



# American College of Physicians Guidance Statement on Colorectal Cancer Screening: Pitfalls of Second-Guessing Guidelines



**Philip Schoenfeld, MD, MEd, MSc (Epi)**

*Chief (Emeritus), Gastroenterology Section, John D. Dingell VA Medical Center, Detroit, MI.*

Dr Philip Schoenfeld  
*Editor-in-Chief*

This summary reviews Qaseem A, Harrod CS, Crandall CJ, et al. Screening for colorectal cancer in asymptomatic average-risk adults: A guidance statement from the American College of Physicians (Version 2). *Ann Intern Med* 2023; 176(8):1092-1100.

Correspondence to Philip Schoenfeld, MD, MEd, MSc. Editor-in-Chief. Email: [EBGI@gi.org](mailto:EBGI@gi.org)

## STRUCTURED ABSTRACT

**Question:** At what age should colorectal cancer (CRC) screening start and stop and what should be the type and frequency of CRC screening tests in average-risk, asymptomatic individuals?

**Methods:** The American College of Physicians (ACP) develops Clinical Guidance statements in an attempt to reconcile published clinical guidelines with conflicting recommendations to help clinicians provide evidence-based care.<sup>1</sup> The ACP Clinical Guidance statement development process neither performs a de novo systematic evidence review nor uses GRADE to assess the certainty of evidence or strength of recommendations.<sup>1</sup> The ACP development process is to have ACP Clinical Policy staff perform a literature search for eligible guidelines which are current and connected to a systematic review, and then rate the quality of guidelines using the Appraisal of Guidelines for Research and Evaluation II (AGREE II) instrument.<sup>2</sup>

The AGREE II instrument asks raters to answer 23 questions about guideline scope

and purpose, stakeholder involvement, rigor of development, clarity of presentation, applicability, and editorial independence with a numeric score. In addition, each ACP appraiser then provides an overall score and determine if the guideline should be recommended for use based on the appraisers' own judgment on the transparency of the guidelines processes.<sup>1</sup>

Guidance statement authors review these guidelines and then make “guidance statements based on an assessment of the reported benefits, harms, costs, and patient preferences and values from the assessed guidelines and their evidence.”<sup>1</sup>

**Patients:** Average-risk, asymptomatic individuals.

**Intended Audience for Guidance Statement:** All clinicians.

**Funding:** The ACP internal budget.

**Results:** Based on literature search, 5 guidelines were identified for review by ACP Clinical Policy staff: the American College of Gastroenterology (ACG), American College of Radiology (ACR), US Multi-Society Task Force (USMSTF), American Cancer Society (ACS), and US Preventive Services Task Force (USPSTF). Per the supplemental material, all of these guidelines contain essentially the same recommendations for starting and stopping CRC screening, and the type and frequency of use of CRC screening tools with the exception of the ACR guideline which only discusses radiologic tools.

All 5 raters recommended against using guidelines from ACG, ACR, and USMSTF, and 2 of the 5 recommended against using the ACS guideline, partly due to perceived lack of editorial independence, stakeholder involvement, and applicability (outlined in Supplemental Table 1). Only the USPSTF guideline was recommended for use, but with modifications. Using the data from the USPSTF 2021 evidence review and decision modeling<sup>3,4</sup>, the authors provided the following guidance statements which differ from ACG, ACS, USMSTF, and USPSTF guidelines:

Clinicians should consider not screening asymptomatic average-risk adults between the ages of 45 to 49 years. They should discuss the uncertainty around benefits and harms of screening in this population (Statement 2). Clinicians should stop screening for colorectal cancer in asymptomatic average-risk adults older than 75 years or in asymptomatic average-risk adults with a life expectancy of 10 years or less (Statement 3). Clinicians should select among a fecal immunochemical (FIT) or high-sensitivity guaiac fecal occult blood test (gFOBT) every 2 years, colonoscopy every 10 years, or flexible sigmoidoscopy every 10 years plus a fecal

immunochemical test every 2 years as a screening test for colorectal cancer (Statement 4b). Clinicians should not use stool DNA or computed tomography colonography.

## COMMENTARY

### *Why Is This Important?*

Family practice physicians, general internists, and other primary care providers are the crucial link to ensure that average-risk adults get CRC screening. Since several options are available, including FIT, stool DNA tests, and colonoscopy, these physicians should educate their patients about the benefits and limitations of each option and perform shared decision-making with their patients. For example, patients should understand that screening colonoscopy is a CRC prevention tool whereas FIT is a tool to identify or detect CRC at an early and treatable stage. In order for family practice physicians and general internists *and* other health care providers to effectively educate their patients, we should follow nationally-recognized and approved guidelines. Essentially, we all want to be on the same page when we talk to patients.

