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Evidence-based Interventions – Wave two

Diagnostics Two: Gastroenterology, Urology and Pathology

Introduction from Helen Stokes-Lampard, Chair of the Academy of Medical Royal Colleges

Prof Sir Terence Stephenson
Prof Martin Marshall
Dr Aoife Molloy

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Important messages

Patient empowerment and improving shared decision-making

National EBI guidance provides recommendations on gold-standard care, but this should still be tailored to individuals. Each patient should have an individual-level discussion with their doctor and supported in shared decision-making for their own treatment and care.

Prioritisation of care to support COVID-19 recovery and reduce patient harm

EBI guidance is based on NICE and NICE-accredited guidance and makes up to date recommendations based on the best available evidence. Implementation of the EBI guidance can aid national plans for COVID-19 recovery by supporting decision-making.

Access to evidence-based tests, treatments and procedures

Due to the increased pressures on the health and care system following the COVID-19 pandemic access to health and social care may be reduced, including for the interventions we are proposing and their alternatives (for example, physiotherapy and community based care). We are working with NICE, patients and clinicians to ensure the best available evidence is put into practice and patients have the best possible outcomes.

Data analysis

Measuring uptake of guidance is always challenging. We are continuously improving our data analysis and feedback in collaboration with NHS Digital, GIRFT, HQIP and commissioners and CSUs and welcome any suggestions you can share with us.

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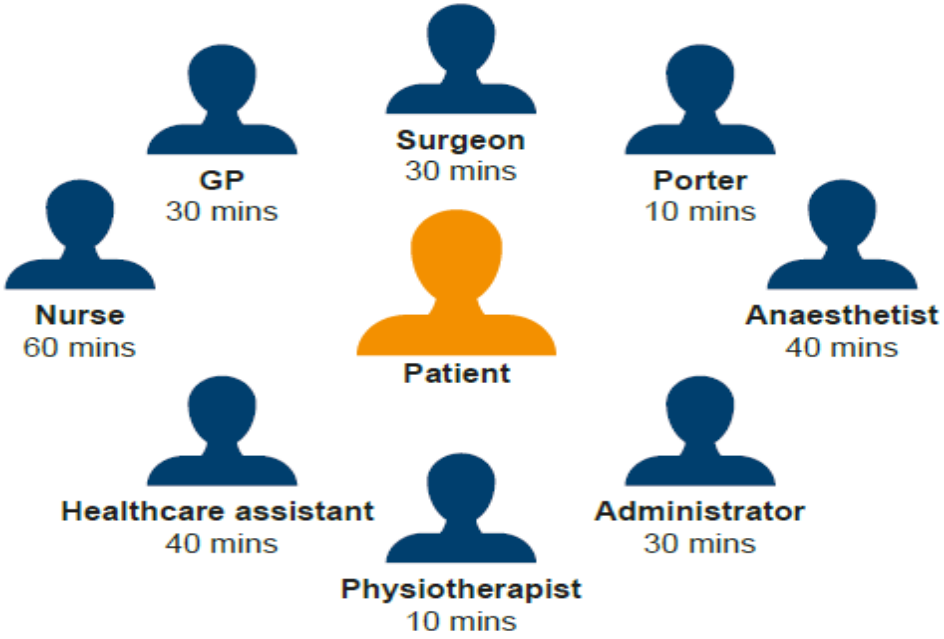
Knee arthroscopy for patients with osteoarthritis

Knee arthroscopy should be not be used as treatment for osteoarthritis because it is clinically ineffective



Average NHS time taken for 1 procedure: 370mins per patient
In 2017/18 we carried out 3,432 procedures which amounts to 881 days

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The independent Expert Advisory Committee

A clinically-led Expert Advisory Committee was established in May 2019 to provide independent leadership, advice and guidance to the EBI programme.

Committee membership

Chairs

- Professor Sir Terence Stephenson, Chair of the Health Research Authority
- Professor Martin Marshall, Chair of the Royal College of General Practitioners

Membership includes

- Patient voices
- Senior clinicians
- Experts on public health
- Clinical commissioners
- Experts on value in healthcare
- Guideline producers

Committee mandate

The committee was asked to

- Recommend a list of interventions proven to be inappropriate based on clinical evidence
- Draft clinical guidance based on rigorous evidence and stakeholder consensus
- Lead engagement programme with relevant Medical Royal Colleges and sub-specialty groups, patient groups and the public
- Maximise implementation of evidence-based guidance

