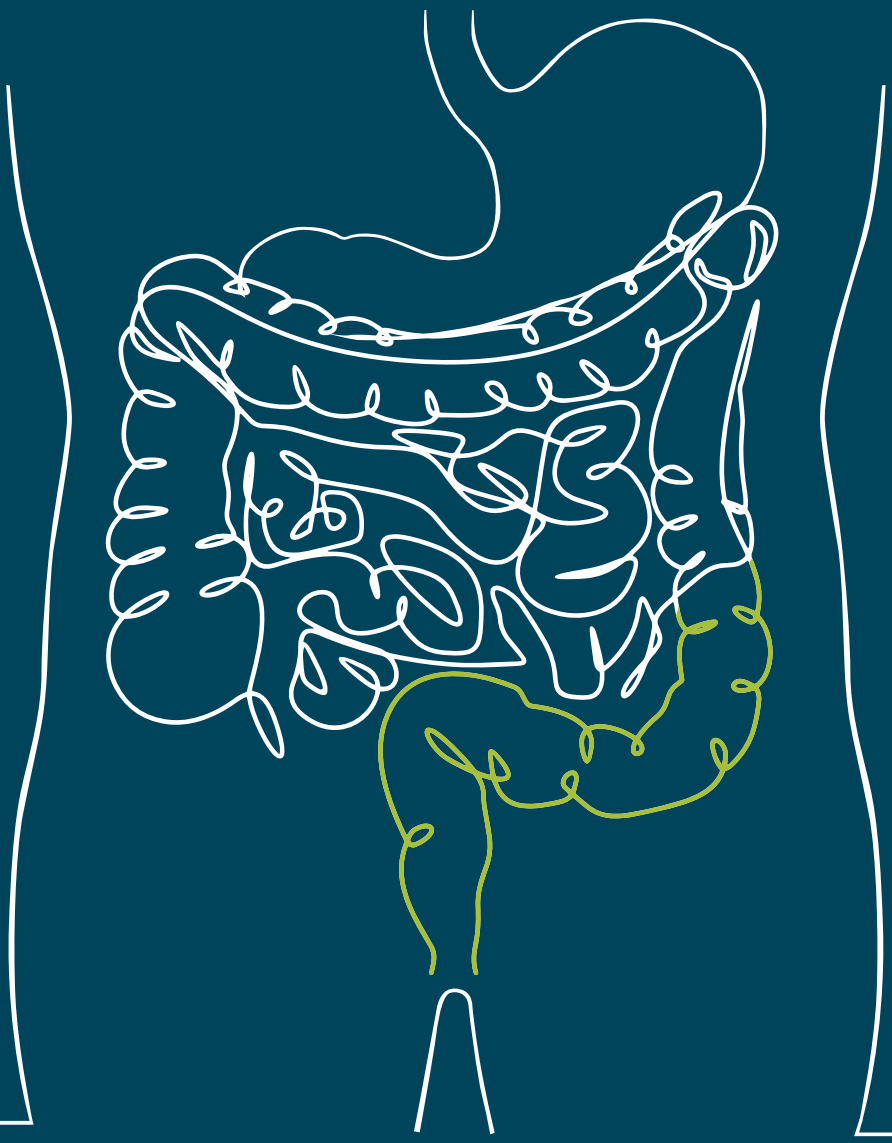
CLINICAL PRACTICE GUIDE

# NSW colonoscopy categorisation guide

## Development process

JANUARY 2020



NSW GOVERNMENT

AGENCY FOR CLINICAL INNOVATION

Gastroenterology Network

**Agency for Clinical Innovation**

1 Reserve Road St Leonards NSW 2065
Locked Bag 2030, St Leonards NSW 1590
T +61 2 9464 4666 | F +61 2 9464 4728
E aci-info@health.nsw.gov.au | **www.aci.health.nsw.gov.au**

Produced by: Gastroenterology Network

Further copies of this publication can be obtained from the Agency for Clinical Innovation website at **www.aci.health.nsw.gov.au**



Preferred citation: *NSW Agency for Clinical Innovation. NSW Colonoscopy categorisation guide – development process.* Sydney: ACI; 2020.

SHPN (ACI) 200557
ISBN 978-1-76081-458-8 (online)

Version: V2; ACI_0321b [11/20] Date amended: January 2020

Cover image credit: Shutterstock.com

Trim: ACI/D20/2741

# Contents

# Section 1: **Colonoscopy Categorisation Guide development process**

## Background

A colonoscopy is a diagnostic test. Colonoscopy refers to the examination of the entire large bowel using a camera on a flexible tube, or colonoscope. It is often performed to look for possible bowel cancer in people with symptoms and signs of bowel disease or those with an increased risk of bowel cancer. It may also be used to help diagnose the cause of other symptoms in conditions such as inflammatory bowel disease or ulcerative colitis. High quality colonoscopy is critical to the early detection and treatment of bowel cancer.[1]

The ever-increasing demand for colonoscopy services has led to the need for consensus-based criteria for the categorisation and prioritisation of NSW colonoscopy procedures. The *NSW Colonoscopy Categorisation Guide* (the Guide) aims to aid clinicians in determining which patients will benefit the most from earlier colonoscopic investigation. The colonoscopy categorisation criteria will demonstrate a structured methodology for prioritising patients who require a colonoscopy. It is intended that this Guide should always be used in conjunction with sound clinical judgement.

Primarily, the Colonoscopy Categorisation Guide is a resource to support gastroenterologists, surgical specialists, general practitioners, clinical nurse consultants and waitlist managers with the appropriate referral and management of 'at risk' patients. The Guide will provide a framework for the categorisation of patients who are identified as most at risk of underlying pathology.

