

Integrating Colorectal Cancer into Preventive Health Programs

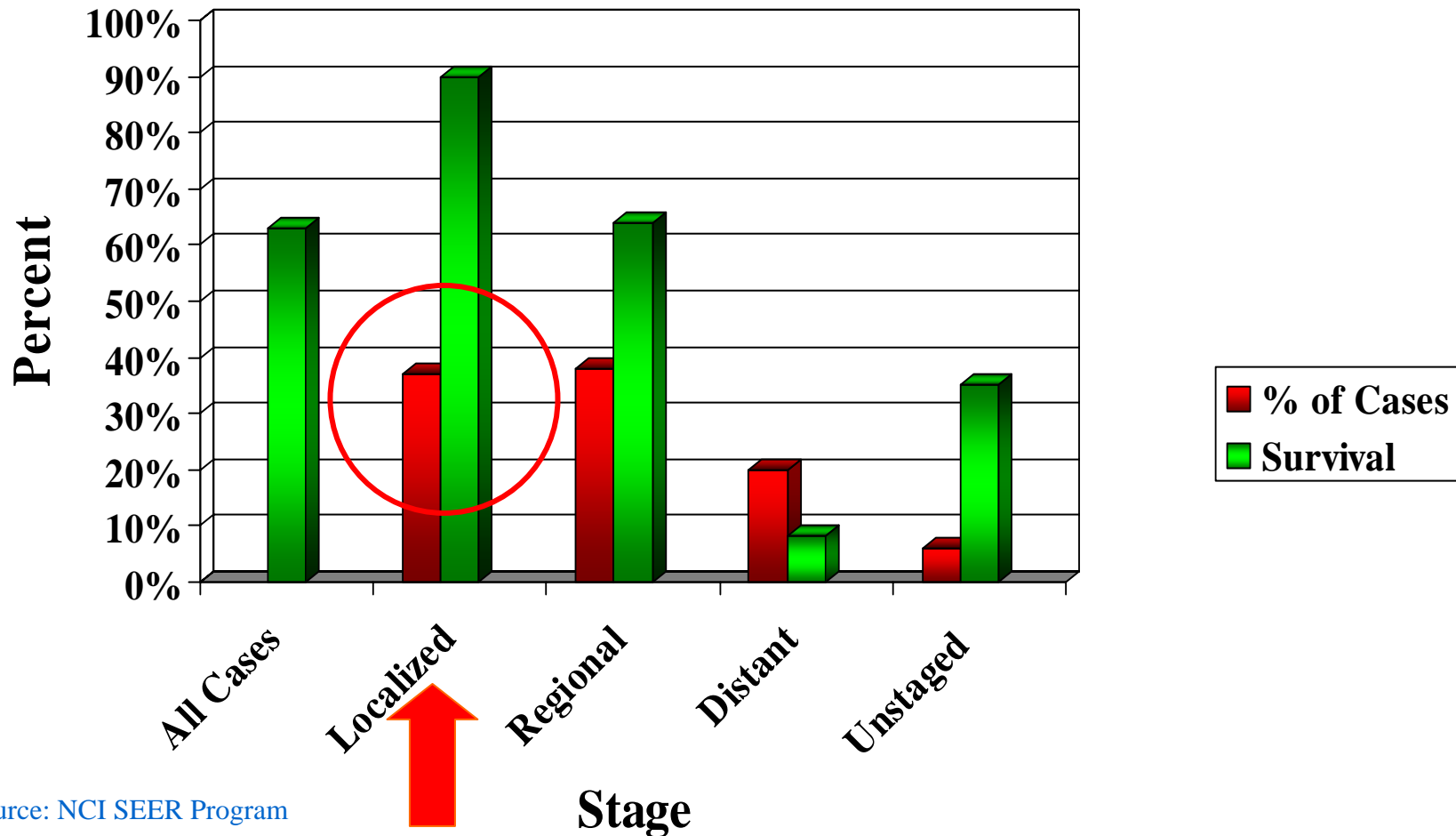
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The current problem in the U.S.

