

THE ALFRED REFERRAL GUIDELINES: ENDOSCOPY

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THE ALFRED REFERRAL GUIDELINES ENDOSCOPY

Open access endoscopy

The Gastroenterology Department at The Alfred offers a diagnostic open access upper gastrointestinal and colonoscopy endoscopy service for patients with no significant co-morbidities. Other endoscopy services require patient evaluation at the Gastroenterology Outpatient Clinic.

To print and complete the referral form: [Gastrointestinal Endoscopy Referral Form](#)

To download and install the Medical Director template of the referral form: [Alfred GI Endoscopy form \(Medical Director format\)](#) (Southcity GP Services website)

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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.

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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

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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.

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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 GIT endoscopy

Upper GIT 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)

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Upper GIT endoscopy is generally not indicated 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

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Sequential or periodic upper GIT endoscopy may be indicated for:

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

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Sequential or periodic upper GIT endoscopy is generally not indicated 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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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 pancolitis eight or more years' duration or left sided colitis 15 or more years' duration every 1-2 years with systematic biopsies to detect dysplasia
 - 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/markings 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)

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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)

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Colonoscopy is generally contraindicated in:

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

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NHMRC Clinical Practice Guidelines for the Prevention, Early Detection and Management of Colorectal Cancer (2005)

Post Adenoma Resection Colonoscopy Surveillance*

| Finding at index colonoscopy | Interval |
|---|--|
| <ul style="list-style-type: none"> • 2 or less tubular adenomas < 10mms. | 5 years. |
| <ul style="list-style-type: none"> • Large adenomas ≥ 10 mms. • Advanced adenoma – high grade dysplasia/villous component. • 3 or more adenomas. | 3 years. |
| <ul style="list-style-type: none"> • Malignant polyps. • Piecemeal resection of large sessile polyps (>2cms) with possible incomplete excision. | Clinician discretion for 1 st surveillance (recommend within 3 months), then standard follow up as per guideline. |

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Family History

| Finding | Advice |
|---|--|
| Average Risk <ul style="list-style-type: none"> • No family history • 1 relative affected age >55 | FOBT 1-2 yearly from age 50 |
| Moderate Risk <ul style="list-style-type: none"> • 1st degree relative affected with colorectal cancer (CRC) Age <55. • Two 1st degree relatives or 2nd degree relatives on same side of family with CRC. | Colonoscopy every 5 years from age 50 (or 10 years younger than youngest affected relative). |
| High Risk <ul style="list-style-type: none"> • HNPCC • FAP • Hyperplastic polyposis, etc | Colonoscopy 1 - 2 yearly from age 25 (or 5 years younger than youngest affected relative). |

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Post Curative Resection for Colorectal Cancer

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|---|
| <ul style="list-style-type: none"> • Complete examination of the colon either pre-operatively or within 1 year of curative surgery. • Subsequent colonoscopy at 3 years and if normal 5 yearly. |
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*For further information, see the [NHMRC Clinical practice guidelines for the prevention, early detection and management of colorectal cancer \(2005\)](#).