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Optimizing the Effectiveness of Colonoscopy for Colorectal Cancer Prevention: Importance of Breaking Down Barriers

Announcer: Welcome to ReachMD. This medical industry feature, titled: "Optimizing the Effectiveness of Colonoscopy for Colorectal Cancer Prevention: Importance of Breaking Down Barriers" is sponsored by Ferring Pharmaceuticals Inc., This program is intended for physicians.

Here's your host, Dr. Balzora.

Dr. Balzora: This is ReachMD and I'm Dr. Sophie Balzora. Joining me to talk about Optimizing the Effectiveness of Colonoscopy for Colorectal Cancer Prevention: Importance of Breaking Down Barriers is Dr. Carol A. Burke, MD, FACG, FASGE, AGAF, FACP Vice Chair in the Department of Gastroenterology, Hepatology and Nutrition at Cleveland Clinic, and Past President of the American College of Gastroenterology. Dr. Burke, welcome to the program.

Dr. Burke: Thank you so much. I appreciate the opportunity to speak with you today.

Dr. Balzora: So, to start us off, why is there a national initiative to increase Colorectal cancer screening?

Dr. Burke: Colorectal cancer is common, and preventable, yet 30% of the eligible Americans have not had colorectal cancer screening. Strong data shows the substantial impact that colorectal cancer screening and particularly colonoscopy has on decreasing the incidence of and mortality from colorectal cancer over the last 30 years. The two biggest reasons cited for lack of screening is that the patient did not get the screening recommendation from their provider or patients fear related to the bowel preparation. Both of those issues are easily surmountable.

We have had a national initiative - the national colon cancer round table, which was suggested 80% by 2018 in which more than 1,500 organizations committed to the shared goal of getting 80% of adults aged 50 years and older being regularly screened for colorectal cancer by 2018. Unfortunately, we didn't make it as a nation...although screening rates in some communities hit the target, but we really need to continue the push as hitting the 80% mark is estimated to prevent 277,000 new cases of colon cancer and 203,000 deaths within the next 20 years.^[1-3]

Dr. Balzora: And since there's been this national push to promote screening, can you tell us about the available screening options?

Dr. Burke: Well according to most experts and the U.S. Preventative Services Task Force, the best colorectal cancer screening test is the one that gets it done.

When you look at the US Multi-society Task Force guidance, they ranked tests into three "tiers" according to the strength of the recommendation for average-risk people. Colonoscopy and FIT or Fecal immunochemical tests fits into Tier 1.

One important feature is that Colonoscopy is both diagnostic and therapeutic. It's highly sensitive for cancer and all classes of precancerous lesions, and it is the only test that allows a patient to be diagnosed and treated in a single session.

Fecal immunochemical testing is less sensitive and must be repeated every year, but it is non-invasive, costs less than colonoscopy and performs well in the detection of cancer. However, whether it is FIT or other alternative screening tests such as cologuard, all positive non colonoscopy screening tests do lead to colonoscopy. The colonoscopy is the definitive strategy for anything short of it, and it is a destination therapy for a positive non-colonoscopy screening test.

Colorectal cancer screening is a federally mandated benefit for patients which should be completely covered by insurance. "Medicare, but not commercially insured patients are surprised when they come in for a colonoscopy to evaluate the reason for a positive alternative colorectal cancer screening test and receive a bill for a copay., Colonoscopy becomes a "diagnostic test", when it is done for follow up and not as the primary colorectal cancer screening method. Both patients and providers get very upset

about this loophole. This is an issue that both the primary care provider and patients need to be aware of when their given options for colorectal cancer screening tests. And I would encourage patients and providers to contact their legislators to support the current bills advocating dropping this loophole in Medicare in the “Removing Barriers to Colorectal Cancer Screening Act”.

Dr. Balzora: Since colonoscopy is frequently used to screen for CRC and is the destination test after a positive screening test, how do you ensure the quality of colonoscopy is maximized?

Dr. Burke: “Bowel preparation quality is a key factor in highly effective colonoscopy. It directly impacts the ability to see polyps and complete the exam safely and efficiently. The US Multi-Society Task Force recommends that endoscopists achieve an 85% or greater adequate bowel preparation rate in practice. If the rate is lower than the benchmark, endoscopists should take steps to optimize their patients' bowel preparation quality. Inadequate bowel preparation is observed in more than 25% of outpatient colonoscopies and higher than that in inpatients.”

Dr. Balzora: Poor bowel preparation seems to be a reoccurring barrier which clinicians commonly face, what are ways to reduce the chance of poor bowel preparation? How can poor bowel preparation as a barrier be reduced?

Dr. Burke: “Our responsibility is to ensure we have a process to educate patients so that they understand the bowel preparation process - so that we get the metrics we aim for. We should engage the patient, offering a choice in volume and taste of bowel preparation, and of course keeping safety in mind. People need to know there are alternatives to drinking a gallon of bowel preparation. Even within the low volume bowel preparation space a variety of options for appropriate patients exist. Factors to consider include the volume of medication patients are ingesting, the taste of the preparation, safety profile, and the option for no forced clear liquids.

The outcome for patients will be better when they are educated and engaged in the preparation process. Additionally, to ensure adequate performance raising the awareness of screening quality metrics are equally important. Several quality metrics exist and are used by providers as a method to be held accountable and delineate quality exams. While there are several quality metrics proposed for use to evaluate the quality of colonoscopy, evidence-based ones such as, cecal intubation rates, adenoma detection rates (ADRs), withdrawal time and overall adequacy of bowel preparations rates are commonly utilized. These metrics can be used as tools in achieving our goal of conducting a quality examination during each procedure, and ultimately providing the best exam to our patients [4].

Dr. Balzora: Well with that I want to thank Dr. Carol Burke, for joining me today to discuss how we can optimize the effectiveness of colonoscopies. Thanks for being here Dr. Burke.

Dr. Burke: I appreciate it – thank you.

Announcer: The preceding program was sponsored by Ferring Pharmaceuticals Inc. To listen to other programs in this series, please visit ReachMD.com/NextGenBowelPrep. This is ReachMD. Be Part of the Knowledge.

References:

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