



2017

Commissioning guide:

Rectal Bleeding

Sponsoring Organisation: Association of Coloproctology of Great Britain and Ireland

Date of evidence search: 2017

Date of publication: December 2017



Commissioning guide 2017

Rectal Bleeding

Contents

Contents	1
Glossary	2
Introduction	5
1 High Value Care Pathway for rectal bleeding	7
1.1 Self-help/community care	7
1.2 Primary Care.....	7
1.3 Primary care management	8
1.4 Referral criteria.....	9
1.5 Secondary Care.....	10
2 Levers for implementation	13
2.1. Audit and peer review measures	13
2.2 Quality Specification/CQUIN (Commissioning for Quality and Innovation).....	14
3 Directory	15
3.1 Patient Information for rectal bleeding	15
3.2 Clinician information for rectal bleeding.....	15
3.3 NHS Evidence studies.....	17
4 Benefits and risks of implementing this guide	18
5 Further information	20
5.1 Research recommendations.....	20
5.2 Other recommendations.....	20
5.3 Evidence base.....	20
5.4 Guide development group for rectal bleeding.....	23
5.5 Funding statement.....	23
5.6 Conflict of Interest Statement.....	24



Commissioning guide 2017

Rectal Bleeding

Glossary

Term	Definition
anal cancer	cancer arising from the anus (distinct from rectal cancer)
angiodysplasia	small vascular malformation of the gut which may cause profuse rectal bleeding
argon plasma coagulation (APC)	endoscopic procedure used to control bleeding in the gastrointestinal tract
asymptomatic	having no symptoms
Audit	evaluation of an investigation or treatment through systematic examination of data
Bowel Cancer Screening Programme (BCSP)	national screening programme for colorectal cancer based on FOB testing
carcino-embryonic antigen (CEA)	tumour marker which may be associated with advanced colorectal cancer
Clinical Commissioning Guide (CCG)	commissioning guidance approved by the National Institute of Health and Care Excellence (NICE) and supported by the Royal College of Surgeons and the surgical subspecialty associations
chronic anal fissure	tear in the anus which has been present for more than six weeks
colonic polyp	growth occurring on the lining of the bowel
colonoscopy	endoscopic examination of the entire large bowel
Commissioning for Quality and Innovation (CQUIN) payment	payment designed to reward excellence in healthcare provision by linking a proportion of income to the achievement of local quality improvement goals
CT colonography	medical imaging procedure using x-rays and computers to produce images of the colon and rectum



Commissioning guide 2017

Rectal Bleeding

Diltiazem	Unlicensed medication to relax the anal sphincter and improve blood supply to allow fissure healing
digital rectal examination (DRE)	medical examination of the back passage with a finger
diverticular disease	pockets in the bowel from weakness of the muscle layers in the bowel wall
faecal calprotectin	stool test for inflammatory bowel disease
faecal occult blood (FOB)	stool test to check whether there is blood hidden in faeces
flexible sigmoidoscopy	telescope examination of the lower bowel
full blood count (FBC)	a blood test for anaemia
Glyceryl trinitrate (GTN)	medication to relax the anal sphincter and improve blood supply to allow fissure healing
haemorrhoidal artery ligation operation	doppler guided haemorrhoidal operation designed to identify and tie off blood vessels
haemorrhoids	piles
high value care pathway	clear and consistent commissioning guideline for a surgical procedure aimed at producing better value high quality clinical practice
infectious gastroenteritis	infection of the bowel caused by bacteria or viruses
inflammatory bowel disease	inflammatory condition of the bowel, usually ulcerative colitis or Crohn's disease
ischaemic colitis	inflammation of the bowel from inadequate blood supply
Joint Advisory Group (JAG) on Gastrointestinal Endoscopy	UK advisory body that ensures the quality and safety of gastrointestinal endoscopy advises on and ensures standards
lateral internal anal sphincterotomy (LIAS)	operation to partially divide sphincter muscle to allow anal fissure to heal
levers for implementation	specific levers to aid implementation of high value care pathways



Commissioning guide 2017

Rectal Bleeding

lower gastrointestinal haemorrhage	sudden heavy blood loss from the back passage, usually requiring emergency hospital admission
occult	unseen or unnoticed
over the counter (OTC)	medications available without prescription
per rectum	through the back passage or via the anus
perianal disease	medical condition affecting the bottom (anus)
positive predictive value (PPV)	the proportion of positive test results that are correct diagnoses
procedures explorer	tool designed to help commissioners understand local clinical variation for a surgical procedure covered by commissioning guidance
quality dashboard	tool designed to help commissioners understand local clinical variation for a surgical procedure covered by commissioning guidance
radiation proctitis	Inflammatory condition of rectum occurring after radiotherapy
second degree haemorrhoids	piles that prolapse on bearing down but go back on their own
solitary rectal ulcer	condition caused by straining at stool, rectal intussusception or anal digitation, with trauma to the lining of the back passage and subsequent ulceration
third degree haemorrhoids	piles that prolapse on bearing down but need to be pushed back to go back inside
transanal haemorrhoidal dearterialization	doppler guided haemorrhoidal operation designed to identify and tie off blood vessels



Commissioning guide 2017

Rectal Bleeding

Introduction

Definition

Rectal bleeding is defined as the passing of blood from the back passage or anus.

