
2026
ACG SUMMER SCHOOL SERIES:
WOMEN'S LEADERSHIP COURSE, IBD SCHOOL AND ESOPHAGUS SCHOOL
JUNE 5-7, 2026 | WASHINGTON MARRIOTT AT METRO CENTER WASHINGTON, DC
Register online: meetings.gi.org

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ACG 2026
OCTOBER 9-14, 2026 | NASHVILLE, TN
CALL FOR Abstracts
SUBMISSION SITE OPENS MARCH 2, 2026
SUBMISSION DATES: MARCH 2 - JUNE 1, 2026
The American College of Gastroenterology invites you to submit abstracts for presentation at the 2026 Annual Scientific Meeting and Postgraduate Course. Abstracts must be clinical or research-oriented, with a focus on gastroenterology or hepatology.
IMPORTANT DATES
MARCH 2
Submission Site OPENS
JUNE 1 | 11:59 PM ET
Submission Site CLOSES (No Exceptions!)
BY JULY 17
Notification of abstract ACCEPTANCE
SEPTEMBER 16
Presenting Authors MUST REGISTER as an attendee
ABSTRACT CATEGORIES
Biliary/Pancreas
Colon
Colorectal Cancer Prevention
Diet, Nutrition, and Obesity
Endoscopy Video
Esophagus
Functional Bowel Disease
General Endoscopy
GI Bleeding
IBD
Infections and Microbiome
Interventional Endoscopy
Liver
Pediatrics
Practice Management
Small Intestine
Stomach and Spleen
Clinical Vignettes/Case Reports
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bit.ly/ACG2026_Abstracts

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2026
ACG FUNCTIONAL GI & MOTILITY DISORDERS SCHOOL & MIDWEST
REGIONAL POSTGRADUATE COURSE
DETROIT

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2026
ACG'S OBESITY AND METABOLIC DISORDERS SCHOOL &
ACG/VGS/MASGNA REGIONAL POSTGRADUATE COURSE
AUGUST 28-30, 2026 | WILLIAMSBURG LODGE, WILLIAMSBURG, VA
Register online: meetings.gi.org

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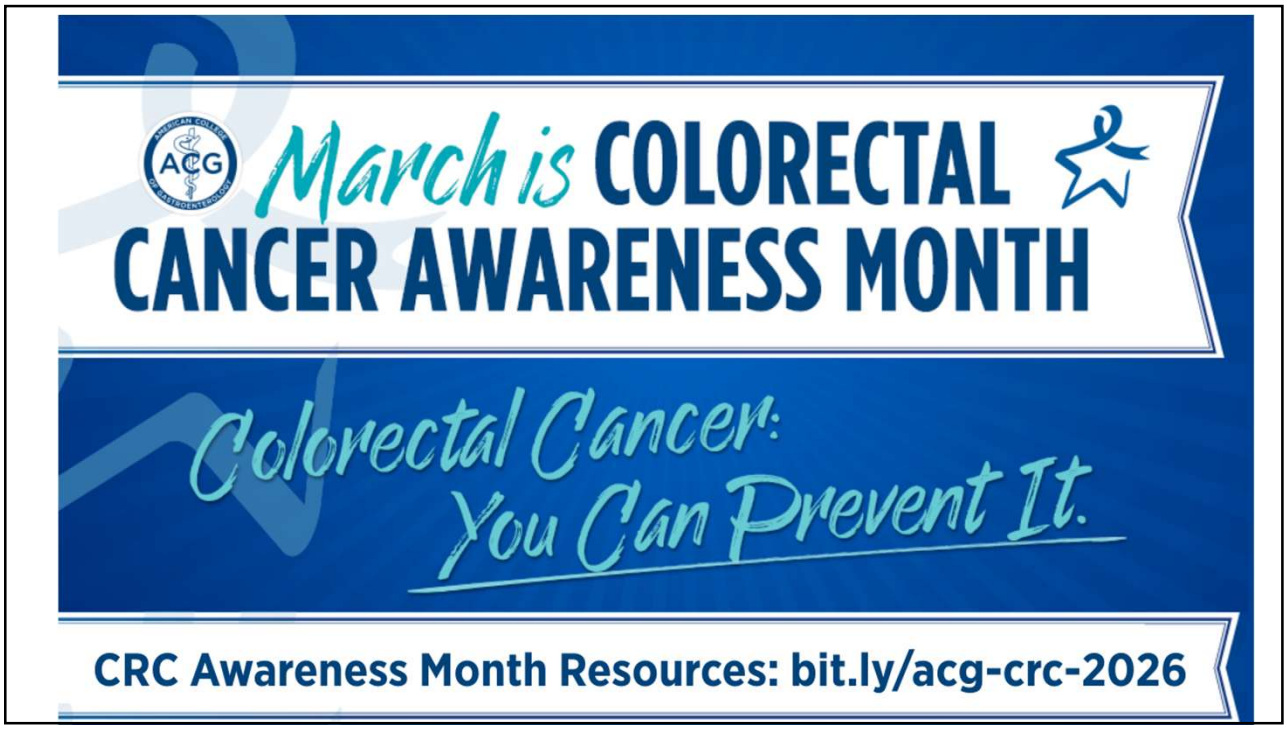
March is COLORECTAL CANCER AWARENESS MONTH
Colorectal Cancer: You Can Prevent It.
CRC Awareness Month Resources: bit.ly/acg-crc-2026

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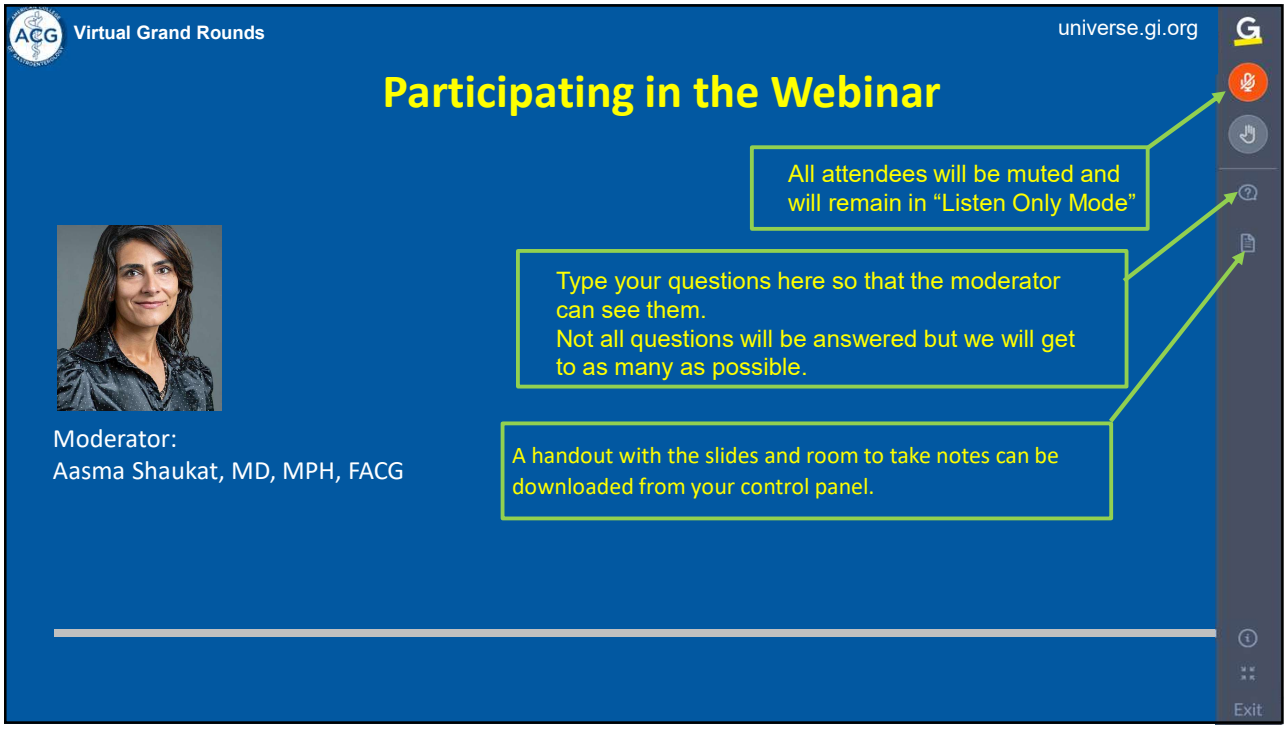
Virtual Grand Rounds
universe.gi.org
Participating in the Webinar
All attendees will be muted and will remain in "Listen Only Mode"
Type your questions here so that the moderator can see them.
Not all questions will be answered but we will get to as many as possible.
A handout with the slides and room to take notes can be downloaded from your control panel.
Moderator:
Aasma Shaukat, MD, MPH, FACG
Exit

