

**PRIME DIAGNOSTICS LTD**

# Community Endoscopy

## Referral Guidelines and Information



# CONTENTS

INTRODUCTION

REFERRAL GUIDELINES

REFERRAL FORMS

DIABETIC GUIDELINES

ANTICOAGULANT GUIDELINES

PATIENT INFORMATION

CONCLUSION

# INTRODUCTION

## OUR SERVICES

Community endoscopy services allow for patients requiring both upper and lower GI endoscopy procedures, to have their investigations carried out within a wider range of locations, such as community hospitals, polyclinics, local NHS hospital trusts and private hospital endoscopy units. Having a wide range of locations offers the patient greater choice of both setting and appointment times, so that their procedure is as convenient for them as possible.

Community endoscopy services are also an efficient way of delivering patient-centred procedures. The community endoscopy service receives patient referrals from GPs via a standardised pro-forma for upper GI endoscopy, sigmoidoscopy and colonoscopy investigations. This pathway is based upon current NICE and BSG guidelines thus representing best practice. The referral protocols in place allow for streamlined pathways from GP to procedure, thus avoiding the need to use a more costly service.

In addition, patients can access community services in a timely manner, thus reducing waiting lists and ensuring the delivery of the 6 week diagnostic pathway. A further benefit of these services being available within the community are that through eliminating unnecessary steps and going straight to test (if clinically appropriate) the number of hospital consultant outpatient and follow up encounters are significantly reduced.

In summary, community endoscopy services provide a safe, convenient and efficient way for patients to access endoscopy procedures in a timely manner.



# REFERRAL GUIDELINES

## Upper GI



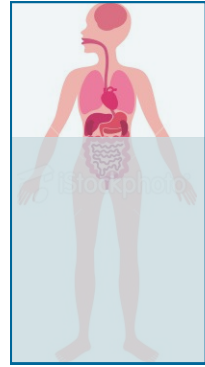
### ADDITIONAL INFORMATION

Following an upper GI investigation such as a gastroscopy, there are a variety of potential outcomes, with some of them detailed here:

#### PPI Medication

This may be prescribed for any of the following reasons:

- As part of triple eradication therapy
- For patients with severe oesophagitis or Barrett's who require long term acid suppression
- HP negative patients with persisting gastritis (often NSAID induced)



## GASTROSCOPY

Symptom	Additional information	Action
An obvious bleed (Haemetemesis / Melaena)	Any age	Admit to Acute Trust
'Alarm Symptoms' - Unexplained anaemia - Dysphagia / persistent vomiting - Unexplained weight loss - Unexplained anorexia	One or more of these 'alarm symptoms' at any age	<b>Request gastroscopy</b>
New onset dyspepsia or reflux symptoms	Over 55 yrs	<b>Request gastroscopy</b>
Ulcer or reflux symptoms	Under 55 yrs	<ul style="list-style-type: none"> <li>✓ Give lifestyle advice and 4 weeks H2 blockers / low dose PPI</li> <li>✓ Test for HP Faecal Antigen. If positive eradicate with standard triple therapy</li> <li>✓ <b>If poor response then request an endoscopy</b> rather than commence long term, high dose PPI Regime</li> </ul>

### Barrett's oesophagitis

Because of the increased risk of progression of Barrett's oesophagitis to malignancy; a surveillance programme is currently recommended. This surveillance will see patients having a repeat procedure every 2 years. If there is evidence of high grade dysplasia then they will be seen more frequently or referred to the Upper G-I malignancy MDT for review of histology and further biopsies.

### Upper GI malignancy

- All patients with malignancy must be fast tracked to the MDT for assessment and treatment.
- The endoscopist will discuss the findings with the patient and will give the patient the choice of which secondary care provider they wish to undertake their care.
- The endoscopist will then complete the 2 week suspected cancer referral document and start the patient on the MDT pathway.
- The endoscopist will also telephone the GP on the day to advise them of their findings.
- The patient will then be discussed at MDT and their treatment plan formulated, this is usually within 10 days.

# Lower GI

## FLEXIBLE SIGMOIDOSCOPY

Symptom	Additional information	Action
Suspected left side or distal colonic disease	Under 50 yrs	<b>Request flexible sigmoidoscopy</b>
Bright red rectal bleeding for more than 6 weeks, with or without perianal symptoms	Under 50 yrs	<b>Request flexible sigmoidoscopy</b>
Alteration in bowel habit towards looseness for more than 6 weeks, after exclusion of infection	Under 50 yrs	<b>Request flexible sigmoidoscopy</b>
Perianal symptoms or persisting left iliac fossa pain	Under 50 yrs	<b>Request flexible sigmoidoscopy</b>

### ADDITIONAL INFORMATION

#### Lower GI - Procedure preparation

##### Bowel cleansing medication

Patients undergoing lower GI procedures, particularly colonoscopy, will need bowel preparation with Picolax. This can cause serious problems in patients with **renal impairment** (eGFR below 30). Therefore these patients should be seen first by a Nephrologist before a decision is made to refer for colonoscopy.

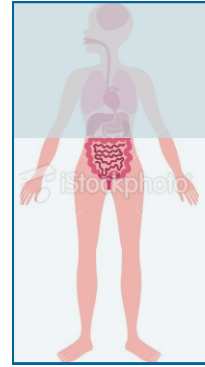
#### Lower GI – Outcomes

##### Polyp disease

Hyperplastic (metaplastic) polyps are common small polyps which carry no long term significance.

