



# Northwest Colorectal Cancer Task Force Quarterly Meeting

October 1<sup>st</sup>, 2024



# Agenda

---

- Welcome & Introductions
- Presentation 1: CRC Data Update- Oregon & Washington
- Share Updates and Events
- Presentation 2 : Resources from ACS National CRC Roundtable
- Presentation 3: CRC Screening Blood Test
- Communication Campaign Workgroup Updates
- Wrap up & Next Steps

# Welcome & Introduction

---

- Please type in the chat :
  - Your name, Organization & Title

## 2025 Quarterly Meeting Dates

---

- February 18<sup>th</sup>, 2025 (Tuesday), 9:00 am- 11:00 am
- June 3<sup>rd</sup>, 2025 (Tuesday), 9:00 am- 11:00 am
- October 7<sup>th</sup>, 2025 (Tuesday), 9:00 am- 11:00 am

# Presentation 1

---

## **CRC Data Update : Oregon & Washington**

Katie Treend, MPH

Comprehensive Cancer Control Program Coordinator

WA State Department of Health



# WASHINGTON AND OREGON CRC DATA UPDATE

Katie Treend, MPH  
Comprehensive Cancer Control Program Coordinator

## Contact

---

EMAIL: [KATIE.TREEND@DOH.WA.GOV](mailto:KATIE.TREEND@DOH.WA.GOV)

NW CRC Task Force



**WASHINGTON DATA**



## WA Data Sources

---

- Incidence Data: WA Dept. of Health Washington State Cancer Registry, released in April 2024.
  - Singular year: 2021
  - Combined years: 2017-2021
- Mortality Data: WA Dept. of Health Washington State Cancer Registry, released in April 2024.
  - Singular year: 2021
  - Combined years: 2017-2021
- Population Data: Washington State Population Interim Estimates (PIE), released in December 2022.
- Screening Data: Behavioral Risk Factor Surveillance System (BRFSS) 2022

## Washington State CRC Screening Rate 2022

---

<b>Type</b>	<b>Rate</b>
Total	74.4
Female	75.1
Male	73.6

Adults aged 50-75 years who report up-to-date with colorectal cancer screening

## Overall Incidence Rates (per 100,000) for 2021

---

<b>Type</b>	<b>Rate</b>	<b>Count</b>
Total	34.3	3,106
Female	31.1	1,464
Male	37.7	1,640

## Late Stage Incidence Rates (per 100,000) for 2021

---

<b>Type</b>	<b>Rate</b>	<b>Count</b>
Total	21.7	1,962
Female	19.4	919
Male	24	1,042

## Overall Incidence Rate (per 100,000) by Race and Ethnicity 2017-2021

<b>Race/Ethnicity</b>	<b>Incidence Rate per 100,000</b>
White, non-Hispanic	34.8
Black	41.7
American Indian or Alaska Native	47.4
Asian	30.5
Native Hawaiian or Pacific Islander	37.8
Hispanic	30.8

# Late Stage Incidence Rate (per 100,000) by Race and Ethnicity 2017-2021

<b>Race/Ethnicity</b>	<b>Incidence Rate per 100,000</b>
White, non-Hispanic	21.3
Black	26.3
American Indian or Alaska Native	28.3
Asian	18.5
Native Hawaiian or Pacific Islander	16.2
Hispanic	19.5

## Overall Incidence Rate (per 100,000) by county of residence 2017-2021

<b>County of Residence</b>	<b>Incidence Rate per 100,000</b>
Washington State Average	34.2
Adams County	37.8
Asotin County	22.6
Benton County	33.7
Chelan County	36.4
Clallam County	36.8
Clark County	28.7
Columbia County	27.3
Cowlitz County	29.8
Douglas County	36.1
Ferry County	19
Franklin County	40.1
Garfield County	^
Grant County	32.3
Grays Harbor County	44.6
Island County	38.2
Jefferson County	36

