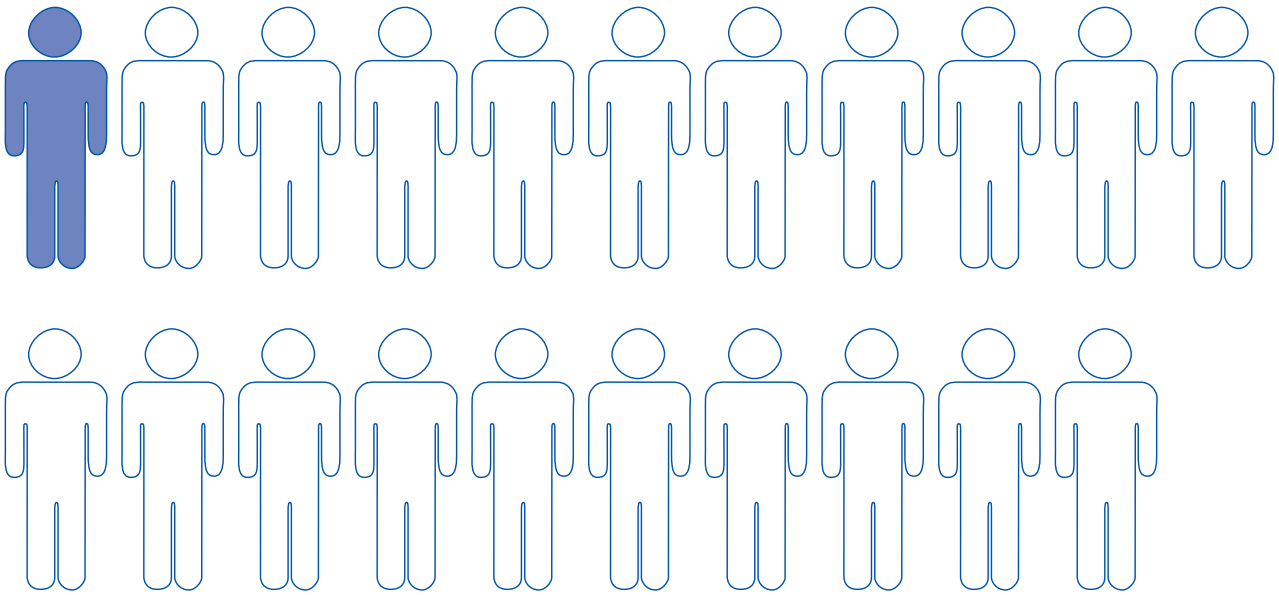
Facts & Figures

Colorectal Cancer in Wisconsin



1 in 21 Lifetime risk of being diagnosed with colorectal cancer

2,540	Number of men and women expected to be diagnosed with colorectal cancer in 2020*
64%	Percentage of all people who survive 5 years or more after being diagnosed with colorectal cancer*
74%	Percentage of adults ages 50 and older who ever had a sigmoidoscopy or colonoscopy**
40%	Percentage diagnosed at an early stage when colorectal cancer is easier to treat†

Source: *Estimates for 2020. American Cancer Society. *Cancer Facts & Figures 2020.* Atlanta: American Cancer Society; 2020. **Wisconsin Behavior Risk Factor Surveillance System, Office of Health Informatics, Division of Public Health, Department of Health Services, 2019. †2016 statistic. Wisconsin Cancer Reporting System, Office of Health Informatics, Division of Public Health, Department of Health Services, and the National Center for Health Statistics.

American Cancer Society®

Colorectal Cancer in Wisconsin

Overview

Colon and rectal cancers have many features in common and are referred to as colorectal cancer. Cancer can develop in any part of the colon or rectum. Colorectal cancer typically develops slowly over a period of several years. Before cancer develops there are usually precancerous growths called polyps.

Screening tests offer a powerful opportunity for the prevention, early detection, and successful treatment of colorectal cancers. While people cannot change their genetic makeup or family health history, most people can help reduce their risk of colorectal cancer by following screening guidelines and making changes to their risk factor exposure.

Based on a study by American Cancer Society researchers, more than half (55%) of colorectal cancers in the US are attributable to potentially modifiable risk factors. Modifiable factors that increase risk include obesity, physical inactivity, long-term smoking, high consumption of red or processed meat, low calcium intake, moderate to heavy alcohol consumption, and very low intake of fruits and vegetables and whole-grain fiber.

