Endoscopy Unit
Referral & Vetting Guidelines for Endoscopic Procedures

1. **New referrals**

Inpatient referrals

- All inpatient referrals are to be made on the electronic Endoscopy request form and sent to the Endoscopy Scheduling team. All Bronchoscopy, ERCP, and complex Endoscopy Procedures must first be discussed and agreed, with an Endoscopy Consultant prior to booking. There needs to be evidence of that discussion.

- Please note the patient selection criteria for each procedure (Appendix 1)

- All inpatient referrals are graded by a Consultant Gastroenterologist before booking unless requested by a Consultant Gastroenterologist, Upper GI or Colorectal surgeon

- Requests for urgent in- patient Gastroscopy must be discussed with an Endoscopy Consultant or Endoscopy Sister or Deputy on the day the procedure is required – please see the Upper GI Bleed protocol for further information

Outpatient referrals

- Direct access requests for OGD can be accepted only from the NWS CCG RSS (North West Surrey Clinical Commissioning Group Referral Support Service) where they are clinically triaged according to agreed protocols. These OGDs can be booked directly by the booking team with urgency as indicated on the form with no further clinical triage.

- All other GP requests for Endoscopy are scanned to the Referral Tracker System and will be reviewed daily by the consultant who will authorise the appropriate referral pathway.

- Referrals from clinic should be made on the Endoscopy Request form including indications, co-morbidities (and NPSA for bowel preparation for colonoscopy for patients over 60 or patients with a relevant clinical history).

- Endoscopy procedures should only be booked where results will have a significant impact on patient management.

- Colonoscopy patients may only be booked if the patient is able to comfortably tolerate full bowel preparation and mobilise from supine to lateral during the procedure.

- All referrals will be vetted for appropriateness against the BSG referral guidelines, on a daily basis, by Endoscopy Staff, before appointments are booked. Incomplete forms or inappropriate referrals will be returned to the requesting team.

2. **Surveillance patients**

- All surveillance patients are clinically and administratively vetted to make sure that the repeat procedure is still required and that the indications meet the BSG guidelines on surveillance for high risk groups and the Adenoma follow up protocol. The Scheduling Team vet the administrative side of the referral. A specialist Doctor or Nurse will lead on any clinical issues and may contact the patient for relevant up-date information.

Appendix 1 - Endoscopy Unit policy regarding patient selection criteria

1.1 Indications for Diagnostic Gastroscopy:

- Iron Deficiency Anaemia
- Unexplained and persistent new dyspepsia aged 55 years and older
- Chronic upper-gastrointestinal bleeding
- Progressive unintentional weight loss
- Dysphagia
- Persistent vomiting
- Assessment of abnormalities found on Barium or CT contrast studies
- Dyspepsia at any age with one or more anaemia, malaena, weight loss, vomiting, upper abdominal mass or no response to PPI
- Assessment of possible non oesophageal manifestation of reflux oesophagitis

Other indications include:

- Acute upper GI bleeding (haematemesis, melaena or haematochezia with haemodynamic compromise)
- Odynophagia, when inflammation or infection is clinically suspected, especially if oesophagitis from *Candida*, cytomegalovirus, or herpes simplex virus is likely
- Surveillance endoscopy for known pre-malignant conditions, such as Barrett's oesophagus
- Targeted biopsies for coeliac disease follow-up
- Suspected gastric outlet obstruction
- Detection of varices in chronic liver disease
- Variceal banding and Sclerotherapy

1.2 The Following Alone Are <u>NOT</u> Indications for Gastroscopy:

- Atypical chest pain
- Normocytic anaemia
- Abdominal pain of unknown aetiology
- Endoscopic screening of heartburn patients
- Uncomplicated cases of duodenal ulcer demonstrated by upper GI series

1.3 Indications for Therapeutic Gastroscopy:

- Sclerotherapy of bleeding oesophageal varices
- Management of upper GI bleeding using electrocautery etc
- APC ablation of oesophageal cancer
- Endoscopic placement of gastro-oesophageal stents
- Placement of PEG/PEJ tubes
- Dilatation of oesophageal strictures
- Polypectomy
- Food bolus removal from oesophagus

