Scottish Government
Riaghaltas na h-Alba
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GUIDANCE FOR THE USE OF FIT IN THE PRIORITISATION OF PATIENTS WITH COLORECTAL SYMPTOMS NOW AND IN THE RECOVERY PERIOD AFTER COVID.

This document is designed to provide guidance on the use of faecal immunochemical testing (FIT) for faecal haemoglobin (f-Hb) and a full blood count (FBC) as *adjuncts* to clinical acumen so that investigation of patients with colorectal symptoms can be targeted to those with the highest risk of colorectal cancer. The reason for this guidance is that individual symptoms are poor predictors of colorectal cancer, but the approach recommended here is *not* intended to replace clinical judgement.

When colonoscopy is either severely restricted or not available (Figure 1)

1. A numerical f-Hb result[a] and a FBC should be available *whenever possible*[bc] before a patient is considered for investigation of large bowel symptoms.
2. In patients with f-Hb ≥400 µg Hb/g faeces, urgent investigation *in keeping with available resource*[j] is indicated. This may take the form of colonoscopy, or non-invasive forms of investigation according to availability such as CT of abdomen and pelvis or colon capsule endoscopy (CCE).
3. In patients with f-Hb <400 µg Hb/g faeces, individual decisions on whether or not to offer investigation should be made on a case-by-case basis, taking account of patient frailty, severity and persistence of the patient's symptoms *and* the numerical f-Hb result. Those with a f-Hb <10 µg Hb/g faeces should only be offered investigation where there is significant ongoing clinical concern[d,e].

In the recovery phase, when restrictions on colonoscopy capacity have started to ease (Figure 2)

1. A numerical f-Hb result and a FBC should be available[a] *whenever possible*[bc] before a patient is considered for investigation of large bowel symptoms.
2. In patients with f-Hb ≥400 µg Hb/g faeces, urgent colonoscopy is indicated. This threshold may be reduced as Boards regain diagnostic capacity[h].
3. In patients with f-Hb ≥10 µg Hb/g faeces but <400 µg Hb/g faeces, colonoscopy or CT colonography (if available) are indicated. If these are still not available, less invasive investigations such as CT abdomen and pelvis or colon capsule endoscopy (CCE) may be indicated. The decision to investigate and which modality to use will depend on availability and patient frailty, with urgency determined on a case-by-case basis, taking account of the nature, severity and persistence of the patient's symptoms *and* the numerical f-Hb result.
4. In patients with f-Hb <10 µg Hb/g faeces, further investigation is not indicated *unless* there are persistent severe symptoms[d,e] or iron deficiency anaemia (IDA).

Notes:

a. Recent data from Glasgow, Tayside and Fife indicate that f-Hb of >400 µg Hb/g faeces has a positive predictive value (PPV) for cancer of 22.8%, and 4 colonoscopies are required to diagnose one cancer. A f-Hb of <10 µg Hb/g faeces has a positive predictive value (PPV) for cancer of 0.7%, and 148 colonoscopies are required to diagnose one cancer.

b. Whenever possible, GPs should use numerical f-Hb results in their decision-making process before referring a patient for colonoscopy, both now and in the future, appreciating that FIT is an *aid* to diagnosis and not a test for cancer. However, it is recognised that in some Boards, use of FIT in primary care may not be desirable or possible. In this case, FIT triage should be employed at a secondary care level (see note f).

c. It is recognized that, rarely, patients either cannot or do not wish to provide a sample for FIT. *This must not be seen as a bar to investigation*, which should be carried out as the symptoms dictate.

d. A FIT result of <10 µg Hb/g faeces must not be seen as an absolute bar to investigation. If a GP has a patient with a FIT result <10 µg Hb/g faeces, but with persistent symptoms, a primary care review *within* six weeks is recommended, of and if there is still doubt as to whether or not to refer, a repeat FIT may be of value.

e. The wording of the Scottish guidelines on urgent suspected cancer referral deserves close attention: "***Repeated*** rectal bleeding without an obvious anal cause or any blood mixed with the stool, ***persistent*** change in bowel habit especially to looser stools (more than 4 weeks), a right-sided abdominal mass or palpable rectal mass, unexplained iron deficiency anaemia". Thus, the *first* presentation of rectal bleeding and/or change of bowel habit should be assessed in the light of the FIT result; if this is <10 µg Hb/g faeces a review *within* six weeks to check for symptom persistence would be appropriate.

f. If a patient is referred for assessment to a secondary care service and, based on an assessment of the symptoms and the numerical FIT result, a decision has been taken not to pursue further investigation, a clear follow-up strategy should be formulated *in secondary care* and communicated to the patient and the GP.

g. In the recovery phase, repeating FIT in patients on the waiting list may help prioritisation.

