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Colorectal cancer management

The role of the GP

Background

Colorectal cancer (CRC) contributes significantly to the morbidity and mortality of Australians. The introduction of the National Bowel Cancer Screening Program has focussed attention on the role of the general practitioner in CRC screening. However, their increasing role across the management spectrum of CRC remains poorly researched.

Objective

This article examines the published literature on the existing and potential roles of the GP in the detection and management of CRC. Evidence about the existing and potential role of the GP was found through a literature search on Medline, PubMed, epidemiological evidence and recent guidelines.

Discussion

The role of the GP in CRC management varies. Some GPs play many roles such as advocate, facilitator, supporter, educator and counsellor. The role of the GP is influenced by GP-specialist communication, practice location, and patient and GP factors. There is a potential to increase this role, especially in providing psychosocial support and counselling for both the patient and their family.

■ **General practitioners play a role in all levels of colorectal cancer (CRC) care including screening, referral, management, follow up and palliative care. With an increasing prevalence of CRC, shorter postoperative hospital stays, and greater emphasis on shared care, the role of the GP in CRC management will be paramount in the coming years.**

Colorectal cancer is the second most registrable cancer and the second most common cause of cancer death in Australia.¹ While there has been little change in the age standardised incidence of CRC, it is expected that the aging population may lead to a large increase in the number of cases. It is thought that the introduction of the National Bowel Cancer Screening Program (NBCSP) may initially cause a rise in CRC incidence. However, it is predicted that the program will eventually cause a decline in incidence and death rates through the early detection and treatment of precancerous conditions.²

From April 2002 to March 2004, the estimated national number of contacts with GPs for colon cancer and large bowel cancer was 108 700. This represents 4.9% of total cancer contacts.³ General practitioner management of all cancers commonly includes prescription of medication, clinical treatments, procedural treatments and ordering of pathology and imaging tests.³

Patients referred to secondary care may seek the advice and familiarity of their GP when presented with treatment options.⁴

Screening

National Health and Medical Research Council (NHMRC) guidelines recommend that GPs screen all asymptomatic patients over 50 years of age for CRC with faecal occult blood testing (FOBT) every 2 years. It is recommended that patients over the age of 50 years who have a family history of CRC be screened by colonoscopy every 5 years.⁵ This underlines the important role for GPs in identifying high risk patients, especially those with a family history. However, identification of patients at high risk of CRC is also the responsibility of patients and their other health care providers. The NBCSP is currently being phased in over a number of years. Its initial phase is limited as it includes patients turning 55 years or aged 65 years between 1 May 2006 and 30 June 2008. In addition, patients are required to

complete the FOBT themselves and the nomination of an attending GP is optional. This in turn may limit the GP's role in CRC diagnosis.⁶

Referral

In Australia, GP referrals for gastrointestinal malignancies are most commonly made to surgeons, followed by gastroenterologists, oncologists and hospitals.⁷ Qualitative research conducted in Scotland found that the perceived quality of care in general practice in regards to referral was dependent on the patient's definition of the role of the GP. Some saw the GP as their 'advocate' while others saw them as a 'gatekeeper' or 'barrier to overcome'.⁸ However, the perceived role of the GP as a gatekeeper may be unique to the United Kingdom where GPs are the 'budget holders' of the National Health Service.

Postreferral

The management of CRC requires the contribution of multiple disciplines.⁹ Most patients with CRC undergo either emergency or elective surgery. The GP's role in CRC management after referral can include the tasks outlined in *Table 1*.

Although the majority of current research focuses primarily on the patient perspective of the GP's role in cancer management, limited research from the perspective of the GP on their role in cancer care exists. International research indicates that GPs play many roles in the management of cancer with some of the most common tasks being: providing pain relief, decision making, general care (including comorbidities), coordination of referrals, and palliative care. In many cases, GPs take on the role of holistic carer.^{10,11}

Psychosocial care

Primary care plays an important role in the psychosocial care of cancer patients. Current NHMRC guidelines suggest that information provided to the patient should include CRC facts and its affect on physical, emotional and sexual health.⁵ General practitioners' understanding of their patients' social and familial context allows for better emotional support.

Follow up care

Approximately one in three CRC patients who have had curative surgery will die from recurrent disease. Therefore follow up is important in the early detection of CRC recurrence or metastases.⁵ Current NHMRC guidelines recommend that follow up be performed by the operating surgeon or associated gastroenterologist together with the GP. Hospital based follow up is not associated with a survival advantage over GP based care.⁵

Communication facilitator

The GP's role as an advocate or gatekeeper has long been debated and cancer care is no exception. A qualitative study in Australia investigated patient perceptions of GPs role in cancer management.¹² Most patients had a good relationship with their GP and trusted their GP to advocate and intervene in the management process. Furthermore, GPs were seen as 'assisting patient empowerment' because patients felt more comfortable asking questions of their GP than their specialists.¹²

Table 1. The GP's role after referral

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|--|--|
| • Advice on treatment options | • Information and cancer services contacts |
| • Preoperative medical assessment | • Psychosocial counselling |
| • Preoperative stomal therapy consultation | • Bowel preparation |

Patient needs vs. GP care

Two recent qualitative research studies have looked at both GP and patient perspectives on cancer management. One study found that both GPs and patients felt that cancer treatment was the responsibility of the hospital, while all other care was the GP's responsibility, thereby describing a system of 'parallel care'. Furthermore, it was very important for the GP to be accessible to the patient both during and after treatment.¹¹ Another study concluded that the optimal role for GPs is unknown, however since patient needs and physician availability vary, there should be flexibility in the cancer care process.¹⁰

Factors influencing GP role

The role of the GP in CRC care may be determined by a complex range of factors including location of practice, involvement of other services and relationship with the patient.¹³ General practitioners perceive lack of information to be a barrier to the fulfilment of their role.^{14–16} A study in Sweden found that despite careful selection of a specialist, the information flow from specialist clinic to GP was insufficient to carry out appropriate follow up in most cases. Those GPs provided with extra information were more likely to be involved in the treatment and follow up period.¹⁵ This suggests that the extra information enabled GPs to better assess patients need for support.¹⁴ Development of information access and communication channels may improve outcomes for patients and increase confidence of GPs in caring for cancer patients.

General practitioners in rural and remote locations may play a more active role in the treatment of patients with cancer than their urban counterparts.¹⁷ A Scottish study found differences in patient expectations between urban and rural areas.⁸ Rural patients seemed to expect less from their GP and were faced with longer delays between diagnosis and referral to specialists.⁸ Once in the system, rural patients made varied choices in regards to treatment. Some chose to receive local care where there was little or no travel involved, while others preferred to travel to specialist care in urban areas.¹³

Conclusion

There is great variability in the role of the GP in CRC management. This is influenced by a range of factors including rurality of practice and the relationship between the GP and specialist services. Further education and research should be undertaken to improve this communication. The introduction of CRC screening has raised the profile of CRC and the role of the GP in early detection. However the GP's role should not end there. At the very least, GPs have an important role in ensuring that patients

negotiate the specialist system appropriately and in providing ongoing psychosocial support to patients and their families.

Conflict of interest: none declared.

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