## Overall Incidence Rate (per 100,000) by county of residence 2017-2021

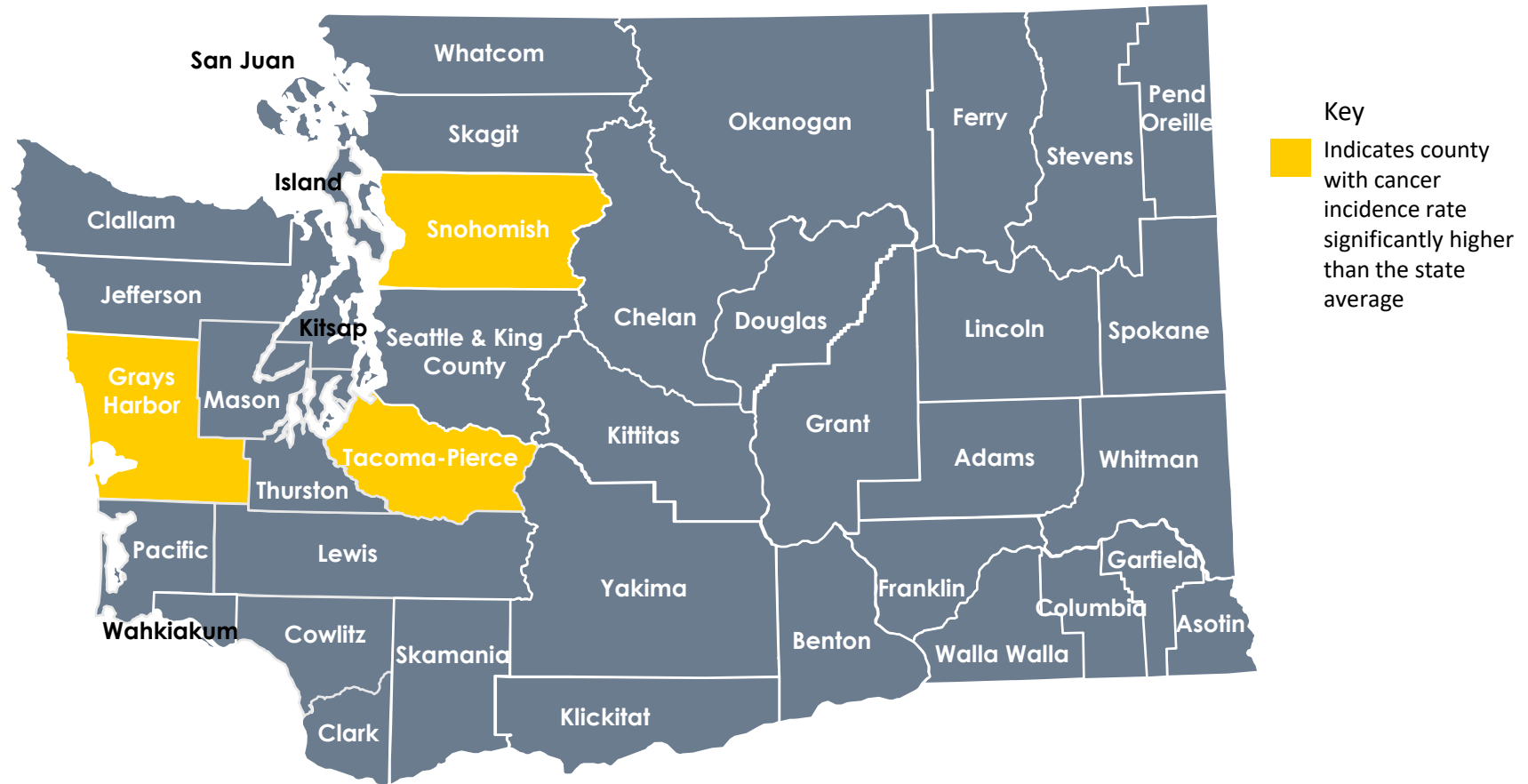
<b>County of Residence</b>	<b>Incidence Rate per 100,000</b>
Washington State Average	34.2
King County	33.5
Kitsap County	34.5
Kittitas County	26.5
Klickitat County	30.4
Lewis County	35.8
Lincoln County	25.4
Mason County	36.2
Okanogan County	39.1
Pacific County	28.9
Pend Oreille County	28.8
Pierce County	36.8
San Juan County	39.8
Skagit County	38.2
Skamania County	46.9



## Overall Incidence Rate (per 100,000) by county of residence 2017-2021

<b>County of Residence</b>	<b>Incidence Rate per 100,000</b>
Washington State Average	34.2
Snohomish County	36.7
Spokane County	31.9
Stevens County	39
Thurston County	35.9
Wahkiakum County	36
Walla Walla County	31.9
Whatcom County	31.4
Whitman County	15.1
Yakima County	32.1

# Significant differences of incidence compared to state average



## Overall Mortality Rates (per 100,000) for 2021

---

<b>Type</b>	<b>Rate</b>	<b>Count</b>
Total	12	1,110
Female	10.8	534
Male	13.3	576

# Overall Mortality Rate (per 100,000) by Race and Ethnicity 2017-2021

<b>Race/Ethnicity</b>	<b>Incidence Rate per 100,000</b>
White, non-Hispanic	12
Black	17.9
American Indian or Alaska Native	18.3
Asian	9.8
Native Hawaiian or Pacific Islander	15.4
Hispanic	8.8

## Overall Mortality Rate (per 100,000) by county of residence 2017-2021

County of Residence	Incidence Rate per 100,000
Washington State Average	11.8
Adams County	10.3
Asotin County	11.2
Benton County	13
Chelan County	10.9
Clallam County	13.2
Clark County	11.6
Columbia County	^
Cowlitz County	12.9
Douglas County	9.7
Ferry County	^
Franklin County	9.5
Garfield County	^
Grant County	11.8
Grays Harbor County	14.1
Island County	14.5
Jefferson County	12.8

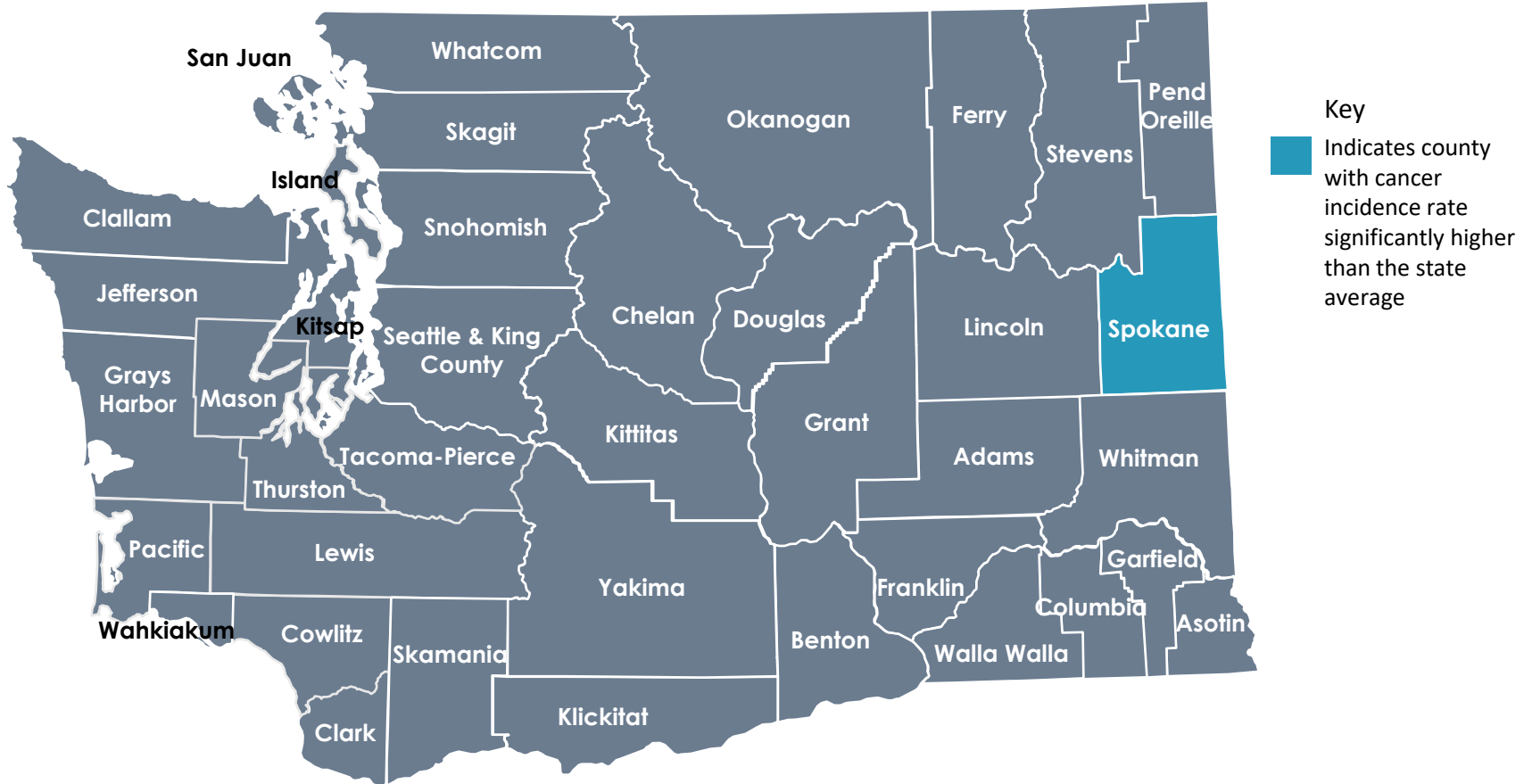
## Overall Mortality Rate (per 100,000) by county of residence 2017-2021

<b>County of Residence</b>	<b>Incidence Rate per 100,000</b>
Washington State Average	11.8
King County	10.7
Kitsap County	11.4
Kittitas County	10.7
Klickitat County	14.9
Lewis County	14.6
Lincoln County	^
Mason County	11.9
Okanogan County	12.7
Pacific County	9.8
Pend Oreille County	13.9
Pierce County	11.4
San Juan County	15
Skagit County	13.3
Skamania County	17.9

## Overall Mortality Rate (per 100,000) by county of residence 2017-2021

<b>County of Residence</b>	<b>Incidence Rate per 100,000</b>
Washington State Average	11.8
Snohomish County	12.5
Spokane County	13.3
Stevens County	15
Thurston County	10.9
Wahkiakum County	^
Walla Walla County	13
Whatcom County	12.2
Whitman County	7.3
Yakima County	13.5

# Significant differences of mortality compared to state average





NW CRC Task Force



**OREGON DATA**

# Oregon Data Sources

---

- Oregon State Cancer Registry
  - Incidence:
    - Overall incidence rate; Singular year: 2021
    - Rates by race/ethnicity and county of residence; Combined years: 2017-2021
- Oregon Health Authority
  - Mortality
    - Overall incidence rate; Singular year: 2021
    - Rates by race/ethnicity and county of residence; Combined years: 2018-2022
- Screening Data: Behavioral Risk Factor Surveillance System (BRFSS) 2022

## Oregon State CRC Screening Rate 2022

---

<b>Type</b>	<b>Rate</b>
Total	71.8
Female	73.5
Male	70.1

Adults aged 50-75 years who report up-to-date with colorectal cancer screening

## Overall Incidence Rates (per 100,000) for 2021

---

<b>Type</b>	<b>Rate</b>	<b>Count</b>
Total	30.8	1,629

## Overall Incidence Rate (per 100,000) by Race and Ethnicity 2017-2021

<b>Race/Ethnicity</b>	<b>Incidence Rate per 100,000</b>
White, non-Hispanic	25.5
Black	24
American Indian or Alaska Native	30.6
Asian or Pacific Islander	22
Non-Hispanic or Latino	25.9
Hispanic or Latino	17.6

## Overall Incidence Rate (per 100,000) by county of residence 2017-2021

County of Residence	Incidence Rate per 100,000
Oregon State Average	25.7
Baker County	22.6
Benton County	21.1
Clackamas County	26.8
Clatsop County	36.3
Columbia County	31.5
Coos County	26.3
Crook County	32.7
Curry County	24.6
Deschutes County	20.9
Douglas County	27.3
Gilliam County	~
Grant County	19.1
Harney County	28.1
Hood River County	32.9

## Overall Incidence Rate (per 100,000) by county of residence 2017-2021

County of Residence	Incidence Rate per 100,000
Oregon State Average	25.7
Jackson County	26.4
Jefferson County	22
Josephine County	26
Klamath County	32.2
Lake County	26.4
Lane County	22.1
Lincoln County	21.6
Linn County	24.7
Malheur County	23.8
Marion County	29.9
Morrow County	25.1
Multnomah County	25.5
Polk County	23.7
Sherman County	~

## Overall Incidence Rate (per 100,000) by county of residence 2017-2021

<b>County of Residence</b>	<b>Incidence Rate per 100,000</b>
Oregon State Average	25.7
Tillamook County	21.5
Umatilla County	34.8
Union County	32.1
Wallowa County	24.2
Wasco County	18.4
Washington County	24
Wheeler County	~
Yamhill County	27



## Overall Mortality Rates (per 100,000) for 2021

---

<b>Type</b>	<b>Rate</b>	<b>Count</b>
Total	12.7	681

# Overall Mortality Rate (per 100,000) by Race and Ethnicity 2018-2022

<b>Race/Ethnicity</b>	<b>Incidence Rate per 100,000</b>
White, non-Hispanic	12.4
Black	13.7
American Indian or Alaska Native	12.9
Asian or Pacific Islander	9.1
Hispanic or Latino	10

## Overall Mortality Rate (per 100,000) by county of residence 2018-2022

County of Residence	Incidence Rate per 100,000
Oregon State Average	12.2
Baker County	~
Benton County	11.8
Clackamas County	11.6
Clatsop County	20.3
Columbia County	12.5
Coos County	13.4
Crook County	16.0
Curry County	13.2
Deschutes County	9.0
Douglas County	13.4
Gilliam County	~
Grant County	~
Harney County	~
Hood River County	13.3

## Overall Mortality Rate (per 100,000) by county of residence 2018-2022

County of Residence	Incidence Rate per 100,000
Oregon State Average	12.2
Jackson County	11.2
Jefferson County	9.5
Josephine County	13.5
Klamath County	15.0
Lake County	~
Lane County	12.8
Lincoln County	14.4
Linn County	11.6
Malheur County	18.6
Marion County	12.3
Morrow County	~
Multnomah County	12.1
Polk County	11.9
Sherman County	~

## Overall Mortality Rate (per 100,000) by county of residence 2018-2022

<b>County of Residence</b>	<b>Incidence Rate per 100,000</b>
Oregon State Average	12.2
Tillamook County	15.2
Umatilla County	17.5
Union County	14.9
Wallowa County	~
Wasco County	13.1
Washington County	9.9
Wheeler County	~
Yamhill County	13.2

Questions?

---



To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email [civil.rights@doh.wa.gov](mailto:civil.rights@doh.wa.gov).

## Share Updates and Events

---

- **Updates from Northwest CRC Task Force**

- Cologuard Coverage Access for Medicaid and Medicare in WA
- American Cancer Society's CRC Campaign in Oregon and Washington
- Color Health & American Cancer Society's Free CRC Kits for Rural FQHCs

- **Task Force Members' Share Updates and Events**

Feel free to unmute and speak, or type in the chat



## Presentation 2

---

### **Resources from ACS National CRC Roundtable**

Emily Bell, MPH

Director, ACS National Colorectal Cancer Roundtable



# American Cancer Society National Colorectal Cancer Roundtable (ACS NCCRT)

*Resources to Improve CRC Screening  
Rates*

Emily Bell, MPH  
Director, ACS NCCRT

# About the ACS NCCRT

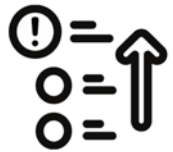


NATIONAL  
COLORECTAL  
CANCER  
ROUNDTABLE



# What does the ACS NCCRT do?

Through coordinated leadership, strategic planning, and advocacy, we provide a neutral platform to convene diverse national partners to:



Establish National Priorities  
Across the CRC Cancer Continuum



Catalyze Policy and  
Patient Care Solutions



Promote Evidence-Based Strategies  
and Translate them into Practice



Leverage Volunteer Knowledge and  
Experiences to Inform the Reduction  
of Health Disparities

# ACS NCCRT Snapshot



**History:** Established by the ACS, in partnership with the CDC, in 1997, to serve as an umbrella organization to engage all types of stakeholders who are committed to save more lives from CRC.



**Mission:** Reduce incidence of and mortality from CRC



**Membership:** Collaborative partnership of 225+ member organizations, including nationally known



**Operations:** Work is coordinated by the ACS NCCRT Team, and is conducted year-round by our members



**Convening:** Each year the ACS NCCRT Annual Meeting addresses important topics and sets the agenda for the following year

# ACS NCCRT Resources

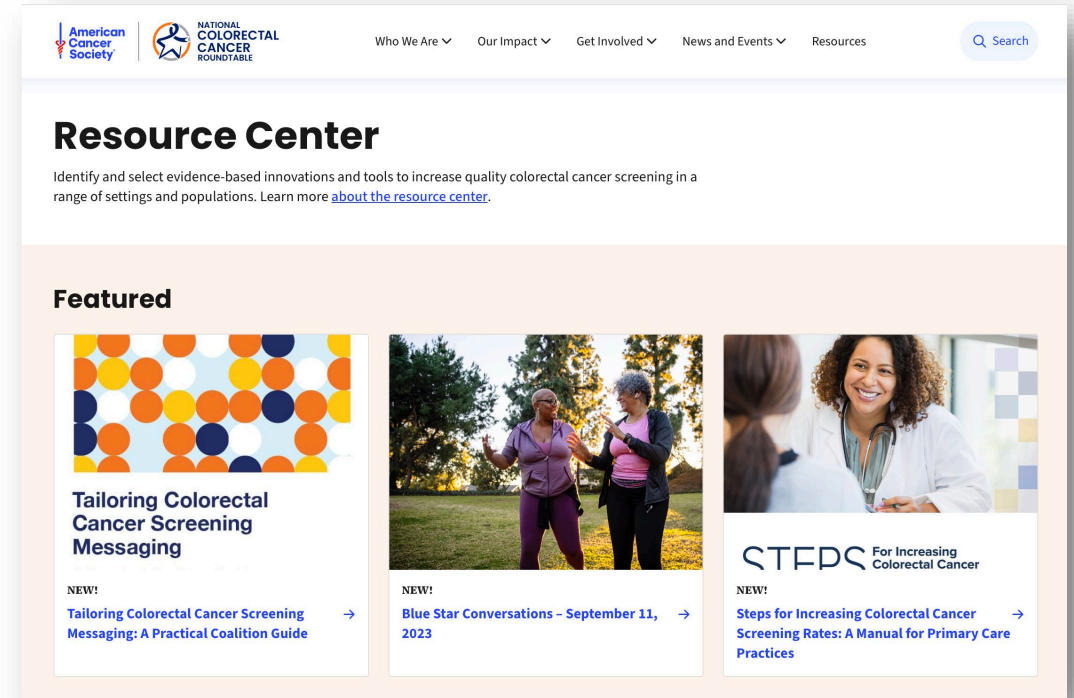


NATIONAL  
COLORECTAL  
CANCER  
ROUNDTABLE



# ACS NCCRT Website & Resource Center

The **ACS NCCRT Website & Resource Center** contains evidence-based resources and tools to help you increase quality colorectal cancer screening in a range of settings and populations.



[nccrt.org/resource-center](https://nccrt.org/resource-center)

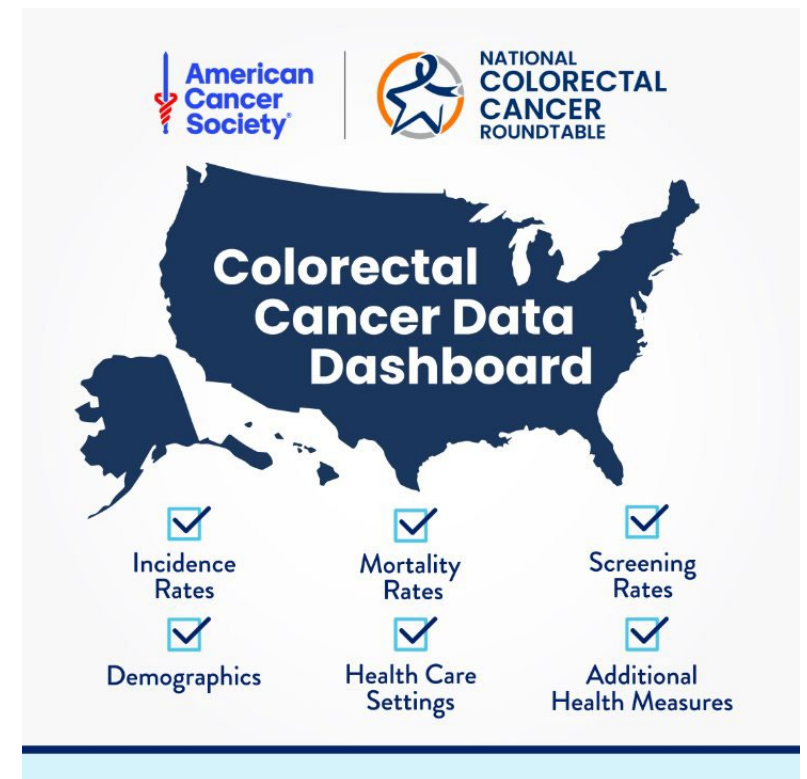


# CRC Data Dashboard

Developed with the ACS Geospatial Solutions Team, led by Dr. Liora Sahar.

This new mapping tool offers an interactive geospatial view of data pertaining to CRC in the US. The dynamic national platform integrates layers from multiple sources and allows you to interactively explore data using maps and graphs, including:

- CRC surveillance data (incidence rates, mortality rates)
- CRC screening rates
- Healthcare settings (Commission of Cancer hospitals, Federally Qualified Health Centers, National Cancer Institute Designated Cancer Centers)
- Demographics (age, race and Hispanic origin, poverty status, educational attainment)
- Additional health measures (smoking, binge drinking, obesity)





# CRC Data Dashboard



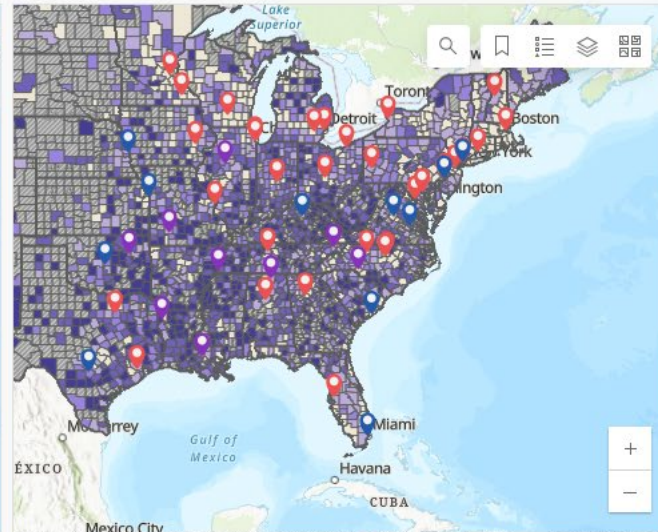
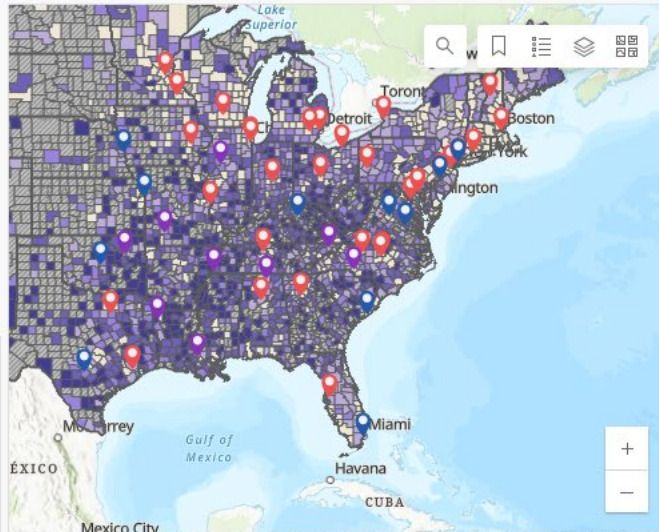
## CRC Data Dashboard

### Colorectal Cancer in the US

Explore data from different sources, including cancer incidence and mortality rates, screening rates, and more

#### State Selector

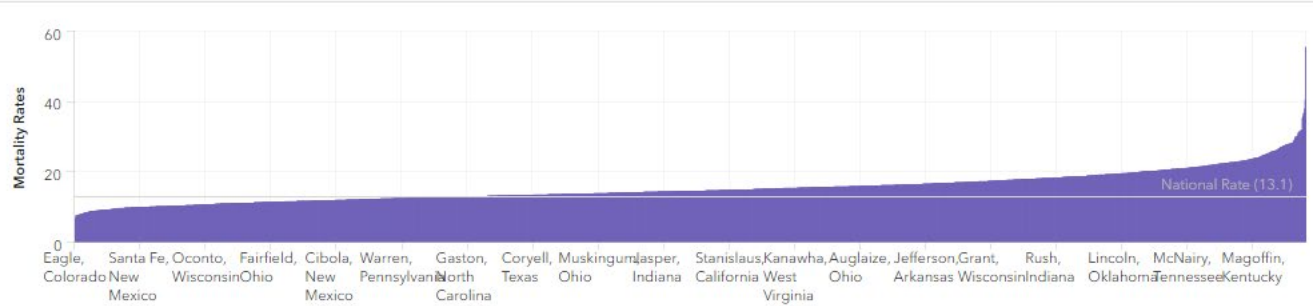
Select one or more states



#### CRC Mortality Rates

Showing the top 400 counties. If you don't see your county, select the state first.

Thurston, Nebraska	Rate: <b>55.50</b> (32.30-88.90)	Total Count: 4
Union, Florida	Rate: <b>40.50</b> (28.60-56.00)	Total Count: 8
Dawes, Nebraska	Rate: <b>38.00</b> (22.40-61.10)	Total Count: 4
Humphreys, Mississippi	Rate: <b>36.90</b> (22.30-58.50)	Total Count: 4
Holmes, Mississippi	Rate: <b>36.50</b> (25.10-51.40)	Total Count: 7
Morris, Texas	Rate: <b>35.80</b> (24.10-51.80)	Total Count: 7
Zavala, Texas	Rate: <b>35.30</b> (20.70-56.40)	Total Count: 4
Lee, Arkansas	Rate: <b>32.00</b> (19.70-50.60)	Total Count: 4
Monroe, Arkansas	Rate: <b>31.90</b> (17.20-55.40)	Total Count: 3



Mortality Rates

Incidence Rates

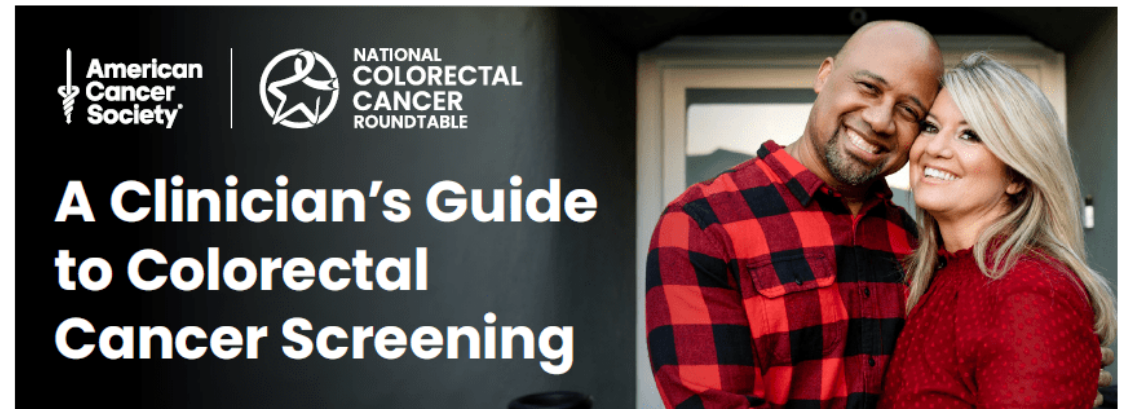
Washington, North Carolina

Mortality



# The Dos and Don'ts of Colorectal Cancer Screening

This one-page flyer may be used to remind clinicians about some of the dos and don'ts when it comes to colorectal cancer screening.



