Colonoscopic Surveillance Intervals - Adenomas

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

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

C  MULTIPLE
≥5 adenomas

D  POSSIBLE INCOMPLETE OR PIECEMEAL EXCISION OF LARGE OR SESSILE ADENOMA

Colonoscopy at 5 years

Colonoscopy at 3 years

Colonoscopy at 1 year

Colonoscopy at <1 year*

Colonoscopy at 3-6 months

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 Risk  As for B
or High Risk  *Consider referral to a genetics service

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**

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.

Developed by: Karen Barclay, Cancer Council Australia Surveillance Colonoscopy Guidelines Working Party. Algorithm for Colonoscopic Surveillance Intervals – Adenomas. 2013. This graphic is licenced under the Creative Commons Attribution-ShareAlike 3.0 Australia licence.