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A Look at Cancer Moonshot: Health Disparities in Cancer Screening

Announcer:

You're listening to ReachMD. This episode of *Project Oncology* is sponsored by GRAIL. Here's your host, Dr. Charles Turck.

Dr. Turck:

Welcome to *Project Oncology* on ReachMD. I'm Dr. Charles Turck, and joining me today to discuss healthcare disparities in cancer screening and new technology for early detection is Dr. Mark Fendrick, who'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, thanks for being here today.

Dr. Fendrick:

It's a pleasure to be on, Dr. Turck.

Dr. Turck:

So Dr. Fendrick, let's start with some background. What do we need to know about the relaunch of the Cancer Moonshot initiative?

Dr. Fendrick:

As some of your listeners might know, this program sets very ambitious goals, to cut the rate of cancer deaths by half over the next quarter century, and also to improve the clinical experience of individuals diagnosed with cancer. An important component of this far-reaching initiative is a very strong commitment to reduce the well-established disparities in the prevention, diagnosis, and treatment of cancer. And from my opinion, the timing of this announcement is very noteworthy, as a spark in the sorely needed healthcare system to jumpstart the restoration of the millions of cancer screenings and treatments that were missed or postponed during the COVID pandemic can actually come to fruition.

Dr. Turck:

And what are some of the solutions that might allow us to realize the goals that you had mentioned?

Dr. Fendrick:

Yeah, it's always great to reach for the stars and say, you know, we want to cut cancer deaths by 10 percent, or in this case, 25 percent. But the program specifically calls for solutions that support patients through the entire cancer screening process. That's not just the initial test, but until the diagnosis of cancer is made or not. It also urges the development of innovative screening tools, particularly those that expand the number of cancers detected, as nearly 50 percent of the cancers diagnosed in the U.S., and that same number of deaths from cancer, do not currently have a recommended screening test.

Dr. Turck:

So with all that in mind, would you tell us a little bit more about some of the primary disparities in cancer screening that exist today?

Dr. Fendrick:

Healthcare disparities have been long described in that underserved populations have not had the access to care that we know would improve their quality and length of life. When it comes specifically to cancer, malignancy disproportionately impacts women, and people who identify as black, brown, indigenous, and Hispanic.

So when you think about cancer screening, and when you think about treatments of diagnosed cancer, there is a requirement of access. And it's really interesting when you think about access to screening, in the current modalities of the screenings that exist now, breast, cervical, colorectal, lung, and prostate, with the exception of home colorectal cancer screening, and blood-based prostate-specific

antigen screening, the other cancer screenings require a separate visit. On top of that, they require people to miss work. And in some situations, you need to have a driver to come with you, which makes it very difficult. And it should come then is no surprise that underserved populations have lower rates of screening.

Dr. Turck:

And how do you think the COVID-19 pandemic has played a role in exacerbating these disparities in care?

Dr. Fendrick:

Well, we've all lived through quite a time. Hopefully, a once-in-a-century situation that our lives were completely turned upside down. And given that, all aspects of cancer screening, diagnosis, and treatment require a significant time commitment from patients and their families to do the things that are evidence based that will ultimately improve their quality and length of life. So the shutdown of the healthcare system early in 2020, led to millions of individuals either postponing or missing cancer screenings, with almost all of them requiring some type of visit to a brick-and-mortar facility to get the screening done.

So what we're seeing now is a slow bounce-back in terms of both cancer screenings, as well as diagnoses and treatments. But sadly, the evidence is becoming quite robust that patients are presenting later in cancers that are potentially early detected and treatable, largely due to the COVID-19 pandemic, and its impact on access to evidence-based screenings.

Dr. Turck:

Now, earlier, you'd mentioned some innovative screening tools that are being developed to help combat these disparities and detect cancer earlier. What are they, and how might they help us?

Dr. Fendrick:

So there's two specific areas that I'm really optimistic about, that actually may bring about somewhat of reduction in healthcare disparities when it comes to cancer screening. And these are specifically highlighted in the literature around the Cancer Moonshot relaunch.

First is the idea that we've all kind of embraced since the pandemic is shifting a fair bit of our care, from bricks-and-mortar visits to home-based approaches. When it comes to the four screenings that are recommended by the U.S. Preventive Services Task Force, one of the modalities that are recommended for colorectal cancer screening actually can be done at home. That's stool-based testing. When it comes to cervical breast and lung cancer screening, there are not at-home options, but I am optimistic, Dr. Turck, that we will soon have a home-based option, in that women might be able to do self-detection of human papillomavirus, or HPV, with an at-home test.

But what's really exciting to me, when it comes to the clinical evidence, is multicancer early detection blood tests. These tests, the science is amazingly sophisticated, allow us to actually assess the potential of 50 or more cancers with one test.

Dr. Turck:

For those just tuning in, you're listening to *Project Oncology* on ReachMD. I'm Dr. Charles Turck, and I'm speaking with Dr. Mark Fendrick about how to improve healthcare disparities in cancer screening.

