



CLINICAL GUIDELINES

Colonoscopy

Version 1.0

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eviCore healthcare Clinical Decision Support Tool Diagnostic Strategies: This tool addresses common symptoms and symptom complexes. Imaging requests for individuals with atypical symptoms or clinical presentations that are not specifically addressed will require physician review. Consultation with the referring physician, specialist and/or individual's Primary Care Physician (PCP) may provide additional insight.

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COLON-0: General Guidelines

- All time intervals in the guideline refer to colonoscopy, unless otherwise stated.
- These guidelines are for initial procedures, unless otherwise stated
 - ◆ Requests for follow-up colonoscopy that are not specifically addressed in these guidelines should be forwarded for Medical Director Review.
- See: **AB-25.1: CT Colonography (CTC)** for guidelines regarding screening CT Colonography and FIT-DNA testing
- Requests for Open-Access Colonoscopy must meet criteria according these guidelines

COLON-1: Average-Risk Screening

- “Average-risk” is defined as no previously diagnosed:
 - ◆ Colorectal cancer
 - ◆ Colonic adenomas
 - ◆ Inflammatory bowel disease involving the colon
- Colonoscopy every 10 years, beginning at age 50 (age 45 in African-Americans), up to age 85¹
 - ◆ Abnormal findings on an average-risk screening examination should be followed up according to the specific guideline for that finding

COLON-2: High-Risk Screening

- Family history of colorectal cancer (CRC)¹:
 - ◆ Colonoscopy every 5 years beginning 10 years younger than the age at which the youngest first-degree relative was diagnosed, or age 40 years, whichever is earlier, if ANY of the following:
 - One or more first-degree relative with CRC or an advanced adenoma (defined as a polyp ≥ 1 cm in size, or with high-grade dysplasia, or required surgery to remove the polyp) diagnosed at age ≤ 60 years
 - Two first-degree relatives (parent, sibling, child) with CRC or documented advanced adenomas at any age
 - One or more first-degree relatives with a documented advanced serrated lesion (a sessile serrated polyp or a traditional serrated adenoma ≥ 10mm in size) or a sessile serrated polyp with cytologic dysplasia
 - ◆ Colonoscopy beginning at age 40 years, but then every 10 years (average-risk screening schedule) if:
 - One first degree relative diagnosed at age > 60 years
- See also: **Background and Supporting Information: High-risk Screening**
- Genetic Syndromes
 - ◆ See: **COLON-11: Genetic Syndromes**

COLON-3: Surveillance after Polypectomy

- The proper application of surveillance guidelines requires information regarding the size, number, and histologic findings from the initial baseline colonoscopy.
- First surveillance colonoscopy intervals after polypectomy:
 - ◆ Adenomatous Polyps:
 - If no polyps found on screening or other colonoscopy: 10 years (average risk)
 - 1-2 tubular adenomas < 10mm: 7-10 years
 - 3-4 tubular adenomas < 10mm: 3-5 years
 - 5-10 tubular adenomas < 10mm: 3 years
 - One or more tubular adenomas ≥ 10mm: 3 years
 - Adenoma with tubulovillous or villous histology: 3 years
 - Adenoma with high-grade dysplasia: 3 years.
 - > 10 adenomas on a single examination: 1 year
 - Piecemeal resection of adenoma ≥ 20mm: 6 months
 - ◆ Hyperplastic polyps:
 - All polyps located in the rectum and/or sigmoid colon:
 - ≤ 20 polyps, size < 10mm: Repeat in 10 years
 - Polyps located proximal to the sigmoid colon:
 - ≤ 20 polyps, size < 10mm: Repeat in 10 years
 - Polyps ≥ 10mm: Repeat in 5-10 years
 - > 20 polyps
 - Follow Serrated Polyposis Syndrome guidelines (**COLON-17: Genetic Syndromes**)
 - ◆ Sessile Serrated Polyps:
 - 1-2 polyps < 10mm in size: Repeat in 5-10 years
 - 3-4 polyps < 10mm in size: Repeat in 3-5 years
 - 5-10 polyps < 10mm in size: Repeat in 3 years
 - Polyp ≥ 10mm: Repeat in 3 years
 - Isolated polyp containing dysplasia: Repeat in 3 years
 - Piecemeal resection of SSP > 20mm: Repeat in 6 months
 - See also: Serrated Polyposis Syndrome in **COLON-17: Genetic Syndromes**
 - ◆ Traditional Serrated Adenoma:
 - Repeat in 3 years
- Second surveillance colonoscopy (stratified by baseline and first surveillance adenoma findings):
 - ◆ **If Baseline Colonoscopy/Polypectomy Findings show 1-4 tubular adenomas < 10 mm:**
 - First surveillance colonoscopy findings:
 - Normal colonoscopy:
 - Second surveillance colonoscopy: Repeat in 10 years
 - 1-2 tubular adenomas < 10mm:
 - Second surveillance colonoscopy: Repeat in 7-10 years
 - 3-4 tubular adenomas < 10mm:
 - Second surveillance colonoscopy: Repeat in 3-5 years
 - Adenoma ≥ 10mm in size:

