

Madigan Army Medical Center

Referral Guidelines

Colonoscopy Surveillance Recommendations for Patients with a Personal History of Colorectal Cancer or Polyps

Diagnosis/Definition

Previous colon cancer or colonic polyp

Initial Diagnosis and Management

Primary care providers are likely the first providers to encounter high risk individuals for colorectal cancer. Therefore, we recommend that all patients be screened for pertinent personal and family history of cancer and colon polyps

Ongoing Management and Objectives

Gastroenterology should ensure that no oncology follow up is indicated in patients with a history of colorectal cancer.

Indications for Specialty Care Referral

1. Personal history of colorectal cancer
 - a. High quality colonoscopy clearance of remainder of the colon at or around the time of resection, followed by colonoscopy at 1 year after curative resection, then at 3 year and then 5 year intervals if results are normal
 - i. If a subsequent colonoscopy reveals colon cancer or a polyp (e.g., surveillance colonoscopy at 1 year after a curative resection), then the most recent colonoscopy report or appropriate Gastroenterology telephone consult should be reviewed to determine the time of the next surveillance colonoscopy
 - b. Additional comment on rectal cancer – flexible sigmoidoscopy: after low anterior resection, if no pelvic radiation or no mesorectal excision every 3-6 months for 2-3 years
2. Personal history of colon adenomas
 - a. Last colonoscopy with 2 or less subcentimeter adenomas and only low-grade dysplasia – surveillance colonoscopy in 5 years
 - b. Last colonoscopy showing advanced neoplasia (villous histology, 1 centimeter or greater in diameter) or 3-10 adenomas – surveillance colonoscopy in 3 years
 - c. Last colonoscopy showing > 10 adenomas – surveillance colonoscopy in 1 year
 - d. Last colonoscopy showing large sessile polyp with potentially incomplete excision – surveillance colonoscopy in 2-6 months
 - e. Regarding a-d above: these are in the absence of concern for a hereditary colon cancer or polyposis syndrome – if this concern exists, refer to Colorectal Cancer Screening Recommendations for Patients with Family History of Colorectal Polyps or Cancer

3. Personal history of large proximal colon hyperplastic polyps
 - a. These polyps can be considered premalignant, and the last colonoscopy report (or subsequent Gastroenterology telephone consults) should be reviewed to determine the next recommended surveillance colonoscopy

4. It is important to note that the completeness of the examination and the quality of the colonoscopy preparation also determine the appropriate time interval between the next colonoscopic examination (this is based on the performing endoscopist's recommendation).
 - a. If the endoscopist recommended a follow up colonoscopy in a shorter time period (e.g., even though no polyps may have been identified), then the shorter follow up interval is recommended.
 - b. Primary care providers should review prior colonoscopy reports and Gastroenterology telephone consults to determine the recommended time for repeat colonoscopy.

5. If a patient develops interim signs, symptoms, or radiographic findings concerning for colonic neoplasia (even if they are up to date on colorectal cancer surveillance), **then gastroenterology should contact the primary care manager to discuss this case (all surveillance modalities have a false negative rate, so these cases should be discussed by a gastroenterologist with the primary care provider** – a consult should be placed if, after this discussion, colon neoplasia cannot be reasonably excluded).

Criteria for Return to Primary Care – completion of colonoscopy, if next colonoscopy is not recommended within the next year

References:

Screening and Surveillance for the Early Detection of Colorectal Cancer and Adenomatous Polyps, 2008: A Joint Guideline from the American Cancer Society, the U.S. Multi-Society Task Force on Colorectal Cancer, and the American College of Radiology

Colorectal Cancer Screening and Surveillance, *Gastrointest Endosc* . 2006; 63: 546-557

Last Review for this Guideline – November 2011

Referral Guidelines require review every 3 years

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