Colon Cancer Screening

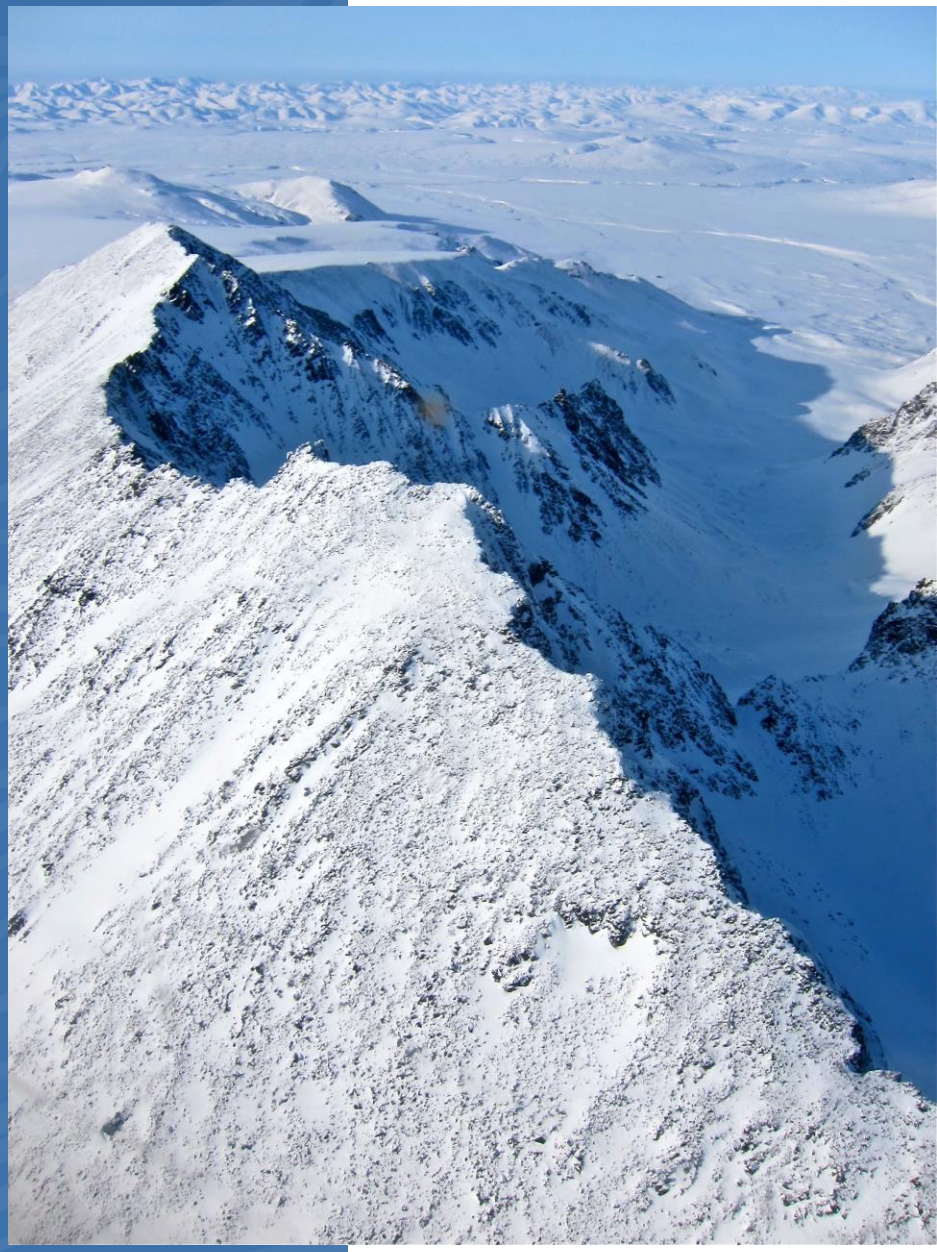
Yukon-Kuskokwim
HEALTH CORPORATION

Summary

- Colon cancer screening overview
- Referral process at YK
- Efficacy of screening
- Quick comment on irritable bowel syndrome

Colon cancer

- Most is adenocarcinoma
- 2/3 colon polyps are adenomatous
- Adenomatous polyp to cancer 10 years
- Hyperplastic polyps, serrated polyps



Incidence

- CRC is the second most common cause of cancer deaths
- One third of people who get CRC will die of it

Risk

- Age
- Family history-primary or first degree relatives
- Prior history of CRC or adenomatous polyps
- Inflammatory bowel disease
- Hereditary syndromes
- Abdominal radiation
- Life style

Screening-early detections allows for cure, removing polyps prevents

- FOBT
- FIT
- Corgard
- Flexible sigmoidoscopy
- Colonoscopy
- Virtual colonoscopy
- Capsule colonoscopy
- No BE, no digital rectal, no FOBT digital

