Maryland
DEPARTMENT OF HEALTH

Wes Moore, Governor · Aruna Miller, Lt. Governor · Ryan Moran, DrPH, MHSA, Acting Secretary

March 17, 2025

Dear Participating Provider:

Thank you for participating in the Maryland Cigarette Restitution Fund Cancer Prevention, Education, Screening and Treatment (CRF CPEST) Program to provide no-cost colorectal cancer screening. The CRF CPEST Program was established to reduce cancer incidence and mortality in Maryland. As colorectal cancer is one of the seven targeted cancers under the CRF CPEST Program, the Program seeks to increase colorectal cancer screening rates among uninsured or underinsured, low-income individuals statewide and, in some instances, to also provide diagnostic and treatment services. When further diagnostic or treatment services for eligible clients screened through CRF CPEST Program are not available, clients will be linked to appropriate programs for funding.

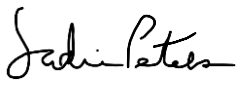
We are pleased to enclose the updated and newly revised "Minimal Clinical Elements for Colorectal Cancer Detection and Diagnosis." The updates include:

- **Page 2, in the left column, under the heading "Recommended Screening Method":** Colonoscopy is no longer listed as "Preferred". To ensure the optimization of CRF-CPEST funds, the CRF-CPEST Program is no longer prioritizing the use of colonoscopies as the preferred method of colorectal cancer screening for asymptomatic, average-risk program clients. As funding remains limited, and the cost of colonoscopies is still prohibitive, local CRF-CPEST Programs may now proactively offer other screening methods for average-risk program clients and reserve colonoscopies for program clients at high risk for colorectal cancer or for diagnostic purposes. When there is colonoscopy funding available and the health care provider orders a screening colonoscopy for an average risk patient, the CRF-CPEST program may be able fund the colonoscopy. The current MCE already permits the use of high-sensitivity fecal immunochemical tests (FIT), FIT-DNA tests (e.g. Cologuard), and CT colonography as alternative screening tests for average-risk program clients. These tests are listed as acceptable screening test options by the United States Preventive Services Task Force and the American Cancer Society.

- **Page 3, B. Individuals Symptomatic for Colorectal Cancer:** Provided clarity that "the CRF-CPEST Program will not reimburse for diagnostic tests employed to confirm non-colorectal cancer diagnoses. If a colonoscopy is indicated to establish a colorectal cancer diagnosis, the program will cover the procedure and its associated cost."
- **Page 3, II. F:** Removed language instructing providers to "reserve the use of FIT-DNA in case by case situations after a colonoscopy has been offered and refused AND a FIT has been offered and refused".
- **Page 4, H:** Removed reference to capsule colonoscopy and stated that the MAC will continue to review emerging technologies to determine their suitability for use in the CRF CPEST Program.
- **Page 4, III. A. 1. Procedure indication(s):** Instructions were added for providers to indicate on the endoscopy report whether the procedure was for diagnostic or screening purposes.
- **Page 5, formerly B. Fecal Immunochemical Test (FIT) or FIT-DNA (i.e., Cologuard):** Text describing possible results for FIT and FIT-DNA were removed.

We appreciate your cooperation in using the new guidelines during your care of CRF CPEST clients. If you have any questions regarding the new "Minimal Clinical Elements for Colorectal Cancer Detection and Diagnosis" for the Maryland CRF CPEST Program, please contact Sadie Peters, MA, MD, MHS, Medical Director of the Center for Cancer Prevention and Control (CCPC) at sadie.peters@maryland.gov.

Sincerely,



Sadie Peters, MA, MD, MHS
Medical Director, Center for Cancer Prevention and Control

Enclosure

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Local CRF CPEST Coordinators

Maryland Department of Health (MDH) Center for Cancer Prevention and Control
Cigarette Restitution Fund Cancer Prevention, Education, Screening, and Treatment (CRF CPEST) Program
Minimal Clinical Elements for Colorectal Cancer Detection and Diagnosis
March 2025

Goal: The goal of the Minimal Clinical Elements for Colorectal Cancer Screening is to provide clients of the Maryland Cigarette Restitution Fund Cancer Prevention, Education, Screening, and Treatment (CRF CPEST) Program with optimal care during colorectal cancer detection and diagnosis.

Objective: To provide clinical guidelines for colorectal cancer screening and diagnostic testing, including the interpretation and management of results.

Section **Page**

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I. Risk Assessment for Colorectal Cancer Screening: An individual that meets the criteria listed below will be enrolled in the CRF CPEST Colorectal Cancer Screening Module for colorectal cancer screening.

