Colon Cancer Screening
Past, Present and Future

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Newfoundland and Labrador Colon Cancer Screening Program
Disclosure of Potential for Conflict of Interest

FINANCIAL DISCLOSURE: Jerry S. McGrath

- Grants/Research Support: None
- Speakers Bureau/Honoraria: None
- Advisory Board: None
- Consulting Fees: None
- Other: None
Disclosure of Potential for Conflict of Interest

FINANCIAL DISCLOSURE: Scott Antle

- Grants/Research Support: None
- Speakers Bureau/Honoraria: None
- Advisory Board: None
- Consulting Fees: None
- Other: None
Objectives

Participants will be able to:

• Identify those patients that may benefit from colorectal cancer screening;
• Compare methods for screening (FOBT, FIT, Colonoscopy, CT Colonography);
• Discuss the implementation of a colorectal screening program in the province;
• Appraise FIT (Fecal Immunohistochemical Testing) as a screening test for population-based colon cancer screening;
• Recognize the impact a provincial screening program may have on resources such as endoscopy.
For more information on the different ways you can be tested, call 1.800.227.2345 or visit www.cancer.org/NYNU.
A Few Clinical Vignettes (2013)

• 54 y.o. woman admitted to HSC with SOB. Otherwise healthy. Found to have iron deficiency. Heavy menses. No family history of CRC.

• 40 y.o. woman admitted to ICU, SOB found on CT to have pulmonary hypertension and diffuse lymphadenopathy.

• 55 y.o. man from central NL with no family history CRC and no symptoms who underwent average risk screening.
WHY SCREEN FOR COLON CANCER?
Goal of NLCCSP

To reduce mortality rates from colorectal cancer in Newfoundland and Labrador
• Research indicates that regular screening for CRC reduce mortality up to 33%.

• If detected early, CRC has > 90% five year survival rate.
Newfoundland and Labrador has the highest incidence and mortality rates in Canada.
## Cancer Facts

### 2013 Estimates Canadian Cancer Society

<table>
<thead>
<tr>
<th></th>
<th>New Dx</th>
<th>Death</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colon</td>
<td>530</td>
<td>240</td>
</tr>
<tr>
<td></td>
<td>310 men</td>
<td>140 men</td>
</tr>
<tr>
<td></td>
<td>220 women</td>
<td>100 women</td>
</tr>
<tr>
<td>Lung</td>
<td>430</td>
<td>390</td>
</tr>
<tr>
<td>Breast</td>
<td>330</td>
<td>95</td>
</tr>
<tr>
<td>Prostate</td>
<td>500</td>
<td>65</td>
</tr>
<tr>
<td>Melanoma</td>
<td>85</td>
<td>20</td>
</tr>
<tr>
<td>Cervical</td>
<td>30</td>
<td>10</td>
</tr>
</tbody>
</table>
Colon Cancer Screening
“Past”
Unpreventable Risk Factors

- Family history of CRC
  - 1\textsuperscript{st} degree
  - familial adenomatous polyposis (FAP)
  - hereditary nonpolyposis colon cancer (HNPCC)
- Inflammatory bowel disease (UC, CD)
- Having polyps
- Having Colon cancer
Unpreventable Risk Factors

Colon Cancer Cases Arising in Various Family Risk Settings

- Sporadic Cases
- Cases with Familial Risk (10% to 30%)
  - Lynch Syndrome (Hereditary Nonpolyposis Colorectal Cancer)
  - Hamartomatous Polyposis Syndromes (<0.1%)
  - Familial Adenomatous Polyposis (<1%)

Gastroenterology, Vol. 119, No. 3, Randall W. Burt, Colon Cancer Screening, Pages 837-853
How to Determine Risk of Developing Colon Cancer

• Risk Factors

  – 1st degree relative
    – with CRC RR=2.25 (2.00-2.53)
    – with Colon Cancer RR=2.42 (2.20-2.65)
    – with Rectal cancer RR=1.89 (1.62-2.21)
    – with Adenoma RR=1.99 (1.55-2.55)

How to Determine Risk of Developing Colon Cancer

• Risk Factors

  – 1st degree relative
    – Parent    RR=2.26 (1.87-2.72)
    – Sibling   RR=2.57 (2.19-3.02)
    – >1 Relative RR=4.25 (3.01-6.08)

