

Lower GI Endoscopy (Colonoscopy or Sigmoidoscopy)

Scope

This policy covers **elective** lower GI endoscopy for diagnosis of suspected cancer and adenomatous polyps (including biopsy and polyp removal in the same procedure), and for periodic surveillance in conditions with raised risk of lower GI cancer. It does not include the NHS bowel cancer screening programme. It does not cover endoscopy in medical emergencies, or in urgent acute care.

Policy

It is the responsibility of referring and treating clinicians to ensure compliance with this policy. Referral proforma should be attached to the patient notes to aid the clinical audit process and provide evidence of compliance with the policy. For patients not meeting the policy criteria, clinicians can apply for funding to the Exceptional Cases Panel by completing the exceptional funding section of the referral proforma: *Click policies to access the CCG clinical policies web page: [policies](#) – select the Endoscopy Policies drop down option and select the Lower GI Endoscopy... Policy to access the referral proforma.*

The CCG will fund elective lower GI endoscopy according to the following criteria:

Urgent two week wait criteria (with results of digital rectal exam, if tolerated by the patient)

- Older than 60 years and persistentⁱ rectal bleeding without perianalⁱⁱ symptoms.
- Older than 60 years and persistentⁱ change in bowel habit to increased frequency and/or looseness of stool.
- Older than 40 years and persistentⁱ rectal bleeding and change in bowel habit to increased frequency and/or looseness of stool.
- Unexplained iron deficiency anaemia.ⁱⁱⁱ
- Unexplained weight loss^{iv}, older than 60 years and any other suspicious lower GI symptoms.
- Palpable rectal or abdominal mass suggestive of bowel pathology.
- First degree relative with colorectal cancer aged younger than 45 years, and other suspicious lower GI symptoms.

Routine surveillance

- Resected colorectal cancer: 3 years post-surgery and 5-yearly until comorbidity risks outweigh benefits.
- Adenomatous polyps [see BSG guideline](#) at 5 years (low risk), 3 years (intermediate risk) and 1 year (high risk).^v
Patients with large polyps undergoing piecemeal resection follow-up at 3 months. Further follow up according to risk profile at follow-up: no/5/3/1 yearly surveillance.^{vi}
- Inflammatory Bowel Disease (IBD): at 10 years after onset, and then at 5 years (low risk), 3 years (intermediate risk) and 1 year (high risk)^{vii}. Further follow up according to risk profile at follow-up.^{vi}
- Acromegaly: older than 40 years - 3 yearly or 5-10 yearly, depending on baseline findings.
- Ureterosigmoidostomy: 10 years after the original intervention, then annually.
- High risk genetic disorders: according to regional genetics service advice.

Routine referral (to a specialist team for an opinion)

- Inflammatory bowel disease (IBD) diagnosis^{viii} and follow-up assessment.
- Highly symptomatic or persistent haemorrhoids or fissures refractory to treatment.
- Persistent rectal bleeding in patients referred to secondary care.
- Unexplained persistent and/or recurrent bleeding with altered blood or blood mixed in stool.
- Rectal bleeding in patients with a past history of pelvic radiotherapy.
- Persistent abdominal symptoms with raised CRP or abnormality detected on imaging.
- Persistent unexplained “low risk” symptoms after all reasonable investigation in primary care.^{ix}

Notes

- i Persistent means usually more than 4-6 weeks.
- ii Perianal symptoms include soreness, discomfort, itching, pain, prolapse mucosal prolapse and lumpiness.
- iii Unexplained anaemia less than 11g/dl in men and less than 10g/dl in non-menstruating women (may be lower in older patients).
- iv Unexplained weight loss more than 3kg or more than 5% body weight lost over 6-12 months.
- v Risk is defined according to the number and size of the adenomas- see Appendix 1.
- vi Patients may fall into different risk categories at follow up to the risk categories at diagnosis endoscopy.
- vii Risk of developing colorectal cancer in patients with IBD is based on extent and severity of disease- see Appendix 1.
- viii Where there is a strong suspicion of Inflammatory Bowel Disease (eg family history, extra-intestinal symptoms, raised CRP/ESR), faecal calprotectin may aid in the diagnosis. While faecal calprotectin is not a definitive diagnostic tests, patients with levels <50 mcg/g can be reassured and patients with levels >200 mcg/g should be referred. Patients with levels between 50-200 mcg/g should have a repeat test after 3 months and referred if levels have gone up or if other features are strongly indicative of a diagnosis of IBD. Faecal calprotectin is a sensitive test with many false positives and may be raised with NSAID treatment (excluding low dose (75mg) aspirin, liver cirrhosis, infectious colitis (salmonella, C Difficile etc). For details on diagnosis and management of Irritable Bowel Syndrome please go to the following links: [Calprotectin advice](#) and [IBS advice](#) or go to the [Digestive diseases](#) page of the CCG web site.
- ix In patients with persistent low risk suspicious symptoms, such as abdominal tenderness or diarrhoea, and who are referred for an opinion on management, following all reasonable assessment and treatment in primary care, endoscopy may be indicated, if less invasive testing is contraindicated by the nature of the presentation.