**Adenomata** vary in their significance; one or two adenomas less than 10mm in size imply minimal risk of more proximal or malignant disease. Patients with these should therefore be offered five year follow up, but if they develop alarm symptoms in the intervening period, they should be investigated as normal.

**Large or multiple adenoma**, or those with villous, or dysplastic changes, will require a screening colonoscopy and polyp surveillance. Younger patients under 55 yrs with low risk polyps will also require a follow up colonoscopy at a later date.



## COLONOSCOPY

Symptom	Additional information	Action
Asymptomatic patients with relevant positive family history, or history of bowel cancer themselves		<b>Request colonoscopy</b>
Patients with established inflammatory bowel disease, or polyp disease		<b>Request colonoscopy</b>
Patients with or without large bowel symptoms but unexplained IRON DEFICIENCY anaemia		<b>Request colonoscopy</b>
Diarrhoea and rectal bleeding for more than 6 weeks, not explained by duodenal biopsy and flexible sigmoidoscopy		<b>Request colonoscopy</b>
Altered bowel habit or rectal bleeding for more than 6 weeks	Over 50 yrs	<b>Request colonoscopy</b>
Patients with a palpable abdominal mass		<b>Request colonoscopy</b>

### Inflammatory bowel disease (IBD)

**Proctitis** is the inflammation of the rectum, which can reach up to 15cm. It carries none of the risks of generalised IBD; treatment is therefore directed towards local measures. A biopsy is required to exclude other types of IBD

**Ulcerative Colitis and Crohns** require a follow up colonoscopy during which biopsies are taken throughout the colon to detect the development of any dysplasia. The interval between colonoscopies becomes shorter the longer the patient has had the colitis.

Treatment is usually with specific anti-inflammatories, but other drugs such as immunomodulators may be needed for resistant cases.

For patients without colitis and suffering with diarrhoea, biopsies are taken throughout the colon to detect microscopic colitis.

### Lower GI malignancy

- All patients with malignancy must be fast tracked to the MDT for assessment and treatment.
- The endoscopist will discuss the findings with the patient and will give the patient the choice of which secondary care provider they wish to undertake their care.
- The endoscopist will then complete the 2 week suspected cancer referral document and start the patient on the MDT pathway.
- The endoscopist will also telephone the GP on the day to advise them of their findings.
- The patient will then be discussed at MDT and their treatment plan formulated, usually within 10 days.

# REFERRAL FORMS



## FORMS AVAILABLE

In order to initiate a referral to any of our endoscopy services you will need to complete a referral form; an example of which can be seen opposite. Please ensure that you select the appropriate form for the procedure that you require and that you complete the form in full. Any forms that are incomplete or that have not been completed in line with the guidance given will not be accepted. Once forms have been completed they should be faxed to the number stated at the bottom of the form. Following receipt of the faxed referral form the administration team will then contact the patient and offer them an appointment.

The referral forms available are:

- Upper endoscopy referral form
- Flexible sigmoidoscopy referral form
- Colonoscopy referral form



## EXAMPLE FORM

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### Upper Endoscopy Referral Form

Patient name:	G.P.:
DoB:	Address:
Address:	
Tel No:	Tel No:
NHS Number:	Fax Number:

**Faecal HP antigen must be tested before endoscopy referral. The antigen clears after eradication of HP.**  
A period of Test and Treat may well avoid an unnecessary endoscopy and is recommended by the NICE guidelines.

Result of Faecal HP antigen \_\_\_\_\_

*Without results, patients will not be offered a procedure date and referrals will be returned*

<b>Urgent:</b> This procedure is not a replacement for the 2 week cancer referral
Dysphagia
Weight loss
Vomiting
Anaemia
<b>Soon: Over 55yrs - New symptoms of continuous:</b>
Dyspepsia
Heartburn
Reflux symptoms
<b>Routine:</b>
Poor response to test and treat
<b>Under 55's:</b>
Please summarise the need for test outside of NICE Guidelines
<i>Please be aware that patients under 55 may be seen in a dyspepsia clinic prior to test</i>

Medication	Other Diseases	Previous investigations
<b>What to do now:</b>	This form should be faxed immediately to: xxxxxx xxxxxx. Your patient will not be offered an appointment until the fax is received.	

## PREPARATION FOR DIABETIC PATIENTS

### Referral

Patients who are diabetic will be identified in the first instance by the administration team, this will be from the referral form completed by the GP on which they will have given details of the patient's condition and medication.

**ALL** patients when spoken to on the telephone by the administration team will be asked to confirm their diabetic status whether it has been documented that the patient is a sufferer of diabetes or not. This will ensure the safe and timely journey of diabetic patients requiring endoscopy who have not been identified by their GP.

### Appointment

When making the appointment the administration staff, having identified that they are making an appointment for a diabetic patient, will offer the patient the first appointment of the morning. Should the patient decline this and request a later appointment the administration staff will bring to the patient's attention that this may cause unnecessary disruption to their medication regime, so should contact their GP or Practice Nurse to discuss.

It should be remembered that many patients have been living with the condition for many years and are very capable of managing it, even with disruption to their medication regime.

