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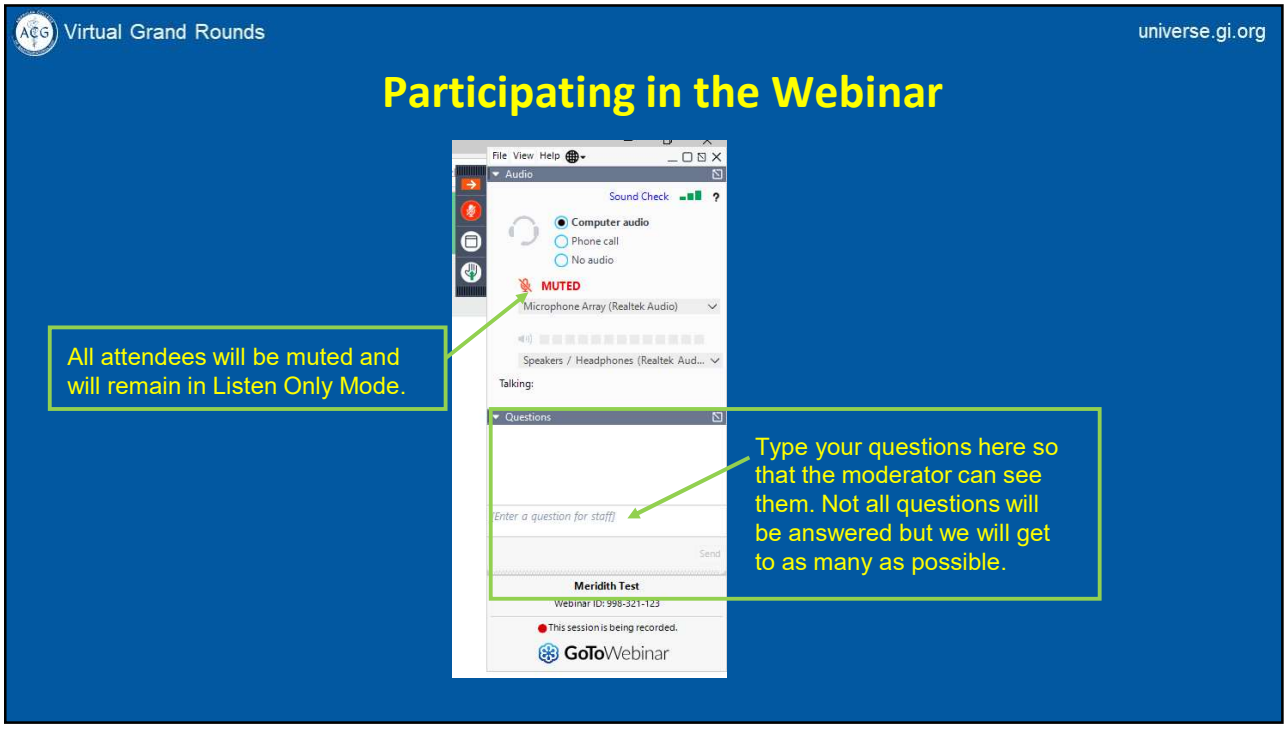
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Type your questions here so that the moderator can see them. Not all questions will be answered but we will get to as many as possible.
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How to Receive CME and MOC Points

LIVE VIRTUAL GRAND ROUNDS WEBINAR

ACG will send a link to a CME & MOC evaluation to all attendees on the live webinar.

ABIM Board Certified physicians need to complete their MOC activities by December 31, 2023 in order for the MOC points to count toward any MOC requirements that are due by the end of the year. No MOC credit may be awarded after March 1, 2024 for this activity.

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MOC QUESTION

If you plan to claim MOC Points for this activity, you will be asked to: Please list specific changes you will make in your practice as a result of the information you received from this activity.

Include specific strategies or changes that you plan to implement.
THESE ANSWERS WILL BE REVIEWED.

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ACG Virtual Grand Rounds
Join us for upcoming Virtual Grand Rounds!
Week 12 – Thursday, March 23, 2023
Lynch Syndrome Awareness: Historical and Current Approaches to Identifying Individuals With Lynch Syndrome
Faculty: Peter Stanich, MD; and Heather L. Hampel, MS, CGC
Moderators: Julie L. Yang, MD; and Elana Levinson, MS, CGC
Host: Jessica Long, MD, CGC
At Noon and 8pm Eastern
Week 13 –Thursday, March 30, 2023
Colon Polypectomy Techniques: Big Polyps, Small Polyps, and Everything in Between
Faculty: Charles J. Kahi, MD, MSc, FACG
Moderator: Jennifer K. Maratt, MD
At Noon and 8pm Eastern
Please NOTE: there will be no ACG Virtual Grand Rounds on April 6 and 13 due to low attendance from Spring Breaks.
Visit gi.org/ACGVGR to Register

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Disclosures

Aasma Shaukat, MD, MPH, FACG

Iterative Scopes Inc.: Advisory Board
Freenome: Consultant
Medtronic: Consultant
Motus GI: Consultant

Janice Cheong, MD

Dr. Cheong has no financial relationships with ineligible companies.

**All of the relevant financial relationships listed for these individuals have been mitigated*

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CRC Screening: How Can We Improve?

Aasma Shaukat, MD, MPH
Director GI Outcomes Research
Robert M. and Mary H. Glickman Professor of Medicine
Professor of Population Health
NYU Grossman School of Medicine

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- National Women History Month
- National Peanut Month
- National Caffeine Awareness Month
- Irish American Heritage Month

- Fun fact: March and November dates fall on the same days of the week
- National Colon Cancer Awareness Month

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Administratio

FEBRUARY 28, 2023

A Proclamation on National Colorectal Cancer Awareness Month, 2023

BRIEFING ROOM › PRESIDENTIAL ACTIONS

During National Colorectal Cancer Awareness Month, we call attention to the second leading cause of cancer deaths in America — by sharing information about risk factors, promoting life-saving early screenings, and improving access to affordable treatment. In remembrance of every life cut short by this devastating disease, my Administration is determined to end cancer as we know it.

