

French Society of Digestive Endoscopy (SFED) Guideline

Indications for colonoscopy in the diagnosis of neoplasia



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Bibliography

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The clinical practice guidelines on the indications for colonoscopy in the diagnosis of neoplasia, published in 1996 by the French National Agency for Accreditation and Evaluation in Healthcare (ANAES, recently renamed “Haute Autorité de Santé” or HAS) [1], were updated in 2004. These guidelines were produced using the three-step method employed by ANAES-HAS: (i) a critical appraisal of the literature, (ii) three meetings of a multidisciplinary working group, and (iii) comments on the draft guidelines obtained from 45 peer reviewers. The guidelines are available in both French and English on the HAS website (www.has.fr) [2]. The report outlining the supportive arguments on which the guidelines are based is available in French only. The guidelines are summarized here in **Table 1**.

These guidelines do not concern mass screening but address the role of colonoscopy in diagnosing neoplasia in people who are at high risk or very high risk of colorectal cancer and in people at average risk of colorectal cancer in special clinical situations. The guidelines also provide recommendations for the surveillance of asymptomatic individuals at high or very high risk of colorectal cancer.

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Anaes Clinical Practice Guidelines

Summary of indications for lower gastrointestinal endoscopy

The guidelines address the role of lower gastrointestinal endoscopy in diagnosing neoplasia:

- ▶ in special clinical situations for subjects at average risk of colorectal cancer,
- ▶ in subjects at high and very high risk of colorectal cancer.

Indications in patients at average risk of colorectal cancer (CRC)

- 1. Patients with isolated gastrointestinal symptoms such as abdominal pain and/or diarrhoea and/or constipation:** Complete colonoscopy is recommended if these symptoms occur:
 - a. after age 50,
 - b. before age 50, in the absence of response to symptomatic treatment.
- 2. Patients with heavy chronic or acute rectal bleeding:** Complete colonoscopy is recommended:
 - a. if there are chronic repeated episodes of dark red rectal bleeding, irrespective of patient age,
 - b. if there is isolated chronic bright red rectal bleeding, occurring after age 50,
 - c. if there is acute heavy rectal bleeding, as soon as the patient's clinical condition allows.

If there is isolated chronic bright red rectal bleeding before age 50, either flexible proctosigmoidoscopy or complete colonoscopy may be used as a first line examination.

3. **Symptomatic diverticulosis of the colon:** Complete colonoscopy is contraindicated when acute inflammation due to diverticulosis of the colon has already been diagnosed by other methods.
Complete colonoscopy is recommended at a time when there are no acute complications, if surgery is indicated or neoplasia is suspected.
4. **Endocarditis:** Complete colonoscopy is recommended if endocarditis is caused by *Streptococcus bovis* or a group D streptococcus.
5. **Before or after organ transplant in asymptomatic patients:** Insufficient data for a guideline.

Indications in patients at high or very high risk of CRC

1. **Surveillance of inflammatory bowel disease (IBD) (Crohn's disease and ulcerative colitis):** The patient should undergo complete colonoscopy with biopsies (every 10 cm, at least 30 biopsies):
 - a. for pancolitis (involvement proximal to the splenic flexure), 10 years after onset of disease, then every 2–3 years,
 - b. for left side colitis, 15 years after onset of disease, then every 2–3 years.

In the event of:

- Undetermined dysplasia: Endoscopic surveillance and biopsies after 6 months.
- Low grade or high grade dysplasia (categories 3 and 4 of the Vienna classification): Confirm diagnosis by a second pathologist before deciding on treatment.
- Polypoid lesions: Biopsy of the lesion and adjacent flat mucosa.

2. **Surveillance of asymptomatic subjects at very high or high risk of CRC: see Table 1.**

Indications for colon and/or ileal biopsies (macroscopic appearance of mucosa normal)

1. **If the patient has chronic diarrhoea, look for:**
 - a. microscopic colitis in non-immunocompromised subjects: rectal and sigmoid biopsies.
 - b. opportunist infection in immunocompromised subjects: ileal and colon biopsies.
2. **Investigation of suspected IBD:** Take multiple biopsies at set intervals along the colon and clearly record their location.

