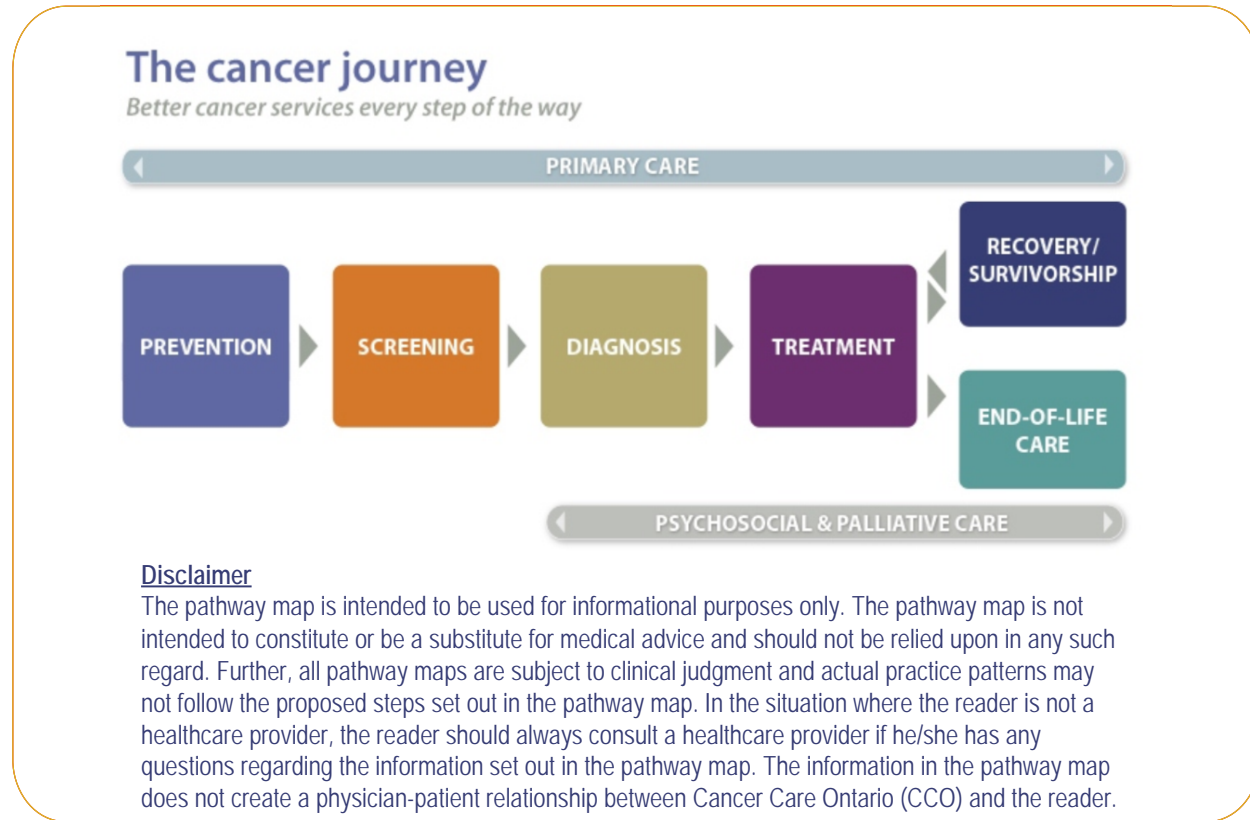


Colorectal Cancer Diagnosis Pathway Map

Version 2018.03




Pathway Map Considerations

- For more information on the Diagnostic Assessment Program (DAP) refer to the [Organizational Standards for DAPs](#)
- Primary care providers play an important role in the cancer journey and should be informed of relevant tests and consultations. Ongoing care with a primary care provider is assumed to be part of the pathway map. For patients who do not have a primary care provider, [Health Care Connect](#), is a government resource that helps patients find a doctor or nurse practitioner.
- Throughout the pathway map, a shared decision-making model should be implemented to enable and encourage patients to play an active role in the management of their care. For more information see [Person-Centered Care Guideline](#).
- Hyperlinks are used throughout the pathway map to provide information about relevant CCO tools, resources and guidance documents.
- The term 'health care provider', used throughout the pathway map, includes primary care providers and specialists, nurse practitioners, and emergency physicians.
- The pathway map is only intended for primary adenocarcinoma. Familial cancers (Lynch/non-Lynch) and cancers in the settings of inflammatory bowel disease are handled differently.










