ENDOSCOPY REFERRAL GUIDELINES

This guidance does not override the individual responsibility of health professionals to make appropriate decision according to the circumstances of the individual patient in consultation with the patient and /or carer. Health care professionals must be prepared to justify any deviation from this guidance.

INTRODUCTION

These guidelines are for clinicians to make appropriate referral for endoscopic procedures. The aim is to avoid unnecessary risk and to provide high quality care. Appropriate referral also makes best use of available resources for those who can benefit from the investigation.

These guidelines are for in-patient and out-patient referral to WAHT endoscopy units.

THIS GUIDELINE IS FOR USE BY THE FOLLOWING STAFF GROUPS:
All GPs referring patients to the endoscopy unit's at Worcestershire Acute Hospitals NHS Trust.
All medical staff at WRH, Alexandra Hospital and Kidderminster Treatment Centre

Lead Clinician(s)

Dr Simon Hellier	Consultant Gastroenterologist
3 month extension approved by Accountable director on:	7th July 2015
Extension approved on:	6th December 2017
Review Date: This is the most current document and is to be used until a revised version is available:	6th November 2020

Key Amendments

December 2017	Document extended for 3 months as per TLG recommendation	TLG
March 2018	Document extended for 3 months as approved by TLG	TLG
June 2018	Document extended for 3 months as approved by TLG	TLG
17th October 2020	Document extended for 6 months whilst new BSG Guidelines are published	Loraine Mahachi
6th May 2020	Document extended for 6 months during COVID period	

ENDOSCOPY REFERRAL GUIDELINES

INTRODUCTION

Performing an unnecessary investigation puts the patient at unnecessary risk and is wasteful of resource. Hence for invasive investigations, such as endoscopy, referral guidelines are designed to improve the appropriateness of referral to aid diagnosis, reduce risk to patients and ensure resources are used appropriately and therefore reduce waiting times for patients who need the procedure. These guidelines make recommendations about appropriate referrals for Upper GI endoscopy, colonoscopy, ERCP and PEG insertion. They also include a management algorhythmn for dyspepsia in the under 55s, an investigation algorhythmn for iron deficiency anaemia, local policy on anticoagulation and endoscopy, and local endoscopy surveillance protocols.

For patient information sheets please refer to link
http://sysdev1/consentformsupplements/supplementdocs.aspx

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UPPER GI ENDOSCOPY REFERRAL GUIDELINES

These guidelines are to help clinicians to make appropriate referral for upper GI endoscoppy. The aim is to provide high quality care and avoid unnecessary risk. Appropriate referral also makes best use of available resources for those who can benefit from the investigation.

Special precautions are needed for patients taking **clopidogrel and warfarin** (see guidelines – pages 14-15) who are at risk of bleeding if therapy is performed; it is essential to discuss management with the endoscopy unit at least two weeks before planned procedures.

Indications for Upper GI Endoscopy

Emergency (within 24 hours)

- Haematemesis +/- melaena
- Bolus obstruction

Urgent (within 2 weeks)

- Dyspepsia WITH alarm symptoms or signs
- Upper abdominal mass
- Abnormal Barium Study/CT
- Persistent vomiting.
- Dysphagia / odynophagia.
- Recent GI blood loss (haematemesis, melaena).
- Unexplained **iron deficiency** anaemia[1] (see algorhythmn – page 17)
- Unexplained weight loss (over 3 kg)
- First follow up after oesophageal varices banding

Routine (within 6 weeks or defined interval)

- Dyspepsia WITHOUT alarm symptoms **> 55 years**
- Oesophageal varices - surveillance in cirrhotics (annual)
  - banding programme
- Barrett's surveillance[2] (2 yearly – see local guidelines, page 18)
- Gastric ulcer healing (6 weeks)
- Small bowel biopsies

Diagnostic Upper GI Endoscopy is generally not indicated for:

- Investigation of dyspepsia in patients aged < 55 years with no alarm symptoms[3]
- Reflux oesophagitis with no alarm symptoms
- Investigation of chest pain

Other indications for Therapeutic Upper GI Endoscopy:

- Insertion and removal of PEGs
- Insertion of Naso-jejunal feeding tubes
- Dilatation of oesophageal strictures
- Dilatation of pyloric and duodenal strictures
- Palliative stenting of oesophageal malignancies
- Palliative stenting of pyloric and duodenal malignancies

For patient information sheets please refer to link
http://sysdev1/consentformsupplements/supplementdocs.aspx

Upper GI Endoscopy Monitoring Tool

- Adherence to 2WW guidelines
- Adherence to local guidelines on management of dyspepsia in patients < 55 years
- Adherence to local guidelines for Barrett's surveillance
- Adherence to investigation of iron deficiency anaemia policy

How will monitoring be carried out?

Annual audit of appropriateness of upper GI endoscopy referral using these guidelines as a standard

Who will monitor compliance with the guideline?

Endoscopy Users Group

STANDARDS	%	CLINICAL EXCEPTIONS
Endoscopy referral guidelines	100	

COLONOSCOPY AND FLEXIBLE SIGMOIDOSCOPY REFERRAL GUIDELINES

These guidelines are to help clinicians to make appropriate referral for colonoscopy. The aim is to provide high quality care and avoid unnecessary risk. Appropriate referral also makes best use of available resources for those who can benefit from the investigation.

Patients having colonoscopy require full bowel preparation. This must be taken into consideration for elderly patients or those with co-morbidity who may require in-patient care.

Special precautions are needed for patients taking **clopidogrel and warfarin** (see guidelines – pages 14-15) who are at risk of bleeding if therapy is performed; it is essential to discuss management with the endoscopy unit at least two weeks before planned procedures.

Referral Criteria and Timing for Colonoscopy in Symptomatic Patients

Emergency (within 24 hours)
Emergency referrals for consideration of colonoscopy are rare and should be discussed with Consultant gastroenterologist or colorectal surgeon.

