Cancer Care Ontario

ColonCancerCheck (CCC)
Recommendations for Post-Polypectomy Surveillance

Initial colonoscopy			Subsequent colonoscopy		
Findings	**Next test[1]**	**Time until next test**	**Findings**	**Next test[1]**	**Time until next test**
No polyps Hyperplastic polyp(s) in rectum or sigmoid	FIT*	10 years	Not applicable		
Low risk adenoma(s)[2]	FIT*	5 years	Not applicable		
High risk adenoma(s)[2]	Colonoscopy	3 years	No polyps, hyperplastic polyp(s) in rectum or sigmoid, or low risk adenoma	Colonoscopy	5 years
			High risk adenoma(s)	Colonoscopy	3 years
>10 adenomas	Clearing colonoscopy[3]	≤1 year	<3 years at endoscopist discretion[3]		
Any sessile serrated adenoma(s) <10mm without dysplasia	Colonoscopy	5 years	At endoscopist discretion[4]		
Sessile serrated adenoma(s) ≥10 mm Sessile serrated adenoma(s) with dysplasia Traditional serrated adenoma	Colonoscopy	3 years			
Large sessile polyp removed piecemeal	Colonoscopy to check polypectomy site	≤6 months			
Serrated polyposis syndrome[2]	Colonoscopy	1 year	1-2 years at endoscopist discretion		

Notes: *Cancer Care Ontario is planning to replace the fecal occult blood test (FOBT) with the fecal immunochemical test (FIT) in the ColonCancerCheck program for people at average risk of colorectal cancer

[1] In cases where the next recommended test is colonoscopy, FIT or flexible sigmoidoscopy is not required between surveillance intervals.
[2] See reverse for definitions.
[3] People with >10 adenomas should undergo genetic assessment for familial adenomatous polyposis syndromes. The subsequent surveillance interval will depend on the results of the genetic assessment and whether the colon is cleared of polyps. If there is no familial adenomatous polyposis syndrome and after the colon is cleared, surveillance recommendation is colonoscopy in <3 years.
[4] Sessile serrated polyps and traditional serrated adenomas require surveillance, but there is currently insufficient evidence to make specific recommendations on subsequent surveillance intervals.

Background

- The recall interval following a normal colonoscopy for people with a family history of colorectal cancer in a first-degree relative should be based on family history or surveillance recommendations, whichever interval is shorter.
- The recommendations are adapted from Canadian[1] and American[2] colonoscopy surveillance guidelines, and informed by an additional systematic review on the risk of advanced adenomas, colorectal cancer and cancer mortality in people with low risk adenomas at initial colonoscopy.[3]
- The recommendations are based on the size and histology of the most advanced lesion and assume a high-quality colonoscopy (i.e., adequate bowel preparation to detect polyps 5 mm in size, complete procedure to cecum, careful examination of the colonic mucosa).

Glossary

- **Low risk adenomas:** 1 to 2 tubular adenoma(s) <10mm in diameter with no high-grade dysplasia.
- **High risk adenomas (also called advanced adenomas):** Tubular adenoma ≥10mm, 3 or more adenomas, adenoma(s) with villous histology or adenoma with high-grade dysplasia.
- **Serrated adenomas:** Either sessile serrated adenomas (SSA) (also called "sessile serrated polyps" [SSP] or "sessile serrated adenoma/polyp" [SSA/P]) or traditional serrated adenoma (TSA). Most serrated polyps will not have any dysplasia; serrated polyps with dysplasia are considered advanced. Traditional serrated adenomas are uncommon and are often protuberant and left-sided.
- **Serrated polyposis syndrome:** At least 5 serrated polyps proximal to the sigmoid colon, with 2 or more being >10mm; any number of serrated polyps proximal to the sigmoid colon in someone who has a first-degree relative with serrated polyposis; or 20 or more serrated polyps of any size, but distributed throughout the colon.[5]
- **Clearing colonoscopy:** Repeat procedure performed to ensure that all neoplasia has been removed from the colon. A clearing colonoscopy is performed earlier than a surveillance colonoscopy.
- **Hyperplastic polyp:** hyperplastic polyps are very common and usually occur as diminutive (<5mm) nondysplastic polyps in the rectum and sigmoid colon. These polyps are not associated with an increased risk of colorectal cancer and are therefore not considered to be screen-relevant lesions.

[1] Leddin D, Enns R, Hilsden R, Fallone C, Rabeneck L, Sadowski D, et al. Colorectal cancer surveillance after index colonoscopy: guidance from the Canadian Association of Gastroenterology. Can J Gastroenterol. 2013;27(4):224-8.
[2] Lieberman D, Rex D, Winawer S, Giardiello F, Johnson D, Levin T. Guidelines for colonoscopy surveillance after screening and polypectomy: a consensus update by the US Multi-Society Task Force on Colorectal Cancer. Gastroenterology. 2012;143(3):844-57.
[3] Dubé C, Yakubu M, McCurdy BR, Lischka A, Koné A, Walker MJ, et al. Risk of advanced adenoma, colorectal cancer, and colorectal cancer mortality in people with low-risk adenomas at baseline colonoscopy: a systematic review and meta-analysis. Am J Gastroenterol 2017; 112(12):1790-1801.
[4] National Colorectal Cancer Screening Network. Classification of benign polyps. Pathology Working Group Report. June 2011.
[5] Snover D, Ahnen D, Burt R, Odze R. Serrated polyps of the colon and rectum and serrated polyposis. In: Bosman F, Carneiro F, Hruban R, Theise N, editors. WHO classification of tumours of the digestive system. Lyon: IARC; 2010.

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