UCLA MEDICAL GROUP / UCLA Santa Monica Bay Physicians – Managed Care Operations		UCLA Health
DEPARTMENT:	Utilization Management	POLICY NUMBER: **TBD**
SECTION:	UM Program	
TITLE:	**Colorectal Cancer Screening Guideline**	ISSUE: EFFECTIVE:
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The UCLA Medical Group recommends routine screening for colorectal cancer in males and females ages 45 through 80, screening at younger ages if sufficient risk factors are present, and generally stopping routine screening after age 80.*

> ***The USPSTF found*** that the evidence is convincing that screening for colorectal cancer with fecal occult blood testing (including fecal immunochemical test (FIT)), sigmoidoscopy, or colonoscopy detects early-stage cancer and adenomatous polyps.
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> The USPSTF concluded that the evidence is insufficient to assess the benefits and harms of computed tomographic colonography and fecal DNA testing as screening modalities for colorectal cancer.
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> The relative sensitivity and specificity of the different colorectal screening tests with adequate data to assess cancer detection—colonoscopy, flexible sigmoidoscopy, and fecal tests—can be depicted as follows:
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> Sensitivity: Hemoccult tests ≤ Fecal Immunochemical Test (FIT) colonoscopy and flexible sigmoidoscopy < FIT = colonoscopy.
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> Specificity: Hemoccult tests < Fecal Immunochemical Test (FIT) < flexible sigmoidoscopy = colonoscopy
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> Fecal DNA testing (Cologuard) has been approved by the FDA but is not yet recommended by USPSTF. It can be considered for those patients refusing endoscopic screening.
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> Because several screening strategies have similar efficacy, efforts to reduce colon cancer deaths should focus on implementation of strategies that maximize the number of individuals who get screening of some type. The different options for colorectal cancer screening tests are variably acceptable to patients; eliciting patient preferences is one-step in improving adherence.

Acceptable strategies for screening standard and intermediate risk patients (depending upon patient preference) include, in order of recommendation:

1. Colonoscopy every 10 years (this is the preferred method for both prevention and detection).
2. Yearly fecal occult blood testing with Fecal Immunochemical Test (FIT); if positive then colonoscopy.
3. Flexible sigmoidoscopy every 5 years (with annual FIT recommended by some guidelines); if positive then colonoscopy.

- **In patients previously screened with sigmoidoscopy with or without fecal occult blood testing, colonoscopy is initiated 5 years following the last negative sigmoidoscopy.**

- **In low risk patients previously screened with colonoscopy who subsequently elect to have annual fecal occult blood testing, the FIT tests should commence 10 years following the last negative colonoscopy (or in the case of sigmoidoscopy, 5 years following the last negative sigmoidoscopy).**

Based on current scientific evidence virtual colonoscopy is not an appropriate first line screening method at this point and time. *

* All virtual colonoscopies must be ordered by a gastroenterologist (or other physician with optical colonoscopy privileges).

*The USPSTF (the 2016 update to the 2008 recommendations) suggested that routine screening stop at age 75, and not be done after age 85, and only be done between 76 and 85 based upon patient factors.

The following grid outlines the use of colonoscopy when used as a screening exam in patients with or without risk factors:

Indicator or Risk Factor	When to initiate	Findings & Procedure Interval	Comments
STANDARD OR INTERMEDIATE RISK			
Patient age 45 and above with no other risk factors*****	Age 45 and above***** Colonoscopy or annual FIT. With prior Sigmoidoscopy, start 5 or more years since last negative exam.	If negative or hyperplastic pathology, Q 10 years with colonoscopy or annually with FIT.	If colonoscopy performed then Subsequent, annual FIT is not recommended. Consider alternative screening methods if warranted or if by patient choice.
HIGH RISK			
Two first degree relatives (regardless of age at diagnosis) with colon cancer	Age 40 or 10 years before index case	If negative, Q 5 years	Colonoscopy is recommended screening test.
One first degree relative with either colon cancer or adenomatous polyps (following NCCP guidelines, age of index<60 is not required)	Age 40 or 10 years before index case	If negative, Q 5 years	Colonoscopy is recommended screening test.
Colon *adenoma* on recent *flexible sigmoidoscopy*	Colonoscopy at the time of diagnosis	See *adenoma*	
Previously removed colon *adenoma** see below*			

