

Update on Polyp Surveillance Guidelines

2020

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Introduction

Te Aho o Te Kahu (the Cancer Control Agency) in partnership with the National Screening Unit, Ministry of Health endorses this advice on surveillance colonoscopy for follow-up after removal of polyps. This advice sets out appropriate practice for clinicians to follow subject to their own judgement. It has been developed to help them make decisions in this area.

The advice was developed to align with recent publications from the United Kingdom, the United States, Australia and Europe.^{1,2,3,4} These publications, based on updated available evidence up to June 2019, indicated that previous guidelines would now recommend over surveillance for some groups.

A technical advisory group with the required expertise was established and has undertaken a systematic review of recent literature. Members of the group included a range of clinicians and some members of the National Bowel Cancer Working Group (NBCWG). Their role was to review the evidence and consider implementation of a similar polyp follow-up approach in New Zealand.

The New Zealand specialists in the technical advisory group are routinely involved in the diagnosis, management and surveillance of patients identified to have bowel polyps. Acknowledgements go to:

- Ian Bissett, Chair of NBCWG, Colorectal surgeon, Department of Surgery, University of Auckland
- Susan Parry, Gastroenterologist, Clinical Lead of National Bowel Screening Programme, Ministry of Health
- Campbell White, Physician, Taranaki Base Hospital
- Chris Hemmings, Pathologist, Clinical Director of Anatomic Pathology, Canterbury Health Laboratories; University of Otago
- David Vernon, General surgeon, Lakes District Health Board (DHB)
- Marianne Lill, General surgeon, Whanganui DHB
- Masato Yozu, Pathologist, Counties Manukau DHB

¹ Rutter MD, East J, Rees CJ, et al. 2020. British Society of Gastroenterology/Association of Coloproctology of Great Britain and Ireland/Public Health England post-polypectomy and post-colorectal cancer resection surveillance guidelines. *Gut* 69(2): 201–23.

² Gupta S, Lieberman D, Anderson JC, et al. 2020. Recommendations for follow-up after colonoscopy and polypectomy: a consensus update by the US Multi-Society Task Force on Colorectal Cancer. *Gastrointestinal endoscopy* 91(3): 463–85.

³ Cancer Council Australia Surveillance Colonoscopy Guidelines Working Party. 2019. *Clinical Practice Guidelines for Surveillance Colonoscopy*. Sydney: Cancer Council Australia. URL: https://wiki.cancer.org.au/australia/Guidelines:Colorectal_cancer/Colonoscopy_surveillance (accessed 13 August 2020).

⁴ Hassan C, Antonelli G, Dumonceau J-M, et al. 2020. Post-polypectomy colonoscopy surveillance: ESGE Guideline Update 2020. *Endoscopy* 52: 687–70.

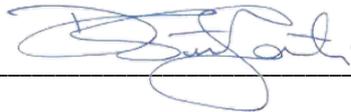
- Russell Walmsley, Gastroenterologist, Waitematā DHB, University of Auckland
- Siraj Rajaratnam, Colorectal surgeon, Waitematā DHB
- Theresa Chalmers-Watson, Gastroenterologist, Canterbury DHB, University of Otago.

For New Zealand’s previous *Guidance on Surveillance for People at Increased Risk of Colorectal Cancer*, published in February 2012, go to www.health.govt.nz/publications.

Ensuring an equity focus is a priority for Te Aho o Te Kahu and the National Screening Unit. Evidence indicates that Māori are less likely to have access to early diagnosis for some cancers, including colorectal cancers, than non-Māori. Breaking down barriers for Māori to access surveillance colonoscopy will allow a greater proportion of cancers to be detected early and managed well, leading to more curative treatment and subsequent improvements in survival for Māori patients.

Note: This document is updating only the polyp surveillance section of the previous guidelines. An update on other aspects will also be developed. New Zealand colonoscopy capacity is constrained, and we anticipate that these guidelines will reduce demand.

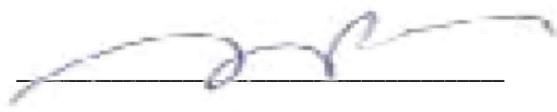
Professor Diana Sarfati
Chief Executive
Te Aho o Te Kahu



Professor Ian Bissett
Chair
National Bowel Cancer Working Group



Dr Susan Parry
Clinical Lead
National Bowel Cancer Screening Programme



Purpose of this advice

This document provides recommendations for surveillance after colonoscopy and polyp excision. The recommendations are the same for initial and subsequent procedures and may, if appropriate, be applied to colonoscopies that have been completed before we released this guidance.

Patients outside the scope of this advice are those with hereditary colorectal cancer syndromes (for example, Lynch syndrome or Familial Adenomatous Polyposis), inflammatory bowel disease, personal history of colorectal cancer, and family history that warrants investigation for hereditary colorectal cancer syndromes.⁵

Audience for these guidelines

This advice is relevant to clinicians providing colorectal polyp surveillance. All district health boards, whether or not they have begun to participate in the National Bowel Screening Programme, are expected to offer colonoscopic polyp surveillance in line with this advice.

⁵ Ministry of Health. 2012. *Guidance on Surveillance for People at Increased Risk of Colorectal Cancer*. Wellington: Ministry of Health. URL: <https://www.health.govt.nz/system/files/documents/publications/colorectal-cancer-surveillance-guidance.pdf> (accessed 13 August 2020).

Associated documents

Table 1: Associated documents

<i>Guidance on Surveillance for People at Increased Risk of Colorectal Cancer</i> , Ministry of Health 2012
British Society of Gastroenterology/Association of Coloproctology of Great Britain and Ireland/Public Health England post-polypectomy and post-colorectal cancer resection surveillance guidelines, Rutter et al 2020
Recommendations for follow-up after colonoscopy and polypectomy: a consensus update by the US Multi-Society Task Force on Colorectal Cancer, Gupta et al 2020

Equity

Survival outcomes for colorectal cancer are significantly poorer for Māori than for non-Māori. Comorbidity and difficulties with accessing health services for colon cancer account for about 30 percent of excess mortality among Māori.⁶ Māori and Pacific peoples are also more likely to be diagnosed with distant disease at diagnosis of colorectal cancer and, significantly, are more likely to be diagnosed after they present at an emergency department, which may reflect poorer access to primary and secondary services.⁷ For this reason, it is important that clinicians make decisions that contribute to equitable outcomes for Māori and Pacific peoples in particular.

⁶ Hill S, Sarfati D, Blakely T, et al. 2010. Survival disparities in Indigenous and non-Indigenous New Zealanders with colon cancer: the role of patient comorbidity, treatment and health service factors. *Journal of Epidemiology & Community Health* 64:117–23.

⁷ <https://www.hqsc.govt.nz/our-programmes/health-quality-evaluation/projects/atlas-of-healthcare-variation/bowel-cancer/>

Clinical advice

Figure 1 summarises the new guidance. This advice was developed in recognition of the:

1. low risk of future colorectal cancer for some groups of patients identified as having adenomas
2. colorectal cancer risk associated with some serrated polyps.

Figure 1: Surveillance intervals based on findings at high-quality colonoscopy

1 year	3 years	5 years	10 years or NBSP (Whichever comes first)
Adenomas* >10 adenomas***	Adenomas* 5–10 adenomas <10 mm Adenoma ≥10 mm Tubulovillous adenoma or Villous adenoma Adenoma with HGD	Adenomas* 3–4 adenomas <10 mm	Adenomas* 1–2 adenomas <10 mm
Serrated polyps* Serrated polyposis syndrome – initial interval after polyp clearance***	Serrated polyps* ≥5 SSL <10 mm SSL ≥10 mm SSL with dysplasia Traditional serrated adenoma	Serrated polyps* 1–4 SSL <10 mm HP ≥10 mm**	

* If there are both adenoma <10mm and SSL <10 mm, sum up the numbers and apply follow-up interval for SSL.

** A 3-year follow-up interval is favoured if concern about consistency in distinction between sessile serrated lesion and hyperplastic polyp locally.

*** Referral to NZ Familial Gastrointestinal Cancer Service (NZFGCS) is recommended. Multiple adenoma referral criteria are advised below

NBSP: National Bowel Screening Programme

SSL: Sessile serrated lesion (= sessile serrated adenoma/polyp)

HGD: High grade dysplasia

HP: Hyperplastic polyp

High-risk polyps

	Conventional adenomas	Serrated polyps
Average-risk polyps	Tubular adenomas < 10 mm	Sessile serrated lesion (SSA/P) < 10 mm Hyperplastic polyp ≥ 10 mm*
High-risk polyps	Adenoma ≥ 10 mm Adenoma with tubulovillous or villous histology** Adenoma with high-grade dysplasia	Sessile serrated lesion (SSA/P) ≥ 10 mm Sessile serrated lesion (SSA/P) with dysplasia Traditional serrated adenoma Serrated adenoma, unclassified (unclassified serrated polyp with dysplasia)

* Follow up as a high-risk polyp if concern exists about consistency in distinction between sessile serrated lesion and hyperplastic polyp locally.

** Minimum 25% of unequivocal villous component is required (6).

Notes on clinical context

High-quality colonoscopy is the prerequisite for these recommendations. To be of high quality, the colonoscopy must involve verified and documented caecal intubation, good colonoscopy technique and adequate bowel preparation (see 'Definitions' below). Surveillance should be adjusted for suboptimal colonoscopy.

Recommended techniques for polypectomy should be followed and complete polyp excision should be performed (see 'Definitions' below).

After piecemeal excision of high-risk polyps, the site should be checked within two to six months and then a further full colonoscopy performed at 12 months. Patients should then undergo surveillance as indicated.

No surveillance is required for anyone who has only hyperplastic polyps smaller than 10 mm, unless the person meets the criteria for Serrated Polyposis Syndrome.

For people older than age 75 years or with significant comorbidities, carefully consider potential benefits and risks before offering any routine surveillance.

