

ALASKA NATIVE MEDICAL CENTER

Colorectal Cancer Screening Guidelines

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ALASKA NATIVE
MEDICAL CENTER



Table of Contents

Background..... 3

Introduction..... 5

Colorectal Cancer Risk Factors 6

Colorectal Cancer Symptoms..... 6

Screening Recommendations..... 6

 Table 1. Alaska Native Screening Age, Test and Interval Recommendations 7

Average Risk and High Risk Screening Recommendations 8

 Average Risk..... 8

 High Risk..... 8

Surveillance Recommendations 9

 Table 2. Recommendations for Surveillance and/or Screening Intervals in Individuals
 with Baseline Average Risk..... 9

 Table 3. Serrated Polyposis Syndrome (SPS) – WHO Diagnostic Criteria 9

Polyp Surveillance..... 10

Repeat Surveillance..... 10

Colonoscopy Quality Measures 11

References 12

Background

The natural history of colorectal cancer (CRC) makes it ideally suited to screening. Most colorectal cancers develop over many years from benign adenomatous polyps. Precancerous polyps can be detected and removed during screening procedures. When CRC is found early and appropriately treated, survival is greatly enhanced, with a five-year relative survival rate of 91%.¹ Colorectal cancer is the third most commonly diagnosed cancer in the United States, and ranks second among Alaska Native people, occurring at almost twice the rate of the US White population.¹ Alaska Native people have the highest CRC incidence (89 per 100,000) and mortality (36 per 100,000) rates in the US. It is double the rates in Non-Hispanic Blacks (42 and 18, respectively) and three times higher than Non-Hispanic Whites (36 and 13, respectively).¹ Incidence is higher at every age group, and as high in 40-49 year old Alaska Native people as in the Non-Hispanic White 50-59 year old age group (Figure 1).²⁻⁴

Nationally there has been an increasing incidence of early onset CRC among those aged <50 years, rising 3% per year since around 2010.¹ Among Alaska Native people, CRC among those aged 20-49 increased 5.2% annually between 1996-2019.⁵ Alaska Native people also have a disproportionately high burden of advanced adenomas, even in those aged 40-49,^{6,7} although cancer stage is similar to the US White population (Figure 2).^{3,4} CRC screening rates have been increasing among the Alaska Native population, but in contrast to other racial and ethnic groups, Alaska Native CRC incidence and mortality rates are not declining.⁸

Notes

Figure 1:

All populations

Rates are per 100,000 people and age-adjusted to the 2000 US Std Population (19 age groups - Census P25-1130) standard.

Error bars represent the 95% confidence interval around the estimated incidence rate.

Colorectal cancer is defined as a combination of site-histology recodes found in the Site Recode ICD-O-3/WHO 2008

Definition provided by SEER.

Figure 2:

All populations

Colorectal cancer is defined as a combination of site-histology recodes found in the Site Recode ICD-O-3/WHO 2008

Definition provided by SEER.

Stage

Stage information for the AIAN population is a combination of (in order of precedence) Summary Stage 2018, SEER Summary Stage 2000, Derived SS2000, SEER Summary Stage 1977, and Derived SS1977 depending on the availability of data.

Stage variables were recoded into four categories (localized, regional, distant, and unknown/NA).

Stage information for the US White population is a combination of (in order of precedence) Combined Summary Stage with Expanded Regional Codes (2004+), Summary Stage 2000 (1998-2017), and SEER historic Stage A (1973-2015) depending on the availability of data.

Stage variables were recoded into four categories (localized, regional, distant, and unknown/NA). Data were limited to include only malignant cancers. In practice, this means that no “in situ” cases were included in the data set.

Figure 1: Colorectal cancer incidence by age at diagnosis among Alaska Native People as compared to US White People (SEER 8), 2019-2023.

