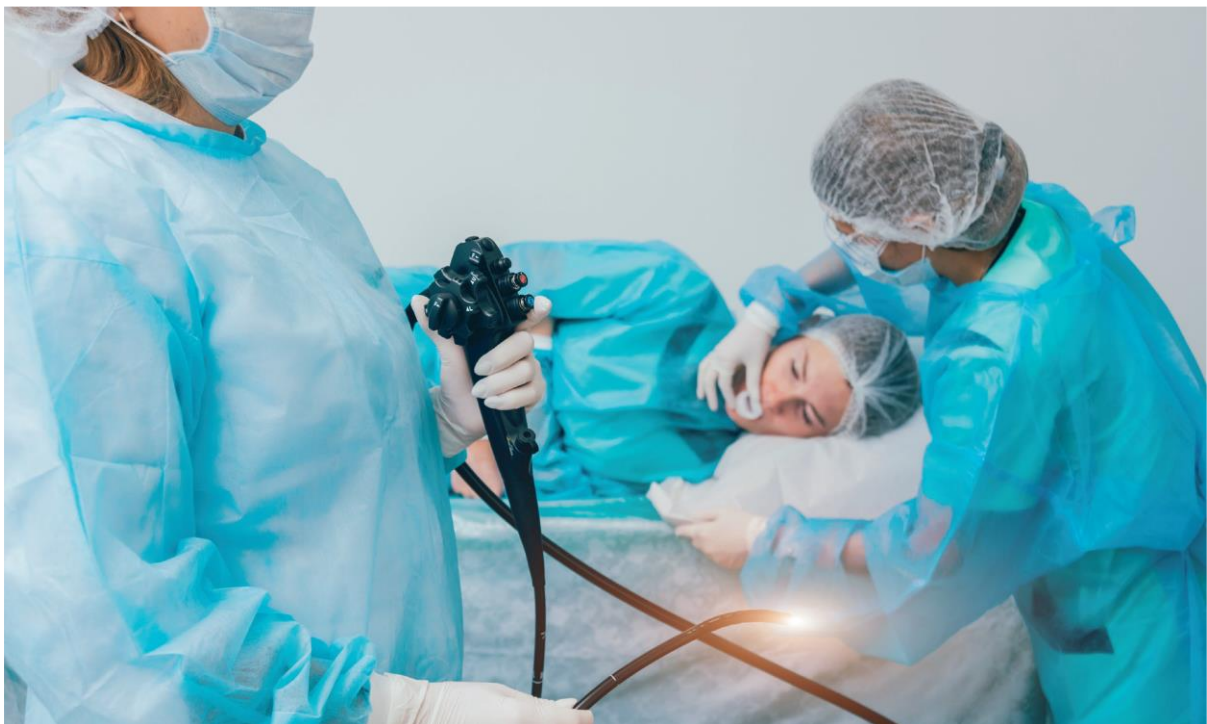




Triage Guidance for Upper and Lower Gastrointestinal Endoscopic Procedures (excluding ERCP and EUS)



HSE Acute Operations Endoscopy Programme

Version 2 March 2023

Table of Contents

Aim	3
Clinical Prioritisation of GI Endoscopy Procedures	3
Scheduling GI Endoscopy Procedures	3
Colonoscopy Triage Pathway	5
Symptomatic patients.....	5
Urgent (P1) colonoscopy	6
FIT testing (where available)	7
Incomplete colonoscopy.....	7
Surveillance colonoscopy	9
Hereditary cancer syndromes.....	9
Asymptomatic with family history of colorectal cancer	9
Gastroscopy Triage Pathway.....	10
Symptomatic patients.....	10
Emergency gastroscopy.....	10
Urgent (P1) gastroscopy	11
Routine (P2) gastroscopy.....	12
Dyspepsia management pathway	12
References	13
Useful resources:	14

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 Acute Operations 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 30minute 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.



Table 1: Endoscopy Prioritisation

<p>Emergency <i>Usual target: within 24hrs</i></p>	<p>Level 1 - Highest Priority Acute GI bleeding (high risk)</p>
<p>Emergency <i>Usual target: up to 72hrs</i></p>	<p>Level 2 - Higher Priority</p> <ul style="list-style-type: none"> • 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
<p>Urgent (P1) <i>Usual target: up to 1 month</i></p>	<p>Level 3 - High Priority</p> <ul style="list-style-type: none"> • 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 <p>Note: The HSE maximum waiting time target is 28 days urgent colonoscopies</p>
<p>Routine (P2) <i>Usual target: 1-3 months</i></p>	<p>Level 4 - Lower Priority</p> <ul style="list-style-type: none"> • 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. <p>Note: The HSE maximum waiting time target is 13 weeks for routine OGDs and routine colonoscopies.</p>
<p>Planned procedures <i>Usual target: 3+ months</i></p>	<p>Level 5 - Lowest Priority All routine endoscopic surveillance including:</p> <ul style="list-style-type: none"> • 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 testing and colon capsule, where available.

