

Colorectal Cancer Screening Promotion Program

Session 1 Training Agenda

Session 1: Increase Knowledge About Screening

Duration: 1 hour

Slide #	Content	Time
1	Welcome and introductions, including roles and usual duties re CRC screening Complete confidential knowledge test	10 minutes
2	Program goals and overview, including objectives for this session	1 minute
3–4 5 6	Brief inquiry into knowledge about the benefits of CRC screening <ul style="list-style-type: none">• Education about where colorectal cancer occurs• Education about what polyps and cancer look like	8 minutes
7–11	Risk factors	3 minutes
12–14 15–20	Screening: what it is and is not Screening for various groups	12 minutes
21–26	Screening method details	6 minutes
27–28	Prevention	3 minutes
29–30	Final summary Complete the evaluation form. Complete and submit knowledge test. Perhaps provide the “Colorectal Cancer Screening Guide” fact sheet and “Colorectal Cancer Screening Saves Lives!” patient handout. Participants report out on what they learned from the presentation.	10–15 minutes

This material was developed through an Oregon Department of Human Services contract with Acumentra Health, Inc., funded by the Centers for Disease Control and Prevention Cooperative Agreement #5U58DP00789-02.

Colorectal Cancer Screening Promotion Program

Session 1 Speaker Notes

Slide #	Notes and References
2	<p>Program goals</p> <p>The Colorectal Cancer Screening and Prevention program was developed by Acumentra Health for the Oregon Department of Human Services and was funded by a grant from the Centers for Disease Control and Prevention.</p> <p>The program was designed to leverage the strong relationships of patients and clinic staff to increase colorectal cancer screening. Clinic staff will participate in two learning sessions.</p> <ul style="list-style-type: none"> • The first session will provide education about colorectal cancer and colorectal cancer screening. • The second session will provide tools and techniques for influencing patients and motivating them to complete colorectal cancer screening. We'll also do a role play to help you think about what you will say to patients. You'll use teaching tools that were developed for this training program, patient handouts, and scripted key messages. <p>The objectives for the two sessions are to enable you to do the following:</p> <p>Session 1</p> <ul style="list-style-type: none"> Explain the value of colorectal cancer screening Describe the three recommended screening choices <p>Session 2</p> <ul style="list-style-type: none"> Increase the number of people in your practice who are screened for colorectal cancer
3	<p>True or false?</p> <p>You received a confidential knowledge assessment. Please complete it if you haven't already done so. After the session, you'll repeat the test and get a copy of the answer key.</p> <p>Let's take a few minutes for you to look at your answers. Then we're going to start off with some discussion of what you know about colorectal cancer.</p> <ul style="list-style-type: none"> • People usually have symptoms when they have colorectal cancer: <ul style="list-style-type: none"> False. Early colorectal cancer can cause rectal bleeding or blood that can be detected with a fecal occult blood test (FOBT). However, symptoms like abdominal pain, bloating, or constipation due to colorectal cancer are caused only by advanced colorectal cancer that blocks the colon or spreads into other parts of the abdomen. FOBT test identifies blood in the stool that is occult—can't be seen. • Colorectal cancer can be prevented. <ul style="list-style-type: none"> True. Precancerous growths called <i>adenomatous polyps</i> can be found and removed during colonoscopy and sigmoidoscopy before they become cancers. People who are found to have polyps on a sigmoidoscopy must get a colonoscopy to see if they have any other polyps in the middle and right side of the colon. All people with precancerous polyps need regular followup

