

American Medical Women's Association
Position Paper on Principals of Prevention & Early Detection of Colorectal Cancer in
Women

The American Medical Women's Association (AMWA) is a national organization of women physicians and physicians-in-training, established in 1915, with a primary mission with bring about improvements in the health of women.

Colorectal cancer (CRC) is the second leading cancer killer in the United States. There is a perception by both the profession and the public that women do not get CRC as frequently as men. That is decidedly untrue. According to the American Cancer Society, in 1999, 129,400 Americans will be diagnosed with colorectal cancer, 62,300 men and 67,000 women. The ACS also predicts that 56,600 Americans will die from colorectal cancer, 27,800 men and 28,800 women (1). This high mortality rate has decreased only slightly in the last twenty years because nearly half of cases are not detected until the CRC has advanced to a later, incurable stage (2,3).

The biological nature of CRC makes it amenable to both prevention and early detection. In most cases, the development of CRC is a slow process, starting with a benign growth, an adenomatous polyp and evolving into cancer over a 10-15 year period. CRC is actually prevented by detection and removal of adenomatous polyps. Because of the slow growth period, regular screening tests can detect CRC in its earliest phase, before any symptoms have occurred (4).

We have effective screening tests for CRC: the fecal occult blood test (FOBT), the flexible sigmoidoscopy, colonoscopy, and the double-contrast barium enema (DCBE). Yet a recent survey (5) showed that less than 10% of the population had had the recommended tests within the appropriate time intervals. Other surveys have shown that women were less likely than men to have had screening. A 1995 survey showed that only 24% of women and 35% of men had had sigmoidoscopy within the past 5 years(6).

The New Guidelines:

We now have new guidelines for CRC screening, published by the American Cancer Society Detection and Treatment Advisory Group on Colorectal Cancer in 1997 (7). These guidelines stratify patients by risk and recommend when screening should commence and by what type of screening procedure. Three risk levels are described: average, moderate, and high.

Average Risk: 70-80% are at average risk. The risk factor is age 50 and above. For average risk patients, starting at age 50, the recommended screening tests are FOBT yearly with flexible sigmoidoscopy every 5 years, colonoscopy every 10 years, or DCBE every 5-10 years.

Moderate Risk: 15-20% are at moderate risk. The risk is a personal or family history of colon polyps or cancer: Moderate risk patients with family history should begin screening at age 40 or 10 years younger than the age at which the affected family member was diagnosed. They should begin screening with a total colon exam (TCE), either colonoscopy or DCBE every 5 years. Patients diagnosed with cancer or polyp should be examined every 3 years with a TCE.

High Risk: 5-10% are at high risk. They have inflammatory bowel disease (IBD) or a family history of an inherited CRC syndrome. High risk patients with IBD require screening starting 8 years after the diagnosis. Those with familial polyposis or nonpolyposis colon cancer syndrome require screening at earlier ages, adolescence or early adulthood, respectively. Total colon exam (TCE) must be done.

Commitment to increase screening:

Patients in the high risk group, or the moderate risk group because of previously diagnosed polyp or cancer, are likely to be in specialty care and receive appropriate surveillance. Screening is much less likely to be offered to those in the average risk group or the moderate risk group with family history only. Cancers in these groups can comprise up to 90% of all CRC.

The American Medical Women's Association has joined the ACS (American Cancer Society) and the CDCP (Centers for Disease Control and Prevention) as a member of their National Colorectal Cancer Roundtable. AMWA commits to educating its members about the guidelines of CRC screening and urges all members to see that all their patients receive age and risk appropriate screening. In particular AMWA will emphasize that women are at the same risk as men and should receive the same advice for screening. AMWA hopes that the rate of screening for CRC will rise to become commensurate with the screening levels for cervical cancer and breast cancer screening in women.

AMWA will also join with the NCCR to promote standards for training and credentialing those doing CRC screening. AMWA advocates research into new technologies to make screening simpler, more effective, and safer. AMWA supports the concept of making CRC screening the standard of care for all health care delivery systems, be they HMO's, MCO's, or individual practices. AMWA also supports including CRC screening as a covered benefit in all private and public supported plans.

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