Colorectal cancer – screening and testing

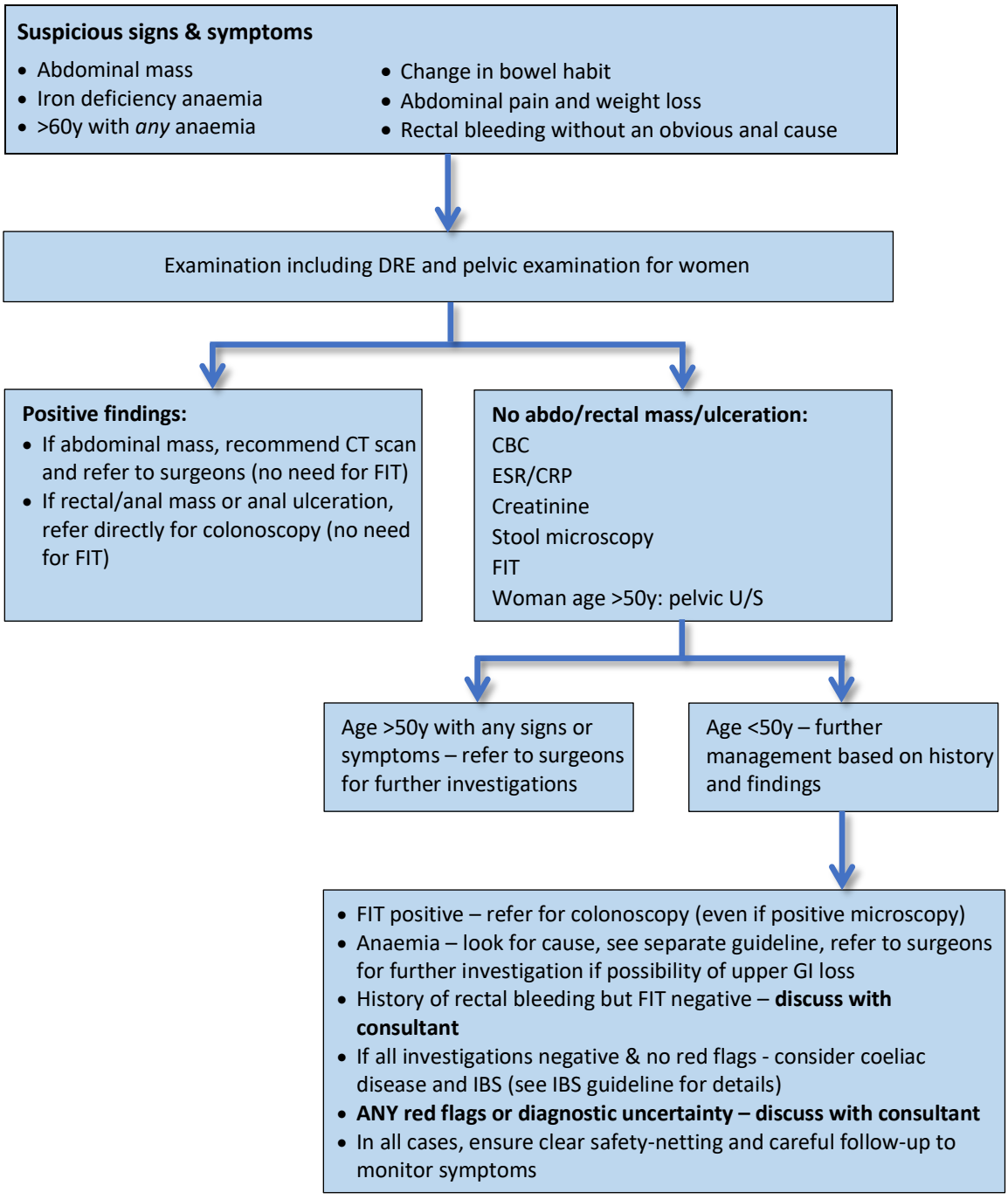
Key Facts

- Among the top cancers affecting both men and women in Kenya; associated with high morbidity and mortality rates as often diagnosed late.
- Symptoms can be non-specific, especially early on, and will vary depending on size and location of the tumour. A high level of suspicion is required!
- CRC is a **preventable disease** if early detection and removal of pre-cancerous polyps. It can also be cured if detected early.
- **Faecal immunochemical test (FIT)** is a good test which detects human haemoglobin in faeces. It only required one stool sample and is much better than the older guaiac FOB as it has much lower rates of false positives and **the FIT test is not affected by diet or upper GI blood loss.**
- FIT testing is used in two ways 1) Screening for CRC in asymptomatic patients
  2) Assessing patients with symptoms – helping to decide need for colonscopy

Risk Factors	Presenting symptoms & red flags	Differential diagnosis
Non-modifiable: age >45y, IBD, family history CRC or polyps, genetic syndromes **Modifiable:** dietary factors (high intake of red and processed meats, low fruit and vegetables, low fibre, high fat), physical inactivity, obesity, alcohol, tobacco	• Change in bowel habit (diarrhoea or constipation) • Nocturnal diarrhoea • PR bleeding • Persistent/worsening abdominal discomfort (cramps, bloating, flatulence, abdominal pain) • Tenesmus (feeling of incomplete bowel emptying) • Weight loss, weakness, fatigue • Unexplained anaemia • Abdominal mass • Family history of colorectal cancer, IBD	• Upper GI cancer • Ovarian cancer • Inflamatory bowel disease (UC, Crohn's) • Coeliac disease • Diverticular disease • Infection • Irritable bowel syndrome / functional GI disorders

Screening for colorectal cancer (asymptomatic patients)		
Average risk	Age >45y, no symptoms, no family history	Offer annual FIT; if positive FIT – refer for colonoscopy Discontinuation of screening can be considered if >75y (or <10y life expectancy) and previous negative screening, especially if negative colonscopy
Increased risk	• CRC or advanced adenoma in one first-degree relative age <50 • Multiple first-degree relatives with CRC diagnosed >50y	10-yearly colonscopy from age 40y, or 10y younger than youngest relative diagnosed with CRC, whichever comes earlier 5-yearly colonoscopy from 50y, or 10y earlier than youngest relative diagnosed with CRC, whichever comes earlier **Refer to surgeons to discuss and plan**
High risk	• Hereditary or genetic predisposition (FAP, polyposis syndrome) • Non-hereditary polyposis • Inflammatory bowel disease	Genetic counselling and testing if available Colonoscopy from age 10y if FAP, 18y for HNPCC, or 10y earlier than any affected relative **Refer to surgeons to discuss and plan**

Investigating possible colorectal cancer
(symptomatic patients)



References:
National Cancer Screening Guidelines, MOH 2018; GUT 2021; 70(6):1130-1138; NICE 2023, DG 56