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Objectives

- Review recent trends in Colorectal cancer (CRC) Incidence in the US
- Updates on recent evidence on CRC Screening
- Improving adherence to CRC screening
- Current and future options for CRC screening
- Take home points

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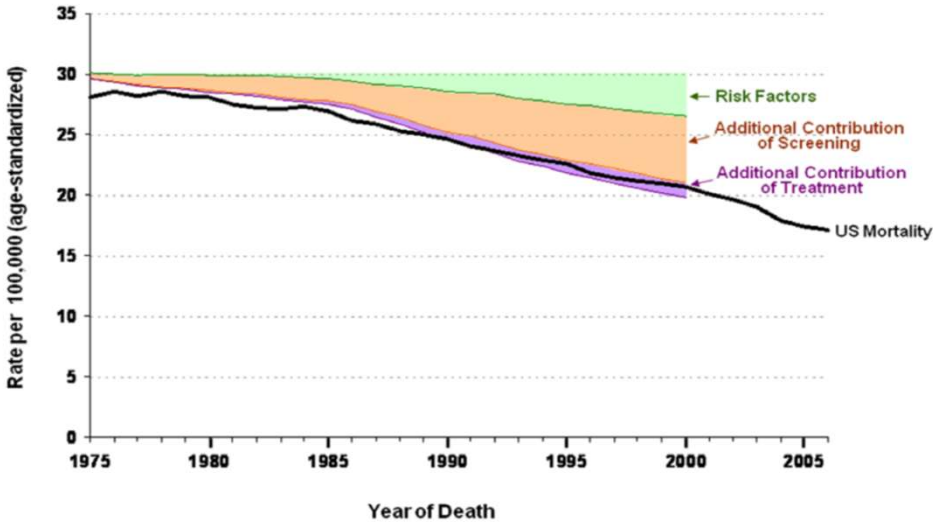
CRC Mortality Over Time



Robertson DJ, et al. Gastroenterology. 2019;156:904-917.

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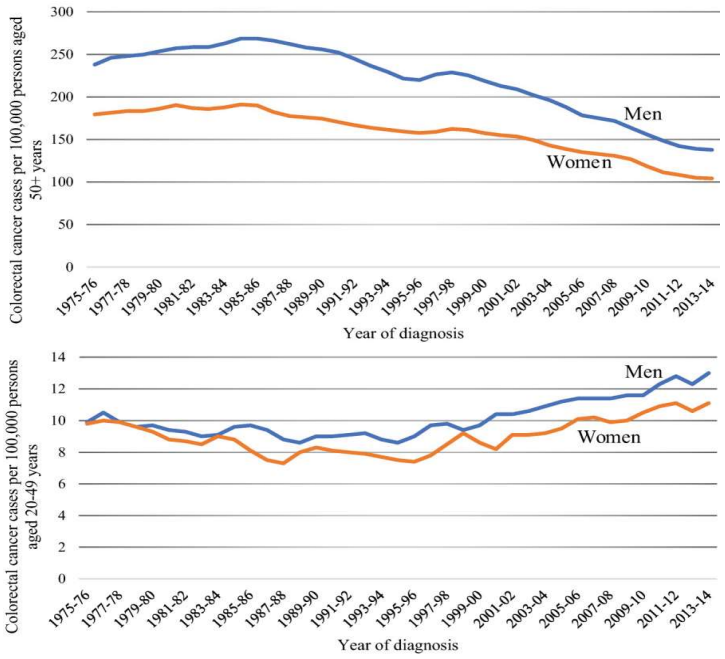
CRC Incidence



Siegel RL et al. J Natl Cancer Inst. 2017;109(8):27-32

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When Should Screening Start For CRC?

ACG

- Recommended in all adults 50 to 75 years of age
- Suggest in all average risk adults 45 to 49 years of age
- Recommend decision to screen after 75 be individualized

USPSTF

- Recommended in all adults 50 to 75 years of age
- Recommended in adults 45 to 49 years of age
- Recommended that clinicians selectively offer screening in adults 76-85 years of age

MSTF

- Suggested to all average-risk adults ages 45 to 49
- For adults ages 76 to 85, the decision to start or continue screening should be individualized and based on prior screening history, life expectancy, CRC risk, and personal preference
- Screening is not recommended after age 85

Shaukat A. et al ACG Clinical Guidelines: AJG 2021;116:458-479; USPSTF. JAMA. 2021;325:1965-1977. Patel SG, et al. Am J Gastro. 2022. 117:57-69.

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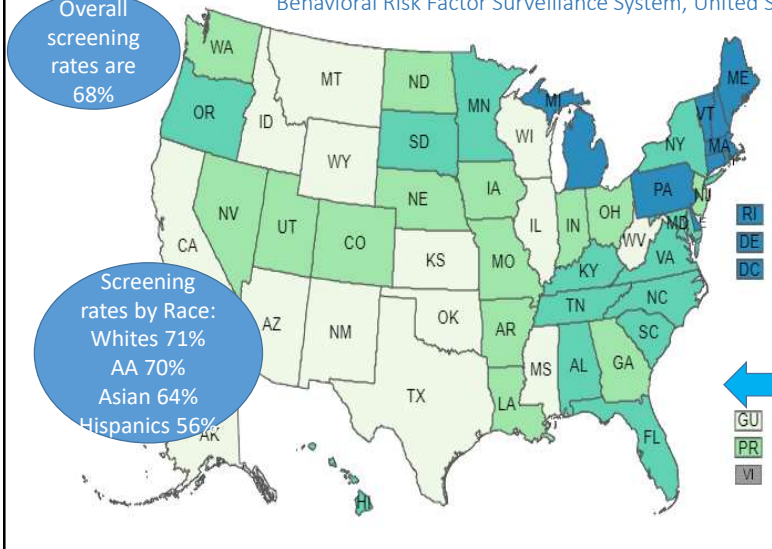
2020: Percentage of Adults 50–75 Years fully meeting USPSTF recommendation for CRC Screening, by State

Behavioral Risk Factor Surveillance System, United States, 2020

Overall screening rates are 68%

Screening rates by Race: Whites 71% AA 70% Asian 64% Hispanics 56%



Health Insurance: Yes 71% No 40%

Regular HCP: Yes 73% No 36%

21 million adults 45-49 yrs

Crude Prevalence (%)

- 53.9 - 70.9
- 71.0 - 74.3
- 74.4 - 77.1
- 77.2 - 81.2
- Data unavailable

Quantile

Legend Settings

Joseph DA, et al. MMWR Morb Mortal Wkly Rep 2020;69:253–259.

