Should we pursue patients who fail to attend colorectal clinics? A 9-year study

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ABSTRACT

INTRODUCTION No uniform protocol exists on how to deal with patients who fail to attend colorectal clinics. Our aim was to identify whether the tendency to 'failure to attend' (FTA) in the colorectal clinic was associated with FTA in other clinics and also whether FTA patients have serious pathology.

PATIENTS AND METHODS This was a retrospective study of a prospectively recorded list of FTA patients, in colorectal urgent or two-week wait clinics from 1996–2004.

RESULTS A total of 151 patients, who failed to attend their first appointment, were included in the study. Of these, 61 (40.4%) were colorectal referrals, 76 (50.3%) were general surgical referrals, and for 14 (9.3%) case notes were not available. There were 59 FTA episodes in 61 colorectal patients associated with 59 FTA episodes in other clinics (Pearson correlation: $r = 0.411$; $P = 0.01$, two-tailed, SPSS v.12). Of 58 colorectal outcomes, five (8.6%) colorectal cancers (CRC) were diagnosed, 23 (39.6%) were persistent non-attenders, 16 (27.5%) had benign colorectal pathology, two (3.4%) benign non-colorectal outcomes and 12 (20.6%) normal outcomes.

CONCLUSIONS Tendency to FTA is habitual. Care needs to be exercised in the management of FTAs to avoid delayed presentation of colorectal cancer.

KEYWORDS

Failure to attend – Did not attend – Colorectal cancer – Two-week wait clinics – Non-attender

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Effective, early diagnosis and management of colorectal cancer (CRC) helps relieve patient anxiety and concern about advanced disease, though no significant improvement in outcome and survival has been demonstrated.¹ The process of referral and investigations leading to a definitive diagnosis can be delayed at any stage. One common reason is in the failure of patients to attend clinic appointments. This cohort of patients has not been critically analysed with respect to the process of care and diagnosis of colorectal cancers. Furthermore, there is a lack of definitive guidance on the management of FTA patients, especially in colorectal clinics. We investigated this group of patients and analysed whether a management strategy could be devised.

Patients and Methods

This retrospective study, performed in our unit, involved FTA patients from 1996 to 2004. The study period spanned the introduction of the 'two-week wait' for suspected

colorectal cancer in 2000.¹ The list of FTA patients was entered prospectively into the hospital Patient Management System (PMS) for urgent colorectal clinics from 1996 to 2000 and for both urgent and 'two-week wait' clinics from 2000 onwards. Individual patient case-notes and hospital electronic records were cross-checked for the study. Data on patient demographics, number of FTAs in colorectal and other departments, numbers of re-appointments sent and outcomes were collected. The colorectal cancers identified in this cohort were looked at in detail to analyse possible reasons for FTA and tumour characteristics were also recorded. Statistical analysis was done using Statistical Programme for Social Science (SPSS v.12) using frequency tables and co-relational analysis.

Results

A total of 151 patients failed to attend their first appointment in colorectal urgent and 'two-week wait' clinics from 1996 to 2004. The mean age of patients in the FTA group was 57

Table 1 Sub-categorisation of FTA by type of clinic

	Number (%)	Urgent clinics 1996–1999	Urgent and 'two-week wait' clinics 2000–2004
Colorectal	61 (40.4)	11	50
General surgical	76 (50.3)	57	19
Notes unavailable	14 (9.3)	3	11
Total	151	71	80

years (range, 17–91 years), with a slight predominance of men (81 male). Of the 151 FTAs, 61 (40%) were colorectal referrals (Table 1). Prior to the introduction of the 'two-week wait', the majority of the FTA patients were booked into urgent general surgical clinics; after 2000, the majority were booked into the urgent and 'two-week wait' clinics (Table 1).

Of 61 colorectal FTA episodes, 34(56%) failed to attend on a single occasion. Forty patients were sent at least one re-appointment. The breakdown of number of failures to attend per patient is shown in Table 2.

