Cancer Care Ontario

ColonCancerCheck (CCC) Recommendations for Post-Polypectomy Surveillance

Frequently Asked Questions

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Overview

ColonCancerCheck (CCC) is Ontario's province-wide organized colorectal cancer screening program, which has the goal of reducing death from colorectal cancer. When CCC was established in 2008, the program adopted the 2006 U.S. Multi-Society Task Force on Colorectal Cancer post-polypectomy surveillance guidelines (1). Since then, new evidence has emerged and CCC began a process to review and update its post-polypectomy surveillance guidelines.

CCC's updated post-polypectomy surveillance recommendations were released in March 2019. To support the transition to the new recommendations, frequently asked questions have been developed that will help primary care providers and endoscopists understand the recommendations and their application.

1. How were ColonCancerCheck's (CCC) post-polypectomy surveillance recommendations developed?

ColonCancerCheck's (CCC's) post-polypectomy surveillance recommendations were developed under the guidance of a panel of experts in gastroenterology, pathology and colorectal surgery. CCC conducted a literature search of English language post-polypectomy surveillance guidelines published from 2007 to 2014 using PubMed.

Following the evidence review, the expert panel opted to use the same polyp classification framework as the 2012 U.S. Multi-Society Task Force on Colorectal Cancer (2) and the 2013 Canadian Association of Gastroenterology guidelines (3), which classify adenomas (pre-cancerous polyps) into high risk and low risk. While European guidelines (4) include an intermediate risk category, the expert panel decided to align with the high and low risk classifications most familiar to Ontario physicians.

In the literature, there was a lack of consensus in guidelines from other jurisdictions about the management of low risk adenomas (LRAs). To address this gap, CCC conducted a systematic review and meta-analysis to evaluate the risk of incident advanced adenomas, colorectal cancer and of colorectal cancer-related death in people with LRAs at their initial colonoscopy (5).

CCC's draft recommendations were sent to national and international stakeholders to review, and their feedback was incorporated.

2. How do ColonCancerCheck's (CCC) post-polypectomy surveillance recommendations differ from previous recommendations?

When CCC was established in 2008, the program adopted the U.S. Multi-Society Task Force on Colorectal Cancer (USMSTF) 2006 post-polypectomy surveillance guidelines (1). Since then, new evidence has emerged, and CCC began a process to review and update its post-polypectomy surveillance guidelines.

Because the approach to surveillance needs to be adjusted over time according to the findings of each subsequent test, CCC's updated recommendations include recommendations based on findings from both the initial and subsequent colonoscopy.

CCC's updated recommendation clarify that people who have no polyps or hyperplastic polyps found in the rectum or sigmoid at their initial colonoscopy can return to screening with the fecal immunochemical test (FIT).

Additionally, based on a systematic review and meta-analysis to evaluate the risk of incident advanced adenomas, colorectal cancer and colorectal cancer-related death in people with LRAs at baseline colonoscopy, CCC no longer recommend colonoscopy surveillance for people with low risk adenomas (LRAs). CCC now recommends that people with LRAs return to average risk screening with FIT beginning five years after their baseline colonoscopy, and then follow CCC's average risk screening recommendations.

3. Why is ColonCancerCheck (CCC) no longer recommending that people with low risk adenomas (LRAs) undergo surveillance colonoscopy?

CCC conducted a systematic review of the primary literature on the risk of high risk adenomas, colorectal cancer and colorectal cancer-related death among people with LRAs (5). This analysis revealed that people with LRAs have a significantly lower risk of colorectal cancer and a significantly lower risk of dying from colorectal cancer than the general population (5). In

addition, a recent publication of the prostate, lung, colon, and ovarian (PLCO) cancer screening trial concluded that people with LRAs had the same risk for colorectal cancer and colorectal cancer death than those with no adenomas at the baseline colonoscopy (6).

CCC's recommendations are designed to ensure that the benefits of surveillance colonoscopies outweigh the potential harms for people who receive the procedure. Therefore, CCC no longer recommends colonoscopy surveillance for people with LRAs, who should instead start screening again with the fecal immunochemical test (FIT) five years after their baseline colonoscopy as per CCC's average risk screening recommendations.

4. What should I do if my patient receives a recommendation from an endoscopist that does not align with ColonCancerCheck's (CCC) recommendations?

Endoscopist recommendations may be influenced by other factors not accounted for in the post-polypectomy surveillance recommendations. For example, CCC's recommendations assume that the previous colonoscopy was high quality and complete. If there was inadequate bowel preparation, or the colonoscopy was not completed to the cecum, the endoscopist will adjust their recommendation accordingly.

Additionally, post-polypectomy surveillance recommendations evolve as new evidence emerges. The recommendation made by the endoscopist at the time of the patient's previous colonoscopy may not reflect more recent knowledge. When sending a referral to the endoscopist, it is important to include the colonoscopy and pathology reports, if possible. This will allow the consulting endoscopist to review the reports to confirm whether the patient is due for surveillance colonoscopy. The consulting endoscopist will then determine the best course of action.

5. What should I look for in the previous colonoscopy report?

When reviewing the colonoscopy report, you need to determine if the colonoscopy was complete and high quality. You should verify that there was cecal intubation and adequate bowel preparation to visualize polyps greater than 0.5 millimeters. You should also review the number of polyps removed, their size and the completeness of the polypectomy. It is important to note that diminutive polyps (less than five millimeters) in the rectum or sigmoid colon are often hyperplastic polyps, which are not associated with progression to colon cancer, and therefore do not require surveillance.

6. What should I look for in the previous pathology report?

When reviewing the pathology report, it is important to take note of the number of screen-relevant polyps (i.e. adenomas or serrated polyps). In the case of adenomas, you should review whether they were one centimeter or larger, whether they were tubulovillous or villous, and whether high-grade dysplasia was present. By definition, all adenomas will have some degree of dysplasia, so only high-grade dysplasia is relevant.

For serrated adenomas, you should identify the size of the polyps and the presence of dysplasia. Not all serrated polyps will be dysplastic, so a serrated polyp with any degree of dysplasia is an indicator of a more advanced lesion.

7. What should I do if I do not have access to the previous pathology report?

The recommendations are based on the pathology findings from the previous colonoscopy. To make an appropriate surveillance recommendation, the pathology findings should be reviewed, if possible. If you do not have access to the pathology report, you should follow-up with the appropriate facility to get the pathology report. If you are unable to get the pathology report, you will need to make a recommendation based on the information you have available to you.

8. What screening test is recommended if my patient has a family history of colorectal polyps?

Up to 50 percent of people over age 50 may have colorectal polyps (4), so it is not uncommon for patients to have a family history of polyps. People with a first-degree relative who had a polyp or adenoma removed are considered average risk and should be screened with the fecal immunochemical test (FIT) according to ColonCancerCheck's recommendations for average risk screening.

Only people with a family history of colorectal cancer that includes one or more first-degree relatives who have been diagnosed with colorectal cancer are considered at increased risk for the disease. These people should be screened with colonoscopy starting at age 50, or 10 years earlier than the age their relative was diagnosed, whichever occurs first, as per CCC's recommendations for increased risk.

References

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