Endoscopy
Specialist Clinic Referral Guidelines

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The impact of COVID-19 has resulted in high demand for specialist clinic consultations. If there is a concern about the delay of the appointment, or any deterioration in the patient's condition, please send an updated referral with additional information.

If the patient's care needs have become urgent, please call the unit registrar on call on 9076 2000.

Referrals for endoscopy must be made using the Gastrointestinal Endoscopy Referral Form
Please fax the completed referral form to **9076 6938.** 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.

Where appropriate and available, the referral may be directed to an alternative specialist clinic or service. Advice regarding referral for specific conditions to the Alfred Endoscopy Service can be found here.

Notification will be sent when the referral is received. The referral may be declined if it does not contain essential information required for triage, if the condition is not appropriate for referral to a public hospital, or is a condition not routinely seen at Alfred Health.

The clinical information provided in the referral will determine the triage category. The triage category will affect the timeframe in which the patient is offered an appointment.

The following conditions are not routinely seen at Alfred Health:

- 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

Please refer to the Department of Health Statewide Referral Criteria for Specialist Clinics for further information when referring for endoscopy in public hospitals.

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Please include in the referral:

Demographic details:	**Clinical information:**
• Date of birth • Patient's contact details including mobile phone number • Referring GP details • If an interpreter is required • Medicare number	• Reason for referral • Duration of symptoms • Relevant pathology and imaging reports • Past medical history • Current medications

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.

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.

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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)

Upper GI Endoscopy (continued)

Upper GI endoscopy is generally <u>not indicated</u> 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 <u>may be indicated</u> for:

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

Sequential or periodic upper GI endoscopy is generally <u>not indicated</u> 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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Dysphagia – diagnostic gastroscopy

DH Statewide Referral Criteria apply for this condition.

Direct to an emergency department for:

- Progressively worsening oropharyngeal or throat dysphagia
- Inability to swallow with drooling or pooling of saliva
- Unresolved food bolus obstruction

Criteria for referral to public hospital service

- Progressive dysphagia

Information to be included in the referral

Information that must be provided

- History of dysphagia (onset, characteristics and duration of symptoms) and other symptoms over time
- Relevant medical history and comorbidities
- Any previous gastroscopy or other relevant investigations
- Current and complete medication history (including non-prescription medicines, herbs and supplements)
- Statement that the patient has indicated interest in having a gastroscopy
- **Anaesthetic risk.** Indicate if the patient has any of the following:
    - body mass index (BMI) > 40
    - a permanent pacemaker
    - any bleeding disorder
    - any cognition issues or impairment
    - any known or prior reaction to anaesthesia (malignant hyperthermia, suxamethonium apnoea, severe post-operative nausea or vomiting, known difficult airway)
    - any neuromuscular condition (e.g. myasthenia gravis, muscular dystrophy, cerebral palsy)
    - a respiratory disease that requires oxygen therapy or limits the patient's daily activities (New York Heart Association (NYHA) Functional Classification class 3)
    - severe obstructive sleep apnoea
    - stage 4 or 5 chronic kidney disease (pre-dialysis or requires dialysis)
    - symptomatic ischaemic heart disease
    - valvular heart disease or congestive heart failure

- **Anticoagulation or antiplatelet therapy**. Indicate if the patient is taking any of the following medicines (or any other anticoagulant or antiplatelet therapy):
  - apixaban
  - aspirin
  - clopidogrel
  - dabigatran
  - low molecular weight heparin
  - prasugrel
  - rivaroxaban
  - ticagrelor
  - warfarin.

Provide if available

- Any relevant imaging, colonoscopy or gastroscopy results, including when and where previous endoscopy procedures were performed.

Additional comments

The Summary and referral information lists the information that should be included in a referral request.

Direct access to gastroscopy requires a clinician to discuss the suitability of the procedure, provide information about the procedure and arrange pre-admission requirements with patients prior to them being placed on the procedure wait list. Where clinically appropriate the referral may be directed to a specialist clinic or service for assessment prior to the procedure.

Referrals for Dysphagia should be directed to gastroenterology service provided by the health service.

