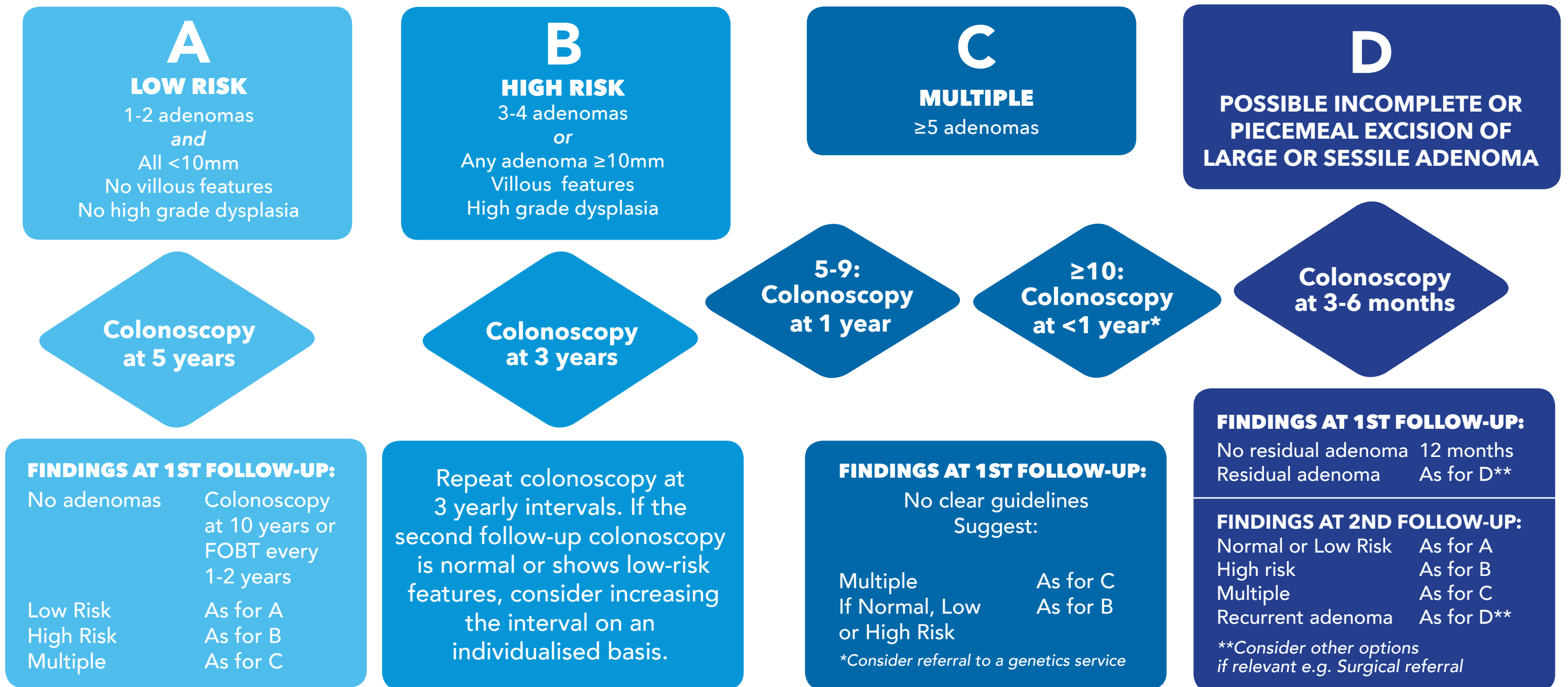


Colonoscopic Surveillance Intervals - Adenomas



NOTES:

- This algorithm is designed to be used in conjunction with the NHMRC approved Clinical Practice Guidelines for Surveillance Colonoscopy – in adenoma follow-up; following curative resection of colorectal cancer; and for cancer surveillance in inflammatory bowel disease (December 2011) and is intended to support clinical judgement.
- Surveillance colonoscopy should be planned based on high-quality endoscopy in a well-prepared colon using most recent and previous procedure information when histology is known.

- Sessile serrated adenomas and serrated adenomas are followed up as for adenomatous polyps given present evidence, although they may progress to cancer more rapidly.
- Most patients ≥75 years of age have little to gain from surveillance of adenomas given a 10-20 year lead-time for the progression of adenoma to cancer. The finding of serrated lesions may alter management.
- Small, pale, distal hyperplastic polyps only do not require follow-up. Consider sessile serrated polyposis if multiple proximal sessile serrated adenomas are found.

- In the absence of a genetic syndrome, family history does not influence surveillance scheduling which is based on patient factors and adenoma history.
- Follow-up of an advanced rectal adenoma by digital rectal examination, sigmoidoscopy or endo-rectal ultrasound should be considered independent of colonoscopic surveillance schedules.

ENDORSED BY:



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Algorithm for Colonoscopic Surveillance Intervals – Adenomas. 2013.
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