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| **Preventive**  **Health**  **Guideline** | Procedure: | Colorectal Cancer Screening |
| Guideline Review Cycle: | 2018 |
| Reviewed By: | QI Committee |
| Review Date: | February 2018 |
| Committee Approval Date: | 02/21/2018 |
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*\*Arizona Priority Care has adopted the Colorectal Cancer Screening Preventive Health Guideline from the US Preventive Services Task Force*

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| **Population** | Adults aged 50 to 75 years | Adults aged 76 to 85 years |
| **Recommendation** | Screen for colorectal cancer starting at age 50 years.  Grade: A | The decision to screen for colorectal cancer is an individual one.  Grade: C |

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| **Risk assessment** | For the vast majority of adults, the most important risk factor for colorectal cancer is older age. Other associated risk factors include family history of colorectal cancer, male sex, and black race. | |
| **Screening tests** | There are numerous screening tests to detect early-stage colorectal cancer, including stool-based tests (gFOBT, FIT, and FIT-DNA), direct visualization tests (flexible sigmoidoscopy, alone or combined with FIT; colonoscopy; and CT colonography), and serology tests (SEPT9 DNA test). The USPSTF found no head-to-head studies demonstrating that any of these screening strategies are more effective than others, although they have varying levels of evidence supporting their effectiveness, as well as different strengths and limitations. | |
| **Starting and stopping ages** | The USPSTF concluded that the evidence best supports a starting age of 50 years for the general population. The age at which the balance of benefits and harms of colorectal cancer screening becomes less favorable varies based on a patient’s life expectancy, health status, comorbid conditions, and prior screening status. The USPSTF does not recommend routine screening for colorectal cancer in adults 86 years and older. | |
| **Treatment and interventions** | Treatment of early-stage colorectal cancer generally consists of local excision or simple polypectomy for tumors limited to the colonic mucosa or surgical resection (via laparoscopy or open approach) with anastomosis for larger, localized lesions. | |
| **Balance of benefits and harms** | The USPSTF concludes with high certainty that the net benefit of screening for colorectal cancer is substantial. | The USPSTF concludes with moderate certainty that the net benefit of screening for colorectal cancer in adults aged 76 to 85 years who have been previously screened is small. Adults who have never been screened are more likely to benefit. Screening is most appropriate for those healthy enough to undergo treatment and those without comorbid conditions that significantly limit their life expectancy. |
| **Other relevant USPSTF recommendations** | The USPSFT has made a recommendation on aspirin use for the primary prevention of cardiovascular disease and colorectal cancer in average-risk adults. This recommendation is available on the USPSFT website (<http://www.uspreventiveservicestaskforce.org>) | |

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| **Colorectal Cancer Screening: Recommendations for Persons with Family History**  **of Colorectal Cancer and Polyps** |
| 1. We suggest that persons with 1 first-degree relative with CRC or a documented advanced adenoma diagnosed at age <60 years or with 2 first-degree relatives with CRC and/or documented advanced adenomas undergo colonoscopy every 5 years beginning 10 years younger than the age at which the youngest first-degree relative was diagnosed or age 40, whichever is earlier (weak recommendation, low-quality evidence). 2. We suggest that persons with 1 first-degree relative diagnosed with CRC or a documented advanced adenoma at age ≥60 years begin screening at age 40. The options for screening and the recommended intervals are the same as those for average-risk persons (weak recommendation, very-low quality evidence). 3. We suggest that persons with 1 or more first-degree relatives with a documented advanced serrated lesion (SSP or traditional serrated adenoma ≥10 mm in size or an SSP with cytologic dysplasia) should be screened according to above recommendations for persons with a family history of a documented advanced adenoma (weak recommendation, very-low-quality evidence). 4. We recommend that persons with 1 or more first-degree relatives with CRC or documented advanced adenomas, for whom we recommend colonoscopy, should be offered annual FIT if they decline colonoscopy (strong recommendation, moderate-quality evidence). |

For summary of the evidence systematically reviewed in making this recommendation, the full recommendation statement and supporting documents, please go to <http://www.uspreventiveservicestaskforce.org>.

gFOBT: guaiac-based fecal occult blood test; FIT: fecal immunochemical test; FIT-DNA: multitargeted stool DNA test; CT: computed tomography; USPSFT: United States Preventive Services Task Force.

Adopted from: US Preventive Services Task Force. Screening for colorectal cancer: US Preventive Services Task Force recommendation statement. JAMA 2016; 315(23):2564-75. Copyright © 2016 American Medical Association. All rights reserved.

Colorectal Cancer Screening: Recommendations for Physicians and Patients from the U.S. Multi-Society Task Force on Colorectal Cancer© 2017 American College of Gastroenterology