## Version Control

This is a controlled document please destroy all previous versions on receipt of a new version.

**Date Approved:** April 2015  
**Review Date:** April 2016

<table>
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<th>Version</th>
<th>Date Issued</th>
<th>Review Date</th>
<th>Brief Summary of Change</th>
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### Contents

**Introduction** ................................................................................................................................ 5  
**Section One: Patient Pathway** ...................................................................................................... 5  
1.1 Network Configuration - 14-1c-101d .................................................................................................. 5  
1.2 Primary Care Referral Guidelines for Colorectal Symptoms .............................................................. 6  
1.3 Prioritisation of clinical referrals for patients with large bowel symptoms ....................................... 7  
1.4 Investigation Protocol for Colorectal Cancer ...................................................................................... 8  
1.5 Policy for the referral of patients diagnosed with malignant or non-malignant colorectal disease .. 9  
1.6 Timed Colorectal Cancer Pathway .................................................................................................... 11  
1.7 Network Guidelines for the Management of Surgical Emergencies - 14-1c-114d ........................... 12  
1.8 Network Policy and List of Laparoscopic Colorectal Cancer Surgical Practitioners - 14-1C-102d .... 14  
1.9 Network Colorectal Stenting Policy - 14-1C-103d ............................................................................ 15  
1.10 Network Policy on Named Medical Practitioner with Clinical Responsibility - 14-1c-113d .......... 16  
1.11 Referrals between multidisciplinary teams ...................................................................................... 17  
1.11.1 Principles of referrals ......................................................................................................... 17  
**Section Two: Anal Cancer** ........................................................................................................... 18  
2.1 Protocol for the management of anal cancer following the failure of chemoradiation .................. 18  
2.2 Anal Pathway .................................................................................................................................... 19  
2.3 Anal MDT Referral Form ................................................................................................................... 20  
**Section Three: Early Rectal Cancer** .............................................................................................. 21  
2.1 Specialist Early Rectal Cancer MDT Referral and Follow-up Guidelines ........................................... 21  
2.2 Specialist Early Rectal Cancer Management Flow ............................................................................ 24  
2.3 Follow up guideline for patients with rectal cancer ......................................................................... 25  
**Section Four: Advanced Colorectal Cancer** .................................................................................. 25  
4.1 Advanced Colorectal Cancer SMDT Operational Policy ................................................................. 25  
4.2 Advanced Colorectal Cancer SMDT Pathway ................................................................................... 27  
**Section Five: Liver Metastases** .................................................................................................... 29  
**Section Six: Oncology** ................................................................................................................. 29  
6.1 Chemotherapy Treatment Algorithms - 14-1C-109d ....................................................................... 29  
6.2 Radiotherapy Protocols .................................................................................................................... 29  
**Section Seven: Supporting Pathways** ........................................................................................... 29  
7.2 TYA Initial Management Pathway .................................................................................................. 30
7.3 TYA Completion of First Line Treatment Pathway ................................................................. 32
7.4 CUP Pathway .......................................................................................................................... 34
7.5 Rehabilitation Pathway ........................................................................................................ 35
7.5 Family History ...................................................................................................................... 35
7.6 Follow Up ............................................................................................................................. 35

Appendix 1.0: Unit Contact Points ........................................................................................ 36
Introduction

The following clinical guidelines have been developed in consultation as appropriate with Trust MDTs, Heads of Service and the Chemotherapy, Imaging, Pathology and Radiotherapy Cross Cutting Groups.

The guidelines are subject to review and update on a regular basis. Once ratified by the CNG individual MDTs agree to abide by them.

At the time of approval the guidelines were widely circulated via the Network to Acute Trust Cancer Management Teams for trust-wide circulation and to Colorectal Clinical Leads for circulation to MDT members.

Section One: Patient Pathway

1.1 Network Configuration - 14-1c-101d

The implementation milestones to meet the requirements of the NICE IOG for Colorectal Cancer have been met.

Each local MDT provides care and treatment for their own catchment population and refers patients to the specialist MDTs in accordance with IOG guidelines. The following policy has been agreed:

(i) The diagnosis and assessment of patients referred from primary care with potential colorectal cancer should only be carried out by the named diagnostic services which are agreed by the network.

(ii) There should be a single initial decision point for prioritising appointments for newly presenting patients for large bowel investigation, rather than direct referral to individual, named colorectal surgeons or gastroenterologists.

(iii) Endoscopy is the preferred initial investigation for making the definitive diagnosis of colorectal cancer.

The identity and location of the different levels of colorectal services with the identified CCG catchment are included in the table below.

<table>
<thead>
<tr>
<th>Hospital Trust</th>
<th>Referring CCG’s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aintree University Hospital NHS Foundation Trust</td>
<td>Knowsley CCG South Sefton CCG Liverpool CCG Southport &amp; Formby CCG</td>
</tr>
<tr>
<td>Countess of Chester NHS Foundation Trust</td>
<td>West Cheshire CCG</td>
</tr>
<tr>
<td>Royal Liverpool &amp; Broadgreen University Hospital NHS Trust</td>
<td>Knowsley CCG Liverpool CCG</td>
</tr>
<tr>
<td>Southport and Ormskirk Hospital NHS Trust</td>
<td>West Lancs CCG Southport &amp; Formby CCG</td>
</tr>
</tbody>
</table>
**SPECIALIST MDT’S**

<table>
<thead>
<tr>
<th>MDT</th>
<th>Host Trust</th>
<th>Referring CCG’s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Liver/Advanced Colorectal ¹</td>
<td>Aintree University Hospitals NHS Foundation Trust</td>
<td>All CMSCN North Wales LHBs</td>
</tr>
<tr>
<td>Anal Cancer ²</td>
<td>Royal Liverpool and Broadgreen University Hospitals NHS Trust</td>
<td>All CMSCN</td>
</tr>
<tr>
<td>Early Rectal Cancer ³</td>
<td>Royal Liverpool and Broadgreen University Hospitals NHS Trust</td>
<td>All CMSCN</td>
</tr>
</tbody>
</table>

¹ Stand-alone MDT that deals with resection of liver metastases/advanced colorectal cancer disease for the network
² Local Colorectal MDT that deals with anal cancer for the network
³ Single early rectal cancer MDT for the network.

CMSCN Colorectal Clinical Network Group (CNG) consists of membership of all local MDT’s, diagnostic services & SMDT’s outlined above.

### 1.2 Primary Care Referral Guidelines for Colorectal Symptoms

The CNG has produced network-wide guidelines for primary care practitioners on the referral for diagnosis of patients with potential colorectal cancer.

The guidelines specify the requirement to refer to a network agreed colorectal diagnostic service, not a named individual consultant, and to use the network-agreed referral proforma

The proforma specifies:
- which type of presentation (in terms of specific symptoms and patient characteristics) should be referred with which level of priority (with regard to how quickly they should be dealt with)
- the single referral contact point for each trust hosting a colorectal diagnostic service in the network.

The primary care guidelines have been distributed to all primary care practices in the network.

In addition, the CNG has agreed a policy governing onward referral from the colorectal diagnostic service when a diagnosis is made of either malignant disease or non-malignant disease.

The policy specifies:
- the procedure to be followed
- the personnel responsible for making the 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


The Network Board in consultation with the Colorectal CNG have agreed that the diagnosis and assessment of patients with colorectal symptoms should only be carried out by the designated hospitals (Table 1) whose referral points are given in the Network primary care referral guidelines.