Now, Dr. Fendrick, you'd mentioned multicancer detection tests just earlier. What are some of the other advantages of this type of screening tool?

Dr. Fendrick:

It's important to reiterate the idea of the fact that the cancers I screen for now, we do them in a single site. In other words, we do a mammogram for breast cancer. We do a colonoscopy or stool-based testing for colorectal cancer, a CT scan for lung cancer, and cytology or HPV testing for cervical cancer. It would be so exciting for me and likely to increase adherence overall, and markedly reduce the disparities in cancer screening if we were able to combine the single-site testing into multicancer type tests. Imagine not the four cancers I mentioned but having a blood-based test that allows to test for 50 cancers. So this is an overwhelming benefit and advantage to these.

A really key point, in that multicancer early detection will be additive, not substituted to existing cancer screenings. In other words, even if you were to get a multicancer early detection blood test, it remains essential and recommended ubiquitously that women continue to get their mammograms and cervical cancer screening, and men and women, when clinically indicated, get their colorectal cancer screening and lung cancer screening.

And I think the last point I'd like to make on this, Dr. Turck, is that getting back to this emphasis in my interest in reducing disparities and enhancing equity. I do believe that if these tests do actually detect cancers earlier and lead to meaningful clinical benefits to patients, that this innovative technology will be equity enhancing.

Dr. Turck:

And what are some of the uncertainties associated with multicancer detection tests?

Dr. Fendrick:

Well, at this stage of the game, the biggest one is we're still waiting to see whether the science behind these multicancer early detection tests actually lead to meaningful benefits in terms of life years gained and cancers detected and treated. But let's just leave that to the experts and clinical trials and other administrators. I'm really excited about the potential for these tests if they borne out to be true, because not only will they enhance access to the multicancer early detection tests themselves, I do believe, as I mentioned earlier, to the fact that they are additive, not substitutive, that more people will actually learn about cancer screening from these initiatives and actually get other cancer screenings done.

Another uncertainty I have, which really does dovetail in work that I've done in more established cancer screening programs, is what happens if you are the unlucky individual who actually tests positive on your initial test? So the same that we potentially see in someone who gets a positive result from a multicancer early detection, is the same burden that's borne by a woman who has a positive Pap smear or mammogram, or a man or woman who comes back with a positive stool-based test or initial lung cancer screen for potential early lung cancer. So as you know, as a clinician, that the emotional and clinical burden of being told that you may have cancer, on top of the fact that patients have to pay out of pocket, often to find out whether they have cancer or not, is an area that I hope is carefully examined as we move multicancer early detection tests forward.

Dr. Turck:

Now uncertainty and cost aside, are there any obstacles preventing access to these types of innovative screening tools? And if so, how can we overcome them?

Dr. Fendrick:

So obviously, healthcare costs in the U.S. are one of the most important public policy initiatives. I feel very, very strongly that there are plenty of resources in the U.S. healthcare system; we just spend it on the wrong services, on the wrong people, in the wrong places, at the wrong time. When it comes to cancer screening, I think we could cover a great deal of additional cancer screenings and multicancer early detections, if we would start having the courage to understand that we're spending millions of dollars each year on cancer screenings on people that are outside of the clinical guidelines. That the men getting screened for prostate cancer over the age of 70, colorectal cancer screening on most individuals over the age of 85, and cervical cancer screening on women who are too young, under 21, and older than 65 who have been adequately screened. Our work has shown that there is a lot of incremental resources that we could devote to new and better cancer screenings, which is why one of my favorite adages when it comes to paying for cancer screening is we have to rob low-value-care Peter, to pay more for high-value-care Paul.

Dr. Turck:

Now, looking to the future, how do you think improving accessibility to these types of tools will impact outcomes for our patients?

Dr. Fendrick:

Yeah, thank you for that question. I think it's the most important one. It's really been the focus of my work, not only in oncology, but my work in healthcare efficiency and equity for 30 years. So it is my hope that, the great Yogi Berra once said, "predictions are dangerous, particularly those about the future." The clinical outcomes of the improved health benefit is actually borne in the clinical trials that we're all waiting for.

I really do believe that multicancer early detection could, and should, be a part of a comprehensive screening program. So, when patients hear about new technologies, they often want to jump the line over older, less-established, less exciting ones that may have the same, less, or more clinical benefit.

So I think that one way MCEdDs can improve accessibility in and of itself, given the amazing science behind it, that if it were coupled with a program that would remind women to get their cervical cancer screening and breast cancer screening, and would remind men and women who are eligible for colorectal cancer screening and lung cancer screening, that patients would be better off, which just motivates me. Strongly believe that equity would be enhanced, particularly in the area of cancer screening, where underserved populations have been disproportionately represented.

Dr. Turck:

Well, with those forward-looking thoughts in mind, I want to thank my guest, Dr. Mark Fendrick, for joining me to talk about broadening access to cancer screening tools and combat healthcare disparities. Dr. Fendrick, it was great speaking with you today.

Dr. Fendrick:

Pleasure working with you and to be on ReachMD.

Announcer:

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