GUIDANCE ON THE INDICATIONS FOR DIAGNOSTIC UPPER GI ENDOSCOPY, FLEXIBLE SIGMOIDOSCOPY AND COLONOSCOPY

Introduction

In 2011 the Independent Practice Committee of the BSG was asked to provide approved guidance on the indications for diagnostic endoscopy. There was none although it was common practice to "validate" requests for endoscopy; indeed this is a requirement of the GRS. Following this request it was agreed that a small working group of individuals from CSSC (Adam Harris), Independent Practice Committee (Simon Greenfield), Endoscopy Section (Steve Hughes and Mark Wilkinson) and Surgical Section (Roger Leicester) would produce a draft list of indications for diagnostic upper GI endoscopy, flexible sigmoidoscopy and colonoscopy. The “evidence-base” for this was unsurprisingly small but wherever possible, the Guidance is supported by published documents from the BSG and NICE.

The first draft was circulated to the members of BSG Endoscopy Section and CSSC. An amended document was sent to William Allum (President, AUGIS) and Rupert Pullen (ACPGBI), Karen Nugent (ACPGBI) and Graham Williams (President, ACPGBI) who took the Guidance to their respective Councils; their helpful comments were addressed to produce the final document. On 22 March 2013 BSG Council approved the tripartite Guidance.

Last, we appreciate fully that this Guidance cannot be fully inclusive and ultimately clinical judgement is required to determine when an endoscopy is required but taking into account these reservations, we hope that you will find this Position Statement useful.

Yours faithfully

Adam Harris

Chair, BSG CSSC
Indications for diagnostic OGD

Symptoms suggestive of upper gastrointestinal cancer\(^1\,\^2\):

- dysphagia
- unexplained upper abdominal pain and weight loss
- upper abdominal mass with or without dyspepsia
- persistent vomiting & weight loss
- unexplained weight loss
- iron deficiency anaemia
- unexplained worsening of dyspepsia
- patients aged ≥55 years with unexplained & persistent recent-onset dyspepsia (after stopping treatment with PPIs)
- abnormal or suspicious findings on barium studies, CT or US scanning

Other indications:

- patients with haematemesis and/or melaena\(^3\)
- to confirm healing of oesophageal or gastric ulcer
- persistent long term reflux, odynophagia or dyspepsia unresponsive to 6 weeks treatment in primary care\(^4\)
- coeliac disease diagnosis (& follow up of non-responders)\(^5\)
- surveillance of Barrett’s oesophagus\(^6\)
- to take small bowel biopsies to investigate malabsorption or enteropathy\(^7\)
- in patients with an adenocarcinoma of unknown primary after discussion at MDT
- surveillance for gastric dysplasia or in patients with a strong family history of gastric carcinoma\(^2\)
- surveillance or screening in patients with FAP because of the risk of duodenal polyps\(^8\)
- surveillance for oesophago-gastric varices in patients with suspicion of portal hypertension (eg, decompensated liver disease, cirrhosis on liver biopsy or equivalent non-invasive testing, presence of varices on abdominal imaging)\(^9\)
Indications for diagnostic flexible sigmoidoscopy

- Investigation of diarrhoea with or without bleeding in acutely ill patients
- Investigation of rectal bleeding in absence of altered bowel habit (≥ 40 years; fresh bleeding not mixed with stool)
- Investigation of equivocal radiological abnormalities in the rectum or sigmoid colon
- Surveillance of rectal stump in FAP
- < 40 years with persistent and/or recurrent bleeding with or without change in bowel habit
- Surveillance by pouchoscopy for patients with IPAA (for IBD or FAP)

Indications for diagnostic colonoscopy

Symptoms suggestive of colorectal cancer:

- ≥40 years with rectal bleeding with a change of bowel habit towards looser stools and/or increased stool frequency persisting 6 weeks or more
- Patients at any age with altered blood or blood mixed in stool
- ≥60 years with rectal bleeding persisting for 6 weeks or more without a change in bowel habit and without anal symptoms
- ≥60 years with a change in bowel habit to looser stools and/or more frequent stools persisting for 6 weeks or more without rectal bleeding
- Men of any age with unexplained iron deficiency anaemia
- Non-menstruating women with unexplained iron deficiency anaemia

Other indications:

- In patients with melaena after upper gi source was excluded
- In patients with emergency admission with rectal bleeding
- Clinically significant diarrhoea of unexplained origin (including microscopic colitis)
- Abnormal or suspicious findings in colon on barium enema, CT or virtual (CT) colonography
- Unexplained abnormalities of terminal ileum on small bowel imaging
- Persistent abdominal symptoms with raised CRP or faecal calprotectin
Assessment of neo-terminal ileal recurrence of Crohns following right hemi-colectomy to determine need for medical therapy

Assessment of extent and activity of known IBD

To confirm mucosal response to treatment with biological agents in patients with Crohn’s disease

Screening in patients with significant family history of, or other risk factors for, colorectal cancer

In patients with positive faecal occult blood tests as part of NHS national bowel cancer screening programme

Surveillance of patients with IBD

Surveillance after resection of colorectal cancer

Surveillance after removal of adenomas and in patients with FAP

After identification of adenomas at flexible or rigid sigmoidoscopy and for clearing the colon of synchronous neoplasia in patients with colorectal cancer

References

