

# Fact Sheet

News from the IBD Help Center

## Colorectal Cancer

Colorectal cancer (CRC) can occur anywhere in the large intestine (colon and rectum), and is the second-leading cause of cancer-related death in this country. While this statistic is alarming, it is important to know that CRC is highly treatable in the early stages. Precancerous tissue can be found during a screening colonoscopy and removed, preventing cancer from developing. Regular screening and early detection are very important.

### Inflammatory Bowel Disease (IBD) & CRC

Ulcerative colitis and Crohn's disease are chronic inflammatory diseases of the gastrointestinal (GI) tract. Inflammation in the colon will damage the lining of the colon over time, increasing the risk of CRC. People with ulcerative colitis or Crohn's disease involving the colon (Crohn's colitis) are at higher risk for developing CRC compared with people who do not have these diseases. Even if your disease is in remission, you are at higher risk due to prior damage from inflammation. Despite this increased risk, it is important for you to understand that the majority of people with ulcerative colitis or Crohn's colitis will never develop CRC.

### Common Risk Factors

Three key risk factors associated with increased CRC risk are:

1. Length of time since diagnosis of Crohn's colitis or ulcerative colitis. The risk for CRC begins to increase 8 to 10 years after you develop ulcerative colitis or Crohn's colitis.
2. Extent of the colon involved. The risk is highest if your whole colon is involved, and lower if inflammation only involves a portion of your colon, like the rectum.
3. Uncontrolled inflammation. Ongoing and uncontrolled inflammation will lead to continued colon damage, increasing your risk of CRC. Healing your colon with medication therapies will help to reduce your CRC risk.

Some patients with IBD also have a chronic liver disease known as primary sclerosing cholangitis (PSC). PSC causes inflammation of the bile ducts, the drainage system for the liver. If you have PSC, you have an even higher risk of developing CRC. Your colon should be screened every year, as soon as the PSC is diagnosed.

### Signs & Symptoms

CRC may develop without any warning symptoms. If you develop CRC, you could see diarrhea or blood in the stool, but these symptoms may be confused with a flare up of ulcerative colitis or Crohn's colitis. If you are experiencing any of these symptoms, speak to your doctor:

- Change in the frequency of bowel movements
- Diarrhea, constipation, or feeling that the bowel does not empty completely
- Bright red or very dark blood in the stool
- Stools that are narrower than usual

- General stomach discomfort such as frequent gas pains, bloating, fullness and/or cramps
- Weight loss with no known reason
- Constant fatigue
- Vomiting

## Diagnosis

Colonoscopy is often used to diagnose IBD, monitor disease activity, or check whether medications are working to control inflammation. But, colonoscopy is also important to look for colon polyps or precancerous tissue in the colon (dysplasia surveillance) and remove it completely (if it is safe to do so), preventing development of cancer.

## Screening Recommendations

All patients with IBD should think about CRC risk, regardless of whether your disease is active or inactive. Generally speaking, screening should begin 8-10 years after a diagnosis of ulcerative colitis or Crohn's colitis and repeated every 1-3 years. Patients with PSC require more intensive screening beginning immediately after diagnosis. However, specific screening recommendations are individualized to each patient based on the type of IBD, length of time with IBD, amount of inflammation, and additional risk factors (PSC, family history of colon cancer, among others). It's important to ask your doctor when and how often you need CRC screening.

## Chromoendoscopy

When used for dysplasia surveillance, your doctor may recommend a colonoscopy with *chromoendoscopy*. During chromoendoscopy, a blue liquid dye is sprayed over the colon surface during the colonoscopy procedure. The blue dye collects and pools in the crevices of the colon lining, drawing your doctor's eye to slight or subtle changes in the lining of your intestine, which may be precancerous areas. Chromoendoscopy cannot be used if the colon is not clean, and it is not very effective if the colon is inflamed. Therefore, an excellent bowel preparation and control of inflammation are very important. It is common to see blue stool for a short time following this procedure. To learn more about chromoendoscopy and studies that have showed its effectiveness for colorectal cancer surveillance, please see the [SCENIC guidelines](#).

## Decreasing Your Risk

- If you have been diagnosed with ulcerative colitis or Crohn's colitis, see your gastroenterologist annually for a general check-up, regardless of how healthy you feel.
- Discuss any concerns you may have with your doctor.
- Report any changes in symptoms.
- Help keep your disease and inflammation under control by staying on your medications, even when you are feeling well.
- You and your doctor should review the medications you are currently taking.
- Update your doctor on family history of colorectal cancer, regardless of whether the family member has IBD.
- Although there is no cure for IBD, early detection and adequate treatment is critical to reducing your risk for CRC.
- Exercise and eat a healthy diet.
- Log onto the Crohn's & Colitis Foundation website, [www.crohnscolitisfoundation.org](http://www.crohnscolitisfoundation.org), for more information about Crohn's disease and ulcerative colitis.

## Checklist: Am I at risk for CRC?

Just about everyone is at risk for CRC. However, there are several key factors that may put you at increased risk.

### Risk Factors for Developing CRC (check all that apply):

- Diagnosed with Crohn's disease involving the colon or ulcerative colitis.
- Eight to 10 year history of Crohn's colitis or ulcerative colitis.
- A personal or family history of colorectal polyps or colorectal cancer.
- A personal history of bile duct inflammation (primary sclerosing cholangitis).

- Genetic syndromes such as familial adenomatous polyposis (FAP) or hereditary nonpolyposis colon cancer (HNPCC).
- Appearance of polyps or bumps in the colon.
- Appearance of dysplasia (changes in cells that are precursors of cancer) of the colon or rectum.

If you've checked any of the boxes in the above checklist, take this fact sheet to your next doctor's appointment. Speak with your doctor about your risk factors for developing colorectal cancer and what you can do to reduce your risk.

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March, 2017

**This educational material is supported by the Maxine and Jack Zarrow Family Foundation. Additional support is provided through the Crohn's & Colitis Foundation's annual giving programs and donors.**

**Thank you to the patients, caregivers, and medical professionals on our Patient and Professional Educational Advisory Committee for their contributions to this resource.**