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.

TABLE OF CONTENTS

Average Risk ........................................................................................................................................ Page 2
Increased Risk ........................................................................................................................................ Page 3
High Risk ............................................................................................................................................. Page 4
Suggested Readings ................................................................................................................................. Page 5
Development Credits .............................................................................................................................. Page 6

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1See 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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**PRESENTATION**

- Patients with average risk:
  - Age 45 years or older
  - No history of adenoma
  - No history of inflammatory bowel disease
  - Negative family history of colorectal cancer

- Colonoscopy (preferred)
  - Normal findings?
    - Yes: Repeat colonoscopy recommended every 10 years
      - No: If adenomatous polyps found, see Page 3 for management

- Computed tomographic colonography
  - Normal findings?
    - Yes: Repeat computed tomographic colonography recommended every 5 years
      - No: Polyp(s) ≥ 6 mm?
        - Yes: Refer for colonoscopy
        - No: Discuss findings with patient and individualize recommendations

- Fecal immunochemical test
  - 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

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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 Preauthorization with patient’s insurance carrier is always advised

Department of Clinical Effectiveness V10
Approved by the Executive Committee of the Medical Staff on 03/09/2022
Colorectal Cancer Screening – Increased Risk

**PRESENTATION**

- Patients with 1 or 2 tubular adenomas < 1 cm
- Patients with 5 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 adenomas > 2 cm or sessile serrated polyps (SSP) that are removed piecemeal
- 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

**RECOMMENDED SCREENING**

- 7-10 years after most recent polypectomy or normal exam
- 3 years after most recent polypectomy (3-5 years for 3 to 4 adenomas)
- 1 year after most recent polypectomy
- 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**

- Patients with 1 or 2 tubular adenomas < 1 cm
- Patients with 5 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 adenomas > 2 cm or sessile serrated polyps (SSP) that are removed piecemeal
- 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**

- 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

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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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PRESENTATION

Genetic diagnosis of FAP or suspected FAP without genetic testing evidence

Genetic or clinical diagnosis of HNPCC (Lynch syndrome) or individuals at increased risk of HNPCC (Lynch syndrome)

Inflammatory bowel disease (chronic ulcerative colitis or Crohn’s disease)

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

RECOMMENDED SCREENING

Annual FSIG to determine if the individual is expressing the genetic abnormality

Colonoscopy every 1 to 2 years

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 Counseling to consider genetic testing
3 If the genetic test is positive, colectomy should be considered
4 This syndrome represents a heterogeneous group depending on the specific genetic alteration. Screening and surveillance should be individualized based on expert consultation, including review by a genetic counselor.
5 First degree relative of known mutation carriers, obligate carriers of a family history concerning for HNPCC (Lynch syndrome)
6 Genetic testing for HNPCC (Lynch syndrome) 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.
7 These patients are best referred to a center with experience in the surveillance and management of inflammatory bowel disease

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Colorectal Cancer Screening

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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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