

## Colorectal Cancer Prevention Program

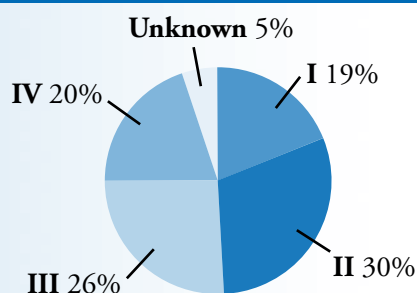
By Dr. Bernie Badley, Medical Director, Colorectal Cancer Prevention Program and Dr. Des Leddin, Head, Division of Gastroenterology, Capital Health and Chair, Education, Colorectal Cancer Prevention Program

**N**ova Scotia is about to become one of only four provinces in the country with a province-wide screening program for colorectal cancer. Family physicians have a key role to play in that program.

Action is required. The incidence of colorectal cancer is very high in this province. Indeed, it is among the highest in the country. Colorectal cancer is the second leading cause of cancer death in Nova Scotia. Approximately 1000 Nova Scotians will be diagnosed with colorectal cancer this year, and 350 will die from the disease. Most of those patients – 80% – will have no family history of colorectal cancer.

Ninety-four per cent of people diagnosed with colorectal cancer are 50 years of age or older, and men are at higher risk than women. However, if diagnosed at Stage 1 (Dukes 'A'), the five-year survival is about 90%. Unfortunately, about half of all colorectal cancer in Nova Scotia is diagnosed at Stage 3 or Stage 4. As a result, their outcomes or survival is not as good.

### Stage distribution of colorectal cancer cases diagnosed between 2001-2005, Nova Scotia



Source: Cancer Care Nova Scotia, Surveillance & Epidemiology Unit, August 2008

### An innovative program

The ultimate goal of *Cancer Care Nova Scotia's* Colorectal Cancer Prevention Program (CRCPP) is to reduce mortality from CRC in Nova Scotia. This screening program can help detect cancer. It can also detect polyps that may develop into a cancer over time. These polyps can be removed during a colonoscopy.

Earlier diagnosis is at the heart of the CRCPP, which will roll out in two phases. The first phase will involve implementing the program in three district health authorities (DHAs): South Shore, Cape Breton and Guysborough-Antigonish-Strait. The second phase will bring remaining districts on in a staged approach toward a province-wide implementation.

The screening program is designed to achieve two important aims:

- increase understanding about colorectal cancer among the general public, and
- promote screening for individuals who are at average risk for developing this cancer.

Beginning in March 2009, screening kits and educational information will be mailed to men and women, aged 50-74, in the pilot DHAs. To be eligible for screening, individuals must have no symptoms, no first-degree relative with colorectal cancer, and no hereditary or inflammatory bowel condition known to increase risk. They will receive a regular invite to undergo screening every two years.

The screening tool being used is called a Fecal Immunochemical Test, or FIT, and requires two consecutive stool samples. These samples will be sent to a central laboratory by prepaid post. Any individual with a positive FIT will need further medical follow-up, including a colonoscopy performed by a CRCPP-accredited colonoscopist.

Individuals with a negative FIT will be invited to repeat the test in two years. There is a chance that a cancer can be missed if it was not bleeding when the screening test was taken. This is why it is so important to screen bi-annually.

“Patients who fall outside the screening parameters may have questions about why they are not part of the program,” said Dr. Stephanie Langley, family physician, Cape Breton District Health Authority and a member of the CRCPP’s Clinical Advisory Committee. “It is important to let them know that colorectal cancer in people younger than 50 who have no family history is very unusual. There is also no good evidence to support routine screening for colorectal cancer in adults over 76 years of age. Indeed, last year the U.S. Preventive Services Task Force specifically recommended against screening for colorectal cancer for this older population because the benefits of screening are small for this age group.”

Although the CRCPP is being phased in across the province and will not be available to everyone in March 2009, people can still be screened by requesting a Fecal Occult Blood Test (FOBT) through their family physician / primary care provider.

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## **A central role for family physicians and other primary care providers**

Because control over the entry-level screening test is in the hands of the individual and not the health care provider, increasing understanding about colorectal cancer, the prevalence of the disease, and the benefits of screening will be central to influencing participation and ultimately reducing CRC incidence and mortality rates in Nova Scotia.

Family physicians and other primary care providers are pivotal to this process. Patients may inquire about the screening program and their need to participate. This is both an opportunity to inform and to encourage participation. As a family physician, you will also be informed of the results of screening tests and any subsequent procedures for your patients.

