

Time to get "FIT"

Fecal immunochemical test (FIT): A non-invasive test for colorectal cancer screening

Disclaimer:

The intended users of these materials are regional primary care leads and regional aboriginal care leads employed by Cancer Care Ontario. For other individuals who wish to present, or otherwise use these materials, please contact: primarycare inquiries @cancercare.On.Ca



After this presentation, you will be able to:



Understand the Burden of Colorectal Cancer (CRC) in Ontario



Compare CRC Screening Tests for Average Risk Patients







Order the Fecal Immunochemical Test (FIT) and Counsel your Patients

Select Appropriate Follow-Up: Screening Interval and Surveillance

Integrate Cancer Care Ontario Tools to Support your Practice

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Approximately how many new cases of CRC will be diagnosed in Ontario in 2018?

a) 8,500
b) 10,100
c) 11,600
d) 10,600





Fill in the blank: If caught early (stage 1), approximately of people with CRC will be disease free at five years?

a) 90% b) 80% c) 35% d) 55%





Within Ontario, approximately how many people will die from **CRC** annually?

a) 5,000 b) 10,500 c) 19,000 d) 3,350 e) 700





Burden of CRC in Ontario





Source: Cancer Care Ontario. Ontario Cancer Statistics 2018. Toronto: Cancer Care Ontario; 2018. 7

CRC & CRC Screening Among Indigenous Populations

- Traditionally, infectious disease was a leading cause of death among Indigenous people in Ontario
- Over the past few decades, colorectal cancer rates have increased among Indigenous people in Ontario
- Rates of colorectal cancer screening among Indigenous people in Ontario are low, and often lower than non-Indigenous Ontarians



Cancer Care Ontario

Sources:

Chiefs of Ontario, Cancer Care Ontario and Institute for Clinical Evaluative Sciences. Cancer in First Nations People in Ontario. Toronto, 2016.

Chiefs of Ontario and Cancer Care Ontario. Cancer in First Nations in Ontario: Risk Factors and Screening. Toronto, 2016 Tungasuvvingat Inuit and Cancer Care Ontario. Cancer Risk Factors and Screening Among Inuit in Ontario and Other Canadian Regions. Toronto, 2017.

Métis Nation of Ontario and Cancer Care Ontario. Cancer in the Métis people of Ontario: Risk Factors and Screening Behaviours. Ottawa, 2015.

Status First Nations

Sex	Ontario Status First Nations Age Standardized Incidence Rates	
Males	56.37	
Females	38.19	

Age-standardized cancer incidence rates (per 100,000) among Ontario Status First Nations and the rest of Ontario population 1991-2010



Cancer Care Ontario

Sources: Chiefs of Ontario, Cancer Care Ontario and Institute for Clinical Evaluative Sciences. Cancer in First Nations People in Ontario. Toronto, 2016. Available at: http://www.snhs.ca/FNCancerInFirstNationsReportCOOCCO.PDF

9 Marrett and Chaudhry. 2003. Cancer incidence and mortality in Ontario First Nations, 1968-1991 (Canada). Cancer Causes and Control . 14:259-268.

Rest of Ontario Age Standardized **Incidence** Rates 41.32

28.41

CRC Incidence Rate in Inuit Populations

Inuit

Sex	Inuit Nunangat Age Standardized Incidence Rates	Rest of Canada Age Standardized Incidence Rates
Males	62.6	43.3
Females	57.6	30.8

Age-standardized incidence rates per 100,000 for residents in Inuit Nunangat and the rest of Canada, 1998-2007



Cancer Care Ontario



Source: Carrière et al. (2012). Cancer patterns in Inuit Nunangat: 1998-2007. Int J Circumpolar Health; 71:18581 10

CRC Incidence Rate in Métis Populations

Métis

Sex	Métis Age Standardized Incidence Rates	
Males	74.3	
Females	37.0	



Source: Mazereeuw et al. (2017). Cancer incidence and survival among Métis adults in Canada: results from the Canadian census follow-up cohort (1992 2009). CMAJ. In Press



Rest of Ontario Age Standardized Incidence Rates 75.4 50.3

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Describe Learnings from Other Jurisdictions



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Integrate Cancer Care Ontario Tools to Support your Practice

Fill in the blank: Of the individuals diagnosed with CRC, approximately _____have no family history of the disease.

a) 50% b) 15% c) 70% d) 90% e) 25%





Ontario's ColonCancerCheck (CCC) Program

- Canada's first organized province-wide CRC screening program launched in 2008
- Sends letters to eligible people
- Screening offered to people ages 50–74 Via primary care provider
 - Average risk: guaiac fecal occult blood test (gFOBT)* until fecal immunochemical test (FIT) is available in Ontario
 - **Increased risk** (≥1 first-degree relative with CRC): colonoscopy 0



hema-screen	hema-soreen	henna-soreen
Date Specimen Collected: YYYY/MM/DD Time Specimen Collected: AMPM TANK NACK FOR PROTOCOLOGY T 1 +	Date Specimen Collected: YYYY/MM/DD Time Specimen Collected: AMPM TIME INCK FOR INSTRUCTIONS T 2 T	Date Specimen Collected: /// YYYY/MM/DD Time Specimen Collected: AMPM TLAP SACK FOR RETROCTORE T 3 T TODO

*Flexible sigmoidoscopy every 10 years is an acceptable screening test.



gFOBT vs. No Screening		Immunosity inc. Immunosity inc. hema-sorreen hema-sorreen Dutte Specimen Collected: Pryvy / MM / DD Time Specimen Collected: PM Max NOR	
	13% redu	ction in CRC deaths	
Outcome	es	Relative Effect (95% CI*)	# of Person-Years (# of studies)
CRC mortality		RR* 0.87	5,344,100
(follow-up range: 17–30 years) (0.82–0.92)		(0.82–0.92)	(4 RCTs)
CRC incidence		RR 0.96	4,866,448
(follow-up range: 17-3	30 years)	(0.90–1.02)	(5 RCTs)

*CI=confidence interval, RR= relative risk, RCT= randomized control trial

Source: Tinmouth J, Vella E, Baxter N, Dubé C, Gould M, Hey A, et al. Colorectal Cancer Screening in Average Risk Populations: Evidence summary. Toronto (ON): CCO; 2015 October 30. Program in Evidence-based Care Evidence Summary No.: 15-14. 15



Organized CRC Screening in Canada



Cancer Care Ontario

Source: National Colorectal Cancer Screening Network Report Survey, July 2016; Colorectal Cancer Screening in Canada: Environmental Scan, April 2017 16



CCC is implementing FIT as the recommended screening test for people at average risk of colorectal cancer (CRC) on June 24, 2019

gFOBT vs. FIT Lab Parameters

	gFOBT
Measures	Heme; non-spec
Test technique	Guaiac; peroxid
Lower limit of blood detection	300–600 µg Hb
Interference	Vitamin C, other so of Hb



No dietary or medicine restrictions





gFOBT vs. FIT Lab Parameters		
	gFOBT	
Shelf life	3 years	
Specimen stability		Les
# of samples required	3	
Lab process	Manual	
Results	Qualitative	







12 to 18 months

s stable at high temperatures and over time

1

Automated

Qualitative or quantitative

FIT Usability for Participants

- At-home stool sample screening test
- 1 sample
- Tube designed for easy sampling
- No dietary or medication restrictions





Accuracy for CRC: One-Time Test

	Sensitivit
FIT (n=15 studies)	82%
gFOBT (Hemoccult II) (n=8 studies)	38%

CCC Cancer Care Ontario

Sources: Lee JK, Liles EG, Bent S, Levin TR, Corley DA. Accuracy of fecal immunochemical tests for colorectal cancer: systematic review and meta-analysis. Ann Intern Med 2014;160:171-181. Canadian Task Force on Preventive Health Care. Screening for Colorectal Cancer [Internet]. Ottawa, Canada: Canadian Task Force on Preventive Health Care; 2014. Available from: 21 http://canadiantaskforce.ca/guidelines/published-guidelines/colorectal-cancer/



FIT vs. gFOBT: Clinical Implications

Outcomes	Relative Effect (95% CI*)
Participation rate	RR* 1.16 (1.05–1.28)
CRC and HRA* detection	RR 2.15 (1.58–2.94)
	• 2X



*HRA= High risk adenoma, CI = confidence interval, RCT= randomized control trial, RR= relative risk Source: Tinmouth J, Vella E, Baxter NN, Dubé C, Gould M, Hey A, et al. Colorectal cancer screening in average risk populations: Evidence summary. Toronto (ON): CCO; 2015 November 11. Program in 22 Evidence-based Care Evidence Summary No.: 15-14.