1.4 Absolute Contra-Indications for Diagnostic Gastroscopy:

- Hypoxaemia with respiratory distress
- Cardiogenic or septicaemic shock
- Uncontrolled hypertension
- Patient refusal
- Oro-pharyngeal disease restricting intubation

1.5 Relative Contra-Indications for Diagnostic Gastroscopy:

- Acute myocardial infarction (in most cases elective Gastroscopy should be delayed for 6 weeks)
- Massive upper GI bleeding with hypotension where emergency surgery is clearly appropriate (OGD may needlessly delay surgery and visualization is often obscured by copious amounts of blood).
- Non-correctable coagulopathy
- Severe coronary artery disease
- Recent upper GI tract surgery where anastomotic sites may still be "fresh"
- (Possible) Zenker's diverticulum – pharyngeal pouch
- Outcome unlikely to change management
- Frail patients with significant co-morbidities, ASA score 3 or above

1.6 Auditable Outcomes for Gastroscopy

- Success of intubation
- Midazolam dosage
- Report quality – S-C junction, scope identity, etc
- Duodenal intubation
- Rate of re bleeding
- Repeat endoscopy for gastric ulcers within 12 weeks (100%). Gastric ulcer defined by break in gastric mucosa >5mm in diameter and beyond sub mucosa. ***If repeat endoscopy not indicated (because of age+/- co-morbidity) this should be recorded in the patient file.***
- At least 8 biopsies are taken from lesions where upper GI malignancy is being confirmed or excluded
- Minimum 4 biopsies/2cm for Barrett's oesophagus surveillance
- Distal duodenal biopsies for suspected coeliac disease
- Appropriate use of drugs – PPI's for ulcers, terlipressin for varices, etc
- Spontaneous bacterial peritonitis in patients with variceal bleeding

1.7 Indications for Oesophageal Dilatation:

Treatment of symptomatic oesophageal obstruction due to:

- Reflux-induced strictures
- Malignancy
- Achalasia
- Iatrogenic: anastomotic; sclerotherapy; radiation
- Webs
- Corrosive-induced strictures

1.8 Absolute Contra-Indications for Oesophageal Dilatation:

- Active perforation
- Patient refusal

1.9 Relative Contra-Indications for Oesophageal Dilatation:

- Recent healed perforation
- Large thoracic aneurysm
- Severe cardio-respiratory disease

1.10 Auditable Outcomes for Oesophageal Dilatation:

- Effective relief of dysphagia by correct positioning of self expanding metal stents in greater than 90% of patients
- Perforation rates following dilatation of:

  Benign stricture <1:100

  Malignant stricture <1.20

  Achalasia <1:20

  Gastric outlet obstruction <1:20
- Infection rates
- 30-day mortality

1.11 Indications for Percutaneous Endoscopic Gastrostomy (PEG) Insertion:

- Severe acute/sub-acute swallowing problems, which are potentially reversible
- Cerebro vascular accident
- Head and neck cancers excluding oropharyngeal lesions
- Chronic, increasingly severe swallowing problems where life expectancy is reasonable e.g. chronic neurodegenerative disorders

1.12 Contra-Indications for PEG Insertion:

- The presence of acute illness, particularly chest problems
- Advanced dementia causing the swallowing problems
- Any terminal/pre-terminal condition where the life expectancy is short
- Oro-pharyngeal cancers
- Patient refusal

1.13 Relative Contra-Indications for PEG Insertion:

- Previous gastric surgery
- Any upper mid-line/left para-median scar
- Chest deformity/scoliosis
- Large hiatus hernia

1.14 Other Important Issues for PEG Insertion:

- Informed consent from the patient or informed consent from relatives/carers is essential.
- An assessment of the tolerance, by the patient, not only of the procedure but also of coping with the presence of a PEG is essential.
- Remember that not everyone who has major swallowing problems needs or can cope with a PEG - a decision regarding this procedure has to be individualised. A PEG multi-disciplinary team reviews all PEG requests.

