BC CANCER COLON SCREENING
Provincial Health Services Authority

BC Cancer Colon Screening
Pre and Post Colonoscopy Standards

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Date and Version: April 2025

Pre and Post Colonoscopy Assessment Standards
Colon Screening Program

This report was produced by the BC Cancer Colon Screening Program.

Preferred citation:

Colon Screening Program Pre and Post Colonoscopy Standards. BC Cancer, 2025.

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Acknowledgements

BC Cancer would like to thank everyone who assisted in the development and refinement of the Colon Screening Program's Pre-Post Colonoscopy Assessment Standards.

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About BC Cancer

BC Cancer, an agency of the Provincial Health Services Authority, provides a comprehensive cancer control program for the people of BC in partnership with regional health authorities. This includes prevention, screening and early detection programs, research and education, and care and treatment.

BC Cancer's mandate is a three-fold mission:

- To reduce the incidence of cancer
- To reduce the mortality rate of people with cancer
- To improve the quality of life of people living with cancer

This mission drives everything we do, including providing screening, diagnosis and care, setting treatment standards, and conducting research into causes of, and cures for cancer.

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1. Introduction

1.1 Colon Screening Program

Colorectal cancer (CRC) is the second most commonly diagnosed cancer and the second leading cause of cancer death in men and third leading cause of cancer death in women. The Colon Screening Program seeks to reduce the incidence and mortality of colorectal cancer by providing timely and equitable access to high quality screening and diagnostic services to eligible people. The program is available in all areas of B.C.

1.2 Purpose of the Standards

These standards are designed to maximize participant safety and program efficiency and efficacy by ensuring pre and post colonoscopy assessment is carried out in a safe, effective, and consistent manner across the province.

1.3 Sources of Information

The Pre-Post Colonoscopy Assessment Standards are based on the experiences of the BC Cancer Colon Check pilot program, the Vancouver Island Health Authority Pilot Program, and the NHS Bowel Cancer Screening Programme (UK).

1.4 General Principles

- Maximize follow-up colonoscopy uptake for participants with a positive FIT.
- Optimize participant understanding of colonoscopy.
- Optimize participant satisfaction.
- Minimize colonoscopy related complications.
- Optimize follow-up screening and surveillance.

1.5 Program Eligibility

Eligible participants are referred to the program by primary care providers. There are three main categories of eligibility:

1. Individuals, age 50 to 74 years, without a personal history of pre-cancerous colorectal lesions nor a high-risk family history of colorectal cancer, will be offered FIT every two years.

2. Individuals with a personal history of a pre-cancerous colorectal lesions will be offered colonoscopy surveillance, when appropriate, or FIT to 74 years of age.

3. A high-risk family history is defined as a single first degree relative (parent, full sibling, child) diagnosed with colorectal cancer at less than 60 years of age or two or more first degree relatives diagnosed with colorectal cancer at any age. Individuals with a high-risk family history of colorectal cancer will be offered colonoscopy every 5 years, commencing at 40 years of age or 10 years younger than the age of colorectal cancer diagnosis of the youngest affected relative, whichever is earliest. The youngest affected relative should be on the same side of the family as the first degree relative with colorectal cancer but does not have to be a first degree relative (e.g. aunt, cousin or half-sibling, etc…).

Primary care providers are provided with information on the eligibility criteria for the program and it is expected that providers consider and adhere to the criteria. However, some participants will be asked to complete a FIT inappropriately.

If the FIT is abnormal, the Colon Screening Program recommends colonoscopy in all of the following scenarios:

- Participant had a normal FIT recently and is not yet due for repeat FIT.
- Participant is in a colonoscopy surveillance program for a personal history of pre-cancerous colorectal lesions or a high-risk family history of colorectal cancer but has a FIT that is abnormal.
- Participant who had an abnormal FIT followed by a colonoscopy in which neither colorectal cancer nor pre-cancerous colorectal lesions were identified, and the next recommended screening is FIT in 10 years. The participant undergoes FIT before they are due and it is abnormal.

Colonoscopy is protective for ten years and previous guidelines based on data using the guaiac fecal occult blood test stated that an abnormal guaiac fecal occult blood test following a negative colonoscopy could be ignored. However, given the improved performance of FIT, more recent guidelines have recommended that colonoscopy be offered to participants with an early FIT that is abnormal. These recommendations were graded as weak and based on low quality evidence. However, a further peer-reviewed publication has demonstrated a risk of post-colonoscopy colorectal cancer in this group. Despite the risk of colorectal cancer for participants with an abnormal FIT who are not yet due for colonoscopy, data does not support the addition of FIT to colonoscopy surveillance in participants with a personal history of neoplastic polyps or a family history of colorectal cancer. There are harms associated with over-screening and the best defense against post-colonoscopy colorectal cancer is ensuring the initial exam is high quality.

Participants not eligible for screening within the Colon Screening Program:

1. Personal history of colorectal cancer or inflammatory bowel disease (Crohn's disease or ulcerative colitis which includes ulcerative proctitis)
    - Require individualized screening directed by a colonoscopist.

2. Outside the screening age range

    - Participants with abnormal FIT results who are under 50 years old are not referred on for further follow-up. Participants up to age 75.5 are referred for further follow-up to allow for participants who may have been offered FIT prior to their 75th birthday but did not complete the test until after. Those over age 75.5 are not referred to the Health Authority for further follow-up.
    - If the participant is older than 74 years, then the participant will not be re-called by the Colon Screening Program for further screening or surveillance.

3. Symptoms that require a full colonoscopist assessment

    - Local processes should be used in determining whether a participant with symptoms should be assessed and booked through the usual Colon Screening Program follow-up process or if the provider should be notified to refer for follow-up through a different process. In general, the Colon Screening Program is supportive of maintaining participants in the program for follow-up to reduce re-routing referrals and improve follow-up efficiency for participants. Participants with significant symptoms should consult with the colonoscopist prior to the procedure.

4. Participants with a high-risk family history or a personal history of pre-cancerous colorectal lesions that are referred for colonoscopy who are not yet due for colonoscopy or who are recommended to screen with FIT

    - Do not complete the colonoscopy and use the Referral Update Form to indicate when the participant is due for colonoscopy or FIT (see Appendix A). The participant will be recalled for colonoscopy or FIT when next due. Participants who will be over the age of 74 years when due will not be referred by the Program.

2. Hospital and Endoscopy Unit Standards

2.1 Assessment and Participant Education

- Contact referred participants and establish a time to complete assessment. Each Regional Health Authority will determine whether the assessment takes place by telephone, in person or through group education sessions. Self-reported height and weight is acceptable for phone assessments.
- Confirm the participant's primary care provider. A primary care provider is required for participants undergoing colonoscopy to support any follow-up that the participant may need.
- Confirm family history of colon cancer or personal history of pre-cancerous colorectal lesions for those being referred for colonoscopy. If the information provided does not meet the program eligibility requirements for colonoscopy, then communicate this back with the participant's primary care provider to ensure appropriate screening is arranged.
- Complete pre-colonoscopy assessment. The elements of a recommended assessment are available in the Assessment Form example (see Appendix B).
    - Identify any high risk factors that require colonoscopist assessment prior to colonoscopy and liaise with colonoscopist as indicated. See Section 3 and Participant Assessment Process document (see Appendix B).
- Identify the presence of a high-risk family history for hereditary colorectal cancer. If a high-risk family history is identified, advise the participant to discuss their history with their primary care provider.
- Provide education to the participant regarding:
    - Implications of an abnormal FIT and the reasons for colonoscopy follow-up.
    - Colonoscopy is always indicated after a positive FIT, even if there is a subsequent negative FIT.
    - Bowel preparation and colonoscopy.
    - Explain the risks of colonoscopy.
    - Provide the participant with the Colon Screening Program Colonoscopy Brochure (sample in Appendix C) to inform them about colonoscopy.
    - Give the participant written bowel preparation instructions, based on the assessment and the local practices for selecting bowel preparation type.
- Book participant for colonoscopy:
    - If not proceeding to colonoscopy, advise primary care provider using Not Proceeding to Colonoscopy letter and send the Referral Update Form to the Colon Screening Program (see Appendix D and A).
- Participants who do not proceed to their colonoscopy within 6 months of the assessment should be re-assessed prior to proceeding to colonoscopy.

2.2 Bowel Preparation

Participants should be provided with written preparation instructions as per the Bowel Preparation Algorithm in Appendix E.

Fleet phospho-soda is contraindicated. (Health Canada Reference: www.healthycanadians.gc.ca/recall-alert-rappel-avis/hc-sc/2009/9807r-eng.php)

Split-dose bowel preparations, in which the second dose of the bowel preparation is given 4 to 6 hours prior to the colonoscopy and same-day bowel preparations for afternoon procedures are recommended. Studies have shown that split-dose bowel preparations improve the quality of the bowel preparation as compared to bowel preparations administered the day prior to colonoscopy and this has led to a significant increase in the adenoma detection rate.

Polyethylene glycol (PEG) based regimens are the preferred preparation for:

- Age > 65 years
- Diuretic use
- Renal insufficiency (GFR < 60)
- Diabetes
- Congestive heart failure
- Liver cirrhosis or ascites

If a colonoscopy is incomplete due to a poor bowel preparation, then the colonoscopist should specify the bowel preparation for the next colonoscopy and re-book the participant in a Colon Screening Program slot. After a failed preparation, an individualized bowel preparation will be required. On the Colonoscopy Reporting Form, the colonoscopist will tick the box for “Repeat Colonoscopy”. Local processes should be used for re-booking the participant. The colonoscopist is responsible for ensuring the participant is re-booked.

3. Alerts for Colonoscopy

3.1 Pre-Colonoscopy Assessment

A pre-colonoscopy questionnaire is a useful tool to identify participants being considered for colonoscopy and polypectomy who may be at increased risk, see Assessment Form (Appendix B). Two methods of contact, separated by a two week interval, is the minimum requirement for contacting participants for colonoscopy assessment. For example, call the participant, wait two weeks, if no response then mail a letter to client requesting they contact the health authority.

