

# Colorectal cancer screening with faecal immunochemical testing, sigmoidoscopy or colonoscopy: A BMJ Rapid Recommendation

**Main editor**

Lise M. Helsingen

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## Contact

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## Summary of recommendations

### 1 - Colorectal cancer screening with faecal immunochemical testing (FIT), sigmoidoscopy or colonoscopy: A BMJ Rapid Recommendation

Weak recommendation

**For healthy, screening-naïve adults aged 50-79 with < 3% estimated risk of colorectal cancer at 15 years**

(Estimate your 15-year risk of cancer here <https://qcancer.org/15yr/colorectal/index.php>)

We suggest no screening

Remark: Find evidence summaries, decision aids and practical issues in user-friendly formats here: <https://magicevidence.org/match-it/190220dist/>

Weak recommendation

**For healthy, screening-naïve adults aged 50-79 with > 3% estimated risk of colorectal cancer at 15 years**

(Estimate your 15-year risk of cancer here <https://qcancer.org/15yr/colorectal/index.php>)

We suggest screening with FIT (every or every two years) or a single sigmoidoscopy or colonoscopy

Remark: Find evidence summaries, decision aids and practical issues in user-friendly formats here: <https://magicevidence.org/match-it/190220dist/>

### 2 - BMJ Rapid Recommendations methods and processes

## 1 - Colorectal cancer screening with faecal immunochemical testing (FIT), sigmoidoscopy or colonoscopy: A BMJ Rapid Recommendation

**For healthy, screening-naïve adults aged 50-79 with < 3% estimated risk of colorectal cancer at 15 years**

(Estimate your 15-year risk of cancer here <https://qcancer.org/15yr/colorectal/index.php>)

Weak recommendation

We suggest no screening

Find evidence summaries, decision aids and practical issues in user-friendly formats here: <https://magicvidence.org/match-it/190220dist/>

### Practical Info

#### Who does this recommendation apply to?

This recommendation applies to presumptively healthy individuals aged 50 to 79 with a life expectancy of at least 15 years. Individuals with symptoms that could be related to colorectal cancer, such as persistent changes of bowel habits, blood in stool or abdominal discomfort or pain, should seek medical advice and not wait for a screening test. The recommendation does not apply to people who have previously been screened, or to those with a history of polyps or colorectal cancer, inflammatory bowel disease or hereditary syndromes that increase the risk of colorectal cancer, such as Lynch syndrome and familial adenomatous polyposis.

#### Cancer risk and age

The most important risk factor for colorectal cancer screening is age (cancer risk increases with older age). For those who decide not to undertake screening at a particular time, they may want to revisit the issue, for instance every five years.

#### Practical issues

See the full evidence summaries and practical issues relevant to consider when making a decision about screening, whether it be with FIT, sigmoidoscopy or colonoscopy: <http://magicproject.org/190220dist/#/>

#### Colonoscopy surveillance

Colonoscopies are performed either as the primary screening test, after a positive sigmoidoscopy or FIT screening, or as surveillance due to the finding of high-risk adenomas (defined as several adenomas or adenomas above 10 mm). After the finding of an high-risk adenoma the individual will be referred to a surveillance colonoscopy after three years, and thereafter repeated colonoscopies with, depending on the findings, intervals of three to five years.

### Evidence To Decision

#### Benefits and harms

Small net benefit, or little difference between alternatives

The magnitude of the benefits in terms of absolute reduction in colorectal cancer mortality or incidence is dependent on the individual risk of cancer, with smaller benefits as the cancer risk decreases. Harms and burdens are less strongly associated with cancer risk. The panel estimated that the majority of well-informed individuals likely would decline screening when the anticipated benefits in colorectal cancer mortality or incidence reductions are small (fewer than 5 per 1000 reduction for FIT screening and fewer than 10 per 1000 reduction for sigmoidoscopy/colonoscopy screening).[1] When the risk of cancer is below 3% the anticipated benefits are smaller than these thresholds set by the panel.

For a 15-year cancer risk of 2% the four screening options may result in similar colorectal cancer mortality reductions of 3-4 fewer per 1000 screened. Colonoscopy may result in a similar reduction in cancer incidence as sigmoidoscopy (7 and 6 fewer per 1000 screened), while FIT every year may give a smaller incidence reduction (3 fewer per 1000). FIT every two years may have little or no effect on cancer incidence (1 fewer per 1000). Screening-related serious gastrointestinal and cardiovascular adverse events are similar and rare for all screening options (3 fewer per 1000).