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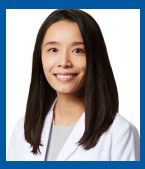
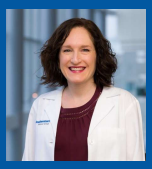
# ACG Virtual Grand Rounds

## Join us for upcoming Virtual Grand Rounds!

**Week 14 – Thursday, April 2, 2026**
There will be no ACG Virtual Grand Rounds presentation on Thursday, April 2, 2026.


**Week 15 – Thursday, April 9, 2026**
Parkinson's Disease and the Gut
Faculty: Amol Sharma, MD, MSc, FACG
Moderator: Ali Keshavarzian, MD, MACG
At Noon and 8pm Eastern

**Week 16 – Thursday, April 16, 2026**
Beyond PPIs: Optimizing GERD Therapy
Faculty: Anh D. Nguyen, MD
Moderator: Kerry B. Dunbar, MD, PhD
At Noon and 8pm Eastern

Visit **gi.org/ACGVGR** to Register

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GIQuIC

- **A gastroenterology registry developed by ACG and ASGE to track performance across various endoscopy quality metrics, including:**
  - **Adherence to recommended surveillance intervals**
  - **Adenoma detection rate**
  - **Cecal intubation rate**
  - **Adequacy of bowel prep**
  - **And more!**
- **GIQuIC also allows data to be contributed for research and to assist in developing guidelines for patient care**

**For more information, please email info@giquic.org or visit giquic.org**

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# Disclosures

Aasma Shaukat, MD, MPH, FACG:
Freenome: Consultant; Geneoscopy: Consultant; Iterative Health: Consultant; UnviersalDx: Consultant

Audrey H. Calderwood, MD, MS, FACG:
No relevant financial relationships with ineligible companies.

**All of the relevant financial relationships listed for these individuals have been mitigated*

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# Colon Cancer Screening and Polyp Surveillance: Considerations for the Older Adult

Aasma Shaukat, MD MPH
Audrey Calderwood, MD, MS

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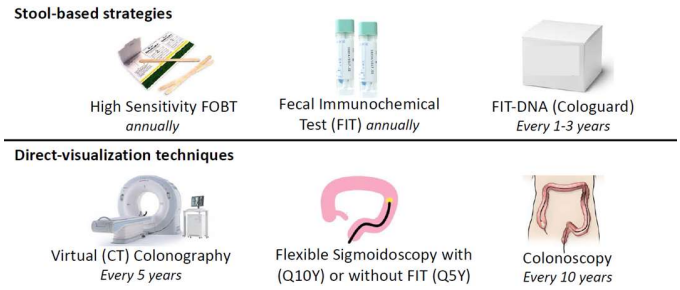
# Screening

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# Outline

01
**Current Screening Gaps**
Identify key areas where colorectal cancer cancer screening falls short of optimal coverage and effectiveness

02
**Emerging Testing Options**
Explore innovative blood-based and enhanced enhanced stool-based screening technologies technologies entering clinical practice

03
**Clinical Implications**
Summarize actionable insights for improving improving patient outcomes through enhanced screening strategies



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# Guidelines agree on age 45 for average risk screening

**ACG**
- Recommended in all adults 50 to 75 years of age
- Suggest in all average risk adults 45 to 49 years of age
- Recommend decision to screen after 75 be individualized

**USPSTF**
- Recommended in all adults 50 to 75 years of age
- Recommended in adults 45 to 49 years of age
- Recommended that clinicians selectively offer screening in adults 76-85 years of age

**MSTF**
- Suggested to all average-risk adults ages 45 to 49
- For adults ages 76 to 85, the decision to start or continue screening should be individualized and based on prior screening history, life expectancy, CRC risk, and personal preference
- Screening is not recommended after age 85

- Shaukat A. et al ACG Clinical Guidelines: AJG 2021;116:458-479; USPSTF. JAMA. 2021;325:1965-1977. Patel SG, et al. Am J Gastro. 2022. 117:57-69.

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## CRC Incidence:

Rise in younger individuals


Siegel RL et al. J Natl Cancer Inst. 2017;109(8):27-32

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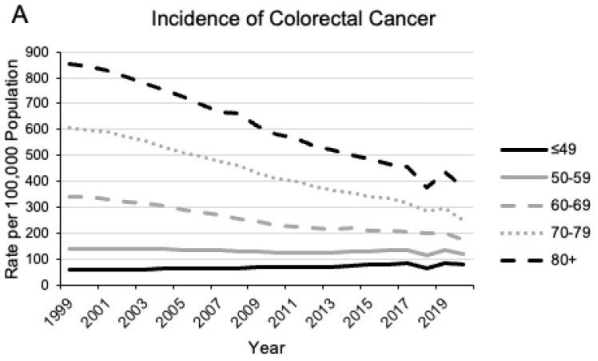
## CRC incidence in the US

- Age is the biggest risk factor for CRC
- Average age of sporadic CRC diagnosis is 64




www.cdc.gov/cancer/uscs/dataviz/download_data.htm

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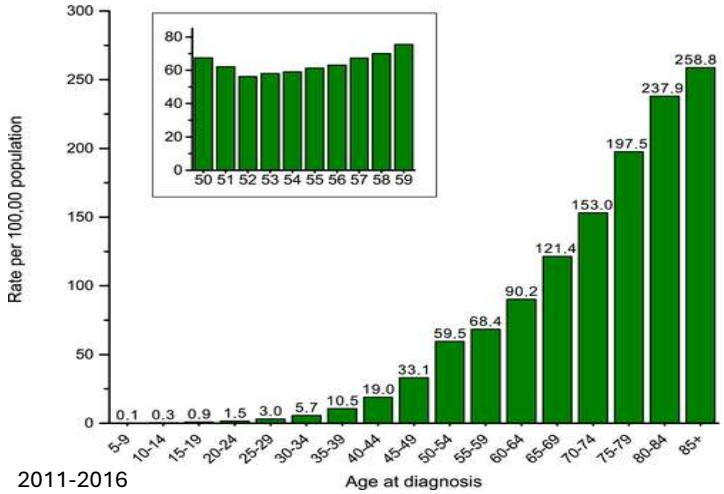
# Older Age as a risk factor




