

Colorectal cancer prevention: colonoscopic surveillance in adults with ulcerative colitis, Crohn's disease or adenomas

Clinical guideline

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www.nice.org.uk/guidance/cg118

Your responsibility

The recommendations in this guideline represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, professionals and practitioners are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or the people using their service. It is not mandatory to apply the recommendations, and the guideline does not override the responsibility to make decisions appropriate to the circumstances of the individual, in consultation with them and their families and carers or guardian.

All problems (adverse events) related to a medicine or medical device used for treatment or in a procedure should be reported to the Medicines and Healthcare products Regulatory Agency using the [Yellow Card Scheme](#).

Local commissioners and providers of healthcare have a responsibility to enable the guideline to be applied when individual professionals and people using services wish to use it. They should do so in the context of local and national priorities for funding and developing services, and in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities. Nothing in this guideline should be interpreted in a way that would be inconsistent with complying with those duties.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should [assess and reduce the environmental impact of implementing NICE recommendations](#) wherever possible.

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Overview

This guideline covers using colonoscopy to check for signs of bowel cancer in people aged 18 and over with ulcerative colitis or Crohn's disease (types of inflammatory bowel disease) or adenomas (also known as polyps). It aims to prevent cancer and prolong life by offering advice on identifying early bowel cancer in adults most at risk.

Who is it for?

- Healthcare professionals
- Adults with ulcerative colitis, Crohn's disease or adenomas, and their families and carers

Recommendations

People have the right to be involved in discussions and make informed decisions about their care, as described in [NICE's information on making decisions about your care](#).

[Making decisions using NICE guidelines](#) explains how we use words to show the strength (or certainty) of our recommendations, and has information about prescribing medicines (including off-label use), professional guidelines, standards and laws (including on consent and mental capacity), and safeguarding.

Healthcare professionals should also follow our guidance on:

- [Patient experience in adult NHS services](#)
- [Shared decision making](#)

The following guidance is based on the best available evidence. The [full guideline](#) gives details of the methods and the evidence used to develop the guidance.

People with inflammatory bowel disease

- 1.1.1 Offer colonoscopic surveillance to people with inflammatory bowel disease (IBD) whose symptoms started 10 years ago and who have either:
- ulcerative colitis (but not proctitis alone) or
 - Crohn's colitis involving more than one segment of colon.
- 1.1.2 Offer a baseline colonoscopy with chromoscopy and targeted biopsy of any abnormal areas to people with IBD for whom colonoscopic surveillance is being considered to determine their risk of developing colorectal cancer (see box 1).

Box 1 Risk of developing colorectal cancer in people with IBD

Low risk:

- extensive but quiescent ulcerative colitis **or**
- extensive but quiescent Crohn's colitis **or**
- left-sided ulcerative colitis (but not proctitis alone) or Crohn's colitis of a similar extent.

Intermediate risk:

- extensive ulcerative or Crohn's colitis with mild active inflammation that has been confirmed endoscopically or histologically **or**
- post-inflammatory polyps **or**
- family history of colorectal cancer in a first-degree relative aged 50 years or over.

High risk:

- extensive ulcerative or Crohn's colitis with moderate or severe active inflammation that has been confirmed endoscopically or histologically **or**
- primary sclerosing cholangitis (including after liver transplant) **or**
- colonic stricture in the past 5 years **or**
- any grade of dysplasia in the past 5 years **or**
- family history of colorectal cancer in a first-degree relative aged under 50 years.

1.1.3 Offer colonoscopic surveillance to people with IBD as defined in recommendation 1.1.1 based on their risk of developing colorectal cancer (see box 1), determined at the last complete colonoscopy:

- low risk: offer colonoscopy at 5 years
- intermediate risk: offer colonoscopy at 3 years
- high risk: offer colonoscopy at 1 year.

- 1.1.4 For people with IBD who have been offered colonoscopic surveillance, continue to use colonoscopy with chromoscopy as the method of surveillance.
- 1.1.5 Offer a repeat colonoscopy with chromoscopy if any colonoscopy is incomplete. Consider whether a more experienced colonoscopist is needed.

People with adenomas

See the recommendations in the [British Society of Gastroenterology's guidelines on post-polypectomy and post-colorectal cancer resection surveillance](#).

Continuing or stopping surveillance

- 1.1.6 After receiving the results of each surveillance test:
- discuss with the person the potential benefits, limitations and risks of ongoing surveillance
 - base a decision to stop surveillance on potential benefits for the person, their preferences and any comorbidities.

Terms used in this guideline

This section defines terms that have been used in a particular way for this guideline.

Adenomas

This term is used in the guideline, but other terms have been used in the clinical studies included in the evidence review, for example 'polyps' or 'adenomatous polyps.'

First-degree relative

Mother, father, daughter, son, sister or brother.

Recommendations for research

We have made the following recommendations for research, based on our review of the evidence, to improve NICE guidance and patient care in the future.

1 Surveillance programmes for people at increased risk of colorectal cancer

How effective are colonoscopic surveillance programmes in improving overall survival and cancer-related survival for people at increased risk of colorectal cancer?

Why this is important

There is no evidence from randomised controlled trials (RCTs) on the effectiveness of colonoscopic surveillance programmes in improving survival for people at increased risk of colorectal cancer. Although there is some observational evidence in people with inflammatory bowel disease (IBD), there is no evidence for people after adenoma removal. RCTs should be done to determine the comparative effect of different surveillance programmes on survival (preferably with a follow-up of 5 years and longer) and quality of life for people at increased risk of colorectal cancer because of IBD or adenomas. Trials should also assess any differential effects associated with risk category (as defined in this guideline).

2 Natural history of progression to colorectal cancer for people at increased risk

What is the natural history of progression to colorectal cancer for people with IBD or adenomas?

Why this is important

There is very limited evidence on the natural history of progression to colorectal cancer, and how factors such as extent of disease, grade of dysplasia and adenoma-related factors affect progression. Long-term studies (ideally with a follow up of 20 years or

longer) should be done to determine the natural history of colorectal cancer for people with IBD or adenomas.

3 Effectiveness of biomarkers for determining level of risk of colorectal cancer

Which biomarkers, including epigenic and genetic markers, are predictors of colorectal cancer? How should these be used to improve risk stratification?

Why this is important

There is no high-quality evidence on the predictive value of biomarkers, including epigenic and genetic markers, for colorectal cancer for people with IBD or adenomas. Research should be done to identify the biomarkers that are predictive of colorectal cancer, if any can improve levels of early detection, and how they can be used to improve risk stratification.

4 Adenoma types and risk of colorectal cancer

Does the risk of colorectal cancer depend on the type of adenoma?

Why this is important

There is no high-quality evidence on the association between risk of colorectal cancer and some adenoma types (sessile, hyperplastic non-adenomatous). Research should be done to determine if the level of risk of colorectal cancer depends on the adenoma type.

Finding more information and committee details

To find NICE guidance on related topics, including guidance in development, see the [NICE topic page on colorectal cancer](#).

For full details of the evidence and the guideline committee's discussions, see the [full guideline](#). You can also find information about [how the guideline was developed](#), including details of the committee.

NICE has produced [tools and resources to help you put this guideline into practice](#). For general help and advice on putting our guidelines into practice, see [resources to help you put NICE guidance into practice](#).

Update information

September 2022: We have replaced recommendations on colonoscopy for adults with adenomas with a link to the [British Society of Gastroenterology's guidelines on post-polypectomy and post-colorectal cancer resection surveillance](#).

Minor changes since publication

February 2026: We simplified the guideline by removing recommendations on general principles of care that are covered in other NICE guidelines.

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