16% increase in participation

of Person-Years
 (# of studies)

52,038 (6 RCT*s) 51,634 (5 RCTs)

2X more accurate Detects CRC and HRA

Adenoma to Cancer





FIT has potential to reduce the incidence of CRC



FIT detects gFOBT detects



Cost Effectiveness of FIT

OPEN O ACCESS Freely available online

PLOS MEDICINE

Colorectal Cancer Screening for Average-Risk North Americans: An Economic Evaluation

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fits and costs of fecal nical testing versus guaiac fecal testing for colorectal cancer

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- screening
- studies

Sources: Heitman S, Hilsden R, Au F, Dowden S, Manns B. Colorectal Cancer Screening for Average-Risk North Americans: An Economic Evaluation. PLoS Medicine. 2010;7(11):e1000370. Goede S, Rabeneck L, van Ballegooijen M, Zauber A, Paszat L, Hoch J et al. Harms, benefits and costs of fecal immunochemical testing versus guaiac fecal occult blood testing for colorectal cancer screening. PLOS ONE. 2017;12(3):e0172864. 24

Modelling techniques used to estimate relative benefits and costs of FIT vs other screening approaches/no

Canadian cost data used in both

Cost Effectiveness of FIT

Key Findings

- biennial screening with FIT is:
 - o more effective and less costly than gFOBT
 - $\circ\,$ as effective as, and less costly than, colonoscopy; and
 - $\circ~$ cost saving compared to no screening

Sources: Heitman S, Hilsden R, Au F, Dowden S, Manns B. Colorectal Cancer Screening for Average-Risk North Americans: An Economic Evaluation. PLoS Medicine. 2010;7(11):e1000370. Goede S, Rabeneck L, van Ballegooijen M, Zauber A, Paszat L, Hoch J et al. Harms, benefits and costs of fecal immunochemical testing versus guaiac fecal occult blood testing for colorectal cancer screening. PLOS ONE. 2017;12(3):e0172864.



BT lonoscopy; and

FIT vs. Colonoscopy for Average Risk Screening

Systematic Review: Average Risk Screening for CRC

Evidence

Fecal tests for occult blood

FIT is at least as good as gFOBT for \downarrow CRC-related mortality

 Flexible sigmoidoscopy vs. no screening

Colonoscopy is at least as sensitive as FS but uncertain risk/benefit ratio

Colonoscopy vs. no screening

Early results are promising

• FIT vs. colonoscopy

Strength

Strong evidence

Strong evidence

Insufficient direct evidence

Strong emerging evidence *3 large-scale RCTs are underway

Quintero et al.: FIT vs. Colonoscopy

The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

Colonoscopy versus Fecal Immunochemical Testing in Colorectal-Cancer Screening

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ABSTRACT

BACKGROUND

Colonoscopy and fecal immunochemical testing (FIT) are accepted strategies for colorectal-cancer screening in the average-risk population.

METHODS

In this randomized, controlled trial involving asymptomatic adults 50 to 69 years of age, we compared one-time colonoscopy in 26,703 subjects with FIT every 2 years in 26,599 subjects. The primary outcome was the rate of death from colorectal cancer at 10 years. This interim report describes rates of participation, diagnostic findings, and occurrence of major complications at completion of the baseline screening. Study outcomes were analyzed in both intention-to-screen and as-screened populations.

RESULTS

The rate of participation was higher in the FIT group than in the colonoscopy group (34.2% vs. 24.6%, P<0.001). Colorectal cancer was found in 30 subjects (0.1%) in the colonoscopy group and 33 subjects (0.1%) in the FIT group (odds ratio, 0.99; 95% confidence interval [CI], 0.61 to 1.64; P=0.99). Advanced adenomas were detected in 514 subjects (1.9%) in the colonoscopy group and 231 subjects (0.9%) in the FIT group (odds ratio, 2.30; 95% CI, 1.97 to 2.69; P<0.001), and nonadvanced adenomas were detected in 1109 subjects (4.2%) in the colonoscopy group and 119 subjects (0.4%) in the FIT group (odds ratio, 9.80; 95% CI, 8.10 to 11.85; P<0.001).

CONCLUSIONS

Subjects in the FIT group were more likely to participate in screening than were those in the colonoscopy group. On the baseline screening examination, the numbers of subjects in whom colorectal cancer was detected were similar in the two study groups, but more adenomas were identified in the colonoscopy group. (Funded by Instituto de Salud Carlos III and others; ClinicalTrials.gov number, NCT00906997.)

N ENGLJ MED 366;8 NEJM.ORG FEBRUARY 23, 2012

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Large RCT in Spain

Ages 50–69

Biennial FIT vs. one-time colonoscopy



Cancer Care Ontario

Mailed invitation to participate

Primary outcome: CRC death at 10 years

Reflects only first round results

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Drs. Quintero and Castells contributed equally to this article.

*The investigators in the COLONPREV study are listed in the Supplementary Appendix, available at NEJM.org.

This article was updated on April 27 2016, at NEJM.org.

N Engl J Med 2012;366:697-706. Copyright © 2012 Massachusetts Medical Society

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Quintero et al.: Patients Prefer FIT



Patients prefer FIT when given the option

26,703 invited for colonoscopy

28% responded

1% offered FIT opted for colonoscopy

4,953 completed colonoscopy

Overall colonoscopy participation: **24.6%**

Quintero et al.: Diagnostic Yield – Intention to Screen

		Colonoscopy n=26,703	FIT n=26,599	P-value
CRC c	letection	30	33	Not significant
HRA	Reflects first round results only	514	231	<0.001
# need 1 CRC	ded to <u>screen</u> to find	191	281	
# need 1 CRC	ded to <u>scope</u> to find	191	18	
# of co	omplications	24	10	<0.001



Colonoscopy Associated Complications: Calgary, Alberta

Complication N=18,456 Total # adverse events: 119

Bleeding

Perforation

Post-polypectomy syndrome

Cardiac

Syncope/hypotension

GI symptoms (minor and transient)

Splenic/hepatic hematoma

Other

Colonoscopy benign proc

Sources: Hilsden RJ, Dube C, Heitman SJ, Bridges R, McGregor SE, Rostom A. The association of colonoscopy quality indicators with the detection of screen-relevant lesions, adverse events, and postcolonoscopy cancers in an asymptomatic Canadian colorectal cancer screening population. Gastro Endosc. 2015 Nov; 82(5):887-94. Cash BD, Saltzman JR, Robson KM. Postpolypectomy electrocoagulation syndrome Postpolypectomy electrocoagulation syndrome

Event Rate* *per 1,000 colonoscopies

	2.93	
	0.22	
	0.16	
	0.22	
	0.27	
	1.95	
is not a	0.11	
edure	0.60	

Screening with Colonoscopy vs. FIT



FIT: same number of colonoscopies • more people screened • more cancers detected • higher diagnostic yield

FIT+ Colonoscopy 100,000 20x with 8,000 FIT 4.5x with 45,000 FIT 32

1.8 Million

18x with

FIT

FIT vs. Colonoscopy: Summary

- Patients prefer FIT
- FIT is safer than colonoscopy
- FIT is as good as colonoscopy at detecting CRC in average risk people
- FIT-positive colonoscopy is high yield colonoscopy used in people most likely to benefit

The CCC program does not recommend screening for average risk people with colonoscopy

FIT → better risk–benefit ratio of screening

CRC in average risk people noscopy used in people most

Case Study 1 - Part 1

You are discussing CRC screening with Rahm, a 52 year old man with no known family history of CRC. Rahm has heard about colonoscopy examination through a friend on his baseball team, and he has decided he really wants one. Rahm has heard that fecal-based testing can often miss identifying cancers. During your conversation, you are emphasizing the benefit(s) of FIT to him. Please identity the benefit(s) of the FIT.

