GASTROENTEROLOGY

National Clinical Priority Access Criteria for Gastroscopy (CPAC)

Category Definitions : These are recommended guidelines for HHS specialists prioritizing referrals from primary care.

Emergency	- AH	- *after hours*
	- NL	- *next list*
Elective	- A	- *within 10 days*
	- A/B	- *between 11 to 20 days*
	- B	- *between 21 to 30 days*
	- C	- *after 30 days*
	-N/I	- *not indic.*

Immediate and Urgent cases must be discussed with the Specialist or Registrar in order to get appropriate prioritisation and then a referral letter sent with the patient, faxed or e-mailed. The times to assessment may vary depending on size and staffing of the hospital department.

Indication	Priority						
	Emergency		Elective				
	AH	NL	A	A/B	B	C	N/I
Upper gastrointestinal haemorrhage							
Continuous or early re-bleeding / unstable	●						
> 65 years of age and on NSAID	○	●	●				
chronic liver disease	○	●					
stable / haemoglobin < 100g/L		●					
stable / minor episode		●	○				
Iron deficient anaemia (No leading GI symptoms)							
- Consider pre booking colonoscopy				○	●		
Foreign body							
Battery in oesophagus	●						
Other foreign body in oesophagus		●					
Caustic burns	●						
- If foreign body remains in oesophagus: gastroscopy within 12 hours - Caustic injuries should not be gastroscoped beyond 24-36 hours							
Dysphagia							
Food bolus obstruction	○	●					
< 3 months, progressive			●	○			
< 3 months, stable			○	●			
> 3 months, stable				●			
longstanding, intermittent				●			
Dyspepsia / Heartburn							
> 50 years OR alarm symptoms				●	○		
all others					●	○	
- Consult National Dyspepsia Guidelines - 'Alarm' symptoms: weight loss, anaemia, severe pain - Gastroscopy preferably performed at least 3 weeks off active acid suppression							
Surveillance							
Barrett's surveillance (see appendix)						●	
Gastrectomy surveillance							●
- According to local / national guidelines							

● - *Preferred priority for investigation* ○ - *Alternative priority for investigation*

Appendix

Endoscopic Surveillance in Barrett's Oesophagus

Principles

1. Endoscopic surveillance is recommended for selected patients with Barrett's oesophagus.
2. There is no literature consensus as to the correct screening interval.
3. At risk groups include those with: a) severe dysplasia
   b) long segments
4. Co-morbidity that precludes oesophagectomy excludes patients from surveillance.
5. Modelling data suggests that surveillance in older patients is unlikely to be cost effective.

Management Protocol

1. Initial endoscopy biopsies ideally 4 quadrant at 2 cm intervals (may not necessarily be practical or possible).

Subsequent Endoscopies

1. **Barrett's with no dysplasia** – repeat endoscopy 2-3 yearly depending on length of segment and age of patient.
2. **Barrett's: Low grade dysplasia** – 6 – 12 monthly endoscopy with biopsy. (Low grade + mild/moderate dysplasia).
3. **Barrett's High grade dysplasia** – consider surgical referral or 3 monthly endoscopy and biopsy.
4. **No dysplasia after previous dysplastic histology** – repeat at one year. If still no dysplasia – then repeat 2-3 yearly depending on length of segment and age of patient.
5. **Screening** – not indicated at age greater than 70 or if patient has co-morbidity and/or is unfit for oesophagectomy.