

DISCLAIMER: The information contained in this document originates from a third party and is intended to provide guidance and, generally, allows for professional discretion and/or deviation when the individual health care provider, or if applicable, the "Approver" deems appropriate under the circumstances. Baylor Scott & White Quality Alliance recommends following the third-party guideline and to support alignment has summarized key findings from the third party as described in this Guideline Alignment.

<b>Title:</b>	Colorectal Cancer Screening
<b>Applicable to:</b>	Primary Care Providers
<b>Source(s):</b>	Located in References
<b>Read Full Guideline:</b>	Located in References
<b>Developer(s):</b>	BSWQA Colorectal Cancer Taskforce
<b>Approver(s):</b>	BSWQA Primary Care Subcommittee, BSWQA Quality Improvement Committee, BSWQA Board of Managers, Jennifer Y. Carter-Clayborn, Medical Director - HP
<b>Document Number:</b>	BSWQA.CLE.007.S
<b>Last Updated:</b>	4/1/2024

## SUMMARY

Adults in the primary care/ambulatory setting. The age for screening depends on the patient's individual risk.

## Risk Factors

- The U.S. Preventive Services Task Force recommends screening for colorectal cancer (CRC) starting patients between 45 to 75 years old<sup>1</sup>. The decision to screen for CRC in adults aged 76 to 85 years should be an individual one, taking into account the patient's overall health, prior screening history, and patient preferences. Screening would be most appropriate among adults who:
  - Are healthy enough to undergo treatment if colorectal cancer is detected, and
  - Do not have comorbid conditions that would significantly limit their life expectancy<sup>2</sup>
- Consider screening earlier with colonoscopy if any of the risk factors or conditions listed below are present<sup>3,4</sup>:
  - Family history is one first degree relative with colon cancer or polyps or 2 or more second degree relatives with colon cancer
  - Prior CRC or adenomatous polyps before age 60
  - Familial adenomatous polyposis
  - Hereditary nonpolyposis colon cancer
  - Inflammatory bowel disease
  - There are other rarer inherited conditions that increase risk of CRC, including MUTYH-associated polyposis, hamartomatous polyposis, Peutz-Jeghers syndrome, and juvenile polyposis syndrome.

## Screenings

- Screening is crucial because when found early, CRC is highly treatable. The following tests qualify as CRC screenings that find polyps and cancer<sup>1,2,3</sup>:
  - Colonoscopy every 10 years
  - CT Colonography\* every 5 years
  - Flexible Sigmoidoscopy\* every 5 years

- Flexible Sigmoidoscopy\* every 10 years with annual FIT\*

\*Complete colonoscopy if positive results

- The following tests qualify as CRC screenings that find cancer<sup>1,2,3</sup>:
  - High-sensitivity guaiac fecal occult blood test (gFOBT)\* or Fecal Immunochemical Test (FIT)\* every year
  - Stool DNA-FIT every 3 years\* (The use of DNA-FIT is not recommended as first line-screening due to cost and false positive rate. The use of the test should be left at the discretion of the treating physician.)

