Referral Guidelines: Direct Access Gastrointestinal Endoscopic Procedures

Referrals for patients deemed not to meet the clinical indications for referral will be returned to the referrer for clinical review.

Who needs endoscopy?

There is a high demand for gastrointestinal endoscopy services across the health system; therefore, it is essential to identify those patients that need procedures most urgently.

In WA, cancers are found in less than 2% of colonoscopies and <1% of upper gastrointestinal endoscopies *(WA DoH Data, 2014).*

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

Essential Referral Requirements

- Referrals for direct access endoscopy must be made using the Request for Direct Access Gastrointestinal Endoscopy (Adult) form.
- All mandatory fields must be complete for the referral to be accepted. Incomplete referrals will be returned to the referring doctor.
- Referrals for patients who require immediate review (within the next seven days) should be referred directly to the appropriate, local hospital in consultation with the Gastroenterology Service. To contact the relevant service, please refer to HealthPathways Acute Gastroenterology assessment (external site)
- All other referrals must be sent to the Central Referral Service – either via fax (1300 365 056) or secure messaging (HealthLink address/ID: **crefserv**).
- Patients who have co-morbidities may be reviewed in the appropriate outpatient clinic prior to consideration of endoscopy.

Referral Decision and Acceptance Considerations

- Referrals will only be accepted if they are submitted on the Request for Direct Access Gastrointestinal Endoscopy (Adult) form, and all mandatory fields are complete.
- All referrals are triaged, and appointments are provided based on clinical priority. The guidelines used for triage categorisation are summarised here.
- Where there is clear-cut concern about the presence of serious GI pathology on the basis of symptoms described below, referral for endoscopy is appropriate and patients will be waitlisted for their procedure.
- Where there is reasonable clinical uncertainty, and patients don't meet the criteria for referral or other investigative action, *especially in lower risk patient groups and in those whose symptoms are of short duration,* it is recommended to arrange a GP review for a future date (suggested 6-12 weeks but this is a clinical decision that remains the responsibility of the GP). The NICE guidelines (2015) recommend that the review in these circumstances may be*:
    - Planned within a time frame agreed with the person **or**
    - Patient initiated if new symptoms develop, the person continues to be concerned, or their symptoms recur, persist or worsen.

  **as per the safety netting recommendations in NICE guidelines (2015)*
  https://www.nice.org.uk/guidance/NG12/chapter/Recommendations-on-patient-support-safety-netting-and-the-diagnostic-process#safety-netting
- Referrals for patients deemed not to meet the clinical indication for referral will be returned to the referrer with a brief explanation of the return reason. These referrals will be returned via the CRS, on behalf of the hospital making the triage decision. Hospitals will be responsible for managing communication with patients regarding the status of their referrals.

Referral Process

Step 1	Step 2	Step 3	Step 4	Step 5
Referral is made using the Request for Direct Access Gastrointestinal Endoscopy (Adult) form.. Referral is sent to the Central Referral Service (CRS).	Mandatory referral content will be checked. The CRS will contact you if further information is required. ***You will be notified by the CRS when your referral is*** received.	The CRS sends the complete referral to the most appropriate hospital based on clinical need and postcode. ***You will be notified when CRS receives the referral.***	The allocated hospital assesses if the referral meets access criteria. Meets acceptance criteria - the referral is triaged and waitlisted according to clinical urgency. ***You will be notified regarding which hospital has accepted the referral.*** Does not meet acceptance criteria – the referral will be returned with advice why.	The hospital will provide the patient with a date when their procedure date is approaching.

Please note: The times to assessment may vary depending on the size and staffing of the hospital department. If you are concerned about the delay of the appointment, or if there is any deterioration in the patient's condition, please contact the Gastroenterology service at the appropriate hospital.

In referring a patient for direct access endoscopy, the referrer should:

- Inform the patient about the procedure – patient information can be accessed here.
- Ensure they are willing to undergo the procedure.
- Consider the ability of the patient to tolerate bowel preparation (if relevant) and the procedure.
- Consider whether the patient will benefit if they are frail, have multiple co-morbidities or advanced malignancy (generally referral implies they are well enough to tolerate further treatment).
- Ensure, if the patient has had a colonoscopy or gastroscopy in the preceding five years, that there is clear indication to repeat the procedure.

