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memo

Date:	September 18, 2023
To:	NH Medical Staff
From:	Dr. Paul Mullins, Medical Lead, NH Colon Screening Program Dr. Zeinab Moinfar, NH Cancer Screening Lead
Re:	Updated *Guideline for Colorectal Screening, Surveillance and Recall*

Northern Health has **updated** the ***Guideline for Colorectal Screening, Surveillance, and Recall*** and developed **new Algorithms** for colorectal screening and follow-up.

Changes are aligned with recent updates from the BC Guidelines and Protocols Advisory Committee (GPAC) and BC Cancer Colon Screening Program. The colonoscopy surveillance recommendations following removal of colorectal lesion(s) have changed.

An education session will be delivered by Dr. Paul Mullins on **Thursday, September 21, 2023 12:00pm – 1:00pm PDT**. Please register via link.
Following the session, the recording may be found on the webpage for Physician Education Resources.

Both documents are **attached** to this memo.

They can also be accessed through Document Source .

Guideline for Colorectal Screening, Surveillance, and Recall – Algorithm	Document #10-021-6086
Guideline for Colorectal Screening, Surveillance and Recall *(supplementary)*	Document #10-021-6085

If you have any questions, please contact NH Cancer Care.

Colorectal Screening

Eligible patient population:

Asymptomatic average risk individuals aged 50-74 years

Asymptomatic individuals with increased risk

Increased Risk

- Longstanding (8+ years) inflammatory bowel diseases involving colon
  - → Initial and surveillance colonoscopy as directed by the specialist providing care
- Family history of Hereditary Colorectal Cancer Syndrome – HNPCC or FAP
  - → Refer to Hereditary Cancer Program at BC Cancer Agency
    Hereditary Cancer Clinical Resources
    - → Colonoscopy every 1-2 years
- **FH CRC**
  1 or more FDR with CRC less than 60 years, **OR**
  2 or more FDR with CRC at any age
  - → Colonoscopy 10 years prior to the youngest affected relative at diagnosis or at 40 years of age, whichever is the earliest

Average Risk:

Patient with either no FH CRC or single FDR with CRC greater than or equal to 60 years

- → Fecal Immunochemical Test (FIT)
  - Positive
    - → Colonoscopy
  - Negative
    - → FIT in 2 years

Patients followed by colonoscopy do not require FIT.

FH - Family History **CRC** - Colorectal Cancer **FDR** - First degree relative = brother, sister, parent, son, daughter
HNPCC - Hereditary Nonpolyposis Colon Cancer **FAP** - Familial Adenomatous Polyposis