At the time of approval the guideline was widely circulated via the Network to Acute Trust Cancer Management Teams for trust-wide circulation; Colorectal Clinical Leads for circulation to MDT members; Primary Care Trust Cancer Managers (for circulation to all GP’s via formal PCT communication processes). Any future updates will be circulated to primary care via Area Team to CCG’s.

1.3 Prioritisation of clinical referrals for patients with large bowel symptoms
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 accord with the National Referral Guidelines for Suspected Cancer as reflected in the CMSCN Urgent Suspected Cancer Proforma (section 1.2).

Urgent referrals – patients with symptoms suggestive of colorectal cancer:
Patients who present with the following symptoms should be referred urgently:
- 6 weeks rectal bleeding & change in bowel habit (looser stools/increased frequency) >Aged 40+
- 6 weeks rectal bleeding without a change in bowel habit/anal symptoms >Aged 60+
- 6 weeks change in bowel habit without rectal bleeding (looser stools/increased frequency) >Aged 60+
- Any age with a right sided lower abdominal mass consistent with involvement of the large bowel
- Any age with a rectal mass (intra luminal and NOT pelvic)
- Unexplained iron deficiency anaemia (<11g males and <10g in post-menopausal females)

Referral of patients with symptoms of colorectal pathology but at low risk of cancer
Referral on the Choose and Book System should be considered for patients with the following symptoms and no abdominal or rectal mass who are thus at a very low risk of colorectal cancer:
- Rectal bleeding with anal symptoms (soreness, itching, lumps, prolapse and pain)
- Change in bowel habit to decreased frequency of defaecation and harder stools
- Abdominal pain without clear evidence of intestinal obstruction

Referral of patients in known high risk groups who develop symptoms:

High risk patients, who are undergoing screening and surveillance as described in the national guidance (Gut 2002; 51 Suppl V28) who develop symptoms, should be referred urgently.

1.4 Investigation Protocol for Colorectal Cancer

The network agreed investigation protocol for clinical presentations caused directly by a large bowel cancer is set out below. This protocol should be read in conjunction with network agreed imaging guidelines. The following investigations are the responsibility of the colorectal MDT.

INITIAL INVESTIGATION

Colon and Rectum
- Total colonoscopy
- CT colonography

STAGING

CT chest, abdomen, pelvis for all patients
MRI pelvis for rectal tumours

PET CT

PET-CT should be considered where routine anatomical modalities for staging such as CT or MRI have been inconclusive.

PATHOLOGY

Blood tests
- Haemoglobin
- Electrolytes, urea and creatinine
- Liver function tests

Diagnostic Biopsy

Histological proof of invasive carcinoma for all rectal and anal tumours and for colonic tumours should be obtained where possible.

Resections

Colorectal cancer resections should be reported according to The Royal College of Pathologists minimum data set for colorectal cancer. Additional data items may be included by local agreement.
Accreditation

Laboratories involved in the investigation and diagnosis of patients with, or suspected to have, colorectal cancer should participate in appropriate external accreditation such as CPA (UK) and external quality assurance schemes.

Emergency admission

Patients found to have colorectal cancer should be referred to the colorectal team within 24 hours of diagnosis.

Tertiary referral

Following discovery of a colorectal carcinoma in the course of investigations by a non-colorectal team the patient should be referred to a named colorectal MDT member. Referral should occur within 24hrs in order for the patient to be discussed at the next available MDT and to ensure the minimum of delay.

Direct access endoscopy

Following direct access to endoscopy, the consultant responsible for the endoscopy list (even if the endoscopy is carried out by a junior doctor or nurse endoscopist) should be responsible for ensuring that where appropriate investigation pathways are immediately commenced (if the tumour is clinically likely to be carcinoma) and that the patient is discussed at the next appropriate MDT. This may depend on the timing of the meeting relative to biopsy results being available etc. It is recognised that the consultant in charge of the list does not automatically take over full care of the patient, but is responsible for ensuring the patient is allocated to an appropriate member of the MDT. It is possible that the GP after discussion with the patient may opt to refer to a different service but this possibility should not delay commencing the patient pathway in the first instance.

Metastasis

Following discovery of a metastasis, possibly of CRC origin, a referral should be made to the clinical nurse specialist to ensure that the case is presented at the next MDT. Patients with advanced colorectal cancer at presentation should be considered for referral to the Advanced Colorectal MDT, if deemed appropriate at the local MDT.

Early Rectal Cancer

Patients with suspected early rectal cancer (T1 or early T2) may be referred to the Early Rectal Cancer MDT at the RLUH, for assessment. A cohort of these patients may be amendable to local excision (TART/TEM or TAMIS) dependent on their staging investigations.

1.5 Policy for the referral of patients diagnosed with malignant or non-malignant colorectal disease

This policy has been developed to ensure that timely and appropriate communication is in place between clinicians and with the patient. This covers onward referral of patients diagnosed with colorectal cancer or non-malignant disease. Members of the colorectal diagnostic service are part of the MDT. This policy should be read in conjunction with the Network Guidelines “Guidelines for Governance and Communication between local and Specialist MDTs”
Details of the policy are as follows:

- Patients who are unexpectedly diagnosed with colorectal cancer or known patients who are diagnosed with recurrent or metastatic disease will be referred to a core member of the MDT within one full working day of the diagnosis being made. In most cases this will be the Colorectal Nurse Specialist.
- The core member of the MDT will ensure that such patients are discussed at the next MDT.
- If cancer is detected, the Radiology Department (Radiologist/Radiographer) or Pathologist will report the result to the referring clinician. The Clinical Nurse Specialist/MDT Co-ordinator will be alerted by a cancer ‘flag’ on the hospital PAS system or by a list generated from the laboratory computer system.
- The referring clinician (i.e., clinician requesting the image) is responsible for informing the patient of their diagnosis verbally.
- If the image has been undertaken following GP direct access, The Clinical Nurse Specialist will contact the GP by telephone to discuss further investigations as appropriate. The GP is responsible for informing the patient of the diagnosis.
- If a patient has been diagnosed via endoscopy, the performing endoscopist is responsible for informing the patient of the diagnosis and onward referral to the MDT. The performing endoscopist is also responsible for informing the GP of the diagnosis.
- If non-malignant disease is diagnosed and further investigation or treatment is required, the report is sent to the referring clinician who will inform the patient and organise further investigation.
- The GP will be informed of a diagnosis of malignancy by the following working day after the patient has been informed.
- Clinical Nurse Specialist may be contacted by bleep, via Hospital Trust switchboards.
1.6 Timed Colorectal Cancer Pathway

**Patient with Suspected Colorectal Cancer**

- **Referral Triage**
  - Flexible sigmoidoscopy
  - Barium enema *
  - Colonoscopy

- **OPD/Straight to Test**
  - CT colonography
  - CT
  - MRI
  - Ultrasound

- **Further diagnostic or staging tests**
  - CT colonography
  - CT
  - MRI
  - Ultrasound

- **MDT**
- **OPD**
  - Follow-up for results and further plans

- **1st Treatment**
  - Surgery
  - Chemotherapy
  - Radiotherapy
  - Palliative

- **MDT – for consideration of any further**

- **1st appointment by Day 7**
- **1st Diagnostic Test by Day 14**
- **Further diagnostic tests by Day 21**
- **MDT discussion for Treatment Plan by Day 31**
- **Referral to Tertiary Centre (if appropriate) by Day 42**
- **Treatment Commences by Day 62**
Areas of good/recommended practice to support timely patient pathways:-

- Good vetting of referrals at outset driven by agreed protocols.
- Create capacity to achieve 1st intervention (OPD/Endoscopy) by Day 7.
- Ensure 1st diagnostic test to be no later than Day 14.
- Fast track electronic systems for flagging of cancer patients to support services.
- Communication is key:-
  - Admin staff
  - MDT members
  - MDT co-ordinators/trackers
  - Tertiary centres
  - Radiological/radiography
  - Specialist Nurses to order CT and MRIs to protocol.
  - Pre-booking of appointments at key stages.
  - Robust escalation process in place backed by Executive Directors.

