



**DEPARTMENT OF VETERANS AFFAIRS
Veterans Health Administration
Washington DC 20420**

IL 10-2005-009

In Reply Refer To: 111A

May 16, 2005

UNDER SECRETARY FOR HEALTH'S INFORMATION LETTER

COLORECTAL CANCER SCREENING

1. This Under Secretary for Health Information Letter provides information regarding the provision of colorectal cancer (CRC) screening within Veterans Health Administration (VHA) facilities.

2. **Background**

a. CRC is the second leading cause of cancer death in the United States (U.S.). A person at age 50 has about a 5 percent lifetime risk of being diagnosed with CRC and a 2.5 percent chance of dying from it. More than 80 percent of CRC's arise from adenomatous polyps. Although less than 1 percent of adenomatous polyps smaller than 1 centimeter will eventually develop into cancer, at least 10 percent of adenomatous polyps greater than 1 centimeter become malignant within 10 years, and about 25 percent become malignant after 20 years. The prevalence of adenomatous polyps increases steadily with age from 20-25 percent at age 50 to 50 percent by age 75-80.

b. Most CRC occurs in persons at average risk, but 20 percent occurs in patients with specific risk factors, such as a family history of CRC.

c. The increasing demand for colonoscopy as the primary method for CRC screening and prevention coupled with the cost of treatment for CRC make the issue of CRC screening in the Department of Veterans Affairs (VA) a high priority. A meeting of gastroenterologists was held September 28, 2004, in Washington, DC, (see Att. A) to formulate recommendations for CRC screening in VHA.

3. **VHA Criteria for CRC Screening**

a. The rationale for current VHA criteria for CRC screening is based on the 2004 Health Plan Employer Data and Information Set (HEDIS[®]) and U.S. Preventive Services Task Force (USPSTF) recommendations.

b. The criteria for CRC screening applies to veterans who are at least 50 years of age at the time of the qualifying visit.

May 16, 2005

c. The four types of CRC screening methods that are used are:

(1) Fecal occult blood test (FOBT); a series of three samples at 12 month intervals; or

(2) Sigmoidoscopy, i.e., either flexible or rigid at 5 year intervals; or

(3) Double-contrast barium enema every 5 years.

(4) Colonoscopy. *NOTE: Newly added for fiscal year 2005, a colonoscopy alone every 10 years.*

d. A positive screening test needs to be followed up with colonoscopy if the primary screening method is anything other than colonoscopy.

4. USPSTF Recommendations. The USPSTF Recommendations on which the VHA Performance Measures are based are as follows:

a. The USPSTF strongly recommends that clinicians screen men and women 50 years of age or older who are at average risk for cancer, for CRC.

b. The USPSTF found fair to good evidence that several screening methods are effective in reducing mortality from CRC. The USPSTF concluded that the benefits from screening substantially outweigh potential harms, but the quality of evidence, magnitude of benefit, and potential harms vary with each method.

c. The USPSTF found good evidence that periodic FOBT reduces mortality from CRC and fair evidence that sigmoidoscopy alone or in combination with FOBT reduces mortality. The USPSTF did not find direct evidence that screening colonoscopy is effective in reducing CRC mortality. Indirect evidence for efficacy of colonoscopy is supported by its integral role in trials of FOBT, extrapolation from sigmoidoscopy studies, limited case-control evidence, and the ability of colonoscopy to inspect the proximal colon. Double-contrast barium enema offers an alternative means of whole-bowel examination, but it is less sensitive than colonoscopy, and there is no direct evidence that it is effective in reducing mortality rates. The USPSTF found insufficient evidence that newer screening technologies (for example, computed tomographic colography) are effective in improving health outcomes. Neither digital rectal examination (DRE) nor the testing of a single stool specimen obtained during a DRE is recommended as an adequate CRC screening strategy.

d. There are insufficient data to determine which strategy is best in terms of the balance of benefits and potential harms or cost-effectiveness. Studies reviewed by the USPSTF indicate that CRC screening is likely to be cost-effective (less than \$30,000 per additional year of life gained) regardless of the strategy chosen. It is unclear whether the increased accuracy of colonoscopy (e.g., the identification of lesions not detected by FOBT or flexible sigmoidoscopy) compared with alternative screening methods offsets the procedure's additional risks, complications, inconvenience, and costs.

5. U.S. Multisociety Task Force Recommendations. The U.S. Multisociety Task Force on CRC, like the USPSTF, recommends screening in average risk adults beginning at age 50. The Task Force reviewed the same modalities (FOBT, flexible sigmoidoscopy, double contrast barium enema, and colonoscopy) for CRC screening. They acknowledged that “no single method is of unequivocal superiority” and suggested that individuals be offered options for screening. In addition, “individuals should be provided with information about the advantages and disadvantages associated with each approach, and should be given an opportunity to apply their own preferences in selecting how they should be screened”.

