Croatia and the EU:
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Against Cancer

IMPROVEMENT OF QUALITY OF THE NATIONAL CANCER SCREENING PROGRAMMES IMPLEMENTATION (CRO SCREENING)

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Quality assurance and quality control in CRC screening performance in GPs/family doctors‘ practices

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Main elements of quality assurance

- *Influencing response rate* of patients from doctors‘ personal list in screening programme
- *Preparation of patients for colonoscopy* to assure safe and quality colonoscopy
- *Involvement in surveillance after polypectomy*

Prerequisites to assure quality in CRC screening performance at GPs/family doctors practices/ PHC level

- Family doctors and other health professionals should know:
  - The algorithm of CRC screening programme very well
  - Standards for quality assurance in programme implementation
  - The response rate of his/her population of patients
  - The reasons for non-responsiveness of patients in the programme
  - Results of the screening programme implementation
- Algorithms and guidelines for QA in the programme implementation for PHC should be developed for procedures:
  - to involve non-respondents in screening programme
  - to prepare patients for safe and quality colonoscopy
  - to manage patients after polypectomy
- Payment system should follow the GPs practices quality standards
  - For example: doctors with higher response rate get more money

Guidelines for the preparation of screen positive patient for colonoscopy
- in the GP‘s clinic

The objectives of the implementation of the guidelines for preparing patients for colonoscopy

- Interdisciplinary coordination of different expert views and standardized preparation of the patient for the colonoscopy.
- Ensuring optimal conditions for safe and successful colonoscopy in chronic patients.
- Health status of chronic patient does not worsen becouse of procedures before/during/after the colonoscopy.
- Patient is properly prepared for the colonoscopy and it is not necessary to postpone it.
- Due to expected high share of polypectomies, it is necessary to prepare patients for screening colonoscopy in line with the protocol for invasive procedures.

Preparing patients for the colonoscopy

Prior to every colonoscopy, it is necessary that GP performs a clinical examination and medical history check.

Oriented family medical history

- Did a relative of first order have a CRC diagnosis before the age of 60 years?

First colonoscopy 10 years before the age at which the family member got the diagnosis or, at the latest, at the age of 40 years and later every 5 years in case of normal test results.

- Did a relative of first order have a CRC diagnosis after the age of 60 years?
- Did two or more relatives of the second order get a CRC diagnosis at any age?

First colonoscopy at the age of 40 years and later every 10 years in case of normal test results.

Oriented personal medical history

- Did a patient with positive FOBT ever undergo a colonoscopy?

It is necessary to present a date and test results; it is recommended to present an original test result.

– Was the patient with positive FOBT ever diagnosed with chronic inflammatory bowel disease?

Examination by the gastroenterologist is required, which will deliberate if colonoscopy is needed.

Haemostasis tests before the planned colonoscopy

Coagulation tests (prothrombin time - PT, partial thromboplastin time - PTT, thrombocyte count, bleeding time**) are not performed in healthy individuals before the colonoscopy.**

- Coagulation tests are performed in patients who:
  - are on anticoagulant treatment;
  - have confirmed coagulation disorders;
  - show possible disturbances after clinical examination (coagulation disturbances in hepatic impairment, lack of various clotting factors, disturbances in fibrinolysis and similar).

Preparing patients with anticoagulant treatment

Colonoscopy is a procedure with high risk for bleeding.

It is necessary to consider the thromboembolic complication and/or unwanted ischemic event!

Preparation of patients for the colonoscopy is generally performed in anticoagulant clinic.

A week before the planned procedure, INR (international normalized ratio) is set and proper treatment scheme is prescribed according to protocol for procedures with high risk for bleeding (whether the treatment is terminated or low-molecular heparin is temporarily introduced).

Preparing patients with anticoagulant treatment

Risk is higher in:

- Persons aged 80+ years,
- Persons who have already experienced stroke,
- Patients with hyperlipidaemia,
- Patients with hypertension,
- Family history of cardiovascular diseases.

