Bowel Cancer Screening Programme
Guideline for Histology Reporting

This guidance does not override the individual responsibility of health professionals to make appropriate decision according to the circumstances of the individual patient in consultation with the patient and /or carer. Health care professionals must be prepared to justify any deviation from this guidance.

INTRODUCTION
This operational guideline refers to the pathway for histology samples and reports.

THIS GUIDELINE IS FOR USE BY THE FOLLOWING STAFF GROUPS :
BCSP Specialist Screening Practitioners (SSPs)

Lead Clinician(s)

Mr S P Lake	BCSP Screening Director
Approved:	4th September 2024
Review Date: This is the most current document and should be used until a revised version is in place	4th September 2027

Key amendments to this guideline

Date	Amendment	Approved by:
October 2015	Document created	Christine Mosedale
April 2020	Full Review of Document	Paula Smith
Feb 2022	Minor amendment to include the site where specimens are taken and reported	Emma Duggan
November 2022	Document approved with no changes	SCSD Governance Meeting
August 2024	Minor amendment to include Lynch Syndrome Patients following Large Non Pedunculated Colorectal Polyps (LNPCP) pathway – page 2	Avril Turley

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Guideline for Histology Reporting

Introduction

This operational guideline refers to the pathway for histology samples and reports.

Details of Guideline

- The endoscopy nurse will label the histology pots. The SSP must ensure that there is one specimen per pot if there is more than one polyp, unless a polyp is removed piecemeal.

- The endoscopy nurse will ensure that both the ICE request form, Unisoft histology form and endoscopy report and histology pot can be identified as Bowel Cancer Screening by applying the BCSP sticker to the histology pot and histology request forms. The SSP is responsible for checking that this has been completed. All details are entered into the histology book in the endoscopy room.

- The endoscopy nurse will ensure that a copy of the endoscopy report will be attached to the histology request form to accompany the specimen. The SSP is responsible for checking that this has been completed.

- All specimens taken during a screening colonoscopy should be sent directly to the Histopathology Department the same day.

    - Specimens taken at Hereford are processed within the histopathology department at Hereford Hospital
    - Specimens taken at Malvern Hospital and any of the Acute sites are processed within the Histology department at Worcestershire Royal Hospital.

- Each SSP will monitor the histology results due from their respective screening lists to ensure that results are received within the 7 day target. SSPs will handover to colleagues/buddy system in the event of annual leave/courses/sickness etc. Delays in receipt of histology should be referred to the histology department by telephoning/emailing histopathology and if unresolved an email should be sent to the Consultant Histopathology Lead. This should take place at 5 days post procedure.

- The histology results will be reviewed on the pathology reporting system (ICE) by the SSP using the BSG criteria for surveillance following adenoma removal. After review the SSP can then contact the patient to either inform them of the results and further management, or to arrange a post investigation appointment. (See guideline: BCSP Guideline for informing patients of post investigation histology).

- For Lynch Syndrome patients, if an LNPCP is identified during the procedure, patients should follow the LNPCP pathway with site checks at 2-6 months and 12 months with the next procedure at 2 years after the 12-month site check instead of the usual 3 years for non-Lynch syndrome patients. It is up to the clinician to decide if they wish to complete a full colonoscopy at the site check, if they are concerned about the surveillance interval being longer than 2 years.

- In the event of any incidental findings within BCSP, this should be discussed with the Clinical Director for onward referral to appropriate service/team to action.

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- In the event of complex results being received or those indicating a suspicious lesion, the SSP should refer to the screening director for advice regarding actions required using the clinical review form. Once the pathway has been established the patient should be invited to attend a results clinic or given the results over the phone if this is their preference.

- The BCSS will be completed for each patient, with all polyps recorded appropriately along with appropriate interventions and whether retrieved. The histology fields should be completed as soon as histology is available, with episode notes being completed for relevant information. The episode should be advanced as appropriate, and letters printed for the patient and GP, with a copy for scanning to CLIP. All letters will be checked to confirm episode outcome prior to sending.

- All relevant documentation to be completed by SSP.

- Results should be filed on ICE.

