



**Webinar: Familial Risk and Colorectal Cancer (CRC) Screening
Additional Questions & Answers
December 8th, 2016**

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Webinar replay: <http://nccrt.org/webinars/>

- 1. Why would our policy not be to have a conversation with your doctor beginning at age 40 about colorectal cancer, which includes your family history, the symptoms, screening options and the benefit of a healthy lifestyle?**

[Dr. Ahnen] I think this would be a very good policy. For colorectal cancer we have done such a good job of promoting average risk screening starting at age 50 that it will take a big educational effort for providers and the public to change the narrative to something like your proposal. I think that effort would be worth it.

- 2. Patients are not fond of the prep for colorectal cancer screening - are there any other new kinds of screening methods in the works?**

[Dr. Ahnen] I agree that the prep is a major barrier to colonoscopy screening for some people. There are now five tests that have been endorsed for screening in the average risk population, including high sensitivity tests for blood in the stool such as fecal immunochemical tests, flexible sigmoidoscopy, CT colonography (virtual colonoscopy), stool FIT and DNA combination test (Cologuard) and colonoscopy. None of these have been tested in the very high risk groups but some of the guidelines do suggest that they are acceptable options for the largest group of families (those with a single first degree relative with CRC over the age of 60). All of the tests have their strengths and weaknesses. There have been some improvements in the prep as well with smaller volumes and split preps. If I was a young investigator I would work on the prep.

- 3. What would you suggest to a patient that doesn't know their biological family but is diagnosed under 50 with colorectal cancer to find out if their cancer is genetic?**

[Dr. Ahnen] The most common hereditary colon cancer syndrome is Lynch syndrome and the current recommendations are to test all CRCs for the molecular markers of Lynch syndrome (loss of DNA mismatch repair protein expression or microsatellite instability testing by polymerase chain reaction). If the patient's tumor was microsatellite unstable or showed loss of DNA mismatch repair protein expression he should be evaluated for Lynch syndrome. Even if the molecular testing for Lynch is negative in the tumor and because there are multiple other

syndromes that are associated with increased colon cancer risk I often offer genetic counseling and testing in this setting.