The Association of Coloproctology of Great Britain and Ireland

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Joint ACPGBI, BSG and BSGAR considerations for adapting the rapid access colorectal cancer pathway during COVID-19 pandemic

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NHS England recently published specialty advice for endoscopy services, advocating continuation of both the rapid access cancer referral pathway and bowel cancer screening with FIT: https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/04/C0076-Specialty-guide-for-endoscopy-and-coronavirus-v1-02April.pdf.

During the COVID-19 pandemic, rapid access two week wait colorectal cancer referrals will continue. Changes to our usual methods of managing these patients will have to be made because:

- Only therapeutic emergency and essential endoscopy is being carried out given the risks of aerosol generating procedures (AGP). Colonoscopy, flexible sigmoidoscopy and rigid sigmoidoscopy are currently classified as procedures that may be deferred during the pandemic. The British Society of Gastroenterology and Joint Advisory Group guidance on Endoscopy during COVID-19 is available at: https://www.bsg.org.uk/covid-19-advice/endoscopy-activity-and-covid-19-bsg-and-jag-guidance/.
- Use of virtual colonoscopy (CT colonography) should also stop unless there is explicit local agreement amongst all relevant stakeholders that capacity exists to continue a reduced service. There will undoubtedly be increased demand for diagnostic and screening CT scanning for patients with confirmed or suspected COVID-19 infection. The British Society of

Gastrointestinal and Abdominal Radiology advice is available at https://www.bsgar.org/static/uploads/CT%20Colonography%20activity%20and%20Covid_v2_(25th%20March%202020).pdf.

- Hospital footfall increases the risk of contracting COVID-19 infection, with the biggest risk of associated mortality applying to older and/or comorbid patients.
- Many patients with newly diagnosed colorectal cancer may have treatment deferred until healthcare resources recover, unless they develop complications requiring emergency admission.

ACPGBI recognises that the yield of new colorectal cancer diagnoses from the current rapid access pathway is low at 3-4%, and many patients are diagnosed through other routes. The low cancer yield from the rapid access pathway means that a complete shift in emphasis is required during COVID-19 restrictions on healthcare practices to identify patients with high risk of colorectal cancer that might precipitate need for urgent or emergency admission rather than providing a cancer exclusion service. Benign neoplasia and early colorectal cancer treatments may be deferred for a few months without risk of major disease progression in most. Delaying treatment in cancer patients until it can be offered in a lower risk, and appropriately resourced, healthcare environment may also be in the patient's best interest during the COVID-19 pandemic: https://www.acpgbi.org.uk/content/uploads/2020/03/ACPGBI-statement-on-CRC-treatment-during-COVID-19-FINAL.pdf.

Once a local strategy has been agreed, this should be communicated to general practice colleagues and local Clinical Commissioning Groups, outlining the rationale for the change and providing clear mechanisms for safety-netting of patients for the duration of the crisis. An "urgent patient only" colorectal cancer clinic stream established locally should prioritise clinical acumen and high level of clinical suspicion on the part of both General Practitioners and clinicians in secondary care, all of whom will be making assessments remotely without opportunity for clinical examination or basic investigations. Where available and provided delivered remotely, FIT testing may help assess level of cancer risk. Dialogue between community referrer and secondary care clinician prior to referral is encouraged. An urgent referral with high index of clinical suspicion may be made to allow further triage in secondary care. Patients with concerning symptoms or a high FIT test result may also be referred for consideration of deferred investigation. The proposed pathway is outlined in Figure 1.

