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National Endoscopy Programme

National Endoscopy Programme

Implementation of Surveillance Guidelines for Post Polypectomy and Post Colorectal Cancer Resection

2019

Contents

Summary

Consensus guidelines for management of post polypectomy and colorectal cancer resection surveillance were published on line in September 2019.These guidelines commissioned by the British Society of Gastroenterology (BSG), the Association of Coloproctology of Great Britain and Ireland (ACPGBI) and Public Health England (PHE) are based on current evidence and should be adopted by Welsh endoscopy units.

Main changes from previous guidance:

- Screening is included
- Serrated polyps are included
- High risk groups are re-defined as those with:
  - 2 or more polyps including at least one advanced colorectal polyp
  - OR 5 or more premalignant polyps
- High risk groups should undergo a **one off** colonoscopy at 3 years
- Post colorectal cancer resection (CRC) patients should undergo a 1-year clearance colonoscopy and then a 3-year surveillance colonoscopy and align with the post-polypectomy surveillance algorithm thereafter

National Endoscopy Programme for Wales Recommendation:

- New guidance should be prospectively applied with immediate effect
- New guidelines should be retrospectively applied as per guidance outlined in this document
- Local teams should develop a plan for management of surveillance to include:
  - Appointing clinical and clerical leads to actively manage the process
  - Development of a protocol to manage surveillance with regular audit
  - Development of trajectories for clearance of backlogs
- Patients waiting for overdue procedures should be prioritised to reduce patient safety risk
- All guideline statements apply only where considered clinically appropriate for surveillance and should take into account other factors such as co-morbidity etc. (refer to statements in full guidance on age and appropriateness)
- Bowel Screening Wales (BSW) surveillance pathway should be aligned with this guidance and the same principles applied

Introduction

Consensus guidelines from the British Society of Gastroenterology (BSG), the Association of Coloproctology of Great Britain and Ireland (ACPGBI) and Public Health England (PHE), for management of post polypectomy and colorectal cancer resection surveillance were published on line in September 2019 based on review of current evidence (summary surveillance algorithm appendix 1).

BSG-ACPGBI-PHE-Post-polypectomy-and-post-colorectal-cancer-resection-surveillance-guidelines.

They provide a rigorous evidence-based framework for the use of surveillance colonoscopy and replace previous guidance. These guidelines have been endorsed by BSG, PHE and ACPGBI as well as extensively peer reviewed internationally.

The updated guidelines aim to make surveillance more evidence based and stratified by outcomes that are clinically relevant, ensuring colonoscopy surveillance is only recommended for people who need it. The need for and timing of surveillance colonoscopy has altered and this updated guidance needs to be implemented in Wales.

The National Endoscopy Programme (NEP) have considered and endorsed the new guidelines for prospective and retrospective application.

1 2019 Guidelines

Aimed at health care professionals the new guidelines address:

- Which patients should commence surveillance
- What is the appropriate surveillance interval
- When can surveillance be stopped

Evidence shows that with high quality colonoscopy and clearance of polyps there is only a small chance of developing further polyps that may turn into cancers. **Therefore, in most cases a single surveillance colonoscopy is recommended based on the findings at each colonoscopy**.

The key recommendations in the new 2019 guidelines are that following histological confirmation, the high-risk criteria for future colorectal cancer (CRC) following polypectomy comprise of either:

- 2 or more premalignant polyps including at least one advanced colorectal polyp
- OR 5 or more premalignant polyps

The definition of advanced colorectal polyp[1]

If colonoscopy is complete to the caecum with good bowel preparation and complete resection of all polyps, patients should undergo a one-off surveillance colonoscopy at three years.

Post colorectal cancer resection patients should undergo a one-year clearance colonoscopy, then a surveillance colonoscopy after three years.

The guidance assumes that the initial colonoscopy procedure is quality assured to a level described by BSG guidelines on patient and operator related factors and Joint Advisory Group (JAG) guidelines on key performance indicators for Colonoscopists (Summary of Quality Standards Appendix 2).

UK Key Performance Indicators & Quality Assurance Standards for Colonoscopy

2 Implementation in Wales

The NEP have considered the new guidelines and recommend implementation in Welsh Endoscopy Units with the following points clarified.

BSG Guidance	Clarity for Wales
Consider site check for 10-19mm LNPCPs[2] without histological confirmation of complete excision	Site should be checked or explained why this is not appropriate
Site check at 2 - 6 months	Site check should be undertaken at 3 months wherever possible
Exceptions section 'or if older than about 75yrs'	Over 75 years
Exceptions section 'consider colonoscopy at 5 or 10years'	5 years

The NEP have developed the following protocol for implementation in order to standardise the approach, reduce patient safety risk and provide a national audit trail.

