|  |
| --- |
| **2O — Repeat Colonoscopy** |
| **Summary of Intervention** |
| Colorectal carcinoma (CRC) is one of the most common cancers in the UK with more than 40,000 new cases diagnosed each year. Polyps are extremely common and certain types (colorectal adenomas and serrated lesions) have the potential to progress into CRC.  Colonoscopy can assist in the diagnosis of CRC and several other pathologies, including colonic polyps. Polyp removal (or polypectomy) can be performed endoscopically and is an effective way to treat pre-malignancy polyps (which includes both serrated polyps (excluding diminutive [1-5mm] rectal hyperplastic polyps) and adenomatous polyps. It does not include other polyps such as post inflammatory polyps) before they progress to cancer. Colonoscopy with or without polypectomy is a safe procedure however there is a small risk of complications - including pain, intestinal perforation or major haemorrhage as well as issues related to any sedative used.  Colorectal carcinoma is often treated by surgical resection, especially for people with potentially curative disease. Individuals who have had treatment for colorectal carcinoma and adenomas are known to be at high-risk of  recurrence.  While reducing colorectal mortality is an important aim of colonoscopic surveillance, the main aim is to prevent colorectal cancer by resecting premalignant polyps. Many patients benefit from this alone and do not require subsequent surveillance.  **This guidance applies to adults aged 19 years and over.** |
| **Number of interventions in 18/19** |
| **415,262** |
| **Proposal** |
| Follow the British Society of Gastroenterology surveillance guidelines for post-polypectomy and post-colorectal cancer resection: https://www.bsg.org.uk/resource/bsg-acpgbi-phe-post-polypectomy-and-post-colorectalcancer-  resection-surveillance-guidelines.html.  Risk Surveillance Criteria for Colonoscopy  Either of the following put individuals at high-risk for future colorectal cancer following polypectomy:  — 2 or more premalignant polyps including at least one advanced colorectal polyp (defined as a serrated polyp of at least 10mm in size or containing any grade of dysplasia, or an adenoma of at least 10mm in size or containing high-grade dysplasia); **OR**  — 5 or more premalignant polyps.  **Surveillance colonoscopy after polypectomy**  For individuals at **high-risk** and under the age of 75 **and** whose life expectancy is greater than 10 years:  — Offer one-off surveillance colonoscopy at 3 years.  For individuals with **no high-risk** findings:  — No colonoscopic surveillance should be undertaken  — Individuals should be strongly encouraged to participate in their national bowl screening programme when invited.  For individuals not at high-risk who are more than 10 years younger than the national bowel screening programme lower age-limit, consider for surveillance colonoscopy after 5 or 10 years, individual to age and other risk factors.  **Surveillance colonoscopy after potentially curative CRC resection:**  — Offer a clearance colonoscopy within a year after initial surgical resection  — Then offer a surveillance colonoscopy after a further 3 years  — Further surveillance colonoscopy to be determined in accordance with the post-polypectomy high-risk criteria.  **Surveillance after pathologically en bloc R0 EMR or ESD of LNPCPs or early polyp cancers:**  — No site-checks are required  — Offer surveillance colonoscopy after 3 years  — Further surveillance colonoscopy to be determined in accordance with the post-polypectomy high-risk criteria.  **Surveillance after piecemeal EMR or ESD of LNPCPs (large nonpedunculated colorectal polyps of at least 20mm in size):**  — Site-checks at 2-6 months and 18 months from the original resection  Once no recurrence is confirmed, patients should undergo postpolypectomy surveillance after 3 years  — Further surveillance colonoscopy to be determined in accordance with the post-polypectomy high-risk criteria.  **Surveillance where histological completeness of excision cannot be determined in patients with: (i) a non-pedunculated polyps of 10-19mm in size, or (ii) an adenoma containing high-grade dysplasia, or (iii) a serrated**  **polyp containing any dysplasia:**  — Site-check should be considered within 2-6 months  — Further surveillance colonoscopy to be determined in accordance with the post-polypectomy high-risk criteria  **Ongoing colonoscopic surveillance:**  — To be determined by the findings at each surveillance procedure, using the high-risk criteria to stratify risk  — Where there are no high-risk findings, colonoscopic surveillance should cease but individuals should be encouraged to participate in the national bowel screening programme when invited. |
| **Rationale for Recommendation** |
| This recommendation is based on the 2019 guidelines published by the British  Society of Gastroenterology, the Association of Coloproctology of Great British and Ireland and Public Health England. The complete guidelines can be found here: https://www.bsg.org.uk/clinical-resource/bsg-acpgbi-phepost-  polypectomy-and-post-colorectal-cancer-resection-surveillanceguidelines/.  Premalignant polyps are common, occurring in a quarter to a half of all people of screening age, yet only about 5% of the population will develop CRC during their life. As such, only a minority of people with polyps will develop  CRC, meaning that most people will not benefit from post-polypectomy surveillance.  It is an increasingly held view that the greatest benefit in terms of CRC prevention is derived from the initial polypectomy, rather than from subsequent surveillance. It is possible to stratify individuals according to future risk and identify cohorts of patients with persistently elevated CRC risk beyond index polypectomy, yet even with current risk stratification, surveillance places a considerable burden on patients and endoscopy services: approximately 5% of the half a million colonoscopies performed each year in the UK are performed for polyp surveillance. |
| **References** |
| 1. BSG/ACPGBI/PHE Post-polypectomy and post-colorectal cancer resection surveillance guidelines: https://www.bsg.org.uk/clinical-resource/bsgacpgbi-phe-post-polypectomy-and-post-colorectal-cancer-resectionsurveillance-guidelines/.  2. NICE Colorectal cancer: diagnosis and management Clinical guideline [CG131]: https://www.nice.org.uk/guidance/cg131/chapter/1-Recommendations#ongoing-care-and-support.  3. NICE Colorectal cancer prevention: Colonoscopic surveillance in adults with ulcerative colitis, Crohn's disease or adenomas guideline [CG118]: https://www.nice.org.uk/guidance/cg118.  4. Cancer Research UK. Colonoscopy: https://www.cancerresearchuk.org/about-cancer/cancer-in-general/tests/colonoscopy. |