What Are We Missing?
Finding Polyps in a Pandemic

PODCAST 15

00:13
Dr. Jane Caldwell:
Welcome to *On Medical Grounds*; our guest for this episode of "What Are We Missing?" is Dr. David Greenwald here to talk with us about missing diagnoses in colorectal cancer. Dr. Greenwald is the director of clinical gastroenterology and endoscopy at Mount Sinai hospital in New York City. He also serves as the education director of the New York Society for Gastrointestinal Endoscopy.

Hello, Dr. Greenwald, and welcome to *On Medical Grounds*.

Dr. David Greenwald:
Well, hello as well. And it's great to be here. Thanks so much for inviting me.

00:49
Dr. Jane Caldwell:
A recent study conducted by Komodo Health found that the pandemic has affected the level of new diagnoses for colorectal cancer. Between July 2020 and July 2021, diagnoses range from 7% to 26% below pre-pandemic averages.

Could you please address some of the potential reasons for this decline?

Dr. David Greenwald:
Absolutely, what a great question. And a thing to be talking about now as the pandemic, the COVID-19 pandemic, seems to be abating just a bit. We are absolutely concerned about the effects of the pandemic on all sorts of healthcare screenings and in particular about colorectal cancer screening.

So there's good data that shows that the number of procedures, colonoscopies, and colon cancer screenings, that were done in 2020 and 2021 dropped well below what had been done previously. The effect of that is very clear. Colorectal cancer screening wasn't being performed at the same rate that it had been performed before. And so diagnoses of colorectal polyps, which are the precancerous lesions that can lead to colorectal cancer or colorectal cancer themselves, were diminished. And the effect of that is going to be felt for years on end, meaning seeing later-stage colon cancers being diagnosed. And we know that probably for decades to come, this may be the case bottom line, is that the reasons for the decline in colorectal cancer screening had to do with people being afraid of coming in for colorectal cancer screening procedures because of fears of COVID-19 and those effects, as I said, are going to go on for a long, long time.

02:39

Dr. Jane Caldwell:

As a colorectal cancer survivor myself, I've seen changes in the way colorectal screenings are conducted. Could you give us a brief history of screening, preps, and procedures?

Dr. David Greenwald:

Yeah, a great question.

So there are lots of different ways to screen for colorectal cancer. I think the most important concept right up front is that most colorectal cancers are preventable. This is a really important concept. What that means is that when we screen for colorectal cancer, we're looking in general for the thing that comes before cancer, which is typically called a polyp. And if we can find a polyp and remove the polyp before the polyp turns into cancer, we prevent colorectal cancer. For those people who we don't prevent colorectal cancer in advance, by removing polyps, if we screen properly, we can often find early-stage cancers and that's better than finding late stage cancers.

So if we find a cancer that's early, it's typically treatable. So, put in summary, then colorectal cancer largely is thought to be preventable or treatable when found early, therefore it's beatable. So to go back to your question, then the history of screening involves looking for abnormalities, either in the stool or in the colon. So we have a number of tests that are designed to look for abnormalities in the stool, particularly looking for blood in the stool or abnormal pieces of polyps or cancer, called abnormal DNA that can be found in this. Or we use screening exams where we look inside the colon directly, including sigmoidoscopy, which is a short colonoscopy, or colonoscopy, and we'll talk more about that later, for sure, to look inside the colon and look for these precancerous lesions, these polyps and remove. A couple of other options that are available include using cat scans or x-rays to look at the colon. And again, look for little polyps or big polyps that might be there.

And we've also been able to use a technology called capsule endoscopy, where a video capsule is inserted in, traverses the GI tract, and can look for polyps. The holy grail ultimately will be to have a blood test for colorectal cancer and polyp detection. There are some early players in that field, but nothing that has been widely accepted at this point.

05:08

Dr. Jane Caldwell:

The pandemic has hastened the trend towards medical testing at home. Could you please describe the at-home testing kits now available?

Dr. David Greenwald:

Sure, absolutely. So one of the offshoots of the pandemic is that people were afraid to come into medical facilities, whether they be offices or ambulatory endoscopy centers, or hospitals for procedures. Everything about colorectal cancer screening involves choice.

In fact at Mount Sinai, we have a program that's exactly titled that, Colorectal Cancer Screening Choice, because there are options and some of those options are at-home screening options. They include testing for blood in the stool, typically known as guaiac testing or FIT testing, which stands for fecal immunochemical

testing. These are basically looking for blood in the stool. Blood in the stool does not always indicate colorectal cancer. It can be caused by other things such as hemorrhoids and other causes of bleeding in the GI tract. But we do worry anytime somebody has a positive test, an at-home test, looking for blood in the stool because it could indicate the presence of cancer. And so those people who have positive tests need to have a follow-up colonoscopy to look for any potential abnormality. The other at-home test, which is available is a combination of fecal immunochemical testing, again, looking for blood in the stool, along with abnormal pieces of DNA. DNA are building blocks within cells. When a person has a polyp or a colon cancer, pieces of that polyp or colon cancer shed off into the stool and we can detect abnormal DNA from that polyp or cancer in the stool.

