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

Expanding Cancer Detection: How MCED Testing Complements Standard Screening

Announcer:
You're listening to *Project Oncology* on ReachMD, and this episode is sponsored by Exact Sciences. Here's your host, Dr. Jennifer Caudle.

Dr. Caudle:
This is *Project Oncology* on ReachMD, and I'm your host, Dr. Jennifer Caudle. Joining me to discuss how multicancer early detection, or MCED, testing can complement guideline-recommended single cancer screening is Dr. Patrick McGill. He's a board-certified family physician and Executive Vice President, Chief Transformation Officer at Community Health Network in Indianapolis. Dr. McGill, welcome to the program.

Dr. McGill:
Absolutely. I really appreciate being here.

Dr. Caudle:
If we start off with some background, Dr. McGill, what are the current guideline-recommended screening options for early cancer detection, and where do they fall short?

Dr. McGill:
I think everybody's familiar with the cancer screenings that we currently have. We have five cancer screenings for breast, lung, colon, prostate, and cervical cancer. But we also know that there's many other cancers that impact people's lives, and that's where the MCED testing comes into place. We know that if we can catch cancer earlier, the outcomes are better, it's easier to treat, and there's better survival, so that's where, I think, our current recommendations for current single cancer screenings are great. But we're starting to look and need additional cancer screening.

Dr. Caudle:
Thank you for that. And if we zero in on MCED testing, how does this newer modality work? And based on what we know from clinical data, what differentiates it from traditional screening methods?

Dr. McGill:
So these tests work by detecting cell-free DNA with certain methylation patterns.

And if you remember—for people without a science background—methylation patterns is what turns genes on and off in our body. And so it's detecting cell-free DNA—DNA that's floating around in our bloodstream—and then identifying certain patterns where a tumor might be coming from.

And so it allows us to, again, detect abnormalities in the blood based on the cell-free DNA and methylation patterns that could show cancers earlier than traditional screening modalities. So think about mammograms or CAT scans for lung cancer. Those are looking for tumors. So you have to have a large enough sample or a large enough tumor for that to be detected on the image. These blood-based tests are able to detect many of these cancers before they ever appear on traditional imaging-based screening tests.

Dr. Caudle:
So with all that being said, when and how should clinicians incorporate MCED testing into their workflows?

Dr. McGill:

So there's certain indications when people need MCED testing. The traditional recommendation is anyone over the age of 50 with or without any risk factors—so general population screening over the age of 50. For many primary care physicians or other providers in their practice, it means layering in or using these cancer screenings in addition to the traditional. It's not meant to replace the traditional cancer screenings. It really should be an augmentation for our current cancer screening guidelines.

So for people that are eligible for mammograms or colonoscopies, they should absolutely still get those tests. What this can do is add another layer of screening. It's another tool in the toolbox for cancer screening in early diagnosis. So many practitioners have incorporated this into their routine screening guidelines for many of their patients who are at, again, a general risk for cancer. We shouldn't think about these as tests for people at higher risk—maybe they have a family history, or they have other risk factors that put them at higher risk—those people should be screened as well, but these tests are really designed for general population screening.

Dr. Caudle:
Thank you. And for those of you who are just tuning in, you're listening to *Project Oncology* on ReachMD. I'm your host, Dr. Jennifer Caudle, and I'm speaking with Dr. Patrick McGill about how MCED testing can help advanced cancer detection and support existing screening protocols.

Now, Dr. McGill, some clinicians may be hesitant to integrate MCED testing into practice due to common misconceptions like thinking it replaces standard screening or guarantees a diagnosis. So how would you counsel your colleagues on its role as a complementary risk stratification tool?

Dr. McGill:
One of the common concerns or questions that we get is: what about false positives? And so these tests have a high specificity, which minimizes the false positives.

Patients who have a negative test can feel confident at that point that there's no cancer, or at least it's very early and undetectable. For patients that have a positive signal, it doesn't necessarily mean that they have cancer; it just means that they need to be worked up for additional testing and diagnosis. So it's very similar to other cancer screenings that we have. Just because someone has an abnormal mammogram, it doesn't mean they have breast cancer. Just because they have a polyp, it doesn't mean they have colon cancer. We need additional biopsies or additional testing.

