REFERENCES:


2. ACS-American Cancer Society

3. ACG-American College of Gastroenterology on Colorectal Cancer Screening for Average and Higher Risk Patients in Clinical Practice. 2000


14. Mayo Clinic Arizona Genetic Counseling Consensus

- 1st-degree relative is parent, sibling, or child. 2nd-degree relative is grandparent, uncle/aunt, or cousin

MAYO CLINIC ARIZONA STANDARDIZED COLON PREP GRADING FOR ALL COLONOSCOPIES

Excellent: minimal amount of debris not hindering proper adequate visualization.

Good: some liquid debris not significantly interfering with the exam.

Fair Adequate: moderate amount of liquid debris, or minimal amount of solid debris to prevent a completely reliable exam. After adequate intraprocedure cleansing, endoscopist confident that lesions over 1 cm have been detected.

Fair Inadequate: large amounts of liquid, or moderate to large amounts of solid debris with inadequate visualization of colon. After adequate intraprocedure cleansing, endoscopist not confident that lesions over 1 cm have been detected.

Poor: solid debris limits nearly entire exam.

MAYO CLINIC ARIZONA CLINICAL RECOMMENDATIONS FOR PREVENTION/SCREENING & MOST SURVEILLANCE EXAMINATIONS BASED ON PREP GRADING:

*Excellent: Standard published guidelines

*Good: Standard published guidelines

*Adequate: standard published guidelines

*Inadequate: For appropriate patients who have never had a prior colorectal cancer prevention examination, the examination should be repeated without delay. Otherwise, for appropriate patients without signs or symptoms, follow up colonoscopy may be deferred for 1 to 2 years.

*Poor: Colon insufficiently evaluated; reexamination by some method should be considered based on clinical circumstances and patient/refering physician preferences

*SPECIAL NOTES:

1. Only excellent or good prep ratings are acceptable for patients with signs or symptoms who are scheduled for diagnostic examinations. Other prep grades warrant individual decision making based on clinical circumstances.

2. Patients who have significant problems with constipation, motility issues, or a prior history of inadequate colonoscopy preparation, will require a minimum two days of clear liquids in preparation for the exam. Please call or consult GI for patients with difficult problems.
Screening/Prevention (Table 1)

<table>
<thead>
<tr>
<th>Patient Category</th>
<th>First Step</th>
<th>Next Step</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average risk patient, no risk factors for colorectal cancer except age ≥ 50 years</td>
<td>Begin screening colonoscopy at age fifty</td>
<td>If normal repeat every ten years</td>
</tr>
<tr>
<td>Average risk patient, no risk factors for colorectal cancer except race (African American)</td>
<td>Begin screening colonoscopy at age fortyfive</td>
<td>If normal repeat every ten years</td>
</tr>
<tr>
<td>Single 1st-degree relative with colorectal cancer diagnosed before age sixty or two 2nd-degree relatives diagnosed with colorectal cancer</td>
<td>Begin screening colonoscopy at age fortyfive</td>
<td>If normal repeat every three-five years</td>
</tr>
<tr>
<td>Single 1st-degree relative with colorectal cancer or tubular adenoma ≤ sixty years or two 2nd-degree relatives of any age</td>
<td>Colonoscopy at age forty, or ten years before affected relative, whichever is earlier</td>
<td>If normal, repeat every three-five years</td>
</tr>
<tr>
<td>Inflammatory bowel disease, chronic UC or Crohn’s disease</td>
<td>Screening colonoscopy eight to ten years after onset of colitis with extensive biopsies to exclude dysplasia</td>
<td>Every one to two years</td>
</tr>
<tr>
<td>Inflammatory bowel disease, chronic UC or Crohn’s disease with, chronic UC or Crohn’s disease with, scarring colangitis</td>
<td>Annual colonoscopy at time of diagnosis with extensive biopsies to exclude dysplasia. Consider chemo prevention with ureosylcyctolic acid and GI consultation.</td>
<td>Every year</td>
</tr>
<tr>
<td>For patients with colorectal cancer before age fifty, multiple polyps before age forty or with a family history of colorectal or other cancers, consider a hereditary colorectal cancer syndrome</td>
<td>Call Genetic Counseling @ (480) 301-4585 or any member of the Colorectal Interest Group: Drs. Gundu, Heigh, Leighton, Efron, Hippiel, Pesha, and Young Fadok</td>
<td>If normal, every two years</td>
</tr>
<tr>
<td>Discontinuation of surveillance colonoscopy should be considered in patients with serious comorbidities with less than 10 years of life expectancy, according to the clinician’s judgment</td>
<td>Consider alternative to colonoscopy for colorectal cancer prevention or surveillance</td>
<td>Follow up is based on results of screening</td>
</tr>
</tbody>
</table>

Surveillance (Table 2)

