BC CANCER COLON SCREENING
Provincial Health Services Authority

BC Cancer Colon Screening Colonoscopy Standards

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Date and Version: April 2024

Colon Screening Program

This report was produced by the Colon Screening Program.

Preferred citation:

Colon Screening Program Colonoscopy Standards. BC Cancer, 2024

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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 Colonoscopy 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 is expected to be the fourth most common cancer diagnosed in British Columbia in 2022, excluding non-melanoma skin cancer, and the second leading cause of cancer death. The primary goal of the Colon Screening Program is to detect and remove pre-cancerous lesions from the colon and rectum that are the precursor lesions of colorectal cancer as well as asymptomatic colorectal cancer. Ultimately, this will reduce colorectal cancer incidence and related mortality.

1.2 Purpose of the Standards

The purpose of developing Colonoscopy Standards is to maximize participant safety and program efficiency and efficacy. There are modifiable factors, which affect the rate of colonoscopy-related complications and the rate of missed lesions. Standardization of colonoscopy quality with a goal of continuing quality improvement can address these factors. Furthermore, by improving the communication amongst health care providers and participants regarding appropriate screening and surveillance intervals, the rate of unnecessary testing will be decreased.

The following items are important determinants of colonoscopy quality and will be addressed in the colonoscopy standards.

Hospital and endoscopy unit standards

- Pre-colonoscopy participant assessment
- Protocol for endoscope cleaning
- Protocol for conscious sedation
- Post-colonoscopy participant instructions

Physician standards

- Documented training/experience with performing colonoscopy
- Direct Observation of Procedural Skills

Colonoscopy performance standards

- Serious adverse events
- Bowel preparation quality
- Cecal intubation rate
- Adenoma detection rate
- Complete resection and retrieval of pre-cancerous lesions
- Standardized colonoscopy report

- Adherence to surveillance guidelines
- Participant satisfaction

The quality of colonoscopies performed will be evaluated through a standardized colonoscopy report, a follow-up participant phone call, pathology review and review of interval cancers diagnosed following colonoscopy.

1.3 Sources of Information

The sources of information for this document were derived from the published literature. Articles were identified from MEDLINE, BC Guidelines and Protocols Advisory Committee, Cancer Care Ontario Colonoscopy Standards, Canadian Association of Gastroenterology and American Society for Gastrointestinal Endoscopy guidelines, American College of Gastroenterology guidelines, American Gastroenterological Association guidelines, European Society for Gastrointestinal Endoscopy, and NHS Joint Advisory Group on GI Endoscopy.

1.4 General Principles

- Minimize colonoscopy related complications
- Minimize missed lesions
- Optimize follow-up screening and surveillance

2. Hospital and Endoscopy Unit Standards

Institutions participating in the Colon Screening Program will be evaluated for the following: appropriate pre-colonoscopy assessment and post-colonoscopy discharge instructions, endoscope cleaning protocol, and conscious sedation protocol.

Participation in the Global Rating Scale (GRS), twice yearly, is required with submission of the action plans to the Health Authority Colonoscopist Lead. The Canadian version of the GRS is at https://www.cag-acg.org/quality/c-grs and a username and password can be obtained from nosheen@cag-acg.org

The wait time benchmarks are as follows:

- Within 56 days for a participant with an abnormal FIT result (abnormal result date to colonoscopy date)
- Within six months for a participant with a family history of colorectal cancer or personal history of neoplastic lesions due for surveillance when the surveillance interval is one year or more (due date to colonoscopy date)
- Within 56 days for a participant who has been recommended to return for an additional colonoscopy within a year (due date to colonoscopy date)

2.1 Pre-Colonoscopy Participant Assessment

Program participants will be evaluated by regional health authority staff prior to the colonoscopy. The assessment will include documentation of co-morbid medical conditions that may increase a participant's risk during bowel preparation, conscious sedation and colonoscopy. See Assessment Form (Appendix A).

The health authority staff will provide education to the participant on colonoscopy, including potential adverse events, and give instructions regarding the bowel preparation. There will be specific alerts in the pre-colonoscopy assessment to prompt a discussion or a participant consultation with the colonoscopist prior to scheduling the colonoscopy. See Pre/Post Colonoscopy Standards.

2.2 Bowel Preparation

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

Fleet phospho-soda is contraindicated as per Health Canada recommendations.

As outlined in the Algorithm, bisacodyl is not recommended in standard bowel preparations as it does not improve bowel cleansing and there is a possible association with the development of ischemic colitis.

Studies have shown that split-dose bowel preparations, in which the second half of the bowel preparation is administered within six hours of the colonoscopy, 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. Split dose bowel preparations are the standard of care.

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 patient. The colonoscopist is responsible for ensuring the patient is re-booked.

2.3 Informed Consent

Health authority staff will review the health authority’s colonoscopy consent form with the participant, citing approximately 1/250 people will have a serious complication. Complications include having a reaction to the bowel preparation or medication used for sedation, cardiopulmonary events, infection, bleeding and perforation. The risk of dying from colonoscopy is less than 1/30,000. There is also a risk of missing a colorectal cancer or high-risk lesion. This occurs in less than 1/10 cases. The participant will be given the opportunity to ask questions and be offered written information on colonoscopy including potential adverse events to review. The colonoscopist will obtain informed consent prior to the procedure.

2.4 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 in 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)

2.5 Need for Prophylactic Antibiotics

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.

2.6 Protocol for Endoscope Cleaning

Hospitals and endoscopy units participating in the Colon Screening Program will be required to document adherence to vendor guidelines for colonoscope cleaning and maintenance, and adherence to hospital infection control standards with periodic monitoring. It is recommended that automated machine, not manual processes, be used for cleaning of endoscopes.

The use of simethicone during colonoscopy reduces the bubbles in the colon thereby improving visibility. Simethicone does not appear to be an infection control issue.

2.7 Protocol for Conscious Sedation

Conscious sedation should be offered to all participants undergoing colonoscopy

unless it is considered to be medically contraindicated by the colonoscopist. The participants should understand that sedation is optional, and they can undergo the colonoscopy without sedation if that is their preference. Each institution providing colonoscopies for the Colon Screening Program will need to ensure the necessary protocol, equipment and personnel are present to provide safe and effective conscious sedation.

2.8 Monitoring Protocol

During colonoscopy with conscious sedation, monitoring of blood pressure, heart rate, oxygen saturation, level of consciousness and level of discomfort is required. The participant should be monitored post-procedure until stable. Each institution providing colonoscopies for the Colon Screening Program will need to ensure the appropriate monitoring protocol is in place.

2.9 Resuscitation Equipment

Oxygen source, airway (oral, endotracheal tube), laryngoscope, defibrillator and Advanced Cardiac Life Support protocol medications should be readily available.

2.10 Personnel Trained in Resuscitation

At least one physician with current certification in Advanced Cardiac Life Support should be available within 5 minutes.

2.11 Post-Colonoscopy Participant Instructions

The participant will be provided with an instruction sheet relaying the results of their procedure, when to seek medical attention for potential colonoscopy related complications and who to contact.

Health authority staff will phone each participant 14 days post-colonoscopy to assess for any unplanned events that may have occurred the day prior to colonoscopy and following colonoscopy. The health authority staff will relay re-screening or surveillance recommendations to the participant based on the colonoscopy findings as per the Colon Screening Program guidelines.

Health authority staff will complete the Follow Up Recommendations Form (Appendix C) and fax it to the Colon Screening Program. The Program will generate a letter based on the Follow Up Recommendations Form, which will outline the next recommended screening test and interval for the participant. This letter will be sent to the primary care provider, the colonoscopist and the health authority. See Appendix D for a sample letter.

If a colorectal cancer is identified, then the colonoscopist will organize the appropriate investigations for staging, and if necessary, a surgery and oncology referral, or the colonoscopist will refer the participant back to the primary care provider for the primary care provider to make these arrangements. There may be other indications for the colonoscopist to continue to care for the participant. For

example, if high-risk or unusual pathology is identified, if inflammatory bowel disease is identified or if the participant has symptoms that require further investigation.

3. Physician Standards

3.1 Physician Standards

Colonoscopists participating in the program will:

- Have formal colonoscopy training.
- Have continuing colonoscopy experience with a minimum of 200 colonoscopies per year averaged over three years prior to beginning Colon Screening Program colonoscopies.
    - For new graduates with less than three years of experience, participation in Colon Screening Program colonoscopies may begin once a minimum of one year is complete and 200 colonoscopies completed.
    - Exceptions may be made for physicians who complete advanced fellowships in which they are performing colonoscopies. For instance, colorectal surgery fellowship or advanced gastroenterology fellowships. In this situation, physicians may begin Colon Screening Program colonoscopies immediately.
- Have competence in biopsy, snare polypectomy (with and without cautery), submucosal injection, polyp retrieval, tattooing and endoscopic hemostasis of post-polypectomy hemorrhage.
- Be in good standing with the College of Physicians and Surgeons of British Columbia.
- Have colonoscopy privileges at a British Columbia hospital.
- Participate in continuing colonoscopy medical education and quality improvement programs including Direct Observation of Procedural Skills (DOPS) (complete every three years).
- Complete Colonoscopy Report Forms for program colonoscopies.
- Meet performance benchmarks as outlined in Section 6.

