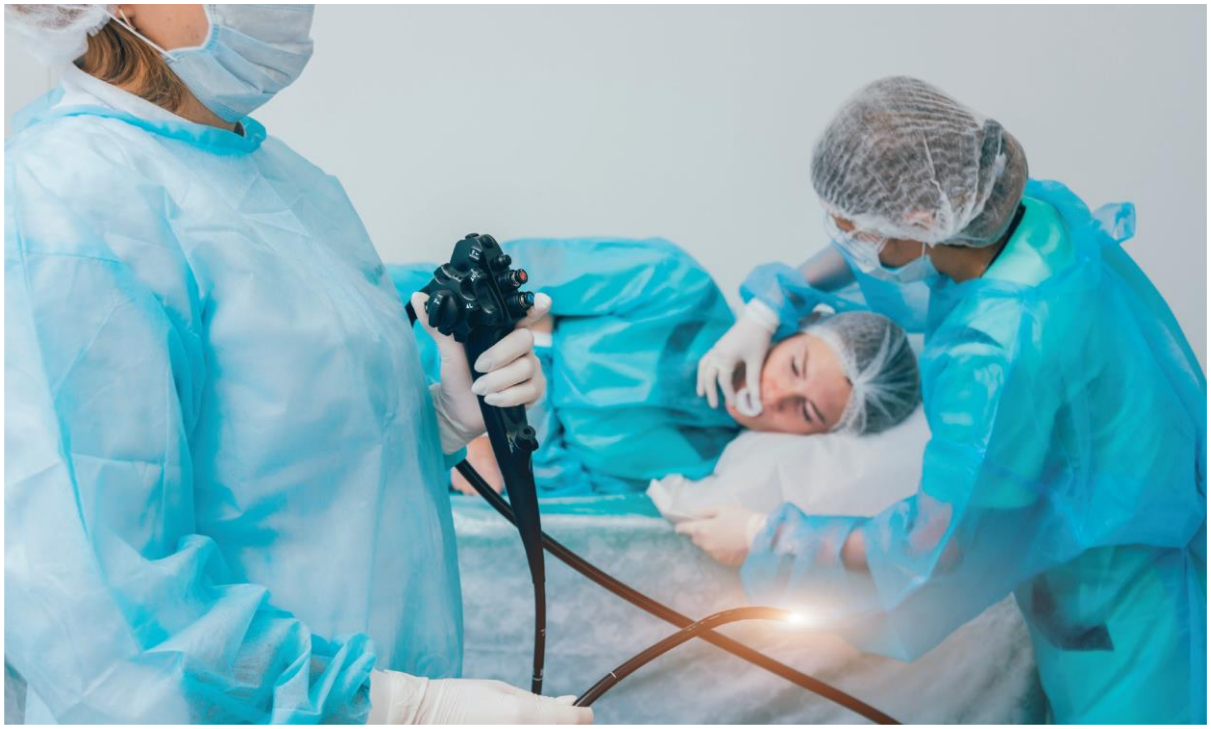
Triage Guidance for Upper and Lower Gastrointestinal Endoscopic Procedures (*excluding ERCP and EUS*)



HSE Endoscopy Programme

Version 3 November 2024

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Aim

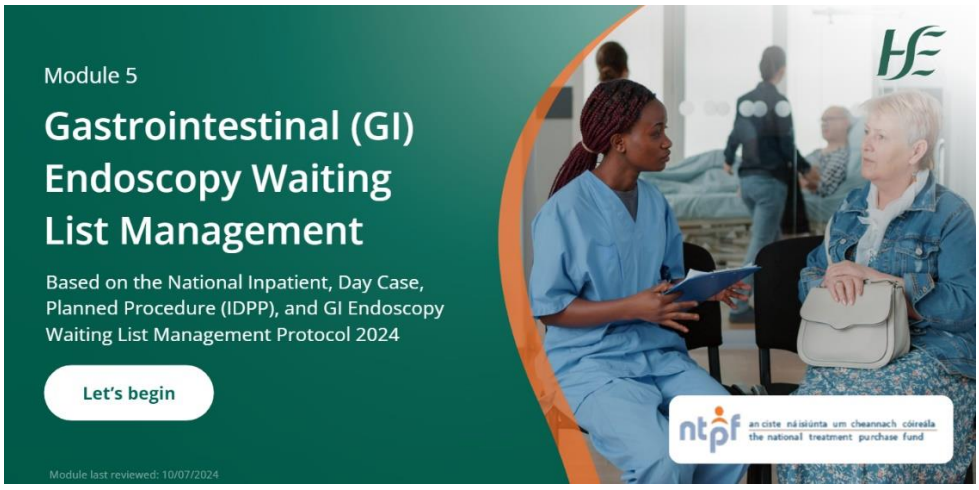
The aim of this document is to provide guidance to clinicians (consultants, SpRs and nurses) with responsibility for triaging endoscopy referrals. It is hoped that this guidance will help to standardise the triage of endoscopy referrals and ensure timely access to treatment for all patients. With adherence to these guidelines, it will ensure that the appropriate patients are on the GI endoscopy waiting list. This triage guidance document has been developed by the HSE Endoscopy Programme. For further information please visit the programme's website.
www.hse.ie/eng/about/who/acute-hospitals-division/clinical-programmes/endoscopy-programme/
This triage guidance is also available in Word format, please contact the programme to request a copy.

