**Faecal calprotectin 'Top Tips'**

**Indication for use**

* For patients where cancer is **not** suspected
* To differentiate irritable bowel syndrome (IBS) from inflammatory bowel disease (IBD)
* Recent but not acute onset symptoms
* Adult patients

**Do not use where cancer is possible**

>40 years with unexplained weight loss and abdominal pain

>50 years with unexplained rectal bleeding

>60 years with iron deficiency anaemia or change in bowel habit or positive faecal occult blood

Please see the NICE guidance for full details: <https://www.nice.org.uk/guidance/ng12/chapter/1-Recommendations-organised-by-site-of-cancer#lower-gastrointestinal-tract-cancers>

**What does the test do?**

* It identifies a neutrophil protein. It’s presence in stool *suggests* GI inflammation.
* It does not diagnoses IBD
* It’s main utility is the negative predictive value
* NSAIDs commonly lead to a raised level
* Other possible causes of raised levels include
  + Infection
  + Drug effects
  + Diverticular disease
  + Polyps
  + Cancer

**Suggested top tips**

* **Do not** use;
  + For patients who meet cancer referral criteria
  + For upper GI symptoms
  + For anaemia
  + In patients over 50
  + In acute diarrhoea
* **Do** 
  + Use the first bowel action in the morning to reduce intra-individual variability
  + Testing should occur within 3 days of the sample being produced
  + Test to exclude inflammatory bowel disease where irritable bowel syndrome is suspected
  + Use Rome criteria to diagnose IBS <https://pathways.nice.org.uk/pathways/irritable-bowel-syndrome-in-adults>
* In patients who meet diagnostic criteria for IBS but IBD is suspected
  + <50µg/g does not need further investigation
  + 50-200µg/g should have a repeat test in 2-4 weeks, ideally off NSAIDs
  + >200µg/g OR persistent levels 50-200µg/g should be referred to secondary care
* Refer patients where you suspect a serious diagnosis
* **Be aware** the following will also increase Calprotectin
  + NSAIDs
  + Diverticular disease
  + Infection
  + Polyps and cancer

**What should I do if the result is negative but I am still concerned that the patient may a have serious underlying disease?**

If clinical suspicion for IBD remains high or an alternative serious diagnosis is being entertained then referral is still indicated.

**Local audit results** (retrospective, 183 patients undergoing primary care calprotectin testing)

* 20% met suspected colorectal cancer referral criteria
  + Recommend using the cancer referral pathways
* 54% of patients with positive results (>100) were referred to secondary care
  + Recommend referring patients with levels >100
* 28% of patients with indeterminate results (50-100) had repeat tests
  + Recommend repeating tests after 2-4 weeks
* 20% of patients with persistently indeterminate results were referred
  + Recommend referring patients with persistently indeterminate levels
* 9% of patients with negative results were referred
  + These patients are not likely to need further investigation but can be seen for management of their symptoms when needed