

American Cancer Society Screening Recommendations for Colon and Rectum Cancer

Beginning at age 50, men and women at average risk should follow one of the examination schedules below:

Tests that find polyps and cancer

- Flexible sigmoidoscopy**, or
- Colonoscopy, or
- Double-contrast barium enema (DCBE)**, or
- CT colonography (virtual colonoscopy)**

When to get one

- Every five years, starting at age 50
- Every 10 years, starting at age 50
- Every five years, starting at age 50
- Every five years, starting at age 50

Tests that mainly find cancer

- Fecal occult blood test (FOBT)*, ** with at least 50% test sensitivity for cancer, or
- Fecal immunochemical test (FIT)*, ** with at least 50% test sensitivity for cancer, or
- Stool DNA test (sDNA)***

When to get one

- Annually, starting at age 50
- Annually, starting at age 50
- Interval uncertain, starting at age 50

*For FOBT or FIT used as a screening test, the take-home multiple sample method should be used. An FOBT or FIT done during a digital rectal exam in the doctor's office is not adequate for screening.

**Colonoscopy should be done if test results are positive.

*** The stool DNA test approved for colorectal cancer screening in 2008 is no longer commercially available. New stool DNA tests are presently undergoing evaluation and may become available at some future date.

Colorectal Cancer in Minnesota



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Colon and Rectum Cancer

Colon cancer is cancer of the large intestine (colon), the lower part of the digestive system. Rectal cancer is cancer of the last several inches of the colon. Together, they are often referred to as colorectal cancer.

Trends in Colorectal Cancer Incidence and Mortality

Colorectal cancer is the third most commonly diagnosed cancer among men and women in Minnesota. From 2005-2009, an average of 2,440 cases of colorectal cancer were diagnosed and 825 deaths occurred each year. Minnesota incidence and mortality rates were slightly lower than national rates.

During this same time period, colorectal cancer was the second leading cause of cancer-related death in Minnesota. About 42% of colorectal cancers in Minnesota are diagnosed at the localized stage, before having spread to adjacent tissues or distant organs. Surveillance, Epidemiology, and End Results (SEER) program cases diagnosed at the localized stage from 2002-2008 had a five-year relative survival rate of 90%.

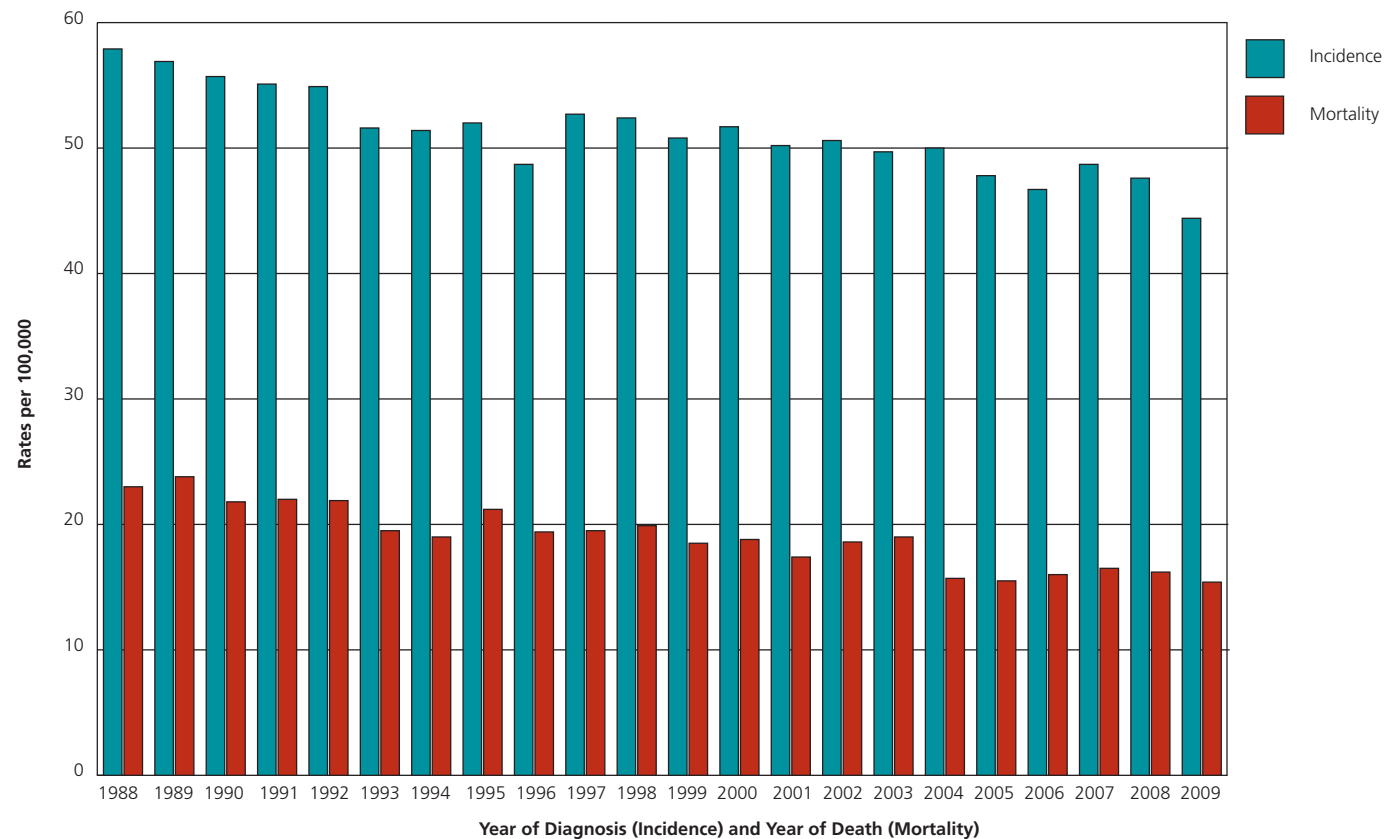
Colorectal cancer rates have declined sharply over the past two decades both in Minnesota and nationally. Research indicates the declines may be due, in part, to increased screening and polyp removal, which may prevent the progression of polyps to invasive cancers. Other factors, such as the use of hormone replacement therapy among women and the use of aspirin to prevent heart disease, may reduce the risk of colorectal cancer.