General Indications for Referral

Endoscopy is generally INDICATED:

- If a change in management is probable based on the results of the 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

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

Endoscopy is generally CONTRAINDICATED:

- When the risks to the patient's 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

Clinical Indications for Referral: Colonoscopy

Indications for Referral

- Rectal bleeding (multiple occurrences or continuous) for >4 weeks
- Positive iFOBT where a colonoscopy has not been performed within the last 2 years
- Altered bowel habit >6 weeks AND in presence of alarm symptoms*
- Alerted bowel habit >6 weeks, age ≥45

- Diarrhoea >6 weeks with negative stool culture
- Unexplained iron deficiency +/- anaemia with no identified cause and/or unresponsive to treatment
- Mass or abnormal imaging
- After first episode of proven diverticulitis to exclude neoplasm (refer 6 weeks post primary presentation)
- Surveillance procedures required within 12 months (HealthPathways- Screening and Surveillance Colonoscopy)

Alarm symptoms

- Persistent rectal bleeding
- Unexplained progressive weight loss
- Persistent severe abdominal pain Unexplained iron deficiency anaemia
- Bloody diarrhoea with negative stool MC&S

Clinical Indications for Referral: Gastroscopy

Indications for Referral

- Unexplained iron deficiency +/- anaemia with no identified cause and/or unresponsive to treatment
- Unexplained recent dyspepsia AND in presence of alarm symptoms*
- Non-responsive GORD (following 6-8 weeks of double dosage PPI treatment)
- Persistent or recurrent (≥4 weeks) dysphagia
- Mass or abnormal imaging
- Upper abdominal pain AND unexplained weight loss (>10%) OR abnormal blood test (low Hb, Low ferritin, microcytosis, hypochromia, raised platelets)
- Persistent nausea/vomiting AND unexplained weight loss (>10%) OR abnormal blood test (low Hb, Low ferritin, microcytosis, hypochromia, raised platelets)
- Suspected Coeliac disease with positive serology
- Known Coeliac disease with no exposure to gluten AND persistent high titres after 12 months OR persistent alarm symptoms*
- Pernicious anaemia (serologically diagnosed) asymptomatic at time of diagnosis
- Surveillance procedures required within 12 months
- Surveillance requested by previous Endoscopist

Alarm symptoms

- Gastrointestinal bleeding
- Unexplained progressive weight loss
- Unexplained iron deficiency anaemia
- Dysphagia
- Early satiety

Mandatory Information Required for Referral

Referrals will only be accepted if they have mandatory information included. Mandatory referral information is listed on the Referral Access Criteria website.

If this information is not provided, the referral will be returned to the referrer for completion.

- Referral for: Public Colonoscopy and/or Public Gastroscopy
- Patient Details:
    - Name
    - Date of Birth
    - Gender
    - Contact number
    - Address
    - Medicare number including reference number and expiry date
    - Interpreter required
- Indication for referral:

    - At least one indication must be ticked under the following sections, or an adequate description provided:
        - Lower GI indications
        - Upper GI indications
- Medical history, risk factors and ***current*** medication list
    - Weight – if exact weight is not known an estimate must be provided
    - Indicate if the patient has cardiac stents/pacemaker/implanted defibrillator (if history of heart disease)
    - List of anti-coagulation medications, and the indication for prescription
- Relevant investigations- Evidence to support reason for referral must be attached e.g.

Colonoscopy	Gastroscopy
Mandatory Evidence to support reason for referral must be attached e.g. • Length of time and/or number of episodes for rectal bleeding • iFOBT result • Description of bowel habit changes • Stool MC&S for diarrhoea • FBC & Ferritin results for unexplained iron deficiency anaemia • Imaging • Summary results of any previous colonoscopy (where relevant) • Weight loss %	**Mandatory** Evidence to support reason for referral must be attached e.g. • Length of time and/or number of episodes for GI bleeding • Description of bowel habit changes • FBC & Ferritin results for unexplained iron deficiency anaemia • Imaging • Results of any previous gastroscopy (where relevant) • Weight loss %

Surveillance Guidelines: Colonoscopy

All patients referred for surveillance colonoscopies after removal of polyps, for family history or following colorectal cancer are triaged according to the guidelines below.