- a) High sensitivity for CRC
- b) Detects high risk adenomas (HRAs)
- c) Easy take-home screening test (e.g., one stool sample, no dietary medication restrictions)
- d) FIT is non-invasive and safer than colonoscopye) All of the above



ol sample, no dietary

After you explain the benefits of FIT, your patient still feels they may want to have a colonoscopy and asks about potential risks. What are the risks associated with colonoscopy?

- a) Colonoscopy-related perforation
- b) Post-polypectomy bleeding
- c) Risks related to bowel preparation
- d) Risks related to the use of sedation
- e) All of the above





Case Study 2

Danielle, a 66 year old woman with no family history of CRC, mentions that she has been experiencing fatigue, shortness of breath, weakness and low energy for the past two months. She denies any rectal bleeding, melena, or hematemesis. You conduct a focused patient history and thorough physical examination and order routine bloodwork. Danielle's hemoglobin is reported back as 108 g/L (it was measured to be 130 g/L one year previously) and her ferritin level is 5 μ g/L (reference range: 11-307 ug/L). Please identify the next appropriate course of action:

a) Complete a FIT requisition for Danielle b) Have Danielle come for an in-office gFOBT c) Refer Danielle for specialist evaluation (including colonoscopy) d) Prescribe iron supplements and counsel Danielle on dietary sources of iron e) c and d
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Cancer Care Ontario

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Colorectal Cancer CRC Screening in Calgary, Alberta

Before fecal immunochemical test (FIT) roll out:

- Primary care providers preferred colonoscopy over guaiac fecal occult blood test (gFOBT)
- Only 23.5% gFOBT participation in Calgary zone

Introduction of FIT:

- Rapid uptake of the FIT
- 31–35% FIT participation in Calgary zone
- Primary care providers quickly saw value of screening with FIT \bullet



FIT Roll Out: Impact on Colonoscopy in Calgary, Alberta





Source: Alberta Health Services. First Year Experience with the Fecal Immunochemical Test. June 2015. 39

Calgary: Lesions Detected at Colonoscopy



CCO





FIT+

Source: Alberta Health Services. First Year Experience with the Fecal Immunochemical Test. June 2015. 40

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ColonCancerCheck (CCC) Eligibility Criteria for FIT

Average risk



- Age 50 to 74
- Asymptomatic
- No first-degree relative diagnosed with colorectal • cancer
- No personal history of colorectal cancer, Crohn's disease involving colon or ulcerative colitis
- No colorectal polyps needing surveillance
- · Valid OHIP number

Eligibility criteria have not changed

Cancer Care Ontario

Source: Cancer Care Ontario. ColonCancerCheck Screening Recommendations Summary (2018). Available at: www.cancercare.on.ca/FIThub

Jamieson is a 52 year old patient who comes to your office indicating that he has recently noticed numerous streaks of blood on his toilet paper. You conduct a thorough physical examination, including a digital rectal exam, and note the presence of hemorrhoids but no mass. During your appointment, you note that Jamieson is due for colorectal cancer screening next month. Please identify the appropriate next course of action:

a) Refer for endoscopic evaluation (may include colonoscopy)
b) Order a computed tomography colonography
c) Repeat digital rectal examination in three months
d) Complete a FIT requisition for Jamieson
e) Reassure Jamieson and recommend topical therapy for hemorrhoids





Your new patient Kelly is a 50 year old woman who presents to your office for a periodic health visit. Kelly has a history of hemorrhoids that were treated with rubber band ligation 10 years ago. Kelly can still feel skin tags when wiping after a bowel movement but hasn't experienced any bleeding since the banding ten years ago. Taking the above into consideration, how and when should Kelly be screened for CRC?

a) Kelly should be screened every ten years with a colonoscopy b) Kelly should be screened every two years with a colonoscopy c) Kelly should be screened every two years with FIT d) Kelly should be screened every two years with flexible sigmoidoscopy e) None of the above





Jessica suffers from chronic atrial fibrillation and has been on dabigatran for the past year. Upon her 72nd birthday, she receives a correspondence letter from Cancer Care Ontario indicating that it's time for her to complete CRC screening. Jessica has completed a number of gFOBT in the past, with no abnormal findings. Taking the above into consideration, is it appropriate to screen Jessica for CRC with FIT?

a) Yes b) No c) Unsure

CO Cancer Care Ontario



Ordering FIT: Steps for Providers

How to Order FIT for Patients



*Patients who live on a First Nation reserve can contact their health centre or nursing station



Step 3

Step 4

Submit completed FIT requisition to LifeLabs

LifeLabs will mail prelabelled FIT kit to patient

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Requisition Changes

MOHLTC lab requisition cannot be used to request CCC program FIT

CCC gFOBT will be removed from MOHLTC lab requisition



Cancer Care Ontario

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Clinician/Practitioner Signature Da 22-84 (2012/11) © Queen's Printer for Ontario, 2012

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- FIT kits can be completed up to 6
 months after lab receives FIT
 requisition
- Supports patients who opt for a different preferred FIT mailing address



Eligibility Criteria:				
Age 50 to 74 Asymptomatic No personal history of colorectal cancer, Crohn's d involving the colon or ulcerative colitis No first-degree relative diagnosed with colorect No colorectal polyps needing surveillance Due for screening (no FIT in the last two years, a flexible sigmoidoscopy or colonoscopy in the last Valid Ontario Health Insurance Plan (OHIP) num	isease al cancer nd no t 10 years) ber		Lab Use Only	
 Note: Do not use for the workup of patients w ColonCancerCheck does not recommer years should include an assessment of r It is not appropriate to screen people or 	vith overt GI bleedin nd routine screening isks and benefits, ar ver 85 years of age.	g and/or anemia. ; for people over 74 years. De id take into consideration he	ecisions to screen those between the salth, life expectancy, and prior screen	ages of 75 to 85 ing history.
 Check box if patient requires a new FIT kit (i.e., 	FIT was lost, damage	d, or not received) and compl	lete this form. Call question	s: 1-833-676-1426
All sections on this form must be acc	urate and comp	plete. Fax the requisiti	on to 1-87	P
1. Requester Information				
Requester Type (check one): Physician D Mobile Coach Nurse Practitioner D Telehealth Ontario	Mobile Coach ID:	CPSO or CN	NO N OHIP Billing N	lumber:
Last Name:	Middle Name (op	tional):	me:	
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Copy to: Physician/Nurse in Charge for Nursing St	ations. If the same a	s Reque	ot complete this section.	
Last Name:	Middle Name (opt	tion	First Name:	
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2. Patient Information	—	etters and other corre	espondence will be sent to the f	Patient Address)
Last Name (on OHIP card):		HIP card, optional):	First Name (on OHIP card):	5
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New FIT Requisition

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Note: • Do not use for the workup of patients with overt GI bleeding and/or anemia.

 ColonCancerCheck does not recommend routine screening for people over 74 years. Decisions to screen those between the ages of 75 to 85. years should include an assessment of risks and benefits, and take into consideration health, life expectancy, and prior screening history. It is not appropriate to screen people over 85 years of age.

