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Colorectal Cancer Patients Need Colonoscopy After Cancer Resection

U.S. Multi-Society Task Force Releases New Recommendations

Feb. 16, 2016, Downers Grove, Illinois — It is critically important that colorectal cancer patients undergo colonoscopy after surgery to ensure that they do not have a second colon cancer, and to find and remove any additional polyps. According to new recommendations from the U.S. Multi-Society Task Force on Colorectal Cancer, the evidence shows that post-operative colonoscopy is associated with improved overall survival for colorectal cancer patients. Between 0.7 and 7 percent of colorectal cancer patients have a second, concurrent cancer.

These recommendations update the 2006 U.S. Multi-Society Task Force consensus guideline, which addressed the use of endoscopy for patients after colorectal cancer resection. The updated document focuses on the role of colonoscopy in these patients, as well as reviews possible adjunctive roles of fecal testing and CT colonography in post cancer resection patients.

Patients who have surgery to remove colorectal cancer should receive colonoscopy on the following schedule:

1. Before cancer resection surgery, if possible. If not, colonoscopy should be performed within three to six months after surgery.
2. One year after surgery or one year after the perioperative (pre-surgery) colonoscopy.
3. Four years after surgery or the perioperative colonoscopy.
4. Nine years after the perioperative colonoscopy.

Subsequent colonoscopies should occur at five year intervals until the benefit of continuing surveillance is outweighed by diminishing life expectancy. If pre-cancerous polyps are found, the intervals for surveillance should follow published guidelines for

polyp surveillance. This does not apply to patients with Lynch syndrome. Review the “Guidelines on Genetic Evaluation and Management of Lynch Syndrome: A Consensus Statement by the US Multi-Society Task Force on Colorectal Cancer” for more information.

Additional considerations in surveillance of rectal cancer

- Patients with rectal cancer have a higher risk of local recurrence compared to those with colon cancer. This is particularly true of those patients with locally advanced rectal cancer who are not treated pre-operatively with radiation and chemotherapy, and in general those rectal cancer patients who are operated on using surgical techniques that do not fall under the method called “total mesorectal excision.” Patients at high risk of local recurrence of rectal cancer should be considered for additional surveillance:
 - Local surveillance with flexible sigmoidoscopy or endoscopic ultrasound should occur every three to six months for the first two to three years after surgery.
- These surveillance measures are in addition to recommended colonoscopic surveillance for second cancers.

Alternatives and adjuncts to colonoscopy

- Patients who have an obstructive colorectal cancer and, therefore, cannot undergo a complete colonoscopy, should receive CT colonography as the best alternative to exclude synchronous neoplasms. Patients can also undergo double-contrast barium enema, if CT colonography is not available.
- There is little evidence to support the routine use of fecal immunohistochemical tests or fecal DNA tests for surveillance after colorectal cancer resection.

Colorectal cancer is the second leading cause of cancer death for both men and women combined in the U.S. More than 132,000 new cases of colorectal cancer were estimated to be diagnosed in 2015 and of those, 70 to 80 percent were expected to undergo surgical resection with intent to cure the disease. Up to 40 percent of patients with locoregional disease (recurrence at or near the original tumor site after removal) will develop recurrent cancer, 90 percent of which will occur within five years.

The U.S. Multi-Society Task Force is composed of gastroenterology specialists with a special interest in colorectal cancer, representing the American Gastroenterological Association, the American College of Gastroenterology and the American Society for Gastrointestinal Endoscopy.

The recommendations, “Colonoscopy Surveillance After Colorectal Cancer Resection: Recommendations of the US Multi-Society Task Force on Colorectal Cancer,” are published online in [GIE: Gastrointestinal Endoscopy](#), the official journal of ASGE; [Gastroenterology](#), the official journal of the AGA Institute; and [American Journal of Gastroenterology](#), the official journal of ACG.

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About Gastrointestinal Endoscopy

Gastrointestinal endoscopic procedures allow the gastroenterologist to visually inspect the upper gastrointestinal tract (esophagus, stomach and duodenum) and the lower bowel (colon and rectum) through an endoscope, a thin, flexible device with a lighted end and a powerful lens system. Endoscopy has been a major advance in the treatment of gastrointestinal diseases. For example, the use of endoscopes allows the detection of ulcers, cancers, polyps and sites of internal bleeding. Through endoscopy, tissue samples (biopsies) may be obtained, areas of blockage can be opened and active bleeding can be stopped. Polyps in the colon can be removed, which has been shown to prevent colon cancer.

About the American Society for Gastrointestinal Endoscopy

Since its founding in 1941, the American Society for Gastrointestinal Endoscopy (ASGE) has been dedicated to advancing patient care and digestive health by promoting excellence and innovation in gastrointestinal endoscopy. ASGE, with more than 14,000 members worldwide, promotes the highest standards for endoscopic training and practice, fosters endoscopic research, recognizes distinguished contributions to endoscopy, and is the foremost resource for endoscopic education. Visit www.asge.org and www.screen4coloncancer.org for more information and to find a qualified doctor in your area.

About the American College of Gastroenterology

Founded in 1932, the American College of Gastroenterology (ACG) is an organization with an international membership of more than 13,000 individuals from 80 countries. The College is committed to serving the clinically oriented digestive disease specialist through its emphasis on scholarly practice, teaching and research. The mission of the College is to serve the evolving needs of physicians in the delivery of high quality, scientifically sound, humanistic, ethical, and cost-effective health care to gastroenterology patients. www.gi.org.

About the AGA Institute

The American Gastroenterological Association is the trusted voice of the GI community. Founded in 1897, the AGA has grown to include 17,000 members from around the globe who are involved in all aspects of the science, practice and advancement of gastroenterology. The AGA Institute administers the practice, research and educational programs of the organization. www.gastro.org.