East of England Guideline for the Referral and Prioritisation of Patients with Gastrointestinal Symptoms During COVID Recovery

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NHS England and NHS Improvement
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1. Background

Following the disruption to services due to COVID-19, there are significant pressures on endoscopy services. As part of COVID recovery, the British Society of Gastroenterology (BSG) and NHS England/Improvement (NHSE/I) have therefore advised that alternative pathways for diagnostic testing are considered and that clinical teams risk assess referrals on a case-by-case basis, with endoscopic procedures reserved for those at greatest risk.

This regional guidance is intended to support clinicians with the process of identifying those patients who are at the highest risk from delays in endoscopy pathways, whether from malignancy or other clinical harm, and who should therefore be prioritised for the endoscopy capacity available. To achieve this, it provides information from national guidance, research and regional clinical consensus on comparable risks and proposes a prioritisation framework. It also provides specific guidance for primary care clinicians on referral pathways and the use of FIT testing for lower GI symptoms.

The recommendations within this guidance are, as far as possible, in accordance with NHSE and BSG recovery guidance on risks, prioritisation and use of alternate pathways, as well as pre-existing NICE and BSG guidelines. Differences in local use and implementation of this guidance are expected to arise due to variation in capacity, participation in pilots such as the “FIT Pioneer” sites and participation in clinical trials of new technologies such as Cytosponge.

Suggestions on use of alternative diagnostic modalities to GI endoscopy are made for certain clinical indications. However, where evidence on newer alternative investigation modalities is limited, these have not been included in this version of the guidance. We expect this guidance to be updated as new evidence is published.

2. Aims

This document aims to:

- Minimise the risk of harm due to delays in endoscopy pathways
- Support avoidance of emergency presentations of the disease
- Support identification of those patients requiring further urgent investigation
- Ensure patients are informed, supported, safety-netted and retained on a diagnostic pathway in line with national guidance
- Enable a standardised approach to triage across the East of England in line with national guidance
- Support demand and capacity planning within endoscopy and radiology units

3. Lower GI: Referral and FIT Testing Guidelines

3.1 Suspected Cancer Pathway

During COVID-19, virtual consultations have become common. For GI symptoms, a face to face consultation in primary care is recommended, where possible, in order to examine for an abdominal or rectal mass. Where examination has not been performed, this must be documented on the referral form.
Before referring patients with suspected cancer to secondary care:

- Ensure the patient is aware that they are on a suspected cancer pathway and wish to be referred for further investigations.
- Ensure it is appropriate to refer the patient for further investigations. All patients must have a documented WHO performance status. Use of the Rockwood Clinical Frailty Score is also strongly recommended.
- Assess and identify whether the patient is able to undertake a telephone consultation.

### 3.2 For non-FIT pioneer sites

GPs should continue to refer patients according to current NICE NG12 guidelines.

As per NICE NG12 and DG30 guidelines, where colorectal cancer is suspected but the NG12 criteria are not met, FIT testing should be used to help guide the referral decision:

- If the FIT is ≥10, the patient should be referred on a 2ww pathway.
- If the FIT is <10, examine patient to rule out any abdominal or rectal mass, investigate other causes, safety-net and monitor in primary care. Advice and Guidance can be sought where a GP continues to have concerns. There is currently no data to support repeating the FIT following a negative FIT result. Referral into alternative local pathways for malignancy of unknown origin (e.g. ‘Vague Symptoms’ Multi-Disciplinary Diagnostics Centre pathway for HWE) could also be considered.

During COVID, FIT testing has additionally been introduced for patients referred on a 2ww pathway - except for those with rectal bleeding, an abdominal or rectal mass, or anal ulceration. These patients should still be referred on the 2ww pathway, regardless of FIT result, as this will solely be used to inform risk stratification and prioritisation in secondary care.

*Table 1* summarises which patients should have FIT and when a 2ww referral should be made. All patients with suspected cancer should also have FBC, ferritin and U&E taken.

*Table 1: Guide to FIT assessment and referrals by patient presentation*

<table>
<thead>
<tr>
<th>Patient Presentation</th>
<th>FIT</th>
<th>Referral</th>
</tr>
</thead>
<tbody>
<tr>
<td>NG12 symptoms:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt;40 with unexplained weight loss and abdominal pain</td>
<td>Yes – for secondary care risk stratification [NEW]</td>
<td>2ww (NG12)</td>
</tr>
<tr>
<td>&gt;60 with iron deficiency anaemia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt;60 with changes in bowel habit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt;50 with unexplained rectal bleeding</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>&lt;50 with rectal bleeding and abdominal pain/change in bowel habit/weight loss/iron deficiency anaemia*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rectal / abdominal mass</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unexplained anal mass / ulceration*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suspected cancer due to unexplained symptoms but not meeting criteria above</td>
<td>Yes – to guide referral</td>
<td>FIT ≥10 → 2ww (DG30) FIT &lt;10 → A&amp;G</td>
</tr>
<tr>
<td>Bowel cancer screening FIT &gt;120</td>
<td>N/A</td>
<td>SSP appt* (BCSP pathway)</td>
</tr>
</tbody>
</table>

* For these presentations, NICE NG12 says to consider 2ww referral. If patient is 16-40 yrs and IBD is suspected but cancer is not suspected despite the presence of these symptoms/signs, urgently refer to gastroenterology, rather than 2ww pathway (as per BSG IBD guidelines in Figure 1). Advice and guidance prior to referral could be considered to confirm the correct pathway for the patient.
3.2 For FIT Pioneer sites

Prior to COVID-19, FIT Pioneer sites were trialling the use of FIT testing for symptomatic patients in primary care as part of the 2ww pathway. Within the East of England, Hertfordshire and West Essex are a FIT Pioneer site. Their pre-COVID-19 FIT testing protocol is shown in Appendix 1.

