Colorectal Cancer Screening and Prevention

1. Guidelines for Screening

A. Average Risk

Age 45-75 years upper age limit is now considered flexible since many 80-year-olds still want to be kept under surveillance
No history of adenoma or colorectal cancer
No history of inflammatory bowel disease
No family history of colorectal cancer or advanced polyps

• Colonoscopy is the preferred test. Cancer prevention screening should be done every 10 years, beginning at age 45, unless polyps are found when the interval to the next colonoscopy will be reduced. Referral to a gastroenterologist, colon cancer screening program or schedule direct access colonoscopy (if available and you are otherwise healthy)

• Patients that decline or are unable to undergo colonoscopy may be offered:

FIT (fecal immunochemical test for blood) or
Cologuard® (fecal DNA test) or
Flexible sigmoidoscopy every 5-10 years

B. Increased risk

(i) African Americans
Recommended screening: same as average risk

Strang Cancer Prevention Institute has developed and updates guidelines for cancer screening and best practices for cancer prevention using guidelines of the National Cancer Institute (NCI), the National Consortium of Cancer Centers Network (NCCCN) and the American Cancer Society (ACS). Strang is synonymous with cancer screening and prevention. Strang was the first medical facility to introduce the Pap test into clinical practice which has saved millions of women's lives worldwide. Strang was opened by first lady Eleanor Roosevelt in 1933.

(ii) Ashkenazi Jews
Recommended screening: same as average risk

(iii) Personal history of
- Adenoma/sessile serrated polyp (see below)
- Colorectal cancer
- Inflammatory bowel disease (ulcerative colitis, Crohn's disease)

Recommended screening: same as average risk but with modified intervals between examinations

(iv) Family history of colorectal cancer or multiple polyps

• Single first-degree relative with colorectal cancer or advanced adenoma diagnosed at age ≥60 years

Recommended screening: same as average risk

• Single first-degree with colorectal cancer or advanced adenoma diagnosed at age <60 years or two first-degree relatives with colorectal cancer or advanced adenomas

Recommended screening: colonoscopy every 5 years beginning at age 40 years or 10 years younger than age at diagnosis of the youngest affected relative

(v) High risk syndromes

Lynch syndrome/Hereditary Nonpolyposis Colorectal Cancer (HNPCC)
Polyposis syndromes
- Familial Adenomatous Polyposis (FAP)
- Attenuated Familial Adenomatous Polyposis (AFAP)
- MLH-associated Polyposis (MAP)
- Peutz-Jeghers Syndrome (PJS)
- Juvenile Polyposis Syndrome (JPS)
- Hyperplastic Polyposis Syndrome (HPP) (rarely inherited)

Recommend referral to a gastroenterologist who may recommend referral for genetic counseling

2. Cancer Prevention

Colorectal cancer can largely be prevented by adherence to the above guidelines
No prospective clinical trial has shown that either a nutritional or pharmaceutical intervention has reduced the risk of colorectal cancer

Recommended Lifestyle changes:
- Eat a variety of fruits, vegetables and whole grains
- Stop smoking
- Exercise most days of the week
- Maintain a healthy weight

COLONOSCOPY - FREQUENTLY ASKED QUESTIONS

What are the benefits of colonoscopy screening?

Colonoscopy is one of the most effective cancer screening and prevention examinations. Colonoscopy enables the removal of precancerous benign polyps from the colon before they can develop into cancer.

At what age and how often should I have a screening colonoscopy?

Screening colonoscopy for colorectal cancer is recommended to start at age 45. If there is an increased risk (such as a family history of colon cancer and some other uncommon conditions) colonoscopy is recommended at an earlier age. If the colonoscopy is normal then it should be repeated every ten years if there is no family history. If polyps are found then screening will be more frequent such as every one, three or five years depending on the number, size and nature of the polyp(s). Colonoscopy can be stopped in most individuals at age 75, but can be extended, depending on the person's state of health.

Are there any problems with the preparation?

Preparation using laxatives and special preparation liquids (taken by mouth) is required to clean the colon. Each preparation plan is designed and described in detail and should be followed exactly to obtain the best results. It is now standard to divide the preparation into two stages during the hours before colonoscopy.

What questions should I ask the physician who is going to carry out the colonoscopy?

1. What is the polyp detection rate of the practitioner performing my colonoscopy?
2. Will I receive documentation, including a picture of the cecum (end of the colon), showing that my colonoscopy has covered my entire colon and is complete?
3. Who will advise me of the results of any polyp examinations and the need for my next colonoscopy?

How is a colonoscopy done?

After preparation of the colon the day before the procedure (during which time no food will be consumed), nothing (i.e. preparation liquid) is allowed by mouth for four hours before the procedure. Intravenous sedation is given and a flexible video-endoscope (the colonoscope) is passed into the rectum and used to examine the entire lining of the colon. If an abnormality is seen during the procedure a biopsy may be taken through the colonoscope. If a polyp is seen it may be removed using a special instrument passed down the colonoscope. Any tissue removed during the procedure is sent to the laboratory to be examined (biopsied) by a pathologist. The result will be ready a few days after the procedure.

How often are polyps found?

Polyps occur in up to 40% of men and 30% of women aged 45 and over who have a colonoscopy. A physician's polyp detection rate that is much lower than this may indicate that the physician is not thorough.

What are the chances of complications during or after a colonoscopy?
Complications are rare. Less than 1 in a 1000 experience a complication. If it is necessary to remove a polyp then 7 in a 1000 experience a complication. If there is removal of a polyp the risk of perforation (making a hole) of the colon is 1 in a 1000 and bleeding occurs in 5 in a 1000, but only 1-2 in a 1000 require blood transfusion or surgery and nearly all events can be treated during the colonoscopy.

What will I do after a colonoscopy?
You will be able to eat a light meal. As the intravenous sedation can take variable amounts of time to wear off, your doctor will advise you not to drive and not to work or make any important decisions that day.

How will I know the results of any biopsies?
The physician that performed your colonoscopy will arrange to inform you of the pathology results and also indicate when you should have your next colonoscopy for surveillance.