So there's one commercially available test right now that combines a fecal immunochemical test along with look, looking, for abnormal DNA markers in the stool. Those are the at-home tests that are available. Very, very, important for anybody listening, if you do one of those tests and you have a positive test, it needs to be followed up with a colonoscopy because if you have a polyp, it needs to be removed.

And if you have a cancer, it needs to be diagnosed. And those at-home tests don't do the actual diagnosis. They just simply do the marker. And then you have to go get the structural exam to find out exactly what you have.

07:31
Dr. Jane Caldwell:
Yes, that's important. Are there populations for whom the at-home kits are not recommended?

Dr. David Greenwald:
Yeah, great question. So the at-home tests are recommended for people who are at average risk. Current guidelines suggest that people get screened for colorectal cancer between the ages of 45 and 75. So that 45 is a change from a previous recommendation of 50. So we've recognized that we want to screen people earlier, starting at age 45.

Again, choice is important. So the choices typically include at-home stool tests or colonoscopy along with the other options that I mentioned before CT, colonography, and capsule procedures. The at-home tests are not recommended for people who've had polyps before or who are at high risk for colorectal cancer. So that would be either a personal history of colorectal cancer or a family history of colorectal cancer. The vast majority of people where I see this being misused is in people who've had polyps before. So if you had a polyp, which is a precancerous lesion identified and removed by colonoscopy previously, your subsequent exam should not be with a stool-based test, but it should be with another colonoscopy because you are at higher risk than the average person for additional colorectal polyps.

09:00
Dr. Jane Caldwell:
Going back to effects of the pandemic, how will the medical community address the backlog in colorectal cancer diagnoses?

Dr. David Greenwald:
Right. So the backlog is very, very important and the backlog is real.

The national colorectal cancer round table did a survey over the first three months of the pandemic and showed that screening rates went down by about 90% over those three months. Well, we know now, of course, as the pandemic didn't last three months, you know, we're just passing the two-year mark, so that backlog continues to pile up again.

The reasons for the backlog had a lot to do with people prioritizing other things in their care, concerns about acquiring COVID when going to a facility, concerns about just simply leaving the house, concerns about COVID itself, and then the medical care community being diverted and resources being diverted to the acute needs of caring for an entire country and entire world, actually, that seemed to be developing COVID.

The backlog is real. The way we have to address it is two-fold, first is to reassure people that it is safe to come in for procedures. And all through the country, there have been a variety of media messages that have been created both by local hospitals and by national organizations and local gastroenterology groups to reassure people of all of the things that were being done to assure safety during colonoscopies and GI procedures. I think those messages are loud and clear and very, very, effective in helping people understand what's being done to ensure their safety. The second thing that I think is really important in adjusting that backlog is just simply reminding people they're regular health care is important and it needs to be prioritized. So people were very, very willing initially to say, "Oh, there's a pandemic, I couldn't go out of my house or I can't do this. I can't do that." The things that we screen for, things like colorectal cancer, breast cancer, skin cancer, prostate cancer, they didn't stop just because of the pandemic.

And we need to remind everybody that they need to go back to their regular health care. I've seen so many patients who deferred their colonoscopy, for example, for a year. And I'm now finding, you know, more and more things that I wouldn't have expected to find because of those delays in care. So it's really a two-fold message.

One is getting back to regular screening and regular health care is very important, and two, that procedures that are being done to look for colorectal polyps are safe and effective and continue to be necessary. And then the third, I guess, is to, again, emphasize that there are choices that are available to people for colorectal cancer screening and they should avail whatever choice makes most sense to them in their practice.

11:58
Dr. Jane Caldwell:
The decline in colorectal cancer diagnoses affected both black and white populations. Similarly, however, the Komodo Health study also found that black patients wait longer for diagnosis and treatment of colorectal cancer than their white counterparts do. And be aware that these data do not include uninsured patients. How do we increase awareness of this disparity in the medical community?

Dr. David Greenwald:
Uh, great question. Disparities within the healthcare system are clear. There've been disparities pointed out in survival amongst COVID patients, for example, that are very clear. When we talk about colorectal cancer screening, we've known for years exactly what that Komodo Health study found is that African-American patients wait longer for a diagnosis and treatment of colorectal cancer than their Caucasian

counterparts. We have been sensitive to this fact for many, many years. And in fact, the American College of Gastroenterology and others recommended screening African-Americans at younger ages than their Caucasian counterparts, as long as 10 years ago because of the understanding of a disparity in healthcare outcomes in colorectal cancer. The way that we address this now is the same way that we've been addressing it, which is to really meet it head on to really say, okay, this is true. Why is it true? The reason it's true is gotta be because of differences in access to healthcare.