Clinical Prioritisation of GI Endoscopy Procedures

Endoscopy services should provide a triage process that reflects their local endoscopy and imaging capacity. This triage guidance, which is based on 2014 HIQA Guidance and the National Cancer Control Programme GP Referral Pathway for Suspected Colorectal Cancer, is intended to assist in risk assessment and standardising the triage of referrals and does not replace the need for individualised clinical evaluation of patients. Where a clinical rationale exists investigations may be deemed more or less urgent, or not appropriate, in the overall clinical context. The table on page four is a framework to assist in prioritisation and scheduling gastrointestinal endoscopy procedures. This does not replace the need for clinical judgement and the triage of all cases by an experienced clinician.

Scheduling GI Endoscopy Procedures

A 30 minute GI endoscopy waiting list management eLearning module is available on www.hseland.ie This module is suitable for all staff, both clinical and non-clinical, working in GI endoscopy waiting list management. The aim of the module is to promote good practice in waiting list management for new staff. It can also be completed as refresher training for existing staff. Search 'endoscopy' on www.hseland.ie to find the course.



Prioritisation of GI Endoscopy Procedures

Endoscopy services should provide a triage process that reflects their local endoscopy and imaging capacity. This guidance document, based on *2014 HIQA Guidance*[1,2] and *NCCP GP Referral Pathway for Suspected colorectal Cancer*[3], and the 2023 *NICE Quantitative faecal immunochemical testing to guide colorectal cancer pathway referral in primary care [DG56]*[4] is intended to assist in risk assessment and standardising the triage of referrals and does not replace the need for individualised clinical evaluation of patients. Where a clinical rationale exists investigations may be deemed more or less urgent or not appropriate in the overall clinical context.

The table below is a framework to assist in prioritisation and scheduling gastrointestinal endoscopy procedures. This does not replace the need for clinical judgement and the triage of all cases by an experienced clinician.

Table 1: Endoscopy Prioritisation

Emergency *Usual target: within 24hrs*	**Level 1 - Highest Priority** Acute GI bleeding (high risk)
Emergency *Usual target: up to 72hrs*	**Level 2 - Higher Priority** • Acute GI bleeding (other than high risk) • Upper GI foreign bodies requiring removal/food bolus • Obstructing upper or lower GI lesion that requires stenting/therapy • ERCP for acute biliary obstruction requiring stenting/cholangitis • Endoscopic drainage of infected pancreatic fluid collection • Urgent inpatient placement of feeding tube or device
Urgent (P1) *Usual target: up to 1 month*	**Level 3 - High Priority** • Urgent out-patient gastroscopy and/or colonoscopy* • EUS for cancer staging/treatment planning • Planned EMR/ESD for high colonic risk lesions • New suspected acute colitis or new IBD diagnosis • Variceal banding in high-risk cases (recent bleeding) • Small bowel endoscopy for therapy (recent or recurrent bleeding) • BowelScreen index patients Note: The HSE maximum waiting time target is 28 days urgent colonoscopies
Routine (P2) *Usual target: 1-3 months*	**Level 4 - Lower Priority** • Routine symptomatic (P2) gastroscopy or colonoscopy following clinical triage and validation • Disease assessment for uncontrolled IBD • High-risk follow-up and repeat scopes – e.g. gastric ulcer healing, 'poor views', check post therapy for high-risk lesion e.g. EMR/RFA/polypectomy • High risk surveillance (e.g. familial cancer syndrome/PSC/Barrett's with dysplasia) • Scheduled variceal banding (no recent bleeding) and follow up for history of varices • EUS for biliary dilatation, possible stones, submucosal lesions, pancreatic cysts without high-risk features • ERCP: for stones where there has been no recent cholangitis and/or a stent is in place; therapy for chronic pancreatitis; stent removal/change; ampullectomy follow-up.

