Have you considered getting screening for Colon Cancer?

March is a Colo-rectal Cancer Awareness Month

History of Cancer in the USA:

As per the American Cancer Society – New cancer cases projected in 2024 are more than 2 million for 1st time ever

Over the last 30 years, the risk of dying from cancer has steadily declined, sparing some 4 million lives in the United States. This downward trend can partially be explained by big wins in smoking cessation, early cancer detection, and treatment advancements.

Cancer incidence, however, is on the rise for many common cancers. In the coming year, there is an expectation to hit a bleak milestone—the 1st time new cases of cancer in the US are expected to cross the 2-million mark. That's almost 5,500 cancer diagnoses a day.

This trend is largely affected by the aging and growth of the population and by a rise in diagnoses of 6 of the 10 most common cancers—breast, prostate, endometrial, pancreatic, kidney, and melanoma. (The other 4 top 10 cancers are lung, colon and rectum, bladder, and non-Hodgkin lymphoma.)

In 2024, over 611,000 deaths from cancer are projected for the US. That's more than 1,600 deaths from cancer each day.

Colorectal cancer is the third leading cause of cancer death for both men and women, with an estimated 53,000 persons in the US projected to die of colorectal cancer in 2024. Colorectal cancer is most frequently diagnosed among persons aged 65 to 74 years. It is estimated that 10.5% of new colorectal cancer cases occur in persons younger than 50 years. Incidence of colorectal cancer (specifically adenocarcinoma) in adults aged 40 to 49 years has increased by almost 15% from 2000-2002 to 2014-2016. In 2016, 25.6% of eligible adults in the US had never been screened for colorectal cancer and in 2018, 31.2% were not up to date with screening.

To update its 2016 recommendation, the US Preventive Services Task Force (USPSTF) commissioned a systematic review to evaluate the benefits and harms of screening for colorectal cancer in adults 40 years or older. The review also examined whether these findings varied by age, sex, or race/ethnicity. In addition, as in 2016, the USPSTF commissioned a report from the Cancer Intervention and Surveillance Modeling Network Colorectal Cancer Working

Group to provide information from comparative modeling on how estimated life-years gained, colorectal cancer cases averted, and colorectal cancer deaths averted vary by different starting and stopping ages for various screening strategies. Asymptomatic adults 45 years or older at average risk of colorectal cancer (i.e., 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]).

The USPSTF concludes with high certainty that screening for colorectal cancer in adults aged 50 to 75 years has substantial net benefit. The USPSTF concludes with moderate certainty that screening for colorectal cancer in adults aged 45 to 49 years has moderate net benefit. The USPSTF concludes with moderate certainty that screening for colorectal cancer in adults aged 76 to 85 years who have been previously screened has small net benefit. Adults who have never been screened for colorectal cancer are more likely to benefit.

The United States Preventive Task Force – USPTF recommends screening all adults aged 45 to 75 years for colorectal cancer. Adults 45 years and older who do not have signs or symptoms of colorectal cancer and who are at average risk for colorectal cancer (i.e., 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]). 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.

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

Colorectal Cancer: Facts

Risk Factors You Can Control

Try to avoid eating a lot of red or processed meats, or those cooked at high temperatures. Obesity (having too much fat around the waist), Not exercising enough, Smoking and Heavy alcohol use.

What Are the Symptoms?

- Colorectal cancer doesn't have early warning signs, so it's important to get checked. Finding it early means it's more curable. As the disease gets worse, you may see blood in your stool or have pain in your belly, bathroom-related troubles like constipation or diarrhea, unexplained weight loss, or fatigue. By the time these symptoms appear, tumors tend to be bigger and harder to treat.

Tests That Find Colorectal Cancer

- Screening tests are key to an early diagnosis. Most people should have a colonoscopy every 10 years once they turn 45. This test uses a tube with a tiny camera to look at the whole colon and rectum. It can help prevent colorectal cancer by finding tumors early. Your doctor will then remove the polyps.

Virtual Colonoscopy

- This uses a CT scan to show a 3-D model of your colon. The test can show polyps or other problems without placing a camera inside your body. The main disadvantages are the test can miss small polyps, and if your doctor does find some, you'll still need a real colonoscopy. Your doctor may suggest a virtual colonoscopy once every 5 years.

Barium Enema

- These X-rays give your doctor a glimpse at the inside of your colon and rectum. It's another way to find polyps, tumors, or other changes in your intestines.
- Like in a virtual colonoscopy, doctors follow up on any unusual signs with a regular colonoscopy. Your doctor may suggest you have a barium enema once every 5 years.

