

AGA INSTITUTE HIGH-VALUE CARE SERIES

When Should Screening Stop for Elderly Individuals at Average and Increased Risk for Colorectal Cancer?

Folasade P. May^{*,‡} and Samir Gupta^{§,||}

**Vatche and Tamar Manoukian Division of Digestive Diseases, Department of Medicine, University of California Los Angeles, Los Angeles, California; †Division of Gastroenterology, Department of Medicine, VA Greater Los Angeles Healthcare System, Los Angeles, California; ‡Veterans Affairs San Diego Healthcare System, San Diego, California; and §Division of Gastroenterology, Department of Internal Medicine, Moores Cancer Center, University of California San Diego, La Jolla, California*

This article is part of a series on enhancing the value of care in gastroenterology and hepatology. Each article in this series examines specific clinical scenarios in which the value of care can be improved over a range of sub-specialties in the field.

David A. Katzka, MD
Guest Special Section Editor

High-Value Care Challenge: Screening for Colorectal Cancer is Widely Recommended, but There is Uncertainty Whether Elderly Patients are Likely to Benefit

The 2016 US Preventive Services Taskforce colorectal cancer (CRC) screening guidelines express uncertainty regarding the benefit of screening individuals age 76–85, and recommend against screening individuals older than age 85 (Table 1).¹ These guidelines were based on a review of the existing literature and comparative modeling studies that use population-based estimates and several starting and stopping ages to project the potential benefits and harms of various screening strategies.^{2,3}

Implications of these recommendations are substantial. More than 19 million adults older than age 75 reside in the United States, a population that is growing in size. For clinicians, patients, and health systems, the US Preventive Services Taskforce recommendations raise two questions: (1) Which elderly persons should be screened for CRC?; and (2) What strategies might help inform screening decisions?

Core Advice for High-Value Care

For individuals age 76–85, providers should objectively assess whether the benefits of screening outweigh the harms based on (1) history of prior screening, (2) health-adjusted life expectancy, (3) CRC

risk, and (4) patient preferences. Modeling studies suggest that individuals with no prior screening are likely to benefit, but among individuals previously screened benefit varies based on age, health-adjusted life expectancy, and CRC risk. Risk and benefits can be estimated using risk calculators, such as those available through ePrognosis (<http://cancerscreening.eprognosis.org/screening/>), which considers life expectancy based on age, health behavior, comorbidity, and functional capacity.⁴ Users are provided with a tailored risk assessment and recommendations about whether CRC screening might be beneficial or harmful on entering patient-specific health information (Supplementary Table 1). For example, the ePrognosis CRC screening calculator estimates that a 78-year-old man with chronic lung disease and type 2 diabetes mellitus is unlikely to benefit, assuming a 10-year time horizon, to realize a survival benefit from screening.⁵

A limitation of the ePrognosis CRC calculator is that it does not take into account level of CRC risk and prior screening history. Modeling work by van Hees et al⁶ considers these factors and suggests that harms outweigh screening benefits for individuals older than 75 with average CRC risk, a normal colonoscopy 10 years prior, and moderate comorbidities. Alternatively, for individuals with 2-fold increased CRC risk, screening benefits seemed to outweigh harms through age 84 in the absence of moderate comorbidities, even with a history of prior screening.⁶ A potential limitation of this modeling is that it does not take into account patient functional status, which has been shown to be a major predictor of life expectancy.⁷

Patient preferences and values must also be considered. Many older than age 75 may be relieved to learn that colonoscopies are no longer routinely indicated, although others may object to stopping screening.⁸ Although some elderly patients value information about

Table 1. US Preventive Services Taskforce Recommendations for Colorectal Cancer Screening

Population	Adults age 50–75 years	Adults age 76–85 years	Adults >85 years
Screening recommendation	Screen starting at age 50	Decision to screen should be individualized	Do not screen
Grade	A	C	D

calculated risk, others do not trust risk estimators.⁹ Patients older than age 75 may choose to continue screening, but should be clearly informed when projected harms outweigh benefits. Patients should also be aware that advancing age is associated with increased colonoscopy risk, whether as a primary screening modality or follow-up for a positive “gateway” screening test (eg, fecal immunochemical test).¹⁰