Clinical Priority Categorisations (CPCs) have been published by *NSW Health for elective surgery* and have previously been published by ACI for colonoscopy in 2007.[2,3] While the NSW Elective Surgery Policy contains four categories of prioritisation, the ACI Colonoscopy Categorisation Working Party aimed to streamline these into three categories. These are described in Section 2.

**Figure 1: Current NSW Ministry of Health Clinical Priority Categories[2]**

| **Clinical Priority Category**<br>***A clinical assessment of the priority with which a patient requires elective admission*** | | |
|---|---|---|
| **Category 1** | Admission within 30 days desirable for a condition that has the potential to deteriorate quickly to the point that it may become an emergency. | Ready for care |
| **Category 2** | Admission within 90 days desirable for a condition which is not likely to deteriorate quickly or become an emergency. | |
| **Category 3** | Admission within 365 days acceptable for a condition which is unlikely to deteriorate quickly and which has little potential to become an emergency. | |
| **Category 4** | Patients who are either clinically not ready for admission (staged) and those who have deferred admission for personal reasons (deferred). | Not ready for care |

## New colonoscopy categorisations

Patients who are identified as 'at risk' will be placed in one of three waitlist categories. These categories are assigned to identify the clinically appropriate timeframe in which a patient should undergo a colonoscopy.

Criteria for Category 1: <30 days

Criteria for Category 2: <90 days

Criteria for Category 3: <365 days, surveillance

## Urgent colonoscopies

During colonoscopy categorisation, some patients may be identified as requiring urgent colonoscopy, and following consultation, are eligible for a fast-track process. This falls outside Categories 1, 2 and 3.

## Development process

### 1. Literature review

During 2018, the NSW Cancer Institute conducted a literature review across all Australian jurisdictions and examined international best practice and published guides for colonoscopy categorisation. Appendix 1 summarises and compares the literature for these Colonoscopy categorisation principles. The project leads from Agency for Clinical Innovation (ACI) and NSW Cancer Institute agreed that the Victorian model of care possessed the greatest synergies with New South Wales (NSW) practices.[4]

The key papers in the literature review were:

- ACI guideline, **Clinical Priority Category Colonoscopy**, 2007
- NHMRC, **Clinical Practice Guidelines for the prevention, early detection and management of Colorectal Cancer**, Oct 2017
- NHMRC, Clinical Practice Guidelines for Surveillance Colonoscopy, 2019 (Section: Colonoscopy after curative resection for colorectal cancer)
- NSW Ministry of Health ) - **Waiting Time and Elective Surgery Policy (PD_2012_011)**
- Victorian State Government, **Colonoscopy categorisation guidelines 2017**
- Cancer Care Ontario, **Colorectal Cancer Diagnosis Pathway Map**
- Cancer Research UK, **Improving diagnostic pathways for patients with suspected colorectal cancer**
- NICE, **Colorectal cancer: diagnosis and management**
- Australian Commission on Safety and Quality in Healthcare, **Colonoscopy Clinical Care Standard (September 2018)**.

### 2. Project plan development

In early 2019, ACI met with the Cancer Institute NSW to develop a Steering Group, project design, project governance and terms of reference for the NSW Colonoscopy Categorisation Working Group.

The Colonoscopy Steering Group comprised ACI and Cancer Institute NSW executives and program managers, ACI Gastroenterology Network Manager, Gastroenterology Network Co-Chair and project managers from both organisations. The Steering Group advised on the key processes for the development of the Guide (see Figure 2) and ratified a reference list of subject matter experts (SME). The SME list had representation from:

- NSW LHDs (rural and metropolitan)
- leading NSW gastroenterologists
- directors of gastroenterology
- directors of endoscopy

- colorectal surgeons
- general surgeons (gastroenterology).

Expressions of interest were sent to the subject matter expert reference list (above) and further invitations were sent to NSW Ministry of Health and a GP representative. A Colonoscopy Categorisation Working Group was formed with a nominated Chair and Deputy Chair.

### 3. Colonoscopy clinical classification baseline survey

A colonoscopy prioritisation and categorisation practice survey was developed together with the ACI Gastroenterology Network Co-Chair to inform the expert group on current practice in NSW. The survey was circulated to ACI Gastroenterology Network clinicians, comprising gastroenterologists, general surgeons and colorectal surgeons from both metropolitan and rural NSW. The survey questions can be found in Appendix 2.

### 4. Colonoscopy Categorisation (CC) Working Group workshops

The Colonoscopy Categorisation Working Group held two workshops in August and September 2019. Professor Ann Duggan, Australian Commission on Safety and Quality in Healthcare (ACSQHC), and Professor Jon Emery, Herman Professor of Primary Care Cancer Research, University of Melbourne and Western Health provided expert advice at the first workshop.

The draft criteria were circulated to the working group for comment, and proposed changes were ratified by the Colonoscopy Categorisation (CC) Steering Group.

### 5. Consultation phase

Broad consultation of the final draft occurred in October 2019 with GESA, GENCA, NSW Ministry of Health, RACS, ACSQHC, NSW LHDs, general practitioners and the ACI Gastroenterology Network.

### 6. Explanatory notes development

To provide necessary resources to NSW colonoscopy referrers, the CC Working Group developed explanatory notes that underpin the new Categories 1, 2 and 3 for colonoscopy prioritisation.

### 7. Final draft approvals

Final drafts of the Colonoscopy Categorisation Criteria and explanatory notes were approved by the Steering Group in January 2020 and final approval obtained by ACI Executive in February 2020.

### 8. Communications plan

A multifaceted communications plan was developed with the ACI Communications team. This included letters and emails to chief executives of each LHD, relevant professional associations and special interest groups, public health networks, health pathways and social media (Twitter) and conference opportunities in 2020.

