



# Surveillance for people with **polyps** or **inflammatory bowel disease**

## Surveillance for people with a history of polyps

It is recognised that the risk of bowel cancer varies with the type and number of polyps found at colonoscopy. Not all bowel polyps have the potential to become malignant and not all patients who have been found to have polyps will go on to have recurrent polyps and therefore an increased risk of bowel cancer.<sup>1,2</sup> The general aim is that surveillance should be performed at the minimum frequency required to reduce morbidity and mortality from bowel cancer.<sup>1</sup> This should be balanced against the risks of harm from colonoscopy, such as any psychological distress or complications of the procedure, and also against the financial impact to the health system (and potentially to individuals).<sup>1</sup> Other evidence-based interventions, such as smoking cessation, a reduction in the consumption of red/processed meats and the use of aspirin, should be discussed with patients.<sup>1,3</sup>

In 2020, updated New Zealand guidance was published for people post-colonoscopy who have had complete removal of adenomas or serrated polyps to address the variation in the intervals required for follow-up (Table 1).<sup>2</sup> Two factors influenced the new advice:

1. That some groups of patients with adenomas have a low risk of colorectal cancer in the future
2. That there is a risk of colorectal cancer with some serrated polyps

## Surveillance for people with a history of inflammatory bowel disease

Inflammatory bowel disease (IBD) is associated with an increased risk of development of bowel cancer. The risk can be classified as low, intermediate or high, largely reflecting the extensiveness and level of activity of the two main forms of IBD, either ulcerative colitis or Crohn's disease.<sup>4</sup>

Recommendations from 2012, state that:<sup>4</sup>

- A baseline colonoscopy and biopsies as appropriate should be performed 8 – 10 years after a definitive diagnosis of IBD
- Ongoing surveillance with colonoscopy should be offered depending on the patient's level of risk:
  - Low risk: colonoscopy at five years
  - Intermediate risk: colonoscopy at three years
  - High risk: colonoscopy at one year

N.B. For those at intermediate or high risk, the intervals can be extended to five years provided there have been two consecutive colonoscopies that show quiescent disease with no dysplasia, and no other risk factors (i.e. family history, a stricture or primary sclerosing cholangitis).

**Table 1:** Surveillance intervals based on findings at high-quality colonoscopy. Adapted from 2020 “Update on polyp surveillance guidelines” with expert advice from the NBCWG.<sup>2</sup>

1 year	3 years	5 years	10 years or NBSP (whichever comes first)
<b>Adenomas*</b> ≥ 10 adenomas**	<b>Adenomas*</b> 5 – 9 adenomas < 10 mm Adenoma ≥ 10mm Tubulovillous adenoma or Villous adenoma Adenoma with HGD	<b>Adenomas*</b> 3 – 4 adenomas < 10 mm	<b>Adenomas*</b> 1 – 2 adenomas < 10 mm
<b>Serrated polyps*</b> Serrated polyposis syndrome – initial interval after polyp clearance**	<b>Serrated polyps*</b> ≥ 5 SSL < 10 mm SSL ≥ 10 mm SSL with dysplasia Traditional serrated adenoma	<b>Serrated polyps*</b> 1 – 4 SSL < 10 mm HP ≥ 10 mm <sup>†</sup>	

\* If there are both adenoma < 10 mm and SSL < 10 mm, the numbers should be summed up and follow-up interval for SSL should be applies

† A 3-year follow-up interval is favoured if concern about consistency in distinction between sessile serrated lesion and hyperplastic polyp locally


\*\* Consider referral to the NZ Familial Gastrointestinal Cancer Service (NZFGCS), see referral criteria below

**NBSP:** National Bowel Screening Programme

**SSL:** Sessile serrated lesion (= sessile serrated adenoma/polyp)

**HGD:** High grade dysplasia

**HP:** Hyperplastic polyp

 For information about surveillance in people with a family history of bowel cancer, refer to the first article in this series: “Referral of patients with features suggestive of bowel cancer: Ministry of Health guidance” <https://bpac.org.nz/2020/bowel-cancer.aspx>

**Acknowledgement:** Thank you to **Professor Ian Bissett** and other members of the National Bowel Cancer Working Group and **Dr Liz Dennett**, Clinical Director, Te Aho o Te Kahu, for expert review of this article.

Article supported by Te Aho o Te Kahu, the Cancer Control Agency.

N.B. Expert reviewers do not write the articles and are not responsible for the final content. bpac<sup>nz</sup> retains editorial oversight of all content.

## References

1. Rutter M, East J, Rees C, et al. British Society of Gastroenterology/Association of Coloproctology of Great Britain and Ireland/Public Health England post-polypectomy and post-colorectal cancer resection surveillance guidelines. *Gut* 2020;69:201–23. doi:10.1136/gutjnl-2019-319858
2. Te Aho O Te Kahu. Update on polyp surveillance guidelines. 2020. Available from: <https://www.health.govt.nz/system/files/documents/publications/update-polyp-surveillance-guidelines-dec20.pdf> (Accessed Jun, 2021).
3. Aune D, Chan DSM, Vieira AR, et al. Red and processed meat intake and risk of colorectal adenomas: a systematic review and meta-analysis of epidemiological studies. *Cancer Causes Control* 2013;24:611–27. doi:10.1007/s10552-012-0139-z
4. New Zealand Guidelines Group. Guidance on surveillance for people at increased risk of colorectal cancer. 2012. Available from: [https://www.moh.govt.nz/notebook/nbbooks.nsf/0/FFA15554B7DE4789CC257A4E0078DBC6/\\$file/Guidance%20on%20Surveillance%20forColorectal%20Cancer%20FINAL.pdf](https://www.moh.govt.nz/notebook/nbbooks.nsf/0/FFA15554B7DE4789CC257A4E0078DBC6/$file/Guidance%20on%20Surveillance%20forColorectal%20Cancer%20FINAL.pdf) (Accessed Jun, 2021).



This article is available online at:  
[www.bpac.org.nz/2021/bowel-polyps.aspx](https://www.bpac.org.nz/2021/bowel-polyps.aspx)