

Clinical Practice Guideline (CPG)

CANCER SCREENING



CONTENTS:

1. Overview of Cancer Screening

Review Period in Years: 1 year
Next Review Date: 01/09/2027

SCOPE:

Family Care PACE Partnership

AUDIENCE:

Interdisciplinary Team Staff (IDTS)

PURPOSE:

To provide best practice approach to Community Care, Inc. Interdisciplinary Team Staff, Physicians and other providers who care for our members.

Community care Clinical Practice Guidelines (CPG) are recommendations intended to guide an overall approach to care. (Please see references for an in-depth review of the condition/disease.)

Individual member factors, comorbidities, member preferences and member “Goals of Care” should be considered when making recommendations for an individual member.

Version: 1.0
Delivery: 10/21/2021
Owner: Primary Care Manager

Reviewer: Medical Management
Approver: Medical Director
Date Approved: 09/20/2024

- **Key Points**
- **Informed and Shared Decision-Making**
- **Breast Cancer**
- **Colon Cancer**
- **Cervical Cancer**
- **Endometrial Cancer**
- **Lung Cancer**
- **Prostate Cancer**

2. Cancer Screening Best Practice Standards

- **Breast Cancer Screening**
- **Colon Cancer Screening**
- **Cervical Cancer Screening**
- **Endometrial Cancer Screening**
- **Lung Cancer Screening**
- **Prostate Cancer Screening**

3. Process for Interdisciplinary Team Staff

4. Quality Assurance Monitoring

5. References

1) Overview of Cancer Screening

- **Key Points**
 - Cancer screening is looking for cancer before someone has any symptoms. By the time symptoms appear, the cancer may have grown and spread. This can make the cancer harder to treat or cure
 - Screening tests have risks.
 - Not all screening tests are helpful, and most have risks. It is important to know the risks of the test and whether it has been proven to decrease the chance of dying from cancer.

- False-positive tests, which shows there is cancer when there is not, are possible, causing anxiety and are followed by more tests, which also have risk.
- False-negative test results, which show there is no cancer when it is present, are possible. False-negative tests occur when a test fails to detect a condition or substance that is present in a sample.
- Finding the cancer may not improve the person's health or help the person live longer.
- Some cancers never cause symptoms or become life threatening. There is no way to know if treating the cancer would help the person live longer than if no treatment were given. In both teenagers and adults, there is a rare risk of attempted or actual suicide in the first year after being diagnosed with cancer. Also, treatments for cancer have side effects.

➤ **Informed and Shared Decision-Making**

- PACE and Partnership members are a heterogeneous group, with differing health profiles, prognoses, preferences and goals of care. Life expectancy and quality-of-life issues require an individualized context within which to apply practice guidelines that may have been developed from and for a population of non-frail adults.
- There are three components of informed and shared decision-making:
 - The provider shares screening options with evidence-based information about benefits, harms and uncertainties;
 - The patient shares preferences with the provider, who helps the patient evaluate these options and preferences and make a decision; and
 - The provider assists with recording and implementing the patient's preferences.

➤ **Breast Cancer**

- Breast cancer is the most common female cancer and the second most frequent cause of cancer death in women (genetic females) in the US. It accounts for over 260,000 new cases each year and over 40,000 deaths.
- Breast cancer mortality rate has been decreasing since the 1970s. This decrease in mortality is due to improved breast cancer screening and improvement in adjuvant therapy.
- Therapy saves lives when breast cancers are treated earlier.
- Average risk for breast cancer if do not have:
 - A personal history of breast cancer;
 - A strong family history of breast cancer;
 - A genetic mutation known to increase risk of breast cancer (such as in a *BRCA* gene);
 - Has not had chest radiation therapy before the age of 30; and
 - Does not have Li-Fraumeni syndrome, Cowden syndrome, or Bannayan-Riley-Ruvalcaba syndrome or have first-degree relatives with one of these syndromes.