Ensure Your Patients Get Their FIT

Confirm that patient information is up to • To obtain a F • To receive re	nt address o date: IT kit sults			Fecal Immunochemical Test (FIT) Requisitie Eligibility Criteria: • Age 50 to 74 • Asymptornatic • No personal history of colorectal cancer, Crohn's disease involving the colon or ulcerative colitis • No frist-degree relative diagnosed with colorectal cancer • No colorectal polyps needing surveillance • Due for screening (no FIT in the last two years, and no flexible sigmoidoscopy or colonoscopy in the last 10 years) • Valid Ontario Health Insurance Plan (OHIP) number Note: • Do not use for the workup of patients with over 00 • ColonCancerCheck does not recommend routine years should include an assessment of risks and be it is not appropriate to screen people over 85 year Check box if patient requires a new FIT kit (i.e., FIT was loss All sections on this form must be accurate and 1. Requester Information Requester Type (check one): Mobile Coach Physician Mobile Coach Nurse Practitioner Telehealth Ontario Last Name Middle 1	on - Form Completion Fee Cod Q150 Lab U: Lab U: Si bleeding and/or anemia. Lab U: Si bleeding and/or anemia. Screening for people over 74 years. Decisions to so enefits, and take into consideration health, life exp rs of age. t, damaged, or not received) and complete this form the complete. Fax the requisition to 1-8 Coach ID: CPSO or CNO Number. Name (optional): First N	Se Only Treen those between the ages of 75 to 85 Tectancy, and prior screening history. A. Call LifeLabs for questions: 1-833-676-1426 CHIP Billing Number: DHIP Billing Number: DHIP Billing Number:
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CCC Cancer Care Ontario				City: Province Ontari 4. Requester Verification Requester Signature: Need this information in an accessible format? 1-855-460	e: Postal Code: Ext. (o 0 Date: yyyy/mm/dd +2647, TTY 416-217-1815 publicaffairs@cancercare.c	optional) Type: Work Home Cell On.ca Type: Work Contario



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Ensure Your Patients Get Their FIT



	Alternate FIT kit	delivery	Eligibilit Age 50 Asymp No per involvi No firs No col Due fo flexible Valid C	y Criteria: 0 to 74 ptomatic rsonal history of colorectal cancer, Crohn ing the colon or ulcerative colitis st-degree relative diagnosed with colore lorectal polyps needing surveillance or screening (no FIT in the last two years e sigmoidoscopy or colonoscopy in the Dontario Health Insurance Plan (OHIP) nu	s disease ectal cancer s, and no last 10 years) imber		Lab Use Only	L/TE	Laps
	option		Note: .	Do not use for the workup of patient ColonCancerCheck does not recomm years should include an assessment of	s with overt nend routine of risks and b	GI bleeding and/or anemi screening for people over penefits, and take into cons	a. r 74 years. Decisions to screen thos sideration health, life expectancy, ar	e between the ag and prior screenin	ges of 75 to 85 ng history.
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Preparing Your Practice for FIT: Requisition

- Call LifeLabs at 1-833-676-1426 if you do not routinely receive laboratory supplies or test results from them
- Add the FIT requisition to your usual process for requesting laboratory tests Add the FIT requisition to your library of custom forms
- Add LifeLabs kit distribution contact information to your address book
 - Phone: 833-676-1426
 - Fax Requisition: 1-833-676-1427
- FIT requisition can be found at: cancercareontario.ca/pcscreeningprograms The FIT requisition will be made available before FIT launch



FIT Kit

- LifeLabs mails the FIT kit within two days of receiving a complete FIT requisition
- Once mailed from LifeLabs most patients can expect to receive their FIT kit from Canada Post within five to 10 days (standard local mail)





Why Centralized Distribution?

Program challenges

- 11.1% of gFOBTs require re-testing
- Majority of rejected tests due to mislabelling
- gFOBT shelf-life: three years
- FIT shelf-life: 12 months

Inappropriate use of gFOBT:

- Repeating gFOBT between recommended screening intervals
- Using the test in people outside the screen-eligible age range

Laboratory verification of patient information during processing of requisition form

Addressing program challenges for FIT

Pre-labelled FIT kit with patient identifiers

Inventory management at central laboratory

Why Centralized Distribution?

Centralized distribution eliminates almost 90% of causes for rejected tests







Ordering FIT for Unattached Patients

 Unattached patients can contact Telehealth Ontario or a mobile coach (where available) to request a FIT kit

ColonCancerCheck

As part of the ColonCancerCheck program, unattached patients (those without a primary care provider) can be screened for colon cancer, for example, by contacting Telehealth Ontario. Unattached patients with an abnormal result need to connect with a primary care provider for appropriate follow-up. By providing the information below, you are indicating you are willing to accept new patients to your primary care practice from the ColonCancerCheck program as of the date of form completion. You can remove your name from the referral list at any time by calling 1-866-662-9233. Please note, if you are a patient enrolment model (PEM) physician and you roster patients referred from Cancer Care Ontario to your practice, you can claim the Q043A New Patient Fee Positive/Increased Risk Colorectal Cancer.

Personal information on this form, such as sex, is collected under the authority of the Cancer Act and will be used to attach patients to you. Questions about this collection should be directed to primarycareinquiries@cancercare.on.ca

Asterisk (*) indicates mandatory fields *Physician's First Name:

*Sex: Male Female

Billing Number:

Organization Name:

Practice Model Type:

- □ Family Health Group
- Family Health Network
- □ Family Health Organization

Please include the requested information for all locations from which you practice and are willing to accept new patients as part of the ColonCancerCheck program.

Practice Location #1 *Address Line 1: *Address Line 2: *City: *Prov: ON *Postal Code: *Phone Number: *Fax Number: Email Address:

*Physician Signature:





Physician Registration for Patient Attachment

Upon completion, please fax or email this form to: 416-971-6888 or screenforlife@cancercare.on.ca

*Physician's Last Name:

*Languages Served:
English
French
Other:

CPSO Number:

Rural Northern Physician Group Agreement Community Health Centre Comprehensive Care Model □ Non-PEM Primary Care Provider □ Other

Practice Location #2 *Address Line 1 *Address Line 2: *City: *Prov: ON *Postal Code: *Phone Number *Fax Number: Email Address:

*Date:



Completing FIT: Steps for Patients

Completing FIT: 3 Steps for Patients



Step 2

Check label accuracy and clearly record specimen collection date on FIT tube

Complete FIT



Step 3

Mail or drop off completed FIT to LifeLabs as soon as possible

Supporting Patients

- Patients will continue to receive CCC program correspondence
 - Invitations/recalls
 - Reminders
 - **Results**
- Physician-linked correspondence helps increase screening rates
- cancercareontario.ca/en/physician-linked-correspondence



Source:

Tinmouth J, Baxter NN, Paszat L, Sutradhar R, Rabeneck L, Yun L. Using physicianlinked mailed invitations in an organised colorectal cancer screening programme: effectiveness and factors associated with response. BMJ. 2014 Mar 12;4(3):e004494. doi: 10.1136/bmjopen-2013-004494



Evidence Supporting CCC Correspondence

- Physician-Linked Correspondence (PLC) Pilot (2009, 2012) lacksquarePLC helps increase screening rates vs no mailed invite, and vs non-PLC invites
- Focus testing & consultation with health behaviorists (2013) lacksquareInformed revisions to CCC correspondence messaging and approach
- Male-specific correspondence RCT (2014)
 - Male-specific invitation: 21% greater odds of screening with gFOBT among men, compared to standard letter
 - Among men & women, receiving any letter significantly increased screening uptake



Source: Tinmouth J, et al. BMJ. 2014 Mar 12;4(3):e004494. Llovet et al., Cancer Care Ontario, 2013.

Supporting Patients

Same place, new test!

The fecal immunochemical test (FIT) is a **simple, safe** and **accurate** way to check for colon cancer

Call your family doctor or nurse practitioner to get the FIT If you do not have a family doctor or nurse practitioner, call Telehealth Ontario **1.866.797.0000**

If you live on a First Nation reserve, contact your health centre or nursing station

CCC Cancer Care Ontario



Supporting Patients

- Patient-friendly FIT materials have been developed, including FIT instructions with more visuals than words
- FIT instructions will be available in 20+ languages and in accessible format online: cancercareontario.ca/FITinstructions





Supporting Patients- Lab Label



Date of birth Your name





FIT Return

Completed FIT kit should be returned as soon as possible to LifeLabs ideally within 2 days of collecting the specimen

- Mail
 - Regular mail
 - Expedited mail included for some areas Ο
- Drop off at LifeLabs Patient Service Centres
- If your patient lives on a First Nations reserve, contact the health centre or nursing station for return options





Results received 15-30 days after collection that are below the positivity threshold will be reported as "invalid"

Patient Service Centre (PSC) Locations

To find the closest PSC to drop off a completed FIT, visit: locations.lifelabs.com





FIT Results and Follow-Up by Primary Care Provider (PCP)

Results



Do NOT repeat FIT- test will be rejected

CCC Cancer Care Ontario

Repeat FIT in the next few weeks – new requisition required

Repeat FIT in 2 years*

PCP is responsible for arranging follow-up colonoscopy to be performed within **8 weeks**

*For people ages 50–74.