\*Complete colonoscopy if positive results

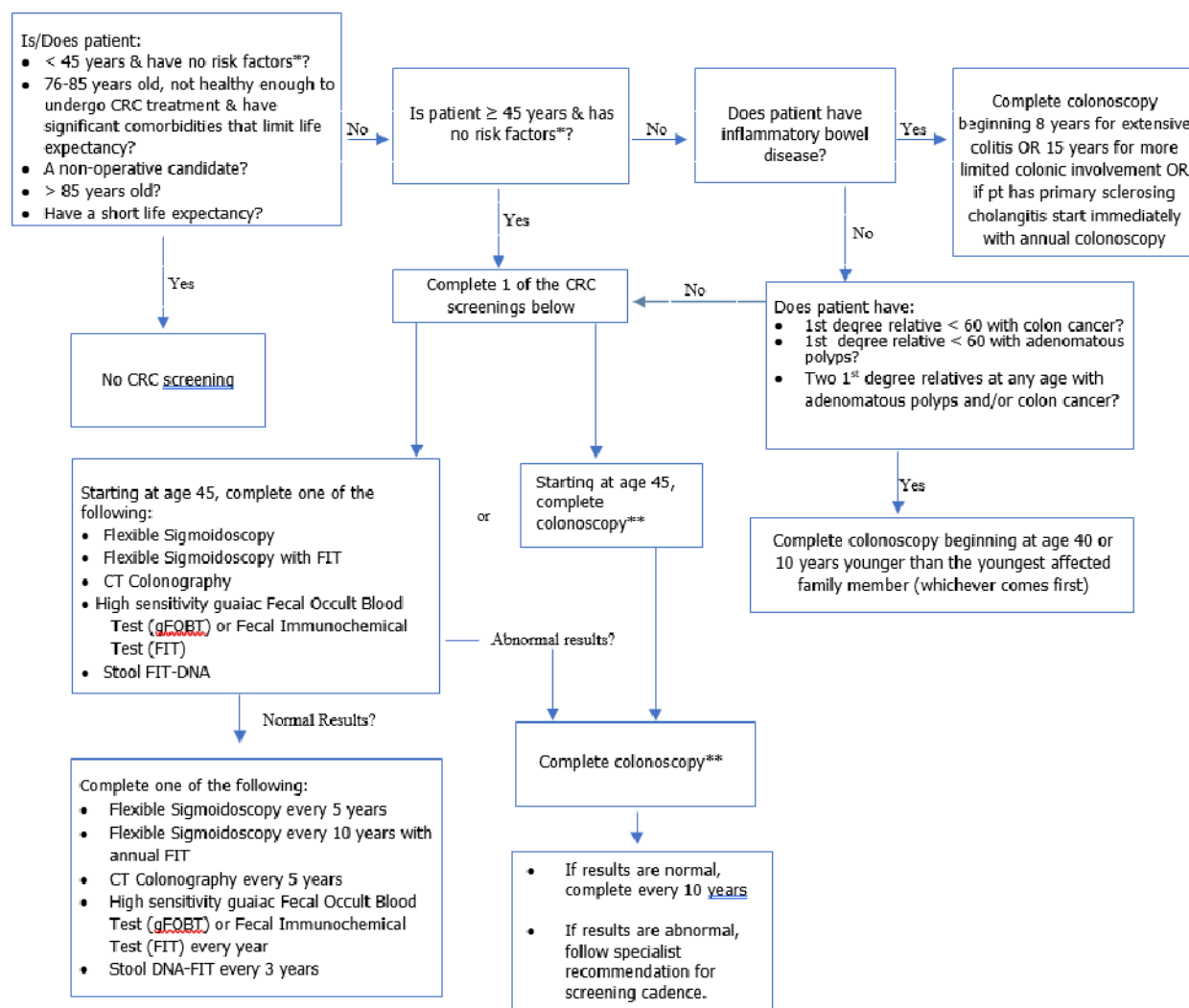
- In the case of a positive FIT-DNA and negative colonoscopy, resume colonoscopy in 10 years.
- The following tests do not qualify as appropriate CRC screenings<sup>1,2</sup>:
  - Digital Rectal Exams (DRE)
  - FOBT tests performed with a sample collected via DRE
  - Double-contrast barium enema
- See Attachment [Resource 1](#) for more details on *Colorectal Cancer Screening Strategies*.
- See algorithm below ([Figure 1](#)) for guidance in deciding age and test for CRC screening.

## **Follow-up**

- Primary care providers should refer patient for a colonoscopy if he/she screens positive for CRC.