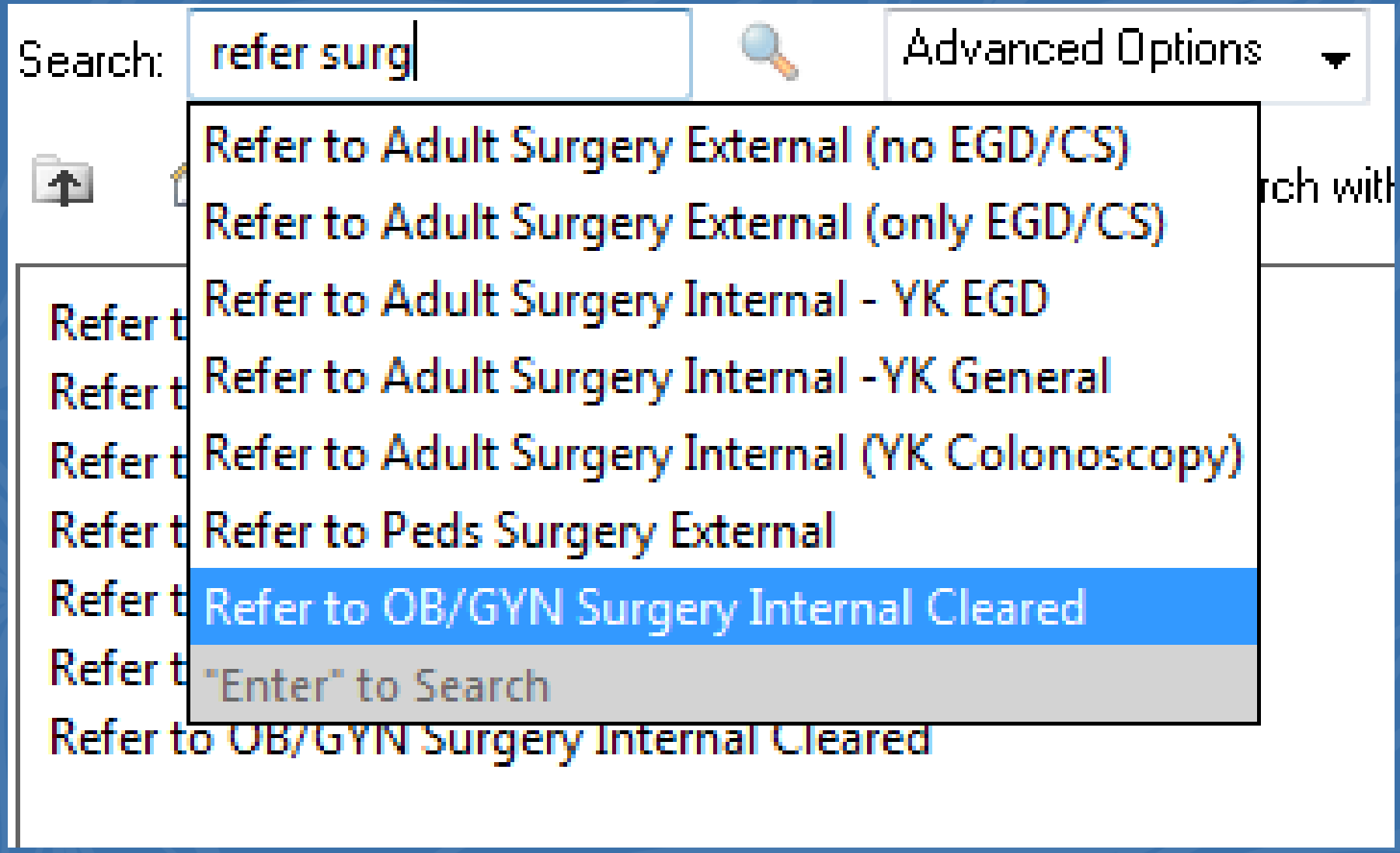
Screening at YKHC

- Age 40-70 years old (50-75 lower 48)
- If FH CRC, 10 years before age of CRC in primary relative
- If hx inflammatory bowel disease, 8-10 years after onset symptoms
- Consider 10 year life expectancy

Surveillance

- History of adenomatous polyps-every 5 years
- History of inflammatory bowel disease every 1-2 years if extensive or left sided UC or greater 1/3 Crohn

