Clinical practice guidelines for surveillance colonoscopy: Administrative Report

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1. Introduction

Colorectal cancer (CRC) is the second most common internal malignancy affecting Australians.\(^1\) Age-standardised incidence and mortality rates are falling, yet CRC still kills more Australians than any other cancer except for lung cancer despite the fact that CRC biology offers a window of opportunity for prevention and cure.

\(a\). Purpose and scope

These guidelines update the 2011 edition by reviewing literature published in the interim. They focus on the appropriate use of colonoscopy in CRC prevention and address three main questions:

- when to repeat colonoscopy after adenomatous polypectomy;
- when to repeat colonoscopy after curative resection of CRC
- when to perform colonoscopy in those patients with inflammatory bowel disease (IBD) who have an increased risk of developing CRC.

\(b\). Intended users

This guideline is intended for use by health professionals advising patients who are at increased risk of CRC (due to a personal past history of precancerous polyps, CRC or IBD) about the need for and timing of future colonoscopy. They may also be of interest to policy makers and educators providing training in medicine or other health sciences.

They are not intended as health information for the general public.

\(c\). Target populations

These guidelines cover a range of Australian populations, including:

- people with precancerous lesions detected on colonoscopy
- people with a diagnosis of CRC
- some people with a diagnosis of IBC (ulcerative colitis or Crohn’s disease).

This guideline is not intended to apply to people, for whom colonoscopy is indicated for screening or investigation of symptoms rather than for the purpose of surveillance:

- people with a family history of CRC or known familial syndromes
- people with symptoms and signs that may suggest CRC
- people with a positive faecal occult blood test.

Clinicians should consider the specific needs of patients with CRC from culturally diverse groups, including younger people, Aboriginal and Torres Strait Islander peoples and culturally and linguistically diverse communities.

It is worth noting that for each systematic review, the search strategies specifically included terms designed to identify data relevant to Aboriginal and Torres Strait Islander peoples. However, the

literature searches did not identify any studies specifically relevant to Aboriginal and Torres Strait Islander populations that met the inclusion criteria.

d. Healthcare settings in which the guideline will be applied
These guidelines apply to the range of public and private healthcare settings in which services are provided for the target populations. These include:

- general practice;
- hospitals;
- specialist clinics;
- imaging services;
- pathology services;
- allied health care services.

e. Funding
The Australian Government Department of Health commissioned and funded Cancer Council Australia to undertake the current revision and update of this guideline.

f. Scheduled review of these guidelines
It is inevitable that parts of this guideline will become out of date as further literature is published. Newly published evidence relevant to each systematic review question will be monitored. If strong evidence supporting a change in the guideline is published, the working party will consider if an update is required for a specific section. We recommend that the guideline as a whole should be reviewed and updated every 5 years.

2. Contributors

a. Management Committee
As a matter of clinical management, the revised Surveillance Colonoscopy Guidelines would closely interlink with the Clinical practice guidelines for the prevention, early detection and management of colorectal cancer that were NHMRC approved on 27/10/2017. Cancer Council Australia proposes that Management Committee currently overseeing the CRC Guidelines Revision project would also manage the Surveillance Colonoscopy Guidelines Revision project.
This Management Committee consists of senior medical experts from relevant disciplines involved in the CRC pathway. Its members have been involved in previous guideline development projects (2005 CRC, 2011 Surveillance Colonoscopy guideline developments). This group brought the required expertise and leadership to effectively oversee this proposed guideline revision project.

A/Prof Tim Price is the Chair of the Management Committee and the CRC Guidelines Revision Party. As previous Chair of the 2011 Surveillance Colonoscopy Working Party, Dr Cameron Bell once again took on the role of Chair of the Surveillance Colonoscopy Guidelines Revision-specific Working Party as well as Deputy Chair of the Management Committee.

This group acted as a steering committee to establish the scope of the guideline revision and ensure that all deliverables agreed in the project plan were delivered to acceptable standards in accordance with NHMRC requirements, within agreed timeframes and within the approved budget.

Membership of this Management Committee is as follows:

<table>
<thead>
<tr>
<th>Member name</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professor Timothy Price</td>
<td>Medical Oncologist, The Queen Elizabeth Hospital, Adelaide</td>
</tr>
<tr>
<td>Dr Cameron Bell</td>
<td>Gastroenterologist, Royal North Shore Hospital, Sydney</td>
</tr>
<tr>
<td>Name</td>
<td>Position</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Professor Alexander (Sandy) Heriot</td>
<td>Consultant Colorectal Surgeon, Director Cancer Surgery, Peter MacCallum Cancer Centre; Director, Lower GI Tumour Stream, Victorian Comprehensive Cancer Centre</td>
</tr>
<tr>
<td>Professor Finlay Macrae AO</td>
<td>Gastroenterologist, Royal Melbourne Hospital, Melbourne</td>
</tr>
<tr>
<td>Dr Elizabeth Murphy</td>
<td>Head, Colorectal Surgical Unit, Lyell McEwin Hospital Adelaide</td>
</tr>
<tr>
<td>Professor Michael Solomon</td>
<td>Colorectal Surgeon, Royal Prince Alfred Hospital, Sydney</td>
</tr>
<tr>
<td>Professor James St John AO</td>
<td>Emeritus Consultant Gastroenterologist, The Royal Melbourne Hospital; Honorary Senior Associate, Cancer Council Victoria; Honorary Clinical Professorial Fellow, The University of Melbourne</td>
</tr>
<tr>
<td>Dr Bernie Towler</td>
<td>Principal Medical Advisor, Population Health Division, Department of Health, Canberra</td>
</tr>
<tr>
<td>Jutta Thwaites</td>
<td>Head, Clinical Guidelines Network (maternity leave from November 2016 - November 2017)</td>
</tr>
<tr>
<td>Laura Wuellner</td>
<td>Project Manager, Clinical Guidelines Network (until November 2016); Acting Head, Clinical Guidelines Network (from November 2016 – January 2018)</td>
</tr>
<tr>
<td>Tamsin Curtis</td>
<td>Project Manager, Clinical Guidelines Network (from March 2018)</td>
</tr>
<tr>
<td>Professor John R Zalberg</td>
<td>Head of Cancer at the School of Public Health and Preventive Medicine, Monash University, Melbourne</td>
</tr>
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</table>

**b. Working Party**

The Surveillance Colonoscopy Guidelines Revision Working Party comprised relevant Management Committee members (including A/Prof Tim Price as Chair of Management Committee and CRC Guidelines Revision Working Party), sections leads of the 2011 Surveillance Colonoscopy Guidelines related chapters, two pathology and one GP representatives, two consumer representatives and epidemiological experts (see table below).

The Working Party members review the draft guidelines content developed by the section leads and their respective sub-committees and attend the face-to-face Working Party meetings pre- and post-public consultation to approve the guidelines content, specifically all recommendations and practice points.

Given the link to the CRC Guidelines revision, all CRC Guidelines Revision Working Party members would be invited to review the draft Surveillance Colonoscopy Guidelines and provide feedback. However, they would not be formally members of the Surveillance Colonoscopy Guidelines Working Party and therefore not required to attend the face-to-face pre- and post-public consultation meetings.
<table>
<thead>
<tr>
<th>Name</th>
<th>Role/s</th>
<th>Speciality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Cameron Bell (Chair)</td>
<td>Chair of Working Party</td>
<td>Gastroenterologist</td>
</tr>
<tr>
<td>Professor Timothy Price</td>
<td>Management Committee member</td>
<td>Medical Oncologist</td>
</tr>
<tr>
<td>Professor Sanchia Aranda</td>
<td>Management Committee member</td>
<td>CEO, Cancer Council Australia</td>
</tr>
<tr>
<td>Professor Finlay Macrae AO</td>
<td>Management Committee member</td>
<td>Gastroenterologist</td>
</tr>
<tr>
<td>Professor James St John AO</td>
<td>Management Committee member</td>
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<td>Management Committee member</td>
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<tr>
<td>Laura Wuellner</td>
<td>Management Committee member</td>
<td>Project Manager, Clinical Guidelines Network (until November 2016); Acting Head, Clinical Guidelines Network (from November 2016 – January 2018)</td>
</tr>
<tr>
<td>Katrina Anderson</td>
<td>CCA Project Team Lead</td>
<td>Project Manager, Clinical Guidelines Network (from November 2016 – December 2017)</td>
</tr>
<tr>
<td>Tamsin Curtis</td>
<td>CCA Project Team Lead</td>
<td>Project Manager, Clinical Guidelines Network (from March 2018)</td>
</tr>
<tr>
<td>A/Professor Gregor Brown</td>
<td>Surveillance colonoscopy guidelines revision section leader</td>
<td>Gastroenterologist</td>
</tr>
<tr>
<td>Dr Karen Barclay</td>
<td>Surveillance colonoscopy guidelines revision section leader</td>
<td>Colorectal Surgeon</td>
</tr>
<tr>
<td>Dr James Moore</td>
<td>Surveillance colonoscopy guidelines revision section leader</td>
<td>Colorectal Surgeon</td>
</tr>
<tr>
<td>Associate Professor Tarik Sammour</td>
<td>Surveillance colonoscopy guidelines revision section leader</td>
<td>Colorectal Surgeon</td>
</tr>
<tr>
<td>Professor Rupert Leong</td>
<td>Surveillance colonoscopy guidelines revision section leader</td>
<td>Gastroenterologist</td>
</tr>
<tr>
<td>Professor Afaf Girgis</td>
<td>Surveillance colonoscopy guidelines revision section leader</td>
<td>Psycho-oncologist</td>
</tr>
<tr>
<td>Dr Anne Duggan</td>
<td>Surveillance colonoscopy guidelines revision section leader</td>
<td>Gastroenterologist</td>
</tr>
<tr>
<td>Professor Anthony Gill</td>
<td>Working Party member/advisor</td>
<td>Pathologist</td>
</tr>
</tbody>
</table>
c. Chapter Subcommittees

Chapter subcommittees comprised of experts involved in the field were convened when required to develop evidence-based guideline content based on individual systematic reviews. The lead author for the individual question involved/recruited/engaged additional experts for this purpose, as well as inviting members of the Working Party as appropriate.