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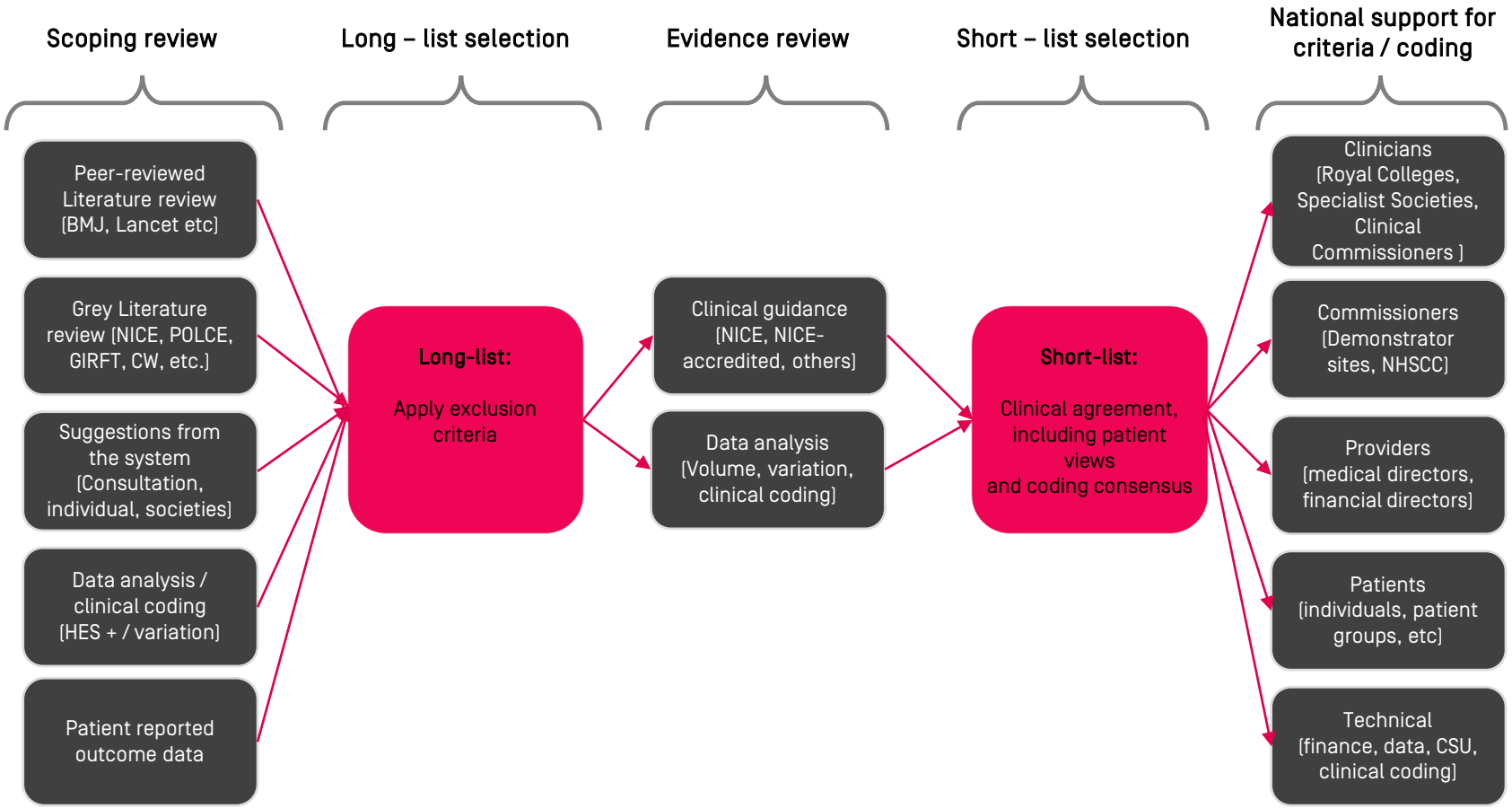
Selecting interventions

Process for shortlisting



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Stakeholder engagement

We have worked with many clinical and patient stakeholder groups over the past year and would welcome continued feedback and input as we continue to develop the guidance now.