- Screening rates are low, and there are racial, class, and geographic disparities--**Only 4 of 10 Americans over age 50 report having had a recent colorectal cancer screening test.**
- Physician recommendation is low, even in the context of a checkup
- Growing data showing serious problems with screening quality and follow-up
- Little in the way of enabling structure or incentive to implement strategies **proven** to increase screening
- All combine to result in a failure to fulfill the findings of evidence-based medicine, **which results in persistent avoidable morbidity and mortality**

Colorectal Cancer 5-Year Survival Rates by Stage and Proportion Diagnosed Within Stage, All SEER Areas, 1995-2001[†]

Only about 1/3 of colorectal cancers are diagnosed while still localized.

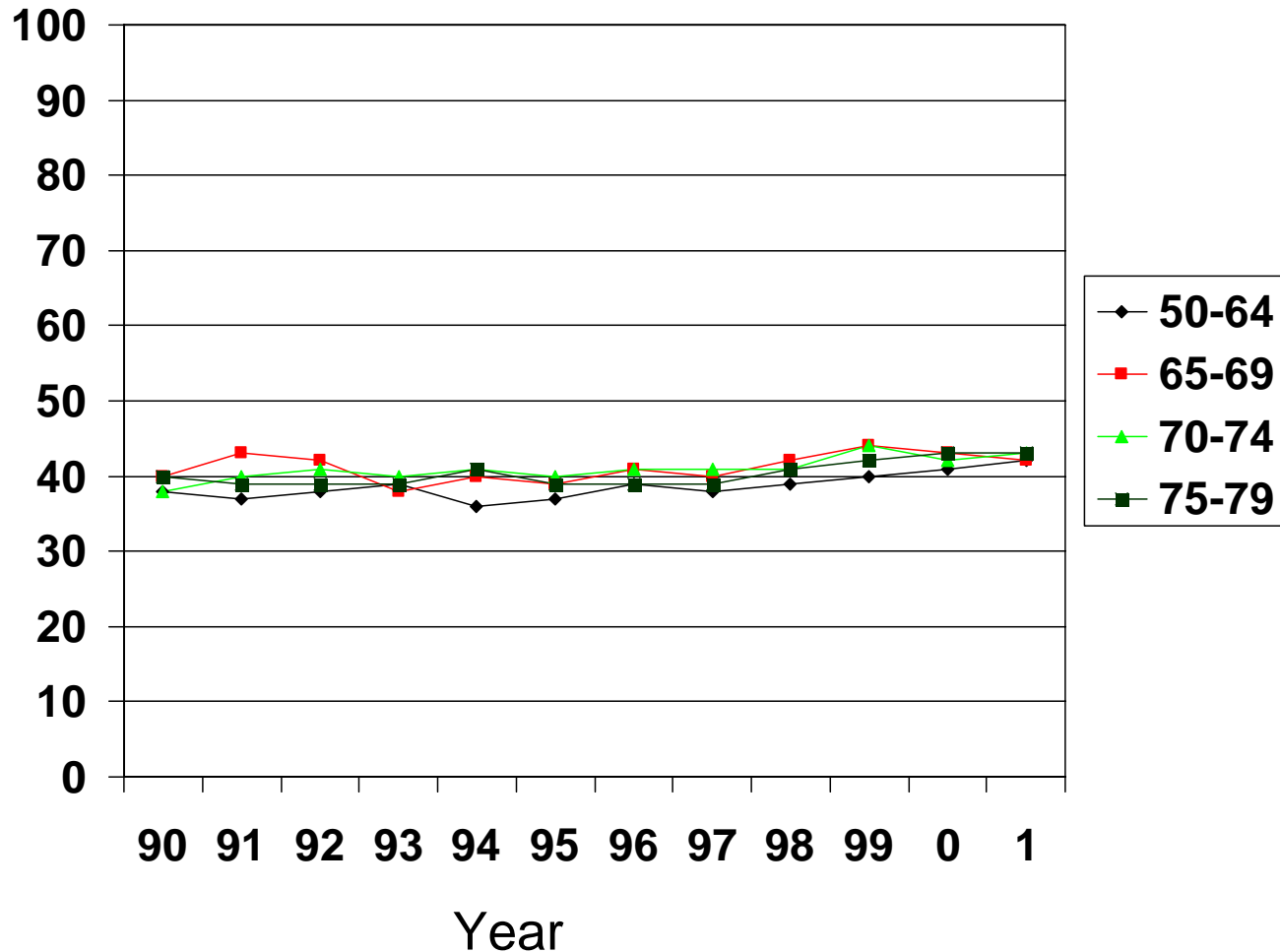


[†] Source: NCI SEER Program

Percent of Incident Colorectal Cancer Diagnosed at a Localized Stage, 1990-2001, U.S. SEER Surveillance System

For individuals aged 50-79, from 1990 to 2001 the percent of CRC diagnosed at a localized stage increased 3%, from 38% to 41%.

