DHA TELEHEALTH CLINICAL GUIDELINES

FOR VIRTUAL MANAGEMENT

OF RECTAL BLEEDING – 09

Version 2

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Health Policies and Standards Department

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INTRODUCTION

Health Regulation Sector (HRS) forms an integral part of Dubai Health Authority (DHA) and is mandated by DHA Law No. (14) of the year (2021) amending some clauses of law No. (6) of 2018 pertaining to the Dubai Health Authority (DHA), to undertake several functions including but not limited to:

- Developing regulation, policy, standards, guidelines to improve quality and patient safety and promote the growth and development of the health sector;
- Licensure and inspection of health facilities as well as healthcare professionals and ensuring compliance to best practice;
- Managing patient complaints and assuring patient and physician rights are upheld;
- Governing the use of narcotics, controlled and semi-controlled medications;
- Strengthening health tourism and assuring ongoing growth; and
- Assuring management of health informatics, e-health and promoting innovation.

The DHA Telehealth Clinical Guidelines aim to fulfil the following overarching DHA Strategic Priorities (2026):

- Pioneering Human-centered health system to promote trust, safety, quality and care for patients and their families.
- Make Dubai a lighthouse for healthcare governance, integration and regulation.
- Leading global efforts to combat epidemics and infectious diseases and prepare for disasters.

- Pioneering prevention efforts against non-communicable diseases.
- Become a global digital health hub.
- Foster healthcare education, research and innovation.

ACKNOWLEDGMENT

The Health Policy and Standards Department (HPSD) developed this Guideline in collaboration with Subject Matter Experts and would like to acknowledge and thank these health professionals for their dedication toward improving quality and safety of healthcare services in the Emirate of Dubai.

Health Regulation Sector

Dubai Health Authority

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EXECUTIVE SUMMARY

Telehealth is based on Evidence Based Practice (EBP) which is the conscientious, explicit and judicious use of current best evidence in making decisions about the care of the individual patient. It means integrating individual clinical expertise with the best available external clinical evidence and guidelines from systematic research.

EBP is important because it aims to provide the most effective care virtually, with the aim of improving patient outcomes. As health professionals, part of providing a professional service is ensuring that practice is informed by the best available evidence.

This guideline is presented in the format comprising of clinical history/symptoms, differential diagnosis, investigations and management. Identification of 'Red Flags' or serious conditions associated with the disease is an essential part of this telehealth guideline as it aids the physician to manage patients safely and appropriately by referrals to ER, family physicians or specialists for a face to face management.

Rectal bleeding is a very common symptom. It occurs in adults of all ages. Most cases of rectal bleeding are due to benign causes, particularly haemorrhoids and anal fissures. However, there are many other possible causes, some of which are sinister like colorectal cancer.

The likely aetiology depends on the age of the patient and the frequency of the underlying diseases in a given population. The initial assessment of the bleeding should include type and amount of the bleeding as well as the age of the patient. The age of the patient gives a clue to aetiology and as a result forms a part of referral guidelines. Those under the age of 30 presenting

with rectal bleeding are more likely to have haemorrhoids, anal fissure or inflammatory bowel disease. For those over the age of 50, there should be a higher suspicion of colorectal cancer.

DEFINITIONS/ABBREVIATIONS

Virtual Clinical Assessment: Is the evaluation of the patient's medical condition virtually via telephone or video call consultations, which may include one or more of the following: patient medical history, physical examination and diagnostic investigations.

Patient: The person who receives the healthcare services or the medical investigation or treatment provided by a DHA licensed healthcare professional.

ABBREVIATIONS

CEA	:	Carcinoembryonic Antigen
CT	:	Computed Tomography
DHA	:	Dubai Health Authority
EBP	:	Evidence Based Practice
ER	:	Emergency Room
FBC	:	Full Blood Count
GI	:	Gastrointestinal
LFT	:	Liver Function Test

1. BACKGROUND

1.1. Common causes of rectal bleeding

1.1.1. Benign anorectal disease:

a. Haemorrhoids

b. Anal fissure

c. Fistula-in-ano

1.1.2. Diverticular disease

1.1.3. Inflammatory bowel disease

1.1.4. Colonic polyps

1.1.5. Colorectal or anorectal cancer

1.2. Less common causes of rectal bleeding

1.2.1. Infectious gastroenteritis

1.2.2. Coagulopathies

1.2.3. Arteriovenous malformation (angiodysplasia)

1.2.4. Massive upper gastrointestinal (GI) bleeding

1.2.5. Radiation proctitis

1.2.6. Ischaemic colitis (mesenteric vascular insufficiency)

1.2.7. Solitary rectal ulcer • Endometritis

1.2.8. Meckle's diverticulum (in adults less often than children)

1.2.9. Rectal varices

1.2.10. GI tract invasion of non-GI tract malignancy

1.2.11. Trauma (possible sexual abuse)

1.2.12. Sexually transmitted infections

1.3. Risk Factors include:

1.3.1. Age > 50 years

1.3.2. Family history of colorectal cancer

1.3.3. Lack of physical activity

1.3.4. Low fiber diet / high fat diet

1.3.5. Smoking

1.3.6. Alcohol

2. SCOPE

2.1. Telehealth services in DHA licensed Health Facilities.

3. PURPOSE

3.1. To support the implementation of Telehealth services for patients with complaints of Rectal Bleeding in Dubai Health Authority (DHA) licensed Health Facilities