h. As awareness of patient risk to staff becomes clearer, such that the level of PPE required to deliver colonoscopy decreases, endoscopy service capacity will increase and it is likely that CT colonography can resume. ***At this point Boards will be able to reduce the threshold for urgent colonoscopy from ≥400 µg Hb/g faeces downwards.***

i. Currently, there is a large number of people with positive CRC screening FIT results awaiting colonoscopy. As with symptomatic patients, it is appropriate to prioritize those with results ≥400 µg Hb/g faeces for colonoscopy, either now or during recovery until screening invitations recommence. Boards will be provided with the numerical FIT results of individuals awaiting screening colonoscopy to allow this.

j. It is recognised that returning to full colonoscopy capacity will be a gradual process which will take many months and will hinge on our understanding of risk to endoscopy staff. In addition, the pace of the transition from the COVID-19 to Post-COVID-19 recommendations may vary from one NHS Board to another. Due to ongoing need for social distancing, pre-investigation testing and use of PPE/enhanced hygiene it will be a considerable time before previous capacity is restored.

k. Failure to implement a FIT-based triage system for prioritisation of investigation is likely to delay diagnosis of cancer due to dilution of the pool of referred patients with actual cancer into a larger referral cohort that cannot be investigated in a timely fashion due to the service capacity limitations incurred by the COVID pandemic.

l. ***It is important that Boards keep this strategy under review, being mindful that NICE are reviewing the topic of using FIT to prioritise investigation of symptomatic patients and that this will provide valuable insight which may be applicable in Scotland.***

