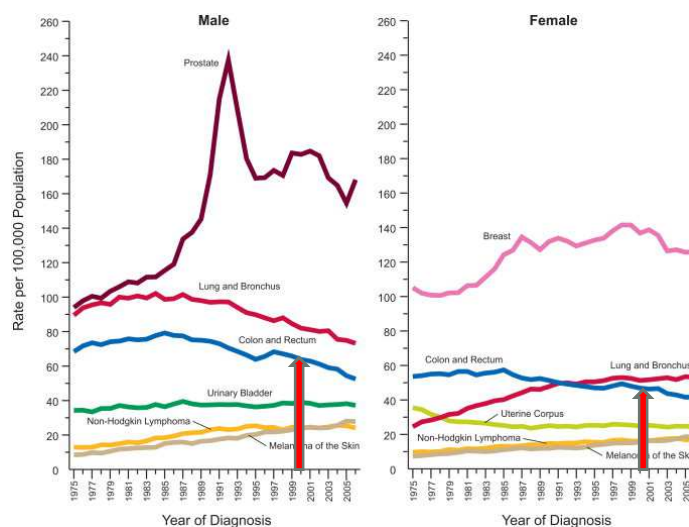


VERMONT COLORECTAL CANCER SUMMIT

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Cancer Statistics, 2010



CA: A Cancer Journal for Clinicians
 Volume 60, Issue 5, pages 277-300, 7 JUL 2010 DOI: 10.3322/caac.20073
<http://onlinelibrary.wiley.com/doi/10.3322/caac.20073/full#fig3>

Colorectal Cancer Screening Vermont

Table 8. Colorectal Cancer Screening^a Prevalence Among Adults Aged 50 Years or Older by Race/Ethnicity and State, United States, 2012

STATE	ALL RACES COMBINED			NON-HISPANIC WHITE			NON-HISPANIC BLACK		
	RANK	%	± 95% CI	RANK	%	± 95% CI	RANK	%	± 95% CI
Massachusetts	1	75.6	1.2	1	76.9	1.2	13	66.1	6.2
New Hampshire	2	74.7	1.7	4	74.5	1.7		b	-
Rhode Island	3	73.0	2.0	2	75.2	1.9		b	-
Maine	4	73.0	1.3	7	73.6	1.4		b	-
Wisconsin	5	72.1	2.4	8	73.3	2.4		b	-
Delaware	6	72.0	2.2	10	72.1	2.3	4	69.8	6.9
Connecticut	7	72.0	1.7	5	73.9	1.7	17	64.1	8.0
Vermont	8	71.2	1.8	11	71.8	1.8		b	-
Minnesota	9	70.7	1.5	9	72.1	1.4		b	-
Maryland	10	70.4	1.6	12	71.4	1.7	3	70.8	3.7
New York	11	69.8	2.2	18	69.2	2.2	1	75.6	7.5
Michigan	12	69.3	1.5	15	70.5	1.6	16	64.5	5.8
Dist. of Columbia	13	69.2	3.2	3	75.0	3.5	5	68.8	4.2
California	14	69.2	1.6	6	73.8	1.5	2	75.0	6.3
Washington	15	68.6	1.3	13	71.0	1.2		b	-

Colorectal Cancer Screening – ACS Guidelines

Tests that find polyps and cancer

- Flexible sigmoidoscopy every 5 years*

- Colonoscopy every 10 years

- Double-contrast barium enema every 5 years*

- CT colonography (virtual colonoscopy) every 5 years*

Tests that mainly find cancer

- Guaiac-based fecal occult blood test (gFOBT) every year**,**

- Fecal immunochemical test (FIT) every year**,**

- Stool DNA test (sDNA) every 3 years*

*Colonoscopy should be done if test results are positive.

** Highly-sensitive versions of these tests should be used with the take-home multiple sample method. An FOBT or FIT done during a digital rectal exam in the doctor's office is not adequate for screening.

Patients with Family History

Risk Category	Age to Begin	Recommended Test(s)	Comment
Colorectal cancer or adenomatous polyps in any first-degree relative before age 60, or in 2 or more first-degree relatives at any age (if not a hereditary syndrome).	Age 40, or 10 years before the youngest case in the immediate family, whichever is earlier	Colonoscopy	Every 5 years.
Colorectal cancer or adenomatous polyps in any first-degree relative aged 60 or older, or in at least 2 second-degree relatives at any age	Age 40	Same options as for those at average risk.	Same intervals as for those at average risk.