Chapter Subcommittees were convened as required to develop the response to individual questions. The lead author for the individual question co-opted additional experts for this purpose using members of the Working Party and external experts as appropriate, subject to Management Committee approval.

The following tables detail the guideline chapters, the section lead and the subcommittee members.

<table>
<thead>
<tr>
<th>ADVANCES IN COLONOSCOPY, CT COLONOGRAPHY AND OTHER METHODS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Background chapter based on general literature summary. The 2011 content was reviewed and updated where required. Practice points were included as guidance.</td>
</tr>
<tr>
<td><strong>Section lead: A/Prof Gregor Brown</strong></td>
</tr>
<tr>
<td><strong>Sub-committee members</strong></td>
</tr>
<tr>
<td>Dr Joshua Butt</td>
</tr>
<tr>
<td>A/Prof David Hewett</td>
</tr>
<tr>
<td>Dr Spiro Raftopoulos</td>
</tr>
<tr>
<td>Dr Mark Appleyard</td>
</tr>
<tr>
<td>A/Prof Rajvinder Singh</td>
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<tr>
<td>Dr Tom Sutherland</td>
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</table>
## COLONOSCOPIC SURVEILLANCE AFTER POLYPECTOMY

**CLINICAL QUESTION SAD1:** What should be the surveillance colonoscopy for patients at low risk (1-2 small <10mm tubular adenomas)?

**CLINICAL QUESTION SAD2:** What should be the surveillance colonoscopy for patients at high risk (size ≥ 10mm, HGD, villosity and/or 3-4 adenomas)?

**CLINICAL QUESTION SAD3:** What is the appropriate colonoscopic surveillance after the removal of large sessile or laterally spreading adenomas?

**CLINICAL QUESTION SAD4:** What is the appropriate colonoscopic surveillance after the identification of sessile serrated adenomas and traditional serrated adenomas?

**CLINICAL QUESTION SAD5:** What should be the surveillance colonoscopy for patients with adenoma multiplicity?

**CLINICAL QUESTION SFH1:** Is the surveillance colonoscopy recommendation different for patients with adenomas who also have a family history of CRC?

### Section lead: Dr Karen Barclay

### Sub-committee members

<table>
<thead>
<tr>
<th>Name</th>
<th>Role and Institution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prof Barbara Leggett</td>
<td>Gastroenterologist, Royal Brisbane and Women’s Hospital; Professor of Medicine, School of Medicine, University of Queensland; Honorary Group Leader, Queensland Institute of Medical Research Berghofer</td>
</tr>
<tr>
<td>Prof Finlay Macrae AO</td>
<td>Gastroenterologist, Royal Melbourne Hospital, Melbourne</td>
</tr>
<tr>
<td>Prof Michael Bourke</td>
<td>Professor of Medicine, University of Sydney; Director Gastrointestinal Endoscopy, Westmead Hospital</td>
</tr>
<tr>
<td>Dr Hooi Ee</td>
<td>Gastroenterologist, Sir Charles Gairdner Hospital, Perth</td>
</tr>
</tbody>
</table>

## THE ROLE OF SURVEILLANCE COLONOSCOPY AFTER CURATIVE RESECTION FOR COLORECTAL CANCER

**CLINICAL QUESTION COL1:** What is the role of pre or peri-operative colonoscopy in CRC patients?

**CLINICAL QUESTION FUC1:** At what time points after CRC resection should surveillance colonoscopy be performed?

### Section leads: Dr James Moore & Associate Professor Tarik Sammour

### Sub-committee members

<table>
<thead>
<tr>
<th>Name</th>
<th>Role and Institution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Andrew Luck</td>
<td>Colorectal surgeon, Lyell McEwin Hospital</td>
</tr>
</tbody>
</table>
### COLONOSCOPIC SURVEILLANCE AND MANAGEMENT OF DYSPLASIA IN INFLAMMATORY BOWEL DISEASE

**Clinical Question SUR1:** What is the appropriate time to commence surveillance in IBD patients (ulcerative colitis and Crohn’s patients, and effects of primary sclerosing cholangitis or family history of CRC)?

**Clinical Question SUR2:** What is the most appropriate time interval for surveillance in IBD patients based on risk?

**Clinical Question SUR3:** What are the recommended surveillance strategies for surveillance in IBD patients?

**Clinical Question MNG1:** What should be the protocol to manage elevated dysplasia in IBD?

**Clinical Question MNG2:** What should be the protocol to manage high grade dysplasia in IBD?

**Clinical Question MNG3:** What should be the protocol to manage low grade dysplasia in IBD?

**Clinical Question MNG4:** What should be the protocol to manage indefinite dysplasia in IBD?

**Section Lead:** Professor Rupert Leong

**Sub-committee Members**

<table>
<thead>
<tr>
<th>Name</th>
<th>Role and Affiliation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Crispin Corte</td>
<td>Gastroenterologist, Royal Prince Alfred Medical Centre, Macquarie University Clinic, Concord Hospital and Concord Medical Centre</td>
</tr>
<tr>
<td>Dr Cherry Koh</td>
<td>Colorectal Surgeon, Royal Prince Alfred Hospital</td>
</tr>
<tr>
<td>Dr Betty Wu</td>
<td>Gastroenterology Fellow, St George Hospital</td>
</tr>
<tr>
<td>Dr Viraj Kariyawasam</td>
<td>Gastroenterologist, University of Western Sydney, Blacktown and Mount Druiit Hospital and GastroHealth Australia</td>
</tr>
</tbody>
</table>

### ANXIETY IN COLONOSCOPY: APPROACHES TO MINIMISE ANXIETY AND ITS ADVERSE EFFECTS

Background chapter based on general literature summary. The 2011 content was reviewed and updated where required. Practice points were included as guidance.

**Section Lead:** Professor Afaf Girgis

**Sub-committee Members**

<table>
<thead>
<tr>
<th>Name</th>
<th>Role and Affiliation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prof Phyllis Butow AM</td>
<td>Professor, School of Psychology; Co-Director, Centre for Medical Psychology and Evidence-based Decision-making (CeMPED); NHMRC Principal Research Fellow, The University of Sydney; Chair, Psycho-oncology Co-operative Research Group</td>
</tr>
</tbody>
</table>

### SOCIO-ECONOMIC FACTORS

Background chapter based on general literature summary. The 2011 content was reviewed and updated where required. Practice points were included as guidance.

**Section Lead:** Dr Anne Duggan

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**d. Consumer representation**

Two consumer representatives are members of the Working Party. Both consumers were engaged through the Consumers CAN Network. This group is active in the areas of cancer diagnosis, information, treatment, research, support, care, survivorship and policy. Members work with decision-makers, ensuring the patient perspective is heard.
Jill Arnott is a long-term colorectal cancer survivor and a regular support group participant. The second consumer, Jeff Cuff, is a widower who founded the Shirley Cuff Colon Cancer Research Fund. His wife Shirley died in July 2013.

The consumer representatives attend meetings of the Working Party and are involved in the development of the guidelines content.

**e. Project personnel, systematic review team and editor**

Project management and governance were overseen by the Head, Clinical Guidelines Network at Cancer Council Australia. The Cancer Council Australia Project Officer and Project Manager were the primary points of contact for the purpose of developing responses to the clinical questions. The Research Assistants performed systematic reviews under the guidance of the Senior Systematic Reviewer.

A medical editor was engaged to review and edit all chapters of the guideline.

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jutta Thwaites</td>
<td>Head, Clinical Guidelines Network, Cancer Council Australia (maternity leave from November 2016 - November 2017)</td>
</tr>
<tr>
<td>Katrina Anderson</td>
<td>Project Manager, Clinical Guidelines Network, Cancer Council Australia (from November 2016 - December 2017)</td>
</tr>
<tr>
<td>Tamsin Curtis</td>
<td>Project Manager, Clinical Guidelines Network (from March 2018)</td>
</tr>
<tr>
<td>Dr Albert Chetcuti</td>
<td>Senior Systematic Reviewer, Clinical Guidelines Network, Cancer Council Australia</td>
</tr>
<tr>
<td>Victoria Freeman</td>
<td>Research Assistant, Colorectal Cancer Guidelines, Cancer Council Australia (from January 2017 – November 2017)</td>
</tr>
<tr>
<td>Ben Lee-Bates</td>
<td>Research Assistant, Colorectal Cancer Guidelines, Cancer Council Australia (from January 207 – April 2017)</td>
</tr>
<tr>
<td>Jennifer Harman</td>
<td>Medical writer and principal, Meducation – Editorial consultant</td>
</tr>
</tbody>
</table>

3. **Organisations formally endorsing the guidelines**

The following medical colleges, professional bodies and charitable organisations will be approached to endorse the guidelines when they are finalised:

- Australian College of Rural and Remote Medicine (ACRRM)
- Colorectal Surgical Society of Australia and New Zealand (CSS ANZ)
- Gastroenterological Society of Australia
- Royal College of Pathologists of Australia (RCPA)
- Royal Australasian College of Physicians (RACP)
- Royal Australian College of Surgeons (RACS)
- Royal Australian College of General Practitioners (RACGP).
4. Declaration and management of competing interests for all people involved in the guideline development process

All Working Party members were asked to declare in writing, any competing interests relevant to the guideline development. The Management Committee was responsible for evaluating all statements of competing interests. The Chairperson’s evaluation of possible conflicts of interest was guided by A Code of Practice for Declaring and Dealing with Conflicts of Interest, which was developed based on the similar document produced by the National Institute for Health and Clinical Excellence. A Code of Practice for Declaring and Dealing with Conflicts of Interest is enclosed as Appendix 1.