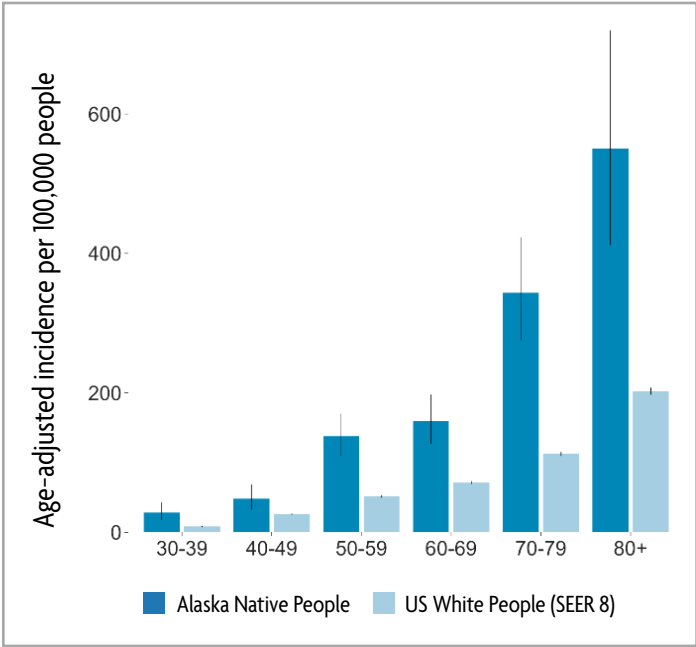
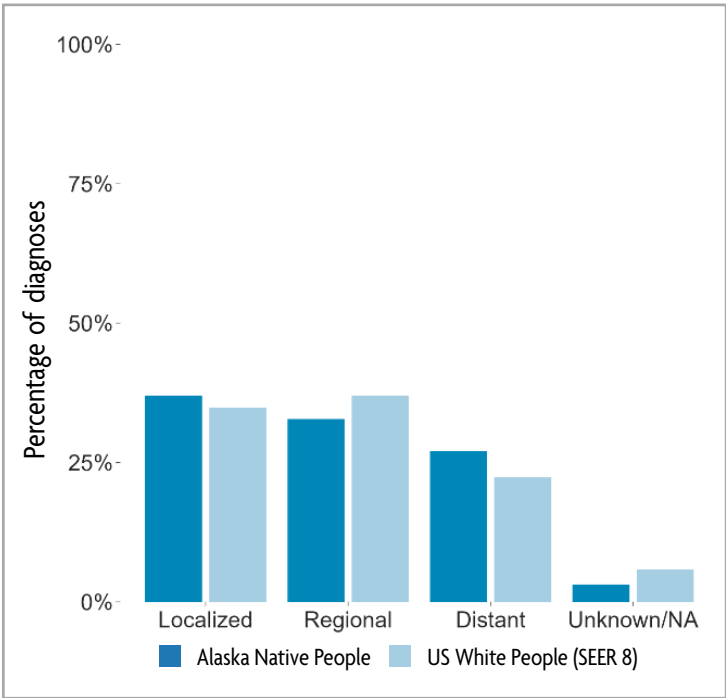


Figure 2: Percentage of colorectal cancer diagnoses by stage at diagnosis among Alaska Native People as compared to US White People (SEER 8), 2019–2023.



Introduction

The Alaska Native Medical Center Colorectal Cancer (CRC) Screening Guidelines were last updated in 2021. The current guideline revisions (2026) include some key recommendations and changes highlighted below.

1. Update of colonoscopy quality measures with new targets and additional quality indicators.

See Colonoscopy Quality Measures section.

Justification: The ANMC screening guidelines have been updated to reflect changes in national colonoscopy quality measures. These include higher targets for adenoma detection rate and bowel prep quality, as well as the addition of several new indicators. The first is the sessile serrated lesion detection rate (SSLDR). Serrated pathway lesions (sessile serrated lesions) account for a substantial fraction of interval cancers. An additional indicator is the rate of post procedure screening and surveillance intervals that are completed according to guidelines. Appropriate intervals avoid both over-surveillance (unnecessary procedures, harms, costs) and under-surveillance. These changes will bring the ANMC guidelines into accordance with the 2024 recommendations from the American College of Gastroenterology (ACG)/American Society for Gastrointestinal Endoscopy (ASGE) Task Force on Quality in Endoscopy.⁹

2. Addition of the multi-target stool DNA test (Cologuard) to the recommended screening tests for the Alaska Native population.

