Clinical position paper on gastrointestinal conditions that do not require surveillance

HSE Acute Operations Endoscopy Programme

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Introduction

The aim of this document is to provide guidance to clinicians (consultants, SpRs and nurses) working in GI endoscopy. The document provides guidance about the types of GI procedures that do not require regular surveillance.

Following a review of published guidelines and position papers for endoscopic surveillance in a variety of conditions, it is the view of the HSE Acute Operations Endoscopy Programme that the following guidelines and position papers should be adopted by all GI endoscopy services in Ireland. Further information about how this position paper was developed is outlined in appendix 1. This document is also available on request in Word format.

Guidance

In line with international guidance, the following low risk gastrointestinal conditions (summarised on table 1), do not require regular endoscopic surveillance.

1. Upper GI Tract

Surveillance is not indicated for:

- an inlet oesophageal patch
- grade A or B (Los Angeles grade) erosive oesophagitis
- <1 cm columnar-lined oesophagus
  See *the National Endoscopy Programme's Clinical Position Paper on Endoscopy Surveillance*

Surveillance of individuals with fundic gland polyps is not indicated in the absence of suspicious endoscopic features or hereditary cancer syndromes.

Surveillance of individuals with intestinal metaplasia limited to the antrum is not indicated unless additional risk factors are present, such as persistent Helicobacter pylori infection, incomplete metaplasia, or a family history of gastric cancer.

Surveillance for duodenal peptic ulcers is generally not indicated, unless symptoms persist despite adequate therapy or concerns regarding potential neoplastic process

2. Lower GI tract

Surveillance for patients with diminutive hyperplastic polyps limited to the rectosigmoid area is not indicated.

Surveillance is generally not indicated for non-high-risk polyps (see *National Endoscopy Programme Clinical Position Paper on Endoscopy Surveillance 2021)*. In the case of low-risk individuals (those with premalignant polyps but falling short of high-risk criteria) who are younger than 40 years of age, surveillance should be considered on an individualised basis with other risk factors (such as family history) taken into consideration.

High risk polyps:

- Two or more premalignant polyps (SSL and adenoma, excluding diminutive rectal hyperplastic polyps) including at least one advanced colorectal polyp (defined as a serrated polyp of at least 10mm in size or containing any grade of dysplasia, or an adenoma of at least 10mm in size or containing high-grade dysplasia)

  or

- Five or more premalignant polyps

The colonic polyp surveillance guidelines are predicated on an assumption that the initial colonoscopy is of an acceptable minimum quality, defined as complete colonoscopy to the caecum with at least adequate bowel preparation, and with clearance of all identified premalignant polyps.

3. Endoscopic Ultrasound (EUS)

Surveillance of gastrointestinal leiomyomas, lipomas, and antral pancreatic rests, provided that these lesions have ***typical*** EUS features.

Surveillance of ***confirmed*** pancreatic serous cystic neoplasms is not indicated.

4. General

In certain circumstances endoscopic surveillance for some of these conditions may be indicated on a case-by-case basis.

Surveillance of gastrointestinal conditions in individuals over 75 years of age, who have less than 10 years of life expectancy and/or poor general health status, is not indicated.

Surveillance in younger individuals who have poor general health status should be determined on a case-by-case basis.

Other relevant guidance

Pease refer to the Clinical Position Paper on Endoscopy Surveillance published by the HSE Acute Operations Endoscopy Programme for Barrett's Oesophagus, colonic polyp and post colorectal cancer endoscopic surveillance guidelines.
https://www.hse.ie/eng/about/who/acute-hospitals-division/clinical-programmes/endoscopy-programme/programme-documents/

Table 1: Low risk GI conditions

	Finding or condition	Prevalence	Malignancy risk
Oesophagus	Inlet patch	0.1% – 12%	0 – 1.6% risk dysplasia
	Erosive oesophagitis	11%	0 – 9% risk of Barrett's oesophagus for LA grade A or B erosive oesophagitis
	<1cm columnar-lined oesophagus	10%	No increased risk of oesophageal cancer
Stomach	Intestinal metaplasia or atrophy limited to one location (i.e. antrum or corpus only)	Up to 25%	0.55% risk of progression to gastric cancer
	Fundic gland polyps	13% – 77%	No documented risk of gastric cancer if <1cm and no suspicious features
Subepithelial lesions	Leiomyoma	0.08% – 0.43%	Benign lesion
	Lipoma	0.2%	Benign lesion
	Pancreatic rest	0.6% – 13.7%	Anecdotal malignant transformation
Duodenum	Duodenal peptic ulcer	2% – 13%	No cancer risk
Pancreas	Serous cystic neoplasm	Up to 16% of pancreatic cystic neoplasms	Benign lesion
Colon	Low risk adenomas	~15% – ~30%	No increased risk versus general population
LA, Los Angeles (classification of gastroesophageal reflux disease)			

Source: ESGE Position Statement. Endoscopy. 2020 Jun;52(6):491-497

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Appendix 1: Development of this position paper

The HSE Acute Operations Endoscopy Programme is supported by a National Working Group with clinical and non-clinical members.

A clinical subgroup was established to review publications that are relevant to endoscopy surveillance as well as gastrointestinal conditions that do not require surveillance.

The surveillance subgroup is chaired by Dr Eoin Slattery and the members are listed below.

Clinician	Key affiliations for the purpose of this subgroup
Dr Eoin Slattery (Chair)	Consultant Gastroenterologist, Galway University Hospital & Clinical Lead for Endoscopy, Saolta University Healthcare Group
Mr Fiachra Cooke	Consultant Colorectal Surgeon, University Hospital Waterford & representative of the National Clinical Programme for Surgery
Dr Garret Cullen	Consultant Gastroenterologist, St Vincent's University Hospital & Clinical Lead for Endoscopy, Ireland East Hospital Group
Dr Jan Leyden	Consultant Gastroenterologist, Mater Misericordiae University Hospital
Dr Caitríona McCarthy	Consultant in Public Health Medicine, The National Cancer Control Programme
Dr Subhasish Sengupta	Consultant Gastroenterologist, Our Lady of Lourdes Hospital, Drogheda & Endoscopy Lead for the BowelScreen Clinical Advisory Group

For more information please do not hesitate to contact Grace O'Sullivan, Programme Manager, HSE Acute Operations Endoscopy Programme graceosullivan@rcpi.ie or visit the programme's website: www.hse.ie/eng/about/who/acute-hospitals-division/clinical-programmes/endoscopy-programme

This position paper is endorsed by

- The National Clinical Programme for Surgery
- BowelScreen The National Bowel Screening Programme
- The National Cancer Control Programme