



Non-Acute Lower GI Bleeding

The Primary Care Blueprint for
Risk Stratification & Management

**Clinical Decision-Support
Playbook** | Adapted from
Med2Date Australian Guidelines

The Primary Care Paradox: Identifying the deadly minority within the benign majority.

**30-40%
Haemorrhoids**

>40% Diverticular Disease
in ages >65

Colorectal Cancer (CRC)

2nd leading cause of cancer mortality in Australia.

~15,500 annual cases.



Clinical Pearl: In Australian practice, rectal bleeding in any patient aged ≥ 50 years should be considered colorectal cancer until proven otherwise. Do not attribute bleeding solely to haemorrhoids without investigation.

Is the patient haemodynamically stable?

ACUTE (Immediate Transfer)

Tachycardia >100 bpm

Systolic BP <100 mmHg

Postural drop ≥ 20 mmHg
or Syncope

ACTION: Emergency transfer for hospital-based endoscopy or interventional radiology.

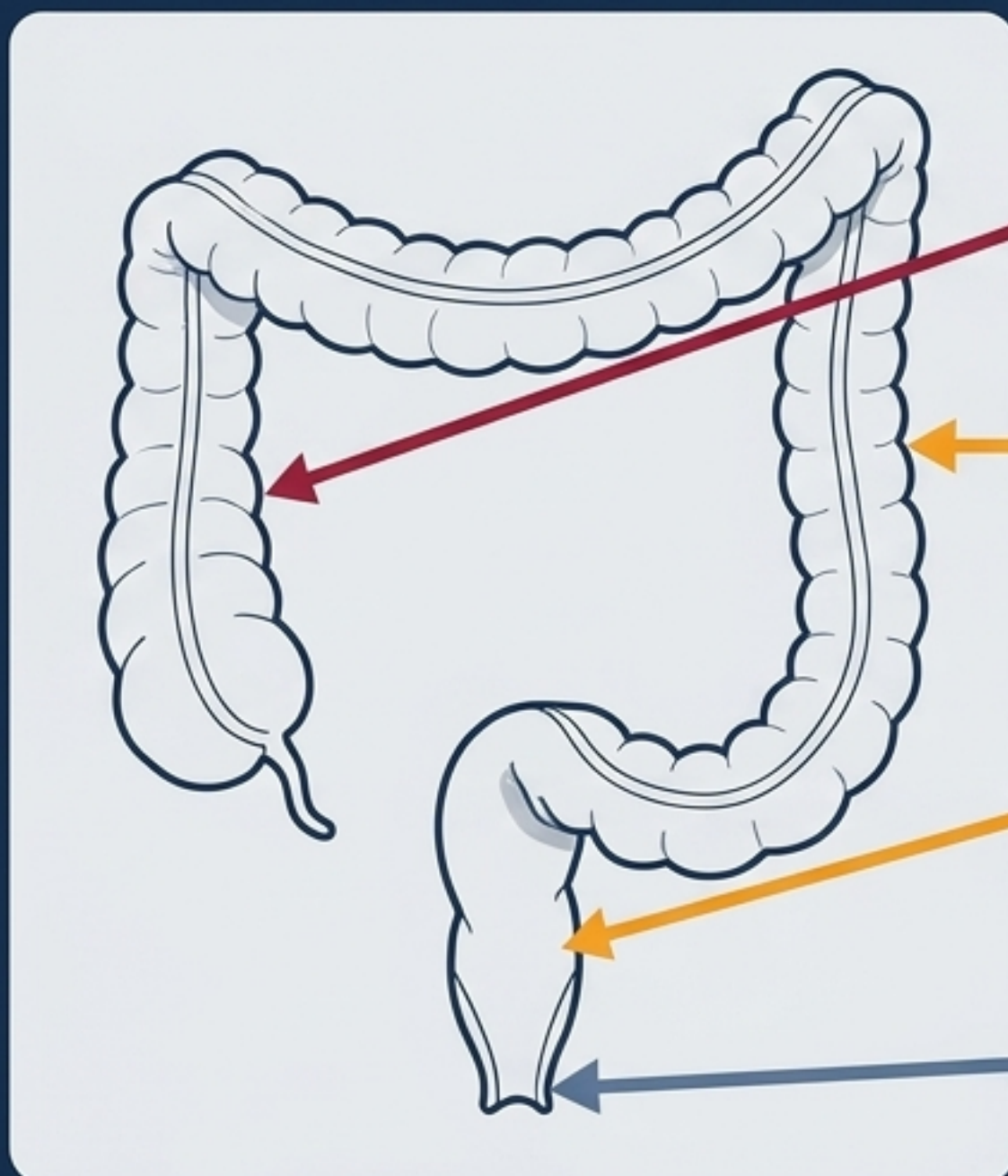
NON-ACUTE (This Deck)

