will comply with MDT standards and KMCC's clinical outcomes audits.

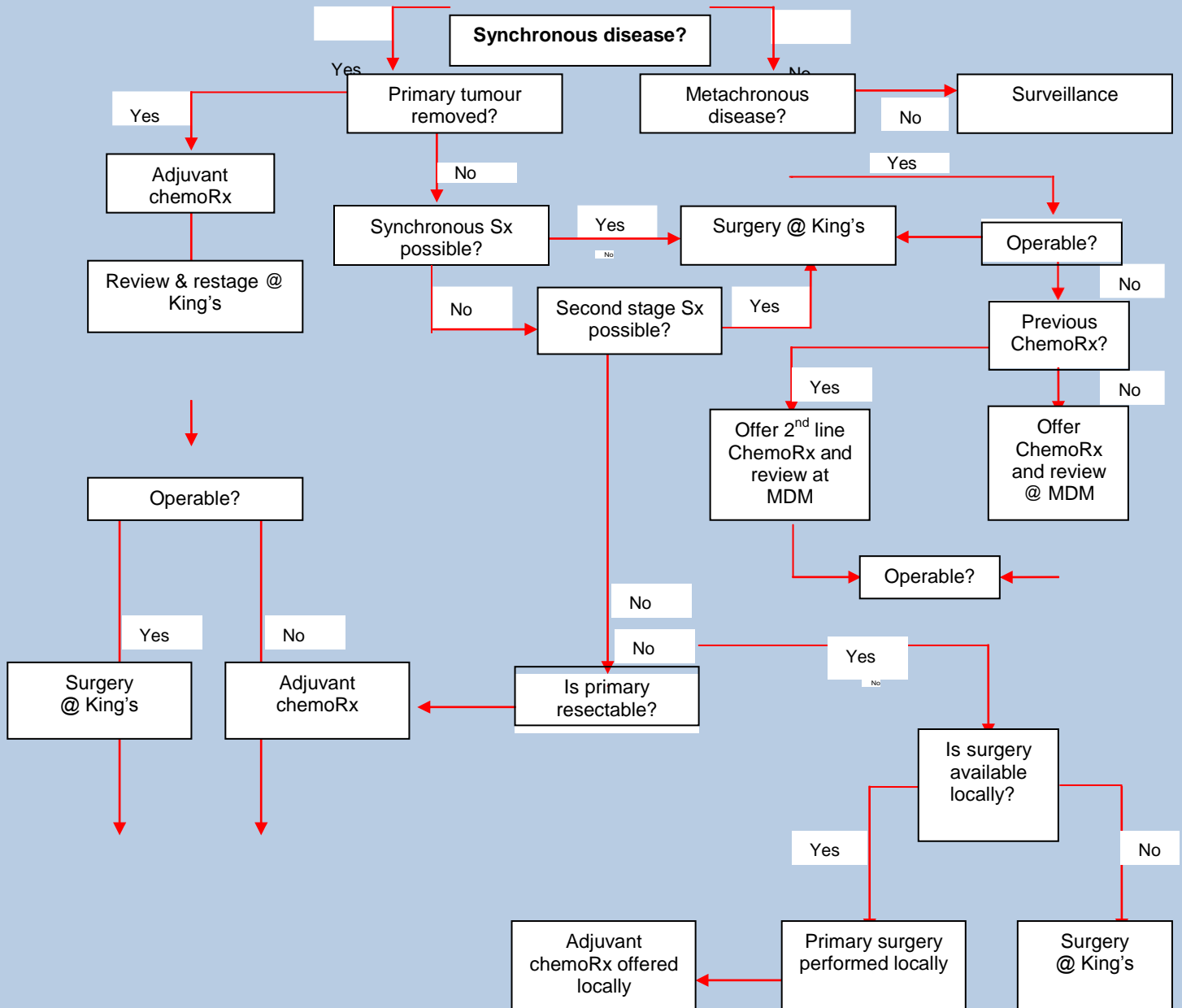
**Note 1:** Referral to King's is via the Kent and Medway designated Bowel Cancer MDTs.

**Note 2:** There are no direct referrals from Primary Care; however, Primary Care clinicians MUST be kept in the communication loop:

- MDT decision to refer
- Progress reports (both directly from King's and the Local MDT as appropriate)

**Patients with potentially resectable liver metastases**

- Joint MDM at which King's Surgeons are present (or)
- In discussion with King's
- Potentially resectable liver mets – refer to King's





## 7.2 Elective surgery for colonic cancers

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It is recommended that the term curative resection should be based on histological confirmation of complete excision of residual tumour.

Surgeons should expect an overall curative resection rate of 60% but this will inevitably depend at least, in part, on the stage at presentation.

Recurrent/relapsed rectal cancers will be managed by local colorectal teams.

## 7.3 Surgical Outcomes for Colorectal Cancer (ACPGBI)

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The 30 day mortality rate should be no worse than 15-25% for emergency surgery and 3-7 % for elective surgery.

