FIRST COLONOSCOPIC SURVEILLANCE INTERVAL AFTER POLYPECTOMY

A. Conventional adenomas* only

Current colonoscopy findings		Conventional adenoma <10mm		Conventional adenoma ≥10mm[d,e]	
		HGD and/or villosity		**HGD** and/or villosity	
		No	Yes	No	Yes
Total number of conventional adenomas	1–2	10Y[a,b,c]	5Y	3Y	3Y
	3–4	5Y	3Y	3Y	1Y
	5–9	3Y	1Y	1Y	1Y
	≥10	1Y	1Y	1Y	1Y

B. Clinically significant serrated polyps** only

Current colonoscopy findings		Advanced serrated polyp (≥10mm, dysplasia or **TSA**)	
		No	Yes
Number of clinically significant serrated polyps	1–2	5Y	3Y
	3–4	3Y	1Y
	≥5	1Y	

C. Clinically significant serrated polyps and synchronous conventional adenomas

Current colonoscopy findings		Low-risk conventional adenomas		High-risk conventional adenomas	
		Advanced serrated polyp (≥10mm, dysplasia or TSA)		Advanced serrated polyp (≥10mm, dysplasia or TSA)	
		No	Yes	No	Yes
Total number of polyps (clinically significant serrated polyps and conventional adenomas)	2	5Y	3Y	3Y	3Y
	3–4	3Y	3Y	1Y	1Y
	5–9	3Y	1Y	1Y	1Y
	≥10	1Y	1Y	1Y	1Y

*Conventional adenoma and **clinically significant serrated polyps terms are defined below.

Tables A, B and C correlate with 3, 9a and 9b, respectively, in the guidelines.

These tables are intended to support clinical judgment and are derived from the *Clinical practice guidelines for surveillance colonoscopy*. A free interactive platform to support use of these guidelines is available at: www.intright.com.

Surveillance recommendations should be made after the colon has been cleared of all significant neoplasia and once histology is known, using polyp size and number as per endoscopist documentation.

Surveillance colonoscopy should be considered in the context of individualised assessment including patient wishes, age and co-morbidity. It is not recommended over the age of 80 years and in those with significant co-morbity from 75–80 years of age as most will have no significant benefit and risks related to the procedure are increased.

Consideration to stopping regular colonoscopy surveillance and return to the NBCSP with iFOBT after 4years in the lowest risk individuals should be discussed, particularly in the context of diminutive polyps only.

[a] Consider colonoscopy at an interval of 5Y in low-risk individuals with clinical evidence of the metabolic syndrome.

[b] If a significant family history of colorectal cancer is present, use screening recommendation if the interval is shorter than 10Y (see the *Clinical practice guidelines for the prevention, early detection and management of colorectal cancer*).

[c] Return to the NBCSP with iFOBT after 4Y is also an appropriate option and should be discussed with the patient.

[d] Complete excision of lesions is required before surveillance intervals can be recommended.

[e] Adenomas ≥20mm are more likely to be excised piecemeal and should be considered under the large and laterally spreading adenomas section.

Advanced serrated polyp: sessile serrated lesion (SSL; previously known as sessile serrated adenoma or polyp) ≥10mm or dysplasia or traditional serrated adenomas (TSAs); ****Clinically significant serrated polyps:** SSLs; TSAs; hyperplastic polyps ≥10mm; ***Conventional adenoma:** tubular, tubulovillous or villous adenoma with low- or high-grade dysplasia; **HGD:** high-grade dysplasia; **High-risk conventional adenoma:** any one of the following: ≥10mm, villous features, HGD; **Low-risk conventional adenoma:** all of the following: <10mm, tubular, low-grade dysplasia (LGD); **'Synchronous' conventional adenoma:** 'present at the same time as...'; **TSA:** traditional serrated adenoma; **Y:** years.

Suggested citation: Barclay K, Leggett B, Macrae F, Bourke M, Hooi Ee, Cancer Council Australia Surveillance Colonoscopy Guidelines Working Party. Colonoscopic surveillance after polypectomy. In: *Clinical practice guidelines for surveillance colonoscopy (2019)*. Available from: https://wiki.cancer.org.au/australia/Guidelines:Colorectal_cancer/Colonoscopy_surveillance. Sydney: Cancer Council Australia.