Pre-existing medical conditions and medications may conflict with a safe bowel preparation, medications used for sedation, electrocautery equipment or be associated with increased risk of complications.

Each individual is unique and the clinical circumstances with each participant prevent clear guidelines as to appropriate adjustments required in every circumstance of identified increased risk. When in doubt as to the appropriate action, the participant's family physician and/or the attending colonoscopist should be consulted for clinical direction.

If any of the following conditions exist, then the health authority staff should alert the colonoscopist and the participant may require a consultation prior to colonoscopy. The participant may also see the colonoscopist prior to the colonoscopy at the participant's request.

GI Symptoms

- Rectal bleeding
- Chronic diarrhea
- Persistent change in bowel habits
- Chronic abdominal pain
- Unexplained weight loss

Significant co-morbid medical illnesses

- Cancer
- Dialysis participants
- Insulin-dependent diabetics
- Bleeding disorders and participants on antithrombotics
- Cardiac disease requiring a pacemaker or defibrillator
- Respiratory disease requiring home oxygen or CPAP
- Congestive heart failure
- Current angina or history of a myocardial infarction

- Severe aortic stenosis
- Cirrhosis with ascites
- Morbid obesity (BMI ≥ 40)

Personal history of precancerous lesions to monitor for polyposis

- Total count of prior adenomas and prior serrated lesions (including hyperplastic polyps) removed, e.g. lifetime precancerous lesion count

Other

- Participant who will not consent to blood products (e.g. Jehovah's Witness)

3.2 Antithrombotic Therapy

Antithrombotic agents are medications that prevent blood clot formation and can be divided into anticoagulants and antiplatelet agents. These medications may increase a participant's risk of bleeding following colonoscopic polypectomy. While previous recommendations state that polypectomy should not be performed while a participant is on anti-thrombotics, recent guidelines consider cold snare polypectomy of lesions up to 10 mm is size as a low-risk procedure which may be performed without cessation of anti-thrombotic medications. Biopsies are permitted.

Non-steroidal anti-inflammatory drugs (NSAIDs) such as ibuprofen and naproxen are not prescribed to prevent clot formation but as a side effect they do inhibit platelet function and increase the bleeding time. Prospective studies have concluded that acetylsalicylic acid (ASA) and NSAIDs can be safely continued for colonoscopy and polypectomy.

Whether a medication is discontinued prior to undergoing colonoscopy involves balancing the risk of bleeding following removal of pre-cancerous lesions and the risk of clotting if the antithrombotic medication is held. Participants on antiplatelet agents (aside from ASA and NSAIDs), anti-thrombin agents and anticoagulants should be reviewed by a physician prior to the colonoscopy to decide timing of the colonoscopy, discontinuation of the antithrombotic agent, the need for bridging anticoagulation and when the antithrombotic agent can be restarted. This is the responsibility of the colonoscopist; however, the decisions regarding discontinuation of anti-thrombotics, need for bridging therapy and resumption of anti-thrombotics may be at the recommendation of the participant's primary care provider, cardiologist, neurologist and/or thrombosis clinic.

Two scenarios that have arisen in the Colon Screening Program and recommended actions are below.

1. If a participant arrives for their scheduled colonoscopy, prepared, but having neglected to hold the antithrombotic as recommended, the colonoscopy should still be undertaken. If a pre-cancerous lesion is discovered, then the colonoscopist and patient may have decided to remove any lesions less than 10 mm with a cold snare. Otherwise, the procedure will be re-scheduled with the anti-thrombotic held. If a mass lesion is discovered, then biopsies can be performed. It is the colonoscopist's responsibility to ensure the participant is re-

booked for the colonoscopy.

2. If a participant cannot safely discontinue an anti-thrombotic agent as the risk of thrombosis is too high, then the colonoscopy should be undertaken while the participant continues the anti-thrombotic medication. This most commonly occurs following coronary stent placement and the requirement for uninterrupted anti-thrombotics is time-limited. If a pre-cancerous lesion is discovered, then the colonoscopist and patient may have decided to remove any lesions less than 10 mm with a cold snare. Otherwise, the procedure will be re-scheduled with the anti-thrombotic held. If a mass lesion is discovered, biopsies can be performed. It is the colonoscopist's responsibility to ensure the participant is re-booked for the colonoscopy.

The following are examples of anticoagulants and antiplatelet agents with the Canadian brand names in brackets. New antithrombotic agents may be available in the near future so this list should not be considered exclusive:

Anticoagulants

- Warfarin (Coumadin)
- Heparin
- Low-molecular weight heparin
    - Enoxaparin (Lovenox)
    - Dalteparin (Fragmin)
- Fondaparinux (Arixtra)
- Dabigatran (Pradax)
- Rivaroxaban (Xarelto)
- Apixaban (Eliquis)
- Desirudin (Iprivask)

Antiplatelet Agents

- Acetylsalicylic Acid
- Cilostazol (Pletal)
- Thienopyridine agents
    - Clopidogrel (Plavix)
    - Ticlopidine (Ticlid)
    - Prasugrel (Effient)
    - Ticagrelor (Brilinta)

3.3 Cardiac Defibrillator

Implantable cardiac defibrillators are increasingly common and may be activated inadvertently during endoscopy if electrocautery is used. Most participants with cardiac pacemakers may undergo routine uses of electrocautery (e.g. polypectomy) with no alterations in management. Some standard precautions are necessary during the procedure to minimize risk.

In all participants with implanted cardiac devices, determine the type of cardiac device, indication for the device and degree of pacemaker dependence before endoscopy. Most participants carry a wallet card, which identifies the device and contact numbers.

In participants with cardiac defibrillators, consultation with cardiologist is recommended and deactivation of the device by qualified personnel should be considered. Continuous cardiac monitoring during the procedure is recommended. The device should be reprogrammed as soon as possible after the procedure.

3.4 Diabetes

People with diabetes may experience difficulty with glucose control and other metabolic disturbances during a modified diet and fasting prior to colonoscopy. Most participants on non-insulin agents can safely continue the medications until their usual diet is interrupted. Most medications should be held once the clear liquid diet begins. Some medications with a longer duration of action will need to be held earlier (eg GLP-1 receptor agonists that are administered weekly and SGLT-2 inhibitors). Medications should be restarted when normal oral intake is resumed after the procedure. The table below displays the recommended anti-hyperglycemic agent dose modification.

Anti-hyperglycemic Agents	**Examples (Brand Name)**	**Dose Adjustment**
Biguanides	Metformin (Glucophage, Glumetza)	Hold once clear liquid diet starts
Sulfonylureas	Gliclazide (Diamicron) Glimepiride (Amaryl) Glyburide (Diabeta)	Hold day prior to colonoscopy
GLP-1 receptor agonists	Dulaglutide (Trulicity) - weekly Exenatide (Byetta)	Hold once clear liquid diet starts. For weekly injectable, if dose due

	Liraglutide (Victoza/Saxenda) Lixisenatide (Adylxine) Semaglutide (Rybelsus) Semaglutide (Ozempic) - weekly	within 2 days prior to colonoscopy, delay until after colonoscopy
SGLT-2 inhibitors	Canagliflozin (Invokana) Dapagliflozin (Forxiga) Empagliflozin (Jardiance)	Hold 72 hours prior to colonoscopy
DPP-4 Inhibitors	Alogliptin (Nesina) Linagliptin (Trajenta) Sitagliptin (Januvia) Saxagliptin (Onglyza)	Hold day of procedure
Metglitinides	Nateglinide (Starlix) Repaglinide (GlucoNorm)	Hold once clear liquid diet starts

Participants requiring insulin will need to reduce the insulin dosage once the clear liquid diet begins. Most participants on insulin have been educated on how to adjust their own insulin during periods of fasting. Participants should be asked to consult with the physician who manages their insulin ahead of the procedure.

Participants with diabetes are at increased risk of renal disease and should be questioned as to any pre-existing renal impairment, as this would impact the type of bowel preparation that would be recommended.

3.5 Iron Tablets

Oral iron compounds interact with colonic mucous and dietary compounds and impair the effect of bowel preparations. Participants should be advised to discontinue oral iron preparations 7 days prior to the procedure. Even oral vitamins containing iron are best discontinued to improve colonoscopy quality.

3.6 Glaucoma

Glaucoma (an optic neuropathy due to increased intro-ocular pressure) is present in ~1-8% of individuals over 40 and more common in diabetics. Participants with increased intraocular pressure or glaucoma are often treated with topical eye drop medications.

Glaucoma can be aggravated by anti-cholinergic drugs, which are occasionally used during endoscopic procedures to reduce smooth muscle spasm. Glaucoma is usually well controlled with topical medications, which should be continued, and does not interfere with colonoscopy or polypectomy. Anti-spasmodic drugs should be avoided during the procedure.

3.7 Renal Insufficiency/Dialysis

Participants with impairment of renal function can be adversely affected by the dehydrating potential of colonoscopy bowel preparations. Participants with significant kidney disease (e.g. eGFR of less than 60ml/min) should be offered an electrolyte solution containing polyethylene glycol (PEG) for bowel cleansing.

Participants receiving dialysis who require colonoscopy present challenges for safe, effective bowel preparation that does not seriously affect their fluid balance. Colonoscopy is best scheduled in consultation with the participant's nephrologists to discuss bowel preparation and appropriate timing of the procedure in relation to the participant's dialysis times.

Routine antibiotic prophylaxis is not recommended prior to colonoscopy. Antibiotic prophylaxis prior to colonoscopy is recommended for participants undergoing continuous peritoneal dialysis to prevent peritonitis. A single dose of ampicillin plus an aminoglycoside may be given intravenously just prior to the colonoscopy. Intraperitoneal antibiotics the night prior to colonoscopy is an alternative strategy. The abdomen should be emptied of fluid prior to colonoscopy.

