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Guideline for Colorectal Screening and Surveillance

This guideline is for colorectal screening and surveillance/recall in asymptomatic patients. Symptomatic patients are investigated by the Physician as clinically indicated.

FH - Family History
CRC - Colorectal Cancer
FDR - First degree relative = brother, sister, parent, son, daughter

INITIAL SCREENING	
Average risk:	
50-74 years [Patient with either no FH CRC or single FDR with CRC greater than or equal to 60 years]	• Fecal immunochemical test (FIT) every 2 years • Follow up ANY abnormal FIT with colonoscopy • Do not use FIT in symptomatic patients • Following adequate negative colonoscopy repeat FIT at 10 years
75-84 years	• Screening may be undertaken on an individualized basis in healthy individuals as above
Greater than 85 years	• Screening is not recommended, benefit is outweighed by risk
Increased risk:	
One or more FDR with CRC less than 60 years **OR** Two or more FDR with CRC at any age	• Colonoscopy 10 years prior to the youngest affected relative at diagnosis
Longstanding IBD	• Colonoscopy every 1-2 years to detect occult neoplasia (dysplasia), or as directed by the specialist providing care
Family history of Familial Adenomatous Polyposis (FAP)	• Refer to Hereditary Cancer Program at the BC Cancer Agency • Refer all FDRs for genetic counselling and testing • In traditional FAP adenomas usually begin in puberty • In attenuated FAP adenomas begin later, often right-sided
Family history of Hereditary Nonpolyposis Colon Cancer (HNPCC) (Lynch syndrome)	• Colonoscopy starting at age 25, or 10 years prior to the age of the youngest affected relative at diagnosis, whichever is earliest • Colonoscopy every 2 years until age 40, then annually • Refer to Hereditary Cancer Program at the BC Cancer Agency
SURVEILLANCE / RECALL	
Average risk:	
50-74 years with negative colonoscopy [Patient with either no FH CRC or single FDR with CRC greater than or equal to 60 years]	• No further screening of any type required for 10 years • At 10 years, resume FIT every 2 years
Patients with hyperplastic polyps (those considered to have no malignant potential)*	• No further screening of any type required for 10 years • At 10 years, resume FIT every 2 years
75-84 years	• Screening may be continued on an individualized basis in healthy individuals as above
Greater than 85 years	• Screening is not recommended to continue, benefit is outweighed by risk.
Increased risk:	
Negative colonoscopy **and:** *One or more FDR with CRC less than 60 years* ***OR*** *Two or more FDR with CRC at any age* ***OR*** *1-2 small (less than 1 cm) tubular adenomas with only low-grade dysplasia*	• Follow-up colonoscopy in 5-10 years • Timing within 5-10 year interval based on clinical factors, e.g., previous colonoscopy findings, family history, patient preferences, judgment of physician
1-2 sessile serrated adenomas/polyps less than 1 cm with no dysplasia	• Follow-up colonoscopy in 5 years
3-10 tubular adenomas or sessile serrated adenomas/polyps or any high risk polyps: • Tubular adenomas greater than or equal to 1 cm • Villous adenomas • Adenoma with/'high grade dysplasia'. • Sessile serrated adenoma/polyp greater than or equal to 1 cm • Sessile serrated adenoma/polyp with dysplasia • Traditional serrated adenoma	• Follow-up colonoscopy in 3 years provided complete adenoma removal • If follow-up colonoscopy is normal or shows 1-2 small (less than 1 cm) tubular adenomas with low-grade dysplasia or 1-2 small (less than 1 cm) sessile serrated adenomas/polyps without dysplasia, interval for next colonoscopy is 5 years
Patients with piecemeal resection of a high-risk polyp where complete removal is uncertain.	• Follow-up colonoscopy within 6 months to verify complete removal • Once complete removal established, subsequent surveillance interval as per high risk polyp (3 years, then 5 years after normal/low risk findings)
Family history indicates HNPCC or FAP	• Colonoscopy every 1 -2 years • Refer to Hereditary Cancer Program at the BC Cancer Agency
Long standing (8+ years) inflammatory bowel disease involving the colon	• Colonoscopy every 1-2 years or as directed by the specialist providing care
Post cancer resection	• Patients with significant co-morbidities, very advanced age, or limited 5 year life expectancy not routinely offered surveillance • If full colonoscopy has not been completed prior to cancer resection, complete cancer and polyp clearing colonoscopy should be performed within 12 months of surgical resection of CRC tumor • After polyp clearing, follow-up colonoscopy at 1 year • If 1-year colonoscopy is normal, next colonoscopy in 3 years • If 3-year colonoscopy is normal, next colonoscopy in 5 years • Repeat colonoscopy every 5 years thereafter • After 1-year colonoscopy, intervals between colonoscopies may be shortened if evidence of HNPCC or adenoma findings warrant earlier colonoscopy • For patients followed by colonoscopy, do not use FIT

*Hyperplastic polyps with no malignant potential, e.g. small rectal hyperplastic polyps. Hyperplastic polyps with increased malignant potential, e.g. large right-sided colonic hyperplastic, second review of histology by Histopathologist and Colonoscopist to make follow up recommendation. When doubt discuss with Colonoscopist.