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	<p>colonoscopies to find new polyps and remove them. People who have blood found on an FOBT may also have precancerous polyps rather than cancer. These people should also have colonoscopies to find the cause of the bleeding.</p> <ul style="list-style-type: none"> Colorectal cancer screening isn't very effective in saving lives. <p>False. Most experts believe as many as 60% of deaths from colorectal cancer could be prevented if everyone received regular screening as recommended in the United States Preventive Services Task Force (USPSTF) guidelines.</p>
5	<p>Colorectal cancer develops in the colon or rectum</p> <p><i>[Click]:</i> The <i>colon</i> begins on the person's right side at the appendix and goes across the abdomen, down the left side of the abdomen</p> <p><i>[Click]:</i> to the <i>rectum</i> and then the <i>anus</i>.</p> <p><i>[Click]:</i> <i>Colonoscopy</i> allows the examiner to usually look at the entire colon, whereas</p> <p><i>[Click]:</i> <i>sigmoidoscopy</i> allows the examiner typically to look at the "left/descending colon" and rectum.</p>
6	<p>What are polyps? Why are they important?</p> <p>The transition from normal colon to development of a precancerous polyp (adenomatous polyp) and finally to development into cancer that grows deep into the wall of the colon and spreads to lymph nodes and other organs is slow. This transition usually occurs over 5 to 10 years.</p> <p>This long time from the first development of polyps that can be seen during a colonoscopy or sigmoidoscopy provides an excellent opportunity for cancer prevention through finding and removing polyps before they become cancers.</p> <p>You can see that a polyp is often on a stalk, and the examiner can cut through the stalk to remove the polyp.</p>
7	<p>True or false?</p> <p>Time for more questions... <i>True or false:</i></p> <ul style="list-style-type: none"> Men are less likely to get colorectal cancer than women. <ul style="list-style-type: none"> False, but trick question. Colon cancer is slightly less common among men than women—but rectal cancer is more common among men. Together, colorectal cancer rates for men and women are roughly equal. Most people who get colon cancer have a family history of colorectal cancer. <ul style="list-style-type: none"> False. Fewer than 1/3 of people diagnosed with colorectal cancer have a close family member with colorectal cancer diagnosed before age 60. Colorectal cancer is increasing in the United States. <ul style="list-style-type: none"> False. The rate in the U.S. has dropped, while colorectal cancer rates have increased in Japan, Slovakia, and the Czech Republic (based on international cancer registry data). The increase in other countries is attributed to obesity and switch to a more Western diet. The drop in the U.S. is attributed to screening and polyp removal.

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9	<p>Who gets colorectal cancer?</p> <p><i>Suggestion: Ask audience members to raise a hand if they have a family member who has or had colon or rectal cancer.</i></p> <p>People with a family member with colorectal cancer are at higher risk of getting colorectal cancer but</p> <p>[Click]: Only 30% of the people who get colorectal cancer have a family history.</p> <p>[Click]: Most people (61%) who get colorectal cancer have no family history of colorectal cancer or other very high risk factors.</p> <p>[Click]: Other people at higher risk are those with one of the known inherited syndromes (e.g., multiple polyps).</p>
10	<p>Colorectal cancer risk factors (first slide)</p> <p>The reasons for these racial and ethnic differences are unclear. The underlying causes of the higher rate of colorectal cancer among African Americans and lower rate for Hispanics are probably some combination of genetic factors; differences in diet, smoking, obesity, and physical activity; and lower screening rates.</p> <p>The higher death rate from colorectal cancer in African Americans appears to be related to lower colorectal cancer screening rates, which leads to diagnosing cancers at a more advanced stage than among Whites, as well as to differences in treatment.</p> <p>Source: ACG press release, 2005. http://www.gi.org/media/releases/march212005.asp. Restatement of recommendations in 2008.</p>
11	<p>Colorectal cancer risk factors (second slide)</p> <p>Likewise, the underlying causes for these ethnic and racial groups' having a higher risk of getting colorectal cancer than Whites are also unclear. They probably also reflect a combination of genetic factors and differences in diet, smoking, obesity, physical activity, and screening rates.</p>
12	<p>Lifestyle changes that reduce risk</p> <p>Unlike race or ethnicity, some risk factors for colorectal cancer can be modified by the patient.</p> <p><u>Smoking:</u></p> <p>Both women and men who are heavy smokers and were still smoking or had quit less than 10 years ago have twice the risk of colorectal cancer or an advanced colon polyp as people who never smoked. Heavy smoking is defined as smoking 30 pack years—for example, smoking 2 packs per day for 15 years or 1 pack per day for 30 years. However, women require less exposure in pack years to have an increase in risk.</p> <p>[Source: Anderson JC et al. "Smoking and colorectal neoplasia: women require less tobacco exposure for similar increased risk as compared to men." American College of Gastroenterology Annual Scientific Meeting, October 6, 2008.]</p> <p><u>High-fat diet:</u></p> <p>Evidence is mixed about the impact of eating meat on colorectal cancer rates, but it appears</p>