A register of disclosed potential conflicts of interest was developed and is enclosed as Appendix 2. The register was available to the Working Party members throughout the development of the guideline, allowing members to take any potential conflicts of interest into consideration during discussions, decision making, and formulation of recommendations. Members were regularly asked to update their information throughout the development of the guideline if they became aware of any changes to their interests, including the Chair asking for any new declarations at the beginning of each meeting.

There were no instances during the guidelines development process where Conflict of Interest management strategies were employed for guideline authors and co-authors.

In the endeavour to circumvent any potential conflicts of interest, executive representatives from Cancer Council Australia and the Department of Health were not directly involved in the systematic review process, the development of the guidelines or voting on recommendations. Their role was to provide governance, which include the approval of procedures and recommendations made by the clinicians and Subcommittees arising from the systematic review. The exclusion from voting for the project sponsor representatives is recorded in the Conflict of Interest register.

When the guidelines enter the updating phase, guideline Working Party members will be responsible for the updating of their Declaration of Interests statements if new interests arise. The members will receive a formal reminder to review their statements and ensure they are up-to-date prior to meetings scheduled to review content updates of a specific guideline.

5. Method used to arrive at consensus-based recommendations or practice points

The Subcommittees, in collaboration with the CCA systematic review team (who conduct the systematic reviews and provide the technical reports), assessed the evidence and drafted the evidence-based recommendations. This included grade assignment and/or consensus-based recommendations/practice points. Emails, teleconferences and face-to-face meetings were used to facilitate this process.

The draft guideline content underwent several iterations until agreement between the members of the Chapter Subcommittee was reached. When needed, any difficult points or areas of disagreement were flagged for the Working Party to discuss. The procedures and requirements outlined in NHMRC additional levels of evidence and grades for recommendations for developers of guidelines and

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Procedures and requirements for meeting the 2011 NHMRC standard for clinical practice guidelines
directed this process.

A face-to-face meeting with Working Party members was held on 14th December 2017, as well as
two teleconference in February and March 2018 to review and finalise the draft guideline for public
consultation. Prior to the meeting and teleconferences, all available draft guideline content was
circulated. All members were asked to review the content, individual recommendations and practice
points in detail, and identify and note any controversies and points to be discussed at the group
meeting. During the meetings, recommendations and practice points were tabled and discussed. The
Working Party Chairperson nominated a particular recommendation/practice point to be reviewed
and members had the opportunity to discuss any issues and suggest revisions to recommendations
and practice points. Each recommendation and practice point was approved once the eligible
members (excluding representatives of the funding bodies and members who cannot vote due to
Conflict of Interest) reached consensus.

After the public consultation period, all comments were compiled and sent to the relevant lead
Working Party section authors and their Chapter subcommittee members to review their draft
content, and assess and consider the received comments. Email and teleconferencing was used to
facilitate this review process. Another face-to-face Working Party meeting was organised after public
consultation during May 2018 to review and consider all public consultation comments and the
amended draft guideline content. The same consensus process that was followed during the
meeting prior to public consultation was followed. All changes resulting from the public consultation
submission reviews were documented and will be made accessible once the guideline is published.

6. Public consultation

   a. Preparation of guidelines for public consultation

The draft content of the guidelines was prepared by the Working Party section lead and Chapter
subcommittees, with support provided by Cancer Council Australia project staff.

The draft content was edited by a professional medical writer experienced in NHMRC guidelines
development, and then circulated to members of the Working Party for review. Concerns or issues
identified were addressed at the Working Party meeting on 14 December 2017. The structure and
draft content of the guidelines were confirmed at this meeting. After the meeting, further editorial
changes to the draft content was prepared by the medical writer to ensure language and wording
was as consistent as possible and adhered to NHMRC requirements. Public consultation timeframe
and process.

The draft version of the guideline was released for a public consultation period from 3 April to 2 May
2018, as required by the National Health and Medical Research Council Act 1992. A number of key
stakeholders, including consumer groups and the Director-General, Chief Executive or Secretary of
each State, Territory and Commonwealth health department, were notified about the public
consultation timeframe.
Additional key professional organisations and consumer organisations that would be involved in, or affected by; the implementation of the clinical recommendations of the guidelines were notified of the public consultation period, these include:

- Colorectal Surgical Society of Australia and New Zealand (CSS ANZ)
- Gastroenterological Society of Australia (GESA)
- Cancer Australia
- Australian College of Rural and Remote Medicine (ACRRM)
- Medical Oncology Group of Australia Incorporated (MOGA)
- Royal College of Pathologists of Australia (RCPA)
- Royal Australasian College of Physicians (RACP)
- Royal Australian College of Surgeons (RACS)
- Royal Australian College of General Practitioners (RACGP)
- Clinical Oncology Society of Australia (COSA)
- Human Genetics Society of Australasia (HGSA)
- The Royal Australian and New Zealand College of Radiologists (RANZCR)
- Australian and New Zealand Society for Geriatric Medicine (ANZGSM)
- General Surgeons Australia (GSA)
- Medicines Australia
- Palliative Care Associations, including the Australian and New Zealand Society of Palliative Medicine
- Australasian Association of Nuclear Medicine Specialists
- Bowel Cancer Australia
- Jodi Lee Foundation
- NPS MedicineWise
- Consumers' Health Forum of Australia
- Australian Nursing Federation
- Clinical Oncological Society of Australia
- Cancer Nurses Society of Australia
- Australia and New Zealand Society of Palliative Medicine
- Australian Healthcare & Hospitals Association
- Cancer Voices Australia
- Royal Australasian College of Physicians
- Australian Faculty of Public Health Medicine
- Cancer Council ACT Inc
- Cancer Council NSW
- Cancer Council NT
- Cancer Council Queensland
- Cancer Council SA
- Cancer Council Tasmania
- Cancer Council Victoria
- Cancer Council Western Australia
- Therapeutic Goods Administration (TGA)
- Pharmaceutical Benefits Advisory Committee (PBAC)
- Medical Services Advisory Committee (MSAC).

The Working Party met on 22nd May 2018 to consider all public consultation submissions and to revise the draft guideline content as required, ensuring alignment with the evidence base. A
summary of responses and actions taken in relation to public consultation submissions was documented during this process. A version of the public consultation submissions summary will be publicly available, with submissions de-identified where applicable.

b. Independent review

As required by NHMRC, two independent reviewers were engaged to assess the guidelines using the Appraisal of Guidelines for Research and Evaluation II (AGREE II) instrument prior to submission of the final draft guidelines to NHMRC for approval.

The purpose of the AGREE II instrument is to provide a framework to 1) assess the quality of guidelines, 2) provide a methodological strategy for the development of guidelines, and 3) inform what information and how information ought to be reported in guidelines3. This instrument enabled the assessment of the guidelines against internationally accepted appraisal instruments.

The accredited AGREE II reviewers:

<table>
<thead>
<tr>
<th>Kelvin Hill</th>
<th>National Manager Clinical Services, Stroke Foundation, NSW, Australia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Melissa Chow</td>
<td>Policy Officer at Residential and Flexible Aged Care Division, Department of Health, Canberra, ACT, Australia</td>
</tr>
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</table>

Comments provided by the reviewers will be discussed by the Working Party, project management personnel and systematic review team, and the guidelines changed where appropriate.

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Appendix 1

A Code of Practice for Declaring and Dealing with Conflicts of Interest

Introduction

Conflict of interest refers to instances where private interest overtakes general interest. In practical terms, it is a situation in which an individual in a position of trust, decision-making or an assessment role has competing personal and/or professional interests, and these interests “could make it difficult for [that] individual to fulfil his or her duties impartially, and potentially could improperly influence the performance of their official duties and responsibilities”. However, it is important to note that “there is nothing inherently unethical about conflicts of interests as long as they are acknowledged and openly declared”.

In ensuring that work is conducted in an ethical, fair and impartial manner, individuals seeking to be appointed onto the Management Committee, working party or subcommittees for the revision of the Clinical Practice Guidelines for Surveillance Colonoscopy project (the ‘Project’) are required to acknowledge and declare any possible or probable conflicts of interest. This is required to meet Standard A6 of the NHMRC Procedures and requirements for meeting the 2011 NHMRC standard for clinical practice guidelines and a pre-requisite of ensuring public confidence in the integrity of guidelines.

This document is designed to ensure that conflicts of interest are identified and therefore can be appropriately negotiated or addressed between the individual and the Guidelines Developer (Cancer Council Australia). The document is to be read in conjunction with the NHMRC policy on identifying and managing conflicts of interest for guideline development. Areas in which an individual could have competing interests and where conflicts of interest could occur include:

- professional positions
- membership of committees of other organisations

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4 Cancer Council Australia acknowledges this document has been adapted from the Conflict of Interest document for the Clinical Practice Guidelines for PSA Testing and Early Management of Test Detected Prostate Cancer (2015), which is based on the National Institute for Health and Clinical Excellence ‘Code of Practice for Declaring and Dealing with Conflicts of Interest’ (2007) and ‘Policy on Conflicts of Interest’ (2014) and National Health and Medical Research Council ‘Guidelines development and conflicts of interests. Identifying and Managing Conflicts of Interest of Prospective Members and Members of NHMRC Committees and Working Groups Developing Guidelines’ (2012).


