Clinical practice guidelines for the prevention, early detection, and management of colorectal cancer: Population Screening. Appendix A.

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Appendix A. Guideline development process

Introduction

The review and update of the Population screening for colorectal cancer and Risk and screening based on family history chapters of the 2017 Clinical practice guidelines for the prevention, early detection, and management of colorectal cancer (the 2017 guidelines, in short), was completed to reflect the emerging evidence around the target age range for the National Bowel Cancer Screening Program (NBCSP).

This current revision and update was commissioned and funded by the Department of Health and Aged Care.
Guideline development, in line with NHMRC procedures and requirements, commenced in May 2022.

Guidelines Development Group

A Working Party of key experts in colorectal cancer was established to support and oversee the update. Key experts involved in the development of the 2017 Guidelines were included and the group was broadened to cover the majority of jurisdictions across Australia. Professor Tim Price, co-chair of the 2017 Guidelines, retained his position as chair of the current guideline chapter updates. Additionally, the Working Party included three Consumer representatives. The update was guided by the clinical questions and processes outlined below by chapter.

The Project Team worked to find interested, available and suitable consumer and expert representatives to be involved with the Working Party who could represent Aboriginal and Torres Strait Islander communities, consumers, and their experiences. Several organisations and contacts were consulted, including Wellbeing South Australia, National Aboriginal Community Controlled Health Organisation (NACCHO) and Cancer Council's Cancer Screening and Immunisation Committee (consisting of state and territory federation members). Unfortunately, the inclusion of Aboriginal and Torres Strait Islander representation specifically in the Working Party, was unable to be secured. However, clinicians working closely with Aboriginal and Torres Strait Islanders along with contacts from Wellbeing SA and NACCHO have provided guidance and review support throughout the development of the guideline chapter

updates. Public consultation was an open process inviting feedback from any interested parties. Comments were received from a number of organisations and individuals relating to Aboriginal and Torres Strait Islander issues. These comments were taken to the Working Party and updates to the guidelines were made where agreed and appropriate.

Population screening for colorectal cancer

Clinical Question: Is population screening based on testing with (a) immunochemical faecal occult blood test (iFOBT), (b) flexible sigmoidoscopy (FSG), (c) colonoscopy, (d) computed tomography (CT) colonography, (e) faecal biomarkers such as DNA, (f) plasma biomarkers such as DNA, (g) any combination of the above screening tests effective in reducing colorectal cancer mortality, colorectal cancer incidence or the incidence of metastases at diagnosis, feasible, acceptable and a cost-effective method of screening for the target population?

a) Is population screening starting at an earlier age more effective, feasible, acceptable and cost-effective, compared with starting at age 50 years? [with 2-yearly iFOBT screening]

b) In population screening, do the harms outweigh the benefits if routine screening by any method is continued beyond the age of 75 years?

The development and update of this question was guided by current evidence and practice and agreed upon by the Working Party. From this clinical question, specific PICO (population, intervention, comparator and outcome) questions were formulated by the Project Team in consultation with the Working Party, and systematic reviews were conducted.

Technical reports of the systematic reviews and predictive modelling studies were completed, and the evidence was appraised using a hybrid approach. This hybrid approach reflects the transition of the former evidence appraisal guidance to the Grading of Recommendations, Assessment, Development and Evaluations (GRADE) methodology now used. The clinical question for population screening was informed by two systematic reviews (PSC1a and PSC1b) and two modelling reports (PSC1c and PSC1d).

An additional modelled evaluation was considered by the Working Party based on a published analysis of age extension modelling for Aboriginal and Torres Strait Islander peoples (1). A summary of the systematic review questions is shown in Table 1 and a summary of the modelling evaluation aims is shown in Table 2.

