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Colorectal Cancer Screening and Prevention in the COVID-19 Era

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On March 18, the Centers for Medicare & Medicaid Services (CMS) issued guidance that all non-urgent surgeries and medical procedures be delayed during the COVID-19 pandemic. This recommendation was made to conserve personal protective equipment, a critical resource in the care of patients with COVID-19. While the necessity of this recommendation is clear, progress must continue to be made on other serious non-COVID-19 challenges in public health.

Among the procedures being delayed are colonoscopies, the most commonly used test to screen for and prevent colorectal cancer, which is the second highest cause of cancer deaths in the United States. Colorectal cancer is largely preventable through screening, but nearly 23 million adults aged 50 to 75 are past due for screening and an estimated 53,000 Americans will die from colorectal cancer this year. To reduce colorectal cancer mortality, the National Colorectal Cancer Roundtable, a coalition established by the American Cancer Society (ACS) and the Centers for Disease Control and Prevention (CDC), launched this year its ‘80% in Every Community’ campaign, which aims to substantially increase colorectal cancer screening rates in all U.S. communities. Since the CMS recommendation to delay non-urgent procedures in mid-March, adult primary care and gastroenterology visits have declined by 49% and 61% respectively, which makes achieving colorectal cancer screening goals even more challenging.

Delaying colorectal cancer screening for the 23 million adults who are past due will lead to delayed diagnoses and cancer deaths. Delays in screening will widen persistent racial, ethnic, and socioeconomic mortality disparities as rising unemployment in disadvantaged populations stifles already limited access to care. Delays will also overwhelm health care systems burdened by long screening backlogs when elective procedures resume.

To address this problem, health care organizations can leverage mailed fecal immunochemical tests (FIT) outreach programs. As states continue ‘shelter in place’ ordinances that keep Americans at home, many health care providers have moved to tele-

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medicine appointments for clinic visits. Primary care physicians and gastroenterologists should similarly advocate for implementing mailed FIT outreach in their health care systems to reduce colorectal cancer mortality.

FIT is an inexpensive, at-home colorectal cancer screening test that checks for blood in stool and can be returned by mail.[1] A meta-analysis that examined test characteristics, found FIT had a pooled sensitivity of 79%, specificity of 94%, and overall diagnostic accuracy of 95% for colorectal cancer.[2] Our prior research found that FIT outreach delivery costs approximately $23 per person and $112 per additional person screened.[3] To further decrease costs, health care systems can consider using through third-party vendors who can increase the scale of FIT distribution at a lower price.

Mailed FIT outreach is an evidence-based strategy that addresses barriers to colorectal cancer screening at the patient level (provides convenience of at-home testing), provider level (addresses clinic visit time limitations), and the health system level (maximizes the reach of screening).[3] Mailed FIT outreach also allows us to triage populations into high and low risk for colorectal cancer. Identifying a high-risk population that will need colonoscopy earlier will facilitate a smooth transition to resuming elective procedures and preserve personal protective equipment for the more urgent COVID-19 response. In Australia, Canada, the Netherlands, and the United Kingdom, stool-based tests, including FIT, are the cornerstone of colorectal cancer screening. All eligible adults are offered a FIT through an organized, population-level screening program, and colonoscopies are made available to those with an abnormal result.[4]

FIT is not a perfect intervention, but its advantages of enabling effective screening in remote healthcare settings at a low cost, makes it ideal during times of mandated social distancing. The two most common arguments against adopting FIT are that it does not reliably identify small polyps and that it is a two-step screening process that requires individuals with an abnormal result to complete a follow-up colonoscopy to remove large polyps or locate early stage colorectal cancer. The benefits, however, are that FIT (1) does not require intensive patient bowel preparation, (2) does not require sedation or a designated driver to transport the patient home, and (3) reduces colorectal cancer mortality disparities due to its low cost and ease of access.

To ensure that mailed FIT outreach does not increase existing colorectal cancer screening disparities, implementation strategies should proactively apply a health equity lens in the following ways: (1) prioritize mailed FIT outreach for individuals who are not up-to-date with screening, (2) ensure mailed FIT outreach includes all individuals within a health care system regardless of health plan or associated incentives, and (3) support passing federal policy that waives co-insurance for follow-up colonoscopy completion after abnormal FIT results.

Primary care physicians and gastroenterologists can maintain momentum in decreasing colorectal cancer mortality within our health care organizations by taking the following steps:

1. Advocate for establishing mailed FIT outreach programs, with an eye toward health equity, that can be executed by medical administration with modest physician oversight,[5]
2. Set clear expectations that follow-up colonoscopies for abnormal FIT results will receive priority scheduling after the moratorium on colonoscopies is lifted,
3. Create workflows to track patients with abnormal FIT results until colonoscopy is completed,[6]
4. Increase gastroenterology staffing to accommodate the expected surge in procedural demand, and
5. Offer evening and or weekend colonoscopy blocks to enable patients and gastroenterologists to catch up on colorectal cancer screening and surveillance backlogs.

In the midst of a pandemic, we cannot and should not abandon disease prevention. Preventable chronic diseases, including colorectal cancer, are still responsible for most deaths worldwide.[7] Creative solutions are needed to survive and thrive after the COVID-19 pandemic. In cancer prevention, colorectal cancer is one of the few cancers for which there are multiple screening options. Now is the time for the United States to use the full arsenal available to combat this disease, because prevention is always better than cure.

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