The intent of this document is to have appointees to the Management Committee, working party or subcommittees identify any potential conflicts of interests in order that:

- such interests can be assessed by the Management Committee and the National Health and Medical Research Council (NHMRC)
- management plans are developed to appropriately address the identified conflicts of interests when necessary
- individuals can form their own judgment about their appropriateness in seeking inclusion in the guideline development process
- for inclusion in the conflict of interest register for this Project
- to meet Standard A6 of the NHMRC Procedures and requirements for meeting the 2011 NHMRC standard for clinical practice guidelines.

The policies and principles outlined in this document aim to assist an individual to identify and transparently declare any conflicts of interest with respect to activities and duties performed as a Management Committee, working party or subcommittee member of the Project.

Some issues that require consideration include, but are not limited to, the following.

1. **What interests are involved?**

   The following is intended as a guide to the types of interest that should be declared. If a person covered by this is uncertain whether an interest should be declared, he or she should seek guidance as follows:

   - Management Committee members and employees of Cancer Council Australia: from Cancer Council Australia CEO and Chair of the Management Committee
   - Working party and sub-committee members: Management Committee via the Chair
   - Evidence contractors’ employees: from his or her head or department
   - Advice from NHMRC will be sought when required.

Although particular attention is given to members’ or employees’ pecuniary interests, Cancer Council Australia is conscious that risks to an individual’s reputation could also be (or perceived to be) prejudicial to his or her advice. Arrangements covering ‘reputational risk’ are therefore also considered in this document (see below).
A. **A personal pecuniary interest** involves a current personal payment, which may either relate to the manufacturer or owner of a product or service being evaluated, in which case it is regarded as ‘specific’ or to the industry or sector from which the product or service comes, in which case it is regarded as ‘non-specific’. The main examples include the following:

- Any consultancy, directorship, position in or work for a healthcare industry that attracts regular or occasional payments in cash or in kind, both those which have been undertaken in the 12 months preceding the meeting at which the declaration is made and which are planned but have not taken place.

- Any fee-paid work commissioned by a healthcare industry for which the individual is paid in cash or in kind, both those which have been undertaken in the 2 months preceding the meeting at which the declaration is made and which are planned but have not taken place.

- Any shareholdings, or other beneficial interests, in a healthcare industry that are either held by the individual or for which the individual has legal responsibility (e.g. children, or relatives whose full Power of Attorney is held by the individual).

- Expenses and hospitality provided by a healthcare industry company beyond that reasonably required for accommodation, meals and travel to attend meetings and conferences, both which have been undertaken in the 12 months preceding the meeting at which the declaration is made and which are planned but have not taken place.

- Funds which include investments in the healthcare industry that are held in a portfolio over which individuals have the ability to instruct the fund manager as to the fund composition.

- Research grants received from Government and non-Government organisations to investigate topics and issues, which are related to the aims of the Project.

No personal interest exists in the case of:

- Assets over which individuals have no financial control (e.g. wide portfolio unit trusts and occupational pension funds) and where the fund manager has full discretion as to its composition.

- Accrued pension rights from earlier employment in the healthcare industry.

B. **A non-personal pecuniary interest** involves payment or other benefit that benefits a department or organisation for which an individual has managerial responsibility, but which is not received personally. This may either relate to the product or service being evaluated, in which case it is regarded as ‘specific’ or to the manufacturer or owner of the product or service, but is unrelated to the matter under consideration, in which case it is regarded as ‘non-specific’. The main examples include the following:
- The holding of a fellowship endowed by the healthcare industry.

- Any payment or other support by the healthcare industry or by the Guideline Developer that does not convey any pecuniary or material benefit to an individual personally but that might benefit him or her. Examples include:
  
  i. A grant from a company for the running of a unit or department for which a member is responsible
  
  ii. A grant or fellowship or other payment to sponsor a post or member of staff in the unit for which a member is responsible
  
  iii. The commissioning of research or other work by, or advice from, staff who work in a unit for which the member is responsible
  
  iv. One or more contracts with, or grants from the Guideline Developer.

An individual covered by this Code is under no obligation to seek out knowledge of work done for, or on behalf of, the healthcare industry within the departments for which they are responsible if they would not normally expect to be informed.

C. A personal non-pecuniary interest in a topic under consideration might include, but is not limited to:

- A clear opinion, reached at the conclusion of a research project, about the clinical and/or cost effectiveness of an intervention under review.

- A public statement in which an individual is covered by this consideration, which could reasonably be interpreted as prejudicial to an objective interpretation of the evidence.

- Holding office in a professional organisation or advocacy group with a direct interest in the matter under consideration.

- Other reputational risks in relation to an intervention under review.

D. A personal family interest relates to the personal interests of a family member and involves a current payment to the family member of the employee or member. The interest may relate to the manufacturer or owner of a product or service being evaluated, in which case it is regarded as ‘specific’, or to the industry or sector from which the product or service comes, in which case it is regarded as ‘non-specific’. The main examples include the following:

- Any consultancy, directorship, position in or work for a healthcare industry that attracts regular or occasional payments in cash or in kind.

- Any fee-paid work commissioned by a healthcare industry for which the member is paid in cash or in kind.
• Any shareholdings, or other beneficial interests, in a healthcare industry which are either held by the family member or for which an individual covered by this Code has legal responsibility (e.g. children, or adults whose full Power of Attorney is held by the individual).

• Expenses and hospitality provided by a healthcare industry company (except where they are provided to a general class of people such as attendees at an open conference).

• Funds which include investments in the healthcare industry that are held in a portfolio over which individuals have the ability to instruct the fund manager as to the composition of the fund.

No personal family interest exists in the case of:

• Assets over which individuals have no financial control (e.g. wide portfolio unit trusts and occupational pension funds) and where the fund manager has full discretion as to its composition (e.g. the Universities Superannuation Scheme).

• Accrued pension rights from earlier employment in the healthcare industry.

Additionally, individuals appointed to Management Committee, working party or subcommittee are expected to adhere to the Guideline Developer’s vision, mission and values, and to conduct themselves in accordance with its policies and procedures. It is never acceptable for an appointed individual to make public statements that are in conflict with Guideline Developer’s stated policies and positions.

2. Disclosing conflicts of interest

Individuals are required to provide information in relation to their personal and professional activities and interests, which could be perceived as having an apparent⁹ or a potential¹⁰ impact on their impartiality when contributing as a member of the Project.

In being appointed to the Management Committee, working party or subcommittee, an apparent or potential conflict of interest may arise in the following situations (though this list is not exhaustive), where an individual:¹¹

• Has a contractual or unpaid/paid employment arrangement with an organisation that is involved in a request, which will be under his/her consideration as a Guideline Developer

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⁹ An apparent (or perceived) conflict of interest exists where it appears that individual private interests could improperly influence the performance of their duties and responsibilities whether or not this is, in fact, the case. Individuals must be conscious that perceptions of conflict of interest may be as important as an actual conflict. (ARC, 2009, p.3)

¹⁰ A potential conflict of interest arises where an individual has a private interest which is such that an actual conflict of interest would arise if the member were to become involved in relevant (that is conflicting) official duties and responsibilities in the future. (ARC, 2009, p.3)

¹¹ A conflict of interest may also exist where the individual’s partner or immediate family member has any of the interests or involvements listed.
board, Management Committee, working party or subcommittee member.

- Owns shares in, or controls a company or other organisation involved in any current application that is under his/her consideration, or in which he/she has direct involvement.

- Is involved in any other Guideline Developer board, Management Committee, working party or subcommittee process where he/she may have a direct or indirect involvement in the matters being considered.

At the time of accepting an appointment to participate in the Project, an individual must provide information (as detailed in this document) of the financial and other private/professional interests of themselves and their immediate family/partner, which may represent an apparent or potential conflict of interest.

The obligation to disclose an apparent or potential conflict of interest is ongoing. Accordingly, subsequent to the initial disclosure, individuals are required to provide updates to Cancer Council Australia if there are significant changes to their or their immediate family/partner’s private interests as they become aware of those changes. The private information provided by individuals will be treated by Cancer Council Australia as confidential and in accordance with the Information Privacy Principles set out in the Privacy Act.

If an individual appointed to participate in the Project has, or acquires, an interest, pecuniary or otherwise, that could conflict with the proper performance of his or her appointed functions, he or she must disclose to Cancer Council Australia, in writing, details of the nature of the interest as soon as possible after the relevant facts come to the individual’s knowledge. In cases where a member declares a conflict of interest in relation to a matter under consideration by Cancer Council Australia, Management Committee, guideline working party or subcommittee, the Management Committee will determine the extent to which that individual may be involved in discussion or decisions concerning that matter.

3. When should interests be declared and what action is required?

Sub Appendix A summarises the actions which should be taken when interests are declared.

A. On appointment

Any uncertainty about potential conflicts of members of advisory bodies on appointment should be resolved at the discretion of the relevant Chair and the Management Committee.

