AGA INSTITUTE GUIDELINES FOR THE
Early Detection of Colorectal Cancer and Adenomatous Polyps
CLINICAL DECISION SUPPORT TOOL

Step 1: Identify higher than average-risk individuals

- Personal hx of colorectal cancer (CRC)
- Personal hx of adenoma
- Personal hx of ulcerative colitis or Crohn’s colitis
- Family history of CRC in first-degree relative

Step 2: Shared decision making screening options

Higher Risk

Average Risk ≥ 50 years

Structural exam of colon

PRIMARY AIMS:
- Detection of early-stage CRC
- CRC prevention by detection/removal of adenomas (Sensitivity for adenomas 80-90%)

Noninvasive stool-based test

PRIMARY AIM:
- Detection of early-stage CRC
SECONDARY AIM:
- Some cancer prevention by detection/removal of adenomas (Sensitivity for adenomas <50%)

Refer to GI specialist or expert in high-risk GI

Continued on next page.
Structural exam of colon
- Options include colonoscopy, sigmoidoscopy or CT colonography
- All require adequate bowel prep

Noninvasive stool-based test
- Options include FIT or stool DNA
- Sample obtained at home
- No bowel prep required

**Repeat 10 years**

**Adenoma or sessile serrated polyp**

**Flexible sigmoidoscopy**

NEGATIVE
Repeat 5 years

POSITIVE*

CT colonography

NEGATIVE
Repeat 5 years

POSITIVE

**Repeat annually**

Fecal immunochemical test (FIT)

POSITIVE*

**Repeat 5 years**

NEGATIVE
Repeat 5 years

POSITIVE*

**Repeat 5 years**

NEGATIVE
Repeat 5 years

POSITIVE*

**Repeat annually**

Stool DNA

POSITIVE

CRC

Referral for surgery/oncology

Polyp surveillance algorithm (ref)

NEGATIVE

**Repeat: interval uncertain**

NEGATIVE

**Interval uncertain**

NEGATIVE

**CRC**

Screening average-risk individuals for CRC includes programmatic follow-up of positive tests with colonoscopy.


Review online at www.gastro.org/crcdecisiontools/screening