

KNOWLEDGE IS POWER

Helping you Stay Informed

*For more information about screening
and treatment, contact:*



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Commonwealth Hematology-Oncology (CHO), with offices and clinical sites throughout Massachusetts, is the largest private practice cancer care network in New England. Known for its leadership in community-based cancer care, CHO physicians have been caring for patients for over three decades. CHO was the first group practice in the state to develop treatment guidelines for specific cancers, the first to develop a computerized software program for chemotherapy ordering, the first to create a free Patient Advocacy program, and the only area practice to be selected by the National Cancer Institute to offer a community-based clinical trials program. CHO also provides genetic testing to community residents at high risk for cancer. For more information, visit www.chomed.com.

With special thanks to the American Cancer Society.



Optimism continues
to grow in the field of cancer care.
Improvements in prevention, early
detection, and treatment of many
forms of cancer are contributing to a
continued decline in the death rate
from cancer.



While this news is encouraging, population trends indicate that more people will be diagnosed with cancer in the years ahead. Most cancers occur predominantly in older persons, and the number of people living with cancer is expected to double by 2050.

What can you do?

Being knowledgeable about your risk for certain types of cancer—and following designated cancer screening guidelines—is critical in detecting cancer in its earliest and most treatable form.

In short, knowledge is power. We hope that the following information about cancer screening guidelines will empower you to assess your personal risk factors and act accordingly.

BREAST CANCER

Screening recommendations for the average-risk individual:

- Annual mammography for women starting at age 40.
- Clinical Breast Exam (CBE) by a physician every three years for women between 20 and 39 and every year for women over 40. A clinical breast exam should be part of every woman's periodic health exam.
- Monthly breast self-examination (BSE)* for women beginning at the age of 20. Any self-detected breast change should be promptly reported to your healthcare provider.

Who is at increased or high risk?

- Women with a prior history of radiation to the chest, especially if this radiation was received prior to the age of 25.
- Women who have a strong family history of breast and/or ovarian cancer.
- Women with a known genetic predisposition to breast cancer.
- Women with lobular carcinoma *in situ* (LCIS) or atypical hyperplasia.
- Prior history of breast cancer.

* The American Cancer Society has recently changed its recommendations regarding breast self-examination. This is recommended for average and increased risk women who are comfortable performing it. If not, get a clinical exam from your healthcare provider. Breast self-examination is strongly recommended for those at increased risk for breast cancer.

Screening recommendations for women at increased or high risk

- Women with a history of radiation to the chest should start screening with annual CBE at age 25. Mammogram and CBE every 6-12 months should also be instituted at age 25.
- Older women without serious health problems should continue having an annual mammogram, regardless of age.
- Screening for women at increased risk (15%-20% lifetime risk) should include yearly CBE and mammogram. Women in this category should also discuss with their doctor the benefits and limitations of adding an MRI to their yearly mammogram.
- Women with a strong family history or other genetic predisposition should start screenings 5-10 years prior to the youngest case of breast cancer in the family.
- Women with Hereditary Breast and Ovarian Cancer (HBOC) should start annual mammogram, MRI, and CBE every 6-12 months at the age of 25.
- Screening for women at high risk (> 20% lifetime risk of developing breast cancer) should include CBE every 6-12 months and both an MRI and mammogram yearly.

CERVICAL CANCER

Screening recommendations for the average-risk individual:

- An annual Pap test and pelvic exam for women approximately three years after they begin having sexual intercourse or at the age of 21, whichever comes first.
- Beginning at age 30, women at low risk for cervical cancer who have had three consecutive normal/negative Pap test results, may start to be screened every two to three years at the discretion of their physician.
- Women 70 years of age or older who have had three or more normal Pap tests in a row with no abnormal results in the last 10 years may choose to stop having cervical cancer screening.
- Women who have had a total hysterectomy (removal of the uterus and cervix) may also choose to stop having cervical cancer screening, unless the surgery was done as a treatment for cervical cancer or a pre-cancerous condition. Women who have had a hysterectomy without removal of the cervix (subtotal hysterectomy) should continue to follow the above screening guidelines.

- Women who have received the HPV vaccine should have regular cervical cancer screenings according to the above screening guidelines.

Who is at increased or high risk?

- Women with multiple sexual partners or those who began having intercourse in their early teens.
- Women with a current or past history of human papilloma virus (HPV), condylomata, herpes simplex virus (HSV), or other sexually transmitted diseases.
- Women with certain risk factors—including those who had diethylstilbestrol (DES) exposure *in utero*; who are immunocompromised due to organ transplant, chemotherapy, bone marrow transplant, or chronic steroid use; or who are HIV-positive—should continue to be screened annually until recommended otherwise by their physician.
- Women with a history of cervical cancer.

Screening recommendations for women at increased or high risk:

- Women at increased or high risk should continue annual cervical cancer screening for as long as they are in reasonably good health and do not have a life-limiting chronic condition.
- Women who had DES exposure *in utero* and who have had a hysterectomy should continue to have yearly screening with a Pap test unless otherwise determined by their clinician.

COLORECTAL CANCER

Screening recommendations for the average-risk individual:

Adults at average risk should begin colorectal cancer screening at age 50 and follow one of these five testing schedules:

- Annual fecal occult blood test (FOBT)* or fecal immuno-chemical test (FIT).
- Flexible sigmoidoscopy every five years. **
- Annual fecal occult blood test (FIT) plus flexible sigmoidoscopy every five years. **
- Double contrast barium enema (DCBE) every five years. **
- Colonoscopy every 10 years.
- Virtual colonoscopy (CT Scan) every five years. **

* For FOBT, the take-home multiple sample method may be used.

