**Colonoscopy & Flexible Sigmoidoscopy Referral Guidelines**

Austin Health Gastroenterology Clinic holds two sessions (Tuesday pm and Friday am) to discuss and plan the treatment of patients requiring a Colonoscopy or Flexible Sigmoidoscopy.

<table>
<thead>
<tr>
<th>Condition / Symptom</th>
<th>GP Management</th>
<th>Investigations Required Prior to Referral</th>
<th>Expected Triage Outcome</th>
<th>Expected Specialist Intervention Outcome</th>
<th>Expected number of Specialist Appointments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive FOBT</td>
<td>Please refer to the guidelines attached to the Colonoscopy &amp; Flexible sigmoidoscopy Request form (see Appendix)</td>
<td>To be included in referral A completed colonoscopy or sigmoidoscopy request form downloaded from the specialist clinics page (Appendix B). Demand for colonoscopy is very high and to best triage patients for urgent care we require detailed clinical information. Clinical history and examination (result of rectal examination must be included in ALL cases of rectal bleeding or suspected CRC). Patient’s ability to provide informed consent. Patient’s suitability for bowel preparation (e.g. renal failure, immobility, frailty)</td>
<td>Urgent: Demand for urgent colonoscopy remains very high. Patients may wait several weeks-months and should be closely monitored for change in condition or development of new symptoms. The endoscopy registrar can be contacted through the Austin switchboard (94965000) if required. Consider other investigations whilst waiting depending on the indication (e.g. faecal calprotectin for IBD, CT scanning for abdominal pain or weight loss). For</td>
<td>Specialist intervention will be dependent on individual patient results and initial referral. As this is a diagnostic procedure a patient may be referred on to a more specialised clinic for further management or be discharged back to their referrer.</td>
<td>A patient may either be discharged directly back to their referring doctor or be seen back in specialist clinics post procedure if follow up is required.</td>
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<tr>
<td>Positive National Bowel Cancer Screening test</td>
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<td>Iron Deficient Anaemia</td>
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<tr>
<td>Abnormal Imaging</td>
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<tr>
<td>Inflammatory bowel disease (diagnostic / surveillance)</td>
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<tr>
<td>Adenoma Surveillance (see Appendix)</td>
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<tr>
<td>Change in bowel habits &gt;6 weeks</td>
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<tr>
<td>Family History of bowel cancers</td>
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</table>

**Department of Health clinical urgency categories for specialist clinics**

**Urgent**: Referrals should be categorised as urgent if the patient has a condition that has the potential to deteriorate quickly, with significant consequences for health and quality of life, if not managed promptly. These patients should be seen **within 30 days** of referral receipt. For emergency cases please send the patient to the Emergency department.

**Routine**: Referrals should be categorised as routine if the patient’s condition is unlikely to deteriorate quickly or have significant consequences for the person’s health and quality of life if specialist assessment is delayed beyond one month.

**Exclusions**: Uncomplicated CT proven diverticulitis without suspicious features (e.g. unusual location), Routine surveillance & follow up colonoscopy for patients in the care of another health service, Single symptoms – abdominal pain, constipation, Low ferritin with normal Hb, Acute diarrhoea <6 weeks, Adenocarcinoma unknown primary without colonic symptoms, Bright rectal bleeding (likely anal/rectal cause) <50 (these patients should be referred for a flexible sigmoidoscopy).
<table>
<thead>
<tr>
<th>Department of Health clinical urgency categories for specialist clinics</th>
<th>Haemorrhoidal banding</th>
<th>Rectal bleeding</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Haemorrhoidal banding</td>
<td>calprotectin, inflammatory markers)</td>
<td>Imaging&lt;br&gt;All imaging including CT, X-ray</td>
</tr>
<tr>
<td>• Rectal bleeding</td>
<td>Known polyp &gt;5mm (imaging or endoscopy)</td>
<td>Diagnostics&lt;br&gt;Previous endoscopy results&lt;br&gt;Instruct patient to bring films &amp; diagnostic results to the Specialist Clinic appointment.</td>
</tr>
<tr>
<td>Previous treatment already tried:</td>
<td>Positive FOBT/National Bowel Cancer Screening</td>
<td>Pathology results including FOBT, Iron studies, faecal calprotectin</td>
</tr>
<tr>
<td></td>
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<td>patients over 50 participation in the National Bowel Cancer Screening Program is STRONGLY recommended.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Routine: Demand for routine colonoscopy remains very high. Patients are likely to wait extended periods of time and should be monitored for change in condition or development of new symptoms. Consider other investigations whilst waiting depending on the indication (e.g. faecal calprotectin for IBD, CT scanning for abdominal pain or weight loss). For patients over 50 participation in the National Bowel Cancer Screening Program is STRONGLY recommended.</td>
</tr>
</tbody>
</table>
### Colonoscopy / Sigmoidoscopy Referral

Please complete fully all relevant sections of this form and attach a completed Request for Procedure / Treatment with a patient referral. Please attach any supporting documents (imaging, endoscopy, pathology reports) and mail/deliver to the address below. **Note – incomplete referrals will be returned**

#### Patient Details
- Preferred contact number
- Preferred contact person (if other than patient)

#### Referring GP/Specialist
- Name (BLOCK LETTERS)
- Date of Referral
- LMO-initiated referral

#### Procedure Requested
- Coloscopy
- Flexible Sigmoidoscopy
- Endoscopic Mucosal Resection

#### Indication – Diagnostic – Symptoms and/or Investigations
- Positive iFOBT
- Previous colonoscopy
- Iron deficiency anaemia
- Rectal bleeding, duration
- Palpable / visible mass on imaging
- Abnormal imaging
- Recent change in bowel habit, duration
- Constipation