Wound infection rates should be less than 10% after elective surgery.

Anastigmatic leak rates should be no greater than 8% for anterior resection and 4% for extra-pelvic anastomoses.

Local recurrence rates of less than 10% should be achieved after potentially curative resection.

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## 8.0 Patients with rectal cancers

The term rectal cancer applies to any cancer whose distal margin is seen at or less than 15 cms from the anal margin with a rigid sigmoidoscope.

Patients with rectal cancers discussed in the MDM setting and considered for pre-operative chemo/radiotherapy.

All patients with rectal cancer in the lower two-thirds should undergo TME, preserving the autonomic plexuses on which sexual potency and bladder function depend.

For tumours of the upper rectum, the mesorectum should be divided at least 5 cms below the margin of the tumour.

### **Patients undergoing neoadjuvant chemoradiation prior to rectal surgery**

Patients with higher risk rectal cancers may be offered neoadjuvant chemoradiation before their rectal surgery. A repeat MRI and CT scan should be carried out 5-6 weeks after completion of chemoradiation. Rectal surgery should be carried out 8-12 weeks after completion of chemoradiation.

### **Patients undergoing short course radiotherapy prior to rectal surgery**

Some patients with rectal cancer will be treated with short course radiotherapy (over 1 week) prior to rectal surgery. Their rectal surgery should be carried out 1 week after completion of the radiotherapy.

### **Patients with early rectal cancer who should be treated at agreed centres include:**

Those patients with T1 tumours not amenable for trans-anal resection who require TEMs

(Some T2 tumours may also be amenable for TEMs)

**Note:** Please cross reference with the relevant section of the CRC High Level Operational Policy. <http://kmcc.nhs.uk/tumour-sites/tumour-site-specific-information/colorectal-tssg/>

**Patients with early rectal cancer who do not need to be treated at an agreed single centre within K&M include:**

- a) Those patients who are unfit for surgery
- b) Those patients more suitable for palliative local thickness resection (e.g. in the presence of distant disease)
- c) Those patients amenable to local thickness disc excision
- d) Those patients who do not want to travel

Recurrent/relapsed rectal cancers will be managed by local colorectal teams.

## 8.1 Definition of “early” rectal cancer

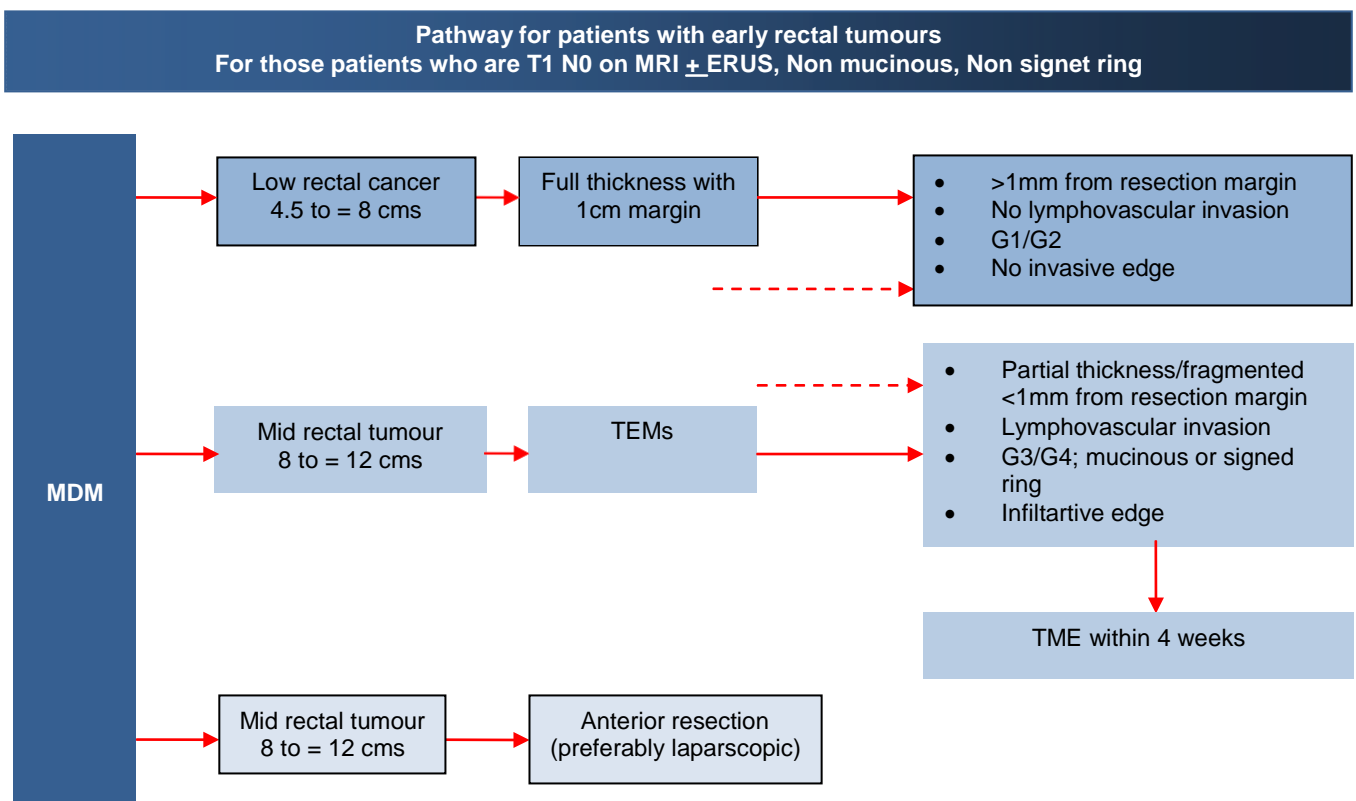
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For purposes of this pathway of care the rectum is defined as that part of the lower GI tract which extends to 15 cms above the anocutaneous junction, with anal canal measuring 4.5 cms being the lowest part.

- Lower 1/3 rd of rectum is therefore 4.5 cms to <8 cms from anal verge.
- Mid 1/3 rd of rectum is between 8 cms and <12 cms from anal verge.
- Upper 1/3 rd of rectum is between 12 and 15 cms from anal verge.

Early rectal cancer is defined as the presence of neoplastic cells confined to the mucosa and inner 2/3<sup>rd</sup> of submucosa [sm1 and sm2] without any evidence of lymph node or distant metastases. This also includes cancers in polyps and incidental finding of a focus of T1 cancer in an excised specimen of Villous or Tubulovillous adenoma.

## 8.2 Pathway for Patients with “early” Rectal Cancers



## 8.3 Types of Early Rectal Cancer

- **Low risk early rectal cancer:**
  - Good or Moderate tumour differentiation [G1 and G2 respectively].
  - No lymphatic invasion – L0.
  - No vascular invasion – V0.
  - Size  $\leq$  6 cms.
  - Tumours located in the posterior or lateral wall [controversial].
  - Tumours in mid or upper rectum [controversial].
  - Full thickness excision.
  - Tumour present more than 1 mm from the resection margin.
  - T1 tumours which are not mucinous or signet ring cell type.
  - SM1 tumours.
  - Well demarcated non-infiltrative front.
- **High risk early rectal cancer:**
  - Poor or undifferentiated [G3 and G4 respectively].
  - Lymphatic invasion – L1.
  - Vascular invasion – V1.
  - Size >6 cms.
  - Tumours in anterior wall [controversial].
  - Tumours in low rectum [controversial].
  - Partial thickness excision or fragmented specimen.
  - Tumour present within 1 mm of resection margin.
  - T1 tumours classified as mucinous or signet ring cell cancers.
  - Poorly demarcated infiltrative front.

