



# crohn's colitis

Name of Clinical Care Pathway

Colonic Dysplasia/Cancer Surveillance

Objective

Early detection of colon cancer/dysplasia

Patient Population

Patients with a known diagnosis of IBD whose disease is in endoscopic remission. Active inflammation precludes a detailed assessment of colonic dysplasia.

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## Highlight Box

The applicability of some suggested recommendations in these guidelines may be impacted by the IBD practitioners' access to recommended resources (colonic dye spray / virtual chromoendoscopy).

These clinical decision support tools were developed by Canadian experts in IBD, based on their interpretation of current evidence and considerations specific to Canadian healthcare. International guidelines from Europe and the United States are available. However, these may reflect regional factors not directly applicable in Canada

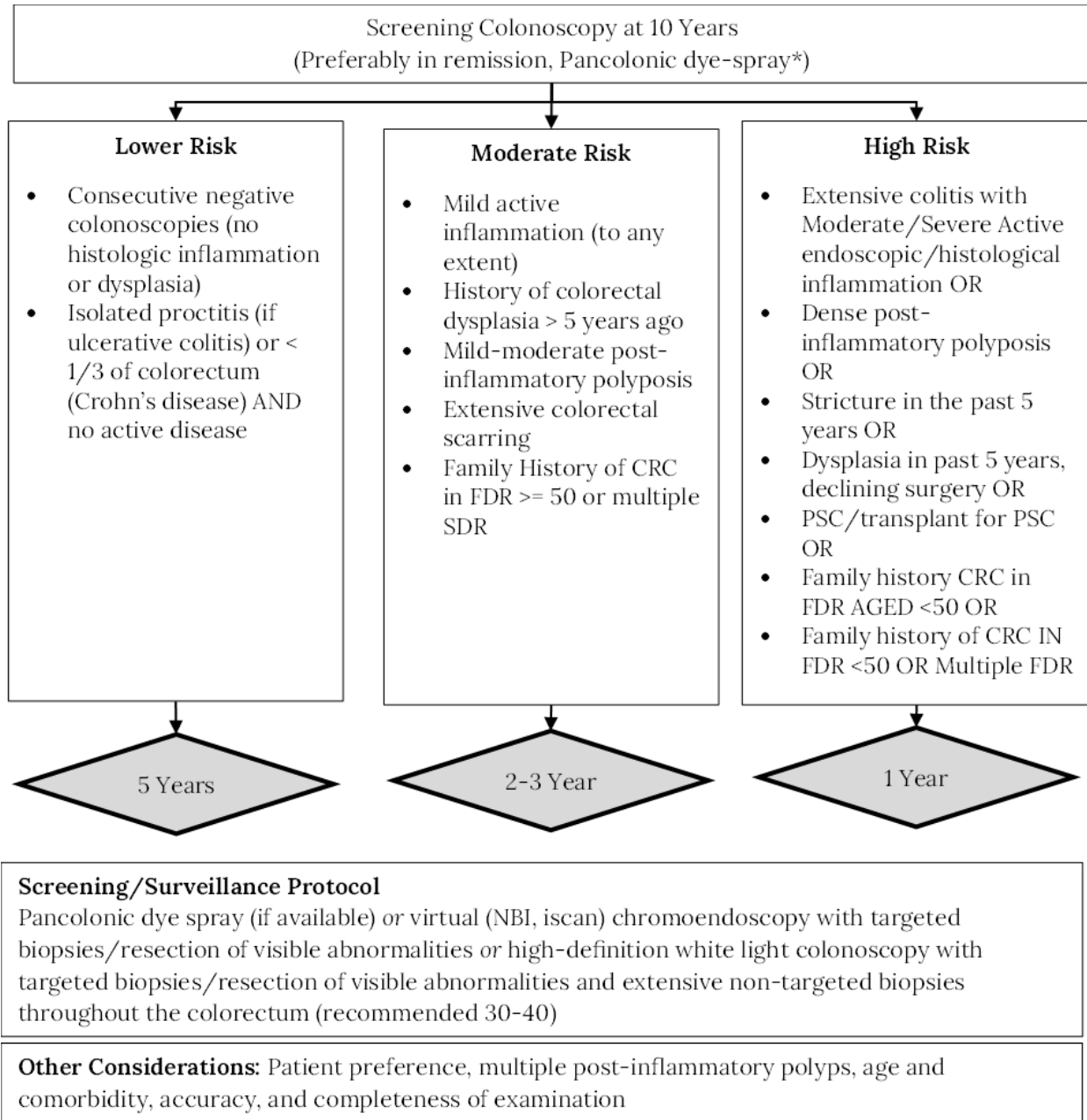
## Introduction

This care protocol aims to provide IBD providers guidelines for colonic dysplasia/cancer surveillance based on patients' risk.