Referrals for oropharyngeal dysphagia should be directed to ENT service provided by the health service.

Referral to a public hospital is not appropriate for

Patients with oropharyngeal dysphagia or patients that do not have a history of oesophageal dysphagia.

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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/marking 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)

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 <u>contraindicated</u> in:

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

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Positive faecal occult blood test (FOBT) – diagnostic colonoscopy

DH Statewide Referral Criteria apply for this condition.

Direct to an emergency department for:

- Potentially life-threatening symptoms suggestive of acute severe lower gastrointestinal tract bleeding

Criteria for referral to public hospital service

- Positive immunochemical faecal occult blood test (iFOBT).

Information to be included in the referral

Information that must be provided

- Faecal occult blood test results and if the test result was or was not detected through the National Bowel Cancer Screening Program (NBCSP)
- Patient age
- Onset, characteristics and duration of symptoms
- Relevant medical history and comorbidities
- Current and complete medication history (including non-prescription medicines, herbs and supplements)
- Statement that the patient has indicated interest in having a colonoscopy
- Statement that the patient understands the need for bowel preparation prior to colonoscopy
- **Anaesthetic risk.** Indicate if the patient has any of the following:
    - body mass index (BMI) > 40
    - a permanent pacemaker
    - any bleeding disorder
    - any cognition issues or impairment
    - any known or prior reaction to anaesthesia (malignant hyperthermia, suxamethonium apnoea, severe post-operative nausea or vomiting, known difficult airway)
    - any neuromuscular condition (e.g. myasthenia gravis, muscular dystrophy, cerebral palsy)
    - a respiratory disease that requires oxygen therapy or limits the patient's daily activities (New York Heart Association (NYHA) Functional Classification class 3)
    - severe obstructive sleep apnoea
    - stage 4 or 5 chronic kidney disease (pre-dialysis or requires dialysis)
    - symptomatic ischaemic heart disease
    - valvular heart disease or congestive heart failure

- **Anticoagulation or antiplatelet therapy**. Indicate if the patient is taking any of the following medicines (or any other anticoagulant or antiplatelet therapy):
  - apixaban
  - aspirin
  - clopidogrel
  - dabigatran
  - low molecular weight heparin
  - prasugrel
  - rivaroxaban
  - ticagrelor
  - warfarin
- **Risk factors for poor bowel preparation for colonoscopy**. Indicate if the patient has any of the following:
  - body mass index (BMI) > 30
  - chronic opioid use
  - constipation
  - type 1 diabetes
  - type 2 diabetes
  - Parkinson's disease
  - previous bowel resection
  - stroke.

Provide if available

- Previous and current gastrointestinal investigations and results, including when and where previous endoscopy procedures were performed.

Additional comments

The Summary and referral information lists the information that should be included in a referral request.

Direct access to colonoscopy requires a clinician to discuss the suitability of the procedure, provide information about the procedure and bowel preparation, and arrange the bowel preparation and other pre-admission requirements with patients prior to them being placed on the procedure wait list. Where clinically appropriate the referral may be directed to a specialist clinic or service for assessment prior to the procedure.

Referrals for Rectal bleeding should be directed to gastroenterology service provided by the health service.

Referrals for Persistent iron deficiency should be directed to gastroenterology service provided by the health service.

Referrals for severe haemorrhoids should be directed to colorectal service provided by the health service.

Note: FOBT is not indicated in asymptomatic people aged > 80 years

Referral to a public hospital is not appropriate for

Other statewide referral criteria should be used for patients that have symptoms but do not have a positive immunochemical faecal occult blood test (iFOBT).

