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Closing the Gaps in CRC Screening: Shared Decision-Making in Practice

Announcer:
You're listening to *Clinician's Roundtable* on ReachMD, and this episode is sponsored by Exact Sciences. Here's your host, Dr. Charles Turck.

Dr. Turck:
Welcome to *Clinician's Roundtable* on ReachMD. I'm Dr. Charles Turck, and joining me to discuss how we can personalize our approach to colorectal cancer screenings are Drs. Harish Gagneja and Robert Baldor. Dr. Gagneja is a board-certified gastroenterologist at Austin Gastroenterology and serves as the governor of the South Texas Region of the American College of Gastroenterology. Dr. Gagneja, welcome to the program.

Dr. Gagneja:
Thank you. Thank you very much. I'm glad to be here.

Dr. Turck:
And Dr. Baldor is a Professor and the Founding Chair of the Department of Family Medicine at the UMass Chan Medical School – Baystate. Dr. Baldor, it's great to have you with us.

Dr. Baldor:
And a pleasure for me to be here as well. Thanks for inviting me.

Dr. Turck:
To start us off, Dr. Gagneja, can you tell us why regular colorectal cancer screenings are so important?

Dr. Gagneja:
Thank you for asking this question. As we all know, colorectal cancer is a leading cause of death in the United States and all over the world. And hence, it's important that we do some screening modalities to prevent this deadly cancer. Importantly, colon cancer is one cancer that gives us opportunity to act before it becomes cancer because colon cancer develops from polyps. Polyps have a long dwell time, almost 10 years or more, so it gives us a lot of time in between where we can remove the polyps and prevent colon cancer. If you look at the screening for the last three decades, there's a 53 percent decrease in colon cancer diagnoses. Putting it in numbers, it's 550,000 cases. That's a remarkable advancement we have made in the screening of colon cancer.

Dr. Turck:
Now turning to you, Dr. Baldor, how can we help educate patients about the importance of these screenings?

Dr. Baldor:
It's incumbent upon us to bring this up to our patients and talk to them about cancer screening and about colorectal cancer screening. This is one of those tests that I don't think there's any controversy about. There's some controversies around different screening tests out there, but this is not one of those things. As you heard, this is lifesaving, and I actually attest to that in the time that I've been practicing. When I was in training, I saw, you know, a number of cases of colorectal cancers. In the last ten years, I've not seen a case. Why is that? It's because we screen. We do have the advantage of the Medicare annual wellness visit which is an opportunity to talk with patients who have Medicare about different aspects of prevention and wellness.

So this is clearly something to bring forward to them as an appropriate screening test. And of course, we're talking about younger folks

too, many who are not on Medicare as the recommendations have dropped for screening. And I think it's just one of those things, people coming in with lots of interest these days on health and wellness, and so when they're coming in, this is a key thing that we should be talking about because it truly is a lifesaving screening modality that we have available to us these days.

Dr. Turck:
And as a follow-up to that, Dr. Baldor, what are the different types of screening methods and how do you approach working with your patients to select the best options for them?

Dr. Baldor:
So we have these wonderful stool screening tests that individuals can do in the privacy of their own home. There are fecal immunochemical tests. There are fecal immunochemical tests with DNA tags on them as well, that are available. So these are wonderful tests. Of course, it's true that if it's positive, people will have to follow up with a colonoscopy, so it's important that they are informed of that component. But if it's negative, they're good. They don't have to have the colonoscopy. So we really have just terrific screening that are safe, easy things you can do in the privacy of your home. And so it's important that they understand and hear about these methodologies that are out there. There are kits and things we can mail to them. They don't even have to come in to the office to have these things done. A whole host of ways of approaching this. But I think it's incumbent upon us to make sure that we're alerting our patients to the availability of these screening tests, and then partaking in a shared decision making with them around which test is going to be best for them and is going to work out, whether it's their busy lifestyle or their personal preference for types of screening to be undergoing.

Dr. Turck:
For those just tuning in, you're listening to *Clinician's Roundtable* on ReachMD. I'm Dr. Charles Turck, and speaking with me today are Drs. Harish Gagneja and Robert Baldor, about how we can utilize shared decision making for our patients undergoing colorectal cancer screening.

So, Dr. Gagneja, once primary care physicians like Dr. Baldor refer patients to you, how do you coordinate their care and create an individualized management plan?

