Note: Screening for adults age 76 to 85 years old 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 years.

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See the Colon or Rectal Cancer Treatment or Survivorship algorithms for the management of individuals with a personal history of colorectal cancer.
Screening and prevention of colorectal cancer (preferred)\(^3\)\(^4\)

Patients with average risk\(^2\):
- Age 50 years or older
- No history of adenoma
- No history of inflammatory bowel disease
- Negative family history

Screening of colorectal cancer only

Multifocal stool DNA test

- Fecal occult blood test\(^7\)
- Fecal immunochemical test

Normal findings?

Colonoscopy or computed tomographic colonography\(^5\)

Colonoscopy

Normal findings?

Normal findings?

Repeat colonoscopy recommended every 10 years\(^6\)

If adenomatous polyps found, see Page 3 for management

Repeat computed tomographic colonography\(^5\) recommended every 5 years\(^6\)

Yes

No

Polyt(s) ≥ 6 mm?

Yes

Refer for colonoscopy

Discuss findings with patient and individualize recommendations

No

Normal findings?

Yes

Repeat recommended annually

No

Refer for colonoscopy

Normal findings?

Yes

Recommend repeating every 3 years

No

Refer for colonoscopy

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

2. African Americans have a higher risk of large polyps and tumors from ages 50-65 years; thus it is important to start screening this population earlier. Initiate screening in African Americans beginning at age 45 years old.

3. Follow-up frequency would be based on colonoscopy findings.

4. 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.

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

6. Preauthorization with patient’s insurance carrier is always advised

7. Discontinuation of screening should be considered when persons up to date with screening, who have prior negative screening (particularly colonoscopy), reach age 75 or have < 10 years of life expectancy

7. High sensitivity fecal occult blood test (guaiac-based or immunochemical)
Colorectal Cancer Screening – Increased Risk

**PRESENTATION**

- Patients with 1 or 2 tubular adenomas < 1 cm with low-grade dysplasia

- Patients with 3 to 10 adenomas or 1 adenoma > 1 cm or any adenoma with villous features or high grade dysplasia

- Patients with > 10 adenomas on a single examination

- Patients with sessile adenomas that are removed piecemeal

**RECOMMENDED SCREENING**

- 5 years after most recent polypectomy or normal exam

- 3 years after most recent polypectomy

- Less than 3 years after most recent polypectomy

- 2 to 6 months to verify complete removal

- Age 40 or 10 years before the youngest case in the immediate family

- Begin screening at age 40 years

- Screening options at intervals recommended for average-risk individuals

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

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

3. Genetic evaluation for familial cancer syndromes is recommended

4. Subsequent 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.

5. Surveillance individualized based on Endoscopist’s judgment

6. Consider Familial Syndrome

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

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Note: Screening for adults age 76 to 85 years old 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 years.

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Colorectal Cancer Screening – High Risk

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Note: Screening for adults age 76 to 85 years old 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 years.

**PRESENTATION**

- Genetic diagnosis of FAP or suspected FAP without genetic testing evidence
- Genetic or clinical diagnosis of HNPCC or individuals at increased risk of HNPCC
- Inflammatory bowel disease (chronic ulcerative colitis or Crohn’s disease)

**RECOMMENDED SCREENING**

- Age 10 to 12 years: Annual FSIG to determine if the individual is expressing the genetic abnormality and counseling to consider genetic testing
- Age 20 to 25 years or 10 years before the youngest case in the immediate family: Colonoscopy every 1 to 2 years and counseling to consider genetic testing
- Cancer risk begins to be significant 8 years after the onset of pancolitis or 12 to 15 years after the onset of left-sided colitis: Colonoscopy with biopsies for dysplasia every 1 to 2 years

FAP = familial adenomatous polyposis
FSIG = flexible sigmoidoscopy
HNPCC = hereditary nonpolyposis colorectal cancer

1. See the Colon or Rectal Cancer Treatment or Survivorship algorithms for the management of individuals with a personal history of colorectal cancer
2. If the genetic test is positive, colectomy should be considered
3. Genetic 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.
4. These patients are best referred to a center with experience in the surveillance and management of inflammatory bowel disease

Colonic or Rectal Cancer Treatment or Survivorship

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SUGGESTED READINGS


Colorectal Cancer Screening

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This screening algorithm is based on majority expert opinion of the Colorectal Screening work group at the University of Texas MD Anderson Cancer Center. It was developed using a multidisciplinary approach that included input from the following:

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