Normal vitals & no acute postural symptoms

Intermittent, self-limiting bleeding episodes

ACTION: Proceed to Primary Care Risk Stratification.

Anatomical Patterns of Lower GI Bleeding



Right / Proximal Colon

Visual: Dark red/maroon mixed with stool.

Likely: Angiodysplasia, right-sided CRC.

Left Colon

Visual: Bright red mixed in stool or water.

Likely: Diverticular, IBD, left-sided neoplasia.

Anorectal / Distal Rectum

Visual: Bright red on formed stool surface.

Likely: Internal haemorrhoid, polyp, proctitis.

Distal Anal Canal

Visual: Bright red on paper only.

Likely: Fissure, external haemorrhoid.



Clinical Pearl: Occult blood only (FIT positive, no visible bleeding) can originate from ANY colonic site and requires NBCSP pathway investigation.

The Alarm Features: Non-Negotiable Fast-Track Triggers



Age Matrix

≥45 years with recurrent/mixed bleeding, OR ≥50 years with new-onset bleeding.



Iron Deficit

Any unexplained Iron Deficiency Anaemia.



Weight Loss

Unintentional loss of >5% body weight in 6 months.



Bowel Habit

New constipation, diarrhoea, or alternating pattern lasting >6 weeks.



Palpation

Palpable abdominal or rectal mass.



Genetics

First-degree relative with CRC diagnosed at <60 years.



Bowel Habit

First-degree relative with CRC diagnosed at <60 years.



Red Flag: The presence of a known benign condition (like haemorrhoids) does NOT negate these alarm features. Patients with changing bleeding patterns require complete re-evaluation.

Primary Care Risk Stratification Triage

Low Risk

Profile: Age <45, bright red blood on paper/surface only, no anaemia, stable.

Action: Manage conservatively in primary care. Refer if persisting >4-6 weeks.

Moderate Risk

Profile: Recurrent or mixed bleeding, mild fatigue, age 45-49, or FIT positive via NBCSP.

Action: Semi-urgent specialist outpatient colonoscopy (within 4-6 weeks).

High Risk

Profile: Any Alarm Feature present.

Action: Fast-track cancer pathway. Urgent colonoscopy (within 2 weeks).

The Focused Clinical History Workup



Bleeding Profile

Duration, volume (drops vs splashing), color, relationship to defaecation, presence of mucus or pus.



Bowel Habit

New constipation or diarrhoea, narrow ribbon-like stools, straining, nocturnal symptoms indicating organic disease.



Risk Factors

Personal or family history of CRC, polyps, or IBD. Dietary check (e.g., beetroot, red food dye).



Medications

Anticoagulants (DOACs, warfarin), Antiplatelets, NSAIDs. (Note: These exacerbate bleeding but do not explain the underlying cause).

Clinical Pearl: A mandatory Digital Rectal Examination (DRE) must follow the history. However, a normal DRE does not exclude significant proximal pathology.