Indications include:

- Treatment of bleeding from such lesions as vascular malformation, ulceration, neoplasia, and polypectomy site (e.g., with electrocoagulation, heater probe, laser or injection therapy).
- On-going melaena after an upper GI source has been excluded at endoscopy.

Urgent (within 2 weeks)
Investigation for suspected colorectal cancer (Summary of NICE 2005[4])

Sign, symptom or combination	**Age threshold**
A right lower abdominal mass consistent with involvement of the large bowel.	All ages
A palpable intraluminal rectal (not pelvic) mass on PR examination.	All ages
*Unexplained iron deficiency anaemia: ▪ In men (Hb < 11 g/dl and non-menstruating women (Hb <10g/dl). ▪ In pre-menopausal women ▪ In pre-menopausal women with lower GI symptoms, a strong family history of colorectal cancer (one affected first degree relative < 45 years old, or two affected first degree relatives).	All ages Over 50 years Less than 50 years
Rectal bleeding persisting for 6 weeks or more.	Over 60 years

Change in bowel habit to looser stools and/or more frequent stools persisting for 6 weeks or more WITHOUT rectal bleeding.	Over 60 years
Rectal bleeding WITH a change in bowel habit towards looser stools and/or increased stool frequency persisting 6 weeks or more.	40 years and older
For evaluation of an abnormality on barium enema or other imaging study, which is likely to be clinically significant, such as a filling defect or stricture suggesting malignancy.	All ages
Metastatic adenocarcinoma of unknown primary site in the absence of colonic signs or symptoms when colonoscopic findings of a tumour will influence management and choice of chemotherapy.	All ages

Patients aged less than 40 years with rectal bleeding and a change in bowel habit towards looser stools/and or increased stool frequency do not usually need urgent referral. A family history of colorectal cancer or inflammatory bowel disease (IBD) or severe symptoms with abnormal baseline blood tests (to suggest IBD) may prompt urgent referral.

Routine (within 6 weeks)

- Investigation of unexplained chronic diarrhoea (6 weeks or more) without rectal bleeding in those between 45 and 60 years.
  (In patients under 45 years the yield of flexible sigmoidoscopy and colonic biopsy is not substantially different from colonoscopy. Flexible sigmoidoscopy is the preferred investigation for functional bowel disease in patients with chronic diarrhoea and atypical symptoms).
- Patients aged less than 40 years with rectal bleeding **and** a change in bowel habit towards looser stools/and or increased stool frequency in whom there is no family history of colorectal cancer or inflammatory bowel disease (IBD) and without severe symptoms or abnormal baseline blood tests (to suggest IBD).
- Chronic inflammatory bowel disease of the colon if more precise diagnosis or determination of the extent of activity of disease will influence management[5].

Screening Colonoscopy (see summary BSG Colorectal Screening and Surveillance guidelines[6] – page 23)

- Family history of CRC (see West Midlands Family Cancer Strategy – http://www.bwhct.nhs.uk/genetics-wmfacs-home.htm)
- Familial adenomatous polyposis
- Juvenile polyposis
- HNPCC

Surveillance Colonoscopy (see summary BSG Colorectal Screening and Surveillance guidelines[6] – page 23)

- After removal of colorectal adenomatous polyps (see local guidelines – page 20)
- Post resection of colonic carcinoma (see local guidelines – page 20)
- Inflammatory Bowel Disease (see local guidelines – page 22)

- Acromegaly 5 yearly from 40 years[6]

Diagnostic colonoscopy is generally not indicated in the following circumstances:

- Chronic, stable, irritable bowel syndrome or chronic abdominal pain
- Acute diarrhoea
- Metastatic adenocarcinoma of unknown primary site, in the absence of colonic signs or symptoms, when it will not influence subsequent management.

- Routine follow-up of inflammatory bowel disease (except for cancer surveillance in chronic ulcerative colitis).
- Upper GI bleeding or melaena with a demonstrated upper GI source
- Constipation (infrequent passage of hard formed stools) is not an indication for colonoscopy.
- Alternating constipation and diarrhoea is rarely a symptom of organic colonic disease.

Therapeutic Colonoscopy is generally indicated for:

- Bleeding from such lesions as vascular malformation, ulceration, neoplasia, and polypectomy site
- Foreign body removal
- Excision of colonic polyps
- Decompression of acute non-toxic megacolon or sigmoid volvulus
- Balloon dilatation of stenotic lesions
- Palliative treatment of tumours
- Marking of a tumour or vascular malformation for surgical localisation

Colonoscopy is generally contraindicated in the following circumstances:
Contraindications are relative – please discuss in case of doubt. Patients unfit for colonoscopy are also likely to be unfit for CT pneumocolon or barium enema (both of which require bowel preparation). If significant large bowel pathology that will affect their management is suspected, an unprepared CT is the investigation of choice.

- Severe acute colitis[5]. (An unprepared flexible sigmoidoscopy is acceptable in this situation)
- Acute diverticulitis.
- Suspected or confirmed perforated viscus
- Colonic obstruction.
- Severe cardiorespiratory disease.
- Large abdominal aortic aneurysm
- Myocardial infarction within 6 weeks

Indications for Flexible Sigmoidoscopy

Flexible Sigmoidoscopy is generally indicated as a diagnostic procedure for:

- Evaluation of suspected distal colonic disease when there is no indication for colonoscopy
- Evaluation of the colon in conjunction with barium enema
- Evaluation for anastomotic recurrence in rectosigmoid carcinoma
- Investigation of acute diarrhoea
- Surveillance 10 years post uretero-sigmoidostomy then annual (BSG guidelines 2002)

Flexible Sigmoidoscopy is generally not indicated:

- When diagnostic colonoscopy is indicated

Flexible Sigmoidoscopy is generally contraindicated for:

- Severe acute diverticulitis

For patient information sheets please refer to link
http://sysdev1/consentformsupplements/supplementdocs.aspx

Colonoscopy and Flexible Sigmoidoscopy Monitoring Tool

- Adherence to BSG polyp follow up protocol
- Adherence to cancer follow up protocol
- Adherence to 2WW criteria for suspected CRC
- Adherence to local IBD surveillance guidelines
- Adherence to screening guidelines for patients with a family history of CRC

How will monitoring be carried out?