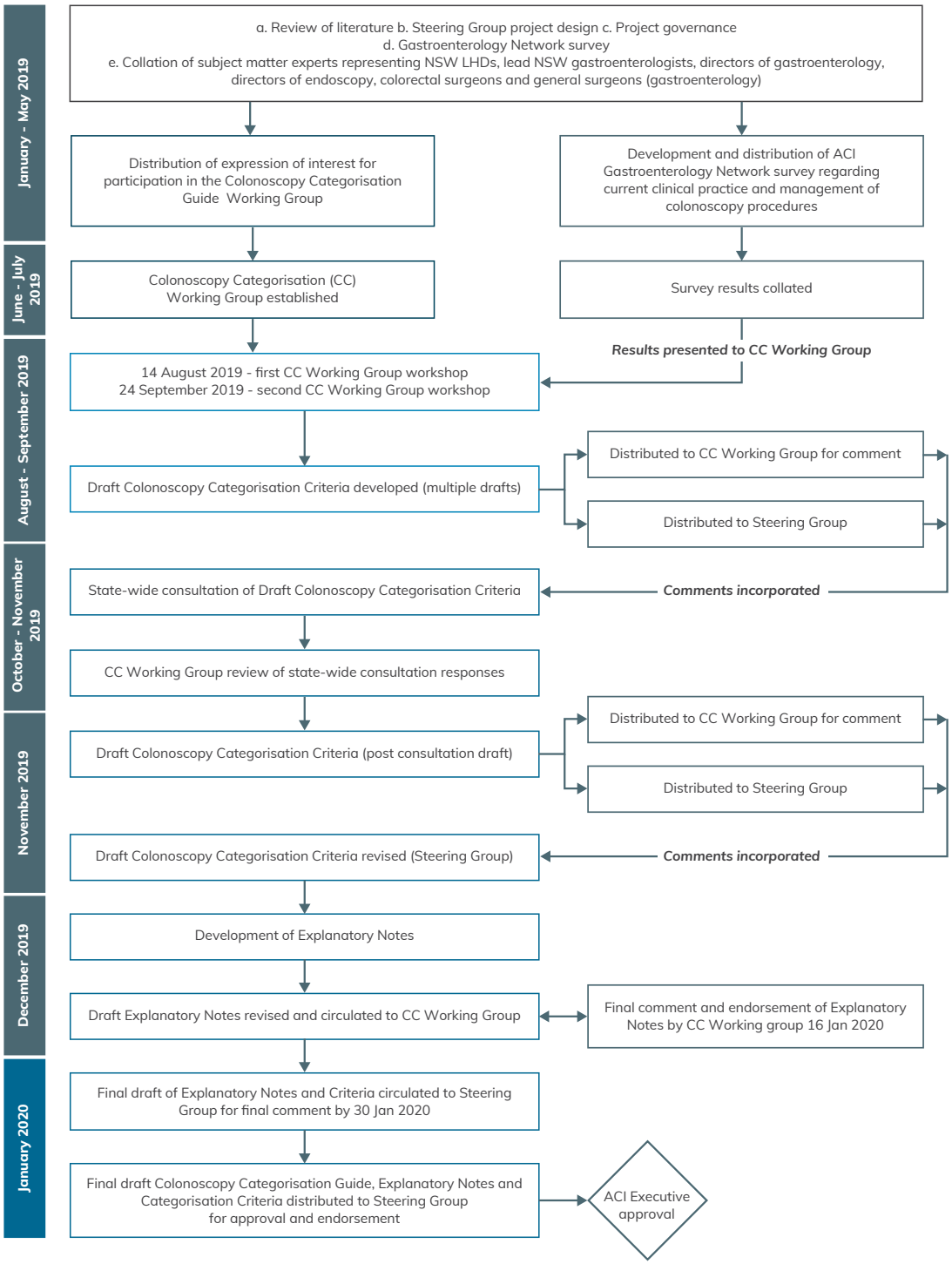
The final approved drafts of the ACI Guide and explanatory notes were published as per the ACI communication plan via the ACI website at the Gastroenterology Network site.

### 9. Evaluation phase

The usability and effectiveness of the Colonoscopy Categorisation Guides will require evaluation 12-months post implementation.

The timeline for the development process (steps 1–9 above) can be seen in Appendix 3.

