Colorectal Cancer Screening and Follow-Up:

A Practice Guide

NYC Health

Key Actions for Colorectal Cancer Screening

Talk with all adult patients about their risk of colorectal cancer (CRC) at least once per year.
Remind patients to update you with any changes. Encourage them to tell you if they develop symptoms that could be CRC (see **potential CRC symptoms** at the bottom of this page).

Recommend timely CRC screening.
For people at average risk of CRC, screening starts at age 45. For people at increased risk, determine if they need to start earlier (see **Increased Risk: Starting Age and Screening Recommendations** on the next page). Refer to a gastroenterologist (GI) if needed to clarify.

Explain the screening options available.
For many people at increased risk of CRC, colonoscopy is the recommended test.

Ensure prompt follow-up.
If a noninvasive test is positive, make an immediate referral for a follow-up colonoscopy and specify the reason. Encourage the patient to schedule promptly, preferably within two months. Avoid wait times longer than six months.

Use workflows and reminder systems to help patients keep up with screening.

Average Risk: Screening Options

Colonoscopy	Stool-based tests	Other options
	Must follow up with colonoscopy if positive.	
Invasive, requires bowel preparation	Noninvasive; no dietary restrictions for FIT, FIT-DNA, or FIT-RNA	Other options (flexible sigmoidoscopy with or without an annual FIT, CT colonography, or cell-free DNA blood test) can be considered for patients who would not accept screening otherwise.
Done at a clinical site, requires an escort home	Done at home and then sent to a lab	
Allows immediate removal of polyps and early cancers	Less likely to detect advanced adenomas	
Every 10 years (if normal)	Annual (FIT or HSgFOBT) or every three years (FIT-DNA or FIT-RNA)	

CT = computed tomography; FIT = fecal immunochemical test; FIT-DNA = FIT with stool DNA test; FIT-RNA = FIT with stool RNA test; HSgFOBT = high-sensitivity guaiac fecal occult blood test

Find out if the GIs you refer to will accept direct referrals for colonoscopies so patients do not need an office visit first. An example of a direct referral form is available at **on.nyc.gov/crc-refer**.

Advanced polyps can include:[1,2]

- Any adenoma that is 10 millimeters (mm) or larger, has villous or tubulovillous features, or has high-grade dysplasia
- Any sessile serrated polyp or lesion that is 10 mm or larger or any serrated lesion that has dysplasia
- Any traditional serrated adenoma

Potential CRC symptoms include:

- Diarrhea or constipation that does not resolve within a few days
- Narrowing or flattening of the stool
- Feeling the bowel does not empty completely
- Rectal bleeding (bright red blood) or maroon or black stools
- Abdominal pain or cramping
- Fatigue or unexplained anemia
- Unintended weight loss

Increased Risk: Starting Age and Screening Recommendations

The following recommendations are adapted from recent guidelines.[1,3,4] **They should be considered in context with all risk factors for each patient.** Review guidelines of expert organizations (such as the American College of Gastroenterology, National Comprehensive Cancer Network, or U.S. Multi-Society Task Force) for additional details and **refer to a GI for additional guidance**.

Family history	Starting age and screening test
CRC or advanced polyps	
One or more first-degree relatives (parents, siblings, or children)	**Age 40, or 10 years younger than the youngest age when a first-degree relative was diagnosed,* whichever is earlier[4]:** A colonoscopy every five years.[1,4] Note: If only one first-degree relative was affected and they were age 60 or older at diagnosis, some experts would start at age 40 but offer a choice of tests, at the same intervals as someone at average risk.[4]
Second or third-degree relatives	**Age 45** Recommendations for screening tests vary. Some experts recommend colonoscopy every 10 years if any second- or third-degree relatives had CRC.[1] If only one second-degree relative had CRC or advanced polyps, some experts screen as average risk, including a choice of screening test.[4]

If the history raises concern for an undiagnosed hereditary CRC syndrome, refer to GI or genetic evaluation; for example:

- Patient or first- or second-degree relative(s) with:
  - CRC before age 50
  - Other Lynch syndrome-associated tumors, especially if before age 50 or in multiple family members, or multiple cancers in the same person
- Patient or first-degree relative with many polyps, such as 10 or more cumulative adenomas.