The panel was informed by a linked review of colorectal cancer screening trials and a linked modelling study. [2] [3] The effect of colorectal cancer screening has only been evaluated in trials of guaiac faecal occult blood testing (gFOBT) and sigmoidoscopy, so in order to make recommendations for the different screening options based on comparable estimates, the panel reviewed

model-estimates for all four screening options. The model assumes 100% adherence to screening and follow-up for 15 years.

### Certainty of the Evidence

Low

The GRADE certainty of evidence is low for all outcomes due to inherent uncertainty in the modelling. This means that the evidence provides some indication of the likely effect, but there is a high likelihood that the actual effect is different, and new evidence might provide different results. [1][3]

### Preference and values

Substantial variability is expected or uncertain

The panel was informed by a systematic review on the values and preferences of individuals considering colorectal cancer screening, which showed a large variability in values and preferences and highlights the need for shared decision making for those considering screening.[1] The review did not provide clear estimates of what benefit most individuals would demand to undergo screening. The panel therefore identified thresholds for the magnitude of required benefit, given the harms and burdens, based on limited evidence from the review and their experience.[1] The panel used these thresholds as guidance when reviewing the benefits of screening and deciding on the recommendations. Based on benefits, harms and burdens of the tests, the panel inferred that a majority of informed individuals with a 15-year risk of colorectal cancer of 3% or higher are likely to choose screening and a majority of individuals with a risk of below 3% are likely to decline screening.

### Resources and other considerations

Important issues, or potential issues not investigated

Our recommendations take an individual perspective rather than a health care systems perspective where cost-effectiveness becomes more important. The individual cost will depend on local health policies and insurance.

Public health efforts should focus on shared decision making for screening-eligible individuals. Screening should be made available for those who choose it after assessing their individual absolute risk for colorectal cancer and their estimated absolute reduction of this risk which may be achieved by screening. Because many well informed individuals will choose to forgo screening, those who measure quality of care, or endeavor to incentivize quality care, should not use colorectal cancer screening participation as a performance indicator for health care services. Measuring and incentivizing shared decision making conversations about colorectal cancer screening would be appropriate.

## Rationale

We considered screening with either FIT every year or every second year, or a single sigmoidoscopy or colonoscopy at 15 years, and we do not recommend any of the screening options over one another. [1]

The recommendation is weak, which means that at any given level of benefit we believe that some fully informed individuals will choose screening and others will not. Shared decision making with a health-care provider, making use of decision-aids, can help choose whether or not to screen and the optimal screening modality for each individual.

We acknowledge that individuals' risk and thus benefit from screening varies widely. Therefore, rather than making a blanket recommendation, we recommend personalized assessment of risk based on a colorectal cancer risk prediction tool. This recommendation may also apply to people below age 50, however, as cancer risk is usually very low in this group, few people will have a 15-year colorectal cancer risk over 3%.

## For healthy, screening-naïve adults aged 50-79 with > 3% estimated risk of colorectal cancer at 15 years

(Estimate your 15-year risk of cancer here <https://qcancer.org/15yr/colorectal/index.php>)

Weak recommendation

We suggest screening with FIT (every or every two years) or a single sigmoidoscopy or colonoscopy

Find evidence summaries, decision aids and practical issues in user-friendly formats here: <https://magicevidence.org/match-it/190220dist/>

### Practical Info

#### Who does this recommendation apply to?

This recommendation applies to presumptively healthy individuals aged 50 to 79 with a life expectancy of at least 15 years. Individuals with symptoms that could be related to colorectal cancer, such as persistent changes of bowel habits, blood in stool or abdominal discomfort or pain, should seek medical advice and not wait for a screening test. The recommendation does not apply to people who have previously been screened, or to those with a history of polyps or colorectal cancer, inflammatory bowel disease or hereditary syndromes that increase the risk of colorectal cancer, such as Lynch syndrome and familial adenomatous polyposis.

#### Cancer risk and age

The most important risk factor for colorectal cancer screening is age (cancer risk increases with older age). For those who decide not to undertake screening at a particular time, they may want to revisit the issue, for instance every five years.