And we have to recognize those disparities exist and we have to keep meeting them ahead on, by specifically targeting the populations that have had lower screening rates in the past with very clear, precise messaging to those communities. Explain why screening is important. So screening for colorectal cancer, again, as I said a while ago now, you know, is something that allows us to prevent a cancer. So this is a really important message that we can prevent colorectal cancer if we can screen people at the appropriate age. And so in the communities that have typically have these disparities, and you mentioned the African-American community, for sure, we have to create clear messages to that community that are targeted to that community, that resound with that community about why it's important to get screened, why the barriers to screening need to be broken down, how we can break those barriers down, and to have people not be embarrassed, not be afraid, not be scared, not mistrust the medical system because, in this case, the medical system is actually trying to help.

14:35

Dr. Jane Caldwell:

A study published this year in the *New England Journal of Medicine*, found that colorectal cancer disparities between black and white adults were eliminated in Kaiser Permanente Northern California members after they initiated a region-wide colorectal cancer screening program. Program managers and electronic systems identified all eligible who were not up to date; they used automated alerts to remind healthcare providers to offer screening at clinical visits. In addition, a fecal immunochemical test was mailed annually to members who were not up to date. Do you have automated electronic notifications for colorectal screenings at Mount Sinai Hospital?

Dr. David Greenwald:

So a great complicated question, Jane. Thanks. We'll just sit in a couple of different parts. The Kaiser system in California in Northern California is a really excellent program.

And the important part there is that it's a program. So I would call that programmatic screening. So what they've done there, and it's a model that's being emulated around the country. Actually, the Veterans Administration system is using a very similar system to identify a way to screen everybody in a certain population and make sure that it's done at the appropriate intervals.

We talked already a little bit about stool-based testing and we talked about it with fecal immunochemical testing and then a combination of fecal immunochemical testing and DNA, abnormal DNA in the stool. Those tests need to be repeated at intervals that are appropriate. So for fecal immunochemical testing, or FIT testing, the interval is one year and for FIT and DNA, that interval is between one and three years.

So the key to the question that you asked about in the *New England Journal of Medicine* article that showed that colorectal cancer disparities could be eliminated in that Kaiser system, then is that they are mailing

out fecal immunochemical testing kits to all of their members on an annual basis. They track the return of those kits and then anybody who's positive gets referred in for a colonoscopy within three months. That is a programmatic screening. So if you do that fecal immunochemical testing, but you only do it once, it's nowhere near as good as if you do it on an annual basis. And this is the strategy that that system has taken to, you know, programmatically screen their entire population. It's an absolutely outstanding system, but it requires a lot of organization and a lot of sort of data managers and proper communication. So to get back to the last part of your question at Mount Sinai, we have a system within our electronic record that shows when a patient is due for a colonoscopy or some sort of colorectal cancer screening and that is available to every practitioner. Within the system, we are working toward an automated electronic notification system, similar to what Kaiser is doing, because we do think that's sort of the holy grail here.

17:39
Dr. Jane Caldwell:
To finish up. What were you hoping that I would ask you about colorectal cancer?

Dr. David Greenwald:
Well, I was hoping I, actually, you asked me almost all the things that I was hoping you would ask me; thanks so much for doing that. What I was hoping is that we would just spend a moment talking about is the fact that most colorectal cancer is two things. One is that the most colorectal cancer, as I said, is either preventative or treatable; therefore, colorectal cancer is beatable. The other thing which I was hoping we would talk about is an increase over the past number of years in colorectal cancers in young people. So we would define young people as under the age of 45. That's a trend that we've seen. We don't exactly know why it's happening, but the message there is that if you are under 45 and have a symptom that is concerning for colorectal cancer screening, for colorectal cancer, rather, and that would mostly be rectal bleeding or a substantial change in bowel habits, that symptom does not simply be ascribed to hemorrhoids, but that if you have that problem that you go seek medical care, and that you make sure that you don't have an early colon cancer and early rectal cancer that can be treated successfully. So those are the messages that I wanted to make sure that I got out there.

And I was hoping that you would ask me about.

Dr. Jane Caldwell:
Superb, Dr. Greenwald, we appreciate your efforts to educate others and improve healthcare disparities. Thank you so much for taking time from your busy schedule to speak with us.

Dr. David Greenwald:
Thank you so much, Jane, it was great to be here and I'm happy to talk with you anytime in the future.

Dr. Jane Caldwell:
And thank you for listening to the *On Medical Grounds* podcast. We know your time is valuable. The resources that were referred to in this podcast can be found at onmedicalgrounds.com. Be sure to check the subscribe button to be alerted when we post new content. If you enjoyed this podcast, please rate and review it and share it with your colleagues and friends.