New Zealand Society of Gastroenterology Inc

INFLAMMATORY BOWEL DISEASE SURVEILLANCE GUIDELINES

Updated 2025

TABLE OF CONTENTS

INTRODUCTION

The Inflammatory Bowel Disease Working Group (IBDWG), as part of the New Zealand Society of Gastroenterology (NZSG), endorses these guidelines on IBD surveillance colonoscopy. This sets out appropriate practice for clinicians to follow, subject to their own judgement.

The advice was developed to align with recent publications and guidelines from Europe (ECCO), the UK (BSG), the United States (AGA), and Australia (GESA), based on updated available evidence up until June 2025. There have been several changes to the previous NZ IBD surveillance guidelines published in 2012.

A technical advisory group with the required expertise was established and has undertaken a systematic review of recent literature. Members of the group included clinicians from the NZ IBDWG. A range of clinicians from NZ, including those who are routinely involved in the surveillance of patients with IBD, were then surveyed on the changes made in order to support implementation of an updated guideline.

Acknowledgements go to:

- Caroline Jiang, Gastroenterologist, Wellington Hospital and member of IBD WG, NZSG
- Rajan N Patel, Gastroenterologist, Christchurch Hospital and member of IBD WG, NZSG
- NZ IBD working group
- Frank Weilert, Gastroenterologist, Waikato Hospital
- Tamara Glyn, Colorectal Surgeon, Christchurch Hospital
- Byron Theron, Gastroenterologist, Whangarei Hospital
- Susan Parry, Gastroenterologist, Clinical Lead of National Bowel Screening Programme, Ministry of Health
- Ian Bissett, Colorectal Surgeon, Auckland Hospital
- Ralph van Dalen, Colorectal Surgeon, Waikato Hospital
- Nathan Atkinson, Gastroenterologist, North Shore Hospital

For New Zealand's previous Guidance on IBD Surveillance, published in February 2012, go to www.health.govt.nz/publications.

Note: This document is updating only the IBD surveillance section of the previous guidelines. New Zealand colonoscopy capacity is constrained. Whilst developing these guidelines, we have remained mindful that these recommendations should align with non-IBD surveillance guidelines (including Polyp Surveillance Guidelines and Surveillance Recommendations for Individuals with a Family/ Whanau History of Colorectal Cancer) in order to share resources equitably across patient groups.

Dr Caroline Jiang
Consultant Gastroenterologist, Wellington Hospital and member of IBD WG, NZSG.

Dr Rajan N Patel
Consultant Gastroenterologist, Christchurch Hospital and member of IBD WG, NZSG.

PURPOSE OF THIS ADVICE

The main purpose of this document is to provide surveillance recommendations for patients with IBD.

Patients outside the scope of this advice are those undergoing polyp surveillance, hereditary colorectal cancer syndromes (for example, Lynch syndrome or Familial Adenomatous Polyposis), personal history of colorectal cancer, and family history that warrants investigation for hereditary colorectal cancer syndromes (Ministry of Health 2012).

EQUITY

Ensuring an equity focus is a priority for NZSG. Evidence indicates that Māori are less likely than non-Maori to have access to early diagnosis for some cancers, including colorectal cancers. Survival outcomes for colorectal cancer are significantly poorer for Māori than for non-Māori. Comorbidity and difficulties with accessing health services for colon cancer account for about 30 percent of excess mortality among Māori (Hill, Sarfati, et al 2010).

For this reason, it is important that clinicians make decisions that contribute to equitable outcomes for Māori and Pacific peoples in particular. Surveillance intervals are determined by IBD extent and severity. There is no evidence that IBD is more severe or extensive in Māori and Pacific peoples.

