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Cancer Care for All: Enhancing CRC Screening in Minority Populations

Announcer:

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

Dr. Caudle:

This is *Clinician's Roundtable* on ReachMD. I'm your host, Dr. Jennifer Caudle, and joining me to discuss how we can improve colorectal cancer screening rates in minority populations is Dr. Paul Doghramji. Not only is Dr. Doghramji a senior family physician with Collegeville Family Practice and the Medical Director of Health Services for Ursinus College in Pennsylvania, but he's also a fellow ReachMD host. Dr. Doghramji, thank you so much for being here today.

Dr. Doghramji:

It's my pleasure to be here.

Dr. Caudle:

Well, we're happy that you are here. So if we start off with some background, can you tell us about the prevalence of colorectal cancer among racial and ethnic minority groups?

Dr. Doghramji:

Absolutely. Well, of course, in primary care, colorectal cancer is extremely important to screen for because it is just so prevalent. Colorectal cancer is the third most common cancer diagnosed and second deadliest cancer amongst all Americans. And in this country, colorectal cancer will affect 150,000 persons and is expected to kill 53,000 people, despite it being a largely preventable disease with an achievable high utilization of screening in the population.

But the thing is, with colorectal cancer, the rates are not even across the U.S. subpopulations. So CRC incidence, cancer stage, and cancer mortality by race and ethnicity are different. So in the non-Hispanic Asian Pacific Islander men, they have the lowest rates of new cancer diagnosis. But then non-Hispanic Caucasians, that's the next one, and then African Americans, they're about 20 percent more likely to get colorectal cancer and about 40 percent more likely to die from it than most other groups. And Native Americans, by the way, have the second-highest rates below the non-Hispanic Caucasians. So there's a disparity amongst the different ethnic groups. And in your patient population, if you have more of one than the other, you should be a little bit more attuned to it obviously.

Dr. Caudle:

Thank you for that. Those statistics are very sobering, and it's helpful to be reminded of this. So as we move forward, how are we doing in terms of screening these patients for colorectal cancer?

Dr. Doghramji:

Well, in the last 20 years, among adults aged 50 to 75 years of age, the use of colorectal cancer procedures has increased for all the racial and ethnic groups included in the analyses that we've made. And so colorectal cancer screening percentages more than doubled for non-Hispanic blacks, Hispanic, and non-Hispanic Asian adults during that period. That's the good news.

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But despite these increases, the prevalence of colorectal cancer screening has been higher amongst non-Hispanic whites at around 65 to 70 percent; for adults that are among non-Hispanic blacks, it's 60 percent, among non-Hispanic Asians, it's about 52 percent, and in Hispanics, it's less than 50 percent. So even though we're doing a better job at screening for colorectal cancer, there still is a disparity that those that are at highest risk of getting colorectal cancer are the least likely to get screened for colorectal cancer.

Dr. Caudle:

And with that in mind, what barriers are contributing to these lower screening rates?

Dr. Doghramji:

So some of the barriers include that clinicians are just not talking to these patients about it. And so patients are thinking, "Well, if my healthcare provider isn't mentioning it to me, I'm just not going to do it." So one of them is that.

The second thing is that there's limitation as far as doing the colorectal cancer screening, whether it's insurance limitations or whether it is provider limitations of doing, let's say, colonoscopies. And interestingly what's happened, and I'm seeing this in some of my patient population that have certain insurances, is that they are getting a fecal immunochemical test sent to them by the insurance so that they'll do that once a year or so. So we're trying to get more and more patients to be screened because there are some barriers.

And by the way, one of the barriers is actually patient barriers. And a lot of it involves misconception. They think that it's going to be painful. They think they're going to be awake during the test. Some of them also have a misconception about the day before, when they're supposed to prep for it. Nowadays, a prep can be very innocuous. I know that, for example, with my last one, I had to drink two glasses of something relatively sweet on the day before my colonoscopy, and I had to have a clear liquid diet. And it was a nice and easy, gentle procedure. And the next day, somebody takes you there for the colonoscopy, and the anesthesia is one where you don't remember anything that's happened to you, and you wake up feeling fine, and you're driven home. Most patients don't know this. So clinicians have to actually be good at describing the colonoscopy in specific so that the patient barriers, the lack of knowledge about it, and the misconceptions can go away so that the patient will say, "Oh, that doesn't sound so bad, I think I can do that."