Health authorities are responsible for credentialing and privileging colonoscopists. It is the responsibility of the health authority to review annually whether a colonoscopist meets the standards as outlined above and to determine if privileges to perform Colon Screening Program colonoscopies will be granted for the coming year. When a colonoscopist does not meet the standards as outlined above, the health authority may decide to credential that colonoscopist to provide screening program colonoscopies within the context of the community and the colonoscopist's specific experience and performance. The health authority has responsibility for monitoring and managing the performance of colonoscopists.

The Colonoscopy Reporting Form, Appendix E, must be used to record details of the procedure. This form is completed in addition to the hospital's standard dictated or synoptic report. Colonoscopists unwilling to provide the level of detail outlined in the Colonoscopy Reporting Form cannot be part of the program.

Locum physicians who cannot document that they are able to meet these standards should not participate in Colon Screening Program colonoscopies.

Colonoscopists will bill MSP with their usual process for colonoscopy and consultation as required.

3.2 Direct Observation of Procedural Skills (DOPS)

The Direct Observation of Procedural Skills (DOPS) is a formative assessment of colonoscopy skills developed by the Joint Advisory Group for Gastrointestinal Endoscopy to ensure high quality colonoscopy was performed in the UK Bowel Cancer Screening Program. DOPS has been validated in the UK for both trainees and independent endoscopists. The DOPS tool consists of four domains that are graded by 2 independent observers assessing at least 2 colonoscopies. Grades 3 and 4 are considered acceptable. Colonoscopist DOPS Assessors have completed a DOPS Assessor Course. The DOPS can be completed during a colonoscopist's regular endoscopy slate and does not require additional equipment. The DOPS policy, DOPS form, grading system and description of grades are in Appendix F. Colonoscopists can register for DOPS by requesting the DOPS Request form from ColonScreeningQuality@bccancer.bc.ca and submitting the completed form.

4. Colonoscopy Performance Standards

The quality of colonoscopies performed will be evaluated in a continuing manner. Several quality indicators will be assessed including serious adverse events, bowel preparation, cecal intubation rate, complete adenoma resection and retrieval, adenoma detection rate and adherence to surveillance guidelines. Individual and aggregate results will be reported annually in the Colonoscopist Quality Report.

4.1 Serious Adverse Events

The Colon Screening Program will monitor for colonoscopy-related complications. Serious adverse events are defined as events resulting in hospitalization, blood transfusion, repeat colonoscopy, interventional radiology procedure, other interventions, surgery, or death.

The overall rate of serious adverse events should be less than 1/250. The perforation rate should be less than 1/1000 for all colonoscopies performed at institutions participating in the program.

4.2 Bowel Preparation

An adequate bowel preparation is associated with increased cecal intubation and adenoma detection rates. If inadequate, further investigations need to be arranged, for instance a repeat colonoscopy with a more intensive bowel preparation.

Categories of bowel preparation quality:

- Excellent = no more than small bits of adherent fecal matter
- Good = small amounts of fluid or fecal matter not interfering with exam
- Fair = adequate to detect all polyps > 5mm
- Poor = inadequate to detect all polyps > 5mm

4.3 Cecal Intubation Rate

Cecal intubation is defined as insertion of the colonoscope beyond the ileocecal valve into the caput coli enabling complete visualization of the medial wall of the cecum proximal to the ileocecal valve.

The expected adjusted cecal intubation rate is ≥ 95% for screening colonoscopies and the unadjusted cecal intubation rate is ≥ 90%. Adjusted cecal intubation rate does not include colonoscopies terminated due to an inadequate bowel preparation or severe colitis, but does include those terminated due to an obstructing lesion.

Photo documentation of the cecum is required. If the cecum is not intubated, further investigations need to be arranged within 60 days; this is the responsibility

of the colonoscopist. Repeat colonoscopy, with referral to an expert colonoscopist if necessary, is strongly recommended because of the high neoplasia detection rate observed in the program. If repeat colonoscopy cannot be completed, then CT Colonography is another option.

Biopsies of the terminal ileum to document a complete colonoscopy is discouraged.

4.4 Adenoma Detection Rate

A high adenoma detection rate is associated with fewer post-colonoscopy colorectal cancers and death due to colorectal cancer.

Adenoma detection rate depends on successful cecal intubation, an adequate bowel preparation and appropriate withdrawal time. However, when these indicators are held constant, the most important predictor of adenoma detection rate is the colonoscopist. Ensuring high quality withdrawal technique to maximize visualization of the colonic mucosa by distending, cleaning, suctioning fluid, examining the proximal side of folds and re-examining colon segments is essential to optimizing adenoma detection.

The adenoma detection rate of individual colonoscopists will be compared to the mean adenoma detection rate for the entire program and will be adjusted for patient gender, age and FIT value.

4.5 Withdrawal Time

A longer withdrawal time is associated with an increased adenoma detection rate.

The minimum colonoscope withdrawal time for colorectal cancer screening is 6 minutes, not including time to perform polypectomy.

The withdrawal time will increase depending on various factors including colon length, bowel preparation quality and haustral prominence. Timing colonoscope withdrawal begins once cecal intubation is confirmed.

An endoscopist’s mean withdrawal time is based on procedures in which no intervention was performed and withdrawal time does not need to be recorded for procedures in which polypectomies are undertaken.

4.6 Complete Adenoma Resection and Retrieval

Incomplete adenoma resection is thought to be associated with interval cancers. All polyps should be completely excised from the colon and rectum with the possible exception of typical hyperplastic rectal polyps. If piecemeal resection of a high risk lesion is required then a repeat colonoscopy to evaluate for adequacy of resection in 6 months is recommended.

Snare polypectomy is more likely to completely resect a polyp than biopsy forceps. Cold snare polypectomy is recommended for polyps less than 1 cm in size as it

decreases the risk of perforation and has not been shown to increase the risk of post-polypectomy hemorrhage. Submucosal injection of saline or other solution prior to snare polypectomy of a sessile lesion may also reduce the risk of perforation. Similarly, many experts recommend blended current for polypectomy rather than pure coagulation in an attempt to reduce the incidence of post-polypectomy perforation. The newer electrosurgical generators produce high frequency pulses of cutting current and a prolonged coagulation current to achieve hemostasis without deep tissue injury.

Large non-pedunculated lesions $\geq$ 2 cm or those in difficult locations may require referral to a colonoscopist who specializes in tissue resection.

Reasonable effort should be made to retrieve all polyp fragments to submit for pathologic assessment.

4.7 Colorectal Cancers Diagnosed Outside of the Screening Program

Screening Program participants will be monitored for the diagnosis of colorectal cancers outside of the screening program. A non-screen detected colorectal cancer is defined as cancer diagnosed in the time interval between the date of the participant's last FIT and the date they were due for their next screening. A post-colonoscopy colorectal cancer is a colorectal cancer diagnosed in the time interval between the date of the participant's last colonoscopy and the date they were due for their next colonoscopy or FIT.

5. Screening and Surveillance Guidelines

5.1 Screening and Surveillance Guidelines

The BC Colon Screening Program guidelines for screening and colonoscopy surveillance align with the BC Guidelines and Protocols Advisory Committee. See Appendix G for surveillance recommendations following colonoscopy.

5.1.1 Individuals without a high risk family history of colorectal cancer

- Participants with an abnormal FIT and a colonoscopy with no pre-cancerous lesions are recalled for FIT in 10 years.

- For participants with a pre-cancerous lesion removed, their risk of developing colorectal cancer is determined by lesion size, number, and histology. Individuals with low risk pre-cancerous lesions removed have a similar or lower risk of developing future colorectal cancer when compared to individuals with no pre-cancerous lesions at colonoscopy or to the general population.

5.1.2 Individuals with a high risk family history of colorectal cancer

- Individuals with 1 first degree relative (parent, full sibling, child) diagnosed with colorectal cancer under 60 years of age or 2 or more first degree relatives diagnosed with colorectal cancer at any age will be recalled for colonoscopy every 5 years.

    - Following removal of high risk pre-cancerous lesions, individuals will be recalled in 3 years for colonoscopy.

5.1.3 Piecemeal resection of a high risk pre-cancerous lesion

- Repeat colonoscopy in 6 months to document complete excision. If the pathologist is able to document complete excision on the pathologic specimen than repeating the colonoscopy within 6 months is not necessary and the surveillance interval is determined using the criteria above. If there is no evidence of residual neoplastic tissue, then the next colonoscopy is 3 years from the original colonoscopy. For lateral spreading tumors, even once complete excision is established, more frequent surveillance may be indicated at the discretion of the colonoscopist.

5.1.4 Removal of Numerous Pre-Cancerous Lesions

Below are two instances when surveillance at an interval less than three years should be considered.

