TITLE-

GUIDELINES PRE-PROCEDURE FOR OPTIMAL UPPER GASTROINTESTINAL ENDOSCOPY

TARGET AUDIENCE	Board-wide
PATIENT GROUP	All patients undergoing oesophago-gastroduodenoscopy

Clinical Guidelines Summary

Pre-Admission:

- A written information leaflet is supplied to patients explaining procedure and preparation (appended below)
- **Appropriate fasting:** fasting for food, including milk, for 6 hours prior to the procedure. Water can be taken until 2 hours prior to the procedure.
- **Continue Proton Pump Inhibitors (PPIs)**.
- **For diagnostic upper endoscopy continue anticoagulants and antiplatelet therapy.** Biopsies are safe to perform in patients on anticoagulant (as long as in therapeutic range) or antiplatelet therapy.
  Warfarin therapy should continue and patient should have INR checked during the week before the endoscopy. If INR is within the therapeutic range then continue with the usual daily dose. If INR is above the therapeutic range, but less than 5, then reduce the daily warfarin dose until the INR returns to therapeutic range. If INR is greater than 5 then defer the endoscopy and contact the anticoagulation clinic, or a medical practitioner, for advice.

Pre-procedure:

- Patients require reassurance : Individual and team Endoscopy Non-technical Skills (ENTS) are important.
- **≥10 minutes prior to the procedure** a pre-endoscopic drink to improve visibility during oesophago-gastroduodenoscopy (OGD) is recommended.
  - 100 ml of water for irrigation with 600mg acetylcysteine soluble tablet and 20mg Simethicone (0.5ml of 40 mg/ml) liquid.
- A venflon is recommended for all patients.

Guideline Body

Content

Background

The National Endoscopy Training Programme (as part of the NHS Scotland Academy) have issued recommendations for achieving an optimal upper gastrointestinal endoscopy. This was following a National training event with guidance and expertise provided by John Anderson, Roland Valori and Nigel Trudgill, and involved collaboration from 16 Scottish endoscopists where each delegate prepped an area of best practice and guidance was agreed within the group (paper appended).

Recommendations and Evidence

Pre-admission

1. In order to be able to give informed consent, information about the proposed procedure and its associated risks must be explained. As the majority of OGDs are performed on an elective basis, information should be provided before the procedure date, with an opportunity to ask questions. There is evidence that information can improve patient experience. Combined written and oral information appears to be better understood than oral information alone. [1]

2. Appropriate Fasting –

Patients referred for UGI endoscopy should be fasting for solids for at least 6 hours prior to the procedure and allowed to take in water until 2 hours prior to the procedure [2]

3. Continuation of PPI, previously patients have been advised to stop PPI 2 weeks prior to endoscopy however the new recommendations are that PPI should be continued to minimise inflammation and improve the detection of early cancers.

4. Continue anticoagulants and antiplatelet therapy for low risk diagnostic scopes. [3]

Pre-procedure

Pre-endoscopic drink is recommended to improve visibility during gastroscopy. Previously endoscopic flushing has been used to improve visibility however trials have suggested that this does not offer equivalent improvements when compared with pre-endoscopic drinks. [4] A liquid medicine will be given to each patient before the procedure which will contain Acetylcysteine 600mg soluble tablet, Simeticone 20mg liquid in 100ml water for irrigation prescribed on endoscopy chart (preprinted). Administration will be signed. These are licensed medicines being used out with our usual product license and the written information sheet provided to the patient explains this and patients consent to taking this as part of their consent form.

Procedure consent

The consenting location should offer sufficient privacy and dignity to allow the patient to consider their decision and be separate from the procedure room.
A patient-centred approach is required where the risks, benefits and alternatives including not undergoing the procedure are discussed with the patient. [Montgomery v Lanarkshire Health Board (2015)A.C.1430].[5]
Postal consent alone does not meet the requirement for a patient centred approach. Where consent forms are posted to the patients these should be supplemented by a dialogue with an appropriate person prior to the procedure
To complete the consent process with the patient, the person needs to have adequate knowledge of the procedure, range of individual risks and procedure alternatives. However, the endoscopist has legal responsibility for ensuring the GMC consent principles are upheld.

The GMC advise that the following information is included in the discussion:

- Recognised risks that you believe anyone in the patient's position would want to know
- The effect of the patient's clinical circumstances on the probability of harm or benefit occurring
- Risks or benefits that the patient would consider significant for any reason
- Any risk of serious harm, irrespective of likelihood
- Expected harms or side effects and what the patient should do if they occur.

References/Evidence

1. Sabina Beg, Krish Ragunath, Andrew Wyman, Matthew Banks, Nigel Trudgill, D Mark Pritchard, Stuart Riley, John Anderson, Helen Griffiths, Pradeep Bhandari, Phillip Kaye, Andrew Veitch Quality standards in upper gastrointestinal endoscopy: a position statement of the British Society of Gastroenterology (BSG) and Association of Upper Gastrointestinal Surgeons of Great Britain and Ireland (AUGIS) . Gut 2017;0:1–14.
2. Raf Bisschops , Miguel Areia , Emmanuel Coron , Daniela Dobru, Bernd Kaskas , Roman Kuvaev , Oliver Pech, Krish Ragunath, Bas Weusten , Pietro Familiari , Dirk Domagk , Roland Valori , Michal F Kaminski, Cristiano Spada , Michael Bretthauer , Cathy Bennett , Carlo Senore , Mário Dinis-Ribeiro , Matthew D Rutter Performance measures for upper gastrointestinal endoscopy: a European Society of Gastrointestinal Endoscopy (ESGE) Quality Improvement Initiative Endoscopy 2016 Sep;48(9):843-64
3. Andrew M Veitch , Franco Radaelli , Raza Alikhan, Jean Marc Dumonceau, Diane Eaton, Jo Jerrome, Will Lester, David Nylander, Mo Thoufeeq, Geoffroy Vanbiervliet, James R Wilkinson, Jeanin E Van Hooft Endoscopy in patients on antiplatelet or anticoagulant therapy: British Society of Gastroenterology (BSG) and European Society of Gastrointestinal Endoscopy (ESGE) guideline update Gut 2021;70:1611–1628

