

### Transcript Details

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

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## Higher Risk, Lowered Age: New Colorectal Cancer Screening Guidelines

Dr. Russell:

Colon cancer is the third leading cause of death in the United States. The American Cancer Society has recently changed its screenings and representations. From our studios in Fort Washington, Pennsylvania, welcome to Clinician's Roundtable. I'm your host, Dr. John Russell. Today I'm joined by Dr. Rich Wender, Chief Cancer Control Officer of the American Cancer Society.

So, Dr. Wender, thank you for being on the show.

Dr. Wender:

Happy to be part of it.

Dr. Russell:

So, how important is colon cancer in the United States?

Dr. Wender:

It's really important. Colorectal cancer is the second leading cause of cancer-related death when we combine statistics for both men and women, and a lot of people don't know that. A lot of women... I just heard this the other day, in fact. "I thought that was a disease of men." But in fact, it's the third leading cause of cancer-related death in women. And you'll often hear us use the term colorectal because we kind of combine 2 cancers, colon cancer and rectal cancer, the rectum being the final part of the colon.

Dr. Russell:

So we've been screening for colorectal cancer for you and I's whole career. Has it made a difference?

Dr. Wender:

It's an incredible success story, something that all of us in medicine, and certainly those of us in primary care who were responsible for recommending screening, can take a lot of satisfaction and pride in. We have actually seen over a 40% decline in death rates from colorectal cancer, and the vast majority of that is due to the advent of screening. It kind of started when we learned how to do fiberoptic scoping. And even if we weren't quite screening yet, we still found some polyps and took them out, but we really started to see progress when screening guidelines came out and saying that everyone over age 50 should have a screening test for colorectal cancer, and we're just seeing a beautiful, steady decline in mortality from this disease. It's a tremendous prevention success story.

Dr. Russell:

So, if we were so successful in screening people starting at age 50, why would you decrease the age recommendation?

Dr. Wender:

It's a great question, John, and as successful as we've been, as you well know, we still haven't reached everybody. The screening rates for the nation as a whole are at about 67%. We're doing a great job in the Medicare population but have a lot of screening gaps. That makes your question even more cogent. If we're not getting everybody 50 and older, why lower it? And the answer is this: We have, over the past few decades, been witnessing a very disturbing trend, and that is a steadily rising risk of developing cancers of the colon and rectum in younger people all the way down into the decade of their 20s. If you look at somebody born around 1990 compared to someone born around 1950, that person born more recently is at 51% higher risk for developing colorectal cancer, about 2.6 times more likely for colon and over 4 times more likely to develop cancer of the rectum. So if you actually look at the risk now in people 45 to 49, it's very similar to what the risk was in 50- to 54-year-olds when we first recommended screening that age group about 20 years ago, so unfortunately, we've been witnessing this steady rise in risk. When we go to write a new screening guideline, we kind of begin the

science from scratch, you know, say, “Based on what we know today, what is the optimal age to start?” which is always a tough question to ask, but all of the evidence we’re able to accumulate based on these trends and on the use of some very sophisticated modeling pointed to the same answer, that the optimal screening age to start is 45.

Dr. Russell:

So I saw our colleagues at Sloan Kettering have said over the last 10 years, they have had 4,000 cancers, colorectal cancers, that they have taken care of in folks under the age of 50. Does that sound about right?

Dr. Wender:

It does. And in fact, this is one change in screening guideline—and I thought it was something that maybe only the cancer specialists would tell me—but I heard this from the primary care clinicians too. A few of them came up and said, “Do you know what? We wondered if this might happen,” meaning the change in guideline. It wasn’t because they were watching the statistics. It was because they were seeing this in their practice. And certainly, the cancer specialists and the colorectal surgeons have been watching this very disturbing trend for some time, and many have been asking, “I wonder if this is the time to move the screening age younger.”

I want to be very clear. When we write a new screening guideline, we don’t start with the conclusion. We didn’t go into this asking, “Gee, do we need to move this younger?” We look at the data and the evidence. And there’s a very careful evidence-based review done by an external group, same review that was done for the Task Force, US Preventive Services Task Force, then we commissioned some additional modeling, and we just asked it in a very basic way. What is, based on current data, the optimal age to start, tradeoff between benefit and the number of screens we’d have to do? And the indication is that that age is 45.

Dr. Russell:

Do you guys have any idea teleologically why these cancers are happening more in our younger patients?

Dr. Wender:

It’s a critical question, John, and one of the first things I always tell folks is, “Let’s not jump to the conclusion before we know with certainty.” So there’s an awful lot of things we need to be looking at. First, it’s definitely a change in the environment, John. It’s not genetics. Genetics don’t change in a few decades. So, what are those things? Is it something in what we’re eating? Is it the increase in overweight and obesity? I don’t think that explains all of it by the way, but maybe that’s some of it. Is it other changes in the diet? Is it a change in the bacterium in our gut, the microbiome? Is it more inactivity, less exercise, change in the amount of fiber that we’re consuming? All of these are candidates. I also wonder about just the stress that people are living under, the effects of income disparity. One interesting and somewhat disturbing observation is that most of this increase has been in the white population. You may recall that there used to be a higher risk for colorectal cancer in black population compared to white, and this is one disparity that’s been eliminated but in the wrong way. Rather than lowering the risk in blacks, the risk in whites has come up to the same level as blacks.

Dr. Russell:

If you’re just tuning in, this is Clinician’s Roundtable. I’m your host, Dr. John Russell. Today I’m speaking with Dr. Rich Wender, Chief Cancer Control Officer of the American Cancer Society on new colon cancer screening guidelines.