	Note: The HSE maximum waiting time target is 13 weeks for routine OGDs and routine colonoscopies.
Planned procedures *Usual target: 3+ months*	**Level 5 - Lowest Priority** All routine endoscopic surveillance including: • Colonic polyp surveillance (routine) • IBD (without dysplasia or history of PSC) • Barrett's or Gastric IM (without dysplasia) • Primary surveillance for varices • Other low risk surveillance procedures • Endoscopic assessment of asymptomatic patients based on positive family history only (other than in familial cancer syndrome)

Colonoscopy Triage Pathway (incorporating Nurse-led triage, FIT and Colon Capsule)

Patient symptoms, medical history and family history, together with blood test results (full blood count, ferritin, urea and electrolytes, C-reactive protein and tissue transglutaminase where appropriate), and faecal immunochemical test (FIT) and faecal calprotectin should be used to help triage colonoscopy referrals. The Endoscopy Triage Nurse will support optimal and efficient use of endoscopy capacity, working as a key member of the multidisciplinary team providing support to the endoscopy unit and patients using the service.

Colonoscopy is generally NOT indicated for:
HIQA guidance on referral for lower GI endoscopy outlines a range of situation where referral for colonoscopy is not appropriate:

- chronic constipation
- isolated lower abdominal pain with normal abdominal imaging
- normochromic, normocytic anaemia with no concomitant GI symptoms
- patients deemed unable to tolerate bowel preparation or conscious sedation
- anal symptoms such as prolapsed piles, rectal prolapse, anal fissure.

Symptomatic Patients

Referral from Primary Care/Secondary Care

- Triage by Consultant or SpR/Registrar or Endoscopy Triage Nurse
- Refer to NCCP/HIQA direct endoscopy/urgent referral guidelines **(Table 2**)
- Consider initial FIT to assist appropriate triage unless ano-rectal lesion or suspected Inflammatory Bowel Disease (IBD)
- Consider CT abdomen/pelvis for unexplained weight loss without colonic symptoms
- Consider colon capsule examination where available for non-urgent referrals
- Consider minimal prep CT colon for persistent change in bowel habit in frail, elderly or patients with comorbidity.

Table 2: Urgent (P1) colonoscopy criteria (including NCCP/HIQA criteria for urgent assessment and/or investigation)

Age ≥ 60	**Age ≥ 40**	**Age <40**	**Any age**
Rectal bleeding > 6 weeks *OR* Change in bowel habit > 6 weeks *OR* Unexplained significant weight loss with symptoms suggestive of colorectal cancer	Rectal bleeding **AND** Change in bowel habit for > 6 weeks	Unexplained rectal bleeding AND/OR change in bowel habit **AND** a family history of colorectal* *OR* Inflammatory Bowel Disease	Palpable abdominal or rectal mass Unexplained iron deficiency anaemia** Significant weight loss with symptoms suggestive of underlying colorectal cancer Abnormal abdominal imaging Suspected Inflammatory Bowel Disease***

** One 1st degree relative diagnosed with colorectal cancer under the age of 50; two or more relatives with colorectal or endometrial cancer, one of these should be a 1st degree relative of the patient and they should be first degree relatives of each other; family history of colorectal cancer syndrome such as Lynch Syndrome or polyposis*

*** Male (any age) ≤11g/100ml; Female (non-menstruating)≤10g/100ml, concordant serum ferritin*

**** Patients with symptoms suggestive of new onset inflammatory bowel disease should receive urgent investigation. Application of non-invasive testing such as faecal calprotectin and imaging studies will assist individuals. Patients aged <40 years with persistent bloody diarrhoea should be referred for Urgent (P1) sigmoidoscopy. Patients aged <40 years with isolated rectal bleeding should be referred for Routine (P2) sigmoidoscopy*

FIT Testing

The HSE Endoscopy Programme endorses the use of FIT for triage of colonoscopy referrals, where appropriate. Patients with a rectal mass, an unexplained anal mass or unexplained anal ulceration do not need to a FIT as part of their initial triage (HSE Endoscopy Programme. FIT Position Paper V2. Nov 2024)

A FIT **<10 microg/g (50ng/ml)** has a negative predictive value (NPV) for CRC of >95% in the absence of iron deficiency anaemia, a palpable abdominal mass, rectal bleeding, or obstructive symptoms, while a FIT test >100ug/gm is associated with approximately a 1:4 chance of CRC or other significant pathology. [5,6,7]

In 2023 NICE updated its FIT recommendations to include patients with high-risk symptoms (DG56).[4] The updated guidance recommended the use of FIT to guide referral for suspected colorectal cancer in adults with the following symptoms or signs:

- with an abdominal mass, or
- with a change in bowel habit, or
- with iron-deficiency anaemia, or
- aged 40 and over with unexplained weight loss and abdominal pain, or
- aged under 50 with rectal bleeding and either of the following unexplained symptoms:
    - abdominal pain
    - weight loss, or
- aged 50 and over with any of the following unexplained symptoms:
    - rectal bleeding
    - abdominal pain
    - weight loss, or
- aged 60 and over with anaemia even in the absence of iron deficiency

Patients with a FIT =/>10 microg/g should be prioritised for colonoscopy and scheduled on the basis of FIT levels. Consider flexible sigmoidoscopy, CT colon or Colon Capsule Endoscopy (CCE) where appropriate.