Percent



ACS 2001 Guidelines for Screening and Early Detection of CRC in Average Risk Individuals

FOBT or FIT annually

FSIG every 5 years

FOBT or FIT annually+ FSIG every 5 years

Colonoscopy every 10 years

DCBE every 5 years

***All positive tests should be followed up with colonoscopy**

CRC Screening Methods

Guidelines emphasize options because:

Individuals differ in their preferences among these choices

Physicians vary in their ability or readiness to refer patients to all options equally

Access is uneven geographically, and in terms of insurance coverage

There still is considerably uncertainty about *program* performance in terms of benefits, harms, and costs

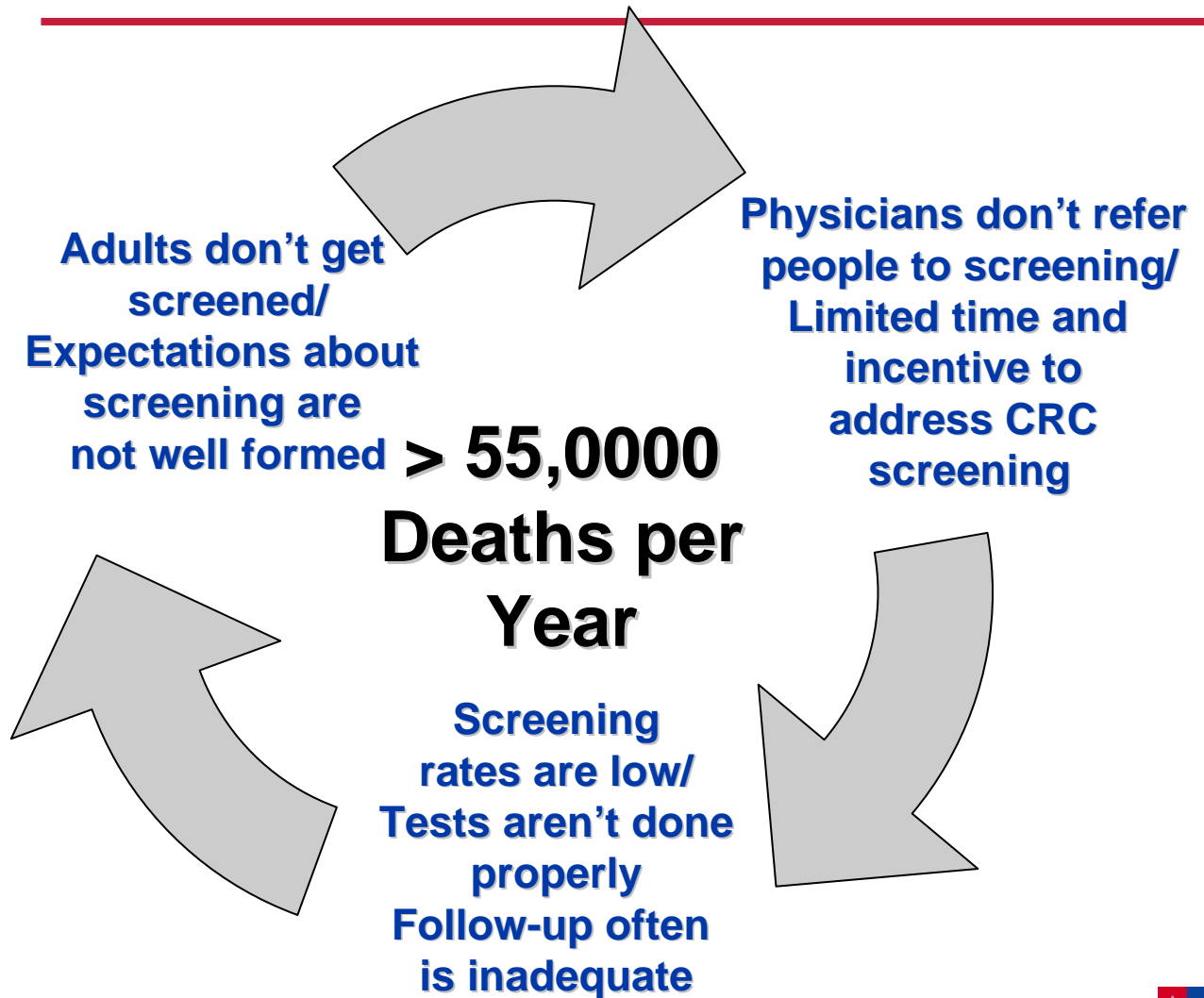
CRC Screening Recommendations show strong agreement between organizations