Note: Guidelines indicated in red are currently undergoing development or review

Pathway Map Legend



Colour Guide

	Primary Care
	Endoscopy
	Palliative Care
	Pathology
	Diagnostic Assessment Program (DAP)
	Surgery
	Radiation Oncology
	Medical Oncology
	Radiology
	Multidisciplinary Cancer Conference (MCC)
	Psychosocial Oncology (PSO)

Shape Guide

	Intervention
	Decision or assessment point
	Patient (disease) characteristics
	Consultation with specialist
	Exit pathway
	Off-page reference
	Patient/ Provider interaction
	Referral
	Wait time indicator time point

Line Guide

	Required
	Possible

Pathway Map Disclaimer

This pathway map is a resource that provides an overview of the treatment that an individual in the Ontario cancer system may receive.

The pathway map is intended to be used for informational purposes only. The pathway map is not intended to constitute or be a substitute for medical advice and should not be relied upon in any such regard. Further, all pathway maps are subject to clinical judgment and actual practice patterns may not follow the proposed steps set out in the pathway map. In the situation where the reader is not a healthcare provider, the reader should always consult a healthcare provider if he/she has any questions regarding the information set out in the pathway map. The information in the pathway map does not create a physician-patient relationship between Cancer Care Ontario (CCO) and the reader.

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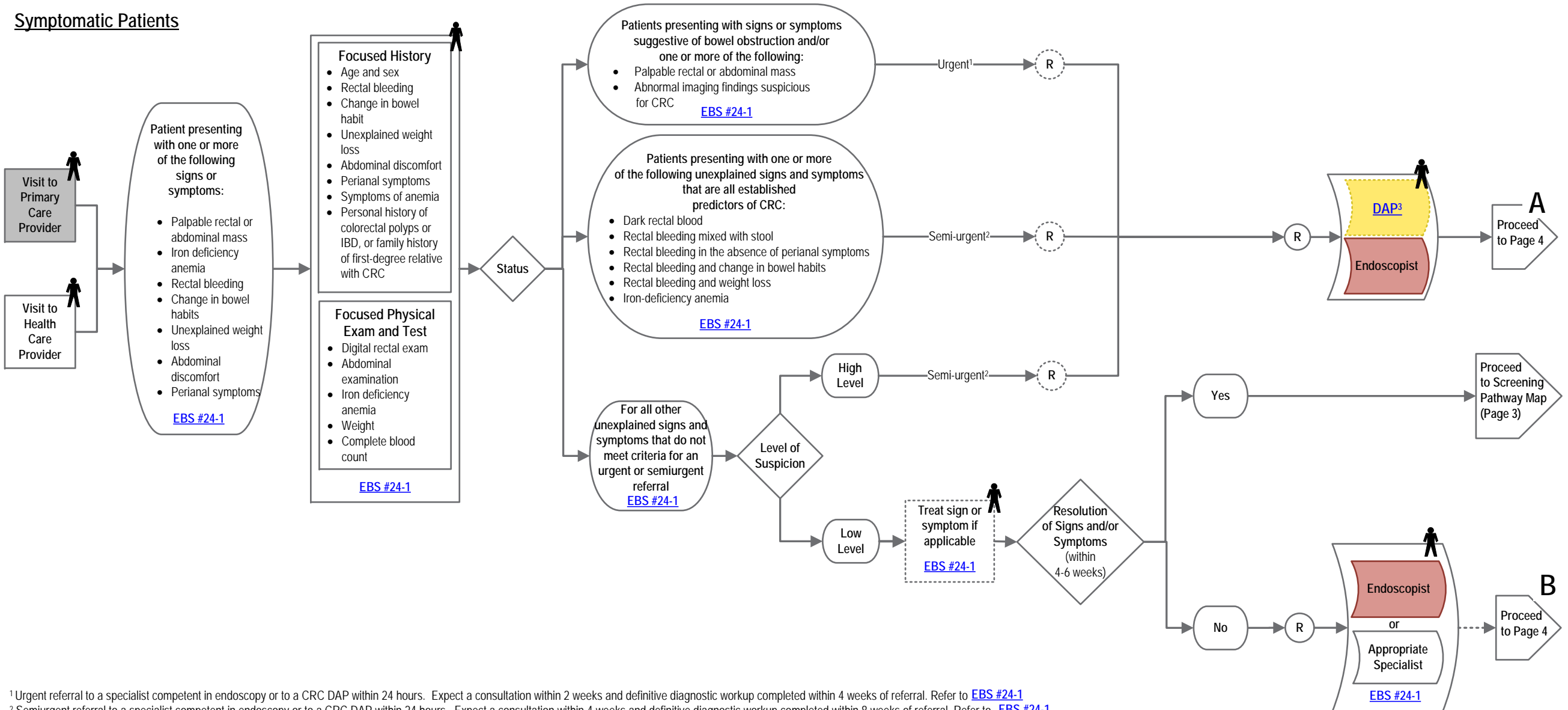
This pathway map may not reflect all the available scientific research and is not intended as an exhaustive resource. CCO and its content providers assume no responsibility for omissions or incomplete information in this pathway map. It is possible that other relevant scientific findings may have been reported since completion of this pathway map. This pathway map may be superseded by an updated pathway map on the same topic.