Annual audit of appropriateness of colonoscopic referrals using these guidelines as a standard.

Who will monitor compliance with the guideline?

Endoscopy Users Group

STANDARDS	%	CLINICAL EXCEPTIONS
Endoscopy Referral Guidelines	100	

ERCP REFERRAL GUIDELINES

These guidelines are to help clinicians to make appropriate referral for ERCP. The aim is to provide high quality care and avoid unnecessary risk. Appropriate referral also makes best use of available resources for those who can benefit from the investigation. Patients referred for ERCP should be discussed with Mr Lake, Dr Hudson or Dr Gee

Special precautions are needed for patients taking **clopidogrel and warfarin** (see guidelines – pages 14-15) who are at risk of bleeding if therapy is performed; it is essential to discuss management with the endoscopy unit at least two weeks before planned procedures.

Indications for ERCP

ERCP may be indicated in the following clinical situations:

- Bile duct stones
- Bile duct obstruction (often due to tumour)
- Post-operative Bile Duct Injury
- Chronic pancreatitis
- Cholangiocarcinoma
- Ampullary Cancer
- Pancreatic pseudocyst
- Primary sclerosing cholangitis
- Sphincter of Oddi dysfunction

ERCP Interventions

- Endoscopic sphincterotomy
- Clearance of common bile duct stones
- Mechanical lithotripsy of large common bile duct stones
- Biliary stenting (plastic / metallic endoprostheses)
- Pancreatic sphincterotomy
- Pancreatic stenting for ruptured pancreatic duct / pancreatic pseudocyst formation and main pancreatic duct strictures in patients with chronic pancreatitis with pain and/or pancreatic exocrine insufficiency

ERCP is rarely a diagnostic procedure alone; most diagnoses can now be made by non-invasive methods. Prior imaging by ultrasound and/or CT scan is essential. MR may also be required.

Patients for ERCP should have a haematology screen, liver biochemistry (including serum amylase and ALT) and clotting studies.

Patient Preparation

- Nil by mouth for six hours
- Intravenous access (preferably in the right hand or arm)
- Check full blood count and INR one day prior to procedure
- If INR>1.3, give either
  2 units of FFP one hour prior to the procedure

Or 10mg Menadiol orally 24 hours prior to procedure
keep well-hydrated by intravenous infusion
check INR on day of procedure.

- Stop anti-platelet therapy at least 7 days before the procedure if possible. The risks of bleeding if anti-platelet therapy is not stopped must be balanced against the risks of postponing the procedure.
- Valid consent with sufficient time to ask questions and consider the risks is essential.
- Hospital notes, drug charts, relevant CT scans and ultrasound films should be sent to the Endoscopy Unit with the patient. Patient allergies should be clearly documented.
- Diabetics to be managed as per ERCP information sheet.

Post-Operative Care

- Quarter-hourly observations for the first hour, then half-hourly observations for the next two hours, then hourly observations for six hours.
- Sips orally until patient is completely awake from procedure
- Patients undergoing pancreatic endotherapy may need to remain on clear fluids until the following day.

For patient information sheets please refer to link
http://sysdev1/consentformsupplements/supplementdocs.aspx

ERCP Monitoring Tool

How will monitoring be carried out?

Annual audit of appropriateness of ERCP referral using these guidelines as a standard

Who will monitor compliance with the guideline?

Endoscopy Users Group

STANDARDS	%	CLINICAL EXCEPTIONS
Endoscopy referral Guidelines	100	

PEG REFERRAL GUIDELINES

Introduction

Enteral tube feeding should be considered for any patient who is unable to meet nutritional requirement through the oral route and has a functioning gastro intestinal tract. This may be either through a nasogastric (NG) tube or PEG. However the benefits of artificial feeding are not established in patients with severe dementia[8], terminal illness or multiple co-morbidities. In such situations careful consideration of long term prognosis by a multidisciplinary team may be beneficial.
An initial period of feeding through a nasogastric (NG) tube should be considered first. NG feeding is less invasive and technically less demanding to place than a PEG. Problems with NG feeding include tube displacement, accidental or intentional removal by the patient, irritation of the nose by the tube and aspiration. Compared with NG feeding a PEG is more invasive but is less likely to be accidentally removed or displaced and is more comfortable to the patient.

Recommendations for PEG

- Refer all patients who require enteral nutritional support for more than 4 weeks in whom NG feeding is inappropriate due to failure or patient choice.
- Refer to dieticians and speech and language therapists.
- Referring team should discuss the pros and cons with the competent patient.
- In the case of patients who are unable to give informed consent, relatives, carers and appropriate multidisciplinary team should be involved in the decision making. The referring Consultant should sign the first part of the appropriate consent form.
- Drugs: Warfarin should be discontinued at least for 5 days prior to the procedure and INR checked on the day should be <1.4[9]. In patients at high risk of thromboembolisation consider heparin according to local peri-operative anticoagulation recommendations
- Antibiotic prophylaxis: Patients should be given co-amoxiclav 1.2 gm IV 30 minutes before the procedure[9] or gentamicin 120mg IV if penicillin allergic (local microbiology guidance), unless they require antibiotic prophylaxis for endocarditis when the appropriate regime should be used. Patients with MRSA should be treated with ‘Staph pack’ for 5 days prior to the procedure and given gentamicin 120mg IV 30 minutes prior to the procedure (local microbiology guidance).