## FACTS AND FIGURES

**Figure 1: Algorithm: Colorectal Cancer Screening Timing and Tests Guide**



*\*Risk factors listed in narrative*

## RESOURCES

- [Resource 1](#): Characteristics of Colorectal Cancer Screening Strategies
- [Resource 2](#): Colorectal Cancer Screening Shared Decision Making Handout (English)
- [Resource 3](#): Colorectal Cancer Screening Shared Decision Making Handout (Spanish)

## Resource 1: Characteristics of Colorectal Cancer Screening Strategies

Source: U.S. Preventive Services Taskforce – Colorectal Cancer: Screenings<sup>1</sup>

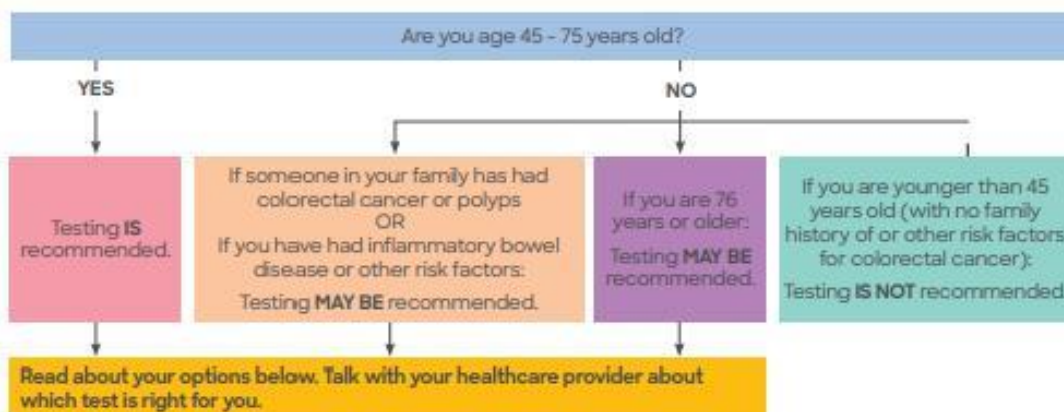
Screening Method	Frequency <sup>b</sup>	Evidence of Efficacy	Other Considerations
Stool-Based Tests			
High sensitivity gFOBT	Every year	RCTs with mortality end points: High-sensitivity versions (eg, Hemoccult SENSА) have superior test performance characteristics than older tests (eg, Hemoccult II)	Does not require bowel preparation, anesthesia, or transportation to and from the screening examination (test is performed at home)
FIT	Every year	Test characteristic studies: Improved accuracy compared with gFOBT Can be done with a single specimen	Does not require bowel preparation, anesthesia, or transportation to and from the screening examination (test is performed at home)
DNA-FIT	Every 1 or 3 y <sup>d</sup>	Test characteristic studies: Specificity is lower than for FIT, resulting in more false-positive results, more diagnostic colonoscopies, and more associated adverse events per screening test Improved sensitivity compared with FIT per single screening test	There is insufficient evidence about appropriate longitudinal follow-up of abnormal findings after a negative diagnostic colonoscopy; may potentially lead to overly intensive surveillance due to provider and patient concerns over the genetic component of the test
Direct Visualization Tests			
Colonoscopy	Every 10 y	Prospective cohort study with mortality end point	Requires less frequent screening. Screening and diagnostic followup of positive results can be performed during the same examination.
CT colonography <sup>e</sup>	Every 5 y	Test characteristic studies	There is insufficient evidence about the potential harms of associated extracolonic findings, which are common
Flexible sigmoidoscopy	Every 5 y	RCTs with mortality end points: Modeling suggests it provides less benefit than when combined with FIT or compared with other strategies	Test availability has declined in the United States
Flexible sigmoidoscopy with FIT <sup>c</sup>	Flexible sigmoidoscopy every 10 y plus FIT every year	RCT with mortality end point (subgroup analysis)	Test availability has declined in the United States  Potentially attractive option for patients who want endoscopic screening but want to limit exposure to colonoscopy

**Abbreviations:** FIT=fecal immunochemical test; FIT-DNA=multitargeted stool DNA test; gFOBT=guaiac-based fecal occult blood test; RCT=randomized clinical trial.

