

NWT Clinical Practice Information Notice

Upon receipt, please file this notice in **Section C, Clinical Practice Information Binder** for future reference.

The following clinical practice has been approved for use in the Northwest Territories Health and Social Services system, and has been distributed to:

<input checked="" type="checkbox"/>	Hospitals	<input checked="" type="checkbox"/>	Community Health Centers	<input checked="" type="checkbox"/>	Homecare	<input checked="" type="checkbox"/>	LTCF	<input checked="" type="checkbox"/>	Lab Directors
<input checked="" type="checkbox"/>	Doctors' Offices		Social Services Offices	<input checked="" type="checkbox"/>	Public Health Units		Other		

The information contained in this document is a Departmental:									
	Policy	<input checked="" type="checkbox"/>	Standard		Protocol		Procedure	<input checked="" type="checkbox"/>	Guideline

Title: NWT Colorectal Screening Guidelines (2011)
Effective Date: March 2011

Statement of approved Clinical Practice:

The Chief Public Health Officer and the NWT Medical Directors have approved and are recommending the implementation of the updated 2011 NWT Colorectal Cancer Screening Clinical Practice Guidelines as a standard of practice throughout the NWT.

Screening for colorectal cancer in the average risk, increased risk and special risk population groups is associated with a reduction in morbidity and mortality for this disease.

These guidelines include information as follows:

- Immediate Referral
- Age of Screening Onset
- Increased Risk screening pathway
- Increased Surveillance
- Risk Assessment
- Average Risk screening pathway
- Special Risk referrals
- Tips for a healthy colon

These March 2011 Colorectal Cancer Screening guidelines, contain the approved clinical practice standard for the NWT, and supersede all previous Colorectal Cancer Screening guidelines.

Attachment:
 NWT Colorectal Cancer Screening Guidelines

This clinical practice is approved. Original Signed by Paddy Meade March 18/11

 (signature)

Deputy Minister Chief Public Health Officer Director, Child & Family Services Director, Adoptions



NWT Colorectal Cancer Screening Clinical Practice Guidelines

Immediate Referral	Refer everyone for diagnostic work-up for colorectal cancer (CRC) if signs and symptoms are present <ul style="list-style-type: none"> ◇ rectal mass, abdominal mass, unexplained weight loss, unexplained change in bowel habits, rectal bleeding, unexplained anemia, persistent urge to evacuate the rectum, unexplained stool incontinence 	
Assess Risk	<ul style="list-style-type: none"> ◇ Average risk: No signs/symptom , no personal history and no first degree relative with CRC or genetic syndromes or Inflammatory Bowel Disease ◇ Increased risk: no signs/symptoms; one first degree relative with CRC (parent, child, sibling) less than age 60 or two first degree relatives with CRC at any age ◇ Special risk: Family history of genetic syndromes (Hereditary Nonpolyposis Colorectal Cancer, Familial adenomatous polyposis & attenuated adenomatous polyposis); longstanding inflammatory bowel disease (IBD) such as Crohn's colitis or Ulcerative colitis 	
Age of Screening Onset	<ul style="list-style-type: none"> ◇ Average risk: Age 50-74 years for average risk ◇ -Increased risk: Age 40 or 10 yrs younger than earliest age of CRC diagnosis in family whichever is first ◇ -Special risk: age of onset varies and can start quite young, please refer to specialist 	
Screening For Average Risk	Do fecal immunochemical (FIT) test	FOLLOW UP POST SCREENING <ul style="list-style-type: none"> • Negative result—repeat FIT test in 1-2 years • Positive result—refer for diagnostic colonoscopy, if negative restart screening in 10 years • Unsatisfactory result—repeat FIT
Screening For Increased Risk	Do screening colonoscopy	FOLLOW UP POST SCREENING <ul style="list-style-type: none"> • Negative result—repeat in 5-10 years • Positive result—treat and repeat colonoscopy based on results (See reverse)
Special Risk	Refer to specialist	Reference: Canadian Association of Gastroenterologists. http://www.cag-acg.org
Increased Surveillance	<ul style="list-style-type: none"> • In those with >2 adenomas ◇ adenoma with high grade dysplasia • in those with 1 adenoma with the following features <ul style="list-style-type: none"> ◇ adenoma ≥1cm OR ◇ adenoma with villous features OR • Sessile adenoma removed piecemeal • In those with a past history of CRC 	
Discontinue Screening	Age 75 years for those with average risk	

Tips for a Healthy Colon

- ◇ Eat between 25 and 30 grams of fiber each day from fruits, vegetables, whole grain breads and cereals, nuts, and beans. Eat a low-fat diet. Colorectal cancer has been associated with diets high in saturated fat. Eat foods with folate, such as leafy green vegetables.
- ◇ Only drink alcohol in moderation.. Quit smoking. Alcohol and tobacco in combination are linked to colorectal cancer and other gastrointestinal cancers.
- ◇ Exercise for at least 30 minutes three to four days a week. Maintain a healthy weight. Obesity may increase the risk of colorectal cancer especially if distributed around the waist.

Useful Statistics

Lifetime risk of CRC:

- 4% if average risk and no signs or symptoms
- 9% if one 1° relative has CRC
- 15% if one 1° relative has CRC at < 45years
- 16% if two 1° relative have CRC
- ~70-100% in untreated hereditary polyposis
- 1-5% of adenomas become CRC particularly if ≥1 cm or villous features or high grade dysplasia

- FIT test is safe, and non-invasive. It requires no bowel preparation and is more specific for bleeding from the colon or lower gastrointestinal tract. It is specific for human globin and is not affected by diet or medications.
- Colonoscopy can examine entire colon , allows for biopsy & polyp removal but is invasive, carries risk of perforation and bleeding. It also requires bowel preparation.

Screening for Average Risk

Assess risk

If signs or symptoms,
any age

**IMMEDIATE
referral for
diagnostic workup**

Average Risk,
<50 years old

No
Screening

Average Risk,
50-74 years old

FIT test

Increased Risk

See *Screening for
increased risk
algorithm*

Negative

Repeat FIT
in 1-2 years

Unsatisfactory

**For SPECIAL risk
(genetic syndrome
or IBD), refer to
specialist**

Negative or hyperplastic polyps

Restart screening in 10 years
unless risk changes

Positive

Refer for **Diagnostic** Colonoscopy

Positive

Endoscopist discretion on follow-up

Screening for Increased Risk

Screening Colonoscopy