Cancer Burden

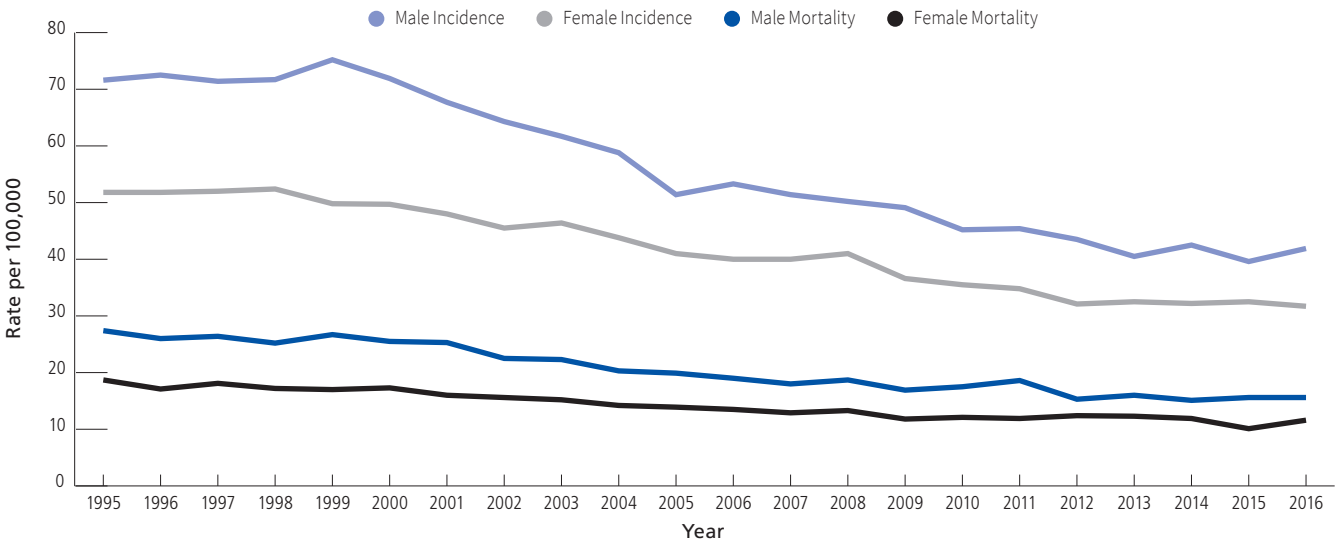
Colorectal cancer incidence rates have been decreasing for the past several decades, which has largely been attributed to the increased use of colorectal screening tests that allow for the detection and removal of colorectal polyps before they progress to cancer. Mortality rates for colorectal cancer continue to decrease because of increased screening, changing patterns in risk factors, and improved cancer treatments.

From 2012-2016, an annual average of 2,551 Wisconsin residents were diagnosed with colorectal cancer. The incidence rate for both sexes combined was 37.2 per 100,000 population. Males had a higher incidence rate than females, 42.3 compared to 32.7, per 100,000, respectively.

Colorectal cancer is the second-leading cause of cancer-related deaths in Wisconsin for males and females combined. From 2012-2016, an annual average of 939 residents died of the disease. The colorectal cancer mortality rate for that period was 13.4 per 100,000, with a rate of 15.6 per 100,000 for males and 11.6 per 100,000 for females.

The overall colorectal cancer incidence rate dropped from 60.0 in 1995 to 36.4 in 2016. The colorectal cancer mortality rate dropped from 22.3 per 100,000 in 1995 to 13.1 per 100,000 in 2016. Figure 1 shows both declining trends by sex for years 1995-2016.

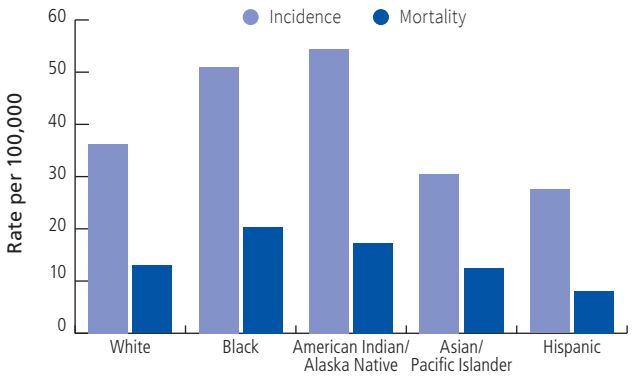
Figure 1. Trends in Colorectal Cancer, Incidence and Mortality by Sex, Wisconsin, 1995-2016



Rates are per 100,000 and age-adjusted to the 2000 US standard population.

Source: Wisconsin Cancer Reporting System, Office of Health, Division of Public Health, Department of Health Services and the National Center for Health Statistics.

Figure 2. Colorectal Cancer Incidence and Mortality by Race and Ethnicity, Wisconsin, 2012-2016



Rates are per 100,000 and age-adjusted to the 2000 US standard population.

Source: Wisconsin Cancer Reporting System, Office of Health Informatics, Division of Public Health, Department of Health Services and the National Center for Health Statistics.