Colorectal Cancer Screening

- Any test is better than no test
- Family history should trigger earlier screening
- Benefit from all colorectal cancer screening ultimately comes from colonoscopy and removal of precancerous or cancerous lesions.

Colonoscopy - Procedure

- Open access endoscopy
 - Shared responsibility
- Special circumstances
 - Anti-platelet and anticoagulation
 - Patients needing anesthesia
 - Patients appropriate for screening



The Procedure – Walk Through

- Schedule
- Prep
- Check-in
- IV
- Sedation
- Procedure
- Recovery
- Follow-up

Characteristics of the Ideal Screening Program

Features of the disease

Significant impact on public health

Asymptomatic period during which detection is possible

Outcomes improved by treatment during asymptomatic period

Features of the test

Sufficiently sensitive to detect disease during asymptomatic period

Sufficiently specific to minimize false-positive test results

Acceptable to patients

WHAT IS NEW?

From: **Increasing Disparities in the Age-Related Incidences of Colon and Rectal Cancers in the United States, 1975-2010**

JAMA Surg. Published online November 05, 2014.1-6 doi:10.1001/jamasurg.2014.1756

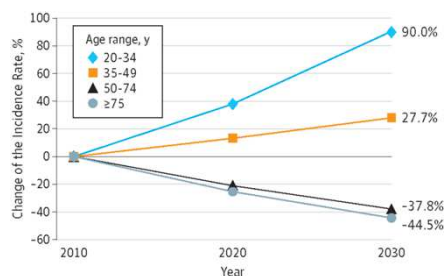


Figure Legend:
Annual Percentage Change–Based Predicted Incidence Rates of Colon Cancer by Age Compared With Incidence Rate in 2010

Date of download: 11/10/2014

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From: **Increasing Disparities in the Age-Related Incidences of Colon and Rectal Cancers in the United States, 1975-2010**

JAMA Surg. Published online November 05, 2014.1-6 doi:10.1001/jamasurg.2014.1756

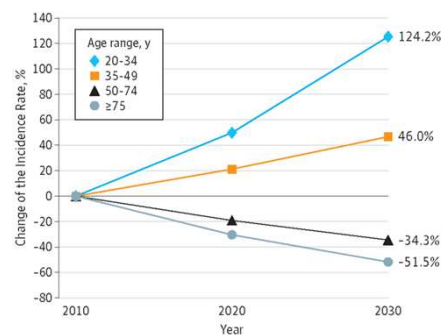


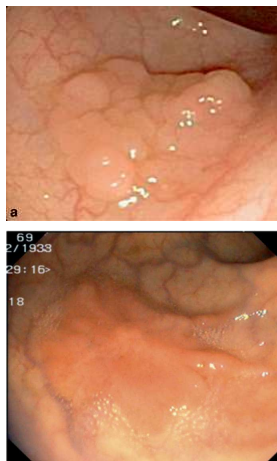
Figure Legend:
Annual Percentage Change–Based Predicted Incidence Rates of Rectosigmoid and Rectal Cancers by Age Compared With Incidence Rate in 2010

Date of download: 11/10/2014

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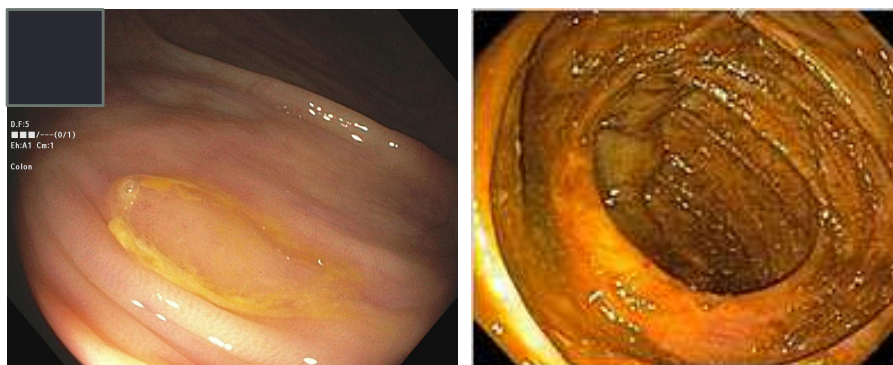
Sessile Serrated Polyps

