

Colorectal Cancer Screening and Prevention 2010

Historically, one of every 17 Americans would be expected to get colon or rectal cancer and most died from it. Thankfully, due to earlier detection and improved treatments, colorectal cancer (CRC) is now much less often a fatal diagnosis. 90% of these cancers are cured if caught early!

The actual incidence of CRC also seems to be decreasing. To a large degree, this is attributable to screening exams. Although they are advertised as “screening for colorectal cancer”, I want to emphasize the importance of actual cancer prevention when pre-cancerous tumors (polyps) are removed at the time of colonoscopy via polypectomy.

Sigmoidoscopy is an office exam which examines the rectum and lower part of the colon and usually does not allow for polyp removal. Stool tests to detect hidden bleeding or abnormal DNA remain frequently inaccurate and are designed to detect an already established colon cancer. If these tests are abnormal, a colonoscopy is indicated. Should a cancer be found, surgery is usually needed for its removal. Chemotherapy and radiation may also then be needed if the cancer has spread.

Barium enema x-rays and CT scan colonography (“virtual colonoscopy”) require thorough bowel cleansing like a colonoscopy, but are not as accurate detecting smaller pre-cancerous polyps. Any suspected abnormality requires a “real” colonoscopy (with a second bowel prep!) for clarification, biopsy or polypectomy.

Only traditional colonoscopy offers a combined diagnostic and therapeutic strategy – a “one stop shopping”, “search and destroy mission” if you will. I like to describe colonoscopy as “preventive maintenance”.

Although early studies suggested up to 90% of colorectal cancer could be prevented by removing polyps, more recent studies have tempered that initial enthusiasm. Apparently, some polyps in the right side of the colon either escape

detection or some cancers in that location develop differently, not from a classic benign polyp. There's been renewed emphasis on both the quality of patient bowel prep and the technical skills of the physician performing the colonoscopy. No test in medicine is perfect. Nonetheless, colonoscopy remains our most sensitive tool, offering a strategy for both early detection and prevention.

I'm pleased that internal quality reviews show that our group exceeds the published national standards with regard to achieving a complete examination of the entire colon and detecting and removing polyps with complications far below national rates.

The American College of Gastroenterology's most recent recommendations are:

- a) Colonoscopy starting at age 45 for African Americans (who have a higher risk of earlier polyps and cancers) and at age 50 for others at average risk. Repeat within 10 years if negative (based on quality of prep and exam details).
- b) With a family history, start at least 10 years earlier than a close relative's cancer or polyp was detected. Repeat every 5 years if negative.
- d) Patients with significant polyps need more frequent examinations.
- e) Patients with familial cancer syndromes and inflammatory bowel disease need even more aggressive screening.
- f) Screening after age 75 is based on individual circumstances.

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