Colorectal Cancer Screening Guidelines

Reviewed and approved by Clinical Committee on August 8, 2018

Colorectal Cancer Screening

Numerator:

Documentation of one or more of the following cancer screenings and date(s)

- Fecal Occult Blood Testing during the measurement period ColoScreen, Fecal immunochemical test (FIT), Flushable reagent stool blood test (EZ Detect, HomeCheck Reveal and ColoCARE), Hemoccult, Stool guaiac test, Seracult
- FIT-DNA (e.g., ColoGuard) during the measurement period or 2 years prior
- Flexible sigmoidoscopy or CT colonography screening during measurement period or4 years prior
- Colonoscopy in measurement period or 9 years prior (virtual colonoscopy not acceptable)

Denominator:

Ages 50 – 75 with a visit in the measurement period (2017)

Exclusion:

Patients with a diagnosis or past history of colorectal cancer or total colectomy

Patient refusal is NOT an acceptable exclusion

Source: medical record review

What is the problem and what is known about it so far?

Cancer is the leading cause of death in Vermont. Colorectal cancer is the second most commonly diagnosed cancer among cancers that affect both men and women. Twenty-eight percent of Vermont adults aged 50-75 are not up to date on their colorectal cancer screening.[i] Screening can prevent the development of colorectal cancers by removing polyps (precancerous lesions) as well as finding cancer early when it is highly curable. Nationally, 90 percent of men and women whose colorectal cancer is diagnosed at a localized stage survive their cancer for at least five years, compared to 14 percent of those diagnosed at a late (distant) stage.[ii] Approximately 57 percent of colorectal cancers in Vermont are diagnosed at a regional or distant stage when prognosis and survival are poor.[iii] Regular screening beginning at age 50 (for average risk individuals) is key to reducing the burden of colorectal cancer.

Health care providers play a critical role in raising awareness of colorectal cancer and increasing screening among patients.

Who should be screened?

A risk assessment must be conducted to determine if the patient is at average, increased, or high risk for colorectal cancer.

These guidelines represent the recommendations of the US Preventative Services Task Force (USPSTF) for men and women who are at *average risk and asymptomatic**.

Population	Recommendation
Adults aged 50 to 75 years	The USPSTF (2016) recommends screening for colorectal cancer for average risk individuals starting at age 50 years and continuing until age 75 years. Multiple effective screening strategies are available to choose from: • Guaiac-based fecal occult blood test (gFOBT) or fecal immunochemical test (FIT) annually

Developed by Kristen Bigelow-Talbert, Sharon Mallory, Lynn Basilio, and Justin Pentenrieder

	• FIT-DNA test every 1 or 3 years • Colonoscopy every 10 years • CT colonography or flexible sigmoidoscopy every 5 years or • Flexible sigmoidoscopy every 10 years plus FIT every year
Adults aged 76 to 85 years	The risks and benefits of different screening methods vary. See the Clinical Considerations section and the Table for details about screening strategies. The decision to screen for colorectal cancer in adults aged 76 to 85 years should be an individual one, taking into account the patient's overall health and prior screening history. • Adults in this age group who have never been screened for colorectal cancer are more likely to benefit • Screening would be most appropriate among adults who 1) are healthy enough to undergo treatment if colorectal cancer is detected and 2) do not have comorbid conditions that would significantly limit their life expectancy

https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/colorectal-cancer-screening2#tab

*The following conditions increase a patient's risk of colorectal cancer:

- A personal history of colorectal cancer or adenomatous polyps
- A personal history of inflammatory bowel disease (ulcerative colitis or Crohn's disease)
- A strong family history of colorectal cancer or polyps (see Colorectal Cancer Risk Factors)
- A known family history of a hereditary colorectal cancer syndrome such as familial adenomatous polyposis (FAP) or Lynch syndrome (hereditary non-polyposis colon cancer or HNPCC)

For men and women at *increased or high risk* for developing colorectal cancer, patients may need to start colorectal cancer screening before age 50 and/or be screened more often.

Additional Screening Guidelines:
There are additional guidelines with slight variations from those listed in the table above. They include:

- American Cancer Society Colorectal Cancer Screening Guidelines:
  The ACS recommends that people at average risk of colorectal cancer **start regular screening at age 45**. This can be done either with a sensitive test that looks for signs of cancer in a person's stool (a stool-based test), or with an exam that looks at the colon and rectum (a visual exam). Please follow the link for more details. https://www.cancer.org/cancer/colon-rectal-cancer/detection-diagnosis-staging/acs-recommendations.html
- Tiered guidelines from the US Multi-Society Task Force on Colorectal Cancer Screening:
  CRC screening tests are ranked in 3 tiers based on performance features, costs, and practical considerations. Please follow the link for more details.
  http://www.gastrojournal.org/article/S0016-5085(17)35599-3/fulltext

Recommendations for Provider Teams:

In a shared decision-making process, these factors should be considered:[iv]

- Patient's age
- Risk profile for colorectal cancer
- Colorectal cancer screening history
- Preference (for example, privacy, preparation for test etc.)
- Barriers to health care
    a. Transportation, interpreter availability, need for companion during screening, need for time off from work
- Comorbidities
- Insurance status/cost to patient

Patients should be screened for colorectal cancer using a screening test that is individualized to the patient's specific situation. There are multiple screening options, each have varying levels of evidence to support their effectiveness. Anecdotally, the field of colorectal cancer screening has heard, "the best test is the one that gets done." The USPSTF recommendation provides a statement that supports this approach.

