Screening for Colon Cancer: How best and how effective?

Richard Rosenberg, MD
Assistant Professor of Medicine
Columbia University Medical Center
Colorectal Cancer Overview

Leading Sites of New Cancer Cases and Deaths – 2009 Estimates

### Estimated New Cases*

<table>
<thead>
<tr>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prostate</td>
<td>Breast</td>
</tr>
<tr>
<td>192,280 (25%)</td>
<td>192,370 (27%)</td>
</tr>
<tr>
<td>Lung &amp; bronchus</td>
<td>Lung &amp; bronchus</td>
</tr>
<tr>
<td>116,090 (15%)</td>
<td>103,350 (14%)</td>
</tr>
<tr>
<td>Colon &amp; rectum</td>
<td>Colon &amp; rectum</td>
</tr>
<tr>
<td>75,590 (10%)</td>
<td>71,380 (10%)</td>
</tr>
<tr>
<td>Urinary bladder</td>
<td>Uterine corpus</td>
</tr>
<tr>
<td>52,810 (7%)</td>
<td>42,160 (6%)</td>
</tr>
<tr>
<td>Melanoma of the skin</td>
<td>Non-Hodgkin lymphoma</td>
</tr>
<tr>
<td>39,080 (5%)</td>
<td>29,990 (4%)</td>
</tr>
<tr>
<td>Non-Hodgkin lymphoma</td>
<td>Melanoma of the skin</td>
</tr>
<tr>
<td>35,990 (5%)</td>
<td>29,640 (4%)</td>
</tr>
<tr>
<td>Kidney &amp; renal pelvis</td>
<td>Thyroid</td>
</tr>
<tr>
<td>35,430 (5%)</td>
<td>27,200 (4%)</td>
</tr>
<tr>
<td>Leukemia</td>
<td>Kidney &amp; renal pelvis</td>
</tr>
<tr>
<td>25,630 (3%)</td>
<td>22,330 (3%)</td>
</tr>
<tr>
<td>Oral cavity &amp; pharynx</td>
<td>Ovary</td>
</tr>
<tr>
<td>25,240 (3%)</td>
<td>21,550 (3%)</td>
</tr>
<tr>
<td>Pancreas</td>
<td>Pancreas</td>
</tr>
<tr>
<td>21,050 (3%)</td>
<td>21,420 (3%)</td>
</tr>
<tr>
<td>All sites</td>
<td>All sites</td>
</tr>
<tr>
<td>766,130 (100%)</td>
<td>713,220 (100%)</td>
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</tbody>
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### Estimated Deaths

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<tbody>
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<tr>
<td>88,900 (30%)</td>
<td>70,490 (26%)</td>
</tr>
<tr>
<td>Prostate</td>
<td>Prostate</td>
</tr>
<tr>
<td>27,360 (9%)</td>
<td>40,170 (15%)</td>
</tr>
<tr>
<td>Colon &amp; rectum</td>
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</tr>
<tr>
<td>25,240 (9%)</td>
<td>24,680 (9%)</td>
</tr>
<tr>
<td>Pancreas</td>
<td>Pancreas</td>
</tr>
<tr>
<td>18,030 (6%)</td>
<td>17,210 (6%)</td>
</tr>
<tr>
<td>Leukemia</td>
<td>Leukemia</td>
</tr>
<tr>
<td>12,590 (4%)</td>
<td>14,600 (5%)</td>
</tr>
<tr>
<td>Liver &amp; intrahepatic bile duct</td>
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</tr>
<tr>
<td>12,090 (4%)</td>
<td>9,670 (4%)</td>
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<tr>
<td>Esophagus</td>
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<td>11,490 (4%)</td>
<td>9,280 (3%)</td>
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<tr>
<td>10,180 (3%)</td>
<td>7,780 (3%)</td>
</tr>
<tr>
<td>Non-Hodgkin lymphoma</td>
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<td>9,830 (3%)</td>
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<tr>
<td>Kidney &amp; renal pelvis</td>
<td>Liver &amp; intrahepatic bile duct</td>
</tr>
<tr>
<td>8,160 (3%)</td>
<td>6,070 (2%)</td>
</tr>
<tr>
<td>All sites</td>
<td>Brain &amp; other nervous system</td>
</tr>
<tr>
<td>292,540 (100%)</td>
<td>5,590 (2%)</td>
</tr>
<tr>
<td>All sites</td>
<td>All sites</td>
</tr>
<tr>
<td>259,800 (100%)</td>
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*Excludes basal and squamous cell skin cancers and in situ carcinoma except urinary bladder.

