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

Screening and prevention of colorectal cancer (preferred)

Screening of colorectal cancer only

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

RECOMMENDED SCREENING

Screening and prevention of colorectal cancer

Colonoscopy or computed tomographic colonography

Computed tomographic colonography

Normal findings?

Yes

If adenomatous polyps found, see Page 3 for management

No

Repeat computed tomographic colonography recommended every 5 years

Polyp(s) greater than or equal to 6 mm?

Yes

Refer for colonoscopy

No

Discuss findings with patient and individualize recommendations

Normal findings?

Yes

Repeat recommended annually

No

Refer for colonoscopy

Multifocal stool DNA test

Normal findings?

Yes

Recommend repeating every 3 years

No

Refer for colonoscopy

Fecal occult blood test

Fecal immunochemical test

Normal findings?

Yes

Repeat colonoscopy recommended every 10 years

No

Colonoscopy

Normal findings?

Yes

Repeat computed tomographic colonography recommended every 5 years

No

Discuss findings with patient and individualize recommendations


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. Limited evidence supports initiating screening in African Americans 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 Preauthorization with patient’s insurance carrier is always advised

6 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 less than 1 cm with low-grade dysplasia
- Patients with 3 to 10 adenomas or 1 adenoma greater than 1 cm or any adenoma with villous features or high-grade dysplasia
- Patients with greater than 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

**Increased Risk patients with history of adenomas from prior colonoscopy**

- Colorectal cancer or adenomatous polyps in a first-degree relative before age 60 years or in 2 or more first-degree relatives at any age
- Either colorectal cancer or adenomatous polyps in a first-degree relative 60 years or older or in 2 second-degree relatives with colorectal cancer

**Increased Risk patients with family history**

1. See the [Colon or Rectal Cancer Treatment or Survivorship](https://example.com) 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

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.
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

- Annual FSIG to determine if the individual is expressing the genetic abnormality and counseling to consider genetic testing
- Colonoscopy every 1 to 2 years and counseling to consider genetic testing
- Colonoscopy with biopsies for dysplasia every 1 to 2 years

Age 10 to 12 years
Age 20 to 25 years or 10 years before the youngest case in the immediate family
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

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

Department of Clinical Effectiveness V7
Approved by The Executive Committee of Medical Staff on 06/25/2019
SUGGESTED READINGS


DEVELOPMENT CREDITS

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:

- Therese Bevers, MD (Cancer Prevention)†
- Robert Bresalier, MD (Gastroenterology, Hepatology & Nutrition)†
- Powel Brown, MD (Cancer Prevention)
- Elise Cook, MD (Cancer Prevention)
- Robin Coyne, FNP, RN (Cancer Prevention)
- Joyce Dains, MD, PH, JD, RN, FNP-BC (Cancer Prevention)
- Ernest Hawk, MD MPH (Cancer Prevention)
- Marita Lazzaro, RN, MS, ANP (Cancer Prevention)
- Patrick Lynch, MD, JD (Gastroenterology, Hepatology & Nutrition)†
- Ana Nelson, FNP, RN (Cancer Prevention)
- Lonzetta Newman, MD (Cancer Prevention)
- Tilu Ninan, ANP, RN (Cancer Prevention)
- Gottumukkala Raju, MD (Gastroenterology, Hepatology & Nutrition)†
- Eduardo Vilar Sanchez, MD (Cancer Prevention)
- David Vining, MD (Diagnostic Radiology)†
- Brian Weston, MD (Gastroenterology, Hepatology & Nutrition)
- Tonya Whitlow, MSPA (Gastroenterology, Hepatology & Nutrition)
- Sonal Yang, PharmD*  

† Core Development Team
* Clinical Effectiveness Development Team