COLORECTAL CANCER SCREENING

1. Colorectal cancer screening is strongly recommended for all asymptomatic, average-risk adults aged 50 - 75.
   a. Any of the following tests and frequencies are acceptable options for colorectal cancer screening in asymptomatic, average-risk adults:¹
      - High-sensitivity guaiac fecal occult blood test (gFOBT) every 1 - 2 years.
      - Immunochemical fecal occult blood test (iFOBT/FIT) every 1 - 2 years.²,³
      - Flexible sigmoidoscopy at least every 10 years.
      - Colonoscopy every 10 years.
      - A combination of high-sensitivity gFOBT every 1 - 2 years and flexible sigmoidoscopy every 10 years.
      - A combination of iFOBT/FIT every 1 - 2 years and flexible sigmoidoscopy every 10 years.
   b. The following additional screening tests are either less-preferred options or not recommended for screening. Though an adult who has had one of these tests is considered screened, follow-up screening using a preferred option is recommended.
      - Standard guaiac fecal occult blood test (gFOBT)³
      - Air contrast barium enema⁴
      - CT colonography (virtual colonoscopy)⁴
      - Fecal DNA testing⁴
   c. For those with no history of routine screening, discontinuation is recommended at age 80. The decision to discontinue screening should be based on physician judgement, patient preference, the increased risk of complications in older adults, and existing comorbidities.

2. Colonoscopy screening beginning at age 40, or 10 years younger than the earliest diagnosis in the first-degree relative, is recommended in adults with the following significant family history of colorectal cancer:
   - One first-degree relative (parent, sibling, or offspring) with a diagnosis of colorectal cancer at age 60 or younger.
   - Two or more first-degree relatives diagnosed with colorectal cancer at any age.

3. For adults with a first-degree relative with a history of advanced adenomas (≥ 10 mm, with villous features or high-grade dysplasia) presenting before age 60, colonoscopy screening beginning at age 50, at least every 10 years, may be the preferred option.⁵

4. For evaluation and follow-up of hereditary colorectal cancer syndromes and inflammatory bowel disease, referral to Gastroenterology is recommended.⁶

5. For blacks/African-Americans, special efforts should be made to ensure that screening occurs using any of the accepted screening modalities.⁷

¹ There is insufficient evidence to choose one screening test over another.
² If a patient has had a normal colonoscopy within the last 10 years, there is insufficient evidence that supplemental gFOBT or iFOBT adds any incremental benefit.
³ FIT is a preferred option over standard gFOBT (Hemoccult II) due to its higher sensitivity and higher patient adherence rates.
⁴ Please note that fecal DNA testing, air contrast barium enema, and CT colonography are not listed as “appropriate screening tests” in 2010 HEDIS specifications for colorectal cancer screening.
⁵ There is fair evidence that a family history of advanced adenomas presenting before age 60 is associated with an increased risk of adenomas or colorectal cancer.
⁶ Hereditary syndromes include familial adenomatous polyposis (FAP), Gardner’s syndrome, and hereditary nonpolyposis colon cancer (HNPCC or Lynch syndrome).
⁷ Observational national data demonstrate an increased risk of colorectal cancer and a more advanced stage of disease at diagnosis among blacks/African-Americans than among whites. It is not clear whether this disparity is due to differences in the biological behavior of colorectal cancer in blacks/African-Americans, differences in socioeconomic status, or differences in access to care.