**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.

### 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 (eg 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).

### Condition / Symptom

<table>
<thead>
<tr>
<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>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 (eg 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 (eg faecal calprotectin for IBD, CT scanning for abdominal pain or weight loss).</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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<tr>
<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 A)</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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</tbody>
</table>

Please refer to the guidelines attached to the Colonoscopy & Flexible sigmoidoscopy Request form (appendix A) **When to Refer:**

- Known or suspected CRC on basis of imaging, colonic mass, palpable mass on PR or seen at sigmoidoscopy
- Unexplained rectal bleeding with Iron deficiency anaemia (Ferritin, MCV and Hb <N range)
- Altered bowel habits (more frequent, looser, >6 weeks duration)
- Suspected IBD (evidence of raised
<table>
<thead>
<tr>
<th>Department of Health clinical urgency categories for specialist clinics</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Haemorrhoidal banding</td>
</tr>
<tr>
<td>• Rectal bleeding</td>
</tr>
<tr>
<td>Previous treatment already tried:</td>
</tr>
<tr>
<td>Imaging</td>
</tr>
<tr>
<td>All imaging including CT, Xray</td>
</tr>
<tr>
<td>Diagnostics</td>
</tr>
<tr>
<td>Previous endoscopy results</td>
</tr>
<tr>
<td>Instruct patient to bring films &amp; diagnostic results to the Specialist Clinic appointment.</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 ☐ No ☐ Yes, LMO details / copy to...........................................................

Procedure Requested
☐ Colonoscopy ☐ Flexible Sigmoidoscopy ☐ Upper endoscopy (add on)

Indication – Diagnostic – Symptoms and/or Investigations
☐ Positive iFOBT ☐ NBCSP ☐ Non NBCSP ☐ Previous colonoscopy, specify year..........................
☐ Iron deficiency anaemia ☐ Family History of Colorectal Cancer in 1st degree relative, specify below
☐ Palpable / visible mass
☐ Abnormal imaging
☐ Rectal bleeding, duration........................................ Hb............. MCV............. Ferritin.............
☐ Recent change in bowel habit, duration........... CRP............. ESR............. Calprotectin...........
☐ Constipation ☐ Diarrhoea

Indication – Surveillance & Screening (Please specify correct group according to classification over page)
☐ Adenoma surveillance – Group ☐ A ☐ B ☐ C ☐ D ☐ History of Colorectal Cancer
☐ Family History Risk – Group ☐ 1 ☐ 2 ☐ 3 Date of CRC diagnosis..........................
☐ Familial syndrome..........................................................
☐ Inflammatory Bowel Disease

Indication – Therapeutic
☐ Haemorrhoidal banding ☐ Polyp ≥ 2cm ☐ Polyp < 2cm

Additional Clinical History

Anticoagulant & Antiplatelet Medications
☐ Warfarin...................................................
☐ Clopidogrel / Prasugrel (or similar)
☐ Rivaroxiban / Apixiban (or similar)
☐ Aspirin

Comorbidities
☐ NIL
☐ Cardiac..........................................................
☐ Respiratory..................................................
☐ Renal, specify eGFR..........................................

Allergies / Alerts

☐ Diabetes - ☐ Type 1 ☐ Type 2
Comments..........................................

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

A
LOW RISK
1-2 adenomas
AND
All <10mm
No villous features
No high grade dysplasia

B
HIGH RISK
>3 adenomas
OR
Any adenoma >10mm
Villous features
High grade dysplasia

C
MULTIPLE
>5 adenomas

D
POSSIBLE INCOMPLETE OR RECECEN EXCISION OF LARGE OR SEVERE ADENOMA

FINDINGS AT 1ST FOLLOW-UP:
No residual adenoma
As for A

FINDINGS AT 2ND FOLLOW-UP:
(As for B)

FINDINGS AT 3RD FOLLOW-UP:
(As for C)

Coloscopy at 3-6 months

FINDINGS AT 1ST FOLLOW-UP:
No residual adenoma
As for A

FINDINGS AT 2ND FOLLOW-UP:
(As for B)

FINDINGS AT 3RD FOLLOW-UP:
(As for C)

Coloscopy at 3-6 months

Starting Time for Surveillance
In At Risk Patients

Extant of disease & associated features

Extant of disease & associated features

Starting time

No later than 3 years after
onset of symptoms

If PSG detected

At time of diagnosis of PSG

If strong risk of CRC

Before any after
onset of symptoms

Optimal Surveillance Intervals

Group 1

Any HIGH RISK FEATURE:
- Chronic active UC
- PG3
- CRC in FDR at ≤50 age
- Multiple inflammatory polyps or shortened colon
- Previous dysplasia

1 yearly Colonoscopy

Group 2

UC without HIGH RISK FEATURES

Quiescent UC without HIGH RISK FEATURES

3 yearly Colonoscopy

Group 3

UC without previous colitis

2 yearly Colonoscopy

5 yearly Colonoscopy

GUIDELINES FOR COLORECTAL CANCER SCREENING – FAMILY HISTORY

Category 1
Slightly above average risk
(RR x 1.5)

1 FDR or SDR age ≥55yrs at diagnosis

FOBT every 1-2yrs and consider sigmoidoscopy (preferably flexible) every 3yrs from age 50yrs

Routine colonoscopy is not recommended

Category 2
Moderately increased risk
(RR x 3-5)

1 FDR age ≤55yrs at diagnosis

2 FDR or 1 FDR and 1 SDR on the same side of the family, any age at diagnosis

Known FAP or Lynch Syndrome (e.g., HNPCC)


COLONOSCOPY SURVEILLANCE INTERVALS – FOLLOWING SURGERY FOR COLORECTAL CANCER

Is surveillance colonoscopy appropriate?

Was the colon cleared of adenomas and synchronous cancers pre-operatively?

Yes

Colonoscopy at 1 year post-op

Colonoscopy at 3-6 months post-op

SUBSEQUENT COLONOSCOPY INTERVAL
DEPENDING ON FINDINGS AT FOLLOW-UP:

Normal – Repeat 5 yearly

Adenomas – Repeat as per adenoma chart

Cancer – Refer to surgery or other as appropriate

No

No colonoscopy

Ensure detailed discussion and complete documentation