



Healthy Insights

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Prevention news for the medical community of New Hampshire

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Colorectal Cancer: One Of The Few Malignancies That Can Be *Prevented* As Well As Detected Early

1. Only 36% of the colorectal cancers in New Hampshire are detected at an early stage (Stage 1)
2. Studies show that when providers recommend screening directly to their patients, they are significantly more likely to comply with screening.
3. Fecal Occult Blood Test (FOBT) is one of the options for early cancer detection that can be used in patients who have low-average risk for colon cancer BUT
 - It should not be used as an office-based test (i.e., as part of rectal exam).
 - If positive, it should be followed up with a colonoscopy (and not repeated for confirmation).

March is the **National Colorectal Cancer Awareness Month** and a great opportunity to share New Hampshire specific data on colorectal cancer with you as well as our plans to support you in your efforts to screen your patients.

Among cancers that affect both men and women, colorectal cancer is the second most commonly diagnosed malignancy in New Hampshire. In the past few decades we have seen reduced incidence of, and mortality from, colorectal cancer, likely due to increased utilization of colonoscopy (preventing cancer by removing pre-cancerous polyps). However, among those who develop colorectal cancer in our state, only 36% are diagnosed at an early stage (Stage I), despite availability of different screening tests for early detection.

The variety of screening options and recommended frequency of screening for different patient populations are reviewed in the attached guidelines document. This document was created by the New Hampshire Colorectal Cancer Screening Program (NHCRCS) based on resources (as referenced) for your ease of use.

The New Hampshire Division of Public Health Services (DPHS) has partnered with the NHCRCSP to implement a CDC grant targeted to improve colorectal cancer screening rates in New Hampshire. This grant has two goals:

- 1. Increase screening rate by 2014 to over 80% of people aged 50 years and older.**
- 2. Help reduce financial barriers for low income uninsured NH residents aged 50-64 who are at average or increased (but not high) risk who should be screened.**

In order to achieve the second goal, limited funding is available to offer some free colonoscopies for eligible individuals across the state. To qualify for funding a person should be uninsured or underinsured (deductible > \$1000) AND be at or below 250% of Federal Poverty Level.

For more information about this program, or for patients who appear to meet the listed criteria to determine if they are eligible, please call the NHCRCSP at 603-653-3702.

Attachment: NH Colorectal Cancer Screening Program: Screening and Surveillance Recommendations



NH Colorectal Cancer Screening Program: Screening and Surveillance Recommendations

Risk Category	Age to Begin Screening	Recommendations
<p>Average risk screening: No family or personal risk factors (and no symptoms)</p>	<p>Age 50*</p>	<p style="text-align: center;"><i>Test Options:</i></p> <p><u>Tests That Find Polyps and Cancer</u></p> <p>Colonoscopy every 10 years (if no findings)</p> <p>Flexible Sigmoidoscopy every 5 years (Flexible sigmoidoscopy every 5 years combined with FOBT every year may offer greater protection than either test alone.)</p> <p>CT Colonography (CTC) every 5years.</p> <p>Air Contrast Barium Enema every 5 years (infrequent primary use - lower sensitivity)</p> <p>Colonoscopy recommended for a positive result of the other tests</p> <p><u>Tests That Primarily Find Cancer</u></p> <p>Fecal Occult Blood Test (FOBT) every year. One test done by the PCP in the office is not adequate for testing.</p> <p><u>Colonoscopy recommended for any positive test (whether guaiac or immunochemical-based FOBT).</u> A positive FOBT should not be repeated for confirmation, but should be considered positive. Following test instructions will improve accuracy. High sensitivity test recommended.</p> <p>Stool DNA (interval uncertain) Colonoscopy for positive test</p>
<p><u>Increased risk</u> Colorectal cancer (CRC) or adenomatous polyp in a 1st degree relative (or CRC in two 2nd degree relatives)</p>	<p>Age 40 or 10 years younger than the earliest age at CRC diagnosis in a 1st degree relative, whichever comes FIRST</p>	<p>Colonoscopy</p>
<p><u>Increased risk**</u> Personal history of CRC or adenomatous polyp</p>		<p>Colonoscopy:**** Interval per guidelines (reference # 3)</p>
<p><u>Highest risk***</u> Personal history of Inflammatory Bowel Disease (ulcerative colitis or Crohn's colitis) or a hereditary syndrome (HNPCC, FAP, or AFAP)</p>	<p>Determined by specialist</p>	<p>Needs specialty evaluation and colonoscopy.</p>

Note:

Tests that are designed to find both early cancer and polyps are preferred, especially for individuals at increased risk, if these tests are available and the patient is willing to have one of these tests. See guidelines (references listed below) for risk levels and recommended followup intervals.