Patients with a FIT <10 microg/g are unlikely to have significant colorectal pathology and could be referred for a clinic review within 6 months or be considered for discharge back to the GP with appropriate advice. Consider CCE or a colonoscopy if ongoing clinical concerns.

No test is perfect. While patients with a FIT <10ug/gm generally will not require endoscopy, patients should not be discharged on the basis of a FIT test alone. As a safety net, both patients and their referring GP should be advised to re-evaluate if symptoms recur or change and consider re-assessment with laboratory testing or re-referral in the event of an ongoing clinical suspicion for colorectal neoplasia or IBD.

Incomplete Colonoscopy

Incomplete Colonoscope with excellent or good prep – consider same day Colon Capsule Endoscopy or CT Colonography (ideally same day) if available.

Surveillance colonoscopy

The Endoscopy Programme has endorsed the BSG endoscopy surveillance guidelines[8] (**Appendix 1**). GI Endoscopy Planned Procedure waiting lists should be re-triaged in line with the latest guidelines. (Clinical Position Paper on Endoscopy Surveillance and Clinical Position Paper on GI conditions that do not require surveillance)

Hereditary Cancer Syndromes

Hereditary Cancer Syndromes, such as Lynch syndrome, represent a small percentage of the overall surveillance cohort. Surveillance procedures are generally recommended every 12 to 24 months (BSG guidelines[9]**)**.

Asymptomatic with Family History of Colorectal Cancer (CRC)

- Average risk – advise participation in BowelScreen (consider FIT or CCE if need to reassure)
- Moderate to high risk - manage as per modified BSG guideline[9] (**Figure 3**)