#### Practical issues

See the full evidence summaries and practical issues relevant to consider when making a decision about screening, whether it be with FIT, sigmoidoscopy or colonoscopy: <http://magicproject.org/190220dist/#/>

#### Colonoscopy surveillance

Colonoscopies are performed either as the primary screening test, after a positive sigmoidoscopy or FIT screening, or as surveillance due to the finding of high-risk adenomas (defined as several adenomas or adenomas above 10 mm). After the finding of a high-risk adenoma the individual will be referred to a surveillance colonoscopy after three years, and thereafter repeated colonoscopies with, depending on the findings, intervals of three to five years.

### Evidence To Decision

#### Benefits and harms

Small net benefit, or little difference between alternatives

The magnitude of the benefits in terms of absolute reduction in colorectal cancer mortality or incidence is dependent on the individual risk of cancer, with increasing benefits as the cancer risk increases. Harms and burdens are less strongly associated with cancer risk. The panel estimated that the majority of well-informed individuals likely would choose screening when the anticipated benefits in colorectal cancer mortality or incidence reductions were equal to or larger than 5 per 1000 reduction for FIT screening and 10 per 1000 reduction for sigmoidoscopy/colonoscopy screening.<sup>[1]</sup> When the risk of cancer is above 3% the anticipated benefits are similar to or larger than these thresholds set by the panel.

For a 15-year cancer risk of 4% the four screening options may result in similar colorectal cancer mortality reductions of 6-8 fewer per 1000 screened. Colonoscopy may result in a similar reduction in cancer incidence as sigmoidoscopy (14 and 11 fewer per 1000 screened), while FIT every year may give a smaller incidence reduction (6 fewer per 1000). FIT every two years may have little or no effect on cancer incidence (2 fewer per 1000). Screening-related serious gastrointestinal and cardiovascular adverse events are similar and rare for all screening options (3-6 fewer per 1000).

The panel was informed by a linked review of colorectal cancer screening trials and a linked modelling study.<sup>[2]</sup><sup>[3]</sup> The effect of colorectal cancer screening has only been evaluated in trials of guaiac faecal occult blood testing (gFOBT) and sigmoidoscopy, so in order to make recommendations for the different screening options based on comparable estimates, the panel reviewed model-estimates for all four screening options. The model assumes 100% adherence to screening and follow-up for 15 years.

#### Certainty of the Evidence

Low

The GRADE certainty of evidence is low for all outcomes due to inherent uncertainty in the modelling. This means that the evidence provides some indication of the likely effect, but there is a high likelihood that the actual effect is different, and new evidence might provide different results. [1][3]

### Preference and values

Substantial variability is expected or uncertain

The screening options have similar reductions in colorectal cancer mortality, but quite different reductions in colorectal cancer incidence and in burdens and practical issues. People are likely to weigh burdens and practical issues very differently. Some individuals will place a high value on avoiding an invasive procedure and are therefore likely to choose FIT. Others who place a high value on preventing colorectal cancer or on avoiding repeated testing are likely to choose sigmoidoscopy or colonoscopy.

The panel was informed by a systematic review on the values and preferences of individuals considering colorectal cancer screening, which showed a large variability in values and preferences and highlights the need for shared decision making for those considering screening.[1] The review did not provide clear estimates of what benefit most individuals would demand to undergo screening. The panel therefore identified thresholds for the magnitude of required benefit, given the harms and burdens, based on limited evidence from the review and their experience.[1] The panel used these thresholds as guidance when reviewing the benefits of screening and deciding on the recommendations. Based on benefits, harms and burdens of the tests, the panel inferred that a majority of informed individuals with a 15-year risk of colorectal cancer of 3% or higher are likely to choose screening and a majority of individuals with a risk of below 3% are likely to decline screening.

### Resources and other considerations

Important issues, or potential issues not investigated

Our recommendations take an individual perspective rather than a health care systems perspective where cost-effectiveness becomes more important. The individual cost will depend on local health policies and insurance.

Public health efforts should focus on shared decision making for screening-eligible individuals. Screening should be made available for those who choose it after assessing their individual absolute risk for colorectal cancer and their estimated absolute reduction of this risk which may be achieved by screening. Because many well informed individuals will choose to forgo screening, those who measure quality of care, or endeavor to incentivize quality care, should not use colorectal cancer screening participation as a performance indicator for health care services. Measuring and incentivizing shared decision making conversations about colorectal cancer screening would be appropriate.

