

Colorectal Cancer Screening - Average Risk

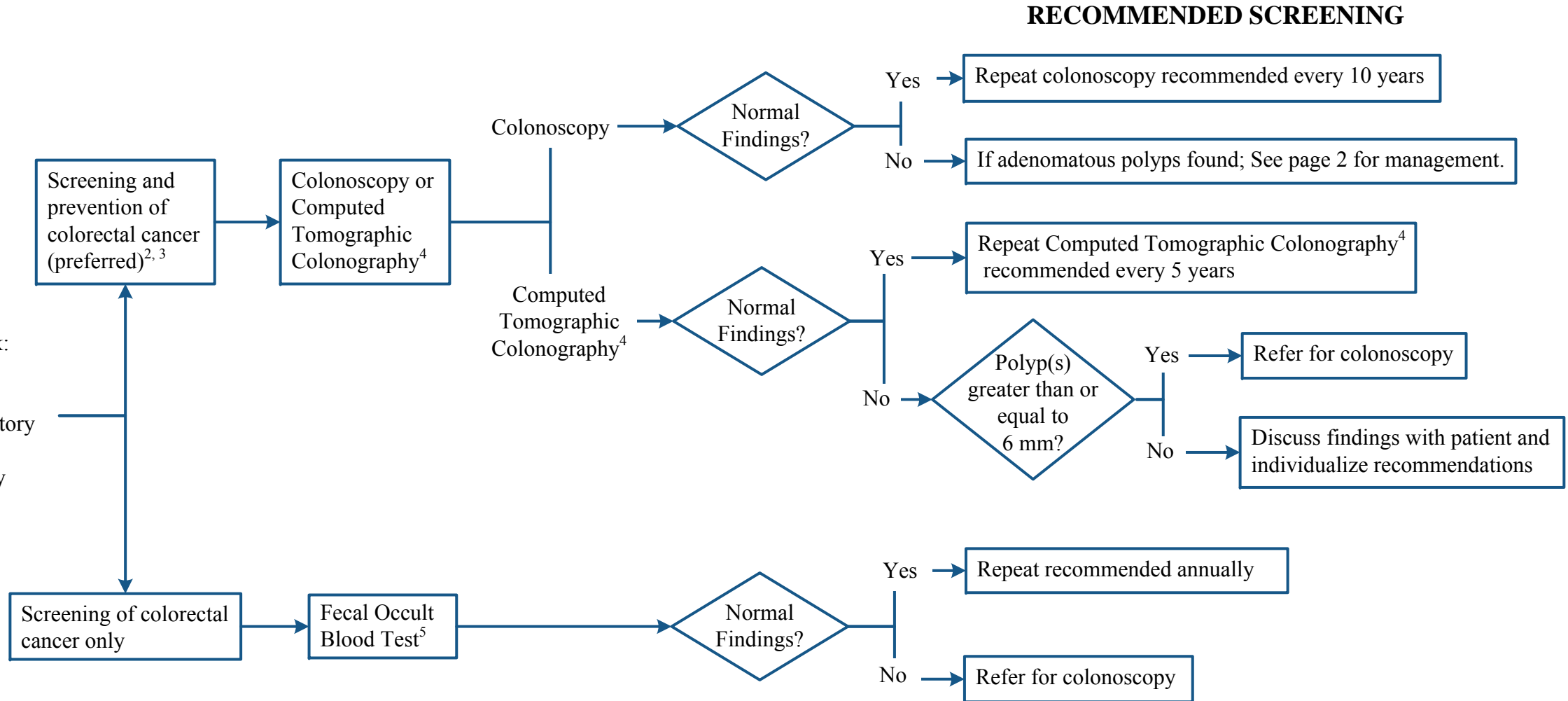
*This practice algorithm has been specifically developed for M. D. Anderson using a multidisciplinary approach and taking into consideration circumstances particular to M. D. Anderson, including the following: M. D. Anderson's specific patient population; M. D. Anderson's services and structure; and M. D. Anderson's clinical information. Moreover, this algorithm is not intended to replace the independent medical or professional judgment of physicians or other health care providers. This algorithm should not be used to treat pregnant women. This algorithm is not intended for individual with a personal history of colorectal cancer.*¹

Note: Screening for adults age 76 to 85 should be evaluated on an individual basis by their health care provider to assess the risks and benefits of screening.

