

Madigan Army Medical Center

Referral Guidelines

Colorectal Cancer Screening Recommendations for Patients with Family History of Colorectal Polyps or Cancer

Diagnosis/Definitions

Family history of colorectal polyp or cancer, including patients with a family history of a hereditary colon cancer or polyposis syndrome

Initial Diagnosis, Management, and Objectives

1. Primary care providers are likely the first providers to encounter high risk individuals for colorectal cancer. Therefore, we recommend that all patients be screened for pertinent personal and family history of cancer and colon polyps, as well as hereditary colon cancer or polyposis syndromes
2. Examples of hereditary colon cancer or polyposis syndromes include the following:
 - a. Familial adenomatous polyposis – defined by the appearance of >100 polyps at colonoscopy in the index patient. All first degree relatives are considered at risk (autosomal dominant). Attenuated FAP can present in the index patient with 5 to 100 (average 30) colon adenomas
 - b. MYH mutation – similar clinical presentation to FAP, although there is no APC mutation
 - c. Hereditary Nonpolyposis Colon Cancer – revised Bethesda Guidelines for Testing of Colorectal Tumors for Microsatellite Instability are the following:
 - i. Colorectal cancer diagnosed in a patient who is less than age 50
 - ii. Presence of synchronous, metachronous colorectal or other HNPCC-associated tumor, regardless of age
 - iii. Colorectal cancer with the MSI-H like histology diagnosed in a patient who is less than 60 years of age
 - iv. Colorectal cancer diagnosed in a patient with one or more first-degree relatives with an HNPCC-related tumor, with one of the cancers being diagnosed under age 50 years.
 - v. Colorectal cancer diagnosed in a patient with two or more first- or second- degree relatives with HNPCC-related tumors, regardless of age
 - vi. HNPCC related tumors include colorectal, endometrial, stomach, ovarian, pancreas, ureter, and renal pelvis, biliary tract, brain tumors, sebaceous gland adenomas, keratocanthomas, and small bowel carcinoma
 - d. Peutz-Jeghers Syndrome
 - e. Hyperplastic Polyposis
 - f. Juvenile Polyposis
 - g. Other rare hereditary polyposis syndromes (for which the index patient's gastroenterologist is responsible for counseling index patient to notify family members)

Ongoing Management, Objectives, and Indications for Specialty Referral

1. Patients with a first degree relative with a hereditary colon cancer syndrome or polyposis syndrome – refer these patients to Gastroenterology

2. Family history that is suggestive of an undiagnosed hereditary colon cancer or polyposis syndrome (such as FAP, HNPCC, etc.)
 - a. Primary care providers should contact a gastroenterologist to discuss these individual cases to better ascertain the best approach such as:
 - b. Whether the index patient (relative with cancer or polyposis) should be informed by the Madigan patient with a recommendation to undergo genetic testing first for confirmation or
 - c. Whether the Madigan patient should be referred for colorectal cancer screening based on age, symptoms, family history, etc.
3. Patients should be counseled to query family members about a history of colon polyps or colon cancer or any index patient's (relative with colon cancer or polyps) physician's recommendations for colorectal cancer screening that pertain to the Madigan patient
4. Management of 1st degree family history of colorectal cancer or adenomatous polyps
 - a. Refer for colonoscopy at age 40 or 10 years younger than youngest affected 1st degree relative's at time of diagnosis (whichever is younger)
 - i. Example – Patient Smith's sister had a colon adenoma diagnosed at age 26. No one else has polyps or colon cancer. Patient Smith should therefore undergo his first colonoscopy starting at age 16 (not 40).
 - ii. If the colonoscopy is normal
 1. Youngest affected 1st degree relative initially diagnosed less than age 40 – Madigan patient should have next colonoscopy in 5 years
 2. Youngest affected 1st degree relative initially diagnosed after age 40 – Madigan patient should have a next colonoscopy in 10 years
 3. The adequacy of the colonoscopy also determines the appropriate time interval for the next colonoscopy. If the endoscopist recommended a shorter interval follow up (based on adequacy of the exam), then the shorter follow up interval is recommended.
5. If only a second or third degree relative has colorectal cancer or adenomatous polyp (no personal history of 1st degree relative with colorectal neoplasia or HNPCC tumors), then the patient is considered an average risk patient (see above recommendations for Screening for Average Risk Individuals)
6. If a patient develops interim signs, symptoms, or radiographic findings concerning for colonic neoplasia (even if they are up to date on colorectal cancer screening), then recommend primary care provider contact a gastroenterologist to discuss this case (all screening modalities have a false negative rate, so these cases should be discussed by the primary care provider with a gastroenterologist – a consult should be placed if, after this discussion, colon neoplasia cannot be reasonably excluded).

Criteria for Return to Primary Care

All patients with a hereditary colon cancer or polyposis syndrome should be followed by gastroenterology

All other patients with a family history of colorectal neoplasia – completion of colonoscopy, if next colonoscopy is not recommended within the year

References:

Screening and Surveillance for the Early Detection of Colorectal Cancer and Adenomatous Polyps, 2008: A Joint Guideline from the American Cancer Society, the U.S. Multi-Society Task Force on Colorectal Cancer, and the American College of Radiology

Colorectal Cancer Screening and Surveillance, *Gastrointest Endosc.* 2006; 63: 546-557

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Referral Guidelines require review every three years

Maintained by the Madigan Army Medical Center - Quality Services Division
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