ARGANZ update on CT Colonography

September 2018

The ever increasing waiting lists for optical colonoscopy (OC) have been in the mainstream media recently as well as in the local medical literature. The current guidelines state that the **diagnosis of colorectal cancer should be made within 120 days of presenting with symptoms or following a positive faecal occult blood screening test**. Sadly many patients wait longer than these recommended times in all Australian States and Territories. ARGANZ, in conjunction with the RANZCR, released a media statement around these findings highlighting that CT colonography (CTC) is a safe, accurate and well tolerated test that is underutilised in Australia.

In 2016 there were a total of 5378 CTC examinations charged under Medicare across all states and territories in Australia. By comparison in 2017 there were **approximately 900,000 colonoscopies** billed under Medicare. Compared to other Western countries this represents a significant underutilisation of CTC. Completion rates of OC of 95% (the target promoted by the Gastroenterology Society of Australia) equates to 45,000 incomplete colonoscopies a year. Clearly a significant number of patients are not having the entire colonic mucosa examined.

Current literature demonstrates that **CTC is equivalent to OC for the detection of polyps** with advanced histology and that no cancers are missed when cathartic and faecal tagging agents are used. CTC has the additional benefit of detecting other intra abdominal abnormalities. The New Zealand society of Gastroenterology suggests that symptomatic patients who; are >80yrs, have relevant co-morbidities including respiratory risk from sedation, have an abdominal mass or have had a failed or incomplete colonoscopy, are referred to CTC rather than OC. It should be noted that even in a symptomatic patient, the prevalence of colorectal carcinoma is only 3.5%.

From discussion it appears that many Australian radiologists, surgeons and gastroenterologists are not aware that the current Medicare criteria allow **referral for CTC** "**for exclusion or diagnosis of colorectal neoplasia in a symptomatic or high risk patient if they are referred by a specialist or consultant physician who performs colonoscopies in the practice of his or her speciality**". i.e a surgeon or gastroenterologist who performs colonoscopies can refer a patient for a CTC instead of OC without the requirement for a failed colonoscopy. There are many situations where CTC is a more clinically appropriate test than OC and its appropriate use will assist in reducing the lengthy OC waiting lists.

We encourage ARGANZ members to **promote the availability and appropriateness of CTC to their referrers** and include some useful facts and references below. It is in the interests of patients to have this test freely available, and part of that is increasing referrer awareness.

We are aware of issues around the availability of CTC which is a double edged sword. Due to the relatively small number of referrals there are only a few radiologists capable of reporting the scan, so the reports take a long time, the referrers don't like to wait that long for a report, so don't order the test and radiologists lose their skills. A significant shift of appropriate referrals to CTC instead of OC would provide more than enough cases to maintain a larger number of reporting radiologists.

At the last Medicare review, MSAC rejected a number of proposals to widen the Medicare criteria, particularly to **make the test more widely available to those in rural areas**. As it stands these patients can still be referred by their GP for a barium enema – a far inferior test – but do not have access to CTC. The lack of evidence and lack of justification for the refusal to expand the rebate was highlighted by an article in the Medical Journal of Australia written by ARGANZ which can be accessed via the link (https://www.mja.com.au/journal/2017/207/4/computed-tomography-colonography-underutilised-australia) and with an MJA podcast discussing the issues which can be accessed at https://www.mja.com.au/podcast/207/4/mja-podcasts-2017-episode-45-virtual-colonoscopy-prof-tom-sutherland.

ARGANZ is committed to advocating to expand Medicare funding to patients who do not have timely access to optical colonoscopy, and to highlight that the Australian restrictions are contrary to the medical literature and is vastly inferior to other countries such as New Zealand. A **new MSAC application** will be started in the next few weeks by ARGANZ on behalf of RANZCR.

While there is no current information from RANZCR on an updated CTC accreditation requirement, it is important that **CTC practitioners remain up-to-date** with techniques, indications and report at least 30 cases per year as per the current RANZCR CTC policy to ensure they have adequate skills. Part of the MSAC application will hinge on proving that we have a highly skilled workforce that maintains these skills to ensure a high quality examination.

Any member wishing to assist with the MSAC application would be greatly welcomed. If you are interested please email tom.sutherland@svha.org.au

Please see below some information which may assist you in discussions with your referring clinicians about the appropriate use of CTC.

Best wishes

Dr Kirsten Gormly and A/Prof Tom Sutherland on behalf of the ARGANZ executive

CT Colonography v Optical colonoscopy

- CTC is equivalent to OC for the detection of cancers [1,2]
- Sensitivity of CTC for adenomatous polyps over 8mm is 93.8% the same as OC [1]
- CTC is the preferable initial test for symptomatic patients who;
    - Are >80 yrs of age
    - Have significant co-morbidities including respiratory risk of sedation [3,4]
- Techniques such as faecal tagging are important to improve the sensitivity
- Radiologists are required to report a minimum number of scans to keep up their technical skills. Report delays are often related to a small number of referrals.
- In 2017 there were an estimated 16,682 new diagnoses of colorectal cancers and around 4,114 CRC related deaths [5]

Current Medicare criteria allow the referral of a symptomatic patient direct to CTC instead of OC if the referrer performs colonoscopies.

Current MBS rebate:

Computed tomography-scan of colon for exclusion or diagnosis of colorectal neoplasia in a symptomatic or high risk patient if:

(a) one [or more] of the following applies:

i. the patient has had an incomplete colonoscopy in the 3 months before the scan;
ii. there is a high-grade colonic obstruction;
iii. the patient is referred by a specialist or consultant physician who performs colonoscopies [in the practice of his or her speciality]; and

(b) the service is not a service to which item 56301, 56307, 56401, 56407, 56409, 56412, 56501, 56507, 56801, 56807 or 57001 applies; and

(c) the service has not been performed on the patient in the 36 months before the scan (R) (K) (Anaes.)

References:

1. Pickhardt et al, Computed tomographic virtual colonoscopy to screen for colorectal neoplasia in asymptomatic adults, NEJM 2003;349(23):2191-2200
2. Pickhardt et al Colorectal Cancer: CT Colonography and Colonoscopy for Detection – Systematic Review and Meta-analysis, Radiology 2011;259(2):393-405
3. NZ society of Gastroenterology. 2015
4. NZ National criteria for direct access out patient colonoscopy. 2015
5. Australian government statistics http://www.aihw.gov.au/cancer/colorectal/