Medical Royal Colleges
Royal College of Anaesthetists
Royal College of General Practitioners
Royal College of Paediatrics & Child Health
Royal College of Pathologists
Royal College of Physicians
Royal College of Radiologists
Royal College of Surgeons of England and Federation of Surgical Societies
Patient organisations
Bladder Health UK
Versus Arthritis
Prostate Cancer UK
GUTS UK
Chartered Society of Physiotherapists
British Heart Foundation

Sub-speciality groups
Association of Surgeons of Great Britain & Ireland
Association of Upper Gastrointestinal Surgeons of Great Britain and Ireland
British Association for Paediatric Otolaryngology
British Association of Perinatal Medicine
British Association of Otorhinolaryngology (ENT UK)
British Association of Urological Surgeons
British Blood Transfusion Society
British Cardiology Society
British Medical Ultrasound Society
British Orthopaedic Association inc. BASK, BASS, BESS, BHS
British Society of Cardiovascular Imaging/ Cardiac Computed Tomography

Sub-speciality groups
British Society of Cardiovascular Imaging and British Society of Cardiac Computed Tomography
British Society of Gastroenterologists
British Society of Gastrointestinal and Abdominal Radiology
British Society of Haematology
British Society of Interventional Radiology
British Society of Thoracic Imaging
Craniofacial Society of GB&I
Great Britain and Ireland Hepato Pancreato Biliary Association
Faculty of Pain Medicine
Pancreatic Society of GB&I
Society of British Neurological Surgeons

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Participate in the engagement and next steps

There have been several online events so the public can comment on the proposals. We would encourage you to get in touch for access to the slides if you couldn't make the earlier events.

Engagement events

- Today is the final of three intervention-focused events looking at 8 proposals on investigative interventions

Slides are available for the previous intervention-focused events which were

- 4 Aug, surgery and devices
- 11 August, cardiology and radiology diagnostics

Additionally there will be

- Data-focused event (19 August)
- Three patient-focused workshops led by the Patients Association
- Post-engagement review (22 Sept)

Please get in touch at ebi@aomrc.org.uk if you have any comments/ questions on the proposals.

Next steps

- All responses to the engagement will be considered and analysed
- A final recommendation will be submitted to the EBI programme partners by the Committee

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Proposals for 31 interventions

The focus of today's webinar are diagnostic interventions. You can still use Slido to choose the intervention(s) you would like to talk about more later.

- Diagnostic coronary angiography for low risk, stable chest pain
- Repair of minimally symptomatic inguinal hernia
- Surgical intervention for chronic sinusitis
- Removal of adenoids
- Arthroscopic surgery for meniscal tears
- Troponin test
- Surgical removal of kidney stones
- **Cystoscopy for men with uncomplicated lower urinary tract symptoms**
- Surgical intervention for benign prostatic hyperplasia
- Discectomy
- Radiofrequency facet joint denervation
- Exercise ECG for screening for coronary heart disease
- **Upper GI endoscopy**
- **Appropriate colonoscopy**
- **Repeat colonoscopy**
- **ERCP in acute gallstone pancreatitis without cholangitis**
- Cholecystectomy
- Appendicectomy without confirmation of appendicitis
- Low back pain imaging
- Knee MRI when symptoms are suggestive of osteoarthritis
- Knee MRI for suspected meniscal tears
- Vertebroplasty for painful osteoporotic vertebral fractures
- Imaging for shoulder pain
- MRI scan of the hip for arthritis
- Fusion surgery for mechanical axial low back pain
- Helmet therapy for treatment of positional plagiocephaly/ brachycephaly in children
- Pre-operative chest x-ray
- Pre-operative ECG
- **Prostate-specific antigen (PSA) test**
- **Liver function, creatinine kinase and lipid level tests – (Lipid lowering therapy)**
- **Blood transfusion**

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8 interventions

Webinar Three

Diagnostics two

Gastroenterology

Urology

Pathology

Gastroenterology

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Endoscopy to investigate gut problems

Upper GI endoscopy should not be used as first-line for investigation of suspected gastrointestinal disease (Group A)

Rationale

Upper GI endoscopy should not be used as the first-line investigation in all patients. Endoscopy is an invasive procedure that is not always well tolerated and carries significant risks. Endoscopy should be offered only as recommended in guidance from NICE and the British Society for Gastroenterology which are incorporated in this guidance.

Non-invasive tests and procedures such as urea breathe testing or stool antigen testing should instead be used as first-line investigation where appropriate.

Avoidable harms

Risk of infection, bleeding, internal tearing/piercing

Alternatives

Non-invasive tests e.g. urea breathe test, stool antigen

Wider impacts

It is important not to impede access for patients who need upper GI endoscopy for appropriate diagnosis, therefore its important that our messaging is aligned with the British Society of Gastroenterology to ensure evidence-based recommendations are implemented

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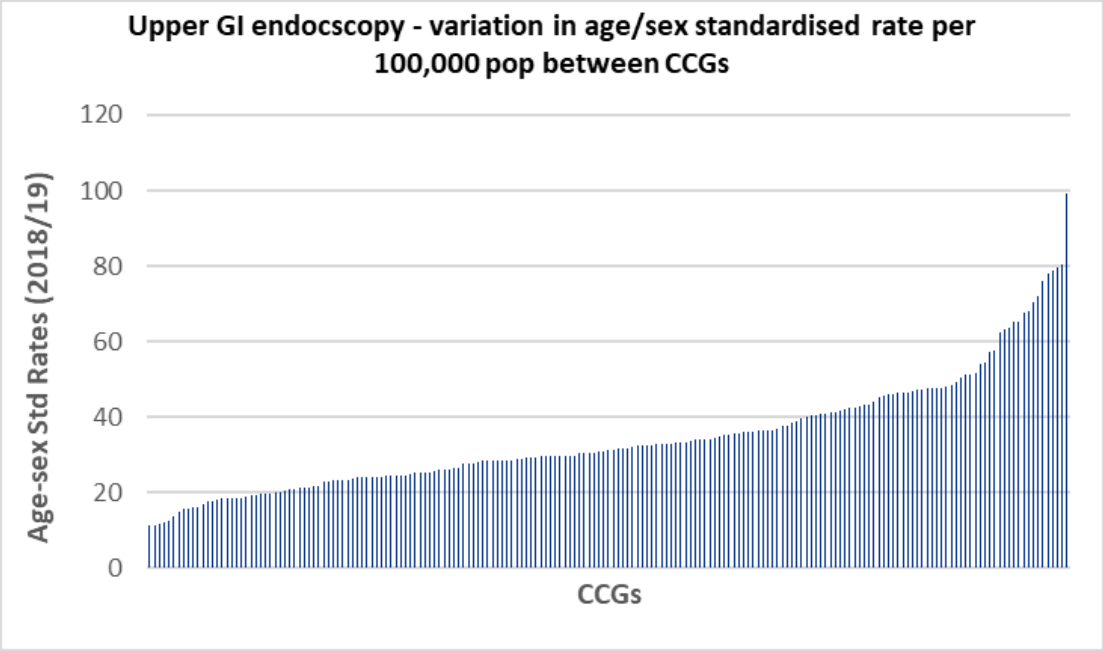
Endoscopy to investigate gut problems

Upper GI endoscopy should not be used as first-line for investigation of suspected gastrointestinal disease (Group A)



Activity

- 20,772 episodes during 2018/19
- Age/sex std rate per 100,000 – 35.0
- Reduction opportunity: 6,966 (34%) based on 25th percentile of activity across CCGs.

Variation

Variation (age/sex std rates):

- N-fold – 2.7
  - 10th percentile – 19.4
  - 25th percentile – 24.7
  - 50th percentile – 31.6
  - 90th percentile – 52.3

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Colonoscopy of the lower intestine

Colonoscopy should only be offered to at risk people identified through risk stratification (Group B)

Rationale

Colonoscopy should not be used as first-line investigation in all patients. Colonoscopy is an invasive procedure which carries a small risk of serious complications, for example intestinal perforation. Colonoscopy should be offered only as recommended by British Society for Gastroenterology which is incorporated in this guidance.

Risk stratification is instead recommended to identify at-risk patients, and non-invasive tests and other procedures such as a Faecal Immunochemical Test (FIT test) should be used as a first-line investigation where appropriate.

Avoidable harms

Risk of infection, bleeding, internal tearing/piercing

Alternatives

Risk stratification, non-invasive tests e.g. FIT tests

Wider impacts

It is important not to impede access for patients who need colonoscopy for appropriate diagnosis, therefore its important that our messaging is aligned with the British Society of Gastroenterology to ensure evidence-based recommendations are implemented

