March is Colorectal Cancer (CRC) Awareness Month. We can do our patients with inflammatory bowel diseases (IBD) a service by providing them with reliable resources about the risk and prevention of CRC. It is also a good time to remind your patients to keep up with general health maintenance actions such as yearly skin cancer screenings, eye exams, dental checkups, pap smears, and prostate exams.

**TIP #1:** *Help your patients understand that surveillance colonoscopies are particularly important for individuals with IBD because IBD increases the risk of developing CRC. In addition, if your IBD patient has Primary Sclerosing Cholangitis (PSC), they require annual colonoscopies.*

Increased risk associated with the IBD diagnosis starts at eight to 10 years after diagnosis (Crohn’s & Colitis Foundation, 2013). Several studies report that IBD patients have a two to five times higher risk than the general population in comparable age groups (Guagnozzi & Lucendo, 2012). Stressing the importance of surveillance colonoscopies to your patients will also assist in helping them remember the date of their last colonoscopy and when the next surveillance exam is necessary.

**TIP #2:** *Let your patients know that the symptoms of IBD can mimic the symptoms of CRC.*

Symptoms of CRC, such as fatigue, diarrhea, cramps, bloating, blood in stool, weight loss, and abdominal pain, may be mistakenly attributed to IBD because these symptoms are similar to those periodically experienced in the course of living with Crohn’s disease and ulcerative colitis. For these reasons, it is especially important for patients with IBD to understand the crucial need to follow through on surveillance CRC screening schedules, as determined by the healthcare provider, in accordance with the individual patient’s history and circumstances.

**TIP #3:** *Reassure your patients that most individuals with IBD will never develop CRC, and that maintaining the appropriate screening schedule is the best way for prevention and early detection of CRC, thereby resulting in better long-term outcomes.*

Nurses who encourage their patients to maintain the appropriate screening schedule can help increase the chances that, if CRC develops, it will be caught early and will be in a highly treatable stage. All of this information, and more, can be obtained in a downloadable brochure available from the Crohn’s & Colitis Foundation website (Crohn's & Colitis Foundation, 2013).

**TIP #4:** *Familiarize yourself with the range of CRC screening recommendations for individuals with IBD.*

Each professional society of gastroenterologists (American Gastroenterological Association, American College of Gastroenterology, European Crohn’s and Colitis Organization, and British Society of Gastroenterology) has its own screening CRC guidelines. Guidelines are determined by patient characteristics such as the length of time since diagnosis and the location of diseased tissue. They are also based on studies that examine effectiveness of several surveillance technologies in the detection of colorectal cancer.

For example, according to SCENIC guidelines (2015), when performing surveillance with white-light colonoscopy, high-definition (HD) is recommended rather than standard definition. Dysplasia is identified in twice as many patients undergoing HD endoscopy compared to standard definition (Laine, 2015; Subramanian, 2013). In a study by Yu, et al. (2016), when performing surveillance colonoscopy, chromoendoscopy is recommended rather than standard or HD white-light colonoscopy. Another study found that when performing surveillance with HD colonoscopy, chromoendoscopy is suggested rather than white-light colonoscopy (Laine. 2015). More investigation on surveillance for CRC will help providers make the best recommendations for their patients, and providers should discuss these options with their patients.
See Table 1 at the end of these tips.

**TIP #5** Provide your patients with strategies for reducing risk of CRC through the adoption of simple healthy lifestyle habits that represent controllable variables related to low level of risk for CRC.

Patients cannot alter CRC risk factors such as their genetic make-up, their age, or whether or not they have IBD. However, patients with IBD can choose the foods and drinks that they consume and the activities in which they engage. Therefore, dietary intake and activity level are important controllable variables related to CRC risk. Nurses can disseminate the good news that an estimated 45 percent of CRC cases in the U.S. might be prevented through the adoption of simple lifestyle changes (American Institute for Cancer Research, 2013). By visiting the American Institute for Cancer Research (AICR) website, nurses can equip themselves with quickly and easily shared recommendations for patients in the natural course of delivering standard nursing care. **See Table 2 at the end of these tips.**

**TIP #6** Make sure your patients know that taking their IBD medications on a regular basis, as prescribed, reduces their risk of CRC.

This month is a good time for nurses to emphasize that individuals with IBD further decrease their risk of CRC when they reduce intestinal inflammation by practicing consistent medication adherence (Crohn’s & Colitis Foundation, 2013).

Table 1: Summary of the differences in recommendations for colorectal cancer surveillance for patients with IBD (adapted from Guagnozzi & Lucendo, 2012).