Figure 1: Colonoscopy Triage Pathway

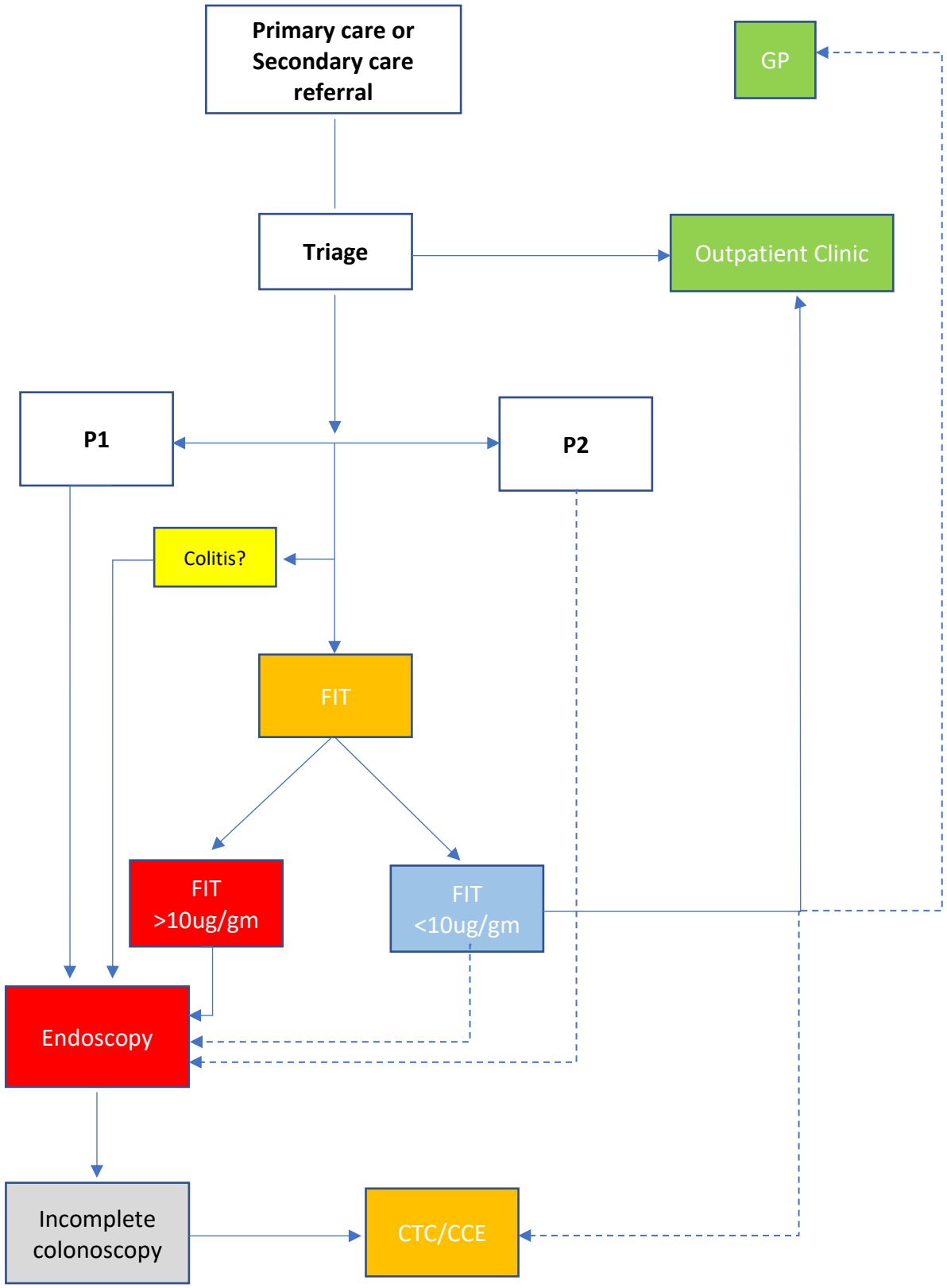


Figure 2: Colon capsule and CT colon follow up

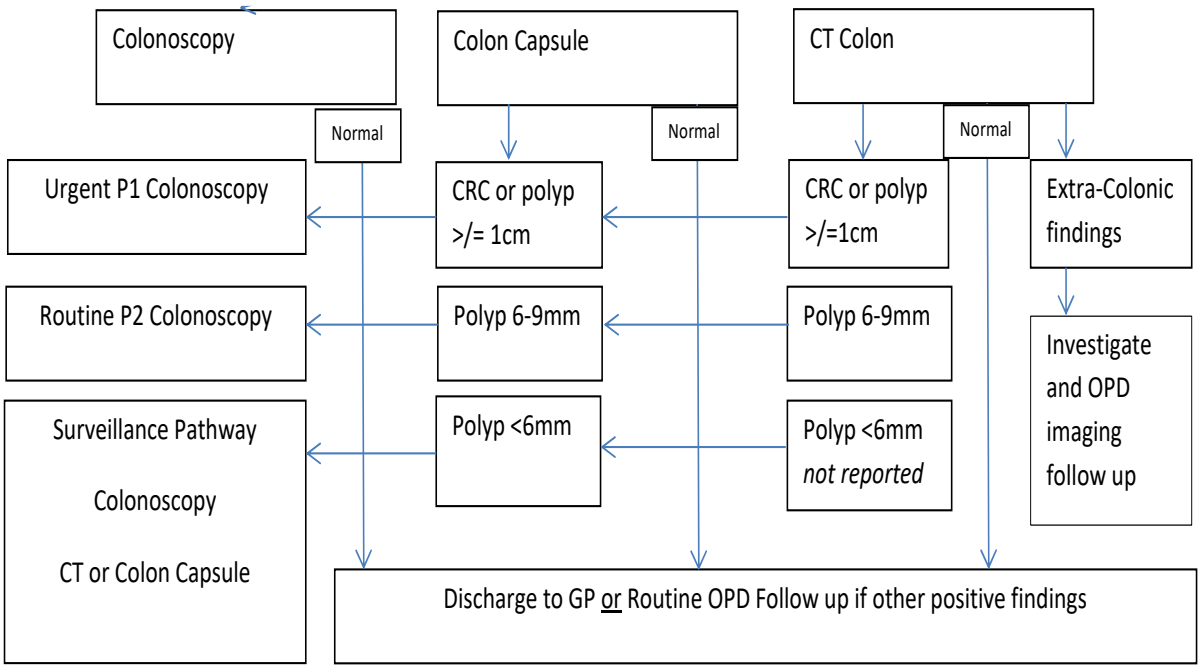
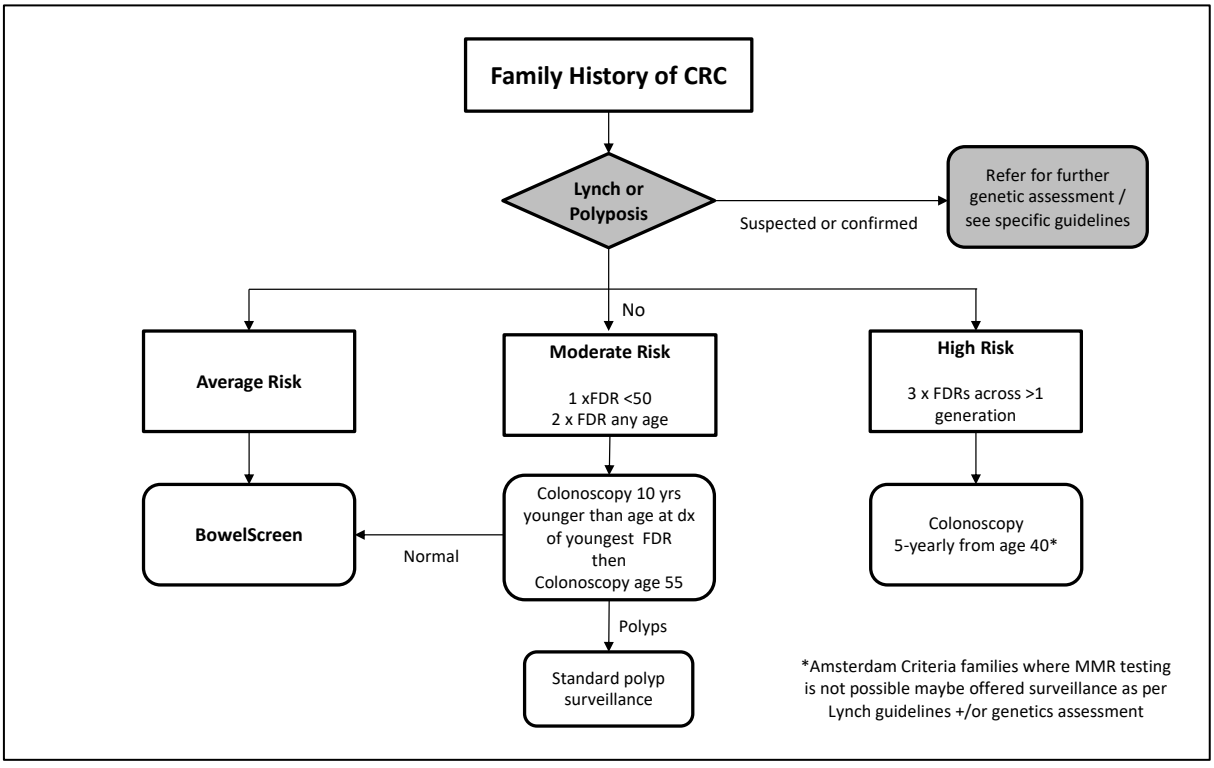