Referral process at YK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Refer to Adult Surgery Internal - YK EGD
Refer to Adult Surgery Internal -YK General
Refer to Adult Surgery Internal (YK Colonoscopy)
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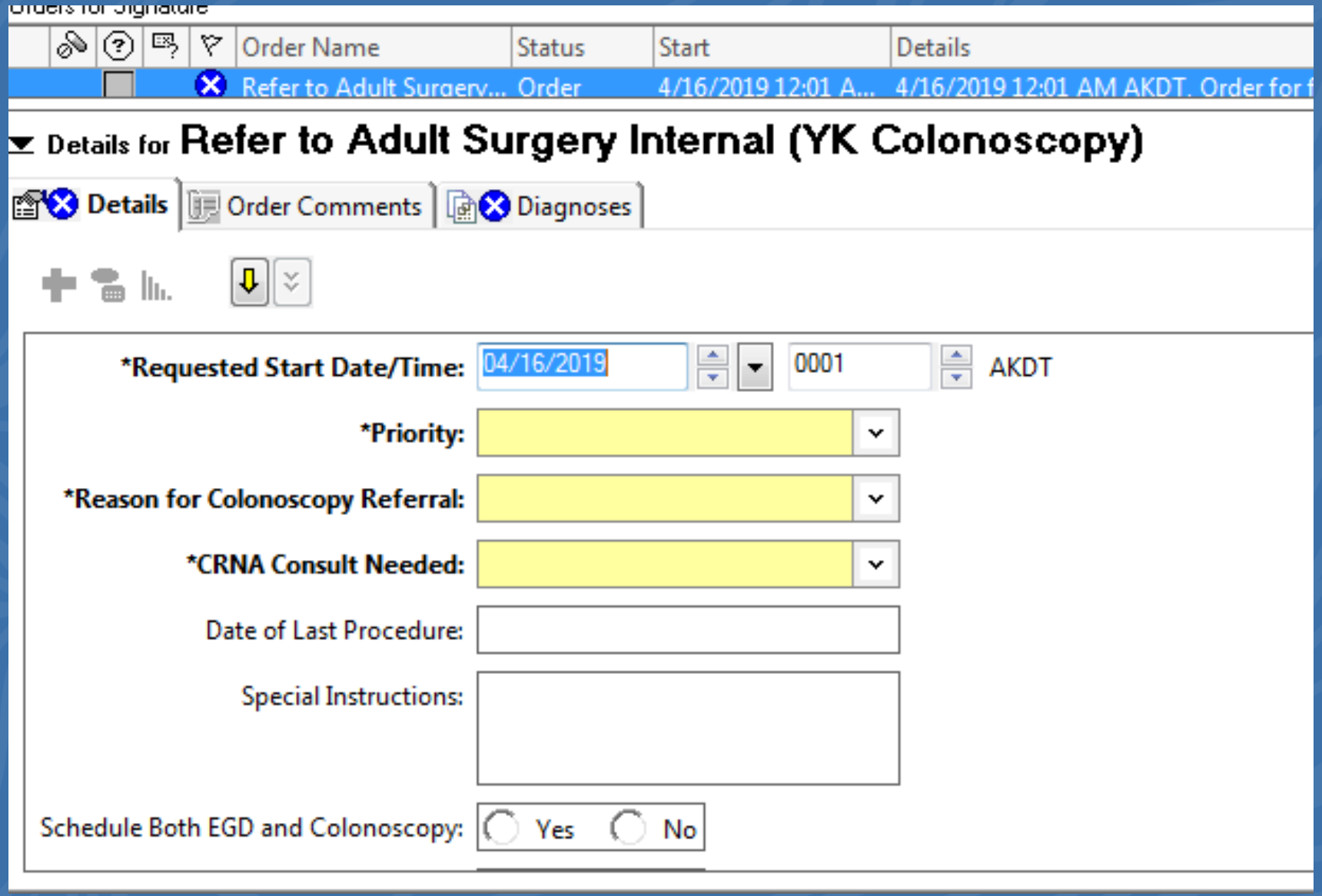
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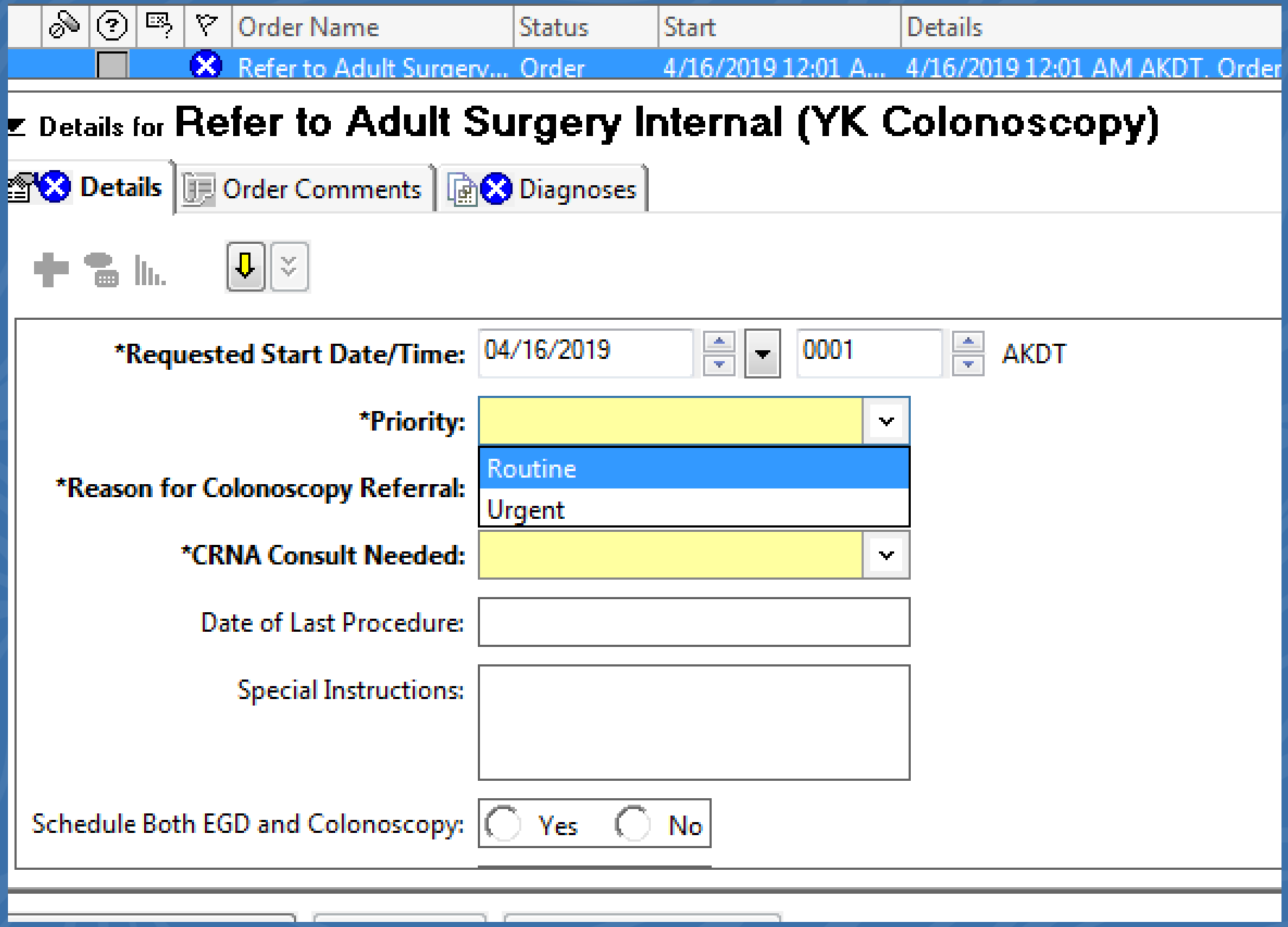
Date of Last Procedure:
Special Instructions:
Schedule Both EGD and Colonoscopy:
Yes
