ENDOSCOPY REFERRAL GUIDELINES

This guidance does not override the individual responsibility of health professionals to make appropriate decisions according to the circumstances of the individual patient in consultation with the patient and /or carer(s). 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 units at Worcestershire Acute Hospitals NHS Trust.

All medical staff at WRH, Alexandra Hospital and Kidderminster Treatment Centre and Evesham Community Hospital

Lead Clinician(s)

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Approval Date	4th October 2023
Review Date: This is the most current document and is to be used until a revised version is available:	4th October 2026

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	
February 2021	Document extended as per Trust agreement 11.02.2021.	
September 23	Document revised and approved at directorate governance as per trust agreement	Karen Macpherson

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 gastrointestinal endoscopy, including Upper GI endoscopy (OGD), colonoscopy, flexible sigmoidoscopy, ERCP, EUS and PEG insertion.

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UPPER GI ENDOSCOPY REFERRAL GUIDELINES

Special precautions are needed for patients taking Anti-coagulants and Anti-platelet drugs (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 link to BSG guidelines in references section)**
- Unexplained weight loss (over 3 kg)
- First follow up after oesophageal varices banding (2-4 weeks after index procedure)

Routine (within 6 weeks or defined interval)

- Dyspepsia WITHOUT alarm symptoms > 55 years
- Oesophageal varices - surveillance in cirrhotic (annual) banding programme
- Barrett's surveillance[2] **(– see link to BSG guidelines in references section)**
- 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

TRANS-NASAL ENDOSCOPY REFERRAL

The guidelines for referral will be exactly the same as for OGD. But TNE is especially useful for patients who are very anxious or who would have otherwise requested the procedure under GA.

UPPER GI 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

COLONOSCOPY AND FLEXIBLE SIGMOIDOSCOPY REFERRAL GUIDELINES

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 Anti-coagulants and /or anti-platelet drugs, refer to 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 Recommendations organised by site of cancer | Suspected cancer: recognition and referral | Guidance | NICE

Please note the exclusion criteria for 2ww referrals:

- If patient is FIT negative and has normal FBC
- No palpable rectal mass.
- These patients must be referred via an alternative route

	FIT POSITIVE PATHWAY – URGENT SUSPECTED CANCER REFERRAL *Patients **MUST** be aged 40 years or over with a positive FIT (≥10 ugHB/g) result and have one or more of the following:*	***Please include FIT value***
1.	*Rectal bleeding with 2 or more episodes in a ≥ 4 week period*	*FIT result:* ……...
2.	*Change in bowel habit (looser/more frequent) ≥ 6 weeks*	*FIT result:* ……...
3.	*Unexplained/Unintentional weight loss (> 10% drop in body weight)* *Please specify: …… kg.*	*FIT result:* ……

	ANY ADULT (18 years or over) WITH ANY OF THE FOLLOWING SYMPTOMS (FIT +/-ve) ***Please refer for FIT test at the same time as the referral - do not wait for the result. An initial face to face appointment will be booked for these patients.***	
4.	*Unexplained and un-investigated in the last 3 years Iron Deficiency Anaemia (< 110 g/L in men or < 100 g/L in non-menstruating women and ferritin <50ng/ml, negative screen for Coeliac Disease; other major clinical causes of IDA excluded and incomplete or not sustained response to IRT)*	*Hb……* *MCV……* *Ferritin……..*
5.	*Abdominal Mass.*	
6.	*Unexplained rectal mass on examination*	
7.	*Anal ulceration/mass on examination*	

Trust guidelines are to follow BSG guidelines for IDA however the BSG and the cancer alliance recommends 2 different pathways to investigate IDA, therefore please note that ALL IDA needs to be investigated but, if the Hb levels are below those in the Colo-Rectal pathway then the patient should be referred via 2ww pathway instead.

