Alberta Health Services

Memorandum

Date: April 29, 2020

To: All endoscopy site medical and administrative leads
All endoscopists

From: Dr. Sander Veldhuyzen van Zanten, Senior Medical Director, Digestive Health SCN
Louise Morrin, Senior Provincial Director, Digestive Health SCN

RE: **GI Endoscopy De-escalation Prioritization Criteria**

There is a need to ensure our AHS resources are focused on the COVID-19 pandemic response and emergency healthcare situations. Therefore elective procedures (including endoscopic procedures) were cancelled effective March 18, 2020. Effective April 1, 2020, the Adult Ambulatory Care Pandemic Plan, which includes out-patient endoscopy, was implemented to Stage 3, meaning ambulatory service delivery is reduced to only essential services to assist with inpatient service delivery amidst resource shortages. At this time, all currently scheduled visits in Ambulatory Care (including GI endoscopy) are to be assessed for urgency and postponed unless they are deemed urgent. AHS Emergency Coordination Centre (ECC) will monitor the status of the pandemic in order to determine appropriate timing for increased ambulatory service delivery, including GI endoscopy.

The Digestive Health SCN, in collaboration with endoscopists from across the province, developed and circulated provincial criteria for urgent GI endoscopy procedures (adult outpatients) and emergent/urgent GI endoscopy procedures (pediatric outpatients). These criteria are being used across Alberta to prioritize patients during the current period where endoscopy activity is limited to urgent procedures. In preparation for when the COVID-19 activity begins to decline and postponed procedures can be rescheduled, this document outlines criteria to guide the order in which these GI endoscopy procedures should be scheduled, starting with the semi-urgent cases followed by the non-urgent cases.

GI endoscopists are strongly encouraged to use these criteria when scheduling patients for endoscopic procedures as the COVID-19 pandemic subsides. *We recognize that these criteria are not all-inclusive and that clinical judgment must be considered in prioritizing endoscopic procedures for individual patients.*

In addition to using these criteria to prioritize patients, GI endoscopists are also encouraged to consider appropriateness of referred patients, and the potential to redirect low risk referrals to primary care, rather than adding these patients to wait lists. Several resources are available to support primary care providers in caring for these patients, including:

- Primary care pathways (chronic abdominal pain, chronic constipation, chronic diarrhea, dyspepsia, GERD, H. pylori, IBS – available at https://www.specialistlink.ca/clinical-pathways/clinical-pathways.cfm)
- Phone advice (ConnectMD in the Edmonton Zone at 1-844-633-2263; Specialist Link in the Calgary Zone at www.specialistlink.ca)
- eReferral Advice Request (available provincially, see https://www.albertanetcare.ca/documents/Getting-Started-Advice-Requests-FAQs.pdf)

NOTES

- It is anticipated that GI endoscopy activity will gradually return to pre-COVID levels, but it may take some time for this to occur. Factors such as physician and staff availability, physical distancing requirements, PPE availability, and others will impact the rate at which endoscopy capacity will increase.
- It is the role of Zone/site operations to work with endoscopists to determine how these factors will be addressed locally as GI endoscopy activity increases.

Adult endoscopic procedures

<table>
<tr><th>Priority 1 / Urgent[1]</th><th colspan="3">Priority 2 / Semi-Urgent[2]</th><th>Priority 3 / Non-urgent[3]</th></tr>
<tr><td rowspan="2">FIT positive presenting with symptoms (e.g. rectal bleeding, abdominal pain, unintentional severe weight loss, change in bowel habits like ribbon stools or new diarrhea)</td><td><u>1st priority</u>
FIT positive test date greater than 6 months</td><td><u>2nd priority</u>
FIT positive test date between 4-6 months</td><td><u>3rd priority</u>
FIT positive test date less than 4 months

Polyp found on sigmoidoscopy or suspected polyp on CT colonography</td><td rowspan="2">Priority list for non-urgent cases:
1) Hereditary Nonpolyposis Colorectal Cancer or Familial Adenomatous Polyposis
2) Overdue for surveillance colonoscopy
3) Personal History of colorectal cancer and/or adenomatous polyps
4) Family history of colorectal cancer and/or high risk adenomatous polyp(s)</td></tr>
<tr><td colspan="3">Considerations - Endoscopy & Screening Programs:
Asymptomatic FIT positive cases with evidence of a high quality colonoscopy occurring within the past 3 years may not require urgent or semi-urgent 2a or 2b prioritization.
1) Previous FIT positive incomplete colonoscopy (e.g., due to poor prep) should be triaged as semi-urgent.
2) FIT positive cases > 6 months may need to be assessed on a case by case basis; those who are now symptomatic should be considered urgent priority.</td></tr>
<tr><td>High suspicion of colorectal cancer based on presence of symptoms, physical exam, abnormal imaging, and/or previous biopsy (example: setting of polyp/mass previously biopsied but not resected</td><td colspan="3"></td><td></td></tr>
<tr><td>High risk variceal screening
Repeat EGD for repeat banding in patient known at higher risk for repeat bleeding</td><td colspan="3">Surveillance for new episode of variceal bleeding (<6 months)</td><td>Routine variceal screening</td></tr>
</table>

