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Navigating the storm of COVID-19 for patients with suspected bowel cancer

Editor


A situation that was unthinkable in the UK at the beginning of March 2020, arose 3 weeks later; surgery for patients with cancer had been stopped in many hospitals, as beds and ventilators were redirected to patients with COVID-19. Non-emergent endoscopy services have been paused¹, creating a backlog of symptomatic patients awaiting investigation, some of whom will have bowel cancer². Within this context, there is a need for policy-makers to consider a new approach for managing patients with suspected bowel cancer symptoms referred under the National Institute for Health and Care Excellence (NICE) 2-week wait (2WW) pathway as 96 per cent do not have cancer. The faecal immunochemical test (FIT) offers an evidence-based way to prioritize 2WW patients for investigation.

Data from NICE FIT study on 9822 patients, together with other large studies from University College Hospital and York will demonstrate FIT positivity rates, sensitivity and cancer prevalence at different FIT thresholds, which can be selected based on capacity. During the pandemic, a higher threshold may be employed to reduce the number of referrals that result in colonoscopies with normal or benign findings. Currently, cancer is expected to be found in one in 30 colonoscopies performed for 2WW patients as opposed to one in six to ten patients who are FIT positive at a FIT threshold of more than 10 µg Hb/g faeces, and one in three patients at more than 150 µg Hb/g faeces³.

FIT may therefore offer a solution, but questions remain about its optimum position and role in the 2WW referral pathway during the pandemic. FIT in primary care was recommended in a joint position statement by the Association of Coloproctology of Great Britain & Ireland (ACPGBI), British Society of Gastroenterology (BSG) and British Society of Gastrointestinal and Abdominal Radiology (BSGAR) for assessing cancer risk, but only 'where available'¹. We suggest that patients are only referred after FIT in primary care; a view supported by the London Cancer Alliances, and implemented across London. Logistically, most GPs in England have been using FIT as a rule-based tool for low risk symptoms since 2017, following the release of NICE DG30⁴. Thus, the existing DG30 system and test-kit allocation could be scaled up to include patients with high risk symptoms. A referral system based entirely on FIT will miss cancers; but with a negative predictive value ranging between 99.1 and 99.8 per cent this may be deemed acceptable in the current environment³. The London pathway involves referring only FIT-positive patients at a threshold over 10 µg Hb/g faeces for investigation; patients with more than 150 µg Hb/g faeces should be prioritized for colonoscopy. This system will reduce referrals by 80 per cent and is unambiguous; this clarity will facilitate implementation by GPs and clinicians. When endoscopy capacity increases, FIT-based selection of patients for investigation can be improved to reduce missed cancers; by increasing FIT sensitivity using a lower threshold and establishing robust safety-netting pathways.

During the COVID-19 storm, we must not lose sight of the 40 000 patients that develop bowel cancer each year. Our duty remains to serve these patients; without endoscopy capacity, a referral system based on FIT in primary care may do the greatest good for the greatest number.

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