Risk is high in:

- Defective cardiac valve,
- Artificial cardiac valve,
- Recovery from acute deep venous thrombosis (↑ risk in first 30 days),
- Lack of protein C and S and Leiden's mutation of V factor (haematologist!).

Preparing patients with antiaggregation treatment

- We do not terminate treatment with NSAIDs.
- We do not terminate treatment with acetylsalicylic acid (Aspirin, Andol, etc.).
- There‘s a higher risk of bleeding in case of acetylsalicylic acid, clopidogrel (Plavix) and ticlopidine (Tagren), thus we generally postpone the colonoscopy until the patient does not need these medications anymore.

Antibiotic protection before the colonoscopy

Colonoscopy is a procedure with low risk of bacteraemia (2 - 5%).

Antibiotic protection is generally not needed, unless it is recommended because of the peculiarities of the patient‘s status.

The decision is individual based on the peculiarities of the patient‘s status (i.e. after endocarditis or status when less than a year has passed since stenting).
Ampicillin/amoxicillin (2 g i.v. or 1.5 g orally), gentamycin (1.5 mg/kg) or vancomycin (1 g i.v.) are used.

Preparing diabetic patients for colonoscopy

Guidelines for the preparation for colonoscopy and adaptation of medications are presented in the materials and published on Svit Programme webpage under the heading *For health workers.*

- Transitionally, higher levels of glycaemia are acceptable;
- Prevention of diabetic ketoacidosis and hyperosmolar hyperglycaemic state;
- Prevention of hypoglycaemia;
- Colonoscopy appointments may be in the morning or in the afternoon;

Preparing for the colonoscopy in patients taking iron preparations

- We recommend the termination 7 to 10 days prior to the examination.

ASA (American Society of Anaesthesiologists) classification; assessment of chronic patient‘s medical fitness for the colonoscopy

1. Patient doesn‘t have any organic, physiological, biochemical or psychiatric disturbance (healthy, without accompanying disease).

2. Mild to medium-severe systemic disease, induced by a disturbance, which should be treated surgically or internally (mild to medium-severe state, which can be controlled with treatment; cases include diabetes, stable cardiovascular disease and stable pulmonary disease).

3. Severe systemic disturbance because of disease regardless of possible cause even if there is not possible to determine the level of impairment (disease that severely limits patient‘s normal functioning and can lead to hospitalization or institutional care; cases include severe heart attacks, poorly controlled heart failure or renal failure).

4. Severe systemic disturbance, which is threatening patient‘s life and where the treatment is not always successful (cases include coma, acute myocardial infarction, respiratory failure requiring mechanical ventilation, renal failure requiring urgent dialysis, septic state with hemodynamic instability).

The end of the examination in GP‘s clinic

1. Completed clinical examination and medical history.

2. Completed „Questionnaire for the preparation for the colonoscopy“. ASA evaluation – assessment of patient‘s medical fitness for the colonoscopy.

