St George's University Hospitals NHS
NHS Foundation Trust
SOUTHWEST THAMES REGIONAL GENETICS SERVICE

Criteria for screening of Colorectal and Lynch-like Cancer families

Adapted from : Guidelines for the management of hereditary colorectal cancer from BSG/ ACPGBI/UKCGG (2019)

V1 In use From 3/2/2021

Risk Category	Family History		Type of Cancer *	Refer to Genetics	Screening
Population	No FDR affected		CRC/LRC	No	Population[1]
	1 FDR ≥50				
Moderate	Both parents (neither diagnosed <50)		CRC	No	1 off Colonoscopy age 55 (only if FDR with CRC)
	2 FDRs[2] (of each other; with at least one a FDR of proband)	At least 1 age > 60 (neither diagnosed <50)	CRC		
	2 FDRs[2] (of each other; with at least one a FDR of proband)	Both ≤60	CRC/LRC	Yes	Genetics to advise
	1 FDR[1] <50		CRC/LRC		
Further assessment needed	Patient affected with 2 primary cancers at any age		CRC/LRC		
High[1]	3 or more x FDR[2] any age (at least one affected relative is FDR of proband; at least one affected relative to be a FDR of the other two)		CRC/LRC		

***Lynch syndrome Related Cancer (LRC) :** Colorectal , Endometrial, Epithelial Ovarian, Pancreatic, Ureteric, Transitional cell cancer (TCC) of renal pelvis, Bladder TCC [3], Gastric, Hepatobiliary tract (excluding liver cancer except cholangiocarcinoma), Small bowel, Glioblastoma, pancreatic, prostate[4], multiple sebaceous adenomata, multiple/sebaceous epitheliomas/keratoacanthomas, sebaceous carcinoma, endocervical cancer

Genetic referral only recommended in those with a FDR with CRC or LRC (If more distant relatives are affected, suggest a closer relative seek advice)

If proband affected with cancer, screening as per personal follow up then consider as FDR

Additional details regarding these criteria are available on Page 3

Abbreviations
FDR – First degree relative(s)
SDR – Second degree relative(s)
CRC – Colorectal Cancer
LRC – Lynch Related Cancer

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CRITERIA FOR SCREENING OF COLORECTAL AND LYNCH-LIKE CANCER FAMILIES

ADAPTED FROM : GUIDELINES FOR THE MANAGEMENT OF HEREDITARY COLORECTAL CANCER FROM BSG/ ACPGBI/UKCGG (2019)

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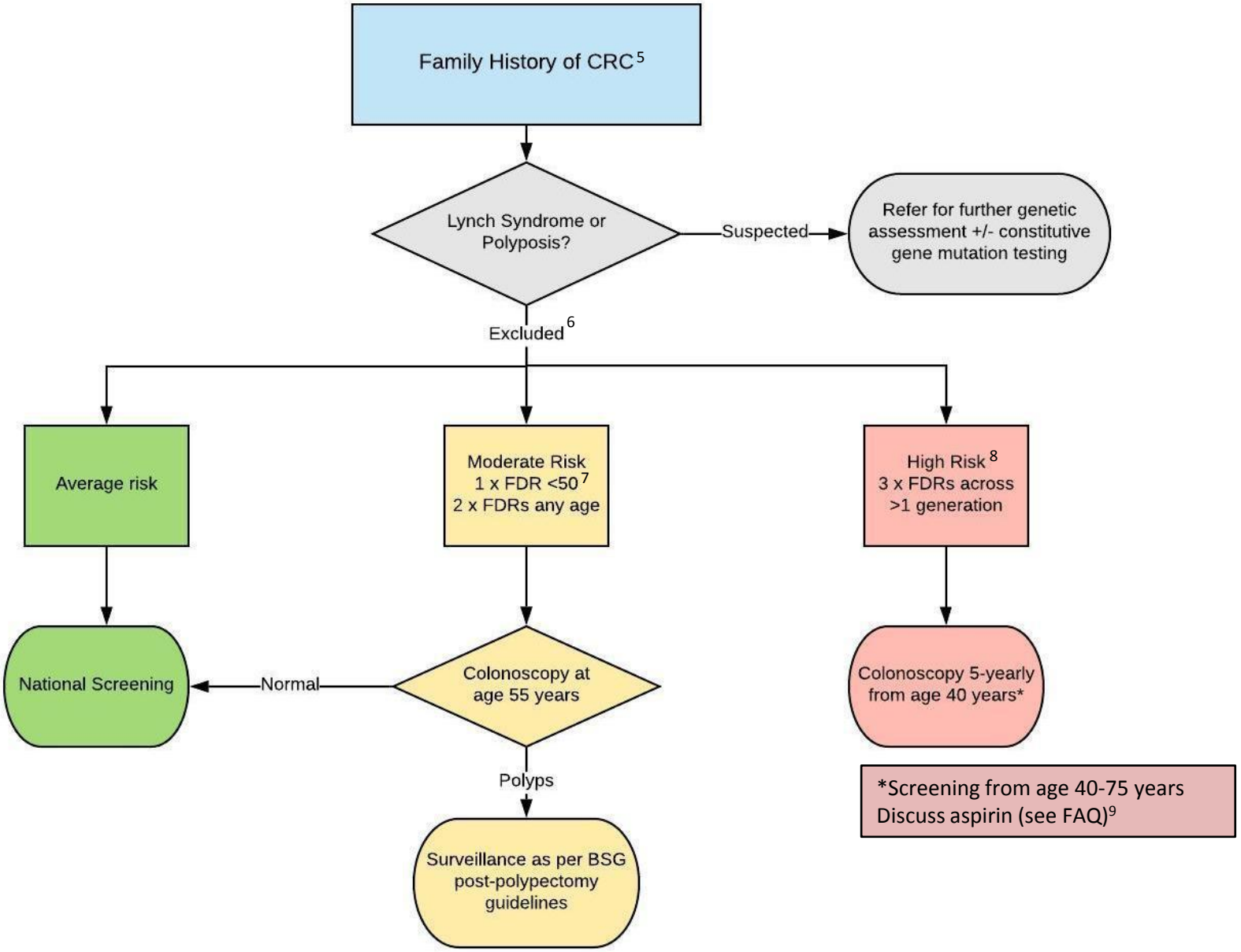