No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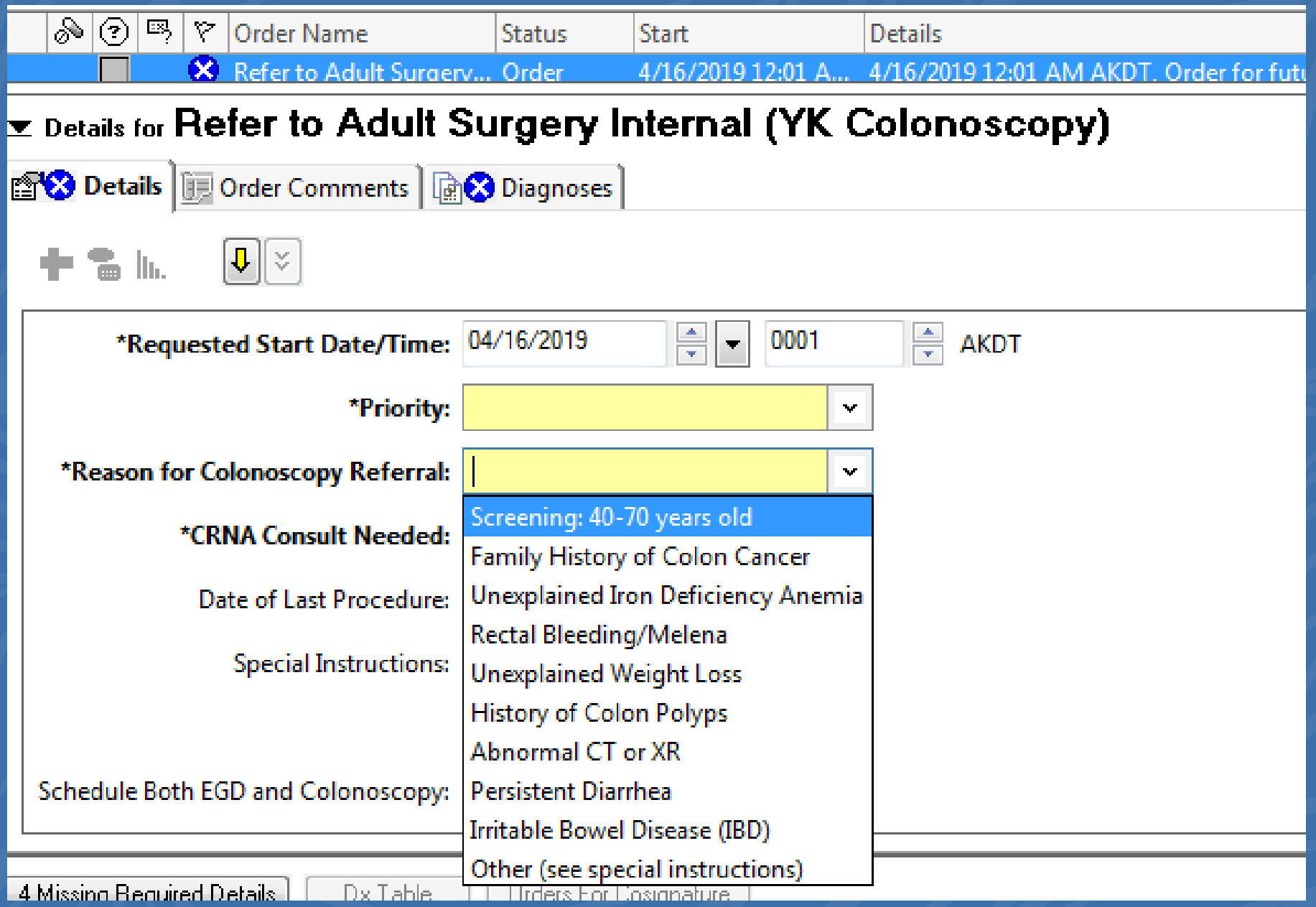
*CRNA Consult Needed:
Date of Last Procedure:
Special Instructions:
Schedule Both EGD and Colonoscopy:
Yes
No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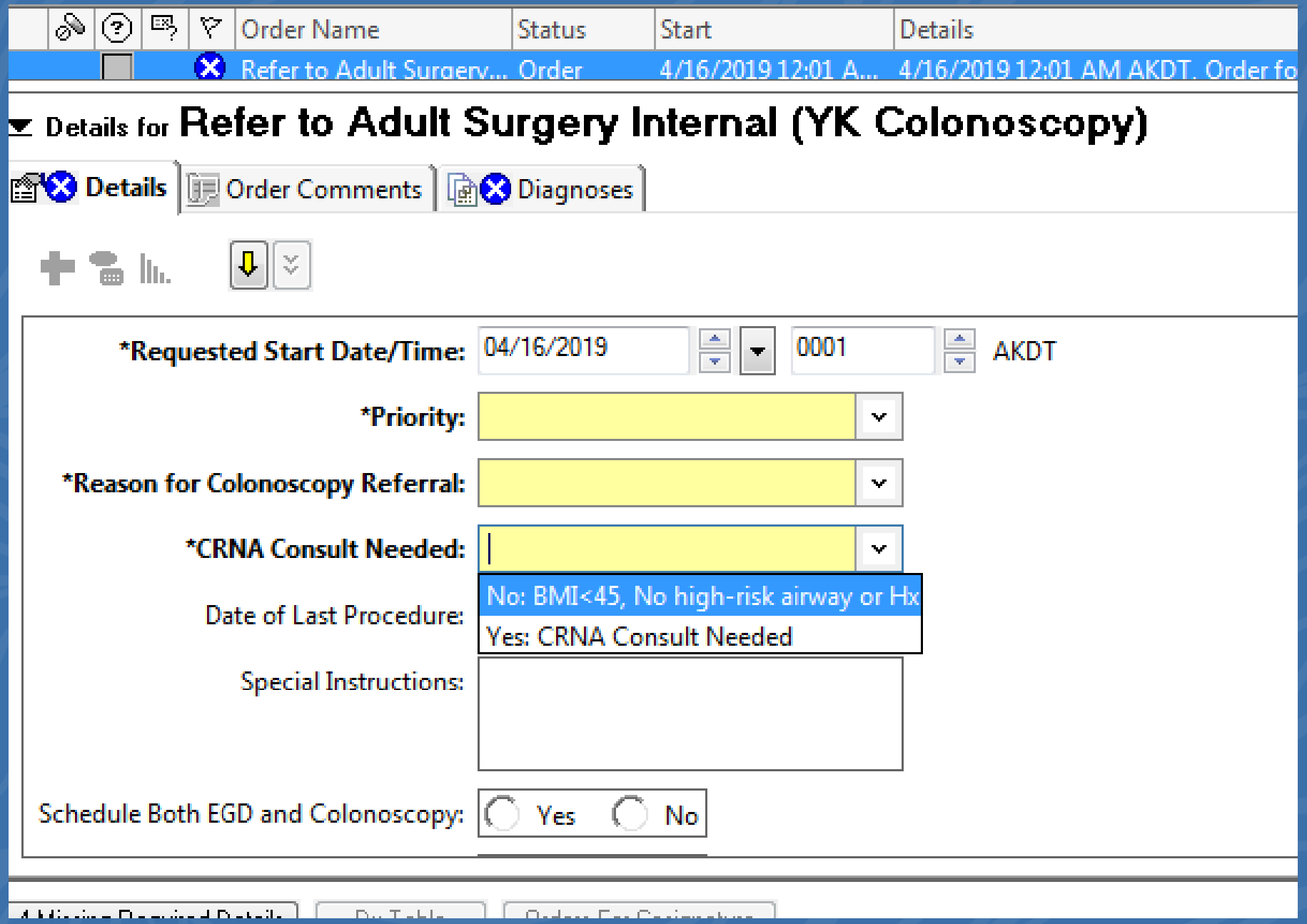
*CRNA Consult Needed:
Date of Last Procedure:
Special Instructions:
Schedule Both EGD and Colonoscopy:
Screening: 40-70 years old
Family History of Colon Cancer
Unexplained Iron Deficiency Anemia
Rectal Bleeding/Melena
Unexplained Weight Loss
History of Colon Polyps
Abnormal CT or XR
Persistent Diarrhea
Irritable Bowel Disease (IBD)
Other (see special instructions)
4 Missing Required Details
Dx Table
Orders For Cosignature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*Priority:
*Reason for Colonoscopy Referral:
*CRNA Consult Needed:
No: BMI<45, No high-risk airway or Hx
Yes: CRNA Consult Needed
Date of Last Procedure:
Special Instructions:
Schedule Both EGD and Colonoscopy:
Yes
No