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Screen for psychosocial needs, and assessment and management of symptoms. [Click here for more information about symptom assessment and management tools](#)

Consider the introduction of palliative care, early and across the cancer journey [Click here for more information about palliative care](#)

Symptomatic Patients



¹ Urgent referral to a specialist competent in endoscopy or to a CRC DAP within 24 hours. Expect a consultation within 2 weeks and definitive diagnostic workup completed within 4 weeks of referral. Refer to [EBS #24-1](#)

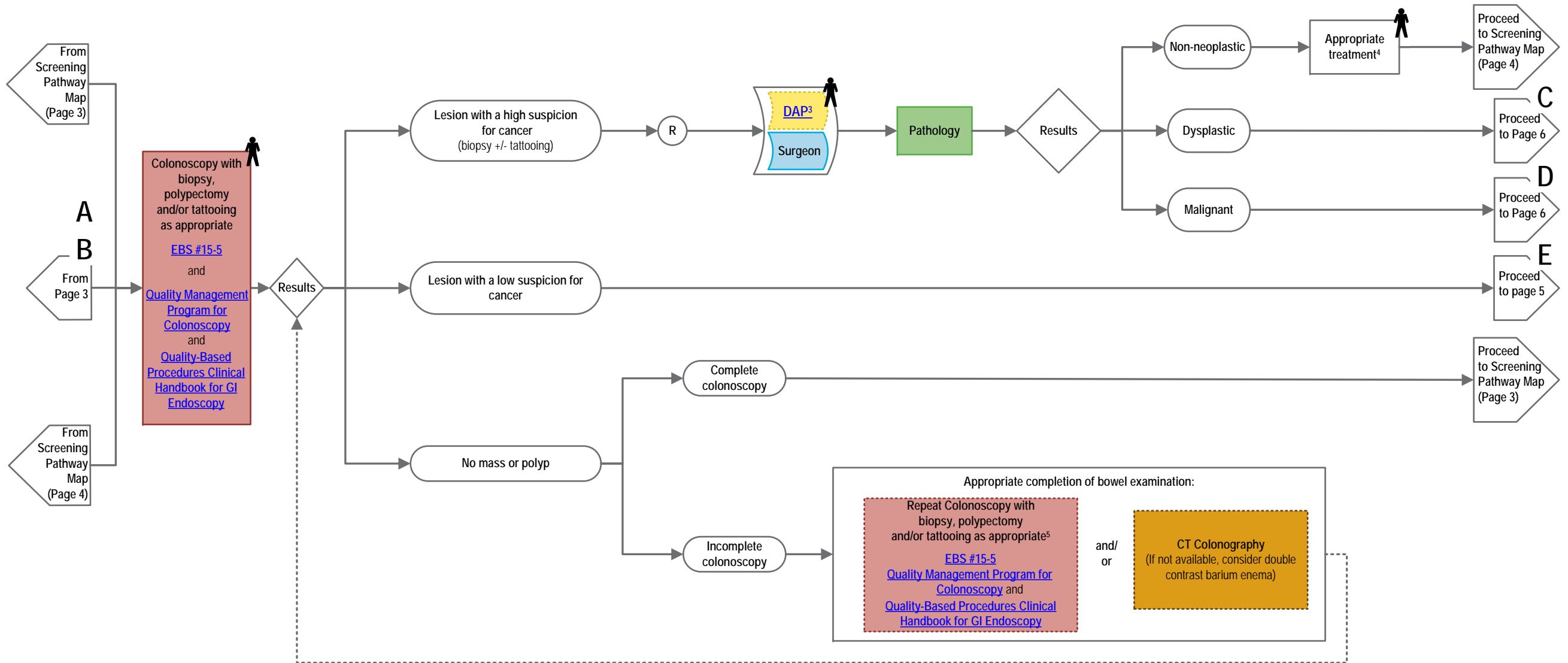
² Semiurgent referral to a specialist competent in endoscopy or to a CRC DAP within 24 hours. Expect a consultation within 4 weeks and definitive diagnostic workup completed within 8 weeks of referral. Refer to [EBS #24-1](#)

³ Development of standardized entry and transfer of care criteria are currently underway.

