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Closing the Colonoscopy Follow-Up Gap: Insights from a JNCCN Study

Dr. Buch:
You're listening to *Clinician's Roundtable* on ReachMD, and I'm Dr. Peter Buch. Today, I'm joined by Dr. Mallik Greene and Dr. Jordan Karlitz, two authors of a newly published study in the *Journal of the National Comprehensive Cancer Network*, which examined follow-up colonoscopy after positive stool-based colorectal cancer screening tests. Together, we'll be walking through this study and its implications for everyday care.

Dr. Greene is a health economics and outcome research expert at Abbott Cancer Diagnostics. Dr. Greene, welcome to the program.

Dr. Greene:
Thank you. It's a pleasure to be here.

Dr. Buch:
And Dr. Karlitz is a volunteer gastroenterology professor at the University of Colorado School of Medicine and a Senior Medical Officer at Abbott Cancer Diagnostics. He's an expert in colorectal cancer screening and prevention. Dr. Karlitz, we're so glad to have you here as well.

Dr. Karlitz:
Yeah, it's a pleasure to be here. I spent most of my career on colorectal cancer screening, so looking forward to discussing this more today.

Dr. Buch:
Let's get right into it. So, Dr. Karlitz, let's start with the big picture. From a gastroenterologist's perspective, why is timely follow-up colonoscopy after a positive stool-based screening test such a critical part of colorectal cancer prevention? And what happens when patients don't complete that next step?

Dr. Karlitz:
We know that delays in follow-up colonoscopy or not completing follow-up colonoscopy after stool-based testing—or just non-invasive testing in general—is associated with increased incidence—so higher incidence—of colorectal cancer, more advanced stage disease, and even increased mortality.

So it's critical that the follow-up colonoscopy step is completed. We also know that, due to this, HEDIS is actually planning a performance measure to assess colonoscopy completion rates after non-invasive colorectal cancer screening tests. So this measure is going to be really important for health systems, healthcare providers, or anyone that's involved in colorectal cancer quality.

I do also want to talk a little bit about early onset colorectal cancer. We know that's an important topic. We know that younger individuals have increase incidence of colorectal cancer, and, unfortunately, are presenting with more advanced disease. So a really important finding of our paper was that we saw very, very high rates of follow-up colonoscopy in 45- to 49-year-olds after a positive multi-target stool DNA test versus after a positive FIT test.

Dr. Buch:
So with that context in mind, Dr. Greene, what gap in the existing literature were you hoping to address in this study, and how was it designed to answer these questions?

Dr. Greene:
One gap we saw was that, although we know a positive stool test needs to be followed by a colonoscopy, we had much less national

real-world information about what actually happens next. Do patients complete the colonoscopy? How long does it take? And do those patterns differ depending on the type of stool test across racial and ethnic groups?

To examine that, we looked back at de-identified records from two large national data sources. The study included more than 362,000 adults between the ages of 45 and 75 who had a positive multi-target stool DNA test or a positive FIT or FOBT result. We followed patients for up to one year to see whether they completed a colonoscopy and how quickly that happened. We also considered factors such as age, insurance type, region, sex, race, and ethnicity.

So, in practical terms, we were looking at the full screening journey in routine care, not just whether someone completed the initial stool test.

Dr. Buch:
Thank you, and staying with that for a moment, Dr. Greene, there are several important findings in this study, from differences in follow-up colonoscopy rates to shorter time to colonoscopy with multi-target stool DNA tests and the consistency of these patterns across racial and ethnic groups. Which of these findings stood out to you the most, and how do you interpret the results?

Dr. Greene:
The finding that stood out most to me was both the size and the consistency of the difference. Within one year of a positive result, about 77 percent of patients in the multi-target stool DNA group completed a colonoscopy, compared with about 45 percent in the FIT or FOBT group. And importantly, that same overall pattern was seen in every racial and ethnic group we studied.

The timing was also striking. More than half of the patients in the stool DNA group completed their colonoscopy within the first 120 days. In contrast, none of the FIT or FOBT patients across all racial or ethnic groups reached 50 percent completion even by the end of the full year.

My broader interpretation is that the pathway surrounding a screening test matters. The initial test is only useful if a positive result leads to the appropriate follow-up. At the same time, this was an observational study, so we should say that the stool DNA pathway was associated with higher and faster follow-up, not that the test itself necessarily caused the difference. Patient navigation, education, clinician notification, and the way patients understand the result may all play a role.

Dr. Buch:
For those just tuning in, you're listening to *Clinician's Roundtable* on ReachMD. I'm Dr. Peter Buch, and I'm speaking with Dr. Mallik Greene and Dr. Jordan Karlitz about their recent study looking at follow-up colonoscopy after abnormal colorectal cancer screening.

Now that we have an overview of the study, let's turn to its implications. Dr. Karlitz, how could these findings change day-to-day practice for gastroenterologists and primary care clinicians?

Dr. Karlitz:
I think the results highlight the importance of GIs, primary care, and others involved in the colorectal cancer screening process knowing their adherence metrics at their own health systems, clinics, and endoscopy centers. I think that's a really critical point. So when a stool-based test is being ordered in primary care, I think GIs really need to understand what percentage of patients are adhering to this test—and also, obviously, if the test is positive, what percentage of those individuals are actually making it into the endoscopy unit.