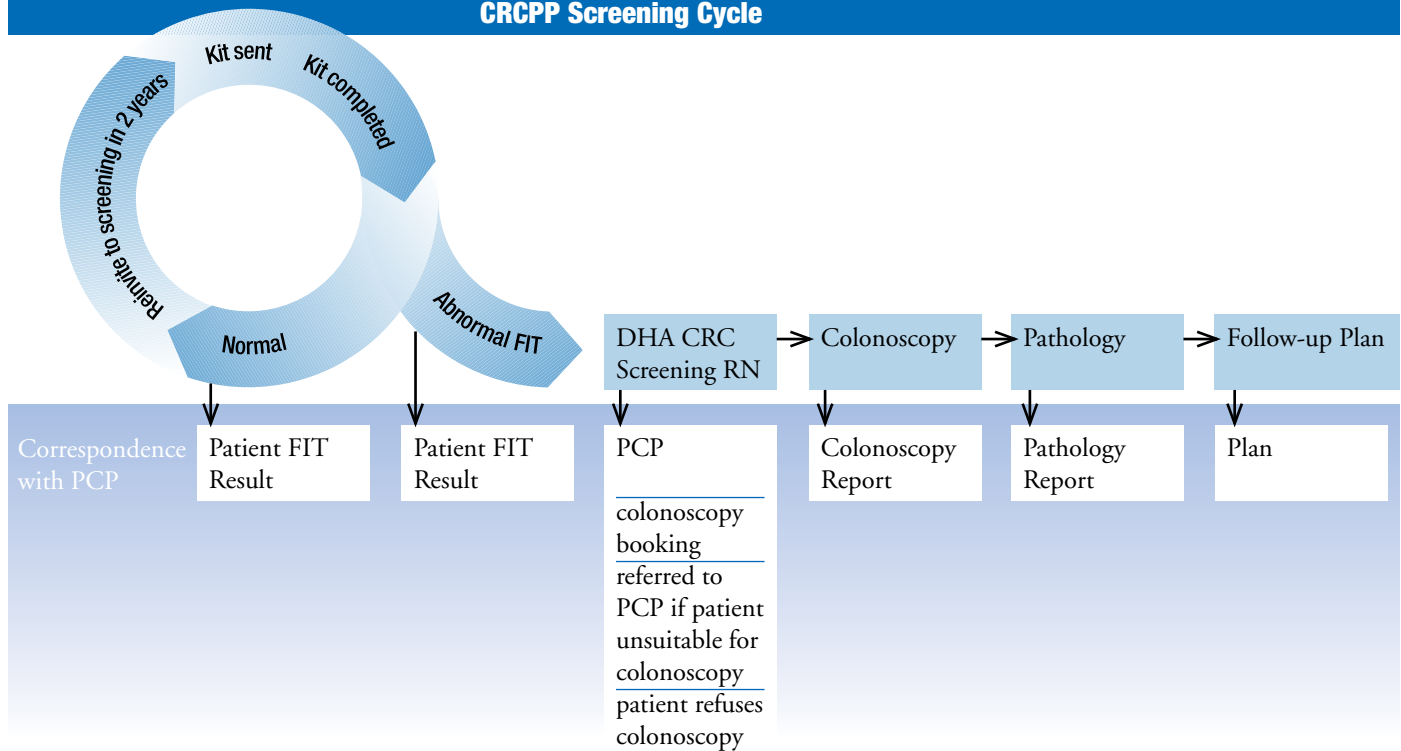
The fact is, most Nova Scotians don’t understand the risk. A survey conducted last year by *Cancer Care Nova Scotia* found that most people did not know colorectal cancer is a leading cause of cancer death and many individuals could not identify symptoms or risk factors of the disease. However, when provided with basic information about colorectal cancer and the screening test, most respondents said they would “definitely” or “probably” complete it.

Furthermore, patients may also have questions about their personal risk for colorectal cancer. People who are symptomatic, have a positive family history, or a hereditary or inflammatory bowel condition are at increased risk for developing CRC and should discuss appropriate screening methods with their family physician. Refer to the figure, Increased Risk Screening Pathway, in the enclosed insert.

Additional information is available, for both patients and health care professionals, by calling *Cancer Care Nova Scotia* toll-free at 1-866-599-2267 or visiting [www.cancercare.ns.ca](http://www.cancercare.ns.ca). The CRCPP is partnering with Dalhousie University’s Community Medicine Program and will be hosting a series of CME events across the province this Spring. Also, the CRCPP will be the focus of the May 12 Cancer Answers Public Lecture Series.