Although the authors of the ACP Guidance Statement write that several clinical guidelines vary on the ages to start and stop screening, screening tests and time intervals, and strength of recommendations, the key recommendations are actually quite uniform in the ACG, ACS, USMSTF, and USPSTF guidelines, as noted in Sup-

plemental Table 2 of the published article. An accompanying editorial<sup>5</sup> comments that the ACP Guidance Statement is more consistent with European guidelines, although these non-US guidelines did not meet ACP criteria to be evaluated by reviewers. Thus, it's unclear why the ACP Clinical Policy staff, which seem to guide this process, felt compelled to second-guess existing evidence-based guidelines while cherry-picking data to support divergent recommendations. Unfortunately, this document may do a considerable disservice to US patients by confusing primary care providers.

Since CRC screening in 45-49 year olds (grade B recommendation) and CRC screening in 50-75 year olds (grade A recommendation) are endorsed by the USPSTF guideline, insurers must cover CRC screening tests at no cost to the patient under the Affordable Care Act. The authors' rationale for suggesting against CRC screening in 45-49 year olds is that the net benefit is inadequate to outweigh potential harms, costs, and impact on healthcare disparities based on their review of modeling studies used by USPSTF while also questioning the methodology of the modeling studies. Although the authors state that individuals older than 75 and in good health may benefit from 1-time screening, the guidance statement does not allow for individualized decision-making between patient and provider as recommended in other

guidelines. Stool DNA tests were not recommended based on an unfavorable cost-analysis performed by the authors, although it's unclear if this analysis accounted for its increased sensitivity for advanced adenomas. Readers are encouraged to review the full ACP Guidance Statement and Supplemental Material for context.

### ***Key Study Findings***

Clinicians should consider not screening average-risk 45-49 year old individuals, and stop CRC screening after age 75. FIT should be performed every 2 years instead of annually, and stool DNA tests are not recommended.

### ***Caution***

There are many limitations inherent in the ACP Guidance Statement process. An abbreviated list would note that the primary authors appear to be a non-practicing physician specializing in healthcare policy and a PhD epidemiologist. While this background is optimal to minimize conflicts of interest, important context is lost when there is no input from practicing gastroenterologists, oncologists, and primary care providers, who actually conduct shared decision-making with patients on a daily basis. The AGREE II tool provides some transparency and standardization to assess guidelines, but the domains and numerical assessments are subjective. Then, the ACP Guidance Statement protocol asks reviewers to make an additional subjective assessment about

whether or not they would recommend the guideline. Notably, only the USPSTF guideline was acceptable to the 5 reviewers, which included only 2 practicing physicians.

While the Guidance Statement emphasizes that it also assesses costs, they do not use a patient's cost perspective. Since USPSTF recommended screening tests almost uniformly have to be covered at no cost to patients, the ACP cost-analysis is more appropriate to the national health services of non-US countries. This should be explicit. Although the text of the ACP Guidance Statement acknowledges that CRC screening may be beneficial for healthy individuals over 75, they recommend against CRC screening in over 75 individuals instead of recommending the individualized approach recommended by ACG, USPSTF, etc. No clear rationale for this discrepancy is stated. Finally, when stating that any benefits of CRC screening in the 45–49-year-old age group are balanced or outweighed by the harms of colonoscopy, the estimated rates of serious GI and cardiovascular complications appear to be partly based on an older, non-screening population. Their assessment of the model probably does not account for the very, very low rates of serious complications in healthy, average-risk 45-49 year olds.

### ***My Practice***

In my own practice, I follow the USPSTF guideline—which are consistent with the ACG, ACS, and USMSTF guidelines—and offer CRC

screening starting at age 45 in average-risk patients while individualizing decisions about CRC screening in individuals over 75. We primarily offer annual FIT or colonoscopy every 10 years, although we'll consider stool DNA tests, too. We do not offer gFOBT which require sampling from three separate stool samples and dietary restrictions while collecting specimens. We do not offer flexible sigmoidoscopy, which is useful for reducing CRC in the recto-sigmoid area but has very limited benefit for impacting CRC beyond these portions of the colon.

Given the uncertainty created by the ACP Guidance Statement, I educate my primary care colleagues about ACG and USPSTF guidelines, while respectfully suggesting that they should not use the ACP Guidance Statement.

### ***For Future Research***

The results of ongoing randomized controlled trials, including the CONFIRM trial comparing annual FIT vs screening colonoscopy, will clarify unanswered questions in all CRC screening guidelines.

### ***Conflict of Interest***

Dr. Schoenfeld reports serving as a consultant for EXACT Sciences within the past 3 years.

## **REFERENCES**

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**Note:** An author of the article published in *Annals of Internal Medicine* are active on social media. Tag them to discuss their work and this EBGI summary.

@pennstate2003 (Amir Qaseem)