TABLE 2 Guidelines for Screening for the Early Detection of Colorectal Cancer and Adenomas for Average-risk Women and Men Aged 50 Years and Older

The following options are acceptable choices for colorectal cancer screening in average-risk adults beginning at age 50 years. Since each of the following tests has inherent characteristics related to prevention potential, accuracy, costs, and potential harms, individuals should have an opportunity to make an informed decision when choosing one of the following options.

In the opinion of the guidelines development committee, colon cancer prevention should be the primary goal of colorectal cancer screening. Tests that are designed to detect both early cancer and adenomatous polyps should be encouraged if resources are available and patients are willing to undergo an invasive test.

### Tests that Detect Adenomatous Polyps and Cancer

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<tr>
<th>Test</th>
<th>Interval</th>
<th>Key Issues for Informed Decisions</th>
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| FSIG with insertion to 40 cm  | Every 5 years | • Complete or partial bowel prep is required  
• Sedation usually is not used, so there may be some discomfort during the procedure  
• The protective effect of sigmoidoscopy is primarily limited to the portion of the colon examined  
• Patients should understand that positive findings on sigmoidoscopy usually result in a referral for colonoscopy |
| or to splenic flexure          |          |                                                                                                   |
| Colonoscopy                   | Every 10 years | • Complete bowel prep is required  
• Conscious sedation is used in most centers; patients will miss a day of work and will need a chaperone for transportation from the facility  
• Risks include perforation and bleeding, which are rare but potentially serious; most of the risk is associated with polypectomy |
| DCBE                          | Every 5 years | • Complete bowel prep is required  
• If patients have one or more polyps ≥6 mm, colonoscopy will be recommended; follow-up colonoscopy will require complete bowel prep  
• Risks of DCBE are low; rare cases of perforation have been reported |
| CTC                           | Every 5 years | • Complete bowel prep is required  
• If patients have one or more polyps ≥6 mm, colonoscopy will be recommended; if same day colonoscopy is not available, a second complete bowel prep will be required before colonoscopy  
• Risks of CTC are low; rare cases of perforation have been reported  
• Extracolonic abnormalities may be identified on CTC that could require further evaluation |

### Tests that Primarily Detect Cancer

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| gFOBT with high sensitivity  | Annual    | • Depending on manufacturer’s recommendations, 2 to 3 stool samples collected at home are needed to complete testing; a single sample of stool gathered during a digital exam in the clinical setting is not an acceptable stool test and should not be done  
• Positive tests are associated with an increased risk of colon cancer and advanced neoplasia; colonoscopy should be recommended if the test results are positive  
• If the test is negative, it should be repeated annually  
• Patients should understand that one-time testing is likely to be ineffective |
| for cancer                    |           |                                                                                                   |
| FIT with high sensitivity     | Annual    |                                                                                                   |
| for cancer                    |           |                                                                                                   |
| sDNA with high sensitivity    | Interval uncertain | • An adequate stool sample must be obtained and packaged with appropriate preservative agents for shipping to the laboratory  
• The unit cost of the currently available test is significantly higher than other forms of stool testing  
• If the test is positive, colonoscopy will be recommended  
• If the test is negative, the appropriate interval for a repeat test is uncertain |

Abbreviations: FSIG, flexible sigmoidoscopy; DCBE, double-contrast barium enema; CTC, computed tomography colonography; gFOBT, guaiac-based fecal occult blood test; FIT, fecal immunochemical test; sDNA, stool DNA test.