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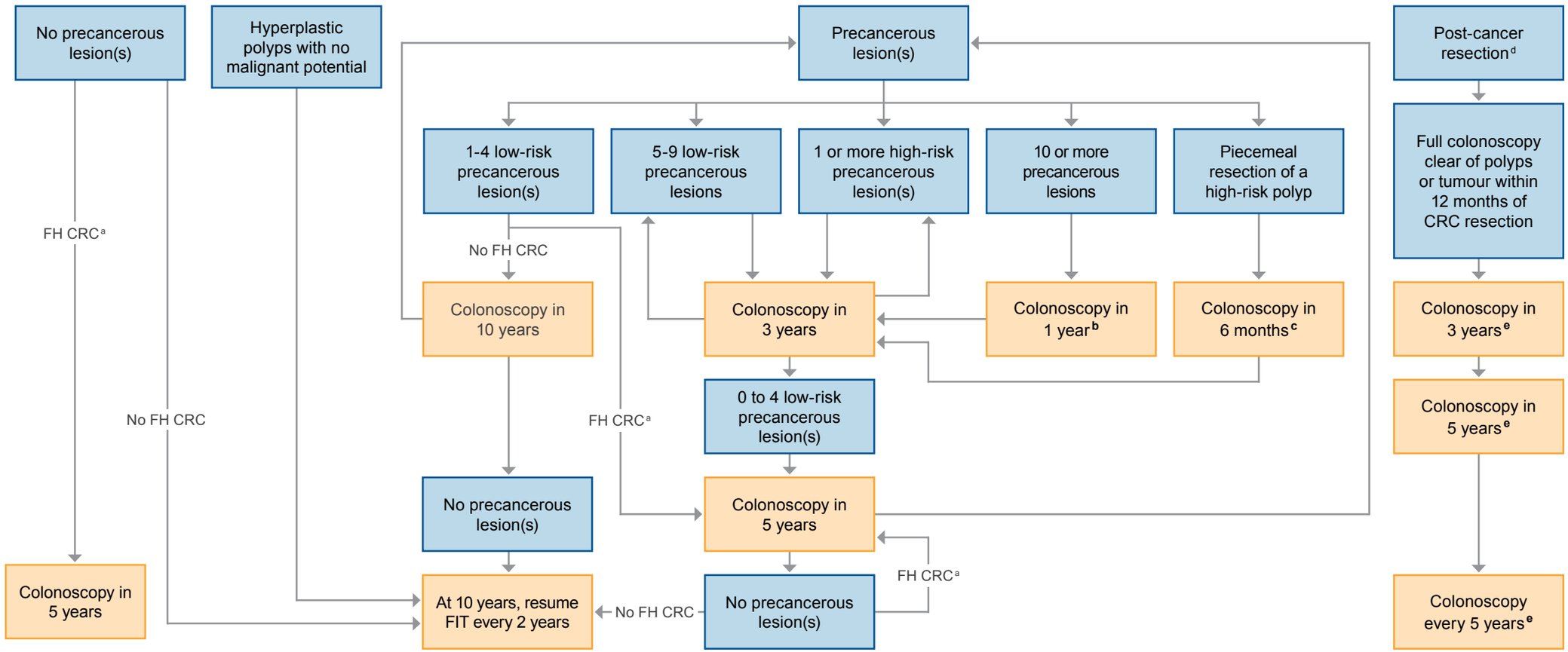
Colonoscopy Follow-up



[a] Family History of Colorectal Cancer (FH CRC): one first degree relative diagnosed with CRC under age 60, OR 2 or more first degree relatives diagnosed with CRC at any age.

[b] If 10 or more precancerous lesions are removed during a single screening round, then follow-up colonoscopy 1 year after the colon has been cleared of all precancerous lesions is recommended.

[c] If there is residual precancerous tissue removed from the site of the piecemeal resection, then the colonoscopist may recommend an earlier colonoscopy.

[d] Patients with significant co-morbidities, very advanced age, or limited 5-year life expectancy not routinely offered surveillance.

[e] Or as defined by Hereditary Cancer Syndrome/Polyp Guidelines.

High-Risk Lesions

- ☐ Adenoma with one or more of
  - ☐ ≥10mm
  - ☐ Villous features, or
  - ☐ High Grade Dysplasia
- ☐ SSL ≥10mm
- ☐ SSL with cytologic dysplasia
- ☐ Traditional Serrated Adenoma
- ☐ Hyperplastic Polyp ≥10mm

Low-Risk Lesions

- ☐ Tubular Adenoma <10mm
- ☐ Sessile Serrated Lesion (SSL) <10mm without dysplasia

If the number of precancerous lesions removed during an individual's lifetime is 10 or more, then referral to the Hereditary Cancer Program for evaluation of a potential genetic predisposition to CRC is recommended.

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Guideline for Colorectal Screening, Surveillance and Recall

This guideline is for colorectal screening and surveillance/recall in asymptomatic patients. Symptomatic patients are investigated by the Physician as clinically indicated. Patients followed by colonoscopy do not require FIT.

High-Risk Lesions – Adenoma with one or more of: ≥10mm, Villous features, or High-Grade Dysplasia; SSL≥10mm; SSL with Cytologic Dysplasia; Traditional Serrated Adenoma; Hyperplastic Polyp ≥10mm. Precancerous lesions that do not meet the above criteria are classified as low-risk.