©2009, American Cancer Society, Inc., Surveillance and Health Policy Research
Joint Guideline: American Cancer Society, US Multi-Society Task Force on Colorectal Cancer, American College of Radiology

- High-sensitivity FOBT or FIT every year
- Flexible sigmoidoscopy every 5 years
- Double-contrast BE every 5 years
- CT colonography every 5 years
- Colonoscopy every 10 years
- Fecal DNA at an unspecified interval
NYC DOHMH: Colonoscopy is the gold standard.

- Most sensitive
- Most specific
- Only test that (directly) prevents cancer
- Cost effective
- Low risk

Krauskopf M, Silver L. Preventing colorectal cancer. *City Health Information*. 2009;28(suppl2):1-4
NYC Colonoscopy Screening: Progress and Goals

*New Yorkers 50+ who report having had a colonoscopy in the past 10 years. Source: NYC Community Health Survey 2003-2008.
Features of a good screening program

- Accessible
- Acceptable
- Accurate
- Accountable
Accessible

- Screening covered by insurance
  - Affordable Care Act - No copay, no deductible
- Public and Primary Care know how to access
- Ease of referral
- Ease of booking colonoscopy
- Acceptable waiting times
Acceptable

- Easy to follow prep instructions

- Tolerable prep options

- Split preps - current gold standard
  - Better tolerated
  - More effective
Acceptable

- Anesthesia options
  - Moderate Sedation – fentanyl & midazolam
  - Heavy Sedation – propofol

- Convenience
  - Prep should not interfere with prior day’s work
  - Waiting time for patient (and escort) minimized
Accurate – Bowel Prep Quality

- Benchmarks for bowel prep quality
  - Several widely accepted scoring systems
  - Bowel prep quality always recorded
  - Percentage of colonoscopy exams that must be repeated prematurely due to suboptimal bowel prep quality
Accurate – Colonoscopy Quality

- Colonoscopy quality parameters
  - The patient has a valid indication for colonoscopy
  - Adherence with recommended time intervals
  - Percent of examinations completed
  - Photographic documentation of landmarks
  - Average scope withdrawal time
    - Only applies to negative exams
  - Adenoma Detection Rate
    - On patients undergoing first time screenings
Accountability

- Patient satisfaction measures
- Reports with follow-up recommendations to patients and referral sources
- Examining quality data by site and provider
- Reporting quality data to oversight authorities
- Continuing education for providers who fall outside quality benchmarks
Overview of Direct Referral
Direct Endoscopic Referral System (DERS) / Open Access Endoscopy (OAE)

- Eligible patients skip the endoscopist consultation prior to a routine screening colonoscopy.
DERS: Benefits

- **Physicians:**
  - Streamlines referral process
  - Endoscopists can do more colonoscopy
  - Frees up clinic capacity for other patients

- **Patients:**
  - Shorter time to procedure → fewer dropouts
  - Fewer lost work hours
  - Less travel
  - Fewer co-pays
Primary Care Perspective

- Get patients screened
  - Timely appointments
  - Ease of referral
  - Direct access preferred by most patients

- Easy access to results
Endoscopist Perspective

- Increase screening rates
- Shorter waits reduce “no shows”
- Avoid incorrect referrals
- Optimize use of limited capacity
Do PCPs have time for DERS?

- Pap smear: 5 minutes to perform
  - 5 minutes/yr X 10 years = 50 minutes

- Mammogram: 3 minutes to order
  - 3 minutes/yr X 10 years = 30 minutes

- Colonoscopy takes 10 minutes to explain options and complete DERS form
  - 10 minutes every 10 years = 10 minutes

## Direct Referral Assessment Form

- **Type of procedure**
- **Reason for procedure**

### Direct Referral For Screening Colonoscopy

**Physicians:** To assess patient fitness for direct referral for colonoscopy, fill out the form below. For patients who are appropriate candidates for direct referral: 1) fax this form to a participating endoscopist (see reverse for referral site); 2) provide the patient with a copy of this form and the endoscopist contact information; 3) instruct patient to call the referral site to schedule their procedure and to receive bowel preparation instructions. For patients who are not appropriate candidates for direct referral: refer patient to a GI specialist for assessment prior to colonoscopy.