Slide #	Notes and References
	<p>that diets high in animal fats and meat (red and white) increase the risk of colorectal cancer. A healthier diet would also include more fruits, vegetables, and legumes (beans, lentils, etc.).</p> <p>[Sources: Lyon JL, Sorenson AW. Colon cancer in a low-risk population (Mormons). <i>AJCN</i>. 1978; 31: S227–S230.</p> <p>Fraser GE. Associations between diet and cancer, ischemic heart disease, and all-cause mortality in non-Hispanic white California Seventh-day Adventists. <i>AJCN</i>. 1999; 70(3): 532S–538S.]</p> <p><u>Obesity:</u></p> <p>Obesity is associated with increased incidence of colon cancer.</p> <p><u>Lack of physical activity:</u></p> <p>A sedentary lifestyle is associated with increased risk of colorectal cancer. The reasons are not clear, but may relate to slower movement of waste through the colon or the association with obesity.</p> <p>[Source: Mayo Clinic. Colon Cancer: Risk Factors. 2009. http://www.mayoclinic.com/health/colon-cancer/DS00035/DSECTION=risk-factors. Accessed August 12, 2009.</p> <p><u>Alcohol:</u></p> <p>In one study of the effect of alcohol on colorectal cancer risk, the amount of daily alcohol use that increased risk compared with nondrinkers was 3 average-size drinks daily.</p> <p>[Source: Cho E, Smith-Warner SA, Ritz J, et al. Alcohol intake and colorectal cancer: a pooled analysis of 8 cohort studies. <i>Annals</i>. 2004; 140(8):603–613.]</p>
14	<p>Screening vs. followup</p> <p><i>Screening</i> is provided for people who have no symptoms of possible colorectal cancer (blood in the stool or on the stool or unexplained abdominal pain) and no history of precancerous polyps or cancer—in other words, it is provided to people who to the best of our knowledge do not have cancer or pre-cancer. People begin screening based on age, family history, and other factors that affect risk. Some gastroenterologists (GI physicians) and researchers recommend that African Americans begin screening at age 45, preferably using colonoscopy rather than sigmoidoscopy or FOBT because of the higher risk of cancer developing at an earlier age and involving the right side of the colon, which can't be seen on sigmoidoscopy.</p> <p>We use the terms <i>surveillance</i> or followup to describe testing for people who have already been diagnosed with a precancerous (adenomatous) polyp or a cancer. Surveillance studies are conducted more frequently than screening studies.</p>
15	<p>Regular screening saves lives</p> <p>Regular screening prevents colorectal cancer by finding and removing precancerous polyps.</p> <p>Some people will already have colorectal cancer at the time of their first screening or may develop cancer between screenings. Regular screening means that most people who have developed cancer will be diagnosed when the cancer is on the surface of the polyp, high in the stalk of the polyp, or before it penetrates below the surface layer of the colon. These cancers are nearly always curable (95%–100%).</p>