ORGANIZATION	YEAR REVIEWED	RECOMMENDATION
U.S. Preventive Services Task Force	2002	<p>“A” Recommendation Good to Fair Evidence for</p> <ul style="list-style-type: none"> • FOBT • FSIG • FSIG + FOBT • Colonoscopy
American College of Gastroenterology	2000	<ul style="list-style-type: none"> • Colonoscopy • FSIG and FOBT • DCBE (in select instances)
Institute for Clinical Systems Improvement	2000	<ul style="list-style-type: none"> • FSIG • FOBT • FSIG + FOBT • TCE
American Society of Colon and Rectal Surgeons	1999	<ul style="list-style-type: none"> • FSIG and FOBT • Colonoscopy • DCBE + FSIG
American Gastroenterology Association	1997	<ul style="list-style-type: none"> • FOBT • FSIG • FSIG + FOBT • DCBE

CRC Screening Methods

If there is strong consensus about screening recommendations, why are screening rates so low?

Cycle of ineffective screening



Opportunistic vs. Organized Screening

Most screening in the U.S. is opportunistic, that is, it depends on a *coincidence of interest and encounters*

The lack of population registers, or reminder systems, means that most men and women do not get any, or regular CRC screening.

This increases the risk of diagnosis of an advanced colorectal cancer, and missed opportunities for prevention and early detection.

Opportunistic vs. Organized Screening

Opportunistic (i.e., *coincidental*) preventive care is inherently limited

Opportunistic screening is encounter based, not population based

Situational context of encounter is a limiting factor

Depends on MD (preoccupation, forgetfulness, lack of familiarity with recommendations, or non-evidence based policy undermine delivery of preventive services)

No adherence, or partial adherence is more likely than complete adherence

More complex situations (follow-up, greater individual risk, etc.) are less likely to be properly addressed

Current Challenges

Obviously, increasing screening is a high priority

Other key challenges include:

Quality of testing ranges from low to highly uneven — consequences range from missed opportunities to significant harms

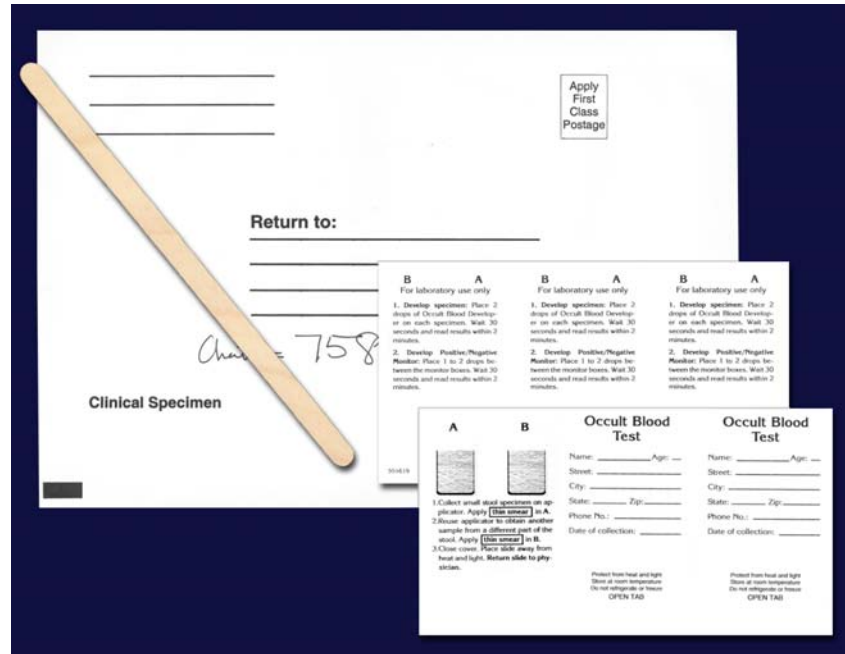
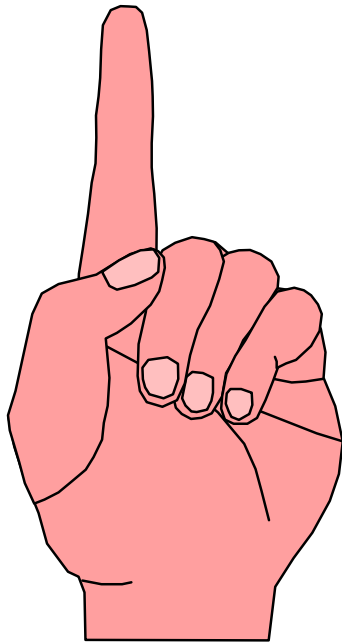
Follow-up of positive tests ranges from non-existent to excessive – same consequences

