

# Improving access to colonoscopy in a South Western Sydney public hospital for patients with positive faecal occult blood test



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## Introduction

- Colorectal cancer is the second most common malignancy in men and women (*Australian Institute of Health and Welfare 2017*).
- Faecal occult blood test (FOBT) has assisted in earlier diagnosis and intervention, which lead to improved outcome.
- Campbelltown is an area of lower socioeconomics (SEIFA disadvantage score 944.8) with a significant percentage of culturally and linguistically diverse (CALD) constituents.
- Since April 2016, with the aid of a Cancer Institute NSW grant, a direct access colonoscopy (DAC) program was commenced at Campbelltown Hospital to improve access to colonoscopy following a positive FOBT.

## Aims

- To evaluate the impact of a DAC program in a public hospital setting in improving access and reducing waiting time for colonoscopy following a positive FOBT.

## Methods

- A clinical nurse-coordinated DAC program was implemented in April 2016.
- Data from each referral from *April 1<sup>st</sup> 2016 until May 1<sup>st</sup> 2017* was obtained including gender, age, date of referral, time to colonoscopy and surgery, screening test used, ethnicity, colonoscopy quality markers (bowel preparation, caecal and ileal intubation rate), findings (polyps, cancer, haemorrhoids, diverticulosis) and lesion characteristics (polyp number, size, location and histopathology).