Scope and purpose of the guide

This guidance applies to the elective management and onward referral for diagnosis, investigation and management of patients who experience rectal bleeding.

This guidance does not supersede cancer pathways. It is not intended to guide commissioning of services relating to suspected cancer, investigation of occult gastrointestinal bleeding (eg iron deficiency anaemia) or emergency management of lower gastrointestinal haemorrhage. However, these pathways will be referenced as rectal bleeding may be a sign of colorectal cancer or gastrointestinal haemorrhage.

This guidance does not refer to asymptomatic patients who are tested in the NHS Bowel Cancer Screening Programme (BCSP).

Background

Rectal bleeding is a very common symptom in adults of all ages. In most people, it is intermittent and often self-limiting. The majority of patients with rectal bleeding will have benign anal conditions such as haemorrhoids or an anal fissure, but rectal bleeding may also be a symptom of inflammatory bowel disease, diverticulosis, or colorectal cancer.^{1,2,3,4,5,6,7,8,9} Other potential causes of rectal bleeding include, but are not limited to:

- diverticular disease
- colonic polyps
- radiation proctitis
- infectious gastroenteritis
- angiodysplasia
- ischaemic colitis
- solitary rectal ulcer
- anal cancer
- sexually transmitted diseases
- anorectal trauma

The age of the patient acts as a guide to the range of potential causes of rectal bleeding. For example, younger patients under 30 years are more likely to have haemorrhoids, anal fissure or inflammatory bowel disease whereas a patient over the age of 50 years with rectal bleeding has a higher risk of colorectal cancer.¹⁰



Commissioning guide 2017

Rectal Bleeding

The prevalence of rectal bleeding is poorly studied but available evidence suggests that one-year prevalence in adults is about 10% in the UK. Only a minority of people with rectal bleeding will seek medical advice.¹¹ The majority of patients seek advice because they are concerned that the bleeding indicates something serious or because the symptoms are troublesome.

Cost to the NHS

In the financial year 2011/2012, the tariff cost to the NHS of colonoscopy and flexible sigmoidoscopy (endoscopic procedures commonly used to investigate rectal bleeding symptoms but also used for other indications) was about £94 million. During the same period, the tariff cost for procedures to treat haemorrhoids and anal fissures (two benign causes of rectal bleeding) was about £28 million.

The market for over the counter (OTC) haemorrhoidal treatments is worth £22 million a year and the OTC laxative market is worth £50 million a year (data kindly provided by the Proprietary Association of Great Britain).



Commissioning guide 2017

Rectal Bleeding

1 High Value Care Pathway for rectal bleeding

1.1 Self-help/community care

As rectal bleeding is a common symptom at all ages, and is often self-limiting, many patients will have already sought over the counter (OTC) treatments from local pharmacies or supermarkets or used internet-based advice prior to seeking medical care. High quality internet resources are listed in the directory. Most perianal causes of rectal bleeding will be improved with application of topical treatment, increased high fibre diet and/or oral fibre supplement with increased oral fluid intake.¹²

1.2 Primary Care

Primary care assessment

In view of the fact that rectal bleeding is common, most primary care clinicians will already have a standardised approach to assessment and management of rectal bleeding.

Best practice in primary care will include careful attention to history, presence or absence of perianal symptoms, age of patient (in view of likely differential diagnosis with each age group), family history of colorectal malignancy and red flag symptoms including weight loss, symptoms suggestive of anaemia, and change in bowel habit.^{10,13,14,15} The presence of anorectal pathology does not preclude other more proximal colorectal pathologies or preclude the need for investigation for these.

Rectal bleeding has a positive predictive value (PPV) for colorectal malignancy of 8% in patients aged over 50 years presenting to primary care.² Rectal bleeding associated with other symptoms may be more predictive of colorectal cancer.⁹

Examination of the abdomen to exclude abdominal mass and digital rectal examination (DRE) to examine for fissure and exclude anal or rectal cancer may be useful. DRE may be deferred to second presentation in patients with a good history for hemorrhoids in low risk groups, eg young patients or those with short duration of symptoms and/or in whom review is planned.