During COVID recovery, GPs in HWE are requested to additionally arrange FIT testing for patients with iron deficiency anaemia who are being referred on a 2ww pathway. These patients should still be referred on a 2ww pathway, regardless of the FIT result. The FIT result will be used by secondary care for risk stratification and prioritisation.

For all other indications, GPs in HWE should continue to follow existing local protocols for FIT testing and referrals (see Appendix 1).

All patients with suspected cancer should also have FBC, ferritin and U&E taken.

3.3 Non-Cancer pathway

- All patients MUST have a full blood count, urea and electrolytes, CRP, and coeliac screen in primary care. Stool culture should be undertaken if clinically indicated.
- If patient is systemically unwell or acute severe colitis is suspected, refer for urgent inpatient assessment.
- If the patient is 16-40 years and IBD is suspected, the BSG guidelines on the management of IBD, as outlined in Figure 1, should be followed. Where there are no NG12 symptoms or signs, faecal calprotectin should be used to determine whether to treat as IBS or refer to gastroenterology. Where there are NG12 symptoms for which NICE says to “consider” 2ww referral, if IBD remains the most likely diagnosis and cancer is not suspected, then patients should be urgently referred to gastroenterology. Due to COVID recovery, please also send a faecal calprotectin with the urgent referral. Advice and guidance may be considered before formal referral to establish the correct pathway (urgent vs 2ww) for the patient.
- Where IBD is not suspected, consider other differential diagnoses if symptoms are not improving or persistent, including bile acid malabsorption (confirmed by positive response to trial of cholestyramine 4g bd or colesevelam 1250mg bd for 14d), or symptoms due to concurrent medications.
- If symptoms are in keeping with a diagnosis of IBS with no alarm symptoms, and the above investigations are normal, treat as IBS according to NICE guidance (CG61).
- Chronic diarrhoea should be investigated as per the BSG guidelines on chronic diarrhoea in adults. If persistent diarrhoea type 5-7 stools, >5 motions per day, without other symptoms, despite the above, consider referral for colonic biopsies to exclude microscopic colitis.
Figure 1: Primary care investigation and referrals for suspected IBD as recommended by BSG

- **Age 16-40 with new lower gastro-intestinal symptoms (for >4 weeks) where IBD is suspected**
- **Rectal bleeding plus any one or more of:** abdominal pain, change in bowel habit, weight loss, or iron deficiency anaemia
- **Or**
- Abdominal, rectal or anal mass or unexplained anal ulceration

**IBD remains suspected diagnosis?**
- Yes
  - Refer via a suspected cancer pathway according to NICE NG12
- No
  - Faecal calprotectin measurement (not appropriate if NSAID use in the past 6 weeks)
- **<100 µg/g**
  - IBS likely, treat as IBS in primary care
- **100-250 µg/g**
  - Consider repeat testing or routine referral to Gastroenterology
- **>250 µg/g**
  - Refer urgently to gastroenterology

* All patients should have full blood count, urea & electrolytes, CRP, coeliac screen, +/- stool culture in primary care. Patients should be admitted for urgent inpatient assessment if systemically unwell or suspected acute severe colitis
** Exact threshold should be based on local assay and audit data
*** Consider other differential diagnoses if symptoms not improving/persistent including bile acid malabsorption, microscopic colitis or symptoms being due concurrent medications. If IBD still suspected, symptoms deteriorate or there remains diagnostic uncertainty then consider referral to secondary care
# Calprotectin should be interpreted in the light of the pre-test probability of IBD. If there is a particularly strong suspicion of IBD (clinical features or family history), onwards referral to gastroenterology for this intermediate range group is advised.
Where the clinical history and symptoms are more suggestive of IBS, a repeat faecal calprotectin test will be reassuring if in the normal range. Consider differential diagnoses as above
## Referral either to urgent gastroenterology clinic or direct colonoscopy according to local resources/waiting times
3.4 Lower GI: Secondary Care Risk Stratification and Prioritisation for Referrals and Waiting List

NHSEI recommends that risk stratification is used at secondary care clinical triage to prioritise patients for investigation (see Appendix 3). Risk stratification across different referral pathways and waiting lists allows the available endoscopy and diagnostic capacity to be prioritised for those who stand to benefit the most and additionally supports demand and capacity modelling.

Whilst it is recognised that triage arrangements are likely to vary by Trust, triage should always be undertaken by a senior clinician. An example of a triage process is provided in Appendix 2. Appendix 3 shows how virtual triage fits into the risk stratification pathway. Local triage processes will also need to reflect the Trust’s clinic and diagnostic capacity (endoscopy, CT Colonoscopy and Colon Capsule).

Patients should be triaged according to their risk of cancer, significant pathology or morbidity, or future need for emergency admission. Table 2 outlines a list of common indications for LGI endoscopy, including patients from 2ww, RTT, surveillance and screening waiting lists, ordered by estimated risk. These are grouped into suggested priority categories, based on approximately comparable risk, as cited in national guidance, research evidence or local consensus opinion. The prioritisation categories are not intended to be prescriptive and the final prioritisation categorisation for any patient should be based on clinical judgement. Factors that may influence an individual patient’s risk assessment include past medical history, risk factors, previous investigations and length of time on waiting list.