A. Individuals Asymptomatic for Colorectal Cancer

RISK CATEGORY	
AVERAGE RISK	**INCREASED RISK**
• Personal and family history negative for increased risk factors for colorectal cancer (as listed in the "Increased Risk" column to the right).	• **Personal history of:** o Colorectal cancer o Precancerous polyps, as listed: adenoma, sessile serrated polyp (SSP)[1], >5 hyperplastic polyps proximal to rectum, polyps ≥10 mm o Inflammatory Bowel Disease (IBD), specifically: ▪ Ulcerative colitis ▪ Crohn's disease o Ovarian or endometrial cancer (diagnosed at <50 years of age) or pelvic radiation o Polyp of unknown pathology • **Family history of:** o First-degree relative (e.g., parent, sibling, son or daughter) diagnosed with colorectal cancer at any age, or with advanced adenomas (i.e., high grade dysplasia, ≥1 cm, villous or tubulovillous histology) or with unknown pathology o More than one second-degree relative (e.g., grandparents, aunt, uncle) diagnosed with colorectal cancer at age <50 years or multiple second-degree relatives diagnosed with colorectal cancer at any age • **Personal or family history of:** o A high-risk syndrome (e.g., Lynch syndrome, polyposis syndromes)
RECOMMENDED SCREENING AGE	
• Begin screening at age 45 years • Individuals ages 76-85 years may be screened, if the provider recommends screening after taking into account comorbidities, longevity and past colorectal cancer screening results	• Age of individuals allowed to enroll in the program is dependent on risk category and findings of clinical investigations conducted prior to program enrollment ***Note:*** *Individuals age <18 years are not eligible for enrollment into the CRF CPEST Program*
RECOMMENDED SCREENING METHOD	
Refer to Attachment 1A • FIT-DNA Test (i.e., Cologuard); *see page 3, section II, letter F* • Fecal Immunochemical Test (FIT) • Colonoscopy • CT Colonography: *Prior authorization is required from the CRF CPEST Program*	• Screen with a colonoscopy at an age and on a schedule depending on risk category and prior findings: *Refer to the appropriate Attachment 2A, 2B, 2C, 2D, 2E or 2F* • CT Colonography: *Prior authorization is required from the CRF CPEST Program*

[1] The terms sessile serrated polyp (SSP), sessile serrated adenoma (SSA) and sessile serrated lesion (SSL) are used synonymously in this document.

B. Individuals Symptomatic for Colorectal Cancer

Regardless of risk category or screening schedule, a program-eligible individual meeting the criteria listed below should be enrolled in the CRF CPEST Program and evaluated by a healthcare provider to determine the need for clinical investigation to rule out colorectal cancer. A diagnostic approach should begin with non-invasive tests to investigate non-colorectal cancer causes of the client's signs/symptoms. The CRF CPEST Program will not reimburse for diagnostic tests employed to confirm non-colorectal cancer diagnoses. If a colonoscopy is indicated to establish a colorectal cancer diagnosis, the program will cover the procedure and its associated cost.

Any individual ≥18 years old with **signs/symptoms suggestive of colorectal cancer, including:**

- Bleeding from rectum or blood in stool
- Change in bowel habits including 'penciling' of stools (narrowing of stool caliber)
- Microcytic (iron deficiency) anemia not explained by another condition (e.g., menstruation, blood donation)
- Unexplained abdominal mass
- Unexplained new onset of abdominal cramps or pain
- Unexplained/unintentional weight loss

II. Notes on Screening Procedures

A. The need for a follow-up colonoscopy after a positive FIT or FIT-DNA result should be clearly explained while offering a stool-based test. An in-office FIT from the digital rectal exam is NOT recommended.

B. The colonoscopy is the gold standard for colorectal cancer screening. The colonoscopy is not only a screening/diagnostic tool, but it is also a preventive procedure when precancerous lesions are identified and removed.

C. A digital rectal exam should be performed at the time of colonoscopy or sigmoidoscopy.

D. The goal during a colonoscopy is that all lesions Identified as polyps or cancer are excised, sent for pathologic diagnosis and managed based on findings. The pathology findings influence the individual's risk category for colorectal cancer, the individual's family members' risk and the interval for the recall screening.

The only exceptions to a complete removal of polyps/lesions are:

- Bleeding from rectum or blood in stool
- **If the lesion is too large for excision:**
  - Biopsy the lesion(s) and send for pathology
- **When numerous (>20) small polyps are encountered:**
  - Remove all polyps ≥10 mm
  - Remove, if possible, all polyps 5 mm - 9 mm
  - Remove at least half the polyps <5 mm
  - Send all removed polyps to pathology
  - If numerous polyps are found, consider referral for genetic testing.

E. Tattoo incomplete or piecemeal polypectomy, or polypectomy of large sessile polyps/hyperplastic polyps or suspected cancer for later identification.

F. When a colonoscopy is not medically indicated (i.e., anticoagulation, inability of the colonoscopy to reach the cecum) for screening an asymptomatic average risk client for whom colon cancer screening is appropriate, consider a FIT-DNA or FIT.