If onward referral is planned based on initial presentation, then DRE is desirable but may not be necessary. If the patient is staying in primary care, good practice requires DRE prior to definitively attributing rectal bleeding symptoms to benign causes.

Baseline blood tests may be useful in selected cases, eg full blood count (FBC).¹⁶ Other blood tests will only be necessary if there are other features in the history, eg unexplained weight loss. There is no evidence for tumour markers, eg CEA, as a tool to aid diagnosis in patients with rectal bleeding.¹⁷ Likewise, faecal occult blood testing (as used in the BCSP to detect asymptomatic disease) has no place in investigating patients with frank bleeding.



Commissioning guide 2017

Rectal Bleeding

In the younger, lower risk patient with suspected inflammatory bowel disease, faecal calprotectin is a useful screening tool. A positive faecal calprotectin result has a high positive predictive value (PPV) for finding inflammatory bowel disease at colonoscopy.^{18, 19, 20} A faecal calprotectin test is relatively cheap (about £10) compared with flexible sigmoidoscopy (about £400).

While proctoscopy may be used by some primary care clinicians as a screening tool in patients with rectal bleeding, it should not be used as a substitute for flexible sigmoidoscopy to rule out serious pathology.

Red flag symptoms and signs in patients with rectal bleeding include:

- associated change in bowel habit, especially diarrhoea or increased frequency
- anaemia
- weight loss
- abdominal or rectal mass

This means that the primary care clinician needs to have a high index of suspicion of other pathology if symptoms and/or clinical cause do not follow common patterns suggestive of benign disease.^{13,14} Persistent or unexplained symptoms should trigger need for investigation, as should intractable pain preventing proper clinical assessment.

1.3 Primary care management

In low risk patients with rectal bleeding who are not overly anxious, it is reasonable to manage their symptoms with treatment and adopt a 'watch and wait' policy. Minimally symptomatic haemorrhoids may be safely observed.

Patients with symptomatic haemorrhoids should be given advice about topical treatment, oral fluid intake, high fibre diet and fibre supplementation.¹² Consideration should be given to referral to a specialist community or secondary care provider of colorectal services if symptoms persist/alter or are particularly troublesome.

An acute anal fissure is a tear in the skin of the anal canal, and may be treated with dietary advice and a bulking agent. Topical glyceryl trinitrate (GTN) 0.4% ointment should be considered for chronic fissures (duration of symptoms >6 weeks or clinical appearances of chronicity) with appropriate advice about application and duration of treatment.²² Topical 2% Diltiazem is an alternative which is equally efficacious and associated with fewer side effects but is unlicensed for this indication.²⁴ There are no benefits based on which dosage form is used i.e cream is as efficacious as ointment. The most cost effective option of topical diltiazem 2% should be used, prices can vary drastically between each dosage form, and prices can vary on a month to month basis and should be regularly checked.

Anal fissures with an atypical appearance or a clinical appearance of chronicity such as scarring or tags suggests referral to secondary care may be needed as topical treatments are unlikely to be effective.

Low risk patients with rectal bleeding who are concerned about colorectal malignancy should be



Commissioning guide 2017

Rectal Bleeding

considered for direct access (direct to test) flexible sigmoidoscopy.^{25, 26}

Please see the directory of patient information websites with information leaflets.

1.4 Referral criteria

Two week wait criteria for suspected cancer

Any patient with rectal bleeding who meets the following criteria should be referred urgently under the two week wait guidelines as recommended by NICE Referral Guidelines for Suspected Cancer (NICE CG27/ NICE CG 12):

- aged ≥ 40 years with rectal bleeding and change in bowel habit towards looser and/or more frequent stools for 6 weeks or more
- aged ≥ 60 years with rectal bleeding persisting for 6 weeks or more without change in bowel habit and without anal symptoms
- rectal bleeding and a palpable rectal mass

Other referrals

Routine referral should also be considered for patients with persistent or highly symptomatic haemorrhoids or fissures. Urgent referral should be considered for patients with concerning symptoms which do not meet the two week wait criteria. Symptomatic patients may be more likely to achieve clinical resolution of their symptoms if referred via this pathway rather than the two week cancer pathway which tends to be a cancer exclusion process.

Direct access flexible sigmoidoscopy provides the best reassurance for patients with rectal bleeding who are primarily concerned about malignancy.

Referral for screening colonoscopy or genetics assessment may be appropriate when rectal bleeding has triggered access to medical care but the primary concern is strong family history of colorectal cancer.

Investigation

Patients referred on the two week wait pathway usually require investigation. In many centres there is now a straight to test virtual clinic pathway.