#### Indication – Surveillance & Screening
- Adenoma surveillance – Group
- History of Colorectal Cancer
- Family History Risk – Group
- Familial syndrome
- Date of CRC diagnosis
- Date of last colonoscopy

#### Indication – Therapeutic
- Haemorrhoidal banding
- Polyp ≥ 2cm
- Polyp < 2cm
- Dilatation

#### Additional Clinical History

<table>
<thead>
<tr>
<th>Anticoagulant &amp; Antiplatelet Medications</th>
<th>Comorbidities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Warfarin</td>
<td>NIL</td>
</tr>
<tr>
<td>Clopidogrel / Prasugrel (or similar)</td>
<td>Cardiac</td>
</tr>
<tr>
<td>Rivaroxiban / Apixiban (or similar)</td>
<td>Respiratory</td>
</tr>
<tr>
<td>Asprin</td>
<td>Renal, specify eGFR</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Allergies / Alerts</th>
<th>Diabetes - Type 1</th>
<th>Type 2</th>
</tr>
</thead>
</table>

Please send with Specialist Clinic Referral form to Specialist Clinics
Fax: 9496 2097 or clinics@austin.org.au
**COLONOSCOPIC SURVEILLANCE INTERVALS – ADENOMAS**

- **LOW RISK**
  - 1-2 adenomas
  - AND
  - All <10mm
  - No villous features
  - No high grade dysplasia
  - Colonoscopy at 5 years

- **HIGH RISK**
  - 3-4 adenomas
  - OR
  - Any adenoma >10mm
  - Villous features
  - High grade dysplasia
  - Colonoscopy at 1 year

- **MULTIPLE**
  - ≥5 adenomas
  - Colonoscopy at 1 year

- **POSSIBLE INCOMPLETE OR PIECEMEAL EXCISION OF LARGE OR SESSILE ADENOMA**
  - Colonoscopy at 3-6 months

**FINDINGS AT 1ST FOLLOW-UP:**
- No residual adenoma: 12 months
- Residual adenoma: As for D

**RECOMMENDATIONS:***
- Colonoscopy at 3 years
- Repeat colonoscopy at 3 yearly intervals. If the second follow-up colonoscopy is normal or shows low-risk features, consider increasing the interval on an individualised basis.

**FINDINGS AT 2ND FOLLOW-UP:**
- Normal or Low Risk: As for A
- High risk: As for B
- Multiple: As for C
- Recurrent adenoma: As for D

**COLONOSCOPIC SURVEILLANCE INTERVALS – INFLAMMATORY BOWEL DISEASE**

**Starting Time for Surveillance in At Risk Patients**
- Extent of disease & associated features
  - UC beyond sigmoid
  - CD >1/3 colon or complicated anorectal disease
  - If PSC detected
  - If strong PHx of CRC

**Starting time**
- No later than 8 yr after onset of symptoms
- At time of diagnosis of PSC
- Before after onset of symptoms

**Optimal Surveillance Intervals**

**Group 1**
- Any HIGH RISK FEATURE:
  - Chronically active UC
  - PSC
  - CRC in FDR at <50yrs age
  - Structure, multiple inflammatory polyps or shortened colon
  - Previous dysplasia
- 1 yearly Colonoscopy

**Group 2**
- Quiescent UC without HIGH RISK FEATURES
- 3 yearly Colonoscopy

**Group 3**
- UC without HIGH RISK FEATURES
  - when two previous colonoscopies are macroscopically inactive and histologically negative for dysplasia
- 6 yearly Colonoscopy

**GUIDELINES FOR COLORECTAL CANCER SCREENING – FAMILY HISTORY**

**Category 1** Slightly above average risk (RR x 1-2)
- 1 FDR or SDR age >65yrs at diagnosis
- FOBT every 1-2yr and consider sigmoidoscopy (preferably flexible) every 5yrs
- Routine colonoscopy is not recommended

**Category 2** Moderately increased risk (RR x 3-6)
- 1 FDR age <55yrs at diagnosis or 2 FDR or 1 FDR and 1 SDR on the same side of the family: any age at diagnosis
- Colonoscopy from age 50yrs or 10yrs younger than the age of first diagnosis of CRC in the family, whichever comes first

**Category 3** High risk
- Known or suspected familial syndrome
- Known FAP or Lynch Syndrome (i.e. HNPCC):
  - Specialist referral, as per NHMRC Guidelines
  - Suspected Lynch Syndrome:
    - Every 1 or 2yrs from age 25yrs or 5yrs younger than the youngest affected family member ( whichever comes first)
    - Suspected FAP or other syndromes:
      - Refer to guideline

**Abbreviations:**
- UC – Ulcerative Colitis
- FDR – Family History
- SDR – Siblings of affected family members
- PSC – Primary Sclerosing Cholangitis
- CD – Crohn’s Disease
- CRC – Colorectal Cancer
- IBD – Inflammatory Bowel Disease
- PHx – Prior History
- FDR – First Degree Relative (Mother/daughter/brother/sister)
- SDR – Second Degree Relative (aunt/uncle/cousin/son/daughter)

**GESA – Gastroenterological Society of Australia**
**CSSANZ – Colorectal Society of Australia & New Zealand**
**Cancer Council Australia**


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21/08/17 Review & Update By: August