1.15 Auditable Outcomes for PEG Insertion:

- Use of analgesia
- Infection requiring antibiotics
- Peritonitis
- Bleeding
- 30-day mortality

1.16 Indications for ERCP:

Consultants carrying out ERCP's or making decisions on patients undergoing ERCP should be part of the HPB MDT structure.

A. Patient s having gall bladder stones on Ultrasound / CT Scan / MRI

- Patient with CBD stones detected on Ultrasound, MRCP and CT Scan.
- Dilated bile duct with obstructive LFT's
- Non-dilated bile duct with worsening obstructive LFT's (To be discussed with ERCP Consultant before placing on the list)
- Patients with gallstone pancreatitis with worsening obstructive LFT's (Confirm patient has no cardio-respiratory compromise, discuss with ERCP Consultant before placing patient on the list)
- Old/Frail patient with one attack of gallstone pancreatitis, who is not fit for cholecystectomy and needs sphincterectomy. (Discuss with the ERCP consultant before placing the patient on the list)
- Patient with previously diagnosed CBD stones with pigtail catheter in CBD awaiting CBD clearance.
- Patient with post cholecystectomy biliary leak or suspected bile duct injury (Discuss with ERCP Consultant)

B. Patient's with Jaundice without gallstones

- Obstructive LFT's plus dilated common hepatic duct or common bile on ultrasound plus CT scan (CT scan has to be carried out before ERCP)
- Obstructive LFT's plus dilated intra hepatic ducts with non-dilated CBD/CHD (hilar obstruction). Please discuss with the ERCP Consultant as may not be suitable for ERCP but PTC)

- Suspected ampullary neoplasm with jaundice.
- Patients with PSC with main duct strictures needing dilatation or stenting (discuss with ERCP Consultant)

C. Non jaundiced patients

- Patient with dilated CBD on CT Scan/MRI suggesting a lesion in distal CBD or stone (discuss with ERCP consultant)
- Patients with choledochal cyst (Discuss with ERCP Consultant)
- Patients with pancreatic fistula needing stenting
- Pancreatic pseudo cyst with pancreatic duct communication (discuss with ERCP Consultant)
- Patients with CBD stricture needing stent replacement or brush cytology
- Patients needing duodenal stent placement

1.17 Absolute Contra-Indications for ERCP:

- Hypoxaemia with respiratory distress
- Cardiogenic or septicaemic shock
- Uncontrolled hypertension
- Patient refusal
- Oro-pharyngeal disease restricting intubation

1.18 Relative Contra-Indications for ERCP:

- Non-correctable coagulopathy
- Recent myocardial infarction
- Severe coronary artery disease
- Active peritonitis
- (Possible) Zenker's diverticulum – pharyngeal pouch
- Outcome unlikely to change management
- Frail patients with significant co-morbidities, ASA score 3 or above

1.19 Auditable Outcomes for ERCP:

- Success in cannulation of CBD and pancreatic duct as required. (Selective duct canulation is preferred to decrease incidence of complications
- Success in stone extraction
- Completion of the intended therapeutic procedure at initial ERCP in at least 80% of cases
- Decompression of obstructed biliary systems within 5 working days of first attempted ERCP
- Success of Needle Knife sphincterotomy in achieving canulation
- Safe sphincterotomy allowing access to CBD
- Complications: pancreatitis, perforation and 30-day mortality
- Sphincterotomy bleeding requiring transfusion < 2%
- Perforation rate <2%
- Clinically symptomatic pancreatitis < 5%
- Mortality <1%
- Continued antibiotic treatment when obstruction unrelieved in 100% of cases
- Number of procedures performed by each operator

1.20 Indications for EUS

~~A.~~ O.G. EUS

- Staging oesophago-gastric cancer
- Assessing depth and respectability of oesophago gastric sub mucosal, lesions/GIST etc.
- Fine Needle Aspiration (FNA) of para-oesophageal / para-gastric lesions or nodes; or left adrenal masses.
- Coeliac plexus block/neurolysis to control pain

