Lower GI investigation/Colonoscopy in older patients and those with comorbidity - Summary Clinical Guideline

Reference no.: CG-ENDO/2023/009

Recommendation for all patients >80 years (or >70 years with significant comorbidities)
All patients in this age group and who are frail should be fully counselled regarding investigation and how it will influence their management. They should not be directed straight to test and the option of no test maybe a sensible option. If a patient is not fit for a subsequent intervention and wishes further investigation then the test should not put the patient at undue risk. In such a situation, however, the result may suggest the need for palliative care or other support

Rectal Bleeding
Differential diagnosis is colitis, polyps, cancer, haemorrhoids and angiectasia. The recommended initial investigation is flexible sigmoidoscopy .

Chronic Diarrhoea
The correct initial investigation is flexible sigmoidoscopy with rectal biopsy (only if the diarrhoea is chronic and unexplained). Patients should have also had coeliac serology and drugs reviewed as these are often the cause of diarrhoea. If sigmoidoscopy does not reveal a cause then consider proceeding to CT Pneumocolon if further investigations required

Abdominal Pain with altered bowel habit
The whole colon needs imaging in these circumstances. The patient needs a CT Pneumocolon (and PR examination).

Iron Deficiency
The whole colon needs imaging in these circumstances. The patient needs a CT Pneumocolon (and PR examination). In addition, for iron deficient patients the upper GI tract needs to be imaged; consider gastroscopy or Barium meal with coeliac serology.

Age >90
Investigate as above but substitute CT abdomen/pelvis for CT Pneumocolon but only after counselling the patient about the pros/cons of investigation and this must include the option of no investigation as this is very unlikely to alter surgical or endoscopic management. It may however allow a patient/family to be fully aware of their current situation and enable involvement of e.g. palliative care and support.

Polypectomy
1. Polyps less than 10mm in size should be regarded as low risk polyps.
2. Polypectomy of high risk polyps in patients over 80 (or over 70 with significant comorbidities) should only be undertaken after appropriate discussion with the patient prior to the procedure.
3. Polypectomy in this group should only be undertaken by experienced endoscopists

Polyp follow up
BSG guidelines state that patients can be offered surveillance until age 75 years. For patients over 70 with significant comorbidities any procedures should be carefully considered and only requested after an up to date review of the patient by the requesting team and considered whether colonoscopic surveillance is still required.