"The USPSTF found no head-to-head studies demonstrating that any of the screening strategies it considered are more effective than others, although the tests have varying levels of evidence supporting their effectiveness, as well as different strengths and limitations." [v]

More information about test options can be found here:
https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/colorectal-cancer-screening2#notea

Follow-up care can include:
- For a Colonoscopy:
- Complete the referral to the specialist.
- Assign a Care Coordinator or Care Navigator to follow-up with the patient to make sure the appointment is made, and patient attends. The CDC has a comprehensive guide on how to walk patients through this process. [vi]

- For a FIT/FOBT:
- Upon receipt of FOBT/FIT card, immediately give it to the lab for analysis.
- If the FOBT/FIT card has not been returned within 1 month, contact the patient. (See attached FIT/FOBT workflow from the American Cancer Society.)

Abnormal results from a FIT/FOBT, or sigmoidoscopy would require a colonoscopy to be performed.

For other screening methods the follow-up care may differ from what is listed above.

Ensure you have a process in place in the event a positive result is received.

Workflows to increase Your Screening Rates:
There are several methods that can be used to boost your screening rates for colorectal cancer and other preventive services. These include:

1. Use Shared Decision Making tools with patients to help them decide on a screening method that is right for them. When patients are involved in the decision making process, they are more likely to complete the screening. A link to shared decision making tools is located in the Resources section.
2. Have a clear screening policy that includes how and where to document that a screening has been completed or declined.
3. Be persistent with reminders; both with reminders for the providers that this screening needs to be completed, and reminders for the patient that it should be done.
4. Measure and monitor progress on your screening rates, and share these with providers.

Key Resources and Tools:

- The US Preventive Services Task Force: Colorectal cancer screening guidelines: https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/colorectal-cancer-screening2#consider
- Aspirin and Cancer Reduction: http://bistatepca.org/uploads/pdf/Health%20Center%20Resources/Clinical%20Guides%20and%20Reports/Aspirin%20and%20Cancer%20Reduction_J.MatthewMD.pdf
- Aspirin to Reduce Cancer Risk: https://www.cancer.gov/about-cancer/causes-prevention/research/aspirin-cancer-risk
- Daily Aspirin and Heart Disease, Colon Cancer Risk: https://www.webmd.com/colorectal-cancer/news/20160411/expert-panel-reaffirms-daily-aspirins-use-against-heart-disease-colon-cancer#1
- The Guide to Community Preventive Services helps you choose evidence-based programs and policies to improve health and prevent disease in your community: http://www.thecommunityguide.org/about/What-Works-Cancer-Screening-factsheet-and-insert.pdf
- Steps for Increasing Colorectal Cancer Screening Rates: A Manual for Community Health Centers: http://nccrt.org/wp-content/uploads/0305.60-ColorectalCancer-Manual_FULFILL.pdf
- Cancer Control P.L.A.N.E.T. (Plan, Link, Act, Network with Evidence-based Tools)—includes Research Tested Intervention Programs that are evidence-based. http://cancercontrolplanet.cancer.gov
- National Colorectal Cancer Roundtable: www.nccrt.org
- The Genetic Testing, Screening, and Prevention for People with a Strong Family History of Colorectal Cancer guidelines: https://www.cancer.org/content/cancer/en/cancer/colon-rectal-cancer/causes-risks-prevention/genetic-tests-screening-prevention.html
- American Cancer Society Guideline for Colorectal Cancer Screening: A Summary for Clinicians: https://www.cancer.org/content/dam/cancer-org/cancer-control/en/booklets-flyers/summary-for-clinicians-acs-guideline-for-colorectal-cancer-screening.pdf
- Shared Decision Making Tools and more patient resources from the American Cancer Society:
    - Patient Brochure: https://www.cancer.org/content/dam/cancer-org/cancer-control/en/booklets-flyers/they-know-how-to-prevent-colon-cancer-handout.pdf
    - Conversation Cards: https://www.cancer.org/content/dam/cancer-org/cancer-control/en/booklets-flyers/conversation-cards-colorectal-cancer-screening.pdf
    - Shared Decision Making Aid: https://www.cancer.org/content/dam/cancer-org/cancer-control/en/booklets-flyers/colorectal-cancer-screening-which-test-is-right-for-you.pdf

References

[i] Vermont Behavioral Risk Factor Surveillance Survey. 2016

[ii] Howlader N, Noone AM, Krapcho M, Miller D, Bishop K, Kosary CL, Yu M, Ruhl J, Tatalovich Z, Mariotto A, Lewis DR, Chen HS, Feuer EJ, Cronin KA (eds). SEER Cancer Statistics Review, 1975-2014, National Cancer Institute. Bethesda, MD, https://seer.cancer.gov/csr/1975_2014/, based on November 2016 SEER data submission, posted to the SEER web site, April 2017.

[iii] Vermont Cancer Registry, Vermont Department of Health (2010-2014)

[iv]: Shared with permission from Lowell Community Health Center

[v] Bibbins-Domingo K, et al. Screening for Colorectal Cancer US Preventive Services Task Force Recommendation Statement, JAMA. 2016;315(23):2564-2575. JAMA article https://jamanetwork.com/journals/jama/fullarticle/2529486

[vi] Tools & Resources – CDC Replication Manual on Colorectal Cancer Screening Patient Navigation http://nccrt.org/provider-education/cdc-patient-navigation-manual/