



## Colorectal Cancer Screening

### **Which patients should be considered for colorectal cancer screening?**

- In the United States, colorectal cancer is the second most common cancer in men and third most common in women, accounting for over 50,000 deaths annually. Screening can help significantly reduce the risk of colon cancer by up to 80%.
- The U.S. Preventive Task Force recommends that adults age 50-75 be screened for colorectal cancer<sup>1</sup>.
- The decision to be screened for patients age 75-85 years old should be made on an individual basis after discussion between a patient and their clinician, however the current recommendation is that there is no benefit to screening on or after age 85<sup>1,2</sup>.
- For African Americans, there is data to support screening on or after the age of 45<sup>3</sup>.
- In high risk individuals (those with a first degree relative who had colon cancer or an advanced adenoma [ $> 1$  cm.] under the age of 60, these patients should have an initial colonoscopy at age 40 or 10 years before the index case. Subsequently, screening should continue every 5 years.
- In general, patients should have an anticipated life expectancy of ten years or more to be considered a candidate for screening.

### **Which screening tests are recommended?**

- AHP and the American College of Gastroenterology recommend colonoscopy every 10 years after the age of 50 (Grade 1B recommendation) or after the age of 45 in African Americans (Grade 2C) as the preferred approach to screening<sup>3</sup>.
- Yearly fecal immunochemical testing (FIT) is recommended as an alternative screening choice in all populations (Grade 1B) but especially those patients who are reluctant to undergo screening colonoscopy but would be willing to undergo diagnostic colonoscopy if FIT screening is positive, or those who have difficulty with access to colonoscopy (live remotely, have poor transportation, etc.).
- Annual FIT testing should also strongly be considered in patients who have difficulty with IV access, respiratory risk to sedation, difficulty achieving adequate bowel prep or other limitations which may preclude or make colonoscopy difficult.

<sup>1</sup> <https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/colorectal-cancer-screening2?ds=1&s=colorectal>

<sup>2</sup> <https://www.cancer.org/cancer/colon-rectal-cancer/detection-diagnosis-staging/acs-recommendations.html>

<sup>3</sup> <https://gi.org/guideline/colorectal-cancer-screening/>



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- It is important to note that Fecal/FIT DNA testing (i.e. Cologuard), which is obtained every three years is different than standard FIT testing and is **NOT** recommended for routine use by AHP. It carries a Grade 2B recommendation by the American College of Gastroenterology, as it is both significantly more expensive (~\$530 per FIT DNA versus ~\$15 per annual FIT) and carries a higher false positive rate.
- While the best screening test for colorectal cancer is the one that the patient will actually obtain, AHP **DOES NOT** recommend FIT DNA, flexible sigmoidoscopy, CT colonography, or hemoccult testing to be performed routinely.
- It is recommended to **AVOID** FIT testing in between normal screening colonoscopies as there is no evidence to support the additional testing.

### How to follow up on a positive FIT screening test:

- It is important to note that FIT testing can be positive in benign adenomas, hemorrhoids and very early stage cancerous lesions. It is therefore important to educate patients prior to them performing a FIT screen that there is a risk of a false positive test. This will hopefully ease any anxiety over a positive outcome.
- If a patient has a positive FIT screen, the patient should undergo colonoscopy for validation within 2-3 months after the positive FIT test.
- If referring for colonoscopy after a positive FIT test, be sure to indicate on the requisition for the colonoscopy that this is for follow-up of a positive FIT. This will ensure more rapid scheduling than a routine screening colonoscopy otherwise would necessitate.

This guideline reviewed and approved by the following: D. Danielle Marino, Dr. Anil Sharma, Dr. Larissa Temple and Dr. Bastian Domajnko.