3.8 Congestive Heart Failure (CHF)

Participants with congestive heart failure may be at increased risk of complications related to colonoscopy bowel preparation and should be offered the PEG based bowel preparations. Participants with severe congestive heart failure, which causes shortness of breath on exertion or significantly limits activity, require a medical consult before colonoscopy should be considered.

4. Informed Consent

Requirements for written informed consent will differ according to the institution. The Colon Screening Program "Answering Your Questions About Colonoscopy" brochure provides information on the risks of colonoscopy. This must be provided to each participant, in addition to any institution specific consent requirements. It's important that the participant be given time to process the consent information and ask questions. The health authority staff will provide the participant with the information necessary to give informed consent. The colonoscopist will obtain consent prior to the procedure.

Colonoscopy has a 1/250 risk of a serious complication. This includes the following:

- Reaction to the bowel preparation
- Reaction to the medication used for sedation
- Cardiopulmonary event
- Infection
- Bleeding
- Perforation (<1/1000)

The chance of death from colonoscopy is 1/30,000.

The chance of a significant abnormality being missed is 1/10.

Additional information to answer participant's questions is provided below.

- Cardiopulmonary event refers to desaturation, low blood pressure and rarely angina or myocardial infarction.
- Infection refers to phlebitis related to the IV, pneumonia (aspiration), and diverticulitis. Infection can be transmitted by the colonoscope between participants or from a contaminated water supply. If infection is transmitted between participants, it indicates an error has occurred in the colonoscope cleaning.
- Bleeding is almost always at the site of a polyp removal. It is usually self-limited but will occasionally require hospital admission with a repeat colonoscopy, blood transfusion, radiologic intervention, or surgery.
- Perforation is usually at the site of a polyp removal. It almost always requires surgery.

5. Post Colonoscopy Assessment

All participants with colonoscopy information recorded on colonoscopy reporting forms – whether assessed and booked by Health Authority staff or by a colonoscopist only – require post-colonoscopy assessment to monitor for unplanned events and to ensure that the program has information on file to recall participants as needed.

5.1 Telephone Follow-up at 14 Days

Fourteen days after the procedure, the health authority staff will contact the participant. Two methods of contact, separated by a two week interval, is the minimum requirement for contacting participants for post-colonoscopy follow-up. For example, call the participant, wait two weeks, if no response then mail a letter to the participant requesting they contact the health authority. The purpose of the 14-day telephone interview is to:

- Assess for any unplanned events following colonoscopy and
- Recommend the next re-screening or surveillance interval

5.2 Unplanned Events

Any unplanned event occurring the day before or following colonoscopy should be recorded using the Unplanned Event Form (Appendix F). A serious adverse event is an adverse event that results in a hospitalization, blood transfusion, interventional radiology procedure, other intervention, surgery, or death.

5.3 Re-screening and Surveillance Guidelines

Re-screening and surveillance intervals are based on the findings at colonoscopy and align with the BC guidelines. See the Colonoscopy Standards document for current program standards. The health authority staff should review the participant's colonoscopy report form for lesion size and whether any lesions were not removed or not retrieved, the pathology report, and the recommendations in the colonoscopist's Procedure Report. If recommendations differ from the re-screening or surveillance guidelines outlined in the Colonoscopy Standards document, then the next recommended screening type and interval should be discussed with the colonoscopist. There is a Colonoscopy Follow-up Algorithm that can be used to help determine the appropriate follow-up interval for participants based on their history and pathology findings (Appendix G).

Complete the Follow-Up Form (Appendix H) based on the guidelines and colonoscopist's recommendations and fax the form to the Colon Screening Program. The Program will generate a letter outlining re-screening/surveillance recommendations to be sent to the family physician, colonoscopist and health authority staff who completed the assessment.

Deviations in the recommendations are appropriate under certain circumstances. Examples are in the Colonoscopy Standards.

Where multiple colonoscopies are needed to complete a screening interval, the final follow-up recommendations should consider the outcomes of all procedures and document the next recommended screening as needed. This can be managed through a deviation if the standard intervals do not apply (e.g. participant needs to return in 30 months from the second procedure when a second was completed to assess a piecemeal resection of a high risk lesion six months after the first procedure).

The only reasons for a participant to leave the Colon Screening Program are for age > 74 years, a diagnosis of colorectal adenocarcinoma and a diagnosis of ulcerative or Crohn's colitis. A diagnosis of ulcerative or Crohn's colitis cannot be determined from a pathology report alone and needs to be determined in discussion with the colonoscopist regarding other clinical findings. Individuals with Lynch Syndrome or adenomatous polyposis syndromes require screening for other malignancies and should also be managed outside the Colon Screening Program by a colonoscopist with expertise in hereditary colon cancer syndromes. All other participants should continue to be screened in the Colon Screening Program and if their screening needs to be individualized, then this can be done by citing a deviation and explanation on the Follow-Up Form.

While there may be an indication to do a colonoscopy at an earlier interval, there is never an indication to do a FIT at an earlier interval. If a colonoscopy is not high quality the participant should have a repeat colonoscopy as soon as possible and certainly within 1 year.

If the colonoscopist disagrees with the Colon Screening Program's recommendations and decides upon a different FIT follow-up interval for a participant who has undergone a high quality colonoscopy, then this will need to be arranged by the colonoscopist outside of the Colon Screening Program. Unfortunately, the primary care provider will receive two different recommendations - those in the colonoscopy report and those from the program.

Regarding participants with an abnormal FIT and a colonoscopy without a cancer or precancerous lesion, the participant will be recalled to undergo repeat FIT in 10 years. Follow-up Forms received by the program that indicate a deviation with FIT prior to the 10 year recall will not have the deviation entered and the follow-up letter to the colonoscopist, health authority staff and primary care provider will indicate rescreening or surveillance based on current guidelines.

Colonoscopies performed within the Colon Screening Program may reveal significant findings beyond the scope of the program. For instance, participants diagnosed with anal intraepithelial neoplasia or squamous cell carcinoma of the anus, carcinoid/neuroendocrine tumors, gastrointestinal stromal tumors, or Peutz-Jehger polyps. In this situation, the colonoscopist should either arrange follow-up or guide the primary care provider in the appropriate management. These participants will remain in the Colon Screening Program and be re-called at the appropriate interval for re-screening or surveillance as outlined in the Colonoscopy Standards.

6. Quality Assurance

6.1 Data Collection

Each colonoscopy unit will need a quality program in place. The Colon Screening Program has a central database where the performance indicators will be maintained and reported back to Health Authorities. By providing complete and accurate information on the relevant forms, health authority staff will help with appropriate data collection for performance indicator and participant outcome monitoring.

6.2 Pre-Post Colonoscopy Assessment Performance Indicators

- Number of participants not proceeding to colonoscopy due to poor medical fitness
- Compliance with follow-up colonoscopy
- Time from positive FIT to colonoscopy
- Time from referral to colonoscopy for surveillance procedures
- Number of participants deemed medically unfit by colonoscopist at time of colonoscopy (i.e. prepped for procedure but medically unfit)
- Bowel preparation quality
- Participant, primary care provider, colonoscopist satisfaction with pre-post colonoscopy assessment

7. Medical Record Retention Policy

The Health Authority is the primary record holder for documentation pertaining to pre and post colonoscopy assessment. Health Authorities follow their own policies with respect to record retention and documentation. The Colon Screening Program is a secondary user of the forms and records that are completed for program participants. Participants and providers requesting copies of screening records will be directed to obtain copies from the facility where the interaction occurred.

8. References

1. Abraham NS, et al. American College of Gastroenterology-Canadian Association of Gastroenterology Clinical Practice Guideline: Management of Anticoagulants and Antiplatelets During Acute Gastrointestinal Bleeding and the Periendoscopic Period. American Journal of Gastroenterology 2022;117:542-558.
2. Armstrong DA, et al. Canadian Association of Gastroenterology consensus guidelines on safety and quality indicators in endoscopy. Canadian Journal of Gastroenterology 2012:26(1):17-31.
3. Canadian Cancer Society (CCS). Canadian Cancer Statistics 2022, www.cancer.ca.
4. Chirila A, et al. Preparing for colonoscopy in people with diabetes: a review with suggestions for clinical practice. Journal of the Canadian Association of Gastroenterology 2023;6:26-36.
5. Guidelines and Protocols Advisory Committee. Screening for the Purposes of Colorectal Prevention and Detection in Asymptomatic Adults. April 2022, www.bcguidelines.ca
6. Guidelines and Protocols Advisory Committee. Follow-up of Colorectal Cancer and Pre-Cancerous Lesions. April 2022, www.bcguidelines.ca
7. Johnson DA, et al. Optimizing Adequacy of Bowel Cleansing for Colonoscopy: Recommendations from the US Multi-Society Task Force on Colorectal Cancer. Gastroenterology 147.4 (2014): 903-924.
8. Khashab MA., et al. Antibiotic prophylaxis for GI endoscopy. Gastrointestinal Endoscopy 2015;81: 81-89.
9. Kim NH, et al. Yield of repeat colonoscopy in asymptomatic individuals with a positive fecal immunochemical test and recent colonoscopy. Gastrointestinal Endoscopy 2019;89: 1037-1043.
10. McIntosh D, et al. The Global Rating Scale – Canada. Canadian Journal of Gastroenterology 2013;27: 74-82.
11. Patterson WA, et al. Canadian consensus on medically acceptable wait-times for digestive health care. Canadian Journal of Gastroenterology 2006;20: 411-423.
12. Rembacken B, et al. Quality in screening colonoscopy: position statement of the European Society of Gastrointestinal Endoscopy (ESGE). Endoscopy 2012; 44: 957–968.
13. Rex DK, et al. Quality indicators for colonoscopy. Gastrointestinal Endoscopy 2015;81(1):31-53.
14. Tomaszewski M, et al. Risks Associated with Colonoscopy in a Population-Based Colon Screening Program: An Observational Cohort Study. Canadian Medical Association Journal Open 2021;9: E940-947.