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SEARCH INTRANET

DIRECTORY MESSENGER

Search Directory

Search

Browse by Name:

A B C D E F G H I J K L M N
O P Q R S T U V W X Y Z

Browse by Department
Browse by Location

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Napartet: Building Excellence

- Our Mission, Vision, and Values
- Our Five Pillars
- Our 2009 Goals
- Napartet Goal Team
- Napartet News

YKHC News

5/29/2018

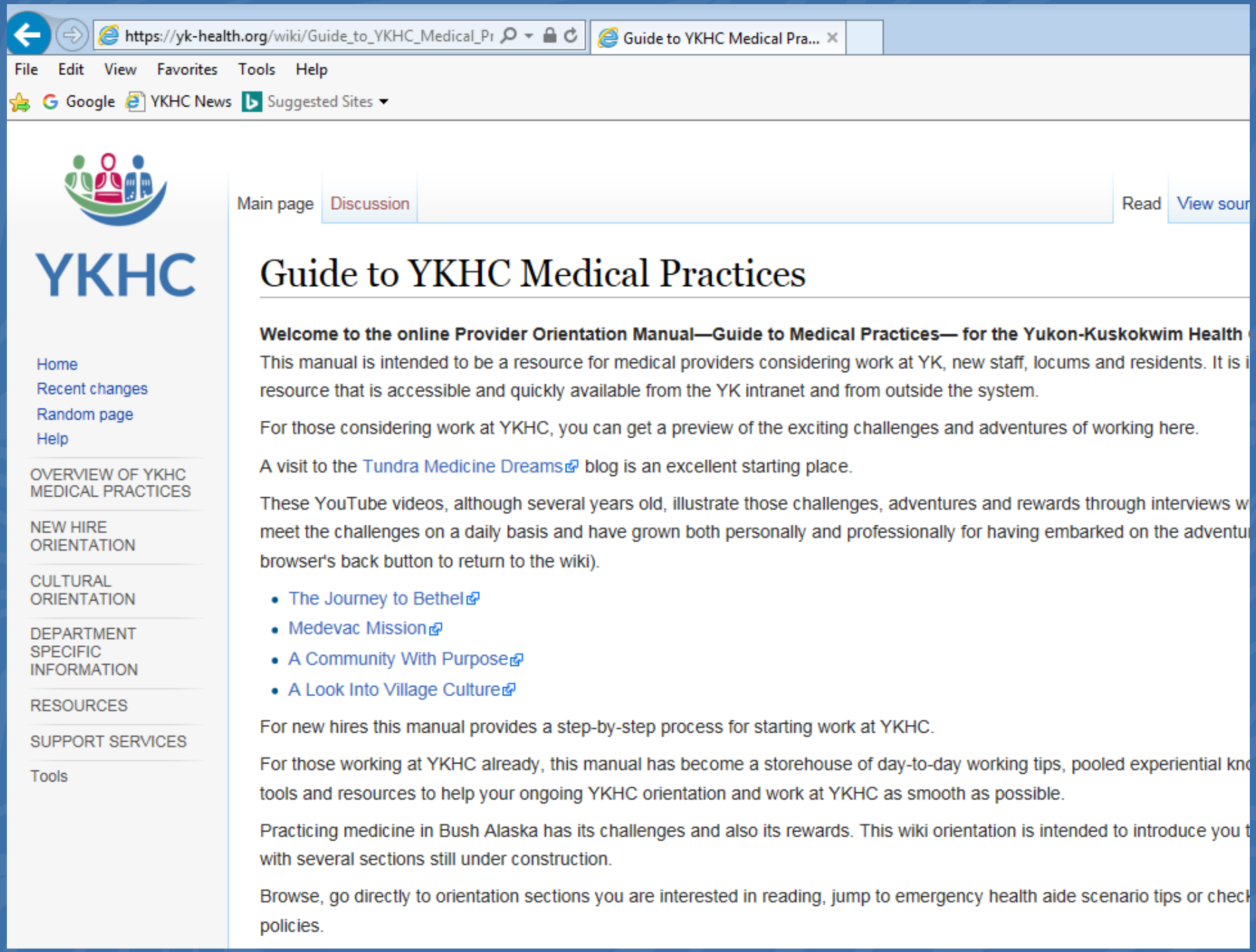
YKHC Announces Planned Launch of New Brand

The physical improvements to our infrastructure and our improved approach to patient care necessitated a refresh of our logo and visual brand. In late 2016 and early 2017, we sought an updated YKHC identity that celebrates our renewed focus on the customer, our corporate values, and the Yukon-Kuskokwim Delta region we call home.