1.7 Network Guidelines for the Management of Surgical Emergencies - 14-1c-114d

The CNG has agreed for each hospital which admits surgical emergencies, network-wide guidelines for the management of surgical emergencies related to colorectal cancer. They should specify at least the following:

- that patients presenting as emergencies with intraluminal large bowel obstruction, should be stabilised pre-operatively, so that surgery can wait until it can be performed under the care of the core surgical colorectal MDT member, unless delay would be life-threatening
- that if the hospital does not host the practice of a core surgical colorectal MDT member, there should be an agreement between the relevant trust cancer lead clinicians to transfer such patients pre-operatively to a named hospital, which hosts the surgical practice of a core surgical colorectal MDT member, for management under the care of that surgeon
- that the guidelines apply within and outside normal working hours.

Perforation

Where the diagnosis of colorectal cancer is made at operation or confirmed histologically later, these patients should be transferred to the care of one of the colorectal surgeons – either during their admission or at discharge. Postoperative management should be discussed at the colorectal MDT during their hospital stay. The responsibility for referral to the colorectal MDT rests with the receiving surgeon.

* Barium enema discontinued in majority of trusts now in the diagnosis of CRC
Obstruction

Patients with radiological evidence of uncomplicated large bowel obstruction should undergo a CT scan +/- unprepared water-soluble contrast enema within 24 hours of admission. Those with a mechanical obstructing lesion should be managed conservatively and their management transferred to one of the colorectal surgeons during weekday working hours. Patients who are admitted out of hours, and at weekends, should be discussed with one of the colorectal surgeons and arrangements for transfer put in place. It is anticipated that, in the absence of peritonitis or evidence of closed loop obstruction, they will have their obstruction relieved (definitive surgery, decompressing stoma or successful stenting) within 48 hours of the diagnosis being made.

Where there is clinical evidence of peritonitis or closed loop obstruction with caecal tenderness, the contrast enema may need to be omitted to allow prompt surgical exploration and/or decompression. In this situation, and if not operated on by a colorectal surgeon, the patient should be managed as for perforation (see above).
1.8 Network Policy and List of Laparoscopic Colorectal Cancer Surgical Practitioners - 14-1C-102d

The CNG has an agreed policy whereby laparoscopic colorectal cancer surgery can only be performed by surgeons on the network agreed list of surgeons authorised to perform laparoscopic colorectal cancer surgery. Entry on the list requires that the surgeon has been trained on the national laparoscopic colorectal surgery programme or is exempt. This policy is reviewed and updated annually.

In order to be exempt, the Chief Executive of the Trust must confirm that the consultant is recognised as having the necessary skills, within their appointment letter or by letter obtained.
retrospectively or the consultant has performed 20 or more laparoscopic colorectal cancer surgical resections prior to 31st December 2009. This must agreed by the Lead Clinician of the MDT.

Each local MDT offers laparoscopic colorectal cancer surgery and therefore patients fulfilling the network criteria will be referred on to the named surgeon within the MDT for an opinion.

The agreed list of authorised surgeons is tabled below.

**TABLE 2: List of named surgeons – laparoscopic colorectal cancer surgery**

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<thead>
<tr>
<th>Hospital Trust</th>
<th>Named Surgeon</th>
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<tbody>
<tr>
<td>Aintree University Hospital NHS Foundation Trust</td>
<td>S. Slawik</td>
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<tr>
<td></td>
<td>J. Arthur</td>
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<td>P. Skaife</td>
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<td>Countess of Chester NHS Foundation Trust</td>
<td>M. Johnson</td>
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<td>D. Vimalachandran</td>
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<td>C. McFaul</td>
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<tr>
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<td>N. Eardley</td>
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<tr>
<td>Nobles, Isle of Man</td>
<td>G. Tebala</td>
</tr>
<tr>
<td></td>
<td>C. Ratnavel</td>
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<tr>
<td>Royal Liverpool &amp; Broadgreen University Hospital NHS Trust</td>
<td>R. Heath</td>
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<tr>
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<td>F. McNicol</td>
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<tr>
<td></td>
<td>S. Ahmed</td>
</tr>
<tr>
<td>Southport and Ormskirk Hospital NHS Trust</td>
<td>M. Zeiderman</td>
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<tr>
<td></td>
<td>D. Artioukh</td>
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<tr>
<td></td>
<td>Harish Babu</td>
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<tr>
<td></td>
<td>Paul Ainsworth</td>
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<td>St Helens &amp; Knowsley Teaching Hospitals NHS Trust</td>
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<td>R. Rajaganeshan</td>
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<tr>
<td></td>
<td>M. Chadwick</td>
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<tr>
<td>Warrington &amp; Halton Hospitals NHS Foundation Trust</td>
<td>A. Abdelrazeq</td>
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<tr>
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<td>M. Tighe</td>
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<tr>
<td>Wirral University Teaching Hospital NHS Foundation</td>
<td>L. Titu</td>
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<td>J. Anderson</td>
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<td>D. Smith</td>
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<td>J. Wilson</td>
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1.9  Network Colorectal Stenting Policy - 14-1C-103d:  **Currently under review**