If the test is positive, and for whatever reason the patient doesn't make it to the endoscopy unit, there has to be reattempts to try and schedule that patient. And that fact that the individual may have not come to their colonoscopy appointment needs to be relayed back to primary care in order to make sure that they have additional attempts to contact that patient.

Dr. Buch:
So continuing, Dr. Karlitz, the paper also digs into patient navigation and disparities, particularly the low follow-up rates among Asian and Hispanic patients. How do you see those issues play out in practice, and where are the biggest opportunities to improve follow-up?

Dr. Karlitz:
With regards to the findings and with regards to the Asian population and Hispanic population in our paper, we did see that the lowest overall follow-up colonoscopy rate—so this was for all stool-based tests combined—was, in fact, in the Asian and Hispanic populations.

But when we did a sub-analysis where we looked at follow-up colonoscopy rates stratified by stool test type—so positive multi-target stool DNA versus positive FIT, looking at follow-up colonoscopy stratified by that—we actually saw that the follow-up colonoscopy rates were significantly higher in the multi-target stool DNA testing group than in the FIT testing group. So we actually think that these results show that multi-target stool DNA testing may be able to help minimize disparities.

I think the results of the study in general highlight the importance of patient navigation, including digital navigation. So this could be text messaging, email, or both. And this is a feature of every multi-target stool DNA test. We do have a Spanish language navigation program, and in another study that we published—I think about a year ago—we actually looked at this Spanish language navigation program in a large FQHC population in California. So before the Spanish language navigation program was instituted, we measured adherence to multi-target stool DNA, and then, we re-measured it after the Spanish language navigation program was put in place. And we saw a significant increase in adherence to the multi-target DNA test.

So I think navigation is critical. Generally, there's no standard navigation program that's built into FIT testing unless a given health system or clinic devotes specific resources to build a navigation program, whereas, with multi-target stool DNA testing, it is built in with every multi target stool DNA test. And obviously, they're concerned in the medical community about how the absence of standardized navigation programs could have negative effects on socially and economically disadvantaged populations.

Dr. Buch:
Coming back to you, Dr. Greene, what limitations should clinicians keep in mind when interpreting these findings, and what questions do you think are important for future research to address?

Dr. Greene:
There are several limitations clinicians should keep in mind.

First, we used existing claims and laboratory records. Those data allowed us to determine whether a colonoscopy was recorded, but they couldn't fully explain why an individual patient did or did not complete it. Claims data can also occasionally miss care or contain coding inaccuracies.

Second, we excluded patients with certain high-risk conditions, and patients had to remain continuously enrolled in their health plan, so the findings may not apply equally to every patient population, particularly people without continuous insurance coverage or those following a high-risk surveillance pathway. We also did not have detailed information about the individual care settings or factors such as language, health literacy, provider recommendations, patient preferences, and local access to colonoscopy.

So, for future research, I think the key is to move from asking what happened to asking why did it happen? What can we do about it? That includes testing patient navigation, outreach, clinician notification, and culturally and linguistically tailored support, especially in underserved settings. We also need to consider cost, patient preferences, test performance, health system capacity before using these findings to make broader screening policy decisions.

Dr. Buch:
Before we wrap up our discussion, I'd love to hear from each one of you one last time. Starting with you, Dr. Greene, if there's one message you'd like clinicians to take away from this study, what would that be?

Dr. Greene:
My main message is that a positive stool-based test is not the end of the screening process. It is the point where timely follow-up becomes essential. In our study, follow-up colonoscopy was more common and happened sooner after a positive multi-target stool DNA test, and that pattern was seen across every racial ethnic group we examined. But disparities still remain, so there is clearly more work to do.

Dr. Buch:
And Dr. Karlitz, the same question for you.

Dr. Karlitz:
The main message here is that completing a stool-based test is just one part of the colorectal cancer screening process, and we need to continue to assure that follow-up colonoscopy rates are optimized after a positive stool-based test.

I'd like to just to reiterate the very critical importance of navigation and built-in navigation in order to complete that multi-step process. We should complete the positive stool-based test—multi-target stool DNA, which we've been talking about—and have that built-in navigation program to complete not just the multi-target stool DNA test, but also helping educate individuals to complete that follow-up colonoscopy.

Dr. Buch:
This has been a wonderful, informative session. I want to thank my guests, Dr. Mallik Greene and Dr. Jordan Karlitz, for joining me to discuss their research on follow-up colonoscopy after abnormal colorectal cancer screening. Dr. Greene, Dr. Karlitz, it was great having you both on the program.

Dr. Greene:
Thank you. It was a pleasure being here. I really appreciate the opportunity to discuss our research and the importance of helping patients complete follow-up after a positive stool-based screening test

Dr. Karlitz:
Thank you very much. Again, a pleasure to be here, and thank you for all the insightful questions, and hopefully this will be of value to your audience.

Dr. Buch:
Thank you both. For ReachMD, I'm Dr. Peter Buch. To access this and other episodes in our series, visit *Clinician's Roundtable* on ReachMD.com where you can Be Part of the Knowledge. Thanks for listening!