

Computed tomographic colonography (virtual colonoscopy)

Interventional procedures guidance

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[nice.org.uk/guidance/ipg129](https://www.nice.org.uk/guidance/ipg129)

Your responsibility

This guidance represents the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, healthcare professionals are expected to take this guidance fully into account. However, the guidance does not override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer.

Commissioners and/or providers have a responsibility to implement the guidance, in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity, and foster good relations. Nothing in this guidance should be interpreted in a way that would be inconsistent with compliance 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.

1 Guidance

- 1.1 Current evidence on the safety and efficacy of computed tomographic colonography (virtual colonoscopy) appears adequate to support the use of this procedure provided that the normal arrangements are in place for consent, audit and clinical governance.

2 The procedure

2.1 *Indications*

- 2.1.1 Computed tomographic (CT) colonography is used to examine the colon and rectum to detect abnormalities such as polyps and cancer. Polyps may be adenomatous (which have the potential to become malignant) or completely benign.
- 2.1.2 Colorectal cancer is the second most common cancer in women and the third most common cancer in men in the UK. Symptoms include blood in the stool, change in bowel habit, abdominal pain and unexplained weight loss. In addition to its use as a diagnostic test in symptomatic patients, CT colonography may be used in asymptomatic patients with a high risk of developing colorectal cancer.
- 2.1.3 Conventional colonoscopy and double-contrast barium enema are the main methods currently used for examining the colon.

2.2 *Outline of the procedure*

- 2.2.1 CT colonography involves using a CT scanner to produce two- and three-dimensional images of the entire colon and rectum. CT colonography is less invasive than conventional colonoscopy.
- 2.2.2 CT colonography is usually performed on an empty bowel although 'faecal tagging' may be used, which eliminates the need for a cathartic bowel preparation. Faecal tagging requires the patient to ingest an iodinated contrast agent with meals approximately 48 hours before the scan. Sedation is not usually required for CT colonography. The colon is distended by insufflation with air or carbon dioxide via a small rectal tube. Antispasmodic agents and/or contrast agents may be administered intravenously before the scan. The images are manipulated and interpreted by a radiologist.

2.3 *Efficacy*

- 2.3.1 A meta-analysis of data from 14 studies with a total of 1324 patients reported the sensitivity and specificity of CT colonography for the detection of polyps, using conventional colonoscopy as the reference standard. The pooled per-

patient sensitivity for polyps 10 mm or larger was 88% (95% confidence interval [CI], 84–93%), for polyps 6–9 mm it was 84% (95% CI, 80–89%), and for polyps 5 mm or smaller it was 65% (95% CI, 57–73%). The pooled per-polyp sensitivity for polyps 10 mm or larger was 81% (95% CI, 76–85%), for polyps 6–9 mm it was 62% (95% CI, 58–67%), and for polyps 5 mm or smaller it was 43% (95% CI, 39–47%). The overall specificity for the detection of polyps 10 mm or larger was 95% (95% CI, 94–97%).

- 2.3.2 A study involving 1233 asymptomatic adults reported that the per-patient sensitivity for polyps 10 mm or larger was 94% (95% CI, 83–99%) for CT colonography and 88% (95% CI, 75–95%) for conventional colonoscopy. The per-patient sensitivity for polyps 6 mm or larger was 89% (95% CI, 83–93%) for CT colonography and 92% (95% CI, 87–96%) for conventional colonoscopy. A study of 615 patients reported per-patient sensitivities of 55% (95% CI, 40–70%) for polyps 10 mm or larger and 39% (95% CI, 30–48%) for polyps 6 mm or larger. Another study of 614 patients reported that CT colonography was significantly more sensitive than barium enema but less sensitive than colonoscopy. A study of 203 patients that used faecal tagging reported an overall per-patient sensitivity of 90% (95% CI, 86–94%). For more details, refer to the Sources of evidence.
- 2.3.3 The Specialist Advisors noted that the procedure may fail to detect small or flat lesions, but commented that this was also the case with other diagnostic techniques.

2.4 *Safety*

- 2.4.1 No significant complications were reported in the studies. Two studies reported on the level of discomfort felt by patients during the procedure. One study reported that 1% (9/696) of patients experienced 'extreme' or 'severe' discomfort during CT colonography, compared with 4% (25/696) for colonoscopy. In the same study, less than 1% (4/617) of patients had 'extreme' or 'severe' discomfort during CT colonography compared with 29% (181/617) during a barium enema ($p < 0.001$). A second study reported that 54% (546/1005) of patients found CT colonography to be more uncomfortable than conventional colonoscopy, but this may have been affected by the fact that patients were sedated for the conventional colonoscopy but not for the CT colonography. In the same study, CT colonography was reported to be more

acceptable in terms of convenience than conventional colonoscopy in 68% (686/1005) of patients.

2.4.2 In one study, 72% (357/494) of patients were reported to prefer CT colonography to conventional colonoscopy, and 97% (518/534) preferred CT colonography to double-contrast barium enema. For more details, refer to the Sources of evidence.

2.4.3 The Specialist Advisors noted that the potential complications are similar to those associated with other techniques, and include bowel perforation and reaction to the intravenous contrast medium.

2.5 *Other comments*

2.5.1 It was noted that this is a rapidly evolving technology, dependent on the type of equipment used and the training and experience of the operator.

2.5.2 It was noted that patient selection was important; this is an alternative procedure to barium enema, and is particularly useful in frail and elderly patients as a diagnostic tool to detect tumours.

Andrew Dillon
Chief Executive
June 2005

3 Further information

Sources of evidence

The evidence considered by the Interventional Procedures Advisory Committee is described in the following document.

'Interventional procedure overview of computed tomographic colonography (virtual colonoscopy)', August 2004.

Information for patients

NICE has produced [information on this procedure for patients and carers](#). It explains the nature of the procedure and the guidance issued by NICE, and has been written with patient consent in mind.

4 About this guidance

NICE interventional procedure guidance makes recommendations on the safety and efficacy of the procedure. It does not cover whether or not the NHS should fund a procedure. Funding decisions are taken by local NHS bodies after considering the clinical effectiveness of the procedure and whether it represents value for money for the NHS. It is for healthcare professionals and people using the NHS in England, Wales, Scotland and Northern Ireland, and is endorsed by Healthcare Improvement Scotland for implementation by NHSScotland.

This guidance was developed using the NICE [interventional procedure guidance](#) process.

It has been incorporated into the NICE pathways on [colonoscopic surveillance](#) and [colorectal cancer](#), along with other related guidance and products.

We have produced a [summary of this guidance for patients and carers](#). Information about the evidence it is based on is also [available](#).

Changes since publication

24 January 2012: minor maintenance.

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Implementation of this guidance is the responsibility of local commissioners and/or providers. Commissioners and providers are reminded that it is their responsibility to implement the guidance, in their local context, in light of their duties to avoid unlawful discrimination and to have

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Endorsing organisation

This guidance has been endorsed by [Healthcare Improvement Scotland](#).