ColonCheck Screening Guidelines

Most people age 50 to 74 should complete a fecal immunochemical test (FIT) every two years.

	Patient Characteristics	Management
AVERAGE RISK[1]	49 years of age and under	Routine screening with FIT is not recommended.
	50 to 74 years of age	Routine screening with FIT every 2 years.
	75 to 85 years of age	Routine screening with FIT is not recommended. Decision to continue screening until 85 years of age is made on a case-by-case basis with consideration given to life expectancy, family history, past screening history (less benefit if up to date with screening), comorbidities, and the potential benefits and harms of screening.
	86 years of age and over	Do not screen.
INCREASED RISK	**Family History of** • One first-degree relative diagnosed with colorectal cancer (CRC) at **60 years of age or older** • One or more first-degree relatives diagnosed with advanced adenomas[2] at any age	Patient Preference Routine screening with FIT every 2 years starting at age 40 or 10 years earlier than the youngest relative's age at diagnosis (whichever occurs first), OR Colonoscopy every 5 to 10 years beginning at age 40 or 10 years earlier than the youngest relative's age at diagnosis (whichever occurs first).
	Family History of • One first-degree relative diagnosed with colorectal cancer **before 60 years of age OR** • Two or more first-degree relatives diagnosed with colorectal cancer at any age	Colonoscopy every 5 years beginning at age 40 or 10 years earlier than youngest relative's age at diagnosis (whichever occurs first). Do not screen with FIT.
	Personal History of • Colorectal cancer or high-risk adenomas requiring surveillance • Inflammatory bowel disease (IBD) with associated colitis • Confirmed or suspected hereditary colorectal cancer syndromes such as Lynch syndrome or familial adenomatous polyposis (FAP)	Surveillance and management as directed by the endoscopist. Consider referring individuals with suspected hereditary colorectal cancer syndromes for genetic counselling and testing. Consider referring individuals with confirmed hereditary gastrointestinal cancer syndromes to the hereditary gastrointestinal cancer clinic at CancerCare Manitoba (fax: 204-786-0621). Do not screen with FIT.

[1]Average risk includes individuals with one or more second-degree relatives diagnosed with colorectal cancer and individuals with a first-degree relative with non-advanced adenomas or polyps of unknown histology.

[2]Adenomas greater than or equal to one centimetre in size, or with high-grade dysplasia, or villous and tubulovillous lesions.

ColonCheck Screening Guidelines (continued)

	Patient Characteristics	Management
INCREASED RISK	Childhood cancer survivors diagnosed with cancer between 0-18 years of age who received radiation to the abdomen, pelvis, spine (lumbar, sacral, whole) or total body radiation.	Preferred test: Colonoscopy every 5 years beginning at age 30 or 5 years after completion of radiation therapy (whichever occurs last). Alternative test: Screening with FIT every 1 year beginning at age 30 or 5 years after completion of radiation therapy (whichever occurs last).
	Young adult cancer survivors diagnosed with cancer between 19-35 years of age who received radiation to the abdomen or pelvis or total body radiation.	Preferred test: Colonoscopy every 5 years beginning at age 35 or 10 years after completion of radiation therapy (whichever occurs last). Alternative test: Screening with FIT every 1 year beginning at age 35 or 10 years after completion of radiation therapy (whichever occurs last).
SYMPTOMATIC	**Symptomatic, including:** • Persistent rectal bleeding • Unexplained iron deficiency anemia • Palpable mass	Refer for endoscopic investigation. Do not screen with FIT.

MANAGEMENT OF COLONOSCOPY RESULTS - POLYP SURVEILLANCE[3]

Recommendations should consider additional risk factors such as family colorectal cancer history which may shorten the surveillance interval. All recommendations assume a complete examination to the cecum with an adequate bowel preparation.

Patient Characteristics	Management
Normal (negative) colonoscopy result Patient at average risk for colorectal cancer, with no findings at procedure. Normal includes patients with rectosigmoid hyperplastic polyps less than 1 centimetre.	Resume routine screening with FIT in 10 years.
Abnormal (positive) colonoscopy result **Conventional adenomas** **Low risk adenoma(s) (LRA)** • 1 or 2 tubular adenoma(s) each less than 1 centimetre without high-grade dysplasia	Patient preference Routine screening with FIT every 2 years starting 5 years post-colonoscopy, OR Repeat colonoscopy in 7 to 10 years.
• 3 or 4 tubular adenomas each less than 1 centimetre without high-grade dysplasia	Colonoscopy in 3 to 5 years.

High-risk adenoma(s) (HRA)
• Advanced adenomas
  • Any tubular adenoma greater than or equal to 1 centimetre
  • Any adenoma with high-grade dysplasia or a villous component (villous or tubulovillous)
• 5 to 10 tubular adenomas
	Repeat colonoscopy in 3 years, then in 5 years once polyp clearance has been achieved.
	Further surveillance at endoscopist discretion.
	Surveillance interval may need to shorten if polyp clearance has not been achieved or high-risk adenomas are present at the second colonoscopy.

• Greater than 10 adenomas	Repeat colonoscopy in 1 year. Further surveillance at endoscopist discretion. Consider referral for genetic testing for familial adenomatous polyposis and MYH polyposis syndromes if 20 or more cumulative adenomas.

MANAGEMENT OF COLONOSCOPY RESULTS - POLYP SURVEILLANCE[3] (Continued)

Patient Characteristics	Management
Serrated Polyps • 1 or 2 non-dysplastic sessile serrated lesions each less than 1 centimetre in size	Repeat colonoscopy in 5-10 years. Further surveillance at endoscopist discretion.
• 3 - 4 non-dysplastic sessile serrated lesions each less than 1 centimetre in size • Hyperplastic polyp(s) greater than or equal to 1 centimetre	Repeat colonoscopy in 3-5 years. Further surveillance at endoscopist discretion.
• 5 - 10 non-dysplastic sessile serrated lesions each less than 1 centimetre in size • One or more sessile serrated lesions greater than or equal to 1 centimetre in size or with dysplasia • Traditional serrated adenoma(s) of any size	Repeat colonoscopy in 3 years. If no polyps requiring surveillance then subsequent colonoscopy in 5 years. Further surveillance at endoscopist discretion.
Serrated Polyposis Syndrome: • Five or more serrated lesions/polyps proximal to the rectum, all being equal to or greater than at least 5 millimetres in size with two or more that are greater than or equal to 1 centimetre. OR • More than 20 serrated lesions or polyps of any size distributed throughout the large colon, with at least five proximal to the rectum.	Repeat colonoscopy in 1 year and then 1-3 years at endoscopist discretion.
Post-curative resection for colorectal cancer	Colonoscopy 1-year post-surgery (or 1 year after the first completed colonoscopy if done after surgery), and then 4 years after initial surgery, then every 5 years unless polyp surveillance requires shorter intervals Refer to the "CancerCare Manitoba colorectal cancer patient follow-up treatment summary" for more information. This can be found at: https://www.cancercare.mb.ca/For-Health-Professionals/follow-up-care-resources
Colon was not cleared of polyps. Includes incomplete excision of an adenoma, in particular those with high-grade dysplasia or villous components, or piecemeal removal of a large sessile adenoma equal to or greater than 2 centimetres in size.	Repeat colonoscopy in less than 6 months. Subsequent surveillance at endoscopist discretion.

[3]For additional information on adenoma surveillance, refer to Colorectal Polyps and Surveillance Recommendations: cancercare.mb.ca/screening/hcp