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<b>Title:</b>	Colorectal Cancer Screening	
<b>Applicable to:</b>	Primary Care Providers	
<b>Source(s):</b>	Located in <a href="#">References</a>	
<b>Read Full Guideline:</b>	Located in <a href="#">References</a>	
<b>Developer(s):</b>	BSWQA Colorectal Cancer Taskforce	
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## SUMMARY

Adults in the primary care/ambulatory setting. The age for screening depends on the patient's individual risk.

### Risk Factors

- The U.S. Preventive Services Task Force recommends screening for colorectal cancer (CRC) starting patients between 45 to 75 years old<sup>1</sup>. The decision to screen for CRC in adults aged 76 to 85 years should be an individual one, taking into account the patient’s overall health, prior screening history, and patient preferences. Screening would be most appropriate among adults who:
  - Are healthy enough to undergo treatment if colorectal cancer is detected, and
  - Do not have comorbid conditions that would significantly limit their life expectancy<sup>2</sup>
- Consider screening earlier with colonoscopy if any of the risk factors or conditions listed below are present<sup>3,4</sup>:
- Family history one first degree relative with colon cancer or advanced adenoma or 2 or more second degree relatives with colon cancer
  - Prior CRC or adenomatous polyps before age 60
- Familial adenomatous polyposis
  - Hereditary syndromes: Familial adenomatous polyposis, Lynch syndrome (hereditary nonpolyposis CRC).
- There are other rarer inherited conditions, including MUTYH-associated polyposis, hamartomatous polyposis, Peutz-Jeghers syndrome, and juvenile polyposis syndrome.

### Screenings

- Screening is crucial because when found early, CRC is highly treatable.
- The following tests qualify as CRC screenings that find polyps and cancer<sup>1,2,3</sup>.
  - Colonoscopy every 10 years

- CT Colonography\* every 5 years
- Flexible Sigmoidoscopy\* every 5 years
- Flexible Sigmoidoscopy\* every 10 years with annual FIT\*
- Flexible sigmoidoscopy availability has declined in the U.S.

\*Complete colonoscopy if positive results

- The following tests qualify as CRC screenings that find cancer<sup>1,2,3</sup>:
  - High-sensitivity guaiac fecal occult blood test (gFOBT)\* or Fecal Immunochemical Test (FIT)\* every year
- Stool DNA-FIT every 3 years\* (The use of DNA-FIT is not recommended as first line-screening due to cost and false positive rate. The use of the test should be left at the discretion of the treating physician.) (this is still listed as an option for screening and is widely being used. There seems to be some confusion with the terms stool DNA-FIT, as it is a type of mt-sDNA )
  - USPSTF and ACS endorse mt-sDNA as an option, though evidence is limited on optimal follow-up if mt-sDNA is positive but colonoscopy is negative. In average-risk patients with a negative high-quality colonoscopy, resuming routine 10-year colonoscopy is reasonable, but shared decision making is recommended.
  - Newer next-generation mt-sDNA tests (i.e., Cologuard Plus) are FDA-approved and available, though USPSTF guidance has not yet changed.

