

CT Colonography Endorsed, With Caveats

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BALTIMORE — A panel of Medicare advisers has tentatively expressed support for the use of computed tomographic colonography to screen for colorectal cancer in average-risk Medicare beneficiaries.

Based on an overview of existing evidence on sensitivity, specificity, and cost-

effectiveness of the technology, the Medicare Evidence Development and Coverage Advisory Committee (MEDCAC) was asked to vote on a series of questions gauging panelists' level of confidence in computed tomographic colonography (CTC) as a screening tool, compared with optical colonoscopy.

The Centers for Medicare and Medicaid Services is considering whether to cover CTC. The agency already pays for

colorectal cancer screening for average-risk individuals aged 50 and older using fecal occult blood testing, sigmoidoscopy, colonoscopy, and barium enema. In March 2008, the American Cancer Society, the U.S. Multi-Society Task Force on Colorectal Cancer, and the American College of Radiology issued new cancer screening guidelines that called CTC an acceptable option.

Most of the MEDCAC panelists were

moderately to highly confident that there is sufficient evidence to determine sensitivity and specificity of CTC in screening for polyps that measure 6-10 mm and for polyps larger than 10 mm. They were less confident that the evidence could determine specificity and sensitivity for polyps smaller than 6 mm.

Most panelists said that CTC would provide a net health benefit for average-risk Medicare beneficiaries—that is, a decrease in morbidity and mortality from identification and removal of polyps, when balanced against the risks of the procedure and the identification of extracolonic abnormalities.

But many committee members said they were concerned about those extracolonic findings, which they said could skew both the health benefits of the procedure and its potential cost-effectiveness.

Dr. Mary Barton, scientific director of the U.S. Preventive Services Task Force, told the panel that the task force's systematic review of CTC found it comparable to optical colonoscopy in sensitiv-

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'It's premature to endorse CTC for average-risk Medicare beneficiaries at this time.'

DR. DOMINITZ

ity and specificity for lesions larger than 10 mm, but not quite similar for lesions larger than 6 mm.

Colonoscopy may cause serious harm in 28 per 10,000 patients, partly because of the risk of perforation, Dr. Barton said. CTC has no significant harms per 18,000 patients, but there is uncertainty about radiation exposure, extracolonic findings, and false positives, she said.

Dr. Ned Calonge, chairman of the U.S. Preventive Services Task Force and chief medical officer of the Colorado Department of Public Health and Environment, said that the unknowns about these potential harms led the group to give CTC a grade of "I," for insufficient evidence. "This is really a call for further research," Dr. Calonge told the Medicare advisers.

Dr. Jason Dominitz of the University of Washington, Seattle, who spoke on behalf of the American Society for Gastrointestinal Endoscopy, agreed that the jury was still out on CTC. "It's our overall belief that it's premature to endorse CTC for average-risk Medicare beneficiaries at this time," Dr. Dominitz told the committee.

CTC should be offered to people with incomplete colonoscopies or to those who refuse to undergo that test, but otherwise, there are too many questions, including questions about its sensitivity for small and flat polyps, how to manage extracolonic findings, the radiation risk, and the appropriate intervals for CTC screening, he said.

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