6. American Cancer Society (ACS) Recommendations. The ACS recommends that, beginning at age 50, both men and women follow one of the following five testing schedules:

- a. Yearly FOBT using the take-home multiple sample method.
- b. Flexible sigmoidoscopy every 5 years.
- c. Yearly FOBT plus flexible sigmoidoscopy every 5 years. *NOTE: The combination of FOBT and flexible sigmoidoscopy is preferred over either of these two tests alone.*
- d. Double-contrast barium enema every 5 years.
- e. Colonoscopy every 10 years.

7. Definitions

- a. Average Risk Screening includes asymptomatic veterans age 50 or older.
- b. High Risk Screening includes asymptomatic veterans with a family history of adenoma or CRC.
- c. First-degree relative is a parent, sibling, or child.
- d. Second-degree relative is a grandparent, aunt, or uncle.
- e. Third-degree relative is a great-grandparent or cousin.

8. VHA Recommendations

- a. Based on a review of the evidence (see At5t. B) and recommendations from the various organizations (see pars. 4, 5, and 6), all eligible veterans at average or high risk for CRC need to be offered CRC screening.
- b. It is emphasized that unless the primary screening method is colonoscopy, any positive screening test need to be followed up with full colonoscopy, unless contraindicated.

c. Regardless of the screening method utilized, veterans of any age with signs or symptoms that suggest the presence of CRC, polyps, or other gastrointestinal disease need to be offered an appropriate diagnostic evaluation.

d. In asymptomatic patients, the appropriate approach to screening needs to begin by determining the individual patient's level of risk (see par. 7), which is based on family and personal medical history.

e. **High-risk Veteran**

(1) Veterans with a first-degree relative with CRC or adenomatous polyps diagnosed at age =60 years, or two first-degree relatives diagnosed with CRC at any age need to be advised to have screening colonoscopy (unless medically contraindicated) starting at age 40 years or 10 years younger than the earliest diagnosis in their family, whichever comes first. The colonoscopy needs to be repeated every 5 years.

(2) Veterans with a first-degree relative with CRC or adenomatous polyps diagnosed at age =60 years, or two second-degree relatives with CRC needs to be advised to be screened as average risk persons, but beginning at age 40.

(3) Veterans with one second-degree relative or third-degree relative with CRC needs to be advised to be screened as average risk persons.

f. **Average-risk Veteran**

(1) Eligible veterans at average risk should be offered screening for CRC beginning at age 50.

(2) Screening options for CRC include the following:

(a) Home FOBT alone every year (three consecutive stool samples).

(b) Flexible sigmoidoscopy alone every 5 years.

(c) Home FOBT every year combined with flexible sigmoidoscopy every 5 years.

(d) Double contrast barium enema every 5 years.

(e) Colonoscopy alone every 10 years.

(3) Given that each modality has advantages and disadvantages and that none has clearly been proven to be superior, the choice of specific screening strategy (absent medical contraindications to a particular method) needs to be based on patient preferences.

g. As required by VHA Handbook 1004.1, Informed Consent for Clinical Treatments and Procedures, veterans need to be offered all of the five screening options identified in subparagraph 8f(2)(a) through 8f(2)(e). The advantages and disadvantages of each option, including the option of no screening, need to be discussed with the veteran. The practitioner may recommend any one of the five screening options, but the veteran has the option of rejecting the recommended method and instead choosing one of the five alternatives, or none of the alternatives.

h. FOBT screening for CRC is the most common screening method in VA, but may be challenging for patients with severe cognitive, musculoskeletal, or neurological impairments. Patients with those conditions who would have difficulty completing FOBT, should be offered the full-choice of screening methods such as flexible sigmoidoscopy alone every 5 years, double contrast barium enema every 5 years, or colonoscopy alone every 10 years.

i. FOBT screening for CRC requires good vision and is not suitable for patients with visual impairments. A visually impaired veteran is defined as one who has low vision or is legally blind and would be unable to complete FOBT screening CRC. Visually impaired veterans should be offered the full-choice of screening methods such as flexible sigmoidoscopy alone every 5 years, double contrast barium enema every 5 years, or colonoscopy alone every 10 years.

9. Optimizing CRC Screening in Practice. The success and stability of a CRC Program are dependent on adequate resources and an efficient infrastructure. Preliminary VA studies have shown that offering veterans a choice of screening methods can be accomplished in a resource efficient manner using different strategies. These strategies might include the following: group “prep” clinics; systematic review of consult requests; and the use of a dedicated nurse manager to coordinate screening schedules and procedures and to ensure that all levels of the program are working together (e.g., review of consults, follow-up on requested information, retrieval of in-house and outside medical records, follow-up of no-shows, follow-up on positive FOBT tests, etc.).