For patient information sheets please refer to link
http://sysdev1/consentformsupplements/supplementdocs.aspx

PEG Monitoring Tool

How will monitoring be carried out?

Annual audit of appropriateness of PEG referral using these guidelines as a standard

Who will monitor compliance with the guideline?

Endoscopy Users Group

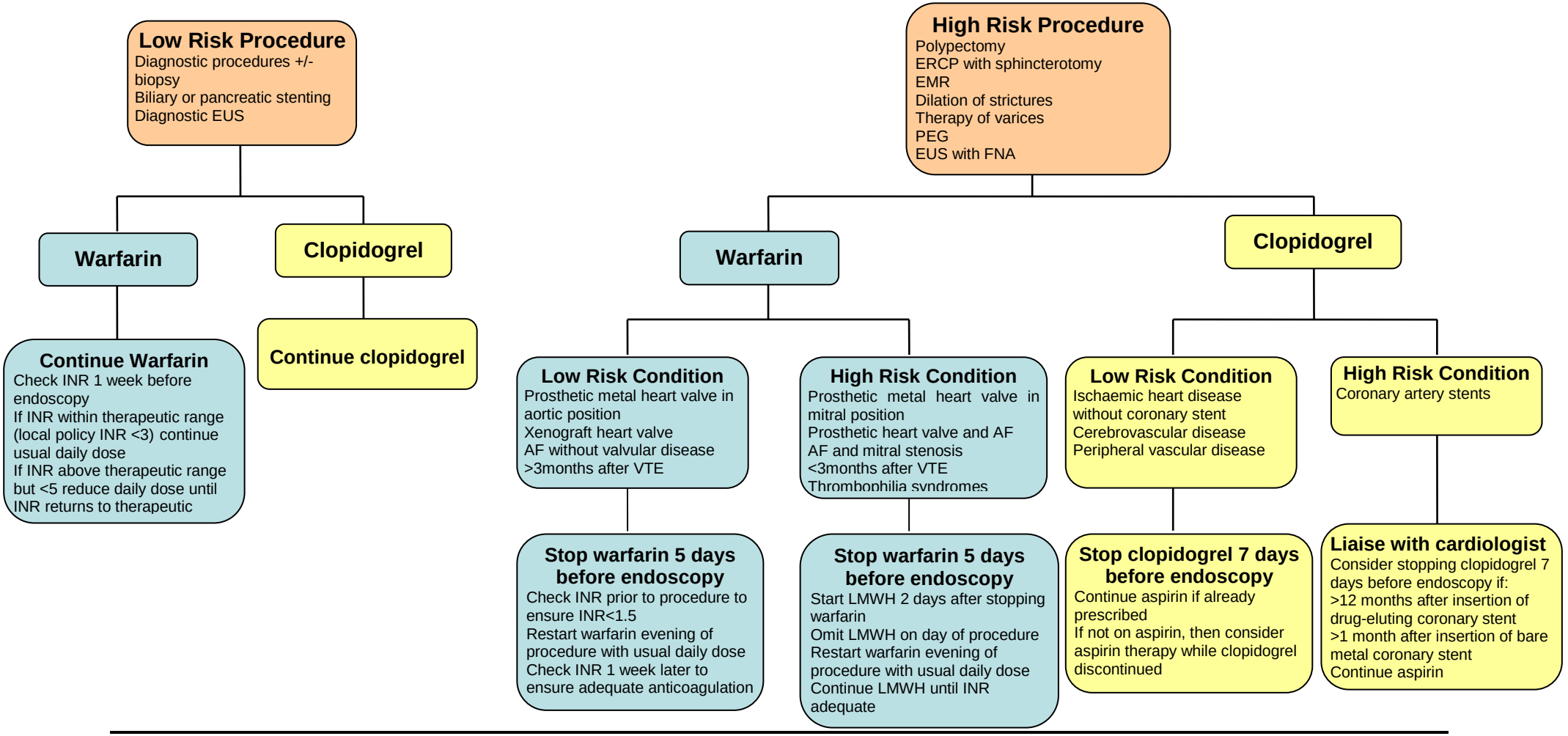
STANDARDS	%	CLINICAL EXCEPTIONS
Endoscopy referral Guidelines	100	

REFERENCES

1. BSG – Guidelines for the management of Iron Deficiency Anaemia http://www.bsg.org.uk/pdf_word_docs/iron_def.pdf
2. BSG - Guidelines for the Diagnosis and Management of Barrett's Columnar-lined Oesophagus http://www.bsg.org.uk/pdf_word_docs/Barretts_Oes.pdf
3. NICE Dyspepsia Management Guidelines http://www.nice.org.uk/page.aspx?o=218377
4. NICE Colorectal Cancer Service Guidance (CSG) http://www.nice.org.uk/page.aspx?o=204541
5. BSG - Guidelines for the Management of Inflammatory Bowel Disease http://www.bsg.org.uk/pdf_word_docs/ibd.pdf
6. BSG - Guidelines for Colorectal Cancer Screening in High Risk Groups http://www.bsg.org.uk/bsgdisp1.php?id=ab8a8ed1bba2f071607f&h=1&sh=1&i=1&b=1&m=00023
7. Nutrition Support for Adults Oral Nutrition Support, Enteral Tube Feeding and Parenteral Nutrition - Published by the National Collaborating Centre for Acute Care at The Royal College of Surgeons of England, 35-43 Lincoln's Inn Fields, London, WC2A 3PE , Commissioned by NICE 2006
8. Percutaneous endoscopic gastrostomy and outcome in dementia. Am. J. Gastroenterol. 2001 Sep;96(9):2556-63
9. BSG - Guidelines on complications of endoscopy 2006

