Clinical practice guidelines for the prevention, early detection and management of colorectal cancer:
Dissemination Plan

1. BACKGROUND

Colorectal cancer is a major cause of morbidity and mortality in Australia. It is the second most common cancer diagnosed in both men and women, and is more common in those aged over 50 years. Colorectal cancer is also the second most common cause of cancer death and accounts for 9% of all cancer deaths. (AIHW 2014 Cancer in Australia). This profile of colorectal cancer in Australia highlights the need for guidelines to ensure clinical best practice.

These draft clinical practice guidelines are a revision and update of the 2005 Clinical practice guidelines for the prevention, early detection and management of colorectal cancer. They were originally developed in 1999, and since then, have been widely used as a reference and referred to by health practitioners, including general practitioners (GPs) and specialists to guide clinical practice.

This current revision and update was commissioned and funded by the Department of Health Commonwealth of Australia.

This guideline aims to provide information and recommendations to guide practice across the continuum of cancer care including colorectal cancer prevention, screening and diagnosis, clinical aspects of surgery, radiotherapy and chemotherapy, follow-up and psychosocial care. The guideline also provides an evidence base for the National Bowel Cancer Screening Program. The guideline includes relevant practice points and recommendations for health professional based on a systematic review of the evidence.

The revised guideline will be published as online guidelines on the Cancer Council Australia wiki platform. The online version of the guideline provides maximum transparency to all stakeholders as it offers access to all background documents (literature searches, literature assessments, recommendation development, public consultation results), so guideline users can get detailed access to the evidence base and rationale that underpins each recommendation.

2. SCOPE OF THE PROJECT

This project aims to revise the Clinical practice guidelines for the prevention, early detection and management of colorectal cancer (2005) according to the procedures and requirements for meeting the 2011 NHMRC standard for clinical practice guidelines and gain
NHMRC approval. The guideline development has been conducted on Cancer Council Australia’s custom-built wiki platform for guideline development.\(^1\)

The developed guidelines, through their application in practice, will maximise best practice cancer care. Moreover, the guidelines will provide recommendations and appropriate management and care, agreed upon by recognised experts in the colorectal cancer field.

3. **AIM AND SCOPE OF THE DISSEMINATION PLAN**

The aim of this dissemination plan is to outline the ways in which Cancer Council Australia will promote and distribute the approved guideline. The outcome is to ensure all relevant health professionals have access to the guideline. This will in turn promote best practice in their health service delivery to their patients.

4. **METHODOLOGY**

Cancer Council Australia has developed a multi-strategy approach for the dissemination of the guideline, as this has been shown to positively influence guideline uptake\(^1,2\). The multidisciplinary Working Party overseeing the guideline was consulted regarding the dissemination plan.

The guideline will be made available as an online resource via the Cancer Council Australia Clinical Guidelines Wiki, making them a web-based global resource. The online guideline wiki platform increases availability as well as accessibility. Usage will be tracked and analysed with a web analytics solution.

Interlinking and listing the guideline on national and international guideline portals is an important part of the digital dissemination strategy. Credible Australian health websites will be approached to link to the online guideline. For example, eviQ – an internationally recognised online resource that provides evidence-based cancer treatment information to help health professionals identify the best course of cancer treatment and care for their patient’s needs\(^3\) and healthdirect Australia – an Internet gateway designed to help individuals find reliable, high quality Australian health information\(^4\).

a. **Target Audiences**

Cancer Council Australia recognise the following target audiences for the guideline:

- Internal stakeholders (State Managers, Support Group and Outreach Coordinators, Chapter Councillors, Ambassadors, State and Territory Cancer Councils)
- External stakeholders (health care professionals, peak body cancer organisations, community sector organisations, cancer treatment centres, Government and the general community)
- Consumer audiences (general population, people at high risk, people affected by colorectal cancer, including specific target population groups such as people from

\(^1\) The wiki platform supports all stages of guideline development, i.e. recording literature searches, conducting the systematic reviews, support internal review and public consultation and providing real-time background documentation and has been proven to be more effective and transparent compared to systems, such as Reference Manager, Word, Excel, Outlook, that we used to develop previous guidelines.
b. Dissemination Activities
Cancer Council Australia will utilise a variety of media, avenues and pathways to promote and disseminate the guideline to the target audiences.