B. At working party meetings

Members and other individuals covered by this Code who are attending to take part in the meeting should declare relevant interests at each working party meeting and at appeal panels and state into which of the following categories they believe the interest falls:

- A person declaring a **personal specific pecuniary or personal family specific interest** shall take no part in the proceedings as they relate to the intervention or matter and will normally
leave the meeting until the matter has been concluded. In exceptional circumstances he or she may, at the discretion of the Chair, answer questions from other members but should then leave the meeting until the discussion has been concluded.

- A person declaring a **personal non-specific pecuniary interest** may take part in the proceedings unless, exceptionally, the Management Committee rules otherwise.

- A person declaring a **non-personal specific pecuniary interest or a personal family non-specific interest** may take part in the proceedings unless he or she has personal knowledge of the intervention or matter either through his or her own work or through direct supervision of other people’s work. In either of these cases he or she should declare this interest and not take part in the proceedings except to answer questions.

- A person declaring a **non-personal non-specific pecuniary interest** may take part in the proceedings unless, exceptionally, the Management Committee rules otherwise.

- When someone declares a **personal no pecuniary interest** the Management Committee shall determine, on a case-by-case basis, whether he or she should take part in the proceedings.

C. **In evidence publications**

Where an individual covered by this Code is responsible for authoring, in whole or part, a document that is prepared specifically to inform the Guideline Developer’s advisory bodies, they must declare any interests in accordance with this Code.

D. **Record of interests and their publication**

A record is kept at Cancer Council Australia of:

- Names of individuals who have declared interests on appointment, as the interest first arises or through the annual declaration, and the nature of the interest.

- Names of individuals who have declared interests at meetings giving dates, names of relevant interventions and companies, details of the interest declared and whether the member took part in the proceedings.

Information about any interests declared under this Code will be disclosed to NHMRC at the time of guideline submission in the form of the Conflict of Interest Register, through the minutes of the meetings and the published guidelines.

4. **Summary**

When an individual is seeking appointment to the Management Committee, working party or subcommittee, he or she is responsible for reading this document, reviewing his or her current
activities for apparent or potential conflicts of interest, and bringing any existing and future possible and probable conflicts of interest to the attention of the Guideline Developer.

The contact person at Cancer Council Australia is: Paul Grogan, Public Policy and Knowledge Management, Email: paul.grogan(at)cancer.org.au

**Form for Disclosure of Potential Conflicts of Interest**

For individuals seeking to be involved in the guideline development, please read this document and the principles outlined in the NHMRC Guidelines development and conflicts of interests publication. Then complete the Form for Disclosure of Interests by providing the information required.

When the completed form is received, the Management Committee will review the content and determine if information provided constitutes a conflict that might disqualify an appointment. If an appointment is to proceed and there are issues which require attention in consultation with the individuals, the Management Committee will determine how the interests will be managed.13

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13 The Management Committee may consider engaging an independent assessor to evaluate all COI submissions.
Development of Clinical Practice Guidelines for Surveillance Colonoscopy

Form for Disclosure of Interests

Introduction

The intent of the disclosure of interests is to have the participants in the clinical practice guidelines development identify any potential conflict(s) in order that:

- Such interests can be assessed and managed appropriately
- Each participant can form their own judgment, while taking the interests of other group members into consideration
- In order to meet the NHMRC Procedures and requirements for meeting the 2011 NHMRC standard for clinical practice guidelines.

The questions in this document are designed to enable participants in the working party to disclose any apparent, perceived or potential conflict(s) of interest with respect to their activities in guidelines development.

The questions pertain to:

- Relationships you or, as far as you are aware, any immediate family members (partner and dependent children) may have with pharmaceutical companies or other companies whose products or services are related to colonoscopic surveillance
- Financial interests or relationships requiring disclosure including, but not limited to, payments, gifts, gratuities, consultancies, honoraria, employment, or stock ownership related to commercial companies that may have an interest in the content or recommendations of the guidelines
- Affiliations or associations with organisations or activities which indicate undue influence due to a competing interest either for or against the issue for which the guideline is being developed
- Involvement in the development of related guidelines, standards, educational materials or fact sheets.

Declared interests will be recorded in a register of interests which will then be distributed to all other potential members of the working party. Disclosure information will be made available for public scrutiny and will also be included in the final published clinical practice guidelines.

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14 Cancer Council Australia acknowledges this form has been adapted from the Conflict of Interest document Guidelines for PSA Testing and Early Management of Test Detected Prostate Cancer (2015), which is based on Medical Research Council form for Disclosure of Interest (Guidelines Development).”

Identifying and Managing Conflicts of Interest of Prospective Members and Members of NHMRC Committees and Working Groups Developing Guidelines” (2012).
Instructions

This form has four sections as follows:

Section 1 – Identifying information
Section 2 – Relates to receipt of benefits from entities with a direct interest in the guidelines
Section 3 – Information about the experience of potential members
Section 4 – Other relationships or activities not covered in sections 2-3.

For sections 2 to 4, complete each row by checking “No” or providing the requested information. Please describe the nature of the interest and/or relationship, and identify the relevant commercial or other entity. Please provide this information or any other relevant comments as an attachment to this form and indicate which attachment applies to your response. You also have the option to provide details of any proposal you may have to manage this interest (e.g. divesting the interest, exclusion from discussions on certain topics).

Section 1: Identifying Information

Given Name(s)  ________________________________

Family Name  _________________________________
Section 2: Relevant Financial Activities

<table>
<thead>
<tr>
<th>Type of interest</th>
<th>No</th>
<th>Yes: Personal benefits (received or expected)</th>
<th>Yes: Benefits to immediate family (received or expected)</th>
<th>Please add any further detail, including comments and/or relevant attachments</th>
</tr>
</thead>
</table>

In relation to 1: Over the past three years, have you been employed by an entity having a commercial or other interest in the subject of the guidelines or guideline recommendations to be developed?

1. Employment

   □  □  □

In relation to 2: Applies to an entity which has a commercial interest in the subject of the guidelines under consideration (including where stock in the entity is not publically traded). This includes stock options but excludes indirect investments through mutual funds and the like.

2. Ownership interests

   □  □  □

In relation to 3-9: Disclosure is required in relation to disbursements over the three years preceding, and any anticipated disbursements in the 12 months following, appointment to the committee or working group.

3. Board membership

   □  □  □

4. Grants

   □  □  □

5. Consultancy fees/honorarium

   □  □  □

6. Support for travel or accommodation

   □  □  □

7. Meals and beverages

   □  □  □

8. Entertainment, gifts or gratuities

   □  □  □

9. Other (e.g. registration fees for conferences, institutional interests, etc – see policy)

   □  □  □
Section 3: Relevant Professional and Organisational Experience

The following question is designed to provide prompts to assist with completion of the table below:

- Have you published or spoken on or advocated or publically debated the topic of the Surveillance Colonoscopy (including the provision of expert testimony)?

If you have published extensively and they are listed on your CV, you may provide your CV as a relevant attachment. If the same position has been expressed in multiple publications, an illustrative sample is sufficient, rather than a complete listing of publications.

<table>
<thead>
<tr>
<th>Relevant Experience</th>
<th>No</th>
<th>Yes</th>
<th>Relevant attachment number</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Publications</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>2. Speeches/lectures</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>3. Expert testimony</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>4. Development of related materials, including guidelines, standards, educational materials or fact sheets</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>5. Other (e.g. unpaid advisory roles)</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
</tbody>
</table>
Section 4: Other Relationships or Activities

The following questions are designed to provide prompts to assist with completion of the table below:

- Are you affiliated or associated with any organisations whose interests are either aligned with or opposed to the subject matter of the proposed guidelines?
- Are there any other relationships or activities that could be perceived potentially to influence your contribution?

<table>
<thead>
<tr>
<th>Other relationships or Activities</th>
<th>No</th>
<th>Yes</th>
<th>Relevant attachment number</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Relationships</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Activities</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Declaration

- I declare that the information provided was correct on the date entered below.
- I declare that I have read the document ‘A Code of Practice for Declaring and Dealing with Conflicts of Interest’ and the NHMRC policy Guideline Development and Conflicts of Interest: Identifying and Managing Conflicts of Interest of Prospective Members and Members of NHMRC Committees and Working Groups Developing Guidelines agree to comply with the policy.
- I agree to this information being provided to other members for their consideration.

In signing this form I hereby agree to:

- Update this information throughout my involvement with the development of the guidelines in the event that my circumstances change, or otherwise in response to requests to update this information (i.e. at least annually)
- Comply with any interest management plan
- Allow the publication of these disclosed interests and any management plan including in the final clinical practice guidelines.