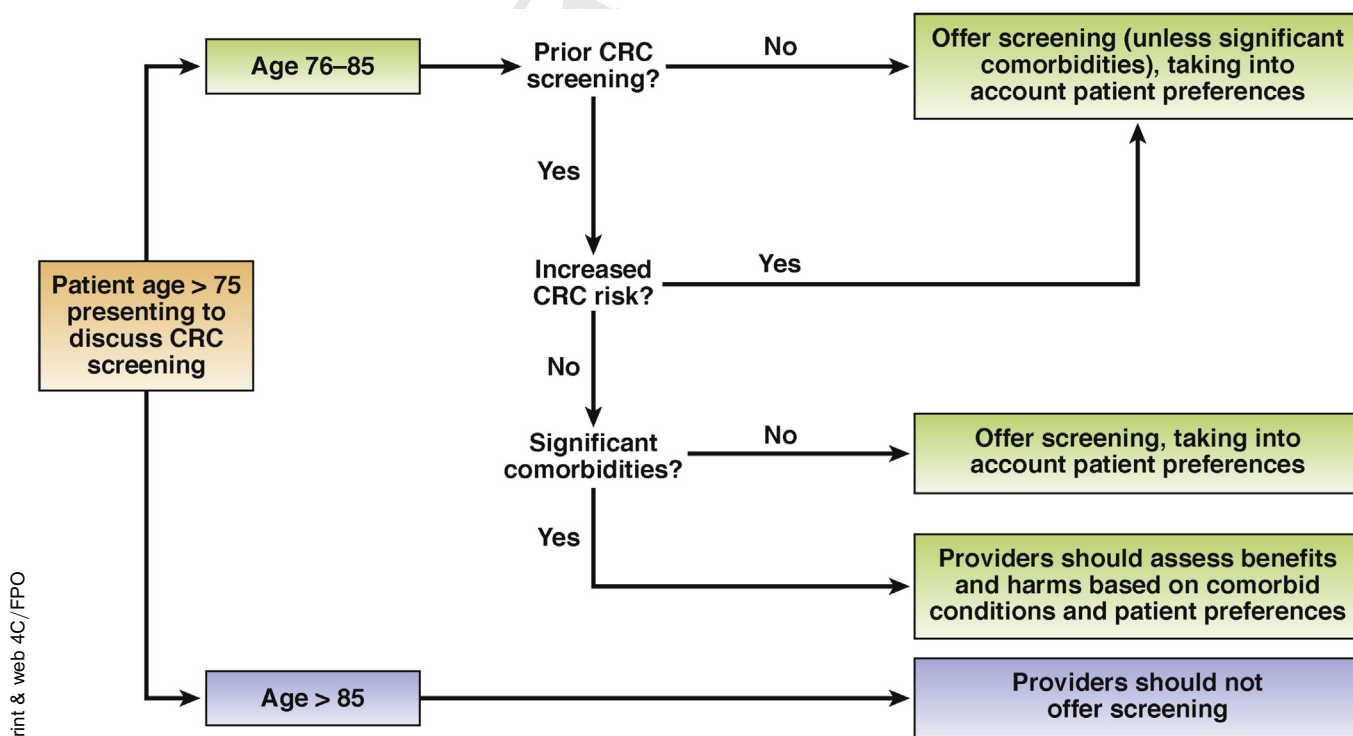
For individuals older than age 85, clinicians should avoid routine CRC screening. Based on ePrognosis CRC calculator estimates, even a healthy 85-year-old man or woman without comorbidities and high functional status is unlikely to benefit from CRC screening, consistent with US Preventive Services Taskforce projections.³ Similarly, the work by van Hees et al⁶ suggests that patients older than age 85 with no prior screening despite 2-fold increased risk for CRC are unlikely to benefit from screening.

Implementation in Practice

Screening is currently overused for as many as 40% of elderly individuals.⁶ In a sample of Medicare enrollees

age 75–79, a total of 43% had a repeat colonoscopy within 7 years of a normal screening colonoscopy, 3 years sooner than the guideline-recommended 10-year interval.¹¹ To optimize high value care, dedicated efforts to avoid screening overuse are needed.

High-value screening care can be promoted by encouraging a specific CRC screening visit for individuals age 75 and older. We discourage routine CRC screening by any method (especially through direct access referral for colonoscopy), and instead encourage primary care providers and gastroenterologists to engage in active discussions during a clinic visit that consider history of prior screening, CRC risk, life expectancy, and patient preferences (Figure 1). Willing patients with no prior screening or elevated CRC risk may benefit from screening older than age 75 if at most moderate comorbidities are present, but are unlikely to benefit if severe comorbidities are present.⁶ For those with average CRC risk and prior screening, decisions can be facilitated by the use of prognostic calculators and eliciting patient preferences. Using careful selection strategies for recommending screening in the elderly has great potential to increase high-yield screening uptake and reduce low-value care.

**Figure 1.** Decision pathway for CRC screening in US adults older than age 75.

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