Colorectal Cancer in the US

Excluding skin cancers, colorectal cancer is the third most common cancer in men and in women. From 2007 to 2016, incidence rates declined by 3.6% annually among adults 55 years of age and older but increased by 2% annually among adults younger than age 55.

Types of Colorectal Cancer

Most colorectal cancers start as polyps, which may or may not develop into cancer. However, the risk for colorectal cancer increases if a polyp is larger than 1 cm, if more than 3 polys are found, or if a polyp shows dysplasia.

Most colorectal cancers are adenocarcinomas. Some subtypes of adenocarcinomas, such as signet ring cell or mucinous, may have a worse prognosis.

Risk Factors

About 55% of colorectal cancers in the US are attributable to potentially modifiable risk factors. Modifiable risk factors include: being overweight or obese, physical inactivity, smoking, high consumption of red or processed meat, low intake of calcium, fruits, vegetables, and whole-grain fiber, and heavy alcohol consumption.

Personal, hereditary and medical risk factors include:

- Older age: Rates in younger adults have increased in recent years, but colorectal cancer is more common after age 50.
- Personal or family history of colorectal cancer or adenomatous polyps
- Hereditary syndromes: About 5% of people who develop colorectal cancer have inherited gene mutations. These may include: Lynch syndrome (hereditary non-polyposis colorectal cancer, or HNPCC), familial adenomatous polyposis (FAP), Peutz-Jeghers syndrome (PJS), or MUTYH-associated polyposis (MAP)
- Race and ethnicity: In colorectal cancer, African Americans have the highest incidence and mortality rates in the US. Ashkenazi Jews have one of the highest risks in the world.
- Personal history of inflammatory bowel disease and Type 2 diabetes

Screening and Detection

Screening is a process used to test for cancer in people who have no symptoms. The American Cancer Society recommends the following screening for people at average risk for colorectal cancer.

Regular screening should start at age 45. People who are in good health and with a life expectancy of at least 10 years should continue regular colorectal cancer screening through the age of 75. For people ages 76 through 85, the decision to be screened should be based on patient preference, life expectancy, overall health, and prior screening history. People over 85 should no longer get colorectal cancer screening.

People at high risk based on family and/or personal history or other factors may need to start screening before age 45, get more frequent screening, or get specific tests. Screening can be done either with a stool-based test or a visual (structural) exam; like a colonoscopy.

**Stool-based tests**

- Highly sensitive fecal immunochemical test (FIT)* every year, or
- Highly sensitive guaiac-based fecal occult blood test (gFOBT)* every year, or
- Multi-targeted stool DNA test (MT-sDNA) every 3 years*
Visual exams of the colon and rectum

- Colonoscopy every 10 years, or
- CT colonography (virtual colonoscopy)* every 5 years, or
- Flexible sigmoidoscopy* every 5 years

*If a person chooses to be screened with a test other than colonoscopy, any abnormal test result should be followed up with a timely colonoscopy.

Signs and Symptoms

Early-stage colorectal cancer patients are typically asymptomatic. Some signs and symptoms may include: rectal bleeding, blood in the stool, change in bowel habits, abdominal cramping or pain, decreased appetite, unintended weight loss, or anemia.

Prevention

Regular screening for colorectal cancer can help prevent it by identifying pre-cancerous polyps before they become invasive tumors.

Also, improving diet and physical activity and maintaining a healthy weight may help decrease the risk of colorectal cancer.

Some patients with hereditary risk factors might benefit from meeting with a certified genetic counselor to better understand their risk and make an informed decision about having genetic testing. If found to have a cancer syndrome, recommendations for earlier screening or surgery might be considered.

Treatment

Surgery is the primary treatment for localized colorectal cancer. Radiation therapy and chemotherapy are sometimes used for initial treatment. For metastasized colorectal cancer, chemotherapy, targeted therapy, or immunotherapy may be used.

Quality of Life

Concerns that patients and survivors most often express include chronic diarrhea or stool incontinence; pain; neuropathy; body image; managing daily activities if they have an ostomy; problems with intimacy or sexual dysfunction; or distress. Younger men and women might be concerned about fertility.

A cancer diagnosis can profoundly impact quality of life. Clinicians should assess for any physical, social, psychological, spiritual, and financial issues. Integrating palliative care can help manage symptoms, address issues, and improve quality of life. It can be offered at any time from the point of diagnosis until the end of life. Throughout a patient’s cancer journey, it’s very important for clinicians to share information and coordinate care to ensure surveillance is ongoing.

References