Colon Ca Screening Practices Are Often Deficient

BY TIMOTHY F. KIRN
Sacramento Bureau

A single digital rectal exam with a fecal occult blood test performed in the office detects only 5% of important colon neoplasias, and yet at least one-third of primary care physicians rely on this approach for colon cancer screening, two studies have shown.

The studies "send a strong message to primary care physicians to reexamine their colorectal cancer screening practices," said Harold C. Sox, M.D., editor of the Annals of Internal Medicine.

Even when physicians are doing a fecal occult blood test (FOBT), many are not doing it right, Dr. Sox said in an editorial (Ann. Intern. Med. 2005;142:146-8).

Positive results on digital FOBT mean that colonoscopy should be performed, but negative results do not rule out advanced neoplasia.

One study enrolled 2,665 individuals aged 50 to 75 years, most of whom were male. They had a digital rectal examination with a fecal occult blood test, were sent home with Hemoccult II cards to collect six fecal samples from three stools, and also underwent a colonoscopy (Ann. Intern. Med. 2005; 142:81-5).

Colonoscopy identified 284 patients with an advanced neoplasia. The single digital FOBT picked up 5% of those patients, compared with 24% with the six-sample FOBT. The digital FOBT picked up 9% of the cancers; the six-sample FOBT picked up 43%.

The digital FOBT had no negative predictive value, said Judith Collins, M.D., and her colleagues in a Department of Veterans Affairs cooperative study group.

Combining the digital FOBT and the six-sample test did not produce results any more useful than the six-sample test alone. Only five patients with advanced neoplasia had a positive digital FOBT and a negative six-sample FOBT, while 59 had positive six-sample FOBT and negative digital FOBT, said Dr. Collins, of the Portland (Ore.) Veterans Affairs Medical Center.

The second study was a national survey on the use of FOBT by primary care physicians. Of the 1,103 physicians who reported doing a FOBT at least once a month and who indicated what method they used, 26% said they had patients collect six samples at home exclusively, 33% used a single-sample, in-office FOBT method, and 41% used both (Ann. Intern. Med. 2005;142:86-95).

Of the 1,120 physician respondents who indicated how they followed up a positive FOBT, 30% said they repeat it, reported Marion Nadel, Ph.D., of the Centers for Disease Control and Prevention, Atlanta.

Expert panels have recommended having the patient collect two samples from each of three, consecutive-day stools, which is how screening was done in the studies that demonstrated its utility, both study reports noted.

And according to the expert panels, the proper follow-up to a positive test is a colonoscopy, not another FOBT or even a sigmoidoscopy.

In-office tests were used by 66% of internists, 76% of family physicians, 67% of general practice physicians, and 89% of obstetrician/gynecologists.

Although physicians may turn to in-office, single-sample testing because they can be sure of getting the sample and not have to worry about patients returning their stool, the colonoscopy follow-up study totally discredits this approach, Dr. Sox said in his editorial.

Calling those findings "a shocker," he said that perhaps "we need to put the guaiac cards [for in-office testing] in a locked drawer labeled 'use only in case of emergency.' "

The investigators were a bit more diplomatic. If an in-office screen is done, and it is negative for occult blood, it must be followed up with an in-home FOBT, Dr. Collins said.

"Positive results on digital FOBT performed as part of a primary care physical examination are associated with a trend toward an increased likelihood of advanced neoplasia, and colonoscopy should be performed," she wrote. "However, negative results do not reduce the likelihood of advanced neoplasia." ■

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Reference: 1. Sunshine A, Olson NZ, Colon A, et al. Analgesic efficacy of controlled-release oxycodone in postoperative pain. *J Clin Pharmacol.* 1996;36:595-603.

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