Upper and Lower GI pathways SNEE May 2021

By A Parr

COVID challenges

- Endoscopy and colonoscopies now resumed but still increased time needed
- Patients need to have COVID swab AND THEN SELF ISOLATE for 72hours AND have procedure WITHIN 2weeks before invasive testing.
- Issues with patients not wanting/able/expecting to do this- can we discuss with pts at referral point? If problems call/CLEARLY ANNOTATE form.
- At West Suffolk most lower GI referrals now STRAIGHT TO TEST with nurse triage first – referral form critical
- FiT test for all inc frank PR bleeding – used quantitively to get best ix

Upper GI pathways – West Suffolk

- Very few 2WW go straight to clinic – mainly for frail patients, to help decide what investigations are appropriate. Waiting for clinic delays investigations significantly
- Therefore, fitness information on ref REALLY important
- Info on ref is used to select whether to investigate for suspected Hepato-Pancreato-Biliary or Oesophago-Gastric cancer
- This is difficult if patients have vague symptoms or those that overlap the 2 pathways (some may be investigated on both pathways)

New upper GI investigations

- Transnasal endoscopy (new service for WSH)
- Cytosponge (building on the BEST 3 community trial for reflux)
- Secondary care can access Upper GI physiology and manometry with regular cinics performed at WSH. However this is more useful for functional conditions, once cancer has been excluded. Not appropriate for 2WW pathway patients.