➤ **Colorectal Cancer (CRC)**

- Annually, approximately 52,980 Americans die of CRC. In the US, CRC incidence rates have been declining by approximately 2% per year, likely due to increasing uptake of screening.
- Most colorectal cancers arise from adenomatous colon polyps that progress from small (<8mm) to large (>8mm) polyps, then to dysplasia and carcinoma. Progression from adenoma to carcinoma is believed to take an average of at least ten years.
- Screening tests for CRC can improve disease prognosis by identifying early-stage CRC that is easier to treat and has a lower mortality rate than CRC detected after symptoms develop.
- Average risk for CRC, if they do not have:
 - A personal history of colorectal cancer or certain types of polyps;
 - A family history of colorectal cancer;
 - A personal history of inflammatory bowel disease (ulcerative colitis or Crohn's disease);

- A confirmed or suspected hereditary colorectal cancer syndrome, such as familial adenomatous polyposis (FAP) or Lynch syndrome (hereditary non-polyposis colon cancer or HNPCC); and
- A personal history of getting radiation to the abdomen (belly) or pelvic area to treat a prior cancer.

➤ **Cervical Cancer**

- Cervical cancer screening detects precancerous changes of the cervix often making treatment possible before cervical cancer develops.
- Screening tests detect cellular changes or infection with types of human papillomavirus (HPV) that may predispose patients to invasive cervical cancer.

➤ **Endometrial Cancer**

- Endometrial cancer develops in 1% to 2% of women in the United States and is the fourth most common cancer in United States women. The incidence peaks between ages 60 and 70 years, but 2% to 5% of cases occur before 40 years of age. Women under age 50, who develop endometrial cancer, are often at risk because of chronic anovulation and/or obesity.

➤ **Lung Cancer**

- Lung cancer is the leading cause of cancer-related death among men and women. The American Cancer Society estimates over 234,000 new cases of lung cancer are diagnosed yearly and over 154,000 lung-cancer associated deaths in the United States.
- Prevention, rather than screening, is the most effective strategy for reducing the burden of lung cancer in the long-term. Most lung cancer is attributed to smoking or environmental smoke exposure.
- The promotion of smoking cessation is essential, as cigarette smoking is thought to be causal in 85% to 90% of all lung cancer.

➤ **Prostate Cancer**

- Among men in the United States, prostate cancer is the leading cause of cancer, accounting for 26% of cancer diagnoses.
- Prostate cancer grows slowly, and most men die of other causes before the disease becomes clinically advanced.
- Men who are being screened for prostate cancer should have a life expectancy of at least ten years.

2) Cancer Screening Best Practice Standards

- Recommendations from the American Cancer Society (ACS) and the U.S. Preventive Services Task Force (USPSTF)

Type	Age	ACS	Age	USPSTF
Breast Cancer	40-44	Mammograms every year after discussion benefits vs. risks.	40-49	Every other year after discussion benefits vs. harm. Increased risk, Family history of breast cancer
Average risk screening with Mammograms	45-54	Every other year or yearly.	45-75	Every other year
	≥55	Yearly if in good health and expected to live ≥ 10.	76-85	Offer based on overall health, prior screening history & preferences.
High risk Mammograms plus MRI	≥30	High risk yearly starting age 30 after informed discussion		≥30 USPSTF for update in progress
Colorectal Cancer Screening Modalities	<45	Increased risk, family history of colorectal cancer	< 45	Increased risk, family history of colorectal cancer
Stool tests gFOBT* yearly	45-75	Regular screening of average risk adults with colonoscopy or FIT testing as primary modality	45-49	Screen all adults average risk (Grade B recommendation)
FIT* yearly			50-75	Screen all adults (Grade A recommendation)
FIT-DNA* q 3y			76-85	Individualize decisions based on patient preferences, life expectancy, health status, and prior screening history (Grade C)
Visual exams				
FSIG* q 5y				
CT-Colonograph y q 5y	76-85	Individualize decisions based on patient preferences, life expectancy, health status, and prior screening history		
FSIG+FIT q 10y	>85	No benefit	>85	