ASSOCIATED DOCUMENTS

Table 1: Associated documents

Gordon et al. ECCO Guidelines on Inflammatory Bowel Disease and Malignancies, *Journal of Crohn's and Colitis*, Volume 17, Issue 6, June 2023, Pages 827–854, https://doi.org/10.1093/ecco-jcc/jjac187
East JE, Gordon M, Nigam GB, et al; British Society of Gastroenterology guidelines on colorectal surveillance in inflammatory bowel disease. Gut Published Online First: 30 April 2025. doi: 10.1136/gutjnl-2025-335023
Murthy SK, Feuerstein JD, Nguyen GC, Velayos FS. AGA Clinical Practice Update on Endoscopic Surveillance and Management of Colorectal Dysplasia in Inflammatory Bowel Diseases: Expert Review. Gastroenterology. 2021 Sep;161(3):1043-1051.e4. doi: 10.1053/j.gastro.2021.05.063. PMID: 34416977.

HIGH QUALITY IBD SURVEILLANCE COLONOSCOPY

High-quality colonoscopy is the prerequisite for these recommendations. Surveillance should be adjusted for suboptimal colonoscopy. To be of high quality and detect dysplastic lesions, the colonoscopy must involve verified and documented caecal intubation, adequate colonoscopy withdrawal time (CWT), good colonoscopy technique and adequate bowel preparation. The ideal CWT for IBD surveillance should be longer than the minimum CWT (6 minutes) for adenoma detection in the general population, ideally aiming for a withdrawal time of 15-17 minutes. Recommended biopsy protocols should be followed.

Surveillance should be performed with high definition colonoscopes with use of HD-white light, dye spray, or virtual chromoendoscopy dependent on availability and user expertise. If only SD scopes are available, an adjunct must be used, or referral is required to a centre with access to HD scopes. Random 10cm four-quadrant biopsies should be restricted to limited indications or where adequate mucosal assessment is not possible (e.g. poor bowel preparation or segments with dense post-inflammatory polyposis).

Where possible, surveillance colonoscopies should be performed when IBD is in remission. Active inflammation can interfere with both endoscopic detection and histologic assessment of dysplasia.

At a minimum, the Boston Bowel Preparation Score (BBPS) on withdrawal needs to be 6 or higher, with no single segment score under 2. A full description of what constitutes the expected good practice is described in the Standards for Individuals Performing BSP colonoscopy (Endoscopy Governance Group for New Zealand 2017).

FAMILY HISTORY

Colorectal cancer (CRC) in first degree relatives (FDR) infers an increased risk of dysplasia, especially if FDR was under 50yo at time of CRC diagnosis. Documenting family history of CRC in IBD patients is crucial to determine optimal surveillance intervals.

Discussion and voting took place to determine how family history is incorporated into IBD surveillance. This occurred both within the IBDWG and later amongst national representatives, which included general gastroenterologists and specialists with expertise in the management of IBD.

These guidelines endorse annual IBD surveillance for patients with FDR CRC <50yo, and 3-yearly surveillance for patients with FDR CRC >50yo. IBD patients at population risk (e.g. proctitis, isolated small bowel involvement) do not require additional IBD surveillance regardless of family history.