Appendix A – Referral Update Form

BC CANCER COLON SCREENING

REFERRAL UPDATE FORM

DO NOT PLACE LABEL ABOVE LINE

AFFIX CLIENT LABEL HERE

PRESS FIRMLY TO ENSURE LEGIBILITY
FAX TOP COPY TO COLON SCREENING PROGRAM: 1 (604) 297-9340

REFERRAL DATE (DD-MMM-YYYY) | COMPLETED DATE (DD-MMM-YYYY) | PATIENT NAME LAST | PATIENT NAME FIRST | SEX (F/M/X/U)

HEALTH AUTHORITY SERVICE CENTRE | AMENDED DATE (DD-MMM-YYYY) | PHN | DATE OF BIRTH (DD-MMM-YYYY)

PRIMARY PROVIDER (MSC) | PRIMARY PROVIDER LAST, FIRST

ONLY ONE SECTION MUST BE COMPLETED BELOW

☐ **SECTION A: TRANSFER REQUEST (Within BC only)** *Complete only if referral requires a transfer to another service centre.*

Transfer Request To: *(Name of Hospital or City)*

Transfer Request Reason:
☐ Medical Reason ☐ Patient Preference ☐ Patient Address Related
☐ Other (Please specify):

☐ **SECTION B: PATIENT NOT PROCEEDING** *Complete only if patient is not proceeding for further follow up at your service centre.*
☐ Letter sent to PCP to inform patient not proceeding

☐ Patient not due for screening/surveillance/follow up
☐ Patient declined/deferred
☐ Other:

If recall is expected, indicate recall type and future date:
Recall for: ☐ FIT ☐ Colonoscopy
Specify Future Date (MMMYYYY):

☐ Patient personal history does not meet colonoscopy eligibility
☐ Patient family history does not meet colonoscopy eligibility
☐ Patient is symptomatic, provider to refer to specialist
☐ Patient is medically unfit for follow up as determined by colonoscopist
☐ Patient was already referred to a specialist for colonoscopy outside of the program
☐ Genetic mutation predisposing to colon cancer (e.g. Lynch Syndrome)
☐ Patient was not able to be contacted
☐ Patient moved out of province
☐ Patient has colorectal cancer history
☐ Patient has Crohn's or ulcerative colitis
☐ Patient is deceased

☐ **SECTION C: PATIENT IS BOOKED FOR COLONOSCOPY**
Complete only when a previous Referral Update Form was sent indicating that the patient was not proceeding.

COMPLETED BY | SIGNATURE

Comments (Not captured by program):

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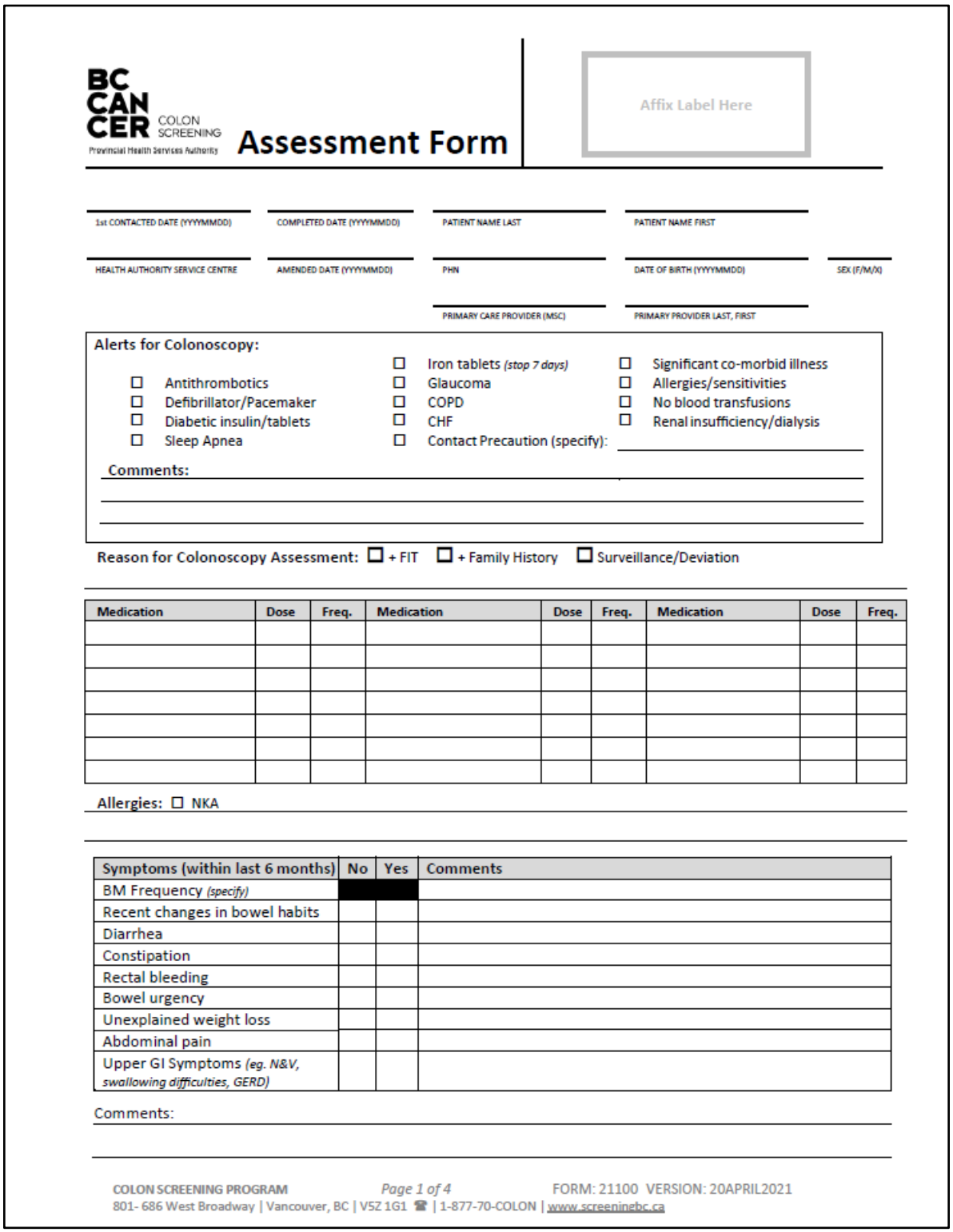
20720

Appendix B – Assessment Form



BC CANCER COLON SCREENING
Provincial Health Services Authority

Assessment Form

Affix Label Here

1st CONTACTED DATE (YYYYMMDD) | COMPLETED DATE (YYYYMMDD) | PATIENT NAME LAST | PATIENT NAME FIRST

HEALTH AUTHORITY SERVICE CENTRE | AMENDED DATE (YYYYMMDD) | PHN | DATE OF BIRTH (YYYYMMDD) | SEX (F/M/X)

PRIMARY CARE PROVIDER (MSC) | PRIMARY PROVIDER LAST, FIRST

Alerts for Colonoscopy:

- ☐ Antithrombotics
- ☐ Defibrillator/Pacemaker
- ☐ Diabetic insulin/tablets
- ☐ Sleep Apnea
- ☐ Iron tablets *(stop 7 days)*
- ☐ Glaucoma
- ☐ COPD
- ☐ CHF
- ☐ Contact Precaution (specify): _____
- ☐ Significant co-morbid illness
- ☐ Allergies/sensitivities
- ☐ No blood transfusions
- ☐ Renal insufficiency/dialysis

Comments: _____

Reason for Colonoscopy Assessment: ☐ + FIT ☐ + Family History ☐ Surveillance/Deviation

Medication	Dose	Freq.	Medication	Dose	Freq.	Medication	Dose	Freq.

Allergies: ☐ NKA

Symptoms (within last 6 months)	No	Yes	Comments
BM Frequency *(specify)*			
Recent changes in bowel habits			
Diarrhea			
Constipation			
Rectal bleeding			
Bowel urgency			
Unexplained weight loss			
Abdominal pain			
Upper GI Symptoms *(eg. N&V, swallowing difficulties, GERD)*			

Comments: _____

COLON SCREENING PROGRAM *Page 1 of 4* FORM: 21100 VERSION: 20APRIL2021
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BC CANCER COLON SCREENING
Provincial Health Services Authority

Assessment Form

Affix Label Here

PATIENT NAME LAST | PATIENT NAME FIRST | PHN | DATE OF BIRTH (YYYYMMDD)

Medical History	No	Yes	Comments
Gastrointestinal *(eg.Ulcers, Barrets, Hiatus hernia, Diverticular disease)*			
Hx colonoscopy or flexible sigmoidoscopy			
Surgery *(eg.Abdominal and other)*			
Cardiac *(eg.A. Fib, Pacemaker, ICD, CHF)*			
Hypertension			
Respiratory *(eg.Sleep apnea, asthma, COPD)*			
Liver			
Renal *(eg.document eGFR <60ml/min, creatinine >100umol/L, if known)*			
Diabetes *(eg.Type 1/ 2, Insulin, oral Hypoglycaemic)*			
Glaucoma			
Neurological *(e.g. Epilepsy, Stroke, MS, Parkinson's, Alzheimer's, dementia, etc.)*			
Cancer			
Bleeding disorder			
Blood transfusion concerns *(eg.Jehovah's witness)*			
Problems with sedation or anaesthesia			

Comments / Other Medical Concerns:

Patient lives: ☐ Alone ☐ With (Specify): _____

Do you consider yourself to have a disability? ☐ No ☐ Yes

☐ Mental health difficulty ☐ Dyslexia ☐ Mobility ☐ Progressive disability (eg MS) ☐ Learning disability