**TABLE 3: List of named colonic stenting personnel**

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<th>Hospital Trust</th>
<th>Named Surgeon</th>
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<tr>
<td>Aintree University Hospital NHS Foundation Trust</td>
<td>Richard Sturgess</td>
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<tr>
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<td>Consultant Gastroenterologist</td>
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<tr>
<td></td>
<td>Sokhail Ahmed</td>
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<td></td>
<td>Consultant Gastroenterologist</td>
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<td>Neil Kapoor</td>
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</tr>
<tr>
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<td>Phil Bliss</td>
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<td>Consultant Gastroenterologist</td>
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<td>Trust and Hospital</td>
<td>Combined approach</td>
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<tr>
<td>Countess of Chester NHS Foundation Trust</td>
<td>Combined approach:</td>
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<tr>
<td></td>
<td>Ghian Abbott</td>
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<tr>
<td></td>
<td>Consultant Radiologist</td>
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<td>Gerry Doyle</td>
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<tr>
<td></td>
<td>Consultant Radiologist</td>
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<tr>
<td></td>
<td>Endoscopists – GI team</td>
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<td></td>
<td>Nicole Eardley</td>
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<td>Consultant Surgeon</td>
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<tr>
<td>Royal Liverpool &amp; Broadgreen University Hospital NHS</td>
<td>Paul O’Toole</td>
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<tr>
<td>Trust</td>
<td>Consultant Gastroenterologist</td>
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<td>Paul Rooney</td>
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<td>Consultant Surgeon</td>
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<tr>
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<td>Neil Haslam</td>
</tr>
<tr>
<td></td>
<td>Consultant Gastroenterologist</td>
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<td>Sanchoy Sarkar</td>
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<tr>
<td>Southport and Ormskirk Hospital NHS Trust</td>
<td>Graham Butcher</td>
</tr>
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<td></td>
<td>Mike Zeiderman</td>
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<td>Consultant Surgeon</td>
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<tr>
<td>St Helens &amp; Knowsley Teaching Hospitals NHS Trust</td>
<td>Ash Bassi</td>
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<tr>
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<td>Consultant Gastroenterologist</td>
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<td></td>
<td>Glenn Massey</td>
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<td>Consultant Radiologist</td>
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<td>R Rajaganeshan</td>
</tr>
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<td>Consultant Surgeon</td>
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<tr>
<td>Warrington &amp; Halton Hospitals NHS Foundation Trust</td>
<td>Barry Taylor</td>
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<td>Jim Anderson</td>
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<td>Nobles Hospital, Isle of Man</td>
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<td>Colorectal Surgeon</td>
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<td></td>
<td>Guy Sissons</td>
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<td>Consultant Radiologist</td>
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1.10 Network Policy on Named Medical Practitioner with Clinical Responsibility - 14-1c-113d

The CNG has agreed a policy specifying the medical practitioner (whether primary care practitioner, consultant surgeon, gastroenterologist or investigational consultant) who is considered to be responsible for the patient at each stage from referral from primary care to the treatment planning decision of the colorectal MDT.

Clinical responsibility for patients with large bowel symptoms

The following policy specifies the medical practitioner considered to be responsible for patients with large bowel symptoms, covering the patient pathway from referral to the treatment planning...
decision of the colorectal MDT. This policy should be read in conjunction with the Network Guidelines “Guidelines for Governance and Communication between local and Specialist MDTs”

- The Clinical Nurse Specialist will be accessible to the patient at every stage of their care and will be the main point of contact
- Where responsibility transfers, the medical practitioner should ensure that the patient has been accepted by another clinician
- Investigative Consultants must ensure that results are reported to the responsible clinician e.g. Colorectal Consultant
- Following positive diagnosis the patient becomes the responsibility of the consultant responsible for treatment i.e. surgeon, oncologist or palliative care physician.
- Patients being treated within the independent sector remain the responsibility of the General Practitioner. When a positive diagnosis is made, the responsibility for the patient passes to the MDT at which point the Consultant Surgeon becomes the responsible clinician.
- Communication with primary care should be maintained at all stages of the patient’s care

<table>
<thead>
<tr>
<th>Stage of care</th>
<th>Responsible medical practitioner</th>
</tr>
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<tbody>
<tr>
<td>Prior to first appointment</td>
<td>General Practitioner</td>
</tr>
<tr>
<td>Diagnostic stage</td>
<td>Colorectal Consultant or Investigative Consultant</td>
</tr>
<tr>
<td>Initial Treatment Phase</td>
<td>Colorectal Consultant</td>
</tr>
<tr>
<td>Primary surgery</td>
<td>Colorectal Surgeon</td>
</tr>
<tr>
<td>Primary oncology</td>
<td>Medical or Clinical Oncologist</td>
</tr>
</tbody>
</table>

1.11 Referrals between multidisciplinary teams

1.11.1 Principles of referrals

Patients may be referred between multidisciplinary teams (MDTs) for clinical reasons or because of patient choice.

All new colorectal cancer patients must be discussed at a colorectal MDT. This will, in the first instance, always be in the Trust receiving the first referral. Onward referral to another MDT should be considered for the following reasons:

1. Radiology: Radiological findings consistent with metastases will be referred to appropriate local or specialist network MDT’s for further management and advice if required.

2. Pathology: Histopathology findings consist with an atypical or secondary cancer e.g. malignant melanoma, lymphoma, angiosarcoma, will be referred to appropriate local or specialist network MDT’s for further management and advice.

3. Patient Choice: Personal circumstances affecting treatment location e.g. travel/family support or second opinion requested by patient. Referrals to another MDT will require further MDT review of diagnostic imaging/pathology findings.

4. Teenage & young adults: Age-related support services for people aged 16 – 24 (access via TYA MDT)

5. Palliative Care: Extensive/incurable disease requiring symptom control and ongoing support.
6. **Further consideration of a complex case:** Referral to regional MDT, following discussion and agreement in local unit.

7. **Cancer of unknown primary cases:** referral to local/specialist CUP MDT.

8. **Specialist Management:** where clinical trials not available locally.

**Communication and waiting times:** A second Colorectal MDT either within the Network or in another network should be contacted via either a core member or the MDT co-ordinator. The referring member should undertake to attend the MDT or pass sufficient information to a core member of the MDT so that all relevant clinical data is available for the referral.

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**Section Two: Anal Cancer**

2.1 **Protocol for the management of anal cancer following the failure of chemoradiation**

The management of patients with anal cancer who fail to respond to chemoradiation, or relapse at a later date following treatment, requires a multidisciplinary team. This should include two colorectal surgeons, a plastic surgeon, urological oncologist, oncologist, gastro intestinal radiologist, colorectal nurse specialist, stoma therapist, and gynaecological oncologist. Patients who develop further recurrence following surgery should have access to high quality palliative care services. The anal cancer pathway (attached) identifies responsibility of the colorectal MDT and the anal cancer MDT within the assessment process.

**Assessment**

Standard investigations determine fitness for surgery.

**Local disease**

- Examination under local anaesthetic.
- Biopsy (all tumours must have histologically confirmed recurrence).
- MRI Scan and transanal ultrasound scanning.

**Metastatic disease**

- Lymph node fine needle aspiration of all suspicious nodes.
- CT scan of abdomen and chest.

**Treatment**

This should be based on the extent of local disease. In the absence on metastatic disease, anorectal excision is the standard procedure. The operative technique should include wide excision of the anal canal and circumferential tissue, ensuring the widest possible pelvic clearance. As the abdominal and perineal part of the procedure may be technically difficult, two colorectal surgeons working synchronously is advisable. Where pre-operative investigations have shown evidence of invasion of adjacent organs, vagina, prostate, bladder, caecum, but surgical cure still remains a possibility, anal rectal excision with en bloc excision of the involved structures should be performed with the assistance of appropriate surgical specialists, urologist, gynaecologist, spinal surgeon.
Reconstruction
In view of the high rate of perineal wound breakdown and the long term healing prospects in many patients, a rectus abdominis flap is generally necessary, unless tissues are favourable at the time of examination under anaesthetic.

Histopathological reporting
Following histopathological review, all cases should be discussed at the MDT meeting to consider further adjuvant therapies.

2.2 Anal Pathway
2.3 Anal MDT Referral Form

Date:

Name
D.O.B.
Address

Referring Hospital:
Referring Consultant:

Hospital No.

