A Comprehensive Review of CRC Screening Modalities Podcast Transcript

Adrian Banning:

Hello, and thank you for joining us today. My name is Adrian Banning, I'm a PA, and I'm an associate professor in the Delaware Valley PA Program in Doylestown, Pennsylvania, just outside of Philadelphia. I'm happy to be joined by PA Carol Antequera, Division of Gastroenterology, Department of Medicine, University of Miami Miller School of Medicine. You are tuning into the "Challenges in Colorectal Cancer Screening: How to Improve Screening Rates" podcast series developed by the American Academy of Physician Associates and The France Foundation, and supported by an independent educational grant from Exact Sciences.

Carol Antequera:

The goal of this series is to provide education and tools to assist PAs and other clinicians by providing the latest screening recommendations, screening modalities, and patient-centric adherence techniques to improve colorectal cancer screening rates among all patients at risk. This is the second episode in a three-part podcast series focused on screening modalities. To kick off this episode, Adrian, would you please set the background for our discussion?

Adrian Banning:

I'd love to. During this episode, we will compare and contrast available screening option details such as benefits, risks, costs, and outcomes, because you and your patients have a few choices for colorectal cancer screening, and we're going to cover them all. As a reminder from the CDC, we know that the USPSTF, or the United States Preventive Services Task Force, recommends that adults of average risk age 45 to 75 be screened for colorectal cancer. The decision to be screened between the ages of 76 and 85 are an individual decision or a case-by-case basis. Patients older than 75 should talk with their healthcare providers in a shared decision-making way. People at an increased risk of getting colorectal cancer should talk to their PCP about when to start screening, which test is right for them, and how often to get tested. So, which test is right? How do we choose? We've got five options, but really only three good ones. The three good options are colonoscopy, fecal immunochemical testing, or FIT, and FIT-DNA testing. We also have FOBT and flex sig, but we don't really love those two, right, Carol?

Carol Antequera:

That's right, Adrian. The fecal occult blood test and the flex sig really are not great options, but let's go through all of the options and this way, we can educate our fellow PAs so that they can also explain these options to their patients.

Adrian Banning:

Great.

Carol Antequera:

So, the CDC tells us that there are several screening tests that can be used to find polyps or colorectal cancer. The task force outlines the following colorectal cancer screening strategies and it is important to note that if your test result is positive or abnormal on some screening tests, such as stool test, flexible sigmoidoscopy, and CT colonography, a colonoscopy is needed to complete the screening process. So, let's discuss the stool test that we have available for colorectal cancer screening.

The first test we're going to discuss is called the guaiac-based fecal occult blood test, also gFOBT, or simply stated as FOBT. This test uses the chemical guaiac to detect blood in the stool. It is recommended to be done once a year and for this test, you do have to make some medication and dietary modifications starting one week before the test, including avoiding red meats, some vegetables, as well as medications such as non-steroidal anti-inflammatories. You can perform this test at home with using a test kit provided by your health care provider. It is done by obtaining a small stool sample and the test kit would then be returned to your doctor or a lab, where the stool sample are then checked for the presence of blood. With the annual FOBT screening, studies showed that there was about only a 33% reduction in colorectal cancer mortality.

Luckily, there have been many more advances in stool-based tests for colorectal cancer screening and the FOBT has largely been replaced by a new stool test, which has a much higher sensitivity for colorectal cancer screening. This test is known as the fecal immunochemical test, or FIT, FIT test, which can detect as little as 20 micrograms of heme per gram of feces. Now, this test also has advantages, such as it can be done at home and, even better than the FOBT test, it does not require any dietary or medication changes prior to this test. The cost can be anywhere from $0 to $22 and the sensitivity is about 79%, with a specificity of 94%. This test uses antibodies to detect blood in the stool. It is also recommended to be done once a year, similar as the FOBT. Again, one of the benefits is that you do not have to change your diet to be able to do this test, nor do you have to stop taking any of your medications.

