COLONOSCOPIC SURVEILLANCE INTERVALS – INFLAMMATORY BOWEL DISEASE

Starting Time for Surveillance in At Risk Patients

Extent of disease & associated features	Starting time
• UC beyond sigmoid • CD >1/3 colon or complicated anorectal disease	No later than 8y after onset of symptoms
• If PSC detected	At time of diagnosis of PSC
• If strong FHx of CRC	Before 8y after onset of symptoms

Abbreviations:

- UC – Ulcerative Colitis
- CD – Crohn's Disease
- FHx – Family History
- CRC – Colorectal Cancer
- PSC – Primary Sclerosing Cholangitis
- IBD – Inflammatory Bowel Disease
- FDR – First Degree Relative (Mother/father/brother/sister/son/daughter)

Optimal Surveillance Intervals

Group 1

Any HIGH RISK FEATURE:

- Chronically active UC
- PSC
- CRC in FDR at <50y age‡
- Stricture, multiple inflammatory polyps or shortened colon
- Previous dysplasia

→ 1 yearly Colonoscopy

Group 2

- Quiescent UC without HIGH RISK FEATURES*

→ 3 yearly Colonoscopy

Group 3

- UC without HIGH RISK FEATURES* when two previous colonoscopies are macroscopically inactive and histologically negative for dysplasia

→ 5 yearly Colonoscopy

- This algorithm is designed to be used in conjunction with the NHMRC approved *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.
- Colonoscopic surveillance is recommended in patients with UC extending further than the sigmoid colon to reduce cancer-related mortality. Although surveillance is not recommended in less extensive disease, periodic examination should be undertaken to ensure disease activity remains localised.
- Although evidence for colonoscopic surveillance in CD is limited, experts recommend it be considered in at risk patients (colitis involving more than 1/3 of the colon, ano-rectal disease, strictures, inflammatory polyps).
- Surveillance colonoscopy should be of high-quality in a well-prepared colon, incorporating previous clinical information.
- Chromoendoscopy/dye spraying with targeted biopsy is superior to white light examination and is the preferred method of surveillance where possible. Alternatively, white light examination with random and targeted biopsies is an option in circumstances where familiarity with or availability of chromoendoscopy is lacking.
- Indeterminate colitis should be followed up as for UC. Those having undergone restorative procto-colectomy could undergo examination of the residual mucosa 5 yearly.
- Visible dysplasia that is completely resected endoscopically requires follow up colonoscopy within 6 months. Visible dysplasia that is not endoscopically resectable requires surgical referral. Management of invisible dysplasia is controversial and depends on grade and distribution (refer to full text Clinical Practice Guidelines).

‡ In a young patient if the only high risk feature is CRC in FDR at <50y of age, the 1 yearly interval could commence at age 10 years younger than the affected FDR and revert to a 3 yearly interval if no sporadic polyps are found.

* HIGH RISK FEATURES include any of the following: chronically active UC; PSC; CRC in FDR at <50y of age; stricture, multiple inflammatory polyps or shortened colon; and previous dysplasia.

Endorsed by: Cancer Council Australia; GESA Gastroenterological Society of Australia; CSSANZ Colorectal Surgical Society of Australia and New Zealand

Suggested citation: *Barclay Karen, Cancer Council Australia Surveillance Colonoscopy Guidelines Working Party. Algorithm for Colonoscopic Surveillance Intervals – Inflammatory Bowel Disease. 2015.*