4. APPLICABILITY

4.1. DHA licensed physicians and health facilities providing Telehealth services.

4.2. Exclusion for Telehealth services are as follows

4.2.1. Emergency cases where immediate intervention or referral is required.

4.2.2. Prescribe Narcotics, Controlled or Semi-Controlled medications.

5. RECOMMENDATION

5.1. Virtual Clinical Assessment

5.1.1. In telemedicine consultation, physician should aim to:

a. Firstly, assess type and amount of the bleeding.

b. Secondly, narrow down the diagnosis; try to distinguish between a GI and non-GI cause.

c. Thirdly, decide whether referral or further investigations are required, and how urgently.

5.1.2. The history should be directed at confirming the diagnosis of scant rectal bleeding and at identifying potentially worrisome symptoms and risk factors

a. Anal pain during or after defecation - is usually due to anal fissures (but can also be present with rectal carcinoma as well as infectious causes such as herpes)

b. Pain associated with itching

c. The quantity and nature of bleeding

i. Fresh bright red blood usually comes from low down in the GI tract. Examples include fissures and haemorrhoids.

ii. Bright red blood, however, can also occur with pathology higher in the GI tract.

iii. Blood mixed in with the stool has usually originated higher in the GI tract.

5.1.3. The quantity of blood is very difficult to assess from the history, but it is important to obtain a description from the patient.

a. Change in bowel habit (both frequency of defecation and consistency of stool) must be recognised.

b. Systemic symptoms such as night sweats, fever, or weight loss (suggest malignancy or chronic infection or inflammation

c. Diarrhea preceding or accompanying passage of blood (suggests colitis)

d. Tenesmus (can be present with proctitis)

e. Nonspecific abdominal pain indicates a process that may include, but is not limited to, the rectum

f. Change in the frequency or caliber of stools is suggestive of colonic malignancy (The presence of these symptoms suggests that further evaluation should be performed).

g. A history of recent rectal trauma from medical procedures like transrectal prostate biopsy or from anal receptive intercourse (may suggest an obvious source of blood loss)

h. Medication history. This may identify causes of bleeding (for example, warfarin and aspirin).

i. Past medical history should consider previous gastrointestinal blood loss and investigations, as well as previously resected colon cancer or polyps.

j. A history of inflammatory bowel disease is important because these patients (after about eight years of disease) are at increased risk of colonic neoplasm.

k. A history of pelvic radiation therapy is noteworthy because radiation proctitis has been known to occur two to three years after therapy

l. Age is a major risk factor for colorectal cancer. It is a rare diagnosis before the age of 40; the incidence begins to increase significantly between the ages of 40 and 50, and age specific incidence rates increase in each succeeding decade thereafter.

m. Family history should be taken in detail to further stratify colorectal cancer risk and should include not only a history of confirmed colorectal cancers, but also a history of family members known to have colonic polyps or other malignancies that could be associated with familial colon cancer syndromes

n. Lifestyle, including physical activity, diet (high/low fiber diet), smoking and alcohol.

o. There are three classifications according to the amount of bleeding:

    i. Occult bleeding - presenting with anaemia.

ii. Moderate bleeding - presenting with rectal bleeding (fresh or dark), or melaena in a patient who is haemodynamically stable.

iii. Massive bleeding - presenting with large amounts of blood passed rectally (may be dark but often fresh). There may be element of hemodynamic instability/shock.

6. RED FLAGS

No individual feature or symptom associated with rectal bleeding is strongly predictive of the eventual cause being diagnosed as colorectal cancer. However, certain associated features do make this cause more likely. These include:

6.1. Weight loss

6.2. Age over 50

6.3. Change in bowel habit

6.4. Iron-deficiency anaemia

6.5. Blood mixed with stool

6.6. Rectal mass or abdominal mass

6.7. A strong family history of colorectal cancer

6.8. Massive bleeding

7. DIFFERENTIAL DIAGNOSIS

7.1. Hemorrhoids – Painless bleeding is usually associated with a bowel movement. Bright red blood typically coats the stool at the end of defecation. Blood may also drip into the toilet or stain toilet paper.

7.2. Anal fissures – Anal fissures are often diagnosed from the history. Affected patients describe a tearing pain with the passage of bowel movements. The passage of stool may be accompanied by bright rectal bleeding, usually limited to a small amount on the toilet paper or on the surface of stool. Some patients complain of an itch or perianal skin irritation.

7.3. Polyps – Polyps, including adenomatous polyps, are generally asymptomatic and are most often detected by colon cancer screening tests. Small adenomas do not typically bleed, but occult bleeding can occur; minimal bright red bleeding is more likely with distal polyps.