Digital Rectal Exam (DRE) & FOBT

In primary care settings in the U.S., DRE followed by FOBT is a common screening strategy.



It is not recommended,
but persists nonetheless



Sensitivity of One time Take Home & In-Office FOBT *

FOBT method	Sensitivity	
	All Advanced Lesions	Cancer
3 card, take-home (Recommended by Manufacturer)	23.9 %	43.9 %
Single sample, in-office	4.9 %	9.5 %

Fecal Occult Blood Test

In-Office FOBT (vs. recommended 3 card, take home)

Nearly 30% of physicians only utilize single-sample, in-office FOBT at the time of rectal exam as their primary method of screening. Nearly 75% use both methods.

Bleeding from cancers and polyps usually *intermittent*

In-office FOBT essentially is worthless as a screening tool for CRC and must be *strongly discouraged*****

Nadel et al, Annals of Int Med Jan 2005

Fecal Occult Blood Test

Inadequate follow up of positive FOBT also is a major problem

Approximately 30% of patients who were told they had a positive FOBT reported that this test was either followed up with a repeat FOBT, or no diagnostic work up.

Other inappropriate follow-up strategies (ie, flexible sigmoidoscopy) also reported.

The majority of primary care physicians surveyed (57%) report inappropriate strategies for following up a positive FOBT

FOBT *use* in the U.S. has major shortcomings

Failure to adhere to the frequency of testing

Failure to adhere to manufacturer's recommendations

Failure to adequately follow-up positive tests

For millions of Americans each year, FOBT is an empty exercise; for those with cancer, a high percentage receive the false reassurance of normal test results, *and delayed diagnosis.*

The current paradox of CRC mortality trends

The Collins, et al report, and the Nadel, et al report prompted Hal Sox to comment in an accompanying editorial....

“We know that the death rate from colorectal cancer has dropped steadily from 29 per 100 000 in 1973 to 20 per 100, 000 in 2001.

However, *we do not know why* the rate of decline has been constant over this period, rather than dropping more rapidly in the 10 years since the reports of the effectiveness of screening first became available.”

Sox, H. *Annals of Internal Medicine* 2005;142(2)

The current paradox of CRC mortality trends

“Low screening rates is one possible explanation.”

Another is that “Clinicians appear to be substituting a poor test for the tests that the evidence supports.”

“This fact may at least partially account for the slower-than-expected decline in the colorectal cancer death rate in the past decade.”

Sox, H. *Annals of Internal Medicine* 2005;142(2)

Are there proven strategies to increase screening and improve the quality of screening? YES!!

- *Embrace proven strategies that increase quality screening. These include:*
 - Outreach to a target population
 - Inreach strategies (chart reminders, reminder systems..etc)
 - Patient education
 - Physician incentives (reimbursement)
 - Physician education
 - Medical audits and feedback (HEDIS)

The barrier to reducing the number of deaths from colorectal cancer is not a lack of scientific data ***but a lack of organizational, financial, and societal commitment***

Daniel K. Podolsky, MD (NEJM 7/20/00)