- Second surveillance colonoscopy: Repeat in 3 years
- Adenoma with tubulovillous or villous history:
 - Second surveillance colonoscopy: Repeat in 3 years
- Adenoma with high-grade dysplasia:
 - Second surveillance colonoscopy: Repeat in 3 years
- 5-10 adenomas < 10mm:
 - Second surveillance colonoscopy: Repeat in 3 years
- ◆ **For any of the following scenarios on baseline colonoscopy/polypectomy:**
 - **Adenoma $\geq$ 10mm**
 - **Adenoma with tubulovillous or villous pathology**
 - **Adenoma with high-grade dysplasia**
 - **5-10 adenomas < 10mm**
 - First surveillance colonoscopy findings:
 - Normal colonoscopy:
 - ◆ Second surveillance colonoscopy: Repeat in 5 years
 - 1-2 tubular adenomas < 10mm:
 - ◆ Second surveillance colonoscopy: Repeat in 5 years
 - 3-4 tubular adenomas < 10mm:
 - ◆ Second surveillance colonoscopy: Repeat in 3-5 years
 - Adenoma $\geq$ 10mm:
 - ◆ Second surveillance colonoscopy: Repeat in 3 years
 - Adenoma with tubulovillous histology:
 - ◆ Second surveillance colonoscopy: Repeat in 3 years
 - Adenoma with high-grade dysplasia:
 - ◆ Second surveillance colonoscopy: Repeat in 3 years
 - 5-10 adenomas < 10mm:
 - ◆ Second surveillance colonoscopy: Repeat in 3 years
- ◆ **If baseline colonoscopy shows: Adenoma or SSP > 20mm with piecemeal resection:**
 - Second surveillance: 1 year from the first surveillance colonoscopy
 - Third surveillance: 3 years from the second surveillance colonoscopy
 - (Note: In this scenario, if any surveillance study after the initial polypectomy reveals local recurrence, subsequent examinations can be performed at 6 month intervals until there is no local recurrence. Once a clear resection site is documented, the next follow-up is at 1 year, and the subsequent follow-ups are at 3 year intervals.)
- ◆ **If baseline colonoscopy shows: Hyperplastic polyps $\geq$ 10mm or SSPs (other than as noted above):**
 - No guidelines exist for second surveillance colonoscopy for these scenarios. Send to medical review. Evidence is lacking at the current time for additional serial surveillance recommendations.