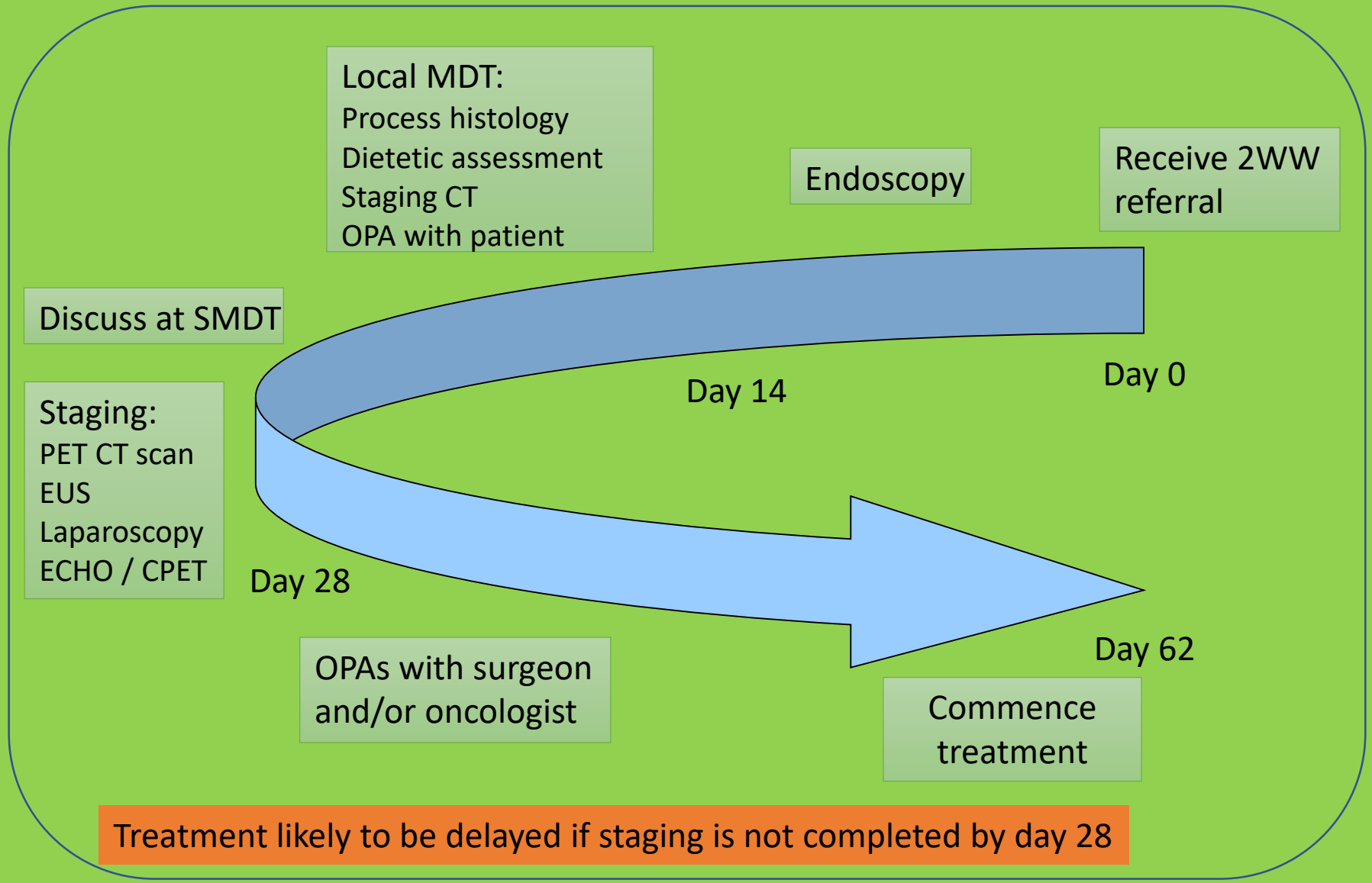
Upper GI pathways - ESNEFT

- About 60% STT -
- Consultant triage
  – scope within 2 weeks
  - 2WW jaundice clinic for HPB with same day USS
  - wt loss 2WW OPD
- Poor links to comm endoscopy reports
- Some ANP referrals miss things like stool culture for diarrhoea

Suspected Oesophago-Gastric Cancer pathway

- Suspected OG cases go straight to gastroscopy
- Has the patient had an endoscopy within the last 18 months – unlikely to be cancer if this was normal
- We can get In Health community endoscopy reports but helpful to send copy as sometimes has been system information sharing issues
- Patients are vetted by nurse endoscopists, often by telephone
- COVID swab 48 to 72 hours before the procedure
- Consider endoscopy appointment as a face to face encounter with a specialist rather than just a procedure
- Benign diagnosis that fits with the symptoms – patient is discharged back to GP
- If cancer is excluded, but there are clinical concerns about patient, further investigations will be arranged by the endoscopist (e.g. colonic Ix, CT or US scan)

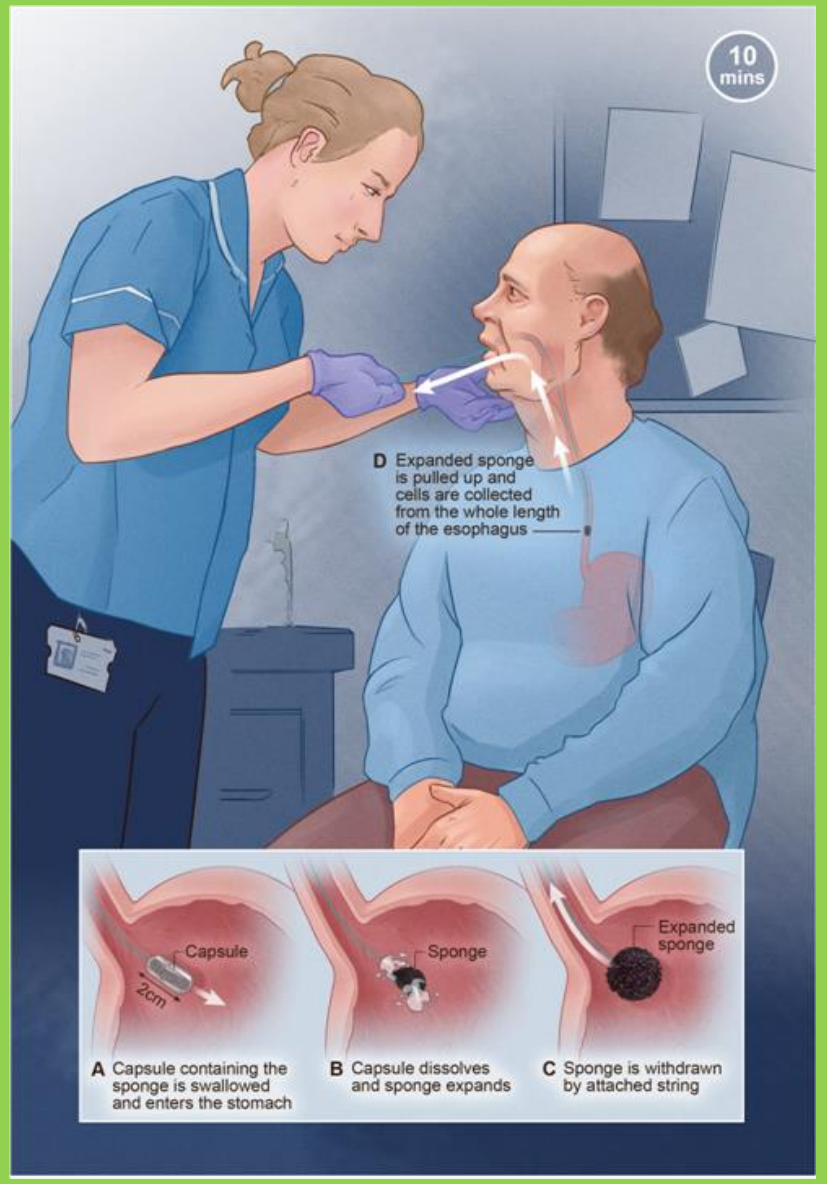
Targets for a patient with OG cancer on the 62 day pathway