B. HPB EUS

- Staging pancreatic cancer
- FNA of pancreatic cancer
- Idiopathic Pancreatitis to evaluate gallbladder and common bile duct
- Pancreas cyst for diagnosis + FNA
- Chronic pancreatitis for diagnosis + FNA if necessary
- Psuedocyst drainage of pancreas
- Evaluate pancreatic duct for divisum/IPMN

1.21 Indications for Flexible Sigmoidoscopy:

- Evaluation of suspected distal colonic disease when there is no indication for colonoscopy, including unexplained BRIGHT RED rectal bleeding
- Evaluation of the colon in conjunction with a barium enema in patients unsuitable for colonoscopy
- Abnormal findings on rectal examination (palpable mass, lesion, polyp)
- Rectal pain or proctitis
- Suspected foreign body
- Evaluation for anastomotic recurrence in recto sigmoid carcinoma
- Reduction of sigmoid volvulus

1.22 Absolute Contra-Indications for Flexible Sigmoidoscopy:

- Severe acute diverticulitis
- Acute severe colitis
- Patient refusal

1.23 Relative Contra-Indications for Flexible Sigmoidoscopy:

- Acute inflammatory bowel disease
- Suspected ischaemic bowel necrosis
- Toxic megacolon
- Recent colonic surgery
- Pelvic adhesions
- Coagulation disorders
- Inadequate bowel preparation

1.24 Auditable Outcomes for Flexible Sigmoidoscopy:

- Extent of scope e.g. splenic flexure
- Polyp detection rate
- Patient comfort
- Quality of bowel preparation

1.25 Indications for Colonoscopy:

N. B. This procedure should only be booked by Consultant Gastroenterologist or Colorectal Surgeon

- Unexplained iron deficiency anaemia showing low MCV, ferritin or low plasma iron
- Evaluation of potentially significant barium enema abnormalities, including ulceration, filling defects, and strictures
- Change in bowel habit for more than six weeks in patients over 45 years
- Chronic inflammatory bowel disease of the colon/terminal ileum if more precise diagnosis or determination of the extent/activity of disease will influence immediate management
- Clinically significant chronic diarrhoea of unexplained origin or unexplained change in bowel habit
- Assess activity or extent of known or suspected inflammatory bowel disease
- Surveillance for cancer, polyps or inflammatory bowel disease according to ACPGB or BSG guidelines (See Colonic surveillance protocol)
- Evaluation of unexplained gastrointestinal bleeding
    - Rectal bleeding in absence of a convincing anorectal source
    - Malaena after an upper GI source has been excluded
    - Presence of faecal occult blood
    - Rectal bleeding (associated with change in bowel habit)
- Discretionary follow-up of colonic lesions of unknown significance, noted on previous examination

1.26 Indications for Therapeutic Colonoscopy:

- Bleeding from lesions such as vascular malformation, ulceration, neoplasia, polypectomy site
- Foreign body removal
- Excision of colonic polyp
- Decompression of acute non toxic mega colon or sigmoid volvulus
- Balloon dilatation of stenotic lesion (e.g. anastomotic strictures)

1.22 The following are <u>NOT</u> Indications for Colonoscopy:

- Chronic, stable, irritable bowel syndrome or chronic abdominal pain; there are unusual exceptions in which colonoscopy may be performed once to exclude organic disease, especially if symptoms are unresponsive to therapy
- Acute, self-limiting diarrhoea
- Melaena with a clearly demonstrable upper GI source (e.g., duodenal ulcer)
- Haematochezia with a clearly demonstrable anorectal source on proctosigmoidoscopy (e.g., anal fissure)

- Routine surveillance of patients with non-neoplastic polyps (hyperplastic polyps) or healed, non-malignant disease
- 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)

