

The rapid access proctology clinic: an appraisal of one year's experience

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SUMMARY

A walk-in, once-a-week clinic was established in May 1993. In the first year, 1268 patients (954 new and 314 follow up) were seen with a reduction in waiting time, high patient and general practitioner satisfaction, and raised awareness of colorectal disease.

Keywords: colorectal cancer; proctoscopy; sigmoidoscopy.

Introduction

COLORECTAL cancer (CRC) is the second most common cause of cancer death in the United Kingdom, with 27 000 new cases and 19 000 deaths annually.¹ Ninety per cent of tumours progress with time from premalignant polyps. Survival is related to the Dukes stage of the tumour at presentation.²⁻⁵ Early detection and removal of polyps may therefore prevent progression to colorectal cancer.

The Rapid Access Proctology Clinic (RAPC) was set up, in addition to ordinary outpatient clinics, to reduce waiting time and improve public and professional awareness of the need for early detection and treatment of colorectal lesions. Pioneered by one of the authors (R JL), it is also the first clinic to offer patients immediate access to a consultant opinion and treatment without prior appointment. Initially financed from private funds, it was subsequently built into contracts.

Methods and patients

All 183 general practitioners (GPs) in the purchasing health authorities of St George's Hospital, London (catchment population 350 000) were circulated details of the clinic, including its aims and indications for referral (rectal bleeding, altered bowel habit, anorectal symptoms, or a family history of bowel cancer or polyps).

The clinic is held every Tuesday evening, and patients require only a referral letter from their GP in order to be seen. Examination included proctoscopy and rigid sigmoidoscopy,

with all those aged over 45, or suspected of a more proximal disease, undergoing flexible sigmoidoscopy in the clinic. Further investigations (colonoscopy and referral to a consultant geneticist) were organised for patients with a positive family history of colorectal cancer.

Results

In the first 12 months, 1268 patients were seen, of whom 954 (496 women and 458 men) were new referrals. Mean age was 48 years (range 6 months–96 years). Waiting time from GP referral to consultation fell from a median of 42 days for 'routine' and 28 days for 'soon' appointments in daytime colorectal clinics to 2 days in the RAPC. Very few patients had previously undergone proctoscopy or occult blood tests at their general practice. A definitive diagnosis was made at the first visit in 93.9% of patients. The mean time from the initial visit to further treatment when required was 13.8 days.

Neoplasms

In 954 patients, 23 cancers were detected (2.4%), one of them inoperable. Those patients who had a family history of colorectal cancer totalled 91 (10%), 14 of whom were asymptomatic. Two of the 91 patients (2.2%) had colorectal cancer and 19 had polyps (20.8%). All patients with polyps returned as day cases for full colonoscopy and polypectomy. Benign lesions (haemorrhoids and fissures) were the most common diagnoses encountered (Table 1). On an out-patient basis, 92.7% of haemorrhoid patients were successfully treated: 164 (42.8%) with rubber-band ligation, 68 (17.7%) with injection sclerotherapy, and 6 (1.6%) with infra-red coagulation. One hundred and seventeen (30.5%) patients were treated conservatively. The remaining 15 were admitted for surgery.

Of the 100 patients surveyed who completed a questionnaire form, 98% liked the idea of an evening and walk-in clinic, and 99% approved of the shortened waiting time. Sixty GPs out of 100 returned completed questionnaires. Ninety-eight per cent of these GPs also approved of the evening and walk-in clinic. The patient feedback to the GP was very good in 95% of those surveyed and 88% of GPs were happy with the no-appointment system.

Discussion

Setting up an additional clinic, in which patients with colorectal symptoms have access to an immediate specialist consultation, has led to a reduction in the duration of suffering from uncomfortable colorectal and anal symptoms. It is unlikely that this modest reduction in time will improve the prognosis of patients with malignant disease, but, in the longer term, malignant disease will be prevented by the early recognition and treatment of colonic polyps.

Only 1.5% of the new patients were asymptomatic relatives within a family history of cancer. There may be more patients within the catchment area with a positive family history. It is hoped that these patients will come forward in the impending years, as a result of easy access to the clinic and greater awareness of CRC by GPs and the lay population.

References

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Table 1. Main diagnostic groups from RAPC.

Diagnostic group	Percentage of patients
Haemorrhoids	40.1
Fissure	14.8
Miscellaneous	17.1
Inflammatory bowel disease	5.5
Polyp	8.4
Cancer	2.4
Diverticular disease	7.2
Perianal haematoma	3.0
No diagnosis	1.5

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