KEY DIFFERENCES TO 2012 SURVEILLANCE GUIDELINES

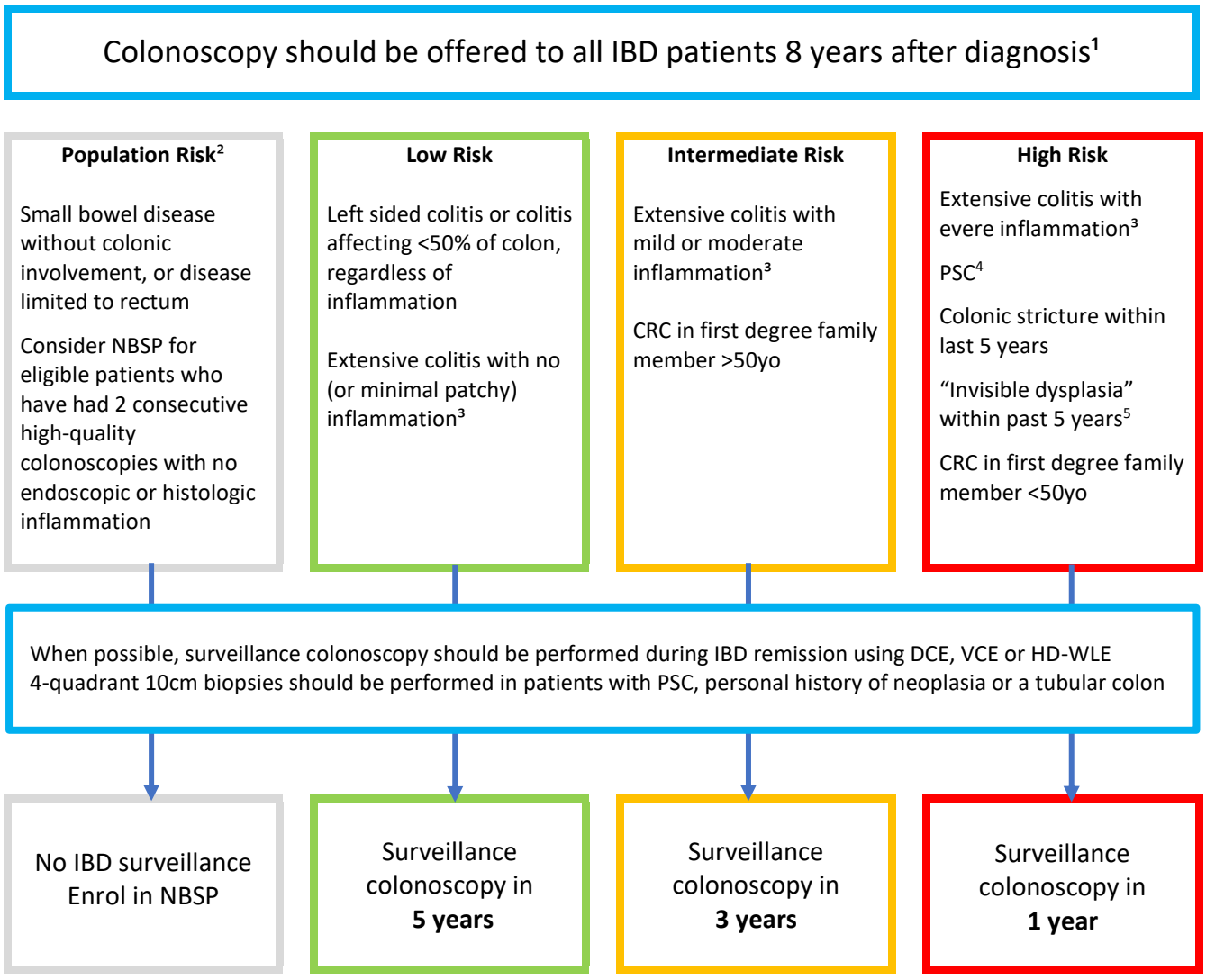
1. Clarification that surveillance is determined based on the degree of inflammation from the most recent colonoscopy, rather than historic colonoscopy findings.
2. Screening colonoscopy should be offered to all IBD patients 8 years after diagnosis to assess for change in disease phenotype. Patients with small bowel Crohn's disease and ulcerative proctitis without disease extension have population risk of CRC and do not require IBD surveillance.
3. Both endoscopic and histologic inflammation infer risk of dysplasia. Standardized reporting should be encouraged, and routine biopsies should be performed from right and left colon to allow for histologic disease activity assessment. Moderate endoscopic and histologic inflammation infer intermediate risk rather than high risk.
4. Post-inflammatory polyps do not infer additional risk as long as mucosal visualization is not impaired.
5. Invisible dysplasia should first be referred to an advanced endoscopist with IBD experience for re-scope, then unresected invisible dysplasia must be followed by annual colonoscopy for a minimum 5 years.
6. Modality of surveillance is dependent on user expertise but at a minimum requires HD-WL or DCE+/-VCE. If only SD-WL is available, then an adjunct must be used, or referral to a centre with access to HD scopes.
7. In addition to targeted biopsies, four-quadrant 10cm biopsies should be encouraged in those with PSC, a personal history of dysplasia/neoplasia, or a tubular colon. Four-quadrant 10cm biopsies should also be considered in cases where full mucosal assessment is suboptimal (eg dense post-inflammatory polyps), suboptimal bowel preparation, or where colitis impairs visualization.
8. Patients not actively involved in the IBD surveillance program should start NBSP when invited.
9. Patients with 2 consecutive high-quality colonoscopies demonstrating deep remission who are eligible for NBSP can exit regular IBD surveillance and enter NBSP.
10. The withdrawal time in IBD needs to be longer than the minimal 6minute CWT for adenoma detection. We encourage an optimal withdraw time of at least 15-17minutes hence IBD surveillance colonoscopies should be allocated appropriate time-slots.