Table 1. Summary of systematic review questions

PICO	**Systematic Review Question**
PSC1a	In persons without a colorectal cancer diagnosis or symptoms that might indicate colorectal cancer, which screening modalities (iFOBT, flexible sigmoidoscopy, colonoscopy, CT colonography, faecal or blood biomarkers, or any combination) compared with no screening, reduce colorectal cancer mortality, colorectal cancer incidence or the incidence of metastases at diagnosis?
PSC1b	For persons without a colorectal cancer (CRC) diagnosis or symptoms that might indicate colorectal cancer, which screening modality (iFOBT, faecal or blood biomarkers, or any combination) performs best in detecting colorectal cancer, and how does the diagnostic performance change with family history, age, or sex?

Table 2. Summary of modelled evaluation aims

	Modelled Evaluation Aims
PSC1c	**Alternative screening age range:** To evaluate the health benefits (i.e. CRC incidence and mortality reduction and life-years saved), burden (i.e. the number of colonoscopies used), harms (i.e. the number of colonoscopy-related adverse events), and cost-effectiveness of extending the NBCSP age range from 40 years of age to 84 years of age using a modelling approach.
PSC1d	**Alternative test technologies:** To evaluate the health benefits (as measure by CRC incidence and mortality reduction and life-years saved), burden (as

	measured by the number of colonoscopies used), harms (i.e. the number of colonoscopy-related adverse events), and cost-effectiveness of yearly iFOBT or 5-yearly faecal biomarker screening, compared to 2-yearly iFOBT screening.
Published evaluation [1]	**Age extension modelling for Aboriginal and Torres Strait Islanders:** To evaluate the health outcomes and cost-effectiveness of the NBCSP and evaluate the potential health benefits and cost-effectiveness of extending the NBCSP to include people from 40 years of age

[1] Lew JB, Feletto E, Worthington J, Roder D, Canuto K, Miller C, et al. The potential for tailored screening to reduce bowel cancer mortality for Aboriginal and Torres Strait Islander peoples in Australia: Modelling study. Journal of Cancer Policy. 2022 Jun;32:100325.

Risk and screening based on family history

Clinical Question: What is the strength of association between family history and colorectal cancer (CRC) risk and what screening strategies should be used for people with a family history based on age, sex, number and relatedness of relatives with CRC?

The development and update of this question was guided by current evidence and practice and agreed upon by the Working Party. From this clinical question, a specific PECO (population, exposure, comparator and outcome) question was formulated by the Project Team in consultation with the Working Party. The systematic review was conducted based on the following PECO question:

> For asymptomatic individuals, is a family history of CRC associated with an increase in risk of occurrence of or death from CRC when compared to individuals who do not have a family history of CRC; and how does this association vary by age and sex of the asymptomatic individuals, and with age, sex, number, and relatedness of relatives with CRC.

A technical report of the systematic review was completed, and the evidence was appraised. Assessment of the certainty of evidence using Grading of Recommendations, Assessment, Development and Evaluations (GRADE) methodology was considered. As GRADE is designed to assess evidence for interventions rather than exposures, it was not possible to assess the certainty of the evidence using this method. Specifically, it was not possible to assess the certainty of the evidence based on study design and to

assess the imprecision of estimates of the magnitude of risks associated with exposures using GRADE methodologies. As a result, the body of evidence (design, number and size of studies and their risk of bias), consistency and clinical impact are assessed along with the generalisability and applicability.

Development of recommendations and practice points

Based on the updated evidence, the Working Party formulated recommendations and practice points for both chapters. Evidence-based recommendations (EBR) were developed through a structured process, considering the body of evidence and its relevance to Australian clinical practice. Each EBR was assigned a grade (either strong or weak) by the expert Working Party, taking into account the certainty of the body of evidence for the 2023 update and the evidence base and consistency for the 2005 guidelines and 2017 update evidence, as well as the generalisability, applicability, acceptability, feasibility and clinical impact of the body of evidence using the using the NHMRC evidence statement form.

Practice points were also developed or adapted to support the recommendations and provide guidance on areas not examined by a systematic review. Practice points were developed where there were issues out of scope of a systematic review. The wording used in the practice points reflects the urgency of the issue. In some cases, the practice points indicate the likelihood of a benefit as a way of highlighting the importance of an issue rather than its urgency.