A prediction calculator for Lynch syndrome is available at **premm.dfci.harvard.edu**.

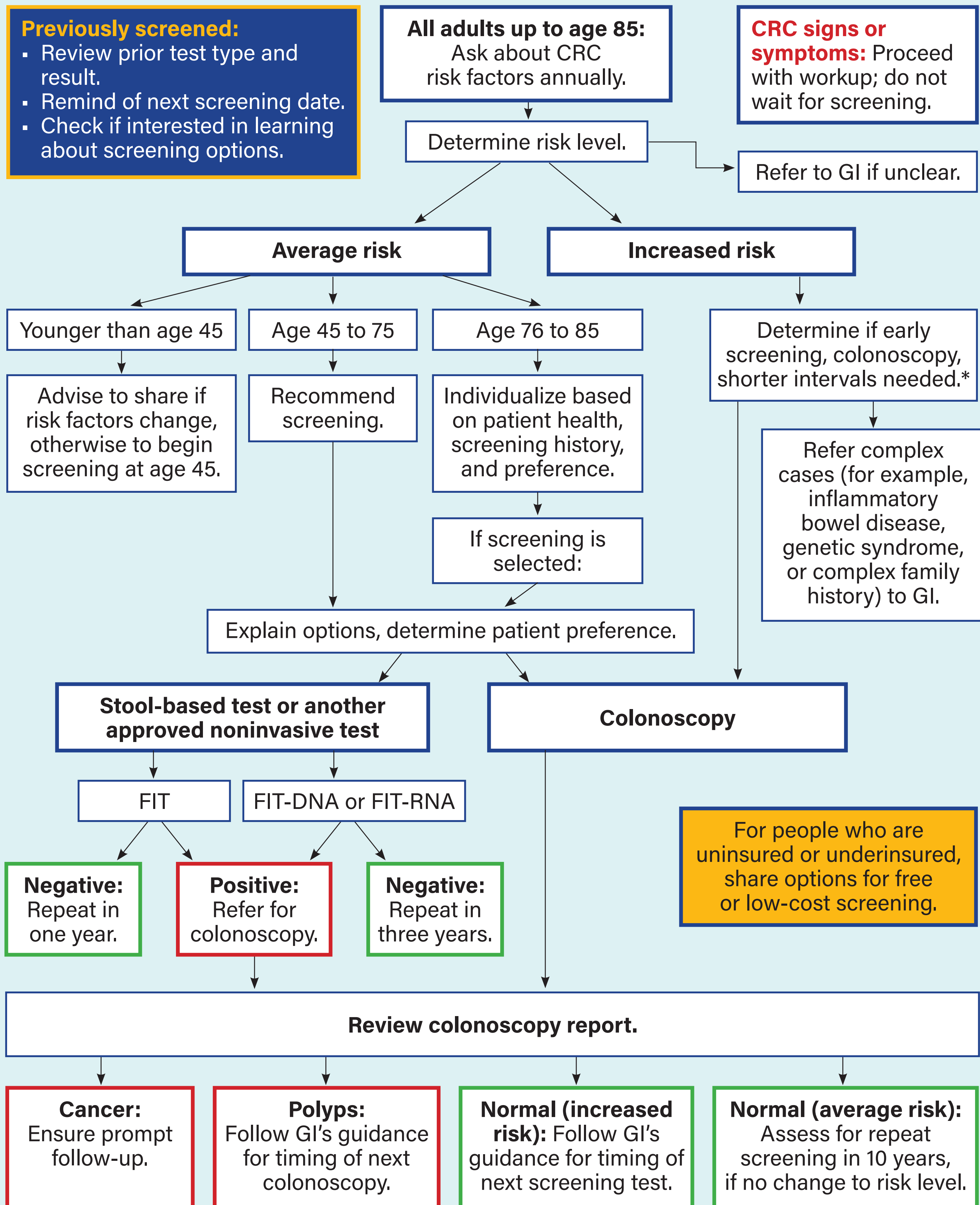
Personal history	Starting age and screening test
Polyps or CRC	**Follow GI's or oncologist's guidance.**
Genetic syndrome, such as Lynch syndrome or familial adenomatous polyposis[3]	**Depends on the variant; in some cases, start in childhood or young adulthood:** A colonoscopy (potentially as often as every year).
Inflammatory bowel disease, such as ulcerative colitis or Crohn's colitis[1]	**Eight years after initial symptoms (may be earlier if additional risk factors)†:** A colonoscopy or chromoendoscopy every one to three years.‡ (May be less intensive if only limited disease.)
Cystic fibrosis[1]	**Age 40; if history of solid organ transplant, age 30 (if older, within two years from the date of transplant):** A colonoscopy every five years.
Cancer before age 40[1]	**May need early screening, depending on age and type of treatment.† Follow GI or oncologist's guidance.**

