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ReachMD
www.reachmd.com
info@reachmd.com
(866) 423-7849

CRC Screening Strategies: Balancing Accuracy, Access, and Adherence

Announcer:
You're listening to *On the Frontlines of Colorectal Cancer* on ReachMD. And now, here's your host, Ryan Quigley.

Ryan Quigley:
Welcome to *On the Frontlines of Colorectal Cancer* on ReachMD. I'm Ryan Quigley, and joining me to discuss current screening modalities for colorectal cancer is Dr. Samuel Muench. He's a board-certified gastroenterologist at Capital Digestive Care in Maryland and Washington, DC.

Dr. Muench, welcome to the program.

Dr. Muench:
Well, thanks for having me. I'm happy to contribute my two cents on screening and helping people get access to screening. It's a very important topic.

Ryan Quigley:
Absolutely. And it's a timely moment to have this discussion, so let's dive right in. Dr. Muench, could you walk us through the current colorectal cancer screening landscape?

Dr. Muench:
Sure. The landscape for colon cancer screening has evolved over the years, but there still are pillars of screening, and the backbone of this remains colonoscopy. It has been since the advent of modern colonoscopy decades ago. The other entry into this field is non-invasive testing, and these are primarily centered around stool-based colon cancer screening. There's a few out there; we'll go into those in just a few minutes. But you have these stool-based colon cancer screening tests and colonoscopy. There is the advent of these even less invasive, blood-based screening mechanisms in place, and then some virtual tests. But there is a variety out there, and that's important to individualize it for each of our patients.

Ryan Quigley:
Now, Dr. Muench, if we look more closely at colonoscopy, why is that considered the gold standard, and where do you see its limitations in practice?

Dr. Muench:
I think in general, historically, invasive tests have always been considered the gold standard in whatever respective field that they're in. For colonoscopy in particular, because it's a direct exam of the colon, we are looking for cancer. We're also looking for pre-cancers, and I'll get into that in a second here. But if we take a pooled sensitivity for colonoscopy, there's about 89 to 95 percent sensitivity at detecting adenomas over a centimeter—that's 10 millimeters—and that's the definition between small and large polyps. There's about a 95 percent detection rate for finding all colon cancer; that includes stage one through stage four colon cancers. The specificity similarly remains very high at 89 percent. With those numbers, it's a very easy interpretation with very high sensitivity and very high specificity. We can find cancers, and we can also rule out cancers with a really high degree of accuracy.

That being said, whenever there's an operator doing a test, whether it's a colonoscopy, a mammogram, or a Pap smear—these are operator-dependent tests. There's differences in skill, and there's different techniques. There's also risk factors and characteristics of the patient. It depends on bowel preparation and anatomy of the patient's colon. It depends on adherence to the bowel preparation. It also

just depends on tolerability of the procedure itself. So that range in sensitivity and specificity really relies on an ideal environment, and many patients unfortunately may not be able to achieve that, but the majority definitely will.

Ryan Quigley:
Now, what about stool-based screening? How do our current options compare in that area?

Dr. Muench:
There's two main different camps in terms of stool-based colon cancer screening. I'll start with the older: FIT, or fecal immunochemical testing. This looks at occult blood, and this actually looks for the detection of blood, but this is done in a laboratory setting. Sensitivity for this ranges considerably—anywhere from 74 percent all the way to 91 percent—for picking up colon cancers. If you look at that lower end of that sensitivity range, this is why it really has started to fall out of favor in terms of a first-line screening strategy. If you're telling us it can miss a quarter of all cancers, especially early-onset cancer, which is what we want to find, we then realize that this may not be our preferred method for screening.

The other part of this is the tediousness of it. It requires a yearly test. Patients every single year have to submit at least one stool test, and that alone is cumbersome. And we know that after about two or three years, the adherence to this falls to significant lows, sometimes even less than 20 percent. We then have the newer iteration of stool-based colon cancer screening tests, and these are the DNA and biomarker-based stool screening tests. When we look at the sensitivities, I'll just use both tests taken together; there is a sensitivity of over 90 percent at detecting colorectal cancer. That is a remarkable improvement over the FIT generation of stool-based colon cancer screening tests. When we look at advanced polyps or advanced lesions—advanced precancerous lesions—that sensitivity drops about 42 percent. What does that tell us? That we can't pick up some of these advanced lesions. You're still unfortunately going to miss over half of these advanced polyps that may ultimately turn into colon cancer, but it still does a really good job. It has a higher sensitivity—certainly better than FIT, but certainly less than colonoscopy. The interval's adjusted for that, and we do this at an every three-year interval, assuming a negative test.

