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Improving Early Detection of CRC with the Latest Screening Recommendations

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 improve the early detection of colorectal cancer using the latest screening recommendations is Dr. Douglas Rex. Dr. Rex is a Distinguished Professor Emeritus of Medicine at Indiana University School of Medicine, the immediate past President of the American Society for Gastrointestinal Endoscopy, and has twice chaired the U.S. Multi-Society Task Force on Colorectal Cancer. Dr. Rex, thanks for being here today.

Dr. Rex:
My pleasure. Thanks for having me.

Dr. Turck:
Let's start with some background, Dr. Rex. Would you tell us why screening for colorectal cancer is important?

Dr. Rex:
Colon cancer is the second leading cause of cancer death overall. We often talk about it being the third for both men and women. And it is because for men prostate cancer is above colon cancer. And for women, breast cancer is above colon cancer. But because colon cancer actually affects both sexes, it ends up being overall the second leading cause of cancer death. And it's the most preventable form of internal cancer that we have screening for that is very cost-effective. So I really can't emphasize enough the importance of screening.

Dr. Turck:
Well with that in mind, let's zero in on the latest screening guidelines. Starting with the U.S. Preventive Services Task Force, what do they recommend?

Dr. Rex:
The U.S. Preventive Services Task Force is a really important group because technically, it's the one that the Centers for Medicare and Medicaid Services, CMS, actually sort of needs to listen to. So their opinion is very important. And they've endorsed colorectal cancer screening for a long time, but they recently updated their recommendations. And the most important change that they made was that they made what they call a qualified recommendation to begin screening in everybody at age 45, rather than age 50. And this is because while over the last couple of decades, we've seen the incidence or the frequency with which colon cancer is occurring in older people go down, largely as a result of screening, the incidence has been going up in younger people. And in fact, it's risen enough over the last few decades that we think now we should move that screening age down to 45.

The U.S. Preventive Services Task Force offers a variety of different ways to screen. And they call this the multiple options approach. All of the different forms of screening have certain advantages and certain disadvantages. And you can look at this array of tests, and hopefully, every provider and every patient can find something on there that they think is suited for screening.

Dr. Turck:
And what about the recommendations from the American Cancer Society? How do they compare?

Dr. Rex:

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The American Cancer Society recommendations, in many ways, are very similar to the U.S. Preventive Services Task Force recommendation because they also made this recommendation to begin screening at age 45. And they actually did it first. They did it before the U.S. Preventive Services Task Force. So really, both of these major groups are now on board with beginning screening at age 45.

So to go back to the definition of screening, what that means is that when you turn 45, even if you have no symptoms whatsoever that would suggest there's a problem going on in the colon—you don't have rectal bleeding, there's no change in your bowel habits, and you're not having abdominal pain; all of your plumbing seems to be working just fine—there still could be something going on. And this is also true even if you have no family history of colon cancer. There's enough risk to warrant talking to your provider about getting screening done.

Dr. Turck:
For those just tuning in, you're listening to *Clinician's Roundtable* on ReachMD. I'm Dr. Charles Turck, and I'm speaking with Dr. Douglas Rex about the latest colorectal cancer screening recommendations from the U.S. Preventive Services Task Force and the American Cancer Society.

Now if we switch gears here a bit, Dr. Rex, what are some of the most common barriers that might prevent clinicians from following these recommendations?

Dr. Rex:
Well I think probably the most common one for primary care providers is just that they have so much to do. They may not be seeing the patient for a wellness visit; they may be seeing the patient for a specific complaint. And this offer of screening often occurs more readily during that wellness visit where you're looking at everything that needs to be updated. But there are a variety of things that are covered in these wellness meetings because there are other forms of screening; there may be vaccines that need to be updated. There's a whole variety of things. And so I think one of the biggest barriers is just finding the time to make the recommendation.

And there are some things that can be done that can help with this. I think it starts with a very motivated provider. But there are reminder systems that sometimes are used in electronic health records that when you pull up that patient's chart for the visit, they will tell you when the last screening episode occurs or send another trigger that reminds you that you need to speak to the patient about colorectal cancer and the need to initiate screening.

Dr. Turck:
And are there any other ways that we could overcome some of those barriers to improve screening rates?

Dr. Rex:
Well, there certainly are a lot of barriers on the patient side of the process too. I think these come in a variety of forms. But probably the biggest one is lack of awareness of risk. People just feel that because they don't have symptoms and because they may not have a family history that they don't have an issue. And so I think one of the best ways to approach patients in the discussion is to explain to them how common this cancer is. That it's extremely preventable through screening and the removal of colon polyps. And it's very important to make the patient understand that they're at risk, even when they feel fine. They've got to sort of recognize that risk before they're going to take the step of getting tested.

So I think how that discussion takes place, in combination with reminders, across most of our country the way we do screening is with opportunistic screening. It has to sort of be initiated either by the physician or the provider in the office.

Another way to do screening, which is done in some of our big healthcare systems and outside the United States, is through nationalized programs for screening, what we call organized screening, where basically, for example, a screening kit gets mailed to everybody that's eligible to undergo a screening test. That kind of approach takes away, to some extent, the need for the physician to remind the patient and discuss it with them. And it can really improve screening rates.

But for most of us in the U.S., we've really got to take on the responsibility of doing this. I think reminder systems, incentive systems, and thinking about it within your healthcare system about how to do it on a systematic basis can be very helpful.

Dr. Turck:
Before we close, Dr. Rex, do you have any final takeaways on colorectal cancer screening or the latest recommendations you'd like to share with us?

Dr. Rex:
Yeah, I think something that can be very helpful to primary care providers as they approach patients to recommend colon cancer screening is to develop a sort of system for how you're going to make the offer so that you can do it in a very efficient and effective way.

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And several different ways of doing this have been discussed. One of them is a so-called multiple options approach where you go through a couple of tests, talk about the pros and cons of those, and have the patient choose.

The reality is that screening in the U.S. is occurring primarily with three tests. One is colonoscopy. The second one is the fecal immunochemical test on stool that tests for blood. And then the third one is a combination of the fecal immunochemical test, the FIT test, plus some tests for abnormal DNA in the stool. So we've got colonoscopy, and then the two stool tests.

I think all three of those approaches are reasonable; they have an evidence base to support them. The most important thing is that you make the offer, but having a way that you feel comfortable doing it systematically can make you more efficient and effective.

Dr. Turck:
Well as those final thoughts bring us to the end of today's program, I want to thank my guest, Dr. Douglas Rex, for joining me to share the latest screening recommendations for colorectal cancer. Dr. Rex, it was great having you on the program.

Dr. Rex:
I appreciate your interest in this topic. Thank you.

Announcer:
This episode of *Clinician's Roundtable* was sponsored by Exact Sciences. To access this and other episodes in this series, visit ReachMD.com/Clinician's Roundtable, where you can Be Part of the Knowledge. Thanks for listening!

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