5.1.4.1 10 or more precancerous lesions at one exam

Participants who have 10 or more pre-cancerous lesions removed require more frequent colonoscopy follow-up. When there are numerous pre-cancerous lesions, a colonoscopist may decide to remove some pre-cancerous lesions at the index colonoscopy and bring the individual back

for additional colonoscopies to remove the remainder due to time constraints or comfort. Once all pre-cancerous lesions have been removed from the colon, the participant should return for surveillance colonoscopy in one year. Subsequent surveillance intervals will depend on findings at the one year surveillance colonoscopy and any recommendations from the Hereditary Cancer Program or other specialist. 10 or more pre-cancerous lesions in a lifetime could indicate a genetic mutation and referral to the Hereditary Cancer Program should be considered (see section 5.4).

5.1.4.2 Serrated Polyposis Syndrome

Serrated Polyposis Syndrome is characterized by large, numerous and proximal serrated polyps. This syndrome is the most common polyposis syndrome and increases an individual's risk of colorectal cancer. More frequent colonoscopic surveillance is indicated (every 1-2 years).

Serrated Polyposis Syndrome is defined by one of the following criteria:

- $\geq$ 5 serrated polyps proximal to the rectum all $\geq$ 5 mm in size with at least 2 being $\geq$ 1 cm in size or;
- $\geq$ 20 serrated polyps of any size distributed throughout the colon and rectum with $\geq$ 5 being proximal to the rectum.

Serrated polyp counts are cumulative over an individual's lifetime.

5.1.5 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 primary care provider this has been done or;
- Refer the participant back to the primary care provider for the primary care provider to arrange staging and treatment.

5.1.6 Following an incomplete (negative) colonoscopy and negative CT colonography

If CT colonography is performed and is negative, then re-screening with FIT should resume in five years. If a high-risk precancerous lesion or five or more low risk precancerous lesions were removed during the incomplete colonoscopy, then the participant should have surveillance colonoscopy in 3 years. If 1 to 4 low risk precancerous lesions were removed during the incomplete colonoscopy, then a surveillance colonoscopy in 5 years is recommended.

5.1.7 Following a positive FIT in a participant not yet due for colonoscopy/repeat FIT

The participant will be referred for colonoscopy. Two potential scenarios are below:

- Participant in a colonoscopy surveillance program for a personal history of pre-cancerous lesions or a high risk family history of colorectal cancer who has a positive FIT.
- Participant who had a positive FIT followed by a colonoscopy in which no neoplasm was identified and the next recommended screening is FIT in 10 years.

Colonoscopy is protective for 10 years and previous guidelines based on data using the guaiac fecal occult blood test stated that a positive 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 patients with an early FIT that is positive. These recommendations were graded as weak and based on low quality evidence. However, a further peer-reviewed publication has also demonstrated a risk of post-colonoscopy colorectal cancer in this group. Despite the risk of colorectal cancer for participants with a positive FIT who are not yet due for colonoscopy, data does not support the addition of FIT to colonoscopy surveillance in patients with a personal history of pre-cancerous lesions 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.

5.1.8 Following a colonoscopy in a participant not yet due for colonoscopy/repeat FIT

Potential scenarios and recommendations are outlined below. However, questions regarding more complex situations can be directed to the Colonoscopy Lead or Medical Director for clarification:

- Participant in a colonoscopy surveillance program for a personal history of pre-cancerous lesions or a high risk family history of colorectal cancer who has a colonoscopy before they are due. This early colonoscopy may be to follow-up an inappropriate FIT that was positive or to investigate symptoms.
    - If the early colonoscopy identifies high risk findings, then this determines the date of the next surveillance colonoscopy.
        - **Example:** Participant has a colonoscopy in 2023 with a low risk lesion removed and is due for surveillance colonoscopy in 2033. In 2025, they have an early colonoscopy to investigate rectal bleeding with a high risk pre-cancerous lesion identified. Their surveillance recommendation changes to colonoscopy in 2028.
    - If the early colonoscopy demonstrates low risk findings or is normal, then the date of the surveillance colonoscopy will depend on the interval between the date of early colonoscopy and the recommended date for the surveillance colonoscopy. There are no published data to guide our decisions and these situations should be reviewed with the Colonoscopy Lead or Medical Director for clarification.

- **Example:** Participant has a colonoscopy in 2023 with a low risk lesion removed and is due for surveillance colonoscopy in 2033. In 2025, they have an early colonoscopy to investigate symptoms and low risk findings are identified. After discussion with the Medical Director, the surveillance recommendation remains unchanged: colonoscopy in 2033.

- **Example:** Participant has a colonoscopy in 2023 with a low risk lesion removed and is due for surveillance colonoscopy in 2033. In 2030, they have an early colonoscopy to investigate symptoms and low risk findings are identified. After discussion with the Colonoscopy Lead, their surveillance recommendation changes to colonoscopy in 2040.

- Participant who had a previous normal colonoscopy and is due for FIT in 10 years has an inappropriate positive FIT or an early colonoscopy. Re-screening with FIT or colonoscopy surveillance will be determined by the most recent colonoscopy findings.

    - **Example:** Participant has a normal colonoscopy in 2023 and is due for repeat FIT in 2033. In 2027, they have an early FIT that is positive and a follow-up colonoscopy that is normal. Their re-screening recommendation changes to FIT in 2037.

    - **Example:** Participant has a normal colonoscopy in 2023 and is due for repeat FIT in 2033. In 2027, they have an early FIT that is positive and a follow-up colonoscopy with low risk findings. Their recommendation changes to colonoscopy in 2037.

5.1.9 Following a colonoscopy where one or more lesions were not retrieved or is non-diagnostic

Potential scenarios and recommendations are outlined below.

- If fewer than five lesions, all < 10mm, were removed and one or more were not retrieved or is non-diagnostic (i.e. cauterized tissue, insufficient tissue) assume it was a low-risk lesion, then the surveillance interval would be 5 years (if there is family history) or 10 years (if no family history) if the other retrieved lesion was also low risk.

- If any > 10mm lesion(s) were removed and one was not retrieved or is non-diagnostic (i.e. cauterized tissue, insufficient tissue) assume it was a high-risk precancerous lesion, the surveillance interval would be 3 years.

- If a patient has five lesions removed and four are precancerous lesions and the fifth was not retrieved during colonoscopy – treat the patient as high-risk, the surveillance interval would be 3 years.

5.2 Deviation from Guidelines

There may be individual variation in colonoscopy surveillance recommendations following pre-cancerous lesion excision based on various factors including the quality of the bowel preparation and concern regarding the completeness of polypectomy or a participant's risk. In these situations, the surveillance interval is left to the colonoscopist's judgment. There is no circumstance in which FIT should be performed at an earlier or later interval than recommended by the guidelines in Section 5.1.

The only reasons for a participant to leave the Colon Screening Program are age >74 years, a diagnosis of colorectal cancer, or a diagnosis of ulcerative or Crohn's disease. Individuals with a genetic mutation predisposing to colorectal cancer (e.g. Lynch Syndrome) 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 and surveyed in the program, and if their screening needs to be individualized, then this can be done by citing and explaining the deviation on the Follow-up Form. Participants can be seen for office visits at the colonoscopist's discretion while still participating in the Colon Screening Program.

5.3 Other significant findings

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 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 colorectal cancer re-screening or surveillance as outlined in section 5.1.

5.4 Hereditary Colorectal Cancer

Referral to the Hereditary Cancer Program may be indicated for Colon Screening Program participants with high-risk colonoscopy findings or a high-risk family history. The colonoscopist, primary care provider or the patient can make the referral. Further information regarding the Hereditary Cancer Program indications for referral are available on the BC Cancer website: http://www.bccancer.bc.ca/our-services/services/hereditary-cancer.

6. Colonoscopy Continuous Quality Improvement

The goal of the Colon Screening Program is to provide safe colorectal cancer screening and prevention in a cost-effective manner for the population of British Columbia. To ensure safe and efficient provision of colonoscopy screening, regular monitoring of colonoscopy outcome data against established standards is essential. Identification of results below benchmarks offer the opportunity for immediate improvement.

Colonoscopy procedure data will be captured at the time of the procedure on the Colonoscopy Reporting Form.

Performance indicators evaluated include the following:

- Adjusted cecal intubation rates
    - Benchmark ≥ 95%
- Unadjusted cecal intubation rates
    - Benchmark ≥ 90%
- Adenoma detection rates
    - Benchmark: The upper 95% confidence interval for an individual colonoscopist's ADR should be greater than the mean ADR of all BC colonoscopists
- Complete adenoma resection rates for lesions ≥ 20 mm in size
    - ≥ 98%
- Adenoma retrieval rates
    - Benchmark: ≥ 90%
- Rates of removal modes
- Unplanned events
    - All colonoscopies for Colon Screening Program participants with unplanned events will be reviewed and serious adverse event aggregate rates monitored.
    - Serious adverse events less than 5/1000 for Colon Screening Program participants and perforation rate of less than 1/1000 for all colonoscopies.
    - Unplanned events the day prior to colonoscopy and within 14 days post-procedure will be captured by the health authority staff during the phone interview.
- Follow-up recommendations based upon the pathology report will be monitored to assure surveillance intervals are in keeping with the published guidelines.
- Participant and physician satisfaction surveys will be administered at regular intervals.