Justification: The multi-target stool DNA test (mt-sDNA; Cologuard) is a combination of a fecal immunochemical test (FIT) and markers for abnormal DNA. The test includes a patient navigation system and is recommended every 3 years. The mt-sDNA test has been tested in the Alaska Native population and had a 1-time sensitivity for CRC of 92%.^{10,11} Advantages of the mt-sDNA test include the highest single-time testing sensitivity for cancer of any noninvasive, non-imaging CRC screening test. It also has higher sensitivity for sessile serrated lesions than FIT. However, it has a lower specificity and high cost relative to FIT.¹² The mt-sDNA test needs to be received by the Abbott laboratory within 6 days of completion. Additionally, if the mt-sDNA is abnormal it requires follow-up colonoscopy similar to other home-based stool tests like FIT.

The mt-sDNA test has been evaluated in the Alaska Tribal Health System through several studies including a randomized controlled trial. It has been shown to be of high provider and patient interest, cost-effective, and feasible for use, especially when combined with patient navigation and programmatic outreach.^{10,13-16}

Colonoscopy remains the preferred screening test among Alaska Native people due to the high rates of pre-cancer and cancer in the population. However, other screening methods, like FIT or mt-sDNA may be appropriate for Alaska Native people who refuse or are unable to complete a screening colonoscopy. If mt-sDNA is used for screening, it should be repeated every three years. An abnormal mt-sDNA result should be followed up with referral for colonoscopy.

FIT is also an acceptable alternative for patients unable or unwilling to undergo colonoscopy and should be repeated on a yearly basis. An abnormal FIT result should be followed up with referral for colonoscopy.

Clinical Note

These guidelines are designed to assist clinicians and are not intended to supplant good clinical judgment or to establish a protocol for all patients with this condition. Patients with symptoms suggestive of possible CRC should be referred for diagnostic procedures and are not appropriate for screening. These guidelines are intended only for CRC screening. Evaluation of gastric cancer or other conditions should be done according to ANMC clinical guidelines available at <https://anmc.org/clinical-guidelines/>.

Colorectal Cancer Risk Factors¹

1. Age
2. Personal history of colorectal cancer or adenomatous polyps
3. Personal history of inflammatory bowel disease (ulcerative colitis or Crohn's disease)
4. Familial adenomatous polyposis (FAP) or hereditary nonpolyposis colorectal cancer (HNPCC)
5. Family history of colorectal cancer or adenomatous polyps
6. Obesity
7. Physical inactivity and unhealthy diet
8. Use of tobacco products and alcohol consumption

Colorectal Cancer Symptoms¹

Signs and symptoms of colorectal cancer typically occur only in advanced stages of the disease. The absence of symptoms should not be a reason to delay or ignore colorectal cancer screening.

1. A change in bowel habits such as diarrhea, constipation, or narrowing of the stool that lasts for more than a few days
2. Abdominal pain
3. A feeling of bloating
4. Bleeding from the rectum or blood in the stool
5. Anemia
6. Decreased appetite
7. Weakness and fatigue
8. Weight loss

Screening Recommendations

Colonoscopy is the preferred screening test for the Alaska Native population. Other options should be used only if colonoscopy is not available or for patients who prefer not to get a screening colonoscopy, including for patients with a positive family history who decline colonoscopy.^{17,18} The fecal immunochemical test (FIT) and the multi-target stool DNA test (mt-sDNA; Cologuard) are available as alternate tests for asymptomatic, average risk patients who refuse colonoscopy. These tests can be done at home and detect cancer at relatively high rates. To maximize the effectiveness of cancer detection and prevention, FIT needs to be done annually and mt-sDNA needs to be done every three years. All abnormal FIT and mt-sDNA results require a follow-up colonoscopy.

Table 1. Alaska Native Screening Age, Test and Interval Recommendations.¹⁸

Age	Risk Category	Test	Interval
40-75 years	Average risk ^a and healthy ^b	Colonoscopy*	10 years
		If colonoscopy refused/unavailable: FIT or mt-sDNA (age≥45)	Annual (FIT) Every 3 years (mt-sDNA)
	Moderate risk Colorectal cancer or an advanced adenoma ^c in a single first-degree relative diagnosed at age ≥60 years OR two second-degree relatives with CRC	Colonoscopy at age 40	Every 10 years
	High risk CRC or an advanced adenoma ^c in two first-degree relatives diagnosed at any age OR colorectal cancer or an advanced adenoma in a single first-degree relative at age <60 years	Colonoscopy at age 40 or 10 years before the age the youngest affected relative was diagnosed, whichever is earlier	Every 5 years
76-85 years	Average risk	No routine screening recommended unless healthy ^b and no screening has been done previously	None
	High risk Moderate risk	Continue surveillance until life expectancy <10 years and no high risk lesions	Follow surveillance interval recommendations
86 and older		No screening recommended	None

***Colonoscopy is the recommended screening test for the Alaska Native population.** Other screening options (FIT and mt-sDNA) should be offered only if colonoscopy is not available or patients prefer not to get a screening colonoscopy. An abnormal FIT or mt-sDNA requires follow-up colonoscopy.

Guaiac-based fecal occult blood testing (FOBT) and double contrast barium enema (DCBE) are not recommended as screening tests for the Alaska Native population.

^aAverage risk: Absence of inflammatory bowel disease, family history of CRC or advanced adenomas, hereditary syndrome associated with increased risk, serrated polyposis syndrome, personal history of CRC or advanced adenoma.

^bHealthy: No significant co-morbidities and life expectancy ≥10 years.

^cAdvanced adenoma: lesion ≥10 mm in size or having tubulovillous/villous histology or high-grade dysplasia.¹⁹

Average Risk and High Risk Screening Recommendations

Average Risk

Average Risk is defined as:

- No personal or family history of CRC or advanced colorectal lesions;
- No history of inflammatory bowel disease (ulcerative colitis or Crohn's disease);
- No history or suspicion of genetic syndromes such as Familial Adenomatous Polyposis (FAP) or Hereditary Non-Polyposis Colorectal Cancer (HNPCC), also known as Lynch syndrome.

Healthy Alaska Native men and women at average risk should begin colorectal cancer screening between ages 40 and 75. The preferred option is a colonoscopy every 10 years. If colonoscopy is declined or not appropriate, an annual FIT (ages 40–75) or mt-sDNA every three years (ages 45–75) may be used as alternative screening options. Guaiac-based fecal occult blood testing (FOBT) and double contrast barium enema (DCBE) are not recommended as screening tests for the Alaska Native population.

Between the ages of 76 to 85, no routine screening is recommended if the last colonoscopy was negative. If never screened, consider co-morbidities and life expectancy prior to recommending screening.

Moderate Risk

Moderate Risk is defined as:

- Persons with a family history of CRC or advanced adenoma in a first-degree relative who was diagnosed ≥ 60 OR in two or more second-degree relatives should have a colonoscopy every 10 years beginning at age 40.

High Risk

High Risk is defined as:

- A personal history on a previous colonoscopy of: advanced adenomas (lesion ≥ 1 cm in size or having high-grade dysplasia or villous elements¹⁹); advanced serrated lesions (sessile serrated lesion or traditional serrated adenoma ≥ 10 mm in size or a sessile serrated lesion with cytologic dysplasia); or 5-10 tubular adenomas < 10 mm;
- A personal history of colorectal cancer;
- A family history of CRC or documented history of advanced adenomas in two first-degree relatives diagnosed at any age OR colorectal cancer or an advanced adenoma in a single first-degree relative (parent, sibling, child) at age < 60 years;
- A person with family history even in absence of inherited syndromes;
- Personal history of inflammatory bowel disease (ulcerative colitis or Crohn's disease);
- Personal history or suspicion of genetic syndromes such as Familial Adenomatous Polyposis (FAP) or Hereditary Non-Polyposis Colorectal Cancer (HNPCC). Persons with inherited syndromes may develop other tumor types in addition to CRC, including tumors of the endometrial, ovarian, gastric, small intestine, brain, ureter, and biliary tract.²⁰

Persons with a family history of CRC or an advanced adenoma in two first-degree relatives diagnosed at any age OR colorectal cancer or an advanced adenoma in a single first-degree relative at age < 60 years should have a colonoscopy every 5 years beginning at age 40, or 10 years before the age the youngest affected relative was diagnosed, whichever is earlier.

Between the ages of 76 and 85, continued screening is recommended until life expectancy < 10 years and/or over age 85. No screening is recommended for patients over the age of 85, or who have significant co-morbid conditions, or have a life expectancy < 10 years.

Surveillance Recommendations

These surveillance recommendations do not include recommendations for follow-up for individuals with hereditary CRC syndromes (e.g., Lynch syndrome and familial adenomatous polyposis), inflammatory bowel disease, or a personal history of CRC (including malignant polyps).

Table 2. Recommendations for Surveillance and/or Screening Intervals in Individuals with Baseline Average Risk.^{9,21}

Baseline colonoscopy	Recommended interval for surveillance colonoscopy (years)
Normal	10
≤20 hyperplastic polyps <10 mm	10
1–2 tubular adenomas <10 mm	7
3–10 tubular adenomas <10 mm	3
Adenoma ≥10 mm	3
Adenoma with tubulovillous or villous histology	3
Adenoma with high-grade dysplasia	3
>10 adenomas on single examination	1
Piecemeal resection of adenoma ≥10 mm	6 months
1–2 sessile serrated lesions <10 mm	5
3–10 sessile serrated lesions <10 mm	3
Sessile serrated lesions ≥10 mm	3
Sessile serrated lesions with dysplasia	3
Serrated adenoma, traditional	3
Serrated adenoma, unclassified	3
Serrated polyposis syndrome	1–2
>10 sessile serrated lesions on single examination	1
Hyperplastic polyps ≥10 mm	3
Piecemeal resection of sessile serrated lesion ≥10 mm	6 months

Note: All recommendations assume examination complete to cecum with bowel preparation adequate to detect lesions >5 mm in size.

Table 3. Serrated Polyposis Syndrome (SPS) – World Health Organization (WHO) Diagnostic Criteria.²²

Criterion	Description
Criterion 1	At least 5 serrated polyps proximal to the rectum, all ≥5 mm in size, with 2 or more ≥10 mm
Criterion 2	More than 20 serrated polyps of any size distributed throughout the colon, with at least 5 proximal to the rectum

Note: Criteria apply cumulatively over time (not just a single colonoscopy). A patient needs to meet only one of the two criteria, not both.

Polyp Surveillance

Polyp surveillance guidelines are based on national recommendations.^{9,21} Discontinuation of surveillance colonoscopy should be considered in persons with serious co-morbidities or with <10 years life expectancy OR at age ≥ 85 . Patients with a history of CRC, genetic syndromes (FAP, HNPCC, etc.) or ulcerative colitis should be followed at appropriate intervals using colonoscopy.