Trans-nasal endoscopy

- Recently started at West Suffolk
- Finer scope- most are done without sedation
- Nurse led
- Faster and better tolerated by patients
- Can be good for pts anxious about swallowing the scope
- Can get biopsies
- Difficult if large hiatus hernia
- Not licenced for Barrett's surveillance yet
- Potential for use in an “office” setting – community diagnostic hubs

The Cytosponge clinic



- Nurse led clinic, telephone pre-assessment
- COVID swab first
- Minimally invasive cell collection device for pan-oesophageal sampling
- Used to detect intestinal metaplasia – marker of Barrett's oesophagus
- And atypia – marker of dysplasia or cancer

Cytosponge in 2WW Upper GI

- It was used in a trial at Addenbrookes during the first wave of COVID, when endoscopy services were severely limited
- Telephone consultation first to assess symptoms, straight to OGD if severe dysphagia, if mild to moderate dysphagia - cytosponge, OGD if atypia was found, if negative or Barrett's found, OGD at a later date
- At WSH, we prioritised OGDs by symptoms, all 2WW referrals have been scoped now
- However there have been two groups patients that were not scoped:
  - Open access referrals with reflux symptoms
  - Patients on Barrett's surveillance programme
- DELTA trial - specifically for COVID have been using cytosponge for Barrett's surveillance - if negative then scope delayed for a year. We have performed > 50 procedures to date
- East of England Cancer Alliance Pilot Study – cytosponge funded for patients with reflux or dyspepsia, without high risk symptoms. Just started at WSH