** If test results are positive, the patient should have a colonoscopy.

Who is at increased risk?

- Individuals previously diagnosed with a single, small (<1cm) polyp.
- Individuals with a large (1 cm+) polyp or polyps with high-grade dysplasia or villous change.
- Individuals with history of surgery for colorectal cancer.
- Individuals with either colorectal cancer or adenomatous polyps in any first-degree relative before age 60, or in two or more first-degree relatives at any age.

Screening recommendations for individuals at increased risk:

- A colonoscopy three to six years after an initial polypectomy for a single, small polyp less than 1 cm.
- A colonoscopy within three years after an initial polypectomy for a large polyp more than 1 cm, multiple polyps with high-grade dysplasia, or villous changes.
- A colonoscopy within one year after cancer resection (individuals with a personal history of curative-intent resection of colorectal cancer).
- Colonoscopy at age 40 or 10 years before the youngest case in the immediate family with colorectal cancer, or adenomatous polyps in any first-degree relative.

Who is at high risk?

- Individuals with a family history of familial adenomatous polyposis (FAP).
- Individuals with a family history of hereditary non-polyposis colon cancer (HNPCC).
- Individuals with inflammatory bowel disease, chronic ulcerative colitis, or Crohn's disease.

Screening recommendations for individuals at high risk:

- For individuals with a family history of familial adenomatous polyposis (FAP), early surveillance with a colonoscopy at puberty.
- For those with a family history of hereditary non-polyposis colon cancer (HNPCC), a colonoscopy and counseling to consider genetic testing at age 21.
- For those with pancolitis or left-sided colitis, a colonoscopy with biopsies eight years after onset to screen for dysplasia, inflammatory bowel disease, chronic ulcerative colitis, or Crohn's disease.

PROSTATE CANCER

Screening recommendations for the average-risk individual:

- A digital rectal exam (DRE) and PSA test should be offered annually, starting at age 50 for men who have a life expectancy of at least 10 years. Although the American Cancer Society no longer recommends regular PSA testing for average-risk men, you should discuss the test with your healthcare provider.

Who is at increased risk?

- Individuals of African descent (specifically sub-Saharan African) or any man with a family history of prostate cancer. This risk increases if the family member was diagnosed with prostate cancer prior to the age of 45.

Screening recommendations for individuals at increased risk:

- Those at increased or high risk should begin testing at age 45. Testing should include digital rectal exam (DRE) and PSA on a yearly basis.

Who is at high risk?

- African American men and men with a strong family history of one or more first-degree relatives diagnosed with prostate cancer at an early age. Even if the PSA is less than 1.0 ng/ml, annual testing and DRE are recommended. While elevated PSAs are not always related to cancer, it is recommended that if the PSA results are in the 2.5–4.0 range, a biopsy should be considered to further evaluate the elevated PSA.

Screening recommendations for individuals at high risk:

- Men at high risk for prostate cancer should begin testing at age 45. Depending on the results of an initial test, no further testing may be needed. These men should be provided with information regarding the controversy surrounding the benefits of early detection and treatment of prostate cancer.

SKIN CANCER AND MELANOMA

Screening recommendations for the average-risk individual:

- Monthly skin self-exam. All areas of the body should be examined, including palms and soles of the feet, the scalp, ears, under nails, and the back. In men, about one of every three melanomas occurs on the back.
- Skin exam by a physician every three years between the ages of 20 and 40.
- Annual skin examination at age 40 and older.

Who is at increased risk?

- Individuals with red or blond hair, blue eyes, fair skin, or skin that freckles easily.
- Individuals with skin that burns and does not tan with sun exposure.
- Individuals with atypical moles (dysplastic nevi) that can appear in areas of the body exposed to the sun, as well as those areas that are usually covered, such as the buttocks and scalp.
- Individuals (such as organ transplant patients) who have been treated with medicines that suppress the immune system.
- Individuals 70 years of age or older. However, melanoma is one of the few cancers found in younger people and is one of the most common cancers in people younger than 30. Melanoma that runs in families occurs at a younger age.

Who is at high risk?

- Individuals with excessive UV exposure.
- Individuals with one or more atypical moles or large moles.
- Individuals with a family history of melanoma.
- Individuals with a strong family history of breast and/or ovarian cancer.
- Individuals with a history of melanoma or other skin cancers.
- Individuals with blistering sunburns as a child.

Screening recommendations for individuals at increased or high risk:

- A primary healthcare provider should see individuals with a suspicious lesion or unusual mole. If melanoma can't be conclusively ruled out, a dermatologist should be consulted.
- Individuals at increased or high risk for skin cancer should speak with their healthcare providers about initiating screenings earlier or establishing shorter intervals between full body skin exams with a dermatologist.

ENDOMETRIAL (UTERINE) CANCER

- Healthcare providers should inform all women, at the time of menopause, about the risks and symptoms of endometrial cancer. Women should report any unexpected bleeding or spotting.
- Beginning at age 35, women with or at high risk for hereditary nonpolyposis colon cancer (HNPCC) should begin annual screening exams, including an endometrial biopsy.