KEY POINTS FROM THE TOOLKIT

Early onset colorectal cancer

- Recognize that the incidence of CRC is increasing in individuals under age 50.
- Be aware that a substantial proportion of early onset CRC may be prevented or detected at an earlier stage by identifying people with a family history of cancer and adenomas.
- Regardless of age, consider CRC in the evaluation of patients with alarm signs and symptoms, including blood in the stool, recent-onset and persistent or progressive diarrhea/constipation, persistent or progressive abdominal pain, abdominal mass, unexplained iron deficiency anemia, and/or unexplained weight loss.
- Promote awareness among young patients.

Developing a system for family history collection

- Collect history that indicates family structure and manifestations of disease.
- Develop a systematic, team-based approach to family history collection and interpretation. This should include a standardized process for family history collection and interpretation as well as guidance for developing a personalized management plan for patients.
- Use a tool (and/or EHR) to assist in family history collection and risk assessment. There are a number of tools available to aid in family history collection and family history risk assessment, with different strengths and limitations. You should pick the tool that best fits the needs of your practice.
- Standardize how and where family history data is recorded in the medical record to increase the usability of this information.

CRC risk assessment & management of risk

- Assess patterns and red flags. Accurate risk assessment involves a synthesis of multiple data points, including family and medical history, patient race or ethnicity and lifestyle, behaviors, and exposures.
- Assign to risk category: Average, increased (moderate or familial), high (hereditary).
- Tailor risk communication to patient learning styles and needs.
- Use patient risk to adapt plan for cancer screening, surveillance, and prevention, and genetic referral. Average risk individuals should follow general population guidelines for cancer screening. Increased risk individuals typically should undergo earlier and/or more frequent screening, and individuals with a first-degree relative with CRC should begin CRC screening at age 40. Individuals at high risk should be referred for genetic counseling and genetic testing. Depending on the results of genetic evaluation, the patient may undergo high-risk cancer screening and surveillance and consider additional treatments.
- Be aware that cancer genetic testing can be complex, and should be done in conjunction with genetic counseling by qualified providers.
- Select a set of CRC screening guidelines for use in practice. There are numerous organizations that have developed guidelines for individuals with a family history of cancer or polyps. Pick the set of guidelines that aligns with your practice's and patient's needs and use this across your patient population.
- Consider implementing evidence-based interventions tailored to the patient's health beliefs and barriers in order to increase CRC screening adherence.
- Track clinical actions taken over time, including (a) referrals to genetic and cancer specialists, and (b) screening and surveillance procedures for those individuals at increased risk.
- Ensure that updates are made to the clinic process when risk assessment or management guidelines are changed.