4. P Bhandari [1], S Green, H Hamanaka, T Nakajima, T Matsuda, Y Saito, I Oda, T Gotoda Use of Gascon and Pronase either as a pre-endoscopic drink or as targeted endoscopic flushes to improve visibility during gastroscopy: a prospective, randomized, controlled, blinded trial Scand J Gastroenterol 2010 Mar;45(3):357-61
5. Burr NE, Penman ID, Griffiths H, Axon A, Everett SM. Individualised consent for endoscopy: update on the 2016 guidelines. Frontline Gastroenterology 2023; 14;273-81

Appendices

1. Governance information for Guidance document

Lead Author(s):	Ms Audrey McCallum, Ms Rebecca Ritchie
Endorsing Body:	National Endoscopy Training Board
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Responsible Person (if different from lead author)	Ms Audrey McCallum

CONSULTATION AND DISTRIBUTION RECORD	
Contributing Author / Authors	Ms Audrey McCallum – Consultant Surgeon, UHW Ms Rebecca Ritchie – Senior Pharmacist, UHW Ms Michelle Thornton – National Endoscopy Training Lead

Consultation Process / Stakeholders:	Guidelines developed at NHS Scotland Academy, National Endoscopy Training Event – National Upper GI Training Event - Guidelines and Best Practice, Nov 2023 (appended) List of members involved in developing protocol Jeyakumar Apollos (Consultant Surgeon, NHS Dumfries and Galloway) Aidan Cahill (National endoscopy co-training lead, Consultant Gastroenterologist, NHS GGC) Jonathan Fletcher (Consultant Gastroenterologist, NHS Borders) Andrew Fraser (Consultant Gastroenterologist, NHS GGC) Joanna Gray (Consultant Surgeon, NHS GGC) Tammy Kingstree (Non-medical Endoscopist, NHS Dumfries and Galloway) Audrey McCallum (Consultant Surgeon, NHS Lanarkshire) Aaron McGowan (Consultant Gastroenterologist, NHS Lothian) Douglas Morran (Consultant Surgeon, NHS A&A) John Morris (Consultant Gastroenterologist, NHS GGC) Maree Pasieka (Non-medical Endoscopist, NHS GGC) Ian Penman (Consultant Gastroenterologist, NHS Lothian) Kevin Robertson (Consultant Surgeon, NHS A&A) Adrian Stanley (Consultant Gastroenterologist, NHS GGC) Michelle Thornton (National endoscopy co-training lead, CfSD, NHS Lanarkshire) Jack Winter (Consultant Gastroenterologist, NHS GGC) With guidance and expertise provided by John Anderson, Roland Valori and Nigel Trudgill Presented, Discussed and Agreed at NHS Lanarkshire Endoscopy Governance meeting Dec 23

Distribution	As above Further Discussion and Agreement by Endoscopists at NHS Lanarkshire Upper GI Upskilling Course May 2024 List of NHS Lanarkshire Endoscopists on Upper GI Upskilling Course Endorsing Guidelines **Faculty** Andrew Fraser (Consultant Gastroenterologist, NHS GGC) Audrey McCallum (Consultant Surgeon, NHS Lanarkshire) Aaron McGowan (Consultant Gastroenterologist, NHS Lothian) Kevin Robertson (Consultant Surgeon, NHS A&A) Adrian Stanley (Consultant Gastroenterologist, NHS GGC) **Supporting** John Paul Seenan (Consultant Gastroenterologist, NHS GGC) Michelle Thornton (National endoscopy co-training lead, CfSD, NHS Lanarkshire) Lee Meharry **Delegates** Debbie Cullion (Nurse Endoscopist, NHS Lanarkshire) Sarah Miller (Consultant Gastroenterologist, University Hospital Hairmyres) Domenic Di Rollo (Consultant Surgeon, University Hospital Hairmyres) Majid Mughal (Specialist doctor General Surgery, University Hospital Hairmyres) Ruairidh Nicoll (Consultant Gastroenterologist, University Hospital Wishaw) Louise Campbell (Nurse Endoscopist, University Hospital Monklands) Khurram Khan (Consultant Surgeon, University Hospital Hairmyres) Lorraine Tyler (Senior Nurse Endoscopist, NHS Lanarkshire) Stacey Murray (Nurse Endoscopist, NHS Lanarkshire) Ryan Ghitta (Consultant Surgeon, University Hospital Hairmyres) Jen Veryan (Consultant Gastroenterologist, University Hospital Monklands) Raju Pareek (Consultant Surgeon, University Hospital Wishaw) Once approved full distribution board-wise.

CHANGE RECORD			
Date	**Lead Author**	**Change**	**Version No.**
		e.g. Review, revise and update of policy in line with contemporary professional structures and practice	1
			2
			3
		.	4
			5

2.You can include additional appendices with complimentary information that doesn't fit into the main text of your guideline, but is crucial and supports its understanding.

e.g. supporting documents for implementation of guideline, patient information, specific monitoring requirements for secondary and primary care clinicians, dosing regimen/considerations according to weight and/or creatinine clearance