- Wait times for colonoscopy
    - Abnormal FIT result (date of FIT result to colonoscopy)
        - Benchmark: 56 days
    - Initial family history screen (date of referral to colonoscopy)
        - Benchmark: 6 months
    - Surveillance (date of previous procedure and recommended interval to colonoscopy)
        - Recommended surveillance interval < 1 year benchmark: 56 days
        - Recommended surveillance interval ≥ 1 year benchmark: 6 months

7. Medical Records

7.1 Medical Record Retention Policy

The hospital site is the primary record holder for documentation pertaining to colonoscopy. Each hospital site follows their 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. Patients and providers requesting copies of their screening record will be directed to obtain copies from the facility where the interaction occurred.

8. References

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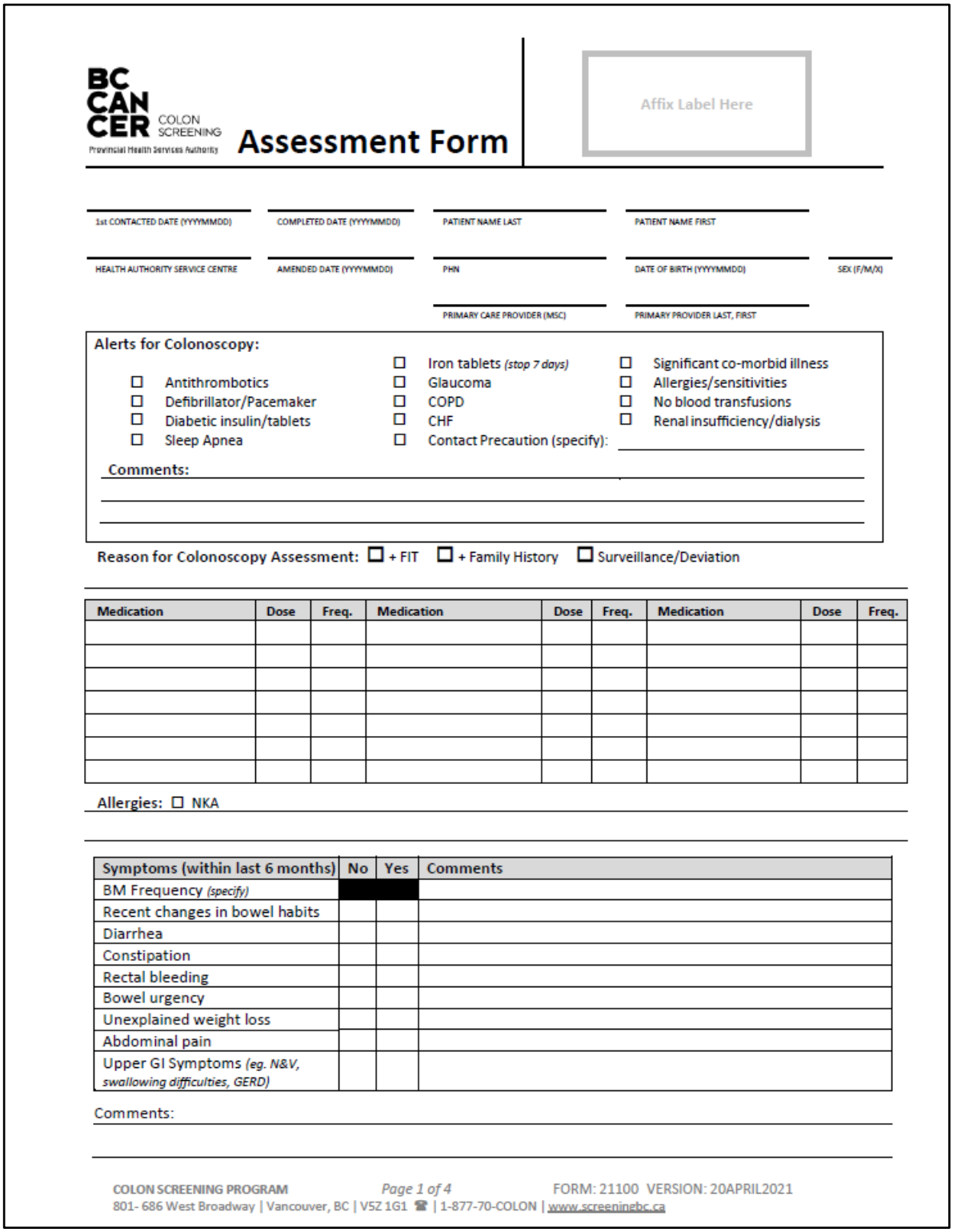
Appendix A – Assessment Form



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
801- 686 West Broadway | Vancouver, BC | V5Z 1G1 ☎ | 1-877-70-COLON | www.screeningbc.ca

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

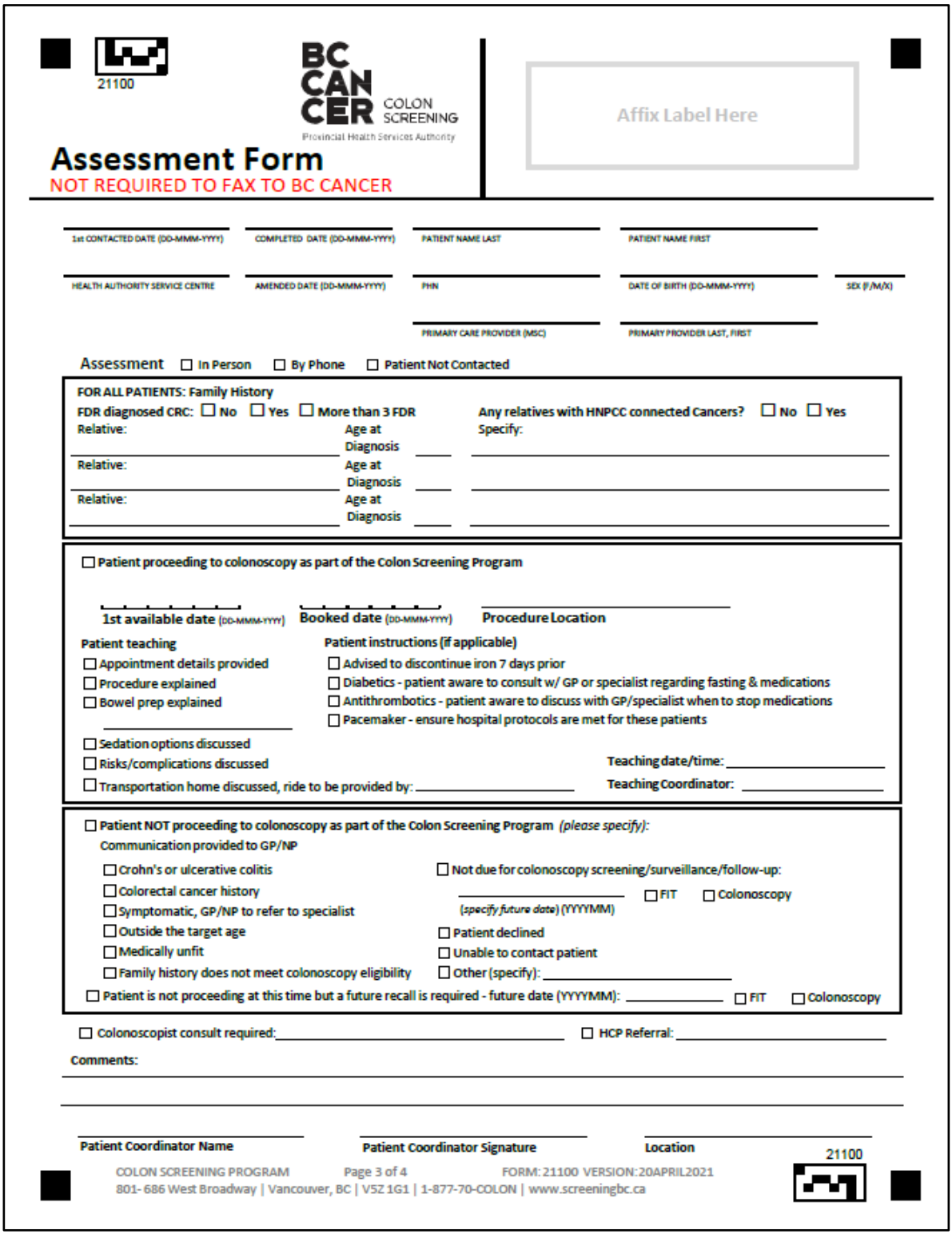
☐ Blind/partially blind ☐ Deaf/HOH ☐ Other *(specify)*: _____

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:** _____



21100

BC CANCER COLON SCREENING
Provincial Health Services Authority

Assessment Form

NOT REQUIRED TO FAX TO BC CANCER

Affix Label Here

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: _____ (*specify future date*) (YYYYMM) ☐ FIT ☐ Colonoscopy
- ☐ 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

