

ADENOMA SURVEILLANCE

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I. CLINICAL POLICY

Current NHS BCSP policy on adenoma surveillance is as follows:

- adenoma surveillance is part of the screening programme and surveillance colonoscopies must be undertaken in accredited screening clinics by accredited screening colonoscopists¹
- accurate pathology reporting is essential to determine the patient pathway and should be carried out in accordance with NHS Bowel Cancer Screening Programme (BCSP)/Royal College of Pathology guidelines²
- adenoma surveillance in the screening programme is always based on current British Society of Gastroenterology (BSG) guidelines.³

This means that:

- patients who are deemed to be at high risk following screening colonoscopy should always be offered a surveillance colonoscopy at an interval of 12 months if they remain within the screening age group; any comorbidities should be assessed shortly before the date of the surveillance appointment
- patients who are deemed to be at intermediate risk following screening colonoscopy should be offered a three yearly surveillance colonoscopy if they remain within the screening age group; there are no acceptable reasons for a shorter interval
- patients who are deemed to be at low risk following screening colonoscopy should be returned to routine recall and sent another faecal occult blood test (FOBT) kit at the appropriate interval if they remain within the screening age group
- there is no need for polyps or adenomas of less than 1 cm to be removed surgically if in an area where access is difficult endoscopically. Such polyps should be tattooed and biopsied if possible. The management of such lesions should be discussed by the screening centre team and the patient may be invited back for repeat endoscopy or then be referred for endoscopic mucosal resection (EMR)
- if polyps are excised but not retrieved at screening colonoscopy and they have been directly observed, they should be assumed to be adenomas and the appropriate surveillance pathway should be determined based on the number and estimated size
- if adenomas are not retrieved intact at screening colonoscopy, the size estimated by direct observation should be used to determine the appropriate surveillance pathway
- sessile polyps which are removed piecemeal and subsequently reported to be adenomas put the patient into the high risk category. Once the lesion has been fully resected, the patient is then automatically allocated to 12 month surveillance colonoscopy. The identification of the polyp as sessile and removed piecemeal is taken from the colonoscopy dataset, the fact that it is an adenoma from the histology dataset.

2. AGE RANGE

The age range for eligibility for the screening programme is 60–74. This means that:

- patients who will be aged 61–74 when their surveillance appointment is due are offered a surveillance appointment within the screening programme
- patients who will be aged 75 or older when their surveillance appointment is due are ceased from the screening programme and must be referred to symptomatic care if any follow up is needed; screening centres must ensure that there are prearranged referral pathways into symptomatic care for patients who may need continued management or surveillance for screening programme findings.

3. MANAGING SURVEILLANCE PATIENTS

Patients in screening programme surveillance are currently managed in accordance with BSG guidelines (2002):³

- high risk patients with repeat high risk status diagnosed at surveillance colonoscopy remain in annual surveillance
- high risk patients with a negative result, or adenomas found at surveillance colonoscopy which confer low or intermediate risk, enter three yearly surveillance; a negative result means no adenomas or cancers found although other pathology may be present
- intermediate risk patients with high risk adenomas found at surveillance colonoscopy convert to annual surveillance
- intermediate risk patients with low or intermediate risk adenomas at three yearly surveillance colonoscopy remain in three yearly surveillance
- intermediate risk patients with a negative result at the first three yearly surveillance colonoscopy remain in three yearly surveillance but may be discharged to routine recall after a second negative result at three yearly surveillance
- patients with a polyp which cannot be removed at surveillance colonoscopy but which leaves them at apparent low risk should remain in surveillance and be recalled in three years; there is no need for such polyps to be removed surgically. The management of such lesions should be discussed by the screening centre team and the patient may then be referred for endoscopic mucosal resection (EMR)
- if polyps are excised but not retrieved at surveillance colonoscopy, and they have been directly observed, they should be assumed to be adenomas and the onward surveillance pathway should be determined based on the number and estimated size
- if adenomas are not retrieved intact at surveillance colonoscopy, the size estimated by direct observation should be used to determine the appropriate surveillance pathway.

4. DISCHARGE FROM SURVEILLANCE

Patients are discharged from surveillance in the screening programme after two consecutive negative results at three yearly surveillance. This is in accordance with BSG guidelines (2002)³ and means that:

- patients classified as being at high risk following screening colonoscopy (high risk patients) remain in surveillance for at least seven years before discharge (one annual surveillance colonoscopy followed by two further surveillance colonoscopies at three yearly intervals)
- patients classified as being at intermediate risk following screening colonoscopy (intermediate risk patients) remain in surveillance for at least six years before discharge (two surveillance colonoscopies at three yearly intervals)
- findings of low or intermediate risk adenomas **at three yearly surveillance** mean that the patient remains in three yearly surveillance until they have had two consecutive negative examinations.

Patients in surveillance are not sent an invitation to take part in FOB testing until they are discharged from surveillance. They will be sent an invitation to take part in FOB testing two years after their last colonoscopy if they remain within the screening age group. This policy will be kept under review as the programme develops.

5. PATIENTS WHO ARE OR BECOME UNFIT FOR COLONOSCOPY

Patients who become unfit (temporarily or permanently) for surveillance colonoscopy should have their future management discussed with them and consideration given to discharge from surveillance or ceasing them from the screening programme if their age and infirmity so indicate. If the problem is temporary, then surveillance could be recommenced at an appropriate time.

