Birmingham and Solihull
Clinical Commissioning Group

NHS Birmingham and Solihull CCG
NHS Sandwell and West Birmingham CCG

Policy for the use of Upper GI Endoscopy.

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The CCG policy has been reviewed and developed by the Treatment Policies Clinical Development Group in line with the groups guiding principles which are:

1. CCG Commissioners require clear evidence of clinical effectiveness before NHS resources are invested in the treatment;
2. CCG Commissioner require clear evidence of cost effectiveness before NHS resources are invested in the treatment;
3. The cost of the treatment for this patient and others within any anticipated cohort is a relevant factor;
4. CCG Commissioners will consider the extent to which the individual or patient group will gain a benefit from the treatment;
5. CCG Commissioners will balance the needs of each individual against the benefit which could be gained by alternative investment possibilities to meet the needs of the community
6. CCG Commissioners will consider all relevant national standards and take into account all proper and authoritative guidance;
7. Where a treatment is approved CCG Commissioners will respect patient choice as to where a treatment is delivered; AND
8. All policy decisions are considered within the wider constraints of the CCG's legally responsibility to remain fiscally responsible.

Upper GI Endoscopy

A gastroscopy is a procedure where a thin, flexible tube called an endoscope is used to look inside the oesophagus (gullet), stomach and first part of the small intestine (duodenum).

It's also sometimes referred to as an upper gastrointestinal endoscopy.

The endoscope has a light and a camera at one end. The camera sends images of the inside of the oesophagus, stomach and duodenum to a monitor.

A gastroscopy can be used to:

- **investigate problems** such as difficulty swallowing (dysphagia) or persistent abdominal (tummy) pain
- **diagnose conditions** such as stomach ulcers or gastro-oesophageal reflux disease (GORD)
- **treat conditions** such as bleeding ulcers, a blockage in the oesophagus, non-cancerous growths (polyps) or small cancerous tumours

A gastroscopy used to check symptoms or confirm a diagnosis is known as a diagnostic gastroscopy. A gastroscopy used to treat a condition is known as a therapeutic gastroscopy.

A gastroscopy is a very safe procedure, but like all medical procedures it does carry a risk of complications.

Possible complications that can occur include:

- a reaction to the sedative, which can cause problems with your breathing, heart rate and blood pressure
- internal bleeding
- tearing (perforation) of the lining of your oesophagus, stomach or duodenum

Endoscopy is an invasive procedure and is not always well tolerated. It carries significant risks and should not be used as a first-line indication in all patients.

Rationale for Recommendation

NICE and the British Society for Gastroenterology recommend the below eligibility criteria for use of endoscopy.

Endoscopy is a very invasive procedure for patients and is not always well tolerated. There are numerous risks associated with endoscopy, such as reaction to sedation, bleeding or perforation, the latter of which could lead to an emergency operation if serious enough. This is one of the reasons why endoscopy should not be a first-line of investigation in all patients.

For example, the first-line testing for H Pylori (and therefore associated dyspepsia) should be Urea breathe test or stool antigen test. This test is much less invasive for the patient.

In regard to the efficiency of services and value for money, endoscopy when used appropriately is of value. However, a literature review and meta-analysis have shown diagnostic overuse with significant resource implications. Of the meta-analyses results it found that 22% of OGDs were inappropriate indications. The aim of this rationale is not only to improve value, whilst still achieving high care for patients, and not submitting patients to unnecessary invasive endoscopies that can hold serious complications.

Eligibility Criteria: Restricted

Upper GI Endoscopy should only be performed if the patient meets the following criteria:

Urgent: (Within two weeks)

- Any dysphagia (difficulty in swallowing), to prioritise urgent assessment of dysphagia please refer to the Edinburgh Dysphagia Score OR
- Aged 55 and over with weight loss and any of the following:
  - Upper abdominal pain
  - Reflux
  - Dyspepsia (4 weeks of upper abdominal pain or discomfort)
  - Heartburn
  - Nausea or vomiting
- Those aged 55 or over who have one or more of the following:
- Treatment resistant dyspepsia (as above), upper abdominal pain with low haemoglobin level (blood level) OR
- Raised platelet count with any of the following: nausea, vomiting, weight loss, reflux, dyspepsia, upper abdominal pain OR
- Nausea and vomiting with any of the following: weight loss, reflux, dyspepsia, upper abdominal pain.

