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Colorectal Cancer A W A R E N E S S

Colorectal cancer is the second leading cancer killer in the United States, projected to affect 148,300 new people this year alone. In order to build awareness about this deadly disease and to demonstrate how screening for early detection can save lives, the month of March has been declared National Colorectal Cancer Awareness Month. More than 90% of new cases of colorectal cancer are treatable if the disease is detected in its early stages. As part of Colorectal Cancer Awareness Month, physicians are encouraged to use colorectal screening to aid in the early detection of this preventable and treatable disease.

Why Should Patients Be Screened?

Colorectal cancer almost always develops from precancerous polyps in the colon or rectum. Screening tests can find these polyps, and procedures such as a colonoscopy can remove them before they develop into cancer. Screening tests can aid in the early detection of cancer, when treatment options are most effective.

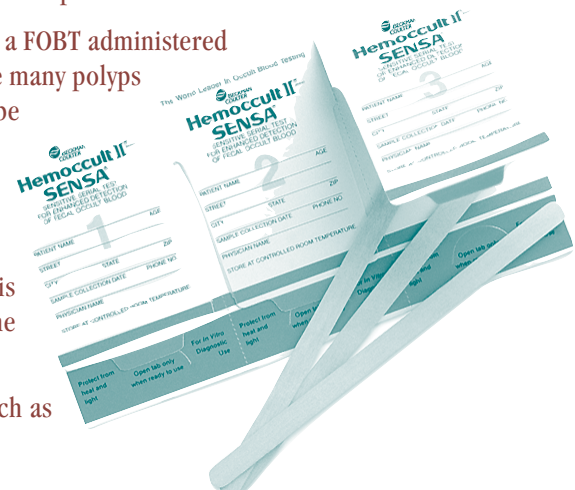
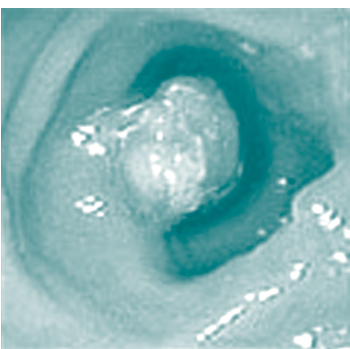
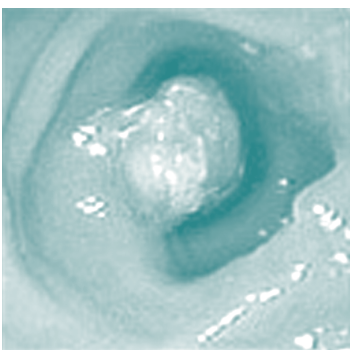
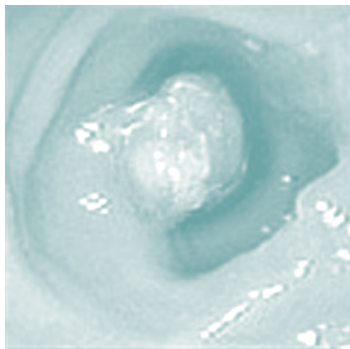
How Can Physicians Screen and Test for Colorectal Cancer?

- Annual Fecal Occult Blood Test (FOBT), which tests for occult (hidden) blood in the stool.
- Flexible Sigmoidoscopy (Flex Sig), performed every five years. Flex Sig is a procedure whereby a tube is inserted into the rectum, allowing the physician to see the lower third of the colon.
- Annual FOBTs Plus Sigmoidoscopy
- Colonoscopy, a similar procedure to the Flex Sig, enabling the physician to examine the entire colon.
- Barium Enema, a procedure that takes an x-ray of the colon.

Generally, a take home triple slide FOBT is the first line of defense in detecting occult blood in the stool, and studies show a 33% reduction in colorectal cancer death rates among participants who were annually screened for the disease using FOBT. In order to adequately screen for fecal occult blood and the presence of polyps, male and female patients aged 50 and older should be given a triple slide FOBT kit from their physician annually, even if they have no symptoms. The triple slide FOBT is the most clinically effective methodology for administering FOBT to patients.

The take home triple slide FOBT is more reliable than a FOBT administered through the use of a digital rectal office exam because many polyps and cancers bleed intermittently or blood may not be present in the part of the stool tested. Therefore, the three separate stool samples required in the take home test better enable providers to detect blood that may not be present in the single sample or in the part of the stool tested. Further, a digital exam is designed only to check for general abnormalities in the lower three inches of the rectum, not the colon.

In the event of a positive result, other procedures, such as a Flex Sig and colonoscopy, should be performed.