The Patient Perspective

An abnormal FIT result can be stressful for your patient and their family • At the time of ordering FIT, explain that an abnormal FIT:

- - Is NOT a cancer diagnosis
 - Needs timely follow-up with colonoscopy within eight weeks Ο
 - Can identify a polyp before it becomes cancerous Ο
- For patient materials explaining an abnormal FIT result, visit: \bullet cancercareontario.ca/FITresult



Anna is a 64 year old woman who has recently completed a FIT. When her FIT result comes back as abnormal, Anna calls you and mentions that she completed her FIT just one day after having a tooth removed by her dentist. Anna would like to repeat the FIT. What should you do and why?

a) Complete another FIT requisition for Anna
b) Refer Anna for flexible sigmoidoscopy
c) Have Anna come for an in-office gFOBT
d) Counsel Anna on the importance of a follow-up colonoscopy and refer her promptly for colonoscopy
e) None of the above





Receiving and Interpreting Lab Reports: Normal and Abnormal

- Lab reports for providers will include the FIT result and recommended next steps, including follow-up
- FIT results will be reported as normal, abnormal, invalid or rejected

Test	Result	Canned Comments
FIT	Normal	Action required for you: Re-screen your patient w ColonCancerCheck eligibility criteria for average
		For more information, please visit cancercareonta ColonCancerCheck's screening recommendation
FIT	ABNORMAL	Action required for you: REFER TO COLONOSC be completed within 8 weeks of the abnormal FIT
		For a list of facilities funded by Cancer Care Onta abnormal FIT result, please visit cancercareontar
		Note: Requests to repeat FIT after an abnormal FIT res after an abnormal FIT or gFOBT is not appropriat

- vith FIT in 2 years if they continue to meet the risk colorectal cancer screening.
- ario.ca/CCCrecommendations to access
- COPY as soon as possible. The colonoscopy should I result.
- ario to provide colonoscopies for patients with an rio.ca/FITcolonoscopy
- sult will not be accepted by the lab. Repeating the FIT te and can lead to delays in diagnosis and treatment.

Receiving and Interpreting Lab Reports: Rejected and Invalid

Test	Result	Canned Comments
FIT	FIT Collection Device Rejected	Comment: The FIT specimen was received more the tested.
		Action required for you: Complete a new FIT requis
		Action required for your patient:
		Please advise your patient to complete a new FIT a possible, ideally within 2 days, to ensure it arrives a
		Please visit cancercareontario.ca/FITinstructions to
FIT	Invalid	Comment: The lab received the FIT collection devidate. It was not possible to get a reliable result.
		Action required for you: Complete a new FIT requis
		Action required for your patient:
		Please advise your patient to complete a new FIT a possible, ideally within 2 days, to ensure it arrives a
		Please visit cancercareontario.ca/FITinstructions to

han 30 days after the collection date and could not be

sition for your patient.

and mail it back to the lab (or drop it off) as soon as at the lab within 14 days of specimen collection.

o access the FIT instructions. ce more than 14 days after the specimen collection

sition for your patient.

and mail it back to the lab (or drop it off) as soon as at the lab within 14 days of specimen collection.

o access the FIT instructions.

Test	Result	Canned Comments
FIT	Requisition Rejected	Comment: A valid Ontario Health Insurar Action required for you: Please contact y complete a new FIT requisition.
FIT	Requisition Rejected	Comment: A FIT collection device was all request. Action required for you: If your patient re was incorrect, please contact the lab dire
FIT	Requisition Rejected	Comment: Your patient is not age-eligible Action required for you: Please contact y FIT kit. For more information, please visit access ColonCancerCheck's screening r

- nce Plan (OHIP) number was not provided.
- our patient to confirm their OHIP information and

- lready sent to this patient within 6 months of this
- equires a new FIT kit or if their address information ectly at 1-833-676-1426.
- e for screening with the FIT.
- our patient to let them know they will not receive a t cancercareontario.ca/CCCrecommendations to recommendations.
Discontinuation of CCC gFOBT in Ontario

- **Do not delay!** Continue to screen your patients with gFOBT until FIT is available through the CCC program
- Laboratories will continue to test gFOBT kits 6 months after FIT is introduced





>1 Month

• FIT data available in screening activity report

>6 Months

Patients who complete gFOBT no longer considered up-to-date for CRC screening

Disposing of CCC gFOBT Kits in Ontario

- Once FIT is available in Ontario, CCC gFOBT laboratory providers will arrange to remove unused CCC gFOBT kits from primary care provider offices, pharmacies, and Cancer Care Ontario mobile screening coaches.
 If you have any questions, contact your CCC gFOBT laboratory provider for
- If you have any questions, contact your CC more information.



After this presentation, you will be able to:



Understand the Burden of Colorectal Cancer (CRC) in Ontario







Order the Fecal Immunochemical Test (FIT) and Counsel your Patients

Select Appropriate Follow-Up: Screening Interval and Surveillance

Integrate Cancer Care Ontario Tools to Support your Practice

Follow-Up of guaiac fecal occult blood test (gFOBT)



Benchmark: follow-up within 8 weeks

Cancer Care Ontario

to: Cancer Care Ontario; 2018. -follow-up

Ensure Timely Follow-Up

- Colonoscopy should be completed within 8 weeks of an abnormal fecal immunochemical test (FIT) result
- Abnormal FIT results are associated with a higher chance of colorectal cancer (CRC)
- Diagnostic delays can lead to disease progression
- Timely follow-up is critical to minimize patient anxiety



gression ent anxiety

Importance of Timely Follow-Up

Time to colonoscopy after FIT+	% cases receiving colonoscopy after FIT+			
	Any CRC	Advanced-stage CRC		
8–30 days	2.97%	0.81%		
2 months	2.78%	0.70%		
3 months	3.06%	0.69%		
4–6 months	3.14%	0.88%		
7–12 months	4.56%	1.49%		
>12 months	7.55%	3.13%		

Impact of diagnostic delay is seen within months - significantly higher risk of CRC outcomes after 6 months



Source: Corley et al. JAMA 2017;317(16):1631-41.

Importance of Follow-Up



Patients with an abnormal FIT who do not undergo colonoscopy are more likely to die from CRC (1.63 fold increase)

Cancer Care Ontario

CCO

Source: Lee et al., Association Between Colorectal Cancer Mortality and Gradient Fecal Hemoglobin Concentration in Colonoscopy Noncompliers. J Natl Cancer Inst (2017) 109(5) 79

You receive a lab report indicating that your 54 year old patient, Katya, has an abnormal FIT result. Following this report, what would the appropriate test and timing be for Katya's follow-up?

a) Follow-up colonoscopy within eight weeks b) Follow-up with colonoscopy or computed tomography colonography within eight weeks

c) Follow-up with colonoscopy within 12 weeks

- d) Follow-up with colonoscopy within six months
- e) None of the above





Proactively follow-up with your patients:

- Preemptively counsel your patient on what to expect before, during and after the procedure
 - Explain that an abnormal result is not a cancer diagnosis
- Set electronic medical record reminders and alerts for FIT results
- Review your Screening Activity Report (SAR) monthly report (for help accessing and using your SAR, visit cancercareontario.on.ca/SAR)
- Verify that patient has been scheduled for a FIT-positive colonoscopy appointment within eight weeks
- Be aware of regional strategies to ensure timely access to colonoscopy for your patients with a positive FIT