CRITERIA FOR SCREENING OF COLORECTAL AND LYNCH-LIKE CANCER FAMILIES

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1. **Should we request IHC in a relative if the patient is at population risk?** IHC or MSI screening is standard of care per NICE guidelines (2017 and 2020) for all people newly diagnosed with bowel or endometrial cancer and should be coordinated by the patient's treatment team. For patients with a prior history of bowel or endometrial where IHC or MSI was not performed, there is a very low chance that a family at population risk is affected with Lynch syndrome. For this reason we would not look to arrange IHC, and so they do not need to be referred to genetics.
2. **Does my patient need multiple affected FDRs to reach moderate or high risk bowel screening?** Your patient must have one FDR affected with CRC; other relatives need to be FDR of each other. For example a patient would be high risk if their mother, maternal uncle and maternal grandmother were diagnosed with bowel cancer.
3. **Is bladder TCC different to other LRC?** As Transitional Cell Carcinoma (TCC) of the bladder is incredibly common it should not be considered a LRC in isolation. Situations where a bladder TCC should be considered are:
    - *Patient affected with bladder TCC under 50*
    - *Patient affected with bladder TCC and a bowel or endometrial cancer*
    - *There is a family history of multiple LRC with bladder cancer diagnosed under 60*
4. **What about prostate cancer only families?** If there is no history of bowel cancer, it is more appropriate to refer the family to the prostate cancer family history clinic at the Royal Marsden Hospital. It is not appropriate to perform IHC or diagnostic Lynch testing in this setting.
5. **Does this screening include LRC?** No, this screening should be based on the family history of CRC only. Where possible, IHC should be carried out on appropriate individuals in order to uncouple LRC history from CRC history. If not eligible for IHC, or IHC not possible, the initial screening should be based on bowel cancer family history only. If there is uncertainty around this, LRC family histories should be taken to Cancer MDT for discussion.
6. **What does 'excluded mean'?** These screening guidelines are based on the assumption that IHC has been done in the family where Lynch syndrome is suspected
7. **What if I can't do IHC and my patient has a FDR affected under 50?** '*If unable to undertake IHC and single young relative <50, then still undertake one off colonoscopy aged 55, risks are not hugely increased in "unknown" setting according to current guidelines*' Kevin Monahan. This includes particularly young bowel cancers. (Cancer Leads Meeting -18/06/20). If 2 FDR with CRC <50 and unable to complete IHC, bring to MDT for discussion.
8. **Who is eligible for high risk bowel screening category?** Those who have 3 or more relatives affected by bowel cancer at any age (at least one affected relative is FDR of proband; at least one affected relative to be a FDR of the other two). A local decision has been made to include those with 3 relatives affected by bowel cancer across 1 generation (FDRs of each other, where at least one affected relative is FDR of proband) within high risk screening. A local decision has been made to count two confirmed primary bowel cancers as equivalent to two relatives with bowel cancer, e.g. father and brother with bowel cancers, one with two primary bowel cancers, would be eligible for high risk screening.
9. **What is the basis for recommending aspirin in high risk patients as well as those with Lynch Syndrome?** Please see the UKCGG position statement of the use of aspirin as bowel cancer chemoprevention in patients with a significant family history of bowel cancer outside of the context of Lynch Syndrome.