

7.4 COLORECTAL CANCER

Introduction

Each year in Northern Ireland around 621 people were diagnosed with *colon* cancer and 364 with cancer of the *rectum, rectosigmoid junction* and *anus*. There are around 298 deaths from colon cancer and 145 from rectal cancer annually. Survival from cancers of the colon and rectum depend on the stage of disease - the earlier the disease is found and treated, the better the survival. Around half of patients with cancer of the colon or rectum are alive 5 years after diagnosis.

By 2005, there were at least 3,300 people living in Northern Ireland with a diagnosis of colon cancer and almost 2,000 with a diagnosis of rectal cancer.

Risk factors

- Diets that are high in red and processed meats.
- Patients with pre-existing inflammatory bowel disease (e.g. ulcerative colitis) have a higher than average risk of colorectal cancer. The risk increases with the duration of the condition.
- Colorectal tumours develop more often in patients with adenomatous (benign) polyps than those without such polyps. This is the rationale behind the introduction of the colorectal screening programme in N. Ireland.
- The risk of developing colorectal cancer is significantly increased in several forms of inherited susceptibility, which accounts for 5% of all colorectal cancers. Hence, genetic screening is vital for people at high risk of developing the disease.

Other relevant standards: Genetic Testing

Overarching standard 33:

All patients undergoing *elective radical* surgery for colorectal cancer should have their operation performed by a colorectal surgeon who is a core member of a colorectal MDT and who carries out a minimum of 20 *resections* per year.

Rationale:

Surgery is the first treatment for approximately 80% of patients with colorectal cancer. High quality surgery is crucial to patients' survival. Surgery should be undertaken by specialist colorectal cancer surgeons who are members of colorectal cancer multi-disciplinary teams (MDTs). Each surgeon in the MDT should carry out a minimum of 20 colorectal resections with curative intent per annum. Concentrating surgery in the hands of fewer, more specialised surgeons, working within MDTs, can be expected to produce fewer post-operative complications, lower local recurrence rates and improved survival.

Evidence:

National Institute for Health and Clinical Excellence (NICE) (2004) Improving Outcomes in Colorectal Cancers <http://guidance.nice.org.uk/CSGCC>

Association of Coloproctology of Great Britain and Ireland (2007) Guidelines for the Management of Colorectal Cancer
http://www.acpgbi.org.uk/assets/documents/COLO_guides.pdf

Responsibility for delivery / implementation

HSC Board
Public Health Agency
HSC Trusts

Quality Dimension**Safe & Effective**

Management of these patients by appropriately trained and experienced surgeons working within MDTs will have better outcomes for the patient.

Increasing specialisation offers valuable opportunities for enhanced clinical training, research and facilitates recruitment to clinical trials.

Performance Indicator	Data source	Anticipated Performance Level	Date to be achieved by
Percentage of colorectal resections undertaken by a surgeon who carries out 20 or more resections each year	CaPPs	95%	March 2011

NOTE: Performance indicators and targets will be reviewed and adjusted as necessary, in the light of the current Budget settlement for 2011/12 to 2013/14.

Overarching standard 34:

All patients diagnosed with rectal cancer who require surgery should, where appropriate, have access to *Total Mesorectal Excision* (TME), and have their operation performed by an appropriately trained and experienced surgeon.

Rationale:

There are improved outcomes for patients when complex surgery like TME is done by surgeons who specialise in this type of surgery and have undergone TME training. Patients live longer, have fewer complications and the cancer is less likely to come back. Patients also spend less time in hospital and are less likely to need a *stoma*. TME is less likely to damage sexual function in men.

Evidence:

Association of Coloproctology of Great Britain and Ireland (2007) Guidelines for the Management of Colorectal Cancer (Surgical Technique pp33)

http://www.acpgbi.org.uk/assets/documents/COLO_guides.pdf

National Institute for Health and Clinical Excellence (NICE) (2004) Improving Outcomes in Colorectal Cancers (pp 70-79 Surgery and Histopathology)

<http://www.nice.org.uk/nicemedia/pdf/CSGCCfullguidance.pdf>

Scottish Intercollegiate Guidelines Network (SIGN) (2003) Management of Colorectal Cancer <http://www.sign.ac.uk/guidelines/fulltext/67/index.html>

Responsibility for delivery / implementation

HSC Trusts

Multidisciplinary teams

Quality Dimension**Safe & effective**

When complex surgery, like TME, is done by surgeons who specialise in this type of surgery and have undergone TME training, there are improved outcomes for patients.