☐ Blind/partially blind ☐ Deaf/HOH ☐ Other *(specify)*: _____

Smoker: ☐ No ☐ Yes #/day: _____ Quit date *(approximate)*: _____

EtOH: ☐ No ☐ Yes units/week: _____

Recreational or illicit Drug Use: ☐ No ☐ Yes Substance: _____ Frequency: _____

Height (cm): _____ **Weight (kg):** _____ **BMI:** _____

COLON SCREENING PROGRAM *Page 2 of 4* FORM: 21100 VERSION: 20APRIL2021
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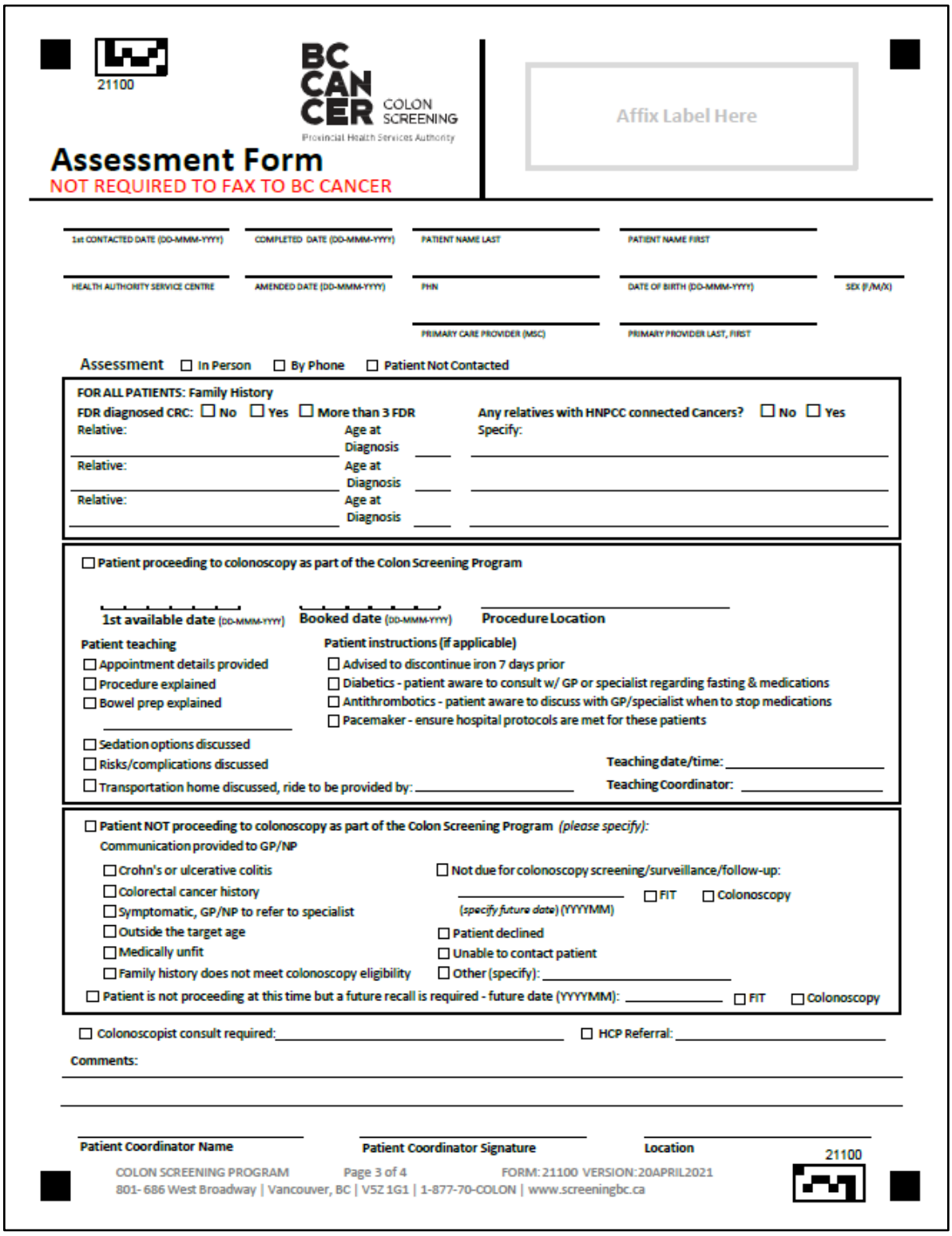

21100

BC CANCER COLON SCREENING
Provincial Health Services Authority

Affix Label Here

Assessment Form

NOT REQUIRED TO FAX TO BC CANCER

1st CONTACTED DATE (DD-MMM-YYYY) | COMPLETED DATE (DD-MMM-YYYY) | PATIENT NAME LAST | PATIENT NAME FIRST

HEALTH AUTHORITY SERVICE CENTRE | AMENDED DATE (DD-MMM-YYYY) | PHN | DATE OF BIRTH (DD-MMM-YYYY) | SEX (F/M/X)

PRIMARY CARE PROVIDER (MSC) | PRIMARY PROVIDER LAST, FIRST

Assessment ☐ In Person ☐ By Phone ☐ Patient Not Contacted

FOR ALL PATIENTS: Family History

FDR diagnosed CRC: ☐ No ☐ Yes ☐ More than 3 FDR

Any relatives with HNPCC connected Cancers? ☐ No ☐ Yes

Relative: Age at Diagnosis ____ Specify:

Relative: Age at Diagnosis ____

Relative: Age at Diagnosis ____

☐ **Patient proceeding to colonoscopy as part of the Colon Screening Program**

1st available date (DD-MMM-YYYY) **Booked date** (DD-MMM-YYYY) **Procedure Location**

Patient teaching

- ☐ Appointment details provided
- ☐ Procedure explained
- ☐ Bowel prep explained
- ☐ Sedation options discussed
- ☐ Risks/complications discussed
- ☐ Transportation home discussed, ride to be provided by: _____

Patient instructions (if applicable)

- ☐ Advised to discontinue iron 7 days prior
- ☐ Diabetics - patient aware to consult w/ GP or specialist regarding fasting & medications
- ☐ Antithrombotics - patient aware to discuss with GP/specialist when to stop medications
- ☐ Pacemaker - ensure hospital protocols are met for these patients

Teaching date/time: _____

Teaching Coordinator: _____

☐ **Patient NOT proceeding to colonoscopy as part of the Colon Screening Program** *(please specify)*:

Communication provided to GP/NP

- ☐ Crohn's or ulcerative colitis
- ☐ Colorectal cancer history
- ☐ Symptomatic, GP/NP to refer to specialist
- ☐ Outside the target age
- ☐ Medically unfit
- ☐ Family history does not meet colonoscopy eligibility
- ☐ Not due for colonoscopy screening/surveillance/follow-up: _____ ☐ FIT ☐ Colonoscopy (*specify future date*) (YYYYMM)
- ☐ Patient declined
- ☐ Unable to contact patient
- ☐ Other (specify): _____

☐ Patient is not proceeding at this time but a future recall is required - future date (YYYYMM): _____ ☐ FIT ☐ Colonoscopy

☐ Colonoscopist consult required: _____ ☐ HCP Referral: _____

Comments:

Patient Coordinator Name | **Patient Coordinator Signature** | **Location**

21100

COLON SCREENING PROGRAM Page 3 of 4 FORM: 21100 VERSION: 20APRIL2021

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BC CANCER COLON SCREENING
Provincial Health Services Authority

Assessment Form

Affix Label Here

PATIENT NAME LAST | PATIENT NAME FIRST | PHN | DATE OF BIRTH (YYYYMMDD)

Date	Notes

Appendix C – Colonoscopy Brochure

Who should get a colonoscopy?

Colonoscopy is recommended for individuals up to age 74 (inclusive), including those with:

- An abnormal fecal immunochemical test (FIT) result; or,
- A personal history of adenomas. Adenomas are a type of precancerous polyp; or,
- One first degree relative (parent, sibling or child) with colon cancer diagnosed under the age of 60; or,*
- Two or more first degree relatives with colon cancer diagnosed at any age.*

*For those with a family history of colon cancer, colonoscopy screening can start at age 40 or 10 years younger than the age of diagnosis of the youngest affected first degree relative - whichever is earliest.

Are there any risks with colonoscopy?

As with any medical procedure, colonoscopy has a small risk of complications.

Approximately 5/1,000 people will have a serious complication. Complications can include a reaction to the bowel preparation or medication used for sedation, heart or lung problems, an infection, bleeding from the colon and/or perforation of the colon (hole in the colon).

If a complication occurs, treatment including antibiotics, blood transfusion, hospitalization, repeat colonoscopy or surgery may be required. The risk of dying from colonoscopy is less than 1/14,000. There is also a risk of missing a significant abnormality. This occurs in less than 1/10 cases.

Certain cancers may never cause any symptoms or affect life expectancy or quality of life. However, research shows that most colon cancers are harmful and that colon cancer should be detected and treated as early as possible.

Contact Us

BC Cancer Colon Screening
801-686 West Broadway
Vancouver, BC V5Z 1G1

Phone: 1-877-702-6566
Email: screening@bccancer.bc.ca
Web: www.screeningbc.ca/colon

This brochure is also available in other languages including Punjabi and Chinese. Visit www.screeningbc.ca to access translated versions.

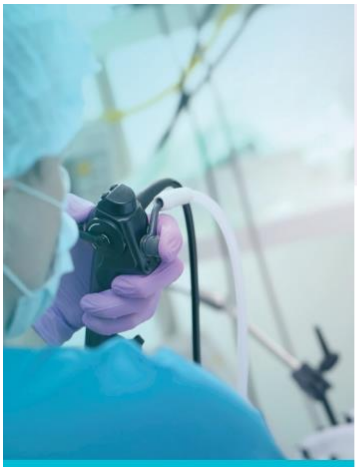
Version: June 2021

BC CANCER COLON SCREENING
Provincial Health Services Authority

Colonoscopy

Answering your questions about colonoscopy

www.screeningbc.ca/colon



What is a colonoscopy?