Clinical Staging

Site
Canal □ Margin □ Not known □

T* Stage
T1 □ T2 □ T3 □ T4 □ TX □

N* Stage
N0 □ N1 □ N2 (canal only) □ N3 (canal only) □ NX □

Pre-treatment assessment

Canal tumours

Size

R

L

cm

Anterior

Posterior

Nodes

Anterior

Posterior

Date of Assessment ☐☐☐☐☐

Margin tumours

R

L

R

L

Please include:

(1) Histology Report
(2) MRI Report
(3) CT Report
Section Three: Early Rectal Cancer

2.1 Specialist Early Rectal Cancer MDT Referral and Follow-up Guidelines

INTRODUCTION

The Early Rectal Cancer MDT was established in November 2008 to operate as a stand-alone specialist advisory MDT for the Merseyside and Cheshire Cancer Network. It is a joint MDT, hosted by the Royal Liverpool and Broadgreen University Hospital Trust (RLBUHT) with specialist input from University Hospital Aintree (UHA) and Clatterbridge Cancer Centre (CCC). The team meets every 2 weeks on the second and fourth Tuesdays of each month at 9:15am. Meetings are held at RLBUHT with a video link from UHA, CCC and Wirral Hospitals.

The aim of the SERC MDT is to ensure optimal, state-of-the-art treatment for all patients with T1 rectal cancer. This is to comply with the NICE recommendation that all patients with early T1 rectal cancer should be considered for local excision.

Selecting cases for local treatment demands expert radiological and endoscopic assessment. If local treatment is considered appropriate, it is necessary to choose from the range of possible techniques: endoscopic mucosal resection (EMR), transanal endoscopic microsurgery (TEMS), standard transanal resection (TART) and radiotherapy (with or without contact treatment). TEMS is a highly specialised, relatively low-volume surgical technique; it is likely that there will be advantages in restricting it to a small number of tertiary centres. Accurate histological assessment of locally resected lesions also benefits from the experience and specialist expertise that can be provided by a dedicated MDT.

Distinguishing early cancer from benign neoplasia in the rectum is difficult. Piecemeal resection of large, sessile rectal polyps can compromise future management if the lesion is subsequently shown to contain malignancy. In such cases, sufficient submucosal tissue should be obtained en-bloc to allow accurate SM staging (Kikuchi levels). This can only be achieved by TEMS (or ESD). For this reason, the MDT encourages referral of all large sessile rectal neoplastic lesions for assessment.

At the MDT meeting, all the available clinical information will be reviewed and a decision made regarding the patient’s suitability for local excision/treatment. If a patient is considered unsuitable for local treatment, or cancer within the lesion is considered very unlikely, their management will remain with the referring clinician.

Additional investigations may be recommended by the MDT. Where possible these will be performed at the referring hospital. However, if the facilities to perform these investigations are not available locally, the patient’s care will be transferred, temporarily, to the RLBUHT or UHA. Review at the SERC MDT following these investigations will determine further management.

Patients considered suitable for local treatment will have their care taken over by the most appropriate SERC MDT clinician at either RLBUHT or UHA (or CCC in the case of radiotherapy). The choice of treatment centre will depend on the patient’s place of residence and personal preference.

MAKING A REFERRAL

Referrals should be sent on the specific referral form to Lorraine Kitts, MDT Co-ordinator on 0151 706 3403 by at least Friday noon before the Tuesday meeting. Referral information should include: all available imaging, endoscopy reports, any endoscopic photographs or videos (ideally in digital format), histology reports and a brief summary of the case including the patient’s performance status. The referral should also have a fax back number and email address of the local MDT making
the referral. In addition the patient’s home telephone number and mobile phone number should be included.

Review of histology may be required, in which case the slides will be obtained directly from the referring hospital by the histopathology department.

All patients with possible T1 lesions will require assessment by endo-anal (EAU) or flexible endoscopic ultrasound (EUS). This will be performed at RLBUHT or UHA if not available locally. Further endoscopic assessment using high-resolution chemoendoscopy may also be required.

**REFERRAL CRITERIA**

CMSCN recommends referral of all lesions within the rectum (i.e. below 15cm from the anal verge) that meet one of the following criteria:

A. Sessile adenomatous polyps >30mm in maximum diameter, even in the absence of histological evidence of malignancy. The risk of cancer in polyps of this size is significant

B. Sessile or flat rectal polyps <30mm that are suspicious for malignancy on endoscopic assessment

C. Biopsy confirmed rectal cancers <30mm in maximum diameter that are considered cT2cN0 or better on MR scan and/or endoanal ultrasound

D. Rectal polyps removed by local excision (endoscopic or transanal) that show unexpected pT1 malignancy on histology without obvious lymph node or distant metastatic spread

Flat, slightly elevated (Paris Ila) lesions, without features suggesting malignancy, are usually suitable for piecemeal EMR and do not require referral. Large pedunculated polyps are also suitable for endoscopic resection at the local hospital provided a clear margins can be achieved. Large semi-pedunculated polyps (Paris Isp) are better treated as sessile and referred to SERC MDT for assessment.

The referring clinician is welcome to attend the MDT (in person or via video link) to discuss the case.

**COMMUNICATION**

The outcome of the SERC MDT discussion will be faxed to the referring clinician within 24 hours using a standard proforma. The proforma will also be made available to core and extended SERC MDT members, the patient’s GP and the local key worker (usually the Colorectal Nurse Specialist). In some cases, the SERC MDT chair may also dictate a letter to the referring consultant with a copy to the GP and other relevant clinicians, summarising the treatment options to be recommended. If the patient’s care is to remain with the referring clinician, communication with the patient is the responsibility of the referring trust’s MDT.

If the patient requires additional investigations at RLBUHT or UHA or is to have his/her care taken over temporarily by a SERC MDT clinician for treatment, they will be assigned a Key Worker (usually an MDT Core Nurse Member) who will be responsible for communicating with the patient. When the patient is discharged back to the referring trust, this will be clearly indicated in writing and the Key Worker will ensure continuity of care by direct communication with the colorectal nurse specialist of the referring trust.

**POST-TREATMENT FOLLOW-UP**

Where treatment has been undertaken by the SERC MDT, the recommended follow-up arrangements are as follows:
Benign pathology:

- Inspection of the excision site by high-resolution endoscopy (+/- narrow-band imaging) at 3 months. This will usually be carried out at the centre where the excision was performed.
- If there is no evidence of recurrent or residual neoplasia, the patient will be discharged back to the referring clinician. Full colonoscopy is recommended after 12 months.
- If there is evidence of recurrent or residual neoplasia, further treatment will usually be undertaken by the SERC MDT and the patient followed up again in a further 3 months.

Malignant pathology treated by local excision (+/- radiotherapy):

At 3 months:
- Inspection of the excision site by high-resolution endoscopy (+/- narrow-band imaging). This will usually be carried out at the centre where the excision was performed.

At 6 months:
- Further endoscopic examination of the excision site
- Repeat MR pelvis
- Clinic review at the centre where the excision was performed.

At 12 months:
- Full colonoscopy at the centre where the excision was performed
- Repeat MR pelvis
- CT chest, abdomen and pelvis
- Clinic review at the centre where the excision was performed

If local excision was performed through the SERC MDT and disease is believed to be cleared, follow-up beyond 12 months will be the responsibility of the referring clinician.
- Clinic review with digital rectal examination and sigmoidoscopy (rigid or flexible) is recommended every 4-6 months for the next 2 years and thereafter every 6 months for the next 2 years.
- Full colonoscopy should be repeated at 5 years.
- CEA and CT liver/chest surveillance as per Network Guidelines

Follow-up arrangements will clearly be influenced by the patient’s age, performance status and likely prognosis.