How to Determine Risk of Developing Colon Cancer

- **Risk Factors**
  - **AGE of relative**
    - Relative <45  \( \text{RR}=3.87 \ (2.40-6.22) \)
    - Relative 45-59  \( \text{RR}=2.25 \ (1.85-2.72) \)
    - Relative >60  \( \text{RR}=1.82 \ (1.45-2.25) \)

How to Determine Risk of Developing Colon Cancer

St. John, Annals of Internal Medicine, 15 May 1993, Vol. 118, No. 10
How to Determine Risk of Developing Colon Cancer

• Risk Factors

– Ulcerative Colitis
  – ulcerative proctitis \( \text{RR}=1.7 \) (0.8-3.2)
  – left-sided colitis \( \text{RR}=2.8 \) (1.6-4.4)
  – pancolitis \( \text{RR}=14.8 \) (11.4-18.9)
How to Determine Risk of Developing Colon Cancer

• Minor Risk Factors
  – Diabetes mellitus and insulin resistance
    » (RR 1.38, 95% CI 1.26-1.51)
  – Race/ethnicity and gender
    » African Americans: 20% higher than whites
    » Men: 25% higher than women
  – Renal transplantation with long-term immunosuppression
    » Shifts the age by 20-30 years
How to Determine Risk of Developing Colon Cancer

• Environmental Risk Factors
  – Cholecystectomy
    – right-sided colon cancer (SIR= 1.16 (1.08-1.24))
  – Alcohol
    – ≤1 drink/day RR=1.00 (0.95-1.05)
    – 2-3 drinks/day RR=1.21 (1.13-1.28)
    – ≥4 drinks/day RR=1.52 (1.27-1.81)
  – Smoking
    – RR=1.18 (1.11-1.25)
  – Obesity
    – Roughly 50% increase
Colon Cancer Screening
“Present”

Figure 4: Age-specific incidence by Gender 2006-2010

<table>
<thead>
<tr>
<th></th>
<th>0-19</th>
<th>20-29</th>
<th>30-39</th>
<th>40-49</th>
<th>50-59</th>
<th>60-69</th>
<th>70-79</th>
<th>80+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>0.1</td>
<td>1.8</td>
<td>4.9</td>
<td>21.9</td>
<td>82.0</td>
<td>190.3</td>
<td>353.6</td>
<td>520.8</td>
</tr>
<tr>
<td>Female</td>
<td>0.0</td>
<td>1.4</td>
<td>5.1</td>
<td>18.5</td>
<td>57.7</td>
<td>123.3</td>
<td>246.9</td>
<td>411.9</td>
</tr>
<tr>
<td>Both</td>
<td>0.1</td>
<td>1.6</td>
<td>5.0</td>
<td>20.2</td>
<td>69.9</td>
<td>155.8</td>
<td>294.8</td>
<td>451.6</td>
</tr>
</tbody>
</table>
FIGURE 32
Percentage of population (age 50-74) reporting FOBT and/or sigmoidoscopy/colonoscopy for asymptomatic reasons

BY PROVINCE/TERRITORY, CANADA—CCHS 2009

* Data suppressed due to statistical unreliability caused by small numbers
E Interpret with caution; coefficient of variation between 16.6% and 33.3%
Data source: Statistics Canada, Canadian Community Health Survey
FIGURE 6
Percentage of Individuals Aged 50–74 at Average Risk Who Reported Having a Fecal Test in the Past Two Years
2009 AND 2011

Average risk includes individuals aged 50–74 not diagnosed with Crohn's colitis, polyps or familial adenomatous polyposis and with no immediate biological family member diagnosed with CRC.
Source: 2009 and 2011 Colon Cancer Screening in Canada surveys, Canadian Partnership Against Cancer
FIGURE 70
Age-standardized incidence rates—all cancers
BY PROVINCE, 2005–2007

95% confidence intervals are indicated on figure.
Data source: Statistics Canada, Canadian Cancer Registry
FIGURE 71
Age-standardized mortality rates—all cancers
BY PROVINCE, 2005–2007