✓ DO

✗ DON'T

# The Dos and Don'ts of Colorectal Cancer Screening

## ✓ DO

- ✓ **Do** make a recommendation! Be clear that screening is important. Ask patients about their needs and preferences. Several test options are available.
- ✓ **Do** use the American Cancer Society and the USPSTF recommendation to start colorectal cancer screening in average-risk adults at age 45.
- ✓ **Do** discuss colorectal cancer screening with patients prior to the age 45. Colorectal cancer is now the leading cause of cancer death in men and the second in women younger than age 50. Conversations about when to screen based on age, familial cancer history, and risk factors should begin early.
- ✓ **Do** assess your patient's family history and medical history.
- ✓ **Do** be persistent with reminders.
- ✓ **Do** communicate that it is essential to follow any positive or abnormal non-colonoscopy test with a timely colonoscopy. Delays in receiving follow-up colonoscopy are associated with increased colorectal cancer incidence and mortality.
- ✓ **Do** develop standard office operating procedures and policies for colorectal cancer screening, including the use of electronic health record prompts and patient navigation.
- ✓ **Do** encourage patients to alert you if they experience symptoms related to colorectal cancer. These may include blood in the stool, persistent abdominal pain, changes in bowel habits, or unexplained weight loss.

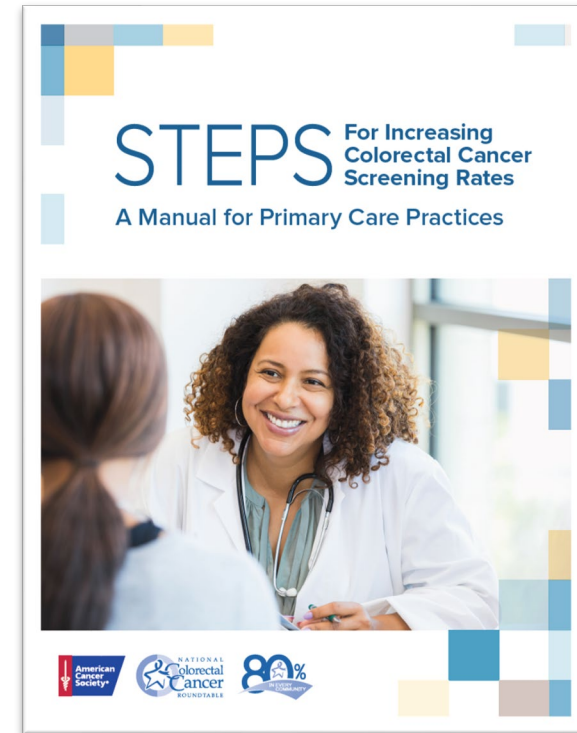
## ✗ DON'T

- ✗ **Do not** use digital rectal exams (DREs) for colorectal cancer screening. In one large study, DREs missed 19 of 21 cancers.
- ✗ **Do not** repeat an abnormal stool test. Any abnormal finding should be followed up with a timely colonoscopy.
- ✗ **Do not** use stool tests on those with a higher risk. A colonoscopy must be performed.
- ✗ **Do not** minimize or ignore symptoms in patients younger than screening age. Evaluate and refer symptomatic patients to colonoscopy as needed, regardless of age.
- ✗ **Do not** forget to use non-clinical staff to help make sure screening gets done. They can help hand out educational materials and schedule follow-up appointments.
- ✗ **Do not** forget to coordinate care across the continuum. Effective care coordination between primary care and other specialty physicians is essential.
- ✗ **Do not** forget how helpful culturally and linguistically appropriate messaging about colorectal cancer screening can be to encourage on-time and regular screening.

# Steps for Increasing Colorectal Cancer Screening Rates: A Manual for Primary Care Practices

## Released in 2022

- Expansion to all primary care
- Latest science and best practices
- Current guidelines and test options
- Expert-endorsed strategies
- Samples, templates, and tools
- 10 case studies



# Updated Resources Coming Soon:

## *Clinician's Reference on Stool-