Figure 3: Family History of Colorectal Cancer (CRC)



Gastroscopy Triage Pathway (incorporating Nurse-led triage)

Patient symptoms, medical history and family history, together with blood test results (full blood count, ferritin, urea and electrolytes, CRP and tissue transglutaminase where appropriate) should be used to help triage gastroscopy referrals. The Clinical Triage Nurse will support optimal and efficient use of Endoscopy capacity, working as a key member of the multidisciplinary team providing support to the Endoscopy unit and patients using the service.

Gastroscopy is generally NOT indicated

HIQA Guidance on referral for upper GI endoscopy outlines a range of situation where referral for gastroscopy is not appropriate:

- Asymptomatic patients with a history of duodenal ulcer or oesophagitis
- Screening for Barrett's oesophagus in absence of risk factors – male, Age >50, obese, chronic reflux symptoms, hiatus hernia, family history of Barrett's oesophagus or oesophageal adenocarcinoma
- Surveillance upper endoscopy is generally not indicated in patients with:
    - atrophic gastritis or pernicious anaemia
    - fundic or hyperplastic gastric polyps
    - isolated gastric intestinal metaplasia

Symptomatic patients

Referral from Primary Care/Secondary Care

- Triage by Consultant or SpR/Registrar or Clinical Triage Nurse
- Refer to HIQA direct endoscopy/urgent referral guidelines[2] **(Table 3**)
- Dyspepsia management pathway if <55 years with dyspepsia or GORD and **NO** alarm symptoms
- Consider CT abdomen/pelvis for unexplained weight loss without gastrointestinal symptoms or anaemia

Emergency gastroscopy

Patients who present with evidence of a significant acute upper GI bleed or severe acute dysphagia or odynophagia should be referred for an emergency review.

Urgent (P1) gastroscopy

Patients with dyspepsia or GORD and/or one of the following 'alarm' signs or symptoms should be referred for an urgent review and, or upper endoscopy within four weeks:

- dysphagia ('difficulty swallowing')
- odynophagia ('painful swallowing')
- progressive unintentional weight loss
- haematemesis and, or melaena
- recurrent unexplained vomiting or regurgitation of food
- new onset early satiety
- confirmed and unexplained iron deficiency anaemia
- clarification of an epigastric mass or abnormal finding on radiology imaging

- worsening symptoms with known Barrett's oesophagus.

Patients aged 55 years or older with new or worsening dyspepsia or GORD symptoms should be referred for urgent review and, or investigation (including endoscopy where appropriate) within four weeks.

Routine (P2) gastroscopy

- Confirmed healing of oesophageal or gastric ulcer (routine endoscopic follow up for duodenal ulceration is not indicated)
- Coeliac disease diagnosis (& follow up of non-responders)
- Small bowel biopsies to investigate malabsorption or enteropathy
- Surveillance of Barrett's oesophagus
- Surveillance for gastric dysplasia or with a strong family history of gastric carcinoma
- Surveillance/screening in patients with FAP because of the risk of duodenal polyps
- Surveillance for oesophago-gastric varices in patients with suspected or confirmed portal hypertension

Dyspepsia Management Pathway

Patients under 55 with no alarm features or risk factors generally do not require routine endoscopy. If people have had a previous endoscopy and do not have any new alarm features, consider continuing management according to previous endoscopic findings.