Soft Launch

When promoting and disseminating information on newly developed guidelines, Cancer Council Australia will conduct ‘Soft Launches’.

The guideline will be launched via an email alert to professional organisations, interested groups and clinical experts in the field, directing them via a URL link to the online guideline. In addition, the final guideline will be launched with a media release to relevant contacts, promoting the guideline and key recommendations.

To promote the availability of the guideline, ongoing activities may be conducted through print and social media campaigns as well as disseminating the guideline through further meetings and national and international conferences.

Conferences

Formal professional forums will be utilised as avenues through which the guideline is disseminated. Conferences will provide a forum to promote the availability of the guideline. The following conferences may be attended in 2017/18 to promote the availability of the guideline:

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<tr>
<th>Conferences</th>
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<tr>
<td>Gastroenterological Society of Australia (GESA) Australian Gastroenterology Week (AGW)-August</td>
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<tr>
<td>Royal Australian College of General Practitioners (RACGP)-October 2017, 2018</td>
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<tr>
<td>Colorectal Surgical Society of Australia and New Zealand (Combined ANZ Colorectal Surgical Meeting)-Nov 2017</td>
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<td>Clinical Oncology Society of Australia (COSA) Conference-Nov 2017, 2018</td>
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<tr>
<td>Cancer Nurses Society of Australia (CNSA) Conference-Winter 2018</td>
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<td>Royal Australasian College of Surgeons (RACS)-May 2018</td>
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<td>Medical Oncology Group of Australia (MOGA)-August 2018</td>
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<td>Australasian Gastro-Intestinal Trials Group-October 2017, 2018</td>
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Where appropriate, Cancer Council Australia will also integrate dissemination activities pertaining to the guideline into their existing promotional activity planning around organisational events, forums and conferences.

Publications

The guideline may be promoted through publications such as Cancer Forum. Research activities pertaining to the development of the guideline may be written up as manuscripts for either submission to peer-reviewed journals for publication or as monograph publications.
External promotion channels

The guideline will also be promoted using external promotion channels. Professional colleges and other organisations will be encouraged to promote the availability of the guideline through their websites and resources such as newsletters.

Additionally, the guideline will be listed on national and international guideline portals such as the NHMRC clinical practice guideline portal, Guidelines International Network (GIN) guidelines library and National Guidelines Clearinghouse.

5. KEY RECOMMENDATIONS FOR PRACTICE WHICH FORM CONTENT FOR MATERIAL FOR DISSEMINATION

The following table is a summary of the key recommendations arising from this guideline that are most likely to lead to improvements in health outcomes, for consideration in implementation.

In the table below, EBR = Evidence-based recommendation; CBR = Consensus-based recommendation; PP = Practice point. Please see the NHMRC approved recommendation types and definitions (Source: National Health and Medical Research Council. Procedures and requirements for meeting the NHMRC standard for clinical practice guidelines. Melbourne: National Health and Medical Research Council, 2011). Also see Appendix 1 for a list of the clinical questions and abbreviations/codes.
For all people aged 50–70 years who are at average risk of colorectal cancer, aspirin should be actively considered to prevent colorectal cancer. A low dose (100–300 mg per day) is recommended for at least 2.5 years, commencing at age 50 to 70 years. The benefit may extend to older ages with longer duration of use. Benefit for cancer prevention (though shorter for cardiovascular risk) is evident only 10 years after initiation so a life expectancy of at least 10 years should be taken into consideration in the advice to use aspirin.

The choice to take aspirin should be personalised based on age, sex and potential reduction in cardiovascular events, cerebrovascular events and thrombotic stroke. The individual should take into account the potential risks of taking aspirin. Aspirin should be avoided in patients with current dyspepsia, any history of peptic ulcer, aspirin allergy, bleeding diathesis, an increased risk of gastrointestinal haemorrhage (such as associated with use of oral anticoagulants or antiplatelet agents), or renal impairment.

The benefit in colorectal cancer risk reduction in women over 65 is less clear cut; however with the limited data available, those older women with cardiovascular risk factors may derive a greater overall benefit than harm.