**Date of Referral:**

**Reason for procedure:**
- [ ] Asymptomatic person age 50 years and older
- [ ] Asymptomatic person at high risk
- [ ] First degree relative with colon cancer or adenomatous polyps
- [ ] Personal history of colon cancer or adenomatous polyps (Most recent exam: __________)

**Medical History:** Check "yes" or "no" for each item below. If "yes" is selected for any of the items below, the patient may not be a candidate for direct referral. Consult with a GI specialist.

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Notes</th>
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</thead>
<tbody>
<tr>
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<td></td>
<td></td>
</tr>
<tr>
<td>Under treatment for heart failure or valve-related concerns?</td>
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<td>Pregnant or possibly pregnant?</td>
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</table>

**Does the patient have...**

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<th>Yes</th>
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<th>Notes</th>
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<td>A history of sleep apnea?</td>
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**Is the patient on medication for diabetes?**
- [ ] Yes
- [ ] No
  - **If yes:** Request an A.M. appointment. Advise patient on how much and when to take their oral diabetes medications, insulin or Exendin-4 (Byetta) to avoid hypoglycaemia while on clear liquid bowel preparation and during procedure.

**Is the patient allergic to LATEX?**
- [ ] Yes
- [ ] No

**Is the patient allergic to any MEDICATION?**
- [ ] Yes
- [ ] No
  - **List:**

Please list all medications and OTC supplements below (attach additional sheets as necessary):

<table>
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<tr>
<th>Medication</th>
<th>Dose</th>
</tr>
</thead>
<tbody>
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<td>Medication</td>
<td></td>
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<tr>
<td>Medication</td>
<td></td>
</tr>
<tr>
<td>Medication</td>
<td></td>
</tr>
</tbody>
</table>

Please note any other relevant medical/surgical history:
- [ ] Abdominopathy/pelvic surgery
- [ ] Abdominal/pelvic radiation
- Other, please list:

**Assessment:** This patient is a good candidate for a direct referral for colonoscopy.
- [ ] Yes
- [ ] No

**Physician Signature:**

**Physician Name (Print):**

**Office Phone:**

**Office Fax:**

**Office Address:**

**Preferred method to send results:**
- [ ] PHONE
- [ ] FAX
- [ ] MAIL

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[New York Citywide Colon Cancer Control Coalition](https://www.nyc.gov)  
[American Cancer Society](https://www.cancer.org)
Reason for Procedure

- Valid indication and interval for colonoscopy
- Direct referral better suited for preventative exams
- Clinic consultation is preferred in most diagnostic situations
**Direct Referral Assessment Form**

**Patient’s medical history**

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**Medical History:** Check “yes” or “no” for each item below. If “yes” is selected for any of the items below, the patient may not be a good candidate for direct referral. Consult with a GI specialist.

<table>
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<tr>
<th>Is the patient...</th>
<th>Yes</th>
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**Does the patient have...**

- Hereditary hemochromatosis, or iron deficiency anemia?
- A pacemaker or automatic implantable cardioverter or defibrillator?
- Inflammatory Bowel Disease (Ulcerative Colitis or Crohn’s Disease)?
- A history of severe cardiac/pulmonary/renal/hepatic disease requiring oxygen supplementation or causing high risk for sedation/anaesthesia?
- A history of endocarditis, rheumatic fever, or intravascular prosthesis?
- A history of difficult, incomplete, or poorly prepped colonoscopy?
- A history of difficulty with previous sedation/anaesthesia?
- A history of sleep apnea?

**Is the patient on medication for diabetes?**

- Yes
- No

If yes: Request an A.M. appointment. Advise patient on how much and when to take their oral diabetes medications, insulin or Exenatide (Byetta®) to avoid hypoglycemia while on clear liquid bowel preparation and during procedure.

