

Figure. Screening for colorectal cancer: clinical summary of a U.S. Preventive Services Task Force (USPSTF) recommendation.*

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SCREENING FOR COLORECTAL CANCER CLINICAL SUMMARY OF U.S. PREVENTIVE SERVICES TASK FORCE RECOMMENDATION

Population	Adults Age 50 to 75 Years*	Adults Age 76 to 85 Years*	Adults Older Than 85 Years*
Recommendation	Screen with high-sensitivity FOBT, sigmoidoscopy, or colonoscopy Grade: A	Do not screen routinely Grade: C	Do not screen Grade: D
	For all populations, evidence is insufficient to assess the benefits and harms of screening with computed tomographic colonography and fecal DNA testing. Grade: I (insufficient evidence)		
Screening Tests	High-sensitivity FOBT, sigmoidoscopy with FOBT, and colonoscopy are effective in decreasing colorectal cancer mortality. The risks and benefits of these screening methods vary. Colonoscopy and flexible sigmoidoscopy (to a lesser degree) entail possible serious complications.		
Screening Test Intervals	Intervals for recommended screening strategies: <ul style="list-style-type: none"> • Annual screening with high-sensitivity FOBT • Sigmoidoscopy every 5 years, with high-sensitivity FOBT every 3 years • Screening colonoscopy every 10 years 		
Balance of Harms and Benefits	The benefits of screening outweigh the potential harms for 50- to 75-year-olds.	The likelihood that detection and early intervention will yield a mortality benefit declines after age 75 because of the long average time between adenoma development and cancer diagnosis.	
Implementation	Focus on strategies that maximize the number of individuals who get screened. Practice shared decision making; discussions with patients should incorporate information on test quality and availability. Individuals with a personal history of cancer or adenomatous polyps are followed by a surveillance regimen, and screening guidelines are not applicable.		
Relevant USPSTF Recommendations	The USPSTF recommends against the use of aspirin or nonsteroidal anti-inflammatory drugs for the primary prevention of colorectal cancer. This recommendation is available at www.preventiveservices.ahrq.gov .		

For a summary of the evidence systematically reviewed in making these recommendations, the full recommendation statement, and supporting documents, please go to www.preventiveservices.ahrq.gov. FOBT = fecal occult blood testing.

* These recommendations do not apply to individuals with specific inherited syndromes (the Lynch syndrome or familial adenomatous polyposis) or those with inflammatory bowel disease.

Table 1. What the U.S. Preventive Services Task Force Grades Mean and Suggestions for Practice*

Grade	Definition	Suggestions for Practice
A	The USPSTF recommends the service. There is high certainty that the net benefit is substantial.	Offer/provide this service.
B	The USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.	Offer/provide this service.
C	The USPSTF recommends against routinely providing the service. There may be considerations that support providing the service in an individual patient. There is moderate or high certainty that the net benefit is small.	Offer/provide this service only if other considerations support offering or providing the service in an individual patient.
D	The USPSTF recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits.	Discourage the use of this service.
I statement	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality, or conflicting, and the balance of benefits and harms cannot be determined.	Read clinical considerations section of USPSTF Recommendation Statement. If the service is offered, patients should understand the uncertainty about the balance of benefits and harms.

* USPSTF = U.S. Preventive Services Task Force.

Table 2. U.S. Preventive Services Task Force Levels of Certainty Regarding Net Benefit

Level of Certainty*	Description
High	The available evidence usually includes consistent results from well-designed, well-conducted studies in representative primary care populations. These studies assess the effects of the preventive service on health outcomes. This conclusion is therefore unlikely to be strongly affected by the results of future studies.
Moderate	The available evidence is sufficient to determine the effects of the preventive service on health outcomes, but confidence in the estimate is constrained by such factors as: the number, size, or quality of individual studies inconsistency of findings across individual studies limited generalizability of findings to routine primary care practice lack of coherence in the chain of evidence. As more information becomes available, the magnitude or direction of the observed effect could change, and this change may be large enough to alter the conclusion.
Low	The available evidence is insufficient to assess effects on health outcomes. Evidence is insufficient because of: the limited number or size of studies important flaws in study design or methods inconsistency of findings across individual studies gaps in the chain of evidence findings that are not generalizable to routine primary care practice a lack of information on important health outcomes. More information may allow an estimation of effects on health outcomes.

* The U.S. Preventive Services Task Force (USPSTF) defines *certainty* as “likelihood that the USPSTF assessment of the net benefit of a preventive service is correct.” The net benefit is defined as benefit minus harm of the preventive service as implemented in a general primary care population. The USPSTF assigns a certainty level based on the nature of the overall evidence available to assess the net benefit of a preventive service.