Table 2 also suggests appropriate investigation modalities for each clinical indication. Some sites may opt to use CT colonography (CTC) as an alternative for certain indications. Evidence and learning from these sites should be shared with the rest of the region.
### Table 2: Proposed risk strata and prioritisation for lower GI

<table>
<thead>
<tr>
<th>Priority</th>
<th>Description</th>
<th>Cancer risk*</th>
<th>Investigation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1</strong> Top priority for urgent investigation</td>
<td>Radiologically proven high risk colonic lesion (for histology or planned EMR/ESD)</td>
<td></td>
<td>Colonoscopy</td>
</tr>
<tr>
<td></td>
<td>Early signs of bowel obstruction (lower abdo pain and distension)</td>
<td>22-36%</td>
<td>AXR +/- CTAP</td>
</tr>
<tr>
<td></td>
<td>Other NG12 Sx and FIT &gt;100 and no colonoscopy in previous 3 yrs</td>
<td>22-36%(^6)</td>
<td>Colonoscopy / CTC</td>
</tr>
<tr>
<td></td>
<td>BCSP with FIT &gt;1000</td>
<td>15.9%</td>
<td>Colonoscopy / CTC</td>
</tr>
<tr>
<td></td>
<td>Other Sx deemed by specialist to merit most urgent investigation (e.g. rectal or abdo mass)</td>
<td></td>
<td>As clinically indicated (Abdo mass – CTAP; Rectal mass – colonoscopy/flexisig)</td>
</tr>
<tr>
<td><strong>2</strong> Priority for urgent investigation</td>
<td>BCSP with FIT 500-1000</td>
<td>10.97%</td>
<td>Colonoscopy / CTC</td>
</tr>
<tr>
<td></td>
<td>Polyps where concern re cancer. For complex polyps, prioritise HGD / rectal lesions / depressed components / laterally spreading tumours (Non-granular &gt; granular with Paris 1s component &gt; granular)</td>
<td>7-15% T1 CRC(^3)</td>
<td>Colonoscopy</td>
</tr>
<tr>
<td></td>
<td>BCSP with FIT 120-499</td>
<td>5.74%(^3)</td>
<td>Colonoscopy / CTC</td>
</tr>
<tr>
<td></td>
<td>NG12 Sx and FIT 10-100(^3)</td>
<td>4.4%(^6) - 4.8%</td>
<td>Colonoscopy / CTC</td>
</tr>
<tr>
<td></td>
<td>Other NG12 Sx and FIT &gt;100 and had a good quality colonoscopy requiring no further Ix in previous 3 yrs</td>
<td>&lt;3% (local data)</td>
<td>Contrast CT / Colonoscopy / CTC</td>
</tr>
<tr>
<td></td>
<td>Suspected new diagnosis or exacerbation of IBD deemed by specialist at triage to merit Ix soon to avoid admission</td>
<td>N/A</td>
<td>Colonoscopy</td>
</tr>
<tr>
<td></td>
<td>Sx deemed by specialist to merit urgent intervention (e.g. IDA, rectal bleeding, weight loss)</td>
<td>PR bleeding: 4.5-5.7%(^{10,11})</td>
<td>As clinically indicated</td>
</tr>
<tr>
<td><strong>3</strong> Non-urgent investigation</td>
<td>Symptoms deemed by specialist GI surgeons/gastroenterologists at the point of triage to merit non-urgent intervention (e.g. suspected micro colitis)</td>
<td>N/A</td>
<td>As clinically indicated</td>
</tr>
<tr>
<td><strong>4</strong> Surveillance</td>
<td>Genetic based screening or surveillance – high risk (e.g. Lynch syndrome, polyposis)</td>
<td></td>
<td>Colonoscopy</td>
</tr>
<tr>
<td></td>
<td>Disease based surveillance (IBD, post polypectomy, post cancer)</td>
<td>post CRC &lt;1%(^3) (\sim 1%)</td>
<td>Colonoscopy</td>
</tr>
<tr>
<td></td>
<td>Genetic based screening or surveillance – low risk (e.g. family hx of CRC)</td>
<td>&lt;1%</td>
<td>Colonoscopy</td>
</tr>
<tr>
<td><strong>5</strong> Lowest risk</td>
<td>NG12 Sx and FIT &lt;10 with no iron deficiency anaemia</td>
<td>Any cancer 2.9%, CRC 0.3%, [UGI 0.2%], &lt;5%</td>
<td>Do not proceed to endoscopy</td>
</tr>
</tbody>
</table>

Please note, this list is not comprehensive and does not include more specialist procedures or post-treatment follow up, which is left to the discretion of clinicians. This should be taken into account when used to support demand and capacity planning.

For patients with suspected new diagnosis or exacerbation of IBD, symptoms and faecal calprotectin can be used to assess risk. For low risk patients, consider empirical treatment. Proceed to endoscopy if needed for diagnosis, to guide management (e.g. if not responding to empirical treatment) or avoid admission.
For investigation of patients with IDA, the BSG recommends performing colonoscopy before OGD due to the lower aerosol generation risk during COVID-19. However, combined OGD and colonoscopy may be possible at clean sites with pre-procedure testing.