For the assessment of Upper GI bleeding:

- For patients with haematemesis, calculate Glasgow Blatchford Score at presentation and any high-risk patients should be referred
- Endoscopy should be performed for unstable patients with severe acute upper gastrointestinal bleeding immediately after resuscitation
- Endoscopy should be performed within 24 hours of admission for all other patients with upper gastrointestinal bleeding.

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For the investigation of symptoms:

- Clinicians should consider endoscopy:
    - Any age with gastro-oesophageal symptoms that are nonresponsive to treatment or unexplained
    - With suspected GORD who are thinking about surgery
    - With H pylori that has not responded to second- line eradication
- Eradication can be confirmed with a urea breath test.

For management of specific cases

H pylori and associated peptic ulcer:

- Eradication can be confirmed with a urea breath test, however if peptic ulcer is present repeat endoscopy should be considered 6-8 weeks after beginning treatment for H pylori and the associated peptic ulcer.

Barrett's oesophagus:

- Where available the non-endoscopic test called Cytosponge can be used to identify those who have developed Barrett's oesophagus as a complication of long-term reflux and thus require long term surveillance for cancer risk

- Consider endoscopy to diagnose Barrett's Oesophagus if the person has GORD (endoscopically determined oesphagitis or endoscopy - negative reflux disease)

- Consider endoscopy surveillance if person is diagnosed with Barrett's Oesophagus.

Surveillance endoscopy:

- Surveillance endoscopy should only be offered in patients fit enough for subsequent endoscopic or surgical intervention, should neoplasia be found. Many of this patient group are elderly and/or have significant comorbidities. Senior clinician input is required before embarking on long term endoscopic surveillance

- Patients diagnosed with extensive gastric atrophy (GA) or gastric intestinal metaplasia, (GIM) (defined as affecting the antrum and the body) should have endoscopy surveillance every three years

- Patients diagnosed with GA or GIM just in the antrum with additional risk factors- such as strong family history of gastric cancer of persistent H pylori infection, should undergo endoscopy every three years.

Screening endoscopy can be considered in:

- European guidelines (2015) for patients with genetic risk factors / family history of gastric cancer recommend genetics referral first before embarking on long term screening. Screening is not appropriate for all patients and should be performed in keeping with European expert guidelines

- Patients where screening is appropriate, for individuals aged 50 and over, with multiple risk factors for gastric cancer (e.g. H. Pylori infection, family history of gastric cancer - particularly in first degree relative -, pernicious anaemia, male, smokers).

Post excision of adenoma:

- Following complete endoscopic excision of adenomas, gastroscopy should be performed at 12 months and then annually thereafter when appropriate.

This guidance applies to adults aged 19 years and over.

This means **(for patients who DO NOT meet the above criteria)** the CCG will **only** fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG.

Guidance

1. NHS Advice: https://www.nhs.uk/conditions/Endoscopy/

2. NICE Guidance: https://www.nice.org.uk/guidance/ng12.

3. British Society of Gastroenterology guidelines: https://gut.bmj.com/ content/68/9/1545.

4. BSG Interim Guidance: COVID-19 specific non-biopsy protocol for those with suspected coeliac disease: https://www.bsg.org.uk/covid-19-advice/ covid-19-specific-non-biopsy-protocol-guidance-for-those-with-suspectedcoeliac-disease/.

5. British Society of Gastroenterology-led multi-society consensus care bundle for the early clinical management of acute upper gastrointestinal bleeding: https://www.bsg.org.uk/wp-content/uploads/2019/11/ flgastro-2019-101395.pdf.

6. NHS Advice: https://www.nhs.uk/conditions/gastroscopy/risks/.

7. Malik HT, Marti J, Darzi A, Mossialos E. Savings from reducing low-value general surgical interventions. Br J Surg. 2018 Jan;105(1):13-25. doi:10.1002/ bjs.10719.

8. Di Giulio E, Hassan C, Marmo R, Zullo A, Annibale. B. Appropriateness of the indication for upper endoscopy: a metaanalysis. Dig Liver Dis 2010; 42: 122 – 126.

9. NICE guidance: Gastro-oesophageal reflux disease and dyspepsia in adults: investigation and management. September 2014. CG184.

10. NICE guidance: Acute upper gastrointestinal bleeding in over 16s management. June 2012. CG141.

11. Van der Post RS et al. J Med Genet. 2015 Jun; 52(6): 361–374. Published online 2015 May 15. doi: 10.1136/jmedgenet-2015-103094.

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