Demographics of Colorectal Cancer

During the five-year period from 2005-2009, about 65% of colorectal cancer diagnoses and 75% of deaths occurred among adults 65 years of age and older. Colorectal cancer rates were about 30% higher among men than women. In Minnesota, American Indians had the highest incidence and mortality rates of colorectal cancer from 2005-2009, about 80% higher than non-Hispanic whites and African Americans. Among American Indians, colorectal cancer rates in Minnesota were two times higher compared to the US as a whole.

In general, the rate of late-stage disease should decline as colorectal cancer screening becomes more widely adopted. During the five-year period from 2005-2009, the rate of late-stage colorectal cancer was significantly higher in the Fairmont, Fergus Falls, and Owatonna micropolitan areas when compared to the state as a whole, and significantly lower in the Minneapolis-St. Paul-Bloomington metropolitan area.

Colorectal Cancer Incidence and Mortality, Minnesota, 1988-2009



Source: Minnesota Cancer Surveillance System (MCSS), December 2011 (incidence) and Minnesota Center for Health Statistics (mortality), with Vintage 2009 population estimates. All analyses were conducted by MCSS. Cases were microscopically confirmed (1988+) or death certificate only (1995+). Rates are age-adjusted to the 2000 US population.

Risk Factors

The risk of colorectal cancer increases with age; 90% of cases are diagnosed in people 50 years of age and older. A personal or family history of colorectal cancer, adenomatous polyposis coli, or inflammatory bowel disease increases the risk of colorectal cancer. Modifiable risk factors also include obesity, physical inactivity, alcohol consumption, tobacco, diets high in red meat/processed meats, and diets low in fruits and vegetables. Studies suggest that estrogen and progestin hormone therapy and nonsteroidal anti-inflammatory drugs, such as aspirin, may also reduce colorectal cancer risk.