### Rationale

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The recommendation is weak, which means that at any given level of benefit we believe that some fully informed individuals will choose screening and others will not. Shared decision making with a health-care provider, making use of decision-aids, can help choose whether or not to screen and the optimal screening modality for each individual.

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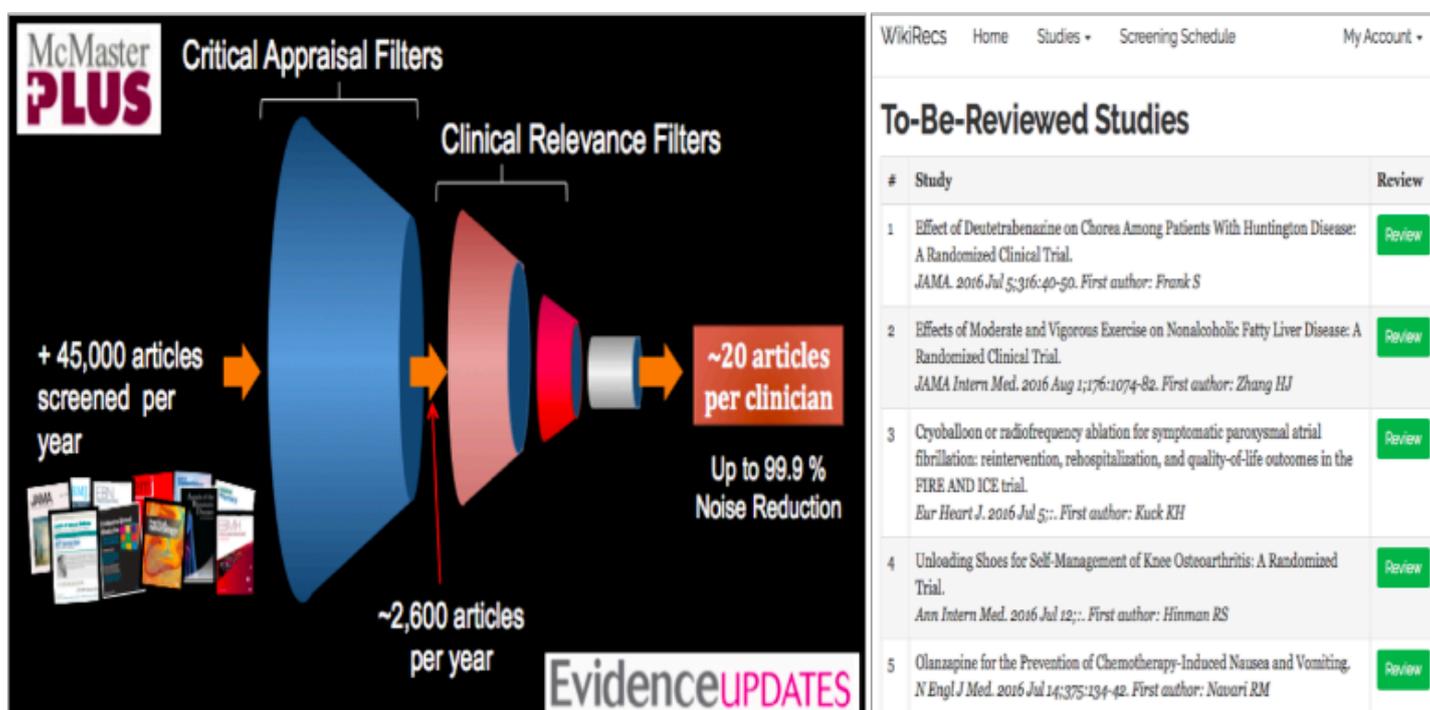
## 2 - BMJ Rapid Recommendations methods and processes

### About BMJ Rapid Recommendations

Translating research to clinical practice is challenging. Trustworthy clinical practice recommendations are one useful knowledge translation strategy. Organisations creating systematic reviews and guidelines often struggle to deliver timely and trustworthy recommendations in response to potentially practice-changing evidence. BMJ Rapid Recommendations aims to create trustworthy clinical practice recommendations based on the highest quality evidence in record time. The project is supported by an international network of systematic review and guideline methodologists, people with lived experience of the diseases or conditions, clinical specialists, and front-line clinicians. This overview is one of a package that includes recommendations and one or more systematic reviews published by the BMJ group and in MAGICapp (<http://www.magicapp.org>). The goal is to translate evidence into recommendations for clinical practice in a timely and transparent way, minimizing bias and centred around the experience of patients. BMJ Rapid Recommendations will consider both new and old evidence that might alter established clinical practice.