Referrals for patients that require a surveillance colonoscopy in greater than 12 months' time, will be returned to the referrer with advice to re-refer closer to the date the colonoscopy is due.

These guidelines are a summary based on Cancer Council Australia Clinical Practice Guidelines for Surveillance Colonoscopy (2019)

Family History

Family History	Advice
Average Risk • No family history • 1st degree or one 1st and one 2nd degree relative affected ≥55	iFOBT 1-2 yearly from age 45 to age 75
Moderate Risk • 1st degree relative affected with colorectal cancer (CRC) age <55 • Two 1st degree relatives with colorectal cancer diagnosed at any age • One 1st degree and at least two 2nd degree relative with colorectal cancer diagnosed at any age or 2nd degree relatives on same side of family with CRC	iFOBT every 2 years from age 40 to age 49 Colonoscopy every five years from age 50 to age 74
• Serrated/Hyperplastic Polyposis Syndrome	Colonoscopy every 2 years after polyps have been removed

Family History	Advice
High Risk *should be managed by specialist referral centre in collaboration with a genetic diseases service.* • Three 1st degree or 2nd degree relatives with colorectal cancer with at least one diagnosed under 55 years • Three 1st degree relatives with colorectal cancer diagnosed at any age	iFOBT every 2 years from age 35 to age 44 Colonoscopy every 5 years from age 45 to age 74
• Lynch syndrome (Hereditary Non Polyposis Colorectal Cancer - HNPCC)	HNPCC: Colonoscopy 1-2 yearly from age 25 (or 5 years younger than youngest affected relative)
• Familial Adenomatous Polyposis (FAP)	FAP: sigmoidoscopy or colonoscopy from 12-15 years of age

After Polypectomy

Finding at Colonoscopy	Interval
Conventional Adenomas only 1 or 2 tubular adenomas <10mms (without HGD)	10 years
1 or 2 tubular adenomas <10mms (with HGD OR 3-4 without HGD)	5 years
1 or 2 adenomas ≥ 10mms (with/without HGD and/or villosity) 3 or 4 < 10mm adenomas (with HGD and/or villosity) OR ≥ 10mms (without HGD and/or villosity)	3 years
3 or 4 ≥ 10mms adenomas (with HGD and/or villosity) 5 or more adenomas	1 year
Serrated polyps only 1 or 2 <10mm sessile serrated polyps without dysplasia	5 years
3 or 4 <10mm sessile serrated polyps without dysplasia 1 or 2 ≥ 10mm (or with dysplasia) sessile serrated polyps OR TSA any size	3 years
3 or 4 ≥ 10mm (or with dysplasia) sessile serrated OR TSA any size 5 or more <10mm sessile serrated polyps without dysplasia	1 year
Malignant polyps Piecemeal resection of large sessile polyps (>20mms)	Clinical discretion (recommend within 4-6 months, then base subsequent surveillance on histological findings, size and number of other adenomas)

*Please use the above information as a guide only. For the full version of surveillance interval recommendations please refer to Cancer Council 2019 Colonoscopy surveillance Summary of recommendations and summary tables.

After Curative Surgery for Colorectal Cancer

Complete examination of the colon before or within 6 months of surgery

Subsequent colonoscopy at 1 year, then as per adenoma surveillance (see box above) – if no polyps detected then 5 yearly surveillance interval

Surveillance Guidelines: Gastroscopy

Referrals for patients with the following indications should be accepted and waitlisted for a surveillance gastroscopy:

Barrett's Oesophagus

Finding at Gastroscopy	Interval
No dysplasia	
Short (<3 cm) segment	3-5 years
Long (>3 cm) segment	2-3 years
'Indefinite for dysplasia' or 'Confirmed dysplasia'	This should be referred and managed at a tertiary centre.

Gastric intestinal metaplasia

If this is a finding at gastroscopy the patient should be referred to a tertiary centre for follow-up in a Gastroenterology outpatient clinic and further surveillance booked as clinically indicated.

Indicative Triage Category

The following provides a general indication regarding how triaging clinicians at hospitals assign urgency categorisation to direct access endoscopy referrals.

While it is anticipated that usual urgency categories and surveillance guidelines will be suitable in most circumstances, it is acknowledged that there will be exceptional cases where the urgency category/surveillance interval will vary, and a different approach will be clinically appropriate.