Health Boards are asked to establish a clinical and clerical team to actively manage surveillance and implementation of the new guidelines prospectively and retrospectively according to the

[1]Advanced colorectal polyp: the term includes both advanced serrated polyps and advanced adenomatous polyps.

[2] Large non-pedunculated colorectal polyps

following protocol. Incidents identified as part of this process, e.g. cases of delayed diagnoses, must be investigated and reported appropriately. The new guidance may change management and reduce overall numbers on surveillance however, Health Boards may need to increase their capacity initially to deal with patients who may need an immediate repeat procedure following review of their case.

2.1 Prospective application

New guidelines should be used for all patients satisfying the criteria above (post polypectomy or cancer resection) following complete colonoscopy with adequate bowel preparation, clearance of all pre malignant polyps and confirmation of histology with immediate effect.

JAG expects all patients on waiting lists for surveillance procedures to be clerically and clinically validated approximately 3 months before their scheduled recall date to ensure the procedure is still indicated at that time point. All services should have mechanisms in place (with allocated time in the job plans) for this to be delivered on an ongoing basis.

Separate guidelines from the BSG/ACPGBI on high-risk (Familial/Genetic cases) surveillance in specific groups thought to be at higher than average risk can be found in the link below.

BSG/ACPGBI/UKCGG-Guidelines-for-the-management-of-Hereditary-Colorectal-Cancer

Further information relating to implementation of management of Hereditary colorectal cancer in Wales will be necessary.

2.2 Retrospective application

The NEP suggests that implementation is prioritised as per the steps below in sequence ensuring that each step is complete prior to moving to the next one.

1. Overdue Procedures

Patients waiting for overdue surveillance procedures should be identified and validated according to NEP guidance (appendix 3). If surveillance is needed patients should be offered a date for the procedure as soon as possible. Trajectories for clearance of the backlog should be developed and submitted to the NEP.

Current 1-year Surveillance List: (algorithm appendix 4)

- Identify patients waiting for 1-year surveillance procedures
- Confirm demographics and that the patient is still alive
- Validate the need for surveillance as per new guidance and check histology
- Assess quality of the previous procedure and operator Key Performance Indicators (KPIs)
- Move to a 3-year surveillance interval if good quality of previous procedure confirmed and other criteria for surveillance met
- If good quality cannot be confirmed discuss case at the local Endoscopy user group, document the groups decision and communicate the outcome to the patient, as per local policy (letter and/or clinic visit). Discuss the option of further surveillance and document the patient discussion
- For those whose criteria for surveillance changes in the new guidance cease from further surveillance if good quality of previous procedure confirmed
- Write to patients using standardised letter (appendix 5) when management has been changed
- If the patient is within the screening eligible age – reinforce the importance of participation in screening
- Log details of all patients where surveillance management has been reviewed (surveillance log spreadsheet – attached separately) – for potential future audit

Current 3 Year Surveillance List: (algorithm appendix 4)

- Identify patients waiting for 3-year surveillance procedures
- Confirm demographics and that the patient is still alive
- Validate the need for surveillance as per the new guidelines and check histology
- Assess quality of the previous procedure and operator KPIs
- If appropriate continue with the first surveillance procedure 3 years after index colonoscopy
- If good quality cannot be confirmed discuss the case at the local Endoscopy user group, document the decision of the group and communicate the decision to the patient, as per local policy (letter and/or clinic visit). Discuss the option of further surveillance and document the patient discussion
- For second and subsequent surveillance procedures:
    - Assess the quality of the previous procedure and operator KPIs
    - Apply the same criteria as for the first 3-year surveillance
    - Remove from surveillance if previous procedure quality and operator KPI’s at the previous procedure are satisfactory
    - If good quality cannot be confirmed invite the patient to clinic and give the option of further surveillance. Document patient discussion

- Write to patients when management has been changed using standardised letter (appendix 5)
- Log details of all patients where surveillance management has been reviewed for potential future audit (surveillance log spreadsheet – attached separately)
- If the patient is within the screening eligible age – reinforce the importance of participation in screening Remove from surveillance if appropriate