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	<p>Although colorectal cancer is NOW the second leading cause of deaths from cancer,</p> <ul style="list-style-type: none"> • it is preventable • it can be cured if diagnosed early • both prevention and cure require screening for everyone, based on your age and risk factors <p>Therefore, discourage people from waiting for symptoms.</p>
16	<p>Remember this?</p> <p><i>[Click]:</i> We begin screening for average people at age 50 because 90% of cancers are diagnosed in people after age 50.</p> <p>[Source: http://www.preventcancer.org/colorectal3c.aspx?id=1036]</p>
17	<p>People who should begin screening earlier ... and get screened more often</p> <p>People identified as “high risk” should begin screening at a younger age and more frequently. They include people with colorectal cancer or with a large (>0.5 inch) or advanced precancerous (adenomatous) polyp. These include</p> <ul style="list-style-type: none"> • patients with one close (1st degree) relative (parent, sister, brother, or child) diagnosed <u>before</u> age 60 • patients with two or more 1st degree relatives diagnosed at age 60 or older <p>Screening for these patients should begin 10 years before the youngest age of diagnosis or at age 40.</p> <p>Screening recommendations are slightly different for the following high-risk patients.</p> <ul style="list-style-type: none"> • Patients with any of the known inherited syndromes, such as multiple polyps, may need to begin screening programs as early as in their 20s. • The American College of Gastroenterology also recommends that African Americans begin colonoscopy screening at age 45 because they are more likely to develop colorectal cancer at a younger age and cancer beyond the reach of the sigmoidoscope than are other groups. <p>[Sources: Screening for colorectal cancer: clinical summary of U.S. Preventive Services Task Force recommendation. <i>Annals</i>. 2008;149(8). http://www.annals.org/cgi/content/full/149/9/627</p> <p>Prevalence of colon polyps detected by colonoscopy screening in asymptomatic black and white patients. Lieberman DA, Holub JL, et al. <i>JAMA</i>. 2008;300(12):1417–22.</p> <p>American College of Gastroenterology Guidelines for CRC Screening 2008. http://www.gi.org/physicians/pdfs/CCSJournalPublicationFebruary2009.pdf</p>
18	<p>Screening: who and how</p> <p>For people at average risk for colorectal cancer, the best balance of risks and benefits comes from starting screening at age 50. Starting before age 50 carries the same risk of complications from screening with less benefit, because cancer is so much less common in younger people who fit the criteria for average risk.</p> <p>The USPSTF recommends screening using any of the three tests (colonoscopy,</p>

Slide #	Notes and References
	<p>sigmoidoscopy, and high-sensitivity FOBT kits) based on studies and statistical models that indicate that the three tests are equally effective at reducing deaths from colorectal cancer for people between the ages of 50 and 75, <u>if people follow the screening recommendations</u>:</p> <ul style="list-style-type: none"> • Colonoscopy every 10 years <ul style="list-style-type: none"> ○ Colonoscopy is particularly good for preventing cancer because precancerous polyps can be found and removed anywhere in the colon. <p>[Click]:</p> <ul style="list-style-type: none"> • We begin screening for average people at age 50, because 90% of cancers are diagnosed in people after age 50. • 20–25% will have precancerous (adenomatous) polyps by age 50, and 50% will have them by age 75–80. <p>[Click]:</p> <ul style="list-style-type: none"> • Sigmoidoscopy every 5 years with FOBT at 3 years <ul style="list-style-type: none"> ○ Sigmoidoscopy only allows the examiner to find precancerous polyps or cancer in the lower part of the colon. <p>[Click]:</p> <ul style="list-style-type: none"> • High-sensitivity FOBT kit <u>every year</u> (Speaker: description of high-sensitivity tests can be found on slide 26). <ul style="list-style-type: none"> ○ Cancers, including early ones, usually bleed, but there may be only small amounts of blood in the stool that can't be seen but can be detected by the FOBT. People with blood in the stool need to undergo a colonoscopy to find the source of the bleeding. <p>As many as 60% of deaths from colorectal cancer could be prevented if everyone age 50 and older were screened regularly. (Speaker: See slide 19 notes for more about disagreements about whether colonoscopy is a better test.)</p> <p>[Sources: Screening for colorectal cancer: clinical summary of U.S. Preventive Services Task Force recommendation. <i>Annals</i>. 2008;149(8). http://www.annals.org/cgi/content/full/149/9/627</p> <p>Division of Cancer Prevention and Control, National Center for Chronic Disease Prevention and Health Promotion. Updated February 15, 2008. http://www.cdc.gov/cancer/colorectal/statistics/screening_rates.htm. Page last updated: February 15, 2008]</p>
19	<p>All three tests save the same number of years of life...</p> <p>Although researchers may disagree about the exact number of days or years of life saved by each test and how many studies are needed to save one year of life, all tests save lives. Colonoscopy may be more effective, but also has more associated risks, including perforating (tearing) the colon and complications due to anesthesia.</p> <p>[Click]: So, the <u>best test is the one that gets done.</u></p> <p>[Source: Screening for colorectal cancer: clinical summary of U.S. Preventive Services Task Force recommendation. <i>Annals</i>. 2008;149(8). http://www.annals.org/cgi/content/full/149/9/627]</p>

