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November 13, 2007

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Dear Mr. Kellog:

We are writing to you to alert you to a statement in the Fall 2007 edition of your publication *For Your Health NEWS* entitled "Colon Cancer Screening Information" that we found quite troubling. The document states, "The combination of FOBT or FIT plus flexible sigmoidoscopy every 5 years is preferred over each of the options alone. All positive tests should be followed up with colonoscopy." In fact, colonoscopy is the ***most effective*** test to prevent colon cancer. The statement is your newsletter could be misleading to readers. We believe a clarification is warranted and would be happy to work with you to educate your enrollee and provider community on the appropriate guidelines.

The American College of Gastroenterology is a physician organization representing gastroenterologists and other gastrointestinal specialists. Founded in 1932, the College currently numbers more than 10,000 physicians among its membership of providers of gastroenterology specialty care. Although the vast majority of these physicians are gastroenterologists, the College's membership also includes surgeons, pathologists, hepatologists, and other specialists in various aspects of the overall treatment of digestive diseases and conditions. The College has chosen to focus its activities on clinical gastroenterology – the issues confronting the gastrointestinal specialist in treatment of patients. The primary activities of the College have been, and continue to be, educational efforts directed at promoting and optimizing quality care.

Recommended by medical and cancer groups for colorectal cancer screening, colonoscopy utilizes direct visualization of the entire colon to detect and remove pre-cancerous growths, including smaller polyps so they cannot become cancerous. This test allows removal of suspicious polyps without surgery at the time of the exam. Three studies have shown that colonoscopy prevents 80 percent or more of colorectal cancers from developing by removing pre-cancerous polyps. (See: Winawer SJ, Zauber AG, Ho MN, et al. Prevention of colorectal cancer by colonoscopic polypectomy. The National Polyp Study Workgroup. N Engl J Med 1993;329:1977-81;
Citarda F, Tomaselli G, Capocaccia R, Barcherini S, Crespi M; Italian Multicentre Study Group. Efficacy in standard clinical practice of colonoscopic polypectomy in reducing colorectal cancer incidence. Gut 2001 Jun;48(6):812-5; and
Thiss-Evensen E, Hoff GS, Sauar J, et al. Population-based surveillance by colonoscopy: effect on the incidence of colorectal cancer. Telemark Polyp Study I. Scand J Gastroenterol 1999;34:414-20.)

Optical colonoscopy is one of the most powerful prevention tools in clinical medicine. Other tools are not nearly as powerful. For example, sigmoidoscopy allows visualization of the lower part of the colon alone. Indeed, a 2005 *New England Journal of Medicine* study (see Schoenfeld, P; Cath, B; Flood, A, et al "Colonoscopic Screening of Average-Risk Women for Colorectal Neoplasia," May 19. 2005. 352:20: 2061-68) showed that colonoscopy revealed advanced neoplasia in 30 percent more cases than flexible sigmoidoscopy alone. A previous 2001 *New England Journal of Medicine* study (Lieberman DA, Weiss DG, for the Veterans Affairs Cooperative Study Group 380, "One-time screening for colorectal cancer with combined fecal occult-blood testing and examination of the distal colon," August 23, 2001;345:555-60) found that performing stool card testing before sigmoidoscopy does not significantly increase the detection of colon cancer, and about one fourth of advanced colonic neoplasia cases would not be detected by this combined regimen

Further, Medicare and most other insurers do not require FOBT of FIT as a precursor to screening colonoscopy. A 2002 U.S. Agency for Healthcare Research and Quality analysis (see: http://www.ahrq.gov/clinic/3rduspstf/colorectal/colocost1.htm) found that colorectal screening overall was highly cost-effective but that the available evidence did not allow distinctions to be made among screening modalities on cost-effectiveness criteria. Given that, physicians working with their patients should be able to select the most appropriate screening modality for a given patient and should be able to use the most accurate method as a first-line modality.

We urge you to update your patient education materials to reflect the fact that colonoscopy is often used most appropriately as a first-line screening modality, and that it is often more precise than other modalities. If you have any questions, please do not hesitate to contact any of us. We look forward to working with you to ensure that all Alabamans are appropriately screened so as to reduce the impact of colon cancer on the state.

Regards,

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