GENERAL INDICATIONS STATEMENTS

I. GI endoscopy is generally indicated:

A. If a change in management is probable based on results of Endoscopy.

B. After an empiric trial of therapy for a suspected benign digestive disorder has been unsuccessful.

C. As the initial method of evaluation as an alternative to radiographic studies.

D. When a primary therapeutic procedure is contemplated.

II. GI endoscopy is generally not indicated:

A. When the results will not contribute to a management choice.

B. For periodic follow-up of healed benign disease unless surveillance of a premalignant condition is warranted.

III. GI endoscopy is generally contraindicated:

A. When the risk to patient health or life are judged to outweigh the most favorable benefits of the procedure.

B. When adequate patient cooperation or consent cannot be obtained.

C. When a perforated viscus is known or suspected.

SPECIFIC INDICATIONS STATEMENTS

ESOPHAGOGASTRODUODENOSCOPY (EGD)

I. EGD IS GNERALLY INDICATED FOR EVALUATING:

A. Upper abdominal symptoms which persist despite appropriate trial of therapy.

B. Upper abdominal symptoms associated with other symptoms and signs suggesting serious organic disease (e.g anorexia and weight loss) or in patients ovr 45 years of age.

C. Dysphagia or odynophagia.

D. Esophageal reflux symptoms, which are persistent of recurrent despite appropriate therapy.

E. Chronic or Recurrent or Persistent vomiting of unknown cause.

F. Other diseases in which the presence of upper GI pathology might modify other planned management. Examples include, patients who have a history of ulcer or GI bleeding who are scheduled for organ transplantation, long-term anticoagulation or chronic nonsteroidal anti-inflammatory drug therapy for arthritis and those with cancer of the head and neck.

G. Familial adenomatous polyposis syndromes.

H. For confirmation and specific histologic diagnosis of radiologically demonstrated lesions:

1. Suspected neoplastic ulcer

2. Gastric or esophageal ulcer

I. Gastrointestinal bleeding:

1. In patients with active or recent bleeding

2. Anemia when the clinical situation suggests an upper GI source or when colonoscopy is negative.

J. When sampling of tissue or fluid is indicated.

K. In patients with suspected portal hypertension to document or treat esophagogastric varices.

L. To assess extent of acute injury after caustic ingestion and to follow up for complications if symptomatic

M. Treatment of bleeding lesions such as ulcers, tumors, vascular abnormalities (e.g., electrocoagulation, heater probe, laser photocoagulation or injection therapy)

N. Banding or sclerotheraphy of varices

O. Removal of foreign bodies

P. Removal of selected polypoid lesions

Q. Placement of feeding or drainage tubes (peroral, perctaneous endoscopic gastronomy, percutaneous endoscopic jejunostomy.

R. Dilation of stenotic lesions (e.g., with transendoscopic balloon dilators or dilation systems employing guidewires).

S. Management of achalasia (e.g., botulinum toxin, balloon dilation).

T. Palliative treatment of stenosing neoplasms (e.g., laser, multipolar electrocoagulation, stent placement).

II. EGD IS GENERALLY NOT INDIATED FOR EVALUATING

A. Upper abdominal symptoms which are considered functional in origin (there are exceptions in which an endoscopic examination may be done once to rule out organic disease, especially if symptoms are unresponsive to therapy.

B. Metastatic malignancies of unknown primary site when the results will not alter management.

C. Radiographic findings of:

1. Asymptomatic of uncomplicated sliding hiatal hernia.

2. Uncomplicated duodenal ulcer which has responded to therapy.

3. Deformed duodenal bulb when symptoms are absent or respond adequately to ulcer therapy.

III. SEQUENTIAL OR PERIODIC EGD MAY BE INDICATED FOR:

A. Surveillance for malignancy in patients with premalignant conditions (i.e. Dysplasia, Barrett's esophagus, FAP)

B. Documentation of complete healing of gut after appropriate therapy.

C. Sequential treatment of and surveillance for recurrence of esophagogastric varices.

IV. SEQUENTIAL OR PERIODIC EGD IS GENERALLY NOT IDICATED FOR:

A. Surveillance for malignancy in patients with gastric atrophy, pernicious anemia, or prior gastric operations.

B. Metastatic adenocarcinoma of unknown primary site when the results will not alter management.

C. Surveillance during repeated examinations of benign strictures unless there is a change in status.

COLONOSCOPY

I. COLONOSCOPY IS GENRALLY INDICATED IN THE FOLLOWIG CIRCUMSTANCES DIAGNOSIS

A. Evaluation of an abnormality on barium enema or other imaging study which is likely to be clinically significant, sch as a filling defect or stricture.