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 https://gut.bmj.com/content/69/3/411

- Family history of CRC (see West Midlands Family Cancer Strategy) https://www.coventryrugbygpgateway.nhs.uk/resources/west-midlands-family-cancer-strategy-wmfacs-cancer-family-history-form-2022/
- Familial adenomatous polyposis
- Juvenile polyposis
- HNPCC

Surveillance Colonoscopy https://gut.bmj.com/content/69/3/411

- After removal of colorectal adenomatous polyps (see BSG guidelines link on page 13)
- Post resection of colonic carcinoma (see BSG guidelines link on page 13)
- Inflammatory Bowel Disease) + post surgical resection assessment of Crohn's (see BSG guidelines link on page 13)
- 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 (<6 weeks' duration)
- 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.
- 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
- Add bowel obstruction

Indications for Flexible Sigmoidoscopy:

Urgent Flexible Sigmoidoscopy Request for Unexplained FIT negative PR Bleeding
GP

- GP sends referral form to endoscopy booking with **all** criteria ticked:

  Confirm they are aged 40 years or over AND

  - Unexplained PR BLEEDING (No investigation within last year)
  - FIT NEGATIVE (<10ug/g)
  - Faecal calprotectin <250ug/g
  - No Iron Deficiency Anaemia
  - No Palpable Rectal / Anal Mass
  - Patient aware of referral for investigation

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 or CT colonography
- **Evaluation for anastomotic recurrence in recto-sigmoid 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

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

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, Dr Gee or Dr Cheung.

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 (NOTE: THESE INTERVENTIONS ARE NOT CARRIED OUT AT WAHT)

Early ERCP in the treatment of acute gallstone pancreatitis, should only be performed if there is evidence of cholangitis or obstructive jaundice with imaging evidence of a stone in the common bile duct. Early ERCP refers to ERCP being performed on the same admission, ideally within 24 hours. **(Please refer to the link in references section)**

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.

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 Teicoplanin if allergy to penicillin (Follow 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 (Follow local microbiology guidance).

EUS REFERRAL GUIDELINES

A request for an Endoscopic Ultrasound (EUS) should be made on ICE and is located under the 'Gastro USS' tab. All requests must be discussed with an endosonographer e.g. Mr Wadley, Dr Wadhwani or Dr Baker and/or have gone through the UGI/HPB MDT in advance.

It is absolutely essential for the patient to have had a consultation to explain the rationale for the EUS prior to any procedure being requested on ICE. They should be aware of the indication prior to them receiving any call from the bookings team as otherwise this can result in considerable communication challenges and patient anxiety/distress, which has unfortunately occurred on a number of previous occasions, all of which were entirely preventable. This communication is essential to have a well-informed patient that is able to provide a valid consent and we appreciate your understanding on this important issue. If the patient is unaware of the indication for the procedure when the bookings team contact them, then it is likely that the referrer will be contacted accordingly so the rationale can be explained to the patient from a clinical perspective prior to them being booked onto a list to avoid any miscommunication.

We ask please that the ICE request is completed in full and all clinical details are included in the free text boxes. An accompanying letter is not required. The referrer will need to know whether the patient has diabetes and whether they are on any anticoagulant or antiplatelet therapy and also their performance status. It is important that relevant information regarding patient's symptoms; for example, abdominal pain, history of pancreatitis and weight loss are also included and that any relevant blood tests including LFTs, and a CA 19-9 blood test for pancreatic cysts, are available in order for cases to be effectively triaged and avoid delays and rejections.

Indications:

- Cancer on imaging – EUS indicated when tissue acquisition will influence onward management e.g. palliative chemotherapy, neo-adjuvant chemotherapy or surgery.
    - If metastatic disease and tissue needed for chemotherapy, then percutaneous approach would be first line if the tissue is accessible
- Pancreatic cysts - If no high-risk (HR) or worrisome features (WF); imaging surveillance as per guidelines rather than EUS. Look for comparable imaging historically for the trend of any change
    - EUS will be reserved for new HR/WF, growth >2mm/yr. or a raised CA 19-9
    - Assessment for the presence of HR/WF on imaging will be made by the GI/HPB radiologist and/or endosonographer as part of the triage process
- All pancreatic cysts that are aspirated for fluid analysis and/or cytology at the time of the EUS are recommended to go back to the UGI/HPB MDT for discussion/interpretation of results to ensure appropriate onward management of the patient and this advice may well evolve with a future dedicated pancreatic cyst pathway which is in development
- Ductal dilatation without a mass on imaging and normal LFTs
    - Not for EUS if main pancreatic duct ≤6mm. 6-12 week interval CT or MRI should be considered to ensure stability - this will stratify patients without malignancy and provide reassurance that an invasive procedure may not be required

