SHIP 8 Clinical Commissioning Groups' Priorities Committee Policy

CEC16/006 - Flexible sigmoidoscopy in suspected colorectal cancer

Date of issue (from SHIP 8 Priorities Committee): April 2016

Date of adoption (by NHS North Hampshire CCG): May 2016

The Priorities Committee has reviewed the evidence for diagnosis using flexible sigmoidoscopy as opposed to proceeding directly to colonoscopy and recommend that patients referred with rectal bleeding are offered flexible sigmoidoscopy, with colonoscopy reserved for those in whom symptoms and the results of sigmoidoscopy suggest disease proximal to the splenic flexure.

- **Reports from flexible sigmoidoscopy should include a clear management plan**

Supporting Information

- Colorectal cancer is a relatively common cancer that presents with bleeding, change in bowel habit, anaemia, weight loss or abdominal mass.
- Natural history of colorectal cancer is long and slow.
- Flexible sigmoidoscopy visualises up to the splenic flexure where 55-60% of cancers occur. It is often done as an outpatient appointment, requires no sedation and takes an average of 10-20 minutes.
- Colonoscopy visualises the whole colon and rectum. It requires more preparation than flexible sigmoidoscopy, including sedation, takes approximately 30-45 minutes and has a 1.8 times higher risk of bowel perforation (approximately 1 vs 2 per 1,000 procedures).

No randomised controlled trials were found. Five studies were found which used various different protocols, not providing a definitive answer as to who should and should not go on to have a colonoscopy.

Both procedures miss a small number of cancers.

Flexible sigmoidoscopies are particularly appropriate for bright red rectal bleeding as this symptom suggests a source in the more distal colon or rectum.

The studies consistently describe the difficulty of offering colonoscopy to the large number of patients presenting with possible colorectal cancer. There is a need to balance demand with supply and provide rapid access to an appropriate investigation. A lack of colonoscopy capacity may lead to delays in diagnosis which effect outcomes.

Clinicians vary the time to further follow-up or investigation depending on the symptoms and the findings of the investigation and a clear plan is important to avoid frequent repeat unnecessary investigations.

Notes:
Exceptional circumstances may be considered where there is evidence of significant health impairment and there is also evidence of the intervention improving health status.
This policy may be reviewed in the light of new evidence or guidance from NICE.