Dr. Gagneja:
Thank you for asking this very important question. So when a patient is referred to us, there's two different ways of tackling this. One is, we can do open access colonoscopy. Second will be the patient is seen in the office. I personally am not a big fan of open access colonoscopy because things can be missed when you have not seen the patient. Having said that, the age for colonoscopy now, as you know, is down to 45. And we have many patients who are 45 years old sent in for screening colonoscopy, but not taking any medications at all. Very, very healthy. So for them, I think open access colonoscopy is a very appropriate thing to do, and we can handle a lot of things over the phone with those patients and get them scheduled. And most of the patients who have some other medications they are taking have other comorbid conditions, such as coronary artery disease, diabetes, hypertension, or taking any other anticoagulant medications would like to see them in our office. Also, seeing them in our office gives us opportunity to discuss other GI symptoms, as well. For example, if I'm seeing somebody who's a white male, having reflux symptoms frequently and obesity, they have a 15 percent chance of having Barrett's esophagus. And now we can do endoscopy and colonoscopy in the same day, rather than having them come back twice, do two procedures, two anesthesia, taking two days off, and at extra cost which adds to society. So we can do that. In addition, somebody is having diarrhea. We can also do biopsies and make sure there's no microscopic colitis and such. So once patient comes to the office, we talk about what other medications they are taking. If they're taking any anti-hypertensives or medications for diabetes, we talk about perioperative management of those medications. If we need to hold their anti-coagulants, such as clopidogrel or warfarin, then sometimes we have to coordinate those with a cardiologist, as well as patients who may have had a recent stent, or whether we can continue those medications. So a lot of decision-making comes into play for that.

The most important thing we talk about with our patients is preparation. I cannot emphasize that preparation for the colonoscopy is one of the most important aspects of a clean, effective screening colonoscopy because without a clean colon, one really cannot clear the colon. So we talk about that at length in our office visit with the patient. We also go over the risks and benefits. Risk of colonoscopy perforation is one in 1,000 or so and in good hands, that's a very low risk. The other risk is bleeding. Bleeding can be one to two percent. We talk about that and the risk associated with anesthesia. We talk about that as well to our patients.

Dr. Turck:
And as we come to a close, I'd like to hear some final thoughts from each of you. Starting with you, Dr. Gagneja, what would you like our audience to take away from this discussion?

Dr. Gagneja:
Absolutely. So number one again, I said before, colon cancer screening saves lives. We have multiple options available. Options are

either with colonoscopy, which is an invasive test, or a non-invasive test as well. But I would also mention that colonoscopy is the only preventive modality. Other modalities are screening modalities. If your patient's doing any noninvasive testing, such as stool-based testing, whether it's FIT testing or DNA testing, then make sure that that patient goes for colonoscopy if the test is positive, of course. Without that, you're not getting any benefit of this screening modality. It's recommended that patient goes for colonoscopy within three months of a positive test. One other thing which I want to mention, let's say you have a patient who had a screening colonoscopy, and that colonoscopy is negative, that patient would require a next colonoscopy in 10 years, but in the intermittent period, please do not do any more testing which is noninvasive testing. It's not necessary, it is not indicated. It's not required.

Dr. Turck:
And how about you, Dr. Baldor? Any final thoughts for our audience?

Dr. Baldor:
The key thing I would like to say is these recommendations for screening, the age has dropped. It's 45. I was just seeing a 47-year-old firefighter in the office yesterday morning for a physical, and I said, "Oh, we have to get you arranged for colon cancer screening." He says, "Oh, I didn't think I was old enough for that." I said, "Yeah, you are. We're talking 45." We've always had a lower age for folks at higher risk but now for everybody, it's 45. So I think that's probably one of the biggest take-home points. The other two take-home points I would say, one is as we do refer people for direct colonoscopies, it's incumbent upon us as primary care clinicians to make sure that we're counseling people about the importance of a good prep so that they have a good, clean colon, which we just heard about. And then the final piece is if you're not interested or for whatever reasons don't feel comfortable with a colonoscopy, there's lots of home-based, stool testing that you can do in the privacy of your home to send off, and if that's negative, that's terrific. If not, of course, you will need a colonoscopy for that. So I think those are the key pieces of this. I'll just come back around to saying there is clearly no controversy about screening for colorectal cancer. We should be talking to patients about this. We should be encouraging it.

Dr. Turck:
Well with those key takeaways in mind, I want to thank my guests, Drs. Harish Gagneja and Robert Baldor, for joining me to discuss the importance of shared decision-making when it comes to colorectal cancer screenings. Dr. Gagneja, Dr. Baldor, it was great having you both on the program.

Dr. Baldor:
Thank you very much for having me. It was a pleasure to be here.

Dr. Gagneja:
Thank you for having us. It's pleasure to be here. Thank you so much.

Announcer:
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