Ryan Quigley:
For those just tuning in, you're listening to *On the Frontlines of Colorectal Cancer*on ReachMD. I'm Ryan Quigley, and I'm speaking with Dr. Samuel Muench about colorectal cancer screening modalities.

So Dr. Muench, when comparing colonoscopy with stool-based strategies, how should clinicians weigh sensitivity, specificity, and real-world adherence?

Dr. Muench:
I think there's a lot of characteristics and features that come into play here, and I could probably spend an entire hour dedicated to just this discussion alone. But when we talk about colonoscopy, at the end of the day, it is a procedure. It might be the gold standard, but it still is a procedure. Procedures take time and preparation, and they cost money. They involve procedural risk as well as anesthetic risk. They also are dependent on a high-resource setting. We need doctors who can do the procedures. We need anesthesiologists and anesthesia providers. We need pathologists who can interpret pathology specimens. We need other technicians, nurses, and a lot of other staff involved. So when we talk about resources, we talk about time, and we also talk about availability and skill of these procedures.

That being said, the way I talk to patients about all these options is, the colonoscopy will always remain not just a reactive test—we're looking for cancer—but it's a very proactive test. We're looking for the precursors to cancer, and I tell patients that it's not only a colon cancer detection test, but potentially a colon cancer prevention test. So that's a very clear distinction, and patients must know that because if you present patients all these tests at an equal value, we're really doing them a disservice.

That doesn't mean that stool-based colon cancer screening strategies are not important. They're extremely important. We know that about 60 or 70 million American adults are not up to date with colon cancer screening. That includes both stool-based screening and colonoscopy. And with this, colonoscopy is not the answer forever. We really need to fine tune it for each patient, whether it's a patient who doesn't want to undergo a procedure, they have fears of the procedure, or they can't get childcare while they undergo a procedure. It is really a discussion between provider and patient so that he or she can pick the screening strategy that's right for them.

Ryan Quigley:
How do you approach shared decision making when you discuss the available options with your patients?

Dr. Muench:
There certainly are different approaches to it. And there are some patients who allow for maybe a more parental approach to it and say, "You know what? You tell me what I need to do, and I'll do it." Even when they're well informed, they say, "I trust you. You're my doctor,

and I will adhere to what your recommendation is." And when I have that approach, I say, "Well, I'm always going to err on the side of proactive versus reactive." So for those patients who are willing and able, colonoscopy is my preferred method. And I fortunately do work and live in an area that has access to colonoscopy, as well as other colon cancer screening strategies. So I do think that plays a role.

For some patients who really want to discuss the specifics and the data that drive this, I do have the data. I have it ready. I walk them through the models that are out there. And fortunately, there are models that can actually, in layman's terms, tell us what sensitivity and specificity mean. Most of us walking around aren't familiar with what those mean; this is a lot of technical jargon, but there are ways that we can approach this. We can use web-based resources and visual resources to help patients feel informed, and when they do make a decision, it is a very informed decision based on their preferences and data.

I always say when we have these discussions that the best screening test is the one that the patient is willing and able to do, or the one that they're at least going to do. We can order a colonoscopy, and if patient's not going to show up or a patient can't prep or a patient can't do the test, then that colon cancer screening method is null and essentially as good as the rest if they're not willing or able to do those. I do think it really requires patients and providers to be on the same level for there to be a mutual discussion on what's right for him or her and for them to make one together. Get them screened. Don't let perfect be the enemy of good.

While we wish everyone got their colonoscopy, I realized that not everyone can. Not everyone is able, and for those patients, the stool-based colon cancer screening strategies really remain a wonderful option in our armamentarium in getting patients screened. Again, there are over 60 million American adults alone who have not been screened. Just get your patients screened.

Ryan Quigley:
That's a great way to round out our discussion. I want to thank my guest, Dr. Samuel Muench, for joining me to explore our approach to colorectal cancer screening.

Dr. Muench, thank you so much for doing this. It was a pleasure having you on the program.

Dr. Muench:
Thanks for having me. It was wonderful.

Announcer:
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