**Module 2.05:**
**Rectal bleeding**

# SCENARIO

**Rectal Bleeding**

Joe Wedgwood, a 65 year-old businessman, has been trying to ignore his recent weight loss and the occasional spotting of blood when he opens his bowels, but this newspaper article about the role of faecal occult blood testing in the NHS Bowel Cancer Screening Programme is now worrying him - the bits of 'green stuff' in his stool might be mucus. The article mentions thousands of colon cancers being 'registered' each year, and suggests that this screening programme should save many lives. It was introduced because it fulfilled the 'screening criteria'.

Mr Wedgwood asks his GP, Dr Jez Derby for such a test. (Dr Derby mentions that there are anxieties about the accuracy of occult blood testing. Apparently about half the patients with cancer would be expected to have a negative test and most of those with a positive test would turn out not to have cancer.) Dr Derby knows about Mr Wedgwood's family history of: *colorectal polyps (father – who had rectal bleeding, but no pain or change in bowel habit or weight); inflammatory bowel disease (sister – who sometimes had severe episodes of diarrhoea); and diverticular disease (uncle – who had often complained about his 'bowels')*. Dr Derby performs a digital rectal examination.

Mr Jonty Poole, a general surgeon, rearranges his clinic to see Mr Wedgwood under the '2-week rule' (hoping that it is not detrimental that he has now deferred Mrs Doulton until next month). Mr Poole agrees that further investigation is necessary and undertakes, after oral consent, a flexible sigmoidoscopy in the clinic. He finds some first degree haemorrhoids, but recommends a full colonoscopy to check for other causes of his bleeding and discharge of mucus. Mr Poole mentions that Mr Westwood *"will need a bowel 'prep'..."*. Mr Wedgwood thinks that he would have preferred a virtual colonoscopy using a CT scan – he read about it on the Web, and thinks this sounds more acceptable (especially given how embarrassed he felt having his 'back passage' examined by Dr Derby). Mr Poole says that this would not allow biopsy sampling for diagnosis, nor allow for polypectomy, and reluctantly Mr Wedgewood agrees to a colonoscopy (after being fully informed of its risks –-- Mr Poole is mindful of *Chester v Afshar (2004)*).

Mr Wedgwood attends for his colonoscopy (completing the consent forms and also consenting to some tissue being retained for research purposes). The procedure is performed under light sedation as a day-case. After resting in the recovery room, Mr Wedgwood is told that a 2 cm diameter polyp found in his lower bowel was removed. Mr Wedgwood had been informed that bleeding or perforation might be a complication following the procedure, but he is relieved to find that he is feeling fine.

Two weeks later, at the outpatient clinic, Mr Poole informs Mr Wedgwood that the polyp is *"well differentiated adenocarcinoma with evidence of a pre-existing tubular adenoma with high grade dysplasia"*, and explains possible molecular alterations. Mr Poole discusses options with Mr Wedgwood, who is devastated and asks how long it must have been there, and whether there are some lifestyle changes he should have made to avoid this. He has been confused by what he has read about the benefits of regular aspirin use, and about dietary fibre, and does not understand why he has not had a barium enema yet (mentioned on some websites). Mr Poole focuses Mr Wedgwood back on the immediate decisions to be taken about managing the condition, and introduces him to a MacMillan nurse, Ms Anna Delft. She tries to answer his questions about the evidence for what causes rectal cancer,

explaining that, while articles in the media might report various possible risk factors, there are criteria for assessing causal association in clinicoepidemiological evidence before making hasty conclusions. Mr Wedgwood finds it easier to discuss this rather than what happens next.