7.4. Proctitis – Patients with proctitis or proctosigmoiditis often present insidiously with intermittent rectal bleeding, passage of mucus, and mild diarrhea associated with fewer than four small loose stools per day.

7.5. Rectal ulcers – Rectal ulcers can present with bleeding, passage of mucus, straining during defecation, and a sense of incomplete evacuation

7.6. Cancer – The majority of patients with symptomatic colorectal cancer have hematochezia, abdominal pain, and/or a change in bowel habits.

7.7. Diverticulosis is a common finding on endoscopy in older adults but is generally an incidental finding in the workup of chronic minimal bright red bleeding per rectum, since diverticular bleeding is usually more acute and of greater volume

8. INVESTIGATIONS

8.1. The investigations chosen will depend on the mode of presentation and likely diagnosis. Unnecessary investigation should not delay referral where there is a high suspicion of malignancy.

8.1.1. Blood tests

a. FBC if bleeding is profound or anaemia suspected.

b. Ferritin and iron studies if iron-deficiency anaemia is suspected.

c. Clotting studies may be appropriate.

d. LFTs may be indicated if liver disease is suspected.

e. Faecal calprotectin is a useful screen in younger patients and has a high positive predictive value for finding inflammatory bowel disease at colonoscopy

8.2. There is no evidence that tumour markers such as carcinoembryonic antigen (CEA) are useful as diagnostic tools in this situation.

8.3. Further investigations are the domain of specialists. These may include the following:

8.3.1. Flexible sigmoidoscopy. This is the investigation of choice for younger patients where there is concern about pathology other than haemorrhoids,

or those who have persistent bleeding following treatment for haemorrhoids.

8.3.2. Colonoscopy. This is the definitive investigation where there is a high suspicion of malignancy, or a family history.

8.3.3. Virtual colonoscopy (computed tomography (CT) colonography). This method uses CT to examine the prepared, distended colon

9. MANAGEMENT

9.1. Refer to APPENDIX 1 for the Virtual Management of Rectal Bleeding Algorithm

9.2. In low risk patients with rectal bleeding who are not overly anxious, it is reasonable to manage their symptoms with treatment and adopt a 'watch and wait' policy. Minimally symptomatic haemorrhoids may be safely observed.

9.3. Patients with symptomatic haemorrhoids should be given

9.3.1. Advice to increase oral fluid intake

9.3.2. High fiber diet

9.3.3. Sitz baths - Sitz baths can relieve irritation and pruritus as well as spasm of the anal sphincter muscles. They should be used with warm, rather than cold water, two to three times per day

9.3.4. Topical / oral treatment

9.4. Topical treatment includes:

Benzocaine 5 to 20% rectal ointment - Sparingly up to six times per day • Proctoglyvenol cream - usually used 2 to 4 times daily, or after each bowel movement.

Dosage is based on patient medical condition and response to therapy

9.5. Oral:

Bulk-forming laxatives,– Methylcellulose - Initially 1 tablespoon (2 grams fiber) or 4 caplets (500 mg fiber per caplet) once per day; may increase to 1 tablespoon or 4 caplets three times per day

9.6. The prime objective of drug therapy as mentioned below is to control the acute phase (bleeding) so that definitive therapy can be scheduled at a convenient time.

Venoactive agents – Daflon - Usual Dose: 2 tablets daily in 2 divided doses, mid-day and evening at meal times. Acute Hemorrhoidal Attack: 6 tablets daily for the first 4 days, then 4 tablets daily for 3 days.

9.7. Acute anal fissure - may be treated with dietary advice and a bulking agent.

9.8. For more details, refer to DHA Telehealth Clinical Guidelines for Virtual Management of Anorectal Pain - 02

10. REFERRAL CRITERIA

10.1. Refer to Family Physician/Specialist

10.1.1. Weight loss

10.1.2. Age over 50

10.1.3. Change in bowel habit

10.1.4. Iron-deficiency anaemia

10.1.5. Blood mixed with stool

10.1.6. Rectal mass or abdominal mass

10.1.7. A strong family history of colorectal cancer

10.1.8. Based on NICE referral guidelines, patients with rectal bleeding should be referred to specialist in the following conditions:

a. Routine referral: Patients with low-risk and benign persistent or highly symptomatic haemorrhoids or fissures.

b. Urgent referral (within two weeks): Based on NICE Referral Guidelines for Suspected Cancer:

i. Aged ≥40 years with rectal bleeding and change in bowel habit towards looser and/or more frequent stools for 6 weeks or more

ii. Those aged ≥40 with unexplained weight loss and abdominal pain

iii. Those aged ≥50 with unexplained rectal bleeding

iv. Those aged ≥60 with anaemia, change in bowel habit

v. ≥60 years with rectal bleeding persisting for 6 weeks or more without change in bowel habit and without anal symptoms of rectal bleeding and a palpable rectal mass

vi. Those whose tests have been positive for occult blood in their faeces

10.1.9. Refer to ER

- Massive bleeding

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APPENDIX 1 – VIRTUAL MANAGEMENT OF RECTAL BLEEDING ALGORITHM