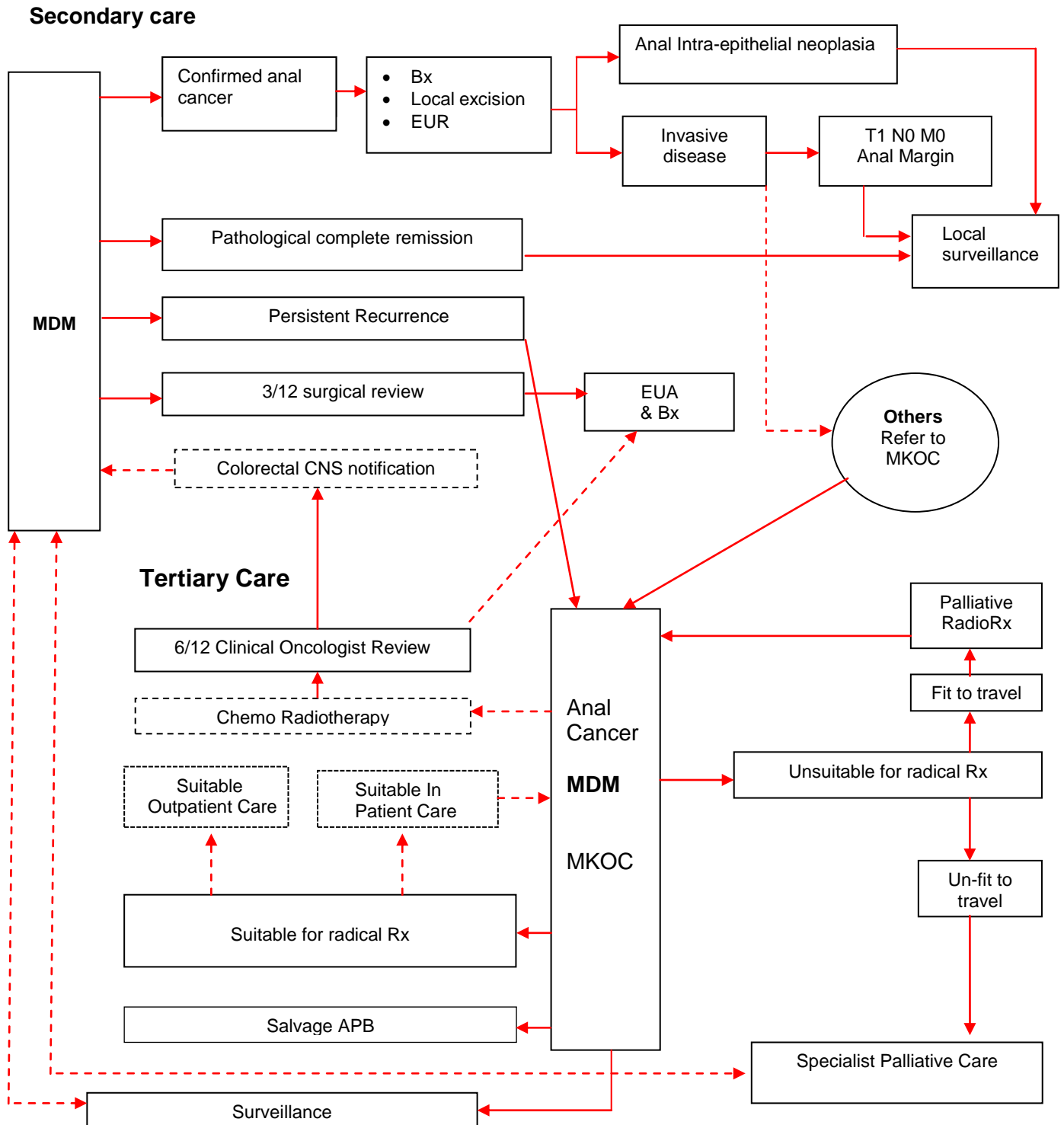
## 8.4 Surgery

**Note:** The details of designated surgeons / centres can be found in the CRC High Level Operational Policy – follow link: <http://kmcc.nhs.uk/tumour-sites/tumour-site-specific-information/colorectal-tssg/>

The TSSG will audit/monitor the outcomes of surgery for early rectal cancer (from local and specialist centres). Measure 1A-272 notes that “Unless there is only one colorectal team in the network, not all of the teams should perform local resection for early rectal cancer”. The audit will assist the TSSG in any deliberations it may hold in relation to the potential rationalisation of these services.

## 9.0 Patients with anal cancers

### Pathway for patients with anal cancers



**Note:** Anal Cancer is a rare disease and specific expertise is important to optimise outcomes for patients

## 9.1 Diagnosis and Staging

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Patients with suspected/confirmed anal cancer should be referred to a colorectal surgeon and investigated under the colorectal MDM.

Patients should be considered for EUA, proctoscopy and biopsy. Small lesions at the anal margin may be considered for local excision. Attention should be paid to achieving clear margins of excision. Lesions in the anal canal should be investigated with sphincter preservation as an important endpoint.

## 9.2 Management

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### 9.2.1 Anal intraepithelial neoplasia (AIN)

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Patients with AIN should be managed and monitored by the colorectal MDM. Selective patients may require input and referral for advice from regional specialist centres (St Marks). Involvement in investigation of novel treatment approaches should be considered.

### 9.2.2 Invasive Disease

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Patients with confirmed invasive disease should be discussed at the colorectal MDM. Those patients considered suitable for radical treatment should undergo staging MRI (following specific protocols previously agreed in the Radiology CCAG) and CT scan Chest and Abdomen. All patients with radically treatable anal cancer (except T1 N0 Anal Margin cancer) should have a PET scan.

Patients with completely excised T1N0M0 Anal Margin Cancers can be managed locally with follow up in the colorectal clinic (suggest 3/12 for first year, 4/12 for second year, 6/12 for 3<sup>rd</sup>, 4<sup>th</sup>, 5<sup>th</sup> year. Then discharge to GP with open access to colorectal clinic via colorectal CNS. No further routine investigations.)

All other patients should be referred and discussed in anal cancer MDT. All staging imaging and pathology should be made available to anal cancer MDT prior to discussion. All patients will be considered if appropriate for radical chemoradiotherapy. Attention to optimising symptom control particularly analgesics with appropriate input from the local symptom control team. Consideration of the roll of defunctioning colostomy should be undertaken after discussion with the Clinical Oncologist.

## 9.3 Referral to Kent Oncology Centre Maidstone Hospital

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Faxed Referral to:

Dr Jeff Summers	Fax No:	01622 225252
	Tel No:	01622 225111
	Mobile No:	07775 801162
	Bleep No:	07659 180910

**or TBC**

Cover for exceptional circumstances: TBC

Patients will be seen within 2 weeks of referral. Patients who require inpatient care will be seen within 1 week of referral to assess necessity of inpatient transfer. Patients will be seen in clinic by the Consultant with the Maidstone Colorectal CNS who will support the patient for the duration of treatment at the Kent Oncology Centre Maidstone Hospital and liaise with the local CNS to ensure seamless care.

