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

How CRC Screenings Could Help Reduce Colonoscopy Backlog: A DDW Poster

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:
Welcome to *Clinician's Roundtable* on ReachMD. I'm your host, Dr. Jennifer Caudle, and here with me today to discuss a poster presented at the 2024 Digestive Disease Week Conference, titled "Eliminating the Colonoscopy Backlog with Stool-based Colorectal Cancer Screening Options," is Dr. Mark Fendrick. He's a Professor of Internal Medicine in the School of Medicine and a Professor of Health Management and Policy in the School of Public Health at the University of Michigan.

Dr. Fendrick, it's a pleasure to have you with us today.

Dr. Fendrick:
Great to be with you.

Dr. Caudle:
So let's start with some background on this poster, Dr. Fendrick. Approximately 40 percent of the eligible U.S. population is not up to date with colorectal cancer, or CRC, screening. Can you explain why this might be?

Dr. Fendrick:
Yeah. As our primary care provider colleagues know, there are lots of reasons why our patients don't do what we want them to do, especially something like colorectal cancer screening, which is a little more difficult to talk about than, say, getting your blood pressure taken or your cholesterol level drawn. The good news is it's well-established, the life-saving impact of colorectal screening. And the very good news is there's lots of modalities now that most evidenced-based guidelines recommend, ranging from most invasive colonoscopy, which is most accurate, to less invasive options, such as stool-based options, and others as well.

And we're very fortunate to be able to present to our patients these evidenced-based options and let them have their own preferences guide them during the screen process, but understanding that in the United States that we only have so many gastrologists and a few surgeons that do colonoscopies, and our colleagues know that colonoscopies are done not only for colorectal screening but for other situations, such as GI bleeding or inflammatory bowel disease. There are only so many colonoscopy slots that are available. This was only made worse by the COVID pandemic that we all lived through.

So the purpose and the aim of this study was to tie into my overall research interest of 30 years is how can we get the most health benefit from the resources that we have? And what would be the potential impact on prevention in cases of colorectal cancer detected, particularly those that are either early or they can be treated more efficiently or found in a premalignant stage that we actually find a polyp that we can remove? So we tried to determine what would be the optimal scenario if we actually had fewer people undergo colonoscopy as screening and shift those individuals to get non-colonoscopic, primarily stool-based testing, as the first line, and then reserve those colonoscopy slots for people who tested positive for which the colonoscopy would be extraordinarily high yield and much more, not only clinically but economically, effective than doing screening when you did preferentially send patients to get colonoscopy who already were deemed to be high-risk by a positive stool test.

Dr. Caudle:

And how are those factors influencing the objective and patient population of the study?

Dr. Fendrick:
So something that's really exciting in the world of colorectal cancer prevention is the United States Preventive Services Task Force, a body of experts that we as primary care providers rely on, on so many preventive services, updated their colorectal cancer screening guidelines recently and lowered the age-bound for which patients are recommended for screening from 50 to 45. This drop in age by five years enabled over 20 million Americans to follow the guidelines and get colorectal cancer screening. And in most situations, given the Preventive Services Provision of the Affordable Care Act, people would get the colorectal cancer screening at no cost to them. So we would like to think that there's already a backlog in colorectal cancer screening. Now we have millions more Americans, Dr. Caudle, who are now eligible to get colorectal cancer screening, but we haven't trained enough gastrologists and surgeons to do screening colonoscopies on all those people.

So to try to be most efficient, and most importantly, to try to use our resources so we benefit population health and addressing issues of equity and disparity reduction, we wanted to think that how can we restructure the flow of the millions of Americans who are not up to date for colorectal cancer screening, make sure they get the screening test they need, and most importantly, optimize population health. So the idea of having more individuals for first-line not use our scarce colonoscopy resources, instead, get highly accurate stool-based testing, particularly stool DNA testing that accurately in a highly-sensitive and highly-specific way, identify patients at risk for colorectal cancer, and tell those who are not at risk that they aren't, would be an efficient way to reallocate first-line testing such that more people would get screened in general. The people who got colonoscopy would be higher risk and maximize the efficiency of those tests. And most importantly, overall population health would be improved because more people are tested, more polyps were ultimately removed, and more cases of colorectal cancer were diagnosed in earlier stages, which as all of us know, is where treatment, whether it be surgical or medical, is most effective.

Dr. Caudle:
Great. And as a quick follow-up to that, can you walk us through the methods that were used?

Dr. Fendrick:
Yeah. So it's a very complicated approach to put on a poster. So first, we are leaning on an extraordinary computer simulation or decision analytic model that has been developed by our colleagues at Exact Sciences that project the clinical and economic implications of the natural history of colon cancer from normal to polyps, which are the premalignant situation, to cancers at various stages. And then we use various data sources and claims to determine what are the current patterns of care in the U.S. in colorectal cancer screening, and then project, given the backlog, meaning the waiting time that our patients, whether be in Ann Arbor or near the Philadelphia area are facing, given the shortages of qualified colonoscopists. And putting that combination of existing data with projections from simulations, we're able to identify what might happen if we shifted the current allocation of colorectal cancer screening, which is currently colonoscopy-heavy, to one that is less colonoscopy heavy and more directed toward stool-based testing, and thus, as you can understand, not only would more people be screened initially, but those who got colonoscopy would not be getting screening colonoscopy per se but getting higher value or more clinically beneficial follow-up colonoscopies after a positive non-invasive test.