For symptomatic patients with FIT >10, the decision between colonoscopy and CT colonoscopy may be based on a number of patient factors, including performance status, patient preference, risk from ionizing radiation, as well as local protocols and local capacity.

3.5 Bowel Cancer Screening Programme patients

When risk stratifying bowel cancer screening programme (BCSP) patients, in addition to FIT result, consider the time since the kit was read and other cancer risk factors such as screening history, age, sex, time since negative gFOBT or FIT, current symptoms and past medical and family history. BCSP patients requiring colonic investigation should undergo colonoscopy unless the patient is unsuitable for colonoscopy, in which case CTC can be undertaken, as per the service specification.

3.6 Priority 4: surveillance patients

For surveillance patients, prioritise based on polyposis registry advice and BSG guideline recommended frequency of surveillance/follow up (i.e. 6-month intervals prioritized over 3-year intervals).

For Lynch syndrome patients, endoscopy units are able to access a new national service offering NHSE-funded FIT testing to ensure they are appropriately prioritised for surveillance during the recovery phase. Units who would like to participate are invited to send a list of patients with their mailing details to the BCSP Southern Hub, who will send a FIT kit to the patients via rsc-tr.BCSPSouthernHub@nhs.net. Please contact 01483 409 850 or k.monahan@nhs.net for further details on the service.

3.7 Priority 5: low risk patients

These patients should not proceed to endoscopy unless additional risk factors are identified during triage.

The following secondary care management of patients with NG12 symptoms but FIT<10 and no iron deficiency anaemia (level 5 in table 2) is recommended:

- Telephone consultation with patient within 2 weeks for review of symptoms and family history and to assess risk of CRC.
- If CRC is no longer suspected, consider whether an alternative suspected cancer pathway would be appropriate.
- If cancer is no longer suspected, transfer the patient on to a routine pathway. Inform the GP of the results and next steps.
- Patients should be advised of who to contact if their symptoms worsen or they develop new symptoms.
- For patients transferred to a routine pathway, conduct a telephone or face to face follow up at 6-8 weeks. Confirm if still symptomatic and consider further investigations such as repeat FIT test, FBC, faecal calprotectin, as clinically appropriate.

All patients referred into the 2ww pathway will be the clinical responsibility of secondary care. Patients should not be discharged from the pathway on the basis of a FIT result alone, except by existing FIT Pioneer service evaluation sites. Patients should be safety netted on a patient tracking list. For Trusts that are not part of the FIT Pioneer national service evaluation, patients must not be transferred to routine pathway unless a telephone consultation has taken place.
with the patient and a letter sent to the GP informing them of the results and next steps. Patients must remain tracked, monitored, safety netted and seen as soon as possible according to their priority level. The patient should not be discharged until a cancer or other disease is confirmed or no longer suspected.

At HWE (a FIT Pioneer site), FIT will now be used for iron deficiency anaemia patients to aid risk stratification. Those with a FIT <10ug/gm may not require endoscopy, however these patients should not be discharged on this basis and may require ongoing investigation and/or monitoring.

3.8 Safety netting

Patients who do not require immediate investigation should be held on a patient tracking list (PTL) managed by MDT co-ordinators, for further management in line with the individual pathway agreed for this patient (usually a non-2ww pathway with investigations). Appropriate safety netting should be put in place for these patients to allow for a further clinical assessment should their symptoms change.

Any MDT recommendations and shared decision-making with patients at variance with pre-pandemic pathways should be recorded.

Patients for whom further investigation is deferred should be reassured that:

- Their FIT result indicates that cancer is unlikely but further tests are needed to investigate the cause.
- The patient should be given clear information about whom to contact if they develop new symptoms or if their existing symptoms worsen.
4. Upper GI: Referral Guidelines

4.1 Suspected cancer pathway

GPs should continue to refer as per NICE NG12 criteria, summarised below. However, rather than direct access OGD, all referrals will be triaged by secondary care.

Table 3: Guide to referrals for upper GI symptoms

<table>
<thead>
<tr>
<th>Patient Presentation</th>
<th>Referral</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upper abdo mass</td>
<td>2ww UGI endoscopy (NG12)</td>
</tr>
<tr>
<td>Dysphagia</td>
<td>Consider non-urgent UGI endoscopy (NG12)</td>
</tr>
<tr>
<td>&gt;55 with weight loss and upper abdo pain / reflux / dyspepsia</td>
<td></td>
</tr>
<tr>
<td>Haematemesis*</td>
<td></td>
</tr>
<tr>
<td>&gt;55 with tx resistant dyspepsia</td>
<td></td>
</tr>
<tr>
<td>&gt;55 with upper abdo pain and low Hb</td>
<td></td>
</tr>
<tr>
<td>&gt;55 with raised platelet count and nausea / vomiting / weight loss / reflux / dyspepsia / upper abdo pain</td>
<td></td>
</tr>
<tr>
<td>&gt;55 with nausea or vomiting and weight loss / reflux / dyspepsia / upper abdo pain</td>
<td></td>
</tr>
<tr>
<td>Pt with UGI symptoms not meeting criteria above but GP concerned re cancer</td>
<td>A&amp;G</td>
</tr>
</tbody>
</table>

* For acute upper GI bleeding see NICE CG 141

Where a GP is concerned about cancer but NG12 criteria for 2ww are not met, Advice and Guidance can be sought. Referral into alternative local pathways for malignancy of unknown origin (e.g. ‘Vague Symptoms’ Multi-Disciplinary Diagnostics Centre pathway for HWE) could also be considered.

