Summary

The Minimal Clinical Elements for Colorectal Cancer Screening in the Center for Cancer Prevention and Control assure a quality continuum of colorectal cancer care congruent with guidance from the Medical Advisory Committee and from relevant national medical and public health organizations.

Minimal Clinical Elements consist of guidelines for:

A. Screening for Early Detection of Colorectal Polyps and Cancer
   1) Begin screening based on a person’s Colorectal Cancer (CRC) risk category:
      a) Average risk: age 50–75
      b) Age > 75 if provider recommends screening based on comorbidities, longevity and past CRC screening results.
   2) If increased risk, may begin screening earlier than age 50:
      a) Family history of CRC or certain adenomatous polyp(s) in one or more first degree relative(s) under the age of 60 years, or two or more first degree relatives at any age.
         i) A first degree relative is a mother, father, sister, brother, or child of the person.
      b) Family history of genetic syndromes such as familial adenomatous polyposis (FAP) or hereditary non-polyposis colorectal cancer (HNPPC).
      c) Personal history of inflammatory bowel disease (ulcerative colitis, Crohn’s colitis); colorectal cancer; adenomatous polyps; anal cancer, carcinoid, cloacogenic carcinoma, squamous cell cancer of the rectum or other non-adenocarcinomas of colon or rectum; radiation to colon or rectum; or cancer of the ovary or endometrium diagnosed under age 50.

B. Recommended Screening Methods:
   a) Colonoscopy (preferred), every 10 years for an average risk individual who has a negative initial colonoscopy that was considered “adequate” and who remains at average risk; or,
   c) High sensitivity fecal occult blood tests (FOBT or FIT), annually; or,
   d) Flexible sigmoidoscopy, every 5 years combined with high sensitivity FOBT/FIT every 3 years.

<table>
<thead>
<tr>
<th>Test</th>
<th>Fecal Occult Blood Test (FOBT)</th>
<th>Fecal Immunochemical Test (FIT)</th>
<th>Sigmoidoscopy</th>
<th>Colonoscopy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency</td>
<td>Annually</td>
<td>Annually</td>
<td>Every 5 years</td>
<td>Every 10 years</td>
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C. Recall Interval or Surveillance Interval following Screening for Early Detection of Colorectal Polyps and Cancer:

<table>
<thead>
<tr>
<th>Findings on Colonoscopy</th>
<th>Recall Interval/Follow-up</th>
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<tbody>
<tr>
<td>● No adenomatous, serrated, or hyperplastic polyp(s) or findings listed below, and an adequate colonoscopy.</td>
<td>● In 10 years if average risk</td>
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<tr>
<td>➢ inadequate colonoscopy (e.g. cecum not reached or inadequate bowel preparation)</td>
<td>● Shorter interval if family or personal history</td>
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<td>➢ new or change in symptoms</td>
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<tr>
<td>➢ uncertain removal (that is: sessile or flat adenoma(s) that are removed</td>
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D. Additional Recommendations:

a) For new symptoms, change in symptoms, inadequate colonoscopy, or uncertain removal of polyps, a shorter recall interval is recommended.

i. Inadequate colonoscopy is one in which the cecum was not reached or the patient had inadequate bowel preparation (bowel preparation insufficient to visualize polyps > 5mm).

ii. If a provider determines that the colonoscopy is “inadequate,” the provider should determine whether additional procedures are necessary to complete this screening.

b) In-office fecal occult blood testing is not recommended.

c) Five years after the colonoscopy, asking the individual at average risk who had a negative colonoscopy about changes in family history, personal risk history, and symptom history may help determine whether the individual should have a colonoscopy sooner than 10 years.

d) An individual who develops signs or symptoms of CRC should not wait for the next scheduled screening to receive medical evaluation.