*Siegel R et al. CA: a cancer journal for clinicians 2020;70:145-164*

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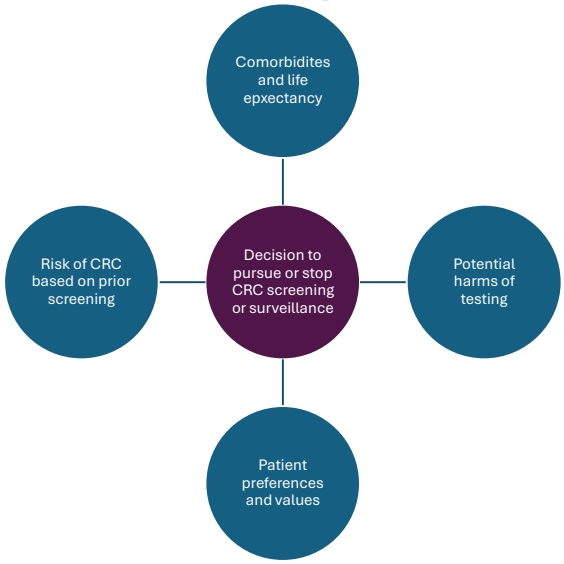
# Framework for approaching CRCS/S

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# Age to Stop Screening

**79-year-old, with hypothyroidism, OA, no prior screening**

**76-year-old with OA, CAD, ESRD and Parkinson's. Negative COL x3 (50, 60 and 70 years). No family hx**

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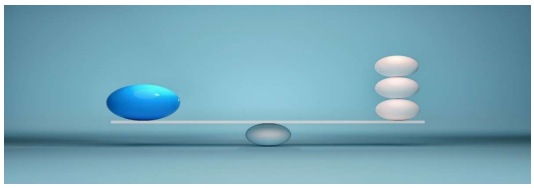
# Age to stop screening



Reducing incidence
Reducing mortality

Risk of anesthesia
Risk of complications
Limited LE limits benefit
Focus on other health priorities

**USPSTF, ACG and ACS:**

- Screening 75-85: Individualize decision
- Over age 85: Discourage Screening: Harms outweigh benefits

**Factors to consider:**

- Overall health, life expectancy, CRC screening history

US Preventive Services Task Force. Screening for Colorectal Cancer: US Preventive Services Task Force Recommendation Statement. *JAMA*. 2021;325(19):1965–1977; Wolf AMD et al. Colorectal cancer screening for average-risk adults: 2018 guideline update from the American Cancer Society. Cancer 2018. https://doi.org/10.3322/caac.21457

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# Age to stop screening

- MISCAN model
- Willingness to pay threshold of $100,000 per QALY
- Age, cancer risk, comorbidities and screening history

**NO PRIOR SCREENING COLONOSCOPY**

**NO COMORBIDITY[2]**

| Background risk for CRC[3] | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Age | 0.5 | 0.6 | 0.7 | 0.8 | 0.9 | 1.0 | 1.2 | 1.4 | 1.6 | 1.8 | 2.0 | 2.5[4] | 3.0[4] | 3.5[4] |
| 66 | 16 | 11 | 9 | 6 | 5 | 3 | 1 | CS | CS | CS | CS | CS | CS | CS |
| 68 | 17 | 12 | 9 | 7 | 5 | 4 | 2 | 0 | CS | CS | CS | CS | CS | CS |
| 70 | 19 | 14 | 10 | 8 | 6 | 5 | 2 | 1 | CS | CS | CS | CS | CS | CS |
| 72 | 24 | 17 | 13 | 10 | 8 | 7 | 4 | 2 | 1 | CS | CS | CS | CS | CS |
| 74 | 29 | 21 | 17 | 13 | 11 | 9 | 6 | 4 | 2 | 1 | 0 | CS | CS | CS |
| 76 | 36 | 27 | 22 | 18 | 15 | 12 | 9 | 7 | 5 | 4 | 2 | 0 | CS | CS |
| 78 | 49 | 36 | 30 | 24 | 21 | 18 | 14 | 11 | 9 | 7 | 6 | 3 | 1 | CS |
| 80 | 67 | 51 | 41 | 35 | 30 | 26 | 21 | 17 | 15 | 13 | 11 | 8 | 5 | 3 |
| 82 | 115 | 85 | 69 | 58 | 50 | 45 | 37 | 31 | 27 | 24 | 21 | 17 | 14 | 11 |
| 84 | 235 | 161 | 126 | 105 | 90 | 79 | 65 | 56 | 49 | 45 | 40 | 33 | 28 | 25 |
| 86 | >500 | 441 | 299 | 229 | 189 | 163 | 129 | 110 | 98 | 87 | 79 | 66 | 57 | 51 |
| 88 | NE | NE | NE | >500 | >500 | >500 | 405 | 312 | 263 | 222 | 199 | 160 | 134 | 120 |
| 90 | NE | NE | NE | NE | NE | NE | NE | NE | NE | >500 | >500 | >500 | >500 | 453 |

Hees F et al. Personalizing colonoscopy screening for elderly individuals by screening history, cancer risk, comorbidity status could improve cost effectiveness. Gastroenterology 2015;149:1425-37

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# Age to stop screening

**NEGATIVE SCREENING COLONOSCOPY 10 YEARS PRIOR**

**NO COMORBIDITY[2]**

| Background risk for CRC[3] | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Age | 0.5 | 0.6 | 0.7 | 0.8 | 0.9 | 1.0 | 1.2 | 1.4 | 1.6 | 1.8 | 2.0 | 2.5[4] | 3.0[4] | 3.5[4] |
| 66 | 124 | 73 | 51 | 37 | 28 | 22 | 14 | 9 | 5 | 3 | 1 | CS | CS | CS |
| 68 | 152 | 86 | 59 | 42 | 31 | 24 | 16 | 10 | 6 | 4 | 2 | CS | CS | CS |
| 70 | 202 | 108 | 70 | 50 | 38 | 29 | 19 | 12 | 8 | 5 | 3 | CS | CS | CS |
| 72 | 324 | 153 | 93 | 67 | 48 | 38 | 24 | 17 | 12 | 8 | 5 | 1 | CS | CS |
| 74 | >500 | 232 | 130 | 88 | 64 | 49 | 32 | 22 | 16 | 12 | 8 | 3 | CS | CS |
| 76 | >500 | 417 | 193 | 123 | 86 | 66 | 43 | 30 | 22 | 17 | 13 | 6 | 2 | CS |
| 78 | NE | >500 | 343 | 186 | 126 | 94 | 59 | 41 | 31 | 24 | 19 | 10 | 6 | 3 |
| 80 | NE | NE | >500 | 323 | 201 | 141 | 86 | 59 | 45 | 36 | 28 | 17 | 11 | 7 |
| 82 | NE | NE | NE | >500 | >500 | 325 | 168 | 107 | 80 | 64 | 51 | 34 | 24 | 18 |
| 84 | NE | NE | NE | NE | NE | >500 | 468 | 237 | 164 | 125 | 98 | 65 | 48 | 36 |
| 86 | NE | NE | NE | NE | NE | NE | NE | >500 | >500 | 349 | 245 | 142 | 99 | 79 |
| 88 | NE | NE | NE | NE | NE | NE | NE | NE | NE | NE | NE | >500 | 322 | 234 |
| 90 | NE | NE | NE | NE | NE | NE | NE | NE | NE | NE | NE | NE | NE | NE |

Hees F et al. Personalizing colonoscopy screening for elderly individuals by screening history, cancer risk, comorbidity status could improve cost effectiveness. Gastroenterology 2015;149:1425-37