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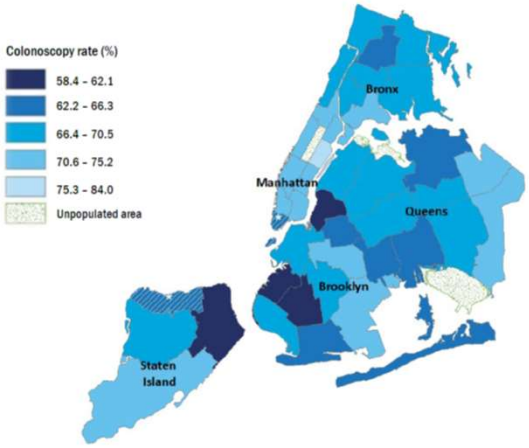
CRC Screening NYC

Prevalence of timely colonoscopy among adults ages 50 and older, by race and ethnicity, New York City, 2003 and 2018

Timely colonoscopy is defined as having had a colonoscopy in the past 10 years. Comparison is not available for stool-based tests.
White, Black, Asian/Pacific Islander (API) race categories exclude Latino/a ethnicity. Latino/a includes Hispanic or Latino/a of any race.
Source: New York City Community Health Survey, 2003 and 2018

Prevalence of timely colonoscopy among New York adults ages 50 and older, by United Hospital Fund neighborhood, 2014 - 2018



NYC DOHMH Bureau of Vital Statistics: New York City Department of Health and Mental Hygiene. 2003, 2013 – 2017.

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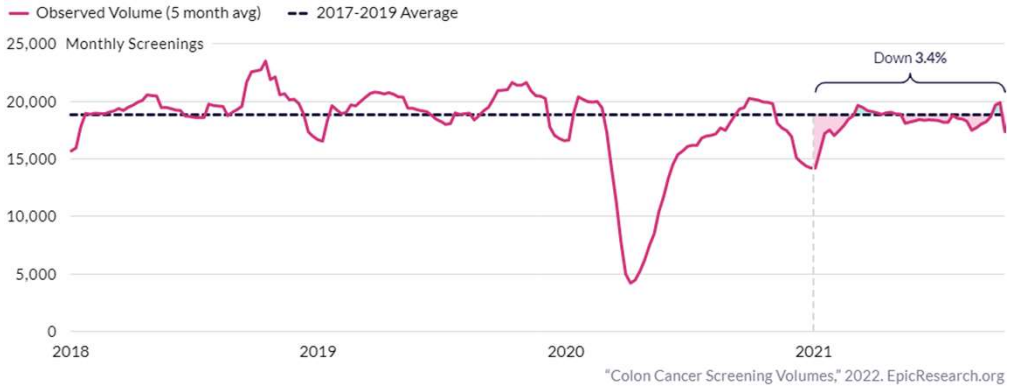
CRC Screening Volumes Still Low

- Data come from Cosmos, a HIPAA-defined Limited Data Set of more than 126 million patients from 156 Epic organizations including 889 hospitals and 19,420 clinics, serving patients in all 50 states



Sharp Declines in Breast and Cervical Cancer Screening. Centers for Disease Control and Prevention. https://www.cdc.gov/media/releases/2021/p0630-cancer-screenings.html

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What do we need to Build?

And who will come?

- **Newly Eligible + Overdue+ never screened**
- **Endoscopic capacity+ Access**
- **Ensuring Health Equity**

What got us here may not be enough to get us there

80% in every Community

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CRC Screening Options

Modality	Sensitivity CRC	Sensitivity AA	Specificity	Invasive	USPSTF	M
Colonoscopy	96%	95%	90%	Y	Y	
FIT	74%	24%	96%	N	Y	Y
mtsDNA stool	92%	42%	87%	N	Y	Y
Septin-9	48%	-	91%	N	N	Y
Liquid Biopsy	-	-	-	N	TBD	TBD

Adherence is Key

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Adherence is Key

The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

Effect of Colonoscopy Screening on Risks of Colorectal Cancer and Related Death

M. Bretthauer, M. Løberg, P. Wieszczy, M. Kalager, L. Emilsson, K. Garborg, M. Rupinski, E. Dekker, M. Spaander, M. Bugajski, Ø. Holme, A.G. Zauber, N.D. Pilonis, A. Mroz, E.J. Kuipers, J. Shi, M.A. Hernán, H.-O. Adami, J. Regula, G. Hoff, and M.F. Kaminski, for the NordICC Study Group*

- Adherence to colonoscopy: 42%
- CRC incidence risk reduction 18%
- NS difference in CRC mortality and all cause mortality

- Emphasizes importance of adherence
- Quality of Colonoscopy
- Underpowered for CRC Mortality difference
- Put in context with other data
- **Message**: Don't let patients be discouraged

or dissuaded

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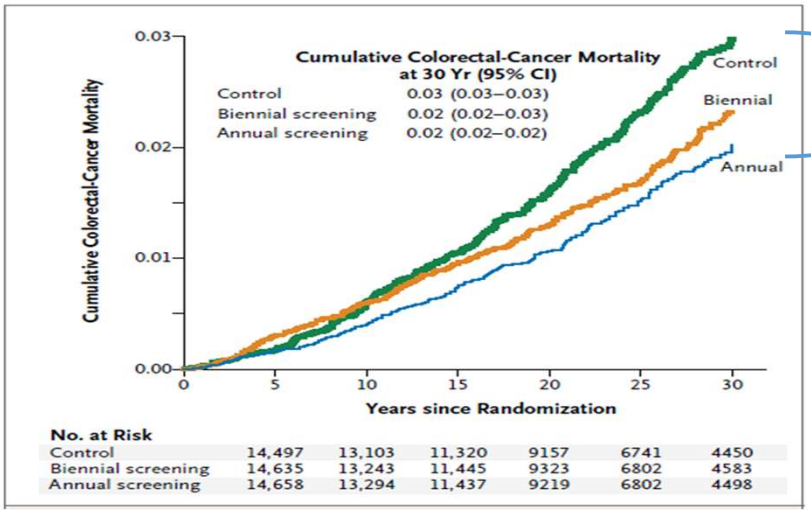
ORIGINAL ARTICLE

universe.gi.org

Long-Term Mortality after Screening for Colorectal Cancer

Aasma Shaukat, M.D., M.P.H., Steven J. Mongin, M.S., Mindy S. Geisser, M.S., Frank A. Lederle, M.D., John H. Bond, M.D., Jack S. Mandel, Ph.D., M.P.H., and Timothy R. Church, Ph.D.



33% sustained reduction in crc mortality; 89% adherence to 1+ stool test

Shaukat A et al. NEJM 2013; 369 (12): 1106-1114

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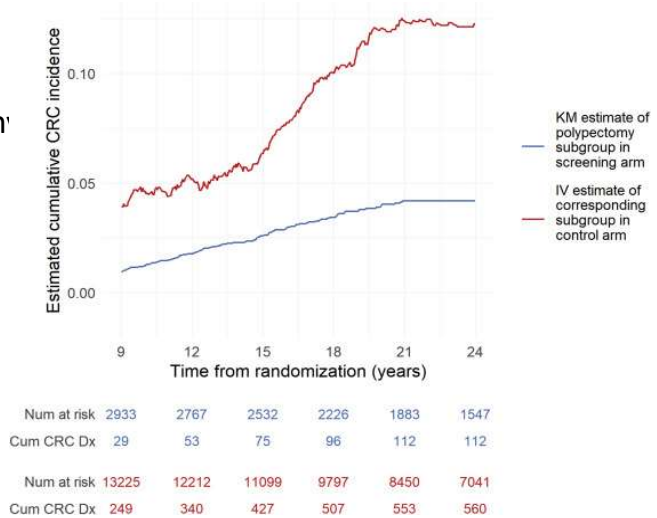
How Effective is Polypectomy?

- Minnesota Screening trial n=46,551
- gFOBT+→Colonoscopy and polypectom
- Instrumental variable approach
- Polypectomy -->CRC incidence
- Any polypectomy **67%**↓in CRC risk

(95% CI 0.23–0.48)

- Adenomatous or advanced histology polyps: 70%↓ in CRC risk

(95% CI 0.20–0.44)



Shaukat A, et al. Colonoscopy With Polypectomy Reduces Long-Term Incidence of Colorectal Cancer in Both Men and Women: Extended Results From the Minnesota Colon Cancer Control Study. Gastroenterology. 2021;160(4):1397-1399

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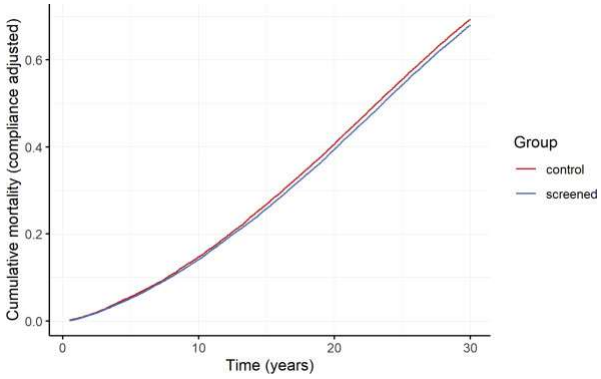
CRC Screening Reduces All-Cause Mortality

- Reduced all-cause mortality by 2% (RR, 0.98; 95% CI, 0.97–0.99)



Shaukat A et al. Effects of Screening Compliance on Long-term Reductions in All-Cause and Colorectal Cancer Mortality. CGH 2021;19:967-975

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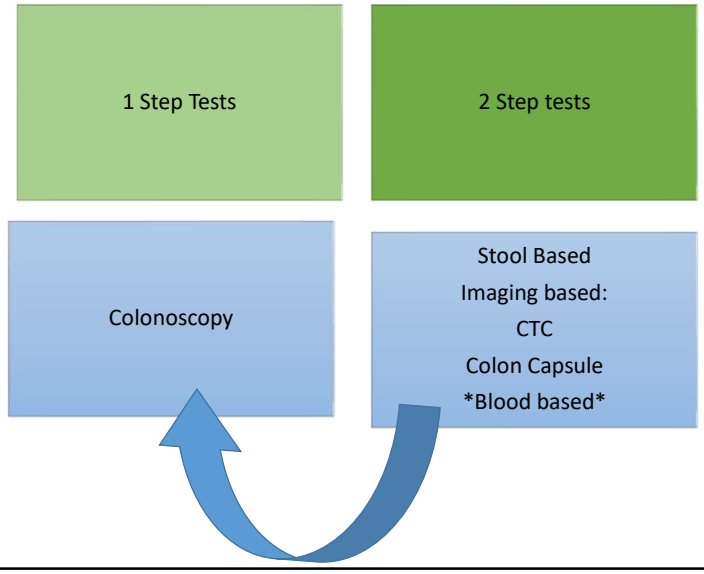
Approach to Colon Cancer Screening



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ACG Clinical Guidelines: Colorectal Cancer Screening 2021

Aasma Shaukat, MD, MPH, FACG[1,2], Charles J. Kahi, MD, MSc, FACG[3-7], Carol A. Burke, MD, FACG[4], Linda Rabeneck, MD, MPH, MACG[5], Bryan G. Sauer, MD, MSc, FACG (GRADE Methodologist)[6] and Douglas K. Rex, MD, MACG[3]

19. We recommend organized screening programs to improve adherence to CRC screening compared with opportunistic screening.