[1] Urgent: non-elective cases that are currently performed

[2] Semi-urgent: cases that should be scheduled first when restrictions are lifted on elective procedures

[3] Non-urgent: cases that are scheduled after semi-urgent cases have been completed

Priority 1 / Urgent[1]	Priority 2 / Semi-Urgent[2]	Priority 3 / Non-urgent[3]
Progressive dysphagia	New onset dysphagia (persistent or progressive)	Non-progressive dysphagia
Need for ERCP or endoscopic ultrasound such as common bile duct stones, gallstone pancreatitis, infected necrosis, pancreatic fluid collection	ERCP, in presence of non-urgent elevated or changing lab values, such as increase in bilirubin, or symptoms.	ERCP stent removal in the absence of changing lab findings or symptoms
IBD flare not responding to acute treatment – includes (partial) small bowel obstruction, possible need for surgical staging	Establish a new diagnosis of IBD Moderate IBD assessment • dilation of stricture (intermittent obstructive symptoms) • assessment for disease activity which would potentially lead to a change in therapy (not just dose escalation) • (e.g. increase in symptoms without FCP, or elevated FCP without symptoms).	IBD surveillance Assess for mucosal healing Assess for post-operative recurrence Dysplasia screening
Foreign body removal		
	Dyspepsia or GERD with alarm features or over 60 years old	Dyspepsia or GERD not responding to therapy or with intermittent vomiting
Acute upper or lower GI bleed. Includes significant drop in hemoglobin, suspected to be GI in origin	Persistent significant rectal bleeding. Persistent rectal bleeding associated with other findings such as weight loss, iron deficiency anemia and abnormal physical rectal exam.	Intermittent rectal bleeding
Significant new onset iron deficiency anemia	Unexplained new onset iron deficiency anemia (drop >20)	Unexplained , new onset iron deficiency anemia (drop <20)
Severe chronic diarrhea, unresponsive to medical management		Chronic diarrhea
	≥2cm polyp resection	Post-polypectomy follow-up
	Barrett esophagus: Repeat ablation procedures – where ablations are in progress Concern about Barrett's esophagus dysplasia findings	Barrett's ablation – new referral Barrett's screening/ surveillance
	Repeat ablation– where ablations are in progress	Ablation– new referral
	Positive celiac serology with symptoms	Positive celiac serology, no symptoms

Pediatric endoscopic procedures

Priority 1 / Urgent	Priority 2 / Semi-Urgent	Priority 3 / Non-urgent
GI Bleed - acute (upper or lower) Includes significant drop in hemoglobin, suspected to be GI in origin	Persistent melena/BRRB associated with other findings such as weight loss, iron deficiency anemia and positive physical rectal exam.	
Foreign body removal • Symptomatic non-esophageal foreign body • Esophageal foreign body • Multiple magnet ingestion	Foreign body removal (gastric with no symptoms)	
Caustic Ingestion		
Intestinal Transplant • Suspected rejection • Protocol biopsies	Intestinal Transplant – Surveillance biopsies	
Repeat EGD for repeat esophageal variceal banding/sclero in patient at high risk for repeat bleeding	Portal Hypertension – screening (High risk)	Known Portal Hypertension surveillance
Acute dysphagia/odynophagia	New progressive dysphagia	Dysphagia - follow up/maintenance
Need for ERCP or endoscopic ultrasound such as common bile duct stones, gallstone pancreatitis, infected necrosis, pancreatic fluid collection	ERCP stent removal in presence of increased bilirubin or symptoms	ERCP stent removal in the absence of lab findings or symptoms
IBD flare not responding to acute treatment – includes (partial) small bowel obstruction, possible need for surgical staging	Mild-Moderate IBD assessment Stricture dilation Evaluation of change in disease activity	IBD surveillance Assess for mucosal healing Assess for post-operative recurrence Dysplasia screening
Failure to Thrive - severe; Malabsorption unresponsive to medical treatment	Failure to Thrive - mild to moderate	
Significant new onset iron deficiency anemia	Uninvestigated, new onset iron deficiency anemia	
Severe chronic diarrhea, unresponsive to medical management	Severe diarrhea with alarm features	Chronic diarrhea
	(>2cm polyp) Post-polypectomy follow-up	
	Positive celiac serology with symptoms	Positive celiac serology, no symptoms
	Dyspepsia or GERD with alarm features	Dyspepsia or GERD not responding to therapy

Priority 1 / Urgent	Priority 2 / Semi-Urgent	Priority 3 / Non-urgent
	Nutritional Support – PEG insertion, G tube/GJ tube insertion	Nutritional Support - G tube/GJ tube change, percutaneous endoscopic
		Eosinophilic Esophagitis - surveillance
		Polyposis Syndrome - screening or surveillance colonoscopy