Guidelines For Endoscopy or Colonoscopy Referral By GPs

Who Needs Endoscopy?

High demand for endoscopy services has resulted in prolonged waiting times. Therefore it is crucial to identify those patients that require more urgent procedures.

The following are guidelines to help you identify patients who have a higher likelihood of significant organic pathology and, to help reduce the number of unnecessary endoscopy referrals.

General Risk Factors for Serious Pathology:

1. Symptoms that have persisted for 6 or more weeks
2. Patients >60 years of age (and especially >70 years of age)
3. Progressive weight loss and anorexia
4. Fe deficiency anaemia (especially if >60 years of age)

Specific Risk Factors:

a) Colonoscopy

1. Change in bowel habit with alarm symptoms at any age (weight loss, severe pain, anaemia, palpable mass)
2. Patient >40yr reporting rectal bleeding with a change in bowel habit towards looser or increased frequency of stools for 6 weeks or more
3. Patient > 60yr with rectal bleeding for >6 weeks and no change in bowel habit or anal symptoms
4. Change in bowel habit > 6 weeks without alarm symptoms in patient aged >60yr
5. Positive FOBT result (including NBCSP participants)
6. Unexplained iron deficiency anaemia in men or non-menstruating women
7. Abnormal CT/Barium imaging (suspected cancer/ large polyp >2cm)
8. Active inflammatory bowel disease or diarrhoea where endoscopy is indicated to progress management
b) Upper GI Endoscopy

1. Chronic GI bleeding
2. Unexplained recent onset persistent dyspepsia in patients aged >55yr (In patients aged less than 55 years, endoscopic investigation of dyspepsia is not necessary in the absence of alarm symptoms - weight loss, severe pain, anaemia, palpable mass)
3. Dysphagia (interference with the swallowing mechanism that occurs within 5 seconds of having commenced the swallowing process)
4. Unexplained upper abdominal pain and weight loss (>10%) or iron deficiency anaemia
5. Upper abdominal mass
6. Persistent vomiting and weight loss
7. Unexplained weight loss or iron deficiency anaemia
8. Obstructive jaundice (an urgent abdominal USS may be considered)
9. Epigastric mass

Recommended Investigations Prior to Referral:

- Full Blood Count and iron studies (including Ferritin) in patients with upper and lower GI symptoms will assist in triaging their care.
- A digital rectal examination is essential for any patient with lower bowel symptoms to help exclude a rectal/anal malignancy.
- Stool MC&S in patients with chronic diarrhoea.

Where there is clear-cut concern about the presence of serious GI pathology on the basis of these sorts of symptoms, especially in high risk patient groups, referral for endoscopy is appropriate and OPH will place high priority on attending to them. The risk factors should be clearly stated on the referral to help triage.

However, where there is reasonable clinical uncertainty, especially in lower risk patient groups and in those whose symptoms are of short duration, “it is reasonable to use a period of 'treat, watch and wait’ as a method of management”* before referring.

In these circumstances, arranging for a clinical review in your rooms in 6 - 8 weeks is the more appropriate first step. If clinical concern remains after this review, referral for endoscopy is then appropriate.

*as per the NICE guidelines (http://www.nice.org.uk/guidance/cg27/chapter/1-guidance/#upper-gastrointestinal-cancer)