SFHP Criteria

Colonoscopy

Revision Dates: October 2012

Accepted by QIC: October 11, 2012

Related P&P:

References:
US Preventive Services Task Force Recommendation Statement
http://www.ahrq.gov/clinic/uspstf08/colocancer/colors.htm
American Society of Gastrointestinal Endoscopy Appropriate Use of GI Endoscopy Guidelines 2012
SF Department of Public Health Colorectal Cancer Screening and Surveillance Guidelines

GUIDELINE:

Colonoscopy will be approved in the following conditions:

1. Positive fecal occult blood test/fecal immunochemical test, or rectal bleeding

2. Unexplained iron deficiency anemia in man, or non-menstruating woman,

3. Chronic, unexplained diarrhea

4. Irritable bowel syndrome when any ONE of the following is present:
   - Older than 50 years,
   - Change in chronic symptoms
   - Alarm symptoms such as unexplained weight loss, greater than 5% of body weight, rectal bleeding, iron deficiency anemia or occult blood loss

5. Melena with negative esophagogastroduodenoscopy

6. Evaluation of patients with chronic inflammatory bowel disease of the colon, if more precise diagnosis or determination of the extent of activity of disease will influence management, or a new medication for treatment is being contemplated.

7. Prior endometrial, uretopelvic or ovarian cancer diagnosed at age <50

8. Decompression of acute megacolon or sigmoid volvulus.

9. Treatment of bleeding from such lesions as vascular malformation, ulceration, neoplasia, and polypectomy site.

10. Evaluation of an abnormality on barium enema or other imaging study that is likely to be clinically significant, such as a filling defect and stricture.

11. Hereditary Nonpolyposis Colorectal Cancer:
12. Genetic or clinical diagnosis of hereditary nonpolyposis colorectal cancer (HNPCC), or who are at increased risk for HNPCC:
    a. Colonoscopy every 1-2 years beginning at age 20-25 years, or 10 years earlier than the youngest age of colon cancer diagnosis in the family--whichever comes first.
    b. Genetic testing for HNPCC should be offered to first-degree relatives of persons with a known inherited mismatch repair (MMR) gene mutation. It should also be offered when the family mutation is not already known, but 1 of the first 3 of the modified Bethesda Criteria is met.

13. History of polyps, or abnormal prior colonoscopy/flexible sigmoidoscopy; followup depending on findings of original colonoscopy. Consensus guidelines are as follows:

Guidelines for Screening and Surveillance for the Early Detection of Colorectal Adenomas and Cancer in Individuals at Increased Risk or at High Risk

Risk category	Age to begin	Recommendation	Comment
Increased Risk—Patients with History of Polyps at Prior Colonoscopy			
Patients with small rectal hyperplastic polyps[26]	—	Colonoscopy or other screening options at intervals recommended for average-risk individuals	An exception is patients with a hyperplastic polyposis syndrome. They are at increased risk for adenomas and colorectal cancer and need to be identified for more intensive follow-up.
Patients with 1 or 2 small tubular adenomas with low-grade dysplasia[26]	5 years after the initial polypectomy	Colonoscopy	The precise timing within this interval should be based on other clinical factors (such as prior colonoscopy findings, family history, and the preferences of the patient and judgment of the physician).
Patients with 3 to 10 adenomas, or 1 adenoma >1 cm, or any adenoma with villous features or high-grade dysplasia[26]	3 years after the initial polypectomy	Colonoscopy	Adenomas must have been completely removed. If the follow-up colonoscopy is normal or shows only 1 or 2 small tubular adenomas with low-grade dysplasia, then the interval for the subsequent examination should be 5 years.
Patients with >10 adenomas on a single examination[26]	<3 years after the initial polypectomy	Colonoscopy	Consider the possibility of an underlying familial syndrome.
Patients with sessile adenomas that are removed piecemeal[26]	2 to 6 months to verify complete removal	Colonoscopy	Once complete removal has been established, subsequent surveillance needs to be individualized based on the endoscopist's judgment. Completeness of removal should be based on both endoscopic and pathologic assessments.
Increased Risk—Patients with Colorectal Cancer			
Patients with colon and rectal cancer should undergo high-quality perioperative clearing [25]	3 to 6 months after cancer resection, if no unresectable metastases are found during surgery; alternatively, colonoscopy can be performed intraoperatively.	Colonoscopy	In the case of nonobstructing tumors, this can be done by preoperative colonoscopy. In the case of obstructing colon cancers, CTC with intravenous contrast or DCBE can be used to detect neoplasms in the proximal colon.
Patients undergoing curative resection for colon or rectal cancer[23]	1 year after the resection (or 1 year following the performance of the colonoscopy that was performed to clear the colon of synchronous disease)	Colonoscopy	This colonoscopy at 1 year is in addition to the perioperative colonoscopy for synchronous tumors. If the examination performed at 1 year is normal, then the interval before the next subsequent examination should be 3 years. If that colonoscopy is normal, then the interval before the next subsequent examination should be 5 years. Following the examination at 1 year, the intervals before subsequent examinations may be shortened if there is evidence of

Risk category	Age to begin	Recommendation	Comment
			HNPCC or if adenoma findings warrant earlier colonoscopy. Periodic examination of the rectum for the purpose of identifying local recurrence, usually performed at 3- to 6-month intervals for the first 2 or 3 years, may be considered after low anterior resection of rectal cancer.
Increased Risk—Patients with a Family History			
Either colorectal cancer or adenomatous polyps in a first-degree relative before age 60 years or in 2 or more first-degree relatives at any age[24]	Age 40 years, or 10 years before the youngest case in the immediate family	Colonoscopy	Every 5 years
Either colorectal cancer or adenomatous polyps in a first-degree relative age 60 or older or in 2 second-degree relatives with colorectal cancer[24]	Age 40 years	Yearly stool testing	Screening should be at an earlier age, but individuals may choose to be screened with any recommended form of testing.
High Risk			
Genetic diagnosis of FAP or suspected FAP without genetic testing evidence[24]	Age 10 to 12 years	Annual FSIG to determine if the individual is expressing the genetic abnormality and counseling to consider genetic testing	If the genetic test is positive, colectomy should be considered.
Genetic or clinical diagnosis of HNPCC or individuals at increased risk of HNPCC[24]	Age 20 to 25 years, or 10 years before the youngest case in the immediate family	Colonoscopy every 1 to 2 years and counseling to consider genetic testing	Genetic testing for HNPCC should be offered to first-degree relatives of persons with a known inherited MMR gene mutation. It should also be offered when the family mutation is not already known, but 1 of the first 3 of the modified Bethesda criteria is present
Inflammatory bowel disease,[24] chronic ulcerative colitis, and Crohn's colitis	Cancer risk begins to be significant 8 years after the onset of pancolitis or 12 to 15 years after the onset of left-sided colitis	Colonoscopy with biopsies for dysplasia	Every 1 to 2 years; these patients are best referred to a center with experience in the surveillance and management of inflammatory bowel disease.

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

The following conditions are not considered appropriate indications for colonoscopy:

1. Chronic, stable irritable bowel syndrome
2. Weight loss
3. Anemia (not due to iron deficiency or overt/occult blood loss)
4. Chronic, stable abdominal pain
5. Acute diarrhea
6. Routine follow-up of stable inflammatory bowel disease (except dysplasia/cancer surveillance in chronic ulcerative colitis after 8 years of disease). Upper gastrointestinal tract bleeding or melena with a demonstrated upper gastrointestinal tract source
7. Metastatic adenocarcinoma or unknown primary site when it will not influence management