- Although a serology test to detect methylated *SEPT9* DNA was included in the systematic evidence review, this screening method currently has limited evidence evaluating its use (a single published test characteristic study met inclusion criteria, which found it had a sensitivity to detect colorectal cancer of <50%). It is therefore not included in this table.
- Applies to persons with negative findings (including hyperplastic polyps) and is not intended for persons in surveillance programs. Evidence of efficacy is not informative of screening frequency, with the exception of gFOBT and flexible sigmoidoscopy alone.
- Strategy yields comparable life-years gained (ie, the life-years gained with the noncolonoscopy strategies were within 90% of those gained with the colonoscopy strategy) and an efficient balance of benefits and harms in CISNET modeling.
- Suggested by manufacturer.
- Strategy yields comparable life-years gained (ie, the life-years gained with the noncolonoscopy strategies were within 90% of those gained with the colonoscopy strategy) and an efficient balance of benefits and harms in CISNET modeling when lifetime number of colonoscopies is used as the proxy measure for the burden of screening, but not if lifetime number of cathartic bowel preparations is used as the proxy measure.

## **Resource 2: Colorectal Cancer Screening Shared Decision Making Handout (English)**

# Choosing the right colon cancer screening test



### Stool test\*

#### Key facts

- Reduces death from colorectal cancer by detecting cancers early
- Safe, available and easy to complete
- Done on your own at home
- Finds cancer early by finding blood in the stool
- Finds most cancers early when done every year

#### Things to consider

- The test may be positive even if you do not have polyps or cancer in the colon.
- If the test is positive, you will have a colonoscopy to look for problems.
- In-home testing requires collecting a small stool sample using the test kit provided, then mailing or taking it to your doctor's office or lab for processing.

\*Stool test = Guaiac Fecal Occult Blood Test (FOBT) or Fecal Immunochemical Test (FIT)

### Colonoscopy

#### Key facts

- Reduces the risk of death by 60% by detecting colorectal cancer early
- Can prevent cancer by removing polyps (or abnormal growths in the colon) during the test
- Looks at the entire colon
- Finds most cancers or polyps that are there when the test is done
- Done at least every 10 years or as recommended by your healthcare provider

#### Things to consider

- Stomach pain, cramping or bloating is possible before, during or after the test.
- The test is done at a hospital or clinic, and you will probably receive light sedation so that you are comfortable.
- You will need someone to drive you home after the test and may need to take the whole day off to rest.
- You will take medicine to clear out your colon the day before. You will also only drink clear liquids. This can cause pain, bloating and diarrhea while your colon clears.
- There is a small risk of serious complications like bleeding or perforated colon.

Please ask your healthcare provider about other screening tests that are available. For a physician referral, call **1.844.BSW.DOCS** or visit **BSWHealth.com**.

