

REFERRAL GUIDELINES: **ENDOSCOPY**
**Essential
Referral
Content**

Referrals for endoscopy must be made using the

Gastrointestinal Endoscopy Referral Form

- Please fax the completed referral form to 9076 2194.
- Incomplete referrals will be returned to the referring doctor.
- Most patients will be assessed in either RACE (Rapid Access Clinic for Endoscopy) or GI Endoscopy Clinic prior to gastroscopy or colonoscopy.


**Exclusion
Criteria**

The following conditions are not routinely seen at the Alfred:

- Patients who are being treated for the same condition at another Victorian public hospital
- Children under 18 years of age are not seen at The Alfred

Patients requiring re-scoping more than 12 months after their initial endoscopy require re-referral 6 weeks prior to the repeat endoscopy date. The Alfred Gastroenterology Department will recall those patients who require re-scoping within one year of the initial procedure.

REFERRAL PROCESS: **ENDOSCOPY****STEP 1**

Referrals for endoscopy must be made using the **Gastrointestinal Endoscopy Referral Form**.
You will be notified when your referral is received by Endoscopy bookings.

**STEP 2**

Essential referral content will be checked.
You will be contacted if further information is required.

**STEP 3**

The referral is triaged by the Endoscopy booking nurse according to clinical urgency. Most patients will be referred for assessment in RACE or GI Endoscopy clinic, or may be scheduled for direct endoscopy if urgent.

Some clinics offer an MBS-billed service. **There is no out of pocket expense to the patient.** MBS-billed services require a current referral to a named specialist– please provide your patient with a **12 month referral addressed to Assoc. Prof Gregor Brown.** Please note that your patient may be seen by another specialist in that clinic, in order to expedite their treatment.

Please note: The times to assessment may vary depending on clinical demand and the indication for endoscopy.

If you are concerned about the delay of the outpatient appointment or if there is any deterioration in the patient's condition, please contact the Gastroenterology Registrar on call on 9076 2000.

Referral Guideline Contents

[General Indications for GI endoscopy](#)

[Indications for upper GI endoscopy](#)

[Indications for colonoscopy](#)

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General indications

The indications and relative contra-indications for doing each of the endoscopic diagnostic procedures are listed below. These guidelines are based on a critical review of available information and broad clinical consensus, and are as specific and definitive as possible.

Clinical considerations may occasionally justify a course of action at variance with these recommendations.

GI Endoscopy is generally indicated:

- If a change in management is probable based on results of endoscopy
- After an empiric trial of therapy for a suspected benign digestive disorder has been unsuccessful
- As the initial method of evaluation as an alternative to radiographic studies
- When a primary therapeutic procedure is contemplated

GI Endoscopy is generally not indicated:

- When the results will not contribute to a management choice
- For periodic follow-up of healed benign disease unless surveillance of a pre-malignant condition is warranted.

GI Endoscopy is generally contraindicated:

- When the risks to patient health or life are judged to outweigh the most favourable benefits of the procedure
- When adequate patient cooperation or consent cannot be obtained
- When a perforated viscus is known or suspected

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Upper GI endoscopy

Upper GI endoscopy is generally indicated for evaluating:

- Upper abdominal symptoms associated with other symptoms or signs suggesting serious organic disease (e.g. anorexia and weight loss) or in patients over 45 years of age.
- Dysphagia or odynophagia
- Oesophageal reflux symptoms, which are persistent or recurrent despite appropriate therapy.
- Persistent vomiting of unknown cause
- Other disease in which the presence of upper GI pathology might modify other planned management. Examples include, patients who have a history of ulcer or GI bleeding who are scheduled for organ transplantation, long-term anti-coagulation or chronic non-steroidal anti-inflammatory drug therapy for arthritis and those with cancer of the head and neck.
- Familial adenomatous polyposis syndromes
- For confirmation and specific histologic diagnosis of radiological demonstrated lesions:
 - Suspected neoplastic lesion
 - Gastric or oesophageal ulcer
 - Upper GIT stricture or obstruction
- Gastrointestinal bleeding:
 - In patients with active or recent bleeding
 - For presumed chronic blood loss and for iron deficiency anaemia when the clinical situation suggests an upper GI source or when colonoscopy is negative
- When sampling of tissue or fluid is indicated
- In patients with suspected portal hypertension to document or treat oesophageal varices
- To assess acute injury after caustic ingestion
- Treatment of bleeding lesions such as ulcers, tumours, vascular abnormalities (e.g. electrocoagulation, heater probe, argon plasma photocoagulation or injection therapy)
- Banding or sclerotherapy of varices
- Removal of foreign bodies
- Removal of selected polypoid lesions
- Placement of feeding or drainage tubes (peroral, percutaneous endoscopic gastrostomy, percutaneous endoscopic jejunostomy)
- Dilatation of stenotic lesions (e.g. with transendoscopic balloon dilators or dilatation systems employing guide wires)
- Management of achalasia (e.g. botulinum toxin, balloon dilatation)
- Palliative treatment of stenosing neoplasms (e.g. laser, multipolar electrocoagulation, stent placement)