A complete list of BSG guidelines can be found at **http://www.bsg.org.uk/bsgdisp1.php?id=87d6c937c883a1bf5f2a&h=1&m=00023**

Appendix 1.1 Guidelines for the management of patients on warfarin or clopidogrel undergoing endoscopic procedures



(EUS: endoscopic ultrasound, ERCP: endoscopic retrograde cholangiopancreatography, EMR: endoscopic mucosal resection, PEG: percutaneous endoscopic gastroenterostomy, FNA: fine needle aspiration, INR: international normalised ratio, AF: atrial fibrillation, VTE: venous thromboembolism, LMWH: low molecular weight heparin)

APPENDIX 2 - Upper GI Endoscopy

Appendix 2.1 - Local Guidelines on Management of Dyspepsia in Patients < 55 years

Following local implementation of the national guidelines on management of dyspepsia 'Dyspepsia: managing adult patients in primary care' (www.nice.org.uk./CG027) it has been agreed with the relevant Primary Care Trusts that patients with uncomplicated dyspepsia who fall outside the current guidelines for endoscopy should not undergo Upper GI endoscopy unnecessarily.

The full text of recommendations is available on the website but in summary:

- Endoscopic investigation of patients under the age of 55 years, presenting with dyspepsia and no alarm signs, is not necessary.

Interventions for un-investigated dyspepsia:

- Lifestyle advice including healthy eating, weight reduction and smoking cessation is appropriate.
- Advice patients to avoid known precipitants of dyspepsia where possible.
- Offer empirical full dose PPI therapy for 1 month in patients with dyspepsia
- Offer *H pylori* test (using faecal antigen test) and treat to patients with dyspepsia
- If symptoms recur after initial strategies, step down PPI therapy to lowest dose required to control symptoms. Encourage patients to use treatment on a 'on demand' basis (taking therapy when symptoms occur) to manage their own symptoms.
- Offer H2 Blockers or prokinetic therapy if there is an inadequate response to PPI therapy.

Reviewing patient care:

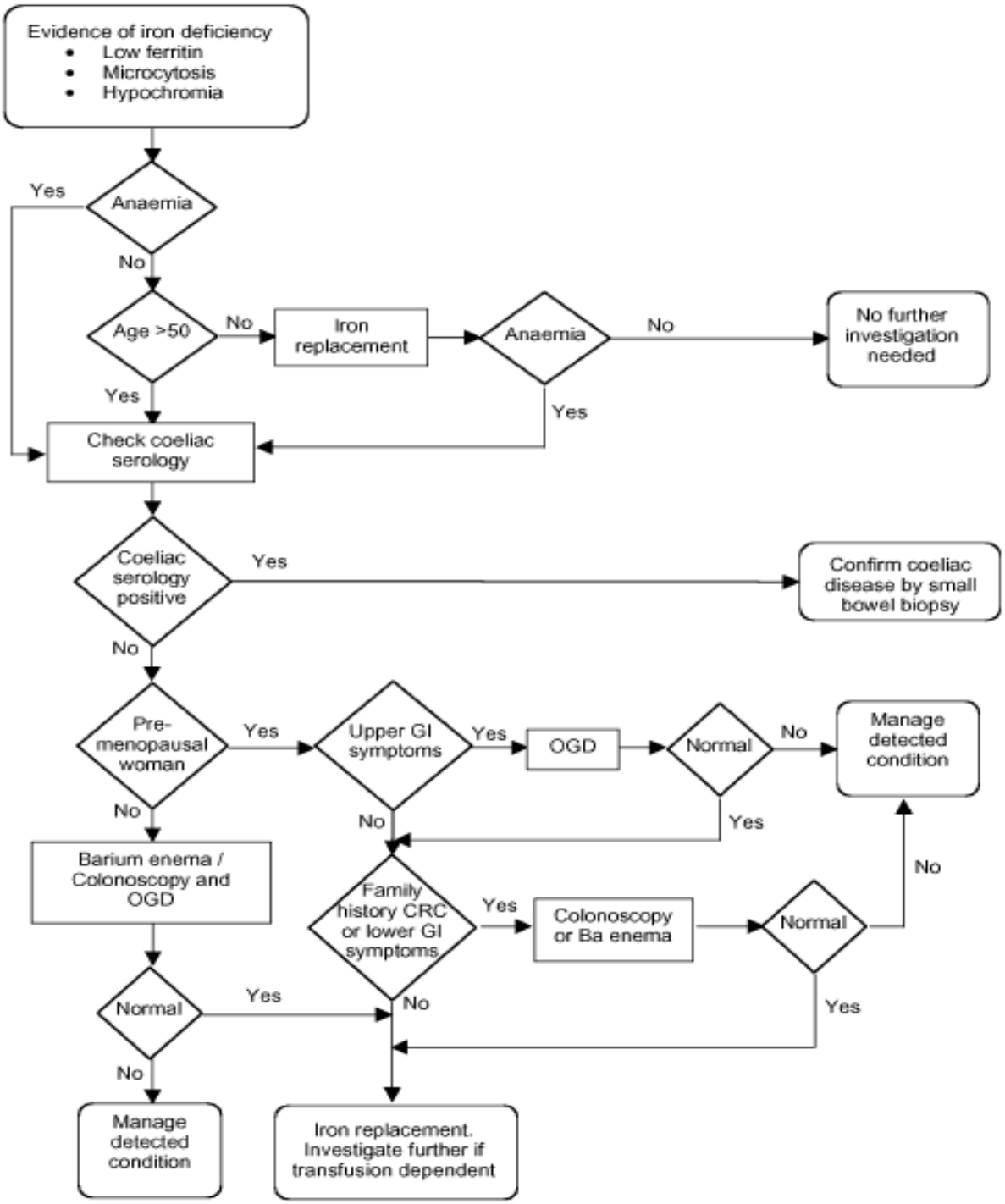
- Patients requiring long-term management of symptoms of dyspepsia should be offered an annual review of their condition and encouraged to try stepping down or stopping treatment.
- A return to self treatment with antacid/or alginate therapy taken as required may be appropriate.
- Simple lifestyle advice, including healthy eating, weight reduction and cessation of smoking is appropriate.
- Advice patients to avoid known precipitants of their dyspepsia where possible.
- Endoscopic investigation of patients under the age of 55 years for inadequate therapeutic response is not necessary, in the absence of alarm symptoms.