## Figure 2: Development of Colonoscopy Categorisation Guide flowchart



# Section 2: **Colonoscopy categorisation criteria**

**Table 1. NSW Colonoscopy categorisation criteria**

| Factor | Category 1: <30 days | Category 2: <90 days | Category 3: <365 days (surveillance) |
|---|---|---|---|
| NSW Ministry of Health definition of category | Procedure within 30 days desirable for a condition that has the potential to deteriorate quickly to the point that it may become an emergency **OR** admission within 30 days. High likelihood of significant organic pathology. Admission within 30 days desirable for conditions likely to deteriorate. | Procedure within 90 days desirable for a condition which is not likely to deteriorate quickly or become an emergency **OR** admission within 90 days lower likelihood of significant organic pathology or deterioration. | Patients who are unlikely to deteriorate quickly and which have little potential to become an emergency **OR** staged patients: Planned patients where a patient requires treatment periodically.<br>A *Not Ready for Care* patient is a patient who is not available to be admitted to hospital until some future date, and is *Staged – not ready for clinical reasons.*<br>The definition of staged from the wait time and elective surgery policy can be found in the *NSW Health Waiting Time and Elective Surgery Policy Directive PD2012_011.* |
| **1. +iFOBT** | Clinically appropriate +iFOBT | Other +iFOBT# | |
| **2. Unexplained iron deficiency or unexplained anaemia** | Unexplained iron deficiency **OR** unexplained anaemia **AND EITHER** any other critical factor* **OR** one or more other symptoms | Iron deficiency with no critical factors* or other symptoms (any age) | |
| **3. Rectal bleeding** | Rectal bleeding **AND** any one of:<br>• any other critical factor*<br>• <12 months duration, age ≥50 years<br>• <12 months with one or more other symptom, age <50 years | Rectal bleeding <12 months duration **AND** no other critical factor* or other symptom **AND** age <50 years (note: Local investigation may be appropriate) | Rectal bleeding >12 months |
| **4. Altered bowel habit** | Altered bowel habit (>6 weeks and <12 months) **AND** any critical factor* | Altered bowel habit (>6 weeks and <12 months) **AND** no critical factor* | |
| **5. Unexplained abdominal pain** | Unexplained abdominal pain **AND** any critical factor* | Unexplained abdominal pain **AND** no critical factor* | |
| **6. Unexplained significant weight loss** | Unexplained significant weight loss **AND** any critical factor* | Unexplained weight loss **AND** no critical factor NOTE: Weight loss is not indicated for no critical factor* + symptoms + normal examination + normal MCH/MCV/iron studies | |

| Factor | Category 1: <30 days | Category 2: <90 days | Category 3: <365 days (surveillance) |
|---|---|---|---|
| **7. Mass** | Palpable rectal or abdominal mass<br>**OR**<br>mass present on rigid/flexible sigmoidoscopy<br>**OR**<br>likely colorectal mass on imaging | | |
| **8. Adenocarcinoma of unknown primary** | Adenocarcinoma of unknown primary | | |
| **9. Colorectal cancer surveillance (post colon cancer resection)** | | Post colorectal resection with incomplete colonoscopy or incomplete clearance of polyps preoperatively.<br>Complete examination of colon (if not done preoperatively) | Family history or personal history (refer to current *National Health & Medical Research Council (NHMRC) Clinical Practice Guidelines for Surveillance Colonoscopy* (section: *Colonoscopy after curative resection for colorectal cancer*)) |
| **10. Polyp management and surveillance** | Polyps requiring referral for excision or incomplete polypectomy requires surveillance as per *NHMRC Clinical Practice Guidelines for Surveillance Colonoscopy* | | Surveillance colonoscopy after polypectomy (refer to current *NHMRC Clinical Practice Guidelines for Surveillance Colonoscopy* (section: *Colonoscopic surveillance after polypectomy*)) |
| **11. Suspected inflammatory bowel disease (IBD)** | Suspected IBD<br>**AND** any one of:<br>• any critical factor* or other symptom<br>• calprotectin (+)<br>• raised C-reactive protein or erythrocyte sedimentation rate<br>• iron deficiency<br>• low albumin<br>• abnormal rigid/flexible sigmoidoscopy | | Surveillance procedure (refer to current NHMRC *Clinical Practice Guidelines for Surveillance Colonoscopy* (section: *Colonoscopic surveillance and management of dysplasia in inflammatory bowel disease*)) |

* Critical factors: +iFOBT, unexplained anaemia, rectal bleeding, age ≥60.

# E.g. +iFOBT in a <50-year-old patient without other critical factors or other symptoms.

# Appendix 1: **Comparison of Australian jurisdictions**

## NSW Health Policy Directive Elective Procedures

**Victoria**

Guidelines developed by RACS in conjunction with ASERNIP-S

## NHMRC Guidelines 2018

**New South Wales**

New South Wales guidelines 2007

**Victoria**

Victoria guidelines 2018

**Queensland**

Queensland guidelines 2019

**Western Australia**

Western Australia guidelines 2017

**South Australia**

South Australia guidelines 2014

## Surveillance 2019 - all 30 days

**New South Wales**

1. Clinically significant overt lower gastrointestinal bleeding
2. Active inflammatory bowel disease or diarrhoea where endoscopy is indicated to progress management
3. Clinically significant iron deficient anaemia
4. FOBT +ve (including NBCSP)

**Victoria - Category 1**

1. +iFOBT
2. Anaemia and either
   a. any other critical factor or
   b. one or more other symptom
3. Rectal bleeding and
   a. any one of any other critical factor
   b. ≤12 months duration age ≥50years
   c. ≤12 months, one or more other symptom age <50 years
4. Altered bowel habit (≥6/52 and ≤12 months) and any other critical factor
5. Abdominal pain (unexplained) and any critical factor
6. Weight loss (unexplained and either
   a. any critical factor or
   b. one or more other symptom
7. Mass palpable (abdominal or rectal) or present on rigid/flexible sigmoidoscopy

8. Possible inflammatory bowel disease (IBD) and any one of
    a. any critical factor or other symptom
    b. calprotectin +
    c. raised CRP or ESR
    d. iron deficiency
    e. low albumin
    f. abnormal rigid/flexible sigmoidoscopy
9. Low MCV/MCH or ferritin and any critical factor
10. Primary of unknown origin and either
    a. any critical factor or
    b. one or more other symptom
11. Abnormal imaging likely colorectal cancer
12. Any surveillance procedure overdue by 60 days
13. Polyps ≥2cms for excision

**Queensland - Category 1**

1. Mass palpable on abdominal or rectal examination
2. Positive faecal occult blood test (iFOBT) asymptomatic
3. Severe abdominal pain with presence of concerning features or significant impact on activities of daily living
4. Anaemia or iron deficiency with no obvious cause and/or persisting despite correction of potential causative factors and/or presence of concerning features
5. Altered bowel habits with progressive or persistent symptoms that are significantly impacting activities of daily living despite medical management and with presence of concerning features
6. Rectal bleeding with presence of concerning features
7. Unexplained weight loss and presence of concerning features
8. Abnormal radiology