Investigation of rectal bleeding should be considered in patients who do not meet the NICE guidelines for suspected malignancy in the following circumstances:

- strong family history of colorectal malignancy
- anxiety about colorectal malignancy
- persistent rectal bleeding despite treatment for haemorrhoids



Commissioning guide 2017

Rectal Bleeding

- rectal bleeding in patients with a past history of pelvic radiotherapy
- assessment of suspected inflammatory bowel disease

The choice of investigation will depend on symptoms but also on the age of the patient as this determines potential causes of bleeding.^{25, 26}

Flexible sigmoidoscopy is the investigation of choice for patients under the age of 45 with persistent rectal bleeding who are concerned about pathology apart from haemorrhoids or who have received treatment for haemorrhoids and still have persistent bleeding.²⁵ Direct access flexible sigmoidoscopy should be offered if at all possible. There is potential for significant savings if this is available locally.²⁷

If there is a family history of colorectal malignancy, colonoscopy may be a better investigation for rectal bleeding as these patients have a higher risk of right colon cancers. Current British Society of Gastroenterology (BSG) guidelines recommend one-off colonoscopy at 55 years or over in asymptomatic individuals with one first-degree relative diagnosed with colorectal cancer under 50 years old, or two (or more) first degree relatives diagnosed at any age.

Patients over the age of 45 with persistent rectal bleeding should be offered either colonoscopy (this may be the more cost effective investigation) or flexible sigmoidoscopy.²³ In elderly, frail or unfit patients, CT colonography with flexible sigmoidoscopy may be better tolerated than colonoscopy (Royal College of Radiologists 2012, Colon cancer: diagnosis guideline).^{21,28,29}

Barium enema has a significant miss rate for colorectal cancer and other pathologies, and does not have a role in investigation of rectal bleeding.²⁸

Service configuration

Direct access flexible sigmoidoscopy services should be available to primary care. An example of service configuration for provision of direct access flexible sigmoidoscopy is referenced the Manchester NHS PCT Service Specification: Direct Access Rectal Bleed Services.

One stop clinics in either specialist community or secondary care may provide good value for patients who require treatment for haemorrhoids and fissures, coupled with flexible sigmoidoscopy to rule out proximal pathology. One stop clinics should offer both investigation and treatment.

1.5 Secondary Care

Haemorrhoids

Each year the NHS carries out more than 20,000 haemorrhoidal treatments. Treatment of bleeding haemorrhoids depends on the degree of prolapse and severity of symptoms. Rubber band ligation is currently the best available outpatient treatment for haemorrhoids with up to 80% of patients satisfied with short term outcomes.³⁰ About 20% of patients require a second banding procedure within six months for symptom control. Local service providers may offer outpatient injection sclerotherapy with oily phenol or infra-red coagulation (laser) therapy, but neither is as effective as suction banding.



Commissioning guide 2017

Rectal Bleeding

Electrotherapy may be an alternative to banding in Grades I-III haemorrhoids but is inferior to banding in randomized controlled trial.³¹

Haemorrhoids Grading System

Grade I	Bleeding and irritation
Grade II	Prolapse at defaecation but reduce spontaneously
Grade III	Prolapse at defaecation but need manual reduction
Grade IV	Prolapse and can not be reduced

All grades can cause problematic bleeding

At present surgery is reserved for bleeding or prolapsing haemorrhoids that have not responded to outpatient treatment (ASCRS Practice Parameters for the Management of Hemorrhoids).³⁰ Doppler-guided haemorrhoidal artery ligation and stapled haemorrhoidopexy are alternatives to formal haemorrhoidectomy.³²

Simple suture fixation mucopexy of the rectum has been shown in a prospective randomized trial to have comparable short term results and favorable long term results when compared with doppler guided haemorrhoidal ligation.³³

The eTHOS trial (a pragmatic, multicentre, randomised controlled trial) has shown that traditional haemorrhoidectomy offers superior long term quality of life and is cheaper than stapled haemorrhoidopexy. Stapled haemorrhoidopexy offered superior quality of life in the first 6 months only.³⁴

A prospective randomized trial, The HubBLE trial³⁵ recruited patients with symptomatic second and third degree haemorrhoids and compared suction banding and Doppler-guided haemorrhoidal artery ligation surgery. This trial has demonstrated that a course of rubber band ligation is as effective clinically and more cost effective than haemorrhoidal artery ligation. Both this HubBLE trial and the eTHOS trial, which was also published in The Lancet were accompanied by editorials highlighting their outcomes in a way that is pertinent for guidance on commissioning.