The next stool test we're going to discuss is the multi-targeted stool DNA test, also referred to as stool DNA test. This test combines the technology of the FIT test, as well as has the ability to detect altered DNA in the stool. For this test, the patient would collect an entire bowel movement, place it in the kit, and send it back to the lab, where it is checked for altered DNA, as well as the presence of blood. This test is recommended to be done once every three years. The copay can be as low as $0. Currently, more than 80% of patients ages 45 to 49 have the option of having this screening test for a $0 out-of-pocket cost.

Moving on into our direct visualization screening modalities, let's discuss flexible sigmoidoscopy. For this test, the patient has to complete a bowel prep similar to that of a colonoscopy. The patient is then typically sedated for comfort and the gastroenterologist then inserts a thin, flexible lighted tube into the rectum and examines the lower third of the colon and rectum. This screening modality is recommended to be performed every 5 years or can be stretched out to every 10 years, as long as the patient has a FIT test done every year. One important thing to note with this testing modality, as well as our non-invasive modalities, such as our stool tests, is that all of these tests mentioned above are considered a two-step approach. This is because if any of these tests are positive or abnormal, the patient will then require a

colonoscopy for further treatment with polypectomy and biopsy. However, the issue is that only 60% to 80% of patients with a positive test will go on to have a colonoscopy.

So, let's discuss colonoscopy. The colonoscopy is similar to the flexible sigmoidoscopy, in that the patient will also require a bowel prep and will also be sedated for comfort. During the colonoscopy, the gastroenterologist will insert the thin, flexible tube into the rectum all the way to the end of the colon, which is known as the cecum and while they are in the colon, they're looking for any abnormalities that they could see, especially polyps, as well as cancers. The colorectal cancer detection rate with a colonoscopy is anywhere between 89% to 95%. The colonoscopy is the only screening modality which is both diagnostic and therapeutic. The colonoscopy only needs to be performed every 10 years for people of average risk and those that do not have any colon polyps. Although it is the most invasive of the tests and sometimes not fun for patients, if all is well and the patients are at average risk, they only have to repeat this test every 10 years.

Adrian Banning:

Carol, one of the tests that the CDC lists as a screening modality is the CT colonography or a virtual colonoscopy. Do you ever see those?

Carol Antequera:

Yes, Adrian, although very rarely, but these tests can be used as a screening modality. However, it also requires the patient to complete a bowel prep and they have to have a very good bowel prep for a good quality exam. Again, one thing to note is that if a polyp or cancer is detected while the patient is having this test, they will need to undergo a colonoscopy. However, in some cases, some patients are not good candidates for sedation or a colonoscopy, then these patients can have a CT colonography for their screening test. This test, also called computed tomography, or CT colonography, is also referred to as a virtual colonoscopy and this test uses x-rays and computers to produce images of the entire colon, which are displayed on a computer screen for the doctor to analyze. For patients who are not candidates for colonoscopy or other screening methods, they can have a CT colonography every 5 years.

So, we know that each test has their advantages and disadvantages, and this is why we say it's so important for providers to talk to patients about the pros and cons of each test and how often they need to be tested. Which test to use depends on several factors. Number one, you want to talk to your patient about their preferences. You also want to discuss any medical conditions that the patient may have. They also may have a personal or family history of colorectal cancer or colorectal polyps. Patients may also have a genetic syndrome such as familial adenomatous polyposis or hereditary nonpolyposis colorectal cancer that runs in their family. You also want to discuss with the patient the likelihood that they will actually get the test done. We know that there is a lot of resources available for testing and follow-up, we just want to make sure that the patient does the test that's right for them.

Adrian Banning:

Carol, are there any tests that you think are either overutilized or underutilized?

Carol Antequera:

That's a little more complicated than a yes or no answer, but I think I would say no. I think getting screened with any testing that the patient is willing to undergo is really the most important thing. It really cannot be stressed enough that colon cancer is preventable and that we have screening tools to help prevent it, and so the most important thing is to provide the patient with the options for screening that are feasible for them.