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	<p>Supplemental information about risks:</p> <p>Complications of colonoscopy: Evidence is adequate to estimate the harms of colonoscopy. In the United States, perforation of the colon occurs in an estimated 3.8 of 10,000 procedures. Serious complications—defined as deaths attributable to colonoscopy or adverse events requiring hospital admission, including perforation, major bleeding, diverticulitis, severe abdominal pain, and cardiovascular events—are significantly more common, occurring in an estimated 25 of 10,000 procedures.</p> <p>Complications of sigmoidoscopy: Evidence is adequate that serious complications occur in approximately 3.4 of 10,000 procedures.</p> <p>[Source: Screening for colorectal cancer: clinical summary of U.S. Preventive Services Task Force recommendation. <i>Annals</i>. 2008; 149 (9):626-637.]</p>
20	<p>Screening older seniors</p> <p>Colorectal cancer develops from polyps over a 10- to 12-year period. The gain in life-years associated with screening from age 75 to 85 is small in comparison to the risks of screening people in this age group. Screening for people age 75 to 85 can extend life only if there is a good chance that they will live for another 10 years or more.</p> <p>For individuals older than age 85, other health conditions make risks of screening greater than benefits. The USPSTF does not recommend routine screening for people age 85 or older.</p> <p>[Source: Screening for colorectal cancer: clinical summary of U.S. Preventive Services Task Force recommendation. <i>Annals</i>. 2008;149(8). http://www.annals.org/cgi/content/full/149/9/627]</p> <p>Supplemental information about risks:</p> <p>Although the overall risk for adverse events after colonoscopy is low, the risk for an adverse event increases with age. Individuals undergoing colonoscopy at age 75 or older have been found to be at increased risk for other gastrointestinal adverse events. The risk for serious gastrointestinal adverse events was 75% higher for persons age 80 to 84 compared with persons age 66 to 69. Although the risk for adverse cardiovascular events increased with age among persons undergoing colonoscopy, the rate of events in the colonoscopy group did not differ significantly from that in the age-equivalent matched group, suggesting that the events were more related to age than colonoscopy.</p> <p>[Source: Adverse Events After Outpatient Colonoscopy in the Medicare Population. <i>Annals</i>. 2009; 150 (12):849-857.]</p>
21	<p>Polyps and colorectal cancer in African Americans</p> <p>The current USPSTF guidelines recommend any of the three tests (FOBT, sigmoidoscopy, or colonoscopy) beginning at age 50 for people at average risk. However, some clinicians, including the American College of Gastroenterology, consider African Americans to be a higher risk group because they are more likely than Whites to get colorectal cancer before age 50 and more often develop cancer in the right side of the colon, where it cannot be seen with a sigmoidoscope. The ACG therefore recommends that African Americans begin screening with a colonoscopy at age 45.</p> <p>[Source: ACG press release, 2005. http://www.gi.org/media/releases/march212005.asp.</p>