Anal fissures

If a patient with a chronic anal fissure has previously used GTN ointment (not recommended for use by NHS Scotland), the first line options in secondary care are topical diltiazem 2% (NICE ESUOM3 as currently an unlicensed indication) or injection of botulinum toxin.^{21,36} Surgical options for anal fissure include fissurectomy with injection of botulinum toxin and lateral internal anal sphincterotomy.^{21,37} Decision making is a balance between efficacy for fissure healing and risk of long term faecal incontinence.³⁷

Inflammatory bowel disease

Patients with significant inflammatory bowel disease should be referred to specialist gastroenterology services for long term management. Mild proctitis may be safely managed in primary care with topical



Commissioning guide 2017

Rectal Bleeding

anti-inflammatory agents, where local guidelines or integrated care exist.

Radiation proctitis

Radiation proctitis responds poorly to topical treatments³⁸ although rectal sucralfate enemas (unlicensed) may be of some benefit in secondary care. Commissioners should liaise with local medicines management for advice on sourcing and administration of this product.³⁹ Access to argon plasma coagulation (APC) is desirable for patients with persistent rectal bleeding from this condition.³⁹

Other conditions

As listed in the background section, there are a number of other pathological conditions causing rectal bleeding. Management of these conditions falls outside the remit of this guide, which assumes that they will be treated appropriately.

Community aftercare

After any treatment for haemorrhoids or fissures, patients should be advised to remain on a high fibre diet with good oral fluid intake to prevent recurrence. Patients with new or recurring symptoms should be reassessed.



Commissioning guide 2017

Rectal Bleeding

2. Levers for implementation

2.1 Audit and peer review measures

The following measures and standards are those expected at primary and secondary care. Evidence should be able to be made available to commissioners if requested.

	Measure	Standard
Primary & Secondary Care	Direct access flexible sigmoidoscopy	<ul style="list-style-type: none">▪ Referral directly from GPs▪ Commissioners can see evidence of this.
Secondary Care	National haemorrhoidal procedure audit	<ul style="list-style-type: none">▪ Provider submits data via HES for haemorrhoid treatment.▪ Commissioners are able to see evidence of submission.
	Missed cancer rate	<ul style="list-style-type: none">▪ Patients presenting with colorectal cancer within a year of endoscopic evaluation
	Waiting time for urgent colonoscopy	<ul style="list-style-type: none">▪ Providers submit data to JAG▪ JAG accreditation



Commissioning guide 2017

Rectal Bleeding

2.2 Quality Specification/CQUIN (Commissioning for Quality and Innovation)

The lower gastrointestinal endoscopy (colonoscopy and flexible sigmoidoscopy) rate is much lower in the UK than most other developed nations. The NHS needs to invest in a lower threshold for investigation in at risk age groups (resulting in increased use and cost of these tests) in order to diagnose distal colorectal cancer at an earlier stage of disease. The CQUIN payment for investigation in rectal bleeding is aimed at promoting high quality use of endoscopic investigation.

Day case rates for haemorrhoidectomy and anal fissure surgery are respectively 74% and 86% (data from British Association of Day Surgery (BADs)). CQUIN payments could be designed to reward high use of day case procedures for haemorrhoids and fissures.

Measure	Description	Data specification (if required)
Day case rate for haemorrhoid procedures	Provider demonstrates 90% day case rate for haemorrhoid surgical procedures	Data available from HES
Day case rate for fissure procedures	Provider demonstrates 92% day case rate for fissure surgical procedures	Data available from HES



Commissioning guide 2017

Rectal Bleeding

3 Directory

3.1 Patient Information for rectal bleeding

Name	Publisher	Link
Rectal Bleeding	NHS Choices	http://www.nhs.uk/conditions/rectal-bleeding/pages/introduction.aspx
Rectal Bleeding (Blood in Faeces)	Patient.co.uk	http://www.patient.co.uk/health/rectal-bleeding-blood-in-faeces
Perianal Disease	The CORE Charity	http://www.corecharity.org.uk/conditions/perianal-disease
Bowel Cancer	The CORE Charity	http://www.corecharity.org.uk/conditions/bowel-cancer

3.2 Clinician information for rectal bleeding

Name	Publisher	Link
NICE Clinical Guideline (CG27). Referral for suspected cancer. London:	National Institute for Health and Care Excellence. 2005.	http://www.nice.org.uk/nicemedia/live/10968/29814/29814.pdf
NICE. Colorectal cancer: the diagnosis and management of colorectal cancer. 131. London:	National Institute for Health and Care Excellence; 2011.	http://www.nice.org.uk/nicemedia/live/13597/56998/56998.pdf
The Royal College of	London: The Royal	http://irefer.org.uk/images/pdfs/cancer_ca23