### 9.3.1 Process

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The patient will be assessed for suitability for radical chemoradiotherapy and considered for randomisation into the ACT 2 study. Patients will be introduced to a named therapeutic radiographer with expertise in patient information and provided with written information about the treatment schedule, pelvic radiotherapy and the drugs to be used. Patients considered suitable for the ACT 2 trial will be introduced to the named Colorectal Research Nurse and given the written patient information sheet for the trial.

Patients will be considered for defunctioning colostomy as appropriate and after discussion of the potential benefits with the Colorectal CNS. If advised this will be co-ordinated via the local CNS.

Patients with anal cancer have increased risk of sexually transmitted diseases. Sexual history taking may suggest patients at risk of being HIV +ve, the latter would benefit from being identified before initiating chemotherapy.

Patients with significant risk factors for HIV and AIDs related malignancies will be referred for HIV counselling and evaluation through the Maidstone & Tunbridge Wells (MTW) Trust GU Clinic.

Patients accepted for radical chemoradiotherapy will be discussed at the MTW Colorectal MDM with the Histology and Radiology in order that they receive the support they require from a specialist team during the treatment at the Kent Oncology Centre Maidstone Hospital.

During the treatment program the patients will be monitored and supported by a named Therapeutic Radiographer, Chemotherapy Nurse and Colorectal CNS.

Patients will be reviewed weekly by the Clinical Oncologist during the treatment program and until after the peak of the early radiotherapy reaction. The local Colorectal CNS will then be notified at this point to maximise the seamless care and transfer back to the local Colorectal MDM.

The patient will then be reviewed by the Clinical Oncologist at 6 weeks post treatment. A letter will then be written to the referring colorectal surgeon requesting a EUA and biopsy of any suspicious areas at 3 months post treatment.

Patients in complete remission will then transfer to follow up 6/12 alternating with Clinical Oncologist/Colorectal Surgeon. Patients considered suitable for Lung and Liver resection will have routine CT Chest and Abdomen at 1 year and 2 years post diagnosis. Patients who develop symptoms will return to the local Colorectal Surgeon via direct access to the Colorectal CNS.

Patients who have required de functioning procedures prior to treatment will be considered for reversal as soon as practical once complete response has been confirmed with due consideration to sphincter function.

Patients who have residual viable disease (Persistent anal cancer) or who develop local or regional recurrence (recurrent anal cancer) at the 3/12 post treatment point will be considered for salvage APR / salvage inguinal lymphadenectomy after repeat MRI pelvis and CT scan Chest and Abdomen and discussion at the colorectal MDM. Salvage surgery tend to be more difficult than standard APR (prior radiotherapy, need for wider perineal / ischiorectal clearance / need for concomitant pelvic & inguinal lymphadenectomy / need for rectus abdominis or gracilis myocutaneous flap reconstruction). Such surgery may have to be concentrated in few centres to optimize results (current opinion of ACPBGI).

Anal Cancer patients may also require diversion stomas for incontinence or malignant or radiation induced rectovaginal & rectourethral fistulae. These can be managed by the referring colorectal surgeon.

Access to Plastic Surgical and Gynae Oncology will be obtained via Dr Jeff Summers / Dr Julia Hall.

Patients who develop systemic recurrence or inoperable loco regional recurrence should be discussed at the colorectal MDM and referred back to the clinical oncologist using the fax referral system for consideration of palliative chemotherapy. Early involvement of the palliative care services should be encouraged to ensure optimal symptom control and support.

Patients who are not considered suitable for radical treatment should be discussed at the colorectal MDM. Early involvement of the palliative care team should be encouraged to optimise symptom control and support.

Patients who are considered suitable to travel to the Kent Oncology Centre Maidstone Hospital should be referred using the fax referral system. Patients will be seen within 2 weeks of referral and considered for palliative radiotherapy. Patients who are not considered suitable to travel to the Kent Oncology Centre Maidstone Hospital should be discussed on the telephone with Dr Jeff Summers or Dr Julia Hall who will offer advice and arrange an oncology opinion as appropriate.

### 9.3.2 Monitoring Process

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A prospective data base of all referrals will be made. The initial stage, Co-morbidity and Performance Status will be recorded. The proportion of patients undergoing radical chemoradiotherapy, entered into ACT 2 and requiring defunctioning will be recorded and made available to the TSSG.

Outcome measures will be recorded:

- Recurrence Rate
- Salvage Surgery Rates
- Defunctioning Colostomy Rates
- Short term and long term impact of treatment

## 10.0 Oncology

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For specific information on oncological treatment details please refer to the KMCC oncological guidance found on the KMCC website:-

<http://kmcc.nhs.uk/tumour-sites/tumour-site-specific-information/colorectal-tssg/>

## 11.0 Patients with recurrent disease

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Patients with recurrent disease should be discussed by the MDT at the MDM as soon as possible after recurrence is confirmed to define the optimal treatment programme.