Pathology Request Form



FBC (MBS 65070)

Assess for **anaemia** (Hb <120 g/L males, <110 g/L females).
Microcytic = iron deficiency; **Normocytic** = chronic disease/acute loss.



Serum Ferritin (MBS 66800)

<30 µg/L is highly suggestive of iron deficiency.
<15 µg/L is diagnostic.
*Note: Acute-phase reactant, interpret with CRP.



Iron Studies (MBS 66812)

Transferrin saturation <20% confirms deficiency.
Crucial if ferritin is equivocal.



Inflammatory Markers
(CRP MBS 65085)

Evaluates for IBD or **infective colitis**.
Elevated CRP + bleeding requires further workup.



Red Flag: Ferritin under 30 µg/L demands action, even if flagged as 'normal' by the laboratory reference range.



ACTION: Requires mandatory **Bidirectional Endoscopy** (Gastrosocopy + Colonoscopy) AND Oral/IV Iron Replacement.

Context: In men and postmenopausal women, this combination is the ultimate red flag. While menstrual blood loss is common in premenopausal women, it may mask coexisting GI pathology.

The Role of FIT: Untangling the Pathways

NBCSP Screening Pathway (Asymptomatic)

Patient: Asymptomatic, age 50-74.

Role of FIT: Primary screening tool
(Sensitivity ~70-75%).

Action on Positive: Refer for colonoscopy.

Symptomatic Patient Pathway (Rectal Bleeding Present)

Patient: Visible rectal bleeding at any age.

Role of FIT: DOES NOT replace colonoscopy.
A negative FIT does not rule out CRC.
A positive FIT only reinforces urgency.

Action: Proceed directly to colonoscopy
based on age/alarm features. Do not wait for
a screening FIT.



Clinical Pearl

FIT may assist triage in cases of minor, intermittent bleeding with clinical uncertainty, where a high result ($>100 \mu\text{g Hb/g}$) supports urgent scoping.

The Primary Care Toolkit: First-Line Management of Benign Causes



Paracetamol (Analgesia)

Dose: 500–1000 mg PO
QID PRN (max 4 g/day).

Renal adjustment: eGFR
<10 max 1 g/day.



PBS General Benefit



Ferrous Sulfate (Oral Iron)

Dose: 325 mg (105 mg
elemental) PO
daily/alternate-day.

Advice: Take on empty
stomach with Vitamin C.

Duration: 3–6 months.



PBS General Benefit



Topical Relief (Lignocaine 5% / Hydrocortisone 1%)

Lignocaine: Applied TDS
PRN.

Hydrocortisone:
Suppositories BD.

Limit: Max duration 7 days
to prevent skin atrophy.



PBS General Benefit

Lifestyle & Conservative Measures



Dietary Fibre

Target 25–30 g/day of soluble/insoluble fibre.
Psyllium husk (e.g., Metamucil) recommended.



Hydration

Target ≥ 1.5 –2 L of water daily to ensure softening of the stool.



Toilet Ergonomics

Avoid prolonged straining.
Use a footstool to optimize the anorectal angle.
Respond promptly to the urge.



Clinical Pearl

Warm water Sitz baths (10–15 mins post-defaecation) significantly reduce anal sphincter spasm and promote fissure healing.

Age-Specific Referral Pathways: Triage for Rectal Bleeding

OVERRIDE RULE:

Presence of **ANY alarm feature** (IDA, weight loss, mass, family history) overrides age and forces immediate **Urgent Fast-Track Referral**.

Age <45

Single episode, clear anorectal cause on DRE. Manage conservatively. Safety-net and refer if recurrent.



Age 45-49

Rising incidence of early-onset CRC. Refer for Semi-Urgent Colonoscopy (4-6 weeks) even if likely benign.



Age ≥50

New-onset rectal bleeding. Requires Urgent Fast-Track Referral (within 2 weeks).



