CDHA GUIDELINES FOR ORDERING GASTROINTESTINAL (GI) FLUOROSCOPY STUDIES

The following guidelines are provided to assist general practitioners and non-gastrointestinal specialists in determining and requesting the most appropriate investigations for patients with suspected pathology of the upper or lower GI tract. Effective November, 2011, requests for GI fluoroscopy studies may be declined or returned to referring physicians with a request for more information about symptoms or prior treatment or investigations. By using these guidelines to ensure that the necessary relevant clinical information has been provided on the initial request form, it is hoped that delays in requested investigations can be avoided.

The following are NOT considered indications for an Esophagram or Upper GI Series:
- Sensation of lump in throat
- Non-obstructive swallowing difficulties
  Referral to the dysphagia clinic or speech language pathology is suggested
- Investigation of suspected gastroesophageal reflux disease (GERD)
  Please note that GERD can reliably be diagnosed clinically, and may require more than 8 weeks of therapy for an improvement in symptoms
- Suspected peptic ulcer disease or ulcer follow up
  Referral for upper GI endoscopy is suggested
- Acute GI bleeding
- Bloating

Accepted Indications for an Esophagram or Upper GI Series:
- Obstructive dysphagia
- Suspected Zenker’s diverticulum
- Odynophagia
- Alarm symptoms in the setting of treated GERD Alarm symptoms include GI tract blood loss, anemia, vomiting, involuntary weight loss, dysphagia, anorexia, and severe pain.
  ***It should be noted that upper GI endoscopy is the test of choice in this setting***
- Unexplained epigastric pain, not suspected to be an ulcer, following a negative ultrasound
- Unexplained chest pain, not typical of GE reflux, with cardiopulmonary causes excluded
- Confirmation of a hiatal hernia if contemplating surgical repair for refractory symptoms
- Suspected neoplasia
- Unexplained anemia
- Clarification of findings at endoscopy or imaging studies
The following are NOT considered indications for a Small Bowel Follow-Through:
- Upper abdominal pain without diarrhea, weight loss, melena, or a history of Crohn’s disease
- Suspected gastroesophageal reflux or peptic ulcer disease

**Accepted Indications for a Small Bowel Follow-Through:**
- Diagnosis and follow-up of Crohn's disease
- Intermittent partial small bowel obstruction
- Unexplained diarrhea
- Clarification of findings on imaging studies
- Unexplained GI hemorrhage, iron deficiency anemia, or weight loss in the setting of negative upper and lower GI tract investigations
- The investigation of diffuse diseases such as lymphoma and peritoneal carcinomatosis
- The investigation of steatorrhea or suspected malabsorption

The following are NOT considered indications for a Barium Enema:
- Chronic constipation
- Palpable abdominal mass
  - Ultrasound or CT scan is preferred unless there is compelling clinical evidence that a mass is primary to the colon
- Bloating

**Accepted Indications for a Barium Enema:**
- Suspected neoplasm (see note below)
- Unexplained anemia
- Unexplained iron deficiency
- Non-acute GI bleeding
- Unexplained weight-loss
- Narrow stool calibre of recent onset
- Confirmation of suspected diverticular disease or its complications
- Suspected Inflammatory Bowel Disease (IBD) - chronic unexplained diarrhea
- Acute IBD exacerbation
- Clarification of findings at endoscopy or on imaging studies

***Please note that colonoscopy and CT colonography are recommended in preference to Barium enema for the investigation of neoplasia, due to their higher sensitivity for polyps and early carcinoma. Patient’s should be made aware that colon cancer can be missed on Barium enema 10% of the time, and individuals with symptoms should report them to their physician for consideration of colonoscopy, rather than be reassured by a negative Barium study.***