Signature  ________________________________

Date  ________________________________

Acknowledgement of source material: This form has been adapted from the National Health and Medical Research Council Form for Disclosure of Potential Conflicts of Interest. See: https://www.nhmrc.gov.au/_files_nhmrc/file/guidelines/developers/coi_interactive_120924.pdf
### A Code of Practice for Declaring and Dealing with Conflicts of Interest
#### Sub Appendix A: Declaring interests at meetings

<table>
<thead>
<tr>
<th>Type of interest</th>
<th>See section</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal specific pecuniary</td>
<td></td>
<td>Declare and withdraw</td>
</tr>
<tr>
<td>Personal non-specific pecuniary</td>
<td></td>
<td>Declare and participate (unless, exceptionally, the Management Committee rules otherwise)</td>
</tr>
<tr>
<td>Personal family specific interest</td>
<td></td>
<td>Declare and withdraw</td>
</tr>
<tr>
<td>Personal family non-specific</td>
<td></td>
<td>Declare and participate (unless, exceptionally, the Management Committee rules otherwise)</td>
</tr>
<tr>
<td>Non-personal specific pecuniary interest</td>
<td></td>
<td>Declare and participate, unless the individual has personal knowledge of the intervention or matter either through his or her own work, or through direct supervision of other people’s work. In either of these cases he or she should declare this interest and not take part in the proceedings except to answer questions</td>
</tr>
<tr>
<td>Non-personal non-specific pecuniary</td>
<td></td>
<td>Declare and participate (unless, exceptionally, the Management Committee rules otherwise)</td>
</tr>
<tr>
<td>Personal specific non-pecuniary</td>
<td></td>
<td>Declare – action is at discretion of the Management Committee</td>
</tr>
</tbody>
</table>
Appendix 2

Conflict of interest register: Revision of *Clinical practice guidelines for Surveillance Colonoscopy (2011)*

Conflict of interest was assessed and managed according to Cancer Council Australia’s *A Code of Practice for Declaring and Dealing with Conflicts of Interest*.15

All of the Working Party members, including consumer and GP representatives and Cancer Council project staff, were asked to declare in writing any interests relevant to the guidelines development. The Chair was responsible for evaluating all statements. The evaluation of possible conflicts of interest was guided by *A Code of Practice for Declaring and Dealing with Conflicts of Interest*.16 All declarations and the evaluation outcome were added to the register of interests for the guidelines.

Members had the option to submit a curriculum vitae (CV) to summarise their experience, skills and publications in the colorectal cancer and surveillance colonoscopy field. However, it was not compulsory to submit a CV. The Chair could request to view a CV if necessary. The information in the CVs provided is intended to complement or provide additional detail about the individual.

This register was available to the Working Party members throughout the development of the guidelines, allowing members to take any potential conflicts of interest into consideration during discussions, decision making and formulation of recommendations. Members were asked to update their information throughout the guidelines development process if they became aware of any changes to their interests.

When the guidelines enter the updating phase, Working Party members will be responsible to update their conflict of interest statements if a new interest arises. The members would receive a formal reminder to review their statements and ensure it is up-to-date.

---

### Management Committee

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Relevant financial activities</th>
<th>Relevant professional and organisational experience</th>
<th>Other relationships or activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Cameron Bell</td>
<td>Gastroenterologist, Royal North Shore Hospital, Sydney</td>
<td>No interest declared.</td>
<td>Development of related guidelines, standards, educational material or fact sheets</td>
<td>No interest declared.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>I chaired the 2012 guidelines relating to surveillance colonoscopy for Cancer Council</td>
<td></td>
</tr>
<tr>
<td>Professor Timothy Price</td>
<td>Medical Oncologist, North Adelaide Oncology, Adelaide</td>
<td>Consultancy fees/honorarium Advisory board member for Merck, AMGEN, SANOFI, BAYER, Roche for CRC agents</td>
<td>Development of related materials ACTH/AGITG CRC Consensus papers</td>
<td>Relationships AGITG Chair</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Support for travel or accommodation AMGEN and MERCK</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professor Sanchia Aranda</td>
<td>CEO, Cancer Council Australia</td>
<td>No interest declared.</td>
<td>Employed by Cancer Council Australia</td>
<td>No interest declared.</td>
</tr>
<tr>
<td>Professor Alexander (Sandy) Heriot</td>
<td>Consultant colorectal surgeon; Director Cancer Surgery, Peter MacCallum Cancer Centre; Director, Lower GI Tumour Stream, Victorian Comprehensive Cancer Centre</td>
<td>No interest declared.</td>
<td>Publications 119 publications, many related to colorectal cancer</td>
<td>No interest declared.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Speeches/lectures 100+ presentations, many related to colorectal cancer</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Development of related materials Chairman of Binational Colorectal Cancer Audit</td>
<td></td>
</tr>
<tr>
<td>Professor Finlay Macrae AO</td>
<td>Gastroenterologist, Royal Melbourne Hospital, Melbourne</td>
<td>Employment</td>
<td>I am employed by The Royal Melbourne Hospital, an active colonoscopist; I also practice in private with reimbursement by Medicare and private insurers on occasions</td>
<td></td>
</tr>
<tr>
<td>---------------------------</td>
<td>----------------------------------------------------------</td>
<td>------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Board Membership</td>
<td>I am Chair of the Board of the Australian and New Zealand Gastroenterology International Training Association; Secretary International Society for Gastrointestinal Hereditary Tumours (London Based)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Consultancy fees/honorarium</td>
<td>I receive an Honorarium for authoring and editing chapters in the on line text UptoDate including on colonic polyps and risk for colorectal cancer, and its prevention; I am a consultant to the CSIRO who have developed products targeting prevention of colorectal cancer, one of which is in trial at present (I am national PI)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Grants</td>
<td>I am in receipt of grants from Cancer Australia (for the study of resveratrol as a prevention for colorectal cancer; and Queensland Cancer Council, Cancer Cancer of NSW, Cancer Council of Victoria and Anti Cancer Council of South Australia, testing the CSIRO product prevent adenoma in FAP; Multiple grants from Pharma to construct trials in IBD, Equipment grant from Medtrons relating to</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Publications</td>
<td>My CV describes a range of research in prevention. Please search PubMed “Macrae F”</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Speeches/lectures</td>
<td>Multiple lectures to honours students, undergraduates and nationally to the Gastroenterological Society of Australia on the Prevention of Colorectal cancer including Chemoprevention; also internationally e.g. to the St Mark’s (London) Frontiers meeting in November 2014 as keynote speaker – on this topic. To an invited lecture in Adelaide on this topic.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Expert testimony</td>
<td>Occasional medico-legal expert advice on matters within my expertise, some of which include colonoscopy and diagnosis of colorectal cancer</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Development of related materials</td>
<td>Guideline documents written with and for the Gastroenterological Society of Australia – currently on Iron Deficiency Anaemia; Criteria for assessment of pathogenicity of Mismatch Repair DNA variants for International Society of Gastrointestinal Hereditary Tumours – published online <a href="http://www.insight-group.org">www.insight-group.org</a> and in Nature Genetics Feb 20914; Educational material for the Familial Cancer Clinic at The Royal Melbourne Hospital on aspirin and</td>
<td></td>
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<td></td>
<td></td>
<td>No interest declared.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Investigator initiated trial of Capsule Colonoscopy in IBD</td>
<td>colorectal cancer prevention. This has been shared also through the Clinical Oncology Society of Australia’s Familial Cancer Committee, nationally</td>
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<tr>
<td><strong>Meals/beverages</strong>&lt;br&gt;Educational meetings supported by Pharma in the field of Inflammatory Bowel Disease</td>
<td><strong>Other (e.g. unpaid advisory roles)</strong>&lt;br&gt;I am vice-chair of the CaPP trial group leading the RCTs of aspirin in Lynch Syndrome. I am Chain, Pathways Project (Colorectal Cancer), Cancer Council NSW. My relationship with the NBCSP is a member of the Clinical Advisory Group.</td>
<td></td>
<td></td>
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<tr>
<td><strong>Gifts/gratuities</strong>&lt;br&gt;Attendance at Investigator Trial initiation meetings in IBD</td>
<td></td>
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<table>
<thead>
<tr>
<th>Dr Elizabeth Murphy</th>
<th>Head, Colorectal Surgical Unit, Lyell McEwin Hospital Adelaide</th>
<th>No interest declared.</th>
<th>Speeches/lectures&lt;br&gt;Will provide CV – presentations at meetings on colorectal cancer</th>
<th>No interest declared.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professor Michael Solomon</td>
<td>Colorectal surgeon, Royal Prince Alfred Hospital, Sydney</td>
<td>No interest declared.</td>
<td>Publications&lt;br&gt;Multiple &gt;80-100&lt;br&gt;Speeches/lectures&lt;br&gt;Multiple &gt;30&lt;br&gt;Development of related materials&lt;br&gt;Previous editor ACN/NHMRC [guidelines]&lt;br&gt;See CV – attachment 9.</td>
<td>No interest declared.</td>
</tr>
<tr>
<td>Professor James St John</td>
<td>Gastroenterologist, Honorary Senior Associate, Cancer Council Victoria, Melbourne</td>
<td>Consultancy fees/honorarium&lt;br&gt;(1) Member of the NBCSP Clinical Advisory Group and the Biennial Screening Working Group: Total sitting fees of $974 paid in 2014;&lt;br&gt;(2) Member of NZ Ministry of Health Bowel Screening Pilot Evaluation Advisory Group: Total sitting fee of $604 paid in 2014;</td>
<td>Publications&lt;br&gt;Most recent publications:&lt;br&gt;(1) Pignone MP, Flitcroft KL, Howard K, Trevena LJ, Salkeld GP, St John DJB. Costs and cost-effectiveness of full implementation of a biennial faecal occult blood test screening program for bowel cancer in Australia. Med J Aust 2011;194:180-185</td>
<td>Relationships&lt;br&gt;Honorary Senior Associate at Cancer Council Victoria, being based in the Cancer Prevention Centre&lt;br&gt;Member, Clinical Advisory Group, National Bowel Cancer Screening Program</td>
</tr>
<tr>
<td>Jutta Thwaites</td>
<td>Head, Clinical Guidelines Network, Cancer Council Australia</td>
<td>No interest declared.</td>
<td>No interest declared.</td>
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</table>

(3) Member of AIHW NBCSP Report and Indicator Working Group in 2012 and 2013, paid at standard Commonwealth rate for sitting fees.

**Other (e.g. registration fees for conferences)**
My registration fee for the World Cancer Congress held in Melbourne in December 2014 was paid by Cancer Council Victoria.

