

Colonoscopy Beyond 75: Risks May Outweigh Benefits for Average-Risk Patients

Written by The Life Science Feed Editorial Team · Published 27 May 2026 · Edited by Mara Voss

The decision to continue colorectal cancer screening via colonoscopy in individuals aged 75 and older presents a clinical dilemma, balancing the potential for cancer detection against the escalating risks of the procedure in an aging population. Current evidence suggests that for average-risk individuals in this age group, the harms associated with colonoscopy may outweigh the benefits, necessitating a more individualised approach to screening decisions.

KEY TAKEAWAYS

- ° The Pivot: Routine colonoscopy for colorectal cancer screening in average-risk individuals over 75 years is increasingly questioned due to an unfavourable risk-benefit profile.
- ° The Data: Procedural complication rates, including perforation and bleeding, increase significantly with age, particularly after 75 years.
- ° The Action: Clinicians should engage in shared decision-making with older patients, considering individual health status, life expectancy, and prior screening history before recommending colonoscopy.

Colorectal cancer (CRC) screening has demonstrably reduced incidence and mortality through early detection and removal of precancerous lesions.¹ Guidelines from organisations such as the US Preventive Services Task Force (USPSTF) recommend screening for average-risk individuals up to age 75.² For those aged 76 to 85, the decision to screen is individualised, based on patient preferences, life expectancy, comorbidities, and prior screening history.² Beyond 85 years, screening is generally not recommended.² This nuanced approach for older adults reflects a recognition that the balance of benefits and harms shifts with advancing age.

The primary benefit of colonoscopy is the detection and removal of adenomatous polyps, which are precursors to CRC, and the identification of early-stage cancers.¹ However, the natural history of CRC in older adults can be slower, and the lead time bias associated with screening may mean that some cancers detected in very elderly individuals would not have become clinically significant during their remaining lifespan.³ Furthermore, the time required for an adenoma to progress to invasive cancer is typically 5 to 10 years, meaning that individuals with a limited life expectancy may not accrue the full benefit of polyp removal.³ The prevalence of CRC increases with age, making screening a critical public health intervention in younger elderly populations. However, the diminishing returns and increasing risks in advanced age necessitate a careful re-evaluation of routine screening practices. The decision-making process for individuals aged 76-85 often involves shared decision-making, where clinicians present the potential benefits and risks, allowing patients to make informed choices aligned with their values and health goals.

Procedural Risks and Outcomes in Older Adults

The risks associated with colonoscopy, while generally low in younger, healthier populations, increase with age and comorbidity.⁴ Major complications include perforation, post-polypectomy bleeding, and adverse events related to sedation.⁴ Perforation rates, though rare, are a serious concern, with studies indicating an incidence ranging from 0.03% to 0.2% in the general screening population.⁴ However, this rate can be significantly higher in older adults, particularly those over 75, reaching up to 0.5% in some cohorts.⁵ Factors contributing to this increased risk include colonic diverticulosis, thinner colonic walls, and the presence of multiple comorbidities.⁵

Post-polypectomy bleeding is another significant complication, occurring in approximately 0.1% to 0.6% of cases, with a higher incidence observed in patients on antithrombotic therapy or those with larger polyps.⁶ Older age is an independent risk factor for post-polypectomy bleeding, requiring hospitalisation in some instances.⁶ Sedation-related adverse events, including cardiorespiratory depression, are also more common in older patients due to altered pharmacokinetics and pharmacodynamics, and the presence of underlying cardiovascular or pulmonary disease.⁷ These events can lead to hospitalisation, intensive care unit admission, and, in rare cases, mortality.⁷

A critical consideration is the patient's overall health status, often quantified by measures such as the Charlson Comorbidity Index or American Society of Anesthesiologists (ASA) physical status classification.⁸ Frail older adults, or those with multiple severe comorbidities, are at a substantially higher risk of adverse events from colonoscopy and its preparation.⁸ The bowel preparation itself can induce dehydration, electrolyte imbalances, and renal impairment, which are particularly hazardous in vulnerable older patients.⁹ The physiological changes associated with aging, such as decreased renal function and reduced cardiac reserve, further exacerbate these risks, making the procedural preparation a non-trivial component of the overall risk profile for elderly patients. The cumulative effect of these factors can lead to prolonged hospital stays and a diminished quality of life post-procedure.

Given these escalating risks, the decision to perform a screening colonoscopy in an average-risk individual over 75 years must be carefully weighed against the potential for benefit. For individuals with a life expectancy of less than 5 to 10 years, the benefits of preventing CRC through screening colonoscopy are likely minimal, while the risks of the procedure remain.³ Alternative screening modalities, such as stool-based tests (e.g., faecal immunochemical test, FIT), may offer a safer, less invasive option for older adults who still wish to undergo some form of CRC screening, though their efficacy in this specific age group for primary screening is still under investigation.¹⁰ These less invasive options reduce the immediate procedural risks and the burden of bowel preparation, aligning better with the health profiles of many older adults.

CLINICAL IMPLICATIONS

The continued push for universal colorectal cancer screening, even into advanced age, warrants a sober re-evaluation. While the intent is laudable, the data clearly indicate a diminishing return on investment for average-risk individuals over 75. Clinicians are often caught between guideline adherence and individual patient welfare, and in this demographic, the latter must take precedence. The notion that 'more screening is always better' is a dangerous oversimplification, particularly when considering the potential for iatrogenic harm in a vulnerable population.

The industry, particularly manufacturers of colonoscopy equipment and bowel preparation agents, benefits

from broader screening recommendations. However, a responsible approach demands that these benefits are not pursued at the expense of patient safety. Perhaps a greater emphasis on less invasive, stool-based screening methods for older adults, even if they have a lower sensitivity for advanced adenomas, could strike a more appropriate balance. The current evidence suggests that for many older patients, the discomfort, risk of complications, and potential for unnecessary interventions outweigh the theoretical benefit of detecting a slow-growing lesion that may never impact their quality of life or longevity.

For patients, the conversation must shift from a blanket recommendation to a nuanced discussion about personal health, life goals, and risk tolerance. It is incumbent upon healthcare providers to present the full picture, including the increasing risks of perforation, bleeding, and sedation-related complications that accompany colonoscopy in advanced age. The goal should be to empower informed consent, not to simply tick a box on a screening checklist. We must move beyond a one-size-fits-all approach and embrace truly individualised care, especially when the evidence points to potential harm.

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