Strong recommendation; low-quality evidence

20. We suggest the following strategies to improve adherence to screening: patient navigation, patient reminders, clinician interventions, provider recommendations, and clinical decision support tools.

Conditional recommendation; very low-quality evidence

ACG Clinical Guidelines: AJG 2021;116:458-479;

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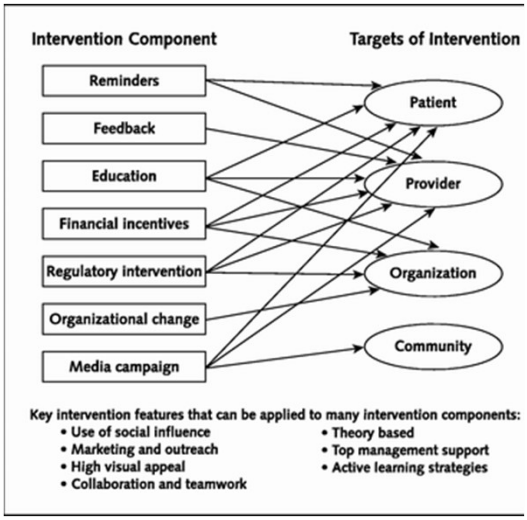
Framework for Improving Adherence



Stone EG et al. Interventions That Increase Use of Adult Immunization and Cancer Screening Services: A Meta-Analysis. Ann Intern Med. 2002;136:641–651

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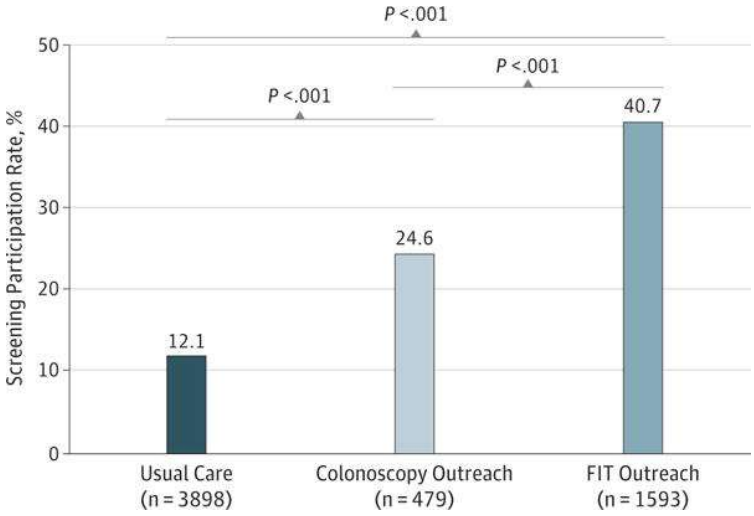
Outreach with Colonoscopy vs. FIT vs. Usual Care



Gupta et al. JAMA Internal Medicine 2013;173:1725-1732

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Organized Screening Program Improves Adherence

- Kaiser Permanente Northern California
- Screening before and after proactive outreach program (FIT and colonoscopy)
- 2000 to 2015

	Before	After	Absolute change
Adherence	38%	82%	+44%
CRC incidence	95 per 100,000	71 per 100,000	-24%
CRC Mortality	30 per 100,000	14 per 100,000	-52%

Levin TR et al. Gastroenterology 2018;155:1383-91

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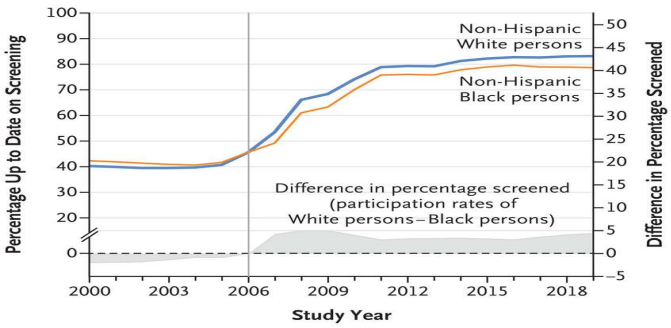
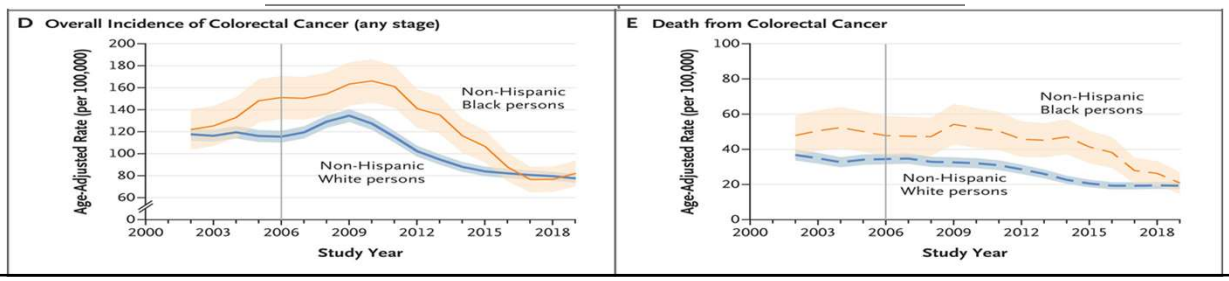
Adherence is Key to Health Equity



