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Colonoscopy changes: a primer for GPs

On 1 November 2019, the government decided to change the colonoscopy MBS numbers from two to eight numbers with a separate number for polypectomy, due to the variation in colonoscopy practice. They adhere closely to the NHMRC guidelines, however problems remain in both the MBS and the guidelines. This primer is to help GPs understand the changes. **Box 1 is a summary of this.**

Box 1. Quick Summary

- Patients will only be eligible for a diagnostic colonoscopy if they have an indication such as symptoms, abnormal imaging, +ve FOBT, anaemia or iron deficiency. Please include their indication in any referrals that you send.
- Screening colonoscopy is reserved for moderate to high-risk family history
- Most patients will have 5-10 yearly surveillance for polyps unless they have high risk features where more regular colonoscopy is allowed.

Box 2. Moderate risk family history

- One 1st degree relative under 60 years OR
- Two 1st degree relatives of any age OR
- One 1st degree relative & one or more 2nd degree relatives of any age

High risk family history

- At least three 1st degree relatives of any age OR
- At least two 1st degree and one 2nd degree relatives with one diagnosed before age 50 OR
- At least two 1st degree and 2nd degree relatives

Both sides of the family are counted together.

1) Colonoscopy has been removed as a screening tool for average risk patients

Due to changes in the MBS numbers, it is now difficult for patients to receive a Medicare (or private insurance) funded colonoscopy for pure screening. Although this is not consistent with current international guidelines that would suggest that FOBT, flexible sigmoidoscopy and colonoscopy are all useful screening tools, this is the current government decision. Therefore patients who have previously received 5-10 yearly colonoscopy with no history of polyps will struggle to have funded colonoscopies, although they could pay the entire cost themselves.

Patients with a moderate risk or high risk (see Box 2) can have a colonoscopy every 5 years. This should start at the age of 50, or 10 years before the youngest relative's diagnosis. Another change is that both sides of the family are counted together ie. total number of affected relatives across both maternal/paternal sides. Those with a suspected or known genetic syndrome should have colonoscopy yearly or 2-yearly.

There is a catch-all MBS number, 32228, which allows provision for a colonoscopy without indication. The problem with this number is that it can only be used once in their lifetime. Therefore, for instance, if a 20-year-old patient has a colonoscopy using this number, it cannot ever be used again for this patient.

2) Strict guidelines as to the indication for initial colonoscopy

The MBS number for a diagnostic colonoscopy with an indication is 32222. Indications include:

- Symptoms "consistent with mucosal abnormality" such as PR bleeding, abdominal pain etc.
- A positive FOBT, anaemia or iron deficiency (without anaemia) or abnormal imaging

Other lesser used indications include: preoperative evaluation, post-cancer surveillance, previous poor bowel preparation or in the management of inflammatory bowel disease. In short, if you feel that a patient should have colonoscopy on clinical grounds, please include their indication in your referral.

3) Changes to surveillance intervals for colonoscopy

Patients with minimal adenomas will get colonoscopies every 5-10 years. Only those with 5-9 adenomas, polyp >1cm, villous polyps, high-grade dysplasia or advanced serrated adenomas will receive colonoscopies 3-yearly. Yearly or more regular colonoscopy is reserved only for patients with >10 adenomas or piecemeal excision.

Conclusion

Unfortunately, there are still holes in the system. E.g. patients after cancer resection are meant to have 3-yearly colonoscopies, but now are only eligible 5-yearly colonoscopies, while patients with advanced adenomas will get colonoscopy 3-yearly; and family history of polyps. It is up to GPs, colorectal surgeons and gastroenterologists to help their patients to navigate these changes while submissions are made to the review committee for change.

If you have questions, please email me on raymondjyap@crsurgery.com.au or call on 8376 6429.