Table 3. Types of recommendations included in these guidelines.

Type	**Process**
Evidence-based recommendations (EBR)	Recommendations based on systematic review conducted for these guidelines
Practice points (PP)	Guidance on a topic for which a systematic review was not conducted, or for which issues were out of scope of the systematic review undertaken

The Working Party followed a structured process and consensus was reached through formal meetings and offline correspondence, where required. The recommendations and practice points were circulated to the Working Party for comments and a voting process was used, both in meetings and offline correspondence, to reach consensus. In this way, Working Party members were able to comment on each recommendation and practice point across the guideline chapters. Any uncertainties were raised and discussed with the Guidelines chair. Comments and suggested changes were circulated to the Working Party. All subsequent changes were raised, discussed, and voted on in Working Party meetings and offline correspondence until no further concerns were raised and it was considered that a consensus had been reached.

The literature searches conducted as part of the systematic reviews were designed to capture priority groups including Aboriginal and Torres Strait Islander populations. Although, no evidence for priority groups was identified for inclusion, it is important to acknowledge related issues including the impact of cultural determinants of health, ongoing effects of colonisation, systemic racism, stigma and social marginalisation on the provision of health care. Successful implementation of population colorectal cancer screening in Australia requires the provision of culturally sensitive and safe health care. Culturally sensitive and safe health services can be provided through an understanding, consideration and respectful accommodation of an individual's cultural, linguistic, religious, sexual and racial/ethnic characteristics to ensure that all are welcome, safe and protected. In Australia, frameworks, manuals and guides have been developed to support health care providers provide culturally sensitive and safe services, specific to Aboriginal and Torres Strait Islanders (2,3), people living in remote communities (4) refugees to Australia (5–7), people impacted by the justice system (8) and to support inclusiveness of gender identities (9). Guidance in this area outline the principles of respect for patients and their families' cultural and religious beliefs, taking time to understand a patient's knowledge, values, cultural needs throughout the decision-making process (10,11). Health care professionals are encouraged to use plain language in communications and to ensure information is accessible and in culturally appropriate formats.

The guidelines were released for targeted expert consultation and public consultation in April 2023. The Working Party considered all submissions and agreed on appropriate amendments in response to comments and proposed changes. The final guidelines were published in 2023.

Guideline chapters scope The *Clinical practice guidelines for the prevention, early detection and management of colorectal cancer: population screening and risk and screening based on family history* chapters aims to provide information and recommendations to guide practice in colorectal cancer screening and the assessment pathway. The guideline chapters also provide an evidence base for the NBCSP.

The first *Clinical practice guidelines for the prevention, early detection and management of colorectal cancer* were developed in 1999 (12) and, since then, have been widely used as a reference and referred to by health practitioners, including general practitioners (GPs), Aboriginal Health Workers, Aboriginal Health Practitioners, and other primary health care workers, to guide clinical practice.

Steps in preparing clinical practice guidelines to NHMRC criteria

Population screening

The Project Team, based at the Daffodil Centre, conducted the systematic reviews, comprising literature searches, screening against pre-determined inclusion and exclusion criteria, and risk of bias assessments , data extraction and GRADE (Grading of Recommendations, Assessment, Development and Evaluations) assessment of the included literature.

Risk and screening based on family history

The Project Team, based at the Daffodil Centre, conducted the systematic review, comprising literature searches, screening against pre-determined inclusion and exclusion criteria, and risk of bias assessments, data extraction and evidence summaries).

The Project Team was responsible for liaising with the Working Party members regarding content development, content review and compiling the document. The clinical practice guidelines were developed according to the procedures and requirements for meeting the 2016 NHMRC Guideline Standards described in the 2018 NHMRC Guidelines for Guidelines following the steps outlined below.