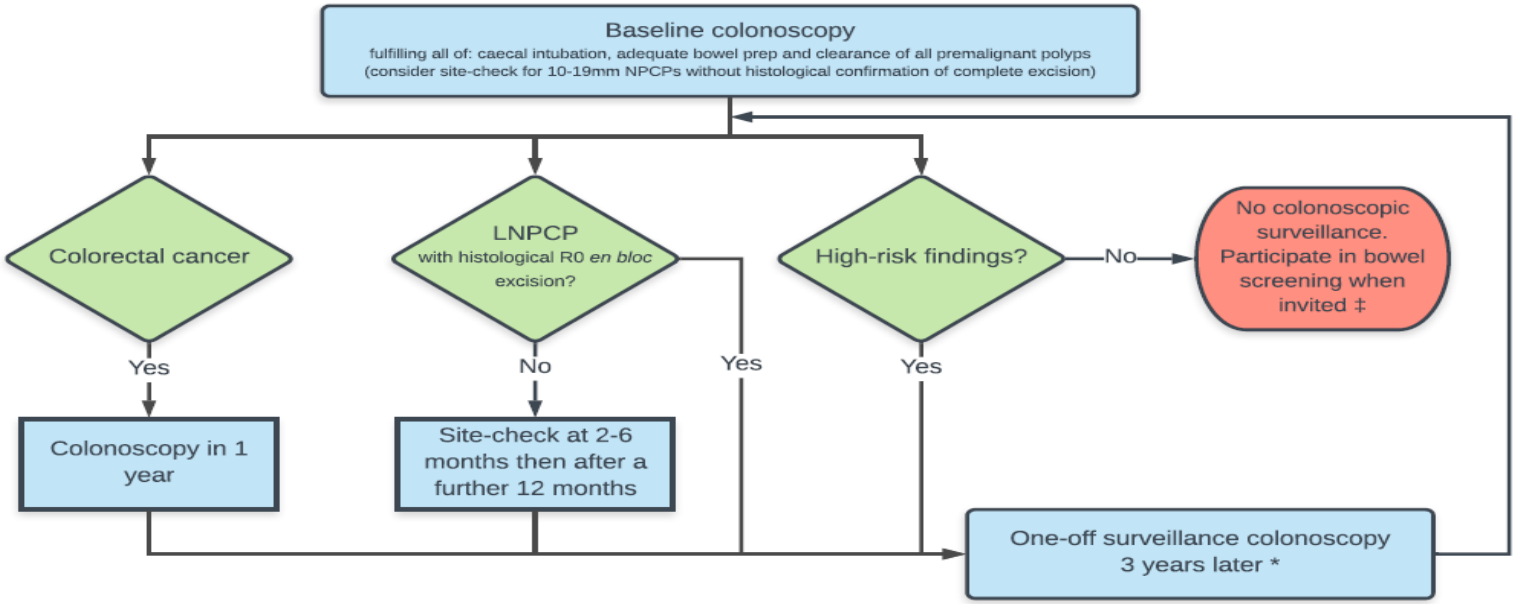
Current 5 Year Surveillance List: (algorithm appendix 4)

- Identify patients waiting for 5-year surveillance procedures
- Confirm demographics and that the patient is still alive
- Validate the need for surveillance as per the new guidelines and check histology
- For those whose criteria for surveillance changes in the new guidance cease from further surveillance if good quality of previous procedure is confirmed
- If good quality cannot be confirmed, discuss the case at the local Endoscopy user group, document the decision of the group and communicate the decision to the patient, as per local policy (letter and/or clinic visit). Discuss the option of further surveillance and document the patient discussion
- Write to patients using the standardised letter (appendix 5) when management has been changed
- If the patient is within the screening eligible age – reinforce the importance of participation in screening
- Remove from surveillance if appropriate
- Log details of all patients where surveillance management has been reviewed – for potential future audit (surveillance log spreadsheet – attached separately)

Frequently asked questions are covered in appendices (appendix 6)

Appendix 1

BSG/PHE/ACPGBI Guidelines for Post-polypectomy and Post-cancer-resection Surveillance



High-risk findings

- **≥2 premalignant polyps including ≥1 advanced colorectal polyp; or**
- **≥5 premalignant polyps**

Definitions:

- *Serrated polyps: umbrella term for hyperplastic polyps, sessile serrated lesions, traditional serrated adenomas and mixed polyps*
- *Premalignant polyps: serrated polyps (excluding diminutive [1-5mm] rectal hyperplastic polyps) and adenomatous polyps*
- *Advanced colorectal polyps: serrated polyp ≥10mm, serrated polyp with dysplasia, adenoma ≥10mm, adenoma with high-grade dysplasia*
- *(L)NPCP: (Large; ≥20mm) non-pedunculated colorectal polyp*

Exceptions

* In general, we recommend no surveillance if life-expectancy <10y or if older than about 75y

‡ If patient is >10y younger than lower screening age and has polyps but no high-risk findings, consider colonoscopy at 5 or 10y

Refer to BSG hereditary CRC guidelines if:

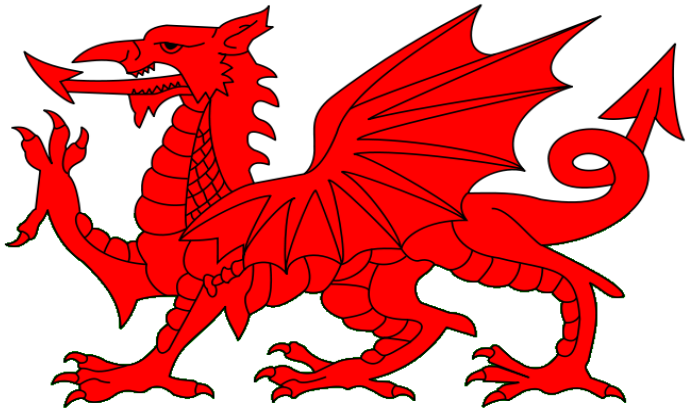
Family history (FH) of colorectal cancer (CRC):
- 1 first-degree relative (FDR) diagnosed with CRC <50y, or
- 2 FDRs diagnosed with CRC at any age

Personal history of CRC
- <50y
- any age, who also has FDR with CRC at any age

Personal history of multiple adenomas:
- <60y with lifetime total ≥10 adenomas; or
- ≥60y with lifetime total ≥20 adenomas, or ≥10 + FH CRC/polyposis

Known/suspected inherited CRC predisposition syndromes including
- Lynch Syndrome or other polyposis syndrome
- Serrated Polyposis Syndrome:
  - ≥5 serrated polyps ≥5mm prox to rectum, with ≥2 of ≥10mm; or
  - ≥20 serrated polyps (any size) including ≥5 prox to rectum

Rutter et al., Gut 2020



Further clarity on recommendations for Wales

Baseline colonoscopy
Site should be checked or explained why this is not appropriate

Site check (2-6mths)
Should be undertaken at 3 months wherever possible

Exceptions
Age clarified as Over 75 years

Younger age than screening age colonoscopy performed at 5-years.

Appendix 2

Summary of Quality standards

Quality indicator	Minimal standard	Aspirational target	Comment
Caecal intubation rate (unadjusted)	90%	95%	Photographic proof of ileocaecal valve, terminal ileum, anastomosis or appendix orifice required in all cases
Adenoma detection rate (ADR) in general all patients population (not screening).	15%	20%	Adenoma detection rate is the quality standard. Given the difficulty in reporting ADR then Polyp Detection Rate or Polypectomy rate may be used where it has been demonstrated to accurately reflect ADR for that unit / clinician.
Bowel preparation of sufficient diagnostic quality to not warrant repeat or alternative test.	90 %	95%	
Rectal retroversion rate	90%		
Colonoscopy withdrawal time (for negative procedures)	Mean of ≥6 mins	Mean of ≥10 minutes	
Sedation level for age < 70 Median total dose ≤ 50mg Pethidine (≤100mcg Fentanyl) ≤ 5mg Midazolam (Or equivalent drugs)	Auditable outcome		

rate			
Colonoscopic perforation rate where polypectomy performed	<1 in 500	<1 in 1500	
Colonoscopic perforation rate where dilatation performed	<3% (<1 in 33)	<1% (<1 in 100)	
Diagnostic FS perforation rate	<1 in 5000	<1 in 10,000	
Colorectal stenting perforation rate	<10%	<5%	
Post polypectomy bleeding rate (intermediate severity or higher)	<1 in 200	<1 in 1000	
Unplanned admission rate	Auditable outcome; Review every case		
Use of reversal agents	Auditable outcome; Review every case		

Sedation level for age ≥ 70 Median total dose ≤ 25 mg Pethidine (≤ 50 mcg Fentanyl) ≤ 2 mg Midazolam (Or equivalent drugs)	Auditable outcome		
Number of colonoscopies undertaken by endoscopist (or directly supervising trainee in room) per year	100	150	If numbers less than 150 then other KPI e.g. CIR and ADR should be scrutinised more closely and if concerns identified then action should be taken
Polyp retrieval rate	≥ 90%		
Tattooing of all lesions ≥ 20mm and / or suspicious of cancer outside of rectum and caecum	100%		Tattoo according to trust policy
Diagnostic biopsies for unexplained diarrhoea	Rectal biopsies taken in 100% of cases	Minimum of 2 right and 2 left colon biopsies	
Post Colonoscopy Colorectal Cancer	Auditable Outcome		All Post Colonoscopy Colorectal Cancers (PCCRC) should be reported as adverse events and each unit should have a policy for capturing PCCRC data.
Comfort level	Auditable Outcome		Units should audit this and units should aim to have less than 10 % of patients with moderate or severe discomfort.
Overall colonoscopic perforation rate	<1 in 1000	<1 in 3000	
Diagnostic colonoscopic perforation	<1 in 2000	<1 in 4000	

Appendix 3

NEP Validation Guidance

Clerical validation

- Identify patients waiting for surveillance procedures
- Check patient demographics and that they are still alive
- Check subsequent colonoscopy procedures after the index procedure
- Collate all previous endoscopy and pathology reports for review