We will also ensure that participants are directed to the most appropriate clinical resources. To decrease the wait time between a positive screening test and a diagnostic follow-up, the DHAs are appointing Colorectal Cancer Screening Nurses who will conduct the pre-endoscopy assessment, instruct the participant on the benefits and risks of colonoscopy, make the appointment for colonoscopy, and provide all relevant information to the colonoscopist and the primary care provider. In other words, Primary Care Providers will be informed of their patient’s status in the program, but will not be responsible for facilitating the referral process for any diagnostic follow-up of a positive FIT. This care model has been implemented successfully in the United Kingdom with their National Health Service (NHS) Bowel Cancer Screening program.

## CRCPP Screening Cycle



### A Good FIT

Colorectal cancer screening is not new. Fecal occult blood tests (FOBT) have been available through primary care providers for decades. Yet despite the evidence supporting screening and the availability of screening tests, screening rates are very low in Canada. Estimates place screening for colorectal cancer in this country at only 10–20%.

The Fecal Immunochemical Test (FIT) is specific for human hemoglobin. Therefore, unlike the guaiac-based FOBT, no dietary restriction is required and only two stool samples need to be taken – two important differences that we hope will result in increased acceptability of the test and participation in screening. Furthermore, the FIT is more sensitive to colonic origin of blood loss and provides greater specificity for significant neoplasms - resulting in fewer false positive tests (and, as a result, fewer colonoscopies).

Another benefit of colorectal cancer screening is that it can detect polyps that may develop into cancer over time. Once detected, these polyps can be removed during a colonoscopy.

The survey conducted by *CCNS* found that most Nova Scotians are comfortable with having the screening tests distributed to them by mail. While some report finding the idea of taking a stool test discomforting, they appreciate being able to do it in the privacy of their home.

Cancer Care Nova Scotia is a program of the Department of Health. Its mandate is to evaluate, coordinate and strengthen the cancer system in Nova Scotia.

Cancer Care Nova Scotia works with and supports professionals and stakeholders in the health care system to bring about patient-centred change. Its ultimate goal is to reduce the burden of cancer on individuals, families, communities and the health care system.

In Practice is a supplement to Cancer Care Nova Scotia's newsletter. It is written specifically for primary care practitioners with information that we hope will make a difference in your cancer practice.

Please contact Christine Smith, Communications Coordinator, Cancer Care Nova Scotia, by phone at 902-473-2932 or by email at christine.smith@ccns.nshealth.ca with comments or suggestions for future topics.



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## Follow-up of an abnormal FIT result

Everyone who takes part in the program will receive their test results, and so will their family physician. Participants will be asked to identify their family physician/primary care provider when they return their completed kits. Arrangements are being made by each DHA to identify family physicians or other PCPs who will accommodate those who do not have one.

The CRCPP informs the appropriate district colorectal cancer screening nurse when there is a positive FIT. The screening nurse contacts participants to schedule a pre-endoscopy visit. During that visit, the screening nurse records relevant family and personal health history; provides a detailed explanation of the colonoscopy procedure, including risks and limitations; assesses overall fitness to undergo colonoscopy; describes the protocol for bowel preparation; and uses agreed algorithms to modify the bowel preparation in special circumstances (e.g., in the case of patients with diabetes).

The screening nurse plays an important role – and helps ensure a seamless process for individuals with a positive FIT. The screening nurse will be in touch with individuals within two weeks of the positive test result to book a colonoscopy, which will be performed by a colonoscopist who has met criteria and received credentials for this program. The criteria include having performed at least 200 colonoscopies a year, reporting their technique with respect to quality of bowel preparation, cecal intubation rate, and withdrawal time, and submitting to a monitoring process.

Individuals who are not appropriate candidates for colonoscopy will be informed – along with their family physician – and other diagnostic measures will be considered for them on an individual basis.

Family physicians and other primary care providers will receive a copy of their patient's report and will be involved every step of the way.

Based on research and modelling projections, this is what is likely to occur with the introduction of the program:

### Predicted outcome of colon cancer screening program

*(based on the experience of the NHS guaiac-based screening program)*

For every **1,000** individuals who complete the FIT



Around **20** will have a positive test



Around **16** will agree to a colonoscopy



Nothing abnormal is found in **8**

Around **6** have polyps

Around **2** have colon cancer

For more information about the Colorectal Cancer Prevention Program, call us at 1-866-599-2267, or visit our website at [www.cancercare.ns.ca](http://www.cancercare.ns.ca)