* When a first-degree relative had only advanced polyps, the National Comprehensive Cancer Network (NCCN) suggests starting at age 40 or their age of diagnosis, whichever is earlier.

† If early screening is not needed, start no later than age 45.

‡ NCCN suggests a high-definition colonoscopy or chromoendoscopy with biopsies.

Steps to On-Time CRC Screening



* See chart on the preceding page for people who may be able to choose between tests.

Considerations for a Practice Workflow

Having a strong workflow can help you increase your screening rates and support patients in keeping up with screening and getting essential follow-up. Here are some questions to guide you:

Do you have an effective reminder system?

- Will it alert clinical staff when screening is due?
- Can it accommodate different types of screening tests with different screening intervals?
- Can it send automated reminders to patients? Are there options for different languages?
- Does the reminder method (for example, phone, text, email, or the patient portal) match how your patients like to receive communications?

What is the process for assessing CRC risk?

- If someone other than the primary care provider collects the patient's personal and family history, how will the primary care provider be made aware?
- Do you have access to a health information exchange (such as Healthix or the Bronx Regional Health Information Organization in NYC) to search for screening records?

Who will educate patients about screening and screening tests?

- Who will discuss screening options with the patient so they can make an informed choice?

Who will distribute stool-based test kits (for those who choose them)?

- How will the patient receive the test kit and instructions?
- How will patients be reminded to return the test?
- How are results documented and recorded in the electronic health record (EHR)?

How will your practice manage GI and colonoscopy referrals?

- Will your practice prescribe bowel preparation medication and provide instructions, or will that be handled by the GI office?

Who will receive and act on screening results?

- How will you track whether patients completed their screening?
- Who will alert patients who need a follow-up colonoscopy?
- How will colonoscopy reports be recorded in the EHR?

For patients without insurance:

- The New York State Cancer Services Program provides CRC screening to uninsured New Yorkers ages 45 to 75. For more information, visit **health.ny.gov/diseases/cancer/services** or call 866-442-CANCER (866-442-2262).
- NYC Health + Hospitals will help patients explore affordable screening, insurance, and payment options.

For more information, visit nyc.gov/health/coloncancer.

[1] National Comprehensive Cancer Network. Colorectal cancer screening, version 2.2025, NCCN Clinical Practice Guidelines in Oncology. June 24, 2025. Accessed September 4, 2025. https://www.nccn.org/guidelines/category_2

[2] American Cancer Society National Colorectal Cancer Roundtable. Advanced colorectal polyp GI brief. 2019. Accessed September 8, 2025. https://nccrt.org/wp-content/uploads/2024/03/Advanced_Colorectal_Polyp_Brief_Final_Ver1.pdf

[3] National Comprehensive Cancer Network. Genetic/familial high-risk assessment: colorectal, endometrial, and gastric, version 1.2025, NCCN Clinical Practice Guidelines in Oncology. June 13, 2025. Accessed September 4, 2025. https://www.nccn.org/professionals/physician_gls/pdf/genetics_ceg.pdf

[4] Shaukat A, Kahi CJ, Burke CA, Rabeneck L, Sauer BG, Rex DK. ACG clinical guidelines: colorectal cancer screening 2021. *Am J Gastroenterol*. 2021;116(3):458-479. doi:10.14309/ajg.0000000000001122

NYC Health