Clinical validation

- Confirm date of procedure to set surveillance i.e. date of the last complete colonoscopy
- Identify operator of previous procedures
- Confirm relevant histology
- Assess KPI data of previous operator (of procedure that sets surveillance)
- Assess the quality of the previous procedure
- If procedure quality or operator KPI data incomplete or substandard refer to the local EUG to determine management decision for surveillance as appropriate
- If operator & procedure KPI's satisfactory plan for surveillance in line with new guidelines
- Collate cases where management has changed for peer review
- Collate details of cases where operator KPI data is substandard for the Clinical Lead to feed back to the individual endoscopist and for themes to be fed into the national programme to inform development of a training programme for upskilling.
- Communicate a change in management to the patient using standardised letter if appropriate
- Invite to clinic to confirm appropriateness and discuss with patient if appropriate.

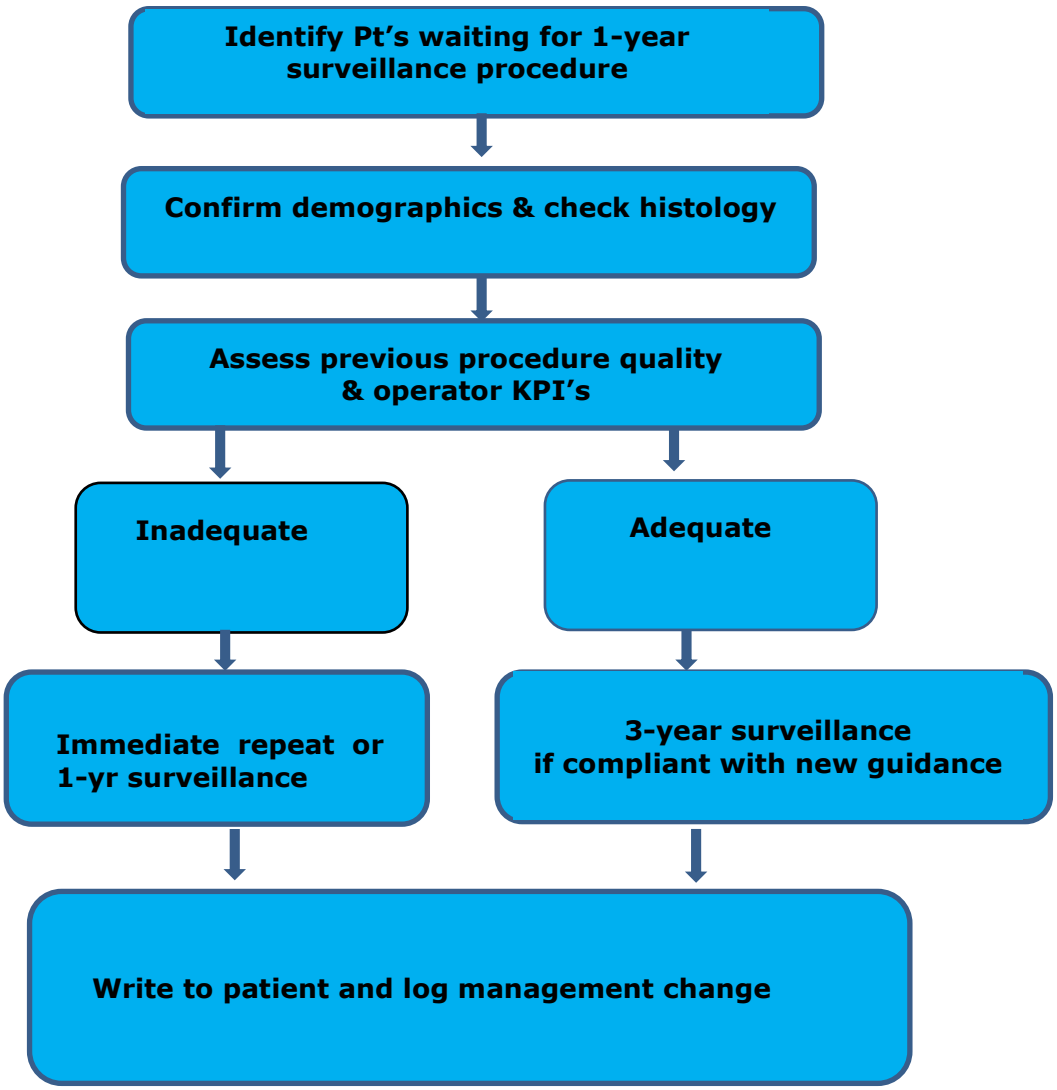
Peer Review

- Dedicated clinician to review all cases where management has changed
- Discrepancies to be further reviewed by the lead consultant
- Log all changes on the NEP spreadsheet for future audit