During COVID-19, virtual consultations have become common. For GI symptoms, a face to face consultation in primary care is recommended, where possible, in order to examine for an abdominal or rectal mass. Where examination has not been performed, this must be documented on the referral form.

Before referring patients with suspected cancer to secondary care:

- Ensure the patient is aware that they are on a suspected cancer pathway and wish to be referred for further investigations.
- Ensure it is appropriate to refer the patient for further investigations. All patients must have a documented WHO performance status. Use of the Rockwood Clinical Frailty Score is also strongly recommended.
- Assess and identify whether the patient is able to undertake a telephone consultation.

4.2 Non-Cancer Pathways

Dyspepsia in the absence of alarm symptoms should be investigated and managed in primary care in line with NICE CG184. This includes appropriate use of H pylori testing and trials of Proton Pump Inhibitors. Patients whose symptoms return after stopping PPI should continue to be managed in primary care. Referral to a specialist service is recommended for people:

- Of any age with gastro-oesophageal symptoms that are non-responsive to treatment or unexplained
• With suspected GORD who are thinking about surgery
• With H pylori that has not responded to second-line eradication therapy.

Serological testing for coeliac disease should be undertaken, in line with NICE NG20\textsuperscript{24}, in patients with:

• persistent unexplained abdominal or gastrointestinal symptoms
• faltering growth
• prolonged fatigue
• unexpected weight loss
• severe or persistent mouth ulcers
• unexplained iron, vitamin B12 or folate deficiency
• type 1 diabetes, at diagnosis
• autoimmune thyroid disease, at diagnosis
• irritable bowel syndrome (in adults)
• first degree relatives of people with coeliac disease.

Although the BSG has issued interim guidance on a no-biopsy diagnosis for a defined group of patients with suspected coeliac disease\textsuperscript{22}, the decision about whether an endoscopy and biopsy is needed, and the final diagnosis of coeliac disease, should be made by a gastroenterologist. Patients with positive serology should therefore continue to be referred to gastroenterology.

4.3 Upper GI: Secondary Care Risk Stratification and Prioritisation for Referrals and Waiting List

Patients should be triaged according to their risk of cancer, significant pathology or morbidity, or future need for emergency admission. Table 4 outlines a list of common indications for UGI endoscopy, including patients from 2ww, RTT and surveillance waiting lists, ordered by estimated risk. These are grouped into suggested priority categories, based on approximately comparable risk, as cited in national guidance, research evidence or local consensus opinion.

The prioritisation categories are not intended to be prescriptive and the final prioritisation categorisation for any patient should be based on clinical judgement. Factors that may influence an individual patient’s risk assessment include past medical history, risk factors, previous investigations and length of time on waiting list.

Potential use of alternative diagnostic modalities e.g. Cytosponge, are still undergoing development. Whether or not it may be appropriate to use these modalities outside of the context of a clinical trial is still undergoing regional review with further guidance to be published in due course.

Patients, whose procedure is deferred or cancelled, should remain on PTL and be followed up at clinic/by telephone to monitor progress and review if procedure becomes necessary.\textsuperscript{2}
Table 4: Proposed risk strata and prioritisation for upper GI

