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Adult Rectal Bleeding Primary Care Clinical Pathway

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Key

- Pi – "Must do" actions for GP's / (Triaged by RSS)
- B – Recommendations for Primary Care
- R – Red flag / urgent referral
- O – Routine referral
- P – Public health intervention
- G – Audio-visual aids for patients and GP
- Click icon for clinical evidence
- Right-click to use hyperlink

Note: Alpha-numeric step references are to aid printing in black & white and colour blindness

Investigations must be within 6 months of date of referral

Patient presents with rectal bleeding

1.0 (B)

2.0 (B)

DIFFERENTIAL DIAGNOSES:
- Haemorrhoids
- Anal fissure
- Inflammatory bowel disease
- Diverticular disease
- Infectious gastroenteritis
- Colonic polyps
- Colorectal cancer
- Angiodysplasia
- Ischaemic colitis (especially if atrial fibrillation)
- Solitary rectal ulcer
- Anal cancer
- Radiation proctitis (if previous history of deep X-ray therapy)
- Sexually transmitted disease (STD)
- Anorectal trauma
- Perianal Haematoma

3.0 (B)

HISTORY
- Presence / absence of perianal symptoms
- Duration of symptoms
- Age of patient - (<30yrs more likely to have haemorrhoids, anal fissure or inflammatory bowel disease (IBD); >50yrs ↑ risk of colorectal cancer)
- Past medical history – e.g. of colitis or colonic polyps
- Medication history – anticoagulants
- FH colorectal malignancy
- Recent travel - infective colitis

EXAMINATION
- Abdo exam
- Anal inspection - Anal spasm and pain may prevent full visualization of a fissure. When the fissure cannot be seen, pain occurs with gentle pressure on the anal margin
- Rectal exam – not recommended in primary care if anal fissure
- Temperature / pulse
- Body mass index –any weight loss?

4.0 (G)

Patient info
https://patient.info/health/rectal-bleeding-blood-in-faeces

5.0 (Pi)

Investigations
FBC, U&Es, LFTs, iron studies, CRP

Consider faecal calprotectin if IBD suspected (see faecal calprotectin pathway) **OR** stool MC&S if infective colitis suspected
qFIT (see qFIT pathway) [**1**]

5.1 (B)

6.0 (R)

Refer 2WW if red flag symptoms/signs:
- ≥ 40 years with jaundice or unexplained weight loss and abdominal pain
- < 50 years with rectal bleeding and any of the following unexplained symptoms: abdominal pain, change in bowel habit, weight loss or iron deficiency anaemia
- ≥ 50 years with unexplained rectal bleeding
- ≥ 60 years with iron-deficiency anaemia or changes in their bowel habit or weight loss and any of the following: diarrhoea, back pain, abdominal pain, nausea, vomiting, constipation or new onset diabetes
- Any age where tests show occult blood in their faeces
- Any age with rectal or abdominal mass or unexplained anal mass or anal ulceration
- Ascites
- New iron deficiency without an obvious cause
- Raised / positive FIT test suggestive of cancer

7.0 (B)

Remember to use Advice and Guidance on eRS when appropriate

8.0 (O)

Routine referral if:
- Strong family history of colorectal malignancy
- Anxiety about colorectal malignancy, which GP cannot reassure
- Persistent rectal bleeding despite treatment for haemorrhoids or fissures (refer to colorectal surgery)

9.0 (R)

Urgent referral if:
- Assessment of suspected IBD
- Rectal bleeding in patients with past history of pelvic radiotherapy

10.0 (B)

Management of perianal conditions causing rectal bleeding

11.0 (B)

Perianal haematoma
- Within first 72hrs -Consider referral to on-call surgeons for incision & drainage under local anaesthetic if pain severe
- After 72hrs – Analgesia, topical anaesthetics and corticosteroids, cold compresses
- Consider admitting people with internal haemorrhoids that have prolapsed and become swollen, incarcerated, and thrombosed
- Perianal sepsis (rare but life-threatening)

12.0 (B)

Haemorrhoids
Advise patients about:
- Oral fluid intake (https://www.bda.uk.com/uploads/assets/337cfde9-13c5-4685-a484a38fbc3e187b/Fluidfood-fact-sheet.pdf)
- High fibre diet (https://www.bda.uk.com/uploads/assets/f602fc35-ff7f-4d2c-90c89b145c43396c/Fibre-food-fact-sheet.pdf)
- Fibre supplementation
- Simple analgesia (such as paracetamol; avoid stronger opioid analgesics)
- Haemorrhoid creams, ointments and suppositories can be purchased from pharmacy for haemorrhoids and be used for 5 to 7 days together with diet and self-care advice https://www.england.nhs.uk/publication/conditions-for-which-over-the-counter-items-should-not-routinely-be-prescribed-in-primary-care-guidance-for-ccgs/
- Topical Treatment with local anaesthetics and corticosteroids. Local infection (for example herpes simplex infection or perianal thrush) must be excluded before use of corticosteroids.

13.0 (B)

Anal Fissure

ACUTE: <6 weeks
- Increase fluid intake (https://www.bda.uk.com/uploads/assets/337cfde9-13c5-4685-a484a38fbc3e187b/Fluidfood-fact-sheet.pdf) and ensure adequate dietary fibre intake
- Treating or preventing constipation (see constipation pathway)
- Topical anaesthetic for extreme pain – consider short course (a few days) of 1-2ml lidocaine 5% ointment
- Sitz baths –hip bath in hot water for 2-5minutes followed by cold water for 1 minute, after bowel movement
- Offer paracetamol or ibuprofen for people with prolonged burning pain following defecation. Avoid opioid analgesics as they can cause constipation and exacerbate symptoms.

If symptoms persist for 1 week or more without improvement consider prescribing glyceryl trinitrate 0.4% ointment (GTN) BD for 6-8 weeks course (25% develop headaches as side effects which may affect compliance).

CHRONIC: >6 weeks
- Increase fluid intake (https://www.bda.uk.com/uploads/assets/337cfde9-13c5-4685-a484a38fbc3e187b/Fluidfood-fact-sheet.pdf) and continue conservative measures (as per acute management).
- Combination bulk forming laxative e.g. ispaghula husk BD and softening laxative e.g. lactulose for the full 8 weeks
- Prescribe GTN 0.4% ointment BD for 6-8 weeks course (25% develop headaches as side effects which may affect compliance).
- If fissure fails to heal (after 8 weeks of GTN) or if side-effects on GTN ointment switch to diltiazem 2% ointment (Anoheal®) -applied topically BD for 8 weeks

14.0 (O)

Referral to colorectal service if:
- Fail to respond to conservative management
- Persistent bleeding, severe prolapse, affecting daily living (caused by above conditions OR any other condition/unknown cause of bleeding)
- Fourth degree haemorrhoids
- Refer patients with persistent low-risk symptoms which do not respond to treatment (after 12 weeks) or which recur after stopping treatment –evidence based intervention and clinical standards approval (previously known as PoLCE)

[**1**] **qFIT Pathway**
https://gps.northcentrallondonccg.nhs.uk/pathways/nhs-london-and-ncl-lgi-pathway