NHS
Derby and Derbyshire
Integrated Care Board

CLINICAL POLICY ADVISORY GROUP (CPAG)

Repeat Colonoscopy

Statement

NHS Derby and Derbyshire ICB, in line with its principles for evidence-based interventions has deemed that Repeat Colonoscopy should only be commissioned for adults aged 19 years who meet the British Society of Gastroenterology Surveillance guidelines for post-polypectomy and post-colorectal cancer resection

These commissioning intentions will be reviewed periodically. This is to ensure affordability against other services commissioned by the ICB.

1. Background

Colorectal carcinoma (CRC) is one of the most common cancers in the UK with more than 40,000 new cases diagnosed each year. Polyps are extremely common and certain types (colorectal adenomas and serrated lesions) have the potential to progress into CRC.

Colonoscopy can assist in the diagnosis of CRC and several other pathologies, including colonic polyps. Polyp removal (or polypectomy) can be performed endoscopically and is an effective way to treat pre-malignancy polyps (which includes both serrated polyps (excluding diminutive [1-5mm] rectal hyperplastic polyps) and adenomatous polyps. It does not include other polyps such as post inflammatory polyps) before they progress to cancer. Colonoscopy with or without polypectomy is a safe procedure however there is a small risk of complications – including pain, intestinal perforation or major haemorrhage as well as issues related to any sedative used.

Colorectal carcinoma is often treated by surgical resection, especially for people with potentially curative disease. Individuals who have had treatment for colorectal carcinoma and adenomas are known to be at high-risk of recurrence.

While reducing colorectal mortality is an important aim of colonoscopic surveillance, the main aim is to prevent colorectal cancer by resecting premalignant polyps. Many patients benefit from this alone and do not require subsequent surveillance.

2. Recommendation

This policy applies to adults aged 19 years and over

The following British Society of Gastroenterology surveillance guidelines for post-polypectomy and post-colorectal cancer resection should be followed

Risk Surveillance criteria for Colonoscopy

Either of the following put individuals at high-risk for future colorectal cancer following polypectomy:

- 2 or more premalignant polyps including at least one advanced colorectal polyp (defined as a serrated polyp of at least 10mm in size or containing any grade of dysplasia, or an adenoma of at least 10mm in size or containing high-grade dysplasia);

OR

- 5 or more premalignant polyps.

Surveillance colonoscopy after polypectomy

For individuals at high-risk and under the age of 75 and whose life expectancy is greater than 10 years offer:

- one-off surveillance colonoscopy at 3 years.

For individuals with no high-risk findings:

- No colonoscopic surveillance should be undertaken
- Individuals should be strongly encouraged to participate in their national bowel screening programme when invited.

For individuals not at high-risk who are more than 10 years younger than the national bowel screening programme lower age-limit, consider for surveillance colonoscopy after 5 or 10 years, individual to age and other risk factors.

Surveillance colonoscopy after potentially curative CRC resection

- Offer a clearance colonoscopy within a year after initial surgical resection
- Then offer a surveillance colonoscopy after a further 3 years
- Further surveillance colonoscopy to be determined in accordance with the post-polypectomy high-risk criteria.

Survellance after pathologically en bloc R0 EMR or ESD of LNPCPs or early polyp cancers:

- No site-checks are required
- Offer surveillance colonoscopy after 3 years
- Further surveillance colonoscopy to be determined in accordance with the post-polypectomy high-risk criteria.

Surveillance after piecemeal EMR or ESD of LNPCPs (large nonpedunculated colorectal polyps of at least 20mm in size)

- Site-checks at 2-6 months and 18 months from the original resection

Once no recurrence is confirmed, patients should undergo postpolypectomy surveillance after 3 years

- Further surveillance colonoscopy to be determined in accordance with the post-polypectomy high-risk criteria.