Once the administration team have made the appointment they will then tell the patient that they will receive a patient information booklet in the post. This will give details of the regime to follow for their procedure and their particular method of controlling their diabetes.

### On admittance for procedure

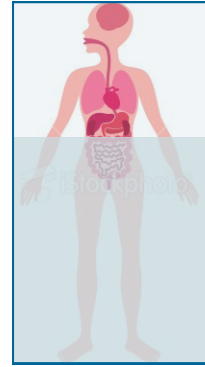
Patients will be admitted as soon as possible when they arrive in the department. Admission will include basic observations and blood glucose monitoring. These same observations will be monitored after the procedure to ensure the patient is fit enough to leave the department.

### Patient queries

Should the administration team receive clinical questions from the patient, relating to their appointment, they will, if unable to answer, contact the nursing team at the department and ask the nurses to make contact with the patient. Should the query be about their prescribed regime they will be asked to contact their own GP or Practice Nurse.

The instructions that patients receive for each procedure can be seen in the following tables.

# Upper GI



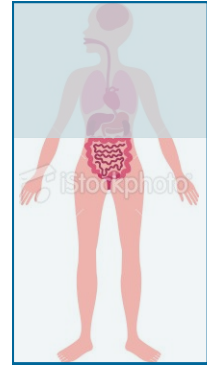
## GASTROSCOPY

Type of Diabetes	Morning Appointment Procedures	Afternoon Appointment Procedures
Insulin controlled	<b>The night before the test</b> - take half your normal dose of insulin and a bedtime snack.	
	<b>On the morning of the test</b> - do NOT take your morning dose of insulin, but bring your insulin with you to the clinic. Do check your blood sugar before leaving home – if it is low take a small amount of a sweet drink.	<b>On the morning of the test</b> - take half your normal dose of insulin and a light breakfast at least 6 hours before the test is due.
	<b>After the test</b> administer your usual morning dose of insulin and then eat as normal.	<b>After the test</b> have a light snack, take your normal evening dose of insulin and normal evening meal – but check your blood sugar levels more often, taking sweet drinks if the level is low.
Tablet controlled	<b>The night before the test</b> - take half your normal dose of tablets and a bedtime snack.	<b>The night before the test</b> - take half your normal dose of tablets and a bedtime snack
	<b>On the morning of the test</b> do not take your tablets but bring them with you to the department.	<b>On the morning of your test</b> have a light breakfast at least 6 hours before the appointment.  Check your blood sugar; if it is low take a small amount of a sweet drink.
	<b>After the test</b> take your tablets and eat a sandwich.	<b>After the test</b> have a light snack, and take your normal tablets in the evening with your evening meal.

# Lower GI

## FLEXIBLE SIGMOIDOSCOPY

Type of Diabetes	Morning Appointment Procedures	Afternoon Appointment Procedures
Insulin controlled	<b>1 Day</b> before your flexible sigmoidoscopy - take your bowel preparation as instructed and follow the diet instructions (clear fluids) and take HALF your normal insulin dose. Check your blood sugars regularly- taking extra sweet drinks if the level is low	<b>1 Day</b> before your flexible sigmoidoscopy - take your bowel preparation as instructed and follow the diet instructions (clear fluids) and take HALF your normal insulin dose. Check your blood sugars regularly- taking extra sweet drinks if the level is low
	<b>Day of the test</b> - do NOT take your insulin; continue taking fluids until 2 hours before the test. Bring your insulin with you to the clinic. Continue to check your blood sugar and take sweet drinks if the level is low	<b>Day of the test</b> - take HALF your morning dose of insulin, and bring your insulin to the clinic. Check blood sugars regularly and take sweet drinks if it is low.
	<b>After the test</b> - take HALF your normal dose of insulin and a sandwich. Return to normal insulin dose in the evening, but continue to check your blood sugar.	<b>After the test</b> - take HALF the morning dose of insulin when you start to eat and drink. In the evening take HALF the evening dose of insulin. Continue to check your blood sugars.
Tablet controlled	<b>The day of bowel preparation</b> - Take your bowel preparation as instructed and follow the diet instructions (clear fluids) and take your normal tablet dose. Check your blood sugars regularly- taking extra sweet drinks if the level is low.	<b>The day of bowel preparation</b> - Take your bowel preparation as instructed and follow the diet instructions (clear fluids) and take your normal tablet dose. Check your blood sugars regularly- taking extra sweet drinks if the level is low.
	<b>Day of the test</b> - do NOT take your tablets; continue taking fluids until 2 hours before the test. Continue to check your blood sugar and take sweet drinks if the level is low.	<b>Day of the test</b> - do NOT take your tablets; continue taking fluids until 2 hours before the test. Continue to check your blood sugar and take sweet drinks if the level is low.
	<b>After the test</b> - return to normal tablet dose, and eat as normal in the evening, but continue to check your blood sugar.	<b>After the test</b> - return to normal tablet dose, and eat as normal in the evening, but continue to check your blood sugar.



