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Evidence-Based Series 15-6

A Quality Initiative of the
Program in Evidence-Based Care (PEBC), Cancer Care Ontario (CCO)

Gastroscopy Following a Positive Fecal Occult Blood Test and Negative Colonoscopy

J. Allard, R. Cosby, M.E. Del Giudice, E.J. Irvine, D. Morgan, and J. Tinmouth

Report Date: March 30, 2009

An assessment conducted in November 2013 deferred the review of placed Evidence-based Series 15-6, which means that the document remains current until is assessed again next year..

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Section 1: Guideline Recommendations
Section 2: Evidentiary Base
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Evidence-Based Series 15-6: Section 1

Gastroscopy Following a Positive Fecal Occult Blood Test and Negative Colonoscopy: Guideline Recommendations

J. Allard, R. Cosby, M.E. Del Giudice, E.J. Irvine, D. Morgan, and J. Tinmouth

A Quality Initiative of the Upper GI Screening Panel and the
Program in Evidence-Based Care (PEBC), Cancer Care Ontario (CCO)

Report Date: March 30, 2009

QUESTION

Should gastroscopy for upper gastrointestinal (UGI) cancer be performed for patients with a positive fecal occult blood test (FOBT) and negative colonoscopy who are participating in a population-based colorectal cancer (CRC) screening program?

TARGET POPULATION

This guideline is targeted toward men and women who participate in a CRC screening program and have had a positive FOBT followed by colonoscopy without identifiable colonic lesions to account for their positive FOBT.

INTENDED USERS

The intended users of this guidance document are health professionals involved in the screening, diagnosis, treatment, and follow up of persons enrolled in a population-based CRC screening program. This may include gastroenterologists, family physicians, surgeons, and other health care professionals.

RECOMMENDATIONS AND KEY EVIDENCE

Recommendation

The current body of evidence is insufficient to recommend for or against, in a population-based CRC screening program, routine esophagogastroduodenoscopy (EGD) in FOBT positive/colonoscopy negative patients to detect gastric or esophageal cancers. The decision to undertake an EGD should be based on clinical judgement and should be individualized.

Key Evidence

- Four prospective (1-4) and five retrospective (5-9) studies of patients who were FOBT positive/colonoscopy negative and had an EGD. Of these, two studies (4,9) reported positive EGD but no information about endoscopic findings and several studies did not document the presence of anemia, upper gastrointestinal (UGI) symptoms or use of non steroidal anti-inflammatory drugs (NSAIDS).
- Based on this limited evidence, EGD had a low yield for UGI cancer, generally ≤1%, even in symptomatic or severely anemic patients. The yield for detecting non-malignant findings potentially contributing to positive FOBT was 11-21% while the yield for incidental findings unlikely contributing to positive FOBT was 10-36%. There were very few data regarding EGD results in the context of anemia or NSAIDS use.

Qualifying Statement

A recommendation regarding the use of EGD for the detection of non-cancerous pathology is not provided because it is beyond the scope of this review.

FUTURE RESEARCH

Further adequately powered studies are needed to investigate the incidence of gastric or esophageal cancer in patients, enrolled in a population based colorectal cancer screening program, who are FOBT positive and colonoscopy negative.

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