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# Age to stop screening

Prior Screening

| | SEVERE COMORBIDITY[2] | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Background risk for CRC[3] | | | | | | | | | | | | | |
| Age | 0.5 | 0.6 | 0.7 | 0.8 | 0.9 | 1.0 | 1.2 | 1.4 | 1.6 | 1.8 | 2.0 | 2.5[4] | 3.0[4] | 3.5[4] |
| 66 | 335 | 160 | 104 | 74 | 56 | 45 | 30 | 21 | 16 | 12 | 9 | 4 | 1 | CS |
| 68 | >500 | 210 | 129 | 89 | 66 | 52 | 35 | 25 | 18 | 14 | 11 | 5 | 2 | CS |
| 70 | >500 | 373 | 187 | 125 | 92 | 70 | 47 | 34 | 25 | 20 | 15 | 9 | 5 | 2 |
| 72 | NE | >500 | 348 | 208 | 139 | 104 | 67 | 49 | 36 | 29 | 23 | 14 | 9 | 6 |
| 74 | NE | NE | >500 | 407 | 229 | 160 | 98 | 69 | 53 | 42 | 34 | 22 | 15 | 11 |
| 76 | NE | NE | NE | >500 | 427 | 272 | 148 | 100 | 75 | 60 | 49 | 32 | 23 | 18 |
| 78 | NE | NE | NE | NE | >500 | >500 | 298 | 177 | 128 | 99 | 79 | 53 | 39 | 31 |
| 80 | NE | NE | NE | NE | NE | NE | >500 | 334 | 220 | 164 | 127 | 81 | 60 | 48 |
| 82 | NE | NE | NE | NE | NE | NE | NE | >500 | >500 | 461 | 311 | 170 | 122 | 96 |
| 84 | NE | NE | NE | NE | NE | NE | NE | NE | NE | NE | >500 | 472 | 267 | 196 |
| 86 | NE | NE | NE | NE | NE | NE | NE | NE | NE | NE | NE | NE | >500 | >500 |
| 88 | NE | NE | NE | NE | NE | NE | NE | NE | NE | NE | NE | NE | NE | NE |
| 90 | NE | NE | NE | NE | NE | NE | NE | NE | NE | NE | NE | NE | NE | NE |

Hees F et al. Personalizing colonoscopy screening for elderly individuals by screening history, cancer risk, comorbidity status could improve cost effectiveness. Gastroenterology 2015;149:1425-37

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# Age to Stop Screening

- CRC microsimulation model, Microsimulation Screening Analysis (MISCAN)-colon
- Modelled Adherence to screening, age, comorbidities and sex
- Biennial FIT screening

| Comorbidities | Screening history | Stopping age | |
|---|---|---|---|
| | | Female | Male |
| None to low | None | 90 | 88 |
| Severe | None | 86 | 82 |
| Low | 75% | 82 | 80 |
| Severe | 25% | 80 | 78 |
| Modest | 75% | 78 | 76 |
| Modest | 100% | 72 | 72 |
| Severe | 100% | 66 | 66 |
| Severe | Colonoscopy 10 y prior | <66 | <66 |

Cenin et al. Calculation of stop ages for colorectal cancer screening based on comorbidities and screening history. *Clin J Gastroenterol.* 2021; 19: 547-555

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# Towards Personalized Screening

- Individualized risk score for harboring advanced neoplasia
- Based on:
  - Non-Modifiable factors: Age, Gender, Race/ethnicity, family history, polygenic risk score, prior screening
  - Modifiable factors: Smoking, BMI, ASA use, diet

Tao S et al. Development and validation of a scoring system to identify individuals at high risk for advanced colorectal neoplasms who should undergo colonoscopy screening. Clin Gastroenterol Hepatol. 2014;12:478-85
Cai QC et al. Derivation and validation of a prediction rule for estimating advanced colorectal neoplasm risk in average-risk Chinese. Am J Epidemiol. 2012 ;175(6):584-93
Kaminski MF et al. A score to estimate the likelihood of detecting advanced colorectal neoplasia at colonoscopy. Gut. 2014 ;63(7):1112-9
Shaukat A et al. Development nad validation of a clinical score for predicting risk of adenoma at screening colonoscopy. Cancer Epidemiol Biomarkers Prev 2015;24:913-20

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# How do patients feel about cessation of screening?

- 1500 veterans mailed survey, 1085 responded

| | |
|---|---|
| Not at all comfortable with cessation of low value CR screening | 300 (28.7%) |
| Age should never be used to decide when to stop screening | 509 (49.3%) |
| Not at all reasonable to use life expectancy calculators | 332 (31.7%) |
| Not at all reasonable to use CRC risk calculators | 255 (24.3%) |

**Factors associated with more comfort with screening cessation:**
(1) higher trust in physician
(2) higher perceived health status
(3) higher barriers to screening

Piper MS et al. Patient Attitudes Toward Individualized Recommendations to Stop Low-Value Colorectal Cancer Screening. JAMA Netw Open. 2018 Dec 7;1(8):e185461

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# Framework for CRC Screening discussion

- Focus on competing priorities
- Discuss concepts such as the duration of the adenoma-carcinoma sequence, lag time to benefit, and the risk of colonoscopy-related adverse events
- “screening after age 75 is unlikely to help people live longer” rather than “screening after age 75 is unlikely to find a new cancer”

Simmons LH, May FP, Gilliam MA. Understanding the Older Patient Perspective on Colorectal Cancer Screening Cessation. *JAMA Netw Open.* 2024;7(12):e2447806

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# Age to stop Screening

No calculators


- Clinical judgement, Shared decision making
- E consults, clinic visits or clinical pathways
- Document!

- Do NOT order a stool test if patient unable to undergo Colonoscopy
- Mts-DNA stool test specificity decreases with age

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# Polyp surveillance

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## Outline

01

**Overuse of polyp surveillance**

Identify factors, current practice, and existing existing guidance

02

**When to stop surveillance surveillance**

Propose a framework based on balance of of long term risk of CRC with different polyp polyp types and potential harms

03

**Opportunities to improve surveillance practice**

Highlight gaps in care and small steps that can that can be implemented into your practice practice



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# Surveillance growing in the US

- More people with colon polyps
  - Aging population (1 in 5; 78 million)
  - Increased uptake of screening
  - Improved technology
- Most common indication in adults ≥ 65 years
  - ~6 million surveillance colonoscopies performed in 2024
- Cadre of people coming attending repeated colonoscopies
  - Actual and perceived potential higher risk of CRC in polyp-bearing patients
  - Enthusiasm for cancer screening
  - Absence of US-based guidance on definitive stopping ages in surveillance

Lieberman D, Gastro 2012; Lieberman D, Gastrointest Endosc 2014
https://www.census.gov/data/tables/2023/demo/popproj/2023-alternative-summary-tables.html