B. Evaluation of unexplained gastrointestinal bleeding

1. Hermatochezia

2. Melena after an upper GI source has been excluded.

3. Presence of fecal occult blood.

C. Unexplained iron deficiency anemia

D. Screening and surveillance for colonic neoplasia

1. Screening of asymptomatic, average risk patients 50 years or older

2. Examination to evaluate the entire colon for synchronous cancer or neoplastic polyps in a patient with treatable cancer or neoplastic polyp

3. Colonoscopy to remove synchronous neoplastic lesions at or around time of curative resection of cancer. Follow-up colonoscopy at three years and 3-5 years thereafter to detect metachronous cancer

4. Following adequate clearance of neoplastic polyp(s) survey at 3-5 years intervals.

5. Patients with significant family history

a. Hereditary non-polyposis colorectal cancer: colonoscopy every two years beginning at age 25, or five years younger than the earliest age of diagnosis of colorectal cancer in the family. After age 40, annual colonoscopy shuld be done

b. Sporadic colorectal cancer before the age of 60: colonoscopy every five years beginning 10 years earlier tha the affected relative or every three years if adenoma is found.

6. In patients with ulcerative or Crohn's pancolitis of eight or more ears duration or left sided colitis of 15 or more years duration every 1-2 years with systematic biopsies to detect dysplasia

E. Chronic inflammatory bowel disease of the colon if more precise diagnosis or determination of the extent of activity of disease will influence immediate management

F. Clinically significant diarrhea of unexplained origin

G. Intraoperative identification of a lesion not apparent at surgery (e.g., polypectomy site, location of a bleeding site)

H. Suspected intestinal TB

I. Marking a neoplasm for localization

TREATMENT

A. Treatment of bleeding from such lesions as vascular malformation, ulceration, neoplasia, and polypectomy site (e.g., electrocoagulation, heater probe, laser or injection therapy)

B. Foreign body removal

C. Excision of colonic polyp

D. Decompression of acute nontoxic megacolon or sigmoid volvulus

E. Balloon dilation of stenotic lesions (e.g., anstomotic strictures)

F. Palliative treatment of stenosing or bleeding neoplasms (e.g., laser, electrocoagulation, stenting)

II. COLONOSCOPY IS GENERALLY NOT INDICATED IN THE FOLLOWING CIRCUMSTANCES:

A. Chronic, stable, irritable bowel symdrome or chronic abdominal pain; there are unusual exceptions in which colonoscopy may be done once to rule out disease, especially if symptoms are unresponsive to therapy.

B. Acute diarrhea

C. Metastatic adenocarcinoma of unknown primary site in the absence of colonic signs or symptoms when it will not influence management

D. Routine follow-up of inflammatory bowel disease (except for cancer surveillance in chronic ulcerative colitis and Crohn's colitis)

E. Upper GI bleeding or melena with a demonstrated upeer GI source

III. COLONOSCOPY IS GENERALLY CONTAINDICATED IN:

A. Fulminant colitis

B. Documented acute diverticulitis

FLEXIBLE SIGMOIDOSCOPY

I. FLEXIBLE SIGMOIDOSCOPY (FS) IS GENERALLY INDICATED FOR:

A. Screening of asymptomatic, average risk patients 50 years and over

B. Evaluation of suspected distal colonic disease when there is no indication for colonoscopy

C. Evaluation of the colon in conjunction with barium enema

D. Evaluation of anastomotic recurrence in rectosigmoid carcinoma

E. Patients with a family history of familial adenomatous polyposis

1. Annually from age 10-12 years with colectomy when polyps develop

2. Annually to age 40 years if no polyps found then every 3-5 years thereafter

II. FLEXIBLE SIGMOIDOSCOPY IS GENERALLY NOT INDICATED:

A. When colonoscopy is indicated

III. FLEXIBLE SIGMOIDOSCOPY IS GENERALLY CONTAINDICATED FOR:

A. Documented acute diverticulitis

IV. THERAPEUTIC FLEXIBLE SIGMOIDOSCOPY MAY BE INDICATED FOR:

A. All coloscopic procedures under special circumstances, (e.g., polypectomy in patient with subtotal colectomy, laser photocoagulation of a rectal carcinoma). However, colonoscopy and not flexible sigmoidoscopy is generally indicated for therapeutic colonic procedures (e.g., polypectomy)