Doubeni et al. N Engl J Med 2022; 386:796-798



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CDC Community Guide

Intervention/activities	Definition
Evidence-based interventions	
Client reminders	Text-based (i.e., letter, postcard, e-mail) or telephone messages advising people that they are due (reminder) or overdue (recall) for screening.
Provider reminders	Prompts to inform healthcare providers that it is time for a patient's cancer screening test (reminder) or that the patient is overdue for screening (recall).
Provider assessment and feedback	Evaluation of provider performance in offering and delivering screening to patients (assessment) and sharing the results with providers (feedback).
Reducing structural barriers	Reducing or eliminating noneconomic burdens or obstacles that impede access to screening by addressing things such as distance to service delivery (e.g., modifying clinic hours, offering services in alternative or nonclinical settings) or administrative procedures.
Supporting activities	
Small media	Distribution of videos and printed materials such as letters, brochures, and newsletters.
Patient navigation	Individualized assistance offered to patients to help overcome healthcare system barriers and facilitate timely access to quality screening, follow-up, and initiation of treatment if diagnosed with cancer.
Professional development/provider education	Interventions such as distribution of educational materials or continuing medical education directed at healthcare staff and providers to increase their knowledge and to change attitudes and practices around cancer screening.
Community Health Workers (CHW)	Community-based workers have a deep understanding of and are often from the community they serve. CHWs educate people about and promote cancer screening and provide peer support to people referred to cancer screening.
Other	
Clinic screening policy	A screening policy in clinics or health systems includes a defined set of guidelines and procedures in place and in use to support CRC screening, a team responsible for implementing the policy, and a quality assurance structure.
Screening champion	A champion is an individual who takes a leadership role in a public health effort. Other variables include frequency of monitoring the CRC screening rate and frequency of implementation support provided to the clinic.

Cancer Prevention and Control | The Community Guide https://thecommunityguide.org/topic/colorectalcancer

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Preferred CRC Screening Tests Among 1,000 Unscreened Americans

	US MSTF Five Recommended Tests					US MSTF Tier 1 Tests	
	MULTITARGET STOOL DNA TEST EVERY 3 YEARS	COLON VIDEO CAPSULE EVERY 5 YEARS	COLONOSCOPY EVERY 10 YEARS	FIT EVERY YEAR	COLON CT SCAN EVERY 5 YEARS	FIT EVERY YEAR	COLONOSCOPY EVERY 10 YEARS
40-49 yo	34.6%	28.2%	13.7%	12.2%	11.3%	68.9%	31.1%
≥50 yo	37.3%	22.9%	13.6%	18.7%	7.6%	77.4%	22.6%

Makaroff KE et al. Patient Preferences for Colorectal Cancer Screening Tests in Light of Lowering the Screening Age to 45 Years, *Clinical Gastroenterology and Hepatology* (2022). DOI: 10.1016/j.cgh.2022.07.012

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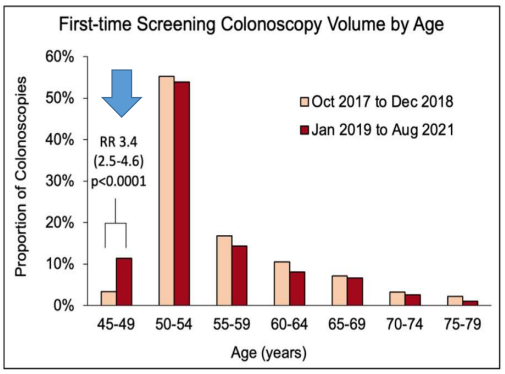
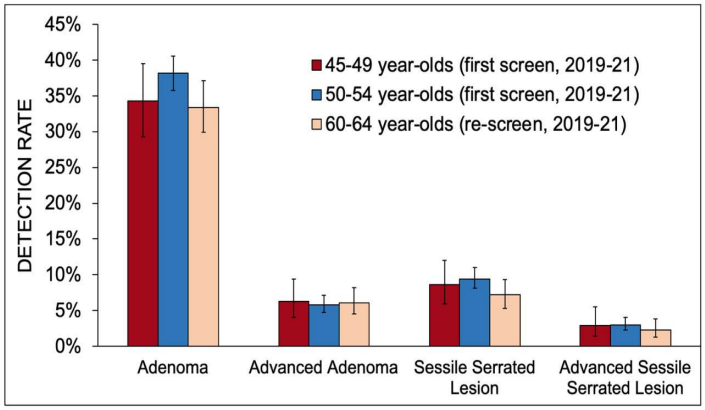
Colonoscopy volume and lesion detection rates in 45-49 year-olds

- Modest increase in proportion of first-time screening colonoscopies at ages 45-49
- Yield comparable to ages 50-54 at first-time screening and ages 60-64 at repeat screening





Ladabaum et al. Adenoma and Sessile Serrated Lesion Detection Rates at Screening Colonoscopy for Ages 45–49 Years vs Older Ages Since the Introduction of New Colorectal Cancer Screening Guidelines. 2022 DOI:https://doi.org/10.1016/j.cgh.2022.04.037

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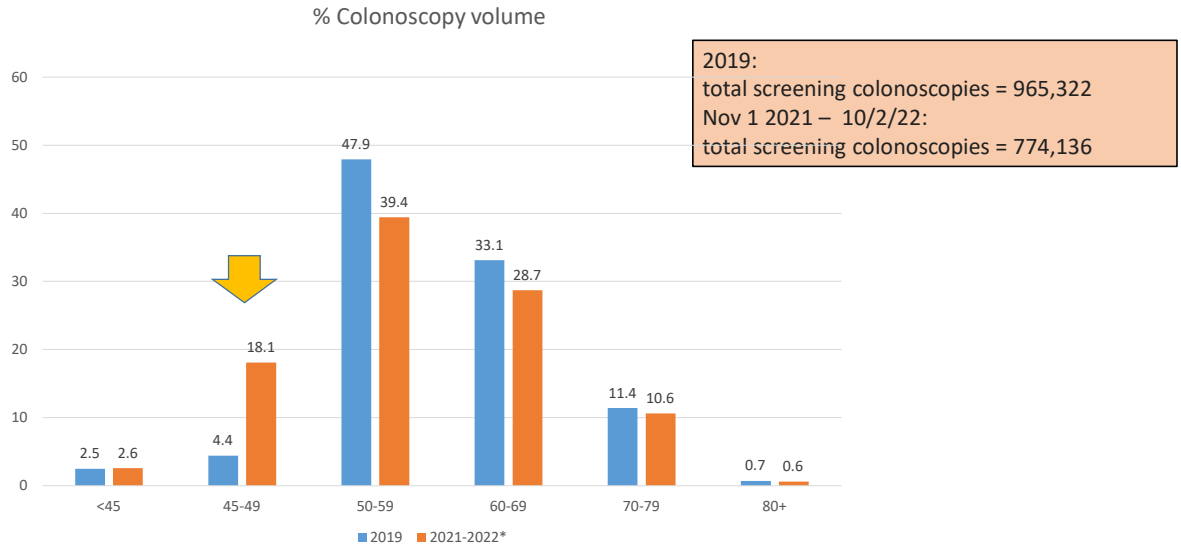
Screening Colonoscopy Volume Trends GIQUIC