Commissioning guide 2017

Rectal Bleeding

Radiologists. Colon cancer: diagnosis	College of Radiologists; 2012.	abstract.pdf
Guidelines for colorectal cancer screening and surveillance in moderate and high risk groups (update from 2002)	BSG	http://www.bsg.org.uk/images/stories/docs/clinical/guidelines/endoscopy/ccs_10.pdf
Service Specification: Direct Access Rectal Bleed Services	Manchester NHS PCT	http://www.manchesterpct.nhs.uk/document/uploads/tender_invites/Rectal_Bleed_SS.pdf
Haemorrhoidal artery ligation. 342. London:	National Institute for Health and Care Excellence; 2010.	http://www.nice.org.uk/nicemedia/live/12236/48673/48673.pdf
Rivadeneira DE. Practice Parameters for the Management of Hemorrhoids	Diseases of the Colon & Rectum.	(Revised 2010). 2011; 54(9):1059-64.
Stapled haemorrhoidopexy for treatment of haemorrhoids	National Institute for Health and Care Excellence	(TA 128) 2007
Interventional procedure overview of haemorrhoidal artery ligation	National Institute for Health and Care Excellence	(IP803) 2009
Evidence summary: unlicensed or off-label medicine ESUOM3: Chronic anal fissure: 2% topical diltiazem hydrochloride	National Institute for Health and Care Excellence	http://publications.nice.org.uk/esuom3-chronic-anal-fissure-2-topical-diltiazem-hydrochloride-esuom3/overview-for-healthcare-professionals
Ulcerative colitis: management. London: National Institute for Health and Care Excellence; 2011.	National Institute for Health and Care Excellence Clinical Knowledge Summary.	http://www.cks.nhs.uk/ulcerative_colitis



Commissioning guide 2017

Rectal Bleeding

MHRA statement regarding independent prescribers (including non medical prescribers)

<https://www.gov.uk/drug-safety-update/off-label-or-unlicensed-use-of-medicines-prescribers-responsibilities>

Nursing and midwifery council's statement on prescription of off label medications

<https://www.nmc.org.uk/globalassets/sitedocuments/standards/nmc-standards-proficiency-nurse-and-midwife-prescribers.pdf>

3.3. NHS Evidence studies

Colorectal Cancer	https://www.evidence.nhs.uk/topic/colorectal-cancer
Haemorrhoids	https://www.evidence.nhs.uk/topic/haemorrhoids
Inflammatory Bowel disease	https://www.evidence.nhs.uk/topic/inflammatory-bowel-disease



Commissioning guide 2017

Rectal Bleeding

4 Benefits and risks of implementing this guide

Consideration	Benefit	Risk
Patient outcome	<ul style="list-style-type: none">▪ Ensure access to effective conservative, medical and surgical therapy.▪ Promote good advice and self-care.	Unrecognised deterioration on conservative therapy.
Patient safety	<ul style="list-style-type: none">▪ Reduce chance of missing colorectal cancer.▪ Quality assured endoscopy services.▪ Treating and caring for people in a safe environment and protecting them from avoidable harm (domain 5 of NHS Patient Experience Framework*)	Potential false reassurance of not having bowel cancer
Patient experience	<ul style="list-style-type: none">▪ Improve access to patient information and support groups.▪ Ensure patient confidence with positive treatment experience (domain 4 of NHS Patient Experience Framework*).	Loss of individual patient confidence or self esteem with invasive examination and/or investigation.
Equity of Access	<ul style="list-style-type: none">▪ Improve access to effective procedures, eg direct access flexible sigmoidoscopy.	
Resource impact	<ul style="list-style-type: none">▪ Reduce unnecessary referral and intervention.▪ Reduce costs of unnecessary community tests.▪ Promote low cost high quality tests and interventions.	Resource required to establish primary care service or community specialist provider



Commissioning guide 2017

Rectal Bleeding

*NHS Patient Experience Framework

www.gov.uk/government/uploads/system/uploads/attachment_data/file/146831/dh_132788.pdf.pdf



Commissioning guide 2017

Rectal Bleeding

5 Further information

5.1 Research recommendations

- Diagnostic accuracy: Future primary care studies should report data completely, preferably using the STARD (Standards for Reporting of Diagnostic Accuracy) criteria.
- Investigations: Research into optimum endoscopic investigation depending on patient age and symptoms
- Investigations: Research into optimum and most cost-effective bowel preparation prior to flexible sigmoidoscopy to ensure adequate investigation with minimal risk, balanced against need to recall patients with inadequate investigation due to poor preparation for repeat procedure using full oral mechanical bowel preparation.
- Patient Reported Outcome Measures (PROMS)
- Cost effectiveness of direct access to investigation, eg flexible sigmoidoscopy

5.2 Other recommendations

- National clinical audit of treatment for haemorrhoids
- Best practice guidelines for management in rectal bleeding in primary care