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 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 clinical triage nurse
- Refer to NCCP / HIQA direct endoscopy / urgent referral guidelines (table 2 below)
- Allocation to FIT for non-P1 cases **without**:
 - unexplained iron deficiency anaemia. Male, any age $\leq 11\text{g}/100\text{ml}$; female, non-menstruating, $\leq 10\text{g}/100\text{ml}$)
 - suspected IBD
- Consider using CT abdomen and pelvis +/- thorax initially for unexplained weight loss without colonic symptoms
- Consider minimal prep CT colon for persistent change in bowel habit in frail, elderly or patients with comorbidity

Urgent (P1) colonoscopy

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

Age ≥ 60	Age ≥ 40	Age <40	Any age
Rectal bleeding > 6 weeks <i>OR</i> Change in bowel habit > 6 weeks <i>OR</i> 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* <i>OR</i> 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 (where available)

Patients who do not meet the urgent (P1) criteria outlined above should have a faecal immunochemical test (FIT) performed to further assist the triage process.

A FIT result of **<50 ng/mL**, which is the equivalent of 10 µg Hb/g, 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.^{4,5,6}

- Patients with a FIT ≥50 ng/mL should be prioritised for colonoscopy and scheduled based on FIT levels.
- Consider flexible sigmoidoscopy, CT colon or colon capsule endoscopy where appropriate.
- Patients with a FIT <50 ng/mL, should be referred for a clinic review within 6 months or be considered for discharge back to the GP with appropriate advice. Consider colon capsule endoscopy if clinically indicated.

No test is perfect. While patients with a FIT < 50 ng/mL generally will not require endoscopy, patients should not be discharged based on 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 colonoscopy with excellent or good prep – consider same day colon capsule endoscopy or CT colonography (ideally same day), if available.

Additional guidance for FIT and capsule endoscopy

Further guidance about FIT and capsule endoscopy can be found on the HSE Acute Operations Endoscopy Programme's website

www.hse.ie/eng/about/who/acute-hospitals-division/clinical-programmes/endoscopy-programme