Sometimes though, patients also feel as if there's a barrier of cost. They'll say, "Well, you know, I have a large copay," or "I have a certain amount that I have to pay before my insurance kicks in." Those also have to be looked into. So cost concerns.

So there's a lot of different barriers that are involved in colorectal cancer screening.

Dr. Caudle:

Excellent. Thank you for those insights. And for those of you who are just tuning in, you're listening to *Clinician's Roundtable* on ReachMD. I'm your host, Dr. Jennifer Caudle, and I'm speaking with Dr. Paul Doghramji about the disparities in colorectal cancer screening rates among minority and underserved patient populations.

So, Dr. Doghramji, if we switch gears a bit and focus on how we can improve adherence in underserved populations, are there any screening options available that can help us address some of the barriers that you talked about?

Dr. Doghramji:

The types of screening that we discuss with them can either be a colonoscopy, a stool test with a FIT, or a multi-target stool DNA test. The colonoscopy, typically for the average person with normal risk, is done every 10 years or so, and depending on what's found during the colonoscopy, it could be done every 5 years or 3 years or even more than that. Again, it depends on what is found on the testing. As far as a FIT test goes, that's done at home, and it's done once a year, and it's a convenient thing that patients appreciate, and we do tell them about how that's done. And then of course, there's the multi-target stool DNA test. Again, those two are for those that are at average risk for colon cancer. The multi-target stool DNA test is done every 3 years, and that can be an advantage to a patient because it's noninvasive, it's done at home, and it's got a higher sensitivity for advanced adenomas and serrated lesions than the FIT. So sometimes patients will choose that. So we discuss these with them and we ask them to decide on which method they would like depending on their risk situation, and we discuss this with them at every time they come in for their annual checkups.

Dr. Caudle:

And what other culturally targeted strategies can we use to reach and screen our patients?

Dr. Doghramji:

Well, some of the culturally tailored strategies, depending on what ethnic groups come to you, they may not think about it or maybe it's not talked about as much as far as colorectal cancer is concerned. So one of the things that we want to do is be very attentive to having

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our patients come in for annual checkups after age 40 or 45, and specifically after 45, so you have an ample opportunity to talk about colorectal cancer screening.

And I also think that a lot of public awareness can occur with advertising, which can be done by governmental agencies. I think that's also very important so that patients will know that it's something that they should go through. I get a lot of patients that come in, and they'll see advertisements about many other types of screening tests or even vaccinations and say, “Hey, I just heard about this, is this for me?” So public awareness is very important that can occur in social media, it can occur in television, and it can be in radio.

But again, I think what's so important is to make sure that your patients come in at age 40 or 45 for annual checkups and make sure that you discuss colorectal cancer screening with them.

Dr. Caudle:

And lastly, Dr. Doghramji, do you have any other thoughts on how we can address the current disparities in colorectal cancer screening?

Dr. Doghramji:

See, that's a tough one. And I think that what we need to do is to educate our healthcare providers about how common colorectal cancer is and how easily detectable it is with the testing that we have. It can save lives. We've seen over the last 10 to 20 years that because of the increased screening, a lot less people are developing colorectal cancer and dying from colorectal cancer. So education to healthcare providers is so important and for them to know how to approach their patients in the way that they do understand. And health literacy comes in here, so clinicians need to know how to explain these tests in terms that their patients can understand in the different cultures that they have in their patient population.

Dr. Caudle:

Well, with those final comments in mind, I'd like to thank my guest, Dr. Paul Doghramji, for joining me to discuss strategies for improving colorectal cancer screening adherence in diverse patient populations. Dr. Doghramji, it was great having you on the program.

Dr. Doghramji:

My pleasure being here.

Announcer:

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