

When to start screening? Start screening average-risk individuals at age 45 years.

What is new: Age to start screening lowered from 50 years to 45 years.

Comments: While the incidence of colorectal cancer (CRC) has been declining in the US for older adults by about 2% per year, it has been rising for both men and women < 50 years by 2% / year^{2,3}. This increase is mostly driven by rectal and left-sided colon cancers and is noted even among 20 to 45-year-olds. Risk factors such as sedentary lifestyle, obesity and diabetes have been rising for all ages, but may disproportionately affect young adults as those > 50 years are “protected” by screening.⁴

Features of CRC in young adults: (1) Advanced stage at diagnosis, may be related to delay in seeking attention for symptoms and delay in referral to specialist for diagnosis⁵; (2) Up to one-third are associated with hereditary CRC syndromes like Lynch syndrome.⁶

Considerations:

1. Educate patients about CRC symptoms
2. Promptly investigate symptoms of rectal bleeding and anemia (especially in men). History and physical exam are inaccurate in differentiating benign from malignant causes of rectal bleeding.^{7,8} Sigmoidoscopy, and if non-diagnostic, colonoscopy; or direct colonoscopy should be considered⁹
3. Obtain detailed family history to identify those with hereditary CRC syndromes

How to screen?

The USPSTF recommends the following screening strategies as acceptable:

- High-sensitivity gFOBT or FIT every year
- sDNA-FIT every 1 to 3 years (Note: sDNA-FIT has higher sensitivity but lower specificity than FIT. Specificity decreases with increasing patient age. “sDNA every 3 years” was inferior to other strategies regarding balance between number of colonoscopies and life-years gained)
- CT colonography every 5 years
- Flexible sigmoidoscopy every 5 years
- Flexible sigmoidoscopy every 10 years + annual FIT
- Colonoscopy screening every 10 years (Note: associated with highest mean life-years gained and CRC cases averted but also colonoscopy-associated harms, when compared with other strategies)

Comments: Most screening in the US is opportunistic (results from office-based interaction between patient and physician) and colonoscopy-based.¹⁰ This model has been highly effective as the US has the highest CRC screening compliance rates and highest decreases in CRC incidence in the world.¹¹ USPSTF estimates that average-risk individuals will need only 4.2 tests/lifetime for colonoscopy-based screening compared with up to 21 tests/lifetime for stool-based strategies, supporting colonoscopy’s preferred role in opportunistic screening model.

When to stop screening?

76 – 85 years: Screen selectively. The net benefit of screening all persons in this age group is small, especially for those who have been adequately screened before. Consider life-expectancy, comorbidities, patient’s overall risk and patient preferences in decision-making.

86 years and older: Unlikely to benefit from screening. Competing causes of mortality likely preclude any survival benefit that would outweigh the harms of screening.

For Additional Information:

Access detailed guidelines and downloadable PDF at:

<https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/colorectal-cancer-screening>

Visit the ASGE Value of Colonoscopy Campaign at ValueofColonoscopy.org for resources to educate patients on screening options and reinforcement that regardless of the test selected, every positive test leads to a colonoscopy, the gold standard of colorectal cancer screening.

References

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