Colorectal Cancer Screening

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March has again been designated National Colorectal Cancer Awareness Month. As physicians, we know that colorectal cancer is common, that it can be prevented, and that survival is related to tumor stage at diagnosis. Thus, colorectal cancer fulfills the criteria for a disease in which screening is appropriate. Unfortunately, screening is not being universally performed, even among physicians and their families. Several factors have limited our efforts. Three of the most important are knowledge, compliance, and economics.

From a knowledge standpoint, we must continue to educate patients and colleagues on colorectal cancer. Colorectal cancer is the second most common cause of cancer-related deaths and one of the few truly preventable cancers. The American Cancer Society estimates that we will diagnose 145,200 new cases of colorectal cancer in 2005 and 56,200 patients will die from this disease (1). Prognosis is related to disease stage, and screening identifies precursors of cancer (e.g., polyps), as well as cancer in its early stages (2–4). Winawer and colleagues demonstrated a reduced mortality if adenomatous polyps are removed (5). In addition to saving lives, screening is cost effective (6).

Multiple studies have confirmed that compliance with screening is low for patients and providers. Compliance with fecal occult blood test (FOBT) during controlled trials has ranged from 53–78% (5). In clinical practice, levels of compliance with one-time FOBT are much lower (15%–63%) (5). Motivation is a factor, however, as 81% of patients with a positive FOBT in one study underwent colonoscopy (6). The requirement for bowel cleansing prior to colonoscopy is the most frequent dissatisfier expressed by patients (7). Newer cleansing methods with reduced volumes, combined with stimulates or even pill forms, are helping to minimize this deterrent. The recommendation of a trusted physician remains a major determinant of patient action.

In our cost-conscious environment, we must critically analyze our recommendations. Screening has been shown to be cheaper than treating colorectal cancer if compliance rates are high and the costs of screening tests are reasonable (5).

Current recommendations for screening range from annual FOBT with flexible sigmoidoscopy at 3–5-year intervals to colonoscopy at 10-year intervals, starting at age 50, for average risk individuals. These screening methods have all shown reduced mortality (2–4). As colonoscopy views the entire colon and can treat polyps, it is the preferred method. This has been recognized by Medicare, which began reimbursement for screening colonoscopy as of July 1, 2001.

On a national and local level, multiple efforts are underway to expand colorectal screening. Television programs, radio spots, print articles, and local lectures contribute, but physician encouragement of screening must become a daily component of our patient care. We also need to lead by example and ensure that each of us, as well as our family members at risk, gets screened. Progress is occurring, but each of us needs to continue and increase our efforts to expand screening until it becomes universal. This remains our best current hope to eliminate this major health concern.

Additional information is available from any of Ochsner's colon and rectal surgeons or gastroenterologists. Open access colonoscopies can be scheduled by calling one of the Ochsner endoscopy scheduling nurses at (504) 842-4015.

REFERENCES

1. `American Cancer Society. ACS: Statistics for 2005. http://www.cancer.org/docroot/STT/stt_0_2005.asp?sitearea=STT&level=1. Accessed 8 February 2007.
2. Mandel JS, Bond JH, Church TR, et al. Reducing mortality from colorectal cancer by screening for fecal occult blood. Minnesota Colon Cancer Control Study. N Engl J Med 1993;328:1365-1371.
3. Selby JV, Friedeman GD, Quesenberry CP, et al. A case-control study of screening sigmoidoscopy and mortality from colorectal cancer. N Engl J Med 1992;326:653-657.
4. Newcomb PA, Norfleet RG, Storer BE, Surawicz TS, Marcus PM. Screening sigmoidoscopy and colorectal cancer mortality. J Natl Cancer Inst 1992;84:1572-1575.
5. Winawer SJ, Zauber AAG, Ho MN, et al. Prevention of colorectal cancer by colonoscopic polypectomy. N Engl J Med 1993;329:1977-1981.
6. Lieberman DA. Cost-effectiveness of colon cancer screening. Am J Gastroenterol 1991;86:1789-1794.
7. American Society of Colon and Rectal Surgeons (ASCRS), American Society for Gastrointestinal Endoscopy (ASGE), Society of American Gastrointestinal and Endoscopic Surgeons (SAGES), et al. A consensus document on bowel preparation before colonoscopy: prepared by a task force from the American Society of Colon and Rectal Surgeons (ASCRS), the American Society of Gastrointestinal Endoscopy (ASGE), and the Society of American Gastrointestinal and Endoscopic Surgeons (SAGES). Surg Endosc 2006;20:1161.