Derby and Derbyshire
Integrated Care Board

CLINICAL POLICY ADVISORY GROUP (CPAG)

Appropriate Colonoscopy in the Management of Hereditary Colorectal Cancer

Statement

NHS Derby and Derbyshire ICB, in line with its principles for evidence-based interventions has deemed that Colonoscopy in the management of hereditary colorectal cancer should only be commissioned for adults aged 19 and over who meet the British Society of Gastroenterology surveillance guidelines for the Management of Hereditary colorectal cancer.

These commissioning intentions will be reviewed periodically. This is to ensure affordability against other services commissioned by the ICB.

1. Background

Colorectal carcinoma (CRC) is one of the most common cancers in the UK with more than 40,000 new cases diagnosed each year. An estimated 35% of CRC is due to heritable factors.

While colonoscopy is a safe procedure, there is a small risk of complications – including pain, intestinal perforation or major haemorrhage as well as issues related to any sedative used. Colonoscopy should therefore be used appropriately in the management of CRC in people who have been identified with an increased lifetime risk of CRC due to hereditary factors.

2. Recommendation

This policy applies to adults aged 19 years and over

The following British Society of Gastroenterology surveillance guidelines should be followed

Family history of CRC

For individuals with a moderate familial CRC risk offer:

- One off colonoscopy at age 55
- Subsequent colonoscopic surveillance should be performed as determined by post-polypectomy surveillance guidelines

For individual with high familial CRC risk (a cluster of 3 x FDR with CRC across >1 generation) offer

- Colonoscopy every 5 years form age 40 years to age 75 years

Lynch Syndrome (LS) and Lynch-like Syndrome

For individuals with LS that are MLH1 and MSH2 mutation carriers offer:

- colonoscopic surveillance every 2 years from age 25 years to age 75 years.

For individuals with LS that are MSH6 and PMS2 mutation carriers offer:

- colonoscopic surveillance every 2 years from age 35 years to age 75 years.

For individuals with Lynch-like Syndrome with deficient MMR tumours without hypermethylation/BRAF pathogenic variant and no pathogenic constitutional pathogenic variant in MMR genes (and their unaffected FDRs), and no evidence of biallelic somatic MMR gene inactivation offer:

- colonoscopic surveillance every 2 years from age 25 years to age 75 years.

Early Onset CRC (EOCRC)

For individuals diagnosed with CRC under age 50 years, where hereditary CRC symptoms have been excluded offer

- standard post-CRC colonoscopy surveillance after 3 years
- Then continue colonoscopic surveillance every 5 years until eligible for national screening.

Serrated Polyposis Syndrome (SPS)

For individuals with SPS offer

- colonoscopic surveillance every year from diagnosis once the colon has been cleared of all lesions >5mm in size
- If no polyps ≥ 10mm in size are identified at subsequent surveillance examinations, the interval can be extended to every 2 years.

For first degree relatives of patients with SPS offer

- an index colonoscopic screening examination at age 40 or ten years prior to the diagnosis of the index case
- a surveillance colonoscopy every 5 years until age 75 years, unless polyp burden indicates an examination is required earlier according to post-polypectomy surveillance guidelines.

Multiple Colorectal Adenoma (MCRA)

For individuals with MCRA (defined as having 10 or more metachronous adenomas) offer:

- annual colonoscopic surveillance from diagnosis to age 75 years after the colon has been cleared of all lesions >5mm in size
- If no polyps 10mm or greater in size are identified at subsequent surveillance examinations, the interval can be extended to 2 yearly.

Familial Adenomatous Polyposis (FAP)

For individuals confirmed to have FAP on predictive genetic testing offer:

- colonoscopic surveillance from 12-14 years
- Then surveillance colonoscopy every 1-3 years, personalised according to colonic phenotype.

For individuals who have a first degree relative with a clinical diagnosis of FAP (i.e. “at risk”) and in whom a APC mutation has not been identified offer:

- colorectal surveillance from 12-14 years
- Then every 5 years until either a clinical diagnosis is made and they are managed as FAP or the national screening age is reached.

MUTYH-associated Polyposis (MAP)

For individuals with MAP offer

- colorectal surveillance from 18-20 years, and if surgery is not undertaken, repeat annually.

For monoallelic MUTYH pathogenic variant carriers:

- The risk of colorectal cancer is not sufficiently different to population risk to meet thresholds for screening and routine colonoscopy is not recommended.