Carefully Consider Where Follow-Up Occurs

- FIT+ colonoscopies are more complex require more expertise, time and resources
- Patients with an abnormal FIT result should be referred to a facility that offers FIT+ colonoscopy













FIT+ Guidance

- Designed to ensure safe, complete and timely FIT procedures
- Provides guidance for facilities and endoscopists
- Informed by best practices from other jurisdictions and experts in GI endoscopy
- FIT+ Guidance includes: ullet
 - **Booking management:** Access to FIT+ colonoscopy should be provided within eight weeks, adequate time and expertise should be available for procedures
 - Endoscopist expertise: Should be comfortable in removing most polyps (e.g., threshold up to 2 cm polyps)
 - Facilities: Should provide access to all the necessary tools and equipment, access to appropriate referral channels for complex cases



Cancer Care Ontario

Source: Cancer Care Ontario. Fecal immunochemical test (FIT)positive colonoscopy facility-level guidance. 2017. Available at: www.cancercare.on.ca/FIThub

Impact of FIT



Cancer Care Ontario

FIT leads to better use of follow-up colonoscopy

Colonoscopy Surveillance Recommendations

Surveillance

- The goal of colonoscopic surveillance is to decrease CRC incidence and subsequent mortality through the removal of adenomas in people with a personal history of colorectal adenomas
- In 2008, ColonCancerCheck endorsed the U.S. Multi-Society Task Force (USMSTF) 2006 guidelines
- Recommendations need to be periodically updated to reflect the most recent evidence



Background

- What is the purpose of CCC's post-polypectomy surveillance recommendations?
 - Intended for endoscopists and endoscopy services to ensure appropriateness of colonoscopy
 - Designed to ensure that the benefits of surveillance colonoscopies outweigh the potential harms for people who receive the procedure
 - Can also be used to support primary care provider's understanding and interpretation of endoscopist surveillance recommendations



CCC's Approach for Developing New Recommendations

- Literature search of existing guidelines lacksquare
 - Polyp nomenclature and framework for new recommendations align with Ο those currently used in Ontario, i.e., Canadian Association of Gastroenterology's (CAG), and the USMSTF
- Identified knowledge gaps ullet
 - Performed systematic review and meta-analysis on low risk adenomas Ο
- Expert panel evidence review and development of recommendations



Developing Surveillance Recommendations

- Recommendations are based on:
 - future probability of CRC, based on size and histology of the most advanced screen-relevant polyp (e.g., low risk adenoma, high risk adenoma)
 - assumption of a high-quality and complete baseline colonoscopy Ο
 - findings of the initial and subsequent surveillance colonoscopy (if applicable), and include the suggested test and interval.



Polyp Types and CRC Risk

Screen-relevant polyps

Low risk polyps

 Low risk adenomas

<u>High risk polyps</u>

• High risk adenomas •

Only screenrelevant polyps are linked to colorectal cancer

- Large sessile serrated polyps
- Sessile serrated polyps with dysplasia
- Small sessile serrated polyps without dysplasia *

Non screen-relevant polyps

- Small hyperplastic polyps in the recto-sigmoid
- Non-neoplastic polyps (e.g., lipomas)

Low Risk Adenomas- Screen Relevant

• 1 to 2 tubular adenomas <10mm in diameter with no high-grade dysplasia



Cancer Care Ontario





High Risk Adenomas- Screen Relevant









• Tubular adenoma \geq 10mm, adenoma with villous histology or adenoma with high-grade dysplasia; also includes people with 3 or more LRAs

NEW: Recommendations for Post-Polypectomy Surveillance

Initial colonoscopy						
Findings	Next test ¹	Time until next test				
No polyps Hyperplastic polyp(s) in rectum or sigmoid	FIT	10 years				
Low risk adenoma(s) ²	FIT	5 years				
High risk adenoma(s) ²	Colonoscopy	3 years				
>10 adenomas	Cleaning colonoscopy ³	≤ 6 months				
Any sessile serrated polyp(s) <10 mm without dysplasia	Colonoscopy	5 years				
Sessile serrated polyp(s) ≥10 mm Sessile serrated polyp(s) with dysplasia Traditional serrated adenoma	Colonoscopy	3 years				
Large sessile polyp removed piecemeal	Colonoscopy	≤ 6 months				
Serrated polyposis syndrome ²	Colonoscopy	1 year				

Patients with small hyperplastic polyps in rectosigmoid do not require surveillance

Patients with a normal colonoscopy (incl. hyperplastic polyps in rectosigmoid) should screen next with FIT, in 10 years

Surveillance tool available at: cancercareontario.ca/CCCsurveillance

Risk of CRC & CRC Mortality After Colonoscopy

Among people with low risk (non-advanced) adenomas:

- No difference in CRC risk compared to those with <u>normal colonoscopy</u> (RR, 1.2 [95% CI, 0.8-1.7]; P = .30)
- No difference in mortality risk compared to those with normal colonoscopy (RR, 1.2 [95% CI, 0.5-2.7], P = .68)

No. at risk Advanced adenoma Nonadvanced adenoma No adenoma



Only people with HRAs have increased risk of CRC and of **CRC** death



94 Source: Click B, et. al. Association of colonoscopy adenoma findings with long-term colorectal cancer incidence. JAMA 2018; 319(19):2021-2031

Risk of CRC Death After Colonoscopy

Among people with low risk adenomas:

- Risk of death from CRC is 25% lower compared to the general population
 - Standardized mortality ratio = 0.75 (95% CI: 0.63–0.88)

Surveillance is not required for people with low risk adenomas



Figure source: Bretthauer M, Loberg M, Kalager M. Long-term colorectal-cancer mortality after adenoma removal. NEJM. 2014;371(21):2036-7.



Cancer Care Ontario

NEW: Recommendations for Post-Polypectomy Surveillance

Initial colonoscopy						
Findings	Next test ¹	Time until next test				
No polyps Hyperplastic polyp(s) in rectum or sigmoid	FIT	10 years				
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High risk adenoma(s) ²	Colonoscopy	3 years				
>10 adenomas	Cleaning colonoscopy ³	≤ 6 months				
Any sessile serrated polyp(s) <10 mm without dysplasia	Colonoscopy	5 years				
Sessile serrated polyp(s) ≥10 mm Sessile serrated polyp(s) with dysplasia Traditional serrated adenoma	Colonoscopy	3 years				
Large sessile polyp removed piecemeal	Colonoscopy	≤ 6 months				
Serrated polyposis syndrome ²	Colonoscopy	1 year				

NEW: Patients with low risk adenomas should screen with FIT in 5 years, and do not require colonoscopy surveillance

> Surveillance tool available at: cancercareontario.ca/CCCsurveillance

NEW: Recommendations Following the FIRST Surveillance Colonoscopy

Initial colonoscopy	Subce		
Findings	JUDSEL		
No polyps Hyperplastic polyp(s) in rectum or sigmoid	Findings		
Low risk adenoma(s)			
High risk adenoma(s)	Not applicable		

New: Recommendations for subsequent surveillance colonoscopy are provided



Cancer Care Ontario



Surveillance tool available at: 97 cancercareontario.ca/CCCsurveillance

Post-Polypectomy Surveillance in People With a Family History of CRC

- The recall interval following a normal colonoscopy for people with a family history of CRC (i.e., a first-degree relative with the disease) should be based on family history or surveillance recommendations, whichever recall interval is shortest
- As a reminder, if a patient's colonoscopy is normal and they have a family history of CRC, the recommendations are*:
 - Colonoscopy should be repeated every five years if their first-degree relative with CRC was diagnosed at <60 years old
 - Colonoscopy should be repeated every 10 years if their relative was diagnosed at ≥60 years old



*Based on emerging evidence, ColonCancerCheck will be reevaluating its recommendations for those with a family history

Primary Care Provider Role in Post Polypectomy Surveillance

- It is important to provide endoscopists with a copy of the prior colonoscopy report and the pathology report if available when referring a patient for surveillance
- Endoscopist can determine if surveillance is indicated at that time



Considerations

- What do I do when endoscopist recommendations do not align with surveillance recommendations?
 - Endoscopist recommendation may be influenced by factors not captured in the surveillance guidelines (e.g., colonoscopy quality)
 - Because surveillance recommendations evolve as new evidence emerges, the recommendation made by the endoscopist at the time of the patient's previous colonoscopy may not reflect more recent knowledge
 - It may be reasonable to reevaluate an endoscopists recommendation, taking into consideration prior colonoscopy and pathology reports. The surveillance recommendations can be used to assist discussions with endoscopists to confirm their recommendation.