## 12.0 Specialist palliative care and support

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All patients with Bowel Cancer will have access to specialist palliative care and support at every stage of the patient journey.

Open and frank discussions with patients should take place with patients at all stages of their journey so that patients are not confused about their prognosis or have unrealistic expectations of any of the forms of treatment offered to them.

Relatives and carers will need to be supported adequately and given appropriate information. However, in accordance with the recommendations set out in the revised Improving Outcomes Guidance in Bowel Cancer, relatives and carers should not be given information different to that given to the patient.

Frail and terminally ill patients with Bowel Cancer should always be discussed with the specialist palliative care team.

For Bowel Cancer patients with end stage disease who become obstructed there are a number of therapeutic options which include:

- Surgical management (including open surgery)
- Surgical/radiological management (including stenting)
- Systemic drug management (including the use of Somatostatin/high dose steroids)
- A combination of the above

Patients with end stage disease may choose to end their days at home and therefore the choice of intervention should always be discussed openly with them and their relatives/carers.

Effective communication with primary care is essential.

All patients should have unlimited access to a Bowel Cancer nurse specialist who is a member of the specialist Bowel Cancer team.



## 13.0 Stomas

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Patients who are to be offered stomas (permanent or temporary) should have the benefits and implications fully explained to them.

Patients should have unlimited access to a Bowel Cancer nurse specialist and or a stoma care nurse specialist.

## 14.0 Clinical trials

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Suitability for entry into Kent & Medway agreed clinical trials should be a standard component of the MDM discussion on each patient with Bowel Cancer.

## 15.0 Follow up

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Patients (their relatives and carers) should have unlimited access to clinical nurse specialists for support.

### 15.1 Clinical follow up

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Patients in high-risk groups (FAP, HNPCC) will be followed up in accordance with BSG guidance.

- Patients will have a colonoscopy at 6-12 months if complete pre-operative colonoscopy is not undertaken. This applies to elective and emergency surgery patients.
- If this colonoscopy is “clean” – repeat colonoscopy at 5 years only. If polyps are found then an earlier scope may be required
- CT chest, liver and abdomen at 1, 2 and 5 years\*
- CEA 6 monthly for 5 years
- Unlimited patient initiated support via CNS outside this guidance. There should be a Specialist Palliative Care / Primary Care / Secondary Care Specialist Nurse Consortium approach to the provision of this service with robust and documented communication / information sharing policies in place to ensure patients do not fall through the net.
- Patients with rectal cancer should have a baseline CT at 6 months.

\* There is no reason why these investigations cannot be co-ordinated via Primary Care and/or Primary/Secondary Care Nursing consortia. Results can be conveyed to patients via the same mechanisms so that patients need only attend for a specialist hospital clinic appointment in the event of an adverse result.

Outside these criteria – concerned patients should have immediate access to clinical nurse specialists who will escalate concerns to the MDT and facilitate an urgent appointment with the relevant clinician – if appropriate.

**Note:** Evidence for follow up in patients with bowel cancer remains contentious. Papers on follow-up are published regularly, the number advocating intensive programmes approximately equalling those advocating non-intensive programmes.

The Kent and Medway Colorectal TSSG will monitor evidence for follow up and, as with all aspects of patient care, review the recommendations set out in this document on a regular basis.

## 15.2 Liver resection follow up

Following resection for liver metastases, the follow up programme agreed with King's is as follows:

- Baseline CT at 4 weeks post resection
- CT (Chest, Abdomen & Pelvis), Tumour Markers, LFTs, FBC, and clinical review every 6/12 for the first 3 years post liver resection and then annually until 5 years
- Follow up scans will be reviewed by the King's team.

## 16.0 Surveillance

Disease Groups	Procedure	Time of initial screen	Screening procedure & interval	Source
<b>COLORECTAL CANCER</b>				
	Consultation LTFs Colonoscopy	Colonoscopy within 6/12 of resection only if pre-op colon evaluation incomplete	Colonoscopy every 5 years* ( <i>until 70-Dunlop, CGM – until not fit for surgery</i> ) CT Chest, liver & abdomen @ 12 & 24 months & 60 months* ( <i>Within 2 years – Dunlop</i> )	ACP, BSG, * = 2004 workshop
<b>COLONIC ADENOMAS</b>				
Low risk 1-2 adenomas Both <10mm	Colonoscopy	No surveillance or 5 years	Cease surveillance	BSG SIGN
Intermediate risk 3-4 adenomas, OR at least 1 adenoma ≥10mm	Colonoscopy	3 years	Every 3 years until 2 consecutive negative colonoscopies, then no further surveillance	BSG SIGN
High Risk ≥5 adenomas OR ≥3 with at least 1 ≥ 10mm	Colonoscopy	1 year	Annual colonoscopy until out of this risk group then interval colonoscopy as per intermediate risk group	BSG
Large sessile adenomas removed piecemeal	Colonoscopy or flexible sigmoidoscopy (depending on polyp location)	3 monthly until no residual polyp: consider surgery		BSG
<b>FAMILY HISTORY SYNDROMES (Need to be seen in specialist clinics)</b>				
3 FDR with colorectal cancer none <50 years (in first degree kinship)	Colonoscopy	Age 50	5 yrly to 75	BSG
2 FDR with colorectal cancer mean age <60 yrs (in first degree kinship)	Colonoscopy	Age 50	5 yrly to 75	BSG
2 FDR with colorectal cancer >60 yrs	Colonoscopy	Age 55	Once only – if normal, no follow up	BSG
1 FDR with colorectal cancer <50 yrs	Colonoscopy	Age 55	Once only – if normal, no follow up	BSG
One other FH of colorectal cancer	None	N/A	N/A	BSG