PLEASE NOTE THAT ALL EUS REFERRALS WILL BE DISCUSSED AT THE UPPER GI MDT.

MONITORING TOOL

How will monitoring be carried out?

Annual audit of appropriateness of any 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 https://www.bsg.org.uk/clinical-resource/guidelines-for-the-management-of-iron-deficiency-anaemia/

2. BSG - Guidelines for the Diagnosis and Management of Barrett's Columnar-lined Oesophagus https://www.bsg.org.uk/clinical-resource/bsg-guidelines-on-the-diagnosis-and-management-of-barretts-oesophagus/

3. NICE Dyspepsia Management Guidelines https://www.nice.org.uk/guidance/cg184

4. NICE Colorectal Cancer Service Guidance (CSG) https://www.nice.org.uk/guidance/ng151

5. BSG - Guidelines for the Management of Inflammatory Bowel Disease https://www.bsg.org.uk/clinical-resource/bsg-consensus-guidelines-on-the-management-of-inflammatory-bowel-disease-in-adults/

   Surveillance Colonoscopy for Inflammatory Bowel Disease: Why, When, How and What Next? - The British Society of Gastroenterology (bsg.org.uk)

6. BSG - Guidelines for Colorectal Cancer Screening in High Risk Groups https://www.bsg.org.uk/clinical-resource/guidelines-for-the-management-of-hereditary-colorectal-cancer-from-the-bsg-acpgbi-ukcgg/

7. BSG – Guidelines for post polypectomy and adenoma surveillance https://www.bsg.org.uk/wp-content/uploads/2019/09/201.full_.pdf

8. BSG/ACPGBI/PHE Post-polypectomy and post-colorectal cancer resection surveillance guidelines | ACPGBI

9. 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 https://www.nice.org.uk/guidance/cg32

