

# **Referral Criteria for Direct Access Outpatient Colonoscopy or Computed Tomography Colonography**

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# Purpose

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

District health board services should 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).

Referral for colonoscopy or CT colonography through the National Bowel Screening Programme is **not** covered by these criteria.

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 5 percent positive predictive value for colorectal cancer (CRC).<sup>1</sup>
- Appropriate access for gastrointestinal (GI) endoscopy/GI investigation is highly ranked as a quality indicator.
- Use of faecal occult blood tests (FIT) is not currently recommended in New Zealand outside of the National Bowel Screening Programme and should not be encouraged.<sup>2</sup>

<sup>1</sup> A table of estimated positive predictive value for symptoms of bowel cancer, based on NICE guidance, can be found in the following journal article: N D'Souza, M Abulafi, *The Faecal Immunochemical Test in low risk patients with suspected bowel cancer*. 2019. British Journal of Hospital Medicine, 80 (1): 22-26

<sup>2</sup> Using FIT for symptomatic patients is currently the subject of a clinical trial by NICE. The outcome of this trial will be monitored by the National Bowel Cancer Working Group, the Ministry of Health's advisory body on the diagnosis and treatment of colorectal cancer.

# Referring a patient

When 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)
- if the patient has had a colonoscopy or CT colonography in the preceding five years, ensure that there is a clear indication to repeat the procedure (the 'miss' rate of lesions >1 cm following a well performed colonoscopy or CT colonography is approximately 6 percent)
- be aware that colonoscopy is the appropriate investigation where:
  - a) \*diarrhoea or rectal bleeding 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.

# How to manage patients who do not meet the referral criteria

While most patients who do not meet the direct access criteria will not have bowel cancer, it is appropriate to continue clinical monitoring until symptoms resolve. 'Safety netting' practices may be required to ensure patients are appropriately monitored, eg, it may be appropriate to actively follow up if a patient does not book a future GP appointment.

If symptoms persist, or the patient's clinical status changes, a referral for colonoscopy or specialist assessment might be indicated. Immediate referral for an FSA may also be appropriate.

Monitoring should include continued review of symptoms, weight, haemoglobin and ferritin as well as regular clinical examination. Additional tests such as liver function tests, erythrocyte sedimentation rate (ESR) blood tests or C reactive protein (CRP) blood tests, coeliac screen, or other tests may be arranged if clinically appropriate. Although the monitoring interval will vary between patients, follow up every 2–3 months is suitable for most patients.

# Referral criteria

## 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)<sup>3</sup>

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) (see Comments for Services section items 1 and 2)

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 >5 mm

## 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 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 – 6 percent is due to CRC and in the absence of clinical, radiological, or tumour marker evidence of CRC, colonoscopy is not indicated

<sup>3</sup> 'Benign anal causes' is defined as haemorrhoids, anal fissure, anal fistula, inflammatory bowel disease, radiation proctitis and mucosal or full thickness rectal prolapse. If no benign anal cause is identified or bleeding continues after the treatment of these, benign causes can be excluded.



# 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.health.govt.nz](http://www.health.govt.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](http://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 that 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 National Bowel Screening Programme 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 measure.
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 measure.
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*. 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 5 percent positive predictive value for colorectal cancer (CRC).

# References

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

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