\*Complete colonoscopy if positive results

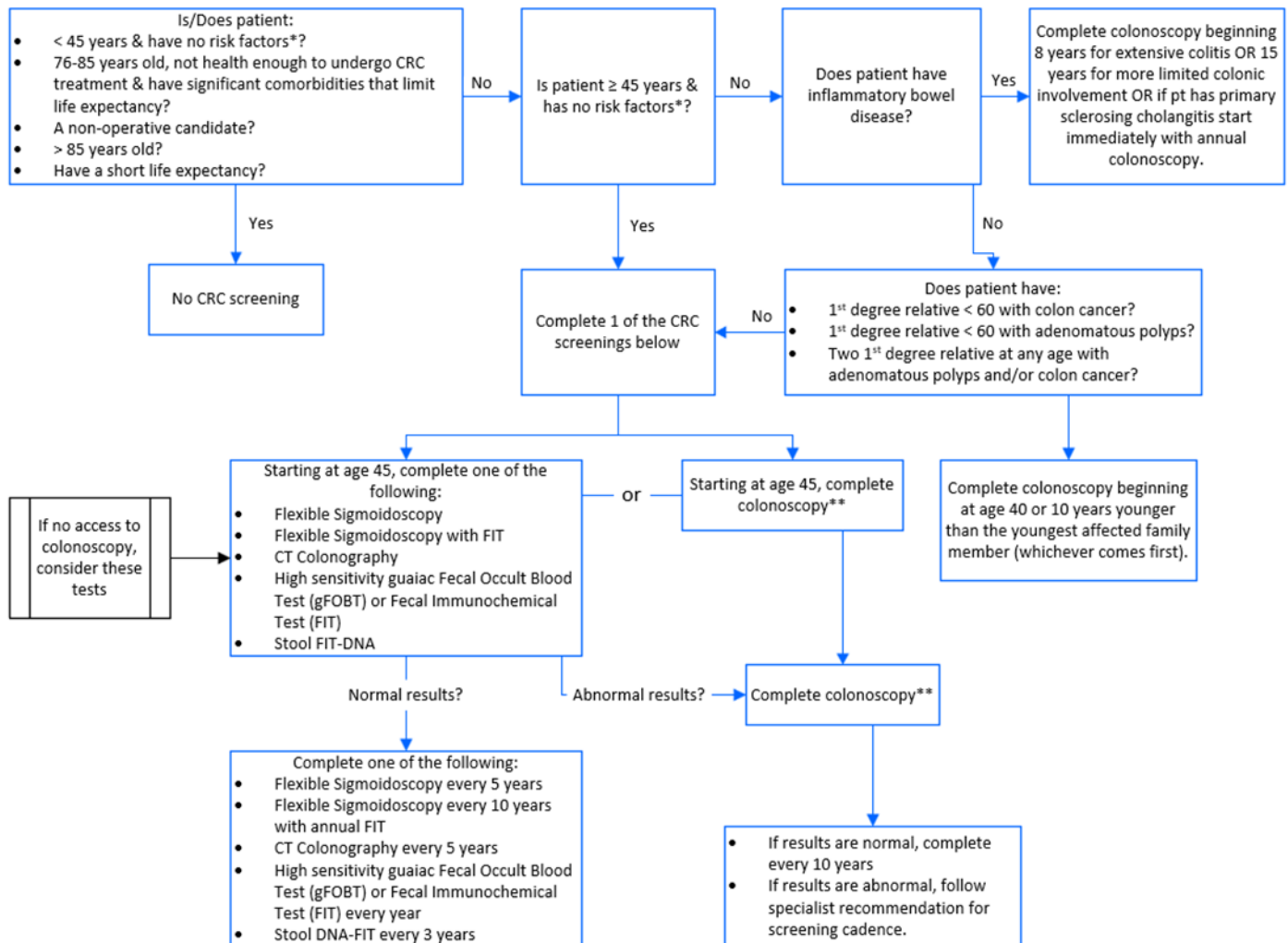
- In the case of a positive FIT-DNA and negative colonoscopy, resume colonoscopy in 10 years.
- The following tests do not qualify as appropriate CRC screenings<sup>1,2</sup>:
  - Digital Rectal Exams (DRE)
  - FOBT tests performed with a sample collected via DRE
  - Double-contrast barium enema
- See [Attachment 1](#) for more details on *Colorectal Cancer Screening Strategies*.
- See algorithm below ([Figure 1](#)) for guidance in deciding age and test for CRC screening.

## **Follow-up**

- Primary care providers should refer patient for a colonoscopy if he/she screens positive for CRC.

