NORTH COAST FAMILY MEDICAL GROUP
FACTS ABOUT COLON CANCER SCREENING

Colon Cancer is the third most common cancer. The lifetime incidence of colorectal cancer in patients at average risk is about 5 percent, with 90 percent of cases occurring after age 50, incidence begins to increase in each succeeding decade after 50 years old. Most colorectal cancers develop from precancerous adenomatous polyps. A small percentage of these polyps become cancerous and spread to other areas. This progression takes at least 10 years in most people.

The optimal screening test depends upon a person's preferences and his or her risk of developing colon cancer. We at North Coast Family Medical Group follow the American Gastrological Guidelines, which asks us to screen our patients for being high-risk or low-risk for colon cancer. Those at higher risk should undergo a higher risk procedure: colonoscopy. Those at lower risk are recommended to have lower risk tests: fecal occult stool cards annually and flexible sigmoidoscopy every 5 years.

No single test is of unequivocal superiority. Incorporating patient personal preferences may increase the likelihood that screening will occur. We encourage screening exams for all those over age 50 and sometimes earlier for those with a strong family history or a medical reason that puts one at higher risk. The goal is to find the polyps that are almost always the precursors of cancer and are usually present for many years before becoming cancer. Studies have shown that colon cancer deaths can be reduced by as much as 75-80% if screening is faithfully done. We would like you to know a few additional facts about the various types of testing available as you decide which test to choose for yourself.

Fecal occult blood test (“stool cards”)

Fecal occult blood test (cards testing for microscopic amounts of blood in the stool) have been demonstrated to reduce mortality by 33 percent after annual screening. Stool tests have low sensitivity for polyps and relatively low specificity for significant disease, leading to workup for many false positive results. The test is non-invasive and inexpensive, but requires colonoscopy for follow-up of positive results. The sensitivity of a single FOBT for colorectal cancer is only about 30 percent; a program of repeated testing has a higher sensitivity of about 80 to 92 percent.

Barium enemas and virtual colonoscopies

Neither of these tests is recommended in this office except for those people who cannot or will not consider some form of a “scope.” Barium enemas visualize the entire bowel and are relatively safe but detect only half of large (>1 cm) polyps which makes them inadequate tests. As recently as 2008 a study was published saying that virtual colonoscopies (which are better than barium enemas) are as good as a colonoscopy at detecting polyps, however the conclusion of that sentence was “polyps larger than 1 centimeter.” One centimeter is a very large polyp and we are concerned that to miss a 7 or 8 mm polyp and then be retested 5-10 years later is not an acceptable risk we would advise our patients to take.

Flexible sigmoidoscopy

Flexible sigmoidoscopies are done in this office, without anesthesia, take 10 minutes and are uncomfortable, but not so painful that people avoid them 5 years later. They do require bowel preparation prior to the exam but not as rigorous as that required for colonoscopy. Sigmoidoscopies allow visualization of only the lower 1/3 of the colon but that is where up to 70% of polyps and cancer are found in any case. Combining them every 5 years with annual stool tests for blood increases the cancer/polyp detection rate to over 80%. Abnormal findings on sigmoidoscopy require colonoscopy for visualization of the entire colon.

Colonoscopy

Colonoscopies are more thorough tests because they see the entire colon, are done by a gastroenterologist under anesthesia in an operating room and allow for removal of polyps that are found at the time of the procedure. We have the equipment and the ability to remove polyps while doing flexible sigmoidoscopies but we don't because when we find a polyp, we want that person to have a full colonoscopy in case there are other polyps higher up. Colonoscopies still miss some polyps and cancers, but the detection rate is probably greater than 95%. Colonoscopies are recommended every 10 years, but more often when there is a family history of colon cancer or a personal history of polyps. Because of the anesthesia a colonoscopy requires resting at home for the remainder of the day afterward, while someone can return to normal activity after the 30 minutes in the office for a flexible sigmoidoscopy. Many patients find the rigorous bowel preparation required for colonoscopy worse than the procedure itself.

There are two drawbacks to colonoscopy. The first is cost. They are 10 times as costly as a sigmoidoscopy. While this may be no factor for those with a PPO insurance or Medicare, it will be for HMO patients and those with high deductable insurance plans. Assume that it will cost over $1000 if you are required to pay for it yourself. Our HMO patients will be authorized for colonoscopies only if there is a family history of colon cancer in a first degree relative (parent, sibling or child) or if there is a personal history of polyps in the past, blood in the occult blood stool test or some other current bowel problem that would warrant the test.

The second drawback is an increase in risk. The risks of colonoscopy are greater than those of other screening tests. The most significant risk of either test is "perforation" of the bowel by the scope, a rare complication in either case, but one which usually requires surgery to repair the hole. The risk of perforation during a sigmoidoscopy is one in 40,000 cases and for colonoscopy is one in 1000 cases. The risks of sigmoidoscopy are significantly smaller than those of colonoscopy. Adverse events within 30 days of colonoscopy occurred more frequently in patients who were older, or had a history of diabetes mellitus, stroke, chronic obstructive pulmonary disease, atrial fibrillation, or heart failure.

We present the data so you can make an informed decision, including those of you who might choose to pay for the colonoscopy if you think it is the right test for you. In any case, we strongly urge having one of these tests regularly as recommended.