Definitions

High-quality colonoscopy in New Zealand

A high-quality colonoscopy is a colonoscopy performed by a credentialed colonoscopist, as defined by the Endoscopy Guidance Group for New Zealand,⁸ where the quality of the bowel preparation for the individual colonoscopy has both a:

- Boston Bowel Preparation Score (BBPS) on withdrawal of 6 or higher, with no single segment score under 2
- subjective rating of Excellent or Adequate (the top two categories on the drop-down menu from Provation).

Serrated polyposis syndrome

Serrated polyposis syndrome occurs where either:⁹

- at least five serrated lesions or polyps are proximal to the rectum, all are 5 mm or larger and at least two are 10 mm or larger
- more than 20 serrated lesions or polyps of any size are distributed throughout the large bowel and at least five are proximal to the rectum.

⁸ Endoscopy Guidance Group for New Zealand. 2018. *Guidelines for Local Credentialing in Adult Endoscopy*. Auckland: Endoscopy Guidance Group for New Zealand. URL: <https://endoscopyquality.co.nz/assets/Uploads/Guidelines-for-Local-Credentialing-in-Endoscopy-v1.pdf> (accessed 13 August 2020).

⁹ International Agency for Research on Cancer. 2019. *Digestive System Tumours*. Lyon: International Agency for Research on Cancer. URL: <https://publications.iarc.fr/579> (accessed 13 August 2020).

High-quality polypectomy

The European Society of Gastrointestinal Endoscopy's 2017 clinical guideline is the current best-practice guideline for performing colonoscopic polypectomy of different morphology, size and location.¹⁰

Measure the size of polyps that are 10 mm or larger in reference to the width of an open snare and photograph them.¹¹

Also consider deferring removal of polyps that are in difficult locations or more than 2 cm in diameter (Level 4 polypectomy) until an appropriately experienced and skilled endoscopist can undertake it because of the close relationship between recurrence and size, and the difficulty of initial lesion removed.^{12,13}

Complete polypectomy is defined as removal of all visual polypoid tissue.

Multiple Adenoma referral criteria to the New Zealand Familial Gastrointestinal Cancer Service

Refer a patient to the New Zealand Familial Gastrointestinal Cancer Service where they have:

- 10 or more adenomas at one time‡ (if aged over 70 years, patient must have at least one advanced adenoma*), or
- 5 or more advanced adenomas* at one time‡, or
- 20 cumulative adenomas, or
- 10 cumulative adenomas if the patient is aged 30 years or younger.

Notes – do not relate referral criteria – can we separate

Notes:

‡ Or within a two-year period.

* Advanced adenoma defined as: 10 mm or larger in size or 25% or greater villous histology (that is, tubulovillous or villous adenoma) or high-grade dysplasia.

¹⁰ Ferlitsch M, Moss A, Hassan C, et al. 2017. Colorectal polypectomy and endoscopic mucosal resection (EMR): European Society of Gastrointestinal Endoscopy (ESGE) clinical guideline. *Endoscopy* 49(3): 270–97.

¹¹ Gupta S, Lieberman D, Anderson JC, et al. 2020. Recommendations for follow-up after colonoscopy and polypectomy: a consensus update by the US Multi-Society Task Force on Colorectal Cancer. *Gastrointestinal endoscopy* 91(3): 463–85.

¹² Sidhu M, Tate DJ, Desomer L, et al. 2018. The size, morphology, site, and access score predicts critical outcomes of endoscopic mucosal resection in the colon. *Endoscopy* 50(7): 684–92.

¹³ Endoscopy Governance Group for New Zealand. 2017. *Endoscopy Standards for Individual Colonoscopists Performing Bowel Cancer Screening in New Zealand*. Auckland: Endoscopy Governance Group for New Zealand. URL: <https://endoscopyquality.co.nz/assets/Uploads/EGGNZ-Endoscopy-Standards-for-Individual-Colonoscopy-Performing-Bowel-Cancer-Screening-in-New-Zealand-Final-v3.0.pdf> (accessed 13 August 2020).

Boston Bowel Preparation Scale

The Boston Bowel Preparation Scale (BBPS) is a scale that describes the quality of bowel preparation at colonoscopy. The large bowel is divided into three sections: the right colon, the transverse colon (including flexures) and the left colon with rectum. Each section is scored individually from 0–3.¹⁴

- 0 = Unprepared colon segment with mucosa not seen due to solid stool that cannot be cleared.
- 1 = Portion of mucosa of the colon segment seen, but other areas of the colon segment not well seen due to staining, residual stool and/or opaque liquid.
- 2 = Minor amount of residual staining, small fragments of stool and/or opaque liquid, but mucosa of colon segment seen well.
- 3 = Entire mucosa of colon segment seen well with no residual staining, small fragments of stool or opaque liquid.

These segment scores are summed for a total BBPS score ranging from 0–9.

¹⁴ Lai EJ, Calderwood AH, Doros G, et al. 2009. The Boston Bowel Preparation Scale: a valid and reliable instrument for colonoscopy-oriented research. *Gastrointestinal endoscopy* 9(3): 620–5.