Read more about the new brand here...

YKHC News Archives

YKHC.org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Guide to YKHC Medical Practices
Welcome to the online Provider Orientation Manual—Guide to Medical Practices— for the Yukon-Kuskokwim Health
This manual is intended to be a resource for medical providers considering work at YK, new staff, locums and residents. It is i
resource that is accessible and quickly available from the YK intranet and from outside the system.
For those considering work at YKHC, you can get a preview of the exciting challenges and adventures of working here.
A visit to the Tundra Medicine Dreams blog is an excellent starting place.
These YouTube videos, although several years old, illustrate those challenges, adventures and rewards through interviews w
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Medevac Mission
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A Look Into Village Culture
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with several sections still under construction.
Browse, go directly to orientation sections you are interested in reading, jump to emergency health aide scenario tips or check
policies.
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NEW HIRE ORIENTATION
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OVERVIEW OF YKHC MEDICAL PRACTICES

NEW HIRE ORIENTATION

CULTURAL ORIENTATION

DEPARTMENT SPECIFIC INFORMATION

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- Pediatrics
- Inpatient
- Residents
- OB & Newborn
- SRC Clinic Provider Orientation
- Women's Health
- OR
- Emergency Room
- Radio Medical Traffic (RMT)
- Medevacs and Transport
- Community Health Aide Training
- Dental
- Optometry
- Behavioral Health

RESOURCES

Guide to YKHC Medical Practices

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Thanks to the many providers that have written large sections of this manual and to all of the providers that

Consult the User's Guide for general information on using wiki software.

Contents [hide]

Category:OR

The YKHC Surgery Department has two operating rooms, one endoscopy room, two PACU rooms, and one four-bed PreOp/PostOP room. An anesthetist is ON-CALL 24/7 for emergent/urge cases in either the operating room or the emergency department.

Contents [hide]

Anesthesia Services

Dental

Endoscopy

Diagnostic, surveillance, and screening procedures are provided for adults and adult-size teens who meet the YKHC Low-Risk Endoscopy Criteria. Therapeutic procedures require referral a higher level of care.

Gynecology

Obstetrics

Urgent/Emergent Procedures

This category currently contains no pages or media.

YKHC Low-Risk Endoscopy Criteria

Contents [hide]

OVERVIEW

Because YKHC has no ICU, serious endoscopy complications require transfer to the Emergency Department and/or Medevac transfer. Prevention of this occurrence is a priority. Therefore endoscopy in Bethel is limited to low risk patients.

The intention of this page is to provide transparent criteria for the most common conditions which increase the risk of an endoscopy complication. This page is not all-inclusive.

These criteria are written with isolated diagnoses in mind. The presence of multiple comorbidities may yield a higher risk than either individually and this effect is not incorporated into these criteria.

The intention of these criteria is to risk stratify based on the functional status of a disease rather than its mere mention in a patient's chart.

In unusual circumstances, exceptions to these criteria will be considered on a case by case basis and must be approved in advance by both the endoscopist and anesthetist.

GENERAL

BMI

- BMI < 45 (non-negotiable limit)
    - for BMI 40-45: anesthesia approval (for non-Bethel patients this should occur PRIOR to ordering)

Acute Illnesses

Patients should be at their baseline health status for outpatient endoscopy in Bethel.

Acute illness is a contraindication for Bethel endoscopy unless the illness is mild and does not involve the nasopharynx, gastrointestinal system, or cardiopulmonary system. Fever or acutely abnormal vital signs are a contraindication. Additionally, patients must be comfortable laying on their side and extending their neck.

Urgent inpatient procedures require discussion with and approval by the endoscopist and the anesthetist. It is accepted that these patients are not at their baseline, but the urgency of the condition frequently necessitates prompt performance of the procedure.

Acute Contraindications

- Fever
- Tachycardia
- SBP > 180 or DBP > 110
- Tachypnea
- Dyspnea
- Chest pain
- Decompensated heart failure (pulmonary crackles, pedal edema, etc)
- Significant rhinorhea or nasal congestion
- Cough
- Wheezing
- Any infection requiring antibiotic treatment and for which symptoms have not completely resolved
- Dizziness
- Weakness
- Mental status change

CARDIAC

CHF

1. Most recent LVEF >= 40%
2. Recent (<6mos) BNP <= 125 pg/mL (or YKHC laboratory's current upper limit of normal)
3. No loop diuretic use (chronic or acute) within the last 12 months
4. No current or recent cardiac-like symptoms which have not been thoroughly investigated

CAD

1. No Acute Coronary Syndrome within the last 12 months unless cleared by cardiology
2. No coronary revascularization (either surgical or endovascular) within the last 12 months unless cleared by cardiology
3. No use of anti-angina agents in the last 12 months
4. Normal cardiac stress test within the last 12 months
5. No current or recent cardiac-like symptoms which have not been thoroughly investigated