95% confidence intervals are indicated on figure.
Data source: Statistics Canada, Vital Statistics Death Database.
FIGURE 81
Age-standardized incidence rates—colorectal cancer
BY PROVINCE, 2005–2007

RATE PER 100,000 POPULATION

95% confidence intervals are indicated on figure.
Data source: Statistics Canada, Canadian Cancer Registry
FIGURE 82
Age-standardized mortality rates—colorectal cancer
BY PROVINCE, 2005–2007

95% confidence intervals are indicated on figure.
Data source: Statistics Canada, Vital Statistics Death Database
Colon Cancer Screening

• The program is being phased in throughout health regions in Newfoundland and Labrador.

• The program will expand based largely on capacity for follow up colonoscopy.

• The goal is to be fully implemented in approximately three years (2015).
Newfoundland and Labrador Colon Cancer Screening Program

Officially launched July 23, 2012 in the Western Health Region
FIGURE 33
Colorectal cancer screening program availability

BY PROVINCE, NCCSN-2011

% of target population for whom organized screening programs are available

- NO ORGANIZED PROGRAM
- 0%
- 1–9%
- 10–49%
- 50–99%
- 100%

Shading reflects the percentage of target population for whom organized CRC screening programs are available.

Data Source: Colorectal Cancer Screening Programs in Canada, National Colorectal Cancer Screening Network.
Newfoundland and Labrador Colon Cancer Screening Program

Expanded June 20, 2013 in the Central Health Region
Colorectal Cancer Screening Program Availability
(Up until April, 2014)

% of population where organized CRC screening programs are available up until April, 2014:

- No Organized Program
- Announced or Planning
- 1-9%
- 10-49%
- 50-99%
- 100%
NLCCSP Target Population

• Screening program will take a population base approach to CRC screening

• 50-74 year old individuals who are at an average risk for developing CRC

• Individuals who are asymptomatic for CRC
FIT Screening Test

- Fecal Immunochemical test (FIT)
- Specific for human hemoglobin in the stool
- There are no dietary restrictions
- Vitamins or medications will not interfere with the results
- Two specimens are self collected at home and forwarded in a pre-paid envelope to St. Clare’s lab.
Negative FIT

1. FIT kit requested
2. FIT sent and completed
3. Normal results
4. Rescreen in two years
5. FIT analyzed and reported
Positive FIT

- Contacted by follow-up coordinator
- Health assessment completed
- Colonoscopy arranged and completed
- Normal colonoscopy rescreen in 5 years with NLCCRSP
- Pathology on colonoscopy follow up with RHA
Evaluation of Hemo Tech NS-Plus system for use in a province-wide colorectal cancer screening program.

<table>
<thead>
<tr>
<th>Colonoscopy Results</th>
<th>Cases</th>
<th>gFOBT</th>
<th>iFOBT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal</td>
<td>115</td>
<td>3 (2.6%)</td>
<td>15 (13%)</td>
</tr>
<tr>
<td>No dysplasia(^a)</td>
<td>65</td>
<td>7 (11%)</td>
<td>17 (26%)</td>
</tr>
<tr>
<td>Low risk adenomas(^b)</td>
<td>63</td>
<td>1 (1.6%)</td>
<td>18 (28%)</td>
</tr>
<tr>
<td>High risk adenomas(^c)</td>
<td>4</td>
<td>0</td>
<td>2 (50%)</td>
</tr>
<tr>
<td>Carcinomas</td>
<td>2</td>
<td>0</td>
<td>2 (100%)</td>
</tr>
<tr>
<td>Total cases</td>
<td>249</td>
<td>11 (4.4%)</td>
<td>53 (21%)</td>
</tr>
</tbody>
</table>

\(^a\)Other biopsied lesions collectively (polyps, diverticulosis colonopathy, angiodysplasia, and inflammatory bowel diseases).

\(^b\)Low risk adenomas are those on Gross exam showing: <10mm, No Villous /furry appearance; and microscopy showing: tubular adenoma or with Tall columnar epithelium, and low grade dysplasia (Tall columnar epithelium, Pseudostratification of nuclei, elongated nuclei, and hyperchromasia).