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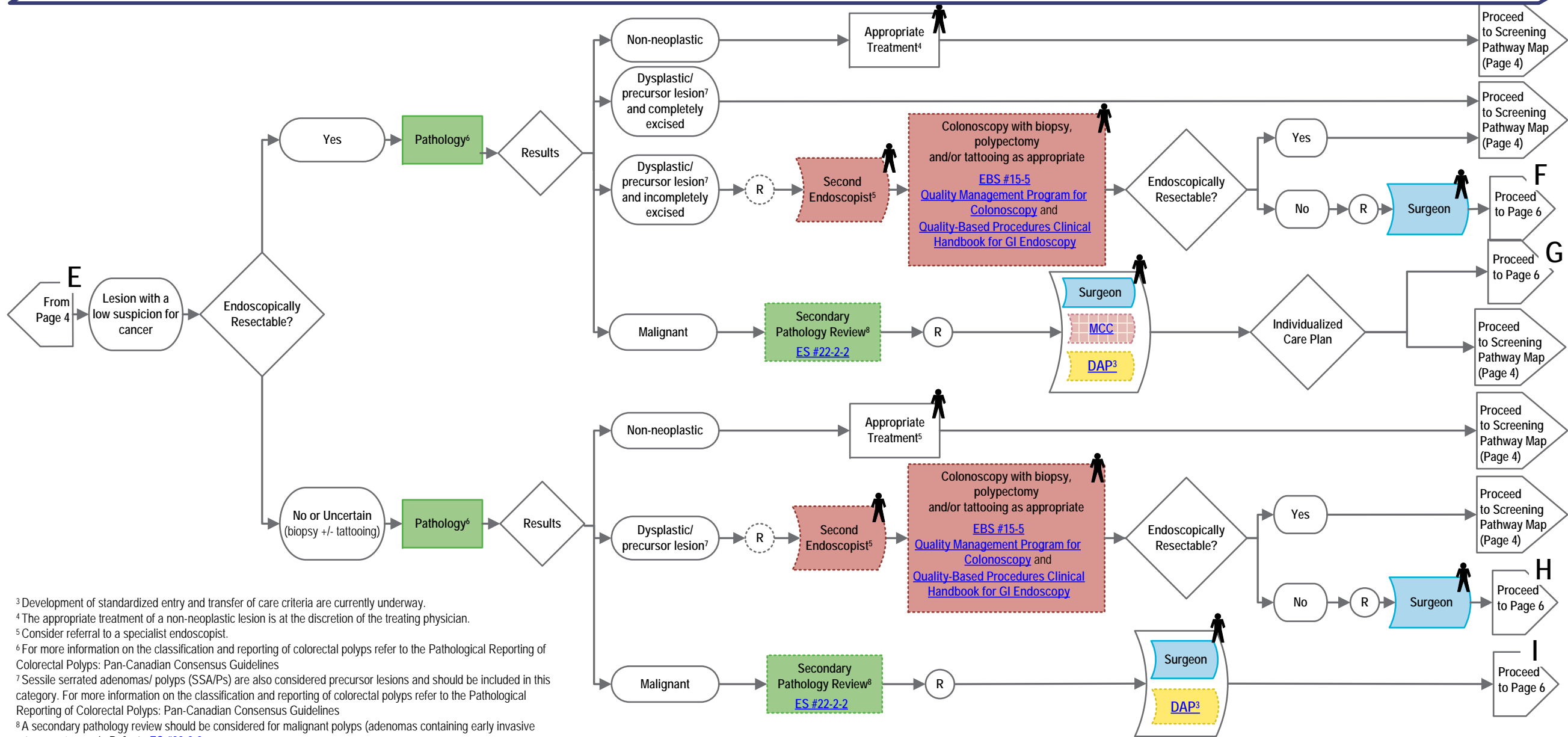
⁴ The appropriate treatment of a non-neoplastic lesion is at the discretion of the treating physician.