BC CANCER COLON SCREENING
Provincial Health Services Authority

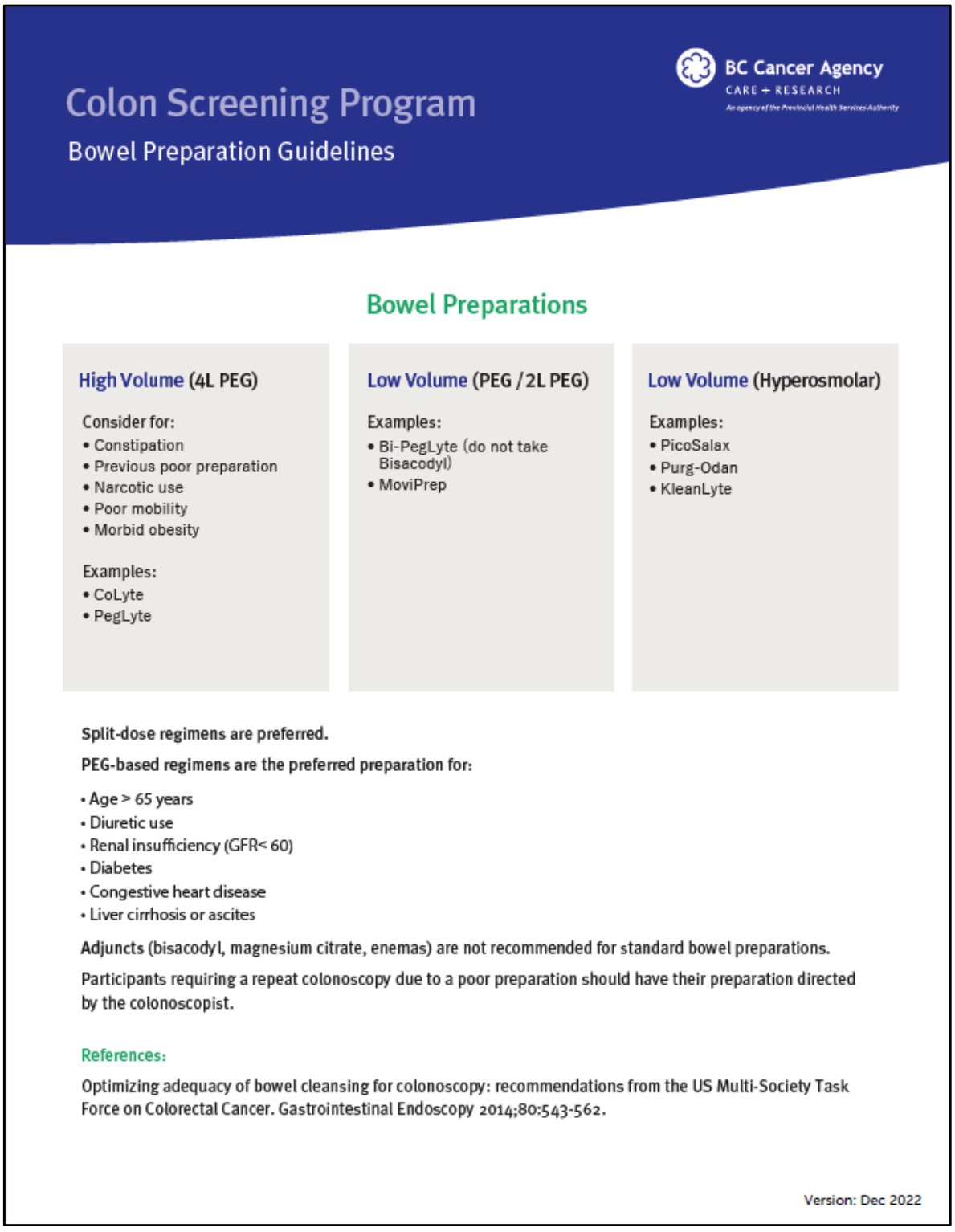
Assessment Form

Affix Label Here

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

Date	Notes

Appendix B – Bowel Preparation Algorithm



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

Colon Screening Program

Bowel Preparation Guidelines

Bowel Preparations

High Volume (4L PEG)

Consider for:
- Constipation
- Previous poor preparation
- Narcotic use
- Poor mobility
- Morbid obesity

Examples:
- CoLyte
- PegLyte

Low Volume (PEG / 2L PEG)

Examples:
- Bi-PegLyte (do not take Bisacodyl)
- MoviPrep

Low Volume (Hyperosmolar)

Examples:
- PicoSalax
- Purg-Odan
- KleanLyte

Split-dose regimens are preferred.

PEG-based regimens are the preferred preparation for:

- Age > 65 years
- Diuretic use
- Renal insufficiency (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: Dec 2022

Appendix C – Follow Up Recommendation 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 lesions

☐ 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 pre-cancerous lesion removal

PATIENT COORDINATOR | PATIENT COORDINATOR SIGNATURE

20420

INFORMATION ON THIS FORM IS CONFIDENTIAL
IF YOU RECEIVE THIS IN ERROR PLEASE FAX TO
QUALITY DEPT: 1 (604) 675-7223

Appendix D – Sample Follow Up Recommendation Letter

BC CANCER COLON SCREENING
Provincial Health Services Authority

17 Oct 2023

Fraser East Colonoscopy Centre
BCCDC TB CLINIC 655 W 12TH AVE
VANCOUVER, BC V5Z 4R4

RE: TestPat-FN-Test TestPat-LN-Test, 05 May 1955, 9852360160

Colon Screening Program Follow-Up Recommendations

PROCEDURE INFORMATION
This patient was booked for a colonoscopy through the Colon Screening Program on 09 Sep 2022.

NEXT STEPS

This patient will be recalled by the Colon Screening Program for a surveillance colonoscopy in 3 years. Further FIT screening is not required for this patient as this recommendation replaces biennial FIT screening.

Patients will not be recalled for re-screening or surveillance when due if they are not registered with a BC address at that time.

COLONOSCOPY UNPLANNED EVENTS
No unplanned events were reported requiring medical attention the day before or in the two week period immediately after the booked colonoscopy date.

Reference Information
The colonoscopist and health authority staff are being sent this letter to validate that the correct follow-up information has been captured for this patient. Please document any requested corrections below, sign and date, then fax to 604-297-9340. An amended letter will then be generated. This information was sent to: BOBBIE PLISDVCD; BOBBIE PLISDVCD; Fraser East Colonoscopy Centre.

Appendix E – 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 (DD-MMM-YYYY) | START TIME (HRS) | PATIENT NAME LAST | PATIENT NAME FIRST | SEX (F/M/X/U)

FACILITY NAME | AMENDED DATE (DD-MMM-YYYY) | PHN | DATE OF BIRTH (DD-MMM-YYYY)

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

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	6-9	10-19	≥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

INFORMATION ON THIS FORM IS CONFIDENTIAL. IF YOU RECEIVE THIS IN ERROR PLEASE FAX TO QUALITY DEPT: 1 (604) 675 7223

20230

Appendix F – DOPS Policy Assessment Form and Grade Descriptors

Policy Title: Reporting of Direct Observation of Procedural Skills (DOPS) to Colon Screening Program Quality Management Committee	
Section: Quality Management	Reference No.
Effective: 14 Dec 2016	Revision:

1. SCOPE

DOPS Assessors

Colonoscopists participating in the Colon Screening Program

Health Authority appointed Colonoscopy Leads

Colon Screening Program Staff

Medical Director, Colon Screening Program

2. POLICY

Direct Observation of Procedural Skills (DOPS) is a peer assessment of colonoscopists' performing colonoscopy for the Colon Screening Program. Responsibility for colonoscopists' performance review, privileging and credentialing remains with the Regional Health Authorities

DOPS reviews are conducted under Section 51 of the BC Evidence Act, for the purpose of quality improvement within the Colon Screening Program.

The Colon Screening Program will be transparent about its purpose, collection and handling of information.

For each DOPS review, two trained DOPS Assessors will simultaneously and independently observe a colonoscopist perform two consecutive colonoscopies. For each observation, each DOPs Assessor will complete a validated DOPS assessment. This will result in four written assessments for each DOPS review performed. The assessment form will be faxed to the Colon Screening Program and then given by the DOPS Assessor to the colonoscopist. The assessment form will not be retained by the DOPS Assessor.

DOPS Assessors will provide feedback to colonoscopists undergoing DOPS. The Colon Screening Program and DOPS Assessors will provide information on continuing education opportunities as part of quality improvement to colonoscopists participating in DOPS.

The Colon Screening Program Quality Management Committee will receive and review

aggregate data.

DOPS Assessors will report concerns identified in DOPS Assessments to the Health Authority appointed Colonoscopist Lead (CL) in that colonoscopist's health authority (HA). The CL will review the concern at the Colon Screening Program Quality Management Committee (QMC).

The recommendations from the QMC will be communicated to the colonoscopist as part of quality improvement. As appropriate, concerns will be reported to the HA senior medical administration.

The College of Physicians and Surgeons of BC should be alerted if a colonoscopist is physically or mentally impaired and unable to perform colonoscopy at the time the DOPS is performed.

The Colon Screening Program will not share results of the DOPS Assessment when reporting concerns to the HA or the College of Physicians and Surgeons of BC. This information will be kept confidential at the BC Cancer Colon Screening Program. It is the colonoscopist's decision to share their DOPS Assessment with their HA.