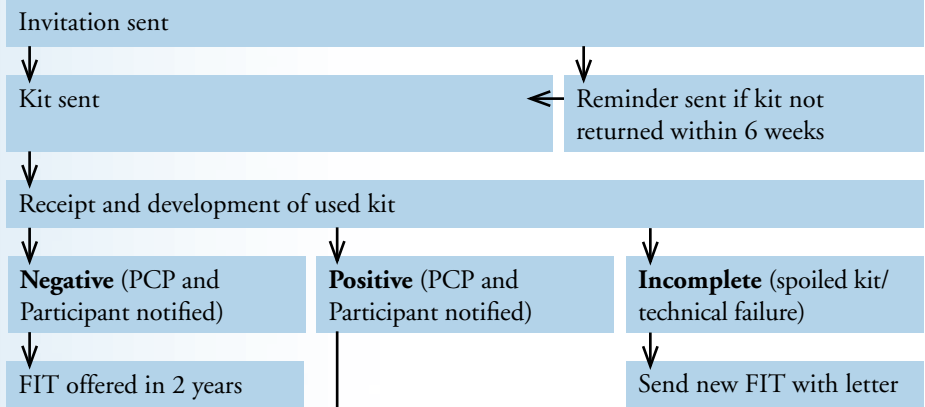
# Colorectal Cancer Screening

## Information for sharing with patients

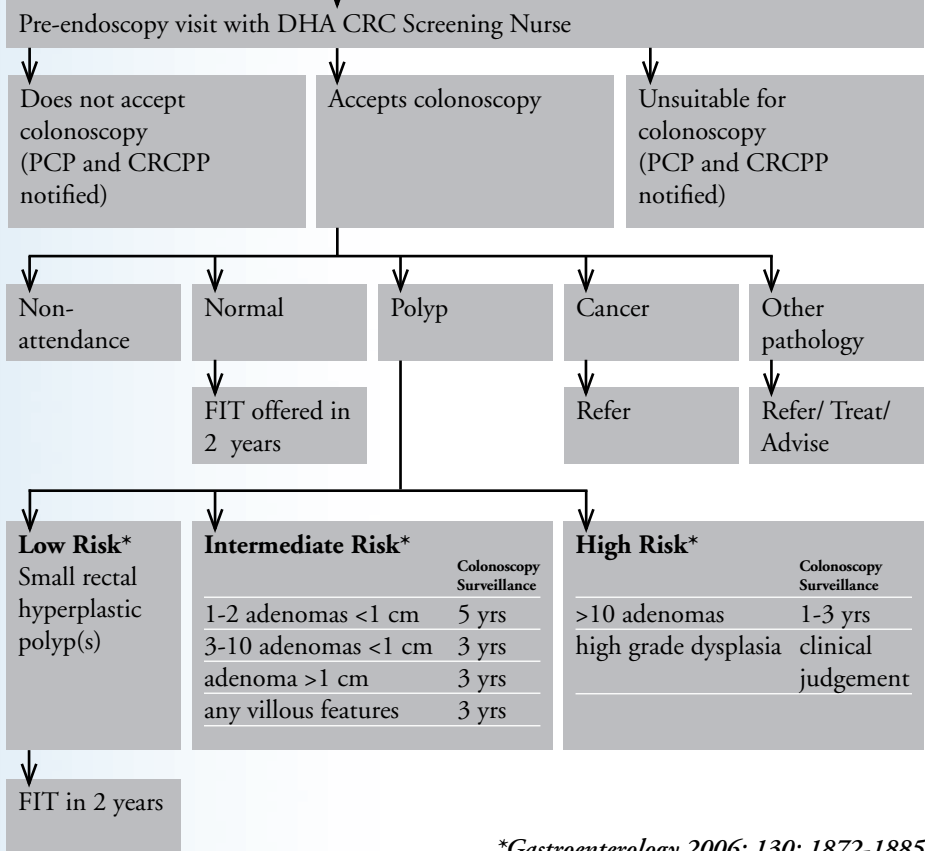
- Colorectal cancer (CRC) is a leading cause of cancer deaths in Nova Scotia.
- The majority of Nova Scotians who develop colorectal cancer are over the age of 50 and have no family history of the disease. The incidence of CRC is higher in men than women.
- Taking part in colorectal cancer screening reduces the chances of dying from colorectal cancer.
- Colorectal cancer screening can also detect polyps that may develop into a cancer over time. These polyps can be removed during a colonoscopy.
- There is a chance that a cancer can be missed if it was not bleeding when the screening test was taken. This is why people are being encouraged to screen every two years.
- Although some people may find completing the FIT kit unpleasant, it can be done in the privacy of the participant's own home.
- An abnormal test result means that further investigations will be offered.
- Most people who have a colonoscopy will not have cancer.
- Although rare, there are risks associated with having a colonoscopy. There is a 1 in 500 risk of bleeding and a 1 in 1000 risk of perforating the bowel.