Flexible Sigmoidoscopy

- Your doctor may recommend this test instead of a colonoscopy. He or she will use a slender tube to look inside your rectum and the bottom part of your colon. The tube has a light and a camera, and it shows polyps and cancer. If your doctor says this is the right test for you, you should get one every 5 years.

Fecal Blood Tests

- The fecal occult blood test and fecal immunochemical test can show whether you have blood in your stool, which can be a sign of cancer. You give two or three small samples of

your stool to the doctor to study. Doctors typically recommend these tests every year. If your samples show signs of blood, you may need a colonoscopy.

Home Choice: DNA Test

- A new test called Cologuard looks for blood or suspicious DNA in your stool sample. The test is very accurate at finding colon cancer, but if it does, you still need to follow up with a colonoscopy.
- Cologuard can't take the place of that exam. The American Cancer Society recommends getting a stool DNA test every 3 years.

The Right Diagnosis

- If a test shows a possible tumor, the next step is a biopsy. During the colonoscopy, your doctor takes out polyps and gets tissue samples from any parts of the colon that look suspicious. Experts study the tissue under a microscope to see whether or not it is cancerous. Shown here is a color-enhanced, magnified view of colon cancer cells.

The Stages of Colorectal Cancer

Experts "stage" any cancers they find -- a process to see how far the disease has spread. Higher stages mean you have a more serious case of cancer. Tumor size doesn't always make a difference. Staging also helps your doctor decide what type of treatment you get.

- Stage 0: Cancer is in the innermost lining of the colon or rectum.
- Stage I: The disease has grown into the muscle layer of the colon or rectum.
- Stage II: Cancer has grown into or through the outermost layer of the colon or rectum.
- Stage III: It has spread to one or more lymph nodes in the area.
- Stage IV: It has spread to other parts of the body, such as the liver, lungs, or bones.

Survival Rates

- The outlook for your recovery depends on the stage of your cancer. You might hear your doctor talk about the "5-year survival rate." That means the percentage of people who live 5 years or more after they're diagnosed. Stage I has a 5-year survival rate of 87% to 92%. But remember that those stats can't predict what will happen for everyone. Many things can affect your outlook with colorectal cancer, so ask your doctor what those numbers mean for you.

Can Surgery Help?

- Surgery has a very high cure rate in the early stages of colorectal cancer. In all but the last stage, doctors remove the tumors and surrounding tissue. If they are big, your doctor

may need to take out an entire piece of your colon or rectum. If the disease affects your liver, lungs, or other organs, surgery probably won't cure you. But it may help ease your symptoms.

Fighting Advanced Cancer

- Colorectal cancer can still sometimes be cured even if it has spread to your lymph nodes (stage III). Treatment typically involves surgery and chemotherapy. Radiation therapy (shown here) is an option in some cases. If the disease comes back or spreads to other organs, it will probably be harder to cure. But radiation and chemotherapy may still ease your symptoms and help you live longer.

Will Chemo Make Me Feel Bad?

- Newer chemotherapy drugs are less likely to make you sick. There are also medicines that can help you control your nausea.

Radiofrequency Ablation (RFA)

- This treatment uses intense heat to burn away tumors. Guided by a CT scan, a doctor inserts a needle-like device into a tumor and the surrounding area. The procedure can destroy some tumors that can't be surgically removed, like in the liver. Chemotherapy can work with RFA.

Prevent Colorectal Cancer with Healthy Habits

- You can take steps to dramatically lower your odds of getting the disease. Eat a nutritious diet, get enough exercise, and control your body fat. Those habits prevent 45% of colorectal cancers.
- The American Cancer Society recommends a diet heavy on fruits and vegetables, light on processed and red meat, and with whole grains instead of refined grains. That will help you keep a healthy weight.

Prevent Cancer with Exercise

- Adults who stay active seem to have a powerful weapon against colorectal cancer. In one study, the most active people were 24% less likely to have the disease than the least active. It didn't matter whether what they did was work or play.
- The American Cancer Society recommends getting 150 minutes per week of moderate exercise, like brisk walking, or 75 minutes per week of vigorous exercise, like jogging. Try to spread your activity throughout the week.