Rationale

Lower GI endoscopy is usually performed in the diagnosis of colorectal cancer, inflammatory bowel disease and adenomas/polyps.

Colorectal cancer is the third commonest cancer in the UK and is associated with increasing age (80% occur after the age of 60 years), genetic and lifestyle factors (smoking, low fibre diet, red and processed meat intake, inactivity, obesity and high alcohol consumption). After the age of 40 years bowel cancer is more common in males than females. The rising incidence of bowel cancer since the 1970s appears to have stabilised in recent years and may be decreasing in the UK. Roll out of a NHS Bowel Cancer Screening Programme (BCSP) for people aged between 60 and 74 years, led to increases in lower GI endoscopies in the period from 2006/7 to 2008/9. This policy does not cover the NHS BCSP which is under the remit of NHS England.

Symptoms of colorectal cancer include rectal bleeding, change in bowel habit to increased frequency and/or looseness of stool, anaemia, weight loss and abdominal mass. Rectal bleeding is a common symptom and in patients below the age of 30 years is more likely to be due to haemorrhoids (piles), anal fissure or inflammatory bowel disease. Patients with haemorrhoids or anal fissures often self-manage with topical treatment, and increasing fluids and fibre in their diet. Eight percent of patients over the age of 50 years presenting to primary care with rectal bleeding will have colorectal cancer.

In patients with IBD, endoscopy may be necessary to confirm a working diagnosis, response to treatment and the extent of the disease. Whilst this argues in favour of earlier referral for endoscopy, symptoms of irritable bowel syndrome (IBS) are common, and are similar to those presented in IBD.

When lower GI endoscopy is not feasible, clinicians may use imaging modalities (CT, Barium enema) instead.

References

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Glossary

Acromegaly:	Acromegaly is a condition in which the body produces too much growth hormone, leading to excess growth of body tissues over time.
Adenomas:	Adenomas are small growths on the inner lining of the intestine.
Faecal calprotectin:	Faecal calprotectin is a substance that is released into the intestines in excess when there is any inflammation there. Its presence can mean a person has an inflammatory bowel disease such as Crohn's Disease or Ulcerative Colitis.
Haemorrhoids:	Also known as piles, are swellings that contain enlarged and swollen blood vessels in or around the rectum and anus.
IBD:	Inflammatory bowel disease is a group of inflammatory conditions of the large and small intestine. The two major types of IBD are Ulcerative colitis and Crohn's disease.
IBS:	Irritable bowel syndrome is a common condition of the digestive system of unknown cause. It can cause bouts of stomach cramps, bloating, diarrhoea and constipation.
Ureterosigmoidostomy:	A surgical procedure where the ureters which carry urine from the kidneys, are diverted into the large intestine.

Policy originated:	New policy endorsed by CCG Governing Body on 6 March 2018 New policy approved by CEC on 13 February 2018 New policy approved by CPF on 9 January 2018
Policy effective from:	March 2018
Policy to be reviewed:	March 2020
Reference:	R:\CPF Pols & working Area\Surg Threshold Pols - Draft and Agreed\CCG Policies\agreed\LOWER GI ENDOSCOPY MARCH 2019 V4 – advice update

Risk of developing colorectal cancer in people with adenomas

- Low risk:** 1-2 adenomas smaller than 1cm.
- Intermediate risk:** 3-4 adenomas smaller than 1cm or 1-2 adenomas if one is larger than 1cm.
- High risk:** more than 5 adenomas smaller than 1cm or more than 3 adenomas if one is larger than 1cm.

Risk of developing colorectal cancer in people with IBD

- No risk:** ulcerative colitis (UC) with proctitis alone, Crohn's disease (CD) with only 1 segment involved.
- Low risk:** extensive, but quiescent UC or CD, left sided UC or CD.
- Intermediate risk:** extensive UC or CD with mild active inflammation that has been confirmed endoscopically or histologically, post-inflammatory polyps, family history of colorectal cancer in first-degree relative older than 50 years.
- High risk:** extensive UC or CD with moderate/severe active inflammation that has been confirmed endoscopically or histologically, primary sclerosing cholangitis, colonic stricture in the past 5 years, dysplasia in the past 5 years, family history of colorectal cancer in first-degree relative younger than 50 years.