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## WHAT'S NEW



# Measures to Monitor Quality of Colorectal Ca Screening Needed

> "Overall, we don't have systems that monitor whether or not people are receiving screening services appropriately."

BY JEFF EVANS

BETHESDA, MD. — Efforts to improve colorectal cancer screening should rely on evidence-based interventions to target underscreened populations and should include a full range of screening options, according to findings from a panel convened by the National Institutes of Health.

In a draft "state-of-the-science" statement issued Feb. 4, the 13-member panel also recommended investing in a variety of quality monitoring methods to ensure that colorectal cancer screening is accompanied by high rates of cancer detection and prevention.

Efforts will need to address financial and geographic barriers to screening as well as appropriate follow-up, the panel advised. In the target population of adults aged 50 and older, screening rates were 55% in 2008.

"We are convinced by evidence in the literature that efforts … to tailor strategies will be very important to test. In different communities and in different population subgroups, there need to be different strategies tested in order to get high [screening] rates," panel chairperson Donald M. Steinwachs, Ph.D., said in a press telebriefing that followed the release of the draft statement.

*See* **Monitor** *page 4*

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# Federal Budget Plan for FY 2011 Targets Medicare Waste, Fraud

> "To those who commit fraud: Stop stealing from seniors and tax payers or we'll put you behind bars."

BY MARY ELLEN SCHNEIDER

The Obama administration wants to combat waste, fraud, and abuse in the Medicare and Medicaid programs and plans to spend more than $500 million to do it.

As part of the administration's budget proposal for fiscal year 2011, the Health and Human Services department is proposing to invest $561 million in discretionary funding to fight health care fraud, a $250 million increase over FY 2010. Specifically, the department plans to expand the Health Care Fraud Prevention and Enforcement Action Team (HEAT), which brings together high-level officials at HHS and the Department of Justice to spot trends and develop new fraud prevention tools.

HHS said the new funding also will be used to minimize inappropriate payments, pinpoint potential weaknesses in program oversight, and target emerging fraud schemes. Department officials estimate that the efforts to fight fraud and abuse will save $9.9 billion over the next decade.

HHS also expects to squeeze more savings out of the Medicare and Medicaid programs by giving more scrutiny to the provider enrollment process, increasing oversight of claims, improving the data analysis within Medicare, and reducing the overutilization of prescription drugs in Medicaid.

"This budget sends a clear message to those who commit fraud: Stop stealing from seniors and tax payers or we'll put you behind bars," Kathleen Sebelius, HHS Secretary, said during a press briefing to release the HHS budget proposal.

The FY 2011 budget proposal focuses on fraud prevention, wellness, and building the public health infrastructure. The

*See* **Federal Budget** *page 2*

# Screening Registry Suggested

**Monitor** *from page 1*

Systems that remind patients to get screened and one-on-one interactions with providers, educators, or patient navigators could help to increase screening, the panel noted. Systems of care that employ these techniques have much higher screening rates than the national average, such as Kaiser Permanente (75% in the Medicare population) and the Veterans Affairs health care system (80%), according to the statement.

The panel also found that a physician's recommendation is the only consistent physician-related factor that has been shown to predict screening.

"The decision on which approach to use is driven by factors like insurance and patient preferences," said panelist Dr. Leonard E. Egede, a professor in the division of general internal medicine and geriatrics at the Medical University of South Carolina, Charleston.

He noted that when patients have no preference for a particular screening method, most primary care physicians provide fecal occult blood test (FOBT)–based screening (followed by colonoscopy if needed) or direct access to colonoscopy.

A wide variety of methods with varying screening intervals are available for screening adults aged 50 and older, including annual FOBT (guaiac or immunochemical), flexible sigmoidoscopy, or double-contrast barium enema every 5 years, and colonoscopy every 10 years. The panel noted that CT colonography is a potentially viable screening option that could be expanded, but it is not currently covered by Medicare. Any positive results from noncolonoscopic screenings need to be followed with a colonoscopy.

When colonoscopy overtook FOBT and flexible sigmoidoscopy in 2001 as the most widely used screening method, there was a subsequent decline in the use of flexible sigmoidoscopy.

In that same time, double-barium contrast enema fell out of favor and the overall use of FOBT declined more gradually, although these stool tests are still widely used in the Veterans Affairs health care system and some managed care systems.

To provide colorectal cancer screening to low-income, uninsured, and underinsured populations, the panel noted that the Centers for Disease Control and Prevention recently began the Colorectal Cancer Control Program in 22 states.

The program is modeled after the agency's successful breast and cervical cancer screening program, but "its reach so far has been limited," Dr. Egede said.

Most of the current sources of information about screening rates do not provide enough detail on the use and quality of colorectal cancer screening, according to the statement.

"Monitoring systems exists in some communities, but overall, we don't have systems that monitor whether or not people are receiving screening services appropriately and whether or not the quality of the services being rendered are the highest," said Dr. Steinwachs, director of the Health Services Research and Development Center at Johns Hopkins University, Baltimore.

The panel suggested that a colorectal cancer screening registry analogous to the existing Breast Cancer Surveillance Consortium should be established to monitor the rates of colorectal cancer screening, overuse, quality, and complications. ■

*The panel based its statement on a report commissioned by the Agency for Healthcare Research and Quality, data presented at an NIH conference, and input from attendees of the conference. The statement is available at http://consensus.nih.gov.*

**TALK BACK**

**What strategy for colorectal cancer screening does your practice use?**

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MY TAKE

## Focus on Screening—By Any Method

We must get more patients screened for colon cancer—the second most common cause of cancer-related deaths in the United States—and the primary care physician is the key to successful screening of average-risk patients.