G. Reserve a CT Colonography for case-by-case situations (i.e., anticoagulation, colonoscopy not medically indicated, inability of the colonoscopy to reach the cecum) where patient and provider discuss and determine that a CT Colonography is indicated for the individual. ***Note:*** *Prior authorization is required from the CRF CPEST Program.*

H. The Medical Advisory Committee, Colorectal Cancer Subcommittee will continue to review emerging technologies to determine their suitability for use in the CRF CPEST Program.

III. Results and Reporting (for purposes of the CRF CPEST Program):

A. COLONOSCOPY or FLEXIBLE SIGMOIDOSCOPY

1. **Colonoscopy/Flexible Sigmoidoscopy Report**: According to *The Quality Assurance Task Group* and *The Multi-Society Task Force – Colorectal Cancer*, the endoscopic report should be structured to include the following information:
   - **Patient demographics and history**
   - **Assessment of patient risk and comorbidity**
   - **Procedure indication(s)**
     - If symptoms suspicious for cancer, please describe and indicate the procedure as "diagnostic"
     - If no symptoms suspicious for cancer, indicate the procedure as "screening"
   - **Procedure: technical description**
   - **Exam Adequacy:** An "adequate" colonoscopy exam is defined as reaching the cecum AND having bowel preparation sufficient to visualize polyps >5mm.
     - **Extent of examination:** Actual extent of examination (anatomic segment: e.g., cecum, ascending colon, hepatic flexure)
       - ☐ If cecum is not reached, provide reason
     - **Bowel preparation quality**
       - ☐ Adequate to detect polyps >5 mm
       - ☐ Inadequate to detect polyps >5 mm
   - **Retroflexion in rectum** (yes/no)
   - **Technical performance**
     - Examination not technically difficult
     - Examination difficult, explain
   - **Length of time of withdrawal**
   - **Endoscopic findings** should be reported using the recommendation of *The Quality Assurance Task Group* and *The Multi-Society Task Force – Colorectal Cancer*, to include the following:
     - **If malignancy is suspected**
     - **Mass, colonic polyp(s)** or **submucosal lesion(s):**
       - ☐ Anatomic location
       - ☐ Amount
       - ☐ Size (in mm)
       - ☐ Bleeding/non-bleeding
       - ☐ Morphology
         - Flat (only slightly raised above surrounding mucosa, with or without a central depression), pedunculated or sessile
       - ☐ Method of removal or biopsy
         - Snare with or without cautery (saline solution injection yes/no)
         - Cold or hot biopsy
         - Fulguration or ablation with cautery
       - ☐ Completely removed (yes/no)
       - ☐ Retrieved (yes/no)
       - ☐ Sent to pathology (yes/no)

- ☐ Tattoo (if done)
- **Mucosal abnormality**
  - ☐ Suspected diagnosis: e.g., ulcerative colitis, Crohn's disease, ischemia, infection
  - ☐ Anatomic location/extent
  - ☐ Pathology obtained (yes/no)
- **Other findings**

- **Assessment** (based on history, symptoms and endoscopic findings)
- **Interventions/Unplanned events:** describe events and unplanned interventions during or immediately after endoscopic procedure
- **Recommendation for the date of the next colonoscopy or other tests** (based on the adequacy of the colonoscopy, the optical findings, the results of pathology and the client's risk category)

2. Pathologist Report:

- **Specimens classification:** normal, polyp, carcinoma or other findings (specify).
  - A polyp or lesion should be classified by:
    - ☐ **Type:**
      - Adenoma: tubular adenoma, tubulovillous adenoma, villous adenoma
      - Serrated polyp or lesion: sessile serrated polyp/adenoma/lesion, traditional serrated adenoma, sessile serrated polyp/adenoma/lesion with dysplasia (mixed adenoma/hyperplastic polyp)
      - Hyperplastic polyp
      - Other polyp: e.g., mucosal polyp, inflammatory, pseudopolyp, submucosal polyp (variety of lesions), lipoma, well-differentiated neuroendocrine (carcinoid) tumor, lymphoma, metastatic tumor
    - ☐ **Dysplasia:**
      - Whether high grade dysplasia (including severe dysplasia, carcinoma in situ and intramucosal carcinoma) is present in a conventional adenoma
      - Whether any dysplasia is present in a sessile serrated polyp/adenoma/lesion
    - ☐ **Presence of involvement of stalk/margin:** If neoplasia is present, determine whether the stalk or margin of the specimen is free of involvement
  - An **invasive carcinoma** should be classified as follows:
    - ☐ Differentiation (well, moderately or poorly differentiated)
    - ☐ If carcinoma is arising in adenomatous polyp:
      - Presence or absence of lymphatic/vascular invasion
      - Margins**:** note whether the margin is involved; distance of the carcinoma from the margin/stalk, or distance of the carcinoma from the cauterized margin of the specimen, depth of invasion measured from the base of the muscularis mucosae.