Please contact the Gastroenterology Department if you wish to redirect your referral for an outpatient consultation.

Endorsed by County wide Endoscopy Users Committee January 2006

Appendix 2.2- Algorhythmn for Management of Iron Deficiency Anaemia (BSG guidelines 2005)

Full guidelines can be found on the BSG website



Appendix 2.3 - Local Guidelines for Surveillance Endoscopy for Barrett's Oesophagus (December 2006)

Screening

- No evidence for screening endoscopy in patients with GORD.

Surveillance

- Should be offered to anyone under the age of 75 with Barrett's who is fit and willing to undergo oesophagectomy, regardless of length of Barrett's segment and the presence or absence of intestinal metaplasia. Surveillance >75 should be at the discretion of the endoscopist after discussion with the patient.

- When surveillance is considered appropriate, it should be performed every 2 years. (Recommendation grade C).

- In surveillance endoscopy, quadrantic biopsies should be taken every 2cm in the columnar segment together with biopsies of any visible lesion. (Recommendation grade C).

Dysplasia

- Indefinite
  - Early re-evaluation + multiple biopsies following PPI
  - Repeat OGD + biopsies at 6months
  - If definite dysplasia not found then routine surveillance

- Low-grade
  - Re-biopsy after intensive acid suppression for 8-12 weeks
  - If persists, surveillance should be 6 monthly for as long as it remains stable
  - If apparent regression occurs on 2 consequent examinations, surveillance intervals may be increased to 2 yearly

- High-grade
  - Confirmed by 2 separate expert pathologists
  - If persists after intensive acid suppression oesophagectomy in a specialised unit is currently recommended in patients considered fit for surgery. If unfit for surgery, endoscopic ablation or mucosal resection should be considered (Recommendation grade C).

Appendix 2.4 - Upper GI 2 Week Wait Proforma

URGENT REFERRAL FOR SUSPECTED UPPER GI CANCER

If you wish to include an accompanying letter, please do so. On completion please **FAX** to the **Cancer Referral Centre - 01562 754312 or 01562 513021**

These forms should only be used for suspected cancer and in conjunction with the NICE Referral Guidelines for Suspected Cancer, June 2005

Have you informed the patient there is a suspicion of cancer? YES ☐ NO ☐

Please tick the corresponding box for preferred appointment location:

Alexandra Hospital		**Worcestershire Royal Hospital**		**Kidderminster Hospital**		**Evesham Community Hospital**	

Patient Details	**GP Details (inc Fax Number)**
Surname Forename D.O.B. Gender Address Postcode Telephone NHS No Interpreter required Yes/No (Delete as applicable) Language	Date of Decision to Refer **Date Referral Faxed** **GP Signature**

Referral information: (Tick relevant box)

ENDOSCOPY - Symptoms for urgent referral:

With or without dyspepsia and:		**Dyspepsia and:**	
Dysphagia	☐	Chronic gastrointestinal bleeding	☐
Epigastric mass	☐	Iron deficiency anaemia	☐
Persistent vomiting	☐	Suspicious barium meal/CT/USS	☐
Progressive unintentional weight loss	☐	>55 with unexplained persistent, recent onset*	☐

**** Recent onset means NEW and not a recurrence of previous dyspepsia***
Persistent defined as longer than expected (usually >6 weeks)
Unexplained after history/GP investigations

OUT PATIENT - Symptoms for urgent Upper GI / gastroenterology referral:

Jaundice (Jaundice clinic where available)	☐
Upper abdominal mass	☐

Consider in worsening dyspepsia and:

Barrett's oesophagus	☐
Known dysplasia, atrophic gastritis, intestinal metaplasia	☐
Peptic ulcer surgery > 20 years ago	☐

Clinical Details

History/Examination/Investigations……

……

Medication ……

For 2ww office use only:

Date Fax Received:		Appointment Date/Time/Site/Consultant:	

Revised November 2006 – THIS FORM **MUST** BE USED FROM 1.1.07 ONWARDS

APPENDIX 3 – Colonoscopy

Appendix 3.1 - Local Guidelines for Colonoscopic Surveillance after removal of Colorectal Adenomatous Polyps and Carcinoma of the Colon (December 2006)

Risk of colorectal cancer and adenomas with advanced pathology **(>1 cm or severely dysplastic**). Risk can be stratified according to findings at baseline and refined at each subsequent surveillance examination. **(Recommendation Grade B)**

- Low risk: Patients with only 1–2, small (<1 cm) adenomas
  Recommendation: no follow up if over 75 years or five yearly until one negative examination.

- Intermediate risk: Patients with 3–4 small adenomas or at least one >1 cm
  Recommendation: three yearly until two consecutive negative examinations.

- High risk: If either of the following are detected at any single examination (at baseline or follow up): >5 adenomas or >3 adenomas at least one of which is >1 cm. **Or with histology showing a villous component or severe dysplasia.**
  Recommendation: An extra examination should be undertaken at 12 months before returning to three yearly surveillance.

Stopping surveillance due to comorbidity or age

The cut off age for stopping surveillance is usually 75 years, but should also depend upon patient wishes and comorbidity. **(Recommendation Grade C)**

Incomplete Examinations

Patients with failed colonoscopies, for whatever reason, should undergo repeat colonoscopy or an alternative complete colon examination. These guidelines are based on accurate detection of adenomas; otherwise risk status will be underestimated.

