

American Cancer Society Guideline for Colorectal Cancer Screening: A Summary for Clinicians



THE AMERICAN CANCER SOCIETY RECOMMENDS:

- ▶ Adults ages 45 and older with an *average risk* of colorectal cancer (CRC) should undergo regular screening with either a high-sensitivity stool-based test or a structural (visual) exam, depending on patient preference and test availability. As a part of the screening process, all positive results on non-colonoscopy screening tests should be followed up with timely colonoscopy.
The recommendation to begin screening at age 45 is a *qualified recommendation*. The recommendation for regular screening in adults ages 50 and older is a *strong recommendation*.
- ▶ Average-risk adults in good health with a life expectancy of more than 10 years continue colorectal cancer screening through the age of 75. (*Qualified recommendation*)
- ▶ Clinicians individualize colorectal cancer screening decisions for individuals ages 76 through 85, based on patient preferences, life expectancy, health status, and prior screening history. (*Qualified recommendation*)
- ▶ Clinicians discourage individuals older than 85 from continuing colorectal cancer screening. (*Qualified recommendation*)

DEFINITIONS

Average risk: No personal history of polyps, colorectal cancer, inflammatory bowel disease, or confirmed or suspected hereditary colorectal cancer syndrome (such as familial adenomatous polyposis or Lynch syndrome); no family history of colorectal cancer

Strong recommendation: Conveys the consensus that the benefits of adherence to that intervention outweigh the undesirable effects that may result from screening

Qualified recommendation: Indicates there is clear evidence of benefit of screening but less certainty about the balance of benefits and harms, or about patients' values and preferences, which could lead to different decisions about screening

RECOMMENDED TESTS AND SCREENING INTERVALS

Offer your patient the choice between a high-sensitivity stool-based test and a structural (visual) exam.

High-sensitivity Stool-based Tests

Screening Test	Considerations
Fecal Immunochemical Test (FIT) <i>Interval:</i> Every year	<ul style="list-style-type: none"> ▶ Evidence of superior performance in cancer and adenoma detection compared to HSgFOBT ▶ High nonadherence (especially in the absence of annual reminder systems)
High-sensitivity Guaiac-based Fecal Occult Blood Test (HSgFOBT) <i>Interval:</i> Every year	<ul style="list-style-type: none"> ▶ Higher false-positive rate than FIT (leads to more colonoscopies) ▶ High nonadherence (especially in the absence of annual reminder systems) ▶ Requires multiple samples, reducing adherence compared with FIT ▶ Requires avoidance of nonsteroidal anti-inflammatory drugs for 7 days; and avoidance of vitamin C, red meat, and cruciferous vegetables for 3 days prior
Multi-target Stool DNA Test (MT-sDNA) <i>Interval:</i> Every 3 years	<ul style="list-style-type: none"> ▶ Evidence of superior performance in cancer and adenoma detection compared with HSgFOBT and FIT. ▶ Improved detection of advanced adenomas and sessile serrated polyps compared to other stool-based tests ▶ Higher false-positive rate than FIT (leads to more colonoscopies) ▶ Uncertainty in management of positive results followed by a negative colonoscopy ▶ New test, needs performance monitoring over time

Structural (Visual) Exams

Screening Test	Considerations
Colonoscopy <i>Interval:</i> Every 10 years	<ul style="list-style-type: none"> ▶ Offers both early detection and prevention of CRC through polypectomy ▶ Risks: bowel perforation – 4 in 10,000; major bleeding – 8 in 10,000; cardiovascular event (due to sedation) – 2-4 in 10,000. These risks increase with age and comorbidity burden. ▶ Laxative preparation may not be done properly, leading to suboptimal visualization.
CT Colonography (CTC) <i>Interval:</i> Every 5 years	<ul style="list-style-type: none"> ▶ Comparable performance to colonoscopy in identifying cancer and advanced adenomas without procedural risks of colonoscopy ▶ Exposure to low-dose radiation ▶ Incidental extracolonic findings may require workup. ▶ May not be covered by insurance (not covered by Medicare at this time)
Flexible Sigmoidoscopy (FS) <i>Interval:</i> Every 5 years	<ul style="list-style-type: none"> ▶ Best evidence among structural exams for reducing CRC mortality and incidence ▶ Risks: bowel perforation – 1 in 10,000; major bleeding – 2 in 10,000 ▶ Self-administration of enemas may not be done properly, leading to suboptimal visualization. ▶ Misses cancers and polyps in the proximal colon

DISCUSSING COLORECTAL CANCER SCREENING WITH YOUR PATIENTS

Emphasize:

- ▶ All types of screening tests are effective at finding colorectal cancer.
- ▶ The best screening test is the one that gets done on time.
- ▶ Screening may lower the number of deaths due to colorectal cancer by as much as half.
- ▶ To be effective, screening must be completed on time.
- ▶ Screening is a long-term commitment.