The recommended strategy for population screening in Australia, directed at those at average risk of colorectal cancer and without relevant symptoms, is immunochemical faecal occult blood testing every 2 years, starting at age 50 years and continuing to age 74 years.

Although modelling indicated that it may be cost-effective, starting screening at age 45 is not recommended for population screening because there is a much less favourable ratio of benefits to harms than for 50–74 years.

Resources should be invested in increasing participation in the existing NBCSP target age group of 50–74, rather than by lowering the starting age of screening, to optimise the balance of effectiveness, cost-effectiveness and ratio of benefits to harms.

In people aged 45–49 years who request screening after being fully informed of the benefits and harms of testing, general practitioners (GPs) could offer an immunochemical faecal occult blood test every 2 years during the lead-up to the first routine invitation by the NBCSP at age 50 years.

The urgency of colonoscopy to investigate symptoms suggestive of colorectal cancer should be based on an assessment of patient age, symptom profile and results of simple investigations including full blood count, iron studies and iFOBT (see Table 10.1 for consensus-based colonoscopy triage categories).
For patients with symptoms suggestive of colorectal cancer, the total time from first healthcare presentation\(^1\) to diagnostic colonoscopy should be no more than 120 days. Diagnostic intervals greater than 120 days are associated with poorer clinical outcomes.

A diagnostic interval of 120 days should be the maximum time from first healthcare presentation\(^1\) to diagnostic colonoscopy for triage Categories 1 and 2, whether it is for a patient with symptoms or after a positive iFOBT used for colorectal cancer screening. Diagnostic intervals greater than 120 days are associated with poorer clinical outcomes.

First healthcare presentation is defined as the date of presentation in general practice with symptoms suggestive of colorectal cancer or positive iFOBT for screening.

Triage category 1 patients, whether due to symptoms or positive iFOBT, should continue to be considered most urgent and prioritised for diagnostic colonoscopy, in any model of care at any jurisdictional level.

Colonoscopy for symptomatic patients should be performed as promptly as possible after referral from general practice, especially for those meeting triage Category 1 criteria. If cancer is present, there is no evidence that prognosis is worsened within 120 days from first presentation to diagnostic colonoscopy. However, performing colonoscopy as promptly as possible after referral from general practice is to minimise the risk of psychological harm in symptomatic or iFOBT-positive patients who are potentially anxious while awaiting investigation. Prompt scheduling will also help to ensure that any unexpected delays between general practice referral and colonoscopy triaging do not flow on to exceed the 120-day threshold after which prognosis can worsen if cancer is present.

**Category 1**: People who have one relative with colorectal cancer diagnosed at age 55 or older should be advised that their own risk of developing colorectal cancer could be up to twice the average risk, but is still not high enough to justify CRC screening by colonoscopy.

**Category 2**: People should be advised that their risk of developing colorectal cancer is at least three times higher than average, but could be up to six times higher than average, if they have any of the following:
- one first-degree relative with colorectal cancer diagnosed before age 55 years
- two first-degree relatives with colorectal cancer diagnosed at any age
- one first-degree relative and at least two second-degree relative diagnosed with colorectal cancer at any age.

**Category 3**: People should be advised that their risk of colorectal cancer is at least seven times higher than average, but could be up to 10 times higher than average, if they have either of the following:

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\(^1\) First healthcare presentation is defined as the date of presentation in general practice with symptoms suggestive of colorectal cancer or positive iFOBT for screening.
- at least three first-degree or second-degree relatives with colorectal cancer, with at least one diagnosed before age 55 years
- at least three first-degree relatives with colorectal cancer diagnosed at any age.

For people with a family history of colorectal cancer who are assessed as having category 1 risk, iFOBT should be performed every 2 years from age 50 to age 74.

See Population screening for colorectal cancer.

For those with one first-degree relative with colorectal cancer, iFOBT every two years from age 45 should be considered.

For category 2 patients, offer iFOBT every 2 years starting at age 40, then colonoscopy every 5 years starting at age 50. CT colonography may be offered if colonoscopy is contraindicated.

For category 3 patients, offer iFOBT every 2 years starting at age 35, then colonoscopy every 5 years starting at age 45. CT colonography may be offered if colonoscopy is contraindicated.

