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

Recapping the 2021 ACG Clinical Guidelines: What's New in Colorectal Cancer Screening?

Dr. Buch:

What do we need to learn from the ACG Clinical Guidelines Colorectal Screening 2021? This is Dr. Peter Buch, your host for *GI Insights* on ReachMD. Joining me today is Dr. Aasma Shaukat, the lead author of this article, which was published in the *American Journal of Gastroenterology*. Dr. Shaukat is also the Robert M. and Mary H. Glickman Professor of Medicine and Gastroenterology at the NYU Grossman School of Medicine. Dr. Shaukat, thanks so much for joining us today.

Dr. Shaukat:

Thank you so much. It's my pleasure to be here.

Dr. Buch:

So Dr. Shaukat, let's dive right in. Why is flexible sigmoidoscopy still listed as a stand-alone test for screening?

Dr. Shaukat:

Great question. There's a lot of evidence supporting that flexible sigmoidoscopy as a stand-alone option compared to no screening does reduce the risk of developing and dying from colon cancer, and these trials were done in Europe and the U.S. So by itself, it is a viable screening strategy and it is used elsewhere in the world, such as many western countries, including U.K. However, in the U.S. we don't tend to use it for several logistic and medical-legal reasons and it's fallen out of favor. However, it does remain a very effective screening intervention and for individuals or health systems that do choose to offer it, we still thought it should be left on the options menu.

Dr. Buch:

That's great. But a follow-up question with regard to that: those countries that use the flexible sigmoidoscopy, do they use a fecal immunochemical test and/or a fecal DNA/fecal immunochemical test as an additional part of that evaluation?

Dr. Shaukat:

They do not. So the studies that were done in U.K., Italy, and Norway essentially only studied flexible sigmoidoscopy, either a one-time exam over ten years or flexible sigmoidoscopy every three to five years and one particular study used flexible sigmoidoscopy along with a fecal immunochemical test done every other year. And all these studies showed that these screening strategies were superior to usual care or no screening. So that's why it's considered a stand-alone option or in combination with FIT and the interval varies. So if it's a stand-alone option, the recommendation is to do this every five years along with annual or every-other-year fecal immunochemical test, or FIT, then the flexible sigmoidoscopy can be done every ten years.

Dr. Buch:

Thank you very much. With a suggested colorectal screening beginning at age 45, should we be screening African American patients five years earlier?

Dr. Shaukat:

That's a great question. And it completely makes sense because we were screening African Americans five year younger than the rest of the population in the prior guidelines, so is there any reason why we shouldn't continue that trend? Well, the answer based on modeling studies seems to suggest "no" and the rationale is two-fold. One, most of the increase in colon cancer incidence that we've seen in individuals younger than 50 seems predominantly to be in non-Hispanic whites, particularly men. Whereas the rates in African Americans have either stayed stable or are declining in this younger group. The second argument is that the modeling studies that were

performed as part of these guidelines that inform the guidelines also suggested that screening African Americans at 45 along with everybody else at 45 was the predominantly important strategy that yielded the most life years gained compared to screening at age 50. Hence, the recommendation is to start everybody at 45 and the whole point with trying to screen minorities is we know that nationally, screening rates are low for Blacks, for Native Americans, American Indians, and Asians. So we need to bring those individuals to screening and have special programs to improve adherence. But again, starting screening at age 45 for everyone.

Dr. Buch:

That's great. Very useful. And if we look ahead, what's the future for blood-based screening tests?

Dr. Shaukat:

The future is extremely bright, I must say. There are about five or six blood-based tests that are currently undergoing studies and in the process of either completing their studies and submitting for FDA approvals and then coverage by Medicare and peers. So in the next five years, I expect that we will have not just one but perhaps more than one blood test available as a screening option. All their pilot data looks very promising and their technologies differ a little bit, but it's a combination of our ability to not just detect tumor markers, but very, very early changes in not just the cell and it's shedding the DNA material into the blood, but also cells free DNA, along with the use of artificial intelligence to enhance the diagnostic ability of these tests. In fact, some of these tests are being developed as pan-cancer tests. So they might actually pick more than one GI cancer. So in addition to colorectal cancer, they might pick up pancreas cancers, liver cancers, gastric, esophageal. So, we'll all start seeing this evidence starting next year and I do expect we'll have more than one blood-based test to add to our screening options.

Dr. Buch:

That's so exciting to hear. Thank you. For those just joining us, this is *GI Insights* on ReachMD. I'm Dr. Peter Buch and today I'm discussing colorectal cancer screening with Dr. Aasma Shaukat.

Dr. Shaukat, do you anticipate that routine screening colonoscopy intervals may be extended in the future?