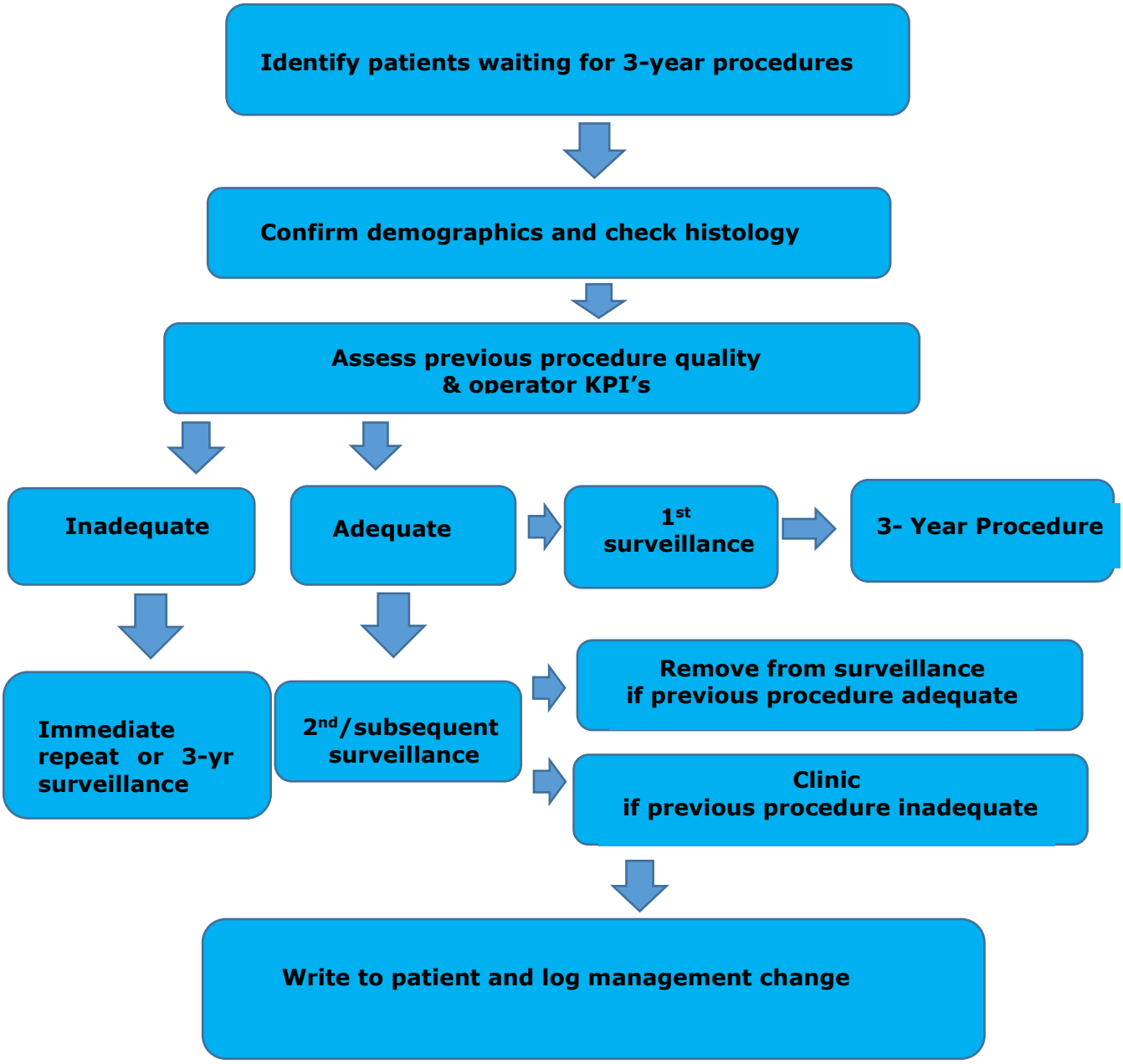
Appendix 4

NEP Surveillance Algorithms

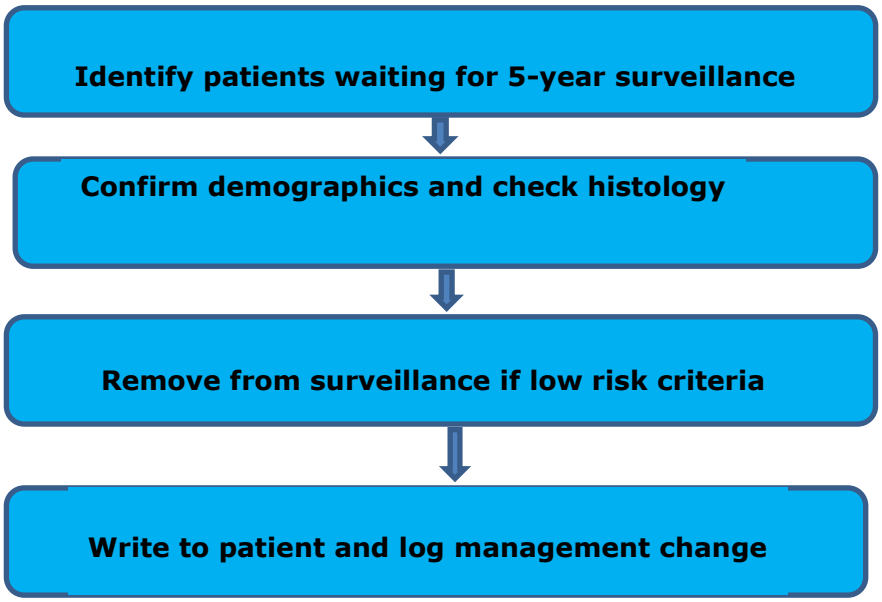
Current 1 Year Surveillance



Current 3 Year Surveillance



Current 5 Year Surveillance



Appendix 5

Sample template letters & BSG Lay person summary of new guidance

Sample text for change of surveillance and ceasing surveillance - for local amendment if necessary and Welsh Translation prior to use

Private and Confidential

Dear …….

We are writing to you because you were currently on our waiting list for a surveillance ("check-up") colonoscopy (a test that uses a thin flexible tube with a tiny camera on the end to look inside your bowel). This test can find polyps (non-cancerous growths) which can usually be removed to lower the risk of developing bowel cancer.

The guidelines that inform us which patients should have a check-up or surveillance colonoscopy, have recently changed following review of the most up to date research evidence. These guidelines were written by the British Society of Gastroenterology (BSG) and other organisations and are being adopted in Wales.,

Our clinical team has recently reviewed your case using these guidelines and we would like to inform you that your next colonoscopy should now be performed in/on xxxxxxxxx

Should you develop any new bowel symptoms it is important you report them promptly to your GP. Some signs or symptoms to look out for would be a change to your normal bowel habit lasting for a few weeks or more, a feeling that the bowel is not emptying completely, or rectal bleeding (bleeding from back passage).

Common questions that patients and their relatives ask are outlined in the information sheet attached with this letter.

If you have further questions or wish to discuss this in more detail, please contact the Endoscopy unit on XXXXX XXXXXX.

Yours Sincerely

The Endoscopy Team
Copy to GP and Consultant

Private and Confidential

Dear ……..

We are writing to you because you were currently on our waiting list for a surveillance ("check-up") colonoscopy (a test that uses a thin flexible tube with a tiny camera on the end to look inside your bowel). This test can find polyps (non-cancerous growths) which can usually be removed to lower the risk of developing bowel cancer.