Dr. Caudle:
Thank you for that. 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 today I'm speaking with Dr. Fendrick about a poster presented at the 2024 Digestive Disease Week Conference that focused on how stool-based colorectal cancer screening options may be able to help alleviate the colonoscopy backlog.

So, Dr. Fendrick, given what we know about the design and methods of the study, what were the key results regarding colorectal cancer screening capacity, and impacts on patient outcomes?

Dr. Fendrick:
Yeah, I very much enjoyed this study because it ties into 30 years of my research and policy experience, which has basically been aimed at trying to get the greatest population health benefit out of a set amount of resources. Sometimes, it's the amount of money, but in this case, it's about the number of colonoscopists we have available to take care of our patients. And because colonoscopies are done to screen for colorectal cancer, done for follow-up after non-invasive tests, and also done for more complicated conditions like GI bleeding and inflammatory bowel disease, we understand our constraint was not per se money, which is typical of my research, but how we could best optimize the use of these colonoscopists to achieve the greatest amount of clinical and equity gains.

And what we found quite clearly is that given the backlog that exists that most people in America who wanted to get a screening colonoscopy can't get it without a significant delay. We could screen many more people, and more importantly, identify more people at risk for cancer and identify pre-malignant polyps and early cases of cancer if we screened more patients initially with non-colonoscopic

methods, such as stool-based testing with high sensitivity and specificity, and allow those colonoscopy spots to be taken by those people who actually are at the highest risk.

And for years, my work, and this is very relevant to this publication, is that we worked for 10 years to put in place federal policies that now requires that most insured Americans can get their follow-up colonoscopy after a positive stool test at no cost to them. And part of the work that led to this federal regulation was some work that I did along with my colleagues at Exact Sciences using this microsimulation model that found that compared to many patients in the U.S. who had positive stool tests, who never followed up. As you know, Dr. Caudle, there's lots of reasons why our patients cannot get into get a colonoscopy. It could be geographic. It could be their workload. It could have been before the federal rule that they didn't have the money to pay out of pocket for a follow-up colonoscopy.

So now that we have eliminated this barrier, we have shown in our modeling that compared to people who don't follow up, people who get a colonoscopy after a positive stool test not only yields incredible amounts of clinical benefit, why you and I went to medical school, but it also saves money because we've identified these people at high-risk for premalignant and early malignancies for colorectal cancer, and of course, this is the whole reason why we do screening programs in the first place.

Dr. Caudle:
Thank you for that. Now you've already commented a little about economics, but do you have any additional comments you'd like to share about the economics of colorectal cancer screening and follow-up?

Dr. Fendrick:
Yeah. Thanks for that question. I think it's important to point out that for those who seek down the poster, we did not explicitly look at cost of care with this. But my work in the area of colorectal cancer and preventive care in general always has an economic component. It should come as no surprise, given the robust data we have for multiple modalities of colorectal cancer screening, it is deemed to be cost-effective. And what that means, of course, it is not going to save money in the long run, but more importantly, it's really good value for money. And such so that again, it used to be statewide, and now it's a federal requirement that if you have, basically just about any type of insurance plan, you will get your colorectal cancer screening regardless of modality at no cost to you.

And importantly, just to reiterate, I've said this not only for colorectal cancer but for breast, cervical, and lung cancer; cancer screening is not a single test. As you know, fortunately, most people test negative, that's a single test, but the reason why we have these programs in place they're to identify those folks who benefit from early detection. So I really want our listeners to understand that while checking the box for preventive services is important, but to really focus on those individuals who test positive, whether it be a cancer screen, or other things, to make sure you get the evidence-based intervention.

Dr. Caudle:
Before we end our discussion today, Dr. Fendrick, what is the overall conclusion of the study? And how can we incorporate its findings into our practice?

Dr. Fendrick:
First is, we know colorectal cancer screening saves lives. We also know that maybe outside of your practice, 100 percent of our patients between 45 and 75 are not up to date with colorectal cancer screening. There is lots of reasons for that. One of them is the tremendous colonoscopy backlog after the COVID pandemic, coupled with the recent recommendation to extend no-cost colorectal cancer screening from age 50 down to 45, incline of 20 million new Americans are going to be added to those roles.

So because we can't get our patients to get screening colonoscopy now, we looked and found, quite convincingly, that using more highly-specific and highly-sensitive stool-based testing in lieu of screening colonoscopy and reserving those rare and hard-to-get colonoscopy slots for people who test positive on that first-line non-invasive test, one, most importantly, improves outcome. And we believe strongly that such a strategy will also reduce the well-described disparities among rural communities of black and brown patients, and low-income people who are falling behind regarding their colorectal cancer screening compared to other Americans.

Dr. Caudle:
Well, thank you so much, and with those tips in mind, I'd like to thank my guest, Dr. Mark Fendrick, for joining me to share the key findings from his poster.

Dr. Fendrick, it was great having you on the program today.

Dr. Fendrick:
It's my pleasure. Thank you so much for having me.

Announcer:

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