Talking About Colorectal Cancer Screening With Your Patients:

A Plain Language Provider Communication Guide

NYC Health

A health care provider's advice is one of the main reasons people decide to get screened for colorectal cancer (CRC).

Effective messaging for talking about screening includes[1]:

- The potential to prevent cancer
- The potential to detect it early
- Having a choice of screening tests

This guide offers plain language answers to common questions and concerns about CRC screening. It is designed to support you as you:

1. **Recommend screening.**
2. **Identify patients at increased risk.**
3. **Advise patients on when to get screened.**
4. **Support patients in choosing the right screening test for them.**
5. **Ensure timely follow-up for any positive screening tests.**
6. **Encourage patients to keep up with screening.**

1. Recommend screening.

Begin the conversation with patients early, starting in their 20s, and continue for as long as they are eligible for screening. For people at average risk of CRC, the U.S. Preventive Services Task Force[2] and the American Cancer Society[3] recommend screening for people ages 45 to 75, with individualized screening up to age 85. For someone at increased risk, age 45 is too late to find out they should have started screening early. Early conversations give people the chance to think about screening and be prepared to start on time.

According to research by the National Colorectal Cancer Roundtable, younger adults want to hear about CRC screening.[4] Even those who already know about CRC screening want to hear about it from their health care provider.

Plain Language Examples

"Do I need colon cancer screening?"

"Everyone has a colon, so everyone should get screened. I recommend you start getting screened for colon cancer as soon as you are eligible and keep up with screening on a regular schedule. Colon cancer screening can help save your life."

"Even if no one in your family has had colon cancer, you should still get screened. About three in every four people who get colon cancer have no relatives with colon cancer."

Many people know about CRC screening but do not understand exactly what it is and why it is done. Not everyone knows CRC can be preventable and treatable or how screening can help.

Plain Language Examples

"What is cancer?"

"Cancer is a disease that happens when some of the cells in a person's body start to grow out of control. These cells can take the place of normal cells and stop your body from working properly. Cells are the tiny building blocks in our bodies that divide, grow, and die in a way that keeps our bodies working."

"What is the colon?"

"Your colon is also called your large intestine or large bowel. It is the last part of your digestive system, where stool is formed. The end of the colon, where stool is stored before you have a bowel movement, is called the rectum."

"What is screening?"

"Screening is part of your regular health care, just like getting an annual checkup. It is a way to catch health issues before you even know they are happening. If you noticed something on your skin that did not look right, you would get it checked out. However, you cannot see inside your colon to know if it is healthy. Screening tests help you know what is going on inside your body."

"How does colon cancer screening help me?"

"There are two reasons to get screened: One reason is to prevent colon cancer. Another is if you have colon cancer and do not know it, screening could help save your life."

"Colon cancer usually starts with a small bump called a polyp on the inside of your colon. Polyps are not cancer, but some could, over time, turn into colon cancer. Screening can help catch those bumps and have them removed before they cause problems."

"If colon cancer has already developed, it often takes years before it grows enough to make you feel sick. You are more likely to get better if you find and treat cancer when it is still small. Colon cancer screening helps by finding cancer when it is small."

Normalize talking about stool and bowel movements. Use terms your patients are comfortable with. Reassure them there is no need to be embarrassed.

2. Identify patients at increased risk.

Encourage all patients to share their family history of cancer, as well as their personal health history. Explain how this affects their own risk of CRC, as well as when and how they should get screened.

Plain Language Examples

"Am I at increased risk?"

"When you are thinking about relatives, only count people who are directly related to you, not those who are only related by marriage. Think about your parents, brothers, sisters, children, and grandparents, as well as your uncles, aunts, nieces, nephews, and cousins."

"Did anyone have anything found on a colonoscopy? Do you remember what that was?"

"What types of cancer did they have? Do you know how old they were when they were diagnosed?"

"If you are comfortable asking your family about this, it would be helpful to know. You should also tell your family if we find any polyps on your screening."

Questions to determine increased risk status should include:

- Family or personal history of advanced polyps and CRC and other cancers, including age at onset
- Genetic syndromes that increase risk of cancer (such as familial adenomatous polyposis or Lynch syndrome)
- Personal history of inflammatory bowel disease (ulcerative colitis or Crohn's disease) or cystic fibrosis

"There are some people who are more at risk of developing colon cancer because of conditions that are passed down through families. Have you or any family members had genetic tests? Do you know what the results were?"

Here are some plain language terms to help with talking about family history.

- **Relatives:**
  - First-degree: Parent, sibling, child
  - Second-degree: Aunt, uncle, grandparent, grandchild, niece, nephew, half-sibling
  - Third-degree: First cousin, great-grandparent, great-aunt, great-uncle, great-niece, great-nephew, great-grandchild, half-aunt, half-uncle
- **Synchronous or metachronous cancer:** More than one kind of cancer in the same person, at the same time (synchronous) or at different times (metachronous)
- **Early-onset CRC:** Colon cancer before the age of 50

3. Advise patients on when to get screened.

Give concrete advice about when to start CRC screening and why. Encourage people who have already begun screening to keep to their recommended schedule. If you are unsure when screening should begin, refer the patient to a gastroenterologist.

