2014 CDHA GUIDELINES
FOR ORDERING GASTROINTESTINAL STUDIES

The following 2014 updated guidelines are based on current guidelines from the Canadian Association of Radiologists. They are provided to assist physicians in determining and requesting the most appropriate investigations for patients with suspected pathology of the upper or lower GI tract. Some fluoroscopy studies traditionally performed for GI tract symptomatology have been replaced by CT enterography, MR enterography and CT colonography. As a consequence, most barium swallows, upper GI studies and barium enemas will no longer be routinely performed. Accepted indications for all of these GI studies are listed below. Requests for GI studies may be declined or returned to referring physicians with a request for more information about symptoms or prior treatment or investigations.

Accepted Indications for Barium Studies:

Barium swallow and Upper GI studies may be considered in:
-Persistent dysphagia associated with obstruction of breathing or accompanied by weight loss, regurgitation or vomiting
-Dysphagia after assessment by the dysphagia clinic
-Conformation or reassessment of a hiatal hernia if surgery is being contemplated
-In patients with prior bariatric surgery with symptoms suspicious for complications

***Please note there are no current indications for a barium enema, unless colonoscopy or CT colonography is unavailable. Barium Enema is no longer considered standard of care in suspected large bowel pathology and has largely been replaced by CT colonography or colonoscopy. However, in consultation with a specialist (Gastroenterology and/or Surgery), there may be specific cases or circumstances in which barium enema is preferred over CTC or colonoscopy and can be arranged. In these cases, documentation of discussion with the specialist will be required on the requisition.

***Outside of the indications CT Enterography, small bowel follow-through may be performed in cases where there is high clinical suspicion for small bowel disease and, in consultation with a specialist, small bowel follow through is felt necessary and/or preferable. Again, documentation of discussion with the specialist will be required for these studies to be arranged.

Accepted Indications for CT Enterography:

-Obscure intestinal blood loss/anemia (chronic or recurrent) in the setting of negative endoscopy and colonoscopy
-Suspected or known small bowel tumors
-New or suspected diagnosis of Crohn's disease

Accepted Indications for MR Enterography:

-Surveillance of known Crohn's disease and non-acute presentations in patients with suspected Crohn's disease at or below the age of 50 years

Accepted Indications for CT Colonography:

1. Symptomatic patients with a concern for neoplasia:

Symptoms suspicious for colorectal neoplasia: change of bowel habit to diarrhea and rectal bleeding in the absence of perianal symptoms, unexplained anemia, iron deficiency, non-acute GI bleeding, unexplained weight loss, recent onset of narrow stool calibre.

2. Asymtomatic patients for screening:

Average risk, >50 years old and asymptomatic. These patients should be encouraged to participate in the provincial screening program. In follow-up of positive screening, CTC may be appropriate if colonoscopy is unavailable, incomplete or contraindicated.

Increased Risk (see below). These patients should be referred to colonoscopy. CTC may be appropriate if colonoscopy is unavailable, incomplete or contraindicated.

CTC may be appropriate for younger patients starting at age 40 who have incomplete colonoscopy or if colonoscopy is contraindicated and the patient is considered to be high risk.

According to the Cancer Care Nova Scotia 2010 Colon Cancer Screening Guidelines, increased risk is defined as follows:

- 1 first degree relative with colorectal cancer or adenoma diagnosed before age 60 or 2 or more second degree relatives with colorectal cancer or adenoma before age 60
- 1 first degree relative with colorectal cancer or adenoma diagnosed in their 60s and 70s or 2 or more second degree relatives with colorectal cancer or adenoma diagnosed in their 60s and 70s
- Personal history of extensive ulcerative or Crohn's colitis (pan-colitis)
- Family history of hereditary non-polyposis colorectal cancer (HNPCC, Lynch Syndrome)
- Family history of familial adenomatous polyposis (FAP)

3. Failed or incomplete colonoscopy or contraindications for or considered at increased risk for complications during colonoscopy (e.g., advanced age, anticoagulant therapy, sedation risk, prior incomplete colonoscopy).

**CTC is not designed for diagnosis or follow-up of inflammatory bowel disease. Endoscopy is the preferred examination in these patients

**CTC should not be performed for 6-8 weeks following colonic biopsy or surgery

Additional information: 2012 CAR Diagnostic Imaging Referral Guidelines