Screening for Colorectal Cancer

Colorectal cancer (CRC) is a cancer of either the colon (large intestine) or the rectum. It is the second-most common cause of cancer death in men and the third-most common cause in women. It often starts as a polyp (abnormal growth) in your colon or rectum that grows into cancer. Some people may have CRC without being aware that they have it, so it is helpful to get tested. One common sign of CRC is blood in the stool.

Please note that **the recommendations do not apply to** people with previous CRC or polyps, inflammatory bowel disease (e.g., colitis or Crohn's disease), signs or symptoms of CRC, history of CRC in one or more of your first-degree family members, or some inherited conditions (such as Lynch syndrome and familial adenomatous polyposis).

Discuss colorectal cancer screening with your primary care provider, and weigh the benefits and harms of each test.

1. When should I get screened for colorectal cancer (CRC)?

- If you are between the ages of 50 and 74, we recommend that you speak to your primary care practitioner about screening.

2. Why should I not get screened if I am under the age of 50 or over the age of 74?

- There is no benefit in screening those younger than 50 as the number of new cases of CRC in this age group is very low.
- There is not enough evidence to show a benefit of screening those older than 75. However, if you still wish to be screened, we recommend that you speak to your primary care provider.

3. What tests are used to screen for CRC and how often should they be done?

- There are two types of tests we recommend: a fecal occult blood test (FOBT) or a flexible sigmoidoscopy.
  - An FOBT is the most common test, and will most likely be the first choice. To do an FOBT, you provide a stool sample that is tested for blood that can't be seen with the naked eye. Blood in the stool can be a sign of CRC.
  - Flexible sigmoidoscopy is less commonly used and requires more resources. It is a procedure that involves inserting a long flexible tube with a light and a camera attached to it into the anus, rectum, and lower colon to look for polyps. Before the procedure, you will need to cleanse your bowel with enemas or laxatives.

4. How often should I be screened?

- If you and your primary care provider choose the FOBT, we recommend screening with this test every 2 years.
- If you and your primary care provider choose flexible sigmoidoscopy, we recommend screening with this test every 10 years.

5. Are there any harms associated with these tests?

- The primary harms of FOBT are false positives and false negatives
  - A false positive result occurs when a test says that someone may have CRC when they actually do not. This can lead to unnecessary further testing, such as a colonoscopy and its related harms.
  - A false negative result occurs when a test says that someone does not have CRC when they actually do.
- Harms for flexible sigmoidoscopy are rare and occur in less than 0.1% of patients. These harms include intestinal puncture, minor bleeding, major bleeding, and death.

6. Which test is best for me?

- If you would prefer to have a less invasive procedure and don't mind getting tested more frequently, the FOBT might be best for you.
- If you would prefer less frequent testing and don't mind having a more invasive test, flexible sigmoidoscopy might be the preferred option, if it is available in your location.
- Remember to check with your primary care provider about the availability of each test in your region. An FOBT is more readily available and therefore the majority of people will be screened with this test.

7. Should I be screened for CRC with a colonoscopy?

- We recommend not using colonoscopy as a routine screening test for CRC. There are several reasons for this:
  - There isn't enough evidence that having a colonoscopy is more helpful than other available tests.
  - This test has a slightly greater risk for harm than flexible sigmoidoscopy.
  - Wait lists for colonoscopy are very long in Canada and have increased over time because the test requires specialized equipment and trained clinicians to perform it.

8. What is the difference between colonoscopy and flexible sigmoidoscopy?

- A colonoscopy lets a doctor look at the lining of the entire rectum and colon, whereas flexible sigmoidoscopy examines only the rectum and lower third of the colon.

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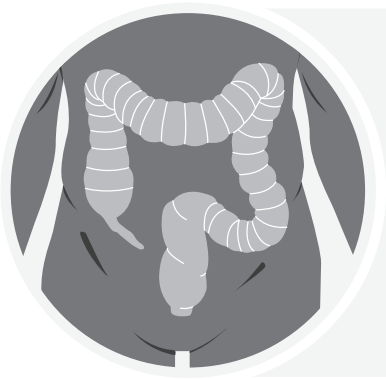

Who do these recommendations apply to?

- These recommendations apply to **asymptomatic adults aged 50 and older who are not at high risk for colorectal cancer (CRC)**. Adults are at **high risk** if they have at least one of the following:
  - Previous CRC or adenomatous polyps (e.g., tubular or villous)
  - Inflammatory bowel disease (e.g., ulcerative colitis or Crohn's disease)
  - Signs or symptoms of CRC (e.g., blood in the stool)
  - History of CRC in one or more first-degree relatives
  - Adults with hereditary syndromes predisposing to CRC (e.g., familial adenomatous polyposis or Lynch syndrome)

This tool provides guidance for primary care practitioners on different screening tests, screening intervals, and recommended ages to start and stop screening.

Age	Screen?	Recommendation Strength	Test
<50	We suggest not screening		
50 - 59	**Yes**	**Weak**	FOBT (either gFOBT or FIT) every 2 years OR flexible sigmoidoscopy every 10 years
60 - 74	**Yes**	**Strong**	FOBT (either gFOBT or FIT) every 2 years OR flexible sigmoidoscopy every 10 years
75 +	**No**	**Weak**	If patient is interested in screening, discuss options and help them reach a decision based on their quality of life, values, and preferences.

- A **strong** recommendation means that most individuals will be best served by the recommended course of action.
- A **weak** recommendation means that many people would want the recommended course of action, but many would not. Primary care practitioners should discuss the potential harms and benefits of screening with their patients.

Resources, test availability, and patient preferences should be considered when choosing which screening test is appropriate.

Other recommendations

- **We recommend not using colonoscopy as a primary screening test for CRC**
  - There is a lack of direct, high-quality evidence of the efficacy of colonoscopy in comparison to that of other screening tests.
  - Colonoscopy has **greater potential for harms** (e.g., minor bleeding, major bleeding, perforation, and death) than the other available tests.
  - Colonoscopy requires more time and expertise to perform, and using colonoscopy for screening means that this test will not be as readily available for people with symptomatic disease, such as visible blood in the stool.

Implementation considerations

- An FOBT test is the most convenient, uses the fewest resources, and will likely be the preferred option in most situations.
- It is important to note that flexible sigmoidoscopy is an option in specific circumstances based on patient values and preferences (e.g., averse to stool testing, prefers less frequent testing) and resource availability.

Evidence summary

- RCT data show that screening those aged 50-74 years for CRC with gFOBT or flexible sigmoidoscopy reduces the incidence of late-stage CRC and CRC mortality.
- FIT has greater sensitivity than gFOBT and similar specificity. Therefore, the reported mortality benefits of gFOBT for people aged 50-74 years can be extended to FIT.
- The only direct harms noted for either gFOBT or FIT in the studies reviewed were false positives and false negatives.
- The harms of flexible sigmoidoscopy are rare but include intestinal perforation, minor bleeding, major bleeding, and death.

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