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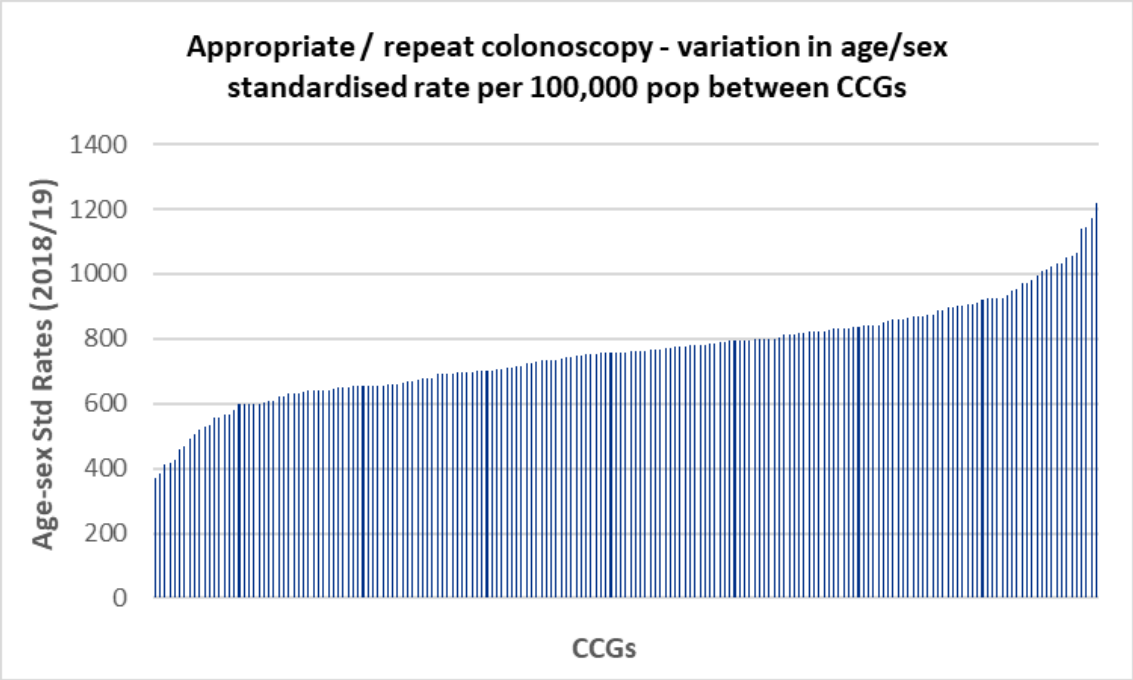
Colonoscopy of the lower intestine

Colonoscopy should only be offered to at risk people identified through risk stratification (Group B)



Activity

- 445,981* episodes during 2018/19
- Age/sex std rate per 100,000 – 750.7
- Reduction opportunity based on 25th percentile of activity across CCGs: not calculated

Variation

Variation (age/sex std rates):

- N-fold – 1.5
  - 10th percentile – 598.3
  - 25th percentile – 657.5
  - 50th percentile – 758.2
  - 90th percentile – 927.1

* This number represents colonoscopies for all indications, including those with symptoms and/or risk factors.

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Follow up colonoscopy of the lower intestine

Surveillance colonoscopy should only be offered to at risk people identified through risk stratification (Group B)

Rationale

Surveillance colonoscopy is not always recommended following surgical resection of colorectal lesions. Colonoscopy is an invasive procedure which carries a small risk of serious complications, for example intestinal perforation.

Surveillance colonoscopy should be offered only as recommended by the British Society for Gastroenterology which is incorporated in this guidance. Instead, risk stratification is recommended to identify patients who require follow up colonoscopy.

Avoidable harms

Risk of infection, bleeding, internal tearing/piercing

Alternatives

Risk stratification

Wider impacts

There are many campaigns to increase awareness of bowel conditions, therefore its important that our messaging is aligned with the British Society of Gastroenterology and national screening programme to avoid confusion and ensure recommendations are implemented

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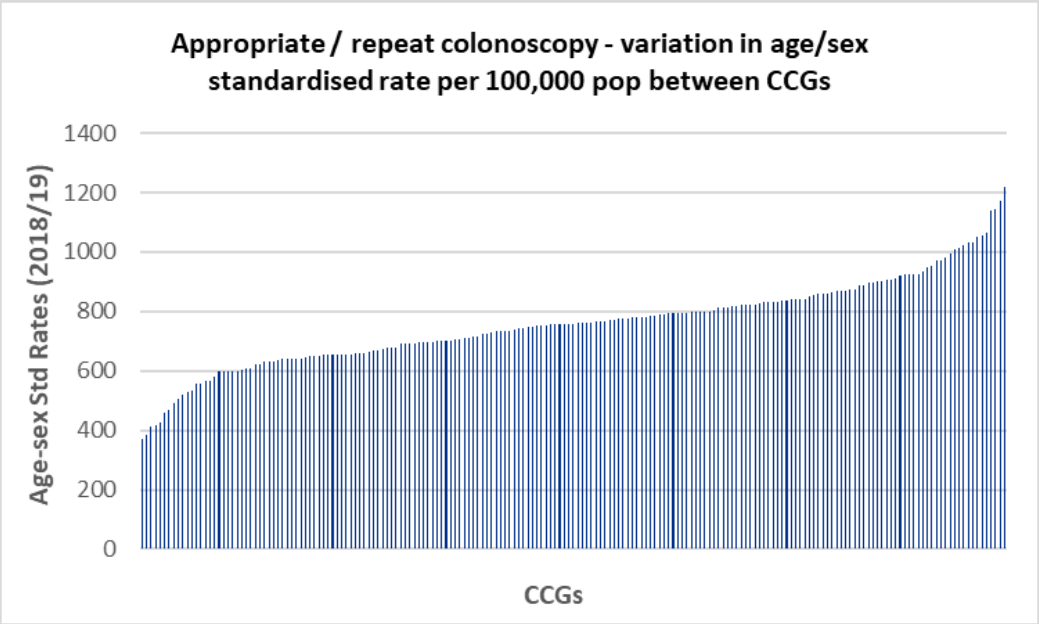
Follow up colonoscopy of the lower intestine