5.3 Evidence base

1. Adelstein BA, Macaskill P, Chan SF *et al*. Most bowel cancer symptoms do not indicate colorectal cancer and polyps: a systematic review. *BMC Gastroenterology* 2011;11:65.
2. Astin M, Griffin T, Neal RD *et al*. The diagnostic value of symptoms for colorectal cancer in primary care: a systematic review. *British Journal of General Practice* 2011;61: e231-e243.
3. <https://www.nice.org.uk/guidance/ng12>
4. <http://cks.nice.org.uk/ulcerative-colitis>
5. <http://cks.nice.org.uk/diverticular-disease>
6. Huggenberger, I. K. and J. S. Andersen (2015). "Predictive value of the official cancer alarm symptoms in general practice--a systematic review." *Danish Medical Journal* 2015; 62(5)
7. Tong, G. X., et al. (2014). Diagnostic value of rectal bleeding in predicting colorectal cancer: a systematic review. *Asian Pacific Journal of Cancer Prevention*. 2014; 15(2): 1015-1021.
8. <http://cks.nice.org.uk/gastrointestinal-tract-lower-cancers-recognition-and-referral>
9. Del Giudice ME *et al*. Systematic review of clinical features of suspected colorectal cancer in primary care." *Canadian Family Physician* 2014;60(8): e405-415.



Commissioning guide 2017

Rectal Bleeding

10. duToit J, Hamilton W, Barraclough K. Risk in primary care of colorectal cancer from new onset rectal bleeding: 10 year prospective study. *BMJ* 2006; 333:69–70.
11. Crosland A, Jones R. Rectal bleeding: prevalence and consultation behaviour. *BMJ* 1995; 311:486–68.
12. Alonso-Coello P, Guyatt GH, Heels-Ansdell D, *et al.* Laxatives for the treatment of hemorrhoids. *Cochrane Database of Systematic Reviews* 2005 (4) CD004649
13. Olde BM, McCowan C, Falk GA *et al.* Diagnostic accuracy systematic review of rectal bleeding in combination with other symptoms, signs and tests in relation to colorectal cancer. *British Journal of Cancer* 2010 102: 48–58.
14. Hippisley-Cox J & Coupl and C. Identifying patients with suspected colorectal cancer in primary care: derivation and validation of an algorithm. *Br J Gen Pract* 2012; 62: e29–e37.
15. Ford AC, Veldhuyzen van Zanten SJ, Rodgers CC *et al.* Diagnostic utility of alarm features for colorectal cancer: systematic review and meta-analysis. *Gut* 2008; 57:1545–53.
16. Jellema P, van der Windt DA, Bruinvels DJ *et al.* Value of symptoms and additional diagnostic tests for colorectal cancer in primary care: systematic review and meta-analysis. *BMJ* 2010; 340:c1269.
17. Fletcher RH. Carcinoembryonic antigen. *Ann Intern Med* 1986; 104:66–73.
18. Van Rheenen PF, Van de Vijver E, Fidler V. Faecal calprotectin for screening of patients with suspected inflammatory bowel disease: diagnostic meta-analysis. *BMJ* 2010; 341:c3369.
19. NICE 2015 Faecal calprotectin diagnostic tests for inflammatory diseases of the bowel: Tools and resources. <https://www.nice.org.uk/guidance/dg11/resources/125977646>
20. Waugh N, Cummins E, Royle P *et al.* Faecal calprotectin testing for differentiating amongst inflammatory and non-inflammatory bowel diseases: systematic review and economic evaluation. *Health Technol Assess* 2013; 17(55): xv-xix
21. <http://cks.nice.org.uk/analfissure>
22. Steele SR, Madoff RD. Systematic review: the treatment of anal fissure. *Alimentary pharmacology & therapeutics* 2006; 24:247–57.
23. Chronic anal fissure: 0.2% topical glyceryl trinitrate ointment - evidence summary unlicensed/off label medicine (ESUOM7). <https://www.nice.org.uk/advice/esuom7>
24. Sajid MS, Whitehouse PA, Sains P, Baig MK. Systematic review of the use of topical diltiazem compared with glyceryltrinitrate for the nonoperative management of chronic anal fissure. *Colorectal Disease* 2013; 15(1): 19
25. Lewis JD, Brown A, Localio AR, Schwartz JS. Initial evaluation of rectal bleeding in young persons: a cost-effectiveness analysis. *Ann Intern Med* 2002;136:99–110.
26. Allen E, Nicolaidis C, Helfand M. The evaluation of rectal bleeding in adults. A cost-effectiveness analysis comparing four diagnostic strategies. *J Gen Intern Med* 2005;20:81–90.
27. MacKenzie S, Norrie J, Vella M *et al.* Randomized clinical trial comparing consultant-led or open access investigation for large bowel symptoms. *British Journal of Surgery* 2003;90:941–47.
28. Halligan S, Wooldrage K, Dadswell E *et al.* Computed tomographic colonography versus barium enema for diagnosis of colorectal cancer or large polyps in symptomatic patients (SIGGAR): a multicentre randomised trial. *The Lancet* 2013; 381: 1185-1189
29. Atkin W, Dadswell E, Wooldrage K, *et al.* Computed tomographic colonography versus