## FACTS AND FIGURES

**Figure 1: Algorithm: Colorectal Cancer Screening Timing and Tests Guide**



\*Risk factors listed in narrative

## ATTACHMENTS

- [Attachment 1: Characteristics of Colorectal Cancer Screening Strategies](#)
- [Attachment 2: Stool-Based Tests – Comparison with Value-Based Care Considerations](#)
- [Attachment 3: Colorectal Cancer Screening Shared Decision-Making Handout \(English\)](#)
- [Attachment 4: Colorectal Cancer Screening Shared Decision-Making Handout \(Spanish\)](#)
- [Attachment 5: Comparison of Stool-Based Colorectal Cancer Screening Tests](#)

## REFERENCES

1. U.S. Preventive Services Task Force. (2021, May 18). Colorectal cancer: Screening. Final recommendation statement. <https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/colorectal-cancer-screening> (USPSTF)
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## Attachment 1: Characteristics of Colorectal Cancer Screening Strategies

Test	Type	Sensitivity (CRC)	Specificity	Sensitivity (Advanced Adenomas)	Interval	Cost (approx.)	Ease of Use	Notes
<b>FIT</b>	Stool	74–88%	90–96%	25–40%	Every 1 year	\$25–\$50	At-home, no prep	USPSTF first-line; low cost, easy
<b>FIT-DNA (Cologuard)</b>	Stool DNA + FIT	92–94%	87–90%	~42%	Every 3 years	\$500–\$650	At-home kit	Higher false positives, less frequent
<b>Colonoscopy</b>	Direct visualization	95%+	—	95%	Every 10 years	\$2,000–\$3,000	Outpatient, sedation	Diagnostic + therapeutic gold standard
<b>CT Colonography</b>	Imaging	85–90%	86–90%	70–85%	Every 5 years	\$800–\$1,200	Bowel prep, no sedation	USPSTF alternative; no polyp removal

Source: U.S. Preventive Services Taskforce – Colorectal Cancer: Screenings<sup>1</sup>

Abbreviations: FIT=fecal immunochemical test; FIT-DNA=multitargeted stool DNA test; gFOBT=guaiac-based fecal occult blood test; RCT=randomized clinical trial.

<sup>a</sup> Although a serology test to detect methylated *SEPT9* DNA was included in the systematic evidence review, this screening method currently has limited evidence evaluating its use (a single published test characteristic study met inclusion criteria, which found it had a sensitivity to detect colorectal cancer of <50%). It is therefore not included in this table.

<sup>b</sup> Applies to persons with negative findings (including hyperplastic polyps) and is not intended for persons in surveillance programs. Evidence of efficacy is not informative of screening frequency, with the exception of gFOBT and flexible sigmoidoscopy alone.

<sup>c</sup> Strategy yields comparable life-years gained (ie, the life-years gained with the noncolonoscopy strategies were within 90% of those gained with the colonoscopy strategy) and an efficient balance of benefits and harms in CISNET modeling.

<sup>d</sup> Suggested by manufacturer.

<sup>e</sup> Strategy yields comparable life-years gained (ie, the life-years gained with the noncolonoscopy strategies were within 90% of those gained with the colonoscopy strategy) and an efficient balance of benefits and harms in CISNET modeling when lifetime number of colonoscopies is used as the proxy measure for the burden of screening, but not if lifetime number of cathartic bowel preparations is used as the proxy measure.

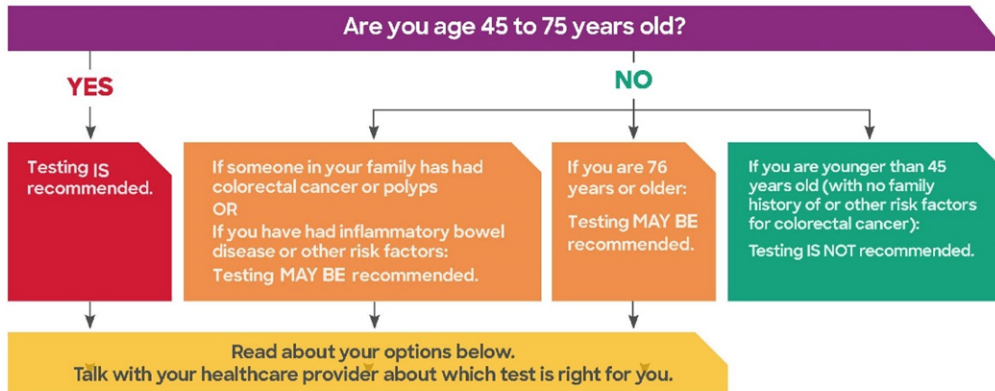
## Attachment 2: Stool-Based Tests – Comparison with Value-Based Care Considerations