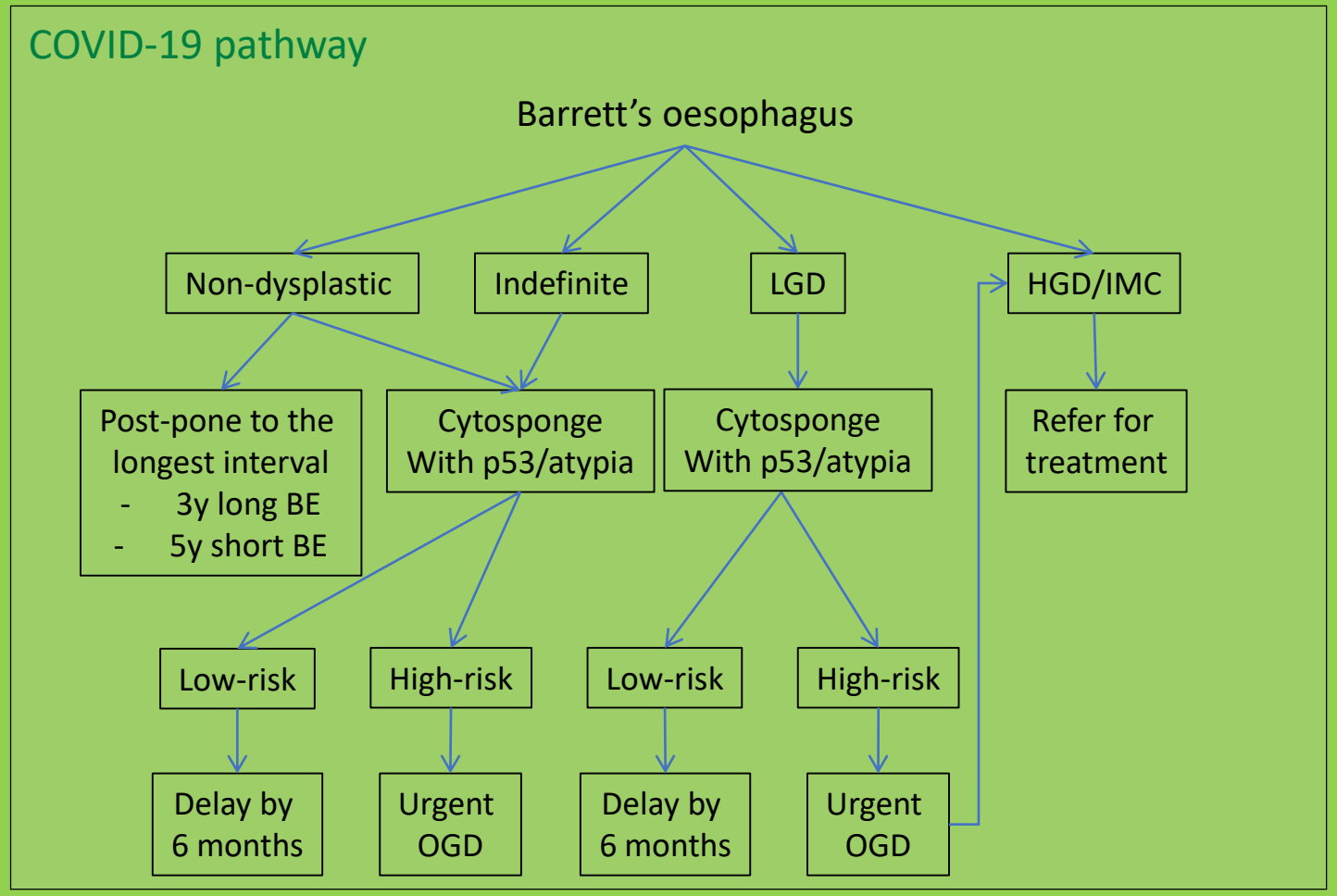
Project DELTA

integrateD diagnostic solution for EarLy deTection of oesophageal cAncer

Primary aim: assess the feasibility and implementation steps of introducing Cytosponge in primary and secondary care as triage tool to endoscopy

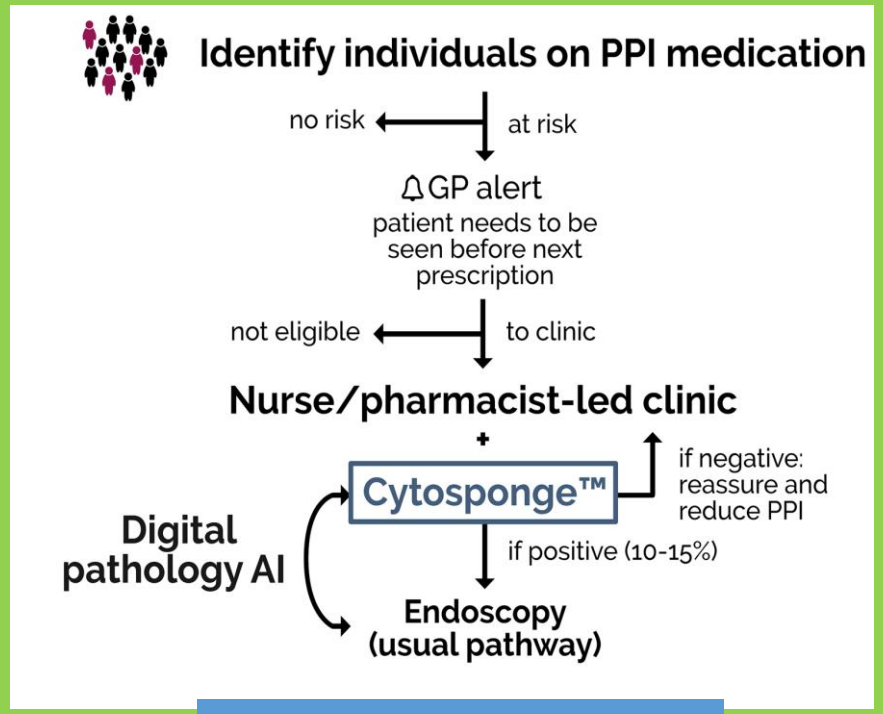
COVID: extended to patients on Barrett's surveillance programmes