## COLONOSCOPY

Type of Diabetes	Morning Appointment Procedures	Afternoon Appointment Procedures
<b>Insulin controlled</b>	<b>3 Days</b> before your colonoscopy - follow diet instructions and take normal insulin.	<b>3 Days</b> before your colonoscopy - follow diet instructions and take normal insulin.
	<b>2 Days</b> before your colonoscopy - follow diet and take normal insulin.	<b>2 Days</b> before your colonoscopy - follow diet and take normal insulin.
	<b>1 Day</b> before your colonoscopy- Take your bowel preparation as instructed and follow the diet instructions (clear fluids) and take HALF your normal insulin dose. Check your blood sugars regularly - taking extra sweet drinks if the level is low.	<b>1 Day</b> before your colonoscopy- Take your bowel preparation as instructed and follow the diet instructions (clear fluids) and take HALF your normal insulin dose. Check your blood sugars regularly - taking extra sweet drinks if the level is low.
	<b>Day of the test</b> - Do NOT take your insulin; continue taking fluids until 2 hours before the test. Bring your insulin with you to the clinic.  Continue to check your blood sugar and take sweet drinks if the level is low.	<b>Day of the test</b> - Take HALF your morning dose of insulin, and bring your insulin to the clinic.  Check blood sugars regularly and take sweet drinks if it is low.
	<b>After the test</b> - Take HALF your normal dose of insulin and a sandwich. Return to normal insulin dose in the evening, but continue to check your blood sugar.	<b>After the test</b> - take HALF the morning dose of insulin when you start to eat and drink. In the evening take HALF the evening dose of insulin  Continue to check your blood sugars.
<b>Tablet controlled</b>	<b>3 Days</b> before your colonoscopy - follow diet instructions and take normal tablet doses.	<b>3 Days</b> before your colonoscopy- follow diet instructions and take normal tablet doses.
	<b>2 Days</b> before your colonoscopy - follow diet and take normal tablet doses.	<b>2 Days</b> before your colonoscopy - follow diet and take normal tablet doses.
	<b>1 Day</b> before your colonoscopy - take your bowel preparation as instructed and follow the diet instructions (clear fluids) and take your normal tablet dose. Check your blood sugars regularly- taking extra sweet drinks if the level is low.	<b>1 Day</b> before your colonoscopy - take your bowel preparation as instructed and follow the diet instructions (clear fluids) and take your normal tablet dose. Check your blood sugars regularly- taking extra sweet drinks if the level is low.
	<b>Day of the test</b> - Do NOT take your tablets; continue taking fluids until 2 hours before the test.  Continue to check your blood sugar and take sweet drinks if the level is low.	<b>Day of the test</b> - Do NOT take your tablets; continue taking fluids until 2 hours before the test.  Continue to check your blood sugar and take sweet drinks if the level is low.
	<b>After the test</b> - Return to normal tablet dose, and eat as normal in the evening, but continue to check your blood sugar.	<b>After the test</b> - Return to normal tablet dose, and eat as normal in the evening, but continue to check your blood sugar.

# Guidelines for the management of anticoagulant and antiplatelet therapy

### INTRODUCTION

There is an intrinsic risk of haemorrhage with endoscopic procedures, therefore the management of anticoagulant and antiplatelet therapy is extremely important when patients attend for such a procedure.

Minor haemorrhage is not uncommon during endoscopic procedures, but it is considered to be clinically significant when necessitating blood transfusion or an unplanned admission to hospital. Haemorrhage may be immediately apparent at the time of endoscopy, or delayed up to 2 weeks or more following the procedure. The latter situation presents a particular risk for patients who have received anticoagulants following the procedure. Diagnostic procedures, including biopsies, have a minimal risk of haemorrhage. It is important therefore to understand baseline risks of haemorrhage associated with common therapeutic endoscopic procedures as these will be exacerbated by agents that inhibit coagulation or platelet action.

A recent survey of UK endoscopists found a wide variation in practice regarding the management of anticoagulants in patients undergoing endoscopy.

There is therefore a need for clear, up-to-date guidance on the management of patients undergoing endoscopic procedures who are receiving these drugs, and who may be at risk from the procedure itself or from discontinuing their medication.

## RELEVANCE AND APPLICATION

The full guidelines as defined by the British Society of Gastroenterology in 'Guidelines for the management of anticoagulant and antiplatelet therapy in patients undergoing endoscopic procedures.' Veitch AM, Baglin TP, Gershlick AH, Harnden SM, Tighe R, Cairns S, can be found here: <http://www.bsg.org.uk/clinical-guidelines/endoscopy/anticoagulant-antiplatelet-therapy.html>

In addition, a full copy of the anticoagulant and antiplatelet guidelines are available from the unit on request.

These are the guidelines that will be followed within all of our community endoscopy settings.

### ANTICOAGULANT GUIDELINES

#### Guidelines

## Guidelines for the management of anticoagulant and antiplatelet therapy in patients undergoing endoscopic procedures

A M Veitch,<sup>1</sup> T P Baglin,<sup>2</sup> A H Gershlick,<sup>3</sup> S M Harnden,<sup>4</sup> R Tighe,<sup>4</sup> S Cairns<sup>5</sup>

<sup>1</sup>Department of Gastroenterology, New Cross Hospital, Walthamstow, UK; <sup>2</sup>Department of Haematology, Addenbrooke's Hospital, Cambridge, UK; <sup>3</sup>Department of Cardiology, University Hospital of Leicester, Leicester, UK; <sup>4</sup>Department of Gastroenterology, Norfolk and Norwich University Hospital, Norwich, UK; <sup>5</sup>Department of Gastroenterology, Royal Sussex County Hospital, Brighton, UK

Correspondence to: Dr A M Veitch, New Cross Hospital, Walthamstow, W17 5DF, UK; [veitch@nhs.uk](mailto:veitch@nhs.uk)

The authors form a working party to the British Society of Gastroenterology, the British Committee for Standards in Haematology and the British Cardiovascular Intervention Society.