COLON-4: Surveillance After Diagnosis of Colorectal Cancer¹¹

- If colonoscopy was not completed pre-operatively (e.g., because of an obstructing lesion)
 - ◆ Repeat colonoscopy 3-6 months post-surgery, for clearance
- For individuals who have undergone curative resection of either a colon or rectal cancer and had a successful peri-operative clearing colonoscopy at diagnosis or subsequently as noted above:
 - Colonoscopy one year after the surgery or one year after the clearing colonoscopy (assuming clearing colonoscopy occurred post-surgery)
 - Thereafter, repeat in 3 years (4 years from the surgery or clearing colonoscopy)
 - Repeat next colonoscopy in 5 years (9 years from the surgery or clearing colonoscopy)
 - Subsequent colonoscopies should occur at 5 year intervals.
- For individuals with Lynch Syndrome, see: **COLON-11: Genetic Syndromes**
- Additional surveillance of rectal cancer:
 - ◆ In addition to the above surveillance colonoscopies, a sigmoidoscopy or EUS can be performed at prescribed intervals.
 - These surveillance strategies are beyond the scope of the current guideline, which only references colonoscopy.
- See: **COLON-5: Inflammatory Bowel Disease** for surveillance of dysplasia

COLON-5: Inflammatory Bowel Disease

- Active inflammatory bowel disease⁴
 - ◆ For assessment of disease activity and/or treatment decisions, including assessment for mucosal healing on therapy
- Chronic inflammatory bowel disease⁴
 - ◆ Routine follow-up of inflammatory bowel disease in remission is not indicated except for cancer surveillance (see below)
- Post-surgery for Inflammatory Bowel Disease⁴
 - ◆ Evaluation of pouchitis, as clinically indicated
 - These requests should be sent for Medical Director Review
 - ◆ After partial colectomy or partial ileocolectomy
 - Examination of the neoterminal ileum 6-12 months after surgery to risk-stratify individuals who may be affected by endoscopic recurrence
- Screening and surveillance for dysplasia in established ulcerative colitis^{3,4,5}
 - ◆ Average risk individuals with ulcerative colitis
 - Begin screening 8 years after symptom onset (includes individuals with pancolitis, and left-sided colitis).
 - Continue surveillance colonoscopy every 1-3 years
 - Individuals with isolated ulcerative proctitis do not appear to be at increased risk of colon cancer. Thus, surveillance is not recommended in this group.
 - ◆ Elevated risk individuals with ulcerative colitis:
 - Begin annual surveillance beginning immediately upon diagnosis in the following high risk individuals:
 - Active inflammation
 - Anatomic abnormality such as a stricture or multiple pseudopolyps
 - Prior history of dysplasia
 - Family history of CRC in a first-degree relative
 - History of primary sclerosing cholangitis
 - ◆ If dysplasia is discovered or a lesion is present which needs follow-up evaluation:
 - If a polypoid or non-polypoid dysplastic lesion has been removed^{3,5}:
 - Colonoscopy surveillance at 1-6 months, then at 12 months, and then yearly
- Screening and surveillance for dysplasia in established Crohn's Disease of the colon:
 - ◆ Colonoscopy every 1-3 years in individuals with Crohn's Disease who have disease involving at least one-third of the colon, beginning 8 years after symptom onset

COLON-6: Irritable Bowel Syndrome

- Irritable Bowel Syndrome is a positive diagnosis, not a diagnosis of exclusion. It is characterized by abdominal pain associated with altered bowel habits, abdominal distension, and bloating over a period of 6 months. Subtypes include IBS-C (constipation-predominant), IBS-D (diarrhea-predominant), IBS-M (mixed), and unclassified IBS. Rome IV Criteria for the diagnosis of IBS are:
 - ◆ Recurrent abdominal pain, on average ≥ 1 day/week in the past 3 months, related to ≥ 2 of the following:
 - Defecation
 - Change in stool frequency
 - Change in stool appearance
- Colonoscopy indications:
 - ◆ The following laboratory studies should be performed prior to colonoscopy in the absence of alarm features:
 - CBC
 - CRP (C-reactive protein), fecal calprotectin, or fecal lactoferrin for non-constipated IBS
 - Serologic tests for celiac disease in non-constipated IBS
 - Stool analysis for giardia in IBS-D
 - ◆ If any one of the following alarm features are present, colonoscopy can be performed:
 - Positive family history of colorectal cancer (first-degree relative)
 - Rectal bleeding in the absence of documented bleeding hemorrhoids or anal fissures (e.g. positive stool occult blood, hematochezia. See: **COLON-9: GI Bleeding**)
 - Unintentional weight loss $\geq 5\%$ of body weight
 - Abdominal pain awakening individual at night-time
 - A change of pattern including frequent passage of stool during night-time
 - Iron-deficiency anemia as manifested by a low hematocrit and/or hemoglobin AND one of the following:
 - Low serum iron
 - Low serum ferritin
 - Elevated serum iron-binding capacity
 - Low serum transferrin saturation
 - Positive inflammatory markers as noted in the above laboratory examinations

