CT Colonography activity and Covid-19: British Society of Gastrointestinal and Abdominal Radiology guidance

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Background

On March 17th 2020 (updated March 20th), the British Society of Gastroenterology (BSG) and Joint Advisory Group on GI endoscopy (JAG) published guidance on the use of endoscopy during the current Covid-19 pandemic (https://www.bsg.org.uk/covid-19-advice/endoscopy-activity-and-covid-19-bsg-and-jag-guidance/) . The guidance will be kept under review.

As part of the need to rationalise imaging activity, clarity is needed on the use of CT colonography (CTC) as an alternative to lower gastrointestinal endoscopy. The background on rationalising colonic investigation is provided by the joint BSG-JAG statement which should be read in conjunction with this document.

The aims are to protect patients and wider public, as well as healthcare staff, while maintaining capacity and resource.

CT colonography and Covid-19: specific considerations

- CT colonography is used as an alternative to endoscopy, in older and/or frail patients, and those with co-morbidities such as cardiovascular and respiratory disease. The incidence of a colorectal cancer diagnosis in this population is low for those referred via a 2 week wait pathway (3-7%) and the incidence on CTC is in the lower part of this range. This compares to a current Covid-19 mortality rate of around 5% in those aged 70-79 and over 9% in those aged 80+. The risks of transmission of Covid-19 must therefore be considered in all clinical decision-making regarding CTC.

- Covid-19 RNA is excreted in faeces at the time of infection and may persist for at least 2 weeks after respiratory samples become negative. Faeces should be considered as infectious for transmission of Covid-19. Currently lower GI endoscopy is not considered an aerosol prone procedure (AGP), although this remains under review. CTC should be considered in the same risk category as lower GI endoscopy, and equivalent levels of PPE should be implemented. This should include appropriate hand washing procedures, gloves, apron and surgical mask. Strong consideration should be made to the use of a protective visor/goggles, accepting the risk of splash events will likely be less than lower GI endoscopy. Although it may not be practicable, consideration should be given to designating a “clean scanner” for patients without known or suspected Covid-19.

- Standard CT abdominal and pelvis (with or without prolonged oral contrast) is an accepted alternative to CT colonography for detecting established colonic cancer, particularly in patients with suggestive symptoms or signs. The diagnostic accuracy of standard CT for tumours falls significantly below that of CT colonography.

- The English national bowel cancer screening program (BCSP) may well pause, and in some regions, there has already been temporary suspension.

- The 2-week cancer referral pathways will likely change, with increased use of FIT testing in primary care to triage patients.

Guidance on the use of CT colonography and abdominal pelvic CT for potential lower GI malignancy

- **CT colonography should not be performed in known or suspected Covid-19 patients, nor in those recently recovered from the infection**

Many hospitals have instigated a triaging system to prioritise medical imaging at the current time. For consistency we have used the categories proposed by the joint BSG JAG guidelines

- **Needs to continue;**
- **Defer until further notice;**
- **Needs discussion (possibly case-by-case, at consultant level)**

The list below is not exhaustive, nor prescriptive and is provided as a guide.

Needs to continue

- Imaging for potentially life-threatening complications of colorectal cancer such as acute obstruction or perforation. Standard CT abdomen and pelvis should be performed in such patients

Defer until further notice

- All referrals for non-specific abdominal symptoms which falls outside the 2 week wait referral process
- Polyp follow up (i.e. repeat CTC for polyps left in situ) and colorectal polyp surveillance (i.e. CTC performed in patients with a personal history of previous polypectomy)
- Suspected benign colonic disease such as non-acute diverticular disease / road mapping of diverticular disease

Needs discussion or agreed pathways

- Two week wait referrals
- Symptomatic patients with an elevated FIT result (precise threshold subject to local agreement)

It is strongly recommended that hospital services should create an **investigation pathway** for patients in this category following direct consultation between appropriate medical professionals including primary care providers, radiologists, gastroenterologists, endoscopists and lower GI surgeons. This pathway, with full instruction on PPE for included investigations, must be disseminated to all appropriate staff including booking and reception teams, radiographers, portering staff and health care assistants.

As noted above, the 2-week cancer referral pathways will likely change with increased use of FIT testing in primary care to triage patients.

Depending on local circumstances it may be appropriate to *replace some or all* CT colonography referrals with standard CT abdomen and pelvis, targeting a symptomatic colonic mass (for example predisposing to bowel obstruction), accepting the lower diagnostic accuracy. Such an approach will require careful consideration of the future management and investigation of such patients if the standard CT is normal, given the risks of undiagnosed colonic neoplasia. It is likely higher-risk patients (based on symptoms or level of FIT positivity) will need to undergo formal luminal testing in the future with either CT Colonography or lower GI endoscopy.

Many services have instigated triage of patients based on levels of symptoms and FIT; for example, performing CT colonography in these with FIT levels 10-150 and lower GI endoscopy in those with levels >150. This may be further nuanced by patient age given the risk of morbidity and mortality of Covid-19 in the older population; although with altered investigation pathways, the demographics of patients referred for CTC may also shift towards a younger cohort. The most appropriate levels of FIT positivity that should trigger colonic investigation in the current situation are not yet defined.

Ultimately, each service (or region) must define their own pathways depending on their current situation, capacity and levels of service provision (ongoing provision of cancer surgery). Pathways must be reviewed on a regular basis.

BSGAR Committee – 21st March 2020

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