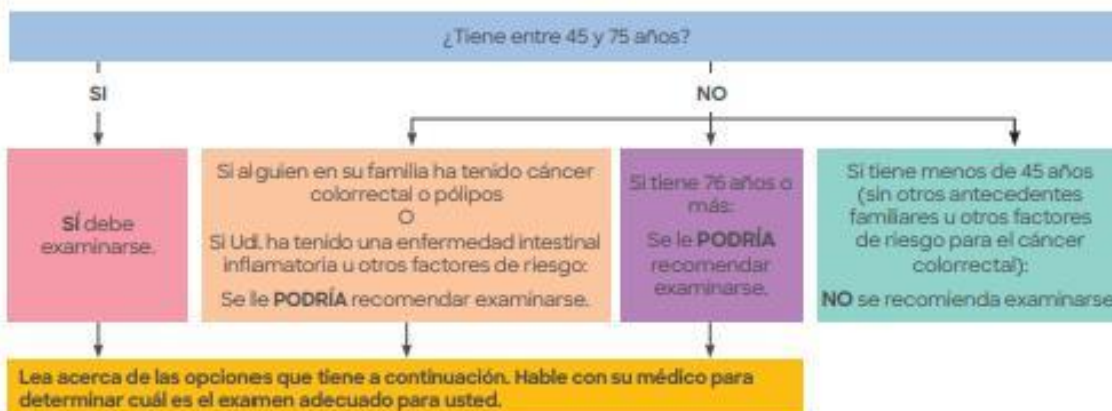


Physicians provide clinical services as members of the medical staff at one of Baylor Scott & White Health's subsidiary, community or affiliated medical centers and do not provide clinical services as employees or agents of those medical centers or Baylor Scott & White Health. ©2021 Baylor Scott & White Health. 99-ALL-230105 GIO



## **Resource 3: Colorectal Cancer Screening Shared Decision Making Handout (Spanish)**

# **Cómo seleccionar el examen de detección colorectal adecuado**



### **Prueba en las heces\***

#### **Información importante**

- Reduce la incidencia de muerte debido al cáncer colorrectal detectándolo en sus primeras etapas
- Seguro, disponible y fácil de hacer
- Se hace en su propia casa
- Detecta cáncer en sus primeras etapas identificando sangre en las heces
- Detecta casi todos los casos de cáncer en sus primeras etapas cuando se hace cada año

#### **Factores que debe considerar**

- El examen podría dar positivo aunque no tenga pólipos ni cáncer en el colon.
- Si el examen es positivo, se le hará una colonoscopia para detectar problemas.
- El examen en la casa requiere obtener una pequeña muestra de heces con un kit que se proporciona y enviarlo por correo o llevarlo al consultorio de su médico o laboratorio para su procesamiento.

\*Prueba en las heces = Guaiac Fecal Occult Blood Test (FOBT) or Fecal Immunochemical Test (FIT)

### **Colonoscopia**

#### **Información importante**

- Reduce el riesgo de muerte en un 60% detectando cáncer colorrectal en sus primeras etapas
- Puede prevenir el cáncer extrayendo pólipos (o tumores anormales en el colon) durante el examen
- Examina el colon entero
- Detecta casi todos los casos de cáncer o pólipos presentes cuando se hace el examen
- Se hace por lo menos cada 10 años o según las recomendaciones de su médico

#### **Factores que debe considerar**

- Posible dolor estomacal, cólicos y gases estomacales antes, durante o después del examen.
- El examen se hace en un hospital o clínica; recibirá un sedante leve para que se sienta cómodo.
- Deberá pedirle a alguien que lo lleve a su casa después del examen y podría tener que reposar en la casa el resto del día.
- Deberá tomar un medicamento para vaciar el colon el día antes. Solo podrá beber líquidos claros. Esto podría causar dolor, gases estomacales y diarrea a medida que se vacía el colon.
- Hay un pequeño riesgo de complicaciones graves, como sangrado o perforación del colon.

Hable con su médico sobre los exámenes de detección que tiene a su disposición.

## REFERENCES

1. Colorectal Cancer: Screening. U.S. Preventive Services Task Force. May 2021. Retrieved from: <https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/colorectal-cancer-screening>
2. Davidson K, Barry M, Mangione C, et al. Screening for Colorectal Cancer: U.S. Preventive Services Task Force Recommendation Statement. Journal of Amer Med Assoc. 2021;325(19):1965-1977. doi:10.1001/jama.2016.5989. Published online June 15, 2016. Last corrected on June 6, 2017.
3. What I should know about screening? Center for Disease Control and Prevention. May 2021. Retrieved from: [https://www.cdc.gov/cancer/colorectal/basic\\_info/screening/index.htm](https://www.cdc.gov/cancer/colorectal/basic_info/screening/index.htm) Reference Citation