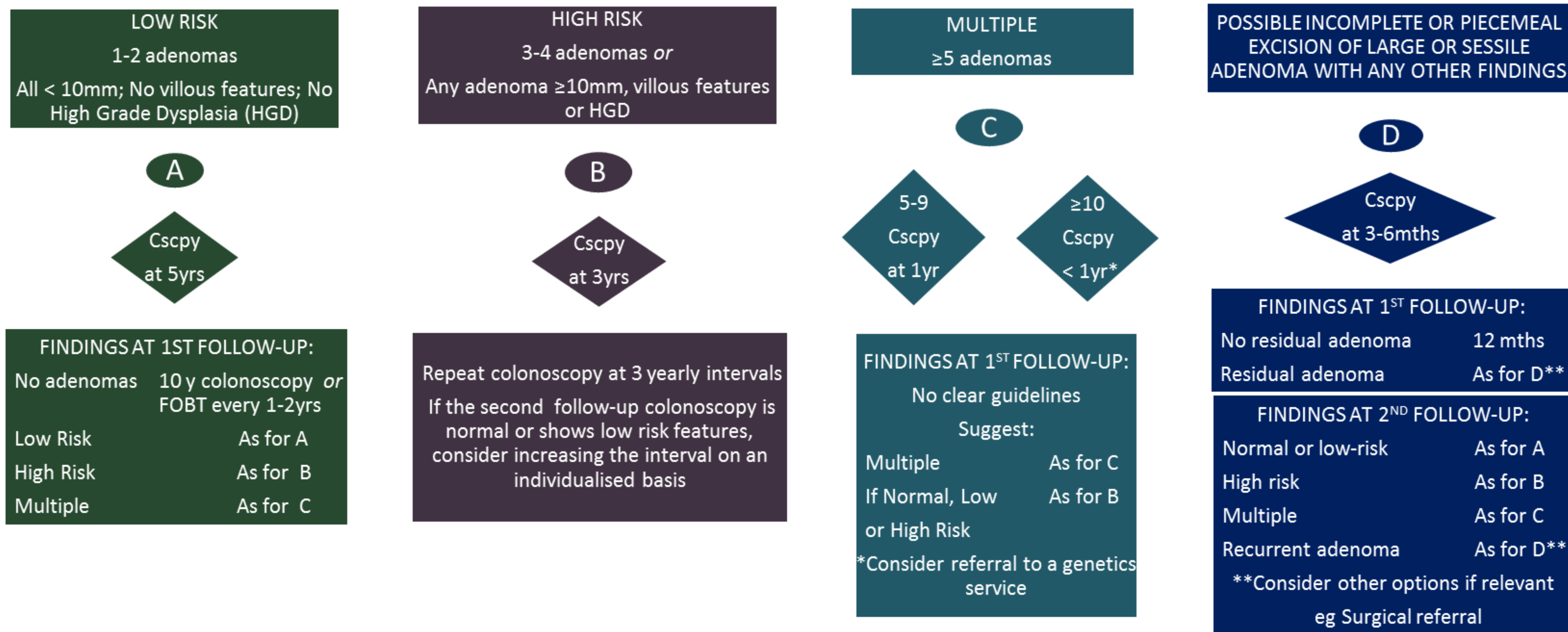
COLONOSCOPIC SURVEILLANCE INTERVALS - ADENOMAS



NOTES:

This algorithm is designed to be used in conjunction with the NHMRC *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 (cscpy) 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 ≥75y 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 hyperplastic polyposis syndrome if multiple proximal hyperplastic polyps 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.

Suggested citation: *Barclay Karen, Cancer Council Australia Surveillance Colonoscopy Guidelines Working Party. Algorithm for Colonoscopic Surveillance Intervals – Adenomas. 2013.*

Cancer Council Australia would like to acknowledge and sincerely thank Ms Karen Barclay for developing this algorithm based on the *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).*

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