(2) Cenin DR, St John DJB, Ledger MJN, Slevin T, Lansdorp-Vogelaar IL. Optimising the expansion of the National Bowel Cancer Screening Program. Med J Aust 2014;201:456-461

**Speeches/lectures**
Educational television and videos on screening for bowel cancer

(1) Panel member in Rural Health Education Foundation program on bowel cancer screening, chaired by Dr Norman Swan July 2012;

(2) Contributor to two educational DVDs on bowel cancer screening, produced by Cancer Council Victoria - in 2012 and 2014;

(3) Media release on 25 May from CCV (See Attachment)

**Development of related materials**
Contributor to recent updates of the chapter of the CCA National Cancer Prevention Policy relating to bowel cancer, including revision of the sections on flexible sigmoidoscopy and stool and plasma biomarkers in 2014

**Other (e.g. unpaid advisory roles)**
Member of the CCA Cancer Screening and Immunisation Committee

No interest declared.
<table>
<thead>
<tr>
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<th>Position</th>
<th>Interest Declared</th>
<th>Publications</th>
<th>Interest Declared</th>
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<tr>
<td>Dr Bernie Towler</td>
<td>Principal Medical Advisor, Population Health Division, Department of Health, Canberra</td>
<td>No interest declared.</td>
<td><strong>Publications</strong>&lt;br&gt;Advisor to AIHW Outcomes Report 2014</td>
<td>No interest declared.</td>
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<tr>
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<td></td>
<td><strong>Speeches/lectures</strong>&lt;br&gt;WAA presentation 2014, GESA presentation 2014</td>
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<tr>
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<td></td>
<td></td>
<td><strong>Development of related materials</strong>&lt;br&gt;Funder to current guidelines</td>
<td></td>
</tr>
<tr>
<td>Professor John Zalcberg</td>
<td>Head of Cancer, School of Public Health and Preventive Medicine, Monash University, Melbourne</td>
<td>Consultancy fees/honorarium Bayer (and expert testimony) Roche Amgen</td>
<td><strong>Publications</strong></td>
<td>No interest declared.</td>
</tr>
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<td></td>
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<td>Grants Merck Serona Roche Amgen</td>
<td><strong>Speeches/lectures</strong></td>
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<td>Support for travel or accommodation Merck Serona Bayer Roche Sanofi</td>
<td>Expert testimony</td>
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<td>Meals/beverages</td>
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<td>Other (e.g. registration fees for conferences)</td>
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<td>Position</td>
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<td>Relevant professional and organisational experience</td>
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<tr>
<td>Laura Wuellner</td>
<td>Project Manager, Clinical Guidelines Network, Cancer Council Australia</td>
<td>No interest declared.</td>
<td>No interest declared.</td>
<td>No interest declared.</td>
</tr>
<tr>
<td>Dr Albert Chetcuti</td>
<td>Senior Systematic Reviewer, Clinical Guidelines Network, Cancer Council Australia</td>
<td>No interest declared.</td>
<td>No interest declared.</td>
<td>No interest declared.</td>
</tr>
<tr>
<td>Katrina Anderson</td>
<td>Project Manager, Clinical Guidelines Network, Cancer Council Australia</td>
<td>No interest declared.</td>
<td>No interest declared.</td>
<td>No interest declared.</td>
</tr>
<tr>
<td>Tamsin Curtis</td>
<td>Project Manager, Clinical Guidelines Network, Cancer Council Australia</td>
<td>No interest declared.</td>
<td>No interest declared.</td>
<td>No interest declared.</td>
</tr>
<tr>
<td>Victoria Freeman</td>
<td>Research Assistant, Clinical Guidelines Network, Cancer Council Australia</td>
<td>No interest declared.</td>
<td>No interest declared.</td>
<td>No interest declared.</td>
</tr>
<tr>
<td>Ben Lee-Bates</td>
<td>Research Assistant, Clinical Guidelines Network, Cancer Council Australia #</td>
<td>No interest declared.</td>
<td>No interest declared.</td>
<td>No interest declared.</td>
</tr>
<tr>
<td>Ms Jennifer Harman</td>
<td>Medical Editor</td>
<td>Owner/Employed by Meducation which provides services to health-related organisations and Government agencies which may be stakeholders in colonoscopy surveillance.</td>
<td>Contractor</td>
<td>No interest declared.</td>
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</table>
## Working Party and Consumer Representatives

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Relevant financial activities</th>
<th>Relevant professional and organisational experience</th>
<th>Other relationships or activities</th>
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<tbody>
<tr>
<td>Jillian Arnott</td>
<td>Consumer representative</td>
<td>No interest declared.</td>
<td>No interest declared.</td>
<td>No interest declared.</td>
</tr>
<tr>
<td>Dr Karen Barclay</td>
<td>Colorectal Surgeon and Senior Lecturer in Surgery</td>
<td>No interest declared.</td>
<td>Development of related materials</td>
<td>No interest declared.</td>
</tr>
<tr>
<td></td>
<td>Acting Head of the Academic Surgical Unit, NCHER</td>
<td></td>
<td>Developed algorithms for educational material based on previous Guidelines.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The Northern Hospital and the University of Melbourne</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>A/Prof Gregor Brown</td>
<td>Head of endoscopy, The Alfred Hospital; Gastroenterologist at a private gastroenterology practice in inner Melbourne</td>
<td>No interest declared.</td>
<td>No interest declared.</td>
<td>No interest declared.</td>
</tr>
</tbody>
</table>
| Prof Karen Canfell | Director, Cancer Research Division, Cancer Council Australia             | Employee of Cancer Council NSW, which has been subcontracted by Cancer Council Australia to perform some work as part of the technical team to develop the Clinical Practice Guidelines for the Prevention, Early Detection and Management of Colorectal cancer. Also a co-PI of an unrelated trial of cervical screening which is funded by the Victorian Cytology Service (VCS). The trial has received equipment and a funding contribution from Roche Molecular Systems, which also manufactures assays for genetic testing for access to targeted therapies in colorectal cancer. | Publications
|                    |                                                                          |                                                | Member of the working party for the 2016 NHMRC clinical management guidelines for colorectal cancer. |                                  |


Greuter, M.J, Xu XM, Lew JB, Dekker E, Kuipers EJ, Canfell K, Meijer GA and Coupe VM. Modeling the Adenoma and Serrated pathway to Colorectal
### Development of related guidelines, standards, educational material or fact sheets

I have been a member of Protocol Advisory Sub-Committee (PASC) a standing sub-committee of the Medical Services Advisory Committee (MASC) since July 2011. The principal role of MSAC is to advise the Australian Minister for Health and Ageing on evidence relating to the safety, effectiveness and cost-effectiveness of new medical technologies and procedures. This advice informs Australian Government decisions about public funding for new, and in some cases existing, medical procedures. PASC determines the decision option or question for public funding of proposed new medical technologies and procedures prior to final lodgement of an application for its consideration by MSAC.

| Prof Andrew Clouston | Managing Pathologist, Envoi Specialist Pathologists, Brisbane; Visiting Senior Specialist, Royal Brisbane & Women’s Hospital, Brisbane; Professor, The University of Queensland, Brisbane | No interest declared. | **Publications**  
See Attachment 1  
**Speeches/lectures**  
See Attachment 1  
**Development of related materials, including guidelines, standards, educational materials or fact sheets**  
No interest declared. |
<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
<th>Support for travel or accommodation</th>
<th>Speeches/lectures</th>
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<tr>
<td>Jeffrey Cuff</td>
<td>Consumer representative</td>
<td>Occasional trips to WEHI for consumer, special events and research reviews. This only includes air fares paid for by WEHI.</td>
<td>Relevant to The Shirley Cuff Research Foundation</td>
<td>AGITG Membership</td>
</tr>
<tr>
<td>Professor Jon Emery</td>
<td>Honorary Senior Visiting Research Fellow, Winthrop Professor of General Practice at the Western University of Australia and Professor of Primary Care Cancer Research at the University of Melbourne (also practising GP)</td>
<td>CI on NHMRC CRE on colorectal cancer screening. NHMRC Practitioner fellowship relates to cancer risk assessment including colorectal cancer.</td>
<td>See Attachment 3. [Multiple publications on topic]</td>
<td>No interest declared.</td>
</tr>
<tr>
<td>Professor Anthony Gill</td>
<td>Professor of Surgical Pathology, University of Sydney; Senior Staff Specialist, Dept of Anatomical</td>
<td>No interest declared.</td>
<td>See Attachment 3. [Multiple speeches/lectures on topic]</td>
<td>No interest declared.</td>
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**Grants**
- CI on NHMRC CRE on colorectal cancer screening. NHMRC Practitioner fellowship relates to cancer risk assessment including colorectal cancer.

**Publications**
- See Attachment 3. [Multiple publications on topic]

**Speeches/lectures**
- See Attachment 3. [Multiple speeches/lectures on topic]

**Development of related materials**
- Development of CRISP and GRAIDS risk assessment tools for cancer risk assessment in general practice.