Surveillance colonoscopy should only be offered to at risk people identified through risk stratification (Group B)



Activity

- 445,981* episodes during 2018/19
- Age/sex std rate per 100,000 – 750.7
- Reduction opportunity based on 25th percentile of activity across CCGs: not calculated

Variation

Variation (age/sex std rates):

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  - 10th percentile – 598.3
  - 25th percentile – 657.5
  - 50th percentile – 758.2
  - 90th percentile – 927.1

* This number represents colonoscopies for all indications, including those with symptoms and/or risk factors.

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Test of the gallbladder

Early endoscopic retrograde cholangiopancreatography (ERCP) is not indicated for investigation of acute gallstone pancreatitis without cholangitis (Group B)

Rationale

Early ERCP should not be used in the investigation of acute gallstone pancreatitis where there is no evidence of cholangitis or ongoing obstruction of the biliary tree. ERCP is a highly invasive procedure and includes the risks associated with ERCP such as pancreatitis and bleeding.

Clinical observation is instead recommended as many gallstones are passed spontaneously. If there is clinical deterioration, delayed ERCP may be indicated.

Avoidable harms

Pancreatitis, bleeding

Alternatives

Clinical observation

Wider impacts

Potentially detrimental to the diagnosis of acute or deteriorating pancreatitis, therefore its important that clinical acumen takes precedence to ensure patients receive appropriate evidence-based care and none are disadvantaged

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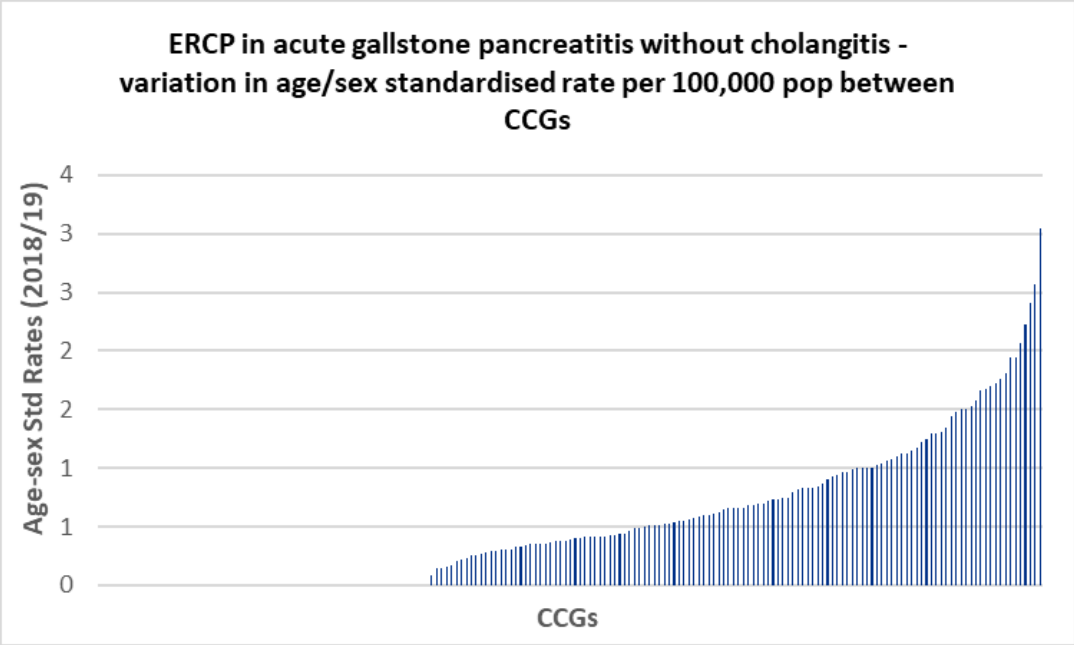
Test of the gallbladder

Early endoscopic retrograde cholangiopancreatography (ERCP) is not indicated for investigation of acute gallstone pancreatitis without cholangitis (Group B)



Activity

- 310 episodes during 2018/19
- Age/sex std rate per 100,000 – 0.5
- Reduction opportunity based on 25th percentile of activity across CCGs: not calculated.