## Average Risk Screening Pathway

### Cancer Care Nova Scotia

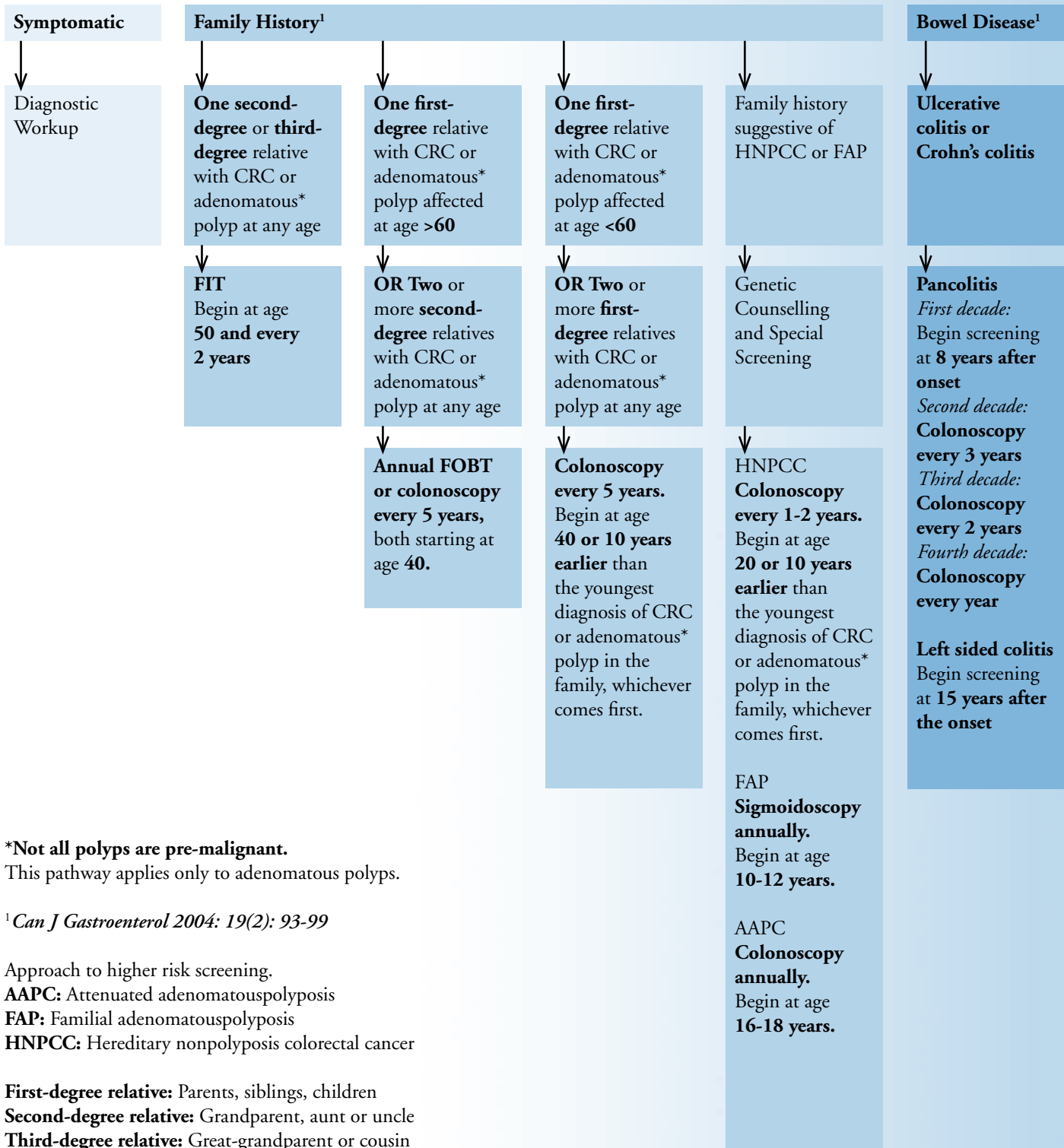


### DHA



\*Gastroenterology 2006; 130: 1872-1885

## Increased Risk Screening Pathway



**\*Not all polyps are pre-malignant.**

This pathway applies only to adenomatous polyps.

<sup>1</sup> *Can J Gastroenterol 2004; 19(2): 93-99*

Approach to higher risk screening.

**AAPC:** Attenuated adenomatous polyposis

**FAP:** Familial adenomatous polyposis

**HNPCC:** Hereditary nonpolyposis colorectal cancer

**First-degree relative:** Parents, siblings, children

**Second-degree relative:** Grandparent, aunt or uncle

**Third-degree relative:** Great-grandparent or cousin