1.23 Absolute Contra-Indications for Colonoscopy:

- Colonic obstruction
- Acute severe colitis
- Severe coagulopathy
- Severe acute diverticulitis
- Acute or recent myocardial infarction, severe cardio-respiratory disease
- Patient refusal
- Large abdominal aneurysm

1.24 Relative Contra-Indications for Colonoscopy:

- Uncontrolled lower GI bleeding
- Recent colon surgery
- Multiple abdominal and pelvic surgeries in the past, with adhesions
- Severe chronic obstructive pulmonary disease (COPD) or arteriosclerotic heart disease (ASHD)
- Pregnancy
- Rectal bleeding alone in patients over 45 years – consider flexible sigmoidoscopy
- Family history of bowel cancer not meeting guidelines
- Patients with known benign strictures
- Patients who have had failed colonoscopy by expert colonoscopist
- Age over 75 years – consider CT scan / colonography

1.25 Auditable Outcomes for Colonoscopy:

- Number of procedures per colonoscopist
- Analgesia and sedation levels
- Patient comfort
- Colonoscopy perforation rates <1:1000
- Post polypectomy bleeding requiring transfusion <1:100 (for >1cm polyps)
- Post polypectomy perforation rate <1:500
- Flexible sigmoidoscopy perforation rate < 1:5000
- > 90% adjusted completion rate (with photographic evidence of IC valve)
- Adenoma detection rate >10% for colonoscopy and flexible sigmoidoscopy
- Polyp recovery >90%
- Tattooing of suspected malignant polyps (100%)
- Tattooing of tumours if small, or if position not clear (100%)
- Good quality bowel prep > 90%
- Diagnostic colorectal biopsies for persistent diarrhoea (100%)

1.26 Indications for Argon Plasma Coagulation (APC):

- Angiodysplasia
- Radiation proctitis
- Destruction of small/medium sessile polyps
- Palliation of symptoms in advanced carcinoma

