Colorectal cancer referrals during the COVID-19 pandemic: the utility of CT and faecal immunochemical testing

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Dear Editor

The abrupt arrival of the first wave of the COVID-19 pandemic brought with it an imperative need to restructure colorectal cancer pathways. Some units have already reported on the usefulness of consultant-led triage; others have adopted faecal immunochemical testing1,2. Our colorectal department (catchment population 600 000) needed to improve the utilization of available diagnostic services and safely investigate patients suspected of having colorectal cancer. We instituted a scheme of consultant telephone assessment for all patients referred with urgent suspected cancer (USC). If appropriate, venous-phase CT of abdomen and pelvis (CTAP) in combination with faecal immunochemical testing (FIT) were then used as the primary modalities of investigation in patients without frank rectal bleeding. Patients with rectal symptoms were triaged directly to flexible sigmoidoscopy. A level of FIT above 10.0 μg haemoglobin/g or suspicious CTAP findings prompted endoscopic assessment. In late March 2020, the rationale for this pathway was to limit potential aerosol-generating procedures and to compensate for the absence of face-to-face consultations in a hospital environment already overrun by patients with COVID-19. Some patients were very reluctant to attend hospital for tests owing to perceived risks of developing COVID-19. We report our initial experience of this alternative method of USC assessment.

There were 277 USC general practitioner (GP) referrals to colorectal surgery between 1 April and 30 May 2020. 41 patients with rectal bleeding went straight to flexible sigmoidoscopy. Consultant colorectal surgeons telephoned 236 patients without bleeding, of whom 196 suitable patients were posted a FIT kit and referred for CTAP. Many patients (40) stated that their symptoms had disappeared, declined investigations, or were downgraded from USC. A letter was dictated to each referring GP after the consultation. In total, 182 CTAP scans and 136 FIT tests were performed (Table 1). Not all patients received both tests: positive CT findings prompted endoscopy referral, a minority did not have a FIT test following further consultant assessment, and some patients declined further investigation.

From the whole group referred over the 2 months, 16 diagnoses of colorectal cancer were made, 15 from the CTAP/FIT group and one following flexible sigmoidoscopy (detection rate 5.8 per cent). This compares with 524 USC referrals and 19 colorectal cancer diagnoses (detection rate 3.6 per cent) over the equivalent 2-month period in 2019, and reflects the degree to which COVID-19 contributed to the reduced number of USC referrals (a 47 per cent reduction) by local GPs. Reassessment of the whole cohort in early November 2020 (minimum follow-up of 6 months) showed that no patient discharged from the USC pathway had re-presented with colorectal cancer.

This new pathway, combining FIT and CTAP in the USC setting, draws on work testing the use of FIT in colorectal cancer detection programmes. For our department, it was intended as an evidence-based, temporary but pragmatic response to the difficulties of the pandemic, rather than an ideal solution. The purpose was to reduce the delay in diagnosis and treatment to avoid the inevitability of cancer stage migration during the pandemic3. However, realization of the high reported sensitivity of FIT in large-scale settings allows us to have confidence that this assessment pathway is robust. The use of FIT will undoubtedly become more widespread throughout the UK, with further literature attesting to its high diagnostic yield4. Our experience of using FIT and CT to exclude colorectal cancer will be relevant in maintaining effective USC services during further waves of widespread coronavirus infection. In future,

Table 1 Demographics, investigations and outcomes

| No. of patients (n) | Age (years) | F : M sex ratio (%) |
|---------------------|-------------|---------------------|
|                     | 69 (41–91)  | (69–78)             |
|                     | 52.4 : 47.6 |                     |

Investigation pathways:

- CTAP/FIT COVID pathway: 196
- Direct to endoscopy: 41
- Referral downgraded from USC: 40

COVID pathway investigations:

- CTAP: 182
- FIT: 136

Outcomes:

- Colorectal cancer diagnosis: 16
- Surveillance: 17
- Discharged from USC following CTAP/FIT pathway: 164
- Discharged from USC following Flexible Sigmoidoscopy: 40

*Values are median (range) (i.q.r.). CTAP, CT of abdomen and pelvis; FIT, faecal immunochemical testing; USC, urgent suspected cancer.
CT may not always be necessary in patients with only genuine colorectal symptoms. The addition of CT allowed us to reassure patients and their GPs that their symptoms (weight loss, abdominal pain) were not obviously from significant pathology.

This challenging period has forced change to several areas of surgery that may well prove beneficial to all in the long term. We have demonstrated effective delivery of an alternative cancer detection pathway through rationalization of investigations and resources that has ultimately benefited our patients, and can safely be used again in the second wave of the pandemic.

Disclosure. The authors declare no conflict of interest.

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