Separate follow-up at CCC for patients treated with radiotherapy will be at the discretion of the relevant oncologist.

Patient’s involved in clinical trials may require additional follow-up. This will usually be the responsibility of the SERC MDT. Arrangements will be made clear in writing to the referring clinician, local key worker and GP.
2.2 Specialist Early Rectal Cancer Management Flow

**SPECIALIST EARLY RECTAL CANCER MANAGEMENT FLOW**

- **GP Referral**
  - Local Colorectal Team
    - Initial investigation and staging:
      - Clinical Diagnosis
      - Histology, Transanal U/S
      - CT Chest/Abdo/Pelvis and MR Pelvis
  - Rapid referral
  - Specialist Early Rectal Cancer MDT RLUH
    - Review pathology/imaging, validate and record data and agree treatment plan
  
  (IF UNSUITABLE FOR LOCAL EXCISION REFER BACK TO LOCAL MDT: CLASSICAL SURGICAL RESECTION +/- RADIOTHERAPY)

- **Consultation at RLBUH or UHA**
  - Local excision:
    - Transanal excision
    - TEMS
    - FMRI

- **Post-excision SERC MDT review**

  **LOW RISK:**
  - R0, T1 ≤ 3cm, mid-upper rectum,
  - well/mod differentiated,
  - no lymphovascular invasion, clear margins, age >45 yrs

  **INTERMEDIATE RISK:**
  - R0, T1 ≤ 3cm with at least one adverse feature:
    - Sm2, lymphovascular invasion, margin < 1mm, lower rectum, age ≤ 45 yrs.
    - CONSIDER RADIOTHERAPY or CLASSICAL SURGICAL RESECTION (Clinical Trial)

  **HIGH RISK:**
  - R1 or piecemeal excision, R0 but Sm3 (or T2), poorly diff, signet ring or mucinous histology.
    - CLASSICAL SURGICAL RESECTION +/- RT (Clinical Trial)

- **Consultation**
  - Discuss treatment plan with local MDT/patient

- **Surveillance**
  - Early rectal cancer
  - Flexi Sig: 3/12, 6/12, 12/12
  - DRE/Sig: 6/12 next 4 ears
  - MR pelvis: 6/12 and 12/12
  - CEA. CT Liver/ Lungs as per guidelines.
  - Colonoscopy: 5 yrly

- **Benign polyps**
  - Endoscopic assessment at 3 months.
  - Full colonoscopy 1 year
  - Then as BSG guidelines
2.3 Follow up guideline for patients with rectal cancer
There are currently no uniform guidelines for follow up after curative rectal cancer treatment. However, it is reasonable to offer:

1) CEA blood tests 6 monthly for first 2 years
2) Cross-sectional imaging (usually CT scan) yearly for first 3 years following resection
3) Full colonoscopy, initially within 12 months of procedure, then 5 yearly if no metachronous polyps identified. If polyps noted, refer to BSG guidelines for polyp surveillance.

Section Four: Advanced Colorectal Cancer

4.1 Advanced Colorectal Cancer SMDT Operational Policy
The Advanced Colorectal Cancer MDT is held every Thursday at University Hospital Aintree. The meeting takes place in the MDT suite, 3rd floor, Elective Care Centre, from 08.15 – 09.15hrs.

Referrals should be sent on the specific referral proforma to the MDT Co-ordinator. The form should faxed to 0151 529 3829 by Monday 12pm before the Thursday meeting. If the meeting falls in a week with a bank holiday, referrals must be received by Friday 12pm to ensure discussion. Referrals should include all available imaging (sent electronically where possible) and reports, histology reports and local colorectal cancer MDT outcome. The referral must have an email address or a fax back number of the local MDT making the referral.

The referral proforma must be completed in full to ensure MDT discussion. If the data is incomplete, the MDT co-ordinator will inform the referring team that the case will not be discussed until all the data is received. Missing data should be received within one working day to ensure there is no delay to the pathway.

Cases that should be referred to the Advanced Colorectal Cancer MDT include:
- Patient with liver only / liver with limited extra-hepatic disease
- Patients presenting de novo in stage 4
- Patients with potentially resectable lung metastases

The referring consultant/colorectal CNS is invited to attend the MDT (in person or via video link) to discuss the case. There will be a clinician from colorectal and thoracic surgery present at the MDT meeting.

The previous MDT outcome(s) on every patient discussed must be reviewed during the MDT meeting before a follow up outcome is decided.

Review of histology may be required, in which case the slides will be obtained directly from the referring hospital by the histopathology department. The case will then be discussed again at the next meeting.
On occasions, additional imaging or biopsy will be recommended. Wherever possible this will be requested and carried out at the referring hospital without the patient having to travel to Aintree in line with network agreed guidelines. This will be highlighted in the MDT outcome and responsibility for organising further investigations, and communicating the outcome to the patient, will remain with the local clinical team.

If the SMDT outcome recommends referral to oncology, it is the referring team’s responsibility to complete this referral and request an oncology appointment.

The patient should be aware of their disease status before they are referred to the Advanced Colorectal Cancer MDT and be informed they are being discussed at this SMDT. Following review of all the available clinical information, any treatment recommendation will be communicated on the Somerset Cancer Registry (SCR) MDT outcome form to the referring clinician who will be responsible for the patient’s continued care.

The patient should be informed of the MDT outcome and proposed treatment plan by the referring team. The responsibility for the patient’s care remains with the local MDT until the patient is reviewed by a member of the specialist MDT (as per MCCN MDT guideline).

The outpatient appointment for discussion of treatment (i.e. chemotherapy/surgery/radiotherapy) should be the following week after the MDT meeting.

All decisions and action plans made at the Advanced Colorectal Cancer MDT will be communicated to the referring team within one working day using the SCR MDT outcome (by email or fax).

The SCR outcome will also be made available to core and extended Advanced Colorectal Cancer MDT members, the patient’s GP and the local key worker (usually the Colorectal Nurse Specialist).

In order to ensure timely management of the advanced colorectal cancer patient it is imperative that the referral is received by day 34 of the pathway if possible (see advanced colorectal cancer SMDT pathway)

**Advanced Colorectal Cancer MDT core membership details:**

- Mr Stephen Fenwick: Consultant hepatobiliary surgeon/clinical lead
- Mr Hassan Malik: Consultant hepatobiliary surgeon
- Dr Carmen Lacasia-Puroy: Consultant anaesthetist
- Dr Andy Smethurst: Consultant radiologist
- Dr Hulya Weishmann: Consultant radiologist
- Dr Aldo Camenzuli: Interventional radiologist
- Dr Jonathan Evans: Interventional radiologist (visiting)
- Dr Chan Ton: Medical oncologist
- Dr Julie O’Hagan: Medical oncologist
- Dr Monica Terlizzo: Histopathologist
- Dr Clare Byrne: HPB Advanced nurse practitioner
- Mrs Louise Jones: HPB Clinical nurse specialist
Mrs Claire Burston  
Mr James Connolly  
Dr Amir Montazeri  

HPB Clinical Nurse Specialist  
HPB MDT Co-ordinator  
Consultant Clinical Oncologist  