Test	Frequency	Approx. Cost (U.S.)	Detects	VBC Considerations	Pros
<b>FIT (Fecal Immunochemical Test)</b>	Every 1 year	\$20–\$30	Human hemoglobin in stool (antibody-based)	Low cost; very cost-effective if adherence maintained	More specific than gFOBT; no diet restrictions; simple at-home kit
<b>High-sensitivity gFOBT</b>	Every 1 year	\$5–\$10	Occult blood (heme, guaiac reagent)	Low upfront cost but more false positives → more downstream colonoscopies	Very inexpensive; widely available
<b>mt-sDNA (e.g., Cologuard/Plus)</b>	Every 3 years	~\$500 (Plus ~\$790 self-pay)	Hemoglobin + abnormal DNA from cancer/polyps	Useful for FIT nonadherent patients; costly, must target carefully	Higher sensitivity for CRC/advanced adenomas vs FIT/gFOBT

## Attachment 3: Colorectal Cancer Screening Shared Decision Making Handout (English)



# Choosing the right colon cancer screening test



### STOOL TEST \*

#### Key facts

- Reduces death from colorectal cancer by detecting cancers early
- Safe, available and easy to complete
- Done on your own at home
- Finds cancer early by finding blood in the stool
- Finds most cancers early when done every year

#### Things to consider

- The test may be positive even if you do not have polyps or cancer in the colon.
- If the test is positive, you will have a colonoscopy to look for problems.
- In-home testing requires collecting a small stool sample using the test kit provided, then mailing or taking it to your doctor's office or lab for processing.

\*Stool test = Guaiac Fecal Occult Blood Test (FOBT) or Fecal Immunochemical Test (FIT)

### COLONOSCOPY

#### Key facts

- Reduces the risk of death by 60% by detecting colorectal cancer early
- Can prevent cancer by removing polyps (or abnormal growths in the colon) during the test
- Looks at the entire colon
- Finds most cancers or polyps that are there when the test is done
- Done at least every 10 years or as recommended by your healthcare provider

#### Things to consider

- Stomach pain, cramping or bloating is possible before, during or after the test.
- The test is done at a hospital or clinic, and you will probably receive light sedation so that you are comfortable.
- You will need someone to drive you home after the test and may need to take the whole day off to rest.
- You will take medicine to clear out your colon the day before. You will also only drink clear liquids. This can cause pain, bloating and diarrhea while your colon clears.
- There is a small risk of serious complications like bleeding or perforated colon.

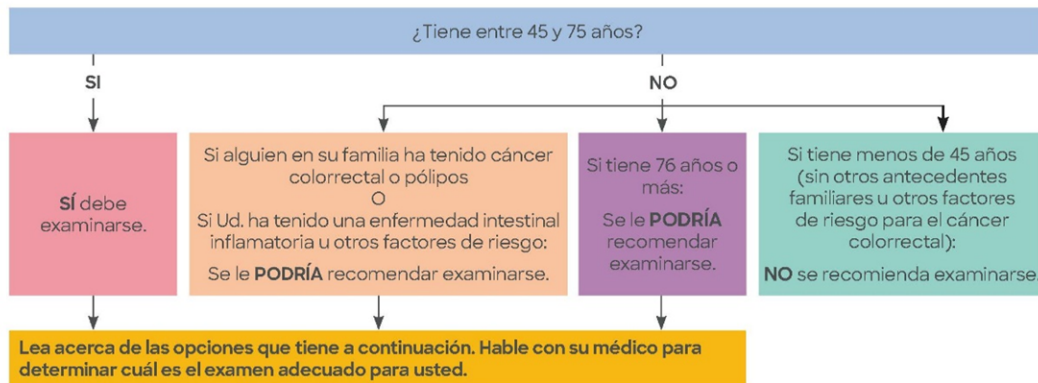
Please ask your healthcare provider about other screening tests that are available. For a physician referral, call **1.844.BSW.DOCS** or visit **BSWHealth.com**.