Slide #	Notes and References
	Accessed February 5, 2009. Restatement of recommendations in 2008.]
22	<p>Colorectal cancer screening (colonoscopy screening zone)</p> <p>The examiner (usually a gastroenterologist) can usually look at the lining of the rectum and the entire colon. However, sometimes it is not possible to examine the entire colon because the scope won't pass beyond a scar band from a prior surgery, an obstruction from a mass, etc.</p>
23	<p>Colonoscopy</p> <p>Any polyp found during the examination will be removed (with a wire loop or clipper) and sent to the lab where the pathologist will look at it under the microscope and make a diagnosis. Polyps that can't be fully removed and growths that look cancerous will be biopsied (a chunk of tissue removed) for diagnosis.</p> <p>Patients found to have precancerous (adenomatous) polyps or cancers are at higher risk of developing cancer or developing a recurrence after a cancer has been removed. Colonoscopies for people with prior precancerous polyps or cancer are called "surveillance" colonoscopies and are performed more frequently than screening colonoscopies.</p>
24	<p>Colorectal cancer screening (sigmoidoscopy screening zone)</p> <p>The examiner uses a sigmoidoscope to look at the lining of the rectum and the lower colon, up to the bend near the left side of the stomach. The scope is named for the sigmoid colon, the s-shaped part of the colon just above the rectum.</p>
25	<p>Sigmoidoscopy</p> <p>The examiner can look at the lining of the rectum and the lower colon up to the bend near the right side of the stomach. Polyps and growths are handled the same way during sigmoidoscopy as during colonoscopy.</p> <p>Patients found to have precancerous (adenomatous) polyps or cancer that does not block the colon must be referred for colonoscopy to look for additional polyps in the rest of the colon. People with polyps are at higher risk and require more frequent colonoscopies than people with normal colons (surveillance).</p>
26	<p>Fecal Occult Blood Tests</p> <p>You are all familiar with these test kits. These tests primarily detect cancer rather than precancer because precancerous growths are less likely to bleed than cancers. The new tests (Hemoccult Sensa, Hemoccult IBT, and FIT) are more sensitive, but also have more false positives. In the end, however, more people with early cancer are diagnosed using the new, high-sensitivity test kits. Anyone who has a test that shows blood in the stool, <i>even if the person has been taking aspirin or a non-steroidal anti-inflammatory like aspirin or ibuprofen</i>, must be referred for a colonoscopy. If polyps are found, then the person moves to a surveillance screening program.</p> <p>[Source: Van Rossum LG, Rijn AN, Laheji RJ, et al. Random comparison of guaiac and immunochemical fecal occult blood tests for colorectal cancer in a screening population. <i>Gastroenterology</i>. 2008.35(1):82–90.]</p>

Slide #	Notes and References
27	<p>CT colonography</p> <p>This test is performed with a CT scanner rather than a colonoscope. Although some private insurers cover this procedure, Medicare recently determined that it will not cover CT colonography because of insufficient evidence that it will increase screening or improve health outcomes.</p>
After the presentation	<p>Please complete the post-training test so that we and you can see what you learned. When you've finished completing the test and the evaluation, pass the test to the person on your right, and we'll do a "round robin" report-out to tell the others what you've learned from the presentation.</p>

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Colorectal Cancer Screening Promotion Program

Session 1 Pre/Post Test

1. You are unlikely to have colorectal cancer if you feel well and you don't see any blood in your stool or have any abdominal pain.
 - a. True
 - b. False
2. What percent of all people who get colorectal cancer have no family history of colorectal cancer?
 - a. About 30%
 - b. About 40%
 - c. About 60%
3. The U.S. Preventive Services Task Force (USPSTF) and the American College of Gastroenterology recommend that people at average risk start routine colorectal cancer screening beginning at age
 - a. 45
 - b. 50
 - c. 60
4. Most colorectal cancers and deaths from colorectal cancer can be prevented.
 - a. True
 - b. False
5. The USPSTF CRC screening guidelines update recommends which of the following screening methods as saving approximately equal numbers of life-years for people at average risk? (circle all that apply)
 - a. Sigmoidoscopy every 5 years with fecal occult blood test (FOBT) at 3 years
 - b. Colonoscopy every 10 years
 - c. High-sensitivity FOBT annually
6. Which group has the highest rate of getting colorectal cancer and highest death rate from colorectal cancer?
 - a. Hispanics/Latinos
 - b. Asian/Pacific Islanders
 - c. African Americans
 - d. Non-Hispanic Whites

7. Which two lifestyle habits are associated with increased risk of getting colorectal cancer?
 - a. Smoking
 - b. Diet high in red meats and processed meats
 - c. Not drinking alcohol

8. Which group has the lowest rate of colorectal cancer and lowest death rate from colorectal cancer?
 - a. Hispanics/Latinos
 - b. Asian/Pacific Islanders
 - c. African Americans
 - d. Non-Hispanic Whites

9. Which is the best test for colorectal cancer prevention?
 - a. Sigmoidoscopy
 - b. Colonoscopy
 - c. FOBT kits

10. People who have a precancerous polyp removed with a colonoscopy don't need to have another colonoscopy for 10 years.
 - a. True
 - b. False

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Colorectal Cancer Screening Promotion Program

Session 1 Answer Key for Pre/Post Test

1. You are unlikely to have colorectal cancer if you feel well and you don't see any blood in your stool or have any abdominal pain.

