

Colorectal cancer screening and surveillance: Clinical guidelines and rationale-Update based on new evidence.

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We have updated guidelines for screening for colorectal cancer. The original guidelines were prepared by a panel convened by the U.S. Agency for Health Care Policy and Research and published in 1997 under the sponsorship of a consortium of gastroenterology societies. Since then, much has changed, both in the research rature and in the clinical context. The present report summarizes new developments in this field and suggests how they should change practice. As with the previous version, these guidelines offer screening options and encourage the physician and patient to decide together which is the best approach for them. The guidelines also take into account not only the effectiveness of screening but also the risks, inconvenience, and cost of the various approaches. These guidelines differ from those published in 1997 in several ways: we recommend against rehydrating fecal occult blood tests; the screening interval for double contrast barium enema has been shortened to 5 years; colonoscopy is the preferred test for the diagnostic investigation of patients with findings on screening and for screening patients with a family history of hereditary nonpolyposis colorectal cancer; recommendations for people with a family history of colorectal cancer make greater use of risk stratification; and guidelines for genetic testing are included. Guidelines for surveillance are also included. Follow-up of postpolypectomy patients relies now on colonoscopy, and the first follow-up examination has been lengthened from 3 to 5 years for low-risk patients. If this were adopted nationally, surveillance resources could be shifted to screening and diagnosis. Promising new screening tests (virtual colonoscopy and tests for altered DNA in stool) are in development but are not yet ready for use outside of research studies. Despite a consensus among expert groups on the effectiveness of screening for colorectal cancer, screening rates remain low. Improvement depends on changes in patients' attitudes, physicians' behaviors, insurance coverage, and the surveillance and reminder systems necessary to support screening programs.

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