IBD colon cancer surveillance guidelines – Summary Clinical Guideline

Reference No: CG-CLIN/4058/22

Derby and Burton IBD colon cancer surveillance guidelines

Introduction
This clinical guideline applies to all adult patients with IBD at UHDB.

When to start

Surveillance should be started eight years following diagnosis except the patients with PSC who should have surveillance started immediately on diagnosis.

Proctitis patient do not need surveillance though a one off colonoscopy at 8 years should be considered as one third of proctitis patients have disease extension proximally.

Patients who have had a colectomy and retained rectal stump have a 2% cancer risk at 20 years (4x SIR for population) IRA 9 x Standard incidence rate) . Survey as per pre-colectomy risk factors.

Surveillance procedure

Surveillance Colonoscopy should be with high definition instruments.

Who should do surveillance

Should be a consultant gastroenterologist list with an interest in inflammatory bowel disease.

Dye spray colonoscopy

They should be performed on a dedicated list with three points per procedure. Indigo Carmine dye spray: it is recommended that 0.03 percent Indigo Carmine (10 ml of 1% solution in 300mls of jet wash fluid) in water with added Infacol is used using the jet wash system. This keeps the biopsy channel free for instruments. If jet wash is not available then 2% Indigo Carmine applied with a spray catheter can be used.
At the time of colonoscopy it is recommended that biopsies are taken from both right and left colon, this is to demonstrate whether there is active inflammation as this will determine in part the next surveillance interval.

Endoscopically resectable lesions should be removed either at that procedure or after discussion at IBD MDT.

Biopsy protocol if dye spray not used.

If dye spray is not possible either because it is not available or that the bowel prep is of insufficiently quality then the biopsy protocol of two biopsies every 10 cm should be followed.

What to do with lesions

- discrete lesions should be resected if lift and not T5 pattern

Management of dysplasia*:
Statements published as part of 2015 SCENIC international[i] consensus: **and taken from BSG 2019 Guidance**

- After complete removal of endoscopically resectable polypoid dysplastic lesions, surveillance colonoscopy is recommended rather than colectomy (strong recommendation, very-low quality evidence), dependant on patient wishes
- After complete removal of endoscopically resectable non-polypoid dysplastic lesions, surveillance colonoscopy is suggested rather than colectomy (conditional recommendation, very-low quality evidence).
- For patients with endoscopically invisible dysplasia (confirmed by a GI pathologist), referral is suggested to an endoscopist with expertise in IBD surveillance using chromoendoscopy with high-definition colonoscopy (conditional recommendation, very low-quality evidence). If dysplastic lesions cannot be resected completely due to extent or multiplicity, referral to MDT for discussion regarding definitive management including surgical options should be arranged.

Repeat surveillance intervals.

- High risk 1yearly
- Intermediate risk 3 yearly
- Low risk 5 yearly

Data needed to assess interval

- extent of the colitis
- degree of inflammation
- any family history of IBD
- family history of IBD with first-degree relative with colorectal cancer less than 50 (FDR<50 CRC)
- previous dysplasia within five years
- PSC or Liver transplant for PSC

Risk stratification.

High risk	intermediate	Low
PSC/liver TP for PSC	Mild inflammation	Uninflamed left sided or pan colitis
Family History FDR <50 CRC	Pseudopolyps	
Moderate or severe inflammation	Family History of FDR > 50 CRC	
Stricture		
Dysplasia within 5 y		

Automated recall and validation process.

There is no automated process for surveillance at present that can take into account all the variables needed. This is aspirational.

References

[1] Laine L, Kaltenbach T, Barkun A, et al. SCENIC international consensus statement on surveillance and management of dysplasia in inflammatory bowel disease. Gastrointest Endosc 2015;81:489–501.

[1] Lamb CA, Kennedy NA, Raine T, et al. Gut Epub ahead of print: doi:10.1136/gutjnl-2019-318484

[1] Laine L, Kaltenbach T, Barkun A, et al. SCENIC international consensus statement on surveillance and management of dysplasia in inflammatory bowel disease. Gastrointest Endosc 2015;81:489–501.