GUIDELINES for OPEN ACCESS ENDOSCOPY

INTRODUCTION

Cotham Endoscopy P/L, based at Cotham Private Hospital, Kew, VIC, offers an on-line open access gastroscopy and colonoscopy service for your patients with no significant co-morbidities. This document provides a useful summary of indications for a gastroscopy and colonoscopy. In the case of open access endoscopy you are asked to discuss with your patient the indication, the procedure(s), possible alternative investigations, risks of the procedure(s), risks specific to the patient and the risks of not having the procedure(s) done.

Once the booking has been received Cotham Endoscopy staff will contact the patient and provide a range of useful information and answer non-medical questions. The staff member will finalize the endoscopy booking, as well as, mail hospital forms, diet instructions, bowel preparation instructions and complementary bowel preparation sachets. On the day of, and prior to the no-gap procedure(s), your patient will also have a no-gap consultation. Following the procedure(s) your patient will be offered a review appointment to discuss findings, pathology results, receive a prescription for medication as needed and will be advised when future procedure(s) should be performed. The Cotham Endoscopy website provides patients with additional information resources (www.cothamendoscopy.com.au).

GENERAL INDICATIONS STATEMENT

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

GI ENDOSCOPY IS GENERALLY INDICATED:

1. If a change in management is probable based on results of endoscopy
2. After an empiric trial of therapy for a suspected benign digestive disorder has been unsuccessful
3. As the initial method of evaluation as an alternative to radiographic studies
4. When a primary therapeutic procedure is contemplated

GI ENDOSCOPY IS GENERALLY NOT INDICATED:

1. When the results will not contribute to a management choice
2. For periodic follow-up of healed benign disease unless surveillance of a pre-malignant condition is warranted.

GI ENDOSCOPY IS GENERALLY CONTRAINDICATED:

1. When the risks to patient health or life are judged to outweigh the most favourable benefits of the procedure
2. When adequate patient cooperation or consent cannot be obtained
3. When a perforated viscus is known or suspected
SPECIFIC INDICATIONS STATEMENT

UPPER GIT ENDOSCOPY IS GENERALLY INDICATED FOR EVALUATING:

1. Upper abdominal symptoms, which persist despite an appropriate trial of therapy
2. 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.
3. Dysphagia or odynophagia
4. Oesophageal reflux symptoms, which are persistent or recurrent despite appropriate therapy.
5. Persistent vomiting of unknown cause
6. 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 long-term anti-coagulation or chronic non-steroids anti-inflammatory drug therapy for arthritis and those with cancer of the head and neck.
7. Familial Adenomatous Polyposis Syndromes
8. For confirmation and specific histological diagnosis of celiac disease or radiological demonstrated lesions, including:
   • Suspected neoplastic lesion
   • Gastric or oesophageal ulcer
   • Upper tract stricture or obstruction
9. 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
10. When sampling of tissue or fluid is indicated
11. In patients with suspected portal hypertension to document or treat oesophageal varices
12. To assess acute injury after caustic ingestion
13. Removal of selected polypoid lesions
14. Dilation of stenotic lesions (eg with trans-endoscopic balloon dilators or dilation systems employing guidewires)

UPPER GIT ENDOSCOPY IS GENERALLY NOT INDICATED FOR EVALUATING:

1. 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).
2. Metastatic adenocarcinoma of unknown primary site when the results will not alter management
3. Radiographic findings of:
   • Asymptomatic or uncomplicated sliding hiatus hernia
   • Deformed duodenal bulb when symptoms are absent or respond adequately to ulcer therapy

SEQUENTIAL OR PERIODIC UPPER GIT ENDOSCOPY MAY BE INDICATED FOR:

1. Surveillance for malignancy in patients with premalignant conditions (i.e. Barrett's oesophagus)
2. Verification of healing of benign disease such as oesophageal, gastric or duodenal ulcer(s)

SEQUENTIAL OR PERIODIC UPPER GIT ENDOSCOPY IS GENERALLY NOT INDICATED FOR:

1. Surveillance for malignancy in patients with gastric atrophy, pernicious anaemia, or prior gastric operations for benign disease.
2. Surveillance during repeated dilations of benign strictures unless there is a change in status
COLONOSCOPY IS GENERALLY INDICATED IN THE FOLLOWING CIRCUMSTANCES:

1. Evaluation of an abnormality on radiological study, which is likely to be clinically significant, such as a filling defect or stricture
2. Evaluation of unexplained gastrointestinal bleeding:
   • Haematochezia
   • Melaena after an upper GI source has been excluded
   • Presence of faecal occult blood (+ FOBT)
   • Unexplained iron deficiency anaemia
3. Screening and surveillance for colonic neoplasia
   • 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 dysplastic and neoplastic polyp(s) survey at 3 year intervals
   • Patients with significant family history
     1. 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.
     2. Sporadic colorectal cancer before the age of 60: colonoscopy every five years beginning at the age 10 years earlier than the affected relative or every three years if adenoma is found.
   • In patient with ulcerative or Crohn’s pan-colitis eight or more years’ duration or left sided colitis 15 or more years’ duration every 1-2 years with systematic biopsies to detect dysplasia
4. Chronic inflammatory bowel disease of the colon if more precise diagnosis or determination of the extent of activity of disease will influence immediate management.
5. Clinically significant diarrhoea of unexplained origin
6. Foreign body removal
7. Excision of colonic polyp
8. Decompression of acute non-toxic megacolon or sigmoid volvulus
9. Balloon dilation of stenotic lesions (eg anastomotic strictures)
10. Palliative treatment of stenosing or bleeding neoplasms (eg laser, electrocoagulation, stenting)

COLONOSCOPY IS GENERALLY NOT INDICATED IN THE FOLLOWING CIRCUMSTANCES:

1. 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.
2. Acute diarrhoea
3. Metastatic adenocarcinoma of unknown primary site in the absence of colonic signs or symptoms when it will not influence management
4. Routine follow up of inflammatory bowel disease (except for cancer surveillance in chronic Ulcerative Colitis and Crohn’s colitis)
5. Upper GI bleeding or melaena with a demonstrated upper GI source

COLONOSCOPY IS GENERALLY CONTRAINDICTED IN:

1. Contraindications listed under General Indications statements
2. Fulminant Colitis
3. Documented acute diverticulitis