ENTEROSCOPY

I. ENTEROSCOPY IS GENERALLY INDICATED FOR:

A. Evaluation of the source of gastrointestinal bleeding not identified by EGD or colonoscopy

B. Evaluation of an abnormal radiographic imaging study of the small bowel

C. Localization of known or suspected small bowel lesions

D. Therapy of small bowel lesions beyond the reach of a standard endoscope

E. Tissue sampling from the small bowel

II. ENTEROSCOPY IS GENERALLY NOT INDICATED:

A. When the source of gastrointestinal bleeding has been indentified by EGD or colonoscopy

B. When the findings of the procedure will not alter therapy

ENDOSCOPIC RETROGRADE CHOLANGIOPANCREATOLOGRAPHY (ECRP)

I. ENDOSCOPIC RETROGRADE CHOLANGIOPANCREATOLOGRAPHY (ECRP) IS GENERRALLY INDICATED IN:

A. The jaundiced patient suspected of having biliary obstruction (appropriate therapeutic maneuvers)

B. The patient without jaundice whose clinical, biochemical and/or imaging data suggests pancreatic or biliary tract disease.

C. Evaluation of signs and symptoms suggesting pancreatic malignancy when results of direct imaging (US and CT or MRI) are equivocal or normal

D. Evaluation of pancreatitis of unknown etiology

E. Preoperative evaluation of the patient with chronic pancreatitis and/or pseudocyst

F. Evaluation of the sphincter of Oddi by manometry

G. Stent placement across benign or malignant strictures, fistulae, postoperative bile leak or in high-risk patients with large unremovable common duct stones

H. Balloon dilation of ductal stritures

I. Placement of nasobiliary drain for prevention of or treatment of acute cholangitis or infusion of chemical agents for common bile duct stone dissolution, for decompression of an obstructed common bile duct or postoperative leak.

J. Drainage of pancreatic pseudocyst in appropriate cases

K. Tissue sampling from bile or pancreatic duct

L. Therapy of disorders of the pancreatic duct

M. Performance of endoscopic sphincterotomy:

1. To facilitate extraction of choledocholithiasis and parasites

2. For papillary stenosis or sphinter of Oddi dysfunction causing signinicant disability

3. To facilitate placement of biliary stent or balloon dilation of biliary stricture

4. Sump syndrome

5. Choledochocoele involving the major papilla

6. Ampullary carcinoma in patients who are not candidates for surgery

7. To facilitate access to the pancreatic duct

8. To facilitate choledochoscopy

II. ERCP IS GENERALLY NOT INDICATED IN:

A. Evaluation of abdominal pain of obscure origin in the absence of objective findings which suggest biliary or pancreatic disease

B. Evaluation of suspected gallbladder disease without evidence of bile duct disease

C. As further evaluation of proven pancreatic malignancy unless management will be altered

ENDOSCOPIC ULTRASOUND

I. ENDOSCOPIC ULTRASOUND IS GENERALLY INDICATED FOR:

A. Staging/re-staging tumors of the gastrointestinal tract, pancreas, bile ducts, lungs, and mediastinum.

B. Evaluating abnormalities of the gastrointestinal tract wall or adjacent structures

C. Tissue sampling of lesions within, or adjacent to the wall of the gastrointestinal tract

D. Evaluation of abnormalities of the pancreas including masses, pseudocysts, recurrent acute pancreatitis and chronic pancreatitis

E. Evaluation of abnormalities of the billiary tree

F. Providing endoscopic therapy under endosonographic guidance

G. Evaluation of gastrointestinal varices

H. Postoperative evaluation for recurrent tumor after equivocal imaging techniques

II. ENDOSCOPIC ULTRASOUND IS GENERALLY NOT INDICATED:

A. When the results will not alter patient care.

B. Staging of tumors shown to be metastatic by other imaging methods (unless the results are the basis for therapeutic decisions)