### Presence of following concerning features

1. Dark blood coating or mixed with stool
2. Bloody or nocturnal diarrhoea
3. Weight loss, ≥5% of body weight in previous 6 months
4. Abdominal/rectal mass on clinical examination or abnormal imaging
5. Persistent abdominal pain
6. Iron deficiency in males and postmenopausal women or unexplained iron deficiency in premenopausal women
7. Patient and family history of bowel cancer (1st degree relative <55 years old)
8. iFOBT or calprotectin +ve

**Note**

*For patients with symptoms suggestive of colorectal cancer, the total time from first healthcare presentation† to diagnostic colonoscopy should be no more than 120 days. Diagnostic intervals greater than 120 days are associated with poorer clinical outcomes.*

† First healthcare presentation is defined as the date of presentation in general practice with symptoms suggestive of colorectal cancer or positive iFOBT for screening. (Cancer Council Australia, 2017)

**Western Australia - Category 1**

1. +iFOBT
2. Rectal bleeding for ≥4 weeks
3. Change in bowel habit ≥6 weeks with alarm symptoms
4. Unexplained iron deficiency anaemia in men and non-menstruating women
5. Active inflammatory bowel disease
6. Bloody diarrhoea with negative stool microscopy, culture and sensitivity test.

**South Australia**

1. +iFOBT including NBCSP
2. Clinically significant rectal bleeding
3. Clinically significant iron deficiency anaemia
4. Change in bowel habit with alarm symptoms
5. Active or suspected inflammatory bowel disease (IBD) or diarrhoea where endoscopy is indicated to progress management
6. Abnormal imaging where cancer is suspected

## 60-90 days

**New South Wales <90 days**

1. Lower likelihood of significant organics pathology example
    a. Functional bowel symptoms without alarm features
    b. Persistent undiagnosed diarrhoea

**Victoria <60 days**

1. Anaemia and all of the following
    a. No other critical factor or other symptom
    b. No likely cause
    c. Any age
2. Rectal bleeding and all of the following
    a. <12 months duration
    b. No other critical factor or other symptom
    c. No likely anorectal cause found (such as normal rigid/flexible sigmoidoscopy) or failed treatment of haemorrhoids
    d. Age <50 years
3. Altered bowel habit (>6/52 and <12 months) and both
    a. No critical factor and
    b. One or more other symptom
4. Abdominal pain (unexplained) and both
    a. No critical factor
    b. One or more other symptom
5. IBD reassessment for change in treatment
6. Low MCV/MCH or ferritin and both
    a. No critical factor
    b. One or more other symptom
7. Abnormal imaging – unlikely colorectal cancer

8. Surveillance – procedures due as per the NHMRC guidelines
9. Polyp <2cms for excision

**Queensland <90 days**

1. Anaemia or iron deficiency with no obvious cause and/or persisting despite correction of potential causative factors and in the absence of concerning features
2. Altered bowel habits with progressive or persistent symptoms that are significantly impacting activities of daily living despite medical management and in the absence of concerning features
3. Rectal bleeding in the absence of concerning features
4. Unexplained weight loss in the absence of concerning features

Absence of the following concerning features:

1. Dark blood coating or mixed with stool
2. Bloody or nocturnal diarrhoea
3. Weight loss, ≥5% of body weight in previous 6 months
4. Abdominal/rectal mass on clinical examination or abnormal imaging
5. Persistent abdominal pain
6. Iron deficiency in males and postmenopausal women or unexplained iron deficiency in premenopausal women
7. Patient and family history of bowel cancer (1st degree relative <55 years old)
8. iFOBT or calprotectin +ve

**Western Australia <90 days**

1. Change in bowel habits >6 weeks without alarm symptoms in patients >60 years
2. Abnormal imaging
3. Diarrhoea >6 weeks where endoscopy is indicated to progress management

**South Australia <90 days**

1. Change in bowel habit without alarm symptoms
2. Persistent/chronic diarrhoea
3. Port diverticulitis
4. Staged surveillance patient due within the next 90 days. This includes:
    a. patients requiring initial surveillance following removal of certain adenomas or in certain circumstances post curative resection for obstructive colorectal cancer
    b. patients requiring surveillance related to family history or previous adenoma, curative resection for CRC or dysplasia in inflammatory bowel disease.

## Category 3 - within 365 days

### New South Wales

1. Family History as per NHMRC Clinical Practice Guidelines
2. Complete examination of colon (if not done preoperatively) within 1 year of curative surgery

### Victoria <180 days

1. Anaemia and all of
    a. No other critical factor or other symptom
    b. Likely non-gastrointestinal tract cause
    c. Age ≥50 years
2. Rectal Bleeding and all of
    a. <12 months duration, occasional
    b. No other critical factor or other symptom
    c. No likely anorectal cause found (such as normal rigid/flexible sigmoidoscopy
    d. Any age
3. Altered bowel habit (>6/52 and <12 months) and
    a. No critical factor or other symptom
    b. Abdominal pain (unexplained and
    c. No critical factor or other symptom
4. Possible IBD and all of
    a. No critical factor or other symptom
    b. Calprotectin (-)
    c. Normal CRP and ESR
    d. No iron deficiency
    e. Normal albumin
    f. Specialist assessment (including normal rigid/flexible sigmoidoscopy)
5. Low MCV/MCH or ferritin and both
    a. No critical factor or other symptoms
    b. Age ≥50 years

### Queensland

Family history of colorectal cancer (CRC) in patients with one first-degree relative diagnosed with CRC <55 years, or two first- or second-degree relatives diagnosed with CRC at any age

### South Australia

Colonoscopy required within 365 days

## Surveillance

### Victoria

See top 2 categories.