Barrett's surveillance pathway



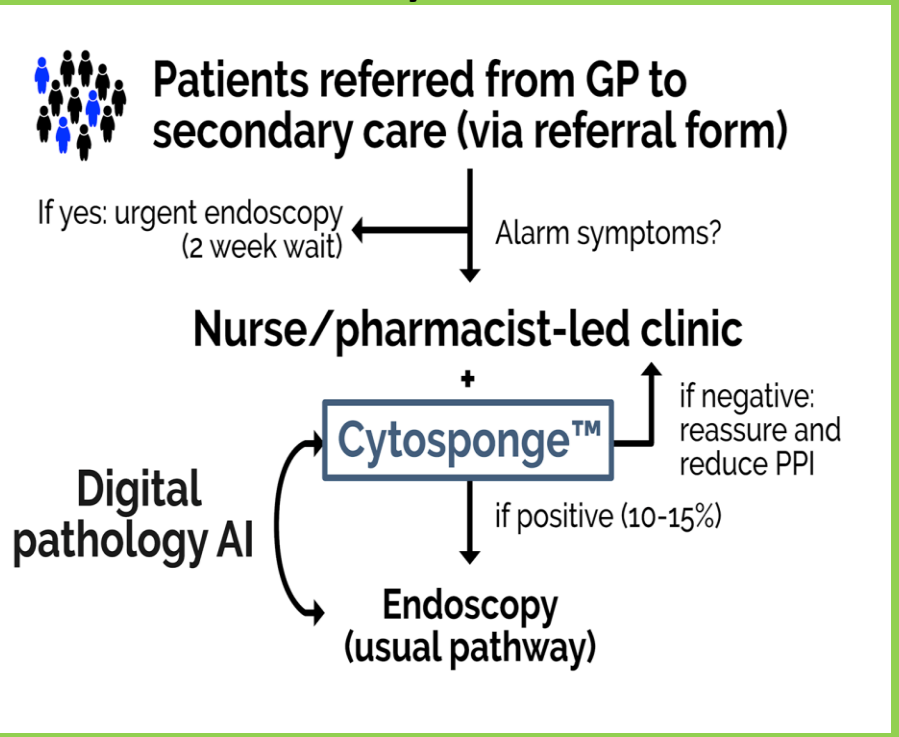
Intended clinical pathways for DELTA, now adopted by EofE Pilot project

Primary care



Mobile Cytosponge clinic will come to primary care sites

Secondary care



Traditionally most would go to OGD, 70% of which are normal

This is expected to reduce routine OGD referrals by 20%

Suspected HPB Cancer pathway

- Suspected HPB cases vetted by CNS first
- US scan is very helpful if jaundiced or palpable mass, less for those with other 2WW criteria.
- If GP has access to rapid US service, please request it at time of making the referral and forward result. Also send blood incl LFTs
- If not, US will be requested as first investigation at WSH
- Some cases may be booked for a consultant telephone consultation / clinic OPA and may then go direct to CT scan or other investigation
- Since COVID, jaundiced patients will be seen as ambulatory case in SAU, with simultaneous USS and consultant assessment

Reminder on Obstructive Jaundice!

- Pale stool (no bilirubin reaching GI tract)
- Dark urine (reflux of conjugated bilirubin into blood then excreted)
- Intra/Extrahepatic
- Liver enlarged and intrahepatic bile ducts dilated
- Infection of bile above obstruction due to cholestasis can cause cholangitis