Colonoscopy is a procedure that allows a colonoscopist to see the inside lining of the rectum and colon using a special instrument called a colonoscope.

A colonoscope is a flexible tube with a miniature camera attached to one end so that the colonoscopist can take pictures and videos of your colon. During a colonoscopy, tissue samples can be collected and polyps can be removed.

The procedure is performed by a colonoscopist (physician trained to perform a colonoscopy) and usually takes 20 to 45 minutes to complete.

You will be closely monitored before, during and after the procedure.

Before the colonoscopy

- Expect to be at the hospital for two to three hours.
- You will be asked to change into a gown.
- A nurse will complete your admission history and measure your vital signs.
- You will be asked to provide a list of your medications.
- A nurse will start an intravenous (IV) to administer sedation and pain medication.

What happens during a colonoscopy?

- A colonoscopist inserts the colonoscope into the rectum and advances it along the length of the colon.
- Air is sent through the colonoscope to expand the colon for better viewing. It is normal throughout the procedure to feel slight pressure or experience cramps.
- Images of the lining of the rectum and colon are sent to a video monitor where the colonoscopist will look for anything unusual, like a polyp. A polyp is a small growth of tissue on the wall of the intestine.
- Polyps can grow very slowly, and some can become cancerous. It may be necessary to take a sample (biopsy) or remove the polyp (polypectomy). This is painless.
- The biopsy or polyp is then sent to a lab for analysis.

What happens after a colonoscopy?

- Have an adult accompany you home. You cannot drive until the following day.
- You may be sleepy after you arrive home from the procedure. It is recommended that you do not operate equipment, sign legal papers or drink alcohol until the following day.
- You will be able to resume your regular diet and medications after your colonoscopy, unless otherwise directed by the health care team in your community.
- The air inside your colon may cause you to feel bloated and/or have cramping after the procedure. It is important to relax and pass the air as soon as possible. If this discomfort increases or is unrelieved, go to the emergency department and advise them that you had a colonoscopy.

What do I need to know about my colonoscopy results?

You will be given preliminary results before you leave the hospital. Then, approximately two weeks after your procedure, the health care team in your community will inform you of your complete results and answer your questions during the follow up call. Your doctor will also receive your results.

If your colonoscopy is normal, your family history will determine when you will be re-screened. The health care team in your community will advise you of your next screening date.

If your colonoscopy is abnormal, further procedures or more regular surveillance may be necessary. The health care team in your community, or your doctor will explain the process for further appointments and next steps.

Appendix D – Sample Not Proceeding to Colonoscopy Letter

Dear Dr. _____ **Fax #** _____ **Date** _____

Patient Name _____ **PHN** _____ **DOB** _____

1. Your patient was referred for pre-colonoscopy assessment on _____ (date) due to:

☐ Abnormal FIT ☐ Family History ☐ Surveillance Requirement

2. Your patient has <u>NOT</u> been booked for a colonoscopy procedure due to:

☐ Patient has a history of inflammatory bowel disease (Crohn's or ulcerative colitis). Please refer the patient to his/her specialist for ongoing care and monitoring. The patient will not be recalled by the Colon Screening Program.

☐ Patient has a history of colorectal cancer. Please refer the patient to his/her specialist for ongoing care and monitoring. The patient will not be recalled by the Colon Screening Program.

☐ Patient indicated symptoms. Please refer the patient directly to a specialist for assessment. The patient will not be recalled by the Colon Screening Program.

☐ Medically unfit for colonoscopy. Colonoscopy has been deferred to _____ (date) and the Program will recall the patient at that time. If no date is indicated, the patient will not be recalled by the Colon Screening Program. The patient was assessed by a Colonoscopist on _____ (date).

☐ Family history information does not meet colonoscopy screening eligibility for the Colon Screening Program. Please provide a requisition for FIT screening for this patient or refer directly to a specialist for consideration of colonoscopy.

☐ Your patient does not meet eligibility for colonoscopy screening as he/she is up to date with colon screening. The patient will be recalled by the Program when he/she is next due for screening _____ (date).

☐ Patient declined proceeding to colonoscopy. If your patient elects to proceed with colonoscopy in the future, please send the Program a Colonoscopy Referral Form.
  ☐ The patient has elected to defer their referral to _____ (date).

☐ We were unable to reach your patient to complete a pre-colonoscopy assessment. A letter was sent to your patient to advise that they have not been booked for a colonoscopy. The patient will not be recalled by the Colon Screening Program. If the patient wishes to participate in the future, please send the Program a Colonoscopy Referral Form.

☐ Patient is required to be scoped outside of the Colon Screening Program.

☐ _____

_____

Sincerely,

COLON SCREENING PROGRAM APRIL 2021
Phone: Fax:

Appendix E – Bowel Preparation Algorithm

BC CANCER COLON SCREENING
Provincial Health Services Authority

Colon Screening Program
Bowel Preparation Guidelines

Bowel Preparations

High Volume (4L PEG)	Low Volume (PEG /2L PEG)	Low Volume (Hyperosmolar)
Consider for: • Constipation • Previous poor preparation • Narcotic use • Poor mobility • Morbid obesity Examples: • CoLyte • PegLyte	Examples: • Bi-PegLyte (do not take Bisacodyl) • MoviPrep	Examples: • PicoSalax • Purg-Odan • KleanLyte

Split-dose regimens are preferred.

PEG-based regimens are the preferred preparation for:

- Age > 65 years
- Diuretic use
- Renal insuciency (GFR< 60)
- Diabetes
- Congestive heart disease
- Liver cirrhosis or ascites

Adjuncts (bisacodyl, magnesium citrate, enemas) are not recommended for standard bowel preparations.

Participants requiring a repeat colonoscopy due to a poor preparation should have their preparation directed by the colonoscopist.

References:

Optimizing adequacy of bowel cleansing for colonoscopy: recommendations from the US Multi-Society Task Force on Colorectal Cancer. Gastrointestinal Endoscopy 2014;80:543-562.

Version: December 2022

Appendix F – Pre/Post Colonoscopy Unplanned Event Form

BC CANCER COLON SCREENING

Pre/Post Colonoscopy Unplanned Event

DO NOT PLACE LABEL ABOVE LINE

AFFIX CLIENT LABEL HERE

FAX THIS PAGE TO COLON SCREENING PROGRAM: 1 (604) 297-9340

EXAM DATE: COLONOSCOPY (YYYYMMDD) | PHN | DATE OF BIRTH (YYYYMMDD)

FOLLOW UP DATE (YYYYMMDD) | AMENDED DATE (YYYYMMDD) | PATIENT NAME LAST | PATIENT NAME FIRST | SEX (F/M/X)

COLONOSCOPIST (MSC) | COLONOSCOPIST LAST, FIRST | PRIMARY PROVIDER (MSC) | PRIMARY PROVIDER LAST, FIRST

DATE OF ONSET SYMPTOMS (YYYYMMDD) **Symptoms ongoing?** ○ No ○ Yes DATE OF RESOLUTION (YYYYMMDD)

The day prior to, or within 14 days after undergoing a colonoscopy, this patient had these uplanned event(s):

- ☐ Bowel prep complication
- ☐ Perforation
- ☐ Rectal bleeding → Anticoagulation: ○ No ○ Yes
- ☐ Respiratory
- ☐ Infection
- ☐ Cardiac
- ☐ Death: _____ (YYYYMMDD)
- ☐ Other: _____

Cause of death: _____

Comments: _____

Patient first obtained medical attention: _____ (YYYYMMDD)

☐ Family Physician ☐ Emergency Room ☐ Other: _____

Patient required the following interventions: *(check all that apply)*

- ☐ Blood transfusion
- ☐ Additional Colonoscopy: _____ (YYYYMMDD)
- ☐ Antibiotics
- ☐ Other: _____
- ☐ Surgery: _____ (YYYYMMDD)
- ☐ Hospital admission: _____ (YYYYMMDD) to _____ (YYYYMMDD)

Comments: _____

Patient Coordinator Name _____ Patient Coordinator Signature _____

COLON SCREENING PROGRAM Page 1 of 1 FORM: 20620 VERSION: 12DECEMBER2019

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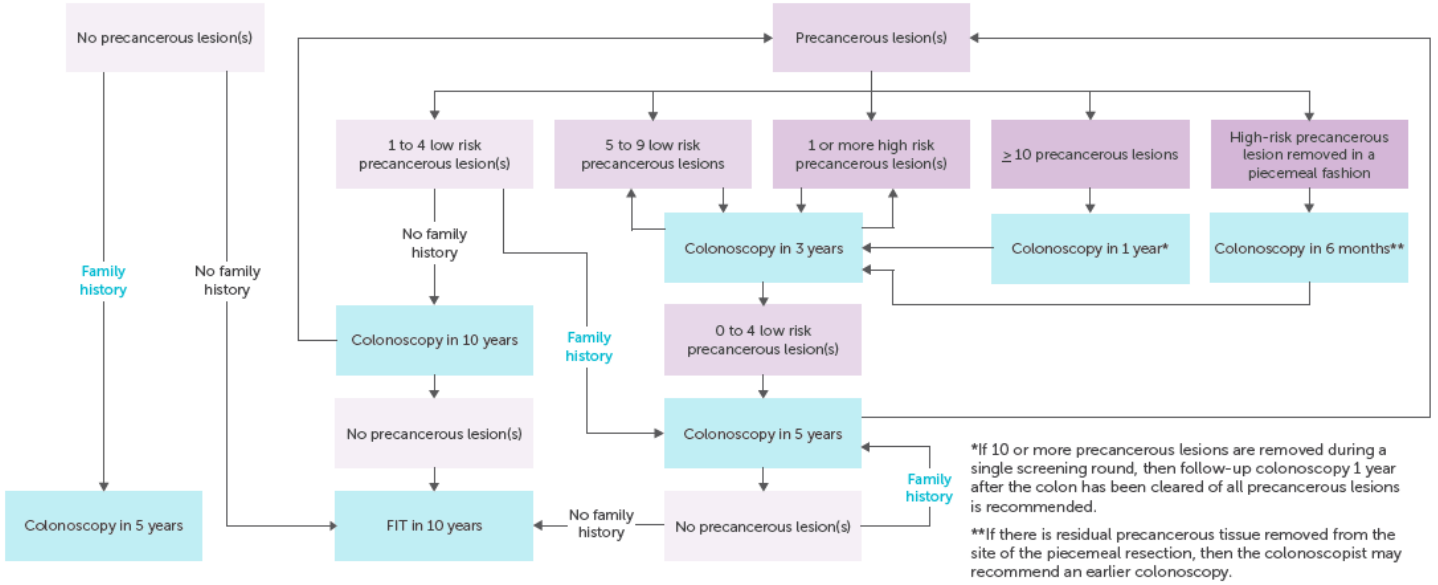
20620

Appendix G – Colonoscopy Follow-up Algorithm

BC CANCER COLON SCREENING
Provincial Health Services Authority

Colonoscopy Follow-up Algorithm

The findings at colonoscopy will determine the timing of further colonoscopies or whether the indivdiual returns to screening with FIT. Patients followed by colonoscopy do not require FIT. The following flowchart outlines the patient follow-up pathway after colonoscopy.



*If 10 or more precancerous lesions are removed during a single screening round, then follow-up colonoscopy 1 year after the colon has been cleared of all precancerous lesions is recommended.

**If there is residual precancerous tissue removed from the site of the piecemeal resection, then the colonoscopist may recommend an earlier colonoscopy.

High Risk Lesions

☐ Adenomas with:
- ☐ Villous features
- ☐ High-grade dysplasia
- ☐ ≥ 10mm

☐ Sessile serrated lesions ≥ 10 mm
☐ Sessile serrated lesions with cytologic dysplasia
☐ Traditional serrated adenomas
☐ Hyperplastic polyps ≥ 10mm

Precancerous lesions that do not meet the above criteria are classified as low-risk.

Low Risk Lesions

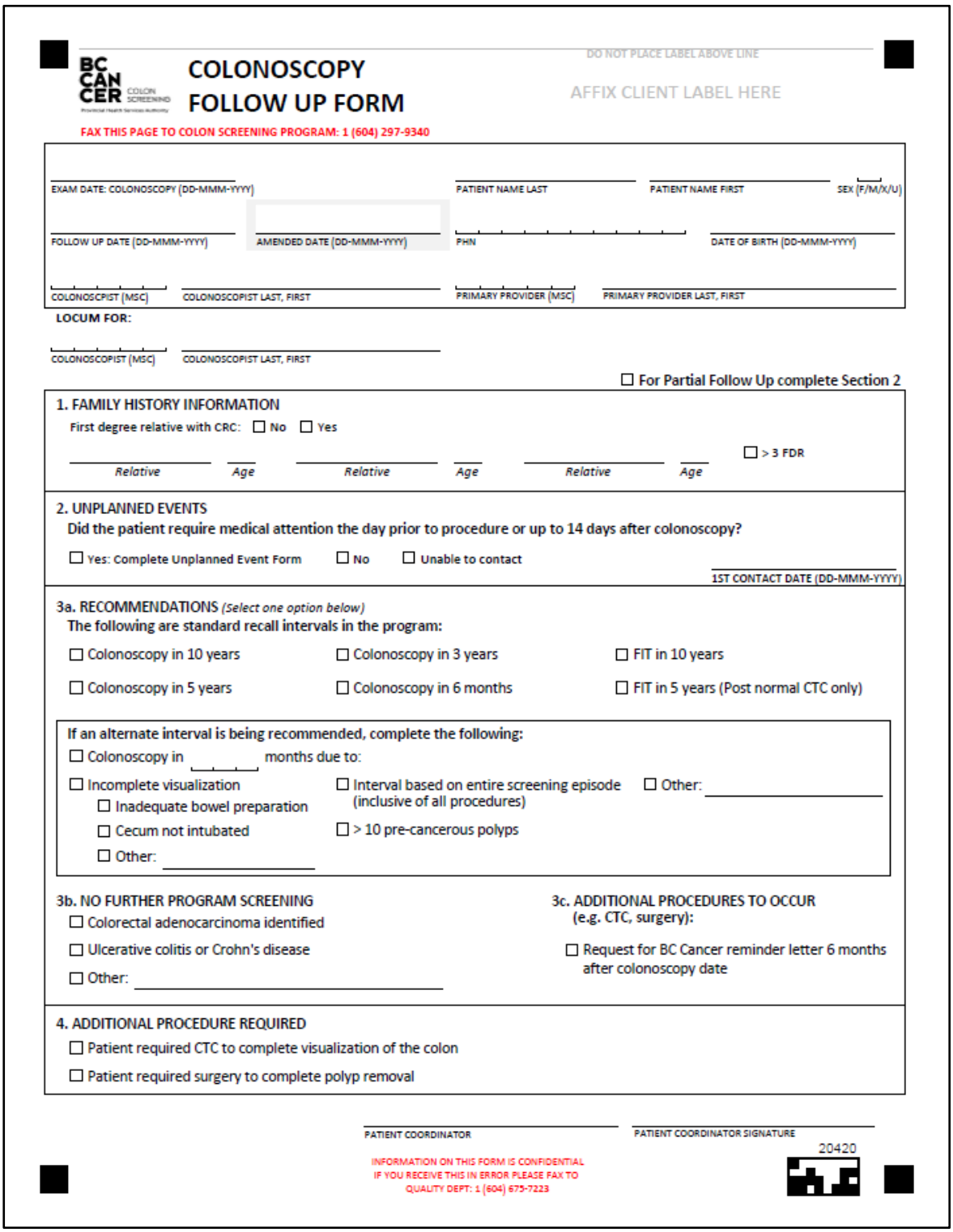
☐ Tubular adenomas <10 mm with low-grade dysplasia
☐ Sessile serrated lesions <10 mm without dysplasia

If the number of precancerous lesions removed during an individual's lifetime is 10 or more, then referral to the **Hereditary Cancer Program** for evaluation of a potential genetic predisposition to CRC is recommended.

Family History: one first degree relative diagnosed with CRC under age 60, **OR** 2 or more first degree relatives diagnosed with CRC at any age.

January 2023

Appendix H – Follow-Up Form



BC CANCER COLON SCREENING

COLONOSCOPY FOLLOW UP FORM

DO NOT PLACE LABEL ABOVE LINE

AFFIX CLIENT LABEL HERE

FAX THIS PAGE TO COLON SCREENING PROGRAM: 1 (604) 297-9340

EXAM DATE: COLONOSCOPY (DD-MMM-YYYY) | PATIENT NAME LAST | PATIENT NAME FIRST | SEX (F/M/X/U)

FOLLOW UP DATE (DD-MMM-YYYY) | AMENDED DATE (DD-MMM-YYYY) | PHN | DATE OF BIRTH (DD-MMM-YYYY)

COLONOSCPIST (MSC) | COLONOSCOPIST LAST, FIRST | PRIMARY PROVIDER (MSC) | PRIMARY PROVIDER LAST, FIRST

LOCUM FOR:

COLONOSCOPIST (MSC) | COLONOSCOPIST LAST, FIRST

☐ For Partial Follow Up complete Section 2

1. FAMILY HISTORY INFORMATION

First degree relative with CRC: ☐ No ☐ Yes

Relative *Age* *Relative* *Age* *Relative* *Age* ☐ > 3 FDR

2. UNPLANNED EVENTS

Did the patient require medical attention the day prior to procedure or up to 14 days after colonoscopy?

☐ Yes: Complete Unplanned Event Form ☐ No ☐ Unable to contact

1ST CONTACT DATE (DD-MMM-YYYY)

3a. RECOMMENDATIONS *(Select one option below)*

The following are standard recall intervals in the program:

☐ Colonoscopy in 10 years ☐ Colonoscopy in 3 years ☐ FIT in 10 years

☐ Colonoscopy in 5 years ☐ Colonoscopy in 6 months ☐ FIT in 5 years (Post normal CTC only)

If an alternate interval is being recommended, complete the following:

☐ Colonoscopy in _____ months due to:

☐ Incomplete visualization
- ☐ Inadequate bowel preparation
- ☐ Cecum not intubated
- ☐ Other: _____

☐ Interval based on entire screening episode (inclusive of all procedures)

☐ > 10 pre-cancerous polyps

☐ Other: _____

3b. NO FURTHER PROGRAM SCREENING

☐ Colorectal adenocarcinoma identified

☐ Ulcerative colitis or Crohn's disease

☐ Other: _____

3c. ADDITIONAL PROCEDURES TO OCCUR (e.g. CTC, surgery):

☐ Request for BC Cancer reminder letter 6 months after colonoscopy date

4. ADDITIONAL PROCEDURE REQUIRED

☐ Patient required CTC to complete visualization of the colon

☐ Patient required surgery to complete polyp removal

PATIENT COORDINATOR | PATIENT COORDINATOR SIGNATURE

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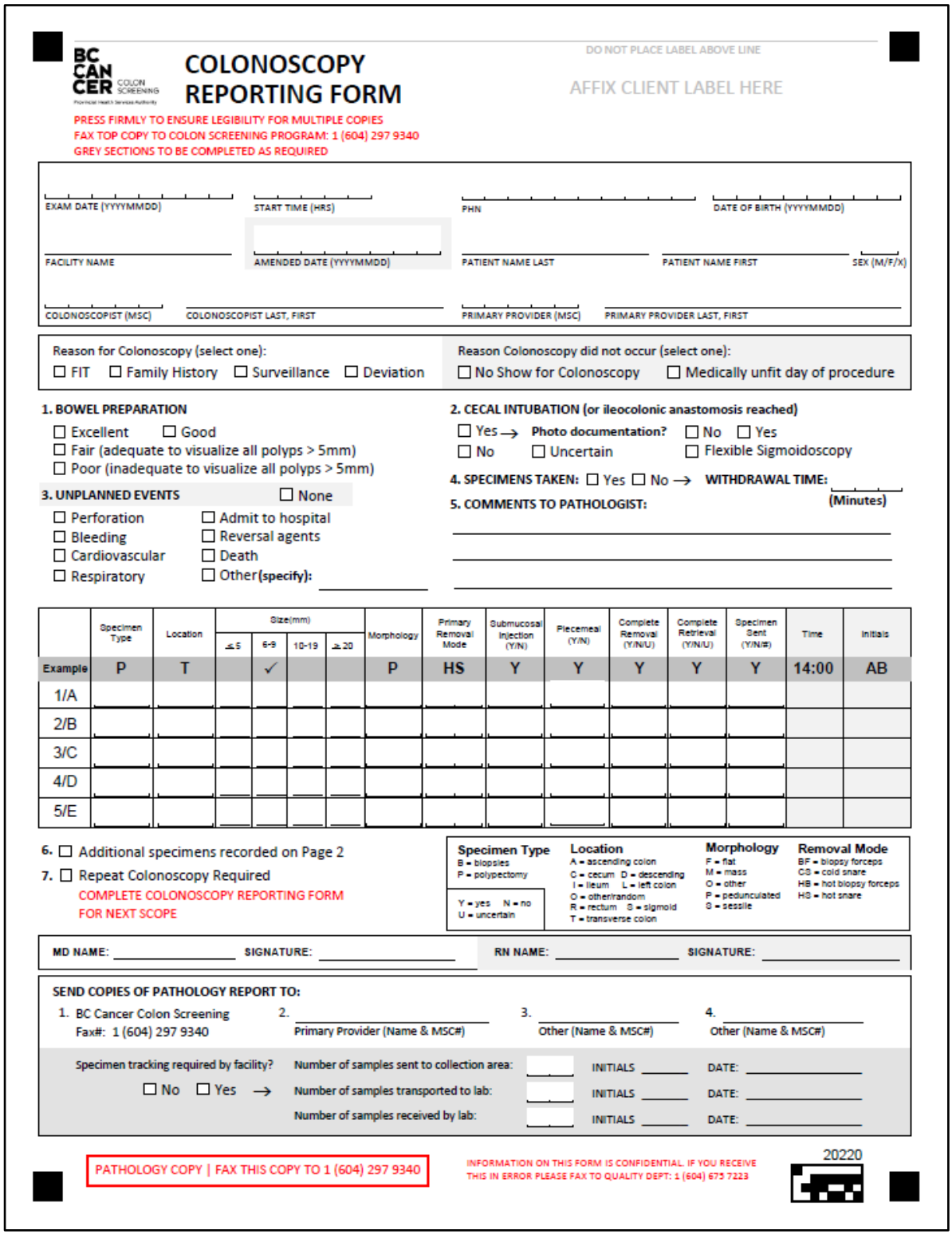
QUALITY DEPT: 1 (604) 675-7223

20420

Appendix I – Colonoscopy Reporting Form



BC CANCER COLON SCREENING

COLONOSCOPY REPORTING FORM

DO NOT PLACE LABEL ABOVE LINE

AFFIX CLIENT LABEL HERE

PRESS FIRMLY TO ENSURE LEGIBILITY FOR MULTIPLE COPIES
FAX TOP COPY TO COLON SCREENING PROGRAM: 1 (604) 297 9340
GREY SECTIONS TO BE COMPLETED AS REQUIRED

EXAM DATE (YYYYMMDD) | START TIME (HRS) | PHN | DATE OF BIRTH (YYYYMMDD)

FACILITY NAME | AMENDED DATE (YYYYMMDD) | PATIENT NAME LAST | PATIENT NAME FIRST | SEX (M/F/X)

COLONOSCOPIST (MSC) | COLONOSCOPIST LAST, FIRST | PRIMARY PROVIDER (MSC) | PRIMARY PROVIDER LAST, FIRST

Reason for Colonoscopy (select one):
☐ FIT ☐ Family History ☐ Surveillance ☐ Deviation

Reason Colonoscopy did not occur (select one):
☐ No Show for Colonoscopy ☐ Medically unfit day of procedure

1. BOWEL PREPARATION
☐ Excellent ☐ Good
☐ Fair (adequate to visualize all polyps > 5mm)
☐ Poor (inadequate to visualize all polyps > 5mm)

2. CECAL INTUBATION (or ileocolonic anastomosis reached)
☐ Yes → **Photo documentation?** ☐ No ☐ Yes
☐ No ☐ Uncertain ☐ Flexible Sigmoidoscopy

3. UNPLANNED EVENTS ☐ None
☐ Perforation ☐ Admit to hospital
☐ Bleeding ☐ Reversal agents
☐ Cardiovascular ☐ Death
☐ Respiratory ☐ Other (specify):

4. SPECIMENS TAKEN: ☐ Yes ☐ No → **WITHDRAWAL TIME:** (Minutes)

5. COMMENTS TO PATHOLOGIST:

	Specimen Type	Location	Size(mm) ≤5	Size(mm) 6-9	Size(mm) 10-19	Size(mm) ≥20	Morphology	Primary Removal Mode	Submucosal Injection (Y/N)	Piecemeal (Y/N)	Complete Removal (Y/N/U)	Complete Retrieval (Y/N/U)	Specimen Sent (Y/N/#)	Time	Initials
Example	P	T		✓			P	HS	Y	Y	Y	Y	Y	14:00	AB
1/A															
2/B															
3/C															
4/D															
5/E															

6. ☐ Additional specimens recorded on Page 2

7. ☐ Repeat Colonoscopy Required
COMPLETE COLONOSCOPY REPORTING FORM FOR NEXT SCOPE

Specimen Type
B = biopsies
P = polypectomy

Y = yes N = no
U = uncertain

Location
A = ascending colon
C = cecum D = descending
I = ileum L = left colon
O = other/random
R = rectum S = sigmoid
T = transverse colon

Morphology
F = flat
M = mass
O = other
P = pedunculated
S = sessile

Removal Mode
BF = biopsy forceps
CS = cold snare
HB = hot biopsy forceps
HS = hot snare

MD NAME: | SIGNATURE: | RN NAME: | SIGNATURE:

SEND COPIES OF PATHOLOGY REPORT TO:
1. BC Cancer Colon Screening Fax#: 1 (604) 297 9340
2. Primary Provider (Name & MSC#)
3. Other (Name & MSC#)
4. Other (Name & MSC#)

Specimen tracking required by facility? ☐ No ☐ Yes →
Number of samples sent to collection area: ____ INITIALS ____ DATE: ____
Number of samples transported to lab: ____ INITIALS ____ DATE: ____
Number of samples received by lab: ____ INITIALS ____ DATE: ____

PATHOLOGY COPY | FAX THIS COPY TO 1 (604) 297 9340

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20220

Log Revision History

Pre-Post Colonoscopy Assessment Standards Change Log Revision History				
Version	**Date**	**Action**	**Pages Affected**	**Details**
1.0	May 2014			
	May 2015			
	March 2016			
1.1	November 2017	Updated	ALL	- Format updated based on the Colonoscopy Standards - Title of document from "Patient Coordinator Standards" to "Pre-Post Colonoscopy Assessment Standards" - Page numbers added to the Table of Contents. Titles and section numbers updated - Dr. Telford Updated Standards. (p. 4-7, 13, 15, 16) - References and Appendices matched and added based on the updated standards.
1.2	January 2018	Addition	6,17	Added statement on confirming participants PCP Added Medical Records Retention policy
1.3	March 2018	Updated	All	New Logo/Branding
1.4	April 2018	Updated	19-24	Updated Appendices
1.5	July 2019	Addition	14	Added requirement for two methods of contact for follow up phone call to participant with time interval, and example
1.6	August 2019	Updated	Section 3.1 Section 5.1	Remove above addition and incorporate minimum contact for assessment standard.
1.7	September 2019	Updated	Section 5.1	Added requirement for two methods of contact for follow up phone call to participant with time interval, and example
1.8	April 2020	Updated	Sections 1.5, 2.2, 3.2,	Clarify eligibility and when colonoscopy should proceed. Assessment when on Antithrombotic Therapy updated.
1.9	October 2021	Updated	Appendices H, I	Clarify eligibility and update process for Referral Update Form and new Follow-up Form. Added two appendices.
2.0	September 2022	Updated	All	Change language to pre-cancerous lesions, update anti-thrombotic information, new GPAC guidelines
2.1	September 2023	Updated	Section 3.1	Added Severe Aortic Stenosis to Significant co-morbid medical illnesses

			Section 3.2 Section 3.4 Section 5.3 References	Added Acetylsalicylic Acid under Antiplatelet agents Added Table to display the recommended anti-hyperglycemic agent dose modification Changed Colorectal Cancer to colorectal adenocarcinoma, Attenuated Familial Adenomatous Polyposis changed to adenomatous polyposis syndromes, Polyps changed to precancerous lesions, Carcinoid tumors changed to carcinoid/neuroendocrine tumors Added new reference - Chirila A, et al
2.2	March 2024	Updated	Section 1.5	Updated Date. Added the word “full” to sibling.
2.3	April 2024	Updated	All Appendix G	Updated header Changed Orientation
2.4	January 2025	Updated	Section 3.1 Section 1.1 Appendix E	Include precancerous lesion count as part of pre-colonoscopy assessment and include as an alert to colonoscopist. Removed sentence stating NHA excluded from CSP. Updated Bowel Preparation Algorithm with new version
2.5	February 2025	Updated	Section 1.5	Clarify family history criteria affected relatives for the basis of start age of screening.
2.6	April 2025	Updated	Section 3.4	Corrected spelling from Glicalazide to Gliclazide