<table>
<thead>
<tr>
<th>Priority</th>
<th>Description</th>
<th>Cancer risk</th>
<th>Investigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1a Top priority for urgent investigation</td>
<td>Endoscopic resection for High Grade Dysplasia**</td>
<td>~1.3%</td>
<td>Urgent OGD²</td>
</tr>
<tr>
<td>Dysphagia [EDS &gt;3.5]</td>
<td>76.2%¹⁴</td>
<td>Urgent OGD¹³,¹⁴</td>
<td></td>
</tr>
<tr>
<td>1b Priority for urgent investigation</td>
<td>Oesophageal High Grade Dysplasia (HGD) follow-up within 1st yr post-treatment*</td>
<td>20% risk metachronous lesions within 2y¹²</td>
<td>Urgent OGD (when due)</td>
</tr>
<tr>
<td>Dysphagia [EDS &lt;3.5] and &gt;55 yrs</td>
<td>~14.1% esophageal carcinoma in EDS &lt;3.5¹⁴</td>
<td>Urgent OGD¹³,¹⁴ or consider alternative e.g. Barium studies or CT</td>
<td></td>
</tr>
<tr>
<td>Benign gastric polypectomy as per BSG indications (adenomas, hyperplastic polyps that do not regress after H pylori treatment)</td>
<td>28.5–40% neoplastic progression of villous adenomas, 5% for tubular adenomas¹⁵</td>
<td>Urgent OGD</td>
<td></td>
</tr>
<tr>
<td>Oesophageal Low Grade Dysplasia (LGD) surveillance**</td>
<td>9.1% progression to HGD/cancer per year (over 39m)¹²</td>
<td>Urgent OGD (when due)</td>
<td></td>
</tr>
<tr>
<td>Sx deemed by specialist to merit urgent intervention</td>
<td>N/A</td>
<td>Urgent OGD¹³,¹⁴ / other as clinically indicated</td>
<td></td>
</tr>
<tr>
<td>1c Priority for urgent investigation</td>
<td>Iron deficiency anaemia</td>
<td>Consider colonoscopy before OGD²²</td>
<td></td>
</tr>
<tr>
<td>Abdominal mass</td>
<td></td>
<td>Urgent CT TAP before consider OGD²</td>
<td></td>
</tr>
<tr>
<td>&gt;60, abdominal pain &amp; weight loss</td>
<td></td>
<td>Urgent CT TAP² before consider OGD²</td>
<td></td>
</tr>
<tr>
<td>2 Urgent investigation</td>
<td>Other higher risk NG12 indications:</td>
<td>2.3 - 2.8%¹³ 2.1 / 1% ²,¹³</td>
<td>Urgently plan OGD¹³,¹²</td>
</tr>
<tr>
<td>Dyspepsia &gt;55yrs AND unexplained weight loss / anaemia</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Haematemesis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 Non-urgent investigation</td>
<td>Other NG12 indications:</td>
<td>1.4 – 1.9%¹³ 1.3%¹³</td>
<td>Non-urgent OGD as capacity allows¹</td>
</tr>
<tr>
<td>&gt;55 with raised platelet count and nausea / vomiting / weight loss / reflux / dyspepsia / upper abdo pain</td>
<td>~1.2%¹³</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt;55 with nausea or vomiting and dyspepsia / upper abdo pain</td>
<td>&lt;1%¹³</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt;55 with tx resistant dyspepsia</td>
<td>0.5%¹³</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other dysphagia (&lt;55 and EDS&lt;3.5)¹</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt;55 with upper abdo pain and low Hb</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sx deemed by specialist to merit non-urgent intervention</td>
<td>N/A</td>
<td>As clinically indicated</td>
<td></td>
</tr>
<tr>
<td>4 LTC Surveillance and elective procedures</td>
<td>Surveillance of other Long Term Conditions:</td>
<td>Gastric ulcer &lt;1.5%</td>
<td>Non-urgent OGD as capacity allows²</td>
</tr>
<tr>
<td>Gastric ulcer 6-8wk check</td>
<td>Barrett’s &lt;1%/y progression ¹³</td>
<td>Consider extending surveillance intervals within BSG guidance limits</td>
<td></td>
</tr>
<tr>
<td>Barrett’s non dysplastic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>gastric atrophy, intestinal metaplasia (IM)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low-risk follow-up and repeat scopes – oesophagitis healing, gastric ulcer healing, ‘poor views’, post therapy checks e.g. EMR/RFA/polypectomy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elective therapeutic procedures (e.g. stricture dilatation, APC for GAVE, RFA, POEM, pneumatic dilatation, Ampullectomy, ERCP stent change)</td>
<td>N/A</td>
<td>Non-urgent OGD as capacity allows</td>
<td></td>
</tr>
<tr>
<td>5 Lowest risk</td>
<td>Dyspepsia in absence of alarm features</td>
<td>N/A</td>
<td>No OGD. PPI and H.pylori testing as per NICE²</td>
</tr>
<tr>
<td>Reflux sx only</td>
<td>N/A</td>
<td>Full dose PPI²</td>
<td></td>
</tr>
<tr>
<td>Variceal surveillance</td>
<td>N/A</td>
<td>Mx with non-cardioselective beta blockers if clinically appropriate²⁰,¹</td>
<td></td>
</tr>
<tr>
<td>Suspected coeliac, &lt;55 yrs, tTG &gt;1Dx upper limit of normal, no alarm features</td>
<td>N/A</td>
<td>Treat on basis of serology²</td>
<td></td>
</tr>
<tr>
<td>Follow up for healing of grade C oesophagitis</td>
<td>N/A</td>
<td>No OGD needed²</td>
<td></td>
</tr>
</tbody>
</table>

Recommended surveillance intervals

*HGD follow up within 1st yr post-treatment: surveillance 3 monthly for 1st year, yearly thereafter¹²
** 6 monthly surveillance, offer ablation for persistent LGD²⁹
***Post-polypectomy one-off at 1y²⁸ Barrett’s 2-3y long segment, 3-5y long with IM, IM 3yrl²⁸

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For investigation of patients with IDA, the BSG recommends performing colonoscopy before OGD due to the lower aerosol generation risk during COVID-19. Combined OGD and colonoscopy may be possible at clean sites with pre-procedure testing.

Please note, this list is not comprehensive and does not include more specialist procedures or post-treatment follow up, which is left to the discretion of clinicians. This should be taken into account when used to support demand and capacity planning.

4.4 Priority 5: Low risk patients

As per BSG guidance on endoscopy recovery, patients in priority 5 do not require OGD and can be managed symptomatically.

4.5 Suspected coeliac

Pending the publication of the new BSG Coeliac Guideline, the BSG has issued COVID-19 specific interim guidance on biopsy in adult coeliac disease. This allows for treatment of patients <55 years with suspected coeliac disease and a tTG >10x the upper limit of normal without a gastroscopy and biopsy to confirm diagnosis. Figure 2 below outlines the protocol.