Large sessile lesions

- Large sessile adenomas removed piecemeal should be re-examined at three months.
- Small areas of residual polyp can be retreated endoscopically, with a further check for complete eradication in three months.
- If extensive residual polyp is seen, open surgical resection needs to be considered.
- If there is complete healing of the polypectomy site, then there should be a sigmoidoscopy or colonoscopy at one year before returning to three yearly surveillance.
- India ink tattooing aids recognition of the polypectomy site at follow up.

Colonoscopic surveillance after resection of ca colon

1. Colonoscopy within 12 months of resection if pre-operative assessment incomplete

2. It is recommended that a “clean” colon is examined by colonoscopy five years after surgery and thereafter at five yearly intervals up to the age of 70 years.
   (Recommendation Grade B)

If adenomas found then surveillance as per adenoma guidelines

Appendix 3.2 - BSG Algorhythmn for Polyp Surveillance

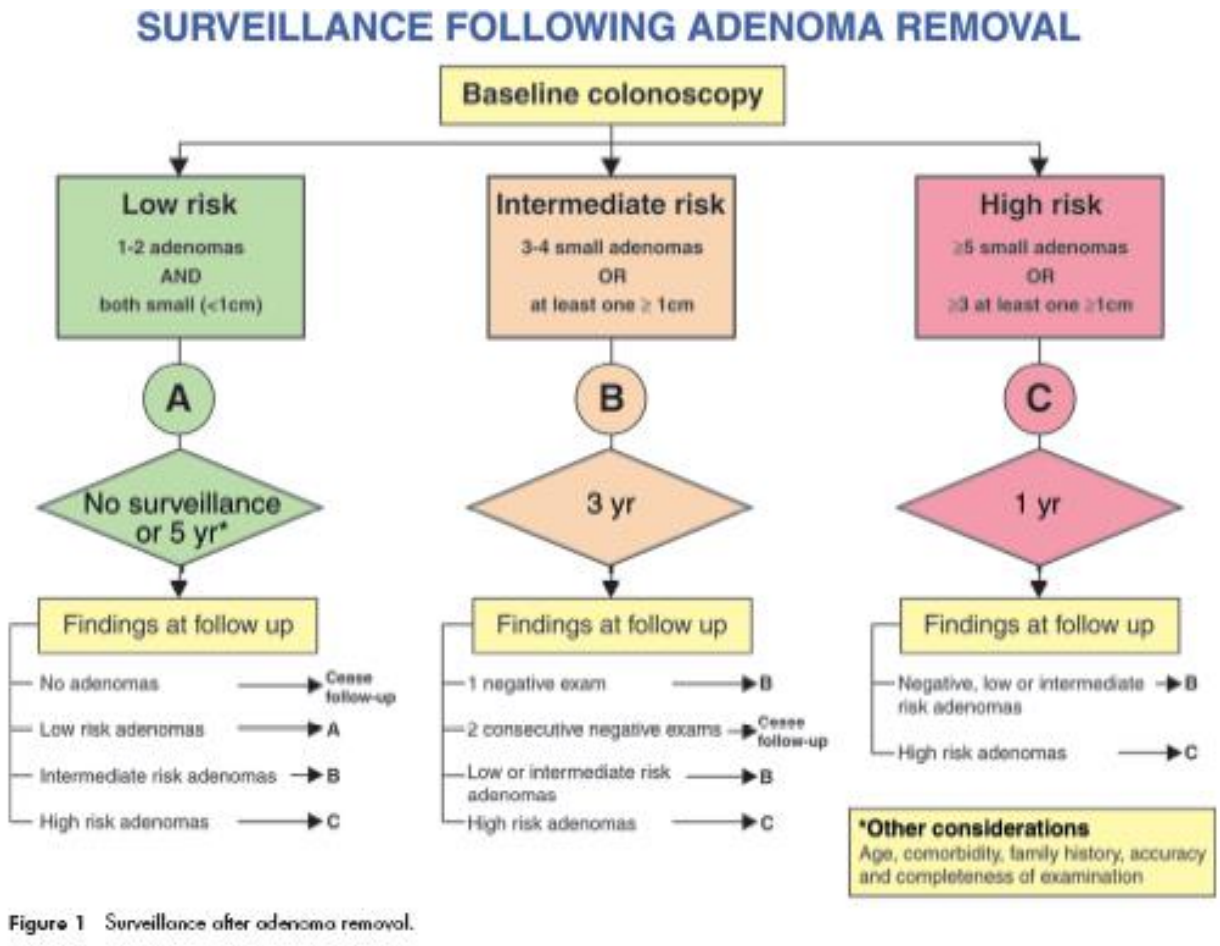


Figure 1 Surveillance after adenoma removal.

Appendix 3.3 - Local Guidelines for Surveillance for Colonic Carcinoma in Inflammatory Bowel Disease (December 2006)

1. Surveillance colonoscopies should be performed when the disease is in remission. (Recommendation Grade: C).

2. All patients should have a screening colonoscopy after 8–10 years that will also clarify disease extent. (Recommendation Grade: C).

3. Regular surveillance should begin after 8–10 years (from onset of symptoms) for pancolitis and after 15–20 years for left sided disease. (Recommendation Grade: C).

4. For patients with pancolitis, in the second decade of disease a colonoscopy should be conducted every three years, every two years in the third decade, and yearly by the fourth decade of disease. (Recommendation Grade: C).

5. Four random biopsy specimens every 10 cm from the entire colon should be taken with additional samples of suspicious areas. (Recommendation Grade: C).

6. Patients with primary sclerosing cholangitis (including those with an orthotopic liver transplant) represent a subgroup at higher risk of cancer and they should have annual colonoscopy. (Recommendation Grade: C).

