

Economic  
Models of **COLORECTAL  
CANCER SCREENING**  
in Average-Risk Adults

Workshop Summary

INSTITUTE OF MEDICINE  
OF THE NATIONAL ACADEMIES

# Economic Models Of Colorectal Cancer Screening In Average Risk Adults Workshop Summary Paperback

**National Cancer Policy Board, Board on  
Science, Technology, and Economic  
Policy, Policy and Global  
Affairs, Institute of Medicine, National  
Research Council**

## **Economic Models Of Colorectal Cancer Screening In Average Risk Adults Workshop Summary Paperback:**

**Economic Models of Colorectal Cancer Screening in Average-Risk Adults** National Research Council, Institute of Medicine, Policy and Global Affairs, Board on Science, Technology, and Economic Policy, National Cancer Policy Board, 2005-04-11 The National Cancer Policy Board and the Board on Science Engineering and Economic Policy convened a workshop in January 2004 on Economic Models of Colorectal Cancer CRC Screening in Average Risk Adults The purpose of the workshop was to explore the reasons for differences among leading cost effectiveness analysis CEA models of CRC screening which public health policy makers increasingly rely on to help them sift through the many choices confronting them Participants discussed the results of a collaborative pre workshop exercise undertaken by five research teams that have developed and maintained comprehensive models of CRC screening in average risk adults to gain insight into each model s structure and assumptions and possible explanations for differences in their published analyses Workshop participants also examined the current state of knowledge on key inputs to the models with a view toward identifying areas where further research may be warranted This document summarized the presentations and discussion at the workshop

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*Economic Models of Colorectal Cancer Screening in Average-Risk Adults* , **Cancer Biomarkers** Institute of Medicine, Committee on Developing Biomarker-Based Tools for Cancer Screening, Diagnosis, and Treatment, 2007-03-27 Many cancer patients are diagnosed at a stage in which the cancer is too far advanced to be cured and most cancer treatments are effective in only a minority of patients undergoing therapy Thus there is tremendous opportunity to improve the outcome for people with cancer by enhancing detection and treatment approaches Biomarkers will be instrumental in making that transition Advances in biotechnology and genomics have given scientists new hope that biomarkers can be used to improve cancer screening and detection to improve the drug development process and to enhance the effectiveness and safety of cancer care by allowing

physicians to tailor treatment for individual patients an approach known as personalized medicine However progress overall has been slow despite considerable effort and investment and there are still many challenges and obstacles to overcome before this paradigm shift in oncology can become a reality *American Book Publishing Record* ,2005

*Cost-effectiveness of Colorectal Cancer Screening in Average-risk Adults* United States. Congress. Office of Technology Assessment,1995 Screening for Colorectal Cancer in Adults Michael Pignone,Melissa Rich,Steven M. Teutsch,Alfred O. Berg,Kathleen N. Lohr,2002

CONTEXT Colorectal cancer is an important cause of cancer related morbidity and mortality in the United States Screening has the potential to reduce the morbidity and mortality from colorectal cancer through early detection and removal of early stage cancers or precancerous adenomatous polyps

OBJECTIVE We conducted a systematic review for the US Preventive Services Task Force to assess the effectiveness and cost effectiveness of different colorectal cancer screening tests

DATA SOURCES We used recently conducted systematic reviews the second edition of the Guide to Clinical Preventive Services the British National Health Service Economic Evaluation database and focused searches of MEDLINE from 1966 through September 2000 to identify relevant studies for inclusion We also conducted hand searches review of bibliographies and consultations with context experts to assure completeness

STUDY SELECTION When available we included the most recent high quality systematic review and then supplemented that review with a search for more recent articles Full MEDLINE searches were performed to examine the accuracy of double contrast barium enema the rates of complications for each of the available screening tests and for studies of the cost effectiveness of screening Two reviewers examined the results of each of the full searches and determined by consensus which articles should be abstracted into evidence tables

DATA EXTRACTION One reviewer abstracted the information from the final set of studies into evidence tables and a second reviewer checked them for accuracy

DATA SYNTHESIS Direct evidence from multiple well conducted randomized trials supports the effectiveness of fecal occult blood testing FOBT in decreasing colon cancer incidence and reducing mortality from colorectal cancer compared with no screening for average risk adults over age 50 Data from well conducted case control studies support the effectiveness of sigmoidoscopy and possibly colonoscopy in reducing colon cancer mortality as well A nonrandomized trial and indirect evidence support the use of combination FOBT and sigmoidoscopy Indirect evidence from diagnostic accuracy studies suggests that double contrast barium enema or virtual colonoscopy may also be effective compared with no screening Data are insufficient to determine with confidence and precision the most effective or cost effective strategies or the age at which screening should be stopped