Developing a structured clinical question

The focus for the guidelines required careful consideration of the clinical questions used in the 2017 Guidelines (described above in Guidelines Development Party) to determine the required updates. PICOs were adapted by the Working Party, under the guidance of the Chair, to guide the systematic reviews for the *Population screening* chapter. The PICO questions focused on the Population, Intervention, Comparison and Outcomes of relevant published literature and was used to define the scope and identify the key components of clinical evidence. Each PICO question was addressed by a systematic review. An adapted PECO question, focused on the Population, Exposure, Comparator and Outcome of relevant published literature, was used to define the scope and identify the key components of clinical evidence for the *Risk and screening based on family history* chapter.

Searching for existing relevant guidelines and systematic reviews

Relevant recent (2016 onwards) guidelines were identified by scanning the citations identified by the literature search, and by searching the International Health Technology and Guidelines International Network databases and websites of potentially relevant guideline developers. To be considered for adoption by the Working Party, guidelines had to be evidence-based and meet the pre-specified criteria of scores of greater or equal to 70% for the following domains: rigour of development, clarity of presentation and editorial independence of the AGREE II instrument (http://www.agreetrust.org/resource-centre/agree-ii/). Guidelines were not considered for adoption if they were not based on systematic reviews of the evidence i.e. did not report using systematic methods to

search for evidence, did not clearly describe the criteria for selecting the evidence or did not assess the risk of bias or where this is not possible, appraise the quality of the evidence.

Conducting the systematic literature searches

Systematic search strategies were developed by the Project Team for each PICO question (see Appendix E for full details on search strategy). Medline (including MEDLINE Epub Ahead of Print, I-Process & Other Non-Indexed Citations) and Embase databases were searched by combining text terms and database-specific subject headings, which varied by PICO. Searches were limited to articles published in English from 1 January 2016 onwards. The dates of the searches and complete lists of the terms used for each PICO question are included as Appendix E. The Cochrane Database of Systematic Reviews was searched on 5 July 2022 combining the search terms “colorectal cancer” and “screen”. Reference lists of included articles, recent relevant guidelines and systematic reviews were checked for potential additional articles. The process of identifying relevant articles for each systematic review, as well as a table of the retrieved articles that were not included and the reason for their exclusion, are documented in Appendix E. The characteristics of all included studies, the results, risk of bias assessments are summarised and described in evidence tables as appropriate for the specific PICO (see Appendix E).

Screening of literature results against pre-defined inclusion and exclusion criteria

As part of the systematic review process all retrieved literature results were screened against the pre-defined inclusion and exclusion criteria in two stages.

a) First screen

During the first screening round, the titles and abstracts of all retrieved literature were screened by one or two reviewers. Clearly irrelevant and duplicate articles were removed.

b) Second screen

Full texts of the remaining articles were assessed for inclusion by one or two reviewers. Articles that met the inclusion criteria were forwarded for critical appraisal and data extraction.

Risk of bias and data extraction of each included article

Two assessors independently assessed the risk of bias of each of the included studies using a study design and type specific assessment tool (see Appendix E for all quality assessment tools). Any disagreements were adjudicated by a third reviewer. For all included articles, the relevant data were extracted and summarised in study characteristics and evidence tables. Extracted data were checked by a second assessor. These tables are included in the technical report for each question (see Appendix E).

Assessing the body of evidence and formulating recommendations

Population screening

Two reviewers assessed the certainty of the extracted body of evidence for each outcome using the GRADE (Grading of Recommendations, Assessment, Development and Evaluations) approach which classifies the certainty of the evidence as high, moderate, low or very low (Table 4). The reviewers presented the evidence with GRADE assessments and interpretations for each outcome in evidence summary tables. The GRADE assessments and evidence summary tables are included in the technical report for each systematic review question and PICO (see Appendix E).

The certainty of the evidence, its clinical impact, generalisability and applicability were considered and evidence statements drafted to enable the development and grading of evidence-based recommendations.