⁵ Consider referral to a specialist endoscopist. Refer to [EBS # 24-1](#)

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⁶ For more information on the classification and reporting of colorectal polyps refer to the Pathological Reporting of Colorectal Polyps: Pan-Canadian Consensus Guidelines

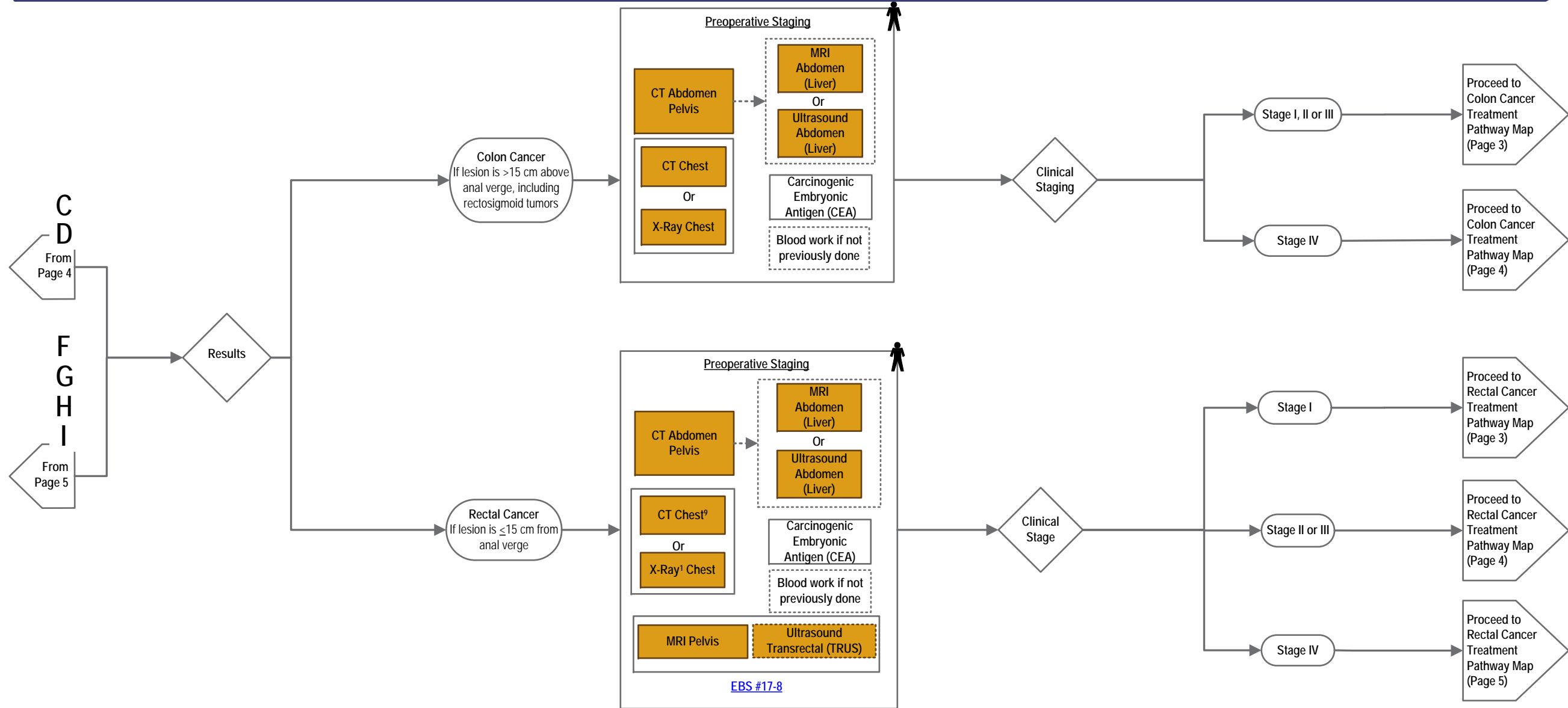
⁷ Sessile serrated adenomas/ polyps (SSA/Ps) are also considered precursor lesions and should be included in this category. For more information on the classification and reporting of colorectal polyps refer to the Pathological Reporting of Colorectal Polyps: Pan-Canadian Consensus Guidelines

⁸ A secondary pathology review should be considered for malignant polyps (adenomas containing early invasive adenocarcinomas). Refer to [ES #22-2-2](#)

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⁹ The choice of CT chest or chest X-ray should be consistent with the modality used for postoperative surveillance. For more information, refer to [EBS #17-8](#)