Failure to attend other clinics

We noted an interesting observation of general tendency of FTA in this cohort of patients. Our data showed 59 colorectal FTA episodes were associated to 59 FTA episodes

Table 2 Number of FTA in colorectal referrals

Number of FTAs	Frequency	Percentage
6	1	2
4	1	2
3	6	10
2	19	31
1	34	55
Total	61

Figure 1 Scatter plot of FTA in colorectal clinics versus FTA in other clinics

in other clinics ($n = 19$) in the same cohort (scatter plot; Fig. 1) and it was found to be statistically significant (Pearson correlation coefficient; $r = 0.411$; $P = 0.01$, two-tailed).

Analysis of clinical outcomes in the colorectal FTA

Five patients (9%) of the FTA group subsequently presented with colorectal cancer. A further 16 patients (28%) have subsequently presented with benign colorectal pathology, and 2 (3%) patients with benign non-colorectal pathology (Table 3). None of the colorectal cancers presented as an emergency but were diagnosed via clinic re-appointments.

Table 3 Final diagnosis

Final clinical outcome	Frequency	Valid percentage
Benign non-colorectal	2	3.4
Colorectal cancer	5	8.6
Normal outcomes	12	20.7
Benign colorectal diagnosis	16	27.6
Persistent non-attender	23	39.7
Total	58	100.0

Only one patient with bleeding haemorrhoids was diagnosed through the emergency route.

The median delay for the five colorectal cancers was 21 days between first FTA appointment and the first clinical episode in secondary care (range, 21–48 days). However, median delay from first clinical episode to definitive diagnosis was longer at 46 days (range, 21–135 days), as two patients had failed to attend investigations. Three patients had tumour in sigmoid colon (Dukes' A, B, D), one in descending colon (Dukes' D) and one in rectum (Dukes' A). The presenting symptom was rectal bleeding in three patients (2 sigmoid and 1 rectal cancer), change in bowel habit to loose stools in one patient with descending colon tumour and abdominal pain in one patient with sigmoid colon cancer.

All of these patients responded to the second appointment offered to attend the hospital. Only one patient mentioned a definite reason for FTA (that they were too unwell to attend). Looking retrospectively and speculating the possible reasons for FTA in the other four colorectal cancers, only one patient was in the working age group and the others were retired. None of the five patients had any history of documented mental illness, of alcohol or drug abuse and none were infirm in the extremes of age.

Discussion

FTAs in clinics have a significant impact for the National Health Service (NHS). UK Department of Health statistics from 2003 have quoted a 10.6% FTA rate for first appointment in consultant-led clinics in England, in all specialties taken together.² The estimated cost in 1984 was felt to be as much as £266 million annually,³ equivalent to £1 million per trust.⁴ More recently, Department of Health figures indicate that as much as £360 million is wasted each year.⁵ FTA rates in colorectal clinics in our hospital were 4.7% for urgent clinics and 3% for fast-track clinics in this study period. This figure, though not as high as in some other specialties like geriatrics,⁴ certainly is a cause for concern, due to the risk of colorectal cancer in those who FTA.

Colorectal cancers were diagnosed in 5 of the 58 colorectal outcomes (9%) in our study. There is thus a significant risk of missing CRC in this FTA group, and a policy of pursuing them is required. The same applies to persistent non-attendeers, who constituted 40% of our colorectal FTA. The elderly are particularly prone to this (8 out of 23 persistent non-attendeers were over 60 years); taken with the increased chance of CRC, there need to be measures to persuade attendance in clinic or robust follow-up strategies in primary care.

An interesting observation for colorectal FTA was the significant positive correlation with the incidence of FTA in other clinics in the same cohort. A similar observation was made previously;⁵ this highlights the various psychological, social and administrative reasons for FTA and has been well described elsewhere.^{5–7}

Measures to reduce the tendency of patients to FTA have been described in various studies, including reminder letters and telephone calls,^{4,8} giving patients a copy of referral letter,⁹ or a nurse practitioner accompanying patients while booking appointments for tests;¹⁰ all successfully lowered FTA rates.

These measures would have to be incorporated in the setting of colorectal urgent and 'two-week wait' clinics to avoid undue delay in diagnosis of CRC in this group of patients. We have, in our hospital, a policy of sending repeat appointment for all FTAs in colorectal urgent and 'two-week wait' clinics. Further FTA results in a letter to the general practitioner to follow-up the patient in primary care. This policy, we feel, helped identification of the five colorectal cancer patients who, otherwise, might have been diagnosed much later.

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