### Process overview

1. On a daily basis, we monitor the literature for practice-changing evidence: Formal monitoring through McMaster Premium Literature Service (PLUS) OR Informal monitoring the literature by BMJ Rapid Recommendations expert groups, including clinician specialists and patients



2. The RapidRecs executive team and editors at The BMJ choose which clinical questions to pursue among the identified potentially-practice changing evidence, based on relevance to a wide audience, widespread interest, and likelihood to change practice.

3. We incorporate the evidence into the existing body of evidence and broader context of clinical practice via:

4. A rapid and high-quality systematic review and meta-analysis on the benefits and harms with a focus on the outcomes that matter to patients

5. Parallel rapid recommendations that meet the standards for trustworthy guidelines(1) by an international panel of people with relevant lived experience, front-line clinicians, clinical content experts, and methodologists.

6. The systematic review and the recommendation panel will apply standards for trustworthy guidelines.(1,2) They use the GRADE approach, which has developed a transparent process to rate the quality (or certainty) of evidence and grade the strength of recommendations.(3,4)

7. Further research may be conducted including:

- A systematic review of observational studies to identify baseline risk estimates that most closely represent the population at the heart of the clinical question, a key component when calculating the estimates of absolute effects of the intervention.
- A systematic review on the preferences and values of patients on the topic.

8. Disseminate the rapid recommendations through:

- Publication of the research in BMJ journals
- Short summary of recommendations for clinicians published in The BMJ
- Press release and/or marketing to media outlets and relevant parties such as patient groups
- Links to BMJ group's Best Practice point of care resource
- MAGICapp which provides recommendations and all underlying content in digitally structured multilayered formats for clinicians and others who wish to re-examine or consider national or local adaptation of the recommendations.

### Who is involved?

Researchers, systematic review and guideline authors, clinicians, and patients often work in silos. Academic journals may publish work from any one or combinations of these groups of people and findings may also be published in the media. But it is rare that these groups work together to produce a comprehensive package. BMJ-RapidRecs circumvents organisational barriers in order to provide clinicians with guidance for potentially practice-changing evidence.

#### Our collaboration involves:

- The RapidRecs group with a designated Executive team responsible for recruiting and coordinating the network of researchers who perform the systematic reviews and the recommendation panels. The RapidRecs group is part of MAGIC ([www.magicproject.org](http://www.magicproject.org)), a non for profit organization that provides MAGICapp ([www.magicapp.org](http://www.magicapp.org)) an authoring and publication platform for evidence summaries, guidelines and decision aids, which are disseminated online for all devices.(5)
- The BMJ helps identifying practice-changing evidence on key clinical questions, coordinates the editorial process and publishes the package of content linking to the MAGICapp that is presented in a user-friendly way.

### METHODS FOR THE RAPID RECOMMENDATIONS

The formation of these recommendations adheres to standards for trustworthy guidelines with an emphasis on patient involvement, strict management of conflicts of interests, as well as transparent and systematic processes for assessing the quality of evidence and for moving from evidence to recommendations.(1,2,6)

### Guidance on how the panel is picked and how they contribute

Panel members are sought and screened through an informal process. The following panel members are important:

- At least one author of the individual systematic reviews.
- At least one patient representative with lived experience of the disease or condition. This person receives patient-oriented documents to explain the process and is allocated a linked panel member to empower their contribution.
- A full spectrum of practicing clinicians involved in the management of the clinical problem and patients it affects, including front-line clinicians with generalist experience and those with deep content clinical and research expertise in the particular topic.
- Methodological experts in health research methodology and guideline development.

#### Any potential conflicts of interest are managed with extreme prudence:

- No panel member can have a financial interest – as assessed by the panel chair, the RapidRecs executive team or The BMJeditors as relevant to the topic.
- No more than two panel members with an intellectual interest on the topic (typically having published statements favouring one of the interventions).

