

Healthy North Carolina 2020  
**EVIDENCE BASED STRATEGIES**

<b>FOCUS AREA</b>	Chronic Disease
<b>OBJECTIVE</b>	3. Reduce the colorectal cancer rate

<b>EBS PROGRAM DESCRIPTION</b>	Routine colorectal cancer screening is now recommended in adults beginning at age 50 and continuing only until age 75 (in people with adequate screening histories). The following screening modalities are recommended: high-sensitivity FOBT, sigmoidoscopy with interval FOBT, or colonoscopy.
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<b>EBS LEVEL</b> <i>CDC Ranking</i>	B = Best/Proven
<b>REFERENCE/CITATION</b> <i>Data Supporting Level/Ranking</i>	The USPSTF recommends screening for colorectal cancer using fecal occult blood testing, sigmoidoscopy, or colonoscopy in adults, beginning at age 50 years and continuing until age 75. The risks and benefits of these screening methods vary. Grade: A recommendation.

<b>PROGRAM ATTRIBUTES</b>																	
Influence Level	<b>ALL</b> -Individual Relationship Community Multi-Level																
Target Population	Adults 50-75 For men, colorectal cancer is the third most common cancer and cause of cancer death. Highest rates of late-stage diagnosis by race/ethnicity – Colorectal cancer: African-American men and women Source: MMWR. 2010; 59(SS09);1-25.  African-American men are more likely than others to be diagnosed and to die from colorectal cancer. Source: U.S. Cancer Statistics Working Group. <i>United States Cancer Statistics: 1999–2008 Incidence and Mortality Web-based Report</i> . Atlanta: U.S. DHHS, CDC and NCI; 2012. Available at <a href="http://www.cdc.gov/uscs">www.cdc.gov/uscs</a> . Accessed 8/15/2012.																
Intervention Setting	Health Departments, physicians' office, participant's home, community, etc.																
Key Measures	<p><b>Screening for Colorectal Cancer</b>  <b>Clinical Summary of U.S. Preventive Services Task Force Recommendation</b></p> <table border="1"> <thead> <tr> <th>Population</th> <th>Adults Age 50 to 75*</th> <th>Adults Age 76 to 85*</th> <th>Older than 85*</th> </tr> </thead> <tbody> <tr> <td>Recommendation</td> <td>Screen with high sensitivity fecal occult blood testing (FOBT), sigmoidoscopy, or colonoscopy. Grade: A</td> <td>Do not screen routinely Grade: C</td> <td>Do not screen Grade: D</td> </tr> <tr> <td colspan="4">For all populations, evidence is insufficient to assess the benefits and harms of screening with computerized tomography colonography (CTC) and fecal DNA testing. Grade: I (insufficient evidence)</td> </tr> <tr> <td>Screening Tests</td> <td colspan="3">High sensitivity FOBT, sigmoidoscopy with FOBT, and colonoscopy are effective in decreasing colorectal cancer mortality. The risks and benefits of these screening methods vary. Colonoscopy and flexible sigmoidoscopy (to a lesser degree) entail possible serious complications.</td> </tr> </tbody> </table>	Population	Adults Age 50 to 75*	Adults Age 76 to 85*	Older than 85*	Recommendation	Screen with high sensitivity fecal occult blood testing (FOBT), sigmoidoscopy, or colonoscopy. Grade: A	Do not screen routinely Grade: C	Do not screen Grade: D	For all populations, evidence is insufficient to assess the benefits and harms of screening with computerized tomography colonography (CTC) and fecal DNA testing. Grade: I (insufficient evidence)				Screening Tests	High sensitivity FOBT, sigmoidoscopy with FOBT, and colonoscopy are effective in decreasing colorectal cancer mortality. The risks and benefits of these screening methods vary. Colonoscopy and flexible sigmoidoscopy (to a lesser degree) entail possible serious complications.		
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	Screening Test Intervals	Intervals for recommended screening strategies: <ul style="list-style-type: none"> <li>• Annual screening with high-sensitivity fecal occult blood testing</li> <li>• Sigmoidoscopy every 5 years, with high-sensitivity fecal occult blood testing every 3 years</li> <li>• Screening colonoscopy every 10 years</li> </ul>	
	Balance of Harms and Benefits	The benefits of screening outweigh the potential harms for 50- to 75-year-olds.	The likelihood that detection and early intervention will yield a mortality benefit declines after age 75 because of the long average time between adenoma development and cancer diagnosis.
	Implementation	Focus on strategies that maximize the number of individuals who get screened. Practice shared decision-making; discussions with patients should incorporate information on test quality and availability. Individuals with a personal history of cancer or adenomatous polyps are followed by a surveillance regimen, and screening guidelines are not applicable.	
	<b>Relevant USPSTF Recommendations</b>	The USPSTF recommends against the use of aspirin or nonsteroidal anti-inflammatory drugs for the primary prevention of colorectal cancer. This recommendation is available at <a href="http://www.uspreventiveservicestaskforce.org">www.uspreventiveservicestaskforce.org</a> .	
<p>*These recommendations do not apply to individuals with specific inherited syndromes (Lynch Syndrome or Familial Adenomatous Polyposis) or those with inflammatory bowel disease.</p> <p>For a summary of the evidence systematically reviewed in making these recommendations, the full recommendation statement, and supporting documents, go to <a href="http://www.uspreventiveservicestaskforce.org">www.uspreventiveservicestaskforce.org</a>.</p> <p>Disclaimer: Recommendations made by the USPSTF are independent of the U.S. government. They should not be construed as an official position of the AHRQ or the U.S. DHHS.</p>			
Cost	Cost depends on the procedure and location.		
Time to Implement	<p><u>Organization:</u> for community event screenings-2-3 months planning and implementation</p> <p><u>Patient/Client:</u> visit to clinic, physician or community screening event</p>		
Difficulty to Implement <i>Resource Intensity</i>	Cost to implement depends on screenings, co-pays and providers. High difficulty projects may require a high level of resources (money/staff time/supplies) and/or buy-in from multiple community partners.		
ROI <i>if known</i>	Reduce rates of colorectal cancer		