IV. Management of Screening Findings

A. Each polypectomy or biopsy noted on the colonoscopy report is matched to a specific histologic diagnosis on the pathology report.
B. Timing interval of surveillance recall is based on risk category and prior findings.
C. For individuals of **Average Risk**, refer to **Attachment 1A or Attachment 1B**
D. For individuals of **Increased Risk**, see below to review appropriate attachment.
- Personal History or Current Finding of Precancerous Polyps- **Attachment 2A**
- Personal History or Current Finding of Colorectal Cancer- **Attachment 2B**
- Personal History of Inflammatory Bowel Disease (IBD)- **Attachment 2C**

- Personal History of Ovarian or Endometrial Cancer <50 Years Old or Radiation Therapy to Colon or Rectum- **Attachment 2D**
- Family History of Colorectal Cancer (CRC)- **Attachment 2E**
- Personal or Family History of Hereditary Non-Polyposis Colon Cancer (HNPCC/Lynch Syndrome) or Familial Adenomatous Polyposis (FAP)- **Attachment 2F**

V. Additional Screening, Diagnostic and Treatment Procedures and Program Coverage

As CRF CPEST program is a safety net program, reimbursement is based on client eligibility, MDH Colorectal Cancer Minimal Clinical Elements and availability of local CRF CPEST Program funds.

Only follow-up and recall procedures that follow the MDH Minimal Clinical Elements recommendations or have been pre-authorized by MDH, will be eligible to receive reimbursement by the CRF CPEST Program.

Based on the findings on colonoscopy or other evaluation, further diagnostic testing and/or treatment may be recommended by the medical care provider(s). Clients requiring further diagnostic testing and/or treatment that is not covered by the CRF CPEST Program may need to be linked to other funding sources.

Note: *Providers should consult with the local CRF CPEST Program for questions about coverage for payment of procedures.*

References for Recommendations:

Final Update Summary: Colorectal Cancer: Screening. U.S. Preventive Services Task Force, 2021. https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/colorectal-cancer-screening (Accessed: May 18, 2021).

NCCN Clinical Practical Guidelines in Oncology, (NCCN Guidelines ®, pg. CSCR-1): Colorectal Cancer Screening, Version 2.2021-April 13, 2021. https://www.nccn.org/professionals/physician_gls/pdf/colorectal_screening.pdf (Accessed: May 18, 2021).

American Cancer Society. Guideline for Colorectal Cancer Screening. Last revised November 17, 2020. Available at: https://www.cancer.org/cancer/colon-rectal-cancer/detection-diagnosis-staging/acs-recommendations.html (Accessed: December 1, 2020).

Dekker, E., Bleijenberg, A. and Balaguer, F. (2020) 'Update on the World Health Organization Criteria for Diagnosis of Serrated Polyposis Syndrome', *Gastroenterology (00165085)*, 158(6), pp. 1520–1523. Available at: https://search.ebscohost.com/login.aspx?direct=true&AuthType=shib&db=edo&AN=142911451&site=eds-live (Accessed: December 1, 2020).

East JE, Atkin WS and Bateman AC (2017) 'British Society of Gastroenterology position statement on serrated polyps in the colon and rectum', *Gut*, (7), p. 1181. Available at: https://search.ebscohost.com/login.aspx?direct=true&AuthType=shib&db=edsghw&AN=edsgcl.506260245&site=eds-live (Accessed: December 1, 2020).

Lieberman, D. *et al.* (2007) 'Standardized colonoscopy reporting and data system: report of the Quality Assurance Task Group of the National Colorectal Cancer Roundtable', *Gastrointestinal Endoscopy*, 65(6), pp. 757–766. Available at:

https://search.ebscohost.com/login.aspx?direct=true&AuthType=shib&db=edo&AN=24861004&site=eds-live
(Accessed: December 1, 2020)

Recommendations from the Medical Advisory Committee Colorectal Cancer Subcommittee, 2021 or prior years.

