

Colon Cancer Check

- The lifetime risk of developing Colorectal Cancer (CRC) is about 1 in 14 (7.1%) in men and 1 in 16 (6.3%) in women.
- CRC risk increases dramatically over age 50—only 6.3% of cases in Canada occur under age 50.
- Ten to 15% of colorectal cancers occur in people with a family history of CRC especially if they have a first degree relative.
- ColonCancerCheck aims to reduce mortality from CRC through an organized population-based screening program and to improve the capacity for primary care to participate in comprehensive CRC screening. The screening method will be determined by risk profile.

Risk Assessment

Assess risk in individuals who have never had colorectal cancer.

1 Assess for Colorectal Cancer Signs and Symptoms

Patients should be referred for diagnostic work-up if they have one or more of the following:

- Rectal mass
- Abdominal mass
- Unexplained weight loss
- Unexplained change in bowel patterns
- Rectal bleeding
- Unexplained anemia
- Urgent feeling to empty bowel
- Unexplained stool incontinence

FOBT is NOT appropriate for symptomatic patients.

2 Assess for Increased Risk of Colorectal Cancer

No CRC signs or symptoms

Refer for Colonoscopy³
Begin at age 50 or 10 years younger than earliest age of diagnosis of relative, whichever comes first

If normal, repeat colonoscopy every 5 - 10 years

One or more first degree relatives with CRC (parent, sibling or child)^{1,2}

See reverse 'Surveillance after Colonoscopy' for abnormal results

3 Average Risk - Asymptomatic Age 50 Years and Older⁴

No CRC signs or symptoms
No affected first degree family member⁵

Fecal Occult Blood Test (FOBT)^{6,7,8}

Positive:^{9,10} refer for colonoscopy

Negative: repeat two years

1 Lifetime risk of CRC:

- One first degree relative with CRC = 9%
- One first degree relative < 45 years with CRC = 15%
- Two first degree relatives with CRC = 16%

2 For other high risk CRC patients including familial and hereditary syndromes refer to specialist.

3 For a list of participating hospitals in your area to refer patients for colonoscopy who have a positive FOBT or one or more first degree relatives with CRC please visit: www.ColonCancerCheck.ca

4 The upper age limit to initiate or continue CRC screening is at the discretion of the clinician and should be based on the individual patient's health status, anticipated life expectancy and risk of CRC.

5 Lifetime risk of CRC for average risk asymptomatic individuals = 4%

6 Restrictions on oral intake of any prescribed medications, including aspirin, NSAIDs or iron, supplements or specific foods

are not advised except for Vitamin C, citrus fruits or juices, which should be discontinued 3 days prior to and during stool collection.

7 Hema Screen kits are provided by ColonCancerCheck. FOBT screening involves 3 stool cards with 2 windows (6 in total). A single stool specimen obtained during rectal examination is NOT an adequate screen.

8 Other CRC screening tests are not funded by the ColonCancerCheck program but will still be available and funded by the MOHLTC.

9 If any one or more of the 6 samples are positive, the patient should be referred for colonoscopy.

10 Research shows that a biennial FOBT screening program will show a positivity rate of 2% and, of that 2%, ~10% will be found to have cancer at a follow-up colonoscopy.

Surveillance After Negative FOBT

- ColonCancerCheck will send a letter to participants with negative results.
- Every two years participants will be sent a letter from ColonCancerCheck to repeat FOBT.

Surveillance After Colonoscopy

- Over 90% of CRC are adenocarcinomas. Most (>95%) arise from adenomatous polyps (AP).
- ~2/3 of polyps are adenomas. The remaining third are hyperplastic (none to minimal malignancy risk).
- AP increase in incidence with age. Prevalence is ~ 25% by age 50 and 50% by age 80.
- ~1-5% of AP will progress into invasive cancer especially if they are larger sized (>1cm), have villous features (versus tubular features) or are highly dysplastic. Progression from normal mucosa to invasive cancer takes ~10-15 years.

Colonoscopy Result	Surveillance Recommendation ¹
Normal Colonoscopy or Hyperplastic Polyps ■ Asymptomatic Average Risk ■ Increased Risk of CRC	■ Colonoscopy or Average Risk screening in 10 years ■ Colonoscopy in 5-10 years (depending on prior colonoscopy findings, family history, etc.)
1 or 2 small (<1 cm) tubular adenomas with only low grade dysplasia	Colonoscopy in 5-10 years (depending on prior colonoscopy findings, family history, etc.)
<ul style="list-style-type: none"> • 3-10 adenomas, or • Any adenoma > 1 cm, or • Adenoma with villous features, or • Adenoma with high grade dysplasia 	<ul style="list-style-type: none"> • Colonoscopy in 3 years (complete adenoma removal, not removed piecemeal) • If follow-up colonoscopy normal or 1-2 small tubular adenomas with low grade dysplasia, then next colonoscopy in 5 years
> 10 Adenomas in 1 exam	Endoscopist discretion for more intense follow-up
Sessile Adenomas removed piecemeal	Endoscopy in 2-6 months to verify complete removal. Then individualized surveillance.

¹Please note that other CRC screening modalities including FOBT are not recommended in the interim.
 Winawer SJ et al. Gastroenterology 2006;130:1872-1885.

Why is ColonCancerCheck Funding Population-Based Biennial CRC Screening Using FOBT for Average Risk Adults?

- Biennial FOBT (followed by colonoscopy for positive FOBT) is the only CRC screening modality with the highest level of clinical evidence from 3 randomized controlled trials (RCT) of average risk adults proven to reduce CRC mortality.
- Based on this evidence, FOBT testing has been recommended by the Canadian Task Force on Preventive Health Care, The Canadian Association of Gastroenterologists and the Guidelines Advisory Committee of Ontario.
- FOBT is safe – there are no risks of perforation or death.
- FOBT can be easily completed at home – no bowel preparation, no dietary or medication restrictions except Vitamin C and no time off work is required.
- FOBT is not perfect. There may be false negatives which could miss cancer or advanced polyps, or false positives which lead to further testing with greater risks of harm.
- All recommended screening strategies for colorectal cancer, including biennial screening with FOBT, are cost-effective compared to no screening.
- Using FOBT in average risk individuals and colonoscopies for increased risk individuals is economically feasible, and allows the use of more resource-intensive procedures for patients with symptoms or higher genetic risk.
- Many jurisdictions in Canada and around the world are implementing population-based FOBT Colorectal Cancer Screening Programs.

Your local ColonCancerCheck centre and fax number: _____