Table 1 Surveillance schedules and methods for each indication for lower gastrointestinal endoscopy

| Indication | Age for starting surveillance, years | Surveillance schedule | Method used |
|--|---|--|------------------------------|
| Surveillance of asymptomatic people at very high risk of colorectal cancer | | | |
| Relatives of a patient with FAP | 10–12 | Every year | Flexible proctosigmoidoscopy |
| People with FAP, after colectomy – surveillance of remaining rectum | – | Every year | Flexible proctosigmoidoscopy |
| Relatives of a patient with attenuated FAP | 30 | Every year | Complete colonoscopy |
| Polyposis of the colon with <i>MHY</i> mutation | 30 | No recommendation | Complete colonoscopy |
| Relatives of a patient with HNPCC | 20–25 | Every 2 years | Complete colonoscopy |
| People with HNPCC, after colon surgery | – | Every 2 years | Complete colonoscopy |
| Juvenile polyposis: patients with the condition and relatives of an affected patient | 10–15 | Every 2–3 years | Complete colonoscopy |
| Peutz–Jeghers syndrome: patients with the condition and relatives of an affected patient | 18 | Every 2–3 years | Complete colonoscopy |
| Surveillance of asymptomatic people at high risk of colorectal cancer | | | |
| Family history of colorectal cancer: in one first-degree relative before the age of 60; or in several first-degree relatives irrespective of age | 45, or 5 years before the age of the index case diagnosis | Surveillance at 5 years, then (if the colonoscopy is normal) two colonoscopies 5 years apart, then (if the colonoscopy is normal) extend intervals between exams | Complete colonoscopy |
| Family history of colorectal cancer in a first-degree relative and discovery of non-advanced adenoma | – | Surveillance colonoscopy at 3 years | Complete colonoscopy |
| Family history of colonic adenoma in a first-degree relative before the age of 60 | 45, or 5 years before the age of the index case diagnosis | Depends on the result of the first colonoscopy | Complete colonoscopy |
| Personal history of colorectal cancer if preoperative colonoscopy was incomplete | – | Surveillance at 6 months, then (if the colonoscopy is normal) at 2–3 years, then at 5 years | Complete colonoscopy |
| Personal history of colorectal cancer if preoperative colonoscopy was complete | – | Surveillance at 2–3 years, then (if the colonoscopy is normal) at 5 years | Complete colonoscopy |
| Patient with acromegaly | At diagnosis of acromegaly | Depends on the result of the first colonoscopy | Complete colonoscopy |

Table 1 Continuation

| Indication | Age for starting surveillance, years | Surveillance schedule | Method used |
|---|--------------------------------------|--|----------------------|
| Surveillance of asymptomatic people at high risk of colorectal cancer, after resection of colorectal polyps | | | |
| Hyperplastic polyps: | | | |
| After resection of one hyperplastic polyp ≥ 1 cm and/or multiple polyps ($n \geq 5$) in the colon and/or in the proximal colon if there is a family history of hyperplastic polyps | – | Surveillance at 5 years, then (if the colonoscopy is normal) at 10 years | Complete colonoscopy |
| Adenoma at the low-grade dysplasia stage and advanced adenomas*: | | | |
| Incomplete resection of an adenoma at the low-grade dysplasia stage (category 3); or advanced adenoma (categories 4.1 and 4.2) | – | Surveillance at 3 months | Complete colonoscopy |
| Complete resection of an advanced adenoma, or of multiple adenomas ($n \geq 3$); or of an adenoma in a patient with a family history of colorectal cancer | – | Surveillance at 3 years (if the colonoscopy is normal), then two colonoscopies 5 years apart, then at 10 years | Complete colonoscopy |
| Complete resection of a nonadvanced adenoma and multiple adenomas ($n < 3$) and no family history of colorectal cancer | – | Surveillance at 5 years, then (if the colonoscopy is normal) colonoscopy at 5 years, then (if the colonoscopy is normal) at 10 years | Complete colonoscopy |
| Transformed adenoma: | | | |
| Incomplete resection of a category 4 transformed adenoma | – | Surveillance at 3 months, then (if the colonoscopy is normal) at 3 years | Complete colonoscopy |
| Complete resection of a category 4 transformed adenoma | – | Surveillance at 3 years | Complete colonoscopy |
| Resection of a category 5 transformed adenoma without additional colectomy | – | Surveillance at 3 months, then (if the colonoscopy is normal) at 3 years | Complete colonoscopy |

FAP, familial adenomatous polyposis; HNPCC, hereditary nonpolyposis colorectal cancer.

* Advanced adenoma, size ≥ 1 cm, or if it contains $> 25\%$ villous tissue, or in cases of high-grade dysplasia or carcinoma in situ (Vienna classification categories 4.1 or 4.2).

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