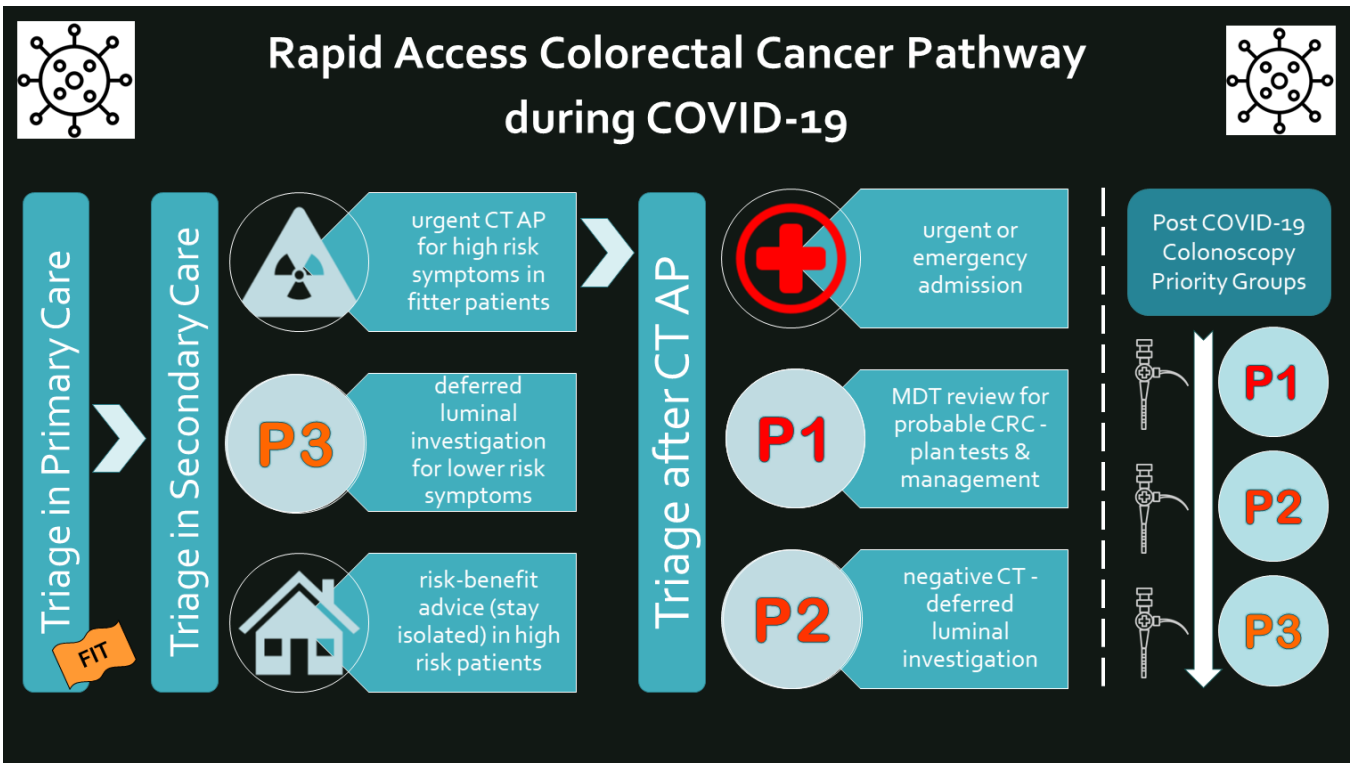

Figure 1: Infographic outlining streamlined urgent referral pathway for colorectal cancer patients based on remote clinical triage, investigation with CT alone in high risk patients, and deferred colonoscopy in prioritise patient groups.

Secondary care will need to establish a virtual remote clinic to assess patients, preferably using video link to improve clinical judgement and communication when discussing relative risks and benefits and managing patient expectations. The urgent referral clinic will further triage the patient based on symptoms, FIT test if available and vulnerability score to:

- urgent but limited investigation
- deferred luminal investigation or CT colonography (third priority category P3) with safety-netting advice
- advice about risk-benefit balance and discharge with safety-netting criteria for subsequent re-referral.

The latter option is the preferred triage option for all vulnerable patients, including the elderly (especially if >80 years), nursing home residents, frail patients and those with dementia or multiple comorbidities. A score to help assess vulnerability of patients during COVID-19 may be found here: https://journals.lww.com/dcrjournal/Documents/Prioritizing_Access_to_Surgical_Care_During_the.99694.pdf.

If urgent investigation is deemed essential for the patient's safety, then CT abdomen and pelvis, as sole investigation, is recommended to identify urgent cases. CT has a high probability of detecting advanced cancers likely to result in complications, as well as other pathologies which may require urgent treatment including complicated diverticulitis, acute severe colitis and obstruction. CT chest should only be added if indicated on elective clinical grounds, given the need to avoid generating new diagnoses of indeterminate lung nodules requiring interval imaging. If the patient requires emergency admission, CT chest should be carried out at time of CT abdomen and pelvis to assess for signs of COVID-19 infection. Based on the CT result, patients would then be triaged to:

- urgent or emergency admission for surgical treatment
- MDT review for cancer management plan
- deferred luminal investigation or CT colonography (second priority category P2).

Patients who are diagnosed with probable colorectal cancer on CT should be discussed in the colorectal cancer MDT to plan further investigation and management, likely to involve the whole spectrum of plans from subsequent staging and luminal investigations with biopsy in top priority group if curative treatment intent probable to palliative care where unresectable metastatic disease is found. Some patients with more advanced or symptomatic rectal cancer may still need limited sigmoidoscopy and biopsy prior to radiotherapy.

All patients referred will need to be logged and tracked. Access to telephone-based specialist cancer nursing advice is desirable after triage. As tracking and advisory roles will increase the burden on colorectal clinical nurse specialists, they should remain in role and supported appropriately rather than re-deployed during COVID-19. A second contact from a patient with deteriorating symptoms or re-referral during the COVID-19 crisis should trigger re-evaluation via the remote secondary care facility. As CT abdomen and pelvis is not a luminal investigation, fit patients who are deferred should be offered colonoscopy or CT colonography when resources allow, and these should be offered in order of priority based on the triage system suggested in Figure 1.

If evidence of COVID-19 infection is detected on CT chest, when done, the patient will need to be contacted to inform them of findings and advise them about need for self-isolation and assess level of

symptoms and severity. Timely notification of CT findings to infectious diseases and primary care will be essential.

Patients with newly diagnosed colorectal cancer, whatever the mode of diagnosis, should be discussed at the colorectal MDT, including those not thought appropriate for immediate treatment given the context of COVID-19 crisis. MDT records should include reference to the context of decision-making during the COVID-19 pandemic, and document plans for deferred investigation (in first priority category P1 for colonoscopy), treatment and follow-up.

Temporising treatments such as colonic stenting as a bridge to deferred surgery should be considered when feasible. Patients with biopsy-proven rectal cancer may be considered for short course radiotherapy and deferred surgery when resources allow. Potential urgent and emergency surgical candidates should be discussed with anaesthetic and critical care colleagues. Patients with a significant burden of metastatic disease or severe symptoms may benefit from palliative care advice. Patients with oligometastatic disease should still be discussed in the relevant MDTs with ideal and modified options documented.

When resources become available for endoscopic evaluation, patients who need luminal investigation should be offered colonoscopy or CT colonography in order of triage priority group, and all these groups should be prioritised ahead of subsequent referrals on the rapid access colorectal cancer pathway. A full recovery phase plan for coping with increased demand for patients needing deferred treatments and investigations will be essential to mitigate the negative impact of COVID-19 on colorectal cancer outcomes, and to allow transition back to established management protocols.

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