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Summary: Follow-up of Colorectal Polyps or Cancer

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Key Recommendations

- Removal of adenomas can prevent colorectal cancers (CRC).
- Individuals with colorectal adenomas or carcinoma are at high risk for recurrence.
- Colonoscopy is the key follow-up test to detect new primary cancers or adenomas.
- Patients followed by colonoscopy do not require fecal occult blood testing (FOBT).
- Early detection and treatment of CRC metastases may prolong survival.

Surveillance of Patients With Prior History

The following patients should undergo a surveillance program:

- Personal history of CRC
- Personal history of an advanced adenoma (tubular adenomas ≥1 cm, villous adenomas, adenoma with high grade dysplasia (HGD), sessile serrated polyps ≥1 cm, sessile serrated polyps with dysplasia, or traditional serrated adenoma.
- Personal history of 1 or 2 non-advanced adenomas

Post-Colorectal Polypectomy Surveillance Recommendations

Risk Group	Surveillance Recommendation
Hyperplastic polyps	Follow-up as average risk. *
1 or 2 small (< 1 cm) tubular adenomas with only low-grade dysplasia	Follow-up colonoscopy in 5 to 10 years. Timing within this interval should be based on other clinical factors (e.g., previous colonoscopy findings, family history, patient preferences, judgment of the physician).
1 or more sessile serrated polyps < 1 cm with no dysplasia	Follow-up colonoscopy in 5 years.
3 to 10 tubular adenomas or any advanced adenomas (tubular adenomas ≥ 1 cm, villous adenomas, adenoma with HGD, sessile serrated polyps ≥ 1 cm, sessile serrated polyps with dysplasia, or traditional serrated adenoma)	Follow-up colonoscopy in 3 years provided that adenomas are completely removed. If the follow-up colonoscopy is normal or shows only 1 or 2 small (< 1 cm) tubular adenomas with low-grade dysplasia, the interval for the subsequent examination should be 5 years.
Sessile adenomas where complete removal is uncertain	Follow-up colonoscopy within 6 months to verify complete removal. Once complete removal has been established, subsequent surveillance should be as for advanced adenomas.
Suspected hereditary colorectal cancer syndrome	When the family history indicates HNPCC and FAP, colonoscopy every 1 to 2 years. **

* FOBT is an appropriate follow-up modality for this group. FOBT should not be used until 10 years after the last colonoscopy for the hyperplastic polyp patient. All other risk groups above should not be followed with FOBT.

** Individuals with HNPCC or FAP should be referred to the Hereditary Cancer Program at the BC Cancer Agency for assessment, counseling and if appropriate, genetic testing.

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Post-Colon Cancer Resection

The goal of follow-up after resection is to identify recurrent disease or metastases and to detect subsequent adenomas.

Patients with significant co-morbidities, very advanced age or limited 5 year life expectancy are not routinely offered surveillance.

Asymptomatic Increased Risk Patient Screening Recommendations

Exams or Procedures	Surveillance Recommendation
Follow-up visits with GP	History and physical every 3-6 months for first 2 years post-resection. Then every 6 months for a total of 5 years. History: elicit gastrointestinal and constitutional symptoms, including nutritional status. Physical examination: attention to the abdomen, liver and rectal evaluation. Perineal inspection and palpation in patients who have had an abdominal perineal resection. Note: Routine laboratory investigations in the absence of symptoms are not useful.
Tumour markers: carcinoembryonic antigen (CEA)	For patients with stage II or III tumors (i.e., tumour through the bowel wall or metastatic to locoregional lymph nodes), CEA is recommended at diagnosis of CRC. Every 3 months for the first 3 years. Every 6 months during years 4 and 5. No CEA is required beyond 5 years.
Liver imaging: CT scan (preferred) or ultrasound	Every 6 months for the first 3 years after CRC resection Then every 12 month during years 4 and 5. Routine CT scanning is not recommended beyond 5 years for most patients. Note: For advanced stage cancers or patients undergoing chemotherapy, follow the recommendations of the oncologist.
Chest CT	Chest CT every 12 months for the first 3 years in cases of advanced cancer or rectal cancer.
Chest X-ray	There is little evidence to show a survival benefit for routine chest x-ray for post CRC resection patients.
Colonoscopy	A complete cancer and polyp clearing colonoscopy prior to or within 12 months of surgical resection. Repeat at one year after resection or clearing colonoscopy. If the one year colonoscopy is normal, the next colonoscopy should be performed in 3 years; if those results are normal, the next colonoscopy should be performed in 5 years. After the one year colonoscopy, the intervals between subsequent colonoscopies may be shortened if there is evidence of HNPCC or if adenoma findings warrant earlier colonoscopy.
FOBT	Performance of FOBT is unnecessary in patients undergoing colonoscopic surveillance.

Surveillance After 5 Years

Continued surveillance is recommended with a colonoscopy conducted every 5 years. There is no place for FOBT in this population.