These guidelines align more closely to the 2023 ECCO guidelines rather than the 2025 BSG guidelines, as the former is felt to be more user-friendly, and have surveillance intervals which align closely to New Zealand national polyp surveillance guidelines.

These guidelines have not encouraged routine use of multivariate risk calculators e.g. https://ibd-dysplasia-calculator.bmrc.ox.ac.uk due to perceived limitations of these risk models, including an over-emphasis on historic inflammation and historic disease distribution, as well as exclusion of family history.

New Zealand Society of Gastroenterology Inc

IBD SURVEILLANCE GUIDANCE 2025



1. Consider starting surveillance 8 years after symptom onset rather than IBD diagnosis, especially if delay to diagnosis
2. Patients at population risk do not require additional IBD surveillance, regardless of family history of CRC
3. Either endoscopic or histologic inflammation
4. Including post-liver transplant patients
5. Includes 'indefinite for dysplasia'

Post-inflammatory polyps do not infer additional risk as long as they do not interfere with mucosal visualisation

Figure 1. Summarises the new guidance for surveillance in patients with IBD

REFERENCES

Gordon H, Biancone L, Fiorino G, Katsanos KH, Kopylov U, Al Sulais E, Axelrad JE, Balendran K, Burisch J, de Ridder L, Derikx L, Ellul P, Greuter T, Iacucci M, Di Jiang C, Kapizioni C, Karmiris K, Kirchgesner J, Laharie D, Lobatón T, Molnár T, Noor NM, Rao R, Saibeni S, Scharl M, Vavricka SR, Raine T. ECCO Guidelines on Inflammatory Bowel Disease and Malignancies. J Crohns Colitis. 2023 Jun 16;17(6):827-854. doi: 10.1093/ecco-jcc/jjac187. PMID: 36528797.

Moussata D, Allez M, Cazals-Hatem D, Treton X, Laharie D, Reimund JM, Bertheau P, Bourreille A, Lavergne-Slove A, Brixi H, Branche J, Gornet JM, Stefanescu C, Moreau J, Marteau P, Pelletier AL, Carbonnel F, Seksik P, Simon M, Fléjou JF, Colombel JF, Charlois AL, Roblin X, Nancey S, Bouhnik Y, Berger F, Flourié B; the GETAID. Are random biopsies still useful for the detection of neoplasia in patients with IBD undergoing surveillance colonoscopy with chromoendoscopy? Gut. 2018 Apr;67(4):616-624. doi: 10.1136/gutjnl-2016-311892. Epub 2017 Jan 23. PMID: 28115492.

