



Colorectal Cancer Fact Sheet

for Health Care Professionals

Colorectal Cancer in the US^{1, 2}

Excluding skin cancers, colorectal cancer is the third most common cancer in men and in women. It is also the second-leading cause of cancer-related deaths in US men and women combined. Colorectal cancer incidence has declined since the mid-1980s, in part from increased screening among adults ages 50 and older. However, rates are increasing in people younger than age 55 so that they now make up 20% of new colorectal cancer cases.

Types of Colorectal Cancer³

Most colorectal cancers start as polyps, which might or might not develop into cancer. However, the risk for colorectal cancer increases if a polyp is larger than 1 cm, if more than three polyps are found, or if a polyp shows dysplasia.

Most colorectal cancers are adenocarcinomas. Some subtypes of adenocarcinomas, such as signet ring cell or mucinous, may have a worse prognosis.

Risk Factors^{1, 2, 3}

More than 55% of colorectal cancers in the US are attributable to potentially modifiable risk factors. Modifiable risk factors include excess body weight; physical inactivity; long-term smoking; high consumption of red or processed meat; low intake of calcium; very low intake of fruits, vegetables, and whole grains; and heavy alcohol consumption.

Personal, hereditary, and medical risk factors include:

- **Age:** Rates in younger adults have increased in recent years, but colorectal cancer is more common after age 50.
- **Personal or family history:** Colorectal cancer risk is higher among individuals with a personal or family history of the disease.
- **Race and ethnicity:** For colorectal cancer, Alaska Natives, American Indians, and African Americans have the highest incidence and mortality rates in the US. Ashkenazi Jews have one of the highest risks in the world.



- **Hereditary syndromes:** About 5% of people who develop colorectal cancer have inherited gene mutations, such as Lynch syndrome (hereditary non-polyposis colorectal cancer [HNPCC]), and familial adenomatous polyposis (FAP).
- Personal history of inflammatory bowel disease
- Type 2 diabetes

Screening and Detection^{1, 2, 3, 4}

The American Cancer Society recommends the following for people at **average risk** for colorectal cancer.

Regular screening should start at **age 45**. People who are in good health should continue regular colorectal cancer screening through the **age of 75**. For people **ages 76 through 85**, the decision to be screened should be based on patient preference, life expectancy, overall health, and prior screening history. People **over 85** should no longer get colorectal cancer screening. Screening can be done either with a stool-based test or a visual exam, like a colonoscopy.

People at **high risk** based on family and/or personal history or other factors may need to start screening **before age 45**, get more frequent screening, or get specific tests.

Stool-based tests

- Highly sensitive fecal immunochemical test (FIT)* every year, or
- Highly sensitive guaiac-based fecal occult blood test (gFOBT)* every year, or
- Multi-targeted stool DNA test (MT-sDNA) every 3 years*

Visual exams of the colon and rectum

- Colonoscopy every 10 years, or
- CT colonography (virtual colonoscopy)* every 5 years, or
- Flexible sigmoidoscopy (FSIG)* every 5 years

**If a person chooses to be screened with a test other than colonoscopy, any abnormal test result should be followed up with a timely colonoscopy.*

Signs and Symptoms^{1, 3}

People with early-stage colorectal cancer are typically asymptomatic. The most common signs and symptoms are rectal bleeding, blood in the stool, change in bowel habits, feeling that the bowel is not completely empty, abdominal cramping or pain, decreased appetite, weight loss, or anemia.

Prevention^{1, 3}

Regular screening can help prevent colorectal cancer by finding and removing polyps before they become cancer. Screening can also find cancer early when treatment may be more successful.

Improving diet and physical activity, staying at a healthy weight, and avoiding alcohol and tobacco may help decrease the risk of colorectal cancer.

People with a family history of colorectal cancer might benefit from meeting with a certified genetic counselor to better understand their risk and make an informed decision about having genetic testing. If a person is found to have a cancer syndrome, it might be appropriate to recommend starting screening at a younger age. For some syndromes, preventive surgery might also be considered.

Treatment^{1, 3, 4, 5, 6}

Treatment options are based on the tumor location, stage, and molecular characteristics, along with patient comorbidities. Surgery, radiation therapy, chemotherapy, targeted therapy, and immunotherapy drugs, either in combination or alone, might be used. Visit [cancer.org/cancer/colon-rectal-cancer.htm](https://www.cancer.org/cancer/colon-rectal-cancer.htm) to learn more about treatment options for colorectal cancer.

References

1. American Cancer Society. *Cancer Facts & Figures 2023*. Atlanta: American Cancer Society; 2023. Accessed at <https://www.cancer.org/research/cancer-facts-statistics/all-cancer-facts-figures/2023-cancer-facts-figures.html> on January 18, 2023.
2. American Cancer Society. *Colorectal Cancer Facts & Figures 2023-2025*. Atlanta: American Cancer Society; 2023. Accessed at <https://www.cancer.org/content/dam/cancer-org/research/cancer-facts-and-statistics/colorectal-cancer-facts-and-figures/colorectal-cancer-facts-and-figures-2023.pdf> on March 3, 2023.
3. American Cancer Society. Colorectal Cancer. [Cancer.org](https://www.cancer.org/cancer/colon-rectal-cancer.html). Updated June 29, 2020. Accessed at <https://www.cancer.org/cancer/colon-rectal-cancer.html> on January 18, 2023.
4. Wolf AMD, Fontham ETH, Church TR, et al. Colorectal cancer screening for averagerisk adults: 2018 guideline update from the American Cancer Society. *CA Cancer J Clin*. 2018;68:250–281.
5. National Comprehensive Cancer Network, Clinical Practice Guidelines in Oncology (NCCN Guidelines®), Colon Cancer, Version 2.2022. Accessed at https://www.nccn.org/professionals/physician_gls/pdf/colon.pdf on January 18, 2023.
6. National Comprehensive Cancer Network, Clinical Practice Guidelines in Oncology (NCCN Guidelines®), Rectal Cancer, Version 3.2022. Accessed at https://www.nccn.org/professionals/physician_gls/pdf/rectal.pdf on January 18, 2023.
7. Edwards RL, Taylor RA, Bakitas MA. Integration of palliative care. In: Haylock PJ, Curtis CP, eds. *Cancer Survivorship: Interprofessional, Patient-Centered Approaches to the Seasons of Survival*. Oncology Nursing Society; 2019: 137-151.

Colorectal Cancer in the US:

2023 estimates¹

New cases:

- 106,970 cases of colon cancer
- 46,050 cases of rectal cancer

Deaths:

- 52,550 from colon and rectal cancers combined

5-year relative survival rate for localized stage (colon cancer): 91%

5-year relative survival rate for all stages combined (colon cancer): 63%

5-year relative survival rate for localized stage (rectal cancer): 90%

5-year relative survival rate for all stages combined (rectal cancer): 68%

Quality of Life^{3, 5, 6, 7}

The most common concerns people with colorectal cancer have include chronic diarrhea, cramping, urgency, or stool incontinence; pain; fatigue; peripheral neuropathy; change in body image; managing daily activities if they have an ostomy; problems with intimacy or sexual dysfunction; or emotional distress. Younger men and women might be concerned about fertility.

A cancer diagnosis can profoundly impact quality of life. **Clinicians should assess for any physical, social, psychological, spiritual, and financial issues.** Integrating palliative care can help manage symptoms, address issues, and improve quality of life. It can be offered at any time, from diagnosis until the end of life. Throughout a person's cancer journey, it's very important for clinicians to share information and coordinate care to ensure ongoing surveillance.