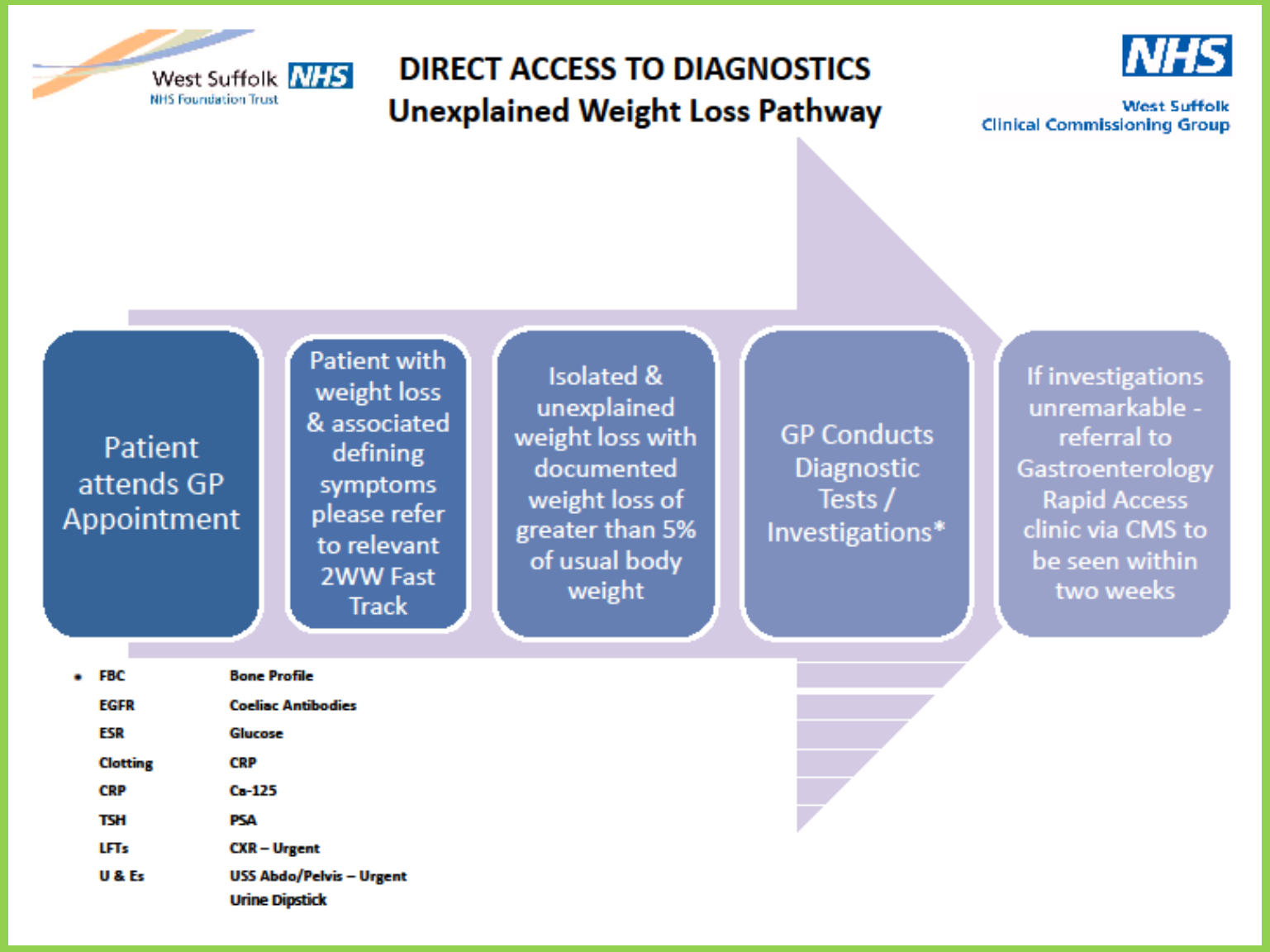
Most common causes – gallstones, carcinoma of head of pancreas

- Extramural :- carcinoma of the ampulla of Vater, Pancreatitis, porta hepatis tumours (often secondary deposits), chronic duodenal ulcerationmural obstruction:
- Mural: -traumatic stricture e.g. ampullary stricture, sclerosing cholangitis, cholangiocarcinoma
- Obstruction of the lumen of the bile ducts: - gall stones, Parasites, iatrogenic:, post-T-tube cholangiography

Key messages

- Many patients now go straight to test
- Often no clinic appointment/cons r/v rely on ix
- GP assessment really important therefore and if lump in neck and not just dysphasia etc clear description and free text on 2WW form
- Fitness for test to be considered
- SAU maybe better option for some patients especially Obstructive Jaundice - THERE IS A PROBLEM!! - same day assessment and often can get USS/CT/Blds/MR within 24 hrs and ERCP if needed
- SAU number also has cons available for advice if needed

Weight loss pathway



Vague symptom pathway

- In West Suffolk and in ESNEFT
- Weight loss is a criteria if other 2WW red flags not present
- GP gut feel also a referral criteria
- Mandated pre ref ix include USS abdo, blds, urine dip, CXR, FiT test
- Aim to be seen within 2 weeks
- Access to further diagnostics if needed

Is patient fit for straight to test? Options….

