*CLINICAL PRACTICE GUIDELINE:*

# COLORECTAL CANCER SCREENING: VCMC GUIDE

| Daniel Clark, M.D. | Medicine Comm. | Feb. 2003 |
|---|---|---|
| Prepared by | Dept Comm | Approval date |

*Colorectal cancer is the fourth most common cancer in the U.S., and the second leading cause of cancer death. This cancer shortens life by an average of 13 years. Eighty percent of CRC arise from adenomatous polyps. Twenty percent of CRC occur in patients with a family history of cancer in first degree relative. Screening is cost effective (<$30,000 for each additional life gained).*

**Average risk patients** - start screening **> 50 years old**

Fecal occult blood testing yearly
Flexible sigmoidoscopy every 5 years

**Moderate-risk patients**[1] – start screening **< 40 years old**

Fecal occult blood testing yearly
Flexible sigmoidoscopy every 5 years

[1] Colorectal cancer in one first degree relative before age 55 years

**High-risk patients**[2]

Fecal occult blood testing yearly
Colonoscopy

[2] F/U FOBT positive patient, family history for familial adenomatous polyposis, family history for colorectal cancer in two or more first degree relatives before age 40 years

**Sources:**

**Am Gastro Assoc, USPSTF, Am Cancer Soc, Inst Clin Sys Improvement, Canadian Task Force** agree that *asymptomatic adults > 50 years, with no risk factors*, should be screened with FOBT and/or flexible sigmoidoscopy. Colonoscopy is *not supported* by randomized controlled trials but remains *an acceptable screening option.*

**USPSTF**: (Ann Intern Med 2002; 137:129-131)

- FOBT – *EBM* - **good evidence** (age 50-80)
- sigmoidoscopy – ***expert opinion*** - fair evidence
- colonoscopy – **no evidence**

**AAFP**: (Am Fam Physician 2002; 66: 297-302)

- FOBT – **RCT** – Level A
- Colonoscopy – **Level B** – *implications for screening unclear*