Figure Legend:

- * Evidence suggests that some groups (such as African-Americans) may develop cancer at an earlier age and should begin screening at age 45. Some evidence suggests that women may have an increased risk of right-sided lesions. (References #5, 6)
- ** Patients with a personal history of CRC or adenomatous polyp undergo surveillance, not screening.
- *** If a 1st degree relative age <50 had CRC, evaluate whether history is consistent with hereditary non-polyposis colorectal cancer (HNPCC or Lynch Syndrome). The Amsterdam II Criteria for HNPCC include the following 3-2-1-criteria: 1) at least *three* relatives with CRC or HNPCC-associated cancers (including colorectal, endometrium, stomach, ovary, small bowel, ureter, renal-pelvis, hepatobiliary tract, brain) with one affected person being a 1st degree relative of the other two 2) at least *two* successive generations should be affected 3) at least *one* cancer should be diagnosed before age 50 and in addition, 4) familial adenomatous polyposis (FAP) should be excluded for those individuals with CRC (reference # 7 and # 8)
- **** Colonoscopy for persons at increased risk is the recommendation of the American Cancer Society and the US Multi-Society Task Force on Colorectal Cancer. Both organizations state that CRC prevention should be the primary goal of screening

Additional considerations:

- Colonoscopy recommendations assume that colonoscopy is complete to the cecum and that bowel preparation is adequate; if not, a repeat (or alternative) examination should be done to ensure visualization of the colon.
- Average-risk people with normal or only a few small hyperplastic (often rectal) polyps at colonoscopy should be followed at 10 year intervals. Large right-sided “hyperplastic” or multiple hyperplastic polyps throughout the colon do not fall into this category.
- Endoscopists should make clear recommendations to primary care physicians and patients about when the next colonoscopy is indicated.
- The evolving nature of surveillance guidelines should be considered in future followup. Clinicians should also consider discontinuation of screening or surveillance colonoscopy in persons with serious comorbidities and less than 10 years of life expectancy.
- Screening and surveillance guidelines are intended for **asymptomatic** people; those with new symptoms may need diagnostic workup.

Guideline References:

1. Screening for Colorectal Cancer: U.S. Preventive Services Task Force Recommendation Statement. U.S. Preventive Services Task Force. *Annals of Internal Medicine*. 2008 Nov 4;149(9):627-37.
2. Levin B, Lieberman DA, McFarland B, et al. 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 *CA Cancer J Clin* 2008;58:130-160
3. Winawer SJ, Zauber AG, Fletcher RH, et al. Guidelines for Colonoscopy Surveillance After Polypectomy: A Consensus Update by the US Multi-Society Task Force on Colorectal Cancer and the American Cancer Society *Gastroenterology* 2006;130:1872-1885

Other References:

4. Sarfaty M. How to Increase Colorectal Cancer Screening Rates in Practice: A Primary Care Clinician's Evidence-Based Toolbox and Guide 2008 Published by the National Colorectal Cancer Roundtable. An activity of the American Cancer Society and the Centers for Disease Control and Prevention 2006, revised 2008.
5. Agrawal S, Bhupinderjit A, Bhutani MS, et al. Colorectal cancer in African Americans. *American Journal of Gastroenterology* 2005;100:515-523
6. Schoenfeld P, Cash B, Flood A, et al. Colonoscopic screening of average-risk women for colorectal neoplasia. *New England Journal of Medicine* 2005;352:2061-2068
7. Lynch HT, de la Chapelle A. Hereditary colorectal cancer. *New England Journal of Medicine* 2003;348:919-932
8. Vasen HFA, Watson P, Mecklin J-P, Lynch HT. New clinical criteria for hereditary non-polyposis colorectal cancer (HNPCC, Lynch syndrome) Proposed by the International Collaborative Group on HNPCC. *Gastroenterology* 1999;116:1453-1456

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