**Notes:**

1. *SIGN = Scottish Intercollegiate Guidelines*
2. *Prof. Chris Marks (past President of ACP has confirmed ACP & BSG guidance jointly drawn up)*
3. *These surveillance guidelines represent a consensus of best practice based on the available evidence at the time of preparation. They may not apply in all situations and should be interpreted in line with specific clinical standards and resource availability.*
4. *The TSSG will review available evidence and update this section where appropriate.*

## **17.0 Data**

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Collection of data at each stage of the pathway is the responsibility of the team looking after the patient at that time. The minimum dataset agreed by the TSSG will be a combination of those data items that meet national requirements, and additional items as agreed by the TSSG.

National data requirements will include:

- Cancer Waiting Times monitoring, including Going Further on Cancer Waits. The data items required will be as defined in ISB0147 at the time of referral and/or treatment.

Details of the Cancer Waiting Times dataset are available from:

[http://www.datadictionary.nhs.uk/data\\_dictionary/messages/clinical\\_data\\_sets/data\\_sets/national\\_cancer\\_waiting\\_times\\_monitoring\\_data\\_set\\_fr.asp](http://www.datadictionary.nhs.uk/data_dictionary/messages/clinical_data_sets/data_sets/national_cancer_waiting_times_monitoring_data_set_fr.asp)

Cancer Waiting Times data will be submitted according to the timetable set out in the National Contract for Acute Services.

- The Cancer Outcomes and Services Dataset. The data items will be as defined in ISB1521, and any subsequent versions, at the time of diagnosis and/or treatment. The requirement will include those fields listed in the “Core” section of the dataset, and any additional tumour site specific sections, as applicable.

Details of the COSD are available from:

[http://www.ncin.org.uk/collecting\\_and\\_using\\_data/data\\_collection/cosd.aspx](http://www.ncin.org.uk/collecting_and_using_data/data_collection/cosd.aspx)

Cancer Registration and Cancer Outcomes and Services (COSD) data will be submitted according to the timetable set out by the National Cancer Registration Service (NCRS).

- Where applicable, teams will also collect additional data items as defined in any corresponding National Clinical Audit Support Programme (NCASP) audit dataset.

Details of these datasets are available from:

<http://www.ic.nhs.uk/services/national-clinical-audit-support-programme-ncasp/cancer>

Data for NCASP audits will be submitted, where applicable, according to timetables as agreed by the TSSG, and within the overall submission deadlines for each audit.

Submission of data to meet these national requirements will be the responsibility of each individual Trust.

Note that these standards are subject to variation from time to time, and where these requirements change, the data items required to be collected by the team will also change in line with national requirements.

Local data requirements will include any additional data items as agreed by the TSSG. These must be selected to avoid overlap with any existing data items, and where possible must use standard coding as defined in the NHS Data Dictionary.

Where possible and applicable, InfoFlex will be used for the collection and storage of data.

Additional areas of the COSD, relating to pathology, radiotherapy, Systemic Anti-Cancer Therapy (SACT), diagnostic imaging and basic procedure details will feed into the dataset from other nationally mandated sources. It is the responsibility of each team to ensure that the whole of the relevant dataset is collected, and it is acknowledged that this may come from a variety of sources.