Colorectal cancer screening is not recommended over age 85.

PRESENTATION

- Patients with average risk:
- Age 50 years or older
 - No history of adenoma
 - No history of inflammatory bowel disease
 - Negative Family history



¹ See the Colorectal Cancer Treatment or Survivorship algorithms for the management of individuals with a personal history of colorectal cancer.

² While there is good evidence to support Fecal Occult Blood Test, tests that both screen for and prevent colon cancer are the preferred screening modality. Annual Fecal Occult Blood Tests should not be performed if colonoscopy or CT colonography is used as the screening measure in an average-risk patient.

³ Flexible sigmoidoscopy is an alternate option, but is not the preferred endoscopic modality as the entire colon is not visualized.

⁴ Preauthorization with one's insurance carrier is always advised.

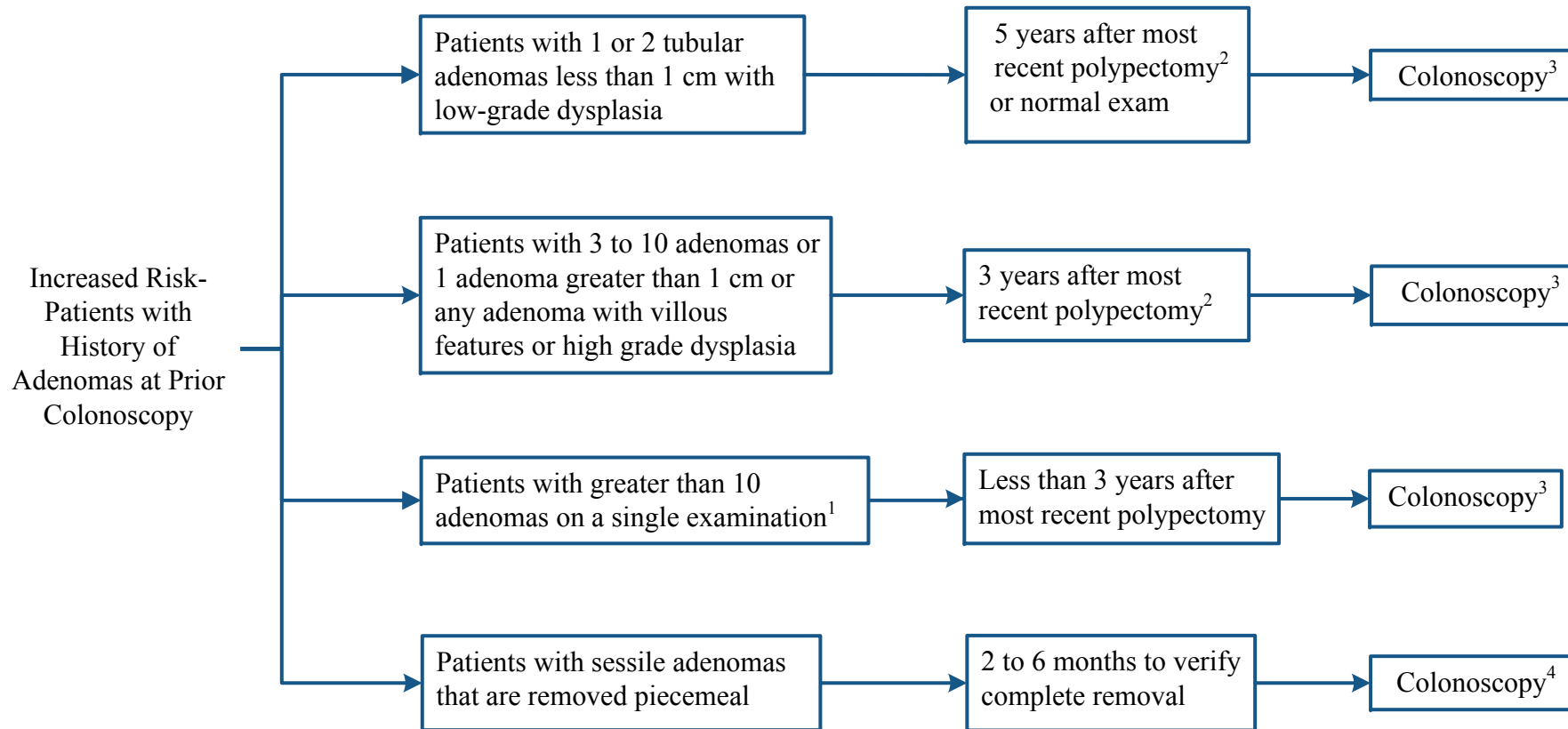
⁵ High sensitivity Fecal Occult Blood Test (guaic-based or immunochemical).

