

Health policy expert discusses guidelines for colorectal cancer screening

June 17 2016, by Beth Duff-Brown

Colorectal cancer is the second leading cause of death from cancer in the United States, after lung cancer, yet many Americans are still loathe to be screened for the disease.

Guidelines released by the U.S. Preventive Services Task Force strongly recommend that adults ages 50 to 75 be screened for colon [cancer](#), and suggest adults ages 76 to 85 make individual decisions about whether to be screened, depending on their overall health and prior screening history. The recommendation and several accompanying editorials were published online June 15 in *JAMA*.

The recommendation from the independent body of national experts in prevention and evidence-based medicine also emphasized that colonoscopy is one of many screening options available.

Douglas K. Owens, the Henry J. Kaiser, Jr., Professor and director of the Stanford Center for Health Policy and Center for Primary Care and Outcomes Research, was a member of the [task force](#) when the guidelines were developed and co-authored the recommendation. He discussed the [screening guidelines](#) with writer Beth Duff-Brown.

Q: What is the most significant finding of this final recommendation?

Owens: The good news is that evidence convincingly shows screening for [colorectal cancer](#) works. The task force strongly recommends

screening adults 50 to 75 for colorectal cancer, as it reduces the risk of dying from the disease. Unfortunately, one-third of people in that age group have never been screened, so we are missing an important opportunity to prevent deaths from colorectal cancer.

Q: How should people decide which screening method is best for them?

Owens: What really matters is that people get screened. There are several options that are effective, so we recommend that people discuss the options with their clinician. There are direct visualization tests, like colonoscopy, and stool-based tests, like fecal immunochemical testing. Each test has different strengths and limitations, and people may prefer one approach over another. For example, colonoscopy can be done every 10 years, but FIT testing should be done every year. But the real message is, choose an approach in consultation with your clinician and get screened.

Q: The task force found that once adults reach age 76, the benefits of screening become smaller and the potential for harm is greater. What should older Americans consider in deciding whether to be screened?

Owens: We recommend individual decision making for patients ages 76 to 85. The benefits are smaller because a person's chance of dying of other causes goes up as they get older. The harms are still small but increase with age, primarily because the risks of the potential complications of colonoscopy (bleeding, perforation and infection) go up with age. Still, some people in this age group will benefit from screening. People most likely to benefit are those who have not been screened before; people who are healthy enough to undergo treatment for colorectal cancer, should it be found; and people who do not have other diseases or conditions that limit their life expectancy substantially.

Q: African-Americans have the highest incidence of colorectal cancer among all racial and ethnic subgroups. Should this group consider more frequent screenings?

Owens: The task force recognizes the burden that colorectal cancer has on African-Americans, who are at higher risk of being diagnosed with and dying from the disease than other racial/ethnic subgroups. We don't know why this is—more research is needed in this area. The task force did not find enough evidence to conclusively support that making a different recommendation specific to African-Americans would result in a greater net benefit for this population. So our recommendations are intended to apply to all racial/ethnic groups. More robust efforts are needed to ensure that at-risk populations actually receive the screening tests and the follow-up treatments or interventions they need, as people are dying unnecessarily from this disease.

Q: What data did the task force use to come to its conclusions?

Owens: We commissioned a comprehensive, systematic review of the available evidence on the benefits and harms of [colorectal cancer screening](#). The task force also commissioned a modeling study from the Cancer Intervention and Surveillance Modeling Network to help it better understand different screening strategies, such as the optimal age to start or stop screening, and the length of time between screenings. The evidence is convincing that [screening](#) reduces the risk of dying from colorectal cancer.

Provided by Stanford University Medical Center

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