Unpublished data

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Future Trends

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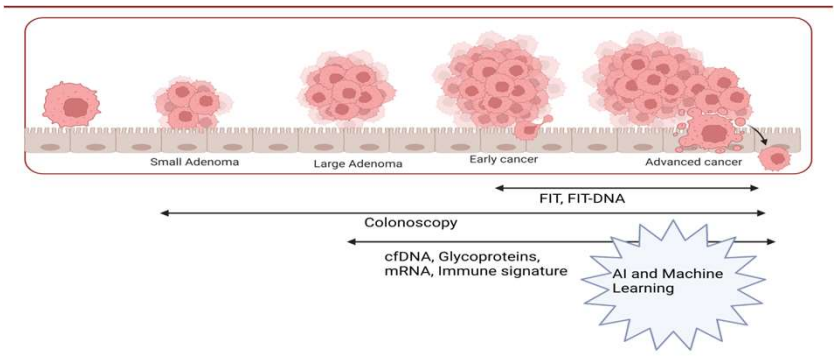
Blood Based CRC Screening Tests



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Test	Details of Technology	Special Considerations	Expected Completion
Stool and blood based			
Clinical genomics	Stool and blood-based biomarker (NCT00843375) for CRC and AN	Study plans to recruit 1800 average risk individuals 18 years+	♦ 2022
Blood-Based			
Freenome	Cell free DNA plus artificial intelligence for CRC and AN (NCT04369053)	Aims to recruit 25,000 average risk individuals between 45-85	♦ 2022
Guardant	ctDNA LUNAR test to detect cell free tumor DNA in blood (NCT04136002)	Aims to recruit 10,000 average risk individuals between 45-84 years	♦ 2022
CancerSEEK	Multi-cancer detection test for 8 common cancers, including CRC Detects circulating proteins and mutations in circulating tDNA	(NCT04213326) has enrolled 6399 cancer free as well as individuals with cancer, ages 50 and older since 2019	♦ 2022
GRAIL	♦ Multi-cancer early detection test (breast, colorectal, pancreatic, lung and hematologic malignancies)	♦ In validation study, specificity 99.5%, sensitivity for cancer 51.5% ♦ Ongoing prospective validation study with 6,600	♦ Not covered by insurance and the list price is $949

Shaukat, A., Levin, T.R. Current and future colorectal cancer screening strategies. *Nat Rev Gastroenterol Hepatol* (2022). https://doi.org/10.1038/s41575-022-00661-3

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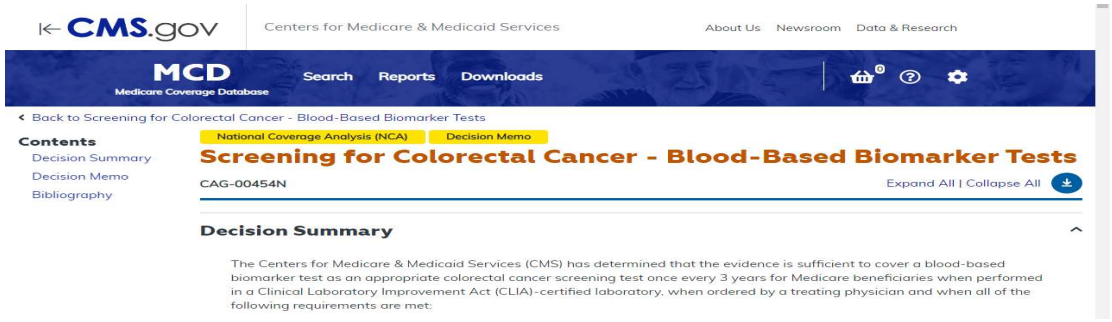
Setting the Bar: CMS National Coverage Decision



Sensitivity for CRC	74%
Specificity for CRC	90%
FDA approval	✓

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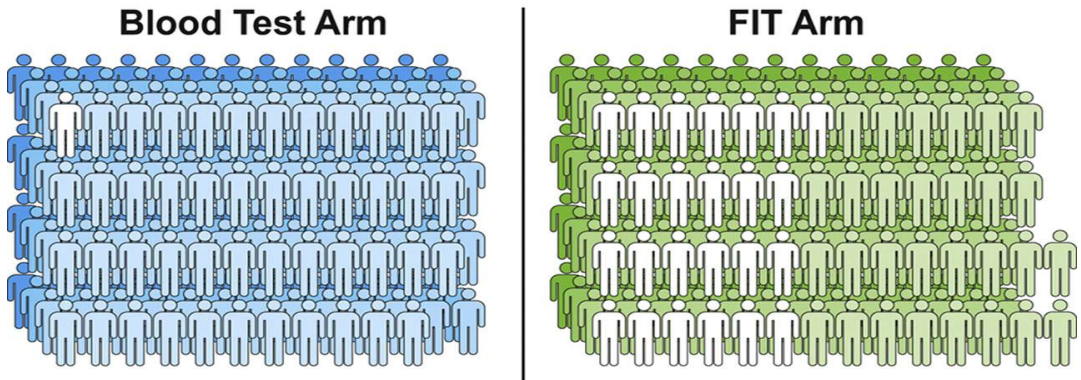
Adherence to Blood Based Tests

413 randomized adults



= a difference of **11.4%** (CI95: 6.9%-15.9%, p<.001)

Liles EG et al. Uptake of a colorectal cancer screening blood test is higher than of a fecal test offered in clinic: A randomized trial. 2017 Cancer Treatment and Research Communications;10: 27-31