Variation

Variation (age/sex std rates):

- N-fold – not calculated
  - 10th percentile – 0.0
  - 25th percentile – 0.0
  - 50th percentile – 0.4
  - 90th percentile – 1.3

- For interventions where the age-sex standardised rate in the 10th percentile is zero, the n-fold variation was not calculated.

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Further questions on gastroenterology interventions?

Please share your comments or ask us any questions using the MS Teams comments box and we will do our best to answer

We're especially interested to hear about:

1. Any suggested changes to the guidance
2. Whether you have any data and supporting evidence you would like to send to ebi@aomrc.org.uk
3. Any impact to access, experience and outcomes for any group protected under the Equality Act 2010 or for individuals who experience health inequalities?

Urology

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Camera test of the bladder in men

Cystoscopy for men with uncomplicated lower urinary tract symptoms (LUTS) should only be offered according to this guidance (Group A)

Rationale

Cystoscopy should not be offered routinely offered to men with LUTS. Cystoscopy can cause temporary discomfort, occasionally pain and haematuria and is associated with a small risk of infection.

Assessment of men with LUTS should initially focus on a thorough history and examination, complemented by use of a frequency – volume chart, urine dipstick analysis and International Prostate Symptom Score where appropriate. This assessment may be initiated in primary care settings.

Avoidable harms

Temporary discomfort, occasionally pain and haematuria, small risk of infection

Alternatives

Clinical assessment, volume chart, urine dipstick, International Prostate Symptom Score

Wider impacts

It is important that we ensure continued awareness of men's health, therefore our messaging is aligned with Prostate Cancer UK and we will continue to work men's health press

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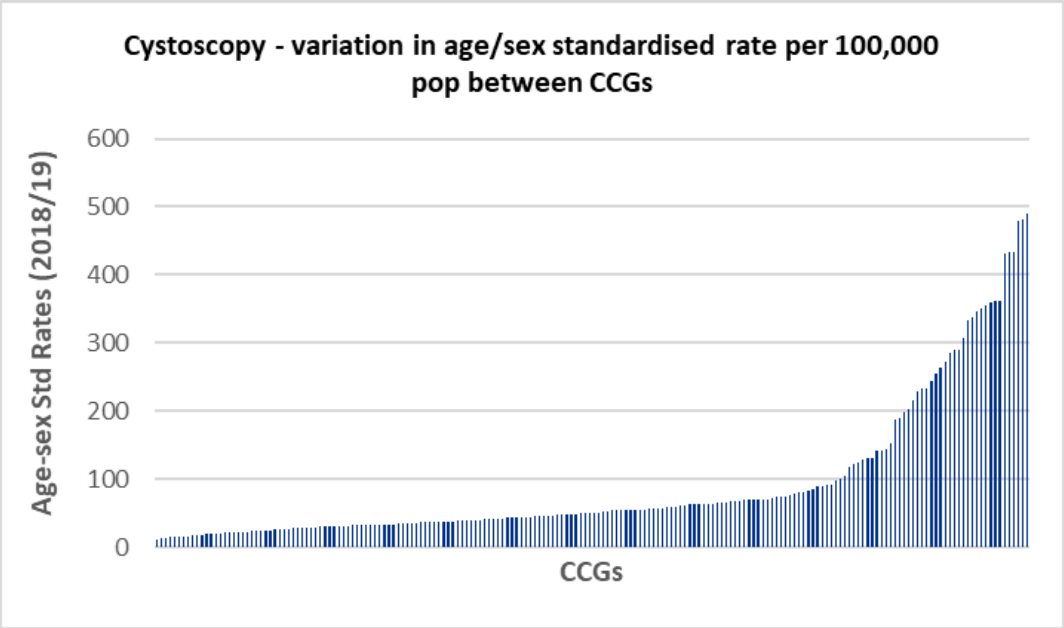
Camera test of the bladder in men

Cystoscopy for men with uncomplicated lower urinary tract symptoms (LUTS) should only be offered according to this guidance (Group A)



Activity

- 50,685 episodes during 2018/19
- Age/sex std rate per 100,000 – 85.3
- Reduction opportunity: 31,687 (63%) based on 25th percentile of activity across CCGs.