1. Exclude alarm symptoms and assess for risk factors
2. Review medication for causative agents(NSAID/aspirin, Bisphosphonates, Calcium antagonists)
3. Lifestyle modifications (smoking cessation, alcohol consumption, diet & weight loss) and patient information including information on diaphragmatic breathing
4. Therapeutic strategies (Both acceptable):
    a. Empirical treatment with full dose PPI for 1-2 months
    b. Testing and treating H.pylori – Carbon-urea breath test or stool antigen test

Referral to secondary care may be appropriate for patients who fail to respond to maximal conservative therapy or who develop alarm symptoms.

Table 3: Urgent gastroscopy criteria (including HIQA criteria for urgent assessment and/or investigation)

Any Age ***Alarm Symptoms***	**Age =/>55** **Dyspepsia/GORD**	**Age <55** **Dyspepsia/GORD**
1. Dysphagia ('difficulty swallowing') 2. Odynophagia ('painful swallowing') 3. Progressive unintentional weight loss 4. Haematemesis and, or melaena 5. Recurrent unexplained vomiting or regurgitation of food 6. New onset early satiety 7. Unexplained iron deficiency anaemia* 8. Abnormal finding on radiology 9. Barrett's with worsening symptoms URGENT REVIEW AND/OR UPPER GI ENDOSCOPY (P1)	New onset dyspepsia/GORD NO alarm symptoms but unexplained and persistent (>4 weeks) *OR* Worsening dyspepsia with risk factors (Hx of Barrett's/Gastric atrophy/IM or dysplasia. PUD surgery. Family history) URGENT REVIEW AND/OR UPPER GI ENDOSCOPY (P1)	New onset or worsening dyspepsia/GORD NO alarm symptoms <u>Follow dyspepsia management pathway</u> Remove causative medications Lifestyle modification Test and treat for H pylori Empirical treatment with PPI URGENT REVIEW AND/OR UPPER GI ENDOSCOPY (P1) **<u>IF NOT RESPONDING, OR DEVELOPS ALARM SYMPTOMS</u>**
Patients who present with evidence of a significant acute upper GI bleed or severe acute dysphagia or odynophagia should be referred for an emergency review. * See triage guidance for colonoscopy - unexplained iron deficiency anaemia, i.e. considered in primary care not to be related to other sources of blood loss. Male (any age) ≤11g/100ml; Female (non-menstruating) ≤10g/100ml. Referral to include a ferritin level where iron deficiency anaemia is the sole indication for referral.		

References

1. Referral thresholds for patients with lower GI symptoms suspected on indicating malignancy https://www.hiqa.ie/sites/default/files/2017-01/HIQA_SP-HTA_Lower_GI.pdf

2. Referral thresholds for patients with upper GI symptoms suspected on indicating malignancy https://www.hiqa.ie/sites/default/files/2017-01/HIQA_SP-HTA_Upper_GI_Symptoms.pdf

3. NCCP. GP Referral Pathway for Suspected Colorectal Cancer https://www.hse.ie/eng/services/list/5/cancer/profinfo/resources/gpreferrals/gp-referral-pathway-for-suspected-colorectal-cancer.pdf

4. NICE. Diagnostics guidance [DG56]. Quantitative faecal immunochemical testing to guide colorectal cancer pathway referral in primary care. National Institute for Health and Care Excellence; 2023

5. Mowat C, Digby J, Strachan JA et al. Faecal haemoglobin and faecal calprotectin as indicators of bowel disease in patients presenting to primary care with bowel symptoms. Gut 2016; 65: 1463–9.

6. Bailey SER, Abel GA, Atkins A, et al. Diagnostic performance of a faecal immunochemical test for patients with low-risk symptoms of colorectal cancer in primary care: an evaluation in the South West of England. Br J Cancer. 2021 Mar;124(7):1231-1236.

7. Bailey JA, Weller J, Chapman CJ, et al. Faecal immunochemical testing and blood tests for prioritization of urgent colorectal cancer referrals in symptomatic patients: a 2-year evaluation. BJS Open. 2021 Mar 5;5(2):zraa056.