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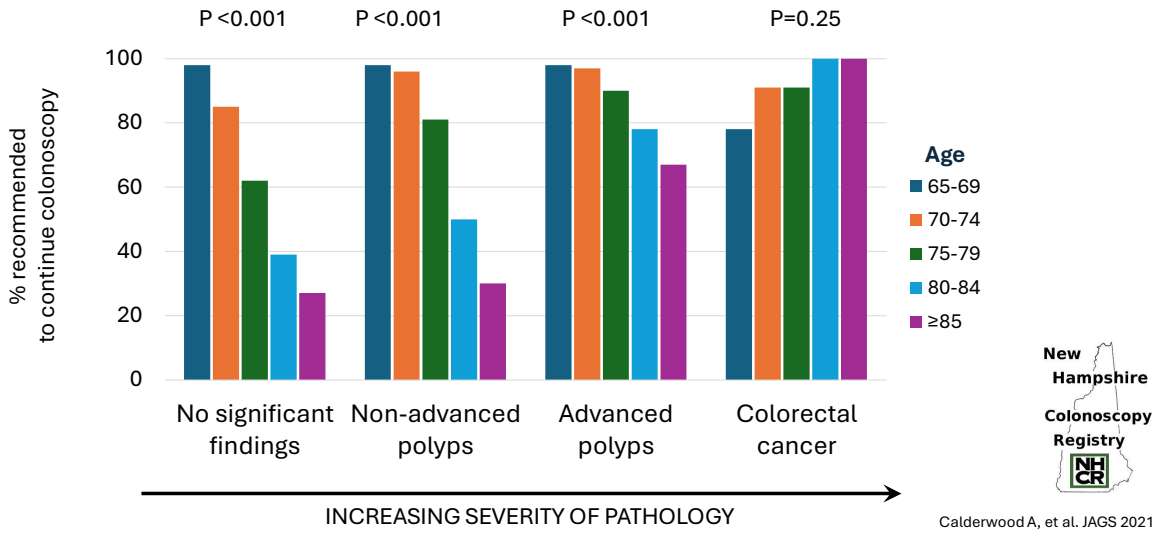
# Most patients recommended to return for surveillance regardless of finding and age




Calderwood A, et al. JAGS 2021

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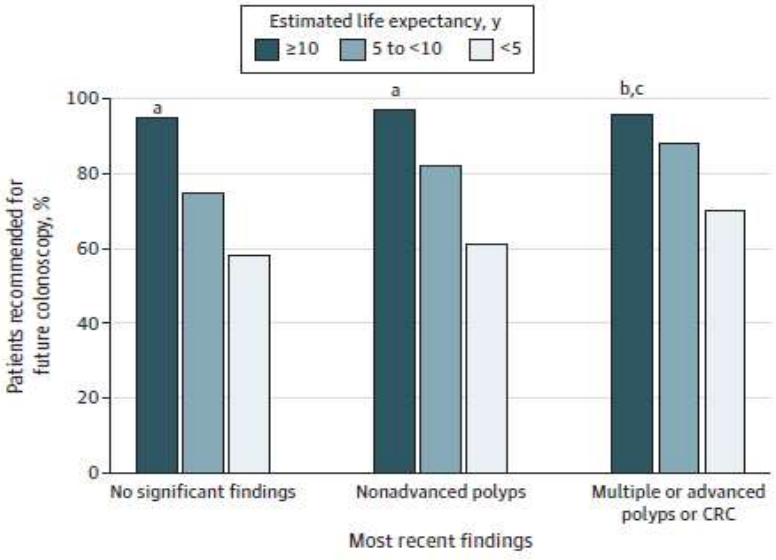
# Even when life expectancy is limited




N=5281

New Hampshire Colonoscopy Registry

Data.CMS.gov

Calderwood A, et al. Ann Intern Med 2023

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# When to Stop Polyp Surveillance

80-year-old healthy active lifestyle
- Advanced adenoma 3 years ago
- Brother with colorectal cancer at age 67

71-year-old with chronic kidney disease, coronary artery disease, and heart failure
- Screening colonoscopy 5 years ago with one 3 mm adenoma - difficulty prepping
- Wants to focus on quality of life
- Not worried about colorectal cancer

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# Guidelines on when to stop surveillance

| Society | Year | Surveillance Colonoscopy Recommendation |
|---|---|---|
| U.S. Multi-Society Task Force on Colorectal Cancer | 2020 | No recommendations |
| | 2012 | Individualize decision to continue, considering benefit, risk, and comorbidities |
| British Society of Gastroenterology (BSG)/ Association of Coloproctology of Great Britain and Ireland (ACPGBI)/Public Health England (PHE) | 2020 | Only perform life-expectancy >10 years<br>In general, not in people older than about 75 years |
| European Society of Gastrointestinal Endoscopy (ESGE) | 2020 | Stop age of 80 years<br>Stop earlier if life expectancy limited by co-morbidities |
| European Union | 2012 | Usually 75 years, dependent upon patient wishes and co-morbidity |

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# Concepts to consider

- How much will it help? — Magnitude of benefit
- When will it help? — Lag time to benefit
- Target surveillance — Life expectancy > lag time to benefit

Lee SJ, et al. JAMA 2013l 310:2609-10.

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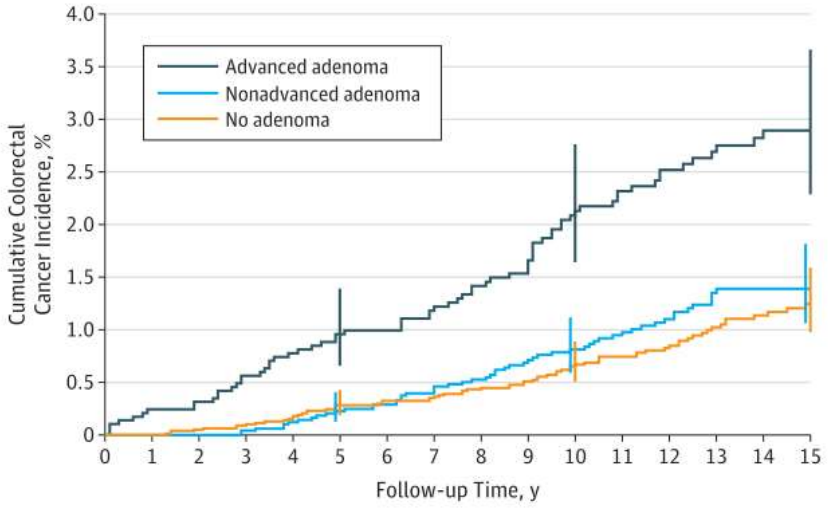
# Small polyps: no increase CRC risk or mortality




N= 15,900
13 years follow-up

Lee, et al. Gastro 2020 ; Click B et al. JAMA 2018

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# Lengthening of interval for low-risk adenomas

**High quality colonoscopy**
- Complete to cecum
- Adequate bowel prep to detect polyps > 5mm
- Adequate colonoscopist adenoma detection rate
- Complete polyp resection

→ **Risk-stratified repeat colonoscopy interval**

**LOW RISK ADENOMAS**
**5 years →**
**5-10 years →**
**7 to 10 years**

**10 years**
- Normal colonoscopy
- ≤ 20 HPs < 10mm

**7 to 10 years**
- 1 to 2 adenomas < 10mm

**5 to 10 years**
- 1 to 2 SSPs < 10mm

**3 to 5 years**
- 3 to 4 adenomas < 10mm
- 3 to 4 SSPs < 10mm
- HP ≥ 10mm

**3 years**
- 5 to 10 adenomas
- 5 to 10 SSPs
- Adenoma or SSP ≥ 10mm
- Adenoma with villous or tubulovillous histology and/or high grade dysplasia
- SSPs with dysplasia
- Traditional serrated adenoma

