Berkshire West Clinical Commissioning Group

Thames Valley Priorities Committee Commissioning Policy Statement

Policy No. TVPC108 **Upper gastrointestinal endoscopy in adults**

Recommendation made by the Priorities Committee: **September 2021**

Date of issue: **October 2021**

Referral from primary care

Urgent referral (within 2 weeks)

Offer an urgent, direct access upper GI endoscopy for:

- Patients with dysphagia.
- Patients aged 55 and over AND weight loss AND any of the following:
  - Upper abdominal pain
  - Reflux
  - Dyspepsia (4 weeks of upper abdominal pain or discomfort)
  - Heartburn
  - Nausea or vomiting
- Patients aged 55 and over who have one of more of the following:
  - Treatment resistant dyspepsia.
  - Upper abdominal pain with low haemoglobin level.
  - Raised platelet count AND any of the following: nausea, vomiting, weight loss, reflux, dyspepsia, upper abdominal pain.
  - Nausea and vomiting AND any of the following: weight loss, reflux, dyspepsia, upper abdominal pain.

Referral for GI endoscopy

Patients fulfilling any of the following criteria may be referred for a GI endoscopy

- Patients of any age with gastro-oesophageal symptoms that are nonresponsive to treatment or unexplained.
- Patients with suspected Gastro-oesophageal reflux disease (GORD) who are thinking about surgery.
- Patients with H pylori that has not responded to second- line eradication.

Acute use in secondary care

- Endoscopy should be performed for unstable patients with severe acute upper gastrointestinal bleeding immediately after resuscitation.
- Endoscopy should be performed within 24 hours of admission for all other patients with upper gastrointestinal bleeding.
- Upper GI endoscopy may be used for the assessment of upper GI bleeding for patients with haematemesis determined as high-risk using the Glasgow Blachford Score.

For management of specific cases in secondary care

H pylori and associated peptic ulcer:

If peptic ulcer is present repeat endoscopy should be considered 6-8 weeks after beginning treatment for H pylori and the associated peptic ulcer.

Barrett's oesophagus:

Endoscopy may be considered to diagnose Barrett's Oesophagus if the person has GORD (endoscopically determined oesphagitis or endoscopy - negative reflux disease). Endoscopy surveillance may be considered for persons diagnosed with Barrett's Oesophagus.

Where available the non-endoscopic test called Cytosponge can be used to identify those who have developed Barrett's oesophagus as a complication of long-term reflux and thus require long term surveillance for cancer risk.

Coeliac disease:

Patients aged 55 and under with suspected coeliac disease and anti-TTG >10x reference range should be referred to a specialist for assessment. Patients may be treated for coeliac disease on the basis of positive serology and without endoscopy or biopsy.

Surveillance endoscopy:

Surveillance endoscopy may be offered every three years for patients who:

- Are diagnosed with extensive gastric atrophy (GA) or gastric intestinal metaplasia, (GIM) (defined as affecting the antrum and the body).
- Are diagnosed with GA or GIM just in the antrum with additional risk factors- such as strong family history of gastric cancer or persistent H pylori infection.

Surveillance endoscopy should only be offered in patients fit enough for subsequent endoscopic or surgical intervention, should neoplasia be found. Senior clinician input is required before embarking on long term endoscopic surveillance.

Screening endoscopy can be considered in:

- European guidelines (2015) for patients with genetic risk factors / family history of gastric cancer recommend genetics referral first before embarking on long term screening. Screening is not appropriate for all patients and should be performed in keeping with European expert guidelines.

- Patients where screening is appropriate, for individuals aged 50 and over, with multiple risk factors for gastric cancer (e.g. H. Pylori infection, family history of gastric cancer - particularly in first degree relative -, pernicious anaemia, male, smokers).

Post excision of adenoma:

Following complete endoscopic excision of adenomas, gastroscopy should be performed at 12 months and then annually thereafter when appropriate.

This policy statement has considered the Evidence-Based Interventions List 2 Guidance (2020) and NICE guideline 12 – Suspected cancer: recognition and referral (2021).

NOTES:

- Potentially exceptional circumstances may be considered by a patient's CCG where there is evidence of significant health status impairment (e.g. inability to perform activities of daily living) and there is evidence that the intervention sought would improve the individual's health status.
- This policy will be reviewed in the light of new evidence or new national guidance, e.g. from NICE.
- Thames Valley clinical policies can be viewed at http://www.fundingrequests.cscsu.nhs.uk/

Clinical codes

OPCS codes:

- G16.1 Diagnostic fibreoptic endoscopic examination of oesophagus and biopsy of lesion of oesophagus
- G16.2 Diagnostic fibreoptic endoscopic ultrasound examination of oesophagus
- G16.3 Diagnostic fibreoptic insertion of Bravo pH capsule into oesophagus
- G16.8 Other specified diagnostic fibreoptic endoscopic examination of oesophagus
- G16.9 Unspecified diagnostic fibreoptic endoscopic examination of oesophagus
- G19.1 Diagnostic endoscopic examination of oesophagus and biopsy of lesion of oesophagus using rigid oesophagoscope
- G19.2 Diagnostic endoscopic insertion of Bravo pH capsule using rigid oesophagoscope
- G19.8 Other specified diagnostic endoscopic examination of oesophagus using rigid oesophagoscope
- G19.9 Unspecified diagnostic endoscopic examination of oesophagus using rigid oesophagoscope
- G45.1 Fibreoptic endoscopic examination of upper gastrointestinal tract and biopsy of lesion of upper gastrointestinal tract
- G45.2 Fibreoptic endoscopic ultrasound examination of upper gastrointestinal tract
- G45.3 Fibreoptic endoscopic insertion of Bravo pH capsule into upper gastrointestinal tract
- G45.4 Fibreoptic endoscopic examination of upper gastrointestinal tract and staining of gastric mucosa
- G45.8 Other specified diagnostic fibreoptic endoscopic examination of upper gastrointestinal tract
- G45.9 Unspecified diagnostic fibreoptic endoscopic examination of upper gastrointestinal tract
- G65.1 Diagnostic endoscopic examination of jejunum and biopsy of lesion of jejunum
- G65.8 Other specified diagnostic endoscopic examination of jejunum
- G65.9 Unspecified diagnostic endoscopic examination of jejunum
- G80.1 Diagnostic endoscopic examination of ileum and biopsy of lesion of ileum
- G80.2 Wireless capsule endoscopy
- G80.3 Diagnostic endoscopic balloon examination of ileum
- G80.8 Other specified diagnostic endoscopic examination of ileum
- G80.9 Unspecified diagnostic endoscopic examination of ileum

ICD10 codes: Not available