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Colon Cancer: Pros & Cons of Screening Younger Patients

Dr. Buch:
Colon cancer rates for those over 50 have decreased, however, the rates for those younger than 50 have increased. Any colon cancer diagnosis is frightening, but a colon cancer diagnosis in young individuals is especially devastating. The colon cancer risk for those younger than 50 is in the 10 to 11% range of all colon cancers; these cancers are often much more aggressive.

Welcome to *GI Insights* on ReachMD. I'm Dr. Peter Buch. Joining me, today is Dr. Joseph Anderson, an Associate Professor of Medicine at Dartmouth, Geisel School of Medicine and the University of Connecticut School of Medicine. Dr. Anderson is the primary author of "To Screen or Not to Screen Adults 45-49 Years of Age: That is the Question." It's located in the *American Journal of Gastroenterology*, 2018. Dr. Anderson, I'm really honored to have you join us here today.

Dr. Anderson:
Good to hear from you.

Dr. Buch:
Thank you for joining us. So, let's review some information contained in the American Cancer Society guideline for colorectal cancer screening for people at average risk. The document states that screening at age 45 is a "qualified recommendation" whereas screening at age 50 is a "strong recommendation." Why is the difference important and what does it mean?

Dr. Anderson:
So, a qualified recommendation simply means that while we have good evidence for people 50 and above in the form of randomized trials, there really are few data for people less than 50, and therefore while the evidence regarding rates of rectal cancers in people less than 50 definitely show an increase in people less than 50 in terms of mortality and incidence, there are little data that are available to demonstrate that there is benefit. So that's why it's "qualified" as opposed to the 50-to-75 year range in which there is good evidence and those are based on trials.

Dr. Buch:
So, let's get into the next question. Why not make the guidelines more inclusive and screen those age 40 to 49?

Dr. Anderson:
Well, I think that is an excellent question, and there are many factors that you have consider when you are recommending screening. First of all, is there gonna be benefit and indeed there is, if you look at the 40 to 49 age group; 40 to 44 has also experienced an increase in incidence and mortality from colorectal cancer. And in fact, the paper that we just published in the *American Journal of Gastroenterology* in 2020 and Dr. Lynn Butterly of the New Hampshire Colonoscopy Registry and I published that data and what we found was there was an actual increase for advanced adenomas at the age of, 40 to 44, 45 to 49 also had an increase, but the increase started at 40 to 44. So therefore, the advanced adenomas, which are precursors which are potential targets for us to remove and prevent cancer, do increase at the age of 40. The other concern is, "Is the biology similar between people less than 50 and people 50 years or older?" It seems that the cancers between 40 and 49 seem to be very similar to those over 50. The real differences seem to come in people less than 30, so starting screening at 40 may be a very plausible recommendation. However, I do think the focus, at this point for many reasons needs to be in that age starting group; the 45 to 49 year age group does have the largest burden of people less than 50 in terms of cancer, especially rectal cancer. So I think that while one could make an argument for people age 40 and older, I think 45 is where we want to focus.

Dr. Buch:

So, I want to add one additional thing and you can comment further. The good old fashioned rectal examination.

Dr. Anderson:
Yes since most of the lesions tend to be in the rectum, I think that one should not take a nihilistic view towards the rectal examination. I have to say that this is a physical exam feature that people have not been doing as much as they should be doing, and since you are able to reach within a few centimeters, when you see someone in the office, certainly an exam should be done at that time. And what you're really feeling for is you feel the normal mucosa and then you won't feel anything hard, unless there's severe desmoplasia, you may feel, like a little bump, but you'll feel something different and that's what you should be looking at, and in looking to see what color the stool is, just basic things like that. If you see blood in the stool, that certainly indicates that there is something that is causing the bleeding that's above the area of the hemorrhoid, 'cause that's often what you're trying to differentiate; it's often very difficult to differentiate that, unless you see the actual hemorrhoid bleeding. If you see a streak of blood with brown stool, that suggests a hemorrhoid as well, but you don't know unless you look. So I agree 100% a rectal examination needs to be done.

Dr. Buch:
Thank you. So, this is a topic that we in the gastroenterology community have been discussing over the last few months. We were all shocked to hear of Chadwick Boseman's passing from colon cancer. He was diagnosed with stage II colon cancer at approximately age 40. Would you kindly review the usefulness of lower GI alarm symptoms?

Dr. Anderson:
Well, rectal bleeding is probably the number 1 alarm symptom because of the fact that the location of these tumors tend to be in the rectum. Rectal cancer is largely what's driving the increase in cancer in young people. And rectal bleeding is probably one of the major alarm symptoms. You know, when we think about rectal cancer, some of the symptoms we think about is tenesmus, and tenesmus has two definitions: either painful defecation or incomplete defecation, it's probably the latter that you'll see, so tenesmus. People may also have change in bowel habits and obstructive symptoms like pain, abdominal pain, and constipation or obstipation, but those are usually fairly late. So while there are not real official guidelines on working up symptoms, I think rectal bleeding in people less than 50 should be considered an alarm symptom and should have prompt endoscopic evaluation for that symptom.

Dr. Buch:
A follow-up question to that which I often get is a primary care doctor has a 22-year-old with rectal bleeding, should that patient get a colonoscopy? Could you comment on that?

Dr. Anderson:
Well, I think that it's hard to really have an age cutoff, even with the rise of young people having cancer, that's an age that doesn't seem to be as much risk as somebody who's in their 40s. However, when you look at the increase in people in 20s and 30s is actually been the steepest increase. So these people are at risk, and, you know, I would probably approach it very similarly where I would hope that the primary care person does, a rectal examination and depending upon what that shows, a prompt evaluation for endoscopy. I think a flexible sigmoidoscopy, although not largely done in the U.S., would not be unreasonable and if it was not diagnostically helpful, in other words, you didn't find something like let's say, ulcerative colitis, 'cause that is also a possibility in someone as young, then a full colonoscopy should be done to make sure that you're not missing a splenic flexure or a descending colon cancer causing hematochezia.