The guidelines that inform us which patients should have a check-up or surveillance colonoscopy have recently changed following review of the most up to date research evidence. These guidelines were written by the British Society of Gastroenterology (BSG) and other organisations and are being adopted in Wales.

Your case has recently been reviewed by our clinical team using these guidelines and we would like to inform you that you **do not** need a further colonoscopy. Your name has therefore been removed from the waiting list.

If you are within the eligible age range for bowel cancer screening, we recommend that you participate and send in samples when you are invited to. This programme provides early detection of polyps and colorectal cancers.

Should you develop any new bowel symptoms it is important you report them promptly to your GP. Some signs or symptoms to look out for would be a change to your normal bowel habit lasting for a few weeks or more, a feeling that the bowel is not emptying completely, or rectal bleeding (bleeding from back passage).

Common questions that patients and their relatives ask are outlined in the information sheet attached with this letter.

If you have further questions or wish to discuss this in more detail, please contact the Endoscopy unit on XXXXX XXXXXX.
Yours Sincerely

BSG/ACPGBI/PHE Post-polypectomy and post-colorectal cancer resection surveillance guidelines

Lay summary

What do these guidelines cover?

A colonoscopy test uses a thin flexible tube with a tiny camera on the end to look inside your bowel. This test can find bowel cancer, and also polyps (non-cancerous growths) which can usually be removed to lower the risk of bowel cancer. These updated guidelines consider the use of surveillance ("check-up") colonoscopies and bowel imaging in people who have had either bowel polyps or a bowel cancer removed.

These guidelines are primarily aimed at healthcare professionals and address:

- Who should have surveillance?
- When should surveillance take place?
- When can surveillance be stopped?

Some people and their families are at particularly high risk of developing polyps due to genetic (inherited) conditions: this guidance does not cover these people – separate guidelines have been published for them.