8. BSG/ACPGBI/PHE Post-polypectomy and post-colorectal cancer resection surveillance guidelines https://www.acpgbi.org.uk/resources/1055/bsgacpgbiphe_postpolypectomy_and_postcolorectal_cancer_resection_surveillance_guidelines/

9. BSG, ACPGBI & UKCGG Guidelines for the management of hereditary colorectal cancer https://www.bsg.org.uk/clinical-resource/guidelines-for-the-management-of-hereditary-colorectal-cancer-from-the-bsg-acpgbi-ukcgg/

Useful resources:

Colonoscopy

- https://www.nice.org.uk/Media/Default/About/COVID-19/Specialty-guides/triaging-patients-with-lower-gi-symptoms.pdf

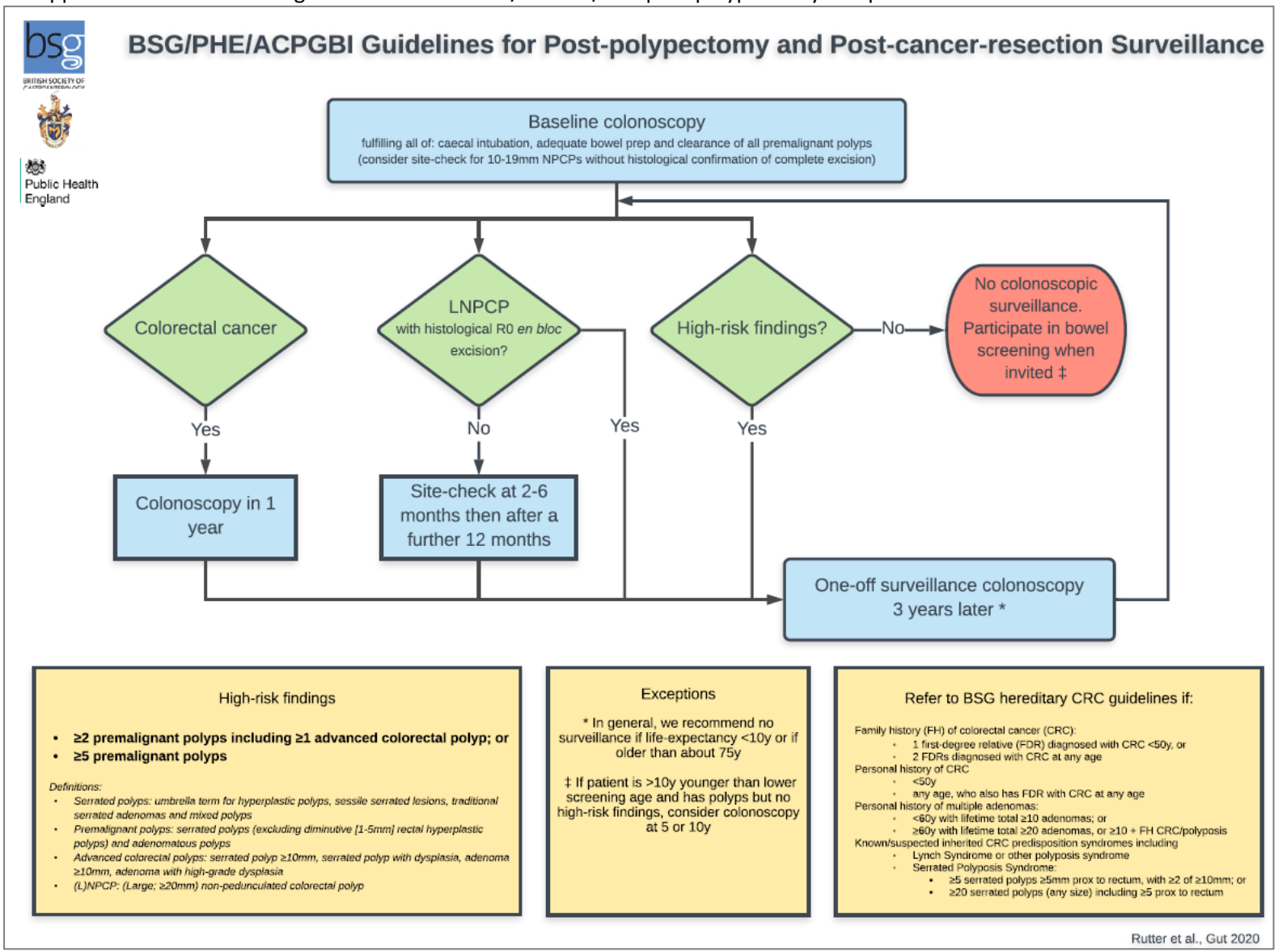
Gastroscopy

- https://www.bsg.org.uk/clinical-resource/guidance-on-the-indications-for-diagnostic-upper-gi-endoscopy-flexible-sigmoidoscopy-and-colonoscopy/
- https://www.nice.org.uk/guidance/cg184

H. pylori eradication guidelines

- https://journals.lww.com/eurojgh/fulltext/2024/08000/the_second_irish_helicobacter_pylori_working_group.4.aspx

Appendix 1: Surveillance algorithm from the B SG/ACPGBI/PHE post-polypectomy and post-colorectal cancer resection surveillance guidelines



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