So I think when we frame this that, again, this is to augment our current cancer screening guidelines, people should still get all the other things that they're recommended. This can layer on top to detect many of those cancers that we don't have a screening test for. Most of those cancers that we don't currently screen for—think about cancers such as pancreatic cancer, renal cell carcinoma, uterine cancer, or some other blood based cancers—those cancers have the highest morbidity and mortality in the cancer space. Up until now, we haven't had a great screening test for them, and they're impacting more people from a mortality standpoint.

So this really allows us to detect many of those very aggressive cancers. Again, think pancreatic cancer, renal cell cancers, and other cancers that are very aggressive. If we can detect those earlier at stage 1 or 2 versus stage 3 or 4 where they're typically diagnosed, we can save lives. We can detect those tumors earlier to get people into treatment faster.

Dr. Caudle:
So, Dr. McGill, can you tell us about how you would handle positive signals?

Dr. McGill:
At Community Health Network, we have developed a standard process for handling those positive signals. So one of the things we wanted to do for our primary care providers who are ordering this test is not leave the diagnostic journey up to them or leave them hanging with trying to figure out what to do on the diagnostic journey.

One of the things that was key with our implementation was giving the "easy button" to those primary care providers. So in our hospital system or hospital network, we refer these patients to what we call the high-risk clinic, which is attached to our oncology department, and they handle the diagnostic workup. So we're arm-in-arm with oncologists and we're arm-in-arm with our primary care providers, but regarding the uncertainty or the 'I'm just not sure how to use this new test' or 'what's going to happen,' we've taken that off of the plate of a busy, already stressed, and struggling primary care provider. We just need them to do the screening and then we'll handle everything else.

Dr. Caudle:
So, Dr. McGill, what challenges have you all encountered as you've launched MCED testing?

Dr. McGill:

One of the main challenges that we encountered very early on is most primary care providers have not been trained. These are new concepts, new technologies, and new frontiers in medicine that if you're someone like me who's in the middle of their career, these things didn't exist when I was in medical school, residency training, or early in my career. So the concept of hereditary genetic testing versus early detection of cancer and blood-based liquid biopsy testing are new concepts. And I think for someone who doesn't have a background or are not familiar with genetics and genomics, these can be very confusing and daunting. So we really frame it around the idea that hereditary genetic testing is testing that people should have after education and conversation with their provider. But that's really looking at your future risk of developing cancer. MCED testing is your current risk of having cancer. So do you have cancer DNA floating around in the bloodstream today? And I think when we frame it in that way, it's easier to help patients understand but it's also easier for primary care providers to understand why we're asking them to screen for different things.

So understanding someone's genetic makeup and their future risk of cancer versus their current risk of having cancer is very important. But these are new concepts and new ideas that when we introduced it in our system, it created a lot of confusion for our providers.

Dr. Caudle:
And before we wrap up, Dr. McGill, how do you see MCED testing fitting into the broader future of precision oncology and population-level screening strategies?

Dr. McGill:
I think there's a huge opportunity for population screening. We know that even in the best-case scenarios, we have challenges and barriers to cancer screening. We have certain populations that are underrepresented or underserved with cancer screening. So is there an opportunity to make this more available to everybody? Everybody deserves the right to be screened for cancer and have the best outcomes.

So there's one level to say, can we break some of those access barriers or challenges in getting a mammogram or having a colonoscopy? Can we add to that? Again, not replace, but add to that with MCED testing? That's one layer.

The other layer is we never get 100 percent compliance with those tests. So again, can we layer on MCED testing as we move through an entire population? That's the second component.

The third component is as we're looking at healthcare costs, healthcare is expensive, so we know that if we can shift cancers from diagnosis at stage 3 or 4 to 1 or 2, the treatment is oftentimes lower or easier to tolerate. It can be more effective. The outcomes are better. Again, morbidity and mortality are improved. So this idea of stage shifting has ramifications across the entire population.

So I absolutely think, and again, let me say it one more time: this is not to replace traditional screening. This is another tool in the toolbox that can affect not only individuals, but populations of people as we're going down this diagnostic journey.

Dr. Caudle:
Excellent. And with those final thoughts in mind, I'd like to thank my guest, Dr. McGill, for joining me to discuss the evolving role of multicancer early detection tests. Dr. McGill, it was great having you on the program today.

Dr. McGill:
Absolutely. It's my pleasure. Thank you.

Announcer:
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