**Other (e.g. unpaid advisory roles)**
- Member of NBCSP Clinical and Biennial Screening Committees.
<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Interest Declared</th>
<th>Publications</th>
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</table>
| Professor Afaf Girgis       | Director, Psycho-oncology Research Group, Centre for Oncology Education and Research Translation (CONCERT), Ingham Institute for Applied Medical Research, South Western Sydney Clinical School, UNSW Medicine; Conjoint Professor, UWS, UQ and Griffith University | No interest declared. | Leong RW, Perry J, Campbell B, Koo J, Turner IB, Corte C, et al. Knowledge and predictors of dysplasia surveillance performance in inflammatory bowel diseases in Australia. Gastrointest Endosc 2015 Oct;82(4):708-714.e4  
Wanders LK, Kuiper T, Kieslich R, Karstensen JG, Leong RW, Dekker E, et al. Limited applicability of chromoendoscopy-guided confocal |
| Professor Rupert Leong      | Senior Staff Specialist gastroenterologist and Director of Endoscopy, Concord Hospital, Sydney. Clinical Professor of Medicine University of Sydney, Macquarie University. Conjoint Professor of Medicine, UNSW. Director of IBD Sydney. | No interest declared. | No interest declared. |

No interest declared.
<table>
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<th>Position and Affiliation</th>
<th>Financial Interests</th>
<th>Other Interests</th>
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<tbody>
<tr>
<td>Dr James Moore</td>
<td>Clinical Director, General Surgery; Surgical Directorate, Royal Adelaide Hospital</td>
<td>No interest declared.</td>
<td>Speeches/lectures</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>I gave an invited lecture on ASCRS/Colorectal Therapies June 2017 in Seattle entitled “The Role of Screening Colonoscopy” No interest declared.</td>
</tr>
<tr>
<td>Prof Dianne O’Connell</td>
<td>Senior Epidemiologist at Cancer Council NSW – University of Sydney</td>
<td>Employee at Cancer Council NSW Grants</td>
<td>No interest declared.</td>
</tr>
<tr>
<td></td>
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<td>NHMRC, PCFA, Cancer Australia, Cancer Council NSW</td>
<td>No interest declared.</td>
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<td>Consultancy fees/honorarium</td>
<td>No interest declared.</td>
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<td>Sitting fees for MSAC ESC (to Dec 2014), NHMRC committees</td>
<td>No interest declared.</td>
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<td>Support for travel or accommodation</td>
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<td>Commonwealth Dept Health and NHMRC for committee meetings</td>
<td>No interest declared.</td>
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<td>Meals and beverages</td>
<td>No interest declared.</td>
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<td>Commonwealth Dept Health and NHMRC for committee meetings</td>
<td>No interest declared.</td>
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<td>Cancer Council Australia for guideline development meetings</td>
<td>No interest declared.</td>
</tr>
<tr>
<td>Dr Tarik Sammour</td>
<td>Associate Professor, Discipline of Surgery, University of Adelaide;</td>
<td>No interest declared.</td>
<td>No interest declared.</td>
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</tbody>
</table>

*References*


Speeches/lectures

Various invited gastroenterology societies, eg Endoscopy Masterclass, Gold Coast 2017
### Colorectal surgeon, Department of Surgery, Royal Adelaide Hospital

Dr Anne Duggan  
Senior Medical Advisor, Australian Commission on Safety and Quality in Health Care

**Employment**  
ACSQHC is developing a clinical care standard for colonoscopy – I act as medical advisor

**Speeches/lectures & Development of related materials, including guidelines, standards, educational materials or fact sheets**  
Medical advisor and spokesman for the 1st Australian Atlas of Healthcare Variation – includes colonoscopy data and commentary

**Relationships**  
Medical advisor to ACSQHC

**Activities**  
Gastroenterologist in part-time private practice including the provision of colonoscopy

### Subcommittee members

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
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<th>Relevant professional and organisational experience</th>
<th>Other relationships or activities</th>
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</table>
| Dr Mark Appleyard     | Director of Gastroenterology and Hepatology Royal Brisbane and Women’s Hospital | Support for travel or accommodation  
To attend endoscopy workshops/research groups  
Meals and beverages  
Attend conference dinners | Speeches/lectures  
Only to advocate for following NHMRC guidelines  
Expert testimony  
Only to advocate for following NHMRC guidelines  
Development of related materials, including guidelines, standards, educational materials or fact sheets  
Only to advocate for following NHMRC guidelines | No interest declared. |
| Prof Michael Bourke   | Professor of Medicine, University of Sydney; Director Gastrointestinal Endoscopy, Westmead Hospital | No interest declared. | No interest declared. | No interest declared. |
| Prof Phyllis Butow    | Professor, School of Psychology; Co-Director, Centre for Medical Psychology and Evidence-based | No interest declared. | Publications  
Journal of Clinical Oncology (Oct 2013) – Multicenter Randomized | No interest declared. |
<table>
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<th>Relationships</th>
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<tr>
<td>Dr Joshua Butt</td>
<td>Head of endoscopy, Northern Health; Gastroenterologist, Royal Melbourne Hospital and Albury Wodonga Health</td>
<td>No interest declared.</td>
<td>No interest declared.</td>
</tr>
<tr>
<td>Dr Crispin Corte</td>
<td>Gastroenterologist, Royal Prince Alfred Medicine Centre, Macquarie University Clinic, Concord Hospital and Concord Medical Centre</td>
<td>No interest declared.</td>
<td>No interest declared.</td>
</tr>
<tr>
<td>Dr Hooi Ee</td>
<td>Gastroenterologist, Sir Charles Gairdner Hospital, Perth</td>
<td>No interest declared.</td>
<td>No interest declared.</td>
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<tr>
<td>A/Prof David Hewett</td>
<td>Director Endoscopy, Mater Health, Mater Misericordiae Ltd, Brisbane; Associate Professor, School of Medicine, The University of Queensland; Gastroenterologist and therapeutic colonoscopist, Brisbane Colonoscopy</td>
<td>Consultancy fees/honorarium</td>
<td>Consultancy fees/honorarium</td>
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<td></td>
<td>Consultant for Olympus Corporation, Japan and Olympus Australia Pty Ltd, Australia.</td>
<td>Publications</td>
<td>Publications</td>
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<td>Consultant for FujiFilm Australia Pty Ltd</td>
<td>Speeches/lectures</td>
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<td>Consultant for Cook Medical Pty Ltd</td>
<td>Expert testimony</td>
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<td>Consultant for Boston Scientific Corporation, Australia</td>
<td>Other (e.g. unpaid advisory roles)</td>
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<td>Member, Lynch Syndrome</td>
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<td>Australia National Advisory Board</td>
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**Trial of Centralized Nurse-led Telephone-based Care Coordination to Improve Outcomes After Surgical Resection for Colorectal Cancer: The CONNECT Intervention**

**Publications**
See Attachment 2

**Speeches/lectures**
See Attachment 2

**Activities**
See Attachment 2

**Relationships**
See Attachment 2

**Consultancy fees/honorarium**
Consultant for Olympus Corporation, Japan and Olympus Australia Pty Ltd, Australia.
Consultant for FujiFilm Australia Pty Ltd
Consultant for Cook Medical Pty Ltd
Consultant for Boston Scientific Corporation, Australia

**Other (e.g. unpaid advisory roles)**
Member, Clinical Advisory Group, National Bowel Cancer Screening Program, Canberra.
Co-chair, World Endoscopy Organization Expert Working
<table>
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<th>Name</th>
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<th>Speeches/lectures</th>
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<tbody>
<tr>
<td>Dr Viraj Kariyawasam</td>
<td>Gastroenterologist, University of Western Sydney, Blacktown and Mount Druitt Hospital and GastroHealth Australia</td>
<td></td>
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<tr>
<td>Dr Cherry Koh</td>
<td>Colorectal surgeon, Royal Prince Alfred Hospital</td>
<td></td>
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<tr>
<td>Prof Barbara Leggett</td>
<td>Gastroenterologist, Royal Brisbane and Women’s Hospital; Professor of Medicine, School of Medicine, University of Queensland; Honorary Group Leader, Queensland Institute of Medical Research Berghofer</td>
<td></td>
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<tr>
<td>Dr Andrew Luck OAM</td>
<td>Colorectal surgeon, Lyell McEwin Hospital</td>
<td></td>
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</tr>
<tr>
<td>Dr Spiro Raftopoulos</td>
<td>Gastroenterologist, Hollywood Private Hospital; Gastroenterologist, Peel Health</td>
<td>Consultancy fees/honourium ERCP teaching module for nurses – Olympus</td>
<td>Speeches/lectures</td>
<td>Development of related materials, including guidelines,</td>
<td></td>
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</table>

**Group (Image-enhanced endoscopy), Colorectal Cancer Screening Committee.**
**Member, Editorial Board, Endoscopy (Journal).**
**Member, Editorial Board, Journal of the Anus, Rectum and Colon (Journal).**

No interest declared.
<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Support for travel or accommodation</th>
<th>Standards, educational materials or fact sheets</th>
<th>Publications</th>
<th>Speeches/lectures</th>
<th>Relationships</th>
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<tbody>
<tr>
<td>A/Prof Rajvinder Singh</td>
<td>Director of Gastroenterology at the Lyell McEwin and Modbury Hospitals, South Australia; Clinical Associate Professor of Medicine, the University of Adelaide</td>
<td>No interest declared.</td>
<td>No interest declared.</td>
<td>No interest declared.</td>
<td>No interest declared.</td>
<td>I am on the executive of the Abdominal Radiology Group of Australia and New Zealand. We are aligned to provide best patient care.</td>
</tr>
<tr>
<td>Dr Tom Sutherland</td>
<td>Abdominal Radiologist, St Vincent’s Hospital</td>
<td>No interest declared.</td>
<td>No interest declared.</td>
<td>No interest declared.</td>
<td>No interest declared.</td>
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<tr>
<td>Dr Betty Wu</td>
<td>Gastroenterology Fellow, St George Hospital</td>
<td>No interest declared.</td>
<td>No interest declared.</td>
<td>No interest declared.</td>
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