Surveillance colonoscopy in IBD

	BSG (2025)	ECCO (2023)	AGA (2021)
When to start	• Approx 8 years after <u>symptom onset</u> for all patients with UC involving more than the rectum. • Immediate colonoscopy at PSC diagnosis	• 8 years after <u>symptom onset</u> for all IBD patients. • Immediate colonoscopy at PSC diagnosis.	• 8-10 years <u>after diagnosis</u> for patients with long-standing, extensive UC or Crohn's colitis. • Immediate colonoscopy at PSC diagnosis.
Colonoscopy interval			
Definitions	Low risk: Extensive but quiescent colitis or left sided only with no other risk factors. Intermediate risk: Post- inflammatory polyps, FH of CRC in first degree relative >50 y/o, or moderate/severe inflammation. High risk: PSC, stricture <5 years, dysplasia <5 years, FH of CRC in first degree relative ≤50 y/o	Low risk: <50% colonic involvement, or extensive colitis with only mild endoscopy/histologic activity. Intermediate risk: FH of CRC in first degree relative >50 y/o, or Extensive colitis with mild to moderate endoscopic &/or histological inflammation High risk: PSC, stricture <5 years, dysplasia <5 years (if no surgery), FDR of CRC ≤50 y/o, extensive colitis with severe active inflammation.	Low risk: Disease in remission since last colonoscopy with mucosal healing plus either: 1) ≥ 2 consecutive exams without dysplasia or 2) minimal historical colitis extent (UC proctitis or <1/3 colon in CD) Intermediate risk: Moderate pseudopolyps, FH of CRC in first degree relative >50 y/o, mild inflammation (any extent), prior low-risk dysplasia >5 years High risk: PSC, prior dysplasia (esp. multifocal or HGD) in the last 5 years, FH of CRC ≤50 y/o, moderate-severe inflammation (any extent), dense pseudo polyps.
• Low risk	Every 10 years or as per population screening. Reassessment of risk factors at annual review	Every 5 years	Every 5 years
• Intermediate risk	Every 3 years	Every 2-3 years	Every 2-3 years
• High risk	Annually		

Fundamentals for surveillance:
1.High definition colonoscope +/- Dy spray (ECCO & BSG) or virtual chromoendoscopy (AGA); 2. Quiescent disease. 3.Appropriate bowel preparation with careful inspection of fully visible mucosa. 4. Targeted biopsies of suspicious mucosa sites or resection if lesion is clearly demarcated without stigmata of invasive cancer. 5. If no Dye spray or virtual chromo then random biopsies of 4 quadrants every 10 cm

*Also consider additional risk factors such: male, age at diagnosis, smoking...
CRC: colorectal cancer ; FH:family history,

1.East JE et al. Gut. 2025; 2. Gordon H et al. J Crohns Colitis. 2023; 3. Murthy SK et al. Gastroenterology.2021