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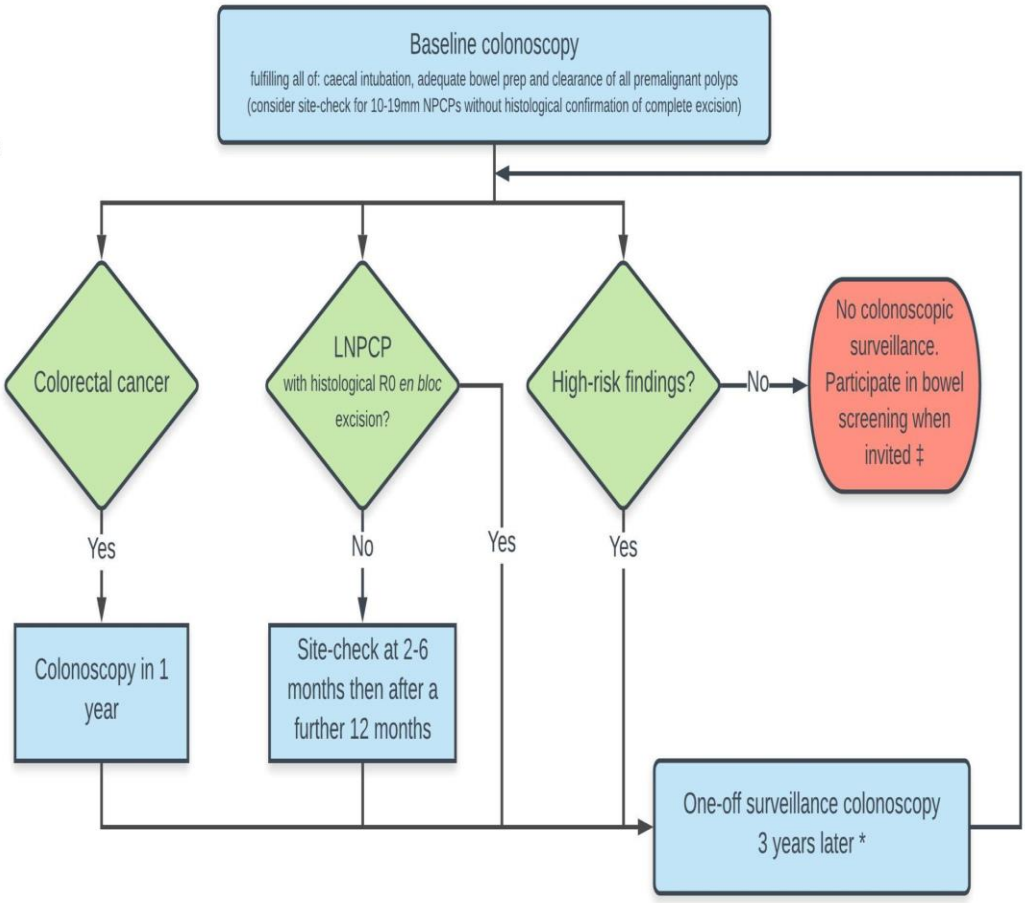
BSG/PHE/ACPGBI Guidelines for Post-polypectomy and Post-cancer-resection Surveillance



High-risk findings

- **≥2 premalignant polyps including ≥1 advanced colorectal polyp; or**
- **≥5 premalignant polyps**

Definitions:

- *Serrated polyps: umbrella term for hyperplastic polyps, sessile serrated lesions, traditional serrated adenomas and mixed polyps*
- *Premalignant polyps: serrated polyps (excluding diminutive [1-5mm] rectal hyperplastic polyps) and adenomatous polyps*
- *Advanced colorectal polyps: serrated polyp ≥10mm, serrated polyp with dysplasia, adenoma ≥10mm, adenoma with high-grade dysplasia*
- *(L)NPCP: (Large; ≥20mm) non-pedunculated colorectal polyp*

Exceptions

* In general, we recommend no surveillance if life-expectancy <10y or if older than about 75y

‡ If patient is >10y younger than lower screening age and has polyps but no high-risk findings, consider colonoscopy at 5 or 10y

Refer to BSG hereditary CRC guidelines if:

Family history (FH) of colorectal cancer (CRC):
- 1 first-degree relative (FDR) diagnosed with CRC <50y, or
- 2 FDRs diagnosed with CRC at any age