CONCLUSIONS Colorectal cancer screening is effective in reducing mortality from colorectal cancer Current data are insufficient to determine the most effective or cost effective strategy for screening although all major strategies have favorable cost effectiveness ratios compared with no screening *Colorectal Cancer Screening* Amy B. Knudsen,2021

IMPORTANCE The U S Preventive Services Task Force USPSTF is updating its 2016 recommendations for screening for colorectal cancer

OBJECTIVE To

provide the USPSTF updated model based estimates of the benefits burden and harms of colorectal cancer screening strategies that vary by the ages to begin and end screening screening modality and screening interval Analyses also identify strategies that may provide an efficient balance of the colonoscopy burden and the life years gained LYG from screening

**DESIGN** Comparative modeling using 3 microsimulation models that simulate outcomes with and without colorectal cancer screening in a hypothetical cohort of previously unscreened average risk U S 40 year olds with no prior colorectal cancer diagnosis

**EXPOSURES** Screening from ages 45 50 or 55 years to ages 70 75 80 or 85 years with fecal immunochemical testing FIT multitarget stool DNA testing FIT DNA flexible sigmoidoscopy SIG alone or in conjunction with interval FIT computed tomographic colonography CTC or colonoscopy Screening intervals varied by modality All persons with an abnormal non colonoscopy screening test were assumed to undergo follow up colonoscopy Full adherence with all screening follow up and surveillance procedures was assumed

**MAIN OUTCOME AND MEASURES** Estimated LYG relative to no screening benefit lifetime number of colonoscopies burden lifetime number of complications from screening harms and balance of incremental burden and benefit efficiency ratios Efficient strategies were those that required fewer additional colonoscopies per LYG relative to other strategies

**RESULTS** Estimated LYG from screening ranged from 171 to 381 per 1000 40 year olds Lifetime colonoscopy burden ranged from 624 to 6817 per 1000 individuals and screening complications ranged from 5 to 22 per 1000 individuals Forty nine screening strategies were found to be efficient options by all 3 models in 41 of these strategies screening began at age 45 No single age to end screening was predominant among the efficient strategies although the estimated increases in LYG from continuing screening after age 75 were generally small With the exception of a 5 year interval for CTC no screening interval was predominant among the efficient strategies for each modality Among the screening strategies highlighted in the 2016 USPSTF colorectal cancer screening recommendations lowering the age to begin screening from 50 to 45 was estimated to result in 22 to 27 additional LYG 2 to 3 fewer colorectal cancer cases and 0.9 to 1 fewer colorectal cancer death but it was also estimated to result in 0.1 to 2 additional complications 161 to 784 additional colonoscopies and 0 with colonoscopy to 3553 additional non colonoscopy tests over the lifetimes of 1000 persons ranges are across screening strategies based on mean estimates across the 3 models Sensitivity analyses indicated that there was little advantage to customizing screening by race and sex the estimated numbers of LYG colonoscopies and complications were similar across race sex groups as were the efficient strategies and their ratios

**Scenario analyses** demonstrated that efficient strategies were similar across 3 scenarios for the population risk of colorectal cancer including one in which the assumed risk increase was less conservative than the assumption for the base case analysis The effect of imperfect adherence on outcomes was estimated by comparing strategies with different ages to begin screening to examine delays in uptake or with strategies with different screening intervals to examine delays in rescreening For example the models estimated that extending the interval of repeat colonoscopy screening from 10 to 15 years would result in a loss of 22

to 38 life years per 1000 and extending the interval of FIT screening from annual to triennial testing would result in a loss of 28 to 41 life years per 1000 LIMITATIONS The models do not simulate the serrated polyp pathway to CRC The models assume that the observed increase in colorectal cancer incidence among 20 to 44 year olds in recent years is a cohort effect and that the increase in risk will be carried forward as individuals age They further assume that the increase in incidence is driven by an increased risk of developing adenomas as opposed to faster or more frequent progression of adenomas to malignancy CONCLUSIONS This comparative modeling study suggests that colorectal cancer screening may lead to sizable reductions in the lifetime risks of developing and dying from colorectal cancer Many screening strategies are estimated to provide an efficient balance of the burden and benefit of screening these strategies encompass a range of screening modalities intervals and ages However when the benefits of screening are measured by the number of LYG most of the efficient screening strategies identified by all 3 models specified screening starting at age 45 Starting screening at age 45 was generally estimated to result in more LYG and fewer colorectal cancer cases and deaths than similar strategies with screening starting at age 50 or age 55 albeit with a higher lifetime burden of both colonoscopy and non colonoscopy testing and slightly higher lifetime risks of complications

AVERAGE RISK COLORECTAL CANCER SCREENING Leslie Anne Campbell,2014 *Is Colonoscopy a Practicable Choice for Primary Colorectal Cancer Screening in Average Risk Adults?* Xiaobo Zheng,2005

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