Peutz-Jeghers Syndrome (PJS)

For asymptomatic individuals with PSJ offer:

- colorectal surveillance from 8 years
- If baseline colonoscopy is normal, deferred until 18 years, however if polyps are found at baseline examination, repeat every 3 years.

For symptomatic patients, investigate earlier.

Juvenile Polyposis Syndrome (JPS)

For asymptomatic individuals with JPS offer:

- colorectal surveillance from 15 years
- Then a surveillance colonoscopy every 1-3 years, personalised according to colorectal phenotype.

For symptomatic patients, investigate earlier.

For some patients with multiple risk factors for CRC, for example those with Lynch Syndrome and inflammatory bowel disease/multiple polyps, more frequent colonoscopy may be indicated. This needs to be guided by clinicians but with a clear scientific rationale linked to risk management.

3. Rationale for Recommendation

This recommendation is based on the 2019 guidelines published by the British Society of Gastroenterology, the Association of Coloproctologists of Great British and Ireland and United Kingdom Cancer Genetics Group.

Heritable factors account for approximately 35% of CRC risk, and almost 30% of the population in the UK have a family history of CRC. It is possible to stratify individuals to identify cohorts of patients with hereditary risk. This can help target management and determine who will benefit the most from colonoscopic surveillance and at what frequency.

4. Personalised Care

Personalised care simply means that people have more control and choice when it comes to the way their care is planned and delivered, considering their individual needs, preferences and circumstances. It includes supporting shared decision making and self-management.
Shared decision-making means people are supported to:

- *understand the care, treatment and support options available and the risks, benefits and consequences of those options*
- *decide on a preferred course of action, based on evidence based, good quality information and their personal preferences.*

Supported self-management means increasing the knowledge, skills and confidence a person has in managing their own health and care. This involves using self-management education, peer support, and health coaching.
Decision support tools, also called patient decision aids support shared decision making by making treatment, care and support options explicit. They provide evidence-based information about the associated benefits/harms and help patients to consider what matters most to them in relation to the possible outcomes, including doing nothing.

5. Useful Resources

- BRAN leaflet – Shared decision-making supports individuals to make the right decision for them. This easy-to-use leaflet supports this people to consider their treatment options.
- Cancer Research UK. Colonoscopy.

6. References

1. Monahan KJ, Bradshaw N, Dolwani S, et al. Guidelines for the management of hereditary colorectal cancer from the British Society of Gastroenterology (BSG)/ Association of Coloproctologists of Great Britain and Ireland (ACPGBI)/ United Kingdom Cancer Genetics Group (UKCGG) Gut 2019;0:1–34. doi:10.1136/gutjnl-2019-319915
2. NICE Guideline (2020) Colorectal cancer [NG151].
3. NICE Guideline (2011) Colorectal cancer prevention: Colonoscopic surveillance in adults with ulcerative colitis, Crohn's disease or adenomas guideline [CG118].
4. Academy of Medical Royal Colleges: Evidence-based Interventions for appropriate colonoscopy in the management of hereditary colorectal cancer

7. Appendices

Appendix 1 - Consultation

All relevant providers/stakeholders will be consulted via a named link consultant/specialist. Views expressed should be representative of the provider/stakeholder organisation. CPAG will consider all views to inform a consensus decision, noting that sometimes individual views and opinions will differ.

Consultee	**Date**
Clinical Policies Advisory Group (CPAG)	August 2021
Academy of Medical Royal Colleges	August 2021
Consultant General & Colorectal Surgeon, CRHFT	August 2021
Clinical Director, Integrated Surgery, CRHFT	August 2021
Divisional Director of Surgical Services, CRHFT	August 2021
Consultant General Surgeon, UHDBFT	August 2021
Consultant Gastroenterologist, Clinical Lead (ACD) for Endoscopy, Clinical Director for South Derbyshire Bowel Cancer Screening Programme, UHDB	August 2021
Clinical Lay Commissioning Committee	August 2021
Academy of Medical Royal Colleges	September 2024
Clinical Policies Advisory Group (CPAG)	March 2025

Appendix 2 - Document Update

Document Update	**Date Updated**
Version 1- new policy for appropriate Colonoscopy in the Management of hereditary colorectal cancer – aligned with Academy of Medical Royal Colleges EBI Guidance	March 2025