These guidelines were written by the British Society of Gastroenterology (BSG), the Association of Coloproctology of Great Britain and Ireland (ACPGBI) and the English Bowel Cancer Screening Programme (Public Health England [PHE]). They are also supported by NHS England (NHSE).

Common questions that patients and their relatives ask are outlined below.

What is the purpose of surveillance?

The purpose of surveillance is to find and remove any new polyps so that they are prevented from potentially developing into cancer in the future. If a cancer does occur, surveillance may also find it at an earlier stage when it is easier to cure.

Why have these guidelines on surveillance been updated?

New evidence has allowed medical professionals to improve the previous guidelines. Moreover, since the last guidance, national bowel screening has been introduced which provides a useful check-up for low-risk people. The updated guidelines aim to make surveillance more personalised, ensuring it is recommended for people who need it, and not recommended to those who do not. This means that the need for and timing of surveillance colonoscopies has altered in this updated guidance.

If I have had polyps removed during a colonoscopy, will I need a surveillance colonoscopy in the future?

Not always. Bowel cancer usually develops from polyps, which is why specialists remove polyps during colonoscopy. Often this is all that is required, but in some people, new polyps can grow in the future. These guidelines tell doctors which people are at risk of new polyps and should have future surveillance colonoscopies.

If you do not need surveillance colonoscopies, we still encourage you to take part in the national Bowel Cancer Screening Programme as/when you are invited (currently from age 50 in Scotland and 60 in Wales, Northern Ireland and England, although Wales and England have made commitments to lower this age to 50 in line with Scotland).

Why do some people with polyps NOT need surveillance?

The two main reasons for this are:

- Not all people who have had polyps removed are at increased risk of developing cancer;
- Having a colonoscopy does have some potential risks. For some people, this risk outweighs the potential benefit.

These guidelines help doctors to decide what is right for each patient.

How often will I need to have surveillance colonoscopies?

This will depend on your individual circumstances, and your doctor will explain this to you using these guidelines.

- Recent evidence has shown that in many cases the intervals previously used for colonoscopy surveillance were too short (i.e. patients were asked to have a colonoscopy too frequently). In most cases, we now recommend an interval of three years;
- Evidence shows that with high quality colonoscopy using the latest techniques, once the bowel is cleared of polyps there is only a small chance of developing further high-risk polyps that may turn into cancers. Therefore, in most cases a single follow-up colonoscopy will be all that is needed.

Why stop at around 75 years of age?

- For a patient around the age of 75, once the bowel has been cleared of polyps they are very unlikely to benefit from further surveillance colonoscopy;
- This is because, even if a new polyp occurs, it usually takes at least ten years for it to grow from a small polyp into a high-risk polyp or cancer;
- Although colonoscopy is usually safe, the risk of a complication of the test itself (e.g. bleeding) or an associated event (e.g. stroke, heart or kidney problem) occurring after a colonoscopy increases significantly in patients over the age of 75;
- Every patient should be able to discuss their own case with their doctor to weigh-up the associated risks and potential benefits of having a further colonoscopy.

Link to website - Lay person summary of surveillance guidance

Appendix 6

Frequently asked Questions

Why does the NEP Implementation section of the guidance in Wales recommend site check at 3 months?

3-month site check is recommended as part of the standardisation of pathways across Wales and is in line with Bowel Screening Wales (BSW)

Why does the NEP Implementation section of the guidance in Wales recommend 5-year follow up in Wales for patients younger than the lower screening age rather than 10 years?

In view of data quality issues and potential uncertainty of quality assurance of non-screening endoscopy, this recommendation has been made to ensure a safe and pragmatic implementation of the guidance.

What do we do if we cannot confirm KPI's of a Colonoscopist and/or procedure?

If KPI's cannot be confirmed the case should be discussed at the local Endoscopy User Group to determine whether to continue, change or cease surveillance, and then communicate the decision to the patient as appropriate.

What do we do if KPI's are available but found to not meet new guidance criteria?
If KPI's do not meet new guidance criteria the Clinical Lead should be informed to feed back to the individual endoscopist's and feed themes into the national programme to inform development of a training programme for upskilling.

If a patient has an incomplete colonoscopy but had CT Colongraphy (Not CT TAP or CT miniprep) imaging to screen the remainder of the colon, can this be determined as adequate?

Yes, CT Colongraphy can be considered adequate if undertaken after an incomplete colonoscopy. Provided the quality of CTC as judged by the criteria used in screening programs but widely accepted throughout by radiology colleagues on CTC quality and reporting guidance are met.

Does this guidance cover what should happen if patients with colorectal cancer have annual CT scans?

No, the radiological follow up of patients isn't covered in this guidance only endoscopic surveillance follow up.

Further questions can be raised by contacting: Hayley.heard@wales.nhs.uk