Colorectal Cancer Screening

Disclaimer: *This algorithm has been developed for MD Anderson using a multidisciplinary approach considering circumstances particular to MD Anderson's specific patient population, services and structure, and clinical information. This is not intended to replace the independent medical or professional judgment of physicians or other health care providers in the context of individual clinical circumstances to determine a patient's care. 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 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

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Colorectal Cancer Screening – Average Risk

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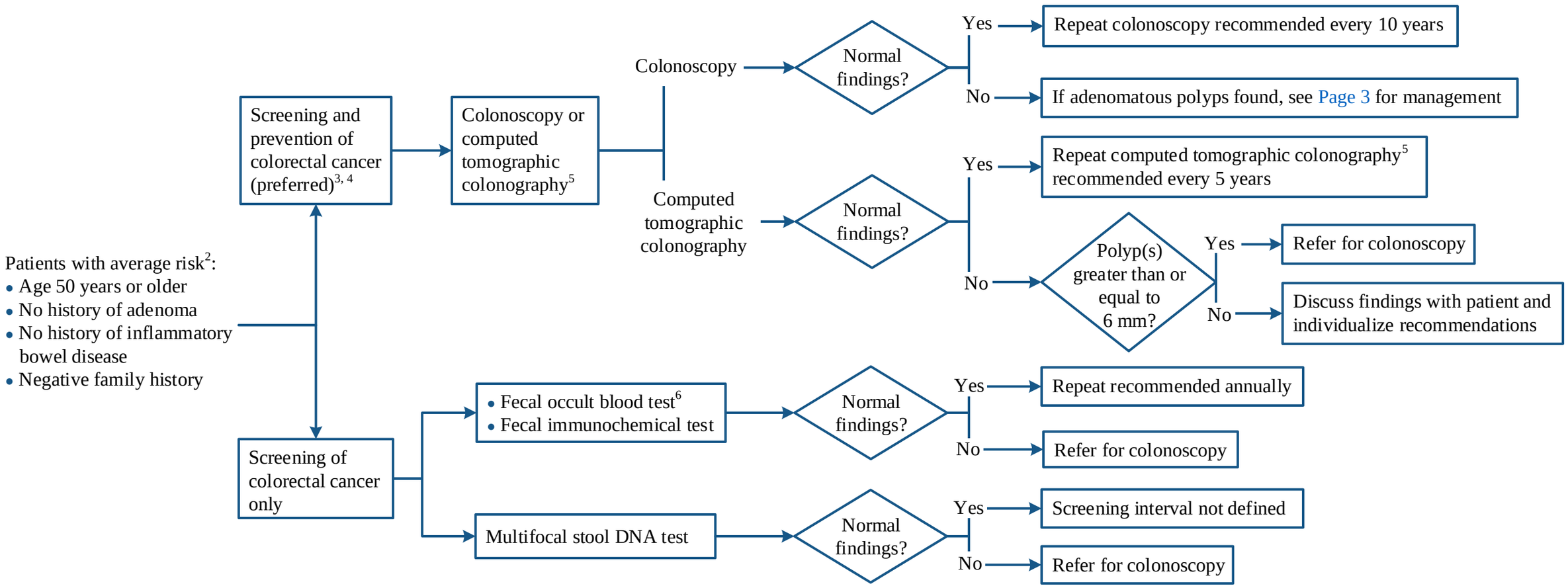
PRESENTATION

RECOMMENDED SCREENING



[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 at 50 years of age. Follow-up frequency would be based on colonoscopy findings.

[3] 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.

[4] Flexible sigmoidoscopy is an alternate option, but is not the preferred endoscopic modality as the entire colon is not visualized

[5] Preauthoriziation with patient's insurance carrier is always advised

[6] High sensitivity fecal occult blood test (guaiac-based or immunochemical)

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Colorectal Cancer Screening – Increased Risk