**1 year**
- > 10 adenomas

USMSTF on CRC Gastro 2020, Am J Gastro 3030; GIE 2020

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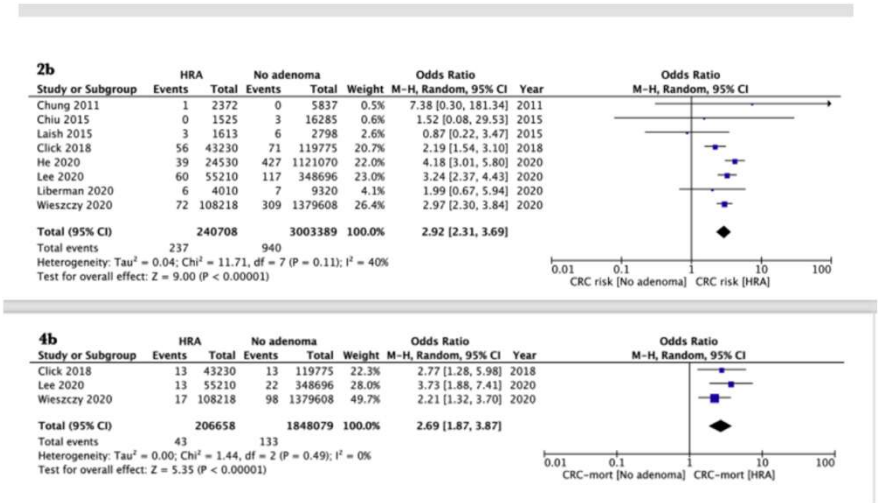
# High risk adenoma patients have increased risk of CRC

Meta-analysis
>500,000 patients




**Risk of CRC**
OR 2.92 (2.31-3.69)

**Risk of CRC death**
OR 2.69 (1.87-3.87)

Duvvuri, A et al. Gastro 2021

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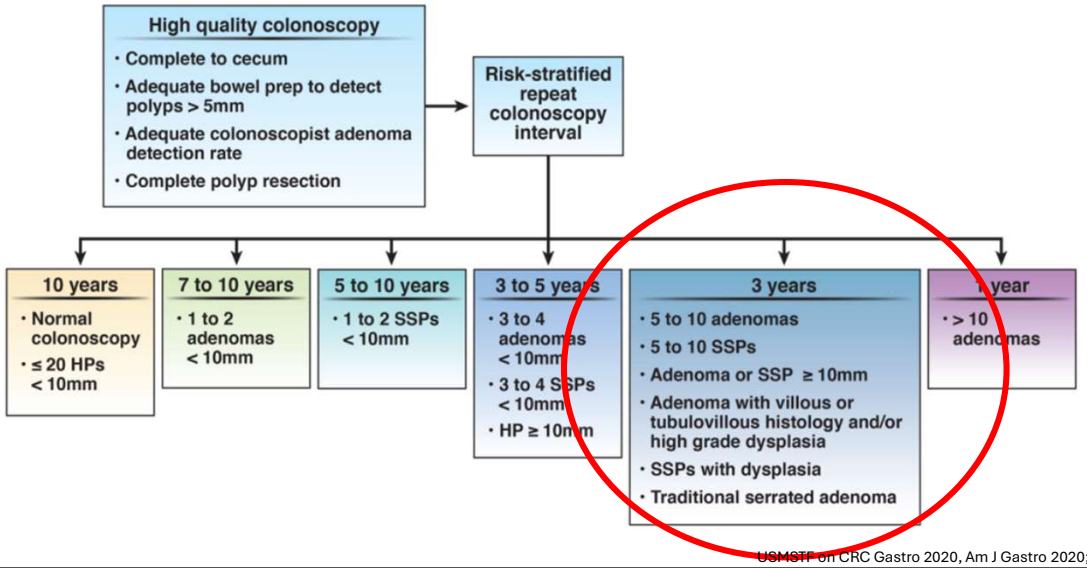
# 3-year interval for high-risk lesions




USMSTF on CRC Gastro 2020, Am J Gastro 2020; GIE 2020

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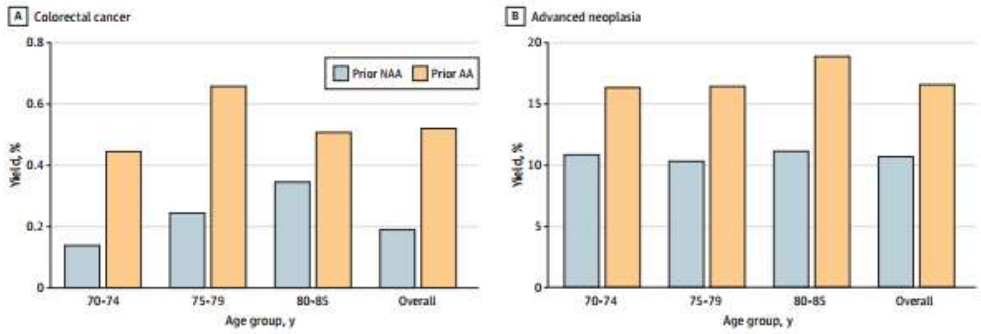
# Surveillance findings among 9600 patients age 70-85

- Overall CRC N=28 (0.3%) and advanced adenomas N=1141 (11.7%)

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# Surveillance findings among 9600 patients age 70-85

- Overall CRC N=28 (0.3%) and advanced adenomas N=1141 (11.7%)
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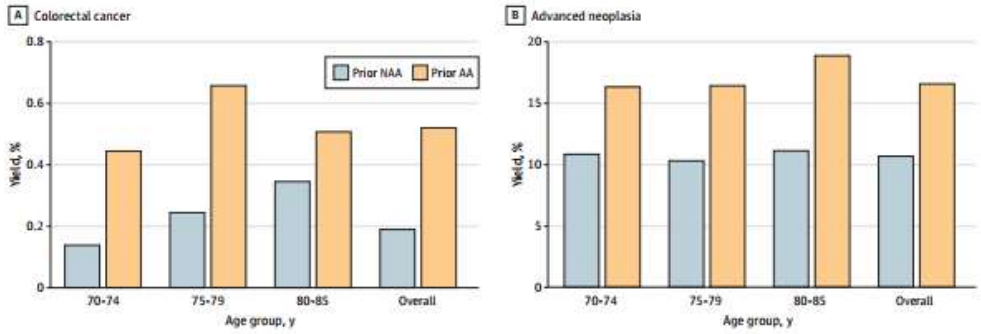


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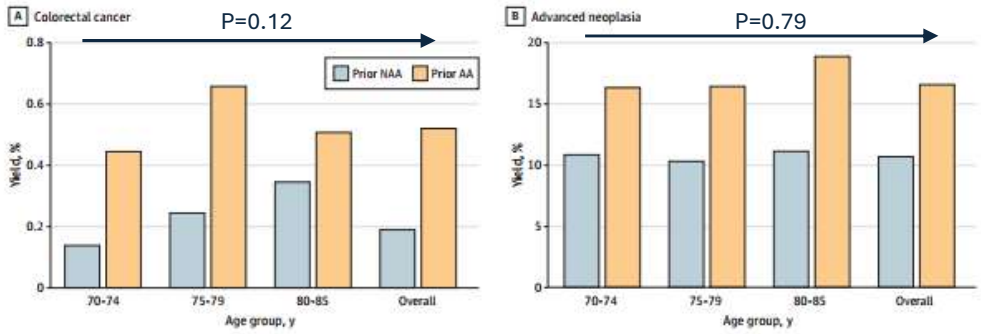


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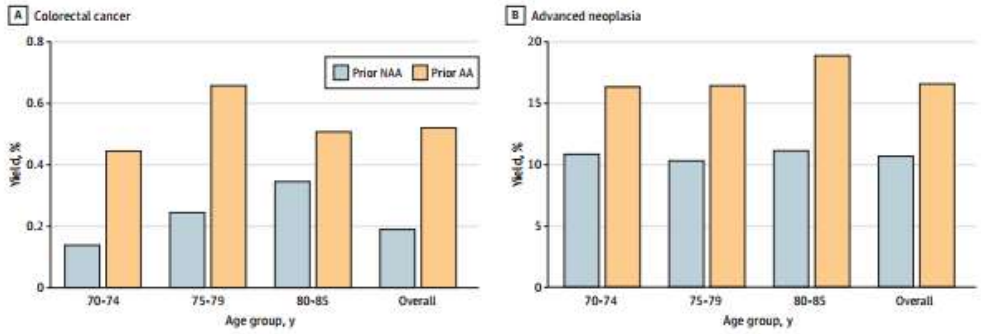
# Surveillance findings among 9600 patients age 70-85