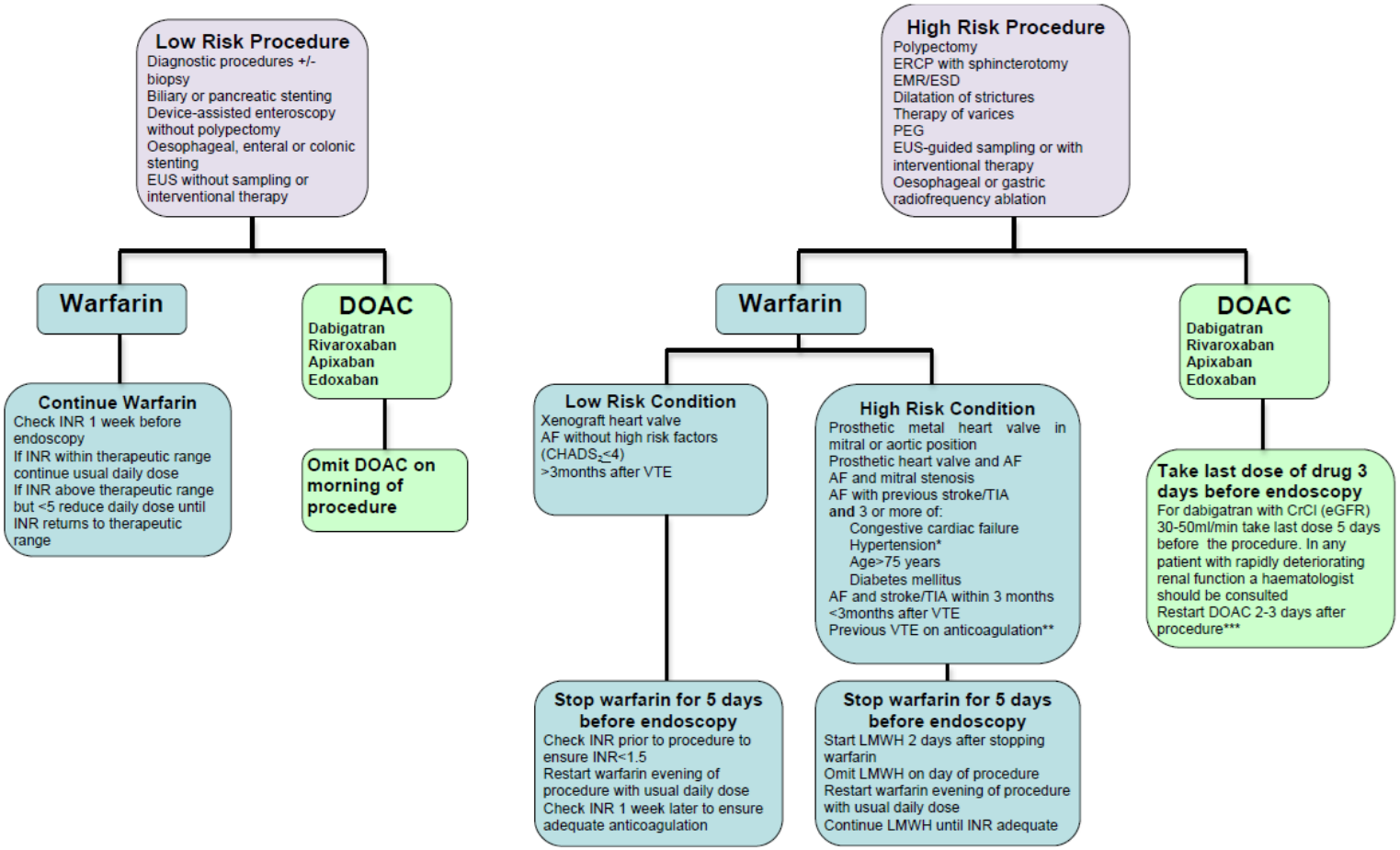
10. Percutaneous endoscopic gastrostomy and outcome in dementia. Am. J. Gastroenterology. 2001 Sep;96(9):2556-63 https://pubmed.ncbi.nlm.nih.gov/11569675/

11. BSG - Guidelines on complications of endoscopy https://www.bsg.org.uk/clinical-resources/endoscopy/endoscopy-guidance/

