The full version of the Canadian colorectal cancer screening guidelines has been published in the *Canadian Journal of Gastroenterology*. The guidelines were prepared collaboratively by the Canadian Association of Gastroenterology (CAG), the Canadian Digestive Health Foundation (CDHF), and the Canadian Society of Primary Care Gastroenterology (CanGut). The technical report of Health Canada's National Committee on CRC Screening can be found at [www.hc-sc.gc.ca/pphb-dgspsp/publicat/ncccs-cndcc/intro_e.html](http://www.hc-sc.gc.ca/pphb-dgspsp/publicat/ncccs-cndcc/intro_e.html).

Colorectal cancer (CRC) is the third most common cancer; 30% of people with CRC will die of it. Preventive strategies are intended to reduce mortality by screening selected populations to:

- detect and treat asymptomatic CRC early, and
- discover and remove adenomatous polyps (AP) before they become malignant.

### Risk assessment

Individual risk can be stratified according to age, personal history, and family history.

**Age.** Risk of CRC developing in the next 10 years of life increases with age and is:

- 1/1000 at age 30 to 39,
- 1/500 at age 40 to 49, and
- 1/125 at age 50 to 59.

**Personal history.** Increased risk accompanies a personal history of:

- inflammatory bowel disease,
- APs, or
- previous colon cancer.

**Family history.** High-risk family histories are found in more than 25% of cases and include:

- positive family history of CRC or AP with greater risk when the family member is a first-degree relative (parent, sibling, or child) affected before age 45 and with more than one affected relative, and
- cancer family syndromes, which account for 5% of CRC cases, including familial adenomatous polyposis, attenuated adenomatous polyposis coli, and hereditary nonpolyposis colon cancer.

### Low-to-average risk screening

Begin screening at age 50 if:

- no personal or family history increases risk of CRC or AP, or
- one second- or third-degree relative has CRC or AP.

Begin screening at age 40 if:

- one first-degree relative older than 60 has CRC or AP, or
- more than one second-degree relative has CRC or AP.

### Choice of screening method

Screening method should be determined by its availability and after discussion between patient and physician. Methods include:

- fecal occult blood test every 2 years,
- flexible sigmoidoscopy (with or without fecal occult blood testing) every 5 years,
- double-contrast barium enema every 5 years, and
- colonoscopy every 10 years.

Detailed information about the operating characteristics of the various methods is available at [http://www.hc-sc.gc.ca/pphb-dgspsp/publicat/ncccs-cndcc/intro_e.html](http://www.hc-sc.gc.ca/pphb-dgspsp/publicat/ncccs-cndcc/intro_e.html).
High-risk screening
Patients at high risk should be offered the following screening.

Personal history
- One to two tubular adenomas larger than 1 cm require colonoscopy in 5 years.
- If more than two APs are found, repeat colonoscopy in 3 years.
- Numerous, advanced, or large polyps require short-interval colonoscopy.
- Patients with previous CRC require colonoscopy at baseline, 3, and 5 years.

Family history
- If patient has a first-degree relative younger than 60 with CRC or AP or if more than one first-degree relative is affected at any age, screen with colonoscopy every 5 years from age 40 or 10 years before the youngest index case, whichever is earlier.
- For familial adenomatous polyposis, recommend genetic counseling and annual flexible sigmoidoscopy from age 10. For attenuated adenomatous polyposis coli and hereditary nonpolyposis colon cancer, recommend genetic counseling and annual flexible sigmoidoscopy from age 16 and age 20, respectively.

The complete guidelines can be accessed at www.cag-acg.org. Additional patient information is available from the Canadian Digestive Health Foundation at www.cdhf.ca and the Colorectal Cancer Screening Initiative Foundation at www.screencolons.ca.

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Reference