Improving Outcomes in Colorectal Cancer Screening

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American Cancer Society
The Scope of Colorectal Cancer

<table>
<thead>
<tr>
<th>Estimated new cases, 2016</th>
<th>Estimated deaths, 2016</th>
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</thead>
<tbody>
<tr>
<td><strong>California, by cancer type</strong></td>
<td><strong>California, by cancer type</strong></td>
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<tr>
<td><strong>Breast (female)</strong></td>
<td><strong>Lung and bronchus</strong></td>
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<td><img src="breast-female.png" alt="Bar chart" /></td>
<td><img src="lung-and-bronchus.png" alt="Bar chart" /></td>
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<td><img src="lung-and-bronchus.png" alt="Bar chart" /></td>
<td><img src="colorectum.png" alt="Bar chart" /></td>
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<td><img src="prostate.png" alt="Bar chart" /></td>
<td><img src="breast-female.png" alt="Bar chart" /></td>
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<td><img src="colorectum.png" alt="Bar chart" /></td>
<td><img src="pancreas.png" alt="Bar chart" /></td>
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<td><img src="melanoma-of-the-skin.png" alt="Bar chart" /></td>
<td><img src="liver-and-intrahepatic-bile-duct.png" alt="Bar chart" /></td>
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<tr>
<td><img src="non-hodgkin-lymphoma.png" alt="Bar chart" /></td>
<td><img src="prostate.png" alt="Bar chart" /></td>
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<tr>
<td><strong>Expansion to see all data</strong></td>
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American Cancer Society, 2016

EIGHTYBY2018

To join this effort visit www.nccrct.org
Trends in CRC incidence and mortality

Research suggests that observed declines in incidence and mortality are due in large part to:

- CRC treatment advances
- Screening → detecting cancers at earlier, more treatable stages
- Screening and polyp removal, preventing progression of polyps to invasive cancers
  - NEJM study Feb 2012 showed polyp removal associated with 53% lower risk of CRC death
Figure 3. Colorectal Cancer Incidence (2009-2013) and Mortality (2010-2014) Rates by Race/Ethnicity and Sex, US


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Risk Factors
Non-Modifiable Risk Factors

Age

Gender

Race/Ethnicity
Age: the most impactful risk factor

CRC screening should begin at age 50 for most people, earlier for those with a family history.
Modifiable risk factors
Modifiable Risk Factors

- Smoking increases risk of CRC by 18%
- Alcohol increases risk of CRC 41%
- Obesity increases risk of CRC 45%
- Diet
  - High intake (>60gm/day) of red, grilled or processed meat increases risk of CRC 35%
  - High intake of fiber DECREASES risk of CRC
  - Dietary supplements – no effect, but food with folate and Vit D/Calcium may decrease risk

National Cancer Institute
http://www.cancer.gov/cancertopics/pdq/prevention/colorectal/HealthProfessional/page2
Screening Impact
Why Screen?

There are two aims of screening:

1. Prevention
   Find and remove polyps to prevent cancer

2. Early Detection
   Find cancer in the early stages, when best chance for a cure

STAGES OF COLON CANCER

- **POLYP**: Most colon cancers develop from these noncancerous growths
- **IN SITU**: Cancer has formed, but is not yet growing inside the colon or rectum walls; nearby tissue unaffected
- **LOCAL**: Cancer is now growing in the colon or rectum walls; nearby tissue unaffected
- **REGIONAL**: Growth beyond the colon or rectum walls and into tissue or lymph nodes
- **DISTANT**: Cancer has spread to other parts of the body such as liver or lungs
Benefits of Screening

Survival Rates by Disease Stage*

<table>
<thead>
<tr>
<th>Stage of Detection</th>
<th>5-yr Survival</th>
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<tbody>
<tr>
<td>Local</td>
<td>90.3%</td>
</tr>
<tr>
<td>Regional</td>
<td>70.4%</td>
</tr>
<tr>
<td>Distant</td>
<td>12.5%</td>
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*1996 - 2003
Screening Rates
Colorectal Cancer Screening* (%), in Adults 50 Years and Older, 2014

* A fecal occult blood test within the past year, or sigmoidoscopy within the past five years or colonoscopy within the past 10 years. Note: The colorectal cancer screening prevalence estimates do not distinguish between examinations for screening and diagnosis.

CRC screening in CA IHS Community Health Centers

- GPRA- 2015
  Colorectal Cancer Screening Rate- 31.2%

- UDS- 2015
  Colorectal Cancer Screening rate for CA FQHC’s – 41.2%
Who’s Not Screened?

Testing status of adults aged 50–75 years

- Up-to-date CRC testing: 65%
- Tested but not up-to-date: 28%
- Never tested: 7%

Insurance status of never tested adults aged 50–75 years

- Insured: 24%
- Uninsured: 76%

Screening Tests
ACS Screening Guidelines

- Options for Average risk adults age 50 and older:
  - Colonoscopy every 10 years, or
  - Flexible sigmoidoscopy (FSIG) every 5 years, or
  - Double contrast barium enema (DCBE) every 5 years, or
  - CT colonography (CTC) every 5 years
  - Guaiac-based fecal occult blood test (gFOBT) with high test sensitivity for cancer every year
  - Fecal immunochemical test (FIT) with high test sensitivity for cancer every year
<table>
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<tr>
<th>Population</th>
<th>Recommendation</th>
<th>Grade (What's This?)</th>
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<tr>
<td>Adults aged 50 to 75 years</td>
<td>The USPSTF recommends screening for colorectal cancer starting at age 50 years and continuing until age 75 years. The risks and benefits of different screening methods vary. See the Clinical Considerations section and the Table for details about screening strategies.</td>
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<tr>
<td>Adults aged 76 to 85 years</td>
<td>The decision to screen for colorectal cancer in adults aged 76 to 85 years should be an individual one, taking into account the patient's overall health and prior screening history.</td>
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<tr>
<td></td>
<td>• Adults in this age group who have never been screened for colorectal cancer are more likely to benefit.</td>
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<tr>
<td></td>
<td>• Screening would be most appropriate among adults who 1) are healthy enough to undergo treatment if colorectal cancer is detected and 2) do not have comorbid conditions that would significantly limit their life expectancy.</td>
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Recommended Screening Tests
ACS and USPSTF