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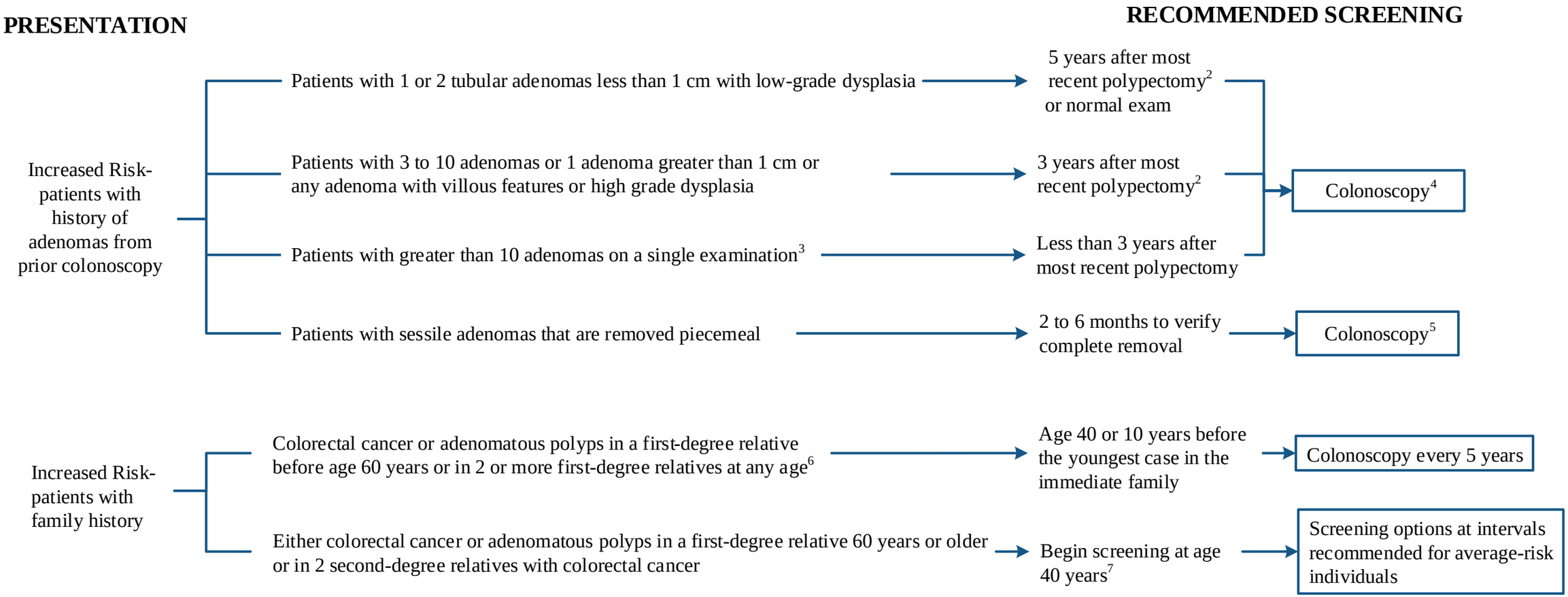

[1] See the Colon or Rectal Cancer Treatment or Survivorship algorithms for the management of individuals with a personal history of colorectal cancer
[2] Precise timing based on clinical factors, patient and physician preference
[3] Genetic evaluation for familial cancer syndromes is recommended
[4] 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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Colorectal Cancer Screening – High Risk