10. Internet Resources

- a. U.S. Prevention Services Task Force: <http://www.ahcpr.gov/clinic/uspstf/uspstfcol.htm>
- b. Task Force Ratings: <http://www.ahcpr.gov/clinic/3rduspstf/ratings.htm#arecec>
- c. National Center for Health Promotion and Disease Prevention:
<http://www.va.gov/NCHP>
- d. Centers for Disease Control and Prevention:
<http://www.cdc.gov/cancer/colorctl/index.htm>
- e. VHA Quality Enhancement Research Initiative (QUERI):
<http://www.hsrp.research.va.gov/queri>

IL 10-2005-009
May 16, 2005

11. References. See Attachment B.

12. Inquiries. Questions regarding this information letter should be directed to T. G. Patel, MD, MACP, Medical - Surgical Services, Veterans Health Administration at 202-273-8490.

S/ Jonathan B. Perlin, MD, PhD, MSHA, FACP
Under Secretary for Health

Attachments

DISTRIBUTION: CO: E-mailed 5/19/05

FLD: VISN, MA, DO, OC, OCRO, and 200 – E-mailed 5/19/05

ATTACHMENT A

**GASTROENTEROLOGY FIELD ADVISORY COUNCIL MEETING MEMBER
ATTENDEES AND CONSULTANTS
SEPTEMBER 28, 2004**

<p>Stephen Sontag, M.D. Chairperson, Gastroenterology Field Advisory Committee Staff Physician, Gastroenterology 5th & Roosevelt VA Medical Center Hines, IL 60141</p>	<p>Thakor G. Patel, M.D., MACP Program Chief, Diabetes, Kidney Diseases, Oncology VHA Central Office 810 Vermont Ave., NW Washington, DC 20420</p>
<p>John Bond, M.D. (excused) Staff Physician, Gastroenterology One Veterans Drive VA Medical Center Minneapolis, MN 55417</p>	<p>Dawn Provenzale, M.D. Staff Physician, Gastroenterology 508 Fulton Street VA Medical Center Durham, NC 27705</p>
<p>Samuel B. Ho, M.D. Staff Physician, Gastroenterology One Veterans Drive VA Medical Center Minneapolis, MN 55417</p>	<p>Douglas Robertson, M.D., M.P.H. Chief, Gastroenterology 215 North Main Street VA Medical Center White River Junction, VT 05009</p>
<p>Vikas Khurana, M.D. Staff Physician, Gastroenterology 510 East Stoner Ave VA Medical Center Shreveport, LA 71101</p>	<p>Elizabeth Weinshel, M.D. Chief Gastroenterology Section and Deputy Chief of Staff 423 East 23rd. St. VA Medical Center New York, NY 10010</p>
<p>Patricia May, M.D., F.A.C.S. Acting Chief, Surgical Service 1000 Locust St. VA Medical Center Reno, NV 89502</p>	<p>Consultant Attendees: Archna N. Sharma, M.D., M.P.H. VISN 5, Quality Management Officer Linthicum, MD 21090</p>

ATTACHMENT B

REFERENCES

1. Smith RA, von Eschenbach AC, Wender R, Levin B, Byers T, Rothenberger D, et al. "American Cancer Society Guidelines for the Early Detection of Cancer: Update of Early Detection Guidelines for Prostate, Colorectal, and Endometrial Cancers," also: "Update 2001-Testing for Early Lung Cancer Detection." CA: Cancer Journal for Clinicians. 51:38-75:2001.
2. Rex DK, Johnson DA, Lieberman DA, Burt RW, Sonnenberg A. "Colorectal Cancer Prevention 2000: Screening Recommendations of the American College of Gastroenterology," American Journal of Gastroenterology. 95:868-77:2000.
3. Lieberman DA, Weiss DG, Bond JH, Ahnen DJ, Garewal H, Chejfec G. "Use of Colonoscopy to Screen Asymptomatic Adults for Colorectal Cancer. Veterans Affairs Cooperative Study Group 380," New England Journal of Medicine. 343:162-8:2000.
4. Lieberman D. Cost. "Effectiveness of Colonoscopy in screening for Colorectal Cancer; Cost-Effectiveness of Screening Colorectal Cancer in the General Population," Gastrointestinal Endoscopy. Oct;54(4):537-8: 2001.
5. Screening for Colorectal Cancer in Adults at Average Risk: A Summary of the Evidence," Agency for Healthcare Research and Quality (AHRQ) Pub No. O3-507A, August 2002.
6. "Colorectal Cancer Screening and Surveillance: Clinical Guidelines and Rationale: Update Based on New Evidence," Gastroenterology. 124: 544-560:2003.
7. Sontag SJ, Schnell TG, Leya J, Saez J (Published Abstract) "Closing the Open-Access to Endoscopy: A Safe and Dramatic Policy Shift to Improve Delivery of GI Services," Gastroenterology. 99: S334; (1014-15A). Abstract (2004)