Anita is a 56 year old woman who had a colonoscopy completed in 2019 following an abnormal FIT result. Her baseline colonoscopy revealed one 5 millimeter tubular adenoma with no high-grade dysplasia (i.e. a low risk adenoma) on the sigmoid colon. When and how should she next be screened for colorectal cancer?

a) Resume screening every two years with FIT; starting in 10 years after the baseline colonoscopy

b) Resume screening every two years with FIT; starting in five years after the baseline colonoscopy

c) Resume screening in 10 years with colonoscopy after the baseline colonoscopy d) Resume screening every three years with colonoscopy; starting in three years after the baseline colonoscopy





For discussion: Upon reading Anita's colonoscopy report, you note that the endoscopist has recommended Anita repeat colonoscopy in five years. You are aware that this is not aligned with ColonCancerCheck's Recommendations for Post-Polypectomy Surveillance. How would you approach this situation? What factors might have contributed to this recommendation?





Mildred is a 65 year old woman with no family history of CRC who has recently undergone a colonoscopy to investigate gastrointestinal symptoms. Her results are reported as normal and her symptoms have resolved. How and when should Mildred be screened next for colorectal cancer?

a) Mildred should return to screening in 10 years with FIT
b) Mildred should return to screening in 10 years with colonoscopy
c) Mildred should return to screening in four years with a FIT
d) Reassess Mildred in 10 years to determine if screening is appropriate
e) a or b





After this presentation, you will be able to:



Understand the Burden of Colorectal Cancer (CRC) in Ontario



Compare CRC Screening Tests for Average Risk Patients





Order the Fecal Immunochemical Test (FIT) and Counsel your Patients



Integrate Cancer Care Ontario Tools to Support your Practice

Tools that Support Colorectal Cancer (CRC) Screening: **ColonCancerCheck Screening Recommendation Summary**



ColonCancerCheck (CCC)

Average Risk Screening with FIT—in Ontario as of [date TBC]



Average risk



- Age 50 to 74 Asymptomatic
- No first-degree relative diagnosed with colorectal cancer
- No personal history of colorectal cancer, Crohn's or ulcerative colitis
- No colorectal polyps needing surveillance¹



- Recommendations for post-polypectomy surveillance: <u>cancercare on ca/cccquidelines</u>
 No flexible sigmoidoscopy or colonoscopy (without polyps) in past 10 years, and no FIT in past 2 years
- Flexible sigmoidoscopy every 10 years is an acceptable screening test

Not at average risk

Is your patient at increased risk?

- One or more first-degree relatives with colorectal cancer
- Colonoscopy—start at age 50, or 10 years earlier than the age their relative was diagnosed, whichever occurs first
- Take a complete history of cancers in the family—if hereditary cancer syndrome is suspected, refer for genetic assessment

Is your patient symptomatic?

- Important symptoms include iron deficiency anemia and rectal bleeding, among others:
- Refer to specialist for evaluation
- Do not use FIT for symptomatic patients See [URL] for more information, including screening intervals

Tests not recommended for colorectal cancer screening

For patients at average risk:

Colonoscopy

For all patients:

- Metabolomic (blood or urine) tests
- · DNA (blood or stool) tests
- Computed tomography colonography
- Capsule colonoscopy
- Double contrast barium enema
- Guaiac fecal occult blood test (now replaced by FIT)

More clinical information and resources

Visit: cancercareontario.ca/en/pcscreeningprograms

Email: screenforlife@cancercare.on.ca

Call: 1-866-662-9233







Cancer Care Ontario

Copies can be found at: <u>cancercareontario.ca/FIThub</u>

About FIT

FIT is an at-home stool-based screening test for people at average risk of colorectal cancer Safe • Sensitive • No dietary or medication restrictions • One sample • Easy to use • Pre-labelled

How to screen with FIT

3 steps for primary care providers:

- 1. Confirm mailing address for FIT kit, patient address and date of birt
- 2. Explain to patient how to complete FIT
- 3. Submit completed FIT requisition to central lab (fax x-xxx-xxxx-xxxx)

Lab: Mail pre-labelled FIT kit to patient

3 steps for patients:

- 1. Check label accuracy and clearly record specimen collection date on FIT tube
- 2. Complete FIT
- 3. Mail or drop off completed FIT to the lab as soon as possible, ideally within 2 days, to ensure it arrives at the lab within 14 days of specimen collection

Lab: Send FIT result to primary care provider

Cancer Care Ontario: Mail FIT result letter to patient

Follow-up by primary care providers:

- Normal FIT result: Repeat FIT in 2 years
- Abnormal FIT result: Refer for follow-up colonoscopy to be perform within 8 weeks

*Make sure patients get their FIT

- To prevent mailing errors and delays, double check patient address information, such as unit number and postal code
- Providers can use the FIT requisition to indicate that the FIT kit should be mailed to an alternate address, which may differ from the patient's primary mailing address (e.g., health centre or nursing station for patients who live on a First Nation reserve; community health centre for home insecure patients).

Placeholder for FIT drop-off messaging

- Des esto endions ectent eiciis eos ulloribusam ra debis delent est dero dolores ciduntia solorae provide nisimossit optione mporeperunt
- Ouibusapit labori toribus apiditas deliguia voluptiant

FIT resources

- Designated FIT lab, including optional FIT drop-off locations and hours: [add phone & URL]
- FIT requisition: [add URL]
- OHIP billing for FIT: [add URL]
- FIT specimen collection instructions for patients: [add URL] More information and resources: cancercare.on.ca/FITHub



Need this information in an accessible format? 1-855-460-2647, TTY 416-217-1815, publicaffairs@cancercare.on.ca

Tools that Support CRC Screening: Physician Linked Correspondence

- Sign up for physician-linked correspondence to improve screening participation!
 - Research has shown that people who 0 receive a personal recommendation from their family physician are more motivated to get screened for cancer than those who do not.

Sign up here! cancercareontario.ca/en/physician-linked-correspondence



Cancer Care Ontario

Source: Tinmouth J, Baxter NN, Paszat L, Sutradhar R, Rabeneck L, Yun L. Using physicianlinked mailed invitations in an organised colorectal cancer screening programme: effectiveness and factors associated with response. BMJ. 2014 Mar 12;4(3):e004494. doi: 10.1136/bmjopen- 106 2013-004494

Use evidence-bas	Use evidence-based methods to motivate more patients to get screened.							
Cancer Care Onta programs.	Cancer Care Ontario is inviting you to participate in physician-linked correspondence for Ontario's cancer screening programs.							
With your enrolme ColonCancerCheo Breast Screening evidence-based s	With your enrolment in physician-linked correspondence, your screen-eligible patients will receive ColonCancerCheck letters sent on your behalf. In the future, letters will be sent on your behalf from the Ontario Breast Screening Program and Ontario Cervical Screening Program. All letters are sent according to current evidence-based screening guidelines, which are subject to change.							
You can withdraw instructions on hor information, includ answers available	from physician-link w to withdraw pleas ling samples of the at cancercare.on.c	ed correspond se call 1-866-6 wording in the ca/pcresources	lence for one or more so 82-9233 or email screer letters sent to your pati or call us at 1-866-662	reening programs at forlife@cancercare. ents, please read ou 9233.	t any time; for on.ca. For more r questions and			
Enrol today!								
FORM COMPLET		N						
 by email to Ontario M An asterisk (*) Contact inform Ontario (CPSC you provide w Please ensure 1 – PEM PHYSIC Note: Examples of PE Organizations (FHOs) 	 screenforlife@cal Cancer Screening 5G 1X3. denotes a mandati hation must be for y please do not u ill be used to contation is your information is IAN INFORMATIO M physicians are mem 	ncercare.on.ca Contact Centr tory field. your office/prace se your persor ct you regardir s also updated bers of Family Hea	; or e, Cancer Care Ontario trice listed with the Colle hal contact information. Ing all matters related to with CPSO. alth Groups (FHGs), Family H	18-505 University A ge of Physicians and The email, phone nur ohysician-linked corr	venue, Toronto, d Surgeons of mber or fax numbe respondence. nd Family Health			
Legal First Name	·		Office Email					
Legal Last Name			Office Phone		Ext.			
2 - SIGNATURE	tian's signature. Delega	te cannot sign for	office Fax Number					
Signature*								
Date*	DD:	MM:	YYYY:					
To improve our ou	treach efforts, plea	se tell us what	prompted you to sign u	p for physician-linked	d correspondence:			
	n organization committed	to ensuring accessi	ole services and communication:	to individuals with	Die			