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PRESENTATION

RECOMMENDED SCREENING



¹Consider familial syndrome

²Precise timing based on clinical factors, patient and physician preference.

³Subsequent follow-up is based on the number and size of polyps at the time of colonoscopy as well as the degree of dysplasia. If the follow-up colonoscopy is negative for adenomatous polyps, follow-up in 5 years is recommended.

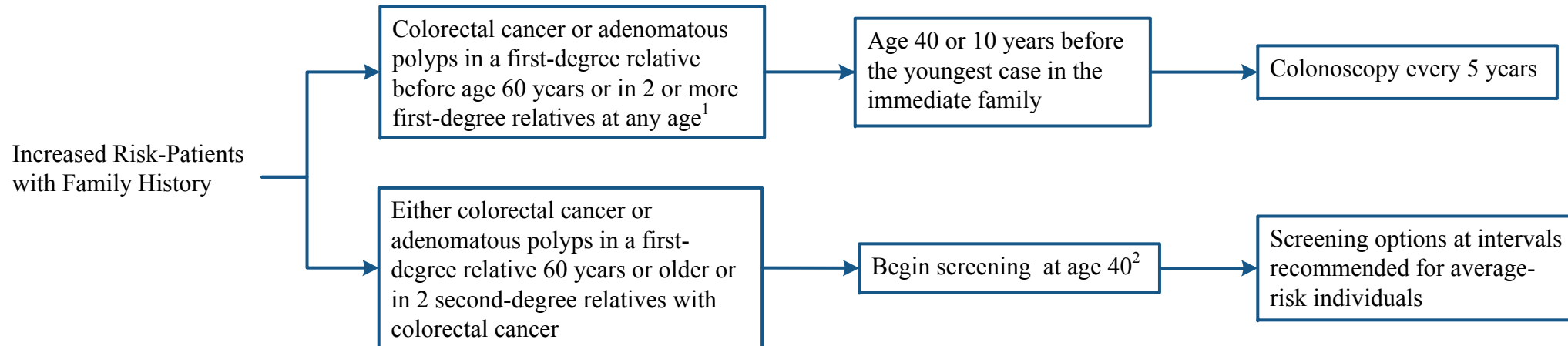
⁴Surveillance individualized based on endoscopist's judgment

