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TOP 5 Low-value practices and interventions

The Gastroenterological Society of Australia (GESA) sets, promotes and continuously improves the standards of practice, training and research in gastroenterology and hepatology in Australia.

The membership includes Fellows and members of the Royal Australasian College of Physicians and the Royal Australasian College of Surgeons interested in the study of gastroenterology. It also extends to medical graduates, trainees, pathologists, radiologists, scientists, allied health professionals, dietitians, and others interested in the science, study or practice of gastroenterology.

1. **Do not repeat colonoscopies more often than recommended by the National Health and Medical Research Council (NHMRC) endorsed guidelines**

2. **Do not undertake faecal occult blood testing in patients who report rectal bleeding, or require investigation for iron deficiency or gastrointestinal symptoms**

3. **Do not continue prescribing long term proton pump inhibitor (PPI) medication to patients without attempting to reduce the medication down to the lowest effective dose or cease the therapy altogether**

4. **Do not undertake genetic testing for coeliac genes as a screening test for coeliac disease**

5. **Do not perform a follow-up endoscopy less than three years after two consecutive findings of no dysplasia from endoscopies with appropriate four quadrant biopsies for patients diagnosed with Barrett's Oesophagus**

EVOLVE is a physician-led initiative to ensure the highest quality patient care through the identification and reduction of low-value practices and interventions.

EVOLVE is patient-centred and evidence-based, with rigorous and transparent processes. Its focus is to stimulate clinical conversations – between colleagues, across specialties, and with patients – to ensure the care that's delivered is the best for each patient.

EVOLVE is part of a worldwide movement to analyse medical practices and reduce unnecessary interventions. It is an initiative in partnership between the RACP and the Specialty Societies, Divisions, Faculties and Chapters.

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1 Do not repeat colonoscopies more often than recommended by the National Health and Medical Research Council (NHMRC) endorsed guidelines

Colonoscopy, with or without polypectomy, is an invasive procedure with a small but not insignificant risk of complications, including perforation or major haemorrhage post-polypectomy, depending on size of lesion. Surveillance colonoscopies place a significant burden on endoscopy services. Consequently, surveillance colonoscopy should be targeted at those who are most likely to benefit and at the minimum frequency required to provide adequate protection against the development of cancer.

Cancer Council Australia guidelines, endorsed by NHMRC, state that if one to two adenomas less than one cm in diameter are removed via a high quality colonoscopy, a follow up interval of five years is recommended. For larger adenomas, three or more adenomas or adenomas containing villous features or high grade dysplasia, which are removed via a high quality colonoscopy, the recommended follow-up period is three years.

2 Do not undertake faecal occult blood testing in patients who report rectal bleeding, or require investigation for iron deficiency or gastrointestinal symptoms

The faecal occult blood test (FOBT) was developed for use in the outpatient setting for colorectal cancer screening in asymptomatic patients with average risk of colorectal carcinoma.

Studies suggest that it has limited positive impact for hospitalised patients who report rectal bleeding or require investigation for iron deficiency or gastrointestinal symptoms, as it is unlikely to change patient management and may in fact delay investigations while waiting for the results of the test.

Inappropriate use of the FOBT may lead to unnecessary additional investigations (e.g. colonoscopy), which also carries risks and may limit the availability of such investigations for more appropriate indications.

3 Do not continue prescribing long term proton pump inhibitor (PPI) medication to patients without attempting to reduce the medication down to the lowest effective dose or cease the therapy altogether

While proton pump inhibitors (PPIs) are effective drugs for the treatment of gastroesophageal reflux disease (GERD), their use has been linked to increased risk of fractures, pneumonia, enteric infections, vitamin and mineral deficiencies, and acute interstitial nephritis, particularly among older people who make up the largest proportion of PPI users.

While there is insufficient evidence to establish causation, these reports deserve consideration when prescribing long term PPI use. This is especially because some patients may be able to stop PPI use immediately after the initial course of therapy without experiencing symptoms. Even though GERD is often a chronic condition, over time the disease may not require acid suppression and it is important that patients do not take drugs that are no longer necessary.