<table>
<thead>
<tr>
<th>Guidelines</th>
<th>Beginning of Surveillance (years after diagnosis)</th>
<th>Surveillance Schedule</th>
<th>Endoscopic Technique Recommended</th>
</tr>
</thead>
<tbody>
<tr>
<td>AGA 2010</td>
<td>Eight years (pancolitis) 10 years (left-sided colitis)</td>
<td>Every one-three years. Yearly if PSC. History of CRC in first-degree relatives, ongoing active endoscopic or histologic inflammation, or anatomic abnormalities such as a foreshortened colon, stricture, or multiple inflammatory pseudopolyps may benefit from more frequent surveillance.</td>
<td>No formal recommendation</td>
</tr>
<tr>
<td>ACG 2010</td>
<td>Eight-10 years</td>
<td>Every one-two years Annually with PSC</td>
<td>No formal recommendation</td>
</tr>
<tr>
<td>ECCO 2013</td>
<td>Six-eight years after symptom onset</td>
<td>Every five years -Colitis affecting &lt;50 percent of the colon surface area)</td>
<td>Chromoendoscopy (For more information on chromoendoscopy, see...</td>
</tr>
</tbody>
</table>
| Crohn’s Disease | Extensive colitis w/mild endoscopic or histological active inflammation  
Every three years  
-Post-inflammatory polyps  
-Colorectal cancer in a first-degree relative older than 50 years  
-Extensive colitis w/moderate or severe endoscopic or histological inflammation  
Annual colonoscopy  
-Stricture w/in the past five years  
-Dysplasia w/in the past five years in patient who declines surgery  
-Colorectal cancer in a first-degree relative younger than 50 years  
PSC | Subramanian, Mannath, Ragunath, & Hawkey, 2011 |
|---|---|
| ECCO 2013 | Eight years (with at least distal colitis from symptoms onset  
Annually following a diagnosis of PSC | Every five years  
-Colitis affecting less than 50 percent of the colon surface area  
-Extensive colitis w/mild endoscopic or histological active inflammation  
Every three years  
-Post-inflammatory polyps  
-Colorectal cancer in a first-degree relative older than 50 years  
Annual colonoscopy  
-Stricture w/in the past five years  
-Dysplasia w/in the past five years in a patient who declines surgery  
PSC  
-Colorectal cancer in a first-degree relative younger than 50 years  
A rectal remnant still requires standard-interval surveillance | Chromoendoscopy |
| BSG 2010 | 10 years | Every five years lower risk
Extensive colitis w/NO
ACTIVE
endoscopic/histological
inflammation
OR left-sided colitis
OR Crohn’s colitis <50
colon
Every three years
intermediate risk
Extensive colitis w/ MILD
active
endoscopic/histological
inflammation
OR post-inflammatory
polyps
OR family history age 50+
Every year for higher risk
Extensive colitis w/
MODERATE/SEVERE
active endoscopic/histologic
inflammation
OR stricture in past five yrs.
OR dyplasia in past five yrs.
declining surgery
OR PSC/transplant PSC
OR family history in aged
<50 | Chromoendoscopy |

AGA, American Gastroenterological Association; ACG, American College of Gastroenterology; ECCO, European Crohn’s and Colitis Organization; BSG, British Society of Gastroenterology

Table 2: Examples of lifestyle recommendations for CRC prevention (adapted from American Institute of Cancer Research and American Cancer Society websites, 2013)

<table>
<thead>
<tr>
<th>Source</th>
<th>Recommendations for reducing CRC risk</th>
<th>Notes</th>
</tr>
</thead>
</table>
| AICR   | 1) Fit activity into your day
2) Stay a healthy weight and watch out for belly fat
3) Eat plenty of fiber
4) Cut red meat and processed meat consumption
5) Go moderate on the alcohol
6) Enjoy plenty of garlic | Each of these six recommendations suggests one small “first step” to get started in the right direction. More information about the research on which these recommendations are founded is contained in the 2010 Continuous Update Project Report: Colorectal Cancer, a joint project of the AICR and the World Cancer Research Fund (2013). |
| ACS    | 1) Don’t smoke
2) Limit red and processed meats
3) Generously consume fruits and vegetables |
4) Generously consume foods rich in calcium and vitamin D
5) Stay at a healthy weight and avoid weight around the mid-section
6) Increase the intensity and amount of your physical activity

AICR, American Institute of Cancer Research; ACS, American Cancer Society

References


**Crohn’s & Colitis Foundation Colorectal Cancer Resources:**
http://www.crohnscolitisfoundation.org/resources/colorectal-cancer.html

- Risk Factors for Developing Colorectal Cancer
- IBD & Colorectal Cancer - I'll Be Determined
- Am I at Risk for CRC?
- Fact Sheet: Colorectal Cancer

- Additional websites: