

Madigan Army Medical Center Referral Guidelines

Colorectal Cancer Screening in Average Risk Patients

Diagnosis/Definition

Average risk patients are defined as patients WITHOUT any of the following risk factors for colorectal cancer:

1. Signs, symptoms, or radiographic findings concerning for colorectal cancer
 - a. Examples include iron deficiency, +hemocult, hematochezia, change in bowel habits, radiographic abnormality, etc.- these patients should be referred to Gastroenterology
2. Patients with a personal history of inflammatory bowel disease – these patients should be referred to Gastroenterology
3. Personal history of colon cancer or adenomatous polyps – refer to Colonoscopy Surveillance Recommendations for Patients with a Personal History of Colorectal Cancer or Polyps
4. Family member with a history of colon cancer or adenomatous polyp – refer to Colorectal Cancer Screening Recommendations for Patients with Family History of Colorectal Polyps or Cancer
5. History of being an affected member of a family with a hereditary colon cancer or hereditary polyposis syndrome
 - a. Examples of these include familial adenomatous polyposis, MYH mutation, Hereditary Nonpolyposis Colon Cancer Syndrome, Hyperplastic Polyposis, Juvenile Polyposis, , Peutz-Jeghers Syndrome, etc.
 - b. Refer to Colorectal Cancer Screening Recommendations for Patients with Family History of Colorectal Polyps or Cancer
6. Family history that is suggestive of an undiagnosed hereditary colon cancer or polyposis syndrome
 - a. For details of examples, refer to Colorectal Cancer Screening Recommendations for Patients with Family History of Colorectal Polyps or Cancer
 - b. Primary care providers should contact a gastroenterologist to discuss these individual cases to better ascertain the best approach such as:
 - c. Whether the index patient (relative with cancer or polyposis) should be recommended to undergo genetic testing first for confirmation or
 - d. Whether the Madigan patient should be referred for colorectal cancer screening based on age, symptoms, family history, etc.

7. Patients should be counseled to query family members about a history of colon polyps or colon cancer or any index patient's (relative with cancer or polyps) physician's recommendations for colorectal cancer screening that pertain to the Madigan patient

Initial Diagnosis and Management

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

Ongoing Management and Objectives

1. African American patients should undergo colorectal cancer screening starting at age 45.
2. All other patients should undergo colorectal cancer screening starting at age 50.
3. Colonoscopy is the preferred screening tool in average risk patients in whom colorectal cancer screening is appropriate.
 - a. Colonoscopy is recommended approximately every 10 years for **average risk individuals** without polyps identified on prior colonoscopies.
 - b. It is important to note that the completeness of the examination and the quality of the colonoscopy preparation also determine the appropriate time interval between the next colonoscopic examination (this is based on the performing endoscopist's recommendation). If the endoscopist recommended a follow up colonoscopy in a shorter time period (less than 10 years) even though no polyps were identified on a colonoscopy, then the shorter follow up interval is recommended.
 - c. Hemoccults are not recommended in between colonoscopies for average risk screening.
 - d. Alternative (less optimal) screening tools include the following:
 - i. Fecal occult blood test of 3 stool samples – annually if negative
 1. If any of the three samples is positive, then recommend referral for a colonoscopy.
 2. This should not be done after a rectal or gynecologic examination.
 3. Should avoid NSAIDS/COX-II inhibitors and greater than one adult aspirin daily for 7 days (latter only if NOT on a cardiovascular protective regimen for prophylaxis based on cardiovascular risk factors)
 4. Should avoid vitamin C in excess of 250 mg from supplements or fruits/juices and red meats for 3 days prior to testing
 - ii. Flexible sigmoidoscopy every 5 years if normal
 - iii. Double contrast barium enema every 5 years if normal
 - iv. CT colonography every 5 years if negative. Primary care provider should follow up on incidental non-colon findings
 - v. Fecal occult blood tests x 3 annually and flexible sigmoidoscopy every 5 years (if all are normal). If both tests are planned together, the fecal occult blood tests

should be performed first because a positive test would be an indication to refer for colonoscopy

- vi. Patients should be counseled that colonoscopy is the preferred method of colorectal cancer screening, with recent data showing reduced mortality from both proximal and distal colon cancer. Patients who choose to opt for alternative screening modality should be counseled on specific limitations of their preferred colorectal cancer screening technique

Indications for Specialty Care Referral

1. Any risk factors for colorectal cancer as discussed above
2. **Positive hemoccult . Note: This pertains to collected stool samples.**
3. Colon polyp, mass, thickening, or other abnormality (other than diverticulosis without associated colon wall thickening) on CT colonography or contrast barium enema
4. Polyp on flexible sigmoidoscopy > 8mm without adequate tissue sampling, multiple hyperplastic polyps on flexible sigmoidoscopy (raising the possibility of Hyperplastic Polyposis Syndrome), or polyp on flexible sigmoidoscopy showing adenoma
5. Incomplete flexible sigmoidoscopy (not able to adequately examine to the proximal descending colon, whether by poor prep, patient tolerance, difficulty of procedure, etc.).
6. Other abnormalities on flexible sigmoidoscopy (such as colitis, etc.)
7. 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).

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

Criteria for Return to Primary Care - completion of colonoscopy, if next colonoscopy is not recommended within the next year

Last Review for This Guideline: **November 2011**

Referral Guidelines require review every 3 years

Maintained by the Madigan Army Medical Center - Quality Services Division
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