- All lower GI ix need good bowel prep.

1) CT colon – rate limiting step specially trained radiographers, more often in older patients
2) Colonoscopy
3) Colon capsule

- Straight to clinic appointment also an option – specialist nurses triage.

FiT prioritisation

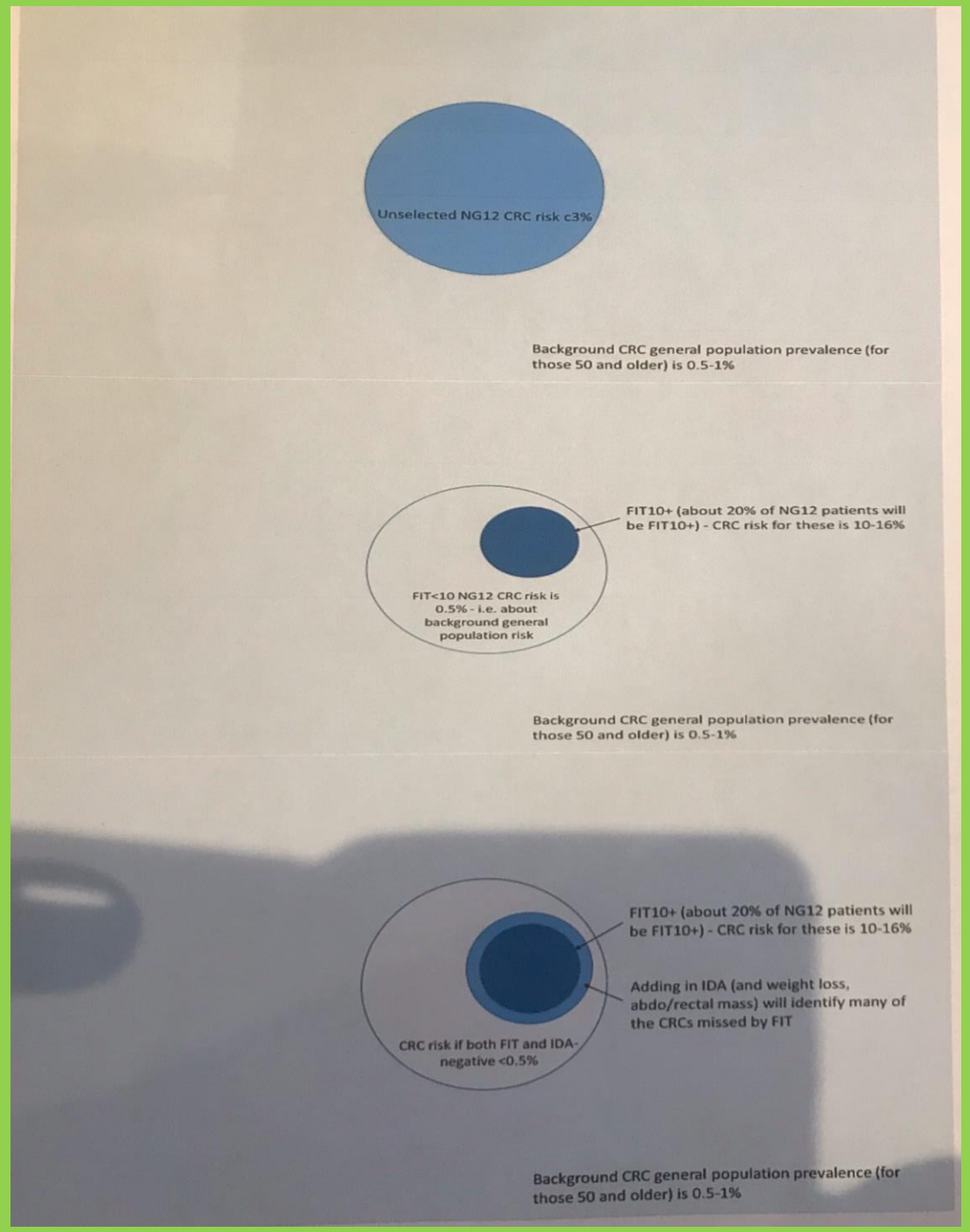
Symptomatic but without rectal bleeding	Positive predictive value for CRC	Actions required	Numbr of colonoscopies to identify one CRC
FIT > 400mcg/g	22.8%	High priority colonoscopy/ CTC	4
FIT >100mcg/g	17.9%		
FIT 10-99mcg/g	est 1-10%	Less urgent colon investigation	
FIT <10mcg/g	<0.7%	Consider other non-colon urgent investigation or low priority colon investigation or no investigation	148