Commissioning guide 2017

Rectal Bleeding

- colonoscopy for investigation of patients with symptoms suggestive of colorectal cancer (SIGGAR): a multicentre randomised trial. *The Lancet* 2013; 381: 1194-202
30. Shanmugam V, Thaha M, Rabindranath K, Campbell K, Steele R, Loudon M. Rubber band ligation versus excisional haemorrhoidectomy for haemorrhoids. *Cochrane database of systematic reviews (Online)*. 2005(3):CD005034
 31. NICE (2015). IPG525 Electrotherapy for the treatment of haemorrhoids: Tools and resources. <https://www.nice.org.uk/guidance/ipg525/resources>
 32. Sajid MS, Parampalli U, Whitehouse P, Sains P, McFall MR, Baig MK. A systematic review comparing transanalhaemorrhoidal de-arterialisation to stapled haemorrhoidopexy in the management of haemorrhoidal disease. *Tech Coloproctol* 2012;16:1–8.
 33. Zhai, M., et al. A Randomized Controlled Trial Comparing Suture-Fixation Mucopexy and Doppler-Guided Hemorrhoidal Artery Ligation in Patients with Grade III Hemorrhoids. *Gastroenterology Research and Practice* 2016
 34. Watson et al. eTHOS trial *Lancet* 2016; 388: 2375-85
 35. Brown et al. HubBLle trial *Lancet* 2016; 388: 356-64)
 36. Sajid MS, Whitehouse PA, Sains P, BaigMK. Systematic review of the use of topical diltiazem compared with glyceryl trinitrate for the nonoperative management of chronic anal fissure. *Colorectal Dis* 2013;15:19–26.
 37. Shao WJ, Li GC, Zhang ZK. Systematic review and meta-analysis of randomized controlled trials comparing botulinum toxin injection with lateral internal sphincterotomy for chronic anal fissure. *Int J Colorectal Dis* 2009; 24:995–1000.
 38. Hong JJ, Park W, Ehrenpreis ED. Review article: current therapeutic options for radiation proctopathy. *Alimentary pharmacology & therapeutics* 2001; 15: 1253–62.
 39. Hanson B, MacDonald R, Shaukat A. Endoscopic and medical therapy for chronic radiation proctopathy: a systematic review. *Dis Colon Rectum* 2012; 55:1081–95.



Commissioning guide 2017

Rectal Bleeding

5.4 Guide development group for rectal bleeding

A commissioning guide development group was established to review and advise on the content of the commissioning guide. This group discussed the review by teleconference with additional interaction taking place via email.

Name	Job Title/Role	Affiliation
Mr Ciaran Walsh (chair)	Consultant Colorectal Surgeon	Association of Coloproctology of Great Britain and Ireland
Dr Simon Campbell	Consultant Gastroenterologist	British Society of Gastroenterology
Ms Helen Livett	Nurse Practitioner in Gastroenterology	British Society of Gastroenterology Nurses Association
Dr Simon Delaney	General Practitioner and CCG commissioner	Royal College of General Practitioners
Dr Amjad Rahi	Patient Representative	Healthwatch Tower Hamlets
Mr Stephen Holtham	Consultant Colorectal Surgeon	Association of Coloproctology of Great Britain and Ireland
Dr Simon Hambling	Senior Partner, Doddington Medical Centre	Royal College of General Practitioners
Mr Andrew Rowlands	Pharmacist WUTH	Royal Pharmaceutical Society
Dr Laurence Stone	General Practitioner	Royal College of General Practitioners

5.5 Funding statement

The development of this commissioning guidance has been funded by the following sources:

- Department of Health Right Care funded the costs of the guide development group, literature searches and contributed towards administrative costs.
- The Royal College of Surgeons of England and the Association of Coloproctology of Great Britain and Ireland provided staff to support the guide development.



Commissioning guide 2017

Rectal Bleeding

5.6 Conflict of Interest Statement

Individuals involved in the development and formal peer review of commissioning guides are asked to complete a conflict of interest declaration. It is noted that declaring a conflict of interest does not imply that the individual has been influenced by his or her secondary interest. It is intended to make interests (financial or otherwise) more transparent and to allow others to have knowledge of the interest.

No interests were declared by members taking part in this update.