Clinical Pearl

Timely referral based on age and override criteria is crucial for early detection and improved outcomes in colorectal cancer.

What Goes in the Referral?

- Bleeding History:** Volume, character, frequency, relationship to defaecation.
- Examination Findings:** Mandatory DRE results, abdominal palpation, vital signs.
- Investigation Results:** FBC, Ferritin, Iron Studies, CRP, and FIT (if performed).
- Risk Factors:** Family history of CRC, IBD, anticoagulant/antiplatelet use.
- Urgency Classification:** Explicitly state 'Fast-track (2 weeks)' or 'Semi-urgent (4-6 weeks)' based on alarm features.

Clinical Pearl: Access varies widely. Utilize local HealthPathways, and in rural/remote areas, look for telehealth and fly-in/fly-out endoscopy services.

Special Populations: Clinical Variations Matrix



Paediatrics

Rare CRC. Suspect fissures, cow's milk allergy, juvenile polyps, IBD. Use Faecal Calprotectin (MBS 66817).



Pregnancy

Haemorrhoids in 35-40%. DRE is safe. Avoid scoping. Aggressive oral iron is first-line; IV iron (Authority Required) if severe.



Elderly (≥65)

Higher procedural risk; consider CT colonography. DOACs/anticoagulants require specialist input before cessation.



Renal Impairment

Avoid NSAIDs. Use PEG-based bowel prep. IV iron often preferred due to poor oral absorption.



Hepatic / Immunocompromised

Correct coagulopathy prior to biopsy. Lower threshold for scoping due to atypical presentations (e.g., CMV, masked signs).



Clinical Pearl: Correct classification of risk factors in special populations guides appropriate management, from conservative measures to specialist referral, avoiding unnecessary procedures.

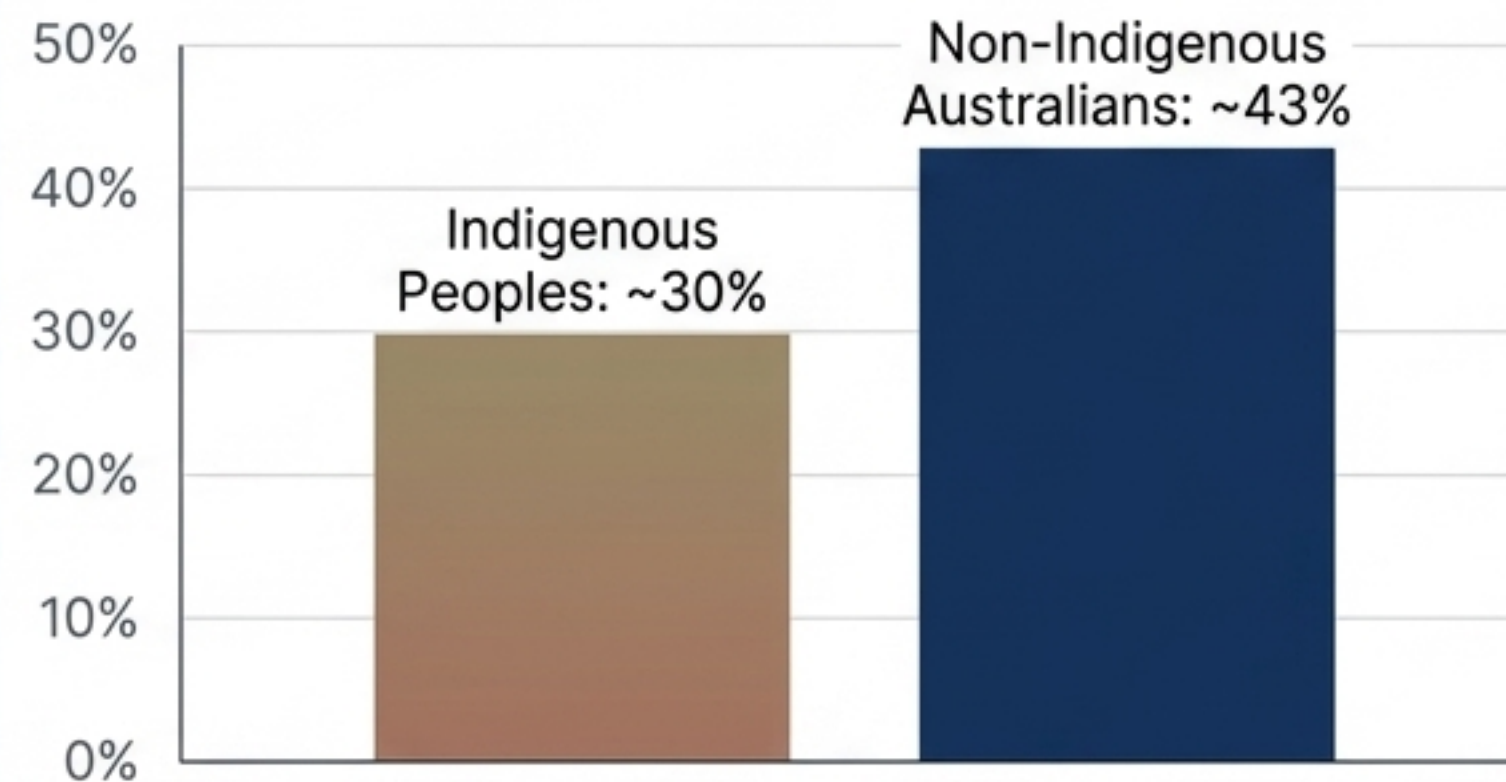
Aboriginal & Torres Strait Islander Health: The Clinical Gap