<table>
<thead>
<tr>
<th>Patient Category</th>
<th>First Step</th>
<th>Next Step</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average risk patient, no risk factors for colorectal cancer except age ≥ 50 years</td>
<td>Begin screening colonoscopy at age fifty</td>
<td>If normal repeat every ten years</td>
</tr>
<tr>
<td>Average risk patient, no risk factors for colorectal cancer except race (African American)</td>
<td>Begin screening colonoscopy at age fortyfive</td>
<td>If normal repeat every ten years</td>
</tr>
<tr>
<td>Single 1st-degree relative with colorectal cancer diagnosed before age sixty or two 2nd-degree relatives diagnosed with colorectal cancer</td>
<td>Begin screening colonoscopy at age fortyfive</td>
<td>If normal repeat every three-five years</td>
</tr>
<tr>
<td>Single 1st-degree relative with colorectal cancer or tubular adenoma ≤ sixty years or two 2nd-degree relatives of any age</td>
<td>Colonoscopy at age forty, or ten years before affected relative, whichever is earlier</td>
<td>If normal, repeat every three-five years</td>
</tr>
<tr>
<td>Inflammatory bowel disease, chronic UC or Crohn’s disease</td>
<td>Screening colonoscopy eight to ten years after onset of colitis with extensive biopsies to exclude dysplasia</td>
<td>Every one to two years</td>
</tr>
<tr>
<td>Inflammatory bowel disease, chronic UC or Crohn’s disease with, chronic UC or Crohn’s disease with, scarring colangitis</td>
<td>Annual colonoscopy at time of diagnosis with extensive biopsies to exclude dysplasia. Consider chemo prevention with ureosylcyctolic acid and GI consultation.</td>
<td>Every year</td>
</tr>
<tr>
<td>For patients with colorectal cancer before age fifty, multiple polyps before age forty or with a family history of colorectal or other cancers, consider a hereditary colorectal cancer syndrome</td>
<td>Call Genetic Counseling @ (480) 301-4585 or any member of the Colorectal Interest Group: Drs. Gundu, Heigh, Leighton, Efron, Hippiel, Pesha, and Young Fadok</td>
<td>If normal, every two years</td>
</tr>
<tr>
<td>Discontinuation of surveillance colonoscopy should be considered in patients with serious comorbidities with less than 10 years of life expectancy, according to the clinician’s judgment</td>
<td>Consider alternative to colonoscopy for colorectal cancer prevention or surveillance</td>
<td>Follow up is based on results of screening</td>
</tr>
</tbody>
</table>

PRELIMINARY PROCEDURE:
- Colonoscopy 1, 2, 6 particularly in African Americans

ALTERNATIVE STRATEGIES:
- Fecal occult blood testing (FOBT): yearly, or ; - FOB every three years
- CTC Colonoscopy: Promising, emerging technology with insurance coverage issues - covered by CMS when - patient has abnormal coagulation profile (including anticoagulation) or - suspected obstruction on any imaging or endoscopy test - covered by Mayo Health Insurance for employee screening - very limited coverage by other insurers

SEDATION POLICY:
- It is mandatory for a responsible adult to accompany the patient at time of patient discharge.

PREP CONSIDERATIONS:
- Ordering MD responsible for providing prescription for all bowel cleansing products. 

MAYO CLINIC ARIZONA STANDARD PREPS:
- Four Liter Lavage with balanced electrolyte solutions & PEG, Given, NuLytely, Colyte, Go-Ready. Studies show absence of Na sulfite in fitleye and NuLynely have better taste. 
- 2 Liter Lavage: Half-Lytely (balanced electrolytes & PEG plus 4 isobacodyl tablets, Na sulfite free).

Available Sodium Phosphosphate Preparations:
- Fleet's Phospho Soda
- OsmoPrep Tablets

This warning is present because complications may occur. 

Sodium Phosphate Preps Warning: Do not use in renal insufficiency (Ccr<30), underlying electrolyte disorders, ascites, CHF, unstable angina, arrhythmias, post GI bypass. Reports of renal failure, acute phosphate nephropathy, and seizures exist. Consider baseline and post colonoscopy labs in those at risk of electrolyte disturbances. Not for use in evaluating diarrhea or IBD due to artifacts. Patients taking sodium phosphate preps must obtain referring MD’s specific consent.

Contraindications for all Preps:
- obstruction, ileus, gastric retention, possible perforation, toxic colitis, megacolon.
- Prevention of disease or conditions that predispose to or result from uncontrolled diarrhea. 

Prep Timing: For AM exam: 4:00 PM afternoon prior; for PM exam: Morning of exam strongly preferred, 4:00 PM afternoon prior acceptable if necessary.

Directions for all Preps: Day prior to exam – Clear liquids all day until 3 hours prior to exam and then NPO until exam.

4 LITER LAVAGE Directions: 4:00 PM day prior drink 8oz prep every 10 minutes until prep is consumed.

2 LITER LAVAGE Directions: 12:00 PM day prior take 4 bisacodyl tablets. After bowel movement, but no later than 6:00 PM, drink 8oz prep every 10 minutes until prep is consumed.

PHOSPHO SOAPA Directions: 4:00 PM day prior mix 1 l½ oz of prep in 12oz water and drink, followed immediately by 12oz water. Drink an additional minimum 24oz water that evening. 4:00 AM day of procedure mix 1oz prep in 12oz water and drink. Follow immediately with 12oz water.

OSMPREP Directions: 4:00 PM day prior take 4 tablets with 8 oz clear liquid every 15 minutes until 20 tablets are consumed. 4:00 AM day of procedure take 4 tablets every 15 minutes until the remaining 12 tablets are consumed.