

OREGON PUBLIC HEALTH DIVISION • DEPARTMENT OF HUMAN SERVICES

COLORECTAL CANCER SCREENING: GET YOUR PATIENTS' REARS IN GEAR

Colorectal cancer is Oregon's fourth most common cancer, with 1,777 new cases reported in 2006, and Oregon's second leading cause of cancer deaths, with 624 deaths reported in 2006.\* Colorectal cancer is preventable and routine screening can reduce deaths through the early diagnosis and removal of pre-cancerous polyps.<sup>1</sup> For these reasons, colorectal cancer continues to be the number one priority of the Oregon Partnership for Cancer Control.<sup>†</sup> This *CD Summary* reviews data on colorectal cancer cases, deaths, and screening rates in Oregon, and provides updated information on screening guidelines.

**RATES IN OREGON**

From 1997-2006, colorectal cancer incidence in Oregon was lower (48.5 per 100,000) than the national rate (52.6 in 1999-2005), as was colorectal cancer mortality (17.9 deaths per 100,000 compared to 19.3 nationally in 1999-2005).

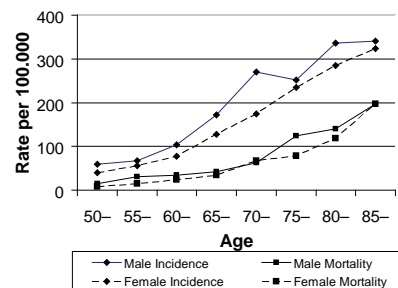
The rate of colorectal cancer increases with age (figure). Incidence and mortality were higher in men than women for all age groups. Two-thirds of the cases of colorectal cancer in Oregon are in white men and women age ≥65 years. By race, incidence in Oregon from 1997-2006 was higher in African Americans (57.0 per 100,000), and lower in Asian/Pacific Islanders (37) and Hispanics (36) than in whites (48). Non-white men and women of all ages make up less than 4% of colorectal cases in Oregon.

**RISK FACTORS**

Risk factors for colorectal cancer include smoking, body adiposity, abdominal adiposity, and consumption of alcohol and red and processed meats. In 2007, 17.0% of adults in

Oregon smoked, compared to 19.8% nationally. In 2008, 25.0% of Oregon adults were obese, compared to 26.7% nationwide.

Colorectal cancer incidence and mortality, Oregon, 2006



Protective factors include physical activity, consuming foods containing dietary fiber, allium vegetables such as onions, garlic and leeks, and diets high in calcium.<sup>2</sup> In Oregon, 56.3% of adults met physical activity recommendations in 2007, reporting 30 or more minutes of moderate activity at least five days a week, or vigorous activity for 20 or more minutes at least three days a week. Nationwide, only 49.5% of adults met physical activity recommendations in 2007.

Even with all primary prevention strategies in place and no additional risk factors, screening is still necessary to find and prevent colorectal cancer. Two-thirds of the people who get colorectal cancer have no family history,<sup>3</sup> making regular screening for the disease especially important.

**SCREENING IN OREGON**

Colorectal cancer screening carries the US Preventive Services Task Force (USPSTF) highest grade for a screening service when performed "beginning at age 50 years and continuing until age 75 years."<sup>1</sup> The Centers for Disease Control and Prevention (CDC) have set a goal of an 80% screening rate of people ≥50 by 2014. According to the CDC, regular screening for everyone age ≥50 years of age would

prevent as many as 60% of deaths from colorectal cancer.<sup>4</sup>

Currently, only 63% of adults over the ≥50 years in Oregon are getting screened.<sup>‡</sup> While men and women are getting screened at the same rate, people with health insurance are much more likely to get screened (64%) than those with no insurance (28%). Daily smokers are less likely to get screened (40%) than those who never smoked (68%), and people who are married/partnered are more likely to be screened (65%) than those who are single, widowed, or divorced (56%).<sup>§</sup>

While we don't have Oregon-specific data on reasons for not getting screened, in Washington 50% of the targeted age group that did not get screened reported not knowing they needed to be screened, and 29% reported that their doctor did not tell them to get screened.<sup>5</sup> Another study found that the main reason people have not had recommended screenings is because they "never thought about it."<sup>6</sup>

The take home message is that recommending screening to your patients will raise screening rates. Results vary, but 90% of people who reported receiving a recommendation for screening from their primary care provider completed that screening. Only 25% of people completed screening without a recommendation from their physician.

**ANY TEST IS BETTER THAN NONE**

Ultimately, the best test is the one that your patient will complete. This can have its challenges. "It's not the test itself, it's the prep" is a phrase you're likely to hear from everyone who has ever had a colonoscopy. As an alternative, the fecal occult blood test (FOBT) requires people to play with

‡ 2008 BRFSS data. Screening is defined as fecal occult blood test within one year, sigmoidoscopy within 5 years, or colonoscopy within 10 years.

§ 2008 BRFSS data

\* [www.oregon.gov/DHS/ph/oscar/arpt2006/colorectal06.pdf](http://www.oregon.gov/DHS/ph/oscar/arpt2006/colorectal06.pdf)

† [www.oregon.gov/DHS/ph/cancer/docs/acalltoaction3-04.pdf](http://www.oregon.gov/DHS/ph/cancer/docs/acalltoaction3-04.pdf)



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their poop. Nonetheless, these screening tests are well worth your time to prescribe for your patients.

The USPSTF recommendations are:<sup>1</sup>

- At home annual high-sensitivity fecal occult blood test (FOBT): either SENSEA guaiac or fecal immunochemical
  - Sigmoidoscopy every 5 years combined with high-sensitivity fecal occult blood testing every 3 years
  - Screening colonoscopy every 10 years
- Not recommended:

- In-office FOBT
- Digital rectal exam

Insufficient evidence to recommend:

- Computed tomographic colonoscopy
- Fecal DNA testing

Follow up to any positive screening test requires a colonoscopy. Regardless of the screening method chosen, adherence to screening guidelines will be what makes the difference in life-years gained.

### RESOURCES FOR PROVIDERS

In addition to the ick factor, barriers to screening on the part of the patient are predictable: lack of insurance,<sup>7</sup> lack of a regular primary care provider,<sup>8</sup> out-of-pocket costs to those with insurance, literacy levels and distrust of the health care system. Patients may underestimate their risk of colorectal cancer and the value of screening. They may overestimate the discomfort and risk of the screening or believe that their previous screening was recent enough.

As if barriers attributed to patients weren't enough, there are screening barriers attributable to providers as well. These include ineffective tracking

systems utilizing medical records, the cost of patient education and reminders, and a general belief that colonoscopy is the only test that should be recommended even though many patients cannot access or afford the test.

A new Colorectal Cancer Screening Toolkit has been released by the Oregon Partnership for Cancer Control and can be downloaded at [www.acumentra.org/CRC](http://www.acumentra.org/CRC). The materials were field tested at a Portland-area medical group, and incorporate several best practices identified by the National Colorectal Cancer Round Table for increasing screening rates:

- A recommendation from a physician or nurse practitioner to complete a CRC screening
- Patient education based on readiness for CRC screening
- Modification of staff roles related to assessing and reminding patients
- Use of client reminder systems

### REFERENCES

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### 2009 CD SUMMARY TOPICS

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