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Colorectal cancer: The importance of screening and follow-up

Colorectal cancer is the second leading cause of cancer-related death in the United States. The American Cancer Society estimates that 57,100 Americans will die of colorectal cancer this year. Approximately 147,500 new cases will be diagnosed in 2003. Colorectal cancer is the third most common cancer in both men and women. This cancer is rare before age 40, and 90 percent of colon cancers occur after the age of 50.

Most colorectal cancers can be surgically cured, especially if they are small, have not metastasized or are localized and are detected before they are symptomatic. Since most colorectal cancers arise from benign polyps, the removal of polyps has demonstrated a reduction in the incidence of subsequent colorectal cancer.

Risk Factors

The risk for developing colorectal cancer increases with advancing age. Risk factors include inflammatory bowel disease, a personal or family history of colorectal cancer or colorectal polyps and certain hereditary syndromes. Lack of regular physical activity also contributes to a person's risk for colon cancer, but does not effect rectal cancer risk. Other factors that may contribute to the risk for colorectal cancer include low fruit and vegetable intake, a low-fiber and high-fat diet, obesity and alcohol consumption. Men and women are essentially at equal risk for colon cancer![1]

Early signs of Colon Cancer

This cancer usually does NOT exhibit clinical signs in its early stages. As the disease progresses, any of the following may be seen:

- Blood in the stool
- Diarrhea
- Constipation
- Bowel obstruction, causing nausea, vomiting and abdominal distention
- Abdominal pain
- Anemia
- Weight loss
- Loss of appetite
- Fatigue[2]

Factors associated with increased risk for colon cancer include:

- Age - nearly 90 percent of colon cancer patients are 50 or older
- Race - African Americans are at greater risk
- Personal or family history of colon cancer
- Personal or family history of colorectal polyps
- Personal history of inflammatory bowel disease (ulcerative or Crohn's colitis)
- Certain genetic conditions (familial adenomatous polyposis, Gardner's syndrome, hereditary nonpolyposis colorectal cancer)
- Physical inactivity
- Diets high in red meat and saturated fats

Source: American Cancer Society

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Of these clinical signs, rectal bleeding is often the first sign associated with an early stage of colorectal cancer. Therefore, blood in the stool, either occult or gross, is a strong indication for colon evaluation in patients at risk for colon cancer.

Rectal bleeding is the presenting symptom in most patients who have successful lawsuits for failure to diagnose colorectal cancer. **Bleeding should not be attributed to hemorrhoids without a complete colon examination.** In general, patients who are at risk for colorectal cancer should have either a colonoscopy or a flexible sigmoidoscopy and double-contrast barium enema to evaluate a complaint of blood in the stool. Colonoscopy is the preferable test when the suspicion of colorectal cancer is present. A flexible sigmoidoscopy and barium enema is preferred when working up isolated symptoms of abdominal pain, diarrhea, constipation and a change in bowel habits.

A new technique is showing promise as a screening tool for colorectal cancer. This "virtual colonoscopy" utilizes high-speed CT scanning. It is currently undergoing comparative tests with colonoscopies. This "virtual colonoscopy" has the potential to become a standard recommendation in the future.

Screening

Screening is done on individuals who do not have any signs or symptoms that may indicate cancer. If symptoms exist, diagnostic work-up rather than screening should be completed.

The American Cancer Society recommends screening people at average risk for colorectal cancer beginning at age 50. Both men and women should follow one of the following testing options:

- Fecal Occult Blood Testing (FOBT) annually
- Flexible sigmoidoscopy every five years
- Annual FOBT plus flexible sigmoidoscopy every five years (preferred over either option above)
- Double-contrast barium enema every five years
- Colonoscopy every 10 years

A digital rectal exam (DRE) continues to be utilized as a test for rectal cancer. However, fewer than 10 percent of colorectal cancers arise within reach of the examining finger, and some of these lesions will already be symptomatic. **The American Cancer Society does not recommend digital rectal exam as a stand-alone screening test for colorectal cancer.** Similar recommendations are issued by the American College of Surgeons[3], the American College of Obstetricians and Gynecologists[4], and the American Academy of Family Physicians[5].

As with all screening recommendations, document that the patient was informed of the need to undergo the screening modality chosen. Even if the patient refuses to undergo the screening, this note can prove invaluable in defending against a "failure to screen" claim.

Discuss with the patient that no screening test, even colonoscopy, will pick up every cancer or pre-cancerous polyp, but any screening for colorectal cancer is much better than no screening at all. The following are settled cases that reflect potential situations from which a claim for failure to diagnose colon cancer can arise.

Closed Claim Abstract

CASE # 1

A 42-year-old male went to his family physician for a routine physical. The physician ordered a fecal occult blood test to determine if the patient had unseen blood in his stool, a possible indicator of colon cancer. The test result was positive, however it was filed in the patient's record without the physician seeing it. Six months later, the patient returned complaining of abdominal pain and diarrhea. The report was then found and the patient was diagnosed with colon cancer. The complaint alleged that because of the delay, the cancer had metastasized and was terminal.

CASE #2

A 54-year-old female, who had been treated by the same primary care physician (an internist) for years, was diagnosed with end-stage colon cancer. It was found that the physician had never ordered any screenings, either fecal occult blood test, or a colonoscopy during the patient's annual exams.