Plain Language Examples

"When should I start getting screened?"

"You and your family do not have anything that makes me think you are at increased risk. Right before your 45th birthday, make an appointment to come in and we will get you set up for screening. I will put a reminder in your chart too."

"Your father was 45 when he was diagnosed with colon cancer. That means you should start screening 10 years before that, at age 35. I see you are 37 now, so let's get you set up for screening."

"I see your last screening was on [date], the test you had was [name of test], and the result was [result]. That means your next screening is due on [date]."

Make sure your patients know that screening is not just a one-time event and which schedule to follow.

4. Support patients in choosing the right screening test for them.

Having a choice of screening tests can make it more likely for people to get screened. Help your patients make informed decisions that take their personal priorities and risk tolerance into consideration. **For many people at increased risk of colorectal cancer, a colonoscopy is the recommended test.**

Plain Language Examples

"How do I get screened?"

"There are a few different test options for screening. Would you like to learn about them?"

"For someone like you who does not have any major risk factors for colon cancer, I recommend either a colonoscopy or stool-based test. What do you already know about these options?"

"For someone with your family history of colon cancer, I recommend a colonoscopy."

Plain Language Examples

"What are the differences between the screening tests?"

"**Colonoscopies** are good at finding both colon cancer and polyps, which are growths that can turn into cancer. Polyps and small cancerous tumors can be removed during the colonoscopy. As long as you are at average risk, and the colonoscopy shows your colon is normal, you only need one every 10 years."

"**Stool-based tests** can also find colon cancer, but they are not as good at finding polyps. That means stool-based tests need to be done more often, every one to three years, depending on which test you use. If a stool-based test is positive, which means not normal, it means something might be wrong. You will then need a colonoscopy to look inside your colon."

Other information you may want to explain to patients:

- Colonoscopies require the person to eat a special diet the day before and take medicine to clean out the colon. A stool-based test can be done at home, without special preparation.*
- During a colonoscopy, a person will go to a health care provider's office and be asleep during the test. For a stool-based test, the person will do the test at home and will be given a kit that tells them how to do it.
- For a colonoscopy, someone else will need to bring the person home after the test. This is because they might still feel sleepy after having sedation, which is medicine to make them sleep.

* Note: Guaiac-based tests have some dietary restrictions — the others do not.

If you choose to offer the new **cell-free DNA blood test** for people who will not accept other forms of CRC screening, explain it to your patients. You could say: "This screening test can help find cancer early, but it is not good at finding polyps to prevent cancer. If you have the blood test and it comes back positive, which means not normal, you will need a colonoscopy."

If you choose to offer computed tomography (CT) colonography or flexible sigmoidoscopy, explain them to your patients as well.

Plain Language Examples

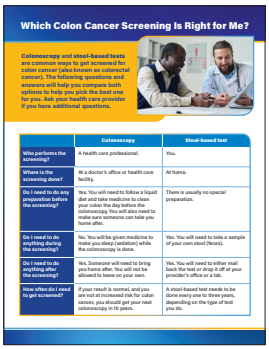
"Why do I have to do bowel preparation for a colonoscopy?"

"You need to clean out your colon so the doctor performing the colonoscopy can see it well. If you still have stool inside your colon, it could cover up a polyp or cancerous tumor."

Incomplete bowel preparation is a major reason why colonoscopies are canceled or discontinued partway through the procedure. Set your patients up for success by taking some time to thoroughly explain bowel preparation.

If your office prescribes the bowel preparation, make sure someone reviews the instructions and timing in detail with the patient. Include a list of foods that are OK to eat and foods to avoid.

If the gastroenterology practice will prescribe the bowel prep, make sure your patients are aware of what to expect in general. Different specialists use different regimens.


Which Colon Cancer Screening Is Right for Me?

Colonoscopy and stool-based tests are common ways to get screened for colon cancer (also known as colorectal cancer). The following questions and answers will help you compare both options to help you pick the best one for you. Ask your health care provider if you have additional questions.

	Colonoscopy	Stool-based test
Who performs the screening?	A health care professional.	You.
Where is the screening done?	At a doctor's office or health care facility.	At home.
Do I need to do any preparation before the screening?	Yes. You will need to follow a liquid diet and take medicine to clean your colon the day before the colonoscopy. You will also need to make sure someone can take you home after.	There is usually no special preparation.
Do I need to do anything during the screening?	No. You will be given medicine to make you sleep (sedation) while the colonoscopy is done.	Yes. You will need to take a sample of your own stool (feces).
Do I need to do anything after the screening?	Yes. Someone will need to bring you home after. You will not be allowed to leave on your own.	Yes. You will need to either mail back the test or drop it off at your provider's office or a lab.
How often do I need to get screened?	If your result is normal, and you are not at increased risk for colon cancer, you should get your next colonoscopy in 10 years.	A stool-based test needs to be done every one to three years, depending on the type of test you do.

