

Referral Criteria for Direct Access Outpatient Colonoscopy or CT Colonography

Purpose:

These criteria are designed to cover the majority of indications for referral for bowel investigation (colonoscopy or CT colonography) by general practitioners and non-gastrointestinal specialists.

District health board services are encouraged to provide direct access to colonoscopy and CT colonography for appropriate patients. There should be a single point of entry and triage of referrals for bowel investigation by either colonoscopy or CT colonography.

For patients falling outside these criteria, referrers should consider referral for a first specialist assessment (FSA).

Notes:

- Patients requiring urgent colonoscopy for suspicion or assessment of inflammatory bowel disease would usually be inpatients or under the care of a specialist.
- Few symptoms in primary care practice have greater than five percent positive predictive value for colorectal cancer (CRC).
- Appropriate access for gastrointestinal (GI) endoscopy/GI investigation is highly ranked as a quality indicator.

In referring a patient for a bowel investigation the referrer should:

- inform the patient about the procedure
 - ensure they are willing to undergo the procedure
 - consider the ability of the patient to tolerate both the bowel preparation and the procedure
 - consider whether the patient being referred will benefit if they are frail, have multiple co-morbidities or advanced malignancy (generally referral implies they are well enough to tolerate further treatment)
 - ensure, if the patient has had a colonoscopy or CT colonography in the preceding five years, that there is a clear indication to repeat the procedure (the 'miss' rate of lesions > 1cm following a well performed colonoscopy or CT colonography is approximately six percent)
 - be aware that colonoscopy is the appropriate investigation where
 - a) *diarrhoea or rectal bleeding (non-outlet type) is the predominant indication
 - b) *a patient has a Category 2 or 3 family history of bowel cancer
 - be aware that CT colonography is an appropriate investigation where the above* are not the predominant indication or the patient being referred is over 80 years and/or has significant co-morbidities.
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Two week category
Known or suspected CRC (on imaging, or palpable, or visible on rectal examination), for pre-operative procedure to rule out synchronous pathology
Unexplained rectal bleeding (benign anal causes treated or excluded) with iron deficiency anaemia (haemoglobin below the local reference range)
Altered bowel habit (looser and/or more frequent) > six weeks duration plus unexplained rectal bleeding (benign anal causes treated or excluded) aged ≥ 50 years.

Six week category
Altered bowel habit (looser and/or more frequent) > six weeks duration, aged ≥ 50 years
Altered bowel habit (looser and/or more frequent) > six weeks duration plus unexplained rectal bleeding (benign anal causes treated or excluded), aged 40-50 years
Unexplained rectal bleeding (benign anal causes treated or excluded) aged ≥ 50 years
Unexplained iron deficiency anaemia (haemoglobin below local reference range) (<i>Refer to Comments for Services section items 1 & 2</i>)
New Zealand Guidelines Group (NZGG) Category 2 family history plus one or more of altered bowel habit (looser and/or more frequent) > six weeks duration plus unexplained rectal bleeding (benign and anal causes treated or excluded), aged ≥ 40 years
NZGG Category 3 family history plus one or more of altered bowel habit (looser and/or more frequent) > six weeks duration plus unexplained rectal bleeding (benign and anal causes treated or excluded), aged ≥ 25 years
Suspected/assessment inflammatory bowel disease (consider FSA)
Imaging reveals polyp > 5mm.

Not accepted
Acute diarrhoea < six weeks duration - likely infectious aetiology and self-limited
Rectal bleeding aged less than 50 years (normal haemoglobin) - consider FSA or flexible sigmoidoscopy if no anal cause
Irritable bowel syndrome (may require specialist assessment)
Constipation as a single symptom
Uncomplicated computed tomography (CT) proven diverticulitis without suspicious radiological features
Abdominal pain alone without any 'six week category' features
Decreased ferritin aged < 50 years with normal haemoglobin
Abdominal mass - refer for appropriate imaging
Metastatic adenocarcinoma unknown primary - six percent is due to CRC and in the absence of clinical, radiological, or tumour marker evidence of CRC, colonoscopy is not indicated.

Surveillance notes (Refer to New Zealand Guideline: Guidance on Surveillance)

Direct access surveillance colonoscopy should be offered to those meeting the guideline criteria where 'offer' is the recommendation. 'Consider' is less imperative than 'offer'.

Family history of colorectal cancer – individuals in the categories below should be offered direct access surveillance colonoscopy.

- Category 2 and 3 as recommended in the New Zealand 2012 guidelines (www.nzgg.org.nz): Guidance on Surveillance for People at Increased Risk of Colorectal Cancer.
- Category 3 as recommended by the New Zealand Familial Gastrointestinal Cancer Service (www.nzfgcs.co.nz) or a bowel cancer specialist.

Personal history of low risk adenomas

- The recommendation for surveillance after detection at index colonoscopy of adenomas associated with a low risk of developing colorectal cancer is to consider colonoscopy at five years – if the colonoscopy is negative (ie, no adenomas are found) then *stop* surveillance'.
- People at low risk are defined as no parental history of colorectal carcinoma and with one or two small (<10 mm) tubular adenomas at index colonoscopy.
- This recommendation is based on moderate quality evidence which shows the time taken for advanced metachronous adenomas to develop in five percent of people at low risk was 10.4 years, in 10 percent it was 12.2 years and in 20 percent it was 16.2 years.

Comments for Services

1. The indication of iron deficiency anaemia requires a haemoglobin level below the local reference range in association with a low ferritin level.
2. Menstruation is the commonest cause of iron deficiency anaemia in women - for women aged less than 55 years a menstrual history should be obtained prior to referral. Coeliac disease and urinary loss should also be excluded.
3. Use of faecal occult blood tests collected in asymptomatic individuals is not currently recommended in New Zealand (outside of the Waitemata District Health Board Bowel Screening Pilot) and should not be encouraged.
4. Patients who meet the 'two week category' at referral are considered to have high suspicion of cancer and are included in the 62 day Faster Cancer Treatment health target.
5. All patients with a confirmed cancer diagnosis, including incidental diagnosis or as a result of a 'six week category' investigation, are included in the 31 day Faster Cancer Treatment indicator.
6. There is some variance in age criteria and timeframes between these criteria for referral to direct access colonoscopy and the timeframes for specialist referral in the guideline Suspected Cancer in Primary Care referenced below. The timeframes in this document are based on what is considered to be achievable and compatible with good practice.
7. Initially, prioritisation within the routine category referrals may still occur at a service level.
8. Patients with atypical presentations outside these criteria may require colonoscopy, usually following specialist referral.
9. Patients requiring urgent colonoscopy for suspicion or assessment of inflammatory bowel disease would usually be inpatients or under the care of a specialist.
10. Few symptoms in primary care practice have greater than a five percent positive predictive value for colorectal cancer (CRC).

References

Suspected Cancer in Primary Care. Guidelines for investigation, referral and reducing ethnic disparities. New Zealand Guidelines Group. Ministry of Health 2009

Guidelines for the management of iron deficiency anaemia Gut 2011Oct; 60(10)01309-16.Epub 2011 May 11

The diagnostic value of symptoms for colorectal cancer in primary care: a systematic review. Br J Gen Pract. 2011 May; 61(586):e231-43

New Zealand 2012 guidelines (www.nzgg.org.nz): Guidance on Surveillance for People at Increased Risk of Colorectal Cancer.