



## AMERICAN COLLEGE OF GASTROENTEROLOGY

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**For Immediate Release**

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### **American College of Gastroenterology Issues Updated Colorectal Cancer Screening Guidelines *New recommendation to begin colorectal cancer screening at age 45 for average risk adults***

**Bethesda, MD (March 5, 2021)** – The American College of Gastroenterology has issued updated evidence-based screening guidelines for colorectal cancer (CRC) in the March issue of *The American Journal of Gastroenterology* that recommend all average risk individuals begin screening at age 45. ACG has recommended that African Americans begin screening at age 45 since 2005.

The guidelines' co-authors are Aasma Shaukat, MD, MPH, FACP; Charles J. Kahi, MD, MSc, FACP; Carol A. Burke, MD, FACP; Linda Rabeneck, MD, MPH, MACG; Bryan G. Sauer, MD, MSc, FACP (GRADE Methodologist); and Douglas K. Rex, MD, MACG.

“One of the ACG’s primary objectives in updating its colorectal cancer screening guidelines is to update the 2009 guidelines in light of new evidence on age to initiate CRC screening, modalities, and interventions to improve screening rates,” said lead author Dr. Aasma Shaukat.

There is a sense of urgency to the updated guidelines as colorectal cancer screening rates have declined during the COVID-19 pandemic and, even before the pandemic, obstacles to CRC screening meant that use of CRC tests was suboptimal. The authors write: “Despite the availability of multiple screening modalities and various public health initiatives to boost colorectal cancer screening, nearly one-third of the eligible United States population is unscreened. Colorectal cancer screening rates must be optimized to reach the aspirational target of >80%.”

#### **Evidence to Initiate Screening in Average Risk Individuals at Age 45**

The authors point to recent studies highlighting a rising incidence of CRC in individuals younger than age 50 in the United States. While CRC incidence has shown continued decline in those 50 and older, the incidence rates have doubled in 20- to 49-year-olds. It has been estimated that persons born around 1990 have twice the risk of colon cancer and four times the risk of rectal cancer compared to those born around 1950.

#### **Detailed Recommendations from The American College of Gastroenterology**

Dr. Shaukat outlined key recommendations in the new guidelines:

- **Age to Initiate Screening** - We suggest starting CRC screening at age 45 in average risk individuals and using either colonoscopy or fecal immunochemical test (FIT) as the primary screening modality. Other screening options include multitarget stool DNA test, CT colonography, and colon capsule.

- **Family History of CRC** - We recommend starting CRC screening at age 40 in individuals with one or two first degree relative with colorectal cancer or advanced colorectal polyps. If the first degree relative is <60, or there are two or more first degree relatives with colorectal cancer or advanced colorectal polyps at any age, colonoscopy should be used, and screening repeated at five-year intervals. If the first degree relative is age 60 or older, any screening modality can be used and, if normal, follow average risk screening intervals. For individuals with history of only one second degree relative with colorectal cancer or advanced polyps, we suggest using average risk recommendations.
- **Aspirin** - Aspirin is not a substitute for colorectal cancer screening and we suggest a narrow category of individuals that may use aspirin, in addition to routine screening, to reduce their risk of colorectal cancer: persons that are age 50-69 with cardiovascular disease risk of at least 10% and willing to take aspirin for at least 10 years.
- **Quality Indicators** - We recommend quality indicators for colonoscopy of Adenoma Detection Rates of at least 25%, withdrawal time of at least 6 minutes and cecal intubation rate of at least 95% for screening exams.
- **Improving Adherence to Screening** - We also provide evidence-based interventions to boost screening rates and suggest having an organized system of screening and follow up to reduce disparities and boost screening rates.

### ***One-Step vs. Two-Step Screening Tests***

An important clinical development is the distinction the new guidelines make between one-step screening tests and two-step screening tests. The authors write: “One approach to CRC screening tests is to divide them as one-step (direct) tests (i.e., colonoscopy which is diagnostic and therapeutic) or two-step tests that require colonoscopy, if positive, in order to complete the screening process. All of the screening tests other than colonoscopy are two-step tests. A major limitation of non-colonoscopy-based CRC screening tests (stool-based, flexible sigmoidoscopy, CT colonography or colon capsule) is that a positive test requires a follow-up colonoscopy. This two-step testing approach represents a continuum of screening, requires strong systems-based support to complete the screening cascade, and is more effectively applied in organized screening.”

