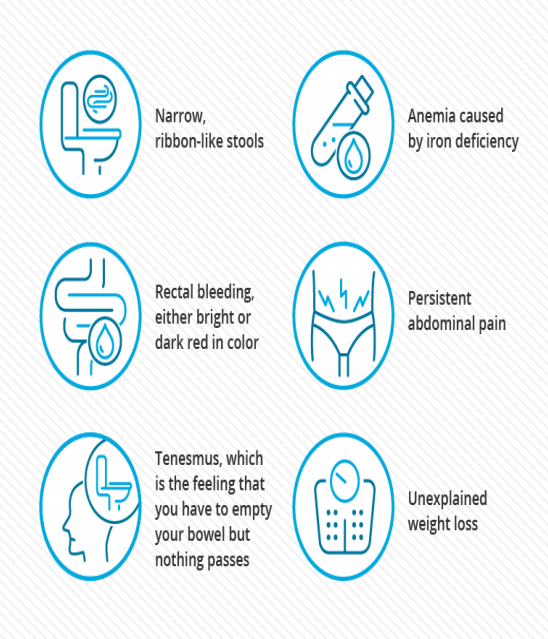
Colorectal CA Screening Clinical Practice Guidelines

Definition

Average risk is:
Those who are between 45 and 75 years old and show no symptoms of the disease and have no family medical history of the disease or polyps.
Modality of screening: FIT test annual

High risk is:
Those who have personal medical history of polyps, have one or more of the first-degree relatives with medical history of the colon cancer or polyps, have two or more of the second-degree relatives with medical history of the colon cancer disease or polyps, or have ulcerative colitis, Crohn's disease, or some other conditions, such as: a personal history of cancer, which requires radiation therapy to the abdomen.
Modality of screening: Colonoscopy (need gastroenterology referral)



Assessment (History and Examination)

1. Identify the complaint:
   a. Onset, duration, frequency (and relation with bowel movement), aggravating and relieving factors, and associated symptoms: abdominal pain or cramps, change in bowel habit, dizziness, anal discharge and itching, weight loss, urge to defecate, or prolonged straining, digital evacuation.
   b. Red flags: fever, unintended weight loss, sweating, change in bowel habit, fatigue, age more than 50 years.
2. Explore ongoing problems and past medical history: diverticulosis or diverticular bleeding, current pregnancy, diabetes mellitus, hypertension, recent surgical procedures as colonoscopy
3. Family history: Colon cancerr
4. Examination: Per rectum exam for ulcers, cauliflower-like lesions, fissures, Leakage of stool. And abdominal examination

Management

Management and education (share deferential diagnosis):

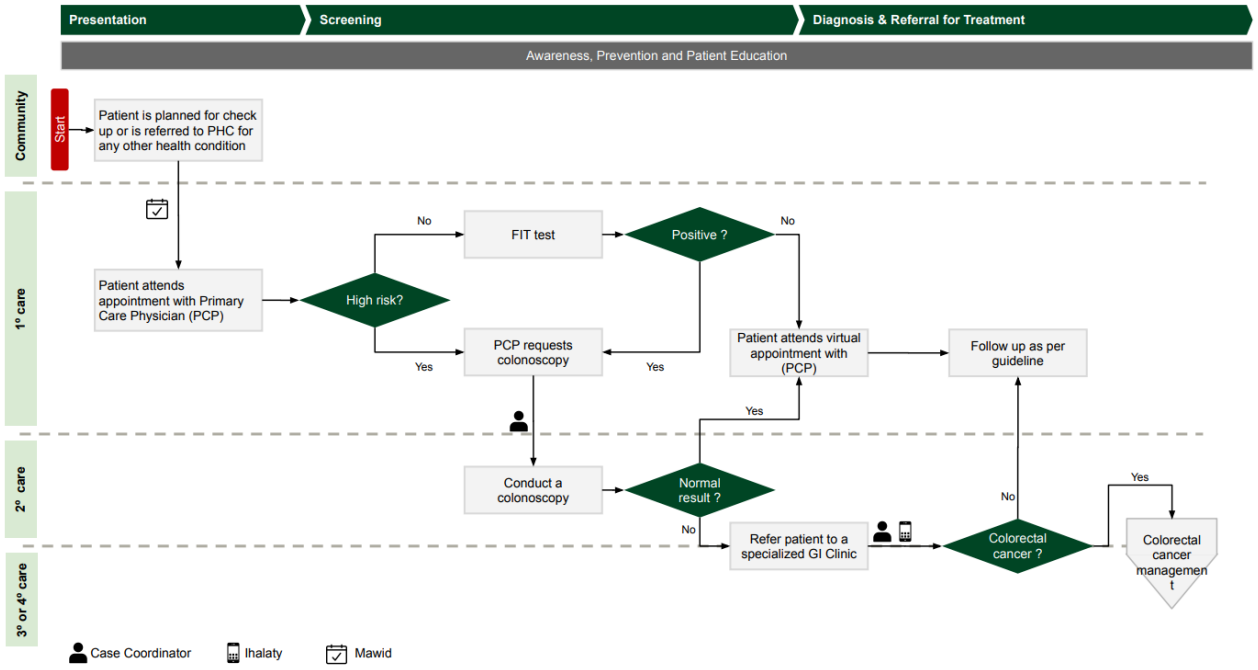
a. Constipation: high-fiber diet, exercise (especially walking), increased water intake and stool softeners (lactulose or polyethylene glycol).
b. Hemorrhoids: Common, knobby varicose veins of the rectal or anal area, which can prolapse outside the anus and hang as small grape-like lumps. Caused mostly by constipation, due to excessive straining. Managed by:
   - Rubber band ligation if grades 1 and 2.
   - Rubber band ligation, excisional or stapled hemorrhoidopexy for grade 3.
   - Excisional or stapled hemorrhoidectomy for grade 4.
   - All grade pain: Combined topical nifedipine and lidocaine cream is more effective than plain xylocaine cream.
   - Cryotherapy, sclerotherapy, and anal dilatation are less effective.
c. Anal Fissure" :A crack or tear at the margin of the anus that extends from the skin into the soft lining of the anus. It can affect all ages and tends to occur in women and infants. The tear, which is generally small, usually develops after stretching of the anus from passing a hard, large stool. It is associated with constipation, multiple pregnancies and Crohn's disease. Anal intercourse increases the likelihood of a fissure. Adults usually recover in about 4 weeks, especially if the fissure is small. More severe cases may not heal without the benefit of a small operation".
   - Management: treat constipation if any, sit bath, analgesics (aspirin, paracetamol), soothing creams (zinc oxide, petroleum jelly, local anesthesia), botulinum toxin injection into the sphincter, or surgical repair.
d. Diverticular bleeding" :Diverticular disease (also called diverticulosis) is the presence of small blind sacs or pouches called diverticula in the wall of your large bowel (colon). It is related to a lack of fiber in your diet. It rarely causes symptoms and most people have it without knowing. A lack of fiber in the diet can cause you to experience bloating, flatulence (desire to pass wind) and abdominal pains. If infection (diverticulitis) develops, you will experience abdominal pain, usually sharp pain in the lower left half of the abdomen, nausea and fever. These symptoms or any rectal bleeding require prompt attention by your doctor".
e. Colorectal cancer: It's the abnormal growth of large bowel lining.
   Management depends on biopsy and grading.