Variation

Variation (age/sex std rates):

- N-fold – 11.7
  - 10th percentile – 22.6
  - 25th percentile – 33.6
  - 50th percentile – 50.8
  - 90th percentile – 264.5

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Further questions on urology interventions?

Please share your comments or ask us any questions using the MS Teams comments box and we will do our best to answer

We're especially interested to hear about:

1. Any suggested changes to the guidance
2. Whether you have any data and supporting evidence you would like to send to ebi@aomrc.org.uk
3. Any impact to access, experience and outcomes for any group protected under the Equality Act 2010 or for individuals who experience health inequalities?

Pathology

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Prostate-specific antigen (PSA) testing

PSA testing in asymptomatic patients is not recommended (Group C)

Rationale

Routine PSA testing in asymptomatic men is not recommended. This is because the benefits have not been shown to clearly outweigh the harm and testing is known to be associated with potential harms including overdiagnosis, infection and complications of treatment for indolent disease. There is also a high risk of false positives.

Where PSA testing is clinically indicated, or requested by the patient, there should (ideally) first be a digital rectal examination, and after careful discussion about the potential risks and benefits of PSA testing which allows for shared decision making, a PSA blood test.

Avoidable harms

Unnecessary investigations, complications of unnecessary treatment, increased anxiety, infection

Alternatives

Physical examination

Wider impacts

It is important that we ensure continued awareness of men's health, therefore our messaging is aligned with Prostate Cancer UK and we will continue to work men's health press

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Regular blood tests when taking cholesterol lowering tablets

Blood analysis for patients taking lipid lowering therapy should be performed in accordance with evidence-based guidance (Group C)

Rationale

Creatine Kinase Testing: Routine monitoring of creatine kinase is not indicated in asymptomatic people who are taking lipid lowering therapy.

Liver Function Testing: Routine monitoring of liver function tests in asymptomatic people is not indicated after 12 months of initiating lipid lowering therapy.

Lipid Testing : Routine monitoring of lipid levels is not always indicated in asymptomatic people after three months of initiating lipid lowering therapy.

Consider an annual non-fasting blood test for non-HDL cholesterol to inform discussion.

Avoidable harms

Unnecessary investigations, increased anxiety

Alternatives

Clinical assessment

Wider impacts

Its difficult to quantify the benefits of avoiding unnecessary blood tests, therefore its important to work relevant stakeholders to align messaging and develop metrics for measurement where possible

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Blood transfusions

Red blood cell (RBC) transfusions should only be given where indicated and then in single-units unless there are exceptional circumstances (Group C)

Rationale

Blood transfusion may be indicated where a patient has a shortage of RBC. NICE recommends restrictive thresholds and single-unit RBC transfusion for adults (or equivalent based on body weight for children or adults with low body weight) who are not actively bleeding, do not have acute coronary syndrome or need regular blood transfusions for chronic anaemia. Restrictive thresholds do not apply to some patients as described in this guidance

Avoidable harms

Pulmonary complications, volume overload, haemolysis, allergy, transmission of infection

Alternatives

Follow recommended guidelines

Wider impacts

Its difficult to quantify the benefits of avoiding unnecessary blood transfusions, therefore its important to work with the British Blood Transfusion society and other relevant organisations to align messaging and develop metrics for measurement where possible

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Further questions on pathology?

Please share your comments or ask us any questions using the MS Teams comments box and we will do our best to answer

We're especially interested to hear about:

1. Any suggested changes to the guidance
2. Whether you have any data and supporting evidence you would like to send to ebi@aomrc.org.uk
3. Any impact to access, experience and outcomes for any group protected under the Equality Act 2010 or for individuals who experience health inequalities?

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Recap

Share your views / ask questions

Let's recap on the interventions looking at the questions below – please use MS Teams chat function to send your questions or feedback.

1. Do you have any suggested changes to the guidance?

2. Do you have any suggested changes or updates to the data, if so, could you send us supporting evidence?

3. Do you think there will be a negative or positive impact to access, experience and outcomes for any group protected under the Equality Act 2010 or for individuals who experience health inequalities?

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Thank you for your time, we would appreciate your feedback on the webinar https://www.surveymonkey.co.uk/r/88XBW3R

Please share any further views or comments, including suggestions for future guidance

Email us ebi@aomrc.org.uk or complete the online survey available at www.aomrc.org.uk/ebi