Some patients are concerned about the safety of getting a colonoscopy. They may have heard about complications or hesitate to have an invasive procedure when they have no symptoms.

Plain Language Examples

"Is it safe to have a colonoscopy?"

"When experts recommend screening, they think about the safety of the screening compared with the risk of dying from cancer. Skipping your screening could actually be riskier than having a colonoscopy. If you have concerns, you can meet with the doctor, called a gastroenterologist, who will do the colonoscopy to discuss it together."

"I'm worried about..."

"I understand you do not want to have a colonoscopy. Let's figure out if an at-home stool test could work for you."

"I agree, bowel preparation is uncomfortable! What part are you worried about? There might be ways to make it easier."

"If you don't have health insurance, I have information about affordable options I can share with you."

Resources to share with patients:

- **Choosing a Colon Cancer Screening Test: Mark's Decision:** on.nyc.gov/colon-screening-novella
  - A comic book-style story about which screening to get.
- **Preparing for a Colonoscopy: Sandra's Story:** on.nyc.gov/colonoscopy-novella
  - A comic-book style story about getting ready for a colonoscopy.
- **How to Do an At-Home Colon Cancer Test:** on.nyc.gov/home-cancer-test-novella
  - A comic-book style story showing how to do a FIT (fecal immunochemical test) or FIT-DNA.

You can order free copies of these materials in multiple languages by calling **311** or the NYC Health Department's Provider Access Line at 866-NYC-DOH1 (866-692-3641).

More plain language information for patients can be found at cancer.org.

- **Colonoscopy Prep: What to Expect:** bit.ly/colonoscopy-prep-video
  - A short animated video showing an example of bowel preparation and how to choose a clear liquid diet.

5. Ensure timely follow-up for any positive screening tests.

A screening is not finished until the patient receives their results and completes any necessary follow-up. Many people assume if they do not hear anything that the screening result is normal.

Plain Language Examples

"How do I get my results?"

"After your colonoscopy, the doctor should talk with you right away. They will tell you if they found anything that was not normal. If they removed any growths, you should get a report from the lab in a few days that tells you exactly what they were. The doctor who did the colonoscopy should let you know if there is anything you need to follow up on."

"After you send in your stool-based test, you should receive the results within a couple of weeks. If the test shows there is any cause for concern, I will give you a referral for a colonoscopy."

Make sure to tell your patients:

- **How they will be notified about their test result.** Will they get a call, a text, a letter, or an email?
- **What to do if the result is not normal.** Should they make a follow-up appointment with you or the doctor who did their colonoscopy? If a stool-based test is positive, will they immediately receive a colonoscopy referral or do they need to contact your office first?

"My stool test was positive. What happens now?"

"There are many reasons why this could happen, so it does not mean you definitely have cancer. However, if it is cancer, the sooner we find out, the sooner we can fight it. The only way to know for sure is to have a colonoscopy."

"Get your colonoscopy scheduled as soon as you can. Waiting gives polyps a chance to turn into cancer, and it gives cancer a chance to grow. If you cannot get an appointment within the next month, please let me know so I can try to help."

6. Encourage patients to keep up with screening.

Reminder systems help patients stay on track with screening. Your ongoing recommendation can help them keep up with screening too.

Plain Language Examples

"Your colonoscopy report says that because you had a polyp removed, you need your next colonoscopy in five years. I will note that in the computer. What can you do to help yourself remember?"

"It is great to see your stool-based test was negative. Do not forget to do another one this time next year. We will send you a letter, but do you want to enter the date in your calendar too?"

"Let me know if anything changes in your family history or if you develop any symptoms that worry you, such as blood in your stool or problems with your bowel movements that do not get better."

[1] American Cancer Society National Colorectal Cancer Roundtable. 2019 colorectal cancer screening messaging guidebook. Accessed July 10, 2025. https://nccrt.org/wp-content/uploads/2023/11/2019-CRC-Communications-Guidebook-v13.pdf
[2] U.S. Preventive Services Task Force. Screening for colorectal cancer: U.S. Preventive Services Task Force recommendation statement. *JAMA*. 2021;325(19):1965-1977. doi:10.1001/jama.2021.6238
[3] Wolf AMD, Fontham ETH, Church TR, et al. Colorectal cancer screening for average-risk adults: 2018 guideline update from the American Cancer Society. *CA Cancer J Clin*. 2018;68(4):250-281. doi:10.3322/caac.21457
[4] American Cancer Society National Colorectal Cancer Roundtable. Lead time messaging guidebook: a tool to encourage on-time colorectal cancer screening. 2023. Accessed July 10, 2025. https://nccrt.org/wp-content/uploads/2023/12/2023-Lead-Time-Messaging-Guidebook-v15.pdf

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

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