Medical Advisory Committee Colorectal Cancer Subcommittee

The following members participated in the formulation of the Minimal Clinical Elements for Colorectal Cancer Screening:

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Medical Oncologist and Epidemiologist
Adjunct Professor, Johns Hopkins Bloomberg School of Public Health

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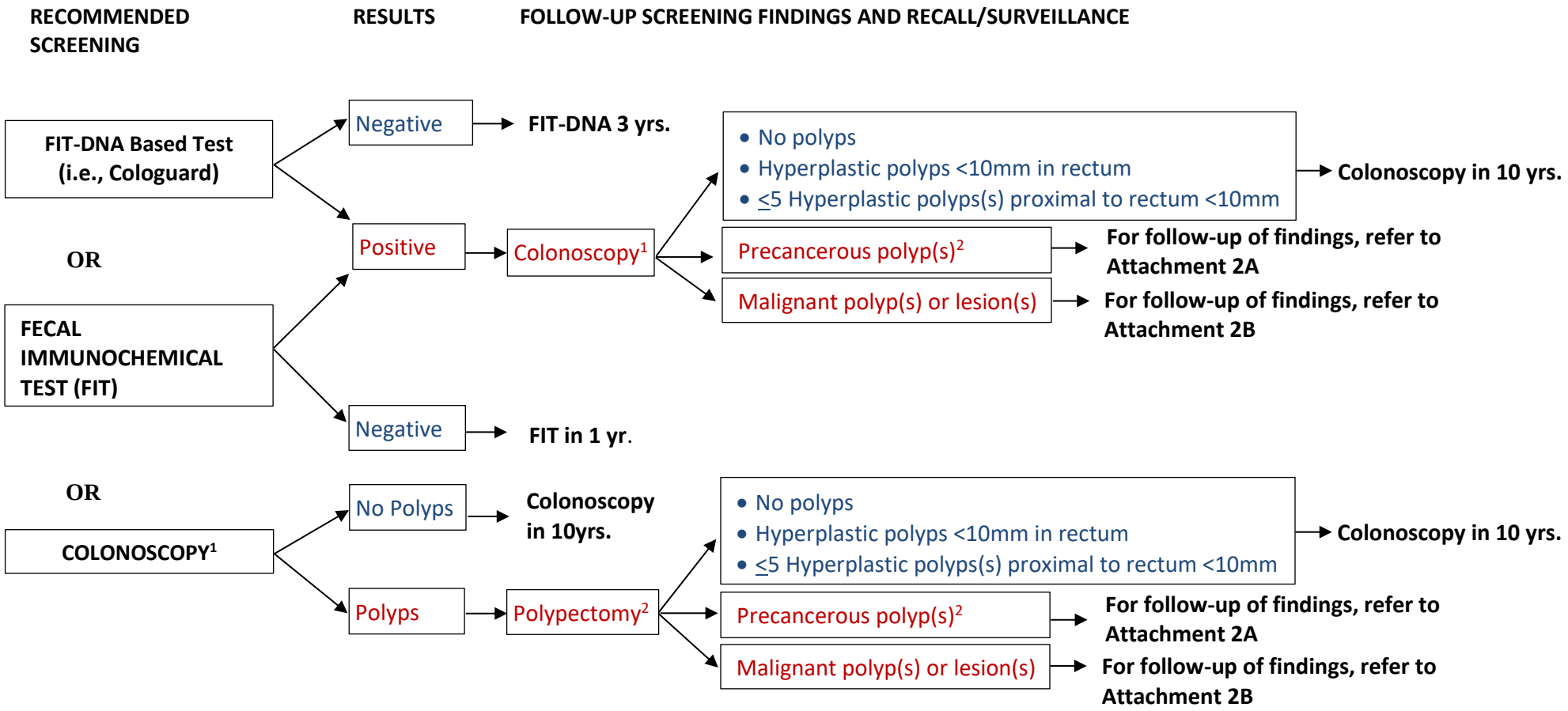
ATTACHMENT 1A- GUIDANCE FOR INDIVIDUALS OF AVERAGE RISK: *RECOMMENDED SCREENINGS*



[1] If the colonoscopy exam is **incomplete** *(inability to reach cecum),* consider another screening modality to complete the screening, **as soon as reasonably possible.**
If the colonoscopy exam is **inadequate** due to ***an inadequate prep*** *(unable to visualize polyps >5mm):*

- For individuals who are symptomatic of CRC or are currently at increased risk: repeat colonoscopy as soon as reasonably possible
- For those that remain average risk: repeat colonoscopy within the year

[2] If incomplete or piecemeal polypectomy, OR polypectomy of large (≥10mm) serrated polyps, OR polyps suspect for colorectal cancer, **ink lesion** for later identification and **repeat colonoscopy within 2-6 months**