Figure 1: Colonoscopy triage pathway

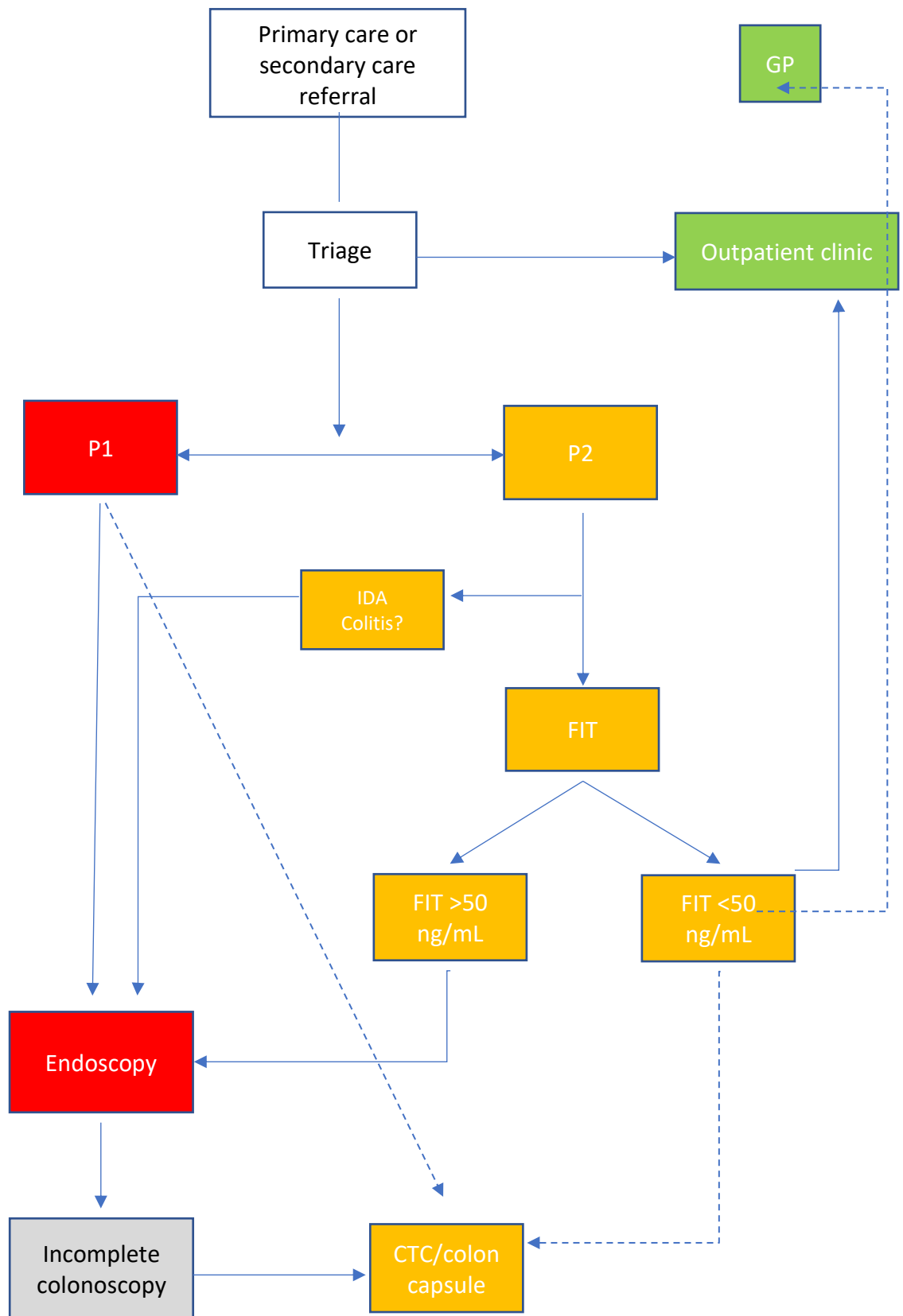
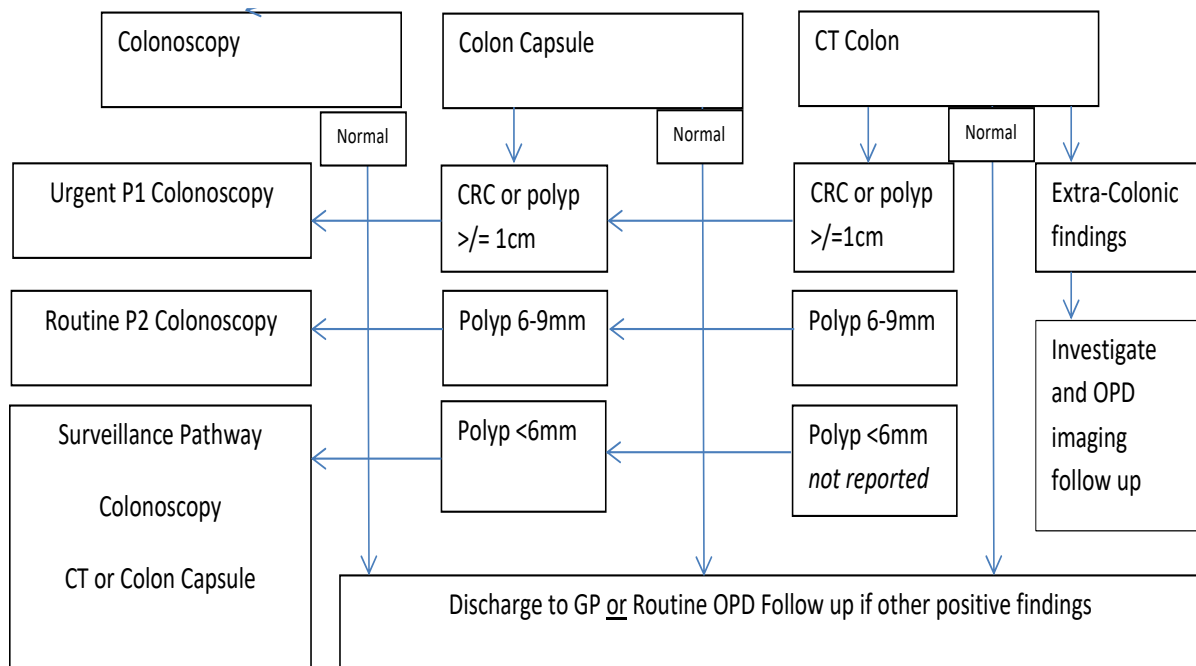


Figure 2: Colon capsule and CT colon follow up



Surveillance colonoscopy

The Endoscopy Programme has endorsed the BSG endoscopy surveillance guidelines; see appendix 1 for a summary. Where clinical validation of surveillance waiting lists is taking place, this should be in line with the most recent guidelines.