Figure 2: The essential practice points of using a non-biopsy protocol in adults

Where EMA is not available locally, it is proposed that patients otherwise meeting the criteria for a no-biopsy diagnosis (<55 yrs, no alarm symptoms and tTG>10x ULN) are treated on the basis of tTG serology, without a gastroscopy.
Units should develop a locally agreed policy with colleagues with expertise in coeliac disease for patients with lower levels of TTG or atypical presentations.\(^2\)

All referrals to secondary care for endoscopy, because of positive coeliac serology, should be tracked and allocated to secondary care triage review at 3-6 months. It is recommended outcomes need to be audited by secondary care as a result of this virtual triage.\(^{22}\)
References


management-of-Barretts-oesophagus.pdf


15. BSG guidelines on the management of gastric polyps doi:10.1136/gut.2009.182089

16. British Society of Gastroenterology guidelines on the diagnosis and management of patients at risk of gastric adenocarcinoma May 2019

https://www.nice.org.uk/guidance/cg184

18. Lv SX et al. Biopsy frm the base and edge of gastric ulcer healing or complete healing may lead to detection of gastric cancer earlier: an 8 years endoscopic follow-up study Hepatogastroenterology. 2012 May;59(115):947-50. doi: 10.5754/hge10692

19. BSG guidelines on the diagnosis and management of Barrett’s oesophagus, addendum 2015

https://gut.bmj.com/content/64/11/1680.info

21. NHS public health functions agreement 2019-20 Service specification no.26 Bowel Cancer Screening Programme


https://www.nice.org.uk/guidance/cg141

https://www.nice.org.uk/guidance/ng20 #


27. NICE Clinical Guideline CG61 Irritable bowel syndrome in adults: diagnosis and management
https://www.nice.org.uk/guidance/cg61

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### Appendix 1: Pre-Covid19 FIT and referral pathway in Herts and West Essex STP (FIT Pioneer Site)

**Decision tool for GPs in HWE (FIT Pioneer Site):**

<table>
<thead>
<tr>
<th>SYMPTOMS</th>
<th>Age Under 40</th>
<th>40-49</th>
<th>50-59</th>
<th>60 and over</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rectal or Abdominal Mass</td>
<td>2WW</td>
<td>2WW</td>
<td>2WW</td>
<td>2WW</td>
</tr>
<tr>
<td>Unexplained Rectal Bleeding</td>
<td>2WW only if has one of Abdo Pain/ CIBH/Weight loss/IDA in addition</td>
<td>2WW only if has one of Abdo Pain/ CIBH/Weight loss/IDA in addition</td>
<td>2WW</td>
<td>2WW</td>
</tr>
<tr>
<td>Iron Deficiency Anaemia in Men or Non Menstruating Women</td>
<td>2WW</td>
<td>2WW</td>
<td>2WW</td>
<td>2WW</td>
</tr>
<tr>
<td>Change in Bowel Habit</td>
<td>Consider other pathways</td>
<td>FIT</td>
<td>FIT</td>
<td>FIT</td>
</tr>
<tr>
<td>Non Iron Deficiency Anaemia</td>
<td>Consider other pathways</td>
<td>Consider other pathways</td>
<td>Consider other pathways</td>
<td>FIT</td>
</tr>
<tr>
<td>Unexplained Weight Loss AND Abdominal Pain</td>
<td>Consider other pathways</td>
<td>FIT</td>
<td>FIT</td>
<td>FIT</td>
</tr>
<tr>
<td>Unexplained Weight loss OR Abdominal Pain</td>
<td>Consider other pathways</td>
<td>Consider other pathways</td>
<td>FIT</td>
<td>FIT</td>
</tr>
</tbody>
</table>

**Note:**
- Iron Deficiency Anaemia in women >50y with menstrual periods or premenopausal women with stable menstrual periods and persistent IDA after iron replacement or other gastrointestinal symptoms should also be referred
- Do NOT use FIT if ANY rectal bleeding

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FIT process pathway for primary care in HWE (FIT Pioneer Site):

Faecal Immunochemical Test (FIT) process pathway for Primary care

Patient presents with symptoms/signs suggestive of lower GI cancer

Use FIT Clinical decision tool

FIT not appropriate and cancer not suspected

Consider other pathways

Provide FIT sample pack provided to patient with FIT information leaflet. Stock of kits will be held in practice

Order the following at the same time:
- FIT test on the ICE system
- fOB
- Ferritin
- eGFR

Ensure patient knows how to label the sample container and follows the enclosed instructions in the FIT sample pack regarding where to send it

GP/Practice to book follow-up appointment or phone call with patient to facilitate discussion about FIT results

Patient completes instructions to collect sample for FIT test

Patient sends FIT kit for analysis as soon as possible

Trust will inform GP practice when FIT ordered and no sample received by day 12

For GP Practices where PAH or WHHT analyse FIT samples: Advise patient to return FIT kit to the GP by hand

Courier collects FIT kit

Sample received by lab who will be running analysis at least twice per week

For GP practices where EHH T analyse FIT samples: Advise patient to return FIT kit via post (Royal Mail) using the enclosed stamped-addressed envelope provided

GP/Practice to follow-up with patient when no sample received before day 12

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Note:

- For patients who require a FIT test in line with the FIT clinical decision tool AND once the result is obtained for these patients, if they then do not meet the criteria in the 2ww form, safety netting procedures must be in place. Irrespective of the FIT result, clinical judgement should still be applied, and a referral may still be appropriate if there are any concerning or persistent symptoms. One of the reasons for this is that whilst FIT has a high negative predictive value, this is not a guarantee of no cancer and clinical judgement still needs to be applied.