\(^c\)High risk adenomas those on Gross exam showing: ≥ 10 mm, villous configuration; and microscopy showing: tubulovillous or villous adenoma, and high grade dysplasia (complex architecture, cribriform glands, rounding of nuclei, and cytoplasmic eosinophilia) or sessile serrated polyps/adenomas.

**FIT Positive Patients are More Likely to Harbour Adenomas**

<table>
<thead>
<tr>
<th>FIT</th>
<th>ADR (All)</th>
<th>CAG (Average Risk)</th>
<th>CAG (Family History)</th>
<th>CAG (Surveillance)</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive</td>
<td>38.9% (21/54)</td>
<td>38.9% (7/18)</td>
<td>50% (5/10)</td>
<td>43.8% (8/17)</td>
<td>11.1% (1/9)</td>
</tr>
<tr>
<td>Negative</td>
<td>25.1% (49/195)</td>
<td>22.0% (9/48)</td>
<td>17.5% (11/63)</td>
<td>41.1% (25/58)</td>
<td>15.4% (4/26)</td>
</tr>
<tr>
<td>p-value</td>
<td>0.01</td>
<td>0.04</td>
<td>0.01</td>
<td>0.39</td>
<td>N/A</td>
</tr>
</tbody>
</table>

CJG February 2013  J. McGrath, M. Borgaonkar, D. Pace, S. Antle, S. Stone, E Randell.
Why not give everyone a colonoscopy?
Why not give everyone a colonoscopy?

- Valuable test
- Diagnostic test
- Not enough endoscopists
- Invasive test
  - Risk of perforation.
  - Risk of bleeding.
  - Risk of infection.
  - Not perfect either!
Colonoscopy

- Advantages:
  - Gold standard
  - Biopsies/polyps can be removed
- Disadvantages:
  - Sedation required
  - Complications
  - Not 100%
- We are not offering a Polyp Screening Program
CT Colonography

Advantages:
- More comfortable
- No sedation
- Shorter than colonoscopy

Disadvantages:
- Incidentaloma
- Radiation
- Biopsies/polyps can’t be removed
FIT Test

• **Advantages:**
  - More comfortable
  - No sedation
  - Shortest test
  - No preparation, no dietary/medication restriction
  - Not invasive
  - Carry out at home
  - Temperature Stable
  - No incidentalomas

• **Disadvantages:**
  - Patient has to carry it out
  - Hemorrhoids
FIT Test

• Email from Dr. Jennifer Leonard

• “You have converted me...very impressed by FIT. One large polyp and one cancer in people with no symptoms and no family history....so far. These are my NASH and Hep C patients.”

April 29, 2014
All programs use, or plan to use, a fecal test as primary screening modality for average-risk individuals

<table>
<thead>
<tr>
<th>Province</th>
<th>Guaiac</th>
<th>FIT</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>NU</td>
<td></td>
<td></td>
<td>N/A – No organized program</td>
</tr>
<tr>
<td>NT</td>
<td></td>
<td>✓</td>
<td>Not programmatic</td>
</tr>
<tr>
<td>YK</td>
<td></td>
<td></td>
<td>N/A – No organized program</td>
</tr>
<tr>
<td>BC</td>
<td></td>
<td>✓</td>
<td>Alere, single sample test, &gt;49ng/ml = abnormal result</td>
</tr>
<tr>
<td>AB</td>
<td>✓</td>
<td></td>
<td>Plans to launch FIT province wide 2013</td>
</tr>
<tr>
<td>SK</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>MB</td>
<td>✓</td>
<td></td>
<td>Hemoccult Sensa</td>
</tr>
<tr>
<td>ON</td>
<td>✓</td>
<td>✓</td>
<td>Completing FIT pilot and planning for FIT implementation</td>
</tr>
<tr>
<td>QC</td>
<td></td>
<td>✓</td>
<td>Moving to fit in 2013</td>
</tr>
<tr>
<td>NB</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>NS</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>PE</td>
<td></td>
<td>✓</td>
<td>FIT as of April 2012</td>
</tr>
<tr>
<td>NL</td>
<td></td>
<td>✓</td>
<td>Completed a validation study comparing FIT to guaiac and colonoscopy results in 2011</td>
</tr>
</tbody>
</table>
1 first-degree relative with cancer or polyp at age < 60 or 2 or more first-degree relatives affected with polyp or colon cancer at any age

Colonoscopy every 5 years beginning at age 40 years or 10 years earlier than the youngest diagnosis of polyp or cancer in the family, whichever comes first.
CAG Colon Cancer Screening

1 first-degree relative affected at age > 60 or 2 or more second-degree relatives with cancer

Average-risk screening, but beginning at age 40. Could include F.O.B.T., X-Ray, Endoscopy or a combination.

