COLORECTAL CANCER SCREENING

Policy: The following will be will be a guide to help ensure all patients get the proper screening and surveillance intervals for CRC (Colorectal Cancer), in patients at average risk*, starting at the age 45.

Purpose: Screening for colorectal cancer (CRC) in asymptomatic patients can reduce the incidence and mortality of CRC. The American Cancer Society recommends that people at average risk* of colorectal cancer **start regular screening at age 45**. Adenomatous polyps are the most common neoplasm found during CRC screening. There is evidence that detection and removal of these cancer precursor lesions may prevent many cancers and reduce mortality.

Procedure: Starting at the age 45, patients that are at average risk should be referred to GI for CRC screening. Any patient who has not had a Colon Cancer Screening should be made an appointment with one of our GI physicians.

Patients are considered **average risk** if they DO NOT have the following:

- A personal history of colorectal cancer or certain types of polyps
- A family history of colorectal cancer
- A personal history of inflammatory bowel disease (ulcerative colitis or Crohn's disease)
- A confirmed or suspected hereditary colorectal cancer syndrome, such as familial adenomatous polyposis (FAP) or Lynch syndrome (hereditary non-polyposis colon cancer or HNPCC)

Patients at **increased or high risk** of colorectal cancer might need to start colorectal cancer screening before age 45, be screened more often, and/or get specific tests. This includes people with:

- A strong family history of colorectal cancer or certain types of polyps. A personal history of colorectal cancer or certain types of polyps
- A personal history of inflammatory bowel disease (ulcerative colitis or Crohn's disease)
- A known family history of a hereditary colorectal cancer syndrome such as familial adenomatous polyposis (FAP) or Lynch syndrome (also known as hereditary non-polyposis colon cancer or HNPCC)

** If a patient is referred to GI for CRC, they MUST leave the office with an appointment with one of the GI physicians. If the patient goes outside the practice for CRC, it is the primary care physicians responsibility to obtain a copy of the most recent report and update the patient's chart.

Fecal FIT Testing: This test should be done YEARLY, regardless of when the last Colonoscopy was performed. The fecal immunochemical Test (FIT) screening method for hemoglobin in the

stool is the new standard of care for the early detection of blood which may be associated with colorectal cancer.

- A negative result- 1 year surveillance interval.
- A positive result - Patient should be referred to GI for Colonoscopy.

Surveillance Intervals: Based on the results of the colonoscopy for patients at average risk, the following screening intervals will be recommended: (This is a baseline surveillance interval guide for Dr. Podeszwa, Dr. Patel and Dr. Leidner, other factors may change the recommended interval.)** Each patient will have a Patient Specific Recall placed in their chart based on the their results. PLEASE DO NOT UPDATE OR CHANGE.

Baseline Colonoscopy	**Recommended Surveillance Intervals**
No Polyps with average or good prep.	5 Years
No Polyps- very poor prep	1 Year
Hyperplastic polyps	5 Years
1–4 small (<10 mm) tubular adenomas or Sessil Serrated	3 Years
5 or more small (<10 mm) tubular adenomas or ses serrated	1 Year
1 or more large tubular adenomas or sessile serra ≥10 mm	1 Year
Tubulovillous adenomas	1 Year
Adenomas / sessile serrated with High Grade Dysp	3 Months.
Crohns / Colitis	Intervals depends on disease progression and how patient has had dx.
10 or More Polyps	Lynch Testing should be performed