COLON-7: Constipation

- Colonoscopy indicated:
 - ◆ For the following alarm symptoms:
 - Rectal bleeding
 - Note: the nature of rectal bleeding should be specific (e.g., bright red blood per rectum, melena, hematochezia, etc. See: **COLON-9: GI Bleeding**)
 - Heme-positive stool
 - Iron-deficiency anemia as evidenced by:
 - Low serum iron
 - Low serum ferritin
 - Elevated serum iron-binding capacity
 - Low serum transferrin saturation
 - Weight loss (>5% loss of body weight)
 - Individuals ≥ 50 years who have not previously had colon cancer screening via colonoscopy
 - For dilation of benign colon strictures or creation of percutaneous cecostomy when clinically appropriate
 - Note: the nature of the stricture should be specified (e.g., anastomotic stricture in the sigmoid)
 - In selected individuals, if there is a documented concern for obstruction secondary to cancer, stricture, or extrinsic compression
 - If surgery is being considered for the treatment of constipation

Background and Supporting Information

- As per ASGE guidelines, colonoscopy is generally NOT performed for the initial evaluation of individuals presenting with symptoms of chronic constipation in the absence of alarm features or suspicion of organic disease. It should be noted that in a retrospective review of 41,775 colonoscopies performed for average-risk CRC screening, constipation only, or constipation with another indication, individuals with constipation alone (as opposed to constipation with another indication) had a lower risk of significant findings than individuals undergoing colonoscopy for average risk screening.³⁰ In general, the yield of colonoscopy for isolated constipation is comparable to that of asymptomatic individuals undergoing colonoscopy for routine CRC screening.

COLON-8: Diarrhea

- Chronic diarrhea (≥ 28 days)^{8,22}
 - ◆ Prior to colonoscopy:
 - Fecal calprotectin or lactoferrin to screen for Inflammatory Bowel Disease.
 - Giardia antigen test or PCR for Giardia.
 - Testing for celiac with IgA tissue transglutaminase (A positive test would warrant confirmation by duodenal biopsy). The use of IgG-tTG or a test for IgG deaminated gliadin peptides can be considered for IgA-deficient individuals.

- ◆ If the diagnosis is inconclusive or suggestive of IBD after the above studies, colonoscopy can be approved.
- Acute diarrhea⁸ (< 28 days):
 - ◆ Immunocompetent individuals:
 - Stool and laboratory tests, including tests for the presence of microbial pathogens are the initial studies for the evaluation of clinical scenarios suggestive of infectious diarrhea
 - Colonoscopy is generally not indicated for the initial evaluation of acute diarrhea in this setting, unless:
 - Findings on sigmoidoscopy are inconclusive
 - Results should be provided
 - Symptoms persist and fail to respond to empirical therapy
 - Type of therapy should be provided
 - The diagnosis is inconclusive after routine blood and stool studies
 - Results of these studies should be provided
 - There is significant blood loss
 - Nature of blood loss should be specified
 - ◆ Immunocompromised Individuals:
 - Stool testing for pathogens is the first-line evaluation
 - Colonoscopy can be considered if stool studies fail to reveal a cause and symptoms persist. In addition, cytomegalovirus infection (CMV) diagnosed by PCR, viral culture, or positive serology may not be indicative of tissue-invasive disease and endoscopic biopsy may be needed.

