



2008 Consensus Guidelines on the Early Detection of Colorectal Cancer and Adenomatous Polyps

American Cancer Society

U.S. Multisociety Task Force on Colorectal Cancer

American College of Radiology



Organizations

- American Cancer Society
- American College of Radiology
- U. S. Multi-Society Task Force on Colorectal Cancer
 - American Gastroenterological Association
 - American College of Gastroenterology
 - American Society of Gastrointestinal Endoscopists
 - American College of Physicians



Overview of Presentation

- Guidelines review – process
- Evidence review
- Panel recommendations/updated guidelines
- FAQs



History of ACS CRC Screening Guidelines

- 1980 – ACS issued first formal CRC screening guidelines for average-risk adults
- Guidelines updated periodically since then
- 1997 – Recommendations for high-risk individuals added
- 2003 – last prior update; added fecal immunochemical test (FIT) to menu of options; assessed CTC and stool DNA and found insufficient evidence to support their inclusion



CRC Screening Guidelines: Process

- Expert panel representing multiple organizations: ACS, U.S. Multi-Society Task Force (mostly GI orgs.) and the American College of Radiology
- Also in regular communication with U.S. Preventive Services Task Force
- Multi-organizational consensus guidelines reduce confusion among health professionals and public, but achieving consensus is a challenge (turf, conflicts of interest, different approaches to evidence, and different organizational approvals process)

It is worth the effort, but it takes longer



CRC Screening Guidelines: Process

- Expert panel reviewed and deliberated on available evidence during 2 face-to-face meetings and a series of conference calls
- Literature published between January 2002 and January 2008, as well as unpublished abstracts and manuscripts, were reviewed by panel



CRC Screening Guidelines: Evidence Review

Reassessed evidence for tests in two broad categories:

1. Tests that are more likely to detect both cancer and premalignant polyps

Flexible sigmoidoscopy, colonoscopy, double contrast barium enema, CT colonography (also known as virtual colonoscopy)

2. Tests that are primarily effective at finding cancer early

Fecal (stool) tests include: guaiac-based and immunochemical-based fecal occult blood tests (gFOBT & FIT), and stool DNA test (sDNA)



CRC Screening Guidelines: Evidence Review

- New recommendations provide information on quality issues related to each form of testing.
- An overriding goal of this update is to provide a practical guideline for physicians and the public to assist with informed decision making related to colorectal cancer screening.



CRC Screening Guidelines: What's New

Groups screening tests into two categories:

- Those that detect cancer and precancerous polyps*
- Those that primarily detect cancer

*It is the strong opinion of the ACS CRC Advisory Group that *colon cancer prevention* should be the primary goal of CRC screening. Exams that are designed to detect both early cancer and precancerous polyps should be encouraged if resources are available and patients are willing to undergo an invasive test.



CRC Screening Guidelines: What Else is New?

- Two new tests recommended:
 - stool DNA (sDNA) and
 - computerized tomographic colonography (CTC) – sometimes referred to as virtual colonoscopy
- Establishes a sensitivity threshold for recommended tests
- Delineates important quality-related factors for each form of testing

New CRC Screening Guidelines

Adults age 50 and older

Tests That Detect Adenomatous Polyps and Cancer

	Flexible sigmoidoscopy (FSIG) every 5 years, or
	Colonoscopy every 10 years, or
	Double contrast barium enema (DCBE) every 5 years, or
	CT colonography (CTC) every 5 years

Tests That Primarily Detect Cancer

	Annual guaiac-based fecal occult blood test (gFOBT) with high test sensitivity for cancer, or
	Annual fecal immunochemical test (FIT) with high test sensitivity for cancer, or
	Stool DNA test (sDNA), with high sensitivity for cancer, interval uncertain



CRC Guidelines – Options Emphasized

- Guidelines continue to emphasize options because:
 - Individuals differ in their preferences for one test or another
 - Primary care physicians have differed in their ability to offer, explain, or refer patients to all options equally
 - Access is uneven geographically, and in terms of test charges and insurance coverage
 - Uncertainty exists about performance of different screening methods with regard to benefits, harms, and costs



CRC Guidelines – Options Emphasized

- Guidelines continue to emphasize options because:
 - The uptake of screening for colorectal cancer has been disappointingly slow.
 - Given the evidence for a range of preferences and variable access, there has been collective agreement that options would enhance uptake.
 - “The best test is the one you get that is *done well.*”



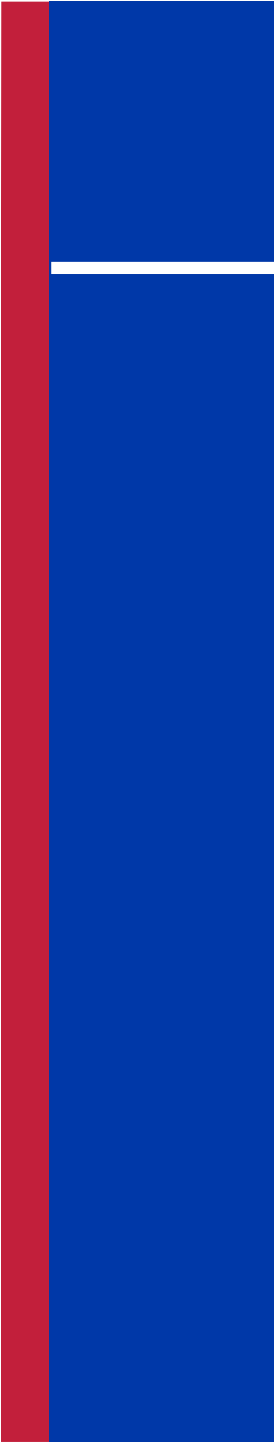
If tests that can prevent CRC are preferred, why not recommend them alone?

- Greater patient requirements for successful completion
 - Require a bowel prep and an office or hospital visit
- Various levels of risk to patients
- Test limitations
- Patient preference – don't want an invasive test that requires a bowel prep, may prefer to have screening in the privacy of their home, or may not have access to the invasive tests due to lack of coverage or local resources.



Are these tests covered by insurance?

- With the exception of the newly added tests, Medicare and most insurers already cover most or all colorectal cancer screening tests.
- Based on these recommendations from the ACS and those of other organizations it is conceivable that major insurance plans will begin to cover the added tests (CTC, and stool DNA).
- As a result, these updated guidelines have a real possibility of contributing to greater access to colorectal cancer screening tests.



How will these guidelines help reduce deaths from CRC?

- Screening of average risk individuals can reduce CRC deaths by detecting cancer at an early curable stage, and by detecting and removing advanced neoplasia.
- It is our hope that these new recommendations facilitate increased rates of CRC screening, and that referring clinicians find these new guidelines ease some of the challenges they have experienced in promoting CRC screening to their patients.



Thank You!