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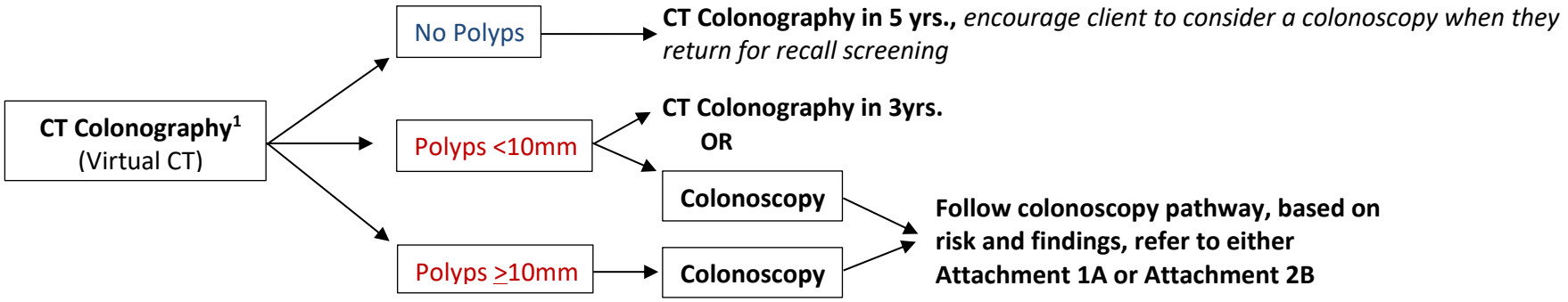
ATTACHMENT 1B- GUIDANCE FOR INDIVIDUALS OF AVERAGE OR INCREASED RISK:
SCREENING REQUIRING PRIOR AUTHORIZATION



[1] CT Colonography algorithm is based on the NCCN Guidelines Version 1.2019: Colorectal Cancer Screening Algorithm, CSCR-3

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ATTACHMENT 2A- GUIDANCE FOR INDIVIDUALS OF INCREASED RISK:
BASED ON PERSONAL HISTORY OR CURRENT FINDING OF PRECANCEROUS POLYPS

FINDINGS AT COLONOSCOPY[1, 2]	RECALL/SURVEILLANCE
Least Advanced • No Polyps • Hyperplastic polyp(s) in rectum <10mm • ≤5 Hyperplastic polyps(s) proximal to rectum <10mm • 1-2 tubular adenomas <10mm	**Repeat colonoscopy between 5-10 yrs.**
Intermediate • Polyp(s) with unknown pathology • >5 Hyperplastic polyp(s) proximal to rectum <10mm • Sessile serrated polyp(s) without dysplasia <10mm	**Repeat colonoscopy in no more than 5 yrs.**
Most Advanced • Hyperplastic polyp(s) anywhere in the colon ≥10mm • Sessile serrated polyp(s) ≥10mm[2] or traditional serrated adenoma(s) • Sessile serrated polyp(s) with dysplasia or adenoma(s) with high-grade dysplasia • 3-10 tubular adenomas <10mm • Adenoma(s) ≥10mm • >10 adenomatous polyps, any size or histology • Villous or tubulovillous histology	**Repeat colonoscopy in no more than 3 yrs.**
Serrated Polyposis Syndrome (SPS) • ≥5 histologically confirmed serrated lesions/polyps proximal to the rectum, all being ≥5mm in size, with ≥2 being ≥10mm in size • >20 serrated lesions/polyps of any size distributed throughout the large colon, with >5 being proximal to the rectum ***Note:*** Any histological subtype of serrated lesion/polyp (hyperplastic polyp, sessile serrated lesion with or without dysplasia, traditional serrated adenomas, and unclassified serrated adenoma) is included in the final polyp count. The polyp count is cumulative over multiple colonoscopies.	**Colonoscopy every 6-12 months** ***Note:*** *These clients are best referred to a center with experience in the management of the*
Malignant polyp/lesion/mass[2]	**Refer to Attachment 2B**

[1] If the colonoscopy exam is **incomplete** *(inability to reach cecum),* consider another screening modality to complete the screening, **as soon as reasonably possible.**
If the colonoscopy exam is **inadequate** due to ***an inadequate prep*** *(unable to visualize polyps >5mm),* **repeat colonoscopy as soon as reasonably possibly**

[2] If incomplete or piecemeal polypectomy OR polypectomy of large (≥10mm) sessile serrated polyps OR polyps suspect of colorectal cancer, **ink lesion** for later identification and **repeat colonoscopy within 2-6 months.** ***Note:*** The terms sessile serrated polyp (SSP), sessile serrated adenoma (SSA) and sessile serrated lesion (SSL) are used synonymously in this document.

