Review of Endoscopy guidelines

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Endoscopy

- Guidance questions the need for ROUTINE NON URGENT ENDOSCOPY
- PATIENTS WITHOUT RED FLAG SYMPTOMS SHOULD BE TREATED CONSERVATIVELY

“ Routine endoscopic investigation of patients of any age presenting with dyspepsia and without alarm signs is not necessary”.

- NICE 2007

Why?

- • In a recent prospective observational study the prevalence of gastric cancer was **4% in a cohort of patients referred urgently for alarm features.**
- Referral for dysphagia or significant weight loss at any age plus age older than 55 years with alarm symptoms would have detected **99.8%** of the cancers found in the cohort. These findings are supported by other retrospective studies.

NICE GUIDANCE 2007

Risks attached

- In the UK, morbidity (non-trivial adverse events) and mortality rates for upper gastrointestinal endoscopy may be as high as 1 in 200 and 1 in 2000, respectively

What does nice say?

- **Non-urgent referral**
- British Society of Gastroenterology recommendations and expert advice suggest non-urgent referral for:
- patients with liver disease, to detect oesophageal varices.
- patients who have resistant *H.pylori* infection with worsening of dyspepsia
- post-treatment (6 to 8 weeks) endoscopy for gastric ulcer and bleeding duodenal ulcer
- coeliac disease, for confirmatory biopsy
- Barrett's oesophagus surveillance
- follow-up of oesophageal ulcer (8 weeks).

Usually secondary care patients

What does nice say?
Urgent referral (within 2 weeks)

- 1. Patients of any age with dyspepsia who present with any of the following should have an urgent referral for endoscopy or referral to a specialist in upper gastrointestinal cancer:

- •chronic gastrointestinal bleeding
- •progressive dysphagia
- •progressive unintentional weight loss
- •persistent vomiting
- •iron deficiency anaemia
- •epigastric mass
- •suspicious barium meal result.

2. Patients aged 55 years and older with unexplained and persistent recent-onset dyspepsia.

3. Patients presenting with the following, even in the absence of dyspepsia, should have an urgent referral for endoscopy or referral to a specialist in upper gastrointestinal cancer:

•dysphagia
•unexplained upper abdominal pain and weight loss, with or without back pain
•upper abdominal mass
•obstructive jaundice (depending on clinical state).
and consider urgent referral for:

•persistent vomiting and weight loss in the absence of dyspepsia
•unexplained weight loss
•iron deficiency anaemia.

4. Consider urgent referral for patients with unexplained worsening of their dyspepsia who are known to have any of the following risk factors:

•Barrett's oesophagus
•dysplasia
•atrophic gastritis (pernicious anaemia)
•intestinal metaplasia
•peptic ulcer surgery more than 20 years ago.

URGENT REFERRAL criteria 1

- 1. Patients **of any age** with dyspepsia who present with any of the following should have an urgent referral for endoscopy or referral to a specialist in upper gastrointestinal cancer:

- •chronic gastrointestinal bleeding
- •progressive dysphagia
- •progressive unintentional weight loss
- •persistent vomiting
- •iron deficiency anaemia
- •epigastric mass
- •suspicious barium meal result.

Urgent referral Criteria 2

- 2. Patients aged 55 years and older with **unexplained and persistent recent-onset dyspepsia**.

Urgent referral Criteria 3

- 3. Patients presenting with the following, even in the **absence of dyspepsia**, should have an urgent referral for endoscopy or referral to a specialist in upper gastrointestinal cancer:

- •dysphagia
- •unexplained upper abdominal pain and weight loss, with or without back pain
- •upper abdominal mass
- •obstructive jaundice (depending on clinical state).
- and consider urgent referral for:
- •persistent vomiting and weight loss in the absence of dyspepsia
- •unexplained weight loss
- •iron deficiency anaemia.

Urgent referral Criteria 4

- 4. Consider urgent referral for patients with unexplained worsening of their dyspepsia who are known to have any of the following risk factors:

- •Barrett's oesophagus
- •dysplasia
- •atrophic gastritis (pernicious anaemia)
- •intestinal metaplasia
- •peptic ulcer surgery more than 20 years ago.

What are the referral options

- MYT
- Morley and northgate surgery
- White Rose Centre

What do the PCT say?

- Further to your enquiry regarding endoscopy referrals*, I have confirmed with contracting colleagues that Mid Yorkshire hospitals remains a referral option for routine endoscopies. However, the PCT strongly encourages referral to community providers of endoscopy services as these have the capacity to offer significantly shorter waiting times, although, we of course recognise the decision is down to patient choice*.

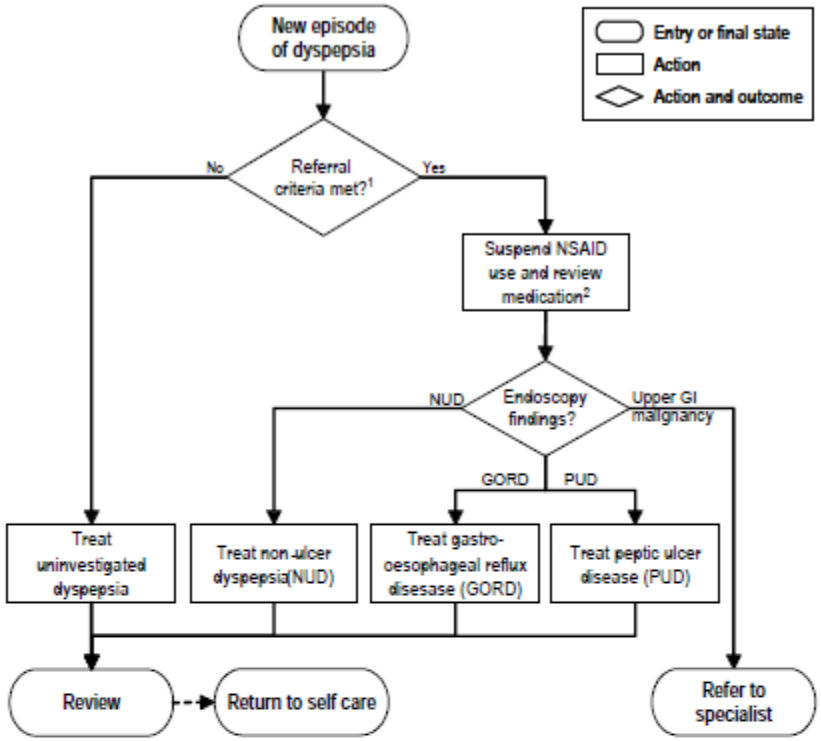
What does the OCMC data suggest?

- Over referral for routine ENDOSCOPY
- Most referrals are going to MYT despite PCT guidance
- Many patients do not want to go to Morley, Pontefract or South Elmsall
- Need for local community venue for endoscopy services

Management

- Treat
- Monitor
- Check for helicobacter
- Refer if develops red flag symptoms

Flowchart of referral criteria and subsequent management



1 Immediate referral is indicated for significant acute gastrointestinal bleeding.

Consider the possibility of cardiac or biliary disease as part of the differential diagnosis.

Urgent specialist referral[a] for endoscopic investigation is indicated for patients of any age with dyspepsia when presenting with any of the following: chronic gastrointestinal bleeding, progressive unintentional weight loss, progressive difficulty swallowing, persistent vomiting, iron deficiency anaemia, epigastric mass or suspicious barium meal.

~~Routine endoscopic investigation of patients of any age, presenting with dyspepsia and without alarm signs, is not necessary. However, for patients over 55, consider endoscopy when symptoms persist despite *Helicobacter pylori* (*H. pylori*) testing and acid suppression therapy, and when patients have one or more of the following: previous gastric ulcer or surgery, continuing need for NSAID treatment or raised risk of gastric cancer or anxiety about cancer.~~

Routine endoscopic investigation of patients of any age, presenting with dyspepsia and without alarm

Nice

Interventions for uninvestigated dyspepsia

- • Initial therapeutic strategies for dyspepsia are empirical treatment with a proton pump inhibitor (PPI) or testing for and treating H. pylori. Thereis currently insufficient evidence to guide which should be offered first.
- A 2-week washout period following PPI use is necessary before testing for H. pylori with a breath test or a stool antigen test.
- beyond a period that would normally be associated with self-limiting problems. The precise period will vary depending on the severity of symptoms and associated features, as assessed by the healthcare professional. In many cases, the upper limit the professional will permit symptoms and/or signs to persist before initiating referral will be 4–6 weeks.

Interventions for gastro-oesophageal reflux disease (GORD)

- • Offer patients who have GORD a full-dose PPI for 1 or 2 months.
- • If symptoms recur following initial treatment, offer a PPI at the lowest dose possible to control symptoms, with a limited number of repeat prescriptions.

Interventions for peptic ulcer disease

- • Offer H. pylori eradication therapy to H. pylori-positive patients who have peptic ulcer disease.
- • For patients using NSAIDs with diagnosed peptic ulcer, stop the use of NSAIDs where possible. Offer full-dose PPI or H2 receptor antagonist (H2RA) therapy for 2 months to these patients and, if H. pylori is present, subsequently offer eradication therapy.

Management of endoscopically determined non-ulcer dyspepsiainvolves

- Management of endoscopically determined non-ulcer dyspepsiainvolves initial treatment for H. pylori if present, followed by
- symptomatic management and periodic monitoring.
- • Re-testing after eradication should not be offered routinely, although
- the information it provides may be valued by individual patients.
- Reviewing patient care