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## Attachment 4: Colorectal Cancer Screening Shared Decision Making Handout (Spanish)

# Cómo seleccionar el examen de detección colorrectal adecuado



### Prueba en las heces\*

#### Información importante

- Reduce la incidencia de muerte debido al cáncer colorrectal detectándolo en sus primeras etapas
- Seguro, disponible y fácil de hacer
- Se hace en su propia casa
- Detecta cáncer en sus primeras etapas identificando sangre en las heces
- Detecta casi todos los casos de cáncer en sus primeras etapas cuando se hace cada año

#### Factores que debe considerar

- El examen podría dar positivo aunque no tenga pólipos ni cáncer en el colon.
- Si el examen es positivo, se le hará una colonoscopia para detectar problemas.
- El examen en la casa requiere obtener una pequeña muestra de heces con un kit que se proporciona y enviarlo por correo o llevarlo al consultorio de su médico o laboratorio para su procesamiento.

\*Prueba en las heces = Guaiac Fecal Occult Blood Test (FOBT) or Fecal Immunochemical Test (FIT)

### Colonoscopia

#### Información importante

- Reduce el riesgo de muerte en un 60% detectando cáncer colorrectal en sus primeras etapas
- Puede prevenir el cáncer extrayendo pólipos (o tumores anormales en el colon) durante el examen
- Examina el colon entero
- Detecta casi todos los casos de cáncer o pólipos presentes cuando se hace el examen
- Se hace por lo menos cada 10 años o según las recomendaciones de su médico

#### Factores que debe considerar

- Posible dolor estomacal, cólicos y gases estomacales antes, durante o después del examen.
- El examen se hace en un hospital o clínica; recibirá un sedante leve para que se sienta cómodo.
- Deberá pedirle a alguien que lo lleve a su casa después del examen y podría tener que reposar en la casa el resto del día.
- Deberá tomar un medicamento para vaciar el colon el día antes. Solo podrá beber líquidos claros. Esto podría causar dolor, gases estomacales y diarrea a medida que se vacía el colon.
- Hay un pequeño riesgo de complicaciones graves, como sangrado o perforación del colon.

Hable con su médico sobre los exámenes de detección que tiene a su disposición.



Los médicos ofrecen servicios clínicos como integrantes del personal médico de una subsidiaria, un centro médico comunitario o un centro médico afiliado de Baylor Scott & White Health, y no como empleados ni repres entantes de dichos centros médicos ni de Baylor Scott & White Health. ©2021 Baylor Scott & White Health. 99-ALL-330105 BID

**Attachment 5: Comparison of Stool-Based Colorectal Cancer Screening Tests**

## Comparison of Stool-Based Colorectal Cancer Screening Tests

<b>FIT</b>	<b>High-sensitivity gFOBT</b>	<b>mt-sDNA (Cologuard)</b>
<i>Every 1 year</i>	<i>Every 1 year</i>	<i>Every 3 years</i>
Human hemoglobin in stool	Occult blood (heme, guaiac reagent)	Hemoglobin + abnormal DNA
Specific, no diet restrictions, simple at-home kit	Very inexpensive, widely available	Highest sensitivity for cancer & advanced adenomas
Misses non-bleeding lesions	Lower sensitivity, diet/med restrictions	High false positives, expensive, colonoscopy required if positive
\$20–\$30	\$5–\$10	\$500–\$600
Most cost-effective with adherence	Cheap but less accurate, increases downstream costs	Reasonable if poor FIT adherence; costly in value-based care