So we’ve always had kind of this big menu of different things we could use for colon cancer screening. So, as you read these guidelines, did you change that at all? Do we still have all the same options?

Dr. Wender:

We have largely the same options. There are 6 tests, but we do have a very important change compared to our previous guideline. Obviously, the headline is the change to 45, but I don’t want to lose sight of the 2 other changes. One is that we recommend offering choice, at least between what we would call the 2 extremes, a fecal immunochemical test, or FIT test—which is cheap, affordable, done in the privacy of the patient’s own home, it’s done every year, you only need a colonoscopy if you test positive on the one extreme—or if it’s available, colonoscopy every 10 years at the other extreme, which is, of course, the most expensive and at least for one-time testing and demands the most interruption of your daily life. Here is the good news. All 6 options, based on our modeling evidence, if you do them the right way at high quality at the regular intervals, will prevent about the same number of colorectal cancer deaths. So it’s the stool blood tests—there’s 2 types, mainly the FIT is our preferred test—it’s colonoscopy, it’s the radiology study, CT colonography, and we still left flexible sig on the menu even though it’s not done much in the United States because our guidelines are looked at around the world, and actually, flexible sigmoidoscopy in some other countries is still a popular screening choice.

Dr. Russell:

So 25 years ago, you and I in our offices might have been doing an annual exam on someone and doing a Hemoccult test checking for colon cancer screening. That has not been a part of the screening profile though, correct?

Dr. Wender:

Yes, it hasn't actually been a recommended screening test for colon cancer really ever, but you're right, John, we used to do that annual rectal exam and just check the stool on the end of the glove. That's been proven in a few trials to be very inaccurate, and some people think it's because it finds too much blood. It's actually the reverse. It doesn't find it often enough. It's not a sensitive enough test. It's pretty close to having not done any test at all. I don't try to tell clinicians what they should include in their physical exam, and there are some doctors who really believe in the rectal exam, and the ACS isn't going to tell them not to do it. What we are going to say is it's not a screening test for cancer of the colon or the rectum, so you still... You can do the rectal exam. That's your choice. But you still need to make sure that the patient gets one of the recommended screening tests.

Dr. Russell:

So, how do insurances go about deciding which screening tests are going to be paid for?

Dr. Wender:

When we passed the Affordable Care Act, there was a provision in there that commercial payers were required to cover every screening test or prevention maneuver that got an A or B rating from the United States Preventive Services Task Force without any copay or deductible, so ever since that passed, the Task Force has been the predominant influencer of commercial coverage. Twenty states, interestingly enough, have laws that link their coverage to the American Cancer Society guidelines for colorectal cancer, so it might be a different story there. But the other thing that we've learned—and it's early yet, the guideline just came out—is that the fecal immunochemical test, the stool blood test that patients collect and do at home, one sample and send in, is quite affordable, and insurance companies almost always will pay for that. They're not going to challenge payment. And then if that test is positive, the colonoscopy will be covered at least as a diagnostic test even if there is a deductible or a copay. Yes, insurance coverage may be a barrier, but I think it's going to be a bigger barrier if the only test we offer people is colonoscopy. You have to use the full menu, and that includes the much more affordable annual FIT test.

Dr. Russell:

So we talked about our younger patients. Is there an age when we should stop doing colorectal cancer screening?

Dr. Wender:

You know, there is, and that's actually true for all cancer screens. For example, if you find a polyp, that polyp isn't going to harm that person in the next year or two. It's going to take a decade or more before it develops into cancer and produces harm, so what we recommend in the guideline is that you screen everybody who's healthy up until 75. Seventy-five to 84, make sure it's a shared decision with the patient, that their health status is good, that they're likely to live another decade or so, and if the patient wants to continue to screen, that's perfectly legitimate. Beyond 85, the harms are very likely to outweigh any benefit, so we do think 85 is kind of the put on the brake absolute stop time. And then 75 to 84 is that shared decision time based on preference and the health of the patient.

Dr. Russell:

And we're talking about patients with a standard risk. Who are some of the people who might be at a higher risk who might need to get screened even earlier?

Dr. Wender:

John, such an important point, that part of these cancers occurring in young people actually are in young people who are at higher risk. They just didn't know it—because at age 15, 20, 25, you're not asking about family history of colon cancer and polyps in your grandparents, and hopefully you would know it in a parent or a sibling, but removal of a polyp you might not know, and that's part of the risk assessment. So if people with a family history of colon cancer or even colon polyps, particularly if they're in multiple relatives or if they occurred at a young age, if you yourself have—if patients themselves have a history of Crohn's disease or ulcerative colitis, they are at very high risk. And obviously, there are the genetic syndromes like Lynch syndrome, hereditary nonpolyposis colorectal cancer syndrome and familial adenomatous polyposis. Those are very serious circumstances where the patients need very aggressive monitoring and surveillance, and they often will cause colorectal cancer at a very, very young age. So family history is key, and people need to assess theirs at a young age.

Dr. Russell:

Does the American Cancer Society have something on their website that someone can go to look for and kind of tease out some of these things?

Dr. Wender:

Absolutely. If you go on [cancer.org](https://www.cancer.org) and you can put in colon/MD, you'll see the whole new guideline. You'll see decision tools to help counsel patients. It will clarify who's at high risk versus average risk, so there's a lot of great information available.

Dr. Russell:

So, Dr. Wender, thank you so much for being on the program today.

Dr. Wender:

Thanks, John.

Dr. Russell:

This was Clinician's Roundtable on ReachMD. For more information on others in the series, please go to [ReachMD.com/cliniciansroundtable](https://ReachMD.com/cliniciansroundtable).