Dr. Buch:
So, the summary there, is that we're getting much more aggressive these days.

Dr. Anderson:
Exactly.

Dr. Buch:
For those just joining us, this is *GI Insights* on ReachMD. I'm Dr. Peter Buch and today, I'm speaking with Dr. Joseph Anderson about the pros and cons of screening younger patients for colon cancer. So, moving on, do you foresee a better colon cancer model in the future that will incorporate sex, obesity, smoking, diet, family history, etc. to predict colon cancer?

Dr. Anderson:
When you look at those models that are being done today in people over 40, there are some good ones, without getting into the weeds on which ones are better, the problem with those models is that when you're building a model, you want to have what we called "ROC" or area under the curve and what that does is tells you how good it is at predicting low versus high-risk individuals. And the models have gotten better. The problem with those models is that the odds ratios are often very modest, even for something like smoking; I've been involved in a lot of investigations with smoking, the odds ratio is often two-fold and without getting too much into the weeds about how we build these models, most of them are in the high 60s or 70s, so the models will have limited usefulness. One area that might be

useful will be genetics. I think that will be very helpful in terms of predicting who's at risk and who's not and then in conjunction with things like smoking, obesity, sex, I think that will be very helpful. But I think at this point, models are very limited. I will say that where models might be very helpful is in differentiating which tests people undergo. For example, if someone is at very high risk: they're a smoker, they're a man, maybe you would have them undergo a colonoscopy because they're more likely to have something and benefit from that risk-benefit. Other individuals, if you're a thin woman who exercises, has never smoked, doesn't drink, that individual may go yearly FIT tests 'cause that is something where you're in the lower-risk group. So, that's how I would see the models used. In terms of the discriminating ability of these models, I think that they are limited because the risk factors are just not that predictive.

Dr. Buch:
Thank you. Some of our non-GI colleagues assume colon cancer has declined in the last 30 to 40 years because of colonoscopy. Would you, kindly, set the record straight?

Dr. Anderson:
I think that would be nice to think that way, but there's a lot of different things that have happened. Certainly, we started screening endoscopically the summer of 2001. The effects of screening would be minimal compared to what we do see, and it would only be for the past 2 decades. If you look at the percentage of individuals who have been screened and in the best studies, the decrease has been relatively modest; what might explain is potential change of risk factors like smoking, that's a very potent risk factor, and certainly this country's done a very good job of decreasing smoking prevalence. So, I think that screening alone does not explain the decrease in mortality. And then finally, I think we're doing better in terms of caring for people with colorectal cancer, the different modalities people do a lot better nowadays than they did 30/40 years ago. So, as much as we gastroenterologists would like to take credit for the real dramatic decrease in people over 50, unfortunately there are many reasons, as I outlined, above.

Dr. Buch:
Great. What would you say to an average risk 45-year-old patient who walks into your office tomorrow and demands to be screened for colon cancer?

Dr. Anderson:
That's an excellent question for many reasons, not the least of which it's something that I'm sure primary care people are dealing with regularly. There are a lot of different things that I think about when I hear a situation like that; I think first of all, it's probably gonna be common, second of all, the U.S. Preventive Task Force draft document gave it a Grade B recommendation, I believe. And so, insurance will have to follow suit, and I think they will be screened if they ask to be screened. When you look at screening people 45 to 49, in addition to everybody else, there've been many concerns about that. One is diverting resources away from people that may be at higher risk. So those are some of the things that come to mind when I hear a scenario like that.

Dr. Buch:
And from my perspective, the most important thing for tomorrow is insurance coverage. Insurance coverage may not cover 45 years old. It still may cover 50.

Dr. Anderson:
Right, the Affordable Care Act essentially provides coverage for any recommendation by the U.S. Preventive Task Force. So if the upcoming recommendations from the U.S. Preventive Task Force endorses screening at 45, insurance coverage will be there. So that won't be problematic. The draft recommendation which came out about a month ago did have it as screening at 45 as a B recommendation. So, I think insurance would cover it.

Dr. Buch:
Thank you. And lastly, what else would you like to share with our audience today?

Dr. Anderson:
Well I think the future for colorectal cancer screening is likely not to be colonoscopy. I think that we're going to see different modalities, I think blood tests, stool tests are gonna be very much on the rise for many reasons, not the least of which convenience, and I think that we'll see a different future. I always tell my fellows that I train to get very good at polypectomy because I think that's what we're gonna be doing a lot; we're gonna be seeing a lot more colonoscopies for diagnostic reasons and less so for screening. And I think we're gonna increase screening whereas right now, screening is opportunistic; you walk into a doctor's office and they say, "Hey have you been screened?", I think that they'll be more programmatic; in other words, you'll get a card saying, "Where is your FIT?" Every 5 years you'll get a card saying, you know, we need to have you have this done. As opposed to going and saying, "Have you had your colonoscopy recently?", "No, I had it 10 years ago.". So I think screening will look a lot different and the stool tests, the blood tests, I think those things will increase in prevalence and already have in many parts of the country.

Dr. Buch:
That's all the time we have for today. But I want to thank Dr. Joseph Anderson for helping clarify the pros and cons of colon cancer screening in younger individuals.

Dr. Anderson:
Thank you for having me, Peter.

Dr. Buch:
My delight. For ReachMD, I'm Dr. Peter Buch. To access this episode and others from *GI Insights*, visit ReachMD.com/GIInsights, where you can be part of the knowledge. Thanks for listening.