- Colonoscopy
- High Sensitivity Fecal Occult Blood Testing
  - Guaiac
  - Immunochemical
- Flexible Sigmoidoscopy (FSIG)
  - Recent studies support efficacy
  - Availability extremely limited in U.S.
Why Colonoscopy is NOT gold standard

- Evidence does not support “best test” or “gold standard”
- Greater patient requirements for successful completion
- Access
- Patient preference
Patient Preferences

Inadomi, Arch Intern Med 2012
Stool Tests

- Look for hidden blood in stool
- Two major types (but multiple brands)
Stool Test: Guaiac

- Most common type in U.S.
- Best evidence (3 RCT’s)
- Need specimens from 3 bowel movements
- Non-specific
- Results influenced by foods and medications
- Older forms (Hemoccult II) have unacceptably low sensitivity
- Better sensitivity with newer versions (Hemoccult Sensa)
Stool Test: Immunochemical (FIT)

- Specific for human blood and for lower GI bleeding
- Results not influenced by foods or medications
- Some types require only 1 or 2 stool specimens
- Higher sensitivity than older forms of guaiac-based FOBT
- Slightly more costly than guaiac tests

FIT use in the US will likely increase due to recent elimination of guaiac-based testing by LabCorp and Quest Labs
Stool Testing Quality Issues

In-office FOBT is essentially **worthless** as a screening tool for CRC and should never be used for this purpose.
Summary - Stool Testing

- In-office FOBT is essentially worthless as a screening tool for CRC and should never be used.
- CRC screening by FOBT should be performed with high-sensitivity FOBT - either FIT or a highly sensitive gFOBT (such as Hemoccult SENSA).
  - Older, less sensitive guaiac tests (such as Hemoccult II) should not be used for CRC screening.
- Annual testing
- All positive screening tests should be evaluated by colonoscopy
Conclusion and Resources
How We Work with Primary Care Systems

• Focus on cancer prevention and early detection to support the work that you are already doing and identify any gaps that we can help support.

• We’re here as a resource and as consultants on the following:
  Colon Cancer • Breast Cancer • Cervical Cancer • HPV Vaccination • Physical Activity • Nutrition

*Our goal is to ensure your patients stay healthy and informed and that your cancer screening rates are at an optimum.
How We Work with Primary Care Systems

Assistance with implementing recommended EBIs.
Resources for Colon Cancer Screening

Reminder:

Colon and rectal cancer (also called colorectal cancer) is the third most common cause of cancer death for men and women.

It is most treatable when caught early. ENSURE your screening is up-to-date and is not overdue. We recommend the following:

- Begin testing at age 50, or earlier if you have certain risk factors.
- Get screened every 10 years with a colorectal cancer screening test.
- Get screened every 8 years with a fecal occult blood test.
- Get screened every 5 years with a flexible sigmoidoscopy.

Your test results may be due in your colorectal cancer screening.

To schedule an appointment or for information on completing your FIT Kit, please call 310-392-8636.

Recortadoria:

El cáncer de colon y recto es la primera causa de muerte por cáncer en los hombres y mujeres.

Familiarízate con lo que puedes hacer. El Instituto American Cancer Society recomienda un examen de colon cada 10 años en hombres, mujeres embarazadas, varones mayores de 35 años y mujeres menores de 40 años. Si tienes una antecedente familiar de cáncer de colon, el examen de colon se debe hacer a los 40 años.

Para más información, visita cancer.org/colon o llama al 1-800-227-2345 para aprender más.

You can help prevent colon cancer.

If you’re 50 or older, talk to your doctor about getting screened for colon cancer.

Colon cancer is the second-leading cause of cancer death in the US when men and women are combined, yet it can be prevented or found at an early stage, when it’s small and easier to treat. Visit cancer.org/colon or call 1-800-227-2345 to learn more.
Recommended Evidence Based Interventions

Provider Assessment & Feedback

- Assessing how many patients receive screenings and sharing feedback with providers using a scorecard or other tracking tool
Recommended Evidence Based Interventions

Provider Reminder & Recall Systems

- Having reminders/recalls as part of the medical record
Other Areas of Support

- Work with QI Team to do Process Mapping/Flow
Other Areas of Support

• Coordinate Physician Speakers on Colorectal and Breast Cancer Screening and HPV Vaccination to present to providers.
Primary Care Tools We Offer

Implementation Guides & Manuals

- Steps for Increasing Colorectal Cancer Screening Rates: A Manual for Community Health Centers
- American Cancer Society FluFOBT Program Implementation Guide for Primary Care Practices
- Steps for Increasing HPV Vaccination in Practice: An Action Guide to Implement Evidence-based Strategies for Clinicians

*Includes pediatricians, family physicians, general internists, obstetrician-gynecologists, nurse practitioners, physician assistants, nurses, medical assistants, and their office managers
Resources

- American Cancer Society
  - www.cancer.org/colonmd
  - www.cancer.org/professionals
  - Colorectal Cancer Facts and Figures 2014 – 2016: 

- National Colorectal Cancer Roundtable
  - www.nccrt.org

- Flu-FIT
  - www.flufit.org
THANK YOU!

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American Cancer Society®