6. PATIENTS WHO DEFAULT

Patients who fail to attend their surveillance appointment on two occasions should be returned to the routine screening programme.

7. ENDOSCOPY OUTSIDE THE BCSP

Occasionally a patient may be subject to emergency endoscopy while in the interval before a surveillance appointment is due. Once the screening programme becomes aware of this, the specialist screening practitioner (SSP) should make an assessment of the situation. The patient's risk status may not be changed, but the colonoscopy date can be reset to a maximum of 12 months from a colonoscopy outside the BCSP. An episode note should be made.

8. SURVEILLANCE PLANNING

Screening centres need to plan surveillance colonoscopies into their colonoscopy workload. The number of surveillance colonoscopies will add to the colonoscopy workload from year 2 onwards. This is shown in Table 1. The model is simplistic as it does not reflect how patients may move from high risk to intermediate risk and from intermediate risk to low risk and that a proportion may leave the programme.

A more specific workload model is being developed for the programme by SchARR which will take account of surveillance and of the expansion of the programme.

Table 1 Expected activity per 500 000 population for screening and surveillance colonoscopies (annual colonoscopy for high risk (HR) polyps and three yearly for intermediate risk (IR)) polyps

Year 1	300 screening colonoscopies
Year 2	300 screening colonoscopies + year 1 (HR) surveillance colonoscopies
Year 3	300 screening colonoscopies + year 1 (HR) surveillance colonoscopies + year 2 (HR) surveillance colonoscopies
Year 4	300 screening colonoscopies + year 1 (HR) surveillance colonoscopies + year 2 (HR) surveillance colonoscopies + year 3 (HR) surveillance colonoscopies + year 1 (IR) surveillance colonoscopies
Year 5	300 screening colonoscopies + year 1 (HR) surveillance colonoscopies + year 2 (HR) surveillance colonoscopies + year 3 (HR) surveillance colonoscopies + year 4 (HR) surveillance colonoscopies + year 2 (IR) surveillance colonoscopies
Year 6	300 screening colonoscopies + year 1 (HR) surveillance colonoscopies + year 2 (HR) surveillance colonoscopies + year 3 (HR) surveillance colonoscopies + year 4 (HR) surveillance colonoscopies + year 5 (HR) surveillance colonoscopies + year 3 (IR) surveillance colonoscopies

Extracted from *Guidance for Public Health and Commissioning* (NHS BCSP Publication No 3).

9. FOLLOW UP DIAGNOSTIC TESTS

A follow up colonoscopy or flexible sigmoidoscopy may be carried out, for example, to check an excision site. Follow up diagnostic tests are part of the original episode (which may be a screening or a surveillance episode) – they are *not* appointments for adenoma surveillance.

A patient can be manually referred for a follow up diagnostic test subsequent to a colonoscopy within a maximum of 6 months from the test date. This can *only* be for one of the following reasons:

- polyp not fully resected
- check polyp site
- multiple polyps, not all removed
- biopsies required
- unexplained symptoms
- therapies required
- incomplete procedure.

After a follow up test, the patient is either returned to routine screening or entered into surveillance if deemed to be at high risk or at intermediate risk after an adenoma is definitively identified.

For patients who are undergoing follow up tests in the same episode to check the excision site, the BCSS automatically defaults to a screening programme surveillance colonoscopy. This is to facilitate adherence to BSG guidelines. This then counts as a new episode and does *not* generate two appointments. It ensures that a patient undergoing flexible sigmoidoscopy is invited to have his or her entire colon re-examined at the appropriate interval.

10. MANAGING SURVEILLANCE ON BCSS

Surveillance episodes are handled automatically on BCSS:

- patients are automatically referred to surveillance if the number and size of adenomas detected classifies them into:
 - high risk
 - intermediate risk
- a classification of high risk requires histological data unless the polyp has not been retrieved after excision but has been directly observed, ie during colonoscopy or flexible sigmoidoscopy
- if a patient has more than one test diagnosing adenomas which leads to the adenomas found being classified definitively as either high risk or intermediate risk, the screening centre can choose the most appropriate test date to use to set the surveillance due date; this should be the most recent date on which the entire colon was examined, ideally by colonoscopy or by imaging, rather than the date of a partial examination such as flexible sigmoidoscopy
- a patient will be automatically discharged from surveillance after two consecutive negative surveillance results at three yearly intervals; the patient will be returned to routine screening and sent another FOB test provided he or she is still within the screening age range
- the screening centre SSP may discharge the patient from surveillance for the following reasons:
 - informed patient choice (patient initiated)
 - no patient contact
 - clinical decision following discussion with the patient (clinician initiated).

Patients discharged from surveillance are automatically returned to routine screening and sent another FOB test in two years' time if they remain within the screening age group unless the patient requests complete ceasing.

REFERENCES

1. *Guide Book for Programme Hubs and Screening Centres* (Version 3, 31 March 2008). NHS Cancer Screening Programmes (available at www.bcsp.nhs.uk).
2. *Reporting Lesions in the NHS Bowel Cancer Screening Programme. Guidelines form the Bowel Cancer Screening Programme Pathology Group*. NHS Cancer Screening Programmes, 2007 (NHS BCSP Publication No 1).
3. Atkins WS, Saunders BP. Surveillance guidelines after removal of colorectal adenomatous polyps. *Gut* 2002, 51 (Suppl. V): v6–v9.

