

# New Colorectal Cancer Screening Guidelines

## Focus On Prevention

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A consortium of cancer groups has published new guidelines for screening colorectal cancer, which for the first time focus on prevention and early detection.

The guidelines are published online in *CA, A Cancer Journal for Clinicians* and were issued by the American Cancer Society Colorectal Cancer Advisory Group, the US Multi-Society Task Force, and the American College of Radiology Colon Cancer Committee.

The new guidelines add two new screening tests: stool DNA and CT or “virtual” colonography to the existing list that already includes options such as the more familiar colonoscopy and double contrast barium enema.

The new recommendations are also more specific about the pros and cons of the different options, for instance some of the more invasive tests are more likely to prevent cancer because they find pre-cancerous polyps which can be removed before the disease develops. Other tests are less likely to find pre-cancerous growths, but still detect most cancers, said the American Cancer Society (ACS) in a press statement.

The aim of the guidelines is to help doctors and patients make better decisions about colon cancer screening.

They are written for people over 50 with an average risk of developing colon cancer and anyone with a higher than normal risk should have more intensive screening, said the ACS.

Colorectal Cancer (CRC, also shortened to colon cancer) is the third most common cancer diagnosed among American men and women and the second leading cause of cancer death in the US. The ACS said that although the rates of new cases is going down, there would be even fewer if more people who should be screened actually did.

All types of screening have the potential to find early stage cancer, but only some can find pre-cancerous growths, which are easier to treat.

The guidelines only include tests described in scientific literature as being able to detect at least 50 per cent of cancers.

The figures show that where colon cancer is stopped before it has spread to lymph nodes and other organs, 90 per cent of patients survive more than 5 years after diagnosis. This compares with a 10 per cent rate of survival for 5 years or more among patients whose cancer has spread.

The guidelines recommend that where tests are available, and patients are willing, doctors should encourage testing for both polyps and cancer.

Dr Durado Brooks, Director of Prostate and Colorectal Cancer at the ACS said this was the first time such guidelines have stated a preference for one type of test over another, explaining that:

“In the past we’ve created a list [of options] and left it up to providers and patients to decide what would work best for them.”

But now, it is becoming clearer with research that some tests are more likely to help prevent cancer, he said, “and for the first time our guidelines state that colorectal cancer prevention should be the primary goal of screening”.

Also, while the guidelines suggest some tests are better than others, the main thing is to get tested, said Brooks, explaining that:

“The best test is the test the patients can get and will take, but patients should be aware that there is a greater potential for certain types of tests to prevent cancer.”

**The new guidelines give 4 tests that give the best chance of finding both polyps and cancer:**

1. **Flexible sigmoidoscopy (recommended every 5 years).**
2. **Colonoscopy (every 10 years).**
3. **Double contrast barium enema (every 5 years).**
4. **CT (computer tomography or “virtual”) colonography (every 5 years).**

In sigmoidoscopy and colonoscopy tests, a camera on the end of a flexible tube is inserted in the patient’s rectum and colon to see if there are any polyps or cancers. Any polyps found can be removed during the procedure. A colonoscopy searches the whole length of the colon, whereas a sigmoidoscopy only looks at the one third nearest the rectum, so if the latter finds anything it is normally followed by a full colonoscopy to look at the unexamined areas.

In the double contrast barium enema test, barium sulfate (a liquid that looks and feels like watery chalk) and air is introduced into the colon via a catheter. X-rays are then taken to see what shape the barium, which is opaque to X-ray, takes and if there are any polyps or cancerous growths. If these are found, then a colonoscopy is usually recommended to confirm the diagnosis.

CT colonography involves taking CT (computed tomography) images (the patient goes into a large circular machine) of the colon while it is filled with air. If this finds polyps or cancerous growths it is usually followed by a colonoscopy to make sure.

The guidelines also specify three types of stool test that **look for cancer, rather than polyps**. These are:

1. Guaiac-based fecal occult blood testing (gFOBT; recommended every year).
2. Fecal immunochemical test (FIT; every year).
3. Stool DNA (frequency not specified).

The first two tests, gFOBT and FIT, look for blood in the stool, which can indicate cancer or it could be a large polyp that has started bleeding.

The third test, stool DNA, is quite new. It looks at the DNA of cells shed via the stool to see if any known DNA signatures of cancer are present. It’s still a new technique and there is not enough information on how frequently the test should be carried out. The ACS warns that it may not pick up all DNA cancer signatures.

Again, a positive result in any of these three tests would normally be followed up with a colonoscopy.

For the first time, the guidelines also deal with quality of tests. Brooks explained this was necessary because there was a “fair amount of testing going on in the marketplace that is of such poor quality that in many ways you’re doing patients a disservice”.

One example is the FOBT test. If this shows a positive or suspicious result, good practice recommends the patient is referred for a colonoscopy, but this sometimes does not happen. Brooks said that is a “mistake”, and carries the risk that “cancers are going to be missed”. Hence the guidelines “go to great lengths to spell out the quality issues that need to be in place for any type of test,” he explained.

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

Levin, Bernard, Lieberman, David A., McFarland, Beth, Smith, Robert A., Brooks, Durado, Andrews, Kimberly S., Dash, Chiranjeev, Giardiello, Francis M., Glick, Seth, Levin, Theodore R., Pickhardt, Perry, Rex, Douglas K., Thorson, Alan, Winawer, Sidney J., for the American Cancer Society Colorectal Cancer Advisory Group, the US Multi-Society Task Force, and the American College of Radiology Colon Cancer Committee.

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