Low-Risk Lesions – Tubular Adenoma <10mm or Sessile Serrated Lesion (SSL) <10mm without dysplasia

INITIAL SCREENING	
Average risk:	
50-74 years (Patient with no FH CRC[a])	• 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:	
FH CRC[a]	• Colonoscopy 10 years prior to the youngest affected relative at diagnosis, or at 40 years of age, whichever is the earliest
Longstanding (8+ years) inflammatory bowel disease (IBD) involving the colon	• Colonoscopy as directed by the specialist providing care
Family history of Hereditary Colorectal Cancer Syndrome – Hereditary Nonpolyposis Colon Cancer (HNPCC) or Familial Adenomatous Polyposis (FAP)	• Refer to Hereditary Cancer Program at the BC Cancer Agency • Review Hereditary Cancer Clinical Resources

RISK GROUP	RECALL/FOLLOW-UP	RESPONSIBILITY	
Average risk:		**Recommendation**	**Follow-up/Recall**
50-74 years with negative colonoscopy (No FH CRC)	• At 10 years, resume FIT every 2 years	Colonoscopist	PCP
Patients with hyperplastic polyps (those considered to have no malignant potential)[b]	• At 10 years, resume FIT every 2 years	Colonoscopist	PCP
75-84 years	• Screening may be continued on an individualized basis in healthy individuals as above	Colonoscopist	PCP
Greater than 85 years	• Screening is not recommended to continue; benefit is outweighed by risk		
Increased risk:		**Recommendation**	**Follow-up/Recall**
Negative colonoscopy **and** FH CRC[a]	• Follow-up colonoscopy in 5 years	Colonoscopist	PCP
1-4 **Low-Risk Lesions**	• No FH CRC - follow-up colonoscopy in 10 years. If follow-up Colonoscopy in 10 years is normal, at 10 years, resume FIT every 2 years • FH CRC - follow-up colonoscopy in 5 years	Colonoscopist	PCP

5-9 **Low-Risk Lesions**
OR
1 or more **High-Risk Lesions**
	• Follow-up colonoscopy in 3 years provided complete adenoma removal
	• If next follow-up colonoscopy shows 0-4 **Low-Risk Lesions**, follow-up colonoscopy in 5 years
	• If subsequent colonoscopy is normal:
	  ◦ No FH CRC - in 10 years resume FIT every 2 years
	  ◦ FH CRC - colonoscopy in 5 years
		Colonoscopist	PCP

10 or more Lesions removed during single screening round	• Follow-up colonoscopy in 1 year provided complete adenoma removal • Subsequent surveillance interval as for High-Risk Lesions	Colonoscopist	Colonoscopist
Patients with piecemeal resection of a high-risk polyp where complete removal is uncertain	• Follow-up colonoscopy within 6 months to verify complete removal. Early colonoscopy may be recommended if residual precancerous tissue removed.	Colonoscopist	Colonoscopist
	• Once complete removal established, subsequent surveillance interval as for **High-Risk Lesions**	Colonoscopist	PCP
Family history indicates HNPCC, FAP or other Hereditary Colorectal Cancer Syndrome	• Colonoscopy every 1-2 years • Refer to Hereditary Cancer Program at the BC Cancer Agency	Colonoscopist	Colonoscopist
Long standing (8+ years) inflammatory bowel disease (IBD) involving the colon	• As directed by the specialist providing care	Colonoscopist	Colonoscopist
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 • Further guidance in BC Colorectal Cancer Follow-up of Colorectal Polyps or Cancer	Colonoscopist	Colonoscopist
	• 1-year colonoscopy normal - Colonoscopy in 3 years • If 3-year colonoscopy normal - 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	Colonoscopist	PCP

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

[a] One FDR diagnosed with CRC under age 60, or 2 or more FDR diagnosed with CRC at any age.

[b] 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 recommendations. When in doubt, discuss with Colonoscopist.

Review by: December 2025

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