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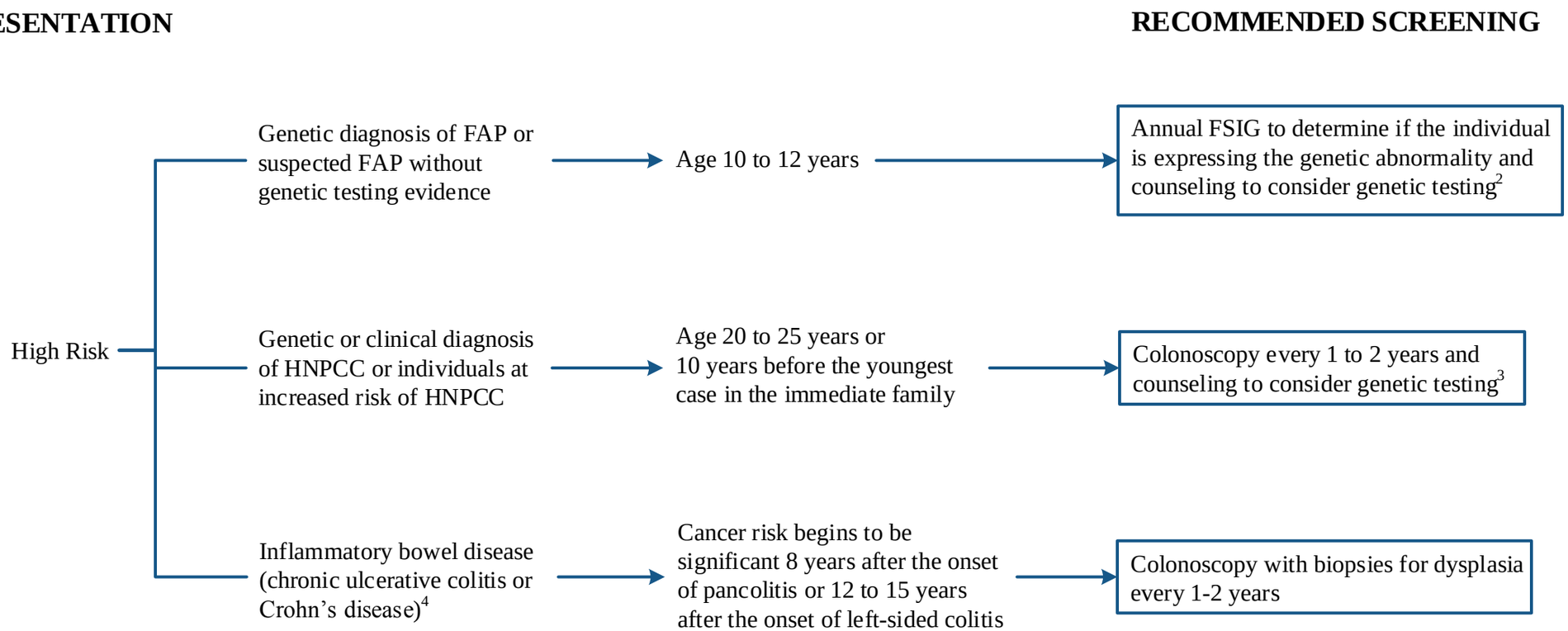

FSIG = flexible sigmoidoscopy
HNPCC = hereditary nonpolyposis colorectal cancer
FAP = familial adenomatous polyposis

[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

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SUGGESTED READINGS

Calonge, N., Petitti, D. B., DeWitt, T. G., Dietrich, A. J., Gregory, K. D., Harris, R., . . . Marion, L. N. (2008). Screening for colorectal cancer. *Annals of Internal Medicine, 149*(9), 627-637.

Imperiale, T. F., Ransohoff, D. F., Itzkowitz, S. H., Levin, T. R., Lavin, P., Lidgard, G. P., . . . Berger, B. M. (2014). Multi-target stool DNA testing for colorectal-cancer screening. *New England Journal of Medicine, 370*(14), 1287-1297.

Johnson, C. D., Chen, M. H., Toledano, A. Y., Heiken, J. P., Dachman, A., Kuo, M. D., . . . Fidler, J. L. (2008). Accuracy of CT colonography for detection of large adenomas and cancers. *New England Journal of Medicine, 359*(12), 1207-1217.

Kahi, C. J., Rex, D. K., & Imperiale, T. F. (2008). Screening, surveillance, and primary prevention for colorectal cancer: a review of the recent literature. *Gastroenterology, 135*(2), 380-399.

Kim, D. H., Pickhardt, P. J., Taylor, A. J., Leung, W. K., Winter, T. C., Hinshaw, J. L., . . . Pfau, P. R. (2007). CT colonography versus colonoscopy for the detection of advanced neoplasia. *New England Journal of Medicine, 357*(14), 1403-1412.

Levin, B., Lieberman, D. A., McFarland, B., Smith, R. A., Brooks, D., Andrews, K. S., . . . Pickhardt, P. (2008). 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: A Cancer Journal for Clinicians, 58*(3), 130-160.

Lieberman, D. A., Williams, J. L., Holub, J. L., Morris, C. D., Logan, J. R., Eisen, G. M., . . . Carney, P. (2014). Race, ethnicity, and sex affect risk for polyps greater than 9 mm in average-risk individuals. *Gastroenterology, 147*(2), 351-358.

Zauber, A. G., Lansdorp-Vogelaar, I., Knudsen, A. B., Wilschut, J., van Ballegooijen, M., & Kuntz, K. M. (2008). Evaluating test strategies for colorectal cancer screening: a decision analysis for the US Preventive Services Task Force. *Annals of Internal Medicine, 149*(9), 659-669.

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This practice consensus 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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