Appendix 3.4 - Summary of BSG Colorectal Screening and Surveillance Guidelines

Summary of recommendations for colorectal cancer screening and surveillance in high risk groups

Disease groups	Screening procedure	Time of initial screen	Screening procedure and interval	Annual procedures 300 000 population
Colorectal cancer	Consultation, LFTs and colonoscopy	Colonoscopy within six months of resection only if colon evaluation pre-op incomplete	Liver scan within two years post-op Colonoscopy five yearly until 70 years	175
Colonic adenomas				
Low risk 1–2 adenomas, both <1 cm	Colonoscopy	No surveillance or five years	Cease follow up after negative colonoscopy	
Intermediate risk 3–4 adenomas, OR at least one adenoma ⩾1 cm	Colonoscopy	Three years	Every three years until two consecutive negative colonoscopies, then no further surveillance	
High risk ⩾5 adenomas or ⩾3 with at least one ⩾1 cm	Colonoscopy	One year	Annual colonoscopy until out of this risk group then interval colonoscopy as per Intermediate risk group	
Large sessile adenomas removed piecemeal	Colonoscopy or flexi-sig (depending on polyp location)	Three monthly until no residual polyp; consider surgery		
Ulcerative colitis and Crohn's colitis	Colonoscopy + biopsies every 10 cm	pan-colitis eight years left-sided colitis 15 years from onset of symptoms.	Colonoscopy 3 yearly in second decade, 2 yearly in third decade, subsequently annually	46
IBD + primary sclerosing cholangitis +/– OLT	Colonoscopy	At diagnosis of PSC	Annual colonoscopy with biopsy every 10 cm	6
Uretero-sigmoidostomy	Flexi Sig	10 yrs after surgery	Flexi Sig annually	3
Acromegaly	Colonoscopy	At 40 years	Colonoscopy 5 yearly	1

Family groups	Lifetime risk of death from CRC	Screening procedure	Age at initial screen (y)	Screening procedure and interval	Annual procedures/ 300 000 population
Familial adenomatous Polyposis (FAP) and variants (refer to clinical geneticist)	1 in 2.5	Genetic testing Flexi Sig + OGD	Puberty	Flexi Sig 12 monthly. Colectomy if +ve	6
Juvenile polyposis and Peutz-Jegher (refer to clinical geneticist)	1 in 3	Genetic testing Colonoscopy + OGD	Puberty	Flexi Sig 12 monthly. Colectomy if +ve	6
At risk HNPCC* , or more than 2 FDR (refer to clinical geneticist). Also documented MMR gene carriers	1 in 2	Colonoscopy +/– OGD	Aged 25 or five years before earliest CRC in family. Gastroscopy at age 50 or five yrs before earliest gastric cancer in family.	Two yearly colonoscopy and gastroscopy	48
2 FDR with colorectal cancer	1 in 6	Colonoscopy	At first consultation or at age 35–40 years whichever is the later	If initial colonoscopy clear then repeat at age 55 years.	23
1 FDR <45 y with colorectal cancer	1 in 10	Colonoscopy	At first consultation or at age 35–40 years whichever is the later	If initial colonoscopy clear then repeat at age 55 years.	12

OLT, orthoptic liver transplant; IBD, inflammatory bowel disease; FAP, familial adenomatosis polyposis; HNPCC, hereditary non-polyposis colorectal cancer; FDR, first degree relative (sibling, parent or child) with colorectal cancer; OGD, oesophageo-gastroduodenoscopy.
*The Amsterdam criteria for identifying HNPCC are: three or more relatives with colorectal cancer; one patient a first degree relative of another; two generations with cancer; and one cancer diagnosed below the age of 50.
The above family groups are for a minimum number of affected relatives - life-time risk rises with additional affected relatives in other generations and with younger onset of disease.
These Guidelines assume complete colonoscopy, if incomplete then either immediate DCBE or planned repeat colonoscopy.
N.B. Family history may be falsely negative.
People with symptoms suggestive of colorectal cancer or polyps should be appropriately investigated; they are not candidates for screening.
This summary has been compiled by S Cairns and J H Scholefield.

Appendix 3.5 - Lower GI 2 Week Wait Proforma

URGENT REFERRAL FOR SUSPECTED COLORECTAL CANCER

If you wish to include an accompanying letter, please do so. On completion please FAX **to the** Cancer Referral Centre 01562 754312 or 01562 513021

These forms should only be used for suspected cancer and in conjunction with the NICE Referral Guidelines for Suspected Cancer, June 2005

Have you informed the patient that this is a suspected cancer referral? YES ☐ NO ☐

It is essential that the patient is aware they are being referred as a suspected cancer, if the tick boxes are not completed the form may be returned

Please tick the corresponding box for preferred appointment location:

Alexandra Hospital		**Worcestershire Royal Hospital**		**Kidderminster Hospital**		**Evesham Community Hospital**	

Patient Details	GP Details (inc fax number)
Surname Forename D.O.B. Gender Address Postcode Telephone NHS No Interpreter required Yes/No (Delete as applicable) Language	Date of Decision to Refer **Date Referral Faxed** **GP Signature**

Do not use this form for patients who do not meet the criteria. Please use a routine letter

6 weeks rectal bleeding > 60 years ☐ _____

6 weeks change in bowel habit (looser stools/ increased stool frequency) > 60 years ☐ _____

6 weeks bleeding and change of bowel habit (looser stools/ increased stool frequency) > 40 years ☐ _____

Right sided abdominal mass ☐ _____

Rectal mass ☐ _____

Unexplained iron deficiency anaemia (<11g males and <10g in post menopausal females) ☐ _____

Clinical Details

History/Examination/Investigations……

Medication ……

For 2ww office use only:

Date Fax Received:		Appointment Date/Time/Site/Consultant:	

Revised November 2006 – THIS FORM **MUST** BE USED FROM 1.1.07 ONWARDS

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