NHS Bowel Cancer Screening Programme

NHS Cancer Screening Programmes

Adenoma surveillance

Second Edition

NHSBCSP PUBLICATION No 9

OCTOBER 2012

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01 October 2012

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Version Control Adenoma Surveillance	
Electronic publication date	Monday, 01 October 2012
Review date (1)	September 2013
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Comments	May be sent to Kiera Chapman, in readiness for review kiera.chapman@cancerscreening.nhs.uk
Document objective	Produced on behalf of the NHSBCSP to provide guidance on adenoma surveillance for healthcare professionals working within the NHSBCSP.
Clinical/healthcare/social questions covered	Risk assessment for bowel cancer surveillance and its impact on frequency of surveillance; management of the screening programme IT system, BCSS.
Population affected	Individuals within the BCSP who have been diagnosed as at low, intermediate, or high risk following screening colonoscopy.
Target audience	Healthcare professionals working within the NHSBCSP.

CONTENTS

1. CURRENT POLICY

1.1 Clinical guidelines

Current NHS Bowel Cancer Screening Programme (NHSBCSP) policy on adenoma surveillance is as follows:

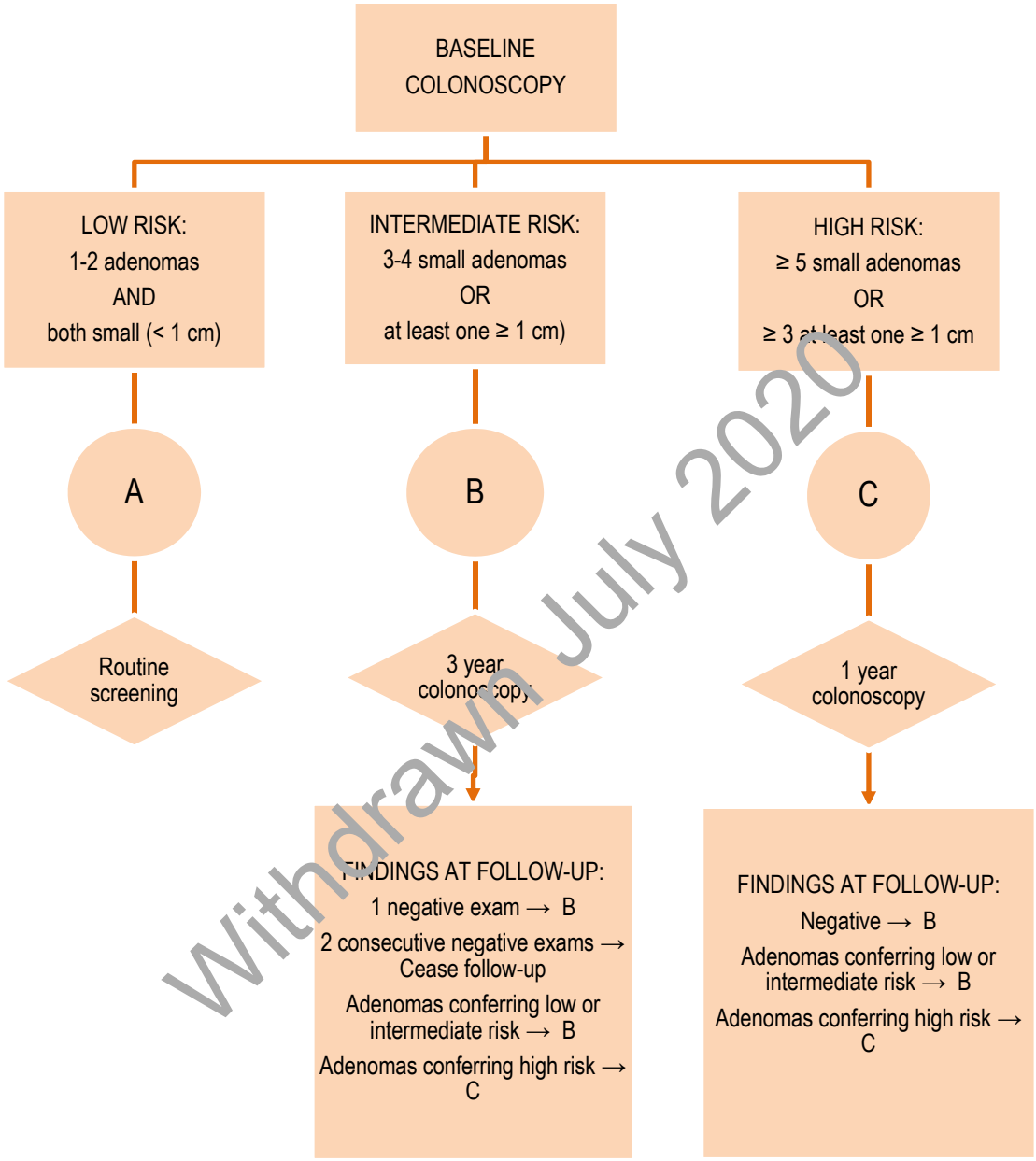
- Adenoma surveillance is part of the NHSBCSP. Surveillance colonoscopies must be undertaken in accredited screening clinics by accredited screening colonoscopists.[1]