## IBD Provider

Patient Populations	Recommendation
Ulcerative colitis extending beyond the rectum or Crohn's disease involving 1/3 or more of the colon, has had disease for at least 8 years	Surveillance colonoscopy recommended, frequency according to risk (see Figure 1) ( <a href="#">PACE QPI 11</a> )
Ulcerative colitis or Crohn's disease (of any duration) <u>and</u> has coexisting primary sclerosing cholangitis (PSC)	Annual surveillance colonoscopy ( <a href="#">PACE QPI 10</a> )
Ulcerative colitis or Crohn's disease has confirmed dysplasia in flat mucosa	Early repeat colonoscopic surveillance using pancolonoscopic dye spray or virtual chromoendoscopy (interval depending on dysplasia risk). Consider surgical referral in very high-risk cases (i.e. high-grade dysplasia or multi-focal dysplasia) ( <a href="#">PACE QPI 19</a> )
Ulcerative colitis or Crohn's disease has confirmed visible dysplasia	Continued endoscopic surveillance if confirmed complete endoscopic resection and no invasive cancer on histology (interval depending on dysplasia risk); otherwise, surgical referral
Total proctocolectomy with an ileal pouch-anal anastomosis (IPAA)	Surveillance endoscopy according to risk (see Figure 2)
IBD with a subtotal colectomy	Consider surgical referral for a completion proctectomy as an alternative to ongoing endoscopic dysplasia surveillance; otherwise, endoscopic surveillance every 1- 5 years, depending on risk factors for colorectal cancer (See Figure 1). ( <a href="#">PACE QPI 8</a> )

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\*If Available CRC-Colorectal Cancer FDR-First Degree Relative PSC-Primary sclerosing Cholangitis

Figure 1: Surveillance recommendations for colonoscopy

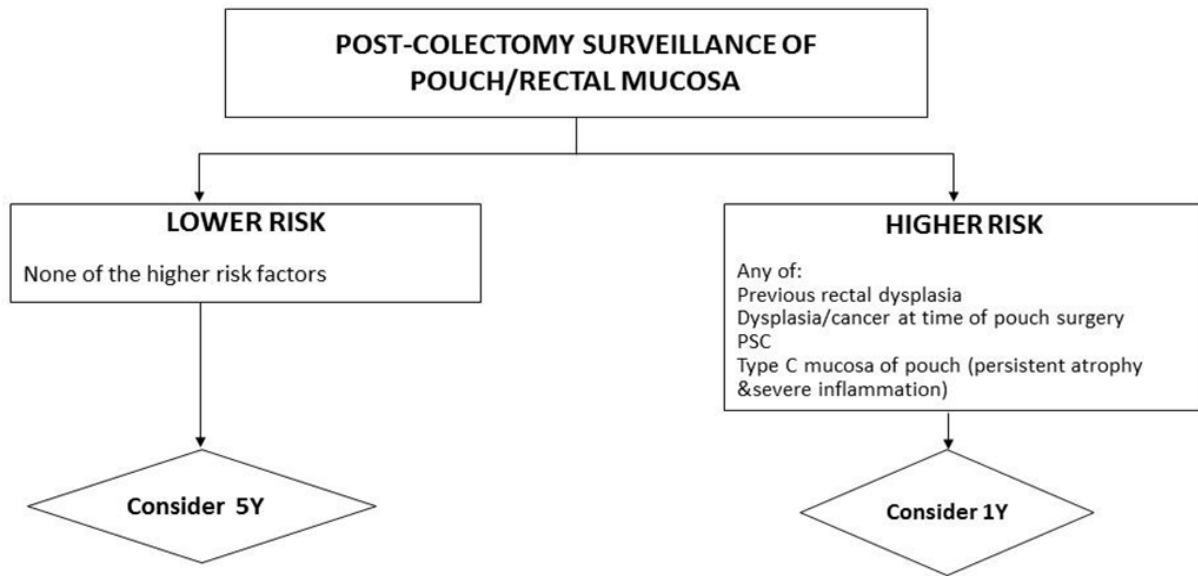


Figure 2: Surveillance recommendations post-colectomy

## References

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