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INTERIM* ALFRED HOSPITAL
COLONOSCOPY SURVEILLANCE GUIDELINES (UPDATED 2024)
Based on
Cancer Council Australia Clinical Practice Guidelines for colorectal cancer (CRC) (2017; updated 2023) and Surveillance Colonoscopy (2019)
INTERIM = pending revision of current complex Australian guidelines*

Family History

FAMILY HISTORY *FDR = First degree relative* *SDR = Second degree relative*	RECOMMENDATION
CATEGORY 1 • No FDR or SDR with CRC • 1 FDR with CRC age ≥60	FOBT 2 yearly from age 45
CATEGORY 2 • 1 FDR with CRC age <60 • 2 FDRs with CRC at any age • 1 FDR + ≥1 SDR with CRC at any age	Colonoscopy 5 yearly from age 50-74 (or 10 years younger than the youngest affected family member, if earlier)
CATEGORY 3 • 2 FDR + 1 SDR with CRC, ≥1 age <50 • 2 FDR + ≥1 SDR with CRC at any age • ≥3 FDR with CRC at any age	Colonoscopy 5 yearly from age 40-74 (or 10 years younger than the youngest affected family member, if earlier) Consider genetics referral

Inflammatory bowel disease surveillance

CLINICAL SITUATION	RECOMMENDATION
• Ulcerative colitis or Crohn's affecting >1/3rd colon	Start at 8 years disease duration
• PSC or significant family history CRC	Start at diagnosis
• Any of active disease, Primary sclerosing cholangitis (PSC), significant family history CRC, colon stricture, multiple inflammatory polyps, dysplasia	Annual colonoscopy
• Inactive or low risk family history CRC	3 yearly colonoscopy
• If 2 prior normal colonoscopies	5 yearly colonoscopy

After curative surgery for colorectal cancer

- Complete examination of the colon before or within 6 months of surgery
- Subsequent colonoscopy at 1 year, then 3-5 yearly (or as per polyp guidelines)

SEE ALSO: "polyp.app" ONLINE TOOL : Polyp Surveillance Calculator

After polypectomy (first surveillance colonoscopy)

FINDINGS AT INDEX COLONOSCOPY	RECOMMENDATION
• ≤2 tubular adenomas <10mm	10 years *or* National Bowel Cancer Screening Program (NBCSP) Faecal occult blood test FOBT
• 3-4 tubular adenomas <10mm • ≤2 SSPs <10mm (SSP = Sessile serrated polyps)	5 years
• 5-9 adenomas <10mm • Adenoma ≥10 mm or high-grade dysplasia (HGD) or villous • 3-4 SSPs <10mm • 1-2 SSP >10mm or dysplastic or TSA • HP ≥10mm *(TSA = Traditional serrated adenoma)*	3 years
• ≥10 adenomas <10mm • 5-9 adenomas, ≥10mm or HGD • ≥5 SSPs <10mm • ≥3 SSPs, >10mm or dysplasia or TSA	1 year Consider genetics referral
• Piecemeal resection of large sessile polyps (>20mm)	3-6 months, then 1 year, then 3 years, then 5-yearly

After polypectomy (second surveillance colonoscopy)

TOTAL NUMBER OF ADENOMAS + SSPs AT 2ND COLONOSCOPY	LOW RISK ADENOMA		HIGH RISK ADENOMA	
	ADVANCED SSP		ADVANCED SSP	
	NO	*YES*	*NO*	*YES*
0-2	5Y	3Y	3Y	3Y
3-4	3Y	3Y	1Y	1Y
5-9	1Y	1Y	1Y	1Y
≥10	1Y	1Y	1Y	1Y

ADAPTED FROM THE FOLLOWING SOURCE DOCUMENTS:

Cancer Council Australia Colorectal Cancer Guidelines Working Party. Clinical practice guidelines for the prevention, early detection and management of colorectal cancer. Sydney: Cancer Council Australia.
[Version URL: https://wiki.cancer.org.au/australiawiki/index.php?oldid=191477, cited 2019 Jul 30].
Available from: https://wiki.cancer.org.au/australia/Guidelines:Colorectal_cancer

Cancer Council Australia Surveillance Colonoscopy Guidelines Working Party. Clinical Practice Guidelines for Surveillance Colonoscopy. Sydney: Cancer Council Australia.
[Version URL: https://wiki.cancer.org.au/australiawiki/index.php?oldid=200800, cited 2019 Jul 30].
Available from: https://wiki.cancer.org.au/australia/Guidelines:Colorectal_cancer/Colonoscopy_surveillance

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