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Closing Gaps in CRC Screening: Patient-Centered Strategies

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

Ryan Quigley:
This is *On the Frontlines of Colorectal Cancer* on ReachMD. I'm Ryan Quigley, and today, I'm joined by Dr. Peter Buch to discuss gaps in colorectal cancer screening and how we can address them. He's a board-certified clinical gastroenterologist and an Associate Professor at the Frank H. Netter MD School of Medicine at Quinnipiac University.

Dr. Buch, thank you so much for doing this. Welcome to the program.

Dr. Buch:
Ryan, it's a pleasure. It is a unique opportunity to be at this end of the microphone, and I look forward to these questions.

Ryan Quigley:
Dr. Buch, when you look at the state of colorectal cancer screening today, where are we making progress, and where are the most concerning gaps?

Dr. Buch:
Let's get right into it. Let's explore some background because we need to have that background before we can understand the gaps involved. So, here's some basic facts that we all need to be aware of. The lifetime incidence of colon cancer in the United States is five percent. Any screening reduces the incidence of colon cancer and death by 18 and 33 percent, respectively. 85 percent of colon cancer occurs over age 50, and 15 percent occurs under age 50. Colon cancer occurs more frequently in men than women.

It's extremely important to know this fact about the sequence of normal colon to polyp to colon cancer: it takes about 10 years. Colonoscopy, as we all know, is the dominant screening modality in the United States. But colonoscopy has its limitations. For instance, small flat lesions, especially in the right colon, may be missed by even the most experienced colonoscopist. These sessile serrated lesions have less malignant potential than the typical adenomatous polyp that we more often see in the left colon, but these sessile serrated lesions may be more readily missed. Fecal immunochemical testing, also called FIT, is used in the rest of the world. If a FIT test is positive, a colonoscopy is necessary. And why is that? Because there can be false positive FIT test results.

So, here's the important thing that all of our GI societies are promoting, and we have been promoting this for years: a one-size-fits-all approach to colon cancer screening limits utilization. We have to choose the right test for the right patient.

Let me ask a question. What's the best test to screen for colon cancer? What do you think that might be? It's the test that gets done. So, that's a paradigm shift, and again, reflective of what we were talking about just a minute ago: a one-size-fits-all approach to colon cancer limits utilization. We want to give the patient an opportunity to make a choice for themselves.

Now, looking at a map of the country, approximately 70 percent of eligible patients for colon cancer screening in the Northeast will choose colonoscopy. But what about the other 30 percent? And if we look at other parts of the country, colonoscopy for screening purposes may only reach 60 percent of the population. Ultimately, how can we increase this figure? The answer is what we talked about a couple of times already: by offering alternative non-invasive tests.

In 2023, Makaroff found that there was a preference for non-invasive stool-based tests, and these can include the FIT testing that we've just talked about, multi-target stool DNA testing, and multi-target stool RNA testing, and we shouldn't forget about a blood test that has become available in recent time. So again, there are many opportunities to proceed further with additional tests besides the

colonoscopy.

Ryan Quigley:
One thing I want to ask is, for the gaps that you've mentioned, what do you see as the biggest barriers driving those gaps?

Dr. Buch:
The biggest barrier is assuming all patients are willing to undergo a colonoscopy. Again, we shouldn't keep our mind in just one direction when it comes to colon cancer screening. We have to think about other ways of approaching this.

I want to give you an example. I remember seeing a very pleasant 68-year-old patient several years ago who was sent by her physician for screening colonoscopy. The problem was that she had an aunt who'd had a colonoscopy with a complication. This patient already knew she would never have a colonoscopy, and she waited eight weeks to see me.

So again, at the primary care level, it's very important to understand what the patient is willing to pursue, and if they are absolutely not willing to pursue a colonoscopy, we have the alternative tests that are out there. If they're willing to pursue a colonoscopy, by all means, send them to your local friend, the gastroenterologist.

