UPPER GASTROINTESTINAL (UGI) TWO WEEK WAIT REFERRALS - COVID 19 UPDATE.

Dear Colleague,

The COVID 19 pandemic has forced a number of restrictions on services and it is essential that we all work together to maintain the integrity and efficiency of the services we offer our patients.

We hope to continue to provide an effective assessment for patients who are likely to benefit from prompt diagnosis of an UGI cancer and, in order to do so, would value co-operation with regard to the following points.

UGI cancer includes oesophago-gastric, pancreatic and hepatobiliary malignancies. Potentially curative treatment for these tumours involves extensive resection or radical chemoradiotherapy. Either modality is associated with significant co-morbidity and a significant mortality.

Whilst there is some merit in achieving a diagnosis for its own sake, during the present pandemic, some consideration must be given the overall benefit to the individual patient in achieving a rapid diagnosis. Patients with extensive co-morbidities and/or frailty, a WHO Performance Status of 3 or higher, or cognitive impairment which means that they lack capacity to give or withhold consent, are unlikely to be considered for anything other than symptom control. For such patients, the benefits of early diagnosis are minimal.

When considering co-morbidity at the time of referral, consideration should be given to the risks of hospital attendance at a time when the COVID 19 virus is present on site. Some patients may be put at a higher overall risk if they are referred at this time, especially for endoscopy.

Furthermore, we must be mindful of the risk of staff exposure to COVID 19 and this risk is higher than average during UGI endoscopy (OGD). Patients who might be at risk of active infection should not be referred for OGD until clear. This group includes those self-isolating because another member of their household is infected. It should be noted that any patient who does have an UGI cancer and who has inter-current COVID 19 infection would not be considered for treatment until confirmed to be infection-free.

Whilst true dysphagia of recent onset is a symptom which normally merits prompt investigation, symptoms which fall into the category of “globus” are not. Similarly, swallowing symptoms which have been present, unchanged, for years in an otherwise well patient are extremely unlikely to be caused by malignancy.

We would ask that referrers from Primary Care consider these principles. Their judicious application will avoid unnecessary referral during this period of increased service pressure.

We would also ask that referrals are made using the relevant electronic proformas and that these are completed in full. In particular, we ask that the sections regarding the history of the presenting complaint and relevant medical history are completed. Some referrals are received which rely solely on a printout of the Primary Care practice record; some may comprise 30 pages or more. It is not reasonable to assume that important clinical information concealed within an extensive problem list is obvious to the recipient. When relevant information is missing, it is likely that the referral will be returned.

Many thanks for your consideration and co-operation.