NATIONAL INSTITUTE FOR HEALTH AND CLINICAL EXCELLENCE

SCOPE

1 Guideline title

Colorectal cancer: colonoscopic surveillance for prevention of colorectal cancer in patients with ulcerative colitis, Crohn's disease and polyps

1.1 Short title

Colonoscopic surveillance for colorectal cancer in high-risk groups: inflammatory bowel disease and polyps.

2 The remit

The Department of Health has asked NICE: 'To produce a short clinical guideline on colonoscopic surveillance for patients with ulcerative colitis, Crohn's disease and polyps to prevent colorectal cancer.'

3 Clinical need for the guideline

3.1 Epidemiology

a) Colorectal cancer is the third most common cancer in the UK, with approximately 32,300 new cases diagnosed and 14,000 deaths in England and Wales each year. Around half of people diagnosed with colorectal cancer survive for at least 5 years after diagnosis.

b) Adults with inflammatory bowel disease (IBD: ulcerative colitis or Crohn's disease) or with polyps have a higher risk of developing colorectal cancer than the general population. Colonoscopic surveillance can be used for people in these high-risk groups to detect any problems early and potentially prevent progression to colorectal cancer.

c) Polyps can be either precancerous (neoplastic adenomas) or non-precancerous (non-neoplastic, including hyperplastic polyps). Strong evidence suggests that detecting and removing adenomas reduces the risk of cancer. Small polyps are rarely malignant and are unlikely to progress to invasive cancers.

d) The prevalence of ulcerative colitis is approximately 100 to 200 per 100,000 and the annual incidence is 10 to 20 per 100,000 respectively. The risk of colorectal cancer for people with ulcerative colitis is estimated as 2% after 10 years, 8% after 20 years and 18% after 30 years of disease.

e) The prevalence of Crohn's disease is 50 to 100 per 100,000 and the annual incidence is 5 to 10 per 100,000. The risk of developing colorectal cancer for people with Crohn's disease is considered to be similar to that for people with ulcerative colitis for the same extent of colonic involvement.

3.2 Current practice

a) In 2002, the British Society of Gastroenterology (BSG) issued guidelines for surveillance after removal of adenomatous polyps. These recommend that the frequency of post-polypectomy surveillance should depend on the size and number of adenomas removed.

b) The 2002 BSG guidance recommended colonoscopic surveillance for IBD should start 8 to 10 years after onset of extensive colitis. They recommended surveillance every 3 years during the 2nd decade of disease, every 2 years for the 3rd decade and annually from the 4th decade onwards. For left-sided disease they recommended colonoscopy should be started after 15 to 20 years of disease and repeated every 5 years, with flexible sigmoidoscopy in the interim years. The guidance recommended annual surveillance in patients with primary sclerosing cholangitis (PSC) because of their higher risk for colorectal neoplasia.

c) Guidelines from the BSG in 2004 suggested that people with IBD should discuss with their clinical team whether colonoscopic surveillance is appropriate for them but should comply with the 2002 guidelines.

d) Updated BSG Guidelines for polyps and IBD are being developed at the moment but due to variations in current practice, there is a need for an evidence-based national clinical guideline on colonoscopic surveillance in these high-risk groups.

4 The guideline

The guideline development process is described in detail on the NICE website (see section 6, 'Further information').

This scope defines what the guideline will (and will not) examine, and what the guideline developers will consider. The scope is based on the referral from the Department of Health.

The areas that will be addressed by the guideline are described in the following sections.

4.1 Population

4.1.1 Groups that will be covered

a) Adults (18 years and older) with IBD (defined as ulcerative colitis or Crohn's disease involving the large bowel).

b) Adults with polyps (including adenomas) in the colon or rectum.

4.1.2 Groups that will not be covered

a) Children (younger than 18 years).

b) Adults with newly diagnosed or relapsed adenocarcinoma of the colon or rectum.

c) Adults with polyps that have previously been treated for colorectal cancer.

d) Adults with a genetic familial - history of colorectal cancer: hereditary non-polyposis colorectal cancer.

e) Adults with a familial history of polyposis syndromes: familial adenomatous polyposis.

4.2 Healthcare setting

a) Primary care.

b) Secondary care.

4.3 Clinical management

4.3.1 Key clinical issues that will be covered

a) Colonoscopic surveillance (using conventional colonoscopy or chromoscopy) for prevention and early detection of colorectal cancer compared with:

- no surveillance
- surveillance using other methods, such as flexible sigmoidoscopy, double-contrast barium enema, computed tomographic colonography,and tri-modal imaging (high resolution white light endoscopy, narrow-band imaging and auto-fluorescence imaging).

b) Initiation of surveillance and the frequency of ongoing surveillance (considering factors including duration and extent of condition, number, size and location of polyps).

c) Information and support needs of people undergoing or considering undergoing colonoscopic surveillance.

4.3.2 Clinical issues that will not be covered

a) Diagnosis and assessment of IBD or polyps.

b) Diagnosis and management of colorectal cancer.

4.4 Main outcomes

a) Progression to colorectal cancer

b) Stage at presentation.

c) Progression or regression of dysplasia at most recent follow-up of IBD.

d) Overall mortality or survival.

e) Reported adverse effects of colonoscopic surveillance techniques.

f) Health-related quality of life (related to colonoscopic surveillance).

g) Resource use and costs.

4.5 Economic aspects

Developers will take into account both clinical and cost-effectiveness when making recommendations involving a choice between alternative interventions. A review of the economic evidence will be conducted and analyses will be carried out as appropriate. The preferred unit of effectiveness is the quality-adjusted life year (QALY), and the costs considered will usually be only from an NHS and personal social services (PSS) perspective. Further detail on the methods can be found in 'The guidelines manual' (see ‘Further information’).

4.6 Status

4.6.1 Scope

This is the final scope.

4.6.2 Timing

The development of the guideline recommendations will begin in January 2010.

5 Related NICE guidance

5.1 Published guidance

5.1.1 NICE guidance to be updated

None.

5.1.2 NICE guidance to be incorporated

This guideline will incorporate the following NICE guidance:

- Computed tomographic colonography (virtual colonoscopy). NICE interventional procedure guidance 129 (2005). Available from www.nice.org.uk/IPG129

5.1.3 Other related NICE guidance

- Improving outcomes in colorectal cancer. Cancer service guidance (2004). Available from www.nice.org.uk/CSGCC
- Wireless capsule endoscopy for investigation of the small bowel. NICE interventional procedure guidance 101 (2004). Available from www.nice.org.uk/IPG101

5.2 Guidance under development

NICE is currently developing the following related guidance (details available from the NICE website):

- Diagnosis and management of colorectal cancer. NICE clinical guideline. Publication expected July 2011.
- The management of Crohn's disease. NICE clinical guideline. Publication date to be confirmed.

6 Further information

Information on the guideline development process is provided in:

- 'How NICE clinical guidelines are developed: an overview for stakeholders the public and the NHS'

- ‘The guidelines manual’.

These are available from the NICE website (www.nice.org.uk/guidelinesmanual). Information on the progress of the guideline will also be available from the NICE website (www.nice.org.uk).