Risk and screening based on family history

As mentioned above, GRADE is designed to assess evidence for interventions rather than exposures, it was not possible to assess the certainty of the evidence using this method. Specifically, it was not possible to assess the certainty of the evidence based on study design and to assess the imprecision of estimates of the magnitude of risks associated with exposures using GRADE methodologies. As a result, the design, number and size of studies and their risk of bias and results were presented in evidence

summary tables included in the technical report (see Appendix E). The evidence base, and its consistency, clinical impact, generalisability and applicability were considered and evidence statements drafted to enable the development and grading of evidence-based recommendations.

The Project Team drafted an outline for each PICO/PECO incorporating existing data and main findings from the technical report. The Working Party reviewed and discussed the technical report and evidence statements for each clinical question. Any queries and concerns were passed on to the Project Team.

After reviewing the technical report and evidence statements, the Working Party reviewed and updated existing recommendations/practice points from the 2017 guidelines chapters. A voting process was used to determine whether each existing recommendation would remain as is, remain and be modified, or be removed. Each recommendation and practice point went through several voting and review sessions until the Working Party reached consensus.

The Working Party, in collaboration with the Project Team assessed the body of evidence and evidence statements and assigned an overall grade to each recommendation (Table 5). The strength of recommendations was determined by the balance between desirable and undesirable consequences of alternative management strategies, quality of evidence, variability in values and preferences, and resource use.

The Working Party also outlined where evidence was lacking.

Table 4. Grading of the certainty of the evidence.

Certainty of evidence	**Description**
High	We are very confident that the true effect lies close to that of the estimate of the effect.

Moderate	We are moderately confident in the effect estimate: the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different.
Low	Our confidence in the effect estimate is limited: the true effect may be substantially different from the estimate of the effect.
Very low	We have very little confidence in the effect estimate: the true effect is likely to be substantially different from the estimate of effect.

Table 5. Overall recommendation grades.

Grade	**Description**	**Criteria**
Strong	*Recommendation is made with strong certainty. Most informed patients would choose the recommended management and clinicians can structure their interactions with patients accordingly.*	*Evidence base consists of least one or two level II studies* with a low risk of bias or several cohort studies or SRs with a low risk of bias and consistency rated as at least: Most studies consistent and inconsistency can be explained/no serious concerns re consistency OR certainty of evidence rated high or moderate for outcomes of interest* *AND* *Clinical impact rated very large or substantial based on ratio of benefits to harms reported for randomised controlled trials*

		AND *Applicability rated as at least:* *Evidence applicable to Australian healthcare context with few caveats* *AND* *Generalisabilty rated as at least:* *Evidence directly generalisable to target population with some caveats*
Weak	Patients' choices will vary according to their values and preferences, and clinicians must ensure that patients' care is in keeping with their values and preferences.	*Does not meet criteria for strong recommendation eg* *Evidence base consists of level II evidence with a moderate risk of bias* *Certainty of evidence rated low or very low* *Clinical impact based on ratio of benefits to harms determined by modelling*
NA		*Based on modelling only*

***** Level II study design depends on whether the PICO is assessing an intervention, diagnostic accuracy or risk factors

Writing the content

For each clinical question, the Project Team and Working Party update the 2017 guidelines chapter text incorporating the evidence statement, narrative and recommendations using the following format:

- General introduction to the clinical question
- Background to the clinical question, including its clinical importance and historical evidence, where relevant

- Recommendation(s) and corresponding grade(s), and practice points
- Review of the evidence, including the number, quality and findings of studies identified by the systematic review
- Evidence summary in tabular form including evidence statements, levels of evidence of included studies, and reference citations
- Implications for implementation of the recommendations, including possible effects on usual care, organisation of care, and any resource implications
- Discussion, including unresolved issues, relevant studies currently underway, and future research priorities
- References.

Review of the draft chapters

Draft guideline sections were circulated to the Working Party. The members were asked to review the content and submit feedback which was then incorporated and discussed with the Working Party chair before the draft guidelines were posted on CCA's website for external / public consultation.

