

A man with rectal bleeding who wishes to avoid colonoscopy

Commentary by **DONALD FROMMER** BSc, FRCP, MD, FRACP

A man with rectal bleeding, haemorrhoids and diverticular disease is reluctant to have a colonoscopy. His brother developed bowel cancer at 45 years of age. Is faecal occult blood testing worth doing? Can colonoscopy be avoided?

Case scenario

I have a patient whose brother developed bowel cancer at 45 years of age. My patient is reluctant to have a colonoscopy because he has heard that it can perforate the bowel. When he was in his thirties, he had a barium enema for abdominal pain, which showed quite marked diverticular disease for a young man. Recently, he has had some bright red rectal bleeding and on inspection had definite external haemorrhoids. Is it worthwhile doing faecal occult blood tests in a patient with diverticular disease and haemorrhoids?

Commentary

The first question is the role of faecal occult blood testing (FOBT) in people who have seen blood with their motions. It should be emphasised that doing FOBT in patients with blood per rectum will add nothing to the evaluation of the case and may, in fact, cause problems if the result is negative. The sensitivity of standard guaiac tests for bowel cancer is about 55%,^{1,2} and much lower for adenomas. Immunological FOBT has a significant false negative rate (possibly as high as 20%), with again a lower sensitivity for adenomas. Therefore, to rely on FOBT to exclude bowel cancers and adenomas would be unjustified.

Although haemorrhoids may well be the cause of bright blood being seen with bowel actions, unfortunately the diagnosis of rectal cancers is still sometimes delayed

until they reach an incurable stage because of the assumption that the blood seen was due to known haemorrhoids.

The patient's brother developed bowel cancer at 45 years. Only about 4% of cancer patients have their tumour at or before the age of 45 years, and therefore he may have a hereditary form of bowel cancer, such as familial adenomatous polyposis or human nonpolyposis colorectal cancer (HNPCC). The former is found in about 0.5 to 1.0% of bowel cancer patients and the latter in about 5%. The practitioner, therefore, should seek details of the brother's bowel cancer, including the number of adenomas in the bowel, the site of the cancer (usually right-sided in HNPCC), and whether there have been other cancers in the brother and in other family members (e.g. endometrial, ovarian, breast, gastric and pancreatic cancers can be found in HNPCC).

The definition of HNPCC requires that three members of the family have had bowel cancer, one being under 50 years of age and at least two successive generations being involved. Because of the cost (usually over \$2000), subsidised genetic testing for familial adenomatous polyposis or HNPCC will not be done unless there is a high likelihood of these syndromes being present. Only about half the cases of HNPCC are confirmed by genetic analysis.

The patient is reluctant to have a colonoscopy because of the fear of a bowel perforation. Its rate is low, about 0.05 to 0.08,³ but there are few data on whether diverticulosis increases the rate.

Diverticular disease itself will not cause



Figure. Colonoscopy showing a rectal polyp with carcinoma.

a positive FOBT result, but obviously diverticulitis can. Also, diverticulosis can make it difficult to diagnose carcinomas by double contrast barium enema because narrowing of the lumen and irregularity of the mucosa in colon cancer can mimic changes seen in severe diverticulosis. In one study, the sensitivity of double contrast barium enema and colonoscopy for rectal cancer was 71 and 95%, respectively.⁴ Another study found that double contrast barium enema missed five times the number of colorectal cancers than did colonoscopy.⁵ Therefore, colonoscopy is vital for investigation of this patient. **MT**

References

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