- a. True
- b. False

Waiting until you have symptoms like blood in your stool (that you can see) or abdominal pain caused by a cancer means that if you are diagnosed with cancer, the cancer will probably be too advanced to be cured. Screening people without symptoms increases the likelihood of finding precancerous polyps that can be removed and early cancers that can be cured.

2. What percent of all people who get colorectal cancer have no family history of colorectal cancer?

- a. About 30%
- b. About 40%
- c. About 60%

Although people with a family history are at higher than average risk of getting colorectal cancer, most people who get colorectal cancer do not have a family history of colorectal cancer.

3. The U.S. Preventive Services Task Force (USPSTF) and the American College of Gastroenterology recommend that people at average risk start routine colorectal cancer screening beginning at age

- a. 45
- b. 50
- c. 60

The USPSTF recommends starting screening for people at average risk at age 50 because 90% of colorectal cancers are diagnosed in people age 50 or older and the average age at diagnosis is age 65.

4. Most colorectal cancers and deaths from colorectal cancer can be prevented.

- a. True
- b. False

Experts' estimates vary, but most calculate that at least 60% of deaths from cancer are preventable if everyone get screening as recommended by the USPSTF.

5. The USPSTF CRC screening guidelines update recommends which of the following screening methods as saving approximately equal numbers of life-years for people at average risk? (circle all that apply)

- a. Sigmoidoscopy every 5 years with fecal occult blood test (FOBT) at 3 years
- b. Colonoscopy every 10 years
- c. High-sensitivity FOBT annually

6. Which group has the highest rate of getting colorectal cancer and highest death rate from colorectal cancer?

- a. Hispanics/Latinos
- b. Asian/Pacific Islanders
- c. African Americans
- d. Non-Hispanic Whites

It is unclear why African Americans are most likely to get colorectal cancer. Lower screening rates contribute to the higher cancer rate because of missed opportunities to find precancerous polyps and prevent the development of cancer. Other possible causes include genetic differences and differences in diet, obesity, smoking, and physical activity. Higher death rates are due to later stage at diagnosis, as a result of lower screening rates and treatment differences. Note that in the Veterans Administration system, which has no barriers to care for veterans, death rates from colorectal cancer are the same for Whites and African Americans who are at the same cancer stage at diagnosis.

7. Which two lifestyle habits are associated with increased risk of getting colorectal cancer?

- a. Smoking
- b. Diet high in red meats and processed meats
- c. Not drinking alcohol

8. Which group has the lowest rate of colorectal cancer and lowest death rate from colorectal cancer?

- a. Hispanics/Latinos
- b. Asian/Pacific Islanders
- c. African Americans
- d. Non-Hispanic Whites

9. Which is the best test for colorectal cancer prevention?

- a. Sigmoidoscopy
- b. Colonoscopy
- c. FOBT kits

Colonoscopy is best for colorectal cancer prevention because the entire colon is screened for polyps. Sigmoidoscopy looks only at the lower third of the colon. People may have early cancers or polyps above the level that the sigmoidoscope screens.

10. People who have a precancerous polyp removed with a colonoscopy don't need to have another colonoscopy for 10 years.

a. True

b. False

People found to have a precancerous polyp may need closer followup. The physician will recommend the appropriate followup depending on size of polyp, pathology findings, family history, etc.

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Colorectal Cancer Screening Promotion Program

Session 1 Evaluation

Learning Objectives

The presentation on colorectal cancer (CRC) screening prepared me to do the following:

	<i>Definitely don't agree</i>			<i>Definitely agree</i>	
1. Explain the value of CRC screening.	1	2	3	4	5
2. Describe the three recommended CRC screening choices.	1	2	3	4	5

Process Change

I would like to see the following change implemented in my office:

Quality of Presentation

	<i>Definitely don't agree</i>			<i>Definitely agree</i>	
1. The content of the slides was clear and informative.	1	2	3	4	5
2. The slides were easy to read and understand.	1	2	3	4	5
3. The speaker presented the content effectively.	1	2	3	4	5
4. There was enough time for questions and discussion.	1	2	3	4	5
5. The presentation was free of commercial bias.	1	2	3	4	5

Suggestions for helping us better achieve the learning objectives:

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