

Colorectal Cancer Screening Guidelines Stress 10-Year Checkups



By Ruth Kava — June 22, 2016



Final [recommendations](#) ^[1] from the US Preventive Services

Task Force (USPSTF) for the frequency and type of test to screen for colorectal cancer were recently released.

Colorectal cancer, or CRC, is the second leading cause of cancer death in the United States — the USPSTF estimates this year that about 134,000 people will get a CRC diagnosis, with roughly 49,000 dying from it. But screening has been found to be effective in finding the disease early, and thus the USPSTF has evaluated the data on different types of screening modalities and based its recommendations on those data.

The USPSTF recommends screening for CRC for the general public (average risk, asymptomatic adults) every 10 years, beginning at age 50 and continuing until age 75. The agency labels this as an "A" recommendation — its strongest grade.

The screening modalities they examined included flexible sigmoidoscopy, colonoscopy, and various types of fecal tests. These latter tests (at least the guaiac fecal occult blood test and the FIT) test are recommended annually — they have the advantage of not requiring bowel preparation or anesthesia and can be done at home.

Both colonoscopy and sigmoidoscopy require anesthesia and bowel preparation. These procedures can sometimes cause adverse events such as bowel perforation or bleeding, but these are rare. In the studies reviewed, bowel perforations occurred four times per 10,000 procedures, and significant bleeding 8 times per 10,000. Most of the bleeding was from polyp removal, not from the colonoscopy itself.

Similarly, the rate of perforation from sigmoidoscopy was 1 in 10,000 procedures, while that of major bleeding was 2 in 10,000 procedures.

Overall, the quality of the studies examined for these recommendation were fair to good — for diagnostic accuracy and effectiveness of screening, according to the report's discussion. The studies from which the information on adverse effects were derived were considered only fair.

The authors of the report note that, "Even though its superiority in a program of screening has not been empirically established, colonoscopy remains the criterion standard for assessing the test performance of other CRC screening tests." However, they also acknowledge that there are other viable options for CRC screening, and that further research will clarify the extent to which each is reliable.

They also emphasize that their review focused on adults who were not at greater than average risk of developing CRC, and thus their advice should not be extrapolated to others.

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