Early Detection/Prevention

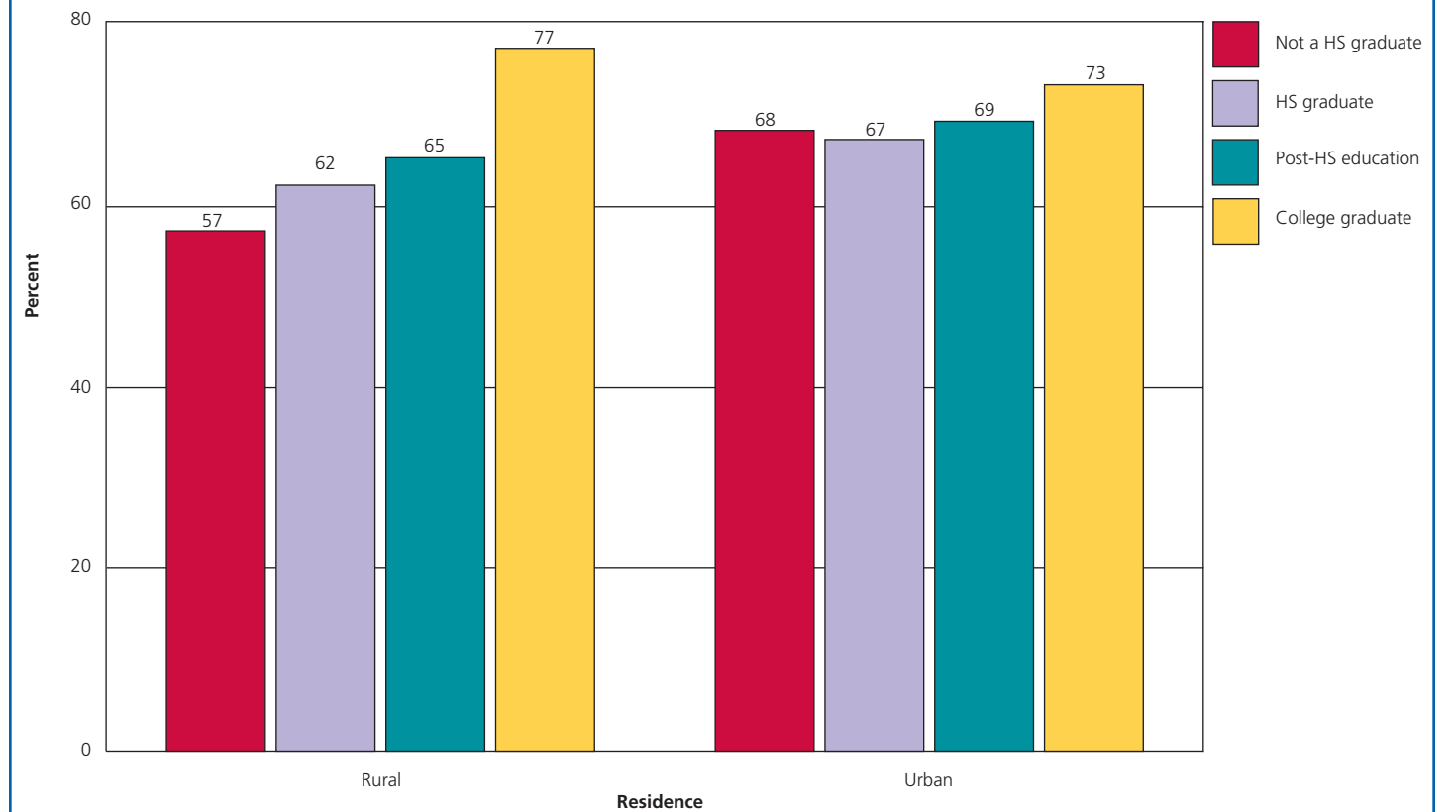
Many colorectal cancers could be prevented through screening. For asymptomatic adults at average risk, it is recommended to begin screening at age 50 with one of several options. In 2008, the American Cancer Society updated its screening guidelines to separate the available tests into those that can prevent colorectal cancer by finding precancerous polyps (sigmoidoscopy, colonoscopy, colonography, and double-contrast barium enema), and those whose primary benefit is finding cancer at an earlier stage (fecal occult blood test, fecal immunochemical

test, and stool DNA test). The Society also recommends screening tests that can find precancerous polyps if these tests are available and people are willing to have a more invasive test at longer intervals.

American Cancer Society Recommendations for the Prevention of Colorectal Cancer

There is broad consensus that adults age 50 and older should be screened for colorectal cancer, even if they have no symptoms. A number of effective tests have been developed to screen for this cancer. They differ in the extent of preparation, test performance, limitations, frequency, and cost. These tests are divided into those whose effectiveness is limited to finding presymptomatic cancer, and those that can prevent cancer by finding polyps (and finding cancers at a presymptomatic stage). Finding and removing polyps can prevent colorectal cancer. These small tissue growths are the precursors of cancer and can be removed on an outpatient basis, usually during a colonoscopy, thus preventing the cancer from forming.

Colorectal Screening among Minnesotans Ages 50 and Older by Education and Residence, 2008



Percent of Adults Up to Date*. Source: Minnesota Behavioral Risk Factor Surveillance System (BRFSS). Analyses were conducted by the Minnesota Cancer Surveillance System (MCSS). *Up to Date means FOBT in the past year, sigmoidoscopy within 5 years, or colonoscopy within 10 years. HS is high school. Urban residents live in one of the 21 counties designated as "metropolitan" by the Census Bureau in 2005.