Colonoscopic Surveillance Intervals - Adenomas

A
LOW RISK
1-2 adenomas
and
All <10mm
No villous features
No high grade dysplasia

Colonoscopy at 5 years

B
HIGH RISK
3-4 adenomas
or
Any adenoma ≥10mm
Villous features
High grade dysplasia

Colonoscopy at 3 years

C
MULTIPLE
≥5 adenomas

5-9: Colonoscopy at 1 year

≥10: Colonoscopy at <1 year*

D
POSSIBLE INCOMPLETE OR PIECEMEAL EXCISION OF LARGE OR SESSILE ADENOMA

Colonoscopy at 3-6 months

FINDINGS AT 1ST FOLLOW-UP:

No residual adenoma	12 months
Residual adenoma	As for D**

FINDINGS AT 2ND FOLLOW-UP:

Normal or Low Risk	As for A
High risk	As for B
Multiple	As for C
Recurrent adenoma	As for D**

***Consider other options if relevant e.g. Surgical referral*

FINDINGS AT 1ST FOLLOW-UP:

No adenomas	Colonoscopy at 10 years or FOBT every 1-2 years
Low Risk	As for A
High Risk	As for B
Multiple	As for C

Repeat colonoscopy at 3 yearly intervals. If the second follow-up colonoscopy is normal or shows low-risk features, consider increasing the interval on an individualised basis.

FINDINGS AT 1ST FOLLOW-UP:
No clear guidelines
Suggest:

Multiple	As for C
If Normal, Low or High Risk	As for B

**Consider referral to a genetics service*

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, sigmoidos copy or endo-rectal ultrasound should be considered independent of colonoscopic surveillance schedules.

ENDORSED BY:

GESA Gastroenterological Society of Australia

CSSANZ COLORECTAL SURGICAL SOCIETY OF AUSTRALIA AND NEW ZEALAND

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Cancer Council Australia