Colorectal Cancer

HEALTH PROFESSIONALS FACTS ON SCREENING

HOW COMMON IS CRC? Colorectal cancer (CRC) is second only to lung cancer as a cause of cancer-related death in the U.S., but more than 33% of deaths from CRC could be avoided if people over 50 had regular screening tests. An estimated 56,300 Americans will die of CRC and 130,200 new cases will be diagnosed in 2000. It affects both men and women, and 93% of cases are diagnosed in those 50 or older.

Why screen?

The natural history of CRC makes it ideally suited to screening. Most cancers develop over many years from benign adenomatous polyps. Precancerous polyps can be detected and removed during certain screening procedures, thereby **preventing colorectal cancer**. And when CRC is found early and appropriately treated, survival is greatly enhanced, with a 5-year relative survival rate of 90%. Currently only 37% of colorectal cancers are diagnosed at an early stage.

Who should be tested?

Men and Women 50 and Older — Everyone 50 and older should be tested routinely. At least 75% of colorectal cancers occur in those with no family or personal history of CRC and no risk factors that would place them at high risk for developing colorectal cancer.

People at Increased Risk — Family and personal history should be considered when determining screening schedule. Among people considered at high risk for CRC are those with a personal or family history of colorectal cancer or polyps, people who have had inflammatory bowel disease (ulcerative colitis or Crohn's disease), and those with genetic syndromes (familial adenomatous polyposis or hereditary nonpolyposis colon cancer).

Currently there is no consensus on screening recommendations for high-risk patients. For the most up-to-date compilation of guidelines from a variety of private, non-profit, and government organizations, please refer to www.guideline.gov, the National Guideline Clearinghouse.

People With Symptoms — Patients with symptoms require immediate diagnostic testing. Symptoms may include rectal bleeding, abdominal discomfort, pain, bloating, a change in bowel habits, iron deficiency anemia, and unexplained weight loss.

Screening Tests

Several tests are used to screen for CRC beginning at age 50. The U.S. Preventive Services Task Force (USPSTF), the American Cancer Society (ACS), and an interdisciplinary task force convened by the Agency for Health Care Policy and Research, or AHCPR (now known as the Agency for Healthcare Research and Quality), all have developed guidelines related to CRC screening. They are:

- **USPSTF** — annual fecal occult blood test (FOBT) and/or periodic sigmoidoscopy. (1996)
- **ACS** — annual FOBT and flexible sigmoidoscopy every 5 years OR total colonic examination with colonoscopy every 10 years or DCBE every 5-10 years. (1997)
- **AHCPR** — annual FOBT and/or flexible sigmoidoscopy every 5 years, or total colonic examination with colonoscopy every 10 years, or double contrast barium enema (DCBE) every 5-10 years. (1997)

Strong scientific evidence shows that when people have either FOBT once a year or flexible sigmoidoscopy every 5 years, there is a reduction in deaths from CRC. The other two tests, colonoscopy and DCBE, are still being evaluated as CRC screening tools.

The Bottom Line

Encourage your patients 50 and over to begin screening for colorectal cancer and visit www.cdc.gov/cancer/ScreenforLife. For more information about colorectal cancer or any other cancer, call the NCI's Cancer Information Service: 1-800-4-CANCER (TTY 1-800-332-9615).

HEALTH PROFESSIONALS FACTS ON SCREENING

SCREENING TEST	SCIENTIFIC EVIDENCE	FREQUENCY & COST*	PURPOSE	IMPORTANT CONSIDERATIONS	COVERED BY INSURANCE/MEDICARE?
FOBT (Note: this is not the same stool test done in the physician's office as part of a DRE, a test that is considered neither appropriate nor sufficient as a CRC screening test.)	Studies show FOBT every 1-2 years in people 50-80 reduces deaths from CRC.	Starting at 50, once a year. $10-$25*	Detects blood from polyps and colorectal cancer. (If blood is detected, patient will need a follow-up colonoscopy or double contrast barium enema)	• Non-invasive • Done at home; patient puts stool samples on test cards for three bowel movements in a row. • Can show false positive or false negative result, as it detects peroxidase activity from any GI source and a number of foods. • Patient avoids some foods & medicines 1-3 days before stool samples are collected and until they're completed.	**Insurance:** Most plans cover once a year. **Medicare:** People 50 or above with Medicare pay no coinsurance or Part B deductible.
Flex Sig **(Flexible Sigmoidoscopy)**	Studies suggest regular screening by flex sig after age 50 may reduce deaths from CRC.	Starting at 50, once every 5 years. $150-$300*	Allows direct visualization of rectum and distal half of colon. Biopsies of polyps and cancers can be taken. Some physicians remove polyps during procedure.	• Provides no visualization of proximal portion of colon. • Patient restricts diet, uses laxatives and/or enemas to prepare. • Patient may feel discomfort during/after exam. • Small risk of perforation, infection, or bleeding. • If polyps or lesions are found, a follow-up colonoscopy generally is necessary.	**Insurance:** Many plans cover every 4-5 years. **Medicare:** Once every 4 years. Patient pays 20% of Medicare-approved amount after Part B deductible.
Combination—Flex Sig & FOBT	Combination of tests may increase chance to find polyps and early cancers.	Starting at 50, FOBT annually and flex sig every 5 years. (See costs above.)	See above	(See above for other "Important Considerations")	See above
Colonoscopy	Still being evaluated; currently there is only indirect evidence to support use as a screening tool.	Starting at 50, once every 10 years. $800-$1,600*	Allows direct visualization of entire colon. Biopsies of polyps and cancers can be taken. Most polyps can be removed during procedure.	• In many cases, offers one-step screening, diagnosis, and treatment. (If polyps or lesions are found, they can be removed during procedure.) • Patient restricts diet, uses laxatives and/or enemas to prepare. • Patient is sedated during procedure and advised not to drive or work on day of exam. • Patient may feel discomfort during/after exam. • Small risk of perforation, infection, and bleeding.	**Insurance:** Some plans cover, especially for patients at higher-than-average risk. Almost all cover for those needing follow-up testing after FOBT or flex sig. **Medicare:** Covers 80% of approved amount, for high-risk patients and those needing a follow-up test after positive FOBT or flex sig. (Check with Medicare for details.)
DCBE **(Double Contrast Barium Enema)**	Still being evaluated; currently no scientific evidence to support use as a screening test.	Starting at 50, once every 5-10 years. $250-$500*	An alternative method for visualizing the rectum and entire colon.	• Provides good view of rectum and entire colon. • May be able to detect clinically significant lesions. • If polyps/lesions are found, a follow-up colonoscopy is necessary. • Small risk of perforation. • Patient restricts diet, uses laxatives and/or enemas to prepare. • Patients may feel discomfort during/after the exam. • Barium causes extreme constipation, so using laxatives and drinking a lot of water is advised after exam.	**Insurance:** Some plans cover, under special conditions. Check with plans. **Medicare:** Under some conditions, can be substituted for flex sig or colonoscopy. (Check with Medicare.) Patients pays 20% of Medicare-approved amount after Part B deductible.

* Cost estimates are listed to show the typical range of rates for each test, and may not include the costs of all related services.

CDC Pub #099-6487 July 2000