1.27 Absolute Contraindications for Argon Plasma Coagulation (APC):

- Resectable Cancers
- Resectable polyps
- Diverticular Disease

1.28 Auditable Outcomes for Argon Plasma Coagulation (APC):

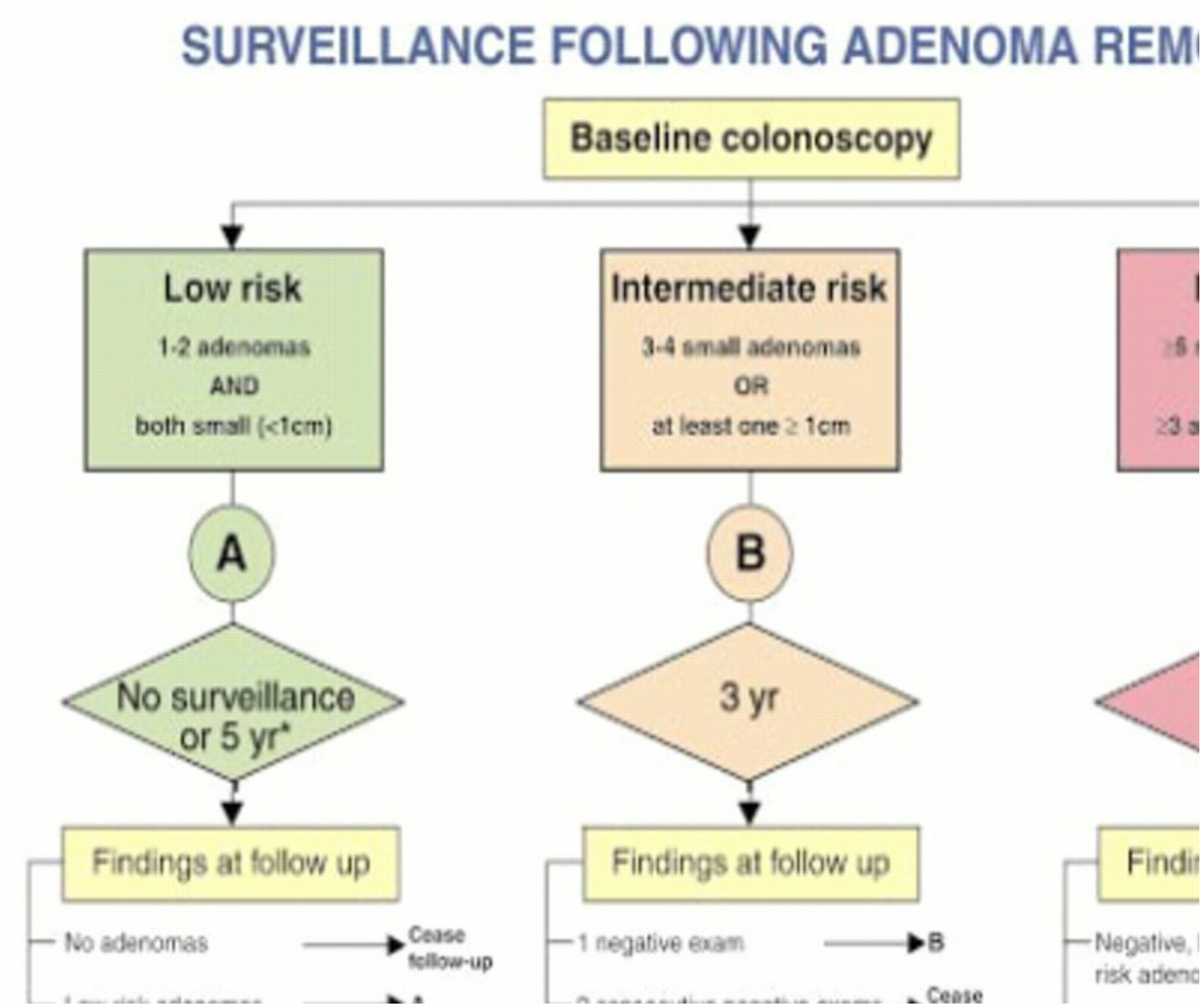
- Follow-up endoscopic appearances
- Symptom relief
- Assessment of possible primary sclerosing cholangitis

2 Guidelines for Surveillance Colonoscopy

2.1 Surveillance following curative resection of colorectal cancer

Provided a total colonoscopy has been performed preoperatively and all polyps removed, colonoscopy should be carried out at 3 years post resection. Further follow up at 5 yearly intervals until age 70

2.2 Surveillance for Adenomatous polyps as per BSG guidelines below



2.3 Surveillance for Chronic Inflammatory Bowel Disease (Ulcerative Colitis and Crohn's Colitis)

- Extent of disease should be assessed at 8-10 years to re evaluate disease
- For extensive colitis every two to three years in second decade, every two years in third decade and annually thereafter
- Patient with primary sclerosing cholangitis are at higher risk and should have annual colonoscopic surveillance
- If biopsies show any evidence of dysplasia, repeat colonoscopy at shorter intervals.

2.4 Surveillance for family history of colorectal cancer

- Patients with on or two first degree relatives with colorectal cancer diagnosed at or before the age of 45 should undergo colonoscopy 10 years before the affected relative. If polyps are found then the standard adenoma follow up protocol is used. If normal, then repeat examination in 10 years.
- Patients with first two degree relatives fitting into suspected HNPCC pedigrees should have the same index colonoscopy as above and be referred to the Clinical Genetics service for counselling, gene testing and recommendations for frequency of further follow up
- Definite HNPCC family members should undergo surveillance at 12 to 18 monthly intervals
- FAPC families should all undergo gene testing. Gene positive individuals should undergo colonoscopy at puberty and then 2 to 3 yearly intervals depending on the findings and indications for surgical intervention.

3.1 Capsule endoscopy

- Patients with unexplained iron deficiency anaemia (and negative upper and lower GI endoscopies)
- Patients with suspected small intestinal Crohn's disease
- Assessment of disease activity for patients with known Crohn's disease
- Patients with coeliac in possible refractory cases or patients with suspected complications
- Patients with overt obscure or occult gastrointestinal bleeding