3. Signed and completed pre-printed white prescription for Moviprep.

4. Explanation of colon cleansing instructions in case of confusion.

5. Issuing a referral for screening outpatient or inpatient colonoscopy.

6. Organizing an appointment for screening colonoscopy: making a call to Svit Programme Call Centre.

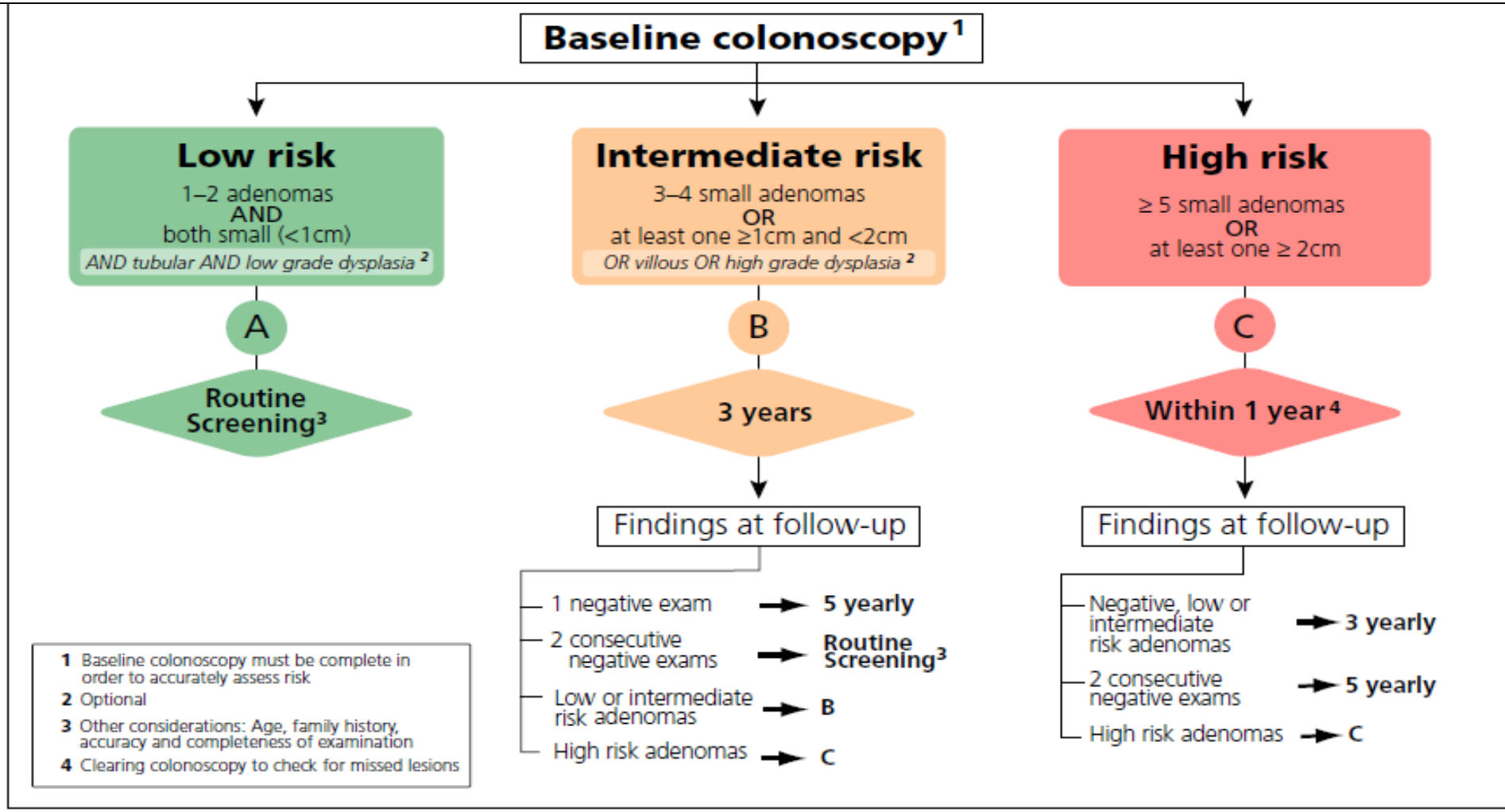
Colon preparation – cleansing

In the Svit Programme, MOVIPREP® is used for colon cleansing. Preparation is effective and safe, and acceptance by the patients is better compared to other preparations for colon cleansing before the colonoscopy. Patient obtains the medication from the pharmacy by enclosing the prescription containing the Svit Programme stamp.

Svit Programme additionally recommends the consumption of 2 litres of Donat Mg.

In order for the colonoscopy to be successful, the colon must be thoroughly cleansed before the procedure. It is important that a patient follows the Svit Programme instructions and the instructions of his/her GP regarding the preparation for the colonoscopy.