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4 Do not undertake genetic testing for coeliac genes as a screening test for coeliac disease

The value of testing for coeliac genes is primarily as a negative test – if the gene test is negative then coeliac disease may be excluded. However as a coeliac gene can be found in approximately one third of the population, a positive result does not make coeliac disease a certainty.

Serological testing, in a patient consuming an appropriate amount of gluten, is the appropriate first line screening test for coeliac disease. A small bowel biopsy is then required if serology is positive.

5 Do not perform a follow-up endoscopy less than three years after two consecutive findings of no dysplasia from endoscopies with appropriate four quadrant biopsies for patients diagnosed with Barrett's Oesophagus

Barrett's Oesophagus (or Barrett's mucosa) is the term given to a change which occurs in the lining of the lower oesophagus. It occurs in a small proportion of patients with longstanding gastro-oesophageal reflux. The condition requires surveillance because of an increased risk of oesophageal adenocarcinoma (EAC). This usually develops slowly over a period of some years and can be predicted by the finding of pre-cancerous changes (dysplasia) on biopsies.

However, systematic surveillance of Barrett's Oesophagus patients has not been shown to be cost-effective, and no randomised controlled trials have been conducted to compare surveillance with the natural history of Barrett's Oesophagus. According to currently-accepted guidelines, it is appropriate and safe to examine the oesophagus and check for dysplasia every three years, as cellular changes occur very slowly.

How this list was developed….

The Gastroenterological Society of Australia (GESA) initially engaged its members through its regular online communications, sharing the aims of the EVOLVE initiative, as well as background information on the US and Canadian versions of Choosing Wisely. Members were provided with a copy of the five recommendations made by the American Gastroenterology Association. GESA also consulted externally, with the EVOLVE Lead Fellow addressing the GUT club and the Inflammatory Bowel Disease Group on the initiative.

All members of GESA were invited to submit proposed items for the Top 5 list. The GESA Council reviewed all items before reaching consensus on the recommended final list.

A review of the evidence for the shortlisted items was then undertaken and the final list and its rationales were signed off by the GESA Council in May 2016.

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Gastroenterological Society of Australia – Top 5 recommendations

EVIDENCE SUPPORTING RECOMMENDATION 1

Cancer Council Australia, 'Clinical Practice Guidelines for Surveillance Colonoscopy', December 2011

Winawer et al, 'Randomized comparison of surveillance intervals after colonoscopic removal of newly diagnosed adenomatous polyps', The National Polyp Study Workgroup. N Engl J Med 1993;328(13): 901-906

EVIDENCE SUPPORTING RECOMMENDATION 2

Friedman et al, 'Use and Abuse of Faecal Occult blood tests in an acute hospital patient setting', Int Med Journal Vol 40, Issue 2 pages 107 - 111, Feb 2010

Ip et al, 'Use of fecal occult blood testing in hospitalized patients: Results of an audit', Can J Gastroenterol Hepatol. 2014 Oct; 28(9): 489–494

Sharma et al, 'An audit of the utility of in-patient fecal occult blood testing', Am J Gastroenterol. 2001 Apr; 96(4):1256-60

EVIDENCE SUPPORTING RECOMMENDATION 3

Choudhry et al, 'Overuse and inappropriate prescribing of proton pump inhibitors in patients with Clostridium difficile-associated disease', QJM 2008;101:445–8

Hollingworth et al 2010, 'Marked increase in proton pump inhibitors use in Australia', Pharmacoepidemiol Drug Saf 2010;19:1019–24

NICE, 'Gastro-oesophageal reflux disease and dyspepsia in adults: investigation and management', Clinical guideline 3 September 2014

EVIDENCE SUPPORTING RECOMMENDATION 4

Fasano and Catassi, 'Celiac disease', NEJM 367:2419 Dec 20 2012

Megiorni and Pezutti, 'HLA-DQA1 and HLA-DQB1 in Celiac disease predisposition: practical implications of the HLA molecular typing', J Biomed Sci. 2012; 19(1): 88

EVIDENCE SUPPORTING RECOMMENDATION 5

Spechler and Souza, 'Barrett's Esophagus', NEJM 371:836 August 28, 2014

Shaheen et al, 'ACG Clinical Guideline: Diagnosis and Management of Barrett's Esophagus', Am J Gastroenterol. 2015 Nov 3. doi: 10.1038/ajg.2015.322

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