Background and Supporting Information

- In the immunocompromised individual (e.g., HIV) evidence indicates that colonoscopy has a higher diagnostic yield than sigmoidoscopy.

COLON-9: GI Bleeding

- History of rectal bleeding
 - ◆ The nature of the rectal bleeding should be specified (e.g., bright red blood per rectum, melena, hematochezia, etc.)
 - For symptoms suggesting outlet-type bleeding (e.g., scant hematochezia, blood on toilet paper, small amount of blood on outside of stool)
 - Individuals age less than 40 years, colonoscopy is indicated when:
 - Flexible sigmoidoscopy does not reveal a local source of bleeding such as hemorrhoids or anal fissure.
 - Findings on sigmoidoscopy suggest a need for further evaluation (e.g., inflammatory bowel disease, adenomatous polyp, etc.)
 - In the presence of alarm symptoms of weight loss or bowel habit changes, or if criteria for colonoscopy is met by other guidelines (e.g. iron deficiency anemia, etc.)
 - For elevated risk individuals with family history of colorectal polyps or cancer or other genetic predisposition to colonic cancer
 - Individuals age 40 years or older, colonoscopy is indicated

- For confirmed positive occult blood, melena, or hematochezia not suggestive of outlet-type bleeding
 - Colonoscopy is indicated
- Iron deficiency anemia as indicated by:
 - ◆ Low serum iron
 - ◆ Low serum ferritin
 - ◆ Elevated serum iron-binding capacity
 - ◆ Low serum transferrin saturation

COLON-10: Abdominal Pain

- Isolated abdominal pain with or without constipation in the absence of bleeding (i.e., no history of rectal bleeding, negative stool occult blood, and normal Hgb):¹⁵
 - ◆ Colonoscopy is indicated in individuals ≥ 50 years of age.
 - ◆ Otherwise, in general, isolated abdominal pain is a poor indication for colonoscopy, but can be considered in individual cases.
 - Requests can be considered as per the alarm symptoms under **COLON-6: Irritable Bowel Syndrome**

COLON-11: Unexplained Weight Loss

- Unexplained weight loss of > 5% body weight
 - ◆ Colonoscopy as requested

COLON-12: Abnormal Radiologic Study

- Abnormal radiologic studies or other examinations indicating colorectal pathology⁶:
 - ◆ Colonoscopy as requested to assess the abnormality as indicated
 - The nature of the abnormality must be documented by description of the radiologic finding (e.g., colon wall thickening on CT scan)

COLON-13: Repeat Colonoscopy for Inadequate Preparation

- Inadequate preparation on initial colonoscopy for screening or surveillance:
 - ◆ For a BBPS (Boston Bowel Prep Scale) score of 2 or 3 in all segments of the colon:
 - Repeat examination as per screening or surveillance guidelines
 - ◆ For BBPS score of 0 or 1 in any segment of the colon:
 - Repeat examination as per the endoscopist
 - ◆ For cases in which the BBPS score is not available:
 - Repeat examination as per the endoscopist with documentation from prior colonoscopy report indicating the inadequacy of the preparation and the need for earlier-than-usual follow-up.

COLON-14: Therapeutic Colonoscopy

- Removal of a foreign body⁶
 - ◆ The nature of the suspected foreign body should be provided (e.g., battery, etc.)