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).

Asymptomatic with family history of colorectal cancer

While a national policy for family history of colorectal cancer is not in place in Ireland yet, aspects of the recent European and British guidance may offer a useful guide for triage. Specifically

- Guidelines for the management of hereditary colorectal cancer from the British Society of Gastroenterology/Association of Coloproctology of Great Britain and Ireland/ United Kingdom Cancer Genetics Group
- Endoscopic management of Lynch Syndrome and of familial risk of colorectal cancer: European Society of Gastrointestinal Endoscopy Guideline

Weblinks to guidelines are in the references section below.

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 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.

Gastroscopy is generally NOT indicated for:

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 (table 3 below)
- Dyspepsia management pathway if <55 years with dyspepsia or GORD and **NO** alarm symptoms
- Consider using CT abdomen and pelvis +/- thorax initially for unexplained weight loss without gastrointestinal symptoms and anaemia
- Consider minimal prep CT colon for persistent change in bowel habit in frail, elderly or patients with comorbidity

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.

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/GORDz
<ol style="list-style-type: none"> 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 	<p>New onset dyspepsia/GORD NO alarm symptoms but unexplained and persistent (>4 weeks)</p> <p><i>OR</i></p> <p>Worsening dyspepsia with risk factors (Hx of Barrett's/Gastric atrophy/IM or dysplasia. PUD surgery. Family history)</p> <p>URGENT REVIEW AND/OR UPPER GI ENDOSCOPY (P1)</p>	<p>New onset or worsening dyspepsia/GORD NO alarm symptoms</p> <p><u>Follow dyspepsia management pathway</u></p> <p>Remove causative medications Lifestyle modification Test and treat for H pylori Empirical treatment with PPI</p> <p>URGENT REVIEW AND/OR UPPER GI ENDOSCOPY (P1) <u>IF NOT RESPONDING, OR DEVELOPS ALARM SYMPTOMS</u></p>
<p>URGENT REVIEW AND/OR UPPER GI ENDOSCOPY (P1)</p>		

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) $\leq 11\text{g}/100\text{ml}$; Female (non-menstruating) $\leq 10\text{g}/100\text{ml}$. Referral to include a ferritin level where iron deficiency anaemia is the sole indication for referral.

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.

References

1. HIQA referral thresholds for patients with upper gastrointestinal symptoms suspected of indicating malignancy
https://www.hiqa.ie/sites/default/files/2017-01/HIQA_SP-HTA_Upper_GI_Symptoms.pdf
2. HIQA referral thresholds for patients with lower gastrointestinal symptoms suspected of indicating malignancy
https://www.hiqa.ie/sites/default/files/2017-01/HIQA_SP-HTA_Lower_GI.pdf
3. National Cancer Control Programme 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. 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.
5. 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.
6. 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.
7. BSG/ACPGBI/PHE Post-polypectomy and post-colorectal cancer resection surveillance guidelines
<https://www.bsg.org.uk/clinical-resource/bsg-acpgbi-phe-post-polypectomy-and-post-colorectal-cancer-resection-surveillance-guidelines/>
8. Guidelines for the management of hereditary colorectal cancer from the British Society of Gastroenterology (BSG)/Association of Coloproctology of Great Britain and Ireland (ACPGBI)/United Kingdom Cancer Genetics Group (UKCGG)
<https://www.bsg.org.uk/clinical-resource/guidelines-for-the-management-of-hereditary-colorectal-cancer-from-the-bsg-acpgbi-ukcgg/>
9. Endoscopic management of Lynch syndrome and of familial risk of colorectal cancer: European Society of Gastrointestinal Endoscopy (ESGE) Guideline
<https://www.thieme-connect.de/products/ejournals/abstract/10.1055/a-1016-4977>

Useful resources:

Colonoscopy

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

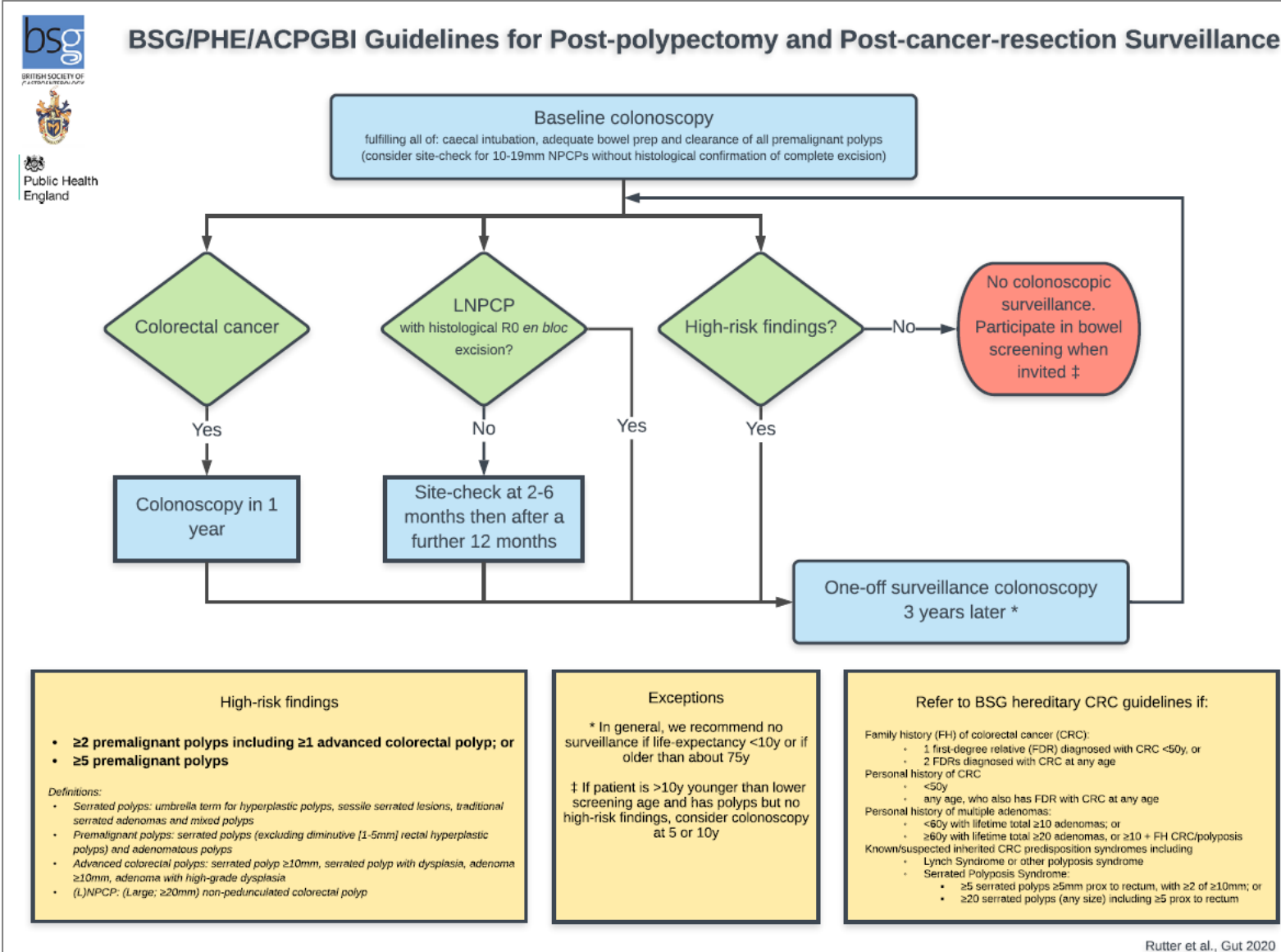
Gastroscopy

- https://www.bsg.org.uk/wp-content/uploads/2019/12/indications_diagnostic_endoscopy_13.pdf
- <https://www.nice.org.uk/guidance/cg184>

H. pylori eradication guidelines

- https://journals.lww.com/eurojgh/Fulltext/2017/05000/The_Irish_Helicobacter_pylori_Working_Group.10.aspx

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





HSE Acute Operations Endoscopy Programme

Health Service Executive

Steeven's Hospital

Steevens' Lane

Dublin 8 D08 W2A8

December 2021