### Queensland

Recall/surveillance endoscopic procedure. Intervals according to NHMRC guidelines. Colonoscopy to be completed within 3 months of due date

### Western Australia

Referrals for patients that are due for a surveillance procedure (as per surveillance guidelines within 12 months of the hospital receiving the referral – the referral will be accepted and waitlisted to have their procedure as close to the due date as possible

## Returned to referrer/not indicated

### Victoria

1. +iFOBT in the context of a recent high-quality complete colonoscopy should be considered on an individual basis after full specialist assessment
2. Anaemia and all of
    a. No other critical factor of other symptom
    b. Untreated likely non-gastrointestinal tract cause such as menorrhagia/diet
    c. Age <50 years
    d. If no response to treatment or recurrence, recommend Category 2 colonoscopy. Consider upper gastrointestinal endoscopy

3. Rectal bleeding >12 months occasional and all of
    a. No other critical factor or other symptom
    b. Likely cause found after specialist assessment including rigid/flexible sigmoidoscopy such as haemorrhoids
    c. In no response to treatment or recurrence, recommend Category 2 colonoscopy
4. Altered bowel habit of less than 6 weeks duration should be fully assessed and treated if no response to treatment or recurrence recommend Category 2 colonoscopy
5. Chronic diarrhoea or constipation (>12 months) with no critical factor or other symptoms should undergo specialist review with consideration to colonoscopy only after full assessment
6. Abdominal pain of less than six weeks duration should be fully assessed and treated with consideration of colonoscopy if no response or persistence
7. Colonoscopy is not indicated in a resolved episode of acute abdominal pain or diverticulitis with typical CT features and both no critical factor and no other symptoms
8. Weight loss and all of
    a. No critical factor or other symptom
    b. Normal examination
    c. Normal MCH/MCV/iron studies
9. Some masses (such as on the superficial abdominal wall) should be assessed by CT prior to consideration of colonoscopy
10. Symptoms of IBD may mimic those of irritable bowel syndrome and include abdominal bloating non-specific abdominal pain and irregular bowel habit
11. Low MCH/MCH or ferritin and both
    a. No critical factor or other symptom
    b. Age <50 years
    c. In no identifiable likely case, no response to treatment or recurrence, consider Category 2 colonoscopy
12. Primary of unknown origin and all of
    a. No critical factor or other symptom
    b. Normal examination
    c. Normal MCH/MCV/iron studies
13. Procedures not in line with NHMRC guidelines

### Queensland

Stated in the outpatient referral

### Western Australia

1. Referrals for patients that are due for a surveillance procedure (as per surveillance guidelines in greater than 12 months from when the hospital receives the referral the referral will be returned to the referrer, requesting a re-referral closer to the time other procedure is due
2. The referral does not meet the WA Health acceptance criteria as described in the referral guidelines
    a. Referrals will be returned to the referrer with advice to 'treat, watch and wait', review in GP practice within 6-12 weeks, and re-refer if the patient's symptoms persist and are of concern
    b. GPs can contact the Gastroenterology Department at their local hospital if they wish to discuss specific concerns regarding their patient

## NRFC

### South Australia

1. Staged surveillance patient for who surveillance is planned at a set interval at some time in the future
2. Deferred patient who required a colonoscopy within the next 12 months but the procedure has been deferred either for clinical reasons or personal reasons.

# Appendix 2: **Gastroenterology Network Survey Questions**

**1. What Categorisation Guidelines do you currently use to triage elective colonoscopy?**

- NHMRC 2018
- NSW MoH
- Hospital Specific Guidelines
- Own Guidelines
- Other (please specify)

**2. What triage category would you use for a +iFOBT referral for a patient between 50 – 74 years who has not had a colonoscopy in the past 2 years?**

- 30 day triage (Category 1)
- 90 day triage (Category 2)
- 365 day triage (Category 3)

**3. Which of the following would you categorise as a 30 day triage (Category 1)?**

- +iFOBT 50-74, no previous colonoscopy
- +iFOBT <45 years, no previous colonoscopy
- +iFOBT >80 years no other symptoms
- Active IBD
- Change in bowel habits >6 weeks with alarm symptoms
- Change in bowel habits >6 weeks with no other symptoms
- Clinically significant rectal bleeding >4 weeks
- Colorectal mass or suspected colorectal cancer on imaging or examination
- Failed treatment of haemorrhoids
- Persistent undiagnosed diarrhoea
- Polyp <2cms for excision
- Polyps >2cms for excision
- Surveillance colonoscopy due in <90 days
- Surveillance colonoscopy overdue by 60 days
- Unexplained iron deficient anaemia in men and non-menstruating women
- Comments

**4. Which of the following would you categorise as a 90 day triage (Cat 2)?**

- +iFOBT 50-74, no previous colonoscopy
- +iFOBT <45 years, no previous colonoscopy
- +iFOBT >80 years no other symptoms
- Active IBD
- Change in bowel habits >6 weeks with alarm symptoms
- Change in bowel habits >6 weeks with no other symptoms
- Clinically significant rectal bleeding >4 weeks
- Colorectal mass or suspected colorectal cancer on imaging or examination
- Failed treatment of haemorrhoids
- Persistent undiagnosed diarrhoea
- Polyp <2cms for excision
- Polyps >2cms for excision
- Surveillance colonoscopy due in <90 days
- Surveillance colonoscopy overdue by 60 days
- Unexplained iron deficient anaemia in men and non-menstruating women
- Comments