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PRESENTATION

RECOMMENDED SCREENING



¹Consider Familial Syndrome

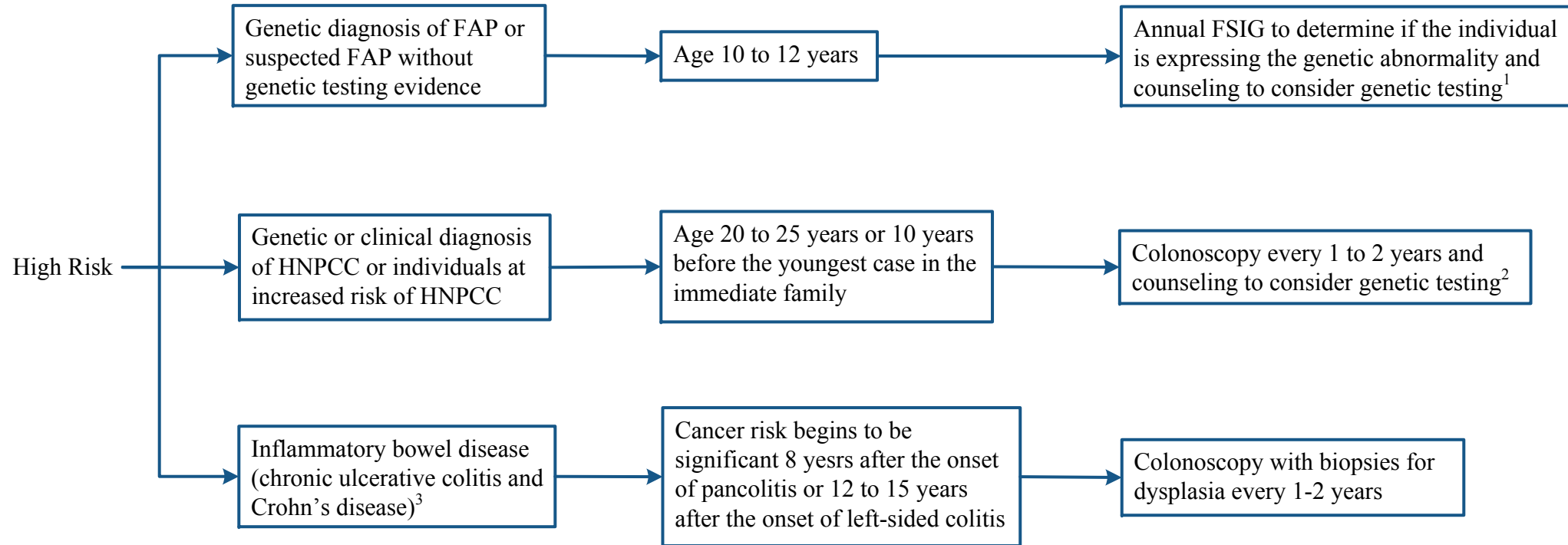
²Screening should begin at an earlier age, but individuals may be screened with any recommended form of testing.

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PRESENTATION

RECOMMENDED SCREENING



¹If the genetic test is positive, colectomy should be considered.

²Genetic testing for HNPCC should be offered to first-degree relatives of persons with a known inherited MMR gene mutation. It should also be offered when the family mutation is not known but 1 of the first 3 of the modified Bethesda Criteria is present.

³These patients are best referred to a center with experience in the surveillance and management of inflammatory bowel disease.

HNPCC = Hereditary Nonpolyposis Colorectal Cancer

FAP = Familial Adenomatous Polyposis

FSIG = Flexible Sigmoidoscopy

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SUGGESTED READINGS

1. Johnson CD et. al. Accuracy of CT colonography for detection of large adenomas and cancers. N Engl J Med. 2008;359:1207-17.
2. Kahi CJ, Rex DK, Imperiale TF. Screening, surveillance, and primary prevention for colorectal cancer:a recent review of the literature. Gastroenterology 2008;135:380-399.
3. Kim DH et. al. CT colonography versus colonoscopy for the detection of advanced neoplasia. N Engl J Med. 2007;357:1403-12.
4. Levin B, Lieberman DA, McFarland B, et al. Screening and surveillance for the early detection of colorectal cancer and adenomatous polyps, 2008: A joint guideline from the American Cancer Society, the US Multi-Society Task Force on Colorectal Cancer, and the American College of Radiology. CA Cancer J Clin 2008;58:130-60.
5. U.S. Preventative Services Taskforce. Recommendations for colorectal cancer: U.S. preventative services Taskforce recommendation staement. Ann Int Med 2008;149:627-637.
6. Zauber AG, Landsdorp-Vogelaar I, Knudson AB, et. al. Evaluating test strategies for colorectal cancer screening:a decision analysis for the U.S. Preventative Services Taskforce. Ann Int Med 2008;149:659-669.

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DEVELOPMENT CREDITS

This practice consensus algorithm is based on majority expert opinion of the Colorectal Screening group at the University of Texas M.D. Anderson Cancer Center. It was developed using a multidisciplinary approach that included input from the following clinical staff.

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