

# Screening, Surveillance and Follow up Recommendations



CancerCare Manitoba, with support from Manitoba Health, has established ColonCheck Manitoba to help detect colorectal cancer (CRC) early and reduce the number of Manitobans who die from the disease. This program is targeting individuals at average risk between the ages of 50 & 74 to be screened with a fecal occult blood test (Hemoccult II Sensa).

The fecal occult blood test (FOBT) was chosen based on high level (randomized controlled trial) evidence at the population level. Furthermore, it meets World Health Organization criteria for screening tests including the feasibility of engaging a majority of the

population and that it is a simple, low cost acceptable test with minimal risk. The Program recognizes that there are other screening tests for CRC and that recommendations vary somewhat depending on the professional group or society.

The purpose of this summary of recommendations is to provide information to health care providers that will support them in the provision of appropriate care for screening, surveillance and follow up care for CRC. These recommendations may change as new evidence becomes available.

## Screening Recommendations

*Adapted from the 2004 Guidelines of the Canadian Association of Gastroenterology and the Canadian Digestive Health Foundation.*

Choice of test and frequency may vary depending on level of evidence, individual patient concerns, coexisting morbidities, evaluation of risk vs benefits, and/or available resources. Double contrast barium enema or CT colonography may be alternatives in individuals with a positive FOBT if colonoscopy is refused or unsuccessful.

PATIENT CHARACTERISTICS	CLASSIFICATION	RECOMMENDATION
50 – 74 years of age with no symptoms of CRC and <ul style="list-style-type: none"> <li>no personal history of CRC, polyps, or diseases of the colon requiring monitoring by colonoscopy</li> </ul>	Average Risk	<b>FOBT every two years followed by colonoscopy if any one sample is positive</b> <i>On an individual basis, other screening tests may be appropriate based on clinical judgment, risk assessment or patient concerns:</i> <ul style="list-style-type: none"> <li>Colonoscopy every 10 years</li> <li>Flexible sigmoidoscopy every 5 years with or without FOBT</li> </ul>
40+ years of age with no symptoms of CRC and <ul style="list-style-type: none"> <li>one first degree relative diagnosed with CRC or advanced adenomatous polyps* at 60 years of age or older</li> <li>2 or more second degree relatives diagnosed with CRC or advanced adenomatous polyps*</li> </ul>	Slightly Above Average Risk	Same as for average risk patient
Individuals with <ul style="list-style-type: none"> <li>one first-degree relative diagnosed with CRC or advanced adenomatous polyps* before the age of 60</li> <li>2 or more first-degree relatives diagnosed with CRC or advanced adenomatous polyps* at any age</li> </ul>	Above Average Risk	Colonoscopy, every 5 years – begin at age 40 or 10 years earlier than youngest diagnosis of CRC or polyps in the family
Individuals with <ul style="list-style-type: none"> <li>a personal history of CRC, adenomatous polyps, inflammatory bowel disease with associated colitis</li> </ul>	High Risk	Ongoing investigation and surveillance with colonoscopy; individuals with IBD should be referred for colonoscopic surveillance 8 years after the onset of colitis
Individuals with <ul style="list-style-type: none"> <li>confirmed or suspected hereditary colon cancer syndrome such as Hereditary Non-Polyposis Colon Cancer (HNPCC) or Familial Adenomatous Polyposis (FAP)</li> </ul>	High Risk	Consider referral for genetic testing (see text on next page); Ongoing endoscopic surveillance



**Individuals with symptoms of CRC such as rectal bleeding, persistent change in bowel habits, abdominal pain, unexplained weight loss or anemia should not undergo FOBT screening as they require urgent investigation.**

\* “Advanced adenomas” or “advanced adenomatous polyps” are defined as having one of the following features:  $\geq 1$  cm in size, high grade dysplasia or villous component (villous or tubulovillous).

## Genetic Testing for Hereditary Colorectal Cancer

A complete family history is important as referral for genetic counseling and/or genetic testing to the WRHA Program in Genetics and Metabolism (Phone 204-787-2494; Fax 204-787-1419) may be appropriate in some cases. Generally, hereditary colorectal cancer (HNPCC, FAP) should be considered when there are:

- multiple family members with disease (colorectal cancer or adenomatous polyps)
- disease at a younger age (<45 years)
- and/or disease present in successive generations

For more detailed guidelines on risk assessment for hereditary colorectal cancer, please refer to the Canadian Association of Gastroenterology guidelines <http://www.cag-acg.org/news/guidelines.aspx>

## Follow up and Surveillance Recommendations after Colonoscopy

*Adapted from the 2008 Joint Guidelines from the American Cancer Society, the US Multi-Society Task Force on Colorectal Cancer, and the American College of Radiology.*

PATIENT CHARACTERISTICS	RECOMMENDATIONS**
Negative colonoscopy with no additional risk factors for CRC (includes hyperplastic polyps and those with positive FOBT and negative colonoscopy)	Rescreen in 10 years
1 – 2 tubular adenomas <1 cm	Rescope in 5 – 10 years
More than 2 tubular adenomas or any advanced adenoma*	Rescope in 3 years; rescope every 5 years when polyp clearance is achieved. Consider referral for genetic testing if >10 adenomas
Post-curative resection for CRC	Colonoscopy end of year 1 (within 6 months if colon is not cleared preoperatively); rescope at 3 years then every 5 years indefinitely if the outcome is normal
Colon was not cleared of polyps; an incomplete polypectomy or removal of an advanced adenoma	Consider rescopying in 3 to 6 months

\*\* Follow up or surveillance may vary according to clinical judgment.

## CancerCare Manitoba Stage II & III Colon Cancer Follow up Recommendations

*Based on the 2005 American Society of Clinical Oncology Guidelines (ASCO) <http://jop.ascopubs.org/cgi/reprint/1/4/137>*

FOLLOW UP†	YEAR 1,2,3	YEAR 4,5
Physician Visit: Complete history and physical including rectal exam	Every 3 months	Every 6 months
Bloodwork: Carcinoembryonic antigen (CEA)	Every 3 months	Not routine
CT Imaging: Chest/abdomen	Annually	Not routine
Chest X-Ray		Not routine
Colonoscopy		See Preceding Table

† Year 1 is the 12 month period beginning on the date of the patient's surgery.

Follow up may vary based on risk of recurrence and feasibility for surgical excision in individual patients.

### Contact ColonCheck Manitoba to:

- ✔ Order poster or pamphlets
- ✔ Order a Reduce Your Risk DVD
- ✔ Request a presentation

### ColonCheck Manitoba

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