The Clinical Burden

Indigenous Australians face a disproportionate burden of CRC, often diagnosed at a younger age and later stage, driving higher mortality rates.

Systemic Barriers: Lack of culturally appropriate materials, historical distrust, competing chronic disease priorities, and geographic isolation.

The Screening Gap (NBCSP Participation)



Clinical Pearl: Rectal bleeding may be normalized or stigmatized in community. Routine health checks must actively destigmatize and initiate these conversations.

Aboriginal & Torres Strait Islander Health: Proactive Clinical Action

Step 1: Routine Integration

Initiate bowel health discussions proactively during MBS Item 715 (health assessments).

Step 2: Community Partnership

Collaborate with Aboriginal Health Workers and ACCHOs to build trust and ensure culturally safe consent.

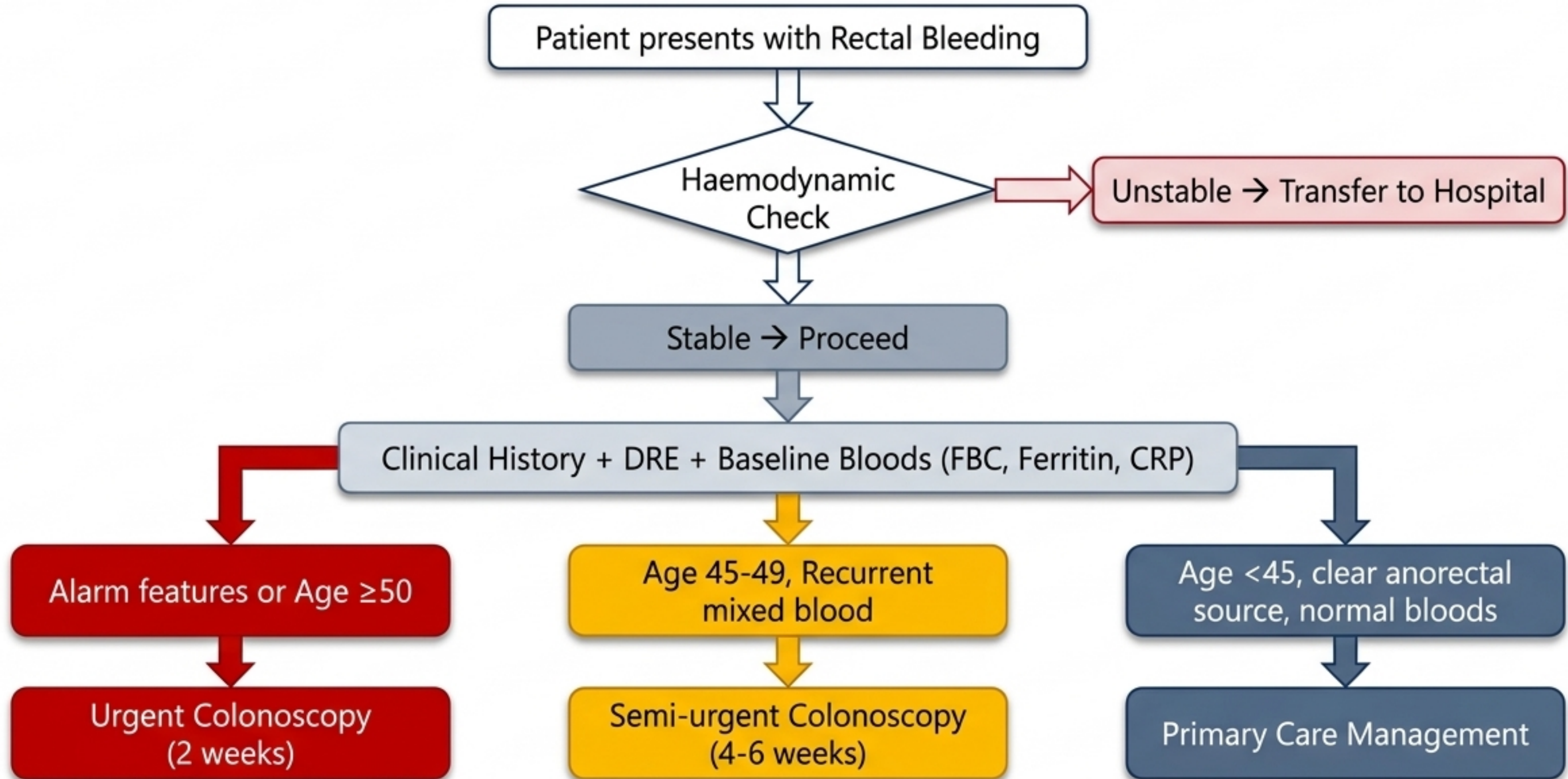
Step 3: Overcoming Geography

Utilize Telehealth for follow-up and advocate for ring-fenced colonoscopy access to reduce wait times.

Step 4: Holistic Follow-up

Integrate GI investigations into broader chronic disease management plans (MBS 721/723).

Master Algorithm: Rectal Bleeding Triage Pathway



Closing the Loop: Mandatory Safety-Netting Protocols

1 The Timeline Rule

All conservatively managed patients must have a scheduled follow-up within 4-6 weeks to confirm symptom resolution.

2 The Volume Rule

Return immediately if bleeding increases in volume, frequency, or fails to stop.

3 The Color Rule

Return immediately if bright red blood changes to dark red, maroon, or black (melaena), indicating a **proximal colonic shift**.

4 The Systemic Rule

Return immediately if new systemic symptoms develop (e.g., dizziness, extreme fatigue, abdominal pain, weight loss).

Source Material & Guidelines

Adapted from Lower GI Bleeding (Non-acute) – Med2Date Clinical Guidelines (2026).

RACGP Guidelines for preventive activities in general practice (Red Book).

GESA Colonoscopy Clinical Care Standards.

Cancer Council Australia Colorectal Cancer Guidelines.

AIHW Epidemiology & Aboriginal and Torres Strait Islander Health Reports (2023).