**5. Which of the following would you categorise as a 365 day triage (Cat 3)?**

- iFOBT 50-74, no previous colonoscopy
- +iFOBT <45 years, no previous colonoscopy
- +iFOBT >80 years no other symptoms
- Active IBD
- Change in bowel habits > 6 weeks with alarm symptoms
- Change in bowel habits > 6 weeks with no other symptoms
- Clinically significant rectal bleeding >4 weeks
- Failed treatment of haemorrhoids
- Persistent undiagnosed diarrhoea
- Polyp <2cms for excision
- Polyps >2cms for excision
- Surveillance colonoscopy due in <90 days
- Surveillance colonoscopy overdue by 60 days
- Unexplained iron deficient anaemia in men and non-menstruating women
- Comments

**6. Approximately what percentage of your Cat 1 (30 days) triage patients have the colonoscopy within 30 days?**

**7. Approximately what percentage of your Cat 2 (90 days) triage patients have a colonoscopy within 90 days?**

**8. What speciality are you?**

Gastroenterologist

Colorectal Surgeon

General Surgeon

Other (please specify)

**9. Are you a Director or Head of Department?**

Yes

No

**10. Please add a comment on issues you have related classification guidelines**

# Appendix 3: **Colonoscopy Categorisation Guideline project timeline**

| Date | Activity | Responsibility/ organisation |
|---|---|---|
| **Oct 2018- Jan 2019** | Literature review (national and international) | CI NSW |
| **Feb - March 2019** | Joint establishment of project design, expert contact list for EOI, survey and consultations | ACI<br>CI NSW |
| **April 2019** | Design of NSW Colonoscopy Categorisation Survey<br>Guide Development Process flowchart | ACI Network manager |
| **May 2019** | Development of project governance<br>Draft terms of reference (TOR), draft expression of interest (EOI) letters | ACI Exec<br>CI NSW<br>ACI Network Manager |
| **June 2019** | Guide development, review and approval of TOR, EOI and survey<br>Release of survey – end June | ACI<br>CI NSW |
| **July 2019** | Survey collation – mid-July<br>EOI selection process for CCR Reference Group | CI NSW and ACI |
| **August 2019** | NSW Colonoscopy Categorisation Reference Group Workshop mid-August<br>Collation of workshop findings draft 1 – end August | CI NSW and ACI |
| **September 2019** | Consultation round 1- with CCG Reference Group – draft 2<br>Consultation round 2- with CCG Reference Group – draft 3 | ACI |
| **October 2019** | Key stakeholder consultation over eight weeks:<br>ACSQHC, CEC, GESA GENCA, RACS, ACI GP CAG, ACI Gastroenterology Network, GP Association, Ministry of Health, LHDs, Pillars | ACI |
| **November 2019** | Wider consultation continued<br>Collation of responses | ACI |
| **Early December 2019** | Finalise actions from state-wide consultation<br>Draft explanatory notes<br>CCC Working Group review of explanatory notes (Jan 16 close) | ACI, CI NSW and CCC Steering Group |
| **Jan 2020** | Approval chain of final draft and recommendations to ACI/CI NSW Steering Group and ACI Executive | ACI Executive |
| **Feb - Oct 2020** | Communication strategy | ACI and CI NSW |

# References


1. Australian Commission on Safety and Quality in Healthcare. Colonoscopy Clinical Care Standard [Internet]. Sydney: ACSQHC; 2018. Available from: https://www.safetyandquality.gov.au/standards/clinical-care-standards/colonoscopy-clinical-care-standard

2. NSW Ministry of Health. Advice for Referring and Treating Doctors - Waiting Time and Elective Surgery Policy [Internet]. Sydney: Ministry of Health; 2012. Available from: https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2012_011.pdf.

3. NSW Agency for Clinical Innovation. Clinical Priority Category: Colonoscopy [Internet]. Sydney: ACI; 2007. Available from: https://www.aci.health.nsw.gov.au/__data/assets/pdf_file/0019/158500/final_advice_colonoscopy.pdf.

4. Victorian Government. Colonoscopy Categorisation Guidelines 2017 [Internet]. Melbourne: Victorian Government; 2017. Available from: https://www2.health.vic.gov.au/about/publications/policiesandguidelines/colonoscopy-categorisation-guidelines.


# Contacts


**Ingrid Klobasa**

Network Manager

Radiology, Nuclear Medicine, Gastroenterology

Preserving and Restoring Through Interventions in Surgery and Medicine

Agency for Clinical Innovation

**aci-info@health.nsw.gov.au**

**Associate Professor Ian Norton**

**Ian.Norton@health.nsw.gov.au**

**Dr Matthew Hall**

**Matthew.Hall1@health.nsw.gov.au**

# Glossary

| | |
|---|---|
| **Colonoscopy** | Diagnostic/therapeutic examination of the colon with a colonoscope |
| CCSG | Colonoscopy Categorisation Steering Group |
| CCWG | Colonoscopy Categorisation Working Group |
| CPC | Clinical priority category |
| CRC | Colorectal cancer |
| CRP | C-reactive protein |
| DAC | Direct access colonoscopy, a clinical initiative of the Leading Better Value Care program |
| IBD | Inflammatory bowel disease |
| IDA | Iron deficiency anaemia |
| iFOBT | Immunochemical faecal occult blood test (also known as faecal immunochemical test or FIT). |
| LHD | Local health district |
| MCH | Mean corpuscular hemoglobin |
| MCV | Mean corpuscular volume |
| NHMRC | National Health & Medical Research Council |
| PET | Positron emission tomography |
| PPV | Positive predictive value |
| RFA | Request for admission |
| **Screening** | Investigation of an individual at standard risk of a condition, usually defined as a single time-point |
| **Surveillance** | The longitudinal investigation of an individual with respect to a condition. The use of this term in colorectal cancer usually implies increased risk for that individual |
| **the Guide** | NSW Colonoscopy Categorisation Clinical Practice Guide |