Dr. Shaukat:

Yes, I do. Since we've started doing colonoscopy for screening, which started roughly around 2000 in this country, over the last 20 or 22 years, we've learned a lot about our ability to do colonoscopy and do it effectively. Also, a lot of advances in technology, our interventions to improve the prep and the ability to see behind folds, and the tools and little gadgets we have during our endoscopy, have dramatically increased our ability to expose the colonic mucosa, get a very, very excellent look at all the folds, not miss anything, even very, very small, and also be able to remove it completely. All these enhancements have resulted in our ability to detect and remove polyps and precursor lesions very, very effectively. And hence individuals that undergo a colonoscopy now we understand that it confers protection for more than ten years. And this has been shown in several studies now already from Europe and I suspect we'll see some studies shortly in the U.S. also. So very slowly we're inching towards performing high-quality colonoscopy, complete exams with excellent preps and then we will be confident enough to space these intervals to ten, to perhaps twelve or fifteen years and that will be a huge advancement in the field. Because like we just talked about, starting screening at age 45, then again, instead of adding the burden of colonoscopies, if we could do a high-quality exam and be confident that we can go as long as fifteen years, well then it's a win-win. And then that would mean that somebody, average risk, may need a minimum of three checks in their life; at 40, at 60, and 75. And we could pretty much effectively reduce their risk of developing or dying from colon cancer.

Dr. Buch:

And that, in addition to the blood testing that we're talking about, may reduce it even further. We don't know.

Dr. Shaukat:

Yes. Absolutely.

Dr. Buch:

So with that being said, can you please describe the Minnesota Colon Cancer Control Study for us?

Dr. Shaukat:

Yeah. Happy to. That study is an extremely valuable study and really put colon cancer screening and our understanding of the benefits of screening in the literature for us. So this study was started before many that are listening to this were even born. The study started in 1974 and essentially it took DMV records and randomized individuals 45 and older that were residents of Minnesota and parts of Wisconsin to either screening, colon cancer screening using the older version of the fecal immunochemical test, called FOBT, or fecal occult coag testing or usual care. Now, there was no screening going on in 1974 because we just didn't understand its importance or have modalities. Therefore, the usual care was pretty much an unscreened population. So individuals that were eligible were invited to participate. If they agreed to participate, they were randomized where they had an equal chance of either getting annual FOBT testing or

nothing at all, our usual care. And then if they had occult blood testing done, if it was negative then the study staff would bug them in a year to complete the test again. And if they had a positive test, then they would be navigated to a colonoscopy. And any polyps found during the colonoscopy were removed.

So the study went on with a small hiatus in between for a good eighteen years. And we continued follow-up of the study for over thirty years. And at thirty years, we reported our findings where we found that there is a sustained reduction in the risk of developing or dying from colon cancer in the individuals that underwent screening with fecal occult blood testing, followed by a colonoscopy if the test was negative. And we also found that there is a sustained effect of removing polyps for individuals that were brought to colonoscopy and these effects are what we think explain the long-term reduction in colon cancer incidence and mortality.

So the study has been very pivotal in our understanding of the benefits of screening and the relative benefits in different age groups and how we should approach screening. It also helps us establish annual screening in the U.S. because the parallel studies in Europe actually did screening every two years using fecal occult blood tests. This study truly established annual testing in the U.S. We now know that people can expect at least a 30% reduction in the risk of dying from colon cancer, using fecal immunochemical testing and from what we understand and we think, colonoscopy lone strategy might be even more effective, but studies are ongoing for that particular aspect.

Dr. Buch:

Lastly, are there any other insights you would like to share with our audience, Dr. Shaukat?

Dr. Shaukat:

Yeah, I'd like to emphasize that the best test is the one that gets done. So, think about who our patients are and what test is most acceptable, accessible, and is able to be completed. And this might be a combination of patient preference, cultural context, what the physicians recommend, and what the healthcare system offers along with insurance coverages. And make the decision that best suits your needs. Colon cancer is unique because we have several screening options, many of which we discussed. So instead of boxing ourselves into just one option, just think broadly, what can we do to get more people screened? Because we realized, getting people screened is probably the most important thing compared to the modality, that comes secondary. And second, no matter what screening strategy is selected, if it leads to a colonoscopy or say it's a colonoscopy itself that's picked, make sure it's a high-quality exam, such that we're confident that it confers protection for the maximum time that it can be.

Dr. Buch:

Well, with those final takeaways in mind, I'd like to thank our guest, Dr. Aasma Shaukat, for walking us through the 2021 ACG Clinical Guidelines for Colorectal Cancer Screening. Dr. Shaukat, it was great having you on the program, today.

Dr. Shaukat:

Thank you so much. It was a pleasure.

Dr. Buch:

For ReachMD, I'm Dr. Peter Buch. To access this episode, as well as others from the series, visit ReachMD.com/GIInsights, where you can Be Part of the Knowledge. See you next time.