Failure-to-diagnose and failure-to-screen claims are on the increase. In both claim examples, the standards of care for colon cancer screening were not met, making the cases indefensible[6].

The Physician Insurers Association of America (PIAA) reports that the average indemnity for claims related to colon cancer since 1995 is $286,043. The physician specialty with the highest number of colon cancer claims is internal medicine, representing 30.7 percent of paid claims and 39.5 percent indemnity. For colon cancer claims closed since 1995, the average indemnity for internist is $410,418, again the highest average for any physician specialty.

PIAA COLON CANCER CLAIMS BY TOP PHYSICIAN SPECIALTIES 1995-2002

	Closed Claims	Paid Claims	Payment Rate	Average Indemnity
Internal Medicine	159	55	34.6%	$410,418.00
General Surgery	157	50	31.8%	$219,330.00
GP/FP	109	36	33%	$217,545.89
Radiology	52	12	23%	$345,972.25

One factor likely to play a significant role in the future of colon cancer claims is the new set of guidelines for colon cancer screening from the American Gastroenterology Association. These guidelines stress the importance of patient history for screening for colon cancer. According to the guidelines, **individuals with a positive family history of colon cancer need to be screened as early as age 20-25 for the disease[7]. This is much earlier than previously established by other guidelines.**

Establishing the need to address patient family medical history in the screening for colon cancer claims is vital. An earlier study by the Physicians Insurers Association of America (PIAA) documented that in 61.6 percent of claims reported, the physician did not record the patient's family history of colon cancer. Of those that did record family history, 19.9 percent had a positive family history. The study clearly indicated that documentation of family history was sorely lacking in colon cancer claims.

Strategies for Risk Reduction for Colon Cancer Claims

1. Physicians need to stay current with clinical practice standards that are applicable to their patient population
2. Medical staff should thoroughly document both patients' and patients' family histories
3. Practices should utilize technology to provide physicians with reminders of necessary follow-up

"Discuss with the patient that no screening test, even colonoscopy, will pick up every cancer..."

4. Practices should establish fail-safe office systems to ensure that all lab and test results are reviewed by the physician in a timely manner

This article is intended to provide steps that can be taken to decrease the level of risk associated with colorectal cancer detection. The strategies are provided with the intention of improving patient care and minimizing malpractice losses.

If you need more information, please contact a MAG Mutual risk management consultant at 404-842-5600, 800-282-4882 or online at www.magmutual.com.

For more information on colon cancer, see:

www.gastro.org
www.cancer.org
www.cdc.gov/cancer

*Footnotes:

(1) Colorectal Cancer Network. Prevention, Awareness and Screening. See article at www.colorectal-cancer.net/prevention.htm.
(2) See 1.
(3) American College of Surgery at www.facs.org/dept/jacs/articles/messing.html.
(4) American College of Obstetricians and Gynecologists. Primary and preventive care: periodic assessments. ACOG Committee Opinion 246. Washington DC: ACOG, 2000.
(5) American Academy of Family Physicians. Summary of policy recommendations for periodic health examination. Revision 5.0, August 2001, Order No. 962, Reprint No. 510. Available at www.aafp.org/exam.xml.
(6) PIAA Research Notes. Colon Cancer. Spring 2003 edition.
(7) American Gastroenterlogical Association, Gastroenterology, Colorectal Guidelines, February 2003.

Verify Physician Applications

Unfortunately, a small number of individuals completing applications for employment or appointment falsify or omit important information concerning their past. Some forget that they have previously lost a license, others may not remember that they never took the board examination and may report that they are certified. Still others may create an employment history in order to cover gaps.

Lack of a credentialing process for physicians may expose the practice to claims of corporate negligence for allowing an "incompetent" individual to practice. A written policy will provide guidelines. The policy and the credential file(s) will serve as evidence that the same thorough evaluation of the education, experience and qualifications of all physicians is routinely performed. Credentialing criteria should be related to the clinical competency of practitioners and affect the provision of quality care.

The purpose of verifying the details on an application is to avoid compromising patient care quality, organizational embarrassment or organizational risk. If information is important enough to require on the application, that information should then be verified by the organization.

Written policies should be developed to provide guidelines for the credentialing activities. A file should be maintained on each credentialed physician. A credentialing policy should include the following:

Written application

- Primary source verification of information; state licensure, schooling and residency completion, Board certification
- Information relating to past or pending claims, lawsuits, or settlements
- Letters of reference
- Documentation of relevant training and experience
- Records of continuing education
- Current Drug Enforcement Agency (DEA) number

If relying on credentialing done by an outside agency, complete documentation of the appropriate information should be obtained and maintained in a confidential file.

MAG Mutual does not presume to establish any standard of care or establish rules for the practice of medicine. The particular patient-care strategies or range of patient-care strategies mentioned in this newsletter should be tempered by the physician's judgment. This publication is produced to inform you of issues relating to medical professional liability insurance and other matters of importance to physicians. Material given in this newsletter does not constitute legal advice or opinion. If you have questions in any of the areas discussed in this publication, you should seek a qualified legal opinion.

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