BRITISH SOCIETY OF GASTROENTEROLOGY

List of recommendations from the BSG/ACPGBI/PHE Post-polypectomy and post-colorectal cancer resection surveillance guidelines

1. We recommend that the high-risk criteria for future colorectal cancer (CRC) comprise either:
   - two or more premalignant polyps including at least one advanced colorectal polyp (defined as a serrated polyp of at least 10mm in size or containing any grade of dysplasia, or an adenoma of at least 10mm in size or containing high-grade dysplasia)
   - or five or more premalignant polyps.
2. We suggest that where histological completeness of excision cannot be determined in patients with non-pedunculated polyps of 10–19mm in size, or an adenoma containing high-grade dysplasia, or a serrated polyp containing any dysplasia, then a site check should be considered within 2–6 months. The need for subsequent surveillance should then be determined based on the high-risk surveillance criteria.
3. We recommend that polyp size should be recorded as the largest dimension of neoplastic tissue (adenoma or serrated) as measured at histopathological examination. For piecemeal resection or where there has been fragmentation of tissue during retrieval, endoscopic assessment of size should be used.
4. We recommend that people with high-risk findings on index colonoscopy who are under the age of 75 years should have a surveillance colonoscopy performed after an interval of 3 years (note the one exception in the next statement)
5. We suggest that due to the long timeline from a clearance colonoscopy through the potential development of new polyps to the possible development of a symptomatic cancer, surveillance should only be performed in people whose life-expectancy is greater than 10 years, and in general not in people older than about 75 years.
6. We recommend that people with no high-risk findings on index colonoscopy should not undergo colonoscopic surveillance, but should be strongly encouraged to participate in their national bowel screening programme when invited (note the one exception in the next statement).
7. We suggest that people with premalignant polyps but no high-risk findings on index colonoscopy, who are more than 10 years younger than the national bowel screening

programme lower age-limit, should be considered for a surveillance colonoscopy performed after an interval of 5 or 10 years, individualised to their age and other risk factors.

8. We recommend that patients who have undergone a potentially curative CRC resection should have a clearance colonoscopy within a year of their diagnosis
9. We recommend that once a clearance colonoscopy has been performed in the postoperative period in patients who have had a CRC resection, their next surveillance should be performed after an interval of 3 years. The need for further surveillance should then be determined in accordance with the post-polypectomy high-risk criteria.
10. We recommend that as recurrence rates after pathologically en bloc R0 endoscopic mucosal resection (EMR) or endoscopic submucosal dissection (ESD) of large nonpedunculated colorectal polyps (LNPCPs) or early polyp cancers are low, no site checks are required, and the patient should undergo post-polypectomy surveillance after an interval of 3 years. The need for further surveillance should then be determined in accordance with the post-polypectomy high-risk criteria.
11. We recommend a site check is performed 2–6 months after piecemeal EMR or ESD of LNPCPs (at least 20mm in size), in line with BSG/ACPGBI LNPCP guidelines. A further site check at 18 months from the original resection is recommended to detect late recurrence. Once no recurrence is confirmed patients should undergo post-polypectomy surveillance after an interval of 3 years. The need for further surveillance should then be determined in accordance with the post-polypectomy high-risk criteria
12. We recommend that the need for ongoing colonoscopic surveillance should be determined by the colonoscopic findings at each surveillance procedure, using the same high-risk criteria to stratify risk.
13. We recommend that people with high-risk findings on a surveillance colonoscopy should undergo a further surveillance colonoscopy at an interval of 3 years (with the same age-related caveats applied again).
14. We recommend that people with no high-risk findings on a surveillance colonoscopy should cease colonoscopic surveillance, but should participate in the national bowel screening programme when invited (with the same age-related caveats applied again).
15. We recommend that surveillance colonoscopies should only be performed by colonoscopists who are either screening accredited, or whose colonoscopy performance measures (key performance indicators—KPIs) exceed the minimum standard as defined in the BSG lower gastrointestinal (GI) quality standards publication

16. We recommend that when colonic surveillance is required after previous polypectomy, computed tomography colonography (CTC) is an acceptable alternative if colonoscopy is incomplete or not possible due to the patient's clinical condition.
17. We recommend that when colonic surveillance is required after curative-intent resection of CRC, CTC should only be used for individuals in whom colonoscopy is contraindicated or not possible due to the patient's clinical condition.
18. We recommend that when post-polypectomy surveillance is indicated, the radiation risk of CTC is likely to be outweighed by its potential benefits.
19. We do not recommend the use of faecal immunochemical testing for surveillance after resection of premalignant colorectal polyps, as there is insufficient evidence.
20. We do not recommend the use of colon capsule for surveillance after resection of premalignant colorectal polyps, as there is insufficient evidence.