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### 1.0 SUMMARY OF RECOMMENDATIONS

Please refer to Fig 1 for an algorithmic representation of the recommendations, and tables 1-3 for a risk stratification of endoscopic procedures and medical conditions requiring anticoagulant or antiplatelet therapy. Aspirin therapy can be continued for all endoscopic procedures.

#### 1.1 Acute gastro-intestinal haemorrhage

Acute gastro-intestinal haemorrhage in patients on anticoagulant or antiplatelet agents is a high-risk situation. The immediate risk to the patient from haemorrhage may outweigh the risk of thrombosis as a result of stopping anticoagulant or antiplatelet therapy. Patients need to be assessed on an individual basis, and it is not possible to give unequivocal guidance to cover all situations. For patients with high-risk conditions on warfarin, then this can be discontinued with or without substitution of heparin depending on the severity of haemorrhage and risk of discontinuing anticoagulant therapy. There is a high risk of acute myocardial infarction or death if clopidogrel is discontinued in patients with coronary stents, particularly early after implantation, but extending up to 1 year after this. Endoscopy should be attempted as soon as safely possible after urgent liaison between the patient's cardiologist and the consultant specialist undertaking endoscopy. Clopidogrel should not be discontinued without discussion with a cardiologist. If clopidogrel therapy needs to be discontinued in this context, then this should be limited to a maximum of 5 days as the risk of stent thrombosis increases after this interval. (Evidence grade III, Recommendation grade B.) Early therapeutic endoscopic intervention may achieve haemostasis with minimal or no cessation of anticoagulant or antiplatelet therapy, and should be the first aim. (Evidence grade IV, Recommendation grade C.)

#### 1.2 Low-risk endoscopic procedures

Anticoagulation or antiplatelet therapy should be continued. (Evidence grade IV, Recommendation grade C.) If warfarin is continued then it should be ensured that the international normalised ratio (INR) does not exceed the therapeutic range. (Evidence grade IV, Recommendation grade C.)

• Tell the patient to continue warfarin and check the INR 1 week before the endoscopy.

• If the INR result is within the therapeutic range then continue with the usual daily dose.

• If the INR result is above the therapeutic range, but less than 5, then reduce the daily warfarin

dose until the INR returns to within the therapeutic range.

• If the INR is greater than 5 then telephone the endoscopy department to defer the appointment and contact the anticoagulation clinic, or a medical practitioner, for advice.

#### 1.3 High-risk endoscopic procedure: low-risk condition

Warfarin should be temporarily discontinued. (Evidence grade III, Recommendation grade B.)

• Stop warfarin 5 days before endoscopy.

• Check INR prior to procedure to ensure <1.5.

• On the day of the procedure restart warfarin with the usual daily dose that night.

• Check INR 1 week later to ensure adequate anticoagulation.

#### 1.3.2 Clopidogrel

Clopidogrel should be stopped 7 days prior to the procedure. (Evidence grade III, Recommendation grade B.) If the patient is on aspirin, this should be continued. If not, then consideration should be given to prescribing aspirin while clopidogrel is stopped. If clopidogrel is discontinued then all attempts should be made to undertake the endoscopic procedure at the end of the planned allowed discontinuation time period. If this has to be postponed beyond this time then consideration should be given to re-starting the clopidogrel and re-scheduling the endoscopy.

#### 1.4 High-risk endoscopic procedure: High-risk condition

Warfarin should be temporarily discontinued and substituted with low molecular weight heparin (LMWH). (Evidence grade III, Recommendation grade B.)

• Warfarin should be stopped 5 days before the procedure.

• Two days after stopping warfarin commence the daily therapeutic dose of LMWH.

• On the LMWH on the day of the procedure.

• Warfarin can be recommenced on the day of the procedure with the usual dose that night.

• Recommence the daily therapeutic dose of LMWH on the day after the procedure.

• Continue LMWH until a satisfactory INR is achieved.

• Patients should be advised that there is an increased risk of post-procedure bleeding compared

#### Guidelines

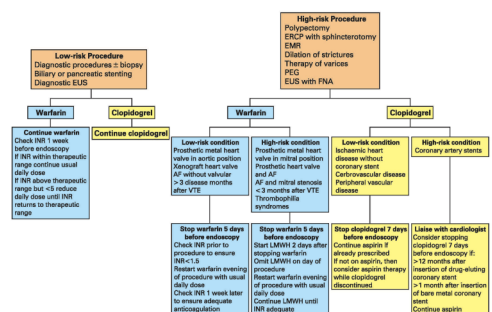


Figure 1 Guidelines for the management of patients on warfarin or clopidogrel undergoing endoscopic procedures. AF, atrial fibrillation; ERCP, endoscopic retrograde cholangiopancreatography; EUS, endoscopic ultrasound; FNA, fine needle aspiration; INR, international normalised ratio; LMWH, low molecular weight heparin; FEG, percutaneous endoscopic gastroenterostomy; VTE, venous thromboembolism.

with non-anticoagulated patients. (Evidence grade III, Recommendation grade B.)