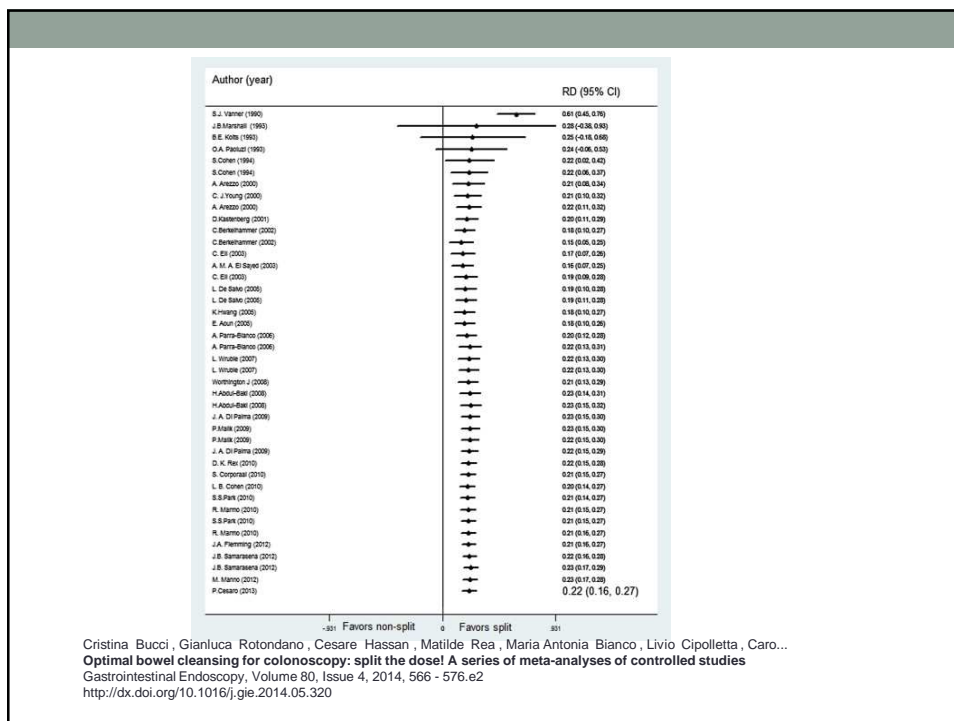
- Distinct pathway to cancer than adenomas
- Often right sided
- Account for 20-30% of colorectal cancers
- Can be difficult to detect



The Prep

- Split the dose!
- Procedure done within 5 hours of last dose





Fecal DNA

Table 1. Sensitivity and Specificity of the Multitarget Stool DNA Test and the Fecal Immunochemical Test (FIT) for the Most Advanced Findings on Colonoscopy.

Most Advanced Finding	Colonoscopy (N=9989)	Multitarget DNA Test (N=9989)		FIT (N=9989)	
		Positive Results	Sensitivity (95% CI)	Positive Results	Sensitivity (95% CI)
	no.	no.	%	no.	%
Colorectal cancer					
Any	65	60	92.3 (83.0–97.5)	48	73.8 (61.5–84.0)
Stage I to III*	60	56	93.3 (83.8–98.2)	44	73.3 (60.3–83.9)
Colorectal cancer and high-grade dysplasia	104	87	83.7 (75.1–90.2)	66	63.5 (53.5–72.7)
Advanced precancerous lesions†	757	321	42.4 (38.9–46.0)	180	23.8 (20.8–27.0)
Nonadvanced adenoma	2893	498	17.2 (15.9–18.6)	220	7.6 (6.7–8.6)
			Specificity (95% CI)		Specificity (95% CI)
All nonadvanced adenomas, non-neoplastic findings, and negative results on colonoscopy	9167	1231	86.6 (85.9–87.2)	472	94.9 (94.4–95.3)
Negative results on colonoscopy	4457	455	89.8 (88.9–90.7)	162	96.4 (95.8–96.9)

N Engl J Med 370;14 nejm.org april 3, 2014

QUESTIONS
