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What to Consider When Selecting a CRC Screening Test

Announcer:

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

Dr. Turck:

Welcome to *Clinician's Roundtable* on ReachMD. I'm your host Dr. Charles Turck, and joining me to discuss colorectal cancer screening options and how we can select a test is Dr. John Russell. In addition to being a fellow ReachMD host, he's a family medicine physician at Abington Family Medicine, which is a part of the Jefferson Health System in Pennsylvania. Dr. Russell, thanks for being here today.

Dr. Russell:

Dr. Turck, it's great to be with you today.

Dr. Turck:

So to get us started, Dr. Russell, would you give us an overview of the screening modalities for colorectal cancer that are currently recommended by the United States Preventive Services Task Force, or USPSTF?

Dr. Russell:

I think one of the important things is it involves lots of different modalities for testing, and I think that that's important as we try to individualize care for our patients. Having more options is going to leave less people unscreened. The test that is most often thought of, I think, is the colonoscopy that would be every 5 to 10 years based on someone's risk factor. There would be a flexible sigmoidoscopy, which has really kind of fallen into disfavor over the last 10-15 years. And then there are a lot of stool-based tests. So the stool-based test could either be a fecal immunochemical test, or a FIT test, as well as a stool DNA test. And then lastly is a CT scan-based colonography, which really has not gotten a ton of uptake.

Dr. Turck:

And based on the USPSTF guidelines, in which of our patients should we be using one of those screening modalities and when?

Dr. Russell:

Well, we really should start screening at 45. And so that's something that's a newer recommendation. As colon cancer has gotten younger in the United States, the American Cancer Society was the first group to lower that age from 50 to 45, and the patients between 45 and 50 have a B recommendation from the USPSTF. The patients from 50 to 75 have an A rating, and for our patients between 75 and 85, it's kind of based on what's happening with the patient, and that has a C recommendation from the United States Preventive Service Task Force.

Dr. Turck:

Now given those recommendations, let's focus on how we should select a test. First, what patient factors do you consider?

Dr. Russell:

Well, I mean, I think part of it is just talking with the patients, right? And I think the strongest thing that's going to make a patient go for

colon cancer screening is a strong recommendation from their personal clinician. So I talk about why I think it's important, and then I talk about different modalities. You know, we are all entering the doctor's office with different things going on in our life. And I say the United States Preventive Task Force views these screening modalities as relatively equal if you follow the intervals and you follow the screening to its completion. So for some people, a colonoscopy is easy; you do it every 10 years, you do a prep the day before, someone drives you, they give you some anesthesia, and you wake up and you don't have to worry about it for a decade hopefully. But for some people, transportation is an issue, doing sedation is an issue, doing a prep is an issue, and having someone to take you and stay there with you is an issue. So the stool-based tests, I think, are great for that population, but we do need to remind people that if there is an abnormality in a stool-based test or even a colonography, they're going to have to follow that up with a colonoscopy.

Dr. Turck:

For those just tuning in, you're listening to *Clinician's Roundtable* on ReachMD. I'm your host Dr. Charles Turck, and I'm speaking with Dr. John Russell about salient factors to consider when selecting a colorectal cancer screening test.

Now from a quality measures perspective, Dr. Russell, what is the healthcare effectiveness data and information set, or HEDIS for short, tell us about these modalities?

Dr. Russell:

So I think one of the things that HEDIS has helped us evolve is this movement from volume to value, and it's not necessarily just how many patients we see, but how good a job we're doing. And it is a way for some national governing bodies to view if we are doing some screening. So for a lot of the screening tests I mentioned, just referring the patient is not enough. So if I give someone a FIT kit in the office and they never send it back, that would not achieve my HEDIS guideline for colon cancer screening. So they actually want to see an end result fitting in the time period that we talked about. For a colonoscopy, they're really going to look in that 10-year period. If I'm doing some FIT testing, annually would be for that; if I'm doing some stool DNA FIT testing, that would be every 2 to 3 years that they would look for. And then also, if someone's had a colon cancer diagnosed, that will trigger that. If someone has a colostomy or if someone's on hospice, a lot of the things would achieve an out for not having to do that screening.

Dr. Turck:

And which screening options qualify for coverage, including if a follow-up colonoscopy is needed after a non-invasive test?

Dr. Russell:

So they should all qualify for testing, and all the commercial insurances have this as part of their parameters. They haven't always, but that is some newer legislation in the last few years.

Dr. Turck:

And lastly, Dr. Russell, do you have any other thoughts on colorectal cancer screening tests and how we might optimize our selection of them?

Dr. Russell:

Colorectal cancer is the number 2 fatal cancer in the United States. One of the things, I think, patients think is that it only happens to people where it runs in their family. And yes, there are some familial tests and some familial states, but most people do not have a family history that would lead them to need some colon cancer screening. And we should screen everyone, and the only bad test is the test that we do not do.

Dr. Turck:

Well, those are some great comments for us to consider as we come to the end of today's program, and I want to thank my guest, Dr. John Russell, for joining me to discuss recommended colorectal cancer screening options. Dr. Russell, it was great having you on the program.

Dr. Russell:

Dr. Turck, thank you so much.

Announcer:

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