#### 1.4.2 Clopidogrel

Discontinuation of clopidogrel therapy should only be considered after discussion with the patient's cardiologist. A consultant gastro-intestinal physician or surgeon should be involved to confirm that the endoscopic procedure is essential.

• If bare metal coronary stents were placed more than 12 months ago then clopidogrel could be temporarily discontinued. (Evidence grade III, Recommendation grade B.)

• If drug-eluting coronary stents were placed more than 12 months ago then clopidogrel could be temporarily discontinued. (Evidence grade III, Recommendation grade B.)

• If drug-eluting coronary stents were placed more than 6 months ago and the procedure is essential, then it may be safe to temporarily discontinue clopidogrel. (Evidence grade IV, Recommendation grade C.)

• Clopidogrel should be stopped 7 days prior to the procedure.

• Aspirin therapy should be continued.

• On the day following the procedure restart clopidogrel.

#### 2.0 ORIGIN AND PURPOSE OF THESE GUIDELINES

These guidelines were commissioned by the British Society of Gastroenterology, and essential expertise was provided by collaboration with the British Committee for Standards in

Haematology and the British Cardiovascular Intervention Society. Prescription of anticoagulants is very common, and in addition there has been increasing prescription of antiplatelet agents for ischemic heart disease, and in the context of coronary artery stenosis. There is a risk of haemorrhage associated with many endoscopic procedures and this may be exacerbated in patients receiving these agents. Excellent guidelines have been produced by the American Society for Gastrointestinal Endoscopy,<sup>1</sup> but these provide limited guidance on the management of cardiac patients on antiplatelet agents. Our guidance does not conflict with the American Society's. There is a need for clear up-to-date guidance on the management of patients undergoing endoscopic procedures who are receiving these drugs, and who may be at risk from the procedure itself or from discontinuing their medication.

These guidelines were drafted by a working party of representative members of the Endoscopy Committee of the British Society of Gastroenterology, the British Committee for Standards in Haematology, and the British Cardiovascular Intervention Society. Authors were nominated as representatives of their respective societies. A literature search was conducted using PubMed, and further sources were obtained from the reference lists of those papers identified. Additional

## After care guidelines

All patients will receive an after care leaflet that lets them know exactly what to expect following their procedure, who to contact if they have any concerns, and how to obtain their results. Examples of these after care leaflets can be seen here.

### After your oral gastroscopy without sedation

- ✓ After your procedure you will need a good few burps to bring up the air
- ✓ Twenty minutes after you were given the anaesthetic spray you can have a drink of water
- ✓ You will then be able to eat and drink normally or as advised by the endoscopist.
- ✓ As the procedure involves passing an endoscope through the gullet you may have a sore throat for about 24 – 48 hours. This can usually be relieved with cold drinks or ice to suck.

In the unlikely event of any severe pain or bleeding, this should be reported at once to your GP. Out of hours contact your GP emergency service via NHS Direct on 0845 46 47 or your nearest Emergency Department.

If you have any problems, or require general advice following the procedure please contact your GP.

### Results

If specimens have been taken the results will be with your GP in approximately **2 to 3 weeks**. Please ring the surgery after this time to check that the GP has your results and if necessary, make an appointment to discuss them with your doctor.

Do not telephone the hospital for the results they will not be available.



### **After your trans nasal gastroscopy**

- ✓ After your procedure you will need a good few burps to bring up the air, the nurse will then give you a drink of water
- ✓ Very quickly you will be able to eat and drink normally or as advised by the endoscopist
- ✓ As the procedure involves passing an endoscope through the gullet you may have a sore throat for about 24 – 48 hours. This can usually be relieved with cold drinks or ice to suck.
- ✓ Please do not blow your nose for 24 hours after the procedure to help prevent any bleeding.

In the unlikely event of any severe pain or bleeding, this should be reported at once to your GP. Out of hours contact your GP emergency service via NHS Direct on 0845 46 47 or your nearest Emergency Department.

If you have any problems, or require general advice following the procedure please contact your GP.

### **Results**

If specimens have been taken the results will be with your GP in approximately **2 to 3 weeks**. Please ring the surgery after this time to check that the GP has your results and if necessary, make an appointment to discuss them with your doctor.

Do not telephone the hospital for the results they will not be available.

# After care guidelines

## After your colonoscopy with sedation

- ✓ You may feel a little drowsy. This is why a responsible adult is required to accompany you home and remain with you for 12 hours
- ✓ Go home and rest quietly for the day
- ✓ You may experience some abdominal discomfort and wind, do not hold it in, allow it to pass out naturally
- ✓ You may also find that you bleed a little, especially when going to the toilet. This is quite normal and will not last long

Because of the lingering effects of the sedation for the next **24 hours** after your Colonoscopy **DO NOT:**

- Drive a car, motorbike or bicycle
- Operate machinery or cook
- Engage in any sporting activities
- Sign any legally binding documents
- Drink alcohol

In the unlikely event of any severe pain or bleeding, this should be reported at once to your GP. Out of hours contact your GP emergency service via NHS Direct on 0845 46 47 or your nearest Emergency Department.

If you have any problems, or require general advice following the procedure please contact your GP.

## Results

Results will be with your GP in **2 to 3 weeks**. Please ring the surgery after this time to check that the GP has your results and if necessary, make an appointment to discuss them with your doctor.

Do not telephone the hospital for the results, they will not be available.

### **After your flexible sigmoidoscopy without sedation**

- ✓ You may experience some abdominal discomfort and wind, do not hold it in, allow it to pass out naturally
- ✓ You may also find that you bleed a little, especially when going to the toilet. This is quite normal and will not last long
- ✓ Go home and rest quietly for the day
- ✓ Eat and drink normally

In the unlikely event of any severe pain or bleeding, this should be reported at once to your GP. Out of hours contact your GP emergency service via NHS Direct on 0845 46 47 or your nearest Emergency Department.

If you have any problems, or require general advice following the procedure please contact your GP.

### **Results**

Results will be with your GP in **2 to 3 weeks**. Please ring the surgery after this time to check that the GP has your results and if necessary, make an appointment to discuss them with your doctor.

Do not telephone the hospital for the results, they will not be available.

## Fact sheets available

There are a wide range of fact sheets available that will provide patients with advice regarding their diagnosis, treatment or management plan. The full list of titles can be seen below.

- Hiatus Hernia
- Helicobacter Pylori
- Reflux
- Barrett's Oesophagitis
- Diverticular Disease
- Inflammatory Bowel Disease
- Coeliac Disease

Patients will be given the appropriate fact sheet following their procedure.

Examples of some of these fact sheets can be seen here:

### Hiatus Hernia

#### What is a hiatus hernia?

A hiatus hernia is caused by part of the stomach pushing up through a weakness in the diaphragm (the muscular sheet that lies underneath the lungs, separating the chest from the abdomen). In many people a hiatus hernia does not cause any symptoms and does not require any treatment or surgery.

#### What are the symptoms caused by a hiatus hernia?

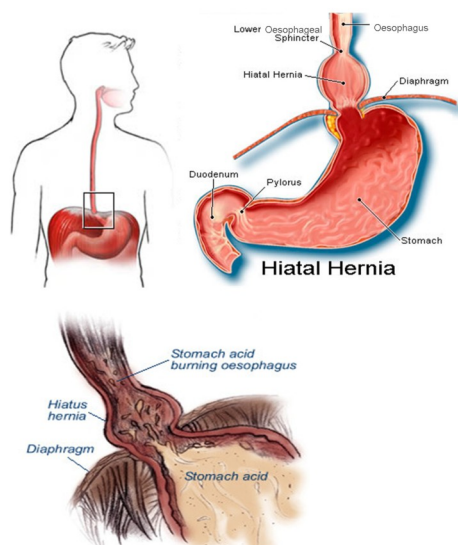
A hiatus hernia can lead to a backwards flow (reflux) of stomach contents or stomach acid into the oesophagus. This reflux causes heartburn, chest pain, water brash (a sudden filing of the mouth with saliva) and regurgitation. These symptoms are worse when lying down, bending or straining after a meal.

#### How is a hiatus hernia diagnosed?

A hiatus hernia can be diagnosed using a barium swallow or endoscopy of the upper digestive tract.

#### How can the symptoms be treated?

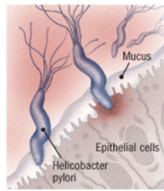
Reflux may be treated with drugs to reduce the amount of acid in the stomach and to speed up the rate at which food is passed out of the stomach into the intestines.



## H. PYLORI

### Helicobacter Pylori

Helicobacter pylori (which is written in an abbreviated form as *H. pylori*) is a type of bacterium, a bug or germ, that only infects human beings, and lives in the sticky fluid (mucus) which coats the lining of the stomach and duodenum. It is usually a life long infection and may cause no problems. However, it is closely associated with peptic ulcer.



### What is a peptic ulcer?

Peptic ulcers look like mouth ulcers. They are sensitive raw patches in the lining of the stomach or duodenum (part of the gut immediately after the stomach), see figure 1 below:

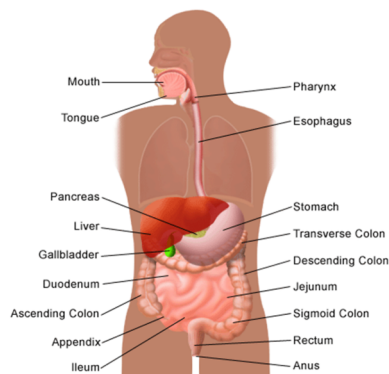


Figure 1

### What are gastric and duodenal ulcers?

Gastric ulcers occur in the stomach and duodenal ulcers occur in the duodenum. Research has shown that *H. pylori* is an important cause of peptic ulcers, see figure 2 below:

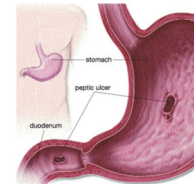


Figure 2

### How do we get infected with *H. pylori*?

It is still not certain how this germ moves from the stomach of one person to the next. These bacteria are rarely detected in saliva, gastric juices or stools. The latest theory is that people may be highly infectious for only a matter of days or weeks – and transmission may be via the fingers when coming into contact with infected vomit or stools. Good hygiene in the home seems to decrease transmission.

### How long does *H. pylori* infection last?

This is a life long infection for most people. Without medical help, the infected person seems incapable of getting rid of it. Long term infection, perhaps for up to 50 years, can result in loss of the stomach's layer of mucus. At that stage, the infection disappears in some people.

### Where do *H. pylori* live within the stomach?

The normal human stomach has a very thin layer of mucus that coats the whole of its inside surface. This mucus has a protective role, acting as a barrier between the acid in the stomach and the sensitive stomach wall. *H. pylori* have adapted to live exclusively in this layer of mucus.

The duodenum can also have this type of mucus, particularly if the stomach secretes a great deal of acid, and therefore *H. pylori* can also survive in the lining of the duodenum.

### How many people are infected with *H. pylori*?

In Britain about half of the population who are over middle age are infected with *H. pylori*. It seems likely that most people get infected in childhood. Probably, almost all of our grandparents were infected with these bacteria but, because of improved hygiene in the modern home, very few children are now infected in Britain. Unfortunately, most children in the developing world still get infected. This means that almost everybody in these countries has a chronic infection with *H. pylori*.

### What do *H. pylori* do?

*H. pylori* act as an irritant to the lining of the stomach and this causes inflammation of the stomach (gastritis). *H. pylori* also appear to be important in the development of peptic ulceration. A combination of factors (including *H. pylori*, gastric acid, genetic background, use of aspirin or drugs for arthritis and cigarette smoking) may combine to cause ulcers of the stomach or duodenum. It is possible that a small proportion of people who are infected go on to develop a cancer of the stomach in later life. This is probably because of the chronic irritation to the lining of the stomach, throughout decades of long term infection. There is no evidence at present that eradication of *H. pylori* in adults will reduce the risk of gastric cancer.

### How do we know *H. pylori* are an important cause of peptic ulcers?

Without treatment almost every ulcer sufferer experiences repeated episodes of painful ulceration. However, such relapses become extremely rare if *H. pylori* are cleared from the stomach by medical treatment. Eradicating *H. pylori* infection can cure most gastric and duodenal ulcers.

### Who should receive treatment to eradicate *H. pylori* infection?

Patients with definite evidence of peptic ulceration are the ideal people to receive treatment to eradicate *H. pylori* infection. If the treatment clears all traces of *H. pylori* infection from the stomach then these patients will usually have a long term cure of their ulcer disease. However if it proves impossible to clear the stomach, ulcer patients can be protected from relapse using a long term daily drug treatment to decrease gastric acidity.

### What about people who are *H. pylori* positive, but without any sign of peptic ulceration?

This type of person is often well with no symptoms and no treatment is indicated. A person who suffers from indigestion without evidence of a peptic ulcer will often feel no better after eradication of *H. pylori* infection.

### Should everyone be tested for *H. pylori*?

In the future, it may well be worthwhile to test everyone for *H. pylori* infection. However at the moment we do not have a simple and inexpensive form of treatment to provide mass eradication of *H. pylori* infection, nor do we know that doing so would help people without an ulcer. It is possible that vaccination may prove to be the answer, but at the moment no vaccines are available against *H. pylori*.

## CONCLUSION

This booklet contains a vast range of information to enable GPs to understand the services offered within a community endoscopy setting.

All of the guidance provided should supply GPs with sufficient information to make appropriate referrals and to inform their patients about the community endoscopy procedure that they have been referred to have carried out.

The guidance provided has been produced in conjunction with both NICE and BSG guidelines to ensure that patient safety is always paramount within our community endoscopy services, and that best practice procedures are adhered to at all times.

All of the information available within this booklet is in a generic form and specific information regarding the community services available within your locality will accompany this booklet.



This booklet has been produced by Prime Diagnostics Ltd; a Primary Care facing organisation with Clinicians at its heart delivering diagnostic services, specifically endoscopy services commissioned by local Primary Care Trusts.

Prime Diagnostics is committed to delivering high quality clinical care, innovation and cost effectiveness to Commissioners. All facilities managed by Prime Diagnostics have completed the relevant quality benchmarks and these are openly displayed. Prime Diagnostics is leading in the use of new technology within endoscopy and can provide innovative patient pathways. Innovation and service redesign opportunities are key to the ongoing vision of Prime Diagnostics.

Prime Diagnostics is led by a Clinician – Dr Patrick Ward Booth who has experience as a GP and as an Endoscopist; he also delivers endoscopy services and provides leadership as Clinical Lead for the National Endoscopy Team.

Prime Diagnostics prides itself on listening and responding to the needs of patients and to Commissioners. We continually evaluate and improve on all aspects of our services through formal feedback processes.

Any information that you feel is not covered in this booklet can be obtained directly from Prime Diagnostics Ltd.

## **MORE INFORMATION**

For more information about Prime Diagnostics Ltd please visit our website.

### **Website details:**

[www.primediagnosics.co.uk](http://www.primediagnosics.co.uk)

## CONTACT US

Jenny Raven, Operations Manager	07912 435998
Heather Pearce, Director of Operations	07825 524794
Dr Stevan Fox, Medical Director	07979 158560
Phil Curran, Managing Director	07775 420019

**PRIME DIAGNOSTICS LTD**