USPSTF Recommendations Summary:

What does the USPSTF recommend?	**For adults aged 50 to 75 years:** **Screen** all adults aged 50 to 75 years for colorectal cancer. **Grade A**
	For adults aged 45 to 49 years: **Screen** adults aged 45 to 49 years for colorectal cancer. **Grade B**
	For adults aged 76 to 85 years: **Selectively screen** adults aged 76 to 85 years for colorectal cancer, considering the patient's overall health, prior screening history, and patient's preferences. **Grade C**
To whom does this recommendation apply?	Adults 45 years or older who do not have signs or symptoms of colorectal cancer and who are at average risk for colorectal cancer (ie, no prior diagnosis of colorectal cancer, adenomatous polyps, or inflammatory bowel disease; no personal diagnosis or family history of known genetic disorders that predispose them to a high lifetime risk of colorectal cancer [such as Lynch syndrome or familial adenomatous polyposis]).
What's new?	The USPSTF expanded the recommended ages for colorectal cancer screening to 45 to 75 years (previously, it was 50 to 75 years). The USPSTF continues to recommend selectively screening adults aged 76 to 85 years for colorectal cancer.
How to implement this recommendation?	**Screen all adults aged 45 to 75 years** for colorectal cancer. Several recommended screening tests are available. Clinicians and patients may consider a variety of factors in deciding which test may be best for each person. For example, the tests require different frequencies of screening, location of screening (home or office), methods of screening (stool-based or direct visualization), preprocedure bowel preparation, anesthesia or sedation during the test, and follow-up procedures for abnormal findings. Recommended screening strategies include • High-sensitivity guaiac fecal occult blood test (HSgFOBT) or fecal immunochemical test (FIT) every year • Stool DNA-FIT every 1 to 3 years • Computed tomography colonography every 5 years • Flexible sigmoidoscopy every 5 years • Flexible sigmoidoscopy every 10 years + annual FIT • Colonoscopy screening every 10 years **Selectively screen adults aged 76 to 85 years for colorectal cancer.** • Discuss together with patients the decision to screen, taking into consideration the patient's overall health status (life expectancy, comorbid conditions), prior screening history, and preferences.
What are other relevant USPSTF recommendations?	The USPSTF has made a recommendation statement on aspirin use to prevent cardiovascular disease and colorectal cancer available at https://www.uspreventiveservicestaskforce.org
Where to read the full recommendation statement?	Visit the USPSTF website (https://www.uspreventiveservicestaskforce.org) to read the full recommendation statement. This includes more details on the rationale of the recommendation, including benefits and harms; supporting evidence; and recommendations of others.

The USPSTF recognizes that clinical decisions involve more considerations than evidence alone. Clinicians should understand the evidence but individualize decision-making to the specific patient or situation.

R3 Colorectal CA Screening Pathway:



APPROVL			
	Name:	**Position:**	**Signature:**
Prepared By:	Dr. Hajar Al Suma	FM Consultant	
Reviewed and Approved By:	Dr. Mansoor Allajhar Dr. Musa Althwayee Dr. Ahmed Al Zahrani Dr. Hajar Al Suma Dr. Ahlam Al Harbi	FM Consultants	

Adopted from;

Saudi MOH Guidelines

USPSTF