Adrian Banning:

So, the patient has had a conversation with you, they agree to get screened, they understand the pros and cons and what the procedure's going to be like in whichever one they choose. What about after screening? What happens if a screening test produces a positive result?

Carol Antequera:

That's when you're going to refer to a GI provider. So, if any patient has a positive stool test, either the FOBT, the FIT test, or a FIT-DNA test, the next step would be a referral to a GI provider and a colonoscopy. Unfortunately, as I mentioned earlier, only about 60 to 80% of these patients will follow through with a colonoscopy.

Adrian Banning:

So, that's really one of the places that the ball can get dropped, so to speak, that someone has an initial screening test that they agree to and did, but then if they need a colonoscopy afterwards, sometimes they don't make that appointment, for whatever reason. So, maybe it's a good idea that when you're talking to your patient initially and you agree on the initial method of screening, if it is one of the stool tests, FOBT, FIT, or FIT-DNA, that you maybe have the conversation to agree that if it comes back positive, the patient's also going to agree to the follow-up colonoscopy so they're prepared for that possibility. Would that be fair, Carol?

Carol Antequera:

Yes, absolutely.

Adrian Banning:

So, they have a screening test, one of the screening tests that's not colonoscopy, it comes back positive, they need a colonoscopy, and we're going to refer them to a GI. Any GI specialist?

Carol Antequera:

Yes, any GI specialist would be able to perform a colonoscopy for a patient.

Adrian Banning:

Great. As the primary care provider, what can you expect as a wait time for your patient to get seen by GI, what's realistic?

Carol Antequera:

Well, I think wait times can vary depending on the location, as well as the availability of the providers in the area. However, this should not discourage anyone from referring their patient to a GI provider or having that patient make an appointment. But typically, I think a few weeks to maybe 1 or 2 months is what I've seen, for the most part. However, patients can always reach out to their primary care provider to help them expedite an appointment.

Adrian Banning:

What's too long, though? How quickly do we need a patient to be seen, if a stool test or stool DNA screening comes back positive?

Carol Antequera:

So, ideally, we want our patients to be seen as soon as possible. So, again, we want them to be seen within those first few weeks. Hopefully, they don't have to wait more than 1 to 2 months, however we know that appointments sometimes can take a little bit with specialists. So, as a primary care PA, I think it's very important to stress that we want to make sure that we follow-up with our patients and make sure that they've made that appointment and that they keep their appointment. If they're having any difficulties in getting an appointment, they can reach out to those GI providers in the community to also help expedite the appointment.

Adrian Banning:

As primary care providers, we can reach out to you, too? How do you feel about it when primary care providers reach out to you directly?

Carol Antequera:

So, as part of the health care team, GI providers, they want to help your patients get screened and followed-up, so that they don't mind, actually, if you reach out to them directly, that way, we can help facilitate screening and follow-up. If patients are found to have cancer or abnormalities after colonoscopy, typically, the GI provider will also communicate back with the primary care provider, as well as other specialists, to ensure that the patient is transitioned to the appropriate provider. So, for example, if a GI provider finds that a patient has cancer or cancerous lesion, they also enlist the help of the colorectal surgeon, as well as the oncology team, who are often consulted, and a referral is made for these patients to be seen also as soon as possible. So, we really do work in a multidisciplinary approach, so we're happy to hear from our primary care counterparts.

Adrian Banning:

Sounds good. It's always good to know when you're picking up that phone that the person on the other end is happy to hear from you. Well, that is going to conclude episode two of our three-part series. I want to thank you for tuning in and joining us and please join us for episode three, where we will discuss the patient communication behind these sometimes confusing or stressful conversations about

colorectal cancer screening. Specifically, we're going to talk about shared decision-making, patient decision tools, and breaking bad news. As a reminder, listening to this podcast makes you eligible to receive CME. To receive CME credit, you must complete the posttest and evaluation in AAPA's Learning Central. Take care.