12. Early endoscopic retrograde cholangiopancreatography (ERCP) in acute gallstone pancreatitis without cholangitis

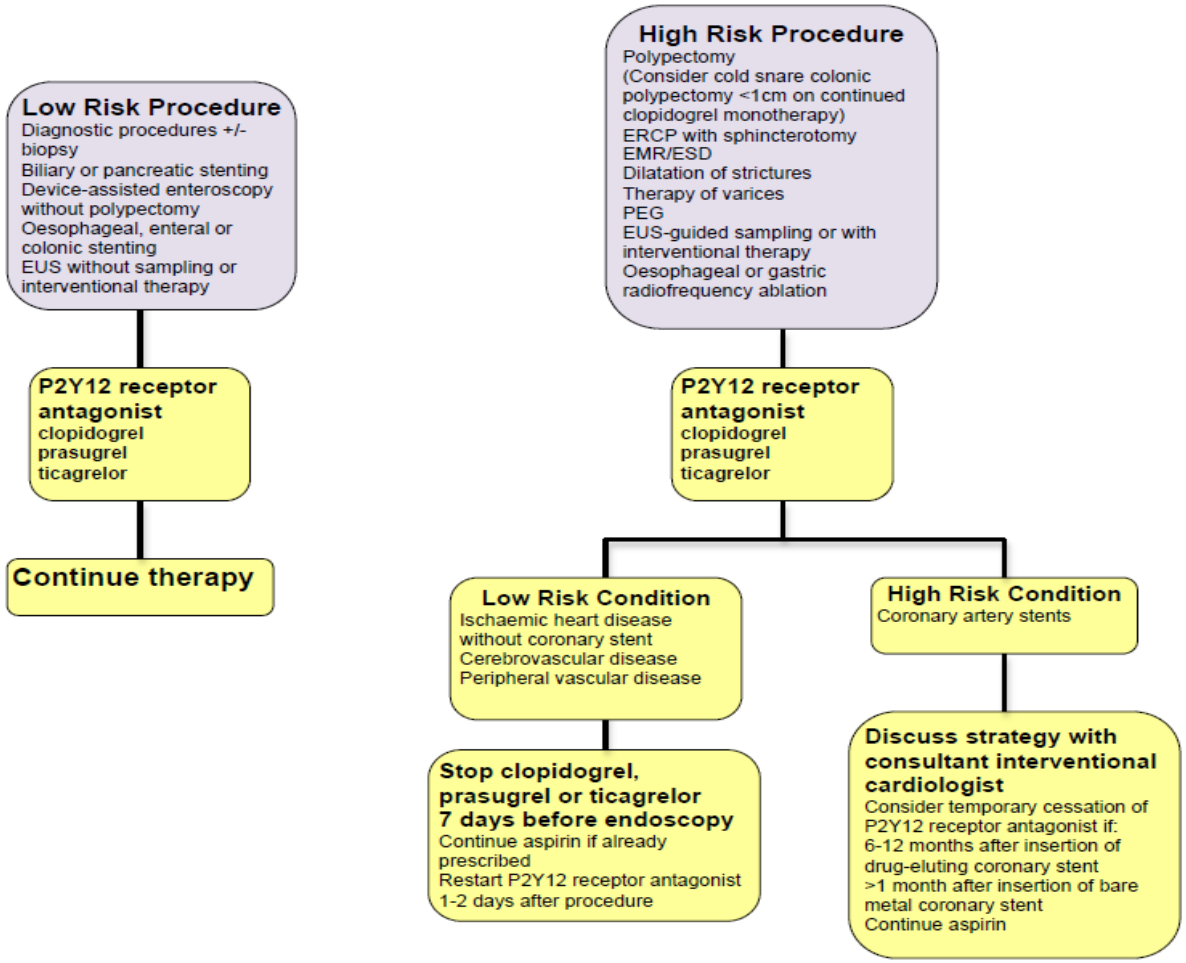
A complete list of BSG guidelines can be found at https://www.bsg.org.uk/resource-type/clinical-resources/guidelines/

Appendix 1: Guidelines for the management of patients on warfarin or Direct Oral Anticoagulants (DOAC) undergoing endoscopic procedures: 2021 update



*Blood pressure >140/90mmHg or on antihypertensive medication **Previous VTE on anticoagulation and target INR now 3.5
***depends on haemorrhagic and thrombotic risk, interval may be extended for ESD
(EUS: endoscopic ultrasound, ERCP: endoscopic retrograde cholangiopancreatography, EMR: endoscopic mucosal resection, ESD: endoscopic submucosal dissection, PEG: percutaneous endoscopic gastroenterostomy, INR: international normalised ratio, AF: atrial fibrillation, VTE: venous thromboembolism, TIA: transient ischaemic attack, LMWH: low molecular weight heparin)

Appendix 2: Guidelines for the management of patients on P2Y12 receptor antagonist antiplatelet agents undergoing endoscopic procedures: 2021 update



(EUS: endoscopic ultrasound, ERCP: endoscopic retrograde cholangiopancreatography, EMR: endoscopic mucosal resection, ESD: endoscopic submucosal dissection, PEG: percutaneous endoscopic gastroenterostomy)

Appendix 3 – Specialist Referrals

Specialist Service Referrals

Appendix 4 - Faecal Immunochemical Testing

Final FIT Comms April 2023 (002).pdf

Contribution List

Key individuals involved in developing the document

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