GUT FEELING GASTROLAB NEWS FOR GPs Autumn 2018

Colorectal Cancer Screening – An Update

Colorectal Cancer (CRC) is Australia's second most common cancer (excluding non-melanoma skin cancer) in both males and females and the second leading cause of cancer death after lung cancer.[1] Recently updated clinical practice guidelines are available on the prevention and early detection of CRC and they provide evidence to support the National Bowel Cancer Screening Program (NBCSP).

A population-based NBCSP was introduced by the Federal Government in 2006. It began by inviting people turning 55 and 65 after August 2006 to have a one off faecal occult blood test (FOBT) and has slowly been phased in to other age groups. By 2020 all Australians, aged 50-74, will be invited to participate in biennial screening with FOBT. The NHMRC-endorsed clinical practice guidelines for the prevention, early detection and management of CRC were updated in October 2017 and support the NBCSP as a method of population screening.[1] Additional key messages from the 2017 guidelines include active consideration of aspirin chemoprophylaxis for primary prevention of CRC, changes to screening recommendations based on family history of CRC, and the pivotal role of the GP in encouraging uptake of the NBSCP.[1]

The NSBCP relies on immunochemical FOBT (iFOBT) which uses globin antibodies to detect blood in the stool. Unlike the guaiac test (gFOBT) which detects chemical activity in haem, the iFOBT is not affected by the presence of red meat or vitamin C supplements in the diet and therefore does not require any change in diet or medication.[2] In 2014-15, the rate of participation in the NBSCP was 39% overall, with 8% of participants returning a positive result.[3] Of those with a positive iFOBT result, 70% went on to have a follow-up diagnostic assessment and 1 in 29 was diagnosed with a confirmed or suspected cancer and a further 1 in 8 was diagnosed with adenomas.[3] An earlier small study however described higher rates of adenoma detection (23% advanced adenomas and 25% non-advanced) and a similar (4.3%) rate of bowel cancer, in colonoscopies done for positive iFOBT.[4] A 15% risk reduction in the likelihood of CRC-related death has been demonstrated in individuals invited to participate in the NBSCP, compared with those not invited.[5]

There is evidence that participation in the screening program is significantly increased by encouragement from GPs or practice staff.[6] Methods suggested include use of GP reminder systems, practice audits and letters signed by the GP endorsing participation in the program (e.g. to 49-year-olds before they receive the kit around the time of their 50th birthday).[6] The GP also has the role of following up those with a positive FOBT with referral for colonoscopy as early as possible but certainly within 120 days, as longer waiting periods are associated with worse outcomes if cancer is present.[1] Finally, the GP has the important role of counselling individual patients with major comorbidities and limited life expectancy to opt out of the NBCSP and to defer testing in those who have had recent major surgery or illness.[1] Those patients who have had a high-quality colonoscopy within the previous two years may skip a round before going back to the iFOBT as part of the NBCSP.

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Changes to the previous recommendations regarding screening in those with a family history are summarised in Table 1.[1] Patients should be encouraged to collect reliable information regarding the family history. Recommendations for age at commencement of screening are now at defined ages depending on the relative risk. Category 3 can now be met with inclusion of relatives from both sides of the family. Referral to a genetic centre for hereditary cancer syndromes should be considered for those with Category 3 risk, as there are specialised recommendations for high risk familial syndromes. Low dose aspirin (100–300mg daily) should be considered for primary prophylaxis of CRC in all people aged 50-70 years, taking into account age, sex, potential reduction of cardiovascular events and the potential risks of GI haemorrhage, peptic ulcer and renal impairment.

TAKE HOME MESSAGES

1. **The NBSCP will be fully implemented by 2020. The GP plays a key role in increasing uptake of the NBSCP.**
2. **Recently updated clinical practice guidelines on the prevention and early detection of CRC include important changes to screening recommendations based on family history.**
3. **Aspirin should be actively considered for primary prevention of CRC with due reflection on the risks and benefits.**

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TABLE 1: RISK ASSOCIATED WITH FAMILY HISTORY OF CRC AND EVIDENCE-BASED SCREENING RECOMMENDATIONS.

CATEGORY 1 1-2 × average risk	CATEGORY 2 3-6 × average risk	CATEGORY 3 7-10 × average risk
• One relative with CRC diagnosed at ≥ 55 yrs	• 1 FDR with CRC diagnosed < 55 yrs *or* • 2 FDRs with CRC diagnosed at any age *or* • 1 FDR + at least 2 SDRs with CRC at any age	• At least 3 FDRs or SDRs with CRC, with at least one diagnosed at < 55 yrs or • At least 3 FDRs with CRC diagnosed at any age
• iFOBT every 2 yrs from age 50-74 • Consider offering iFOBT every 2 yrs from age 45 in those with 1 FDR with CRC	• iFOBT every 2 yrs from age 40 then colonoscopy every 5 yrs from age 50 • CT colonography if colonoscopy contraindicated	• iFOBT every 2 yrs from age 35 then colonoscopy every 5 yrs from age 45 • Consider referral to genetic centre for hereditary cancer syndromes

First degree relative (FDR): Mother, father, son, daughter, brother, sister. Second degree relative (SDR): Grandparent/child, uncle, aunt, nephew, niece, half siblings.

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