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ATTACHMENT 2B- GUIDANCE FOR INDIVIDUALS OF INCREASED RISK:
BASED ON PERSONAL HISTORY OR CURRENT FINDING OF COLORECTAL CANCER

FINDINGS AT COLONOSCOPY	RECALL/SURVEILLANCE
Colorectal cancer (Curative intent resection of invasive colorectal adenocarcinoma)	→ **Colonoscopy[1, 2] in 1yr. following colorectal cancer treatment** → If normal at that time, **perform colonoscopy[1, 2] in 3 yrs.[3]** → If normal, **perform colonoscopy[1, 2] in 3-5 yrs.[3]**

Rectal cancer: In addition to the above, consider **endoscopic ultrasound** or **flexible sigmoidoscopy at 3-6 month intervals for the first 2 yrs. after resection.**

Anal, neuroendocrine lesions (carcinoid), cloacogenic carcinoma, rectal squamous cell, or other non-adenocarcinomas of colon or rectum	→ **Surveillance for anal and/or colorectal cancer per provider's recommendation**

[1] If the colonoscopy exam is **incomplete** *(inability to reach cecum),* consider another screening modality to complete the screening, **as soon as reasonably possible.**
If the colonoscopy exam is **inadequate** due to ***an inadequate prep*** *(unable to visualize polyps >5mm),* **repeat colonoscopy as soon as reasonably possibly.**

[2] If incomplete or piecemeal polypectomy OR polypectomy of large (≥10mm) sessile serrated polyp or hyperplastic polyp, **ink lesion** for later identification & **repeat colonoscopy within 2-6 months.**

[3] Shorter intervals may be indicated based on findings or on patient's age, family history or tumor testing indicating possible HNPCC/Lynch Syndrome.

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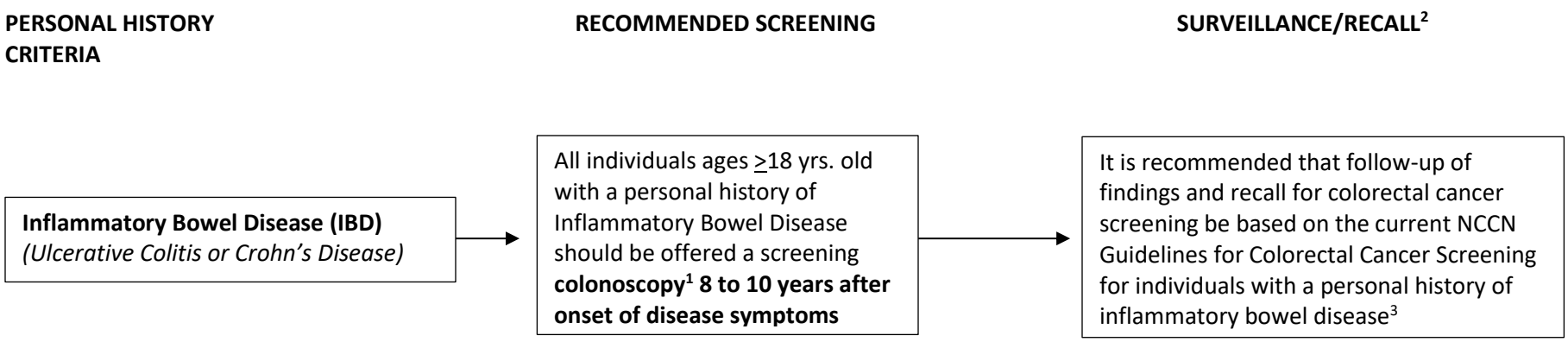
ATTACHMENT 2C- GUIDANCE FOR INDIVIDUALS OF INCREASED RISK: *BASED ON PERSONAL HISTORY OF INFLAMMATORY BOWEL DISEASE (IBD)* (C*rohn's Disease or Ulcerative Colitis)*



[1] If the colonoscopy exam is **incomplete** *(inability to reach cecum),* consider another screening modality to complete the screening, **as soon as reasonably possible.**
If the colonoscopy exam is **inadequate** due to ***an inadequate prep*** *(unable to visualize polyps >5mm),* **repeat colonoscopy as soon as reasonably possibly**
[2] The CRF CPEST Program does not fund colonoscopies for the sake of IBD surveillance. The CRF CPEST Program is a colorectal cancer screening program.
[3] The NCCN Guidelines for Colorectal Cancer Screening can be found at https://www.nccn.org/professionals/physician_gls/default.aspx#colorectal_screening

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ATTACHMENT 2D- GUIDANCE FOR INDIVIDUALS OF INCREASED RISK: *PERSONAL HISTORY OF OVARIAN OR ENDOMETRIAL CANCER <50 YEARS OLD or BASED ON RADIATION THERAPY TO COLON OR RECTUM*

PERSONAL HISTORY CRITERIA	RECOMMENDED SCREENING	SURVEILLANCE
Personal history of ovarian or endometrial cancer diagnosed <50 yrs. old	**Colonoscopy**[1] at time of diagnosis or at appropriate age per colorectal cancer risk category *(whichever is earlier)*	**Repeat colonoscopy in 3-5yrs.**[2] **or if positive for precancerous or cancerous polyps, repeat colonoscopy per findings** *(whichever is earlier)* Consider genetic testing for Lynch Syndrome (HNPCC)
Personal history of radiation therapy to colon or rectum (to include radiation to pelvis, prostate, cervix or uterus that involved the colon or rectum)	**Colonoscopy**[1] beginning 3-5 yrs. after radiation or at appropriate age per colorectal cancer risk category *(whichever is earlier)*	**Repeat colonoscopy in 3-5yrs.**[2] **or if positive for precancerous or cancerous polyps, repeat colonoscopy per findings** *(whichever is earlier)*