Public consultation

A complete draft of the guideline was posted on CCA's website for external/public consultation, as well as, sent to specific organisations and individuals to provide feedback in April 2023.
All feedback received during the consultation period was summarised and disseminated to the relevant Working Party for review. They updated the guidelines in consultation with their Working Party members as appropriate.

Areas of major debate

Members of the Working Party did not have any strong opposing views, however, there were robust discussion around the following areas:

- Initial discussions about the proposed modifications to the population screening age range were informed by the systematic review evidence and the modelling evaluations. Given that the systematic reviews did not find evidence on the health benefits for screening under 50 years or older than 74 years, there was some uncertainty relating to age range modifications to population screening for CRC. The modelling evaluation were used to guide the age range recommendations and centred around the benefits, harms, and cost effectiveness provided, and health system implications of modifying age ranges. Discussions for modifying the screening age range pertained to EBR #1, EBR #3, EBR #4, and Practice Point #8.
- Given the reported NBCSP screening participation rate in people aged 50-74 years are relatively low and increases by age, some Working Party members expressed concern about the need to focus on increasing NBCSP participation in those 50-74 and the potential low screening participation rate in people aged under 50, as they have never been included in organised CRC screening. Modelling results of the hypothetical scenario of 100% participation (perfect adherence) was used to illustrate the health and economic impact of various age ranges for screening without the uncertainty of participation rates while developing the recommendations. Additionally, the Working Party agreed to include practice points #18 and #21 to recommend for ongoing efforts to improve organised population screening participation.
- Extending the age range to those 75 and over was informed by the modelled evaluations and the United States Preventive Services Task Force (USPSTF) guidelines. Based on this, the Working Party agreed by consensus to maintain the upper age limit of 74 (the upper limit of the NBCSP target age range as of 2023) due to potential harms outweighing the benefits of extending screening this upper age limit. It was agreed that an additional practice point #6 would be developed to cater to individuals 75 years and over.
- The Working Party discussed the appropriateness of including an upper age limit for iFOBT screening for people aged 75 and above, who are fit, well and healthy, and request screening (Practice Point #6). The Working Party members acknowledged that individual's health conditions (e.g. life-expectancy, comorbid conditions etc) varied significantly in people aged 75 and above, and therefore, the age of stopping screening should be assessed on individual basis. However, the Working Party agreed that there should be an upper age limit when screening become less likely to result more benefits than harms for healthy asymptomatic individuals. This agreement was reinforced by the USPSTF's rationale for recommending selective

colorectal cancer screening until the age of 85 years . The USPSTF decision was based on: (i) a previous US modelling study which found that the balance of benefits and harms of colorectal cancer screening becomes less favourable in adults aged 76-85 years, (ii) limited evidence suggested that colonoscopy complication rate increased by age, and (iii) limited evidence on benefits and harms of colorectal cancer screening for people aged 86 years and older, and (iv) the competing causes of mortality that would likely to preclude any survival benefit that would outweigh the harms of screening (13,14). As a result of the discussion, the Working Party agreed to include 85 years as the upper age limit for iFOBT screening in practice point #6.

- Modelling of the effectiveness and cost effectiveness of population screening for CRC was used to help inform recommendations for the possible screening age ranges for the Australian context. The modelling and its results were discussed at length by the Working Party to both ensure the modelling results were being interpreted appropriately and confirm their relevance to the Australian population.
- Another area of debate was around the guidance provided in the event of an iFOBT protocol breach in sample collection (Practice Point #15) to determine a clear call for action and timeframe to aid clinical practice. Concerns were raised regarding possible contaminants of iFOBT samples, such as menstrual blood or haemorrhoids, which could lead to false positives. Hence practice point #15 was also developed to advise clinicians on preferred actions to take in such cases.
- The Working Party further discussed the issue regarding lowering the screening start age for Aboriginal and Torres Strait Islander peoples to 40 years compared to the suggested 45-year start age recommended. This was based on a published modelling evaluation which outlines that Aboriginal and Torres Strait Islander peoples are often diagnosed with bowel cancer at an earlier age, with more advanced disease, and has a poorer long-term outcome (1). Comparing the findings of the previous modelling evaluation with the findings of the current guidelines modelling analysis for the general population, lowering the screening start age from 50 to 40 or 45 years was predicted to result in a broadly similar relative changes in health benefits, cost-effectiveness, and benefits-and-burden balance in the two populations. However, lowering the screening start age was estimated to result in a greater increase in colonoscopy utilisation and colonoscopy-related adverse events (i.e. the burden and harms of screening) for Aboriginal and Torres Strait Islander peoples (20-24% increase if screening starts from the age of 45 years, and a 47-59% increase if screening starts from the age of 40 years) than for general population (12-