Either an open approach or a laparoscopic approach can be used for the resection of colon cancer. Laparoscopic colectomy has post-operative advantages over open colectomy and should be performed when the surgical expertise and hospital infrastructure are available.

Open surgery is the standard approach for resection of rectal cancer. Laparoscopic resection can be considered in selected cases if the surgical expertise (including advanced laparoscopic skills) and hospital infrastructure are available noting that it is a technique that has yet to be proven safe and efficacious in all patients for rectal cancer.

Intensive follow-up after curative surgery for colorectal cancer should include CEA and CT scan, with the aim of early detection of recurrence or residual disease where there is the possibility for curative resection.

PET/CT scan can be used as an effective adjunct for detection of recurrence, especially when the CEA and/or CT scans are suggestive of recurrence.
## Appendix 1. List of clinical questions and codes

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<th>Abbreviation/code</th>
<th>Clinical question</th>
<th>Corresponding PICO question/s</th>
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<tr>
<td>PPR1</td>
<td>What is the risk-benefit ratio for use of aspirin for prevention of colorectal cancer stratified by risk of colorectal cancer itself? (What is the optimal dose and frequency of administration?)</td>
<td>In an asymptomatic population at average risk or increased risk of colorectal cancer, what is the cost-benefit ratio of prophylactic Aspirin use in reducing the mortality and incidence of colorectal cancer?</td>
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| PSC1 (a-d)        | Is population screening based on testing with (a) immunochemical FOBT (iFOBT), (b) flexible sigmoidoscopy, (c) colonoscopy, (d) CT colonography, (e) faecal biomarkers such as DNA (f) plasma biomarkers such as DNA (g) any combination of the above screening tests effective in reducing bowel cancer mortality rates, feasible, acceptable and a cost-effective method of screening for the target population? a) Is population screening starting at an earlier age more effective, feasible, acceptable and cost-effective, compared with starting at age 50 yr? b) In population screening, do the harms outweigh the benefits if routine screening by any method is continued beyond the age of 75yr? | PSC1a: In persons without a colorectal cancer diagnosis or symptoms that might indicate colorectal cancer, which screening modality (immunochemical FOBT, flexible sigmoidoscopy, colonoscopy, CT colonography, faecal or blood biomarkers, or any combinations) compared with no screening, reduces colorectal cancer mortality, or the incidence of metastases at diagnosis?  
PSC1b: For persons without a colorectal cancer diagnosis or symptoms that might indicate colorectal cancer, which screening modality (immunochemical FOBT, flexible sigmoidoscopy, colonoscopy, CT colonography, faecal or blood biomarkers, or any combinations) performs best in detecting colorectal cancer, and how does the diagnostic performance change with family history, age, or gender?  
PSC1c: In persons without a colorectal cancer diagnosis or symptoms that might indicate colorectal cancer, what is the most cost-effective, feasible and acceptable screening modality (iFOBT, flexible sigmoidoscopy, colonoscopy, CT colonography, faecal or blood biomarkers test, or any combinations) compared with no screening?  
PSC1d: Is population screening starting at an earlier age more effective and as feasible, acceptable and cost-effective as screening starting at age 50 years? In population screening, do the harms outweigh the benefits if routine screening is continued beyond the age of 75 years? |
<p>| SPT1-2 (a,b)      | What signs/symptoms alone or in combination are most predictive of CRC and what is the optimal maximum time | SPT1-2a: In symptomatic patients without a colorectal cancer diagnosis, what signs or symptoms (persistent changed bowel movements, persistent diarrhoea or |</p>
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<td>from referral to diagnosis and treatment (diagnostic interval)?</td>
<td>constipation, unexplained rectal bleeding, general or localised abdominal pain, unexplained palpable abdominal or rectal mass, unexplained weight loss, iron deficient anaemia, tiredness, fatigue, or any combination) correlate best with a diagnosis of colorectal cancer?</td>
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<td><strong>SPT1-2b:</strong></td>
<td>In symptomatic patients without a colorectal cancer diagnosis, what is the optimal maximum diagnostic interval that achieves better than or equivalent outcomes in terms of survival, mortality, and diagnosis of metastatic disease?</td>
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<td><strong>FHS2</strong></td>
<td>What is the strength of association between family history and colorectal cancer risk and how do these associations vary by, number of affected relatives and degree of relatedness and age and sex of affected relatives and by the age and sex of the at-risk person?</td>
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<td><strong>PTH1</strong></td>
<td>What is the optimal molecular profiling of colorectal cancer?</td>
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<td><strong>PRP2-5, 7</strong></td>
<td>Can perioperative management be optimised?</td>
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<td><strong>COL1-2 (a,b)</strong></td>
<td>What is the optimal approach to resection of colorectal cancers?</td>
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<td><strong>REC3</strong> What is the most effective treatment for early rectal cancer?</td>
<td>In patients diagnosed with stage I-II rectal cancer, what is the most effective treatment strategy to achieve the best outcomes in terms of length and quality of life?</td>
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<td><strong>COLMNG5</strong> What are the benefits of stenting or colostomy vs. acute resection with primary anastomosis in acute obstruction due to left-sided colon or rectal carcinoma?</td>
<td>In patients diagnosed with colorectal cancer and acute obstruction, does stenting or colostomy achieve equivalent or better outcomes compared to acute resection with primary anastomosis?</td>
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<td><strong>COLMNG3</strong> What is the role for peritonectomy with or without PIC in the treatment recurrent as well as primary colorectal cancer with peritoneal involvement (not including appendiceal neoplasia)?</td>
<td>For patients diagnosed with colorectal cancer and peritoneal involvement or isolated peritoneal recurrence of colorectal cancer, does peritonectomy, with or without perioperative intraperitoneal chemotherapy (PIC), achieve better outcomes in terms of length and quality of life than usual care?</td>
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<td><strong>ADJ1</strong> What is the efficacy of adjuvant combination chemotherapy in elderly patients with colon cancer?</td>
<td>In elderly patients (≥70 years) diagnosed with colon cancer, what is the efficacy of surgery and adjuvant combination chemotherapy (involving either 5-fluorouracil or capecitabine combined with oxaliplatin), compared to surgery with a single chemotheterapeutic agent (fluoropyrimidine based) in achieving the best outcomes in terms of colorectal cancer mortality, recurrence, quality of life and adverse effects?</td>
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| **NEO1 (a,b)** Which patients with rectal cancer stage I-II could be considered for definitive chemoradiotherapy (no surgery), neo-adjuvant chemoradiotherapy or surgery alone? | **NEO1b:** For patients diagnosed with stage I-III rectal cancer, for which patients does neoadjuvant treatment (short or long course chemoradiotherapy) with surgery achieve equivalent or better outcomes in terms of length and quality of life than surgery alone?  
**NEO1a:** For patients diagnosed with stage I-III rectal cancer, for which patients does neoadjuvant treatment (short or long course chemoradiotherapy) with surgery achieve equivalent or better outcomes in terms of length and quality of life than neoadjuvant chemoradiotherapy alone? |
| **MNG13** Which patients with locally recurrent colon or rectal cancer are more suitable for curative surgery? | In patients with locally recurrent colon or rectal cancer, what is the role of curative surgery (+/- chemotherapy +/- radiotherapy) when compared to surgical palliation +/- palliative chemotherapy +/- palliative radiotherapy or other palliative interventions in terms of outcomes (overall survival, disease free survival, quality of life and complications)? |
| **MNG14** | Which patients with resectable synchronous or metachronous metastatic colon or rectal cancer are suitable for curative surgery? | In patients with resectable synchronous or metachronous metastatic colorectal cancer, what is the role of surgical resection +/- chemotherapy when compared to non-surgical/palliative interventions in terms of outcomes (overall survival, disease free survival, progression free survival, quality of life and complications?) |
| **MNG16** | What is the impact of different liver directed therapies in patients with incurable metastatic colorectal cancer? | In patients with incurable metastatic colorectal cancer, what are the effects of liver-directed therapies on survival and quality-of-life outcomes, compared with standard care? |
| **FUR1-2** | What is the optimal intensity of follow up post curative resection of colorectal cancer? And where? | In patients who have had curative resection of colorectal cancer, what surveillance protocol achieves the best outcomes in terms of detected recurrent disease, 5-year survival, quality of life, and colorectal cancer-related mortality? |