Which test you utilize may be less important than ensuring that all of your patients are screened in a timely and recurring manner. Colonoscopy every 10 years is widely favored as the ideal screening test, but annual stool guaiac testing coupled with flexible sigmoidoscopy every 3 years or with sigmoidoscopy and double-contrast barium enema every 5 years also are recommended. CT colonography, or virtual colonoscopy, is not yet approved for payment by Medicare but appears to be effective as a screening tool.

The issue is simple: Get your patients screened for colon cancer and precancerous polyps by one of the available methods.

ROWEN K. ZETTERMAN, M.D., *a gastroenterologist, is dean of the school of medicine at Creighton University, Omaha, Neb. He reported no relevant conflicts of interest.*

# Evidence Lacking for Long-Term Opioids for Noncancer Pain

BY SHERRY BOSCHERT

VITALS

**Major Finding:** When opioids were used long-term for noncancer pain, 6%-23% of patients stopped taking them due to inefficacy or side effects and 0.3% developed signs of addiction.

**Data Source:** Cochrane Collaboration review of 26 clinical studies with 4,893 participants.

**Disclosures:** None were reported in relation to the review.

One of the first systematic reviews of data on long-term use of opioids found weak evidence to support the idea that adults who can take chronic opioids get chronic pain relief, though effects on function or quality of life are unclear.

In a Cochrane Collaboration review of 26 prospective studies with 4,893 participants, 6%-23% of patients (depending on the route of drug administration) dropped out of the clinical trials due to inefficacy or side effects, but those who finished the studies maintained clinically significant reductions in pain for up to 48 months, Meredith Noble and her associates reported.

The review also suggested that opioid abuse or addiction were rare, but acknowledged that the findings are compromised by the limited quantity and poor quality of the studies. Only 7 (0.3%) of 2,613 patients developed signs of addiction or took their medicine inappropriately in the studies that reported those outcomes (Cochrane Database Syst. Rev. 2010 [doi: 10.1002/14651858.CD006605]).

Most of the studies excluded patients with risk factors for abuse. The low rate of addiction may be generalizable only to patients with no history of abuse or addiction, wrote Ms. Noble, a senior research analyst at the Economic Cycle Research Institute, one of 14 evidence-based practice centers under the Agency for Healthcare Research and Quality. A previous study suggested that addiction or abuse may develop in 3% of patients in all studies of opioid use for chronic pain and in 0.2% of patients in studies that screened out participants with a history of abuse or addiction (Pain Med. 2008;9:444-59).

The evidence of long-term relief of noncancer pain with chronic opioid use was too sparse in the current review to draw firm conclusions, the investigators said.

Among 3,040 patients taking oral opioids, 23% discontinued treatment due to adverse effects and 10% dropped out because of insufficient pain relief. Among 1,628 on transdermal opioids, 12% stopped due to adverse effects and 6% stopped due to insufficient pain relief. Intrathecal pumps delivered opioids in 231 patients who could not find pain relief any other way; of these, 9% stopped due to adverse effects and 8% dropped out due to insufficient pain relief.

One of the studies in the review was a randomized trial comparing two opioids; the other 25 studies were case series or uncontrolled continuations of short-term trials of opioids for noncancer pain. None included comparisons with placebo or nonopioid therapies.

The only other systematic review of opioid use for chronic noncancer pain was a 2008 study by the same investigators.

Solid estimates are lacking for the number of people with chronic noncancer pain who are taking opioids long-term. Two U.S. studies suggest that 0.65% of people with medical insurance use opioids chronically.

However, two pain experts said in interviews they fear clinicians might read too much into the review's limited findings.

The report is "very encouraging, but it's far from the whole story," Dr. Perry Fine said. Because there are no good substitutes for opioids on the horizon, physicians need to find ways to make long-term opioid use more effective and safe, he said.

Dr. Fine, president of the American Academy of Pain Medicine (AAPM) and professor of anesthesiology at the University of Utah, Salt Lake City, compared current use of long-term opioids for noncancer pain with the use of surgical anesthesia 20-30 years ago when it had significant morbidity and mortality. "That didn't stop us from doing surgical procedures when necessary, but it did motivate research and improvements."

Primary care internist Dr. Roger Chou said that the 0.3% rate of addiction reported is "a little misleading, because it's based on pretty crummy data." The review's findings on addiction, pain relief, and adverse events apply to very select groups of patients, not the more complicated cases that raise concerns for physicians considering long-term opioids.

Mainly, the review shows how little is known about prescribing long-term opioids, suggested Dr. Chou, of Oregon Health and Science University, Portland, and lead author of clinical guidelines on chronic opioids for noncancer pain by the American Pain Society and the AAPM. "We really don't have good quality, long-term data on this, which is scary because we're prescribing these medications so much," Dr. Chou said. ■

**Disclosures:** *Neither commentator is associated with the Cochrane review. Dr. Chou reported no conflicts of interest. Dr. Fine has been a speaker for Wyeth and an adviser for many pharmaceutical companies that manufacture opioids.*

Pages 4a—4b