FIT or Colonoscopy
CAG Colon Cancer Screening

1 second-degree relative or third-degree relative affected

Average-risk screening beginning at age 50. Could include F.O.B.T., X-Ray, Endoscopy or a combination.

No affected family member

Begin screening at age 50
Are People Interested in FIT

Total on Screening Waitlist for CNRHC= 629

CNRHC Contact Calls = 456
• Yes to FIT (removed from waitlist)= 259
• No to FIT= 24
• Not eligible for FIT = 133
• Waiting response back= 40

Filtered and therefore not called = 61
• Most had colonoscopy in last 5 years thus not eligible for FIT

CNRHC Total Outstanding= 112
Are People Interested in FIT

**Total on Screening Waitlist for CNRHC = 629**

**CNRHC Total Outstanding = 112**

- No answer to date = 96
- Phone numbers no longer in service = 11
- Reclassified from screening to surveillance = 5
**Home Screening kits mailed between July 9, 2013-October 15, 2014**

<table>
<thead>
<tr>
<th>Kit</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screening Kits mailed*</td>
<td>408</td>
<td></td>
</tr>
<tr>
<td>Screening Kits returned</td>
<td>366/408</td>
<td>89.4%</td>
</tr>
<tr>
<td>No Response</td>
<td>42/408</td>
<td>10.6%</td>
</tr>
<tr>
<td>FIT positive results</td>
<td>66/366</td>
<td>18%</td>
</tr>
<tr>
<td>FIT negative results</td>
<td>298/366</td>
<td>81.4%</td>
</tr>
<tr>
<td>FIT inconclusive results</td>
<td>2/366</td>
<td>0.6%</td>
</tr>
</tbody>
</table>

* Patients sent a reminder letter 6 weeks after mailing of home kit if no response, a second reminder letter was sent in January 2014
FIT positive colonoscopy findings:

<table>
<thead>
<tr>
<th>Finding</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>FIT positive</td>
<td>66/366</td>
<td>18.0%</td>
</tr>
<tr>
<td>Normal</td>
<td>21/66</td>
<td>31.8%</td>
</tr>
<tr>
<td>Adenoma</td>
<td>33/66</td>
<td>50%</td>
</tr>
<tr>
<td>Carcinoma</td>
<td>6/66</td>
<td>9.1%</td>
</tr>
<tr>
<td>Hyperplastic polyp</td>
<td>2/66</td>
<td>3.0%</td>
</tr>
<tr>
<td>Polyp not retrieved</td>
<td>2/66</td>
<td>3.0%</td>
</tr>
<tr>
<td>Refused colonoscopy*</td>
<td>2/66</td>
<td>3.0%</td>
</tr>
</tbody>
</table>

