

Clinician Tip Sheet for Discussing Colorectal Cancer (CRC) Screening with Patients Aged 76-85

3-Step Shared Decision Making Process

- 1) Tailor evidence: Determine potential benefit and risk of CRC screening
- 2) Invite patient to participate and Elicit goals, concerns and preferences about CRC testing
- 3) Inform patients and come together on a decision

We distilled evidence to help with Step 1: Tailor Evidence

Start with Estimate of Life Expectancy: The following presents the 25th, 50th and 75th percentiles of life expectancy (in rounded years) from the 2023 National Vital Statistics Reports for 75, 80 and 85 year old females and males:

	Female			Male		
	75yo	80yo	85yo	75yo	80yo	85yo
Good health (75 th)	17	13	10	15	11	8
Average for age (50 th)	12	9	7	11	8	6
Poor health (25 th)	7	5	3	6	3	2

Then use life expectancy and prior screening to Estimate Benefit: The following table describes four main groups based on life expectancy and prior screening history. Generally, screening can cut the lifetime risk of dying from CRC in half.

	Life Expectancy			
	<5 years	>5 years		
		Prior screening history		
		Fully screened with consistently normal results (no polyps or hyperplastic polyps only)	Incomplete or no prior screening, with or without prior low-risk polyps	High risk polyps (think ALL): - Advanced: adenoma with tubulo-villous or villous histology, adenoma with high-grade dysplasia, or - Large: any adenoma ≥10 mm, or - Lots: 5-10 tubular adenomas <10 mm
Lifetime risk of dying from CRC	<<1%	<1%	1%	4%
Benefit of testing (reduction in mortality risk)	<<1%	<<1%	0.5%	2%
Summary	For patients with < 5yr life expectancy, CRC screening <u>not</u> recommended	Pts with small risk have little to no benefit of testing. If pt has strong preference to continue, consider stool test to minimize complications	Testing can cut risk of CRC death in half; reasonable to stop, use stool test or colonoscopy depending on patient preference and prior history	Testing can cut risk of CRC death in half; reasonable to stop or use colonoscopy depending on patient preference; no evidence to support stool testing for surveillance of polyps yet

Potential Risks of Colonoscopy: Procedural risks of colonoscopy, increase with age and poor health: need to consider complications of the prep, complications of sedation, as well as potential for bleeding and perforation. Risk of serious bleeding doubles (24 per 10,000) and risk of perforation quadruples (16 per 10,000) for patients age 70-80 compared to younger patients.

A few other considerations:

- Family history of CRC is a minor risk enhancer once patients are 75+; they have “outgrown” their increased risk.
- At present, the only evidence-based method of polyp surveillance is colonoscopy. Studies are ongoing to determine how stool testing performs as a CRC detection test for patients with prior polyps. Some patients may be interested in switching from colonoscopy to stool testing; the limitations of stool testing as a polyp surveillance test should be discussed with patients.
- For patients who decide to stop testing, make sure to inform them about reporting any symptoms or changes in bowel habits

Here are a few scripts to introduce the decision and to explore patients’ views on continued testing:

- (For a fully screened patient with normal results): “You’ve done a great job taking care of your health, including your cancer screening. All the prior tests were normal, and that means your chance of dying from colorectal cancer is very low, less than 1%. We’re at a point we don’t have to continue doing tests. What are your thoughts on colon cancer screening, does it still seem worth it to you?”
- (For a patient with low-risk polyps resected): “Given that you have had polyps removed over the years, you’ve greatly reduced your risk of having colon cancer. Your risk of dying of colon cancer is about 1% in the next 10 years. Any further testing is now a decision we make after talking about the pros and cons of colorectal cancer screening.”
- (For high-risk patients with short-interval colonoscopy recommended but have competing serious illnesses): “Your colonoscopy 3 years ago showed (*multiple polyps, high-risk pathology, etc*). The recommendation from your gastroenterologist is to continue colonoscopies every 3 years, to reduce your risk of dying from colon cancer. I know you have been dealing with a lot with your health this past year, [*e.g. your hospital stay for your heart condition*]. Would you like to talk about pros and cons of doing further colonoscopies today?”

Here are a few questions to elicit patient’s goals, concerns and preferences:

- How worried are you about colon cancer? Does screening still seem worth it to you?
- How important is it to you to keep screening versus focus efforts on other health priorities?
- How do you feel about stopping testing?
- What do you hope to gain by continuing to test?

Sources and additional resources

Lee Schonberg (e-prognosis) Index to generate a life expectancy estimate: <https://eprognosis.ucsf.edu/leeschonberg.php>

NCI CRC risk calculator (requires diet and activity data): <https://ccrisktool.cancer.gov>

Knudsen AB, et al. Colorectal Cancer Screening: An Updated Modeling Study for the US Preventive Services Task Force. JAMA. 2021 May 18;325(19):1998-2011. PMID: 34003219

SEER*Explorer: An interactive website for SEER cancer statistics [Internet]. cited 2024 Aug 4. Available from: <https://seer.cancer.gov/statistics-network/explorer/>

Gupta S, et al. Recommendations for Follow-Up After Colonoscopy and Polypectomy: A Consensus Update by the US Multi-Society Task Force on Colorectal Cancer. Am J Gastroenterol. 2020 Mar;115(3):415-434. PMID: 32039982.