Colon Screening Program

Colonoscopist Reference

BC Cancer Agency
CARE + RESEARCH
An agency of the Provincial Health Services Authority

Colonoscopy Dictation Guidelines

Standardized reporting systems facilitate quality improvement. Clear documentation facilitates communication amongst health care providers and participants.

Quality indicators for colonoscopy reporting have been identified by expert consensus.

A comprehensive colonoscopy report includes:

- Participant demographics
- Pre-assessment including co-morbid illnesses
  - e.g. anti-thrombotic agents, defibrillator
- Indication for colonoscopy
  - e.g. positive FIT, screening, surveillance, family history
- Medication type and dose used for conscious sedation
- Bowel preparation quality
- Cecal intubation with photo documentation
- Indication of completeness of visualization of the colonic mucosa
- Assessment of the degree of difficulty of the procedure
- Withdrawal time
- Documentation of findings
  - Polyp location, morphology, size, method of removal, and completeness of removal and retrieval
- Unplanned events
  - Use of reversal agents for conscious sedation
  - Control of bleeding
  - Immediate post-procedure interventions
- Recommendations for follow-up
  - Relayed to the participant prior to discharge
  - Review of pathology specimens may alter recommendations and should be clearly documented at that time

Follow Up Recommendations as per Program Re-Screening and Surveillance Guidelines

The recommendations for re-screening and surveillance following colonoscopy are summarized below.

Following a negative (no adenomas) colonoscopy:

- Average risk participants who had a positive FIT result but a negative colonoscopy will re-enter FIT screening in the 10th year following colonoscopy.
- Participants with one first degree relative with CRC diagnosed under the age of 60 years or ≥ 2 first degree relatives with CRC diagnosed at any age will have a repeat colonoscopy in five years.
- Adenoma identified at last prior screening episode, repeat colonoscopy in five years.
- For patients who have previously had a low risk adenoma resected and a normal colonoscopy at the 5 year surveillance interval, the colonoscopist may elect to extend the interval for the next colonoscopy out to 10 years at their discretion.

Further investigations of a positive FIT following a negative colonoscopy may be indicated in a participant with upper gastrointestinal symptoms or anemia and will be at the discretion of the participant's physician.

Following a colonoscopy with removal of an adenoma:

- Repeat colonoscopy in five years for a low risk adenoma.
- Repeat colonoscopy in three years for a high risk adenoma or ≥ 3 low risk adenomas. A high risk adenoma includes the following:
  - High grade dysplasia
  - Villous features
  - Size ≥ 10 mm
  - Sessile serrated polyp/adenoma ≥ 10 mm in size
  - Sessile serrated polyp/adenoma of any size with dysplasia
  - Traditional serrated adenoma of any size

Following a colonoscopy where cancer is identified:

Referral for staging and treatment should be arranged through the usual practice in the community. The colonoscopist would either:

- Arrange staging and treatment and advise the family physician this has been done or;
- Refer the patient back to the family physician for the family physician to arrange staging and treatment.