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Physician News

Colorectal Cancer - A Time for Action

Detecting Increased Risk in Patients is Critical

According to the National Colorectal Cancer Roundtable, Colorectal cancer (CRC) is both the nation's second-leading cause of cancer mortality and one of its most preventable cancers.

In the report "How to Increase Colorectal Screening Rates in Practice," www.cancer.org/acs/groups/content/documents/document/acspc-024588.pdf, the Roundtable writes that if adenomatous polyps were removed before they transformed into cancers, starting at age 50 for those at average risk and earlier for those at increased risk, there would be a precipitous drop in the number of new colorectal cancers. Consequently, if developing CRCs were detected at earlier stages and ages, mortality rates would fall dramatically, and the increase in survival would be impressive. This accomplishment could be one of the great medical achievements of the 21st century.

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What Really Matters in Screening

Family history matters when it comes to identifying patients who are at increased risk for colon cancer. Factors to consider in these patients include the number of relatives with colon cancer, the age of the relative when diagnosed, and whether it is a first-degree relative (parents, sibling) or second-degree relative (uncle, aunt, grandparent) who had the diagnosis. According to the report mentioned above, this table summarizes risk:

Individual Risk Based on Family History of Colorectal Cancer (CRC)	
Familial Setting	Approximate Lifetime Risk of CRC
No history of colorectal cancer or adenoma (General population in the United States)	6%
One **second- or ***third-degree relative with CRC	About a 1.5-fold increase
One *first-degree relative with an adenomatous polyp	2-to-3-fold increase
Two second-degree relatives with colon cancer	About a 2-to-3-fold increase
Two first-degree relatives with colon cancer	3-to-4-fold increase
First-degree relative with CRC diagnosed at <50 years	3-to-4-fold increase

*First-degree relatives include parents, siblings, and children

**Second-degree relatives include grandparents, aunts and uncles

***Third-degree relatives include great grandparents and cousins

www.cancer.org/acs/groups/content/documents/document/acspc-024588.pdf, p. 20.

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Average risk patients should start screening at age 50. But what about those at higher risk? After identifying a high-risk patient because of family history, the 2009 guidelines published by the American College of Gastroenterology recommend:

Familial Risk Category	Screening Recommendation
Single first-degree relative with CRC or advanced adenoma diagnosed at age >= 60 years	Same as average risk
Single first-degree with CRC or advanced adenoma diagnosed at age <60 years or two first-degree relatives with CRC or advanced adenomas.	Colonoscopy every five years beginning at age 40 years or 10 years younger than age at diagnosis of the youngest affected relative.

http://gi.org/guideline/colorectal-cancer-screening

You occasionally may find an otherwise healthy patient who has a young family member with colon cancer. These patients are at much higher risk, and the general rule is to start screening by colonoscopy when the patient is 10 years younger than the age of the relative at diagnosis, no later than age 40. For example, if your patient had a brother diagnosed at age 40 with colon cancer, your patient should then have his or her initial colonoscopy at age 30.

When to Start Screening?

Sometimes the decision about when to start colon screening is unclear. What about patients who don't know their family history? At what age should patients with a polyposis syndrome have their colonoscopy? What do you tell a patient who has family members with multiple other cancers? Should they have earlier screening?

It all boils down to your clinical practice. However, all evidence-based guidelines reiterate the need for screening. "Unfortunately, many people aren't getting tested because they don't believe they are at risk or they aren't aware of the different testing and screening options," said Arek Keledjian, MD, Gastroenterology Division chair at John Muir Medical Center, Concord.

While colonoscopy has almost tripled in its use for screening since 1995, it still isn't widespread enough. Currently only about 60 percent of Americans are getting screened. Colonoscopies have long been considered the gold standard for colorectal cancer screening. Other viable non-invasive options include the fecal immunochemical test (FIT) and Cologuard® stool tests. Both are potentially covered by insurance, but require invasive follow-up testing with a positive result.

"During Colorectal Cancer Awareness Month, take a moment to talk to your patients if they haven't been screened (and more than 40 percent of the U.S. adult population has not) for this potentially preventable disease," says Dr. Keledjian.

Nearly 50,000 people were projected to lose their lives from both diseases last year. For a physician, these are tough numbers to digest. And it's why the National Colorectal Cancer Roundtable has prompted organizations and individuals throughout the country to do something about it.

The American Cancer Society estimates that 134,490 cases of colorectal cancer will occur in 2016, and an estimated 49,190 deaths. Colon and rectum cancers ranked third among the number of Observed New Cases, Deaths and Existing Cases of Common Cancers in in California.

(Source: American Cancer Society, California Cancer Facts & Figures 2015).