*Illustrative example: For the BMJ Rapid Recommendations on antiretroviral therapy for pregnant women living with HIV, the panel recruitment of content experts and community panel members was challenging. Content experts in this area are infectious diseases experts, many of whom have financial conflicts of interests through interactions with the pharmaceutical industry through advisory boards and participation in industry-funded trials. The group reached out to more than 17 potential panel members who were eventually excluded from participating because of conflicts – notably, all of these persons had not disclosed any relevant conflicts on related and recent publications in the topic area. Many more potential panel members were not recruited because of publicly declared conflicts. The chair and MAGIC team were able, with considerable effort and ingenuity, to recruit several excellent and unconflicted content experts.*

#### How the panel meets and works

The international panel communicates via teleconferences and e-mail exchange of written documents throughout the process. Minutes from teleconferences are audiorecorded, transcribed, and stored for later documentation (available for peer-reviewers on request).

Teleconferences typically occur at three timepoints, with circulated documents by e-mail in advance:

- At the initiation of the process to provide feedback on the systematic review protocol (for example, on selection of patient-important outcomes and appropriate prespecified analysis of results) before it is performed.

- At the evidence summary stage with discussion, feedback and agreement on draft evidence (GRADE evidence profile) prepared by the Chair and the methods co-chair based on the systematic review.
- At the recommendation formulation phase with discussion, feedback and agreement on draft recommendations and other content underlying the recommendation (e.g. GRADE SoF-table, key information, rationale, practical advice)

Following the last teleconference the final version of the recommendations is circulated by e-mail specifically requesting feedback from all panel members to document agreement before submission to The BMJ. Additional teleconferences are arranged as needed.

*Illustrative example: For the BMJ Rapid Recommendations on antiretroviral therapy for pregnant women living with HIV, two large-group teleconferences were arranged. First, content experts provided crucial input to evidence assessment (e.g. subgroups to identify). For the recommendation formulation phase the panel needed two teleconferences to discuss all elements in detail, followed by more than 100 e-mails with specific issues to be sorted out. Multiple teleconferences were held to allow the scheduling flexibility required so that all could participate.*

## How we move from research findings to recommendations

### What information is considered?

The panel considers best current evidence from available research. Beyond systematic reviews - performed in the context of the BMJ Rapid Recommendations - the panel may also include a number of other research papers to further inform the recommendations.

### How is a trustworthy guideline made?

The Institute of Medicine (IOM)'s guidance on out how trustworthy guidelines should be developed and articulated key standards as outlined in the table below.(1) The standards are similar to those developed by the Guideline International Network (G-I-N).(2) These standards have been widely adopted by the international guideline community. Peer reviewers of the recommendation article are asked whether they found the guideline trustworthy (in accordance with IOM standards). The table below lays out how we hope to meet the standards for our rapid recommendations:

#### 1. Establishing transparency

**"The processes by which a CPG is developed and funded should be detailed explicitly and publicly accessible."**

This method is available and published as a supplementary file as well as in MAGICapp where all recommendations and underlying content is available.

We ask the peer-reviewers to judge whether the guidance is trustworthy and will respond to concerns raised.

#### 2. Managing conflicts of interest

**"Prior to selection of the guideline development group, individuals being considered for membership should declare all interests and activities potentially resulting in COI with development group activity..."**

Interests of each panel member are declared prior to involvement and published with the rapid recommendations. No one with any potential financial interests in the past three years, or forthcoming 12 months will participate - as judged by the panel chair and The BMJ. No more than two panel members have declared an intellectual conflict of interest. Such conflicts include having taken a position on the issue for example by a written an editorial, commentary, or conflicts related to performing a primary research study or written a prior systematic review on the topic. The Chair must have methods expertise, a clinical background and no financial or intellectual interests. Funders and pharmaceutical companies have no role in these recommendations.

#### 3. Guideline Development Group Composition

**"The guideline development group should be multidisciplinary and balanced, comprising a variety of methodological experts and clinicians, and populations expected to be affected by the CPG."**

The RapidRecs group will aim to include representation from most or every major geographic region in the world, with specific efforts made to achieve gender-balance.

We will facilitate patient and public involvement by including patient experience, via patient-representatives and systematic reviews addressing values and preferences to guide outcome choices and relative weights of each outcome, where available. Patient-partners will be given priority during panel meetings and will have an explicit role in vetting the panel's judgments of values and preferences.