<b>PROGRAM CONTACT INFORMATION</b>	
Organization	Colon Cancer Alliance
Contact Person	
Email / Telephone	<b>CCA Toll-free Helpline</b> (877) 422-2030 <b>CCA Clinical Trial Matching Service</b> (866) 278-0392
Web Site	<a href="http://www.ccalliance.org/index.html">www.ccalliance.org/index.html</a>

<b>CURRENT NC-DPH SUPPORT</b>	
T.A. – Yes/No Specific group? Other limitations?	Yes-limited to education
T.A. Contact	Kelcy Walker: <a href="mailto:Kelcy.walker@dhhs.nc.gov">Kelcy.walker@dhhs.nc.gov</a> Linda Rohret: <a href="mailto:Linda.rohret@dhhs.nc.gov">Linda.rohret@dhhs.nc.gov</a>
Funding – Yes/No Specific group? Other limitations?	No
Funding Contact	N/A

<b>EBS PROGRAM IMPLEMENTED BY / NC EXAMPLES</b>	
#1 – Organization Name / Contact Information	
#2 – Organization Name / Contact Information	
#3 – Organization Name / Contact Information	

<b>OTHER COMMENTS / NOTES</b>
<p><a href="#">Center for Colon Cancer Research (USC): Toolkits to Promote Colon Cancer Screening and Prevention in Your Community</a></p> <p><a href="#">CDC Colorectal Cancer Demonstration Project</a></p> <p><a href="#">CDC Colorectal Cancer Prevention and Control initiatives</a></p> <p><a href="#">Colon Cancer Alliance</a></p> <p><a href="#">National Colorectal Cancer Roundtable</a></p> <p><a href="#">Public Health Grand Rounds Collaborating to Conquer Colorectal Cancer: Fulfilling the Promise of Prevention, June 2005</a></p> <p><a href="#">Screen for Life</a></p> <p><a href="#">US Preventive Services Task Force Recommendations: Screening for CRC, 2008</a></p>