Asymptomatic general population prevelance	<1%	Encourage participation in the National screeing program

FiT Management

- Pt with abdo symptoms and FiT<10 has 99.6% chance of NOT having CRC (same as general population)
- If NO iron def anaemia (IDA), wt loss, norm examination (inc PR) consider other pathways ie urology/gynae CA125
- Safety netting and r/v 4-6 weeks consider colorectal A+G if still unclear
- If frank blood FiT STILL HELPFUL- only 44% in large study of this group had positive FiT
- If negative FiT even with PR bleeding 0.1% CRC
- PR examination is important - look for obvious mass.

FiT – how IDA, wt loss and examination affect safety and use



Fit with frank rectal bleeding

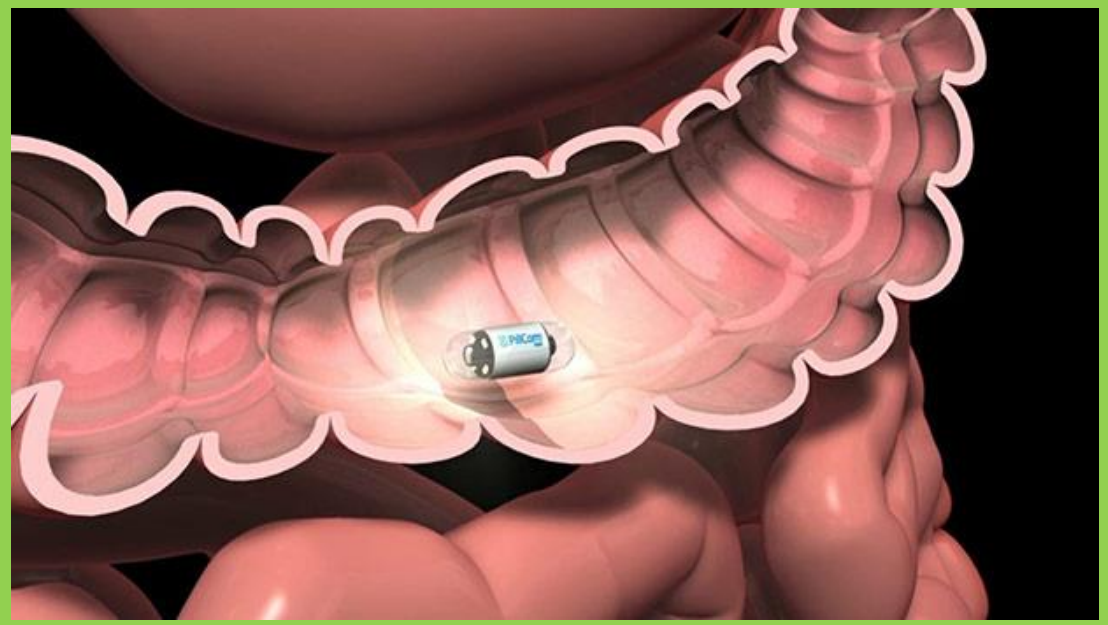
- 44% positive
- Try to take sample form stool without fresh blood visible
- Of the positive 44% 10.4 CRC, 32.9% serious bowel disease
- Faecal Calprotectin can be helpful ix
- Of the 56% negative FiT 0.1% CRC (less than background population risk)

Colon capsule – currently on trial at ESNEFT and West Suffolk

- Most aggressive bowel prep of lower GI ix
- Currently more younger 2WW patients
- Lower risk 2WW (as if biopsy needed would need colonoscopy) – relates to FiT level
- No swallowing restrictions
- Need to be technology aware and be able to access videos online
- After swallowing wait 45 min to check proceeding and return the next day, pt wears recording box whilst in.
- No further ix on 2WW pathway if NAD

Colon Capsule

Size of large antibiotic- assesses large bowel



Useful webpage and contact for Vague symptoms

- VAGUESYMPTOMS (NHS IPSWICH AND EAST SUFFOLK CCG) iesccg.vaguesymptoms@nhs.net

- https://www.northerncanceralliance.nhs.uk/wp-content/uploads/2020/11/LGI-2WW-FAQ_V3.pdf