#### 4. Clinical Practice Guideline-Systematic Review Intersection

**"CPG developers should use systematic reviews that meet standards set by the IOM. Guideline development group and systematic review team should interact regarding the scope, approach, and output of both processes."**

Each rapid recommendation will be based on one or more high-quality SRs either developed and published in parallel with our BMJ Rapid Recommendations or produced by other authors and available at the time of making the recommendation. The recommendation panel and SR teams will interact, with up to three members participating in both teams to facilitate communication and continuity in the process.

#### 5. Establishing Evidence Foundations for and Rating Strength of Recommendations

**"For each recommendation: explain underlying reasoning, including a clear description of potential benefits and harms, a summary of relevant available evidence and description of the quality., explain the part played by values, opinion, theory, and clinical experience in deriving the recommendation, provide rating of strength of recommendations."**

The GRADE approach will provide the framework for establishing evidence foundations and rating strength of recommendations.(6) For

each recommendation systematic and transparent assessments are made across the following key factors:

- Absolute benefit and harms for all patient-important outcomes through structured evidence summaries (e.g. GRADE Summary of Findings tables) (4)
- Quality of the evidence(7)
- Values and preferences of patients
- Resources and other considerations (e.g. feasibility, applicability, equity)

Each outcome will - if data are available through systematic reviews - include an effect estimate and confidence interval, with a measure of certainty in the evidence, as presented in Summary of Findings tables. If such data are not available narrative summaries will be provided. A summary of the underlying reasoning and all additional information (e.g. key factors, practical advice, references) will be available online in an interactive format at [www.magicapp.org](http://www.magicapp.org). This summary will include descriptions of how theory (e.g. pathophysiology) and clinical experience played into the evidence assessment and recommendation development. Recommendations will be rated either weak or strong, as defined by GRADE.(8)

If the panel members disagree regarding evidence assessment or strength of recommendations, we will follow a structured consensus process customized to the GRADE system and report any final differences in opinion, with their rationale, in the online supplement and online at [www.magicapp.org](http://www.magicapp.org).

## 6. Articulation of recommendations

**"Recommendations should be articulated in a standardized form detailing precisely what the recommended action is, and under what circumstances it should be performed, and so that compliance with the recommendation(s) can be evaluated."**

Each recommendation will appear at the top of the guideline infographic, published in The BMJ, and will be available in standardised formats in MAGICapp, articulated to be actionable based on best current evidence on presentation formats of guidelines.(9) There will be a statement included in each summary article in The BMJ and in the MAGICapp that these are recommendations to provide clinicians with guidance. They do not form a mandate of action and should be contextualised in the healthcare system a clinician's works in, and or with an individual patient.

## 7. External review

**"External reviewers should comprise a full spectrum of relevant stakeholders..., authorship should be kept confidential....., all reviewer comments should be considered....a rationale for modifying or not should be recorded in writing.... a draft of the recommendation should be made available to general public for comment..."**

At least two external peer-reviewers and one patient reviewer will review the article for The BMJ and provide open peer review. Each will have access to all the information in the package. They will be asked for general feedback as well as to make an overall judgement on whether they view the guidelines as trustworthy. A BMJ series adviser with methodological and/or statistical expertise will review the BMJ Rapid Recommendations publication and the systematic reviews. The RapidRecs panel will be asked to read and respond to the peer review comments and make amendments where they judge reasonable. The BMJ and RapidRecs executive team may, on a case-by-case basis, choose to invite key organizations, agencies, or patient/public representatives to provide and submit public peer-review. There will be post-publication public review process through which people can provide comments and feedback through MAGICapp (or through The BMJ). The Chair will, on behalf of panel authors, aim to respond to each publicly-available peer-review within 30 days, for a period of six months after publication.

## 8. Updating

**"The date for publication, systematic review and proposed date for future review should be documented, the literature should be monitored regularly and the recommendation should be updated when warranted by new evidence."**

The RapidRecs panel will, through monitoring of new research evidence for published BMJ Rapid Recommendations, aim to provide updates of the recommendations in situations in which the evidence suggests a change in practice. These updates will be initially performed in MAGICapp and submitted to The BMJ for consideration of publication of a new Rapid Recommendation.

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