Colonoscopy q 10y	<25	<21	No Benefit
Cervical Cancer Screening	25-65	Not recommended	21-29 Not recommended
	>65	A primary HPV test done every 5 years. If a primary HPV test is not available, a co-test (an HPV test with a Pap test) every 5 years or a Pap test every 3 years No testing if had regular cervical cancer testing in the past 10 years with normal results	30-65 >65 Ages 30 to 65 years, test every 3 years with cervical cytology alone, every 5 years with HPV test alone, or every 5 years with HPV test in combination with a Pap test (co-test) No testing if had regular cervical cancer testing in the past 10 years with normal results and are not otherwise at high risk for cervical cancer
Cervix remov ed		Recommends against unless a history of a high-grade precancerous lesion or cervical cancer	Cervix remov ed Recommends against unless history of a high-grade precancerous lesion (ie, cervical intraepithelial neoplasia [CIN] grade 2 or 3) or cervical cancer.
Endometrial Cancer	55-75	All women at menopause-inform of risks and symptoms of endometrial cancer. Women should report any unexpected vaginal bleeding or spotting to their doctors	
Lung Cancer	≥45	Yearly low-dose CT scan for people who are in fairly good health, currently smoke or have quit in the	50-80 Low-dose CT scan for people who have a 20 pack-year smoking history and currently smoke or have quit within the past 15 years

	45-49	past 15 years and have at least a 30 pack-year smoking history.	55-69y	
Prostate Cancer				After discussion of benefits vs. harms of screening
PSA with or without a rectal exam	50 y	African American men or men with family history of prostate cancer before age 65 after discussion benefits vs. harms of screening	70 or older	Recommends against

Starting at age 50, all men discussion risks vs benefits, informed decision

- gFOBT guaiac-based fecal occult blood test * FIT fecal immunochemical test
- FIT-DNA FIT plus a stool DNA test (Multi-targeted stool DNA test (mt-sDNA)) * CT colonography (virtual colonoscopy)
- FSIG Flexible sigmoidoscopy

3) Process for Interdisciplinary Team Staff (IDTS)

- Review preventive screening at initial assessment and then annually.
- Educate members regarding risks and benefits of cancer screening.
- Offer testing utilizing a shared and informed decision-making process.
- Use motivational interviewing techniques to assess barriers to testing.
- Collaborate with Primary Care Provider (PCP).
- Incorporate in member care plan if a member goal for the next six months.

4) Quality Assurance Monitoring

- Community Care monitors quality of care provided to all its members via Internal File Reviews, target audits, risk reports, HEDIS data, Acumen data, electronic health record guideline reports, Clinical Dashboards and feedback from providers.

- Community Care recognizes that Clinical Practice Guidelines are intended to assist in decision-making and may not apply to all members or circumstances. Complete compliance is not expected for all guidelines.

5) References

- a. Cancer Screening Overview (PDQ®)–Health Professional Version
NIH National Cancer Institute
<https://www.cancer.gov/about-cancer/screening/hp-screening-overview-pdq>
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- b. O'Connor AM, Llewellyn-Thomas HA, Flood AB: Modifying unwarranted variations in health care: shared decision making using patient decision aids. *Health Aff (Millwood) Suppl (Variation): VAR63-72*, 2004.
- c. Charles C, Gafni A, Whelan T: Shared decision-making in the medical encounter: what does it mean? (or it takes at least two to tango). *Soc Sci Med 44 (5): 681-92*, 1997.
- d. United States Preventive Services Task Force Published Recommendations
https://uspreventiveservicestaskforce.org/uspstf/topic_search_results?topic_status=P accessed 10/22/22.
- e. American Cancer Society Prevention and Early Detection Guidelines
<https://www.cancer.org/health-care-professionals/american-cancer-society-prevention-early-detection-guidelines.html> accessed 10/22/21.