Personal history of CRC
- <50y
- any age, who also has FDR with CRC at any age

Personal history of multiple adenomas:
- <60y with lifetime total ≥10 adenomas; or
- ≥60y with lifetime total ≥20 adenomas, or ≥10 + FH CRC/polyposis

Known/suspected inherited CRC predisposition syndromes including
- Lynch Syndrome or other polyposis syndrome
- Serrated Polyposis Syndrome:
  - ≥5 serrated polyps ≥5mm prox to rectum, with ≥2 of ≥10mm; or
  - ≥20 serrated polyps (any size) including ≥5 prox to rectum

Rutter et al., Gut 2020

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Patients for Clinical Review

Name	
NHS	
Date of Birth	
Reason for Clinical Review	
Completed Date & Time	
Completed by: Print & Sign	

Outcome	

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Review Date & Time	
Reviewed by: Print & Sign	

REFERENCES

- Rutter, et al. British Society of Gastroenterology/Association of Coloproctology of Great Britain and Ireland/Public Health England post-polypectomy and post-colorectal cancer resection surveillance guidelines. Gut (2020).

- NHS BCSP Publication No 1 September 2007 Reporting Lesions in the NHS BCSP.

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Monitoring Tool

Page/ Section of Key Document	Key control:	Checks to be carried out to confirm compliance with the policy:	How often the check will be carried out:	Responsible for carrying out the check:	Results of check reported to: *(Responsible for also ensuring actions are developed to address any areas of non-compliance)*	Frequency of reporting:
	WHAT?	**HOW?**	**WHEN?**	**WHO?**	**WHERE?**	**WHEN?**
Two	Accurate labelling of specimen pots.	SSP, endoscopy nurse(s) check specimen pot(s) against patient identification data and procedure report.	At the end of the colonoscopy procedure.	SSP and Endoscopy Nurse(s).	Endoscopy unit.	As AVIS raised.
Two	Completion of histopathology results on BCSS.	Reported date specimen received by pathology laboratory and date results reported.	On receipt of histopathology results.	SSP.	Incomplete datasets audit report.	Monthly.

Contribution List

This key document has been circulated to the following individuals for consultation;

Designation
BCSP Screening Director
BCSP Matron
Specialist Screening Practitioners (SSPs)
Lead SSP
SSPs
BCSP Programme Manager
BCSP Matron

This key document has been circulated to the chair(s) of the following committee's / groups for comments;

Committee
BCSP Operational Group
Endoscopy Directorate Meeting

Supporting Document 1 - Equality Impact Assessment Tool

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

		Yes/No	Comments
1.	**Does the policy/guidance affect one group less or more favourably than another on the basis of:**	No	
	• Race	No	
	• Ethnic origins (including gypsies and travellers)	No	
	• Nationality	No	
	• Gender	No	
	• Culture	No	
	• Religion or belief	No	
	• Sexual orientation including lesbian, gay and bisexual people	No	
	• Age	No	
2.	**Is there any evidence that some groups are affected differently?**	NA	
3.	**If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?**	NA	
4.	**Is the impact of the policy/guidance likely to be negative?**	NA	
5.	**If so can the impact be avoided?**	NA	
6.	**What alternatives are there to achieving the policy/guidance without the impact?**	NA	
7.	**Can we reduce the impact by taking different action?**	NA	

If you have identified a potential discriminatory impact of this key document, please refer it to Human Resources, together with any suggestions as to the action required to avoid/reduce this impact.

For advice in respect of answering the above questions, please contact Human Resources.

Supporting Document 2 – Financial Impact Assessment

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

	Title of document:	**Yes/No**
1.	Does the implementation of this document require any additional Capital resources	No
2.	Does the implementation of this document require additional revenue	No
3.	Does the implementation of this document require additional manpower	No
4.	Does the implementation of this document release any manpower costs through a change in practice	No
5.	Are there additional staff training costs associated with implementing this document which cannot be delivered through current training programmes or allocated training times for staff	No
	Other comments:	None

If the response to any of the above is yes, please complete a business case and which is signed by your Finance Manager and Directorate Manager for consideration by the Accountable Director before progressing to the relevant committee for approval