Surveillance where histological completeness of excision cannot be determined in patients with: (i) a non-pedunculated polyps of 10-19mm in size, or (ii) an adenoma containing high-grade dysplasia, or (iii) a serrated polyp containing any dysplasia:

- Site-check should be considered within 2-6 months
- Further surveillance colonoscopy to be determined in accordance with the post-polypectomy high-risk criteria

Ongoing colonoscopic surveillance:

- To be determined by the findings at each surveillance procedure, using the high-risk criteria to stratify risk

- Where there are no high-risk findings, colonoscopic surveillance should cease but individuals should be encouraged to participate in the national bowel screening programme when invited.

3. Rationale for Recommendation

This recommendation is based on the 2019 guidelines published by the British Society of Gastroenterology, the Association of Coloproctology of Great British and Ireland and Public Health England.

Premalignant polyps are common, occurring in a quarter to a half of all people of screening age, yet only about 5% of the population will develop CRC during their life. As such, only a minority of people with polyps will develop CRC, meaning that most people will not benefit from post-polypectomy surveillance.

It is an increasingly held view that the greatest benefit in terms of CRC prevention is derived from the initial polypectomy, rather than from subsequent surveillance. It is possible to stratify individuals according to future risk and identify cohorts of patients with persistently elevated CRC risk beyond index polypectomy, yet even with current risk stratification, surveillance places a considerable burden on patients and endoscopy services: approximately 15% of the half a million colonoscopies performed each year in the UK are performed for polyp surveillance.

4. Personalised Care

Personalised care simply means that people have more control and choice when it comes to the way their care is planned and delivered, considering their individual needs, preferences and circumstances. It includes supporting shared decision making and self-management.
Shared decision-making means people are supported to:

- *understand the care, treatment and support options available and the risks, benefits and consequences of those options*
- *decide on a preferred course of action, based on evidence based, good quality information and their personal preferences.*

Supported self-management means increasing the knowledge, skills and confidence a person has in managing their own health and care. This involves using self-management education, peer support, and health coaching.
Decision support tools, also called patient decision aids support shared decision making by making treatment, care and support options explicit. They provide evidence-based information about the associated benefits/harms and help patients to consider what matters most to them in relation to the possible outcomes, including doing nothing.

5. Useful Resources

- BRAN leaflet – Shared decision making supports individuals to make the right decision for them. This easy-to-use leaflet supports this people to consider their treatment options.
- Cancer Research UK. Colonoscopy.

6. References

1. Rutter MD, et al. (2019) BSG/ACPGBI/PHE Post-polypectomy and post-colorectal cancer resection surveillance guidelines: Gut 2020;69:201–223. doi:10.1136/gutjnl-2019-319858.
2. NICE Guideline (2020) Colorectal cancer [NG151].
3. NICE Guideline (2011) Colorectal cancer prevention: Colonoscopic surveillance in adults with ulcerative colitis, Crohn's disease or adenomas guideline [CG118].
4. Academy of Medical Royal Colleges : Evidence Based Interventions for repeat Colonoscopy

7. Appendices

Appendix 1 - Consultation

All relevant providers/stakeholders will be consulted via a named link consultant/specialist. Views expressed should be representative of the provider/stakeholder organisation. CPAG will consider all views to inform a consensus decision, noting that sometimes individual views and opinions will differ.

Consultee	**Date**
Clinical Policies Advisory Group (CPAG)	August 2021
Academy of Medical Royal Colleges	August 2021
Consultant General & Colorectal Surgeon, CRHFT	August 2021
Clinical Director, Integrated Surgery, CRHFT	August 2021
Divisional Director of Surgical Services, CRHFT	August 2021
Consultant General Surgeon, UHDBFT	August 2021
Consultant Gastroenterologist, Clinical Lead (ACD) for Endoscopy, Clinical Director for South Derbyshire Bowel Cancer Screening Programme, UHDBFT	August 2021
Clinical Lay Commissioning Committee	August 2021
Academy of Medical Royal Colleges	September 2024
Clinical Policies Advisory Group (CPAG)	March 2025

Appendix 2 - Document Update

Document Update	**Date Updated**
Version 1 – new policy for Repeat Colonoscopy – aligned with Academy of Medical Royal Colleges EBI Guidance	March 2025