- If the patient does not meet the referral criteria, but the GP has a ‘gut feeling’ of malignancy or serious pathology and no other urgent pathway is suitable then consider referring to the Multi-disciplinary Diagnostic Centre (MDDC).
Appendix 2: Suggested Lower GI Referral Triage Guidance at West Hertfordshire Hospitals NHS Trust

Secondary care triage to
- Straight to test (STT)
- Telephone Assessment Service (TAS)
- Face to face assessment (F2F)

Colorectal Cancer NOT suspected

Rectal bleeding without other symptoms not meeting NG12 criteria
- STT Flexible sigmoidoscopy

Rectal bleeding with other symptoms
- STT or TAS.
- F2F when above not appropriate

Other symptoms with suspected IBD (raised Faecal calprotectin)
- STT or TAS

Other symptoms not suspected IBD (normal faecal calprotectin)
- Advice and Guidance/ Asynchronous virtual appointment with results
- Telephone or F2F where clinical judgement deems necessary

Suspected Cancer

- All 2ww referrals managed through TAS
- (IDA will undergo a lower GI investigation as the first procedure and will proceed to gastroscopy if this is normal).
## Appendix 3: Recommended Process for Triage and Prioritisation

<table>
<thead>
<tr>
<th>Priority Straight to test Colonoscopy or CT Colon / CT / Flexi Sig +/- OGD</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Early signs of a large bowel obstruction, e.g. lower abdominal pain and distension</td>
</tr>
<tr>
<td>- Other NG12-specified symptoms and a FIT &gt;100µg/g, and who have not had a colonoscopy in the previous three years</td>
</tr>
<tr>
<td>- Symptoms deemed by specialist GI surgeons/ gastroenterologists to merit urgent intervention.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Endoscopy waiting list or colonic imaging (CTC, plain CT or colon capsule endoscopy)</th>
</tr>
</thead>
<tbody>
<tr>
<td>- NG12-specified symptoms and a FIT 10–100µg/g</td>
</tr>
<tr>
<td>- Other NG12-specified symptoms and a FIT &gt;100µg/g, and who have had a colonoscopy requiring no further investigation in the previous three years.</td>
</tr>
<tr>
<td>- Patients with positive FIT test (&gt;120µg/g) in the national bowel screening programme</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Safety-netted on a patient tracking list until investigations can be completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low risk patients: NG12-specified symptoms and a FIT &lt;10µg/g.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cancer unlikely</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient informed; management according to local protocol. Patient referred onwards if investigation indicates polyp, IBD or other serious diagnosis</td>
</tr>
</tbody>
</table>
Addendum to Guideline – Cytosponge

A potential endoscopy alternative to enable backlog reduction

This is an addendum to the ‘EoE guideline for Endoscopy referrals and prioritisation’, specifically related to the ‘Proposed risk strata and prioritisation for upper GI’ (Table 4, page 12).

The focus, at this time, is on alternatives for patients currently on the pathway for endoscopy and is aimed at the backlog (particularly in relation to the COVID-19 pandemic), and compliments the draft East of England (EoE) regional document that has already been written.

The recommendations, which have been made in collaboration with Dr Danielle Morris, and Dr Rosemary Phillips, Gastroenterologists at ENHT and PAH, respectively, are that the following cohort of Barrett’s surveillance patients would be suitable for Cytosponge.

The cohorts of patients where Cytosponge could be of benefit – but not enough data/evidence is currently available - would likely need formal trials, agreed pilots, research/academic settings, and/or formal guidance from NHSE/I. Of note, the current DELTA study will further evaluate the role of Cytosponge for both the Barrett’s surveillance and Chronic reflux cohorts.

Barrett’s surveillance & stratification
- Patient cohort: existing ‘non dysplastic’ Barrett’s Oesophagus surveillance patients. (Of note, patients with known low and high grade dysplasia have a follow-up with endoscopy as a 1a ['Top priority for urgent investigation'] and 1b ['Priority for urgent investigation']).
- Cytosponge would enable triage of patients into those then found to have dysplasia into those (i) who need endoscopy, and (ii) whose endoscopy can be deferred.

Where further data and evidence is required (e.g. could be part of a pilot/formal trial)

Chronic reflux (no red flags) & Dysphagia (EDS <3.5)
- These two cohorts of chronic reflux and dysphagia (EDS <3.5) would be in priority group 5 ['Lowest risk'] and group 3 ['Non-urgent investigation'], respectively.
- Cytosponge may be useful for selected patients with acid reflux. An example where cytospone would not be required would be where patients have a known hiatus hernia.
(identified on a previous gastroscopy); instead CT/barium studies – along with pH manometry – could be used to further assess those patients suitable for surgery

- For patients with dysphagia who are frail and/or are otherwise unfit for gastroscopy and in selected patients with high dysphagia symptoms, barium studies may be an alternative to endoscopy (NB – some of these patients may need subsequent gastroscopy if abnormalities are found on the barium study).

- Brief evidence for these recommendations:
  **Reflux patients:**
  (6) https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)31099-0/fulltext

  **Dysphagia:** 'Use of cytosponge as a triaging tool to upper gastrointestinal endoscopy during covid-19 pandemic' Di Pietro et al 2020 lancet https://doi.org/10.1016/S2468-1253(20)30242-9

Patients with *Eosinophilic Oesophagitis* who do not have strictures and are awaiting routine follow-up gastroscopy

- These patients can be managed symptomatically in the peri-covid era but if step up treatment is required cytosponge could be useful to determine activity and efficacy of treatment. This cohort would fall into Priority Group 5 (in table 4). (Ref: Katzka DA, Smyrk TC, Alexander JA, et al. Accuracy and Safety of the Cytosponge for Assessing Histologic Activity in Eosinophilic Esophagitis: A Two-Center Study. Am J Gastroenterol. 2017;112:1538–1544)