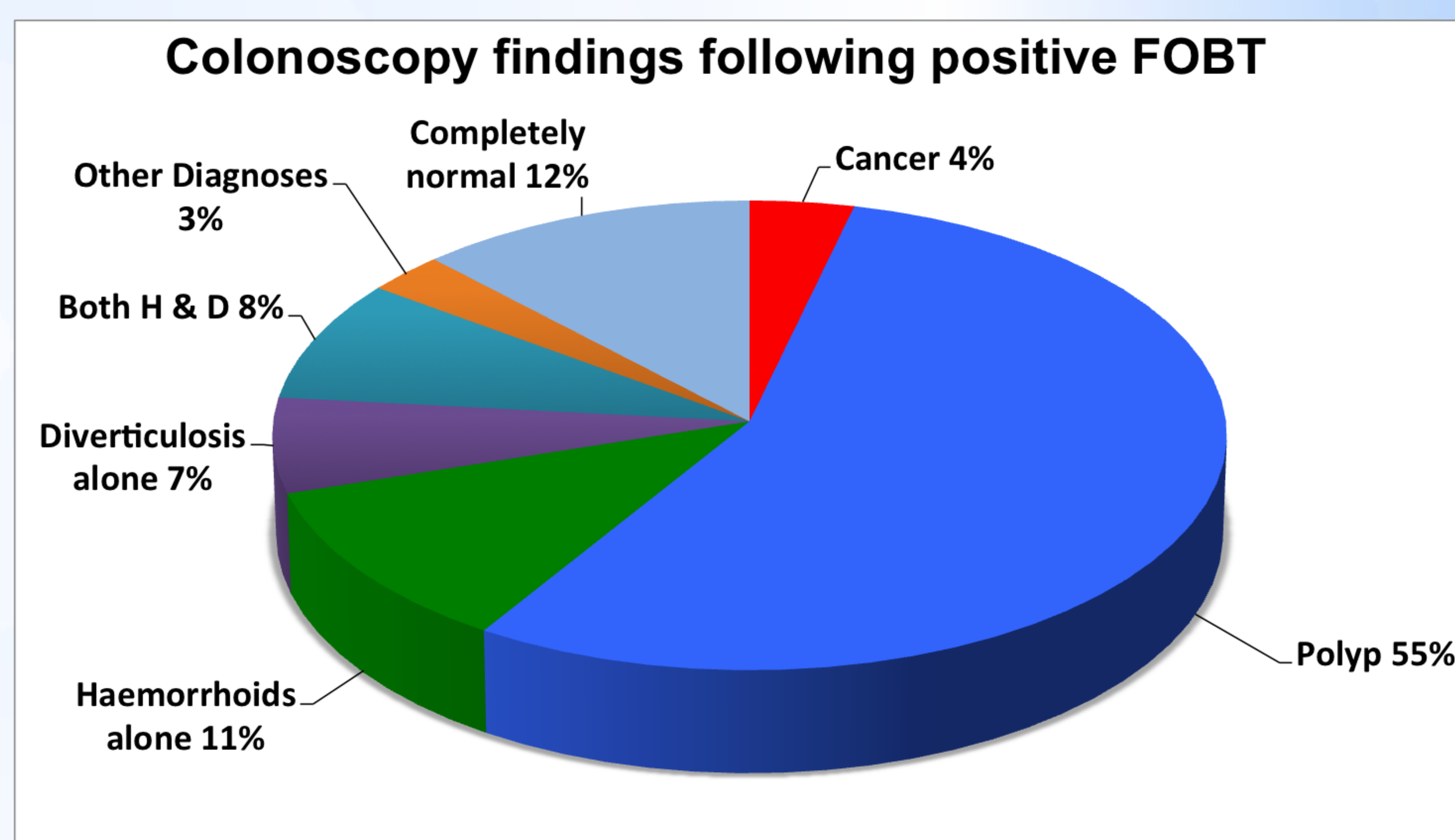
## Results

**Table 1: Cohort details**

Number of referrals	137
Number of colonoscopies performed	107
Number of male patients	55
Median patient age (years)	64
Patients of culturally and linguistically diverse (CALD) background	37 patients (34.6%)

- Of the 137 referrals, 12 elected to attend a private facility, 12 were outside program criteria, 3 failed to be contacted/no show for the procedure, and 3 were awaiting their procedure at the time of analysis.
- Median time from general practitioner (GP) referral to colonoscopy was 36 days (range 18-85 days).
- There was no statistically significant difference in median waiting time between the CALD (40 days) and non-CALD (36 days) patients (p-value=0.17).
- Markers of quality for colonoscopy: bowel preparation (94.4% adequate), and intubation rates (95.3% to caecum including 63.6% to terminal ileum).
- 5 (4.7%) incomplete colonoscopies (2 due to poor bowel preparation, 2 due to looping and 1 with a severe diverticular stricture); all underwent CT colonography and/or repeat colonoscopy as required.

## Results



**Table 2: Colonoscopy results**

Detection of histologically significant polyps of any size:	
59 colonoscopies (55.1%) found polyps of any size and 31 of these colonoscopies found at least one polyp >10mm	Tubular adenoma (TA) - 47 cases (79.7%) Tubulovillous adenoma (TVA) - 10 cases (16.9%) High Grade Dysplasia (HGD) - 2 cases (3.4%)
Distribution of polyps: no significant differences between right and left colon.	
Detection of colorectal cancer:	
4 colonoscopies (3.7%) found a cancer	Adenocarcinoma - 3 cases Mucinous adenocarcinoma within a TVA - 1 case
Right-sided cancer - 3 cases Left-sided cancer - 1 case	
Male to Female Ratio - 3:1	
Surgical Resection	
-Referral to Private - 1 case -Public Hospital - 3 cases	
Median time to surgical resection - 38 days (Range 27-67 days)	

## Conclusion

- As per NHMRC data, patients with a positive FOBT have 30-45% risk of adenomas; 3-10% risk of colorectal cancer. Our data demonstrate similar results with 55% of colonoscopies finding adenomas, and a 3.7% cancer detection rate.
- The benchmark for colonoscopy after positive FOBT is within thirty days (NSW Ministry of Health National Definition for Elective Surgery Categories, 2012). In comparison with a previous internal audit performed prior to DAC program being implemented, our median time from GP referral to colonoscopy for a positive FOBT test has decreased from 100 days to 36 days.
- CALD patients accessing the service has increased from 18% to 34.6%, and there was no difference between waiting times for CALD vs non-CALD patients. This indicates good acceptance of this method of colonoscopy referral. Future plans include more outreach by DAC coordinator within local CALD communities.