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Upper GI endoscopy (continued)

Upper GI endoscopy is generally not indicated for evaluating:

- Symptoms which are considered functional in origin (there are exceptions in which an endoscopic examination may be done once to rule out organic disease, especially if symptoms are unresponsive to therapy).
- Metastatic adenocarcinoma of unknown primary site when the results will not alter management
- Radiographic findings of:
 - Asymptomatic or uncomplicated sliding hiatal hernia
 - Uncomplicated duodenal ulcer which has responded to therapy
 - Deformed duodenal bulb when symptoms are absent or respond adequately to ulcer therapy

Sequential or periodic upper GI endoscopy may be indicated for:

- Surveillance for malignancy in patients with premalignant conditions (i.e. Barrett's oesophagus)

Sequential or periodic upper GI endoscopy is generally not indicated for:

- Surveillance for malignancy in patients with gastric atrophy, pernicious anaemia, or prior gastric operations for benign disease.
- Surveillance of healed benign disease such as oesophageal, gastric or duodenal ulcer
- Surveillance during repeated dilatations of benign strictures unless there is a change in status

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Colonoscopy

Colonoscopy is generally indicated in the following circumstances:

- 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
- Evaluation of unexplained gastrointestinal bleeding:
 - Haematochezia
 - Melaena after an upper GI source has been excluded
 - Presence of faecal occult blood
 - Unexplained iron deficiency anaemia
- Screening and surveillance for colonic neoplasia in patients at moderate or high risk as per NHMRC guidelines (see attached)
- Examination to evaluate the entire colon for synchronous cancer or neoplastic polyps in a patient with treatable cancer or neoplastic polyp
- Colonoscopy to remove synchronous neoplastic lesions at or around time of curative resection of cancer followed by colonoscopy at three years and 3-5 years thereafter to detect metachronous cancer.
- Following adequate clearance of neoplastic polyp(s) survey at 3-5 year intervals
- Patients with significant family history: Hereditary non polyposis colorectal cancer: colonoscopy every two years beginning at the earlier of age 25, or five years younger than the earliest age of diagnosis of colorectal cancer. Annual colonoscopy should begin at age 40.
- In patient with ulcerative or Crohn's colitis as per [Cancer Council Australia Clinical Practice Guidelines for Surveillance Colonoscopy \(December 2011\)](#)
- Chronic inflammatory bowel disease of the colon if more precise diagnosis or determination of the extent of activity of disease will influence immediate management.
- Clinically significant diarrhoea of unexplained origin
- Endoscopic identification/marketing of a lesion not apparent at surgery (e.g. neoplasm, polypectomy site, location of a bleeding site)
- Treatment of bleeding from such lesions as vascular malformation, ulceration, neoplasia, and polypectomy site (e.g. electrocoagulation, heater probe, laser or injection therapy)
- Foreign body removal
- Excision of colonic polyp
- Decompression of acute non-toxic megacolon or sigmoid volvulus
- Balloon dilation of stenotic lesions (e.g. anastomotic strictures)
- Palliative treatment of stenosing or bleeding neoplasms (e.g. laser, electrocoagulation, stenting)

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Colonoscopy (continued)

Colonoscopy is generally not indicated in the following circumstances:

- Chronic, stable, irritable bowel syndrome or chronic abdominal pain: there are unusual exceptions in which colonoscopy may be done once to rule out disease, especially if symptoms are unresponsive to therapy.
- Non-specific, mild abdominal pain or bloating
- Acute diarrhoea
- Metastatic adenocarcinoma of unknown primary site in the absence of colonic signs or symptoms when it will not influence management
- Routine follow up of inflammatory bowel disease (except for cancer surveillance in chronic ulcerative colitis and Crohn's colitis)
- Upper GI bleeding or melaena with a demonstrated upper GI source
- Patients not at increased risk of bowel cancer (ie 'routine screening' for Category 1 patients as per NHMRC Guidelines – see below)

Colonoscopy is generally contraindicated in:

- Contraindications listed under General Indications statements
- Fulminant Colitis
- Documented acute diverticulitis