

August 28, 2018

Susan J. Curry, Ph.D.
Chairperson
U.S. Preventive Services Task Force
5600 Fishers Lane
Mail Stop 06E53A
Rockville, Maryland 20857

Dear Dr. Curry and Members of the U.S. Preventive Services Task Force (USPSTF):

We wanted to bring to your attention that the American Cancer Society (ACS) recently published an updated guideline for colorectal cancer screening that recommends that screening for colorectal cancer should begin at age 45 for people at average risk instead of age 50 as recommended in the previous guideline. The ACS' updated colorectal cancer screening guideline was influenced by new evidence published since the USPSTF's updated recommendations for colorectal cancer screening were published in 2016. As such, we are recommending the reconsideration of the USPSTF's 2016 Colorectal Cancer Screening recommendation, which will allow the USPSTF to consider these new data.

The updated ACS guideline was based, in part, on data that show increasing rates of colorectal cancer in young- and middle-aged populations. Specifically, ACS looked closely at a recent epidemiological study by ACS and NCI researchers published in the Journal of the National Cancer Institute (JNCI) showing that rising incidence of colorectal cancer in adults under age 55 was due to a strong birth cohort effect, which also is expected to carry over as they age.¹ Notably, this study had not yet been published when the USPSTF updated their colorectal cancer screening recommendations in 2016; yet, even with modeling studies unadjusted for rising incidence, two of the three models commissioned by the USPSTF supported the initiation of screening at age 45. Our ACS colleagues have told us that the USPSTF decision to continue recommending starting screening at age 50 was reasonable in 2016 based on the considerations outlined in the report, but new data related to a birth cohort effect on incidence leads to a stronger case to begin screening at age 45 than could be made in 2016.

While the ACS utilized the systematic review and modeling report that was used by the USPSTF for their 2016 update, they also collaborated with two CISNET modeling groups to reproduce the

¹ Siegel RL, Fedewa SA, Anderson WF, et al. Colorectal cancer incidence patterns in the United States, 1974-2013. JNCI 2017;109:djw322.

analysis that was done for the 2016 update, with models unadjusted similar to the 2016 update, but also adjusted to reflect the rising incidence in these younger birth cohorts. Based on this rising incidence, two CISNET models evaluating outcomes under the increased risk scenario demonstrated model-recommendable strategies at conventional screening intervals beginning at age 45. Based on the more favorable efficiency ratios, the ACS Guideline Development Group concluded that screening should now begin at age 45 instead of age 50.

Because there is strong evidence of the benefit of screening with both stool tests and endoscopic examinations, we believe that microsimulation modeling can be used to evaluate different screening strategies. As noted above, the ACS found the supporting evidence used by the USPSTF for the update of their CRC screening recommendations, along with a supplemental literature review, was a solid foundation for their guideline update. However, because the CISNET models are based on pre-screening incidence rates to avoid bias from the effect of screening, they are not informative about changes that may be warranted in the age to begin screening based on incidence trends over time.

Based on the new evidence, and new findings from two of the three microsimulation models used for the 2016 USPSTF update, including the MISCAN model, which was the outlier in 2016, we are nominating the 2016 USPSTF Colorectal Cancer Screening recommendation for an update and respectfully request that the USPSTF reconsider the 2016 colorectal cancer screening recommendation in order to examine this new information on increasing incidence of colorectal cancer in younger birth cohorts. We also request that the USPSTF give consideration to the concept of the screening continuum, i.e., if a patient has a positive finding on a non-colonoscopy test, the screening process is incomplete until the patient has had a colonoscopy.

Respectfully,

American Cancer Society Cancer Action
Network
AliveAndKickn
Bluestem Health
Bryan Health
C5 (New York Citywide Colon Cancer
Control Coalition)
Colon Cancer Alliance for Research and
Education for Lynch Syndrome
Colon Cancer Coalition
Colon Cancer Foundation of Iowa
COLONTOWN, CRC Patient Community
Colorectal Cancer Alliance
Fight Colorectal Cancer
GCA Centre for Adult Autism

Kiel Colon Cancer Foundation
Michael's Mission
Polymedco
Raymond Foundation
Society of Gastroenterology Nurses and
Associates, Inc.
Stand Up To Cancer
The Blue Hat Foundation
The National Colorectal Cancer Research
Alliance
The Prevent Cancer Foundation
Washington State Colon Cancer Stars