- Overall CRC N=28 (0.3%) and advanced adenomas N=1141 (11.7%)
- No significant increase in yield by age
- Prior advanced adenoma - ↑ CRC (0.5% vs. 0.2%), advanced neoplasia (16.5% vs. 10.6%)

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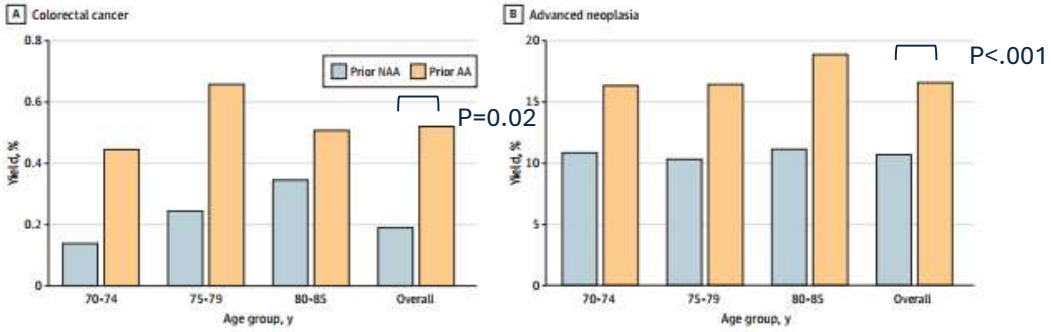


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# Most patients with ≥ 3 small adenomas likely low risk for CRC

- Increasingly common with modern colonoscopy
  - High adenoma detection rate paradox: Patients may have lower CRC risk but higher chance of aggressive surveillance
- Risk for advanced neoplasia and incident CRC may be low
  - Advanced neoplasia
    - 1.8% with 3-4 small adenomas vs. 1.2% with 1-2 small adenomas
    - 4.6% with >3 small adenomas vs. 6.3% with 1-2 small adenomas
  - Incident CRC per 10,000 person years
    - 10.2 with >3 small adenomas vs. 8.9 with 1-2 small adenomas
- Data suggest an opportunity for less aggressive surveillance for 3-4 adenomas

Rouphael C. J Clin Gastroenterol; Vemulapalli KC 2014; Click JAMA 2018

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# Relaxing of interval for multiple low-risk adenomas

**High quality colonoscopy**
- Complete to cecum
- Adequate bowel prep to detect polyps > 5mm
- Adequate colonoscopist adenoma detection rate
- Complete polyp resection

→ **Risk-stratified repeat colonoscopy interval**

**3-4 LOW RISK ADENOMAS**
**3 years→**
**3 to 5 years**

| 10 years | 7 to 10 years | 5 to 10 years | 3 to 5 years | 3 years | 1 year |
|---|---|---|---|---|---|
| • Normal colonoscopy<br>• ≤ 20 HPs < 10mm | • 1 to 2 adenomas < 10mm | • 1 to 2 SSPs < 10mm | • 3 to 4 adenomas < 10mm<br>• 3 to 4 SSPs < 10mm<br>• HP ≥ 10mm | • 5 to 10 adenomas<br>• 5 to 10 SSPs<br>• Adenoma or SSP ≥ 10mm<br>• Adenoma with villous or tubulovillous histology and/or high grade dysplasia<br>• SSPs with dysplasia<br>• Traditional serrated adenoma | • > 10 adenomas |

USMSTF on CRC Gastro 2020, Am J Gastro 3030; GIE 2020

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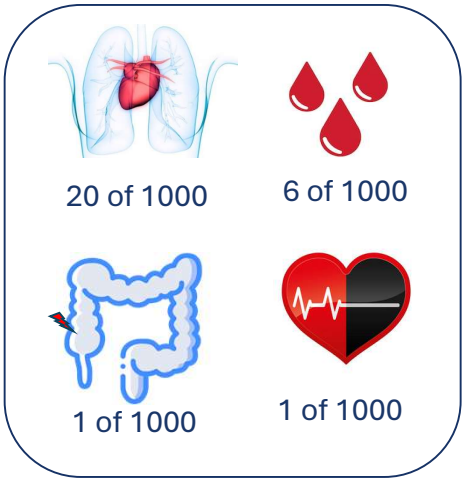
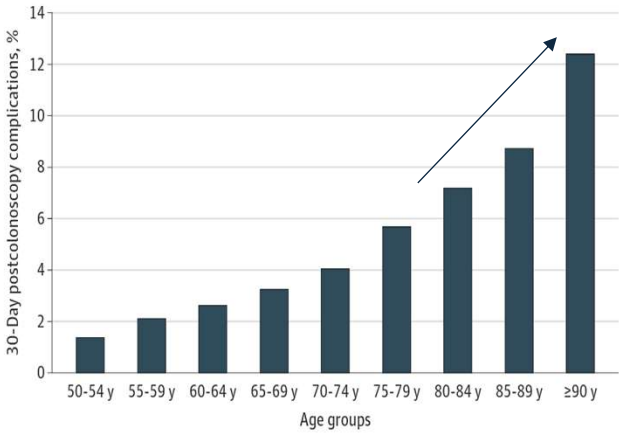
# Harms of colonoscopy increase with age

**28 out of 1000**




Warren J. Ann Int Med 2009; Ko CW, et al. Clin Gastro Hep 2010; Day LW, et al. Gastrointest Endosc 2011
Causada-Calo, et al. JAMA Network Open 2020

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# Harms of colonoscopy increase with age

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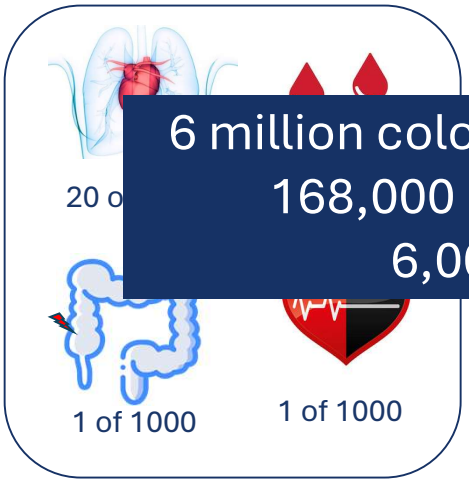
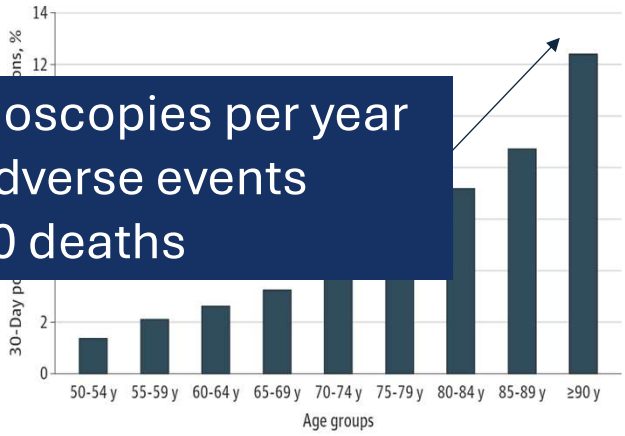