**Is the patient allergic to LATEX?**

- Yes
- No

**Is the patient allergic to any MEDICATION?**

- Yes
- No

Please list any other relevant medical/surgical history:

- Abdominal/pelvic surgery
- Abdominal/pelvic radiation
- Other, please list:

**Assessment:** This patient is a good candidate for a direct referral for colonoscopy.  □ Yes □ No

**Physician Signature:**

**Physician Name (Print):**

**Office Phone:**

**Office Fax:**

**Office Address:**

**Preferred method to send results?**

- PHONE
- FAX
- MAIL

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**NYC Health**

**American Cancer Society**

**New York Citywide Colon Cancer Control Coalition**
Medical History Checklist

- Over 75 years old
- Chronic kidney disease
- Lung disease
- Anticoagulants and anti-platelet drugs
- Diverticulitis
- Chronic bleeding
- Implantable cardiac devices
- Valvular heart disease
- History of sleep apnea or anesthesia problems
**Direct Referral Assessment Form**

**Medications and allergies**

<table>
<thead>
<tr>
<th>Medication</th>
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<tbody>
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<td></td>
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**Assessment:** This patient is a good candidate for a direct referral for colonoscopy. **Yes**  **No**

**Physician Signature:**

**Physician Name (Print):**

**Office Phone:**

**Office Fax:**

**Office Address:**

**Preferred method to send results:**  **PHONE**  **FAX**  **MAIL**

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**Is the patient on medication for diabetes?**

If yes: Request an A.M. appointment. Advise patient on how much and when to take their oral diabetes medications, insulin or Exenatide (Byetta®) to avoid hypoglycemia while on clear liquid bowel preparation and during procedure.

**Is the patient allergic to LATEX?**

**Is the patient allergic to any MEDICATION?**

List:

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**Please note any other relevant medical/surgical history:**

- Abdominal/pelvic surgery
- Abdominal/pelvic radiation

**Other, please list:**

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**New York Citywide Colon Cancer Control Coalition**

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**NYC Health**

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**American Cancer Society®**

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**New York Citywide Colon Cancer Control Coalition**

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**NYC Health**
Medications and Allergies

- **Diabetes drugs** – Adjustment to avoid hypoglycemia during prep
  - Insulin, Byetta
  - Sulfonylureas

- **Drugs where a missed dose can have clinical impact**
  - Antiarrythmics
  - Anticonvulsants

- **Allergies**
  - Latex
  - Agents commonly used for sedation
**Direct Referral Assessment Form**

### Medical History

**Is the patient...**

<table>
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**Is the patient allergic to LATEX?**

☐ Yes ☐ No

**Is the patient allergic to any MEDICATION?**

☐ Yes ☐ No

*List:*

**Please list all medications and OTC supplements below: (attach additional sheets as necessary):**

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<tr>
<th>Medication</th>
<th>Dose</th>
<th>Notes</th>
</tr>
</thead>
</table>

**Please note any other relevant medical/surgical history:**

- ☐ Abdominal/pelvic surgery
- ☐ Abdominal/pelvic radiation
- Other, please list: __________

**Assessment:** This patient is a good candidate for a direct referral for colonoscopy.

☐ Yes ☐ No

**Other history**

- Physician Signature: ____________________________
- Physician Name (Print): _________________________
- Office Phone: __________________ Office Fax: ________
- Office Address: ________________________________
- Preferred method to send results? ☐ PHONE ☐ FAX ☐ MAIL

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**NYC Health**

**American Cancer Society**

**New York Citywide Colon Cancer Control Coalition**
Other History

- Prior abdominal surgery
- Pelvic irradiation
- History or risk factors for difficult sedation
- History of incomplete or uncomfortable colonoscopy
- History of chronic constipation or poor bowel prep
Direct Referral: New York-Presbyterian Hospital

- Direct referral began in conjunction with patient navigator program
- Waiting time to obtain a screening colonoscopy for a Medicine Clinic patient went from several months to 1-2 weeks
- Screening colonoscopy volume over first 12 mos for the target population increased by 54%
- Screening colonoscopy volume for the control group (private outpatients) over the same period was ↓5%
Direct Referral: New York-Presbyterian Hospital

- 5 early stage cancers detected in direct referrals during the first year.
- Cecal Intubation Rate was 97%
- Adenoma Detection Rate was 27%
- Referring Provider and Patient acceptance rate was high
Summary

- Colon cancer is preventable
- Colonoscopy is cost effective and still underutilized
- Convenience and quality under scrutiny
- Pre-op clinic visit presents a barrier that may lower screening rates in some systems
- DERS is popular with patients and referring providers and improves screening efficiency
Thank You!

Questions?