Cancer Council

SECOND OR SUBSEQUENT COLONOSCOPIC SURVEILLANCE INTERVAL AFTER POLYPECTOMY

D. Conventional adenomas only on the last two colonoscopies

D.1. LOW RISK on first* colonoscopy

Second** colonoscopy findings		<10mm HGD and/or villosity		≥10mm HGD and/or villosity	
		No	Yes	No	Yes
Number of adenomas	0	*iFOBT screening as per NBCSP*			
	1–2	10Y	5Y	3Y	3Y
	3–4	5Y	3Y	3Y	1Y
	5–9	3Y	1Y	1Y	1Y
	≥10	1Y	1Y	1Y	1Y

D.2. INTERMEDIATE RISK on first* colonoscopy

Second** colonoscopy findings		<10mm HGD and/or villosity		≥10mm HGD and/or villosity	
		No	Yes	No	Yes
Number of adenomas	0	10Y			
	1–2	5Y	5Y	3Y	3Y
	3–4	5Y	3Y	3Y	1Y
	5–9	3Y	1Y	1Y	1Y
	≥10	1Y	1Y	1Y	1Y

D.3. HIGH RISK on first* colonoscopy

Second** colonoscopy findings		<10mm HGD and/or villosity		≥10mm HGD and/or villosity	
		No	Yes	No	Yes
Number of adenomas	0	5Y			
	1–2	5Y	3Y	3Y	3Y
	3–4	3Y	3Y	3Y	1Y
	5–9	3Y	1Y	1Y	1Y
	≥10	1Y	1Y	1Y	1Y

D.4. HIGHEST RISK on first* colonoscopy

Second** colonoscopy findings		<10mm HGD and/or villosity		≥10mm HGD and/or villosity	
		No	Yes	No	Yes
Number of adenomas	0	5Y			
	1–2	5Y	3Y	1Y	1Y
	3–4	3Y	1Y	1Y	1Y
	5–9	1Y	1Y	1Y	1Y
	≥10	1Y	1Y	1Y	1Y

E. Clinically significant serrated polyps only on the last two colonoscopies

E.1. No synchronous conventional adenomas on second colonoscopy

Second** colonoscopy findings		Advanced serrated polyps (≥10mm, dysplasia or TSA)	
		No	Yes
Number of clinically significant serrated polyps	1–2	5Y	3Y
	3–4	3Y	1Y
	≥5	1Y	

E.2. Synchronous conventional adenomas on second colonoscopy

Second** colonoscopy findings		Advanced serrated polyps (≥10mm, dysplasia or TSA)			
		Low-risk conventional adenoma		High-risk conventional adenoma	
		No	Yes	No	Yes
Combined number of clinically significant serrated polyps and synchronous adenomas	2	5Y	3Y	3Y	3Y
	3–4	3Y	3Y	1Y	1Y
	5–9	1Y	1Y	1Y	1Y
	≥10	1Y	1Y	1Y	1Y

*'First' refers to the oldest colonoscopy.
**'Second' refers to the most recent colonoscopy.

F. Clinically significant serrated polyps on first* colonoscopy, normal or conventional adenomas only on second** colonoscopy

F.1. INTERMEDIATE RISK on first* colonoscopy

Second** colonoscopy findings		<10mm HGD and/or villosity		≥10mm HGD and/or villosity	
		No	Yes	No	Yes
Number of adenomas	0	5Y			
	1–2	5Y	5Y	3Y	3Y
	3–4	3Y	3Y	3Y	1Y
	5–9	3Y	1Y	1Y	1Y
	≥10	1Y	1Y	1Y	1Y

F.2. HIGH RISK on first* colonoscopy

Second** colonoscopy findings		<10mm HGD and/or villosity		≥10mm HGD and/or villosity	
		No	Yes	No	Yes
Number of adenomas	0	5Y			
	1–2	5Y	3Y	3Y	3Y
	3–4	3Y	3Y	3Y	1Y
	5–9	3Y	1Y	1Y	1Y
	≥10	1Y	1Y	1Y	1Y

F.3. HIGHEST RISK on first* colonoscopy

Second** colonoscopy findings		<10mm HGD and/or villosity		≥10mm HGD and/or villosity	
		No	Yes	No	Yes
Number of adenomas	0	3Y			
	1–2	3Y	3Y	1Y	1Y
	3–4	3Y	1Y	1Y	1Y
	5–9	1Y	1Y	1Y	1Y
	≥10	1Y	1Y	1Y	1Y

This algorithm is intended to support clinical judgment and is derived from the *Clinical practice guidelines for surveillance colonoscopy*.

A free interactive platform to support use of these guidelines is available at: www.intright.com.

Tables D, E and F correlate with 14, 15 and 16, respectively, in the guidelines.

Surveillance recommendations should be made after the colon has been cleared of all significant neoplasia, once histology is known and in the context of individualised assessment of patient benefit. Polyp size as per endoscopist documentation should be used for determining surveillance intervals.

See page 1 for table legend and further information.

Cancer Council