Figure 1

DURING COVID PANDEMIC

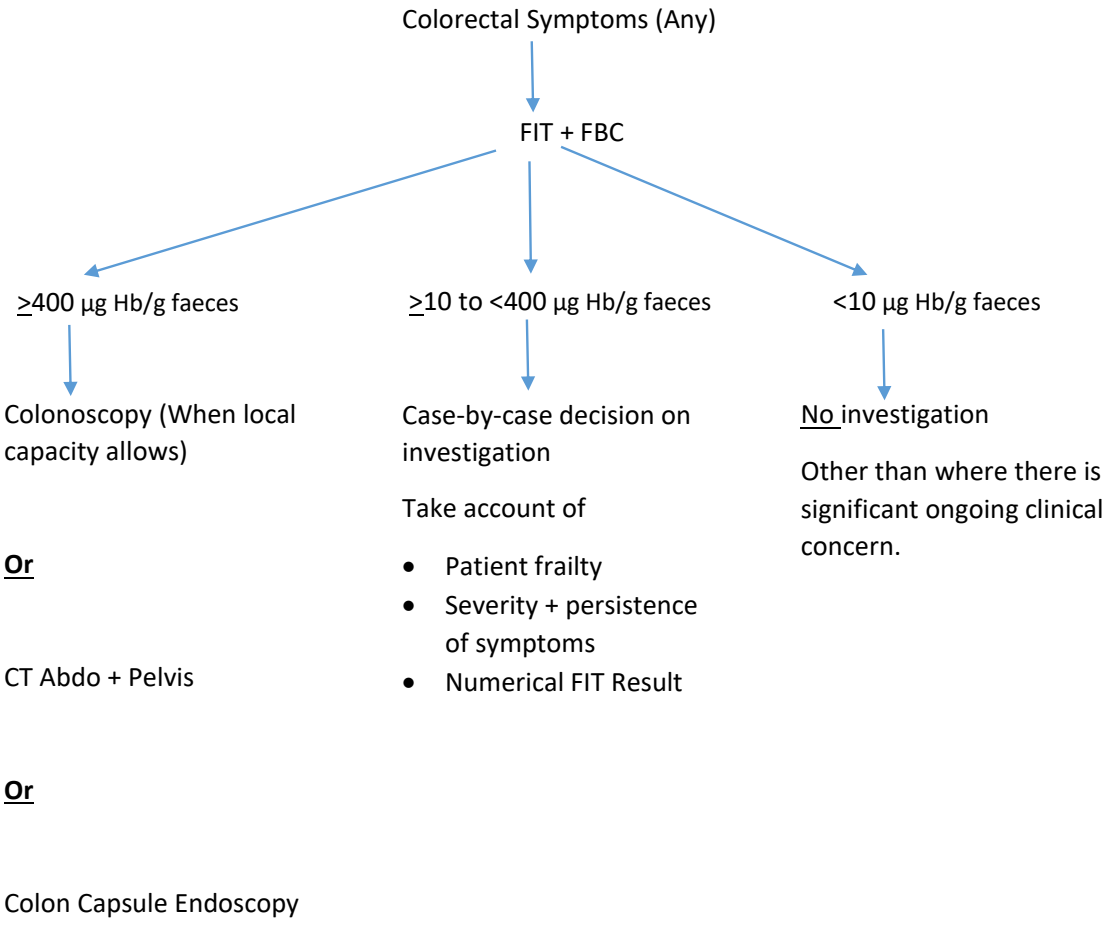
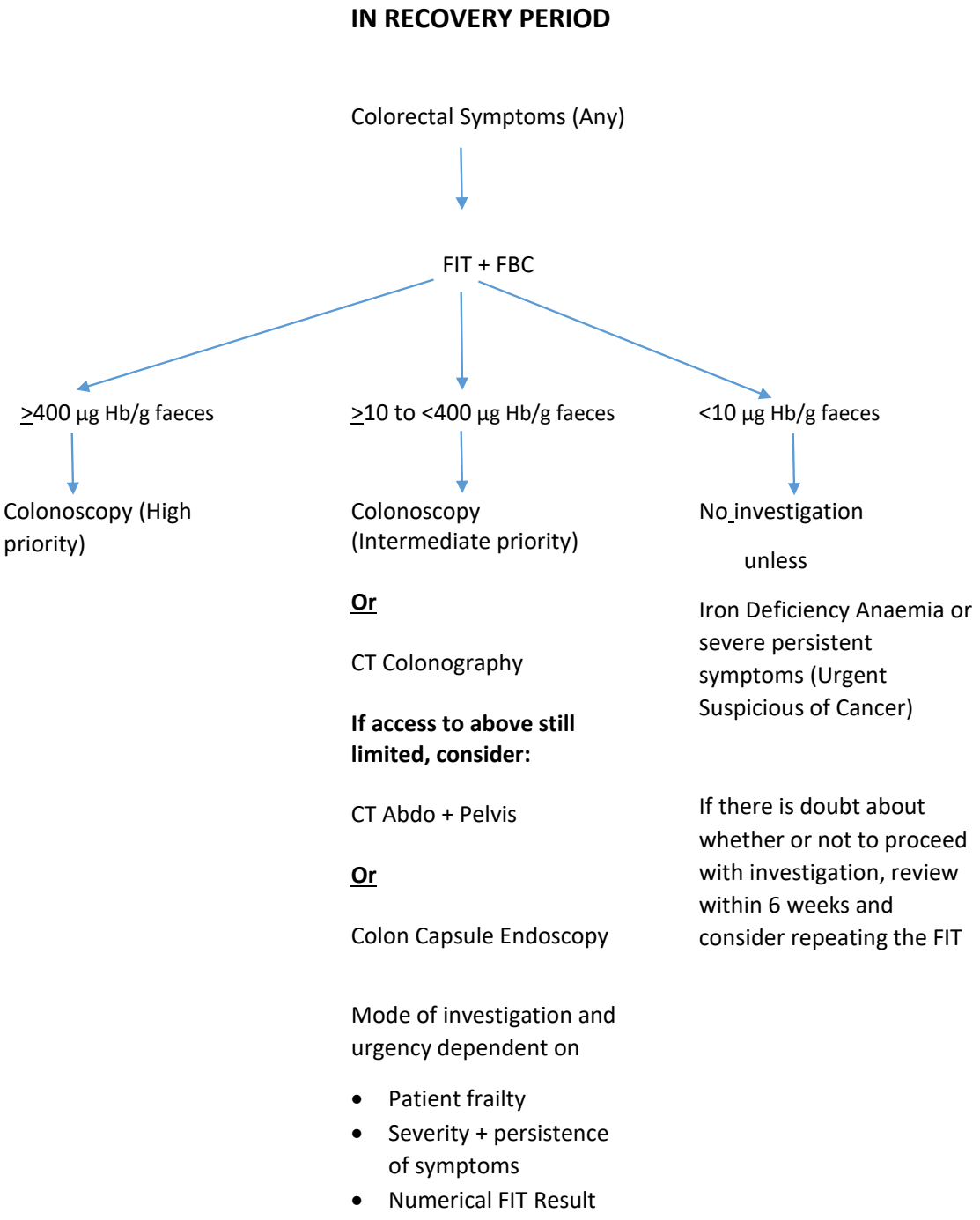


Figure 2


IN RECOVERY PERIOD
Colorectal Symptoms (Any)
FIT + FBC
≥400 µg Hb/g faeces
≥10 to <400 µg Hb/g faeces
<10 µg Hb/g faeces
Colonoscopy (High priority)
Colonoscopy (Intermediate priority)
Or
CT Colonography
If access to above still limited, consider:
CT Abdo + Pelvis
Or
Colon Capsule Endoscopy
Mode of investigation and urgency dependent on
• Patient frailty
• Severity + persistence of symptoms
• Numerical FIT Result
No investigation
unless
Iron Deficiency Anaemia or severe persistent symptoms (Urgent Suspicious of Cancer)
If there is doubt about whether or not to proceed with investigation, review within 6 weeks and consider repeating the FIT