- Patients with no polyps or ≤ 20 hyperplastic polyps <10 mm in the rectum or sigmoid colon should be considered to have normal colonoscopies and should be rescreened in 10 years.
- Patients with one or two small (<10 mm) tubular adenomas should have their next surveillance colonoscopy in 7 years. The precise timing of this interval should be based on other clinical factors such as prior colonoscopy findings, family history, and the preferences of the patient and judgment of the physician.
- Patients with three to ten tubular adenomas <10 mm should have their next surveillance colonoscopy in 3 years.
- Patients with an adenoma >10 mm or greater should have their next surveillance colonoscopy in 3 years.
- Patients with adenomas with tubulovillous or villous histology, or an adenoma with high-grade dysplasia, should have their next surveillance colonoscopy in 3 years.
- Patients with 10 or more adenomas on single examination should have their next surveillance colonoscopy in 1 year.
- Patients with piecemeal resection of adenoma or resection of sessile serrated lesion ≥ 10 mm should be rescoped in 6 months.
- Patients with one to two sessile serrated lesions <10 mm with no dysplasia should have their next surveillance colonoscopy in 5 years.
- Patients with three to ten sessile serrated lesions <10 mm with no dysplasia should have their next surveillance colonoscopy in 3 years.
- Patients with sessile serrated lesions ≥ 10 mm OR sessile serrated lesions with dysplasia OR traditional serrated adenoma OR serrated adenoma (unclassified) should have their next surveillance colonoscopy in 3 years.
- Patients with >10 sessile serrated lesions on single examination should have their next surveillance colonoscopy in 1 year.
- Patients with serrated polyposis syndrome (at least five serrated polyps proximal to the rectum, all ≥ 5 mm in size, with 2 or more ≥ 10 mm OR >20 serrated polyps of any size distributed throughout the colon, with at least five proximal to the rectum) should have their next surveillance colonoscopy in 1-2 years.
- Large hyperplastic polyps (≥ 10 mm), especially polyps located proximal to the splenic flexure or those seen in the context of serrated polyposis syndrome (previously known as hyperplastic polyposis syndrome) are now considered more likely to harbor malignant potential and may undergo malignant transformation more rapidly than adenomatous polyps. Patients with these atypical flat hyperplastic polyps should have their next colonoscopy in 3 years.²³

Repeat Surveillance

For patients with history of baseline adenoma removal and 1 subsequent colonoscopy, recommendations for subsequent surveillance should take into account findings at baseline and first surveillance.²¹

Colonoscopy Quality Measures

The following are quality measures that are indicative of high quality colonoscopy and should be measured when infrastructure is in place to allow consistent and reliable data collection.^{9,24}

- Bowel preparation is adequate to detect polyps ≥ 5 mm with description of bowel prep using the Boston Bowel Preparation Scale
 - GOAL: $\geq 90\%$
- Adenoma detection rate (ADR) for average risk patients^a
 - GOAL: $\geq 35\%$ overall
 - GOAL: $\geq 40\%$ for male patients
 - GOAL: $\geq 30\%$ for female patients
 - GOAL: $\geq 50\%$ for colorectal screening test-positive (e.g., FIT+, mt-sDNA+)
- Adenomas Per Colonoscopy (APC). Number of conventional adenomas detected per colonoscopy⁹
 - GOAL: ≥ 0.6
- Sessile Serrated Lesion Detection Rate (SSLDR)
 - GOAL: $\geq 6\%$
- Cecal intubation rate with photodocumentation of cecal landmarks
 - GOAL: $\geq 95\%$ for screening colonoscopies
- Photodocumentation of polyps ≥ 10 mm. Photo should include an open snare or biopsy forceps to allow size comparison.
 - GOAL: $\geq 80\%$
- Percentage of polyp resections for which the report documents the lesion size, shape, location, and method of resection
 - GOAL: $\geq 98\%$
- Recommended Screening/Surveillance Interval Adherence
 - GOAL: $\geq 90\%$

Additional Indicators

- Average withdrawal time for all colonoscopies regardless of biopsy or polypectomy
 - GOAL: ≥ 8 minutes
- Cold-snare use for 4–9 mm lesions
 - GOAL: $\geq 90\%$
- Serious adverse events monitoring
 - GOAL: $\geq 95\%$ of serious adverse cases (i.e. perforation, delayed bleeding, or death) are tracked/documented/reviewed by QI committee

^aADR goal for men and women is set at the national quality benchmark for average risk screening and is a minimum threshold. Alaska Native ADR is expected to be higher.

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