The Facts

- Both men and women are at risk of developing premalignant polyps and/or colorectal cancer
- 93% of all cases occur in people age 50 or older
- Many people with polyps or colorectal cancer show no symptoms, particularly in the early stages
- Premalignant polyps are often found in people with positive FOBTs, and removed during colonoscopy
- Screening can prevent colorectal cancer or detect the disease in the early stages. When detected early, the 5-year survival rate for colorectal cancer is 91%
- As many as 30,000 lives a year could be saved through adoption of colorectal cancer screening if colorectal cancers were found in their early stages

What This Means for Providers

ALL patients with no family history should begin colorectal screening at age 50, when the risk of developing colorectal cancer is greatest. Screening should start with yearly FOBT triple slide tests, but patients also have the option of receiving a Flex Sig every 5 years, a colonoscopy every 10 years, or a barium enema every 5–10 years.

Patients with a personal or family history of colorectal cancer, colorectal polyps, inflammatory bowel disease, or breast, uterine, or endometrial cancer should be tested more often. It also may be necessary for these higher risk patients to begin their yearly screenings earlier than age 50.

Patients exhibiting warning signs, including blood in stool, unexplained stomach cramps, altered bowel habits such as narrower-than-usual stool, and unexplained weight loss, should see their physician immediately for a health check-up.

Screening Costs:

FOBT (HCPC G0107) is clinically proven to be the most cost effective screening methodology, ranging between \$10 and \$15. Physicians should be asked to prescribe a clinically proven FOBT. Among patients, FOBT is the most popular screening method because samples are taken in the privacy of the home, the test is non-invasive, and the test presents no risk of bowel tears or infections.

Flex Sig (G0104) is a low- to mid-priced screening test, ranging between \$150 and \$200 each test. Flex Sig is quick, requires minimal bowel preparation, offers minimal discomfort, and does not require a specialist. However, the Flex Sig only checks the lower third of the colon, and is not 100% effective at identifying all polyps and cancers.

Barium Enema (G0122) is a mid- to high-cost test, priced at \$300 to \$400 each. The procedure enables the physician to view the entire colon, results in few complications, and requires no sedation.

Colonoscopy (G0120) is a high-cost test, priced at roughly \$1,000 a procedure. Colonoscopy can be used to view the entire colon and permit removal of polyps during the procedure. Colonoscopy also can diagnose other diseases that may be present.

Adapted from CDC's "Basic Facts on Screening"

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ASSESSING RISK

Average Risk

Is the patient 50 years or older, with no other risk factors?

- Take FOBT every year and/or Flex Sig every 5 years starting at age 50. Physicians may perform barium enema every 5 years and colonoscopy every 10 years.

Increased Risk

Does the patient have a single, small adenoma?

- Test 3–6 years after the removal of the polyp with colonoscopy. If normal, screen using annual FOBT and/or Flex Sig.

Does the patient have large or multiple adenomas with high-grade dysplasia?

- Test within 3 years after the initial removal of the polyp with colonoscopy. If normal, repeat in 3 years and conduct annual FOBT and/or Flex Sig tests.

Does the patient have a personal history of a surgical resection of colorectal cancer with hope of cure?

- Test within 1 year of resection using colonoscopy. If normal, screen using colonoscopy in 3 years. If normal, screen with colonoscopy every 5 years.

Does the patient have a history of colorectal cancer or adenoma in first-degree relative younger than age 60 or two or more first-degree relatives of any age?

- Test using colonoscopy at age 40, or 10 years before the youngest case in the family. If normal, test in 5–10 years using colonoscopy. Annual FOBT and Flex Sig every 5 years can also be added.

Does the patient have a history of colorectal cancer in other relatives (not first-degree relatives)?

- Begin testing before age 50 using annual FOBT and Flex Sig every 5 years.

High Risk

Does the patient have a family history of familial adenomatous polyposis (FAP)?

- Test at puberty using colonoscopy. Consider genetic tests, and refer to center experienced in FAP.

Does the patient have a family history of hereditary non-polyposis colon cancer (HNPCC)?

- Test at age 21 using colonoscopy. Consider genetic tests, and test with colonoscopy every 1–2 years until age 40. At age 40, test using colonoscopy every year.

Has the patient been diagnosed with inflammatory bowel disease, Crohn's disease, and/or ulcerative colitis?

- Test 8 years after the start of pancolitis or 12–15 years after the start of left-sided colitis using colonoscopy with biopsies for dysplasia. Continue testing using colonoscopy every 1–2 years.

Adapted from the American Cancer Society's "Colorectal Cancer: Early Detection." Guidelines 2002

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