* 1 – 2 adenomas < 1 cm without advanced histology (e.g.villous features or sessile)	repeat colonoscopy in 5years		2021 guidelines state that the interval may vary from 3 years to 7 years based on colonoscopy findings
* Any adenomas > 1cm , 3 or more adenomas or any one withvillous features or sessile.	Repeat colonoscopy in 3years		
Colon *carcinoma* (personalhistory)	Colonoscopy at the time ofdiagnosis	Colonoscopy one year after initial diagnosis. If results are negative will repeat colonoscopy at the thirdand fifth year.	If negative after 5 years, thenQ 5 years
Ulcerative Colitis (Pan)	Colonoscopy after 8 yearsof disease	Colonoscopy Q 1-2 years	Frequency depends uponclinical issues
Ulcerative Colitis (Left sideonly)	Colonoscopy after 15years of disease	Colonoscopy Q 1-2 years	As Above
Familial Polyposis Syndrome	Colonoscopy before age 20	Colonoscopy Q 1-2 years	As Above
Non-polyposis colorectal cancer syndrome	Colonoscopy age 25 or 10 years before index case	Colonoscopy Q 2 years	As above

American College of Gastroenterology recommends:

http://gi.org/guideline/colorectal-cancer-screening/

Preferred CRC prevention test: colonoscopy every 10 years (Grade 1 B)

The ACG recommends that quality colonoscopy be offered to patients. In clinical settings, in which economic issues preclude primary screening with colonoscopy, or for patients who decline colonoscopy, one of the alternative cancer prevention tests or the preferred cancer detection test, occult blood detection through the FIT should be offered.

Preferred cancer detection test: annual FIT (Grade 1 B)

The preferred cancer detection test is annual FIT. This test has superior performance characteristics when compared with older guaic-based Hemoccult II cards; additionally, there were 10 and 12% gains in adherence with the FIT inthe first two randomized controlled trials comparing the FIT with guaiac-based testing. The overall result of superior performance and improved adherence was a doubling in the detection of advanced lesions, with little lossof positive predictive value. The ACG supports the joint guideline recommendation that older guaiac-based fecal occult blood testing be abandoned as a method of CRC screening. Because of more extensive data (compared withHemoccult Sensa), and the high cost of fecal DNA testing, the ACG recommends the FIT as the preferred cancer detection test.

<u>Age to begin screening in average-risk persons:</u>

The ACG recommends that screening begin at age 45 years in average-risk persons (i.e. those without a family history of colorectal neoplasia) (Grade 1 B). UCLA recommends screening consistent with USPSTF and AGA, and recommends screening be offered to patients starting at age 45.

Note: A "Negative" finding on colonoscopy means either no findings or hyperplastic pathology, as a hyperplastic polyp is not a risk factor for the development of colorectal cancer

The Banff Consensus Statement (CAG/AGA), the National Comprehensive Cancer Network (NCCN) and the U.S. Multi-Society Task Force on colorectal cancer (US-MSTF) provide recommendations on screening which were used to develop these guidelines. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7302941/

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Note: Routine screening is generally stopped after age 75- 80. There are exceptions based on overall health status or prior history e.g. there are some 80 year olds who have at least 10 more years of life expectancy or who have had multiple polyps in the past.

Based upon UCLA Medical Group/UCLA Healthcare colonoscopy guidelines as approved 1/5/00, American Cancer Society Guidelines January 2002, USPSTF May 2021, Literature Review, ACG website referenced 06/03/2021.

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