15% increase and 27-33% increase, respectively). This would likely be due to a higher false iFOBT rate which was modelled for Aboriginal and Torres Strait Islander peoples, informed by higher overall iFOBT positive rates and a higher proportion of follow-up colonoscopy assessments with negative findings after a positive iFOBT result observed among the Aboriginal and Torres Strait Islander NBCSP participants in 2012-2017. Considering the significant increase in the burden and potential harms of starting screening from 40 years for Aboriginal and Torres Strait Islander peoples, the Working Party agreed to maintain the screening start age of 45 years for the population overall. In light of this, no new recommendations or practice points were added.

- The Working Party further discussed the appropriate time frames for how long a colonoscopy wait time can be following a positive iFOBT. They agreed that the colonoscopy should be performed within 120 days of a positive iFOBT (practice point #17). The emphasis was given to avoid psychological harm as the progression of disease during this time frame was less likely (practice point #16).

In all instances, the Working Party was able to reach a consensus in decision about the content and recommendations and/or practice points.

Organisations with whom endorsement will be sought

Endorsement of the guidelines will be sought from the following organisations:

- Royal Australian College of General Practitioners (RACGP)
- Royal Australasian College of Surgeons (RACS)
- Royal Australasian College of Physicians (RACP)
- Royal College of Pathologists of Australasia (RCPA)
- Gastroenterological Society of Australia (GESA)
- Clinical Oncology Society of Australia (COSA)

Dissemination and implementation

CCA will be responsible for and lead the implementation of the final guidelines, with guidance from the Project Team and the Working Party.

CCA is following a multi-strategy approach for the dissemination and implementation of the guidelines.

The guidelines will be published online via the CCA website, alongside the suite of Clinical Guidelines, making them a web-based global resource. A short-form PDF version may be available on request for reference, including all recommendations. The online guideline version increases availability as well as accessibility, and usage will be tracked and analysed with a web analytics solution.

CCA will undertake media and PR activity including, press releases to appropriate medical media contacts and PR activity in trade and clinical publications. In addition, the final guideline will be launched via email alert to professional organisations, interested groups and clinical experts in the field, directing them via URL link to the wiki guidelines and all associated resources. Australian health websites, such as EviQ will be approached to link to the online guidelines.

Promotion and dissemination will also be conducted through publication of papers in peer-reviewed journals, promotion at scientific meetings, national and international conferences and other continuing medical education events. Working Party members, and other identified local opinion leaders may be identified and approached to facilitate dissemination and act as champions for the guidelines.

Journal articles developed out of the guideline

The Project Team and lead authors of the guidelines aim to develop and submit scientific, peer-reviewed articles to promote usage of the guidelines.

Future updates

Newly published evidence relevant to each systematic review question will continue to be monitored by Cancer Council Australia via their Cancer Screening and Immunisation Committee. If there is strong evidence emerging in colorectal cancer screening, Cancer Council Australia, as the Guideline Developers, will discuss this with key members of the Working Party and the Working Party will be reconvened to assess if this warrants a guideline update (full or partial), and determine the resources required to conduct this revision. It is recommended that the guideline chapters be updated within 5 years.

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