The burden of colorectal cancer incidence and mortality varies considerably by race and ethnicity as shown in Figure 2. Blacks have the highest incidence and mortality rates of all racial/ethnic groups.

Risk Factors

Several risk factors may contribute to the development of colorectal cancer. They include:

- Age (90% of colorectal cancer cases are diagnosed in individuals ages 50 and older)

Hereditary and Medical Factors

- Personal or family history of colorectal cancer and/or polyps
- Inherited genetic conditions (familial adenomatous polyposis [FAP] and hereditary non-polyposis colorectal cancer [HNPCC], also known as Lynch syndrome)
- Personal history of chronic inflammatory bowel disease (ulcerative colitis or Crohn's disease)
- Type 2 diabetes

Modifiable Risk Factors

- Lack of physical activity
- A diet that is high in red or processed meat
- Obesity
- Long-term smoking
- Alcohol consumption
- Very low intake of fruits and vegetables

Risk Reduction

Screening tests that detect and remove adenomatous polyps are the most reliable method of preventing colorectal cancer.

Modifiable factors for reducing the risk of the disease include healthy eating, being physically active, maintaining a healthy body weight, and avoiding smoking.

Screening/Early Detection

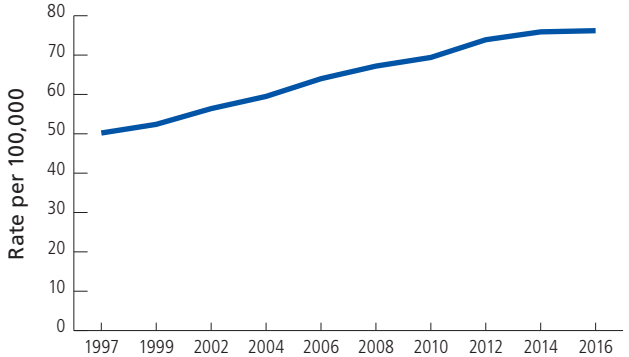
Early-stage colorectal cancer does not typically have symptoms, so screening is usually necessary to detect this cancer at its earliest stage.

Figure 3 represents the trend in colorectal cancer screening rates in Wisconsin between 1998 and 2016.

The American Cancer Society recommends screening beginning at age 45 for women and men who are at average risk for developing colorectal cancer. Screening can result in the detection and removal of colorectal polyps before they become cancerous. Screening can also find the disease early, when treatment can be most effective.

Individuals at increased risk of colorectal cancer should begin screening before age 45 and should discuss their screening options with their health care provider.

Figure 3. Trends in Persons Ages 50 Years and Older Who Have Ever Had a Sigmoidoscopy or Colonoscopy in Wisconsin, 1998-2016



Source: Wisconsin Behavior Risk Factor Surveillance System, Office of Health Informatics, Division of Public Health, Department of Health Services, 2019.

Stage at Diagnosis

Five-year relative survival from colorectal cancer is 90% when the cancer is diagnosed at the early, localized stage before it has extended beyond the intestinal wall. During 2012-2016, 38.6% of invasive colorectal cancers were diagnosed at an early, localized stage in Wisconsin.

Survival is around 71% when the disease is diagnosed at the regional stage; 35.4% were diagnosed at the regional stage during that five-year period. Survival drops to 14% when diagnosis occurs at a later, distant stage of disease; 20.9% were diagnosed at that distant stage.

American Cancer Society Screening Recommendations for Colorectal Cancer

Beginning at age 45, men and women at average risk should follow one of the examination schedules below:

Tests that find polyps and cancer:	**When to get screening test:**
Colonoscopy, or	Every 10 years
Flexible sigmoidoscopy (FSIG), or	Every 5 years alone, or consideration can be given to combining FSIG performed every 5 years with a highly sensitive gFOBT* or FIT* performed annually. Colonoscopy should be done if test results are positive.
CT colonography (virtual colonoscopy)	Every 5 years. Colonoscopy should be done if test results are positive.
Stool based tests:	
Guaiac-based fecal occult blood test (gFOBT)* with at least 50% sensitivity, or	Annually. Colonoscopy should be done if test results are positive.
Fecal immunochemical test (FIT)* with at least 50% sensitivity, or	Annually. Colonoscopy should be done if test results are positive.
Multi-target stool DNA test	Every 3 years. Colonoscopy should be done if test results are positive.

*Single stool testing during a clinician office visit is not recommended, nor are "throw in the toilet bowl" tests. In comparison with guaiac-based tests for the detection of occult blood, immunochemical tests are more patient-friendly and are likely to be equal or better in sensitivity and specificity. There is no justification for repeating FOBT in response to an initial positive finding.

American Cancer Society®

Attacking from every angle.™

BBB ACCREDITED CHARITY
bbb.org/charity