Performance Indicator	Data source	Anticipated Performance Level	Date to be achieved by
Percentage of operations where the mesorectum has been removed intact for tumours in the middle and lower thirds of the rectum (in some cases this is not possible, e.g. when the tumour has extended beyond the mesorectal fascial)	Colorectal MDT dataset / Histopathology Reports	Establish baseline Performance level to be determined once baseline established	March 2011
Percentage of operations where the mesorectal fascia has been removed intact for tumours in the upper third of the rectum	Colorectal MDT dataset / Histopathology Report	Establish baseline Performance level to be determined once baseline established	March 2011

NOTE: Performance indicators and targets will be reviewed and adjusted as necessary, in the light of the current Budget settlement for 2011/12 to 2013/14.

Overarching standard 35:

All patients who have had surgery for *colorectal cancer* should have their *histology* reported to the format of the Association of Coloproctology of Great Britain and Ireland/Royal College of Pathology Dataset. This report should be presented at the *Multidisciplinary Team Meeting* (MDM) within 10 days of surgery.

Rationale:

Reliable *staging* of a tumour ensures that the ongoing care of the patient is appropriately planned and managed. In order to provide reliable staging information, pathologists should complete the minimum dataset for colorectal cancer that has been developed by the Royal College of Pathologists and discuss this at the first available colorectal cancer term meeting. In patients with colon cancer who are treated with curative intent, 12 or more lymph nodes should normally be examined.

Evidence:

Dataset for Colorectal Cancer, 2nd Edition, Royal College of Pathologists (September 2007) <http://www.rcpath.org/resources/pdf/G049-ColorectalDataset-Sep07.pdf>

National Institute for Health and Clinical Excellence (NICE) (2004) Improving Outcomes in Colorectal Cancers (pp 7, 24-29) <http://www.nice.org.uk/nicemedia/pdf/CSGCCfullguidance.pdf>

National Institute for Health and Clinical Excellence (NICE) (2004) Improving Supportive and Palliative Care for Adults with Cancer <http://guidance.nice.org.uk/nicemedia/pdf/CSGSPfullguidance.pdf>

Scottish Intercollegiate Guidelines Network (SIGN) (2003) Management of Colorectal Cancer <http://www.sign.ac.uk/guidelines/fulltext/67/index.html>

Responsibility for delivery / implementation

HSC Board
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Multidisciplinary teams

Quality Dimension			
Patient centred, safe, timely & efficient			
Good quality, clear staging information ensures that the patient's ongoing care is appropriately planned and managed. This information, explained by skilled and trained surgeons, allows the patient to make more informed choices about any further treatment.			
Performance Indicator	Data source	Anticipated Performance Level	Date to be achieved by
Percentage of colorectal cancer <i>surgical specimens</i> reported using the Association of Coloproctology / Royal College of Pathologists proforma	Pathology and Colorectal Cancer MDM datasets	70% 90%	March 2012 March 2013
Percentage of Association of Coloproctology / Royal College of Pathologists reports discussed at the MDM within 10 days of surgery	Colorectal Cancer MDM dataset	70% 90%	March 2012 March 2013

NOTE: Performance indicators and targets will be reviewed and adjusted as necessary, in the light of the current Budget settlement for 2011/12 to 2013/14.

Overarching standard 36:

All patients who have a stoma should have a named nurse with expertise in stoma care, know who this is, and have available to them the full range of HSC approved stoma care products.

Rationale:

People who have a stoma should have access to high quality treatment and care. This should be provided by the Northern Ireland Health and Personal Social Services. People should also receive experienced stoma nursing care after their stoma operation and receive full and impartial information about all relevant supplies and products available through the health service. They should have the opportunity to choose from a variety of products without prejudice.

Evidence:

Ostomy Patients' Charter, Developed and endorsed by the Campaign for Impartial Stomacare, the Ileostomy Association, the British Colostomy Association, the Urostomy association and the RCN Stoma Care Forum.

Responsibility for delivery / implementation

HSC Trusts
Stoma Nurses

Quality Dimension**Safe & effective**

Patients have access to stoma products appropriate to their needs and receive a safe and effective service from Northern Ireland Health and Personal Social Services.

Performance Indicator	Data source	Anticipated Performance Level	Date to be achieved by
Percentage of patients who have a stoma that have a named nurse with expertise in stoma care	Stoma nurse records PAS Theatre Records	Establish baseline Performance level to be determined once baseline established	March 2011

NOTE: Performance indicators and targets will be reviewed and adjusted as necessary, in the light of the current Budget settlement for 2011/12 to 2013/14.