	Colonoscopy	Gastroscopy

Category 1
 	
Appointment within 30 days
	• Rectal bleeding for >4 weeks, AND any one of:
	  ○ +iFOBT,
	  ○ unexplained anaemia,
	  ○ bloody diarrhoea with negative stool MC&S,
	  ○ age ≥45 years
	• Rectal bleeding for >4 weeks, age <45 years and alarm symptoms or elevated CRP
	• +iFOBT AND ≥45 years
	• Altered bowel habit >6 weeks and alarm symptoms
	• Diarrhoea >6 weeks with negative stool culture and raised Faecal calprotectin or stool leukocytes
	• Unexplained iron deficiency +/- anaemia in men or non-menstruating women and presence of other alarm symptoms
	• Mass palpable (abdominal or rectal) OR likely colorectal mass on imaging
		• Unexplained iron deficiency +/- anaemia in men or non-menstruating women and the presence of alarm symptoms
		• Unexplained recent dyspepsia, age ≥45 and the presence of alarm symptoms
		• Non-responsive GORD (following 6-8 weeks of double dosage PPI treatment) and the presence of alarm symptoms
		• Dysphagia, persistent or recurrent (≥4 weeks)
		• Mass/abnormal imaging, likely oesophageal or gastric cancer
		• Upper abdominal pain or persistent nausea/vomiting, age ≥45 years and unexplained weight loss (>10%) or abnormal blood test

Category 2 Appointment within 90 days	• Rectal bleeding for >4 weeks, age <45 years in the absence of alarm symptoms • +iFOBT and <45 years	• Unexplained iron deficiency +/- anaemia with no obvious cause and/or unresponsive to treatment. • Unexplained recent dyspepsia, age <45 and

	Colonoscopy	Gastroscopy
	• Altered bowel habit >6 weeks in the absence of alarm symptoms in patients ≥45 years. • Diarrhoea >6 weeks with negative stool culture • Unexplained iron deficiency +/- anaemia with no identified cause and/or unresponsive to treatment • Abnormal imaging, unlikely colorectal cancer • 6 weeks post primary presentation for acute diverticulitis • Procedures due as per NHMRC Clinical Practice Guidelines for surveillance colonoscopy	the presence of alarm symptoms • Dyspepsia (≥45) AND non-responsive to PPI and/or H. pylori therapy or H. pylori negative. • Non-responsive GORD (following 6-8 weeks of double dosage PPI treatment) • Upper abdominal pain or persistent nausea/vomiting, age <45 years and unexplained weight loss (>10%) or abnormal blood test • Suspected Coeliac disease with positive serology • Known Coeliac disease with no exposure to gluten and persistent high titres after 12 months or persistent alarm symptoms • Pernicious anaemia (serologically diagnosed), asymptomatic at time of diagnosis • Procedures due as per Gastroenterological Society of Australia surveillance guidelines • Surveillance requested by previous Endoscopist (report must be attached)
Return to GP	The referral does not meet the WA Health referral access criteria. Referrals will be returned to the referrer with advice to "treat, watch and wait", review in GP practice within 6-12 weeks, and re-refer if the patient's symptoms persist and are of concern. GPs can contact the Gastroenterology Department at their local hospital if they wish to discuss specific concerns regarding their patient. To contact the relevant service, please refer to HealthPathways Gastroenterology Advice (external site)	
Surveillance	Referrals for patients that are due for a surveillance procedure (as per surveillance guidelines) within 12 months of the hospital receiving the referral – the referral will be accepted and waitlisted to have their procedure as close to the due date as possible. Referrals for patients that are due for a surveillance procedure (as per surveillance guidelines) in greater than 12 months from when the hospital receives the referral – the referral will be returned to the referrer, requesting a re-referral closer to the time the procedure is due. **Colonoscopy** • Surveillance for past history of bowel cancer, polyps, inflammatory bowel disease • Surveillance for significant family history of bowel cancer **Gastroscopy** • Surveillance of Barrett oesophagus, gastric intestinal metaplasia	

Links to relevant/supporting information

- Request for Direct Access Gastrointestinal Endoscopy (Adult) Form
- Direct Access Gastrointestinal Endoscopy Referral Access Criteria
- HealthPathways WA – Endoscopy Requests
- Patient Information – Colonoscopy, Gastroscopy
- Frequently Asked Questions