- Treatment of a known bleeding source (e.g., radiation proctitis, arteriovenous malformation, etc.)
- Excision of a known polyp⁶
 - ◆ This would apply to a known polyp not previously resected. Documentation of the nature of the retained polyp should be provided (e.g., large polyp for which endoscopic mucosal resection is being planned)
 - ◆ For colon polyp surveillance, see: **COLON-3: Surveillance after Polypectomy**
- Decompression of acute nontoxic megacolon or sigmoid volvulus⁶
 - ◆ Documentation of the history should be provided
- Balloon-dilation of stenotic lesions⁶
 - ◆ The nature of the stenosis should be specified (e.g., dilation of an anastamotic sigmoid stricture)
- Palliative treatment of stenosing or bleeding neoplasms⁶
 - ◆ The type of neoplasm and location should be specified
- Marking a neoplasm for localization⁶
 - ◆ The type of neoplasm and location should be specified
- Intra-operative colonoscopy for site identification at time of surgery⁶
 - ◆ The nature of the planned surgical procedure should be specified (e.g., surgical treatment of a polypoid lesion)

COLON-15: Metastatic Cancer of Unknown Primary Site

- Metastatic adenocarcinoma of unknown primary site when, in the opinion of the treating physician responsible for oncology care, the results will not alter management.
 - ◆ Colonoscopy is NOT indicated⁶

COLON-16: Colonoscopy Via Stoma

- Colonoscopy via stoma can be performed for any of the above indications, and in addition¹³:
 - ◆ To evaluate stoma complications (e.g., hernia, retraction, prolapse, stenosis, fistula, etc.)

COLON-17: Genetic Syndromes

- Lynch Syndrome (NOTE: Screening colonoscopy begins at the stated age as indicated below, or 5 years before the youngest age of diagnosis of colorectal cancer in an affected family member, whichever occurs first)
 - ◆ MLH1/MSH2 Mutation:
 - Annual colonoscopy beginning at age 20
 - ◆ MSH6/PMS2 Mutation:
 - Annual colonoscopy beginning at age 25
- Polyposis Syndromes
 - ◆ FAP (Familial Adenomatous Polyposis):
 - Annual colonoscopy beginning at age 10
 - ◆ Attenuated FAP:
 - Annual colonoscopy beginning at age 18
 - ◆ MUTYH-associated polyposis:
 - Annual colonoscopy beginning at age 25
 - ◆ Juvenile Polyposis Syndrome
 - Colonoscopy at age 12. If polyps are present, repeat yearly. If no polyps, repeat every 2 years.
 - ◆ Serrated Polyposis Syndrome:
 - Colonoscopy yearly
 - Criteria for diagnosis - at least one of the following:
 - At least 5 serrated polyps proximal to the sigmoid colon with ≥ 2 of these being $> 10\text{mm}$
 - Any number of serrated polyps proximal to the sigmoid colon in an individual who has a first-degree relative with serrated polyposis
 - > 20 serrated polyps of any size, distributed throughout the colon
 - ◆ Puetz-Jeghers Syndrome:
 - Colonoscopy at age 8. If polyps are present, can be repeated every 3 years. If no polyps are discovered, repeat at age 18, then every 3 years, or earlier if any symptoms occur.
 - ◆ Cowden Syndrome:
 - Colonoscopy beginning at age 15. Can be repeated every 2 years if no polyps are discovered. If polyps are found, repeat as requested.
 - ◆ Family Colon Cancer X Syndrome:
 - Colonoscopy every 3 years beginning 10 years before the age at diagnosis of the youngest affected relative.
 - ◆ Hereditary Gastric Cancer (Hereditary Diffuse Gastric Cancer-HDGC Syndrome):
 - Colonoscopy beginning at age 40. Interval has not been established.
 - ◆ BMMRD (Biallelic Mismatch Repair Deficiency)
 - Colonoscopy annually beginning at age 6. Once polyps are found, colonoscopy is recommended every 6 months.
 - All heterozygous family members are eligible for Lynch Syndrome Screening (See above for Lynch Syndrome)

Background and Supporting Information

- High Risk Screening:
 - ◆ If there is no information regarding the pathology of the first-degree relative's polyp, it can be assumed that the adenomas or polyps were NOT advanced, unless surgery was required to remove the polyp.

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