[1] If the colonoscopy exam is **incomplete** *(inability to reach cecum),* consider another screening modality to complete the screening, **as soon as reasonably possible.**
If the colonoscopy exam is **inadequate** due to ***an inadequate prep*** *(unable to visualize polyps >5mm),* **repeat colonoscopy as soon as reasonably possibly**
[2] Multiple (2 or more) negative colonoscopies may support stepwise lengthening in the colonoscopy interval.

Maryland Department of Health (MDH) Center for Cancer Prevention and Control
Cigarette Restitution Fund Cancer Prevention, Education, Screening, and Treatment (CRF CPEST) Program
Minimal Clinical Elements for Colorectal Cancer Screening
March 2025

ATTACHMENT 2E- GUIDANCE FOR INDIVIDUALS OF INCREASED RISK: *BASED ON FAMILY HISTORY OF COLORECTAL CANCER (CRC)*

FAMILY HISTORY CRITERIA	RECOMMENDED SCREENING	SURVEILLANCE
First-degree relative with colorectal cancer at any age	**Colonoscopy** beginning at age 40 yrs. or 10 yrs. before earliest diagnosis of CRC (*whichever is earlier)*	**Repeat colonoscopy every 5 yrs.[2] or if positive for precancerous or malignant polyps, repeat per colonoscopy findings** *(whichever is earlier)*
More than one second-degree relative diagnosed with colorectal cancer aged < 50 yrs. or multiple second-degree relatives diagnosed with colorectal cancer at any age	**Colonoscopy** beginning at age 45 yrs.	**Repeat colonoscopy every 5-10 yrs.[2] or if positive for precancerous or malignant polyps, repeat per colonoscopy findings** *(whichever is earlier)*
First-degree relative with advanced adenoma(s) (i.e., high dysplasia, ≥ 1cm, villous or tubulovillous histology)	**Colonoscopy** beginning at age 40 yrs. or at age of onset of adenoma in relative *(whichever is earlier)*	**Repeat colonoscopy every 5-10 yrs.[2] or if positive for precancerous or malignant polyps, repeat per colonoscopy findings** *(whichever is earlier)*

[1] If the colonoscopy exam is incomplete *(inability to reach cecum),* consider another screening modality to complete the CRC screening, as soon as reasonably possible.
If the colonoscopy exam is inadequate due to ***an inadequate prep*** *(unable to visualize polyps >5mm),* repeat colonoscopy **as soon as reasonably possibly.**
[2] Multiple (2 or more) negative colonoscopies may support stepwise lengthening in the colonoscopy interval.

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ATTACHMENT 2F- GUIDANCE FOR INDIVIDUALS OF INCREASED RISK: *BASED ON PERSONAL OR FAMILY HISTORY OF HEREDITARY NON-POLYPOSIS COLON CANCER (HNPCC/LYNCH SYNDROME) OR FAMILIAL ADENOMATOUS POLYPOSIS (FAP)*

HISTORY CRITERIA	RECOMMENDED SCREENING	SURVEILLANCE
Family history of Hereditary Non-polyposis Colon Cancer (NHPCC/Lynch Syndrome) or a family history consistent with NHPCC	**Colonoscopy**[1] beginning at age 20-25 yrs. or 2-5 yrs. before youngest case of first degree relative *(if diagnosed before age 25)* AND counseling to consider genetic testing (***Note:*** *Individuals age <18 years are not eligible for enrollment into the CRF CPEST Program*)	If genetic test positive or if client has not had genetic testing, **colonoscopy every 1-2 yrs. until age 40, then every 1 yr.** **Note:** *These clients are best referred to a center with experience in the management of HNPCC/Lynch Syndrome who will make the screening recommendations*
Personal history of familial adenomatous polyposis (FAP) or who is at risk of FAP, based on family (and genetic testing has not been performed)	Early surveillance with **colonoscopy**[1] or flexible sigmoidoscopy beginning age 10-12 yrs. AND counseling to consider genetic counselling and testing and a referral to a specialty center (***Note:*** *Individuals age <18 years are not eligible for enrollment into the CRF CPEST Program*)	**These clients are best referred to a center with experiences in the management of FAP who will make the screening recommendations**

[1] If the colonoscopy exam is **incomplete** *(inability to reach cecum),* consider another screening modality to complete the screening, **as soon as reasonably possible.**
If the colonoscopy exam is **inadequate** due to ***an inadequate prep*** *(unable to visualize polyps >5mm),* **repeat colonoscopy as soon as reasonably possible**