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| **2M — Upper GI endoscopy** |
| **Summary of Intervention** |
| 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.  **This guidance applies to adults aged 19 years and over.** |
| **Number of interventions in 18/19** |
| **644,038** |
| **Proposal** |
| 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.  **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 oesphagus:**  — 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.  **Coeliac disease:**  — Patients aged 55 and under with suspected coeliac disease and anti-TTG >10x reference range should be treated for coeliac disease on the basis of positive serology and without endoscopy or biopsy.  **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 36 Academy of Medical Royal Colleges EBI - List 2 Guidance  — 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 Hpylori 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. |
| **Rationale for Recommendation** |
| NICE and the British Society for Gastroenterology recommend the above  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. |
| **References** |
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