* Letter sent to patient’s primary care provider to arrange follow-up
<table>
<thead>
<tr>
<th>Year 1</th>
<th>Newfoundland and Labrador Colon Cancer Screening Program Results (2012-13)</th>
<th>Newfoundland and Labrador Colon Cancer Screening Program Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>FIT KITS = 1836</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Number of FIT positive colonoscopies performed</td>
<td>109</td>
</tr>
<tr>
<td></td>
<td>Cancer Detection</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Adenoma Detection Rate (FIT positive patients)</td>
<td>55.6%</td>
</tr>
<tr>
<td></td>
<td>Polypectomy Rate</td>
<td>65.7%</td>
</tr>
<tr>
<td></td>
<td>Polypectomy Retrieval Rate</td>
<td>89.7%</td>
</tr>
<tr>
<td></td>
<td>Withdrawal Time</td>
<td>12.8 minutes</td>
</tr>
<tr>
<td></td>
<td>Withdrawal Time was Reported</td>
<td>82 (75.2%)</td>
</tr>
<tr>
<td>Number of FIT positive colonoscopies performed</td>
<td>342 (2 no show)</td>
<td></td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>----------------</td>
<td></td>
</tr>
<tr>
<td>Cancer Detection</td>
<td>23 (17 men, 6 women)</td>
<td></td>
</tr>
<tr>
<td>Cancer Detection Goal</td>
<td>1-2/1000 FIT completed</td>
<td></td>
</tr>
<tr>
<td>Adenoma Detection Rate (FIT positive patients)</td>
<td>54.5% overall</td>
<td></td>
</tr>
<tr>
<td>Adenoma Detection Rate (FIT positive patients)</td>
<td>64.7% men</td>
<td></td>
</tr>
<tr>
<td>Adenoma Detection Rate (FIT positive patients)</td>
<td>44.94% women</td>
<td></td>
</tr>
<tr>
<td>Adenoma Detection Rate (FIT positive patients)</td>
<td>≥ 50% overall</td>
<td></td>
</tr>
<tr>
<td>Polypectomy Rate</td>
<td>62.1%</td>
<td></td>
</tr>
<tr>
<td>Polypectomy Rate Goal</td>
<td>≥ 60%</td>
<td></td>
</tr>
<tr>
<td>Polypectomy Retrieval Rate</td>
<td>90.3%</td>
<td></td>
</tr>
<tr>
<td>Polypectomy Retrieval Rate Goal</td>
<td>≥ 90%</td>
<td></td>
</tr>
<tr>
<td>Withdrawal Time</td>
<td>8.9 minutes</td>
<td></td>
</tr>
<tr>
<td>Withdrawal Time Goal</td>
<td>7 minutes</td>
<td></td>
</tr>
<tr>
<td>Withdrawal Time was Reported</td>
<td>100% of colonoscopies</td>
<td></td>
</tr>
</tbody>
</table>
Other 2013 data.....

Wait times

- Western 97 days
- Central 30 days

Bowel Preparation

- Adequate 303 88.60%
- Suboptimal 22 6.43%
- Not Reported 16 4.68%
Future.....
Newfoundland and Labrador Colon Cancer Screening Program

• Challenges
  – Physician Resources
  – Participation Rate
  – Culturally Sensitive Issues
  – Travel/Distance
  – Bowel Preparation
  – Privacy Legislation

• Benefits
  – Sample done at home
  – Temperature and time stability
As for the cases...

- 54 y.o. woman admitted to HSC with SOB. Otherwise healthy. Found to have iron deficiency. Heavy menses. No family history of CRC.
  - Liver mets.
  - Surgery for obstruction now on chemo.

- 40 y.o. woman admitted to ICU, SOB found on CT to have pulmonary hypertension and diffuse lymphadenopathy.
  - Autopsy revealed primary transverse colon with mets to liver, lung, mediastinal/abdominal nodes and pulmonary hypertension was secondary to mets.
55 yo man no family history and no symptoms

A simple home medical test helped save his life

Al and Carol Dwyer are smiling in this photo, but had Al waited much longer to get tested for colon cancer, they might not have so much to smile about. Thanks to a simple home test provided by Central Health, doctors were able to detect cancer early, perform surgery and save Al’s life. While Al will require chemotherapy, he says his doctors are confident he will make a full recovery........
Questions

"Why Should I Get Screened?"

"I don't have symptoms."
FACT: Colorectal cancer doesn't always cause symptoms, especially early on.

"It doesn't run in my family."
FACT: Most colorectal cancers occur in people with no family history.

"But that test..."
FACT: There are several kinds of screening tests for colorectal cancer.

Colorectal Cancer Screening Saves Lives
Colorectal cancer is the 2nd leading cancer killer in the U.S. But it can be prevented. Screening helps find precancerous polyps so they can be removed before they turn into cancer. Screening can also find colorectal cancer early, when treatment is most effective.

If you're 50 or older—don't wait. Talk to your doctor and get screened.

www.cdc.gov/screenforlife
1-800-CDC-INFO (1-800-232-4636)

Screen for life
National Colorectal Cancer Action Campaign

Eastern Health
Contact Information

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