McMillan C, Li DK, Mohamed G, Alsadoun DA, Almohsen LA, Gaidos JKJ, Proctor DD, Al-Bawardy B. Longer Colonoscopy Withdrawal Time Is Associated With the Detection of Visible Dysplasia in Patients With Inflammatory Bowel Disease. Crohns Colitis 360. 2024 Mar 23;6(2):otae020. doi: 10.1093/crocol/otae020. PMID: 38585555; PMCID: PMC10998460.

Al Bakir I, Kabir M, Yalchin M, Hart A. Optimising inflammatory bowel disease surveillance and dysplasia management-Where do we stand? United European Gastroenterol J. 2022 Dec;10(10):1054-1062. doi: 10.1002/ueg2.12330. Epub 2022 Nov 8. PMID: 36349435; PMCID: PMC9752268.

Lutgens MW, van Oijen MG, van der Heijden GJ, Vleggaar FP, Siersema PD, Oldenburg B. Declining risk of colorectal cancer in inflammatory bowel disease: an updated meta-analysis of population-based cohort studies. Inflamm Bowel Dis. 2013 Mar-Apr;19(4):789-99. doi: 10.1097/MIB.0b013e31828029c0. PMID: 23448792.

Choi CR, Al Bakir I, Ding NJ, Lee GH, Askari A, Warusavitarne J, Moorghen M, Humphries A, Ignjatovic-Wilson A, Thomas-Gibson S, Saunders BP, Rutter MD, Graham TA, Hart AL. Cumulative burden of inflammation predicts colorectal neoplasia risk in ulcerative colitis: a large single-centre study. Gut. 2019 Mar;68(3):414-422. doi: 10.1136/gutjnl-2017-314190. Epub 2017 Nov 17. PMID: 29150489; PMCID: PMC6581019.

Fumery M, Pineton de Chambrun G, Stefanescu C, Buisson A, Bressenot A, Beaugerie L, Amiot A, Altwegg R, Savoye G, Abitbol V, Bouguen G, Simon M, Duffas JP, Hébuterne X, Nancey S, Roblin X, Leteurtre E, Bommelaer G, Lefevre JH, Brunetti F, Guillon F, Bouhnik Y, Peyrin-Biroulet L. Detection of Dysplasia or Cancer in 3.5% of Patients With Inflammatory Bowel Disease and Colonic Strictures. Clin Gastroenterol Hepatol. 2015 Oct;13(10):1770-5. doi: 10.1016/j.cgh.2015.04.185. Epub 2015 May 19. PMID: 26001338.

Choi CH, Ignjatovic-Wilson A, Askari A, Lee GH, Warusavitarne J, Moorghen M, Thomas-Gibson S, Saunders BP, Rutter MD, Graham TA, Hart AL. Low-grade dysplasia in ulcerative colitis: risk factors for developing high-grade dysplasia or colorectal cancer. Am J Gastroenterol. 2015 Oct;110(10):1461-71; quiz 1472. doi: 10.1038/ajg.2015.248. Epub 2015 Sep 29. PMID: 26416190; PMCID: PMC4697133.

Askling J, Dickman PW, Karlén P, Broström O, Lapidus A, Löfberg R, Ekbom A. Family history as a risk factor for colorectal cancer in inflammatory bowel disease. Gastroenterology. 2001 May;120(6):1356-62. doi: 10.1053/gast.2001.24052. PMID: 11313305.

Trivedi PJ, Crothers H, Mytton J, Bosch S, Iqbal T, Ferguson J, Hirschfield GM. Effects of Primary Sclerosing Cholangitis on Risks of Cancer and Death in People With Inflammatory Bowel Disease, Based on Sex, Race, and Age. Gastroenterology. 2020 Sep;159(3):915-928. doi: 10.1053/j.gastro.2020.05.049. Epub 2020 May 20. PMID: 32445859.

East JE, Gordon M, Nigam GB*, et al*. British Society of Gastroenterology guidelines on colorectal surveillance in inflammatory bowel disease. *Gut* Published Online First: 30 April 2025. doi: 10.1136/gutjnl-2025-335023