**Advanced Colorectal Cancer MDT extended membership details:**

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professor Graeme Poston</td>
<td>Consultant hepatobiliary surgeon</td>
</tr>
<tr>
<td>Mr Mike Johnson</td>
<td>Consultant colorectal surgeon</td>
</tr>
<tr>
<td>Mr Paul Rooney</td>
<td>Consultant colorectal surgeon</td>
</tr>
<tr>
<td>Mr Ciaran Walsh</td>
<td>Consultant colorectal surgeon</td>
</tr>
<tr>
<td>Mr Mike Shackloth</td>
<td>Consultant thoracic surgeon</td>
</tr>
<tr>
<td>Dr Ashok Khatti</td>
<td>Consultant radiologist</td>
</tr>
<tr>
<td>Dr Sun Myint</td>
<td>Clinical oncologist</td>
</tr>
<tr>
<td>Miss Lisa Jones</td>
<td>Upper GI dietician</td>
</tr>
<tr>
<td>Dr Amir Montazeri</td>
<td>Consultant Clinical Oncologist</td>
</tr>
</tbody>
</table>
4.2 Advanced Colorectal Cancer SMDT Pathway

**Advanced Colorectal Cancer SMDT Pathway**

- Patient presenting with stage IV colorectal cancer
- Local fitness assessment & CT CAP +/- rectal staging as per local protocol
- Treatment of the primary tumour locally if symptomatic

**Advanced Colorectal Cancer (ACC) sMDT**

- Potentially resectable disease in all sites
  - PET CT, MR Liver & KRAS *
    - Commence systemic therapy +/- Radiotherapy to rectum with sMDT discussion in parallel
    - Do not wait for PET CT/MR results before treatment commences
    - Re-discuss at ACC sMDT with post treatment imaging

- Borderline resectable disease in one or more sites
  - PET CT, MR Liver & KRAS *
    - Commence systemic therapy +/- Radiotherapy to rectum with sMDT discussion in parallel
    - Do not wait for PET CT/MR results before treatment commences
    - Re-discuss at ACC sMDT with post treatment imaging

- Unresectable or incurable disease
  - Palliative Treatment
  - Refer to local oncologist

---

* It is the responsibility of the referring team to request investigations unless specified otherwise on the sMDT outcome

**Principles:**

- Oncology appointment needs to be requested by the referring team before results of PET CT/MR liver are known/discussed at sMDT to avoid delays in the pathway
- Clinical responsibility remains with the referring clinician until the sMDT clinician confirms they are taking over their care
- sMDT outcome will be sent to referring teams by Friday lunchtime
Section Five: Liver Metastases

Section Six: Oncology

6.1 Chemotherapy Treatment Algorithms - 14-1C-109d

The CNG, in consultation with the Network Chemotherapy Group (NCG) has agreed a list of acceptable chemotherapy treatment algorithms


Responsibility for updating the protocols has been delegated to The Clatterbridge Cancer Centre NHS Foundation Trust. An electronic version of the protocol book which is available on CCC internet site and subject to bi-annual review and as a result will be updated as required during the year.

6.2 Radiotherapy Protocols

The CNG, in consultation with the Network Radiotherapy Group (NRG) has agreed a list of acceptable radiotherapy protocols. A hard copy is available at network-level.

Responsibility for updating the protocols has been delegated to The Clatterbridge Cancer Centre NHS Foundation Trust. An electronic version of the protocol book which is available on CCC intranet site and subject to bi-annual review and as a result will be updated as required during the year. The CNG, in consultation with the Acute Oncology & Chemotherapy CNG will agree a list of acceptable chemotherapy treatment algorithms. The list will be updated bi-annually.

Section Seven: Supporting Pathways

7.1 Skin/Anal Pathway

![Skin/Anal Cancer Pathway Diagram]
### 7.2 TYA Initial Management Pathway

**Patient registration to NW/CS and TYAC**

- **TYA MDT outcome form** sent to referring MDT
- **TYA MDT weekly Tuesday and CCC**
  - All TYA patients will be discussed at this MDT. Member of site specific team to present patient.
  - Agree treatment plan made by site specific MDT.
  - Team to discuss patients individual support networks, identify any psychosocial issues to address.
  - Clinical trials to be considered.

**Suspected cancer referral (GP/A&E screening/other referral route)**

- Notify TYA MDT when diagnosis confirmed, complete TYA referral form Fax or email to MDT coordinator.

**Diagnostic tests leading to confirmed diagnosis (final responsibility for diagnostic process lies with site specific MDT)**

**Cancer Diagnosis**

- **Treatment Planning** (Communication, agreed plan and key worker recorded by both MDT’s)
  - Colorectal - Site specific MDT meeting
    - Patient discussed and treatment plan identified as per clinical guidelines.
    - The agreed site specific consultant is the person who remains in overall charge of the patient’s treatment.
    - Fertility discussion (if appropriate).
    - Clinical trials to be considered.
    - TYA MDT member present if appropriate.
    - Agree place of care with patient.

**Identify TYA team members input (social worker, psychologist, lead nurse, youth support)**

- TYA team to make contact with patient and discuss required support.

**Support from TYA MDT members throughout patients treatment as required. Responsibility to provide appropriate support and environment lies with the TYA MDT**

**In Treatment**

- Aged 16-18 years treatment at Principal Treatment Centre in age appropriate setting.
- 18-24 years treatment location choice at principal treatment centre in age appropriate setting or designated hospital.

**Post Treatment**

- Palliative care end of life care.
- Follow up pathway according to site specific protocols.
- Progression/relapse.

**Further information on reverse of page.**
TYA MDT Details-

TYAMDT co-ordinator Theresa Otty

Clatterbridge Cancer Centre, Tuesday 9am JKD library, video and conference call available. Lead Clinician Dr Nasim Ali

Colorectal MDT Details-

Aintree: TYA lead Clinician Dr Lynny Yung

(0151 525 5980) Lead Clinician: Mr Paul Skaife

Countess of Chester: Not a Designated Hospital for TYA lead

(01244 365 000) Lead Clinician: Mr Michael Johnson

Royal Liverpool and Broadgreen: TYA Lead Clinician Dr Nagesh Kalakonda

(0151 706 2000) Lead Clinician: Mr Paul Rooney

Southport & Ormskirk: Not a Designated Hospital for TYA lead

(01704 547 471) Lead Clinician: Mr H Babu

St Helens and Knowsley: TYA Lead Clinician: Dr Majed Gharib

(01744 646 461) Lead Clinician: Mr Ajai Samad

Warrington and Halton: Not a Designated Hospital for TYA lead

(01925 635 911) Lead Clinician: Mr Mark Tighe

Wirral University Teaching Hospital: TYA Lead Clinician: Dr Ranjit Dasgupta

(0151 678 5111) Lead Clinician: Mr Liviu Titu

TYA location options for care-

Surgical option 16-24yrs in accordance with local site specific pathways Chemotherapy 16-24yrs delivered by Clatterbridge Cancer Centre Radiotherapy 16-24yrs delivered by Clatterbridge Cancer Centre
7.3 TYA Completion of First Line Treatment Pathway

Follow up Pathway for Teenagers and Young Adults (TYAs) Following Completion of First Line Treatment
Tumour Type: Colorectal

TYA MDT

- Continuing TYA team involvement, coordination of age appropriate clinical and psychological care

CLIC Sargent social worker will send introduction letter with information and offer initial grant for a person 16 to 24 years at diagnosis and release. A more in-depth service will be offered on assessed needs.