- Accurate pathology reporting is essential to determine the patient pathway, and should be carried out in accordance with NHSBCSP/Royal College of Pathology (RCPath) guidelines.[2]

- Adenoma surveillance in the screening programme is based on current British Society of Gastroenterology (BSG) guidelines, which have been adapted to cope with the requirements of a population-based screening programme.[3]

Section 1.2 provides a diagram, summarising surveillance protocols following adenoma removal. This is reproduced here with the kind permission of the original authors.[3] It also defines the number and size of adenomas that confer low, intermediate, and high risk.

1.2 Surveillance following adenoma removal



1.3 Risk assessment and the first surveillance colonoscopy

- Patients who fall within the age range for bowel cancer screening and who are found on screening colonoscopy to have adenomas that confer a high risk of bowel cancer should always be offered a surveillance or 'clearing' colonoscopy. This should be at an interval of twelve months from their screening colonoscopy. As with all surveillance colonoscopies, any comorbidities should be assessed shortly before the date of the surveillance appointment.

- Patients who have adenomas that confer a high risk of bowel cancer, but who are older than the upper limit of the eligible screening age range, are not eligible for surveillance colonoscopy within the screening programme. Instead they should be referred outside of the NHSBCSP to NHS symptomatic care for future surveillance and management on an individually-tailored basis (see section 1.4).

- Patients who are found on screening colonscopy to have adenomas that confer an intermediate risk of bowel cancer should be offered a three-year surveillance colonoscopy if they remain within the eligible screening age range (see section 1.4). There are no acceptable reasons for a shorter surveillance interval within the NHSBCSP.

- 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) at the appropriate interval while they remain within the eligible screening age range (see section 1.4).

- There is no need for polyps or adenomas less than 1 cm in size to be removed surgically if they are located in an area that is endoscopically difficult to access. 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 referred for repeat endoscopy with advanced polypectomy where necessary.

- If polyps are directly observed, and excised but not retrieved at screening colonoscopy, they should be assumed to be adenomas. The appropriate surveillance pathway should be followed, based on their number and estimated size.

- If polyps are not retrieved intact at screening colonoscopy, an estimate of their size based on direct observation should be used to determine the appropriate surveillance pathway.

- A high risk is conferred by sessile polyps that are removed piecemeal and subsequently reported to be adenomas. Once such a lesion has been fully resected, the patient must be allocated a twelve month surveillance colonoscopy. Such cases are identified automatically from two datasets within BCSS: the piecemeal removal and sessile status of the polyp are noted in the colonoscopy dataset, while the fact that the polyp is an adenoma is recorded in the histology dataset. The clock for the surveillance colonoscopy starts from the date of the patient's last complete colonoscopy in an episode (including follow-up colonoscopy). This ensures that the whole colon is checked at 12 months.

1.4 Age range for surveillance in the NHSBCSP

People aged 60 to 74 inclusive are eligible for the NHSBCSP. This means that:

- Individuals who will be aged 61 to 74 when their surveillance appointment is due are offered a surveillance appointment within the screening programme.
- Individuals who will be 75 or older when their surveillance appointment is due are ceased from the screening programme. They must be referred to NHS symptomatic care if any follow-up is needed, and screening centres must arrange robust referral pathways to ensure continued surveillance or management as required.

1.5 Managing surveillance patients

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

- High-risk patients who receive a repeat diagnosis of high-risk status at surveillance colonoscopy, either at 12 months or subsequently, will be offered another colonoscopy at twelve months.

- High-risk patients whose twelve month surveillance colonoscopy yields a negative result, or reveals adenomas that confer low or intermediate risk, enter three-yearly surveillance. A negative result means that no adenomas or cancers were found, although other pathology may be present.

- Patients at intermediate risk whose surveillance colonoscopy finds high-risk adenomas convert to high-risk status and are offered a surveillance colonoscopy at twelve months.

- Individuals with adenomas conferring a low or intermediate risk at three-yearly surveillance colonoscopy remain in three-yearly surveillance.

- Intermediate-risk patients with a negative result at their first three-yearly surveillance colonoscopy remain in three-yearly surveillance. They may be discharged to routine recall after a second consecutive negative result at three-yearly surveillance.