European guidelines for surveillance after polypectomy



Deviations, noticed in Svit Programme implementation

1. Positive Faecal Occult Blood Test (FOBT):

- **In all cases, the patient needs a referral for the colonoscopy**; if his/her current medical condition does not allow the procedure, it needs to be performed later and Svit Call Centre need to be informed on the delay.
- In impaired persons who cannot perform the colon cleansing by themselves, an inpatient colonoscopy can be arranged exceptionally through the Svit Call Centre.
- Haemorrhoids must not be the reason that you do not issue a referral for the colonoscopy.
- If a patient has undergone a colonoscopy recently, and this information was not reported, Svit Call Centre must be contacted in order to consult the supervisory gastroenterologist and to arrange further treatment (generally, screening colonoscopy follows the positive FOBT).
- Medications (aspirin, NSAIDs, etc.) do not influence the FOBT results and are not the cause of positive results.

Deviations, noticed in Svit Programme implementation

2. Repeating the FOBT after the Svit test results were positive:

- Repetition of the test is a professional error!
- Each patient with positive test results should be referred to colonoscopy, which will explain the cause of bleeding!
- Lesions in the intestine bleed in intervals/occasionally.
- The results of different tests are not comparable; tests are different by the way of performance, sensibility and specificity, by stability of samples, and they have different cut-off values for positive test results.

Deviations, noticed in Svit Programme implementation

3. Respecting the fact that screening tests are not 100 %:

- Negative FOBT needs to be repeated every two years, a lesion can bleed in intervals; CRC develops slowly thus the possibility of positive test results in case of present pathology is increasing with the repetition of screening tests.
- **If FOBT is negative and the patient reports problems,** which could indicate the pathology in the area of colon and rectum, such patient **needs a referral to diagnostic colonoscopy outside the Svit Programme.**
- **Interval cancer:** it can appear after the negative FOBT and before the test is repeated in the next screening round.
- The occurrence of interval cancer is also possible in case of negative colonoscopy.
- In **family medical history of CRC, the FOBT is not a replacement for colonoscopy;** a control colonoscopy needs to be performed in accordance with all valid guidelines.

Deviations, noticed in Svit Programme implementation

4. Patients are not properly prepared for the colonoscopy:

- They did not complete the „Pre-colonoscopy questionnaire“.
- They do not have a referral for outpatient or inpatient screening colonoscopy.
- The prescription for Moviprep is not properly completed/signed.
- They do not have instructions on medications in case of chronic disease (hypertension, hyperlipidaemia, antiaggregation therapy, anticoagulant therapy, diabetic patients, etc.)
- **Each patient undergoing the colonoscopy, needs to be prepared in accordance with Svit Programme guidelines.**

We suggest

5. Authorisations for the gastroenterologist:

A referral for screening colonoscopy, issued by GP, should include all necessary authorisations, which will enable the repetition of the examination for the gastroenterologist (referral to another colonoscopy centre if lesion is too big, technically demanding examination, improperly cleansed intestine, etc.) or the referral for further diagnostics/treatment in case of detection of CRC.

The referral should be marked **„Svit-colonoscopy“,** which will enable the traceability, because some people undergo a colonoscopy outside the Svit Programme (possibility of obtaining information).

Invitation for active support in increasing responsiveness

6. Non-respondents on the level of Statement of Participation / Screening test / Colonoscopy:

- **Key active role of GP in changing the patient‘s decision on participation!**
- **The support of community nurse;** in some places, private practitioners do not forward the list of non-respondents to community nursing service in community healthcare centre.
- The support of **Svit contact point (prevention** centre) in community healthcare centres.
- The support of Charge nurses in reference clinics.
- The support of community healthcare centre management for the Svit Programme!

The deciding role of community healthcare centre management and the director for increasing responsiveness in Svit Programme on municipal level

- Svit Programme is a national programme, which needs active support of decision makers and responsible authorities on local level (community healthcare centre directors, mayors, etc.).
- The inclusion of community healthcare centre director for supporting Svit Programme on local level:
  - Interest for responsiveness in Svit covered by community healthcare centre (six-months Svit reports – received by the director).
  - Encouraging GPs and community nursing service to regularly activate non-responsive individuals.
  - Partnerships for Svit and higher responsiveness made by mayors, regional NIJZ units, etc. and organization of Svit events, media promotion, innovative approaches, etc.

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