Tools that Support CRC Screening: FIT Resource Hub

- Information and tools to help prepare for FIT: cancercareontario.ca/FIThub
- Available on the FIT Resource Hub:
 - Frequently asked questions
 - Primary care provider mail-out contents
 - FIT CPD (for reference only)
 - First Nations, Inuit, Métis and Urban Indigenous screening toolkit and fact sheet



Home / Fl

FIT Resource Hub

24, 2019.

This Resource Hub contains tools and resources to prepare primary care providers, endoscopists and others for the transition to FIT in Ontario. Please visit this page regularly as it will be updated when new resources become available

Cancer Care Ontario Ontario Renal Network					Recently Viewed	EN FR		
ncer Care Ontario	HOME	DRUG FORMULARY	GUIDELINES & ADVICE	PATHWAY MAPS	DATA & RESEARCH	٩		
ancer Cancer Treatments Get Checked for Cancer Find Services Indigenous								
Resource Hub								
a a come a la locale								

The fecal immunochemical test (FIT) will be available in Ontario as part of Cancer Care Ontario's ColonCancerCheck program as of June

- FIT will replace the guaiac fecal occult blood test (gFOBT) for people at average risk of getting colorectal cancer. Although there is highquality scientific evidence to support screening with gFOBT, FIT offers several advantages over gFOBT
- FIT is a more sensitive screening test, which means it is better at detecting colorectal cancer and pre-cancerous polyps;
- There are no medication or dietary restrictions (including anticoagulants and vitamin C);
- FIT is simple to use and helps reduce contact with stool; and
- Only one stool sample is needed.

If you have any guestions, please contact Cancer Care Ontario toll-fee at 1.866.662.9233 from Monday to Friday 8:30 a.m. to 5:00 p.m. or screenforlife@cancercare.on.ca

Thank you for supporting a successful transition to the FIT in Ontario



Tools that Support CRC Screening: Screening Activity Report (SAR)

 Sign up for Cancer Care Ontario's SAR to identify screen-eligible patients and to monitor FIT results that may require follow-up: <u>cancercareontario.ca/SAR</u>



🚾 https://www.cancercareontario.ca/en/guidelines-advice/treatn 🔎 👻 🖴 😋 Screening Activity Report (S 🗙									
View	Favorites	Tools	Help						
			cc	CO Cancer C	Care Ontario	Ontario Renal Network	k		
CCC Cancer Care Ontario						HOME	DRUG FORMULARY	GUIDELINES & ADVICE	
Browse Guidelines 👻 Toolkits					Education & Events	Symptom Mana	gement		

Screening Activity Report (SAR)

The Screening Activity Report (SAR) is an online tool available to primary care physicians who practice as part of a patient enrolment model. It provides screening data for breast, cervical and colorectal cancers to help physicians improve their cancer screening rates and appropriate followup. It also helps physicians better understand Cancer Care Ontario's cancer screening guidelines. The report platform is interactive, allowing physicians to quickly find specific cancer screening information for each patient.

Access your SAR

Forgot your ONE® ID login?

Forgot your ONE® ID password?

Edit your ONE®ID profile or manage delegates 다



can only be exported as a PDF. When accessing the data to perform comprehensive tasks, physicians should export and save the report to their computer. The old report is always replaced by the most recent version at the time of refresh.
Tools that Support CRC Screening: eLearning Modules

 First Nations, Inuit and Métis history, culture, health landscape and improved person-centered care continuing professional development: elearning.cancercare.on.ca



The course provides a historic context to the current-day issues facing FNIM people in Canada, as well as the impact of these issues on their health, and relations with the government and healthcare industry. The course also explores the current-day FNIM governance and political leadership model.

empathy.





Aboriginal Relationship and Cultural Competency Courses

Earn Mainpro credits and enhance your knowledge of First Nations, Inuit and Métis (FNIM) cancer care by completing the courses available for this subject area:

- · First Nation, Inuit and Métis Culture, Colonization and the Determinants of Health
- Aboriginal History and Political Governance
- · The Need for Cultural Competence in Health Care
- Current Array of Aboriginal Health Services
- CCO and the Aboriginal Cancer Strategies
- Indigenous Knowledge and Traditional Health Aboriginal Community Health Services
- · The Cancer Landscape of FNIM People
- · Cancer Control Issues and Challenges

First Nations, Inuit and Métis Culture, Colonization and the Determinants of Health

The health status of First Nation, Inuit and Métis (FNIM) people has been improving, but is still lower than the Canadian average. This course examines the impact social and economic measures have on FNIM people. It explores the broader cultural determinants of health in an Aboriginal context including:

- · Socio-economic, gender, age, education, nutrition, culture
- Differences between Aboriginal and non-Aboriginal definitions of health
- · An overview of the main cultural variances among First Nations, Inuit and Métis people

Aboriginal History and Political Governance

Canada's history and treatment of First Nations, Inuit and Métis (FNIM) people has shaped current day relationships and perspectives of FNIM to non-Aboriginal Canada. Many issues and challenges have been acknowledged, which continue to affect relations with FNIM people.

The Need for Cultural Competence in Healthcare

Racism persists. The First Nations, Inuit and Métis (FNIM) population has noted that they have experienced culturally insensitive healthcare, and at times, they are meet with subtle and overt racism. This course stresses the importance for frontline healthcare professionals to understand and apply FNIM cultural sensitivity and safety to provide effective care. It also examines the concept of cultural sensitivity and safety for FNIM people, including cultural awareness, safety, competence, sensitivity, self-reflection and

Current Array of Aboriginal Health Services

Over the last 20 years, essential changes have occurred in the policies guiding and structuring the delivery of health care to Canada's First Nations, Inuit and Métis (FNIM) people; the changes over the last 10 years have been particularly dramatic. This course provides historical context for the status of present-day Aboriginal health services at

Clinical Pearls for Average Risk Screening

Use FIT, not colonoscopy

Centralized FIT kit distribution will minimize errors

FIT+ colonoscopy needed within 8 weeks

Screen with guaiac fecal occult blood test (gFOBT) until FIT is available







After an abnormal FIT result, what is the recommended follow-up intervention and timing?

a) Follow-up colonoscopy within 12 weeks
b) Follow-up colonoscopy within eight weeks
c) Follow up flexible sigmoidoscopy within eight weeks
d) Repeat FIT or gFOBT within four weeks
e) b or c





With the shift from the gFOBT to the FIT, the recommended screening interval for people at average risk of developing **CRC** will be:

a) Screen every two years between ages 50 - 74 b) Screen every year beginning at age 50 c) Screen every year beginning at age 40 d) Screen every year beginning at age 40; and every two years after age 50

e) Screen every year between ages 50 - 74





Which of the following is/are appropriate indications for FIT?

- a) Confirmation of rectal blood loss
- b) Anemia
- c) CRC screening
- d) Abdominal pain
- e) a and c





Your patient Jenny is a 60 year old woman who completed CRC screening with flexible sigmoidoscopy two months ago. At a recent book club meeting, Jenny's friend mentions to her that she has recently completed a FIT. Jenny calls your office to find out if she is eligible to complete a FIT. How should you respond to Jenny?



