2 Week Rule Referral Guidelines – Upper GI

www.nice.org.uk/CG027

Upper gastrointestinal cancer

General recommendations

A patient who presents with symptoms suggestive of upper gastrointestinal cancer should be referred to a team specialising in the management of upper gastrointestinal cancer, depending on local arrangements. **D**

Specific recommendations

An urgent referral for endoscopy or to a specialist with expertise in upper gastrointestinal cancer should be made for patients of any age with dyspepsia[1] who present with any of the following: **C**

- chronic gastrointestinal bleeding
- dysphagia
- progressive unintentional weight loss
- persistent vomiting
- iron deficiency anaemia
- epigastric mass
- suspicious barium meal result.

In patients aged 55 years and older with unexplained[2] and persistent recent-onset dyspepsia alone, an urgent referral for endoscopy should be made. **D**

In patients aged less than 55 years, endoscopic investigation of dyspepsia is not necessary in the absence of alarm symptoms. **D**

In patients presenting with dysphagia (interference with the swallowing mechanism that occurs within 5 seconds of having commenced the swallowing process), an urgent referral should be made. **C**

Helicobacter pylori status should not affect the decision to refer for suspected cancer. **C**

---

[1] The definition of dyspepsia is taken from the NICE guideline on *Dyspepsia: management of dyspepsia in adults in primary care* (www.nice.org.uk/CG017). Dyspepsia in unselected patients in primary care is defined broadly to include patients with recurrent epigastric pain, heartburn or acid regurgitation, with or without bloating, nausea or vomiting.

[2] In this guideline, unexplained is defined as 'a symptom(s) and/or sign(s) that has not led to a diagnosis being made by the primary care professional after initial assessment of the history, examination and primary care investigations (if any)'. In the context of this recommendation, the primary care professional should confirm that the dyspepsia is new rather than a recurrent episode and exclude common precipitants of dyspepsia such as ingestion of NSAIDs.

In patients without dyspepsia, but with unexplained weight loss or iron deficiency anaemia, the possibility of upper gastrointestinal cancer should be recognised and an urgent referral for further investigation considered. **C**

In patients with persistent vomiting and weight loss in the absence of dyspepsia, upper gastro-oesophageal cancer should be considered and, if appropriate, an urgent referral should be made. **C**

An urgent referral should be made for patients presenting with either: **C**

- unexplained upper abdominal pain and weight loss, with or without back pain, or
- an upper abdominal mass without dyspepsia.

In patients with obstructive jaundice an urgent referral should be made, depending on the patient's clinical state. An urgent ultrasound investigation may be considered if available. **C**

Risk factors

In patients with unexplained worsening of their dyspepsia, an urgent referral should be considered if they have any of the following known risk factors: **C**

- Barrett's oesophagus
- known dysplasia, atrophic gastritis or intestinal metaplasia
- peptic ulcer surgery more than 20 years ago.

Investigations

Patients being referred urgently for endoscopy should ideally be free from acid suppression medication, including proton pump inhibitors or H_2 receptor antagonists, for a minimum of 2 weeks. **C**

In patients where the decision to refer has been made, a full blood count may assist specialist assessment in the outpatient clinic. This should be carried out in accordance with local arrangements. **D**

All patients with new-onset dyspepsia should be considered for a full blood count in order to detect iron deficiency anaemia. **D**