3. RELATED POLICIES

N/A

4. RESPONSIBLE PARTY

Medical Director, Colon Screening Program

Screening Operations Director, Colon Screening Program

Approved by Colon Quality Management Committee on December 14, 2016.

DOPS Formative Assessment Form (version Sept 2023)

Formative DOPS Assessment Form for Colonoscopy

Colonoscopy

Adapted from Joint Advisory Group on GI Endoscopy

BC CANCER COLON SCREENING
Provincial Health Services Authority

Colonoscopist

Trainer / Peer

Date (DD/MM/YYYY) **Case Number**

Scale and Criteria Key

- 4 Highly skilled performance
- 3 Competent and safe throughout procedure, no uncorrected errors
- 2 Some standards not yet met, aspects to be improved, some errors uncorrected
- 1 Accepted standards not yet met, frequent errors uncorrected
- n/a Not applicable
- ▪ Major Criteria
- o Minor Criteria

CRITERIA	SCALE	COMMENTS
PRE-PROCEDURE ▪ Appropriate indication, patient risk assessment ▪ Informed consent using a standardized approach o Explanation of procedure o Explanation of risks o Opportunity for questions o Respect for patient perceptions ▪ Appropriate dose of sedation, adequate patient monitoring ▪ Communication with nursing staff (dosage, vital signs) o Checks endoscope function o Performs DRE		
PROCEDURE o Appropriate use of torque and tip steering o Appropriate use of distention, suction, lens clearing ▪ Loops: prevention, recognition, resolution ▪ Inserts in a luminal direction, avoids red-out ▪ Recognizes cecal landmarks or incomplete examination, photo-documentation ▪ Withdraws slowly with thorough mucosal visualization ▪ Appropriate use of maneuvers known to increase ADR ▪ Aware of patient discomfort, takes appropriate action o Appropriate pace and progress, completes in a reasonable time		
FINDINGS ▪ Accurate Identification and assessment of abnormal findings ▪ Appropriate management aligned with current guidelines ▪ Minimizes complication risk ▪ Recognizes and manages complications appropriately		
POST-PROCEDURE ▪ Appropriate management plan ▪ Communicates procedure outcome, management plan and follow-up with patient and referring provider		
ENDOSCOPIC NON-TECHNICAL SKILLS ▪ Communication and Teamwork ▪ Situation awareness ▪ Leadership ▪ Judgement and decision making		

Case Difficulty

Extremely easy	Fairly easy	Average	Fairly difficult	Very challenging
1	2	3	4	5

Learning Objectives for Next Cases

Version September 2023

DOPS Grade Descriptors: Colonoscopy and Flexible Sigmoidoscopy (version Oct 2023)

When grading DOPS, in order to achieve the ***highest level (4)***, the candidate must meet all of the criteria under that level. Only grade in single, whole numbers. Do not give a range or a 0.5.

1. PRE-PROCEDURE

Indication and Risk Assessment

Grade 4 and 3

- Appropriate indication
- Complete assessment of patient co-morbidity including medication history
- Complete assessment of any patient-specific procedure related risks
- Takes appropriate action to minimize risk

Grade 2

- Appropriate indication
- Incomplete assessment of patient co-morbidity including medication history
- Incomplete assessment of any patient-specific procedure related risks
- No action to minimize risk

Grade 1

- Inappropriate indication
- No assessment of patient co-morbidity including medication history
- No assessment of any patient-specific procedure related risks
- No action to minimize risk

Adapted from Joint Advisory Group on GI Endoscopy from thejag.org.uk

Informed Consent

Grade 4

- Complete and clear explanation of colonoscopy and polypectomy
- Quantification of risk and consequences (e.g. 1/250 risk of a serious adverse event)
- Includes risk of missing a lesion
- No omissions
- Does not raise unnecessary concerns
- No medical jargon
- Encourages questions by verbal and non-verbal skills.
- Respectful of individual's views, concerns, and perceptions
- Good rapport with patient

Grade 3

- Clear explanation with few omissions
- Some quantification of risk
- Little medical jargon
- Opportunity for question
- Responds to individual's views, concerns and perceptions

Grade 2

- Explains procedure but with several omissions
- No quantification of risk
- Raises unnecessary concerns
- Some medical jargon
- Limited opportunity for questions or sub-optimal responses to questions
- Incomplete acknowledgement of individual's views, concerns or perceptions

Grade 1

- Incomplete explanation with several significant omissions and inadequate discussion
- No quantification of risks
- Raises significant fears
- A lot of medical jargon
- Does not ask for questions
- Fails to acknowledge or respect individual's views, concerns or perceptions

Sedation and Monitoring

Grade 4

- Appropriate doses of analgesia and sedation according to patient's age and physiological state
- Medication dosing clearly checked and confirmed with nursing staff
- Patient very comfortable throughout
- Oxygenation and vital signs monitored continuously
- Rapid and appropriate action taken for any deterioration in vital signs

Grade 3

- Appropriate doses of analgesia and sedation according to patient's age and physiological state
- Medication dosing checked and confirmed with nursing staff
- Patient reasonably comfortable throughout
- Oxygenation and vital signs monitored regularly
- Oxygenation and vital signs remain satisfactory throughout or appropriate action taken
- Clear communication with endoscopy staff

Grade 2

- Inappropriate doses of analgesia and sedation resulting in over-sedation
- Medication dosing incompletely checked or confirmed with nursing staff
- Patient uncomfortable throughout
- Oxygenation and vital signs monitored less frequently
- Oxygenation and vital signs unsatisfactory and action delayed
- Sub-optimal communication with endoscopy staff

Grade 1

- Inappropriate doses of analgesia and sedation resulting in over-sedation
    - Use of reversal agents
- Medication dosing inadequately or inaccurately checked or confirmed with nursing

staff
- Patient in discomfort throughout or significant periods with severe discomfort
- Oxygenation and vital signs not monitored or rarely monitored
- Oxygenation and vital signs unsatisfactory and action not taken
- No, minimal or inaccurate communication with endoscopy staff

Equipment Check
Grade 4 and 3
- Checks colonoscope function

Grade 2 and 1
- Omits to check colonoscope function

DRE
Grade 4 and 3
- Performs DRE

Grade 2 and 1
- Omits DRE

Adapted from Joint Advisory Group on GI Endoscopy from thejag.org.uk

2. PROCEDURE

Torque and tip steering
Grade 4
- Smooth scope handling with coordinated use of angulation control dials and torque steering
- Skilled torque steering with right hand/fingertips remaining on colonoscope shaft
- Skilled manipulation of dials with left hand

Grade 3
- Adequate torque steering
- Adequate manipulation of dials with left hand and occasional use of right hand
- Adequate coordinated torque and tip steering

Grade 2
- Inadequate torque steering
- Frequent use of right hand on dials

Grade 1
- Little or no torque steering

Distention, suction, and lens cleaning
Grade 4 and 3
- Appropriate use of water infusion or gas insufflation and suction to minimize over-distention of colon while maintaining adequate views
- Appropriate use of lens cleaning to maintain adequate views

Grade 2

- Some over/under distension and/or lack of lens cleaning

Grade 1

- Frequent over/under distension and/or lack of lens cleaning

Loops: prevention, recognition, and resolution

Grade 4

- Prevention of loop formation with proactive position change, water infusion, torque steering
- Rapid recognition and logical resolution of loops

Grade 3

- Quick recognition of loops and logical attempt of resolution

Grade 2

- Recognizes most loops with reasonable attempts at resolution

Grade 1

- Recognizes loops late or not at all and no attempt at resolution

Insertion in a luminal direction

Grade 4

- Correctly identifies luminal direction using all visual cues
- Minimizes unnecessary mucosal contact
- No or minimal blind negotiation (slide-by or red-out)

Grade 3

- Correctly identifies luminal direction using all visual cues
- Some unnecessary mucosal contact
- Some blind negotiation

Grade 2

- Loss of luminal views
- Use of blind negotiation too long or too frequently

Grade 1

- Frequent loss of luminal views
- Frequent use of blind negotiation

Cecal intubation

Grade 4

- Recognition of all cecal landmarks or rapid acknowledgement of incomplete exam
    - Appendiceal orifice, ileocecal valve, tri-radiate fold
- Photo-documentation of cecum

Grade 3

- Correctly identifies cecal landmarks or incomplete exam

Grade 2

- Slow to recognize cecal landmarks or incomplete exam

Grade 1

- Incorrect identification of cecal landmarks or fails to recognize incomplete exam

Withdrawal technique

Grade 4

- Ensures complete and optimal views throughout withdrawal
- Appropriately uses maneuvers associated with good withdrawal technique
    - Slow withdrawal
    - Position change
    - Washing the mucosa
    - Suctioning all pools of fluid
    - Looking behind folds
    - Re-examination of segments
    - Adjuncts such as artificial intelligence and cuff-devices
- Visualizes the proximal side of the ileocecal valve
    - Generally, best seen in right lateral position
- Rectal retroflexion

Grade 3

- Adequate mucosal visualization
- Appropriately uses maneuvers associated with good withdrawal technique
- Visualizes the proximal side of the ileocecal valve
- Rectal retroflexion, or attempted

Grade 2

- Inadequate mucosal visualization with intermittent loss of mucosal visualization
- Attempts some maneuvers associated with good withdrawal technique
- Fails to attempt rectal retroflexion

Grade 1

- Frequent and/or prolonged loss of mucosal visualization
- Does not attempt maneuvers associated with good withdrawal technique
- Fails to attempt rectal retroflexion

Patient comfort

Grade 4

- Patient reasonably comfortable throughout
- Conscious awareness of patient comfort throughout
- Reacts quickly to patient discomfort with appropriate colonoscopy techniques, escalation of sedation
    - Loop reduction, water infusion, position change, suctioning gas

Grade 3

- Patient reasonably comfortable throughout

- Conscious awareness of patient comfort throughout
- Reacts to patient discomfort with some appropriate colonoscopy techniques, escalation of sedation

Grade 2

- Patient uncomfortable throughout or over-sedated
- Less aware of patient comfort
- Reacts slow to patient discomfort
- Lacks logical strategy to decrease discomfort through colonoscopy technique

Grade 1

- Patient in discomfort throughout or significant periods with severe discomfort or over-sedated
- Less aware of patient comfort
- Does not react appropriately to discomfort
- Lacks logical strategy to decrease discomfort through colonoscopy techniques

Pace and progress

Grade 4 and 3

- Timely completion of colonoscopy
- Appropriate pace during insertion to minimize loops and patient discomfort
- Appropriate withdrawal time to maximize mucosal views
- Able to complete colonoscopy at a pace consistent with standard endoscopy slates

Grade 2

- Completes colonoscopy slightly too fast or too slow

Grade 1

- Completes colonoscopy much too quickly or slowly

Adapted from Joint Advisory Group on GI Endoscopy from thejag.org.uk

3. FINDINGS

Identification and Assessment of Pathology

Grade 4

- Accurate determination of normal and abnormal findings
- Obtains a clear view and determines the full extent of the lesion
- Recognizes lesion features associated with submucosal invasion
- Appropriate use of mucosal enhancement techniques
- Appropriate use of photo- or video-documentation

Grade 3

- Accurate determination of normal and abnormal findings
- Suboptimal evaluation of extent of lesion
- Recognizes features associated with submucosal invasion
- Suboptimal use of mucosal enhancement techniques

- Suboptimal use of photo- or video-documentation

Grade 2

- Most pathology identified with occasional missed or misidentified lesions
- Does not obtain a clear view to determine the full extent of the lesion
- Does not use mucosal enhancement techniques
- Does not photo-document pathology

Grade 1

- Misses significant pathology
- Fails to recognize malignant features in a lesion

Management of pathology

Grade 4

- Performs appropriate interventions (including taking no action)
    - Tattoo applied appropriately
    - Contrast agent (not tattoo) in submucosal injection
- Skilled lesion resection in accordance with current guidelines
    - All lesions less than 10 mm are removed with a cold snare
    - Non-pedunculated lesions 10 – 19 mm are removed with cold or hot snare
        - Consider SMI to prevent deep thermal injury with hot snare unless underwater polypectomy is performed
    - Pedunculated lesions $\geq$ 10 mm are removed with a hot snare
    - Non-pedunculated lesions $\geq$ 20 mm are removed with EMR or ESD
- Inspects polypectomy site, correctly identifies and removes residual neoplastic tissue

Grade 3

- Performs some appropriate interventions (including taking on action)
    - Tattoo applied appropriately
- Lesion resection in accordance with current guidelines
    - All lesions less than 10 mm are removed with a cold snare

Grade 2

- Appropriate interventions are not performed
    - Tattoo not applied when indicated
- Lesions are not resected according to current guidelines
    - Resection of lesions less than 10 mm using hot snare or piecemeal with biopsy forceps
    - Lesion incompletely resected and recognized by candidate

Grade 1

- Appropriate interventions are not performed
    - Tattoo applied into lesion rather than adjacent to lesion
- Lesions are not resected according to current guidelines
    - Lesion incompletely resected and not recognized by candidate
    - Ablation (snare tip or APC) of visible neoplastic tissue as opposed to resection
    - Hot biopsy forceps are used for resection

Complications

Grade 4

- Appropriate attempts to minimize complication risk according to current guidelines
    - Use of cold snare for lesions < 10 mm
    - Prophylactic mechanical ligation of stalk for pedunculated polyps with a head ≥ 20 mm or stalk ≥ 5 mm
    - When feasible, prophylactic closure of polypectomy defect for lesions ≥ 20 mm in the right colon
- Rapid recognition and appropriate management of complications: post-polypectomy deep injury/perforation or bleeding

Grade 3

- Some attempts to minimize complication risk according to current guidelines
- Recognition and appropriate management of complications

Grade 2

- Inadequate attempts to minimize complication risk according to guidelines
- Recognition but inadequate management of complications

Grade 1

- No attempt to minimize complication risk
- Unsafe use of cautery
    - Treatment of incidental angioectatic lesions is not recommended
- Lack of recognition and/or no attempt to manage complications

Adapted from Joint Advisory Group on GI Endoscopy from thejag.org.uk

4. POST-PROCEDURE

Management Plan

Grade 4 and 3

- Records a full and accurate description of procedure and findings
    - Colonoscopy quality indicators are recorded as per Colonoscopy Standards
    - Appropriate management plan communicated to patient and provider
    - Screening/surveillance follow-up as per 2022 BC guidelines
    - When to resume anti-thrombotic medications

Grade 2

- Records an accurate description of colonoscopy and findings with some quality indictors missing
- Inadequate management plan communicated to patient and/or provider

Grade 1

- Incomplete record of colonoscopy with many quality indicators missing
- No management plan communicated to patient and/or provider
- Screening/surveillance follow-up not aligned with 2022 BC guidelines

Adapted from Joint Advisory Group on GI Endoscopy from thejag.org.uk

5. ENDOSCOPIC NON-TECHNICAL SKILLS

Grade 4

- Performance was of a very high standard, enhancing patient safety. It could be used as a positive example for others.

Grade 3

- Performance was satisfactory but could be improved.

Grade 2

- Performance indicated some cause for concern. Considerable improvement is needed.

Grade 1

- Performance endangered or potentially endangered patient safety. Serious remediation is required.

Communication and teamwork

- Maintains clear communication with staff
- Gives and receives knowledge and information in a clear and timely fashion
- Ensures the team is working together using the same core information and understand the 'big picture' of the case
- Ensures that the patient is at the center of the colonoscopy, emphasizing safety and comfort
- Clear communication of results and management plan with patient and primary care practitioner

Situation awareness

- Ensures colonoscopy is carried out with full respect for privacy and dignity
- Maintains continuous evaluation of the patient's condition
- Ensures lack of distractions and maintains concentration
- Intra-procedural changes to scope set-up monitored and rechecked

Leadership

- Provides support to team members by tailoring leadership and teaching style appropriately
- Supports safety and quality by adhering to current protocols and codes of clinical practice
- Adopts a calm and controlled demeanor when under pressure, utilizing all resources to maintain control of the situation and taking responsibility for patient outcome

Judgement and decision making

- Considers options and possible courses of action to solve an issue or problem, including assessment of risk and benefit
- Communicates decisions and actions to team members prior to implementation
- Reviews outcomes of colonoscopy and options for dealing with problems, if applicable
- Reflects on issues and institutes changes to improve practice

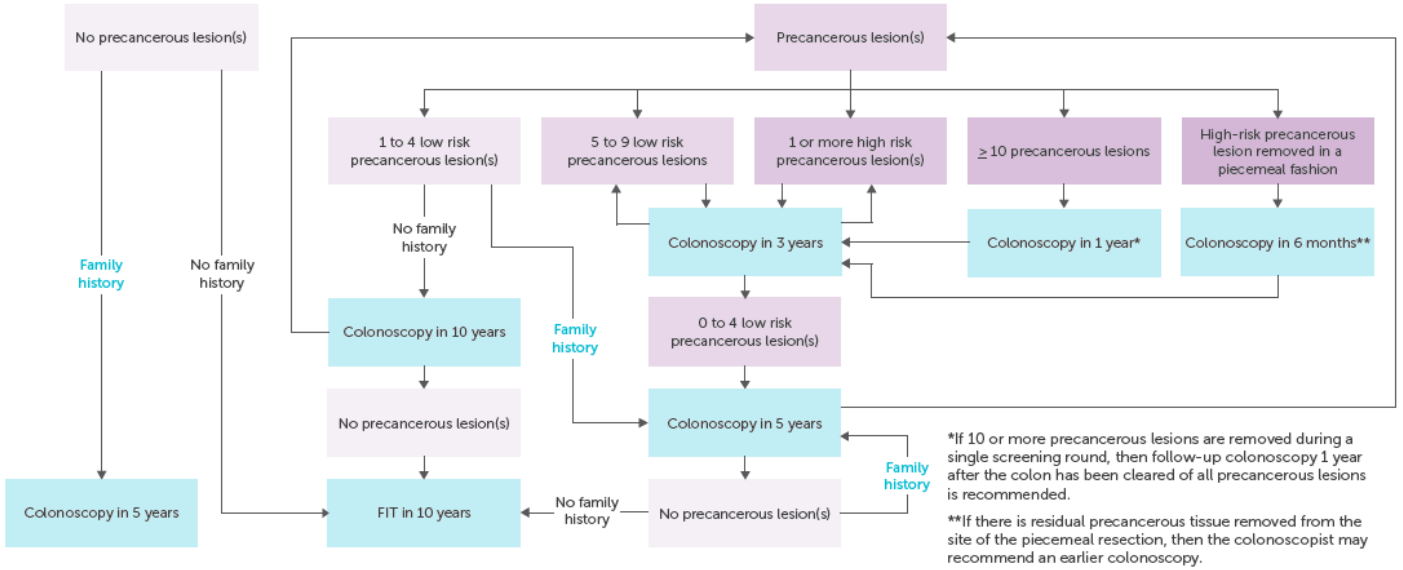
Adapted from Joint Advisory Group on GI Endoscopy from thejag.org.uk