### ***Colorectal Cancer in African Americans***

The authors describe CRC’s disproportionate impact among African Americans: “African Americans have one of the highest rates of colorectal cancer of any racial/ethnic group in the United States. Compared to whites, incidence rates are 24% higher in African American men and 19% higher in African American women. Stage adjusted CRC mortality is also disproportionately higher in African Americans, with rates being 47% higher in African American men and 34% higher in African American women compared to whites. The reasons for these differences are not entirely clear but disparities in care, such as lower rates of screening, diagnostic follow up, and treatment are postulated.” They add, “Based on recent SEER data, modelling studies show similar benefit of CRC screening in African Americans and whites starting at age 45. Special efforts and outreach programs are needed to boost screening among African Americans, in order to reduce the disparities in screening rates and reduce incidence rates.”

### ***Importance of Provider Recommendation***

“At the provider level, the involvement of the Primary Care Provider (PCP) or General Practitioner is associated with increased participation in both organized and opportunistic screening settings. A recommendation to be screened from a PCP - who is known and trusted by the person - is clearly effective in raising participation,” observe the authors.

### ***Helpful Highlights: Updated 2021 ACG CRC Guidelines***

In Table 2, the authors provide a “Summary of Performance Characteristics for CRC Screening Tests” in which they present key metrics and review pros and cons of various screening modalities. In Appendix 2, the authors note changes in the 2021 ACG Clinical Guidelines on Colorectal Cancer Screening from the 2009 ACG recommendations. Notable changes in the 2021 ACG guidelines compared to the College’s previous 2009 guidelines include:

1. Age to initiate CRC screening in average risk men and women is lowered to 45
2. Decision to offer CRC screening beyond age 75 should be individualized
3. Screening should be considered a multi-step process: For example, a one-step process, such as colonoscopy, or two-step, such as a stool-based test followed by colonoscopy, if positive
4. African Americans should start screening at age 45, and special efforts are required to improve screening rates and reduce disparities in treatment and outcomes
5. Colon capsule is added as an option for CRC screening for individuals unwilling or unable to undergo colonoscopy or a FIT. If negative, screening may be repeated in five years
6. Suggestion to initiate CRC screening at age 40 or 10 years before the youngest affected relative, then resume average-risk screening recommendations for individuals with CRC or advanced polyp in one first degree relative at age  $\geq 60$ . Colonoscopy or FIT are reasonable options
7. Endoscopists should measure quality indicators for screening colonoscopy and achieve minimum benchmarks for cecal intubation ( $\geq 95\%$ ), adenoma detection rate ( $\geq 25\%$ ) and withdrawal time ( $\geq 6$  minutes)
8. Suggestion to use low dose aspirin, in addition to CRC screening, in individuals between the ages of 50 and 69 with a cardiovascular disease risk of  $\geq 10\%$  over the next 10 years, who are not an increased risk for bleeding and willing to take aspirin for at least 10 years to reduce CRC risk
9. Organized screening programs should be developed to improve adherence to CRC screening and follow-up of a two-stage screening test if positive
10. The following strategies may be implemented to improve organized screening: Patient navigation, patient reminders, clinician interventions, provider recommendations and clinical decision support tools
11. A positive multitarget stool DNA test followed by a colonoscopy with no findings should not prompt any further work up, and repeat screening should be offered at 10 years

## **Read the Guidelines**

Open access to full text of the guideline is posted on the *AJG* site:

[https://journals.lww.com/ajg/Fulltext/2021/03000/ACG\\_Clinical\\_Guidelines\\_Colorectal\\_Cancer.14.aspx](https://journals.lww.com/ajg/Fulltext/2021/03000/ACG_Clinical_Guidelines_Colorectal_Cancer.14.aspx)

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Published monthly since 1934, *The American Journal of Gastroenterology (AJG)* is the official peer-reviewed journal of the American College of Gastroenterology. The goal of the Journal is to publish scientific papers relevant to the practice of clinical gastroenterology. It features original research, review articles, and consensus papers related to new drugs and therapeutic modalities.

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Founded in 1932, the American College of Gastroenterology (ACG) is an organization with an international membership of over 16,000 individuals from 86 countries. The College's vision is to be the preeminent professional organization that champions the prevention, diagnosis, and treatment of digestive disorders, serving as a beacon to guide the delivery of the highest quality, compassionate, and evidence-based patient care. The mission of the College is to enhance the ability of our members to provide world class care to patients with digestive disorders and advance the profession through excellence and innovation based upon the pillars of Patient Care, Education, Scientific Investigation, Advocacy and Practice Management. [www.gi.org](http://www.gi.org)

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