## 18.0 Personnel and Contact Information

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A comprehensive, up to date list of MDM contact details can be found on the KMCC website via the following link: <http://kmcc.nhs.uk/tumour-sites/terms-of-reference/>

## 19.0 Glossary

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Acronyms in common usage throughout KMCC documentation

CNB	Cancer Network Board
CYP	Children & Young People (in relation to the IOG)
DCCAG	Diagnostic Cross Cutting Advisory Group
DOG	Disease Orientated Group (NSSG/TWG)
DVH	Darent Valley Hospital
EK	East Kent
EKHUFT	East Kent Hospitals University Foundation Trust
HoP	High Level Operational Policy
IOSC	Improving Outcomes: A Strategy for Cancer
K&C	Kent & Canterbury Hospital, Canterbury, (EKHUFT)
KMCC	Kent & Medway Cancer Collaborative
KMCRN	Kent & Medway Cancer Research Network
LSESN	London & South East Sarcoma Network
MFT	Medway Foundation Trust
MTW	Maidstone & Tunbridge Wells NHS Trust
NOG	Non-Surgical Oncology Group ( <i>Permanent oncologist sub group of the TSSGs with a specific responsibility for chemo/rad pathways and advice to the TSSG, KMCC and geographical locations on new drugs</i> )
PoC	Pathway of Care ( <i>KMCC agreed disease site specific clinical guidelines</i> )
QEQM	Queen Elizabeth the Queen Mother Hospital, Margate (EKHUFT)
QoL	Quality of life
RAT	Research and Trial Group ( <i>Permanent sub-group of the TSSGs with a specific responsibility for taking forward the clinical trials agenda</i> )
RMH	Royal Marsden Hospital
RNOH	Royal National Orthopaedic Hospital
TSSG	Tumour Site Specific Group
TYA	Teenage & Young Adult
QVH	Queen Victoria Foundation Trust Hospital East Grinstead
UCLH	University College Hospital London
WHH	William Harvey Hospital, Ashford (EKHUFT)
WK	West Kent

## 20.0 Document Administration

Document Title	The Management of Colorectal Cancer
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Revision History			
Date of revision	New Version Number	Nature of Revision	Confirmation of Accuracy by
01/08/2005	0.1	Initial draft – all sections reviewed	A.Jackson/CRC DOG
09/02/2006	0.2	Final draft – final updates agreed CRC DOG 08/02/2006	CRC DOG
21/02/2006	1.0	Published - final comments from M.Parker	C.Evans/M.Parker
21/08/2007	1.1	Revised draft – overall review, updated section for anal cancers, updated contacts lists	A.Jackson/J.Summers
28/08/2007	1.2	Revised draft - updated contacts lists	C.Evans
30/08/2007	1.2	Revised drafts – chart on pg29 removed as per N.Rao, Rectal Ca flow chart amended, updates on f/u,rectal cancer, stenting & referral	A.Jackson/CRC DOG
04/11/2007	1.3		A.Jackson/J.Summers/ N.Heaton
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07/01/2008	2.0	Published – insertion of final comments	A.Jackson/CRC DOG
18/02/2008	3.0	Published – corrections of definitions to rectal tumours	A.Jackson/J.Schofield
06/11/2009	3.1	Revision draft – updates in line with new Peer Review requirements – alignment to HOP	A.Jackson
01/03/2010	4.0	Final – updates on flexible sigmoidoscopy triage following Feb 2010 CRC DOG meeting	A.Jackson
08/03/2010	4.1	Revision draft – updated contacts lists	C.Tsatsaklas
12/05/2010	5.0	Final – laparoscopic surgery and ERP	A.Jackson
20/09/2010	5.1	Revisions – updates in line with internal review	C.Peters
21/09/2010	6.0	Final	C.Tsatsaklas
10/04/2011	6.1	Updates under f/u and oncology	I.Vousden
06/10/2011	6.2	Revisions – grammatical corrections	C.Peters
June 2012	6.3	Draft – updated all weblinks inc. imaging, pathology & contacts; general formatting & content checking	S.Stanley/C.Tsatsaklas
September 2012	6.4	Draft – data collection section updated	A.Brittle/C.Tsatsaklas
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May 2014	7.1	Draft – general admin text updates made (weblinks etc) and revision to section 9.2.2 regards PET scan	J.Hall/Colorectal TSSG/ C.Tsatsaklas
November 2014	7.2	Draft – Bowel Cancer Insert added	D.Lawes/N.Aluwalia
December 2014	8.0	Following ratification by Operational & Quality Group, final published version	N.Aluwalia
September 2016	8.1	Draft – Revision due. Web links amended, timeline added and general admin updates. Draft to be discussed at TSSG 20/9/16	N.Aluwalia
January 2017	8.2	Amendments made following TSSG. HW to check further clinical detail prior to ratification. Replaced contact details for F.Muller with H.Wegstapel.	N.Aluwalia
January 2017	8.3	Added NG12 criteria into 2ww section, approval by H.Wegstapel.	N.Aluwalia
March 2017	8.4	Added amendments noted via TSSG circulation	N.Aluwalia
July 2017	8.5	Final amendments to follow up as agreed in the TSSG made by H.Wegstapel, emailed to O&Q for ratification.	H.Wegstapel/N.Aluwalia
July 2017	9.0	Final ratified document, added final changes	N.Aluwalia
August 2019	10.0	Amendments to 3.0, 4.1, 5.2.3, 5.7, 9.0, 9.2.2, 9.3. Remove Barium Enema. 7.3 removed (Laparoscopic section) TSSG Lead updated	A.Wiltshire