

Preface

Cancer Screening in Primary Care: So Much Progress, So Much Left to Do



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In this update on cancer screening, it is sobering to realize that the first comprehensive evaluation of cancer screening guidelines took place 40 years ago when the American Cancer Society (ACS) commissioned Dr David Eddy and his colleagues to apply the principles of evidence-based medicine to the ACS' recommendations for the early detection of cancer.¹ Shortly thereafter in 1984, the US Preventive Services Task Force was commissioned and charged with bringing evidence-based medicine to the evaluation of common interventions in the primary care setting, and 5 years later, issued its first report on 169 preventive health interventions, including several cancer screening tests.² Over the years, these 2 organizations and others have regularly updated guidance to clinicians and the public, and although there have been differences, they always have shared more in common than they differed. Also important, over the past several decades, guideline development methodology has steadily evolved to promote rigor, transparency, and the obligation to address not only the benefits of cancer screening but also the limitations and potential harms.^{3,4}

The importance and value of regularly updated evidence-based cancer screening recommendations are overshadowed by a simple reality. The potential to avert disability and premature deaths from those cancers for which we have evidence for the efficacy of screening is dependent on the quality of the screening process and protocol, and regular attendance by the target population. All screening guidelines are based on an assessment of population-based benefit, a starting age is based on the underlying prevalence of disease, a stopping age is based on the likelihood of benefit in the context of longevity, and screening intervals are based on what is known about the tumor's detectable preclinical phase. However, the guidance and the infrastructure do not benefit the adult who does not attend screening; the potential to benefit from

screening may be less in the adult who attends irregularly and is diagnosed with an advanced cancer after a lapse in attendance, and regular attendance can be an empty exercise if a detectable cancer is missed due to poor quality. Thankfully, the importance of quality assurance in cancer screening has received considerable attention, and although shortcomings in quality still exist, the average adults undergoing screening can be confident that they are receiving a good-quality examination. This leaves lack of attendance and irregular attendance as the principal factors contributing to the unfulfilled potential of cancer screening.

Early on, there was growing recognition of the critically important role of the referring physician's recommendation,⁵ the importance of that recommendation being accompanied by informed and shared decision making,⁶ and the importance of office systems and policies⁷ that would overlay principles of population-based medicine to ensure timely cancer screening and follow-up beyond what is achievable under a model of opportunistic screening, for instance, when referrals to screening depend on encounters with health services, where, for a variety of reasons, a referral may or may not take place.⁸ Insufficient time, and the nature of the encounter are common reasons screening referrals don't take place, and thus, it should come as no surprise that patients who have had a preventive health examination are much more likely to report recent cancer screening than patients who only have encounters for acute and chronic complaints.⁹ It also is well established that access to cancer screening and screening outcomes in the United States vary by race/ethnicity, education, health literacy, income, occupation, insurance status, geography, and so forth,¹⁰ and that institutional barriers are deeply rooted in the health care system as well.¹¹ However, most unscreened and underscreened adults who would undergo screening have health insurance, and only need the focused, sometimes relentless, advice from their provider to motivate them to attend screening. For this to happen, practice settings must know who among their patient panel is due for screening, and it must be a practice policy and priority that as many patients who will choose to undergo screening receive regular screening according to the recommendations from expert groups. Most adults will not develop the cancers for which screening is recommended. However, if they do, regular screening will give them the best chance to prevent a pre-cancerous lesion from becoming invasive, to avoid a diagnosis of advanced disease, and to avert a premature death.

In this issue you will find up-to-date advice from leading experts in cancer screening. It has been our pleasure to assemble them to contribute to this issue of *Medical Clinics of North America*, and we are deeply grateful that they agreed to share their wisdom. We also are grateful to the editorial team for support.

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