Scoping Workshop – Colonoscopic Surveillance

Friday 9th October

After welcoming attendees to the meeting, speakers presented an overview of NICE, the short clinical guideline process, the role of the Patient and Public Involvement Programme (PPIP) in guideline development. The draft scope was then introduced.

Questions on the draft scope – Summary

1. Is the appropriate population covered by the draft scope?

- Issue surrounding type of polyp. Are we discussing polyps or adenomas? The general view at the workshop was that we are mainly concerned with adenomas.

- More specific wording when discussing patients with Crohns – use 'Crohns coliltis'.

- Presentation of polyps – can be identified through surgery of the appendix and duodenum could these be added. The conclusion was that appendicular polyps were minutiae; small bowel polyps may be of significance and should lead to an examination of the large bowel. If large bowel polyps were found, this guideline would apply.

- Group concerned around the exclusion of those with a family history of colorectal cancer, Hereditary Non-Polyposis Colorectal Cancer [HNPCC], Adults with a family history of polyps and Familial Adenomatous Polyposis [FAP]. However, these were explicitly excluded from the remit. Debate was mainly around whether those with a family history of polyps but not cancer were included but the thought was that these were excluded too. The NICE technical team will confirm this.

- There is current British Gastroenterology Society guidance (update in 2009) on these issues.

2. ***Are the healthcare settings proposed appropriate?***

- Some discussion around those patients who have had a colectomy due to ulcerative colitis being treated in specialist centres but the group agreed that the primary/secondary care settings were appropriate

3. ***Is it sufficient to consider conventional colonoscopy and chromoscopy as the appropriate interventions for colonoscopic surveillance in this guideline?***

- Issues surrounding those patients who cannot tolerate colonoscopic techniques. Those patients should receive CTC, narrow band imaging or adjunct technologies.

- Issues of over exposure to repeated CTs, no evidence base for this

4. **Are there any surveillance techniques that are commonly used for these high-risk groups that have not been covered as comparators?**

- Discussion as above

5. **Have all the important outcomes, appropriate for this guideline, been covered in the current draft Scope**

- Remit is to prevent colorectal cancer. But screening and surveillance are both about prevention and early detection. This is not in the remit, but is needed in the Scope.

- Some people may not be able to afford repeat attendance (time off work etc) so this may be a factor. However, this is an issue of acceptability but not a clinical effectiveness matter.

Suggested GDG Composition

The group agreed that the list was comprehensive

There were issues around the input that a nurse endoscopist could provide to the group.