# Acknowledgements

The ACI gratefully acknowledges the following people who contributed to this Guide:

**Colonoscopy Categorisation Working Group**

A/Prof. Ian Norton – Chair
Gastroenterologist/Head of Dept.
Royal North Shore Hospital

Dr Matthew Hall
Deputy Chair Gastroenterologist/
Head of Dept,
Sutherland Hospital, SESLHD

Prof Jon Gani
Surgeon/Head of Dept.
John Hunter Hospital,
Hunter New England LHD

Dr Bruce Hodge
Colorectal Surgeon,
Port Macquarie Hospital,
Mid North Coast LHD

Dr John Barker
General Surgeon,
Hunter New England LHD

A/Prof Thomas Lee
Gastroenterologist,
Wollongong Hospital

Dr David Whitaker
Gastroenterologist,
Lismore Hospital

Dr Kenneth Koo
Gastroenterologist,
Liverpool Hospital

Dr Michael Bourke
Gastroenterologist,
Westmead Hospital

Dr Darryl Mackender
Gastroenterologist,
Orange Hospital

Dr Michael Payne
General Surgeon,
Murrumbidgee LHD

Dr Neil Wright
Head of Surgery,
Moruya Hospital

Dr Cameron Bell
Gastroenterologist,
Royal North Shore Hospital

Prof Peter Katelaris
Gastroenterologist,
Concord Hospital

A/Prof Martin Weltmann
Gastroenterologist/Head of Dept,
Nepean-Blue Mountains

Dr Martin Grehan
Gastroenterologist,
Nepean Blue Mountains Hospital

Dr Viraj Kariyawasam
Gastroenterologist,
Blacktown and Mt Druitt Hospitals

**Cancer Institute NSW**

Christopher Horn
NSW Bowel Cancer Screening
Program Manager

Sarah McGill
Director, Cancer Screening
and Prevention

Blythe O'Hara
Project Consultant

Brooke Selby
Leading Better Value Care
Direct Access Colonoscopy
Implementation Lead

**NSW Ministry of Health**

Melinda Pascoe
Principal Policy Officer
– Surgical Services,

Vincent Salomon
Senior Policy Officer,
System Purchasing Branch

**External advice**

Gastroenterology Network members

Prof Anne Duggan
Australian Commission on Safety
and Quality in Healthcare
Commission

Prof. Jon Emery
Herman Professor of Primary Care
Cancer Research, University of
Melbourne and Western Health

Dr Darren Pavey
Gastroenterology Network Co-Chair
and Gastroenterologist

Victorian State Government
Department of Health and Human
Resources, Colonoscopy
Categorisation Guidelines 2017

**ACI Gastroenterology Network Executive**

Ellen Rawstron
Clinical Associate Director Surgery,
Anaesthesia and Interventional
Medicine

Sarah-Jane Waller
Acting Clinical Associate Director
Surgery, Anaesthesia and
Interventional Medicine PRISM

**ACI Project Lead**

Ingrid Klobasa
Network Manager Radiology
Nuclear Medicine and
Gastroenterology

### Collaborators

The Agency for Clinical Innovation with the support of the Cancer Institute NSW agreed to develop the state-wide clinical categorisation guide for the appropriate management of colonoscopy for NSW public health services. Previous ACI guides were developed in 2007.

The guides were developed in collaboration with clinical experts from NSW local health districts (LHDs) with both rural and metropolitan representatives. The clinical leads include the head of endoscopy departments, gastroenterologists, colorectal surgeons, general surgeons, and a general physician and waitlist manager representative.

### Consultation

The final draft document underwent extensive consultation with:

ACSQHC - Australian Commission on Safety and Quality in Health Care

Royal Australasian College of Surgeons (RACS)

- RACS NSW Branch
- RACS - Rural Surgery Section
- RACGP, RACGP NSW and ACT Faculty

Nursing and Midwifery Office, NAMO

Gastroenterological Society of Australia (GESA)

- Australian Gastrointestinal Endoscopy Association (AGEA)
- Gastrointestinal Cancer Special Interest Group
- Australian Inflammatory Bowel Disease Association (AIBDA)

Gastroenterological Nurses College of Australia (GENCA)

Colorectal Surgical Society of Australia and New Zealand (CRSSANZ)

Gastroenterological Nurses College of Australia (GENCA)

ACI Networks - ACI General Practitioners Clinical Advisory Group (GPAG)

Gastroenterology Network

The consultative process (October 2019) ensured that appropriate clinical categorisation guides could be adopted for colonoscopies within the NSW public health system.

The Agency for Clinical Innovation (ACI) is the lead agency for innovation in clinical care.

We bring consumers, clinicians and healthcare managers together to support the design, assessment and implementation of clinical innovations across the NSW public health system to change the way that care is delivered.

The ACI's clinical networks, institutes and taskforces are chaired by senior clinicians and consumers who have a keen interest and track record in innovative clinical care.

We also work closely with the Ministry of Health and the four other pillars of NSW Health to pilot, scale and spread solutions to healthcare system-wide challenges. We seek to improve the care and outcomes for patients by re-designing and transforming the NSW public health system.

Our innovations are:

- person-centred
- clinically-led
- evidence-based
- value-driven.

**www.aci.health.nsw.gov.au**

NSW GOVERNMENT

AGENCY FOR CLINICAL INNOVATION

*Our vision is to create the future of healthcare, and healthier futures for the people of NSW.*