Even in 2026, patients may not be aware of screening options. It seems hard to believe. In the field, we are talking about it all the time, but there are patients out there who just have not heard about it. There's some other things that I want to just point out. They may be in denial, where no symptoms means no problem. And we know the important fact here is, no symptoms may be the best possible time of checking for polyps and cancers. Also, fear of cancer, and the thought in the patient's mind might be, “What I don't know won't hurt me.” And when our patients are thinking about colon cancer, they automatically concentrate on colostomy. Again, those of us in the field know that sometimes needs to happen, but more often than not, when we catch an early colon cancer, we can avoid that entirely. That is the key message.

Let's take a look at some other important items I want to share. Cultural issues can lead to persistent disparities in screening rates. There's also a mistrust of healthcare, cancer as a social taboo, a fatalistic view on healthcare outcomes, and a reliance on family for approval for medical decisions. These are some additional things that may weigh on the patient. Colonoscopy, although very safe, includes procedural and anesthesia risks. And we know that on average, the risk of a colon perforation during a colonoscopy is probably in the range of one in 3000, depending upon the literature that you look at.

Costs and copays may interfere with compliance. The patient needs to take off time for a colonoscopy. Sometimes babysitting is necessary. Rides home are, of course, always necessary. I want to give another example that I often talk about. Think about this particular situation. A single mom is about to get a colonoscopy, and she needs to take time off from work. She happens to work two jobs. She's paying for a babysitter, and the colonoscopy prep is just not good. What do you think the chances are that mom is ever going to come back for another procedure? I just want you to think about that. It's really important to consider when we're talking about other options that may be out there.

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. Peter Buch about barriers to colorectal cancer screening. So, Dr. Buch, if we turn now to potential solutions, how can we better leverage the full range of screening options, especially stool-based tests?

Dr. Buch:
We really need to know some pros and cons, and let's get into it. Let's start with fecal immunochemical testing, or FIT testing. The pros: easy to perform. Of course, the cons: it cannot be used for rectal bleeding, or any symptoms at all; for known hereditary cancers; for strong family history of colon cancer; or inflammatory bowel disease. And let's talk about sensitivity and specificity because again, that's another area that is very important to understand—how accurate the results are going to be. So the sensitivity is 79 percent and the specificity is 94 percent for colon cancer. With FIT testing, there are about four to six percent false positives. Sensitivity for detecting any polyps is very low at 10 to 30 percent sensitivity for advanced adenomas. The ones that are more of concern is 21 to 40 percent.

Let's move on to multi-target stool DNA testing. Again, it's easy to perform. We have to remember the cons are exactly the same as they were for the FIT testing. In other words, no rectal bleeding, no symptoms, no hereditary cancer, et cetera. Now, something really important that we need to understand is the sensitivity and specificity are 94 and 91 percent, and when we are dealing with that kind of a situation, we are dealing with the potential of up to eight percent being false positives. The sensitivity for advanced adenomas, the ones that we really get concerned about, we're talking 43 to 47 percent. And multi-target stool DNA testing is not designed to detect other polyps.

There's something else that I want to share with you. And it's a newer test. It's called a multi-target stool RNA test. There's similar

results to the multi-target stool DNA testing, but because it's so new, data needs to be confirmed, and we'll see what happens over time.

I also wanted to mention one other thing that I think is very important for the audience to be aware of. There are new blood tests. The sensitivity and specificity for colon cancer are 83.1 and 89.6 percent. There are 10 percent false positives, but here's the key: sensitivity for stage one cancer is 55 to 65 percent. Sensitivity for advanced adenomas is 13.2 percent. So again, the real key when we're talking about early detection is catching those early stage one cancers.

The guidelines are as follows: the FIT testing interval is yearly. Multi-target stool DNA testing is every three years. The testing interval for the newer tests has not yet been established, nor has there been any data yet in combining tests for higher accuracy.

Ryan Quigley:
With all of that in mind, I want to thank my guest, Dr. Peter Buch for joining me to share his perspective on gaps in colorectal cancer screening. Dr. Buch, it was great having you on the program. Thank you so much for doing this.

Dr. Buch:
Ryan, it's always a pleasure working with you. I look forward to working with you again very soon.

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