Australian Government
Medical Services Advisory Committee

57th MSAC Meeting
29-30 November 2012

Application 1150: Insertion of Colonic Stents

MSAC noted that the clinical management for malignant colorectal obstruction includes patients medically fit for surgery and patients who are medically unfit for surgery. For the second group of patients, self-expanding metallic stent (SEMS) insertion provides an additional palliation option with MSAC acknowledging that colostomy may be an alternative intervention if a patient is medically unfit for major surgery.

MSAC noted that there are no comparative data with best supportive care for either safety or clinical effectiveness. SEMS insertion compared with surgery was also limited to two randomised controlled trials. The major stent related risk relates to bowel perforation. MSAC concluded that SEMS insertion is equivalent to multi-stage surgery in comparative safety.

MSAC noted that clinical effectiveness outcomes for surgery included a shorter hospital stay with SEMS, although the clinical relief was higher in the emergency surgery group and the QALY was not determined. However, MSAC acknowledged that while there is limited evidence, the procedure is already being performed in Australia and that local evidence indicates that the proposal would be cost saving.

MSAC noted that the estimated number of services per year provided by the Colorectal Surgical Society of Australia and New Zealand (CSSANZ) was within the range provided in the economic evaluation. MSAC also noted that it is difficult to account for all clinical presentations and acknowledged that the CSSANZ has indicated that it is only in exceptional circumstances where patients are near death on presentation that palliation without relief of the obstruction would be an acceptable standard of clinical care.

MSAC noted that an important benefit of SEMS insertion as a bridge to surgery is that a patient can progress to timely and well planned elective surgery and/or systemic cancer treatment. MSAC also noted that there is also a steep learning curve for a surgeon to be able to perform SEMS insertion.

MSAC agreed that, if public funding is approved, the MBS item descriptor needs to include a more specific description of the stent such as ‘metallic’ or ‘mesh’ stent. MSAC also agreed that a similar comparator in terms of time and complexity for SEMS insertion is the insertion of a biliary stent.

Noting the shortage of evidence, MSAC agreed that there is an area of need for colonic stents and there is a patient population identified as benefiting from the procedure. MSAC agreed that the MBS fee based on the time and complexity should be the same as for insertion of a biliary stent, which is currently $555.35.

MSAC's advice to the Minister

After considering the strength of the available evidence in relation to the safety, clinical effectiveness and cost-effectiveness of the insertion of colonic stents, MSAC supports public funding for endoscopic stenting for large bowel obstruction, stricture or stenosis due to a pre-diagnosed colorectal cancer, or cancer of an organ adjacent to the bowel or an unknown diagnosis.