Below is the Guidelines from the United States Preventive Services Task Force – USPSTF, American Cancer Society and American Gastroenterology Association:

Colorectal Screening Guidelines: Increased Risk and High Risk

Increased Risk: Patients with History of Polyps at Prior Colonoscopy

Risk Category	Age to Begin	Recommendation/Comment
Patients with small rectal hyperplastic polyps	Same as those with average risk	**Colonoscopy or other screening options** at same regular intervals as for those at average risk. Those with hyperplastic polyposis syndrome are at increased risk for adenomatous polyps and cancer, and should have more intensive follow-up.
People with 1 or 2 small (≤1 cm) tubular adenomas with low-grade dysplasia	5–10 years after the polyps are removed	**Colonoscopy:** Time between tests should be based on other factors such as prior colonoscopy findings, family history, and patient and doctor preferences.
People with 3 to 10 adenomas, or a large (≥1 cm) adenoma, or any adenomas with high-grade dysplasia or villous features	3 years after the polyps are removed	**Colonoscopy:** Adenomas must have been completely removed. If colonoscopy is normal or shows only 1 or 2 small tubular adenomas with low-grade dysplasia, future colonoscopies can be done every 5 years.
People with more than 10 adenomas on a single exam	Within 3 years after the polyps are removed	**Colonoscopy:** Consider possibility of genetic syndrome (such as FAP - Familial adenomatous polyposis or HNPCC - Hereditary non-polyposis colon cancer).
Patients with sessile adenomas that are removed in pieces	2–6 months after adenoma removal	**Colonoscopy:** If entire adenoma has been removed, further testing should be based on physician's judgment.

Increased Risk: Patients with Colorectal Cancer

Risk Category	Age to Begin	Recommendation/Comment
People diagnosed with colon or rectal cancer	At time of colorectal surgery, or can be 3–6 months later if person doesn't have cancer spread that can't be removed	**Colonoscopy** to view entire colon and remove all polyps. If the tumor presses on the colon/rectum and prevents colonoscopy, CT colonoscopy (with IV contrast) or DCBE may be done to look at the rest of the colon.
People who have had colon or rectal cancer removed by surgery	Within 1 year after cancer resection (or 1 year after colonoscopy to make sure the rest of the colon/rectum was clear)	**Colonoscopy:** If normal, repeat exam in 3 years. If normal then, repeat exam every 5 years. Time between tests may be shorter if polyps are found or there is reason to suspect HNPCC. After low anterior resection for rectal cancer, exams of the rectum may be done every 3–6 months for the first 2–3 years to look for signs of recurrence.

Increased Risk: Patients with a family history

Risk Category	Age to Begin	Recommendation/Comment	
Colorectal cancer or adenomatous polyps in any first-degree relative before age 60, or in 2 or more first-degree relatives at any	Age 40, or 10 years before the youngest case in the immediate family, whichever is earlier	**Colonoscopy:** Every 5 years	
Colorectal cancer or adenomatous polyps in any first-degree relative aged 60 or higher, or in at least 2 second-degree relatives at any age	Age 40	**Fecal occult blood test:** 3 times annually.	

Risk Category	Age to Begin	Recommendation/Comment
Familial adenomatous polyposis (FAP) diagnosed by genetic testing, or suspected FAP without genetic testing	Age 10 to 12	**Yearly flexible sigmoidoscopy** to look for signs of FAP. Provide counseling to consider genetic testing if it hasn't been done. If genetic test is positive, removal of colon (colectomy) should be considered.
Hereditary non-polyposis colon cancer (HNPCC), or increased risk of HNPCC based on family history without genetic testing	Age 20 to 25, or 10 years before the youngest case in the immediate family	**Colonoscopy** every 1–2 years; counseling to consider genetic testing if it hasn't been done. Genetic testing should be offered to first-degree relatives of people found by genetic tests to have HNPCC mutations. It should also be offered if 1 of the first 3 of the modified Bethesda criteria[1] is met.
Inflammatory bowel disease: • Chronic ulcerative colitis • Crohn's disease	Cancer risk begins to be significant 8 years after the onset of pancolitis (involvement of entire large intestine), or 12–15 years after the onset of left-sided colitis	**Colonoscopy** every 1–2 years with biopsies for dysplasia. These patients are best referred to a center with experience in the surveillance and management of inflammatory bowel disease.

Courtesy, Credit & Resources: US Preventive Services Task Force – USPSTF, JAMA & American Cancer Society
https://www.uspreventiveservicestaskforce.org/home/getfilebytoken/2Wc3FRHpVDPX2jT_WzjEXX

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