A-Fib

1. Currently in sinus rythm
2. No subjective or objective A-Fib occurrence within 12 months
3. No use of anti-arrythmic drugs within 12 months
4. Meets all of the "CHF" criteria above
5. No current or recent cardiac-like symptoms which have not been thoroughly investigated

PULMONARY

Asthma

Prior to endoscopy (and preferably prior to the referral), asthma severity should be classified in accordance with the *Guidelines for the Diagnosis and Management of Asthma*

Asthma Classification Resources:

- *Asthma Care Quick Reference* is a summary of the above guideline.
- *CheatSheets* for asthma classification (pages 5, 6, and 7 from the Quick Reference).
- *Asthma Control Test* (ACT) is a quick, simple, validated questionnaire for patients to complete.

    - when the ACT is performed, please scan into the multimedia manager and reference it in the visit note

Endoscopy in Bethel is limited to only those asthma patients who meet the following criteria:

- If treated, must meet criteria for ***Well Controlled*** asthma.
- If UNtreated, must meet criteria for ***Intermittent*** asthma.

COPD

- Post-bronchodilator FEV_1 >= 60% of predicted

    - order as "*PFT (Pre-&Post-Albuterol) Eval*"

    - view results in Multimedial Manager —> EKG Folder

OSA

- Positive pressure ventilation has NOT been recommended/prescribed
- Anesthesia approval (for non-Bethel patients this should occur PRIOR to ordering)

MEDICATIONS

Antiplatelets and Anticoagulants

Endoscopy with simple biopsy is considered low risk for bleeding, therefore antiplatelets/anticoagulants usually do not require adjustment/cessation for EGD.

However, polypectomy is considered high risk for bleeding, therefore colonoscopy may require antiplatelet/anticoagulant adjustment or cessation. Antiplatelet/anticoagulant management is a decision best made by the referring physician (possibly in consultation with a managing specialist and/or the anticipated endoscopist). Patients on antiplatelets/anticoagulants should not be referred prior to formulating (and documenting) a medication management plan. The referral order comment section should specify where to find the plan.

- **Aspirin**[1]
  - *Aspirin and NSAIDs can be continued safely during colonoscopy with polypectomy.*
- **Thienopyridines**[1]
  - Drugs in this class include: clopidogrel (Plavix), prasugrel (Effient), and ticlopidine (Ticlid).
  - Thienopyridines, either as a single agent or in combination with aspirin (dual anti-platelet therapy, a.k.a. **DAPT**), present a meaningful risk of a post-polypectomy bleed (approximately 2.4%). Additionally, the fact that many of our patients will return to a village means that delayed post-polypectomy bleeding (which can occur up to 2 weeks post-polypectomy) may have worse outcomes than those in the published literature (due to lack of easy access to intervention and/or transfusion).
  - DAPT is frequently used only for limited duration (i.e. 3-12 months) after an event (such as thromboembolic CVA) or procedure (such as coronary stent placement). Therefore serious consideration should be given to the urgency of the indication and the possibility of postponing the referral until the DAPT period is complete.
  - If there is strong rationale that colonoscopy will not involve polypectomy, then colonoscopy referral can be placed while on a thienopyridine or DAPT.
  - If the colonoscopy indication is truly urgent and the risk of thienopyridine discontinuation is unacceptably high, then the patient should be referred to Anchorage.
- **Warfarin**[1]
  - Warfarin presents a substantial risk of post-polypectomy bleeding, whether stopped, bridged, or continued. If polypectomy is expected, these patients should be referred to Anchorage.

Nurse Review

- Medical diagnosis-cardiac (murmurs, afib), pulmonic (asthma, COPD), sleep apnea
- BMI 40-45 (greater 45 automatic ANMC)
- SBP >160, HR>100
- Anti-platelet or anti-coagulate agents except aspirin and NSAIDs (automatic ANMC)
- Any pending specialty referrals
- Age>70

If any questions, ask them

- CRNAs available
- Endoscopists available
- OR nurses available
- Preop midlevels available

Efficacy of screening

- Swartz,A.W., et al 2017. Re-analysis of all-cause mortality in the US Preventive Services Task Force 2016 evidence report for colorectal cancer screening. Ann. Intern. Med. 167 (8), 602-603.

Flexible sigmoidoscopy

- Swartz, A.W., et al 2019. Preventing colorectal cancer or early diagnosis: Which is best? A re-analysis of the U.S. Preventive Task Services Task Force Evidence Report. Preventive Medicine. 118, 104-112.

Irritable bowel syndrome

- **Alarm features** – Alarm features include [10]:
  - Age of onset after age 50 years
  - Rectal bleeding or melena
  - Nocturnal diarrhea
  - Progressive abdominal pain
  - Unexplained weight loss
  - Laboratory abnormalities (iron deficiency anemia, elevated C-reactive protein or fecal calprotectin)
  - Family history of IBD or colorectal cancer