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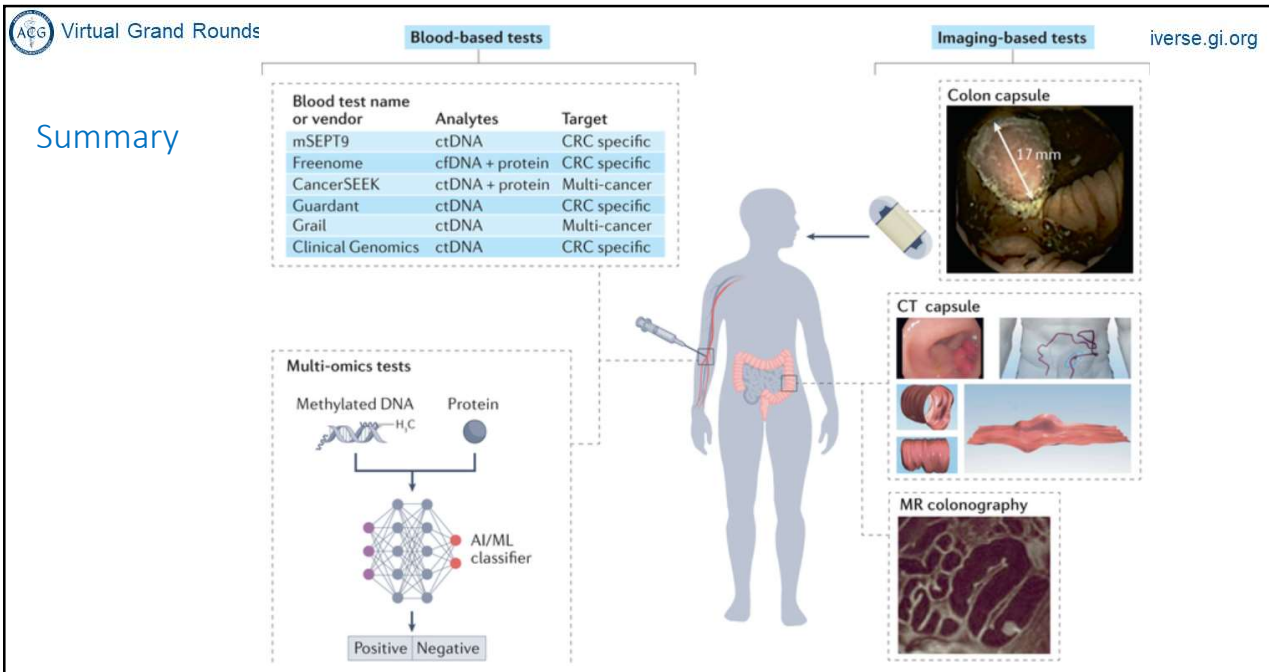
Summary



Shaukat, A., Levin, T.R. Current and future colorectal cancer screening strategies. *Nat Rev Gastroenterol Hepatol* (2022). https://doi.org/10.1038/s41575-022-00612-y

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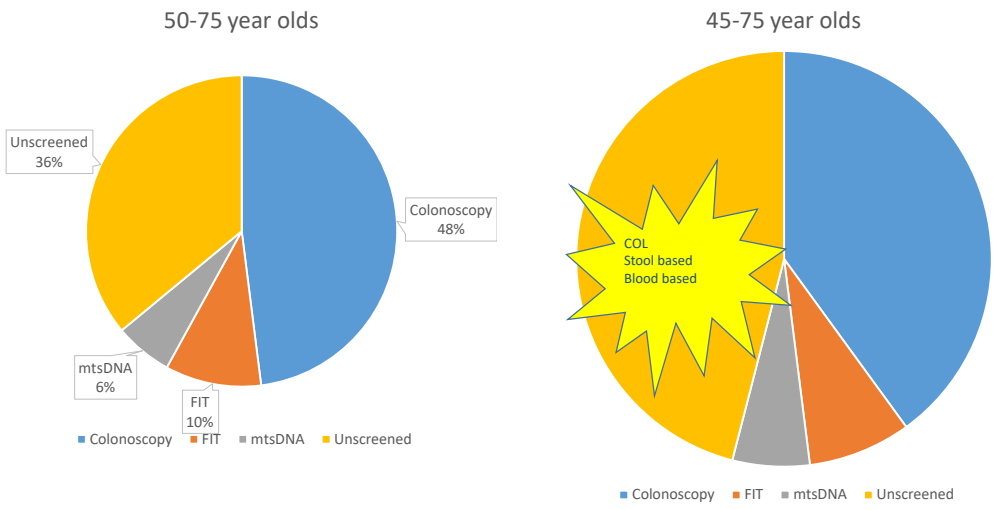
CRC Screening: Pie Gets Larger!



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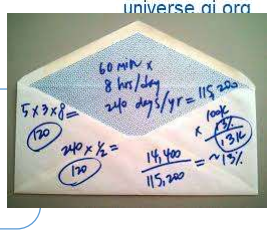
Back of the Envelope Calculations



Current

- 100 million 50-75
- 67 million screened; 33million unscreened
- 20 million 45-49 unscreened
- 53 million unscreened

Colonoscopy offered only

- Adherence of 50%
- 26 million colonoscopies needed
- Current US capacity is 18 million/year

Col +Non invasive tests offered

- Adherence 80%; 7% abnormal initial test
- 42 million screened; 2.9 million positive test→ Colonoscopy
- Over 10 years: 29 million colonoscopies
- Higher neoplasia yield (and more surveillance exams)

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Getting to 80% in Every Community

- Education/ awareness
- Removing barriers
- Research
- Advocacy
- Public Policy

- Covering Screening age 45
- Removing barriers to CRC screening Act 2020
- No Surprise Act 2022

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Summary

- Screening for CRC is effective, current rates at 70%
- Programmatic approaches are needed to identify unscreened
- Adherence is key
- Demand for Colonoscopy will increase, indication may shift to surveillance

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Thank you!

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Questions?

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