6 million colonoscopies per year
168,000 adverse events
6,000 deaths




Warren J. Ann Int Med 2009; Ko CW, et al. Clin Gastro Hep 2010; Day LW, et al. Gastrointest Endosc 2011
Causada-Calo, et al. JAMA Network Open 2020

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# Stopping surveillance more complex than screening

- Perceived high risk across all polyp types and history
- Timing of decision
  - Lead time of surveillance decision
- Ownership of decision-making unclear
- Automatic recall systems

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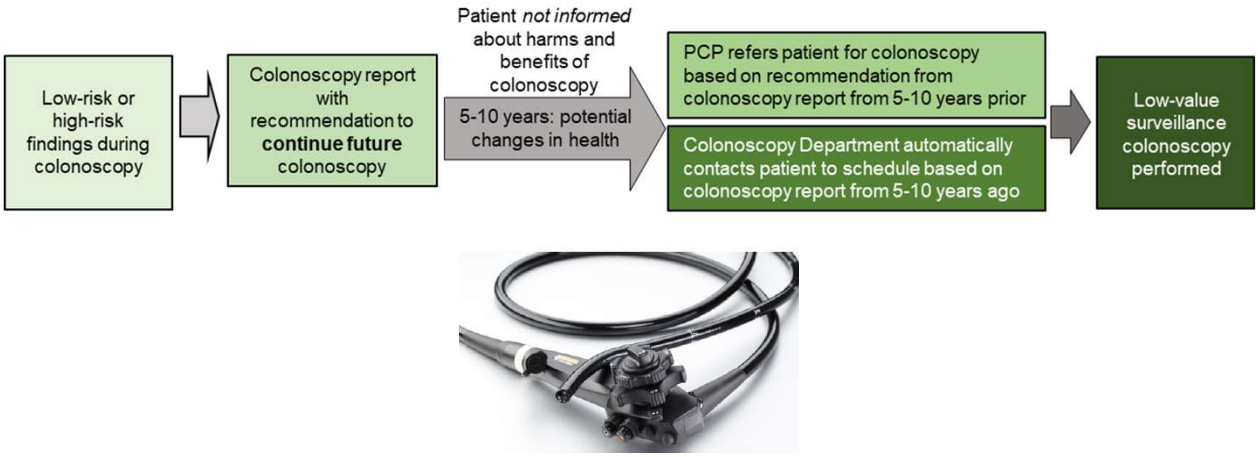
# Current surveillance processes promote ongoing use

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# De-escalation in older adults

- Consider context of whole patient – co-morbidities, function, preferences
- Age-specific CRC risk based on polyp history → refine magnitude of benefit when thinking about performing colonoscopy
  - 5-year risk of CRC
    - No polyps – 0.5%
    - LRA – 0.5%
    - AA – 0.8%
- Absence of studies evaluating de-implementation
  - Australian RCT of older adults - frailty assessments had no impact on surveillance colonoscopy decision-making
- Will surveillance affect care?
  - Review of patients >75 years undergoing colonoscopy, 10 out of 15 patients found to have CRC did not pursue treatment

Koloski N. Abstract DDW 2025; El Halabi J, JAMA IM 2023

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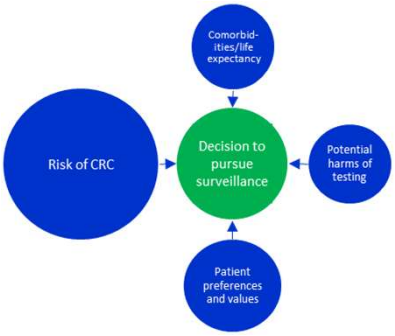
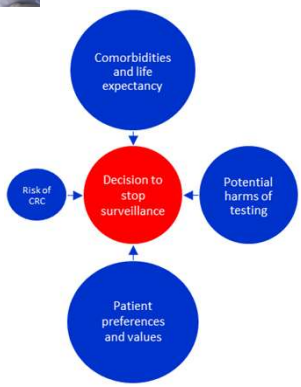
# When to Stop Polyp Surveillance

- Active 80-year-old
- Advanced adenoma 3 years ago
- Brother with CRC age 67

- 71-year-old with multiple co-morbidities
- Low risk adenoma 3 years ago
- Not worried about colorectal cancer

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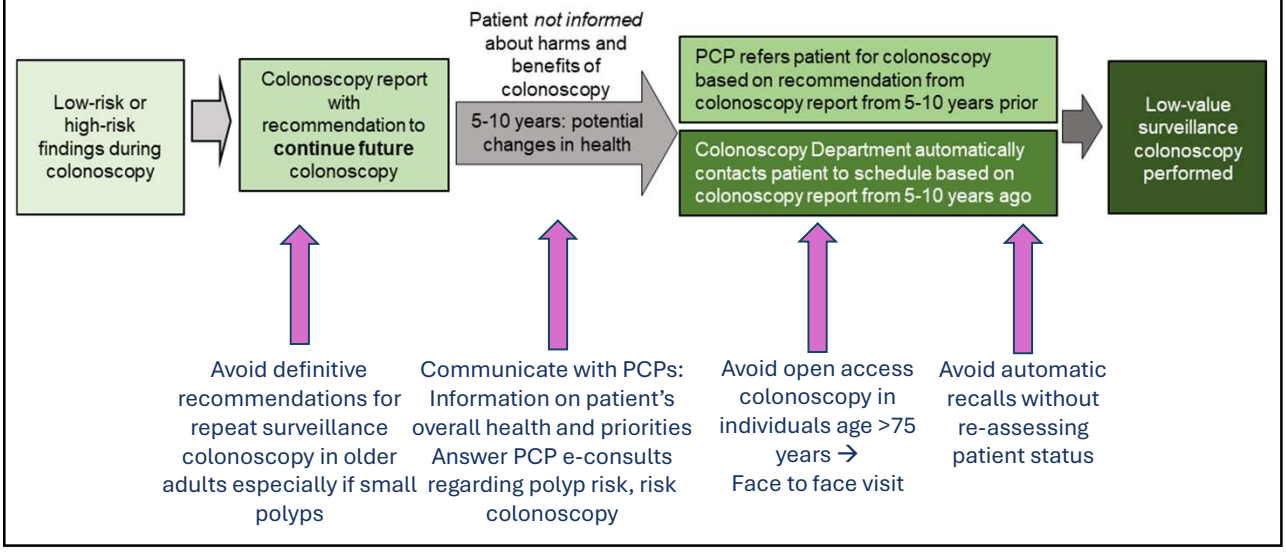
# Opportunities to improve surveillance practice

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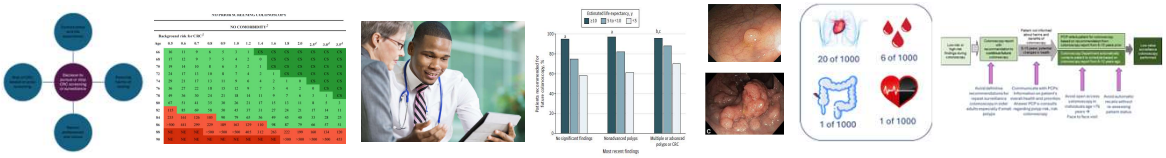
# Summary




- With increasing age, balance of benefits and harms of screening and surveillance can shift and requires individualized assessment
- Consider prior screening or polyp history, comorbidities, life expectancy and patient preferences
- Shared decision making and communication are important

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# Thank you

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# Questions

Aasma Shaukat, MD, MPH, FACG

Audrey H. Calderwood, MD, MS, FACG

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