Cost

- ▶ Cost without insurance varies from \$20-30 for HSgFOBT and FIT, and from one to several thousand dollars for colonoscopy, with other testing methods falling between the two extremes.
- ▶ Medicare and most commercial insurance products cover CRC screening with no copay or deductible due to a provision of the Patient Protection and Affordable Care Act (ACA).
- ▶ Medicare does not cover CT colonography at this time.
- ▶ Follow-up colonoscopy for a positive test (other than colonoscopy) may be subject to out-of-pocket costs.
- ▶ Polypectomy and anesthesia for colonoscopy may be subject to out-of-pocket costs.

How to talk to your patients about logistical barriers to screening

Screening Test	Potential Patient Barriers	Discussion Points and Alternatives
Fecal Immunochemical Test (FIT)	<ul style="list-style-type: none"> ▶ Inconvenience of collecting stool sample 	<ul style="list-style-type: none"> ▶ Inform patient that they do not directly handle specimen. ▶ Offer MT-sDNA instead.
High-sensitivity Guaiac-based FOBT (HSgFOBT)	<ul style="list-style-type: none"> ▶ Inconvenience of collecting stool sample ▶ Inconvenience of dietary and medication restrictions ▶ Inconvenience of needing samples from 3 separate stools 	<ul style="list-style-type: none"> ▶ Inform patient that they do not directly handle specimen. ▶ Offer FIT or MT-sDNA instead.
Multi-target Stool DNA (MT-sDNA)	<ul style="list-style-type: none"> ▶ Inconvenience of collecting stool sample ▶ Costly, depending on insurance coverage 	<ul style="list-style-type: none"> ▶ Inform patient that they do not directly handle specimen. ▶ Offer HSgFOBT or FIT instead.
Colonoscopy	<ul style="list-style-type: none"> ▶ Inconvenience of laxative regimen ▶ Need for ride to colonoscopy site ▶ Inconvenience of time commitment ▶ Costly, depending on insurance coverage 	<ul style="list-style-type: none"> ▶ Consider reduced-volume laxative regimen. ▶ Offer stool-based testing instead.
CT Colonography (CTC)	<ul style="list-style-type: none"> ▶ Inconvenience of laxative regimen ▶ May require second prep if same-day colonoscopy not available for positive test ▶ Costly, depending on insurance coverage (not covered by Medicare at this time) 	<ul style="list-style-type: none"> ▶ Consider reduced-volume laxative regimen. ▶ Consider alternative strategy if same-day colonoscopy not available for positive test. ▶ Offer stool-based testing instead.
Flexible Sigmoidoscopy (FS)	<ul style="list-style-type: none"> ▶ Concern about discomfort with enema prep or FS itself 	<ul style="list-style-type: none"> ▶ Counsel to use enema with pre-lubricated tip (e.g., Fleet®) or consider alternative screening method.

ABOUT THE AMERICAN CANCER SOCIETY GUIDELINE DEVELOPMENT PROCESS

The American Cancer Society Guideline Development Group (GDG) is responsible for developing and updating our cancer screening guidelines, which are then approved and adopted by the American Cancer Society Board of Directors. The GDG is a multidisciplinary panel of clinicians, biostatisticians, epidemiologists, economists, and a patient representative. This group is responsible for interpretation of the evidence, judgments about the balance of benefits and harms, and the framing of the recommendations and writing of the guidelines. The GDG panel votes on each recommendation and the strength of that recommendation, on the basis of the balance between desirable

and undesirable outcomes, the quality of evidence, and variability in values and preferences. Individuals with relevant clinical and research expertise in the areas of colorectal cancer natural history, detection, diagnosis, and decision-making also advise the GDG but do not participate in deliberations on recommendations or voting. The American Cancer Society protocol for developing and disseminating guidelines includes a transparent process for disclosing and managing financial, professional, and intellectual conflicts that minimizes bias. More information about the guideline development process can be found at <https://jamanetwork.com/journals/jama/fullarticle/1104727>.