- Patients with a polyp that cannot be removed at surveillance colonoscopy but that leaves them at apparent low risk should remain in surveillance and should be recalled in three years within the NHSBCSP. There is no need for such polyps to be removed surgically. The management of such lesions should be discussed by the screening centre team to determine whether the risk to the patient has genuinely altered, prior to referral for advanced polypectomy.

- Polyps which have been excised during surveillance colonoscopy, and directly observed but not retrieved should be assumed to be adenomas. The onward surveillance pathway should be determined based on their number and estimated size.

- If polyps are not retrieved intact at surveillance colonoscopy, the size estimated during direct observation should be used to determine the appropriate surveillance pathway.

1.6 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 remain in surveillance for at least seven years before discharge (one twelve month surveillance colonoscopy, followed by two negative surveillance colonoscopies at three-yearly intervals).

- Patients classified as being at intermediate risk following screening colonoscopy remain in surveillance for at least six years before discharge (two negative surveillance colonoscopies at three-yearly intervals).

- Where adenomas conferring low or intermediate risk are found at three-yearly surveillance, the patient must remain in three-yearly surveillance until he or she has 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. If they remain within the eligible screening age range (see section 1.4) they will then be sent an invitation to take part in FOB testing two years after their last colonoscopy. This policy will be kept under review as the programme develops.

1.7 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. Consideration should be given to discharging them from surveillance, or ceasing them from the screening programme, if their age and infirmity indicate that they will be unable to participate in future. If the problem is temporary, then surveillance should be recommenced at an appropriate time.

1.8 Patients who default

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

1.9 Endoscopy outside the BCSP

Occasionally a patient may be subject to emergency endoscopy 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 be unchanged, but the colonoscopy date can be reset to allow a maximum interval of twelve months between a colonoscopy outside the BCSP and a subsequent surveillance colonoscopy. This avoids unnecessary repeat colonoscopy at a short interval. An episode note should be made on BCSS.

2. 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 two onwards.

A more specific workload model has been developed for the programme by Sheffield University's School of Health and Related Research (ScHARR). This takes surveillance and the expansion of the programme into account. For more information, see the report, *Reappraisal of the options for colorectal cancer screening,* available at http://www.cancerscreening.nhs.uk/bowel/scharr-report-201202.html.[4]

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3. FOLLOW-UP DIAGNOSTIC TESTS

A follow-up colonoscopy or flexible sigmoidoscopy may be carried out within the screening programme, 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), and are **not** appointments for adenoma surveillance.

A patient can be manually referred for a follow-up diagnostic test within six months of a colonoscopy. 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 (if they are deemed to be at high or intermediate risk after definitive identification of an adenoma) entered into surveillance (see section 1.1).

Patients undergoing follow-up tests within a screening episode (for example, to check an excision site) may in some cases have an examination which falls close to the date scheduled for their surveillance colonoscopy. If the date for a follow-up test falls within eight weeks of the twelve month surveillance recall date, the BCSS will automatically highlight this to the SSP. The SSP can consider closing the first screening episode, and inviting the patience for surveillance colonoscopy instead of a follow-up test. Where there is a clinical rationale for conducting a separate follow-up test, this can still be booked prior to the surveillance colonoscopy.

Where a patient has undergone several procedures, the Screening Colonoscopist can select the most clinically suitable procedure date for the commencement of the twelve month recall period. The BCSS thus facilitates adherence to BSG guidance, and ensures that a patient undergoing follow-up tests (including flexible sigmoidoscopy) is invited to have his or her whole colon re-examined at the appropriate interval, while avoiding unnecessarily short recall periods.

4. MANAGING SURVEILLANCE ON BCSS

Surveillance episodes are handled automatically on BCSS:

- A patient is automatically referred to surveillance if the number and size of adenomas detected classifies them as:
    - High risk, or
    - Intermediate risk
- A classification of high or intermediate risk requires histological data, unless the polyp was directly observed but not retrieved after excision during an endoscopy procedure.
- If a patient has more than one test diagnosing adenomas in an episode, and is therefore cumulatively classified as at high or intermediate risk, the screening centre can choose the most appropriate test date from which to set the subsequent 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. If they are within the eligible screening age range, they will be returned to routine screening and sent another FOBt kit.
- The screening centre SSP may discharge the patient from surveillance for the following reasons:
    - Informed patient choice (patient initiated).
    - No patient response (including failure to attend two surveillance appointments).
    - Clinical decision following discussion with the patient (clinician initiated).

Unless the patient requests to be ceased from the programme, he or she will be automatically returned to routine screening when discharged from surveillance. The individual will therefore be sent another FOBt kit in two years, provided that they are within the eligible screening age range (see section 1.4).

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October 2012