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 – Colonoscopy Dictation Guidelines

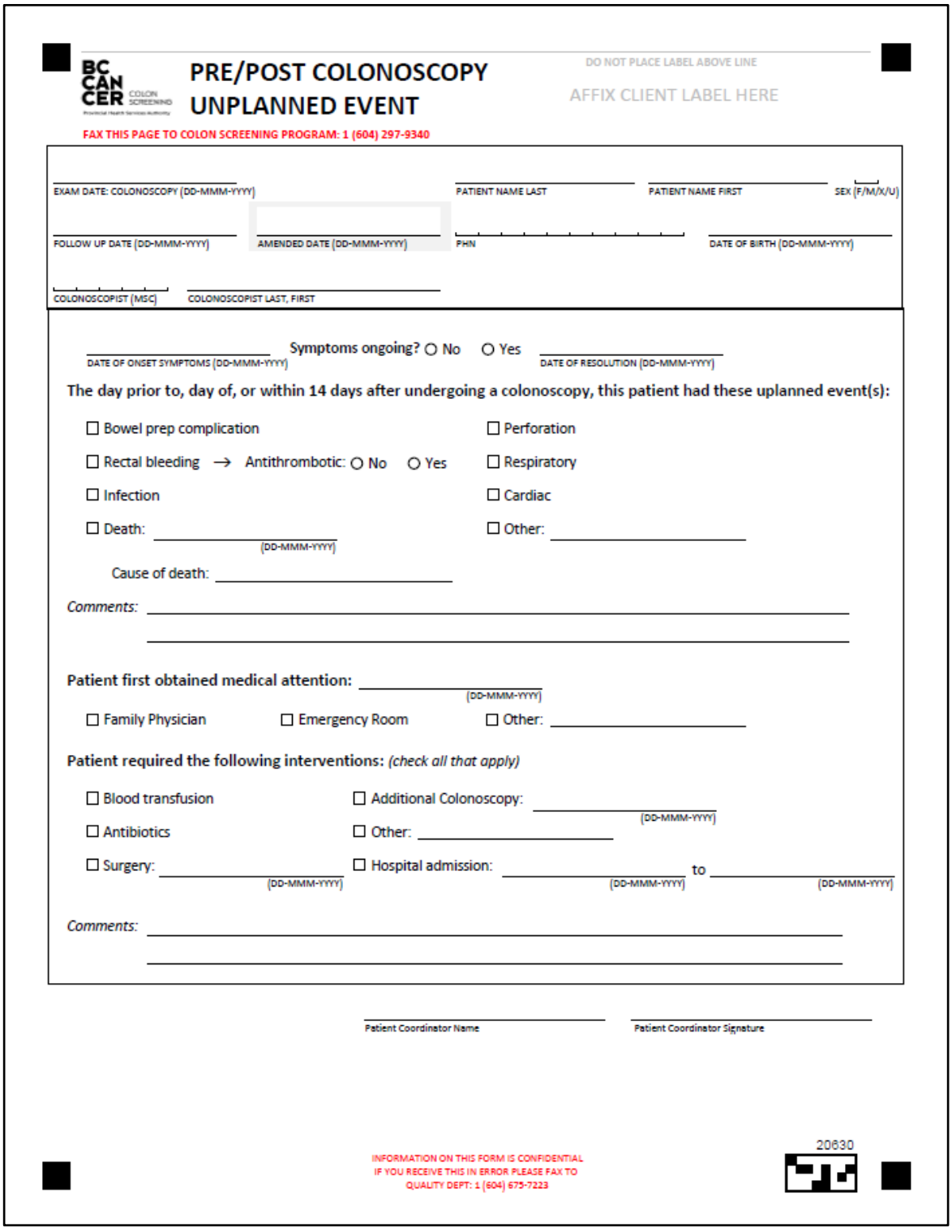
Standardized reporting systems facilitate quality improvement. Clear documentation facilitates communication amongst health care providers and participants.

Quality indicators for colonoscopy reporting have been identified by expert consensus[3].

A comprehensive colonoscopy report includes:

- Participant demographics
- Pre-assessment including co-morbid illnesses
    - e.g. ASA classification, anti-thrombotic agents, defibrillator
- Indication for colonoscopy
    - e.g. positive FIT, screening, surveillance, family history
- Medication type and dose used for conscious sedation
- Type and timing (day prior, same day, split dose) of bowel preparation
- 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
- Participant comfort
- 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

Appendix I – 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 (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)

COLONOSCOPIST (MSC) | COLONOSCOPIST LAST, FIRST

DATE OF ONSET SYMPTOMS (DD-MMM-YYYY) Symptoms ongoing? ○ No ○ Yes DATE OF RESOLUTION (DD-MMM-YYYY)

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

- ☐ Bowel prep complication
- ☐ Rectal bleeding → Antithrombotic: ○ No ○ Yes
- ☐ Infection
- ☐ Death: _____ (DD-MMM-YYYY)
  - Cause of death: _____
- ☐ Perforation
- ☐ Respiratory
- ☐ Cardiac
- ☐ Other: _____

Comments: _____

Patient first obtained medical attention: _____ (DD-MMM-YYYY)

☐ Family Physician ☐ Emergency Room ☐ Other: _____

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

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

Comments: _____

Patient Coordinator Name | Patient Coordinator Signature

INFORMATION ON THIS FORM IS CONFIDENTIAL
IF YOU RECEIVE THIS IN ERROR PLEASE FAX TO
QUALITY DEPT: 1 (604) 675-7223

20630

Log Revision History

Colonoscopy Standards Change Log Revision History				
Version	**Date**	**Action**	**Pages affected**	**Details**
1.0	05 November 2013	Created	All	New release
1.1	16 October 2015	Updated	9, 19, 20, & 21	2.5 Need for Prophylactic Antibiotics, Benchmarks, and References.
1.2	22 March 2016	Updated	1, 3, 4, 6, 7, 8, 9, 10, 11, 12, 13, 16, 17, 18, 19, 20, 26, 27, 33,	Dr. Telford updated standards. Appendix A – Non Program colonoscopy data collection tool removed. Appendix C – new sample form. Appendix D – latest version of CRF.
1.3	7 September 2017	Updated	All	Dr. Telford updated standards. Patient coordinator language changed to health authority staff. Section 2.2, Section 2.6, 2.11, 4.1, 4.5, 4.6, 4.7 (new), 5, 5.1, 6 Appendices updated as appropriate. Updated TOC and added appendix. I, updated appendix E Formatted and updated references
1.4	30 January 2018	Addition	22	Added Medical Records section. New Branding. Updated Assessment form.
1.5	20 April 2020	Updated		Sections: 2.2, 2.4, 4.4, 4.7, 5.1, 6 and 8.
	March 2021	Updated	3.1 and 5.1	Physician standards section wording added for clarification. SSA/P terminology updated to SSL. Large, right sided . Appendix A, G template.
	October 2021	Updated	3.1, 5.1.3 and Appendix A, B, D & G	Updated colonoscopist requirements. Updated > 10 polyps description. Updated appendices.

	August 2022	Updated	All	Changed to pre-cancerous lesions. Updated information based on new GPAC guidelines.
	September 2022	Updated	Appendix C Appendix G	Updated appendix versions.
	January 2024	Updated	Section 2.4 Section 2.7 Section 4.6 Section 5.1.4.1 Section 5.1.8 Section 5.1.9 Appendix B Appendix E Appendix F Appendix I	Updated from aspirin to ASA. Sedation is optional. Cold snare polypectomy is only recommendation. Updated criteria from “more than 10” to “10 or more”. Example recommendations added for participants scoped and not yet due. Example recommendations added when lesions are not retrieved or non-diagnostic. Updated appendix version. Updated appendix version. Updated DOPS Assessment Form and DOPS Descriptors Updated appendix version.
	March 2024	Updated	Section 5.1.2	Updated to add parent, full sibling, and child as first degree relative.
	April 2024	Updated	Section 2.4 Appendix D	Updated Antithrombotic Therapy. Added new Follow Up template.