Government of Western Australia
Department of Health

# Referring to Direct Access Endoscopy Services

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

## Key information for referrers

- Referrals to public metropolitan services will only be accepted if they are submitted on the WA Health ***Request for Gastrointestinal Endoscopy*** form. This will be accessible via the Central Referral Service (CRS) website.
- Referrals will only be accepted if they have mandatory information included. Mandatory referral information is listed on the CRS website. If this information is not provided, the referral will be returned to the referrer.
- All referrals (*excluding those that require immediate review*) should be sent to the Central Referral Service.
- 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 on-call Gastroenterologist.
- Further information relating to referring to Direct Access Endoscopy Services can be accessed via the CRS website.

## Clinical Indications for Referral

### Colonoscopy

#### Indications for Referral

- Rectal bleeding for >4 weeks
- Positive FOBT result (including NBCSP participants)
- Bloody diarrhoea with negative stool MC&S
- Change in bowel habit >6 weeks with alarm symptoms at any age
- Change in bowel habit >6 weeks without alarm symptoms in patient aged >60yr
- Unexplained iron deficiency anaemia in men or non-menstruating women
- After first episode of proven diverticulitis to exclude neoplasm
- Abnormal imaging
- Active inflammatory bowel disease where endoscopy is indicated to progress management
- Surveillance for past history of bowel cancer, polyps, inflammatory bowel disease
- Surveillance for significant family history of bowel cancer

#### Alarm symptoms

- Persistent rectal bleeding >4 wks
- Unexplained progressive weight loss
- Severe pain
- Unexplained iron deficiency anaemia
- Palpable mass
- Bloody diarrhoea with negative stool MC&S

#### General Risk Factors for Serious Pathology

- New symptoms that have persisted for >6 weeks
- Patients >60yr
- Iron deficiency anaemia (especially if >60yr)

### Gastroscopy

#### Indications for Referral

- Unexplained upper GI bleeding (haematemesis, melaena)
- Unexplained iron deficiency anaemia in men or non-menstruating women
- Unexplained recent dyspepsia in patients >55yr
- Unexplained recent dyspepsia in patients <55yr with alarm symptoms
- Dysphagia, odynophagia
- Unexplained upper abdominal pain and weight loss (>10%)
- Persistent vomiting and weight loss
- Reflux refractory to medical therapy
- Upper abdominal mass
- For duodenal biopsy following positive serology in suspected coeliac disease
- Surveillance of Barrett oesophagus, intestinal metaplasia, oesophageal or gastric dysplasia

#### Alarm symptoms

- Unexplained iron deficiency anaemia
- Overt bleeding (haematemesis, melaena)
- Dysphagia
- Unexplained progressive weight loss with upper GI symptoms
- Severe pain
- Palpable mass

#### General Risk Factors for Serious Pathology

- New symptoms that have persisted for >6 weeks
- Unexplained progressive weight loss and anorexia
- Iron deficiency anaemia (especially if >60 yr)
- Patients >60 yr

## Recommended Investigations Prior to Referral

The following results/supporting information must be included to support relevant referral indications:

- Abdominal imaging – if performed
- Ferritin and Haemoglobin levels (for unexplained iron deficiency)
- U&E for patients with kidney disease

- LFT/INR/Platelets for patients with liver disease
- A digital rectal examination is essential for any patient with lower bowel symptoms to to help exclude a rectal/anal malignancy
- Stool MC&S in patients with chronic diarrhoea

## 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' will be returned to the referrer with advice to re-refer closer to the date the colonoscopy is due.

These guidelines are based on *Cancer Council Australia Clinical Practice Guidelines for Surveillance Colonoscopy (December 2011).*

### Family History

| Family History | Advice |
|---|---|
| **Average Risk**<br>• No family history<br>• 1 relative affected >55 | FOBT 1-2 yearly from age 50 |
| **Moderate Risk**<br>• 1st degree relative affected with colorectal cancer (CRC) age <55<br>• Two 1st or 2nd degree relatives on same side of family with CRC<br>• Serrated/Hyperplastic Polyposis Syndrome | Colonoscopy every 5 years from age 50 (or 10 years younger than youngest affected relative)<br>Colonoscopy every 2 years after polyps have been removed |
| **High Risk** *should be managed by specialist referral centre in collaboration with a genetic diseases service.*<br>• Lynch syndrome (Hereditary Non Polyposis Colorectal Cancer -HNPCC)<br>• Familial Adenomatous Polyposis (FAP) | HNPCC: Colonoscopy 1-2 yearly from age 25 (or 5 years younger than youngest affected relative)<br>FAP: sigmoidoscopy or colonoscopy from 12-15 years of age |

### After Polypectomy

| Finding at Colonoscopy | Interval |
|---|---|
| 1 or 2 tubular adenomas <10mms | 5 years |
| Large adenomas ≥ 10mms<br>Advanced adenoma – high grade dysplasia/villous component<br>3 or more adenomas | 3 years |
| 5 or more adenomas | 1 year |
| Malignant polyps<br>Piecemeal resection of large sessile polyps (>2cms) | Clinical discretion (recommend within 3-6 months, then 1 year, then 3 years, then 3-5 yearly) |

### 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

### Barrett's Oesophagus

| Finding at Gastroscopy | Interval |
|---|---|
| No dysplasia<br>Short (<3 cm) segment<br>Long (>3 cm) segment | <br>3-5 years<br>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.