Peer Support: Young people will be invited to peer support activities for 2 years post treatment and can access the Young Support Co-ordinator in this time.

Discussion and outcomes sent to GP and site specific consultant as appropriate.

Patient completed first line treatment. (Could include any combination of surgery, chemotherapy and/or radiotherapy)

Colorectal MDT

- End of treatment summary (disease status, prognosis, treatments recorded, toxicities) and care plan produced by medical team within six months of treatment

- Disease progression supportive care only

- Clinical follow up as per colorectal pathway

- Local palliative care team referral and discussion at palliative care MDT, symptom management

- Re-referred to tya mdt, continue as tya initial management pathway as appropriate

- Outpatient clinic reviews, toxicity monitoring, late effects

- Surveillance monitoring: imaging and/or laboratory investigations as protocol

- Refer to colorectal support groups as appropriate

Recurrence disease or new primary via self referral, gp or surveillance. Refer back to responsible consultant

Notes:
- There will be unhindered access into the tya mdt if clinicians have concerns about any patient after completion of first line treatment or if the patient wishes to be discussed.
- Late effects 5 years post diagnosis, the TYA MDT co-ordinator will contact the site specific team to consider referral to the late effects service and late effects mdt if appropriate as part of the patients care plan.
Colorectal CNG Clinical Guidelines 2014 V. 1.0
Page 33 of 36

TYA MDT Details-
TYA MDT co-ordinator Theresa Otty
Clatterbridge Cancer Centre, Tuesday 9am JKD library. Lead Clinician Dr Nasim Ali

Colorectal MDT Details-
Aintree: Lead Clinician: Mr Paul Skaife
(0151 525 5980) TYA lead Clinician Dr Lynny Yung

Countess of Chester: Lead Clinician: Mr Michael Johnson
(01244 365 000) Not a Designated Hospital for TYA lead

Royal Liverpool and Broadgreen: Lead Clinician: Mr Paul Rooney
(0151 706 2000) TYA Lead Clinician Dr Nagesh Kalakonda

Southport & Ormskirk: Lead Clinician: Mr H Babu
(01704 547 471) Not a Designated Hospital for TYA lead

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Warrington and Halton: Lead Clinician: Mr Mark Tighe
(01925 635 911) Not a Designated Hospital for TYA lead

Wirral University Teaching Hospital: Lead Clinician: Mr Liviu Titu
(0151 678 5111) TYA Lead Clinician: Dr Ranjit Dasgupta
7.4  CUP Pathway

[Flowchart showing the colorectal cancer pathway]
### 7.5 Rehabilitation Pathway

#### Clinical Indicators for Referral to Colorectal Cancer Rehabilitation

Patients are at risk of developing or experiencing the following clinical indicators and should be assessed for referral to rehabilitation pathway interventions at all stages in the cancer care pathway as described below:

<table>
<thead>
<tr>
<th>Diagnosis &amp; Care Planning</th>
<th>Treatment</th>
<th>Post Treatment</th>
<th>Monitoring/Survivorship</th>
<th>Palliative Care</th>
<th>End of life Care</th>
</tr>
</thead>
</table>

**Consider level of intervention required:**
- Information support
- General rehabilitation services
- Specialist oncology/palliative rehabilitation.
- Ensure patient has contact details for timely future access to rehabilitation services (see local cancer services directory-rehabilitation services).

#### Physiotherapy

- **Difficulties with function, movement and symptom control:**
  - Trunk movement disorder (especially post surgery/pre radiotherapy)
  - Difficulty walking and getting around

- **Breathing difficulties/cough**
- **Pain**
- **Sensory changes**
- **Body image concerns**
- **Fatigue/tiredness**
- **Weakness (focal or generalized)**
- **Impaired Balance**
- **Equipment/information needs**

#### Occupational Therapy

- **Difficulties with activities of daily living, leisure and work resulting from:**
  - Physical symptoms and changes in sensation
  - Functional impairment, (especially post surgery)
  - Fatigue
  - Impaired balance
  - Weakness

- **Difficulty walking and getting around**
- **Anxiety**
- **Adjustment to role and function change**
- **Body image concerns**
- **Cognitive impairment**
- **Equipment/information needs**

#### Dietician

- **Nutrition and diet:**
  - Reduced appetite
  - Nausea and vomiting

- **Weight loss/Weight management/weight gain**
- **Fatigue/tiredness**
- **Difficulties swallowing**
- **Information needs**

#### Speech & Language Therapist

- **Impairment or risk of impaired communication, eating and drinking:**
  - Food sticking the throat
  - Recurrent chest infections
  - Aspiration related

- **Weak or hoarse voice/Loss of volume**
- **Difficulty understanding or speaking**
- **Dry mouth**

### 7.5 Family History

### 7.6 Follow Up
## Appendix 1.0: Unit Contact Points

<table>
<thead>
<tr>
<th>Trust</th>
<th>Lead Clinician</th>
<th>Contact Number</th>
<th>Clinical Nurse Specialist(s)</th>
<th>Contact Number</th>
<th>MDT Co-ordinator</th>
<th>Contact Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aintree University Hospital NHS Foundation Trust</td>
<td>Mr Paul Skaife</td>
<td>0151 525 5980</td>
<td>Maureen Williams</td>
<td>0151 525 5980</td>
<td>Margi McGeeney</td>
<td>0151 525 5980</td>
</tr>
<tr>
<td>Countess of Chester NHS Foundation Trust</td>
<td>Mr Michael Johnson</td>
<td>01244 365000</td>
<td>Ms C Smith</td>
<td>01244 365000</td>
<td>Mrs A McLennon</td>
<td>01244 365000</td>
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<tr>
<td>Royal Liverpool &amp; Broadgreen University Hospital NHS Trust</td>
<td>Mr Paul Rooney</td>
<td>0151 706 2000</td>
<td>Sue Kennedy</td>
<td>0151 706 2000</td>
<td>Gemma Hodgson</td>
<td>0151 706 2000</td>
</tr>
<tr>
<td>Southport and Ormskirk Hospital NHS Trust</td>
<td>Mr Babu</td>
<td>01704 547471</td>
<td>Jo Sutton</td>
<td>01704 547471</td>
<td>Lynn Schinkel</td>
<td>01704 547471</td>
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<tr>
<td>St Helens &amp; Knowsley Teaching Hospitals NHS Trust</td>
<td>Dr Amir Montazeri</td>
<td>0151 426 1600</td>
<td>Angela Fitzgerald Smith</td>
<td>0151 426 1600</td>
<td>Louis Fox</td>
<td>0151 426 1600</td>
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<tr>
<td>The Clatterbridge Cancer Centre NHS Foundation Trust</td>
<td>Mr Mark Tighe</td>
<td>01925 635911</td>
<td>Louise Foley</td>
<td>01925662837</td>
<td>Dawn Ingham</td>
<td>01925 635911</td>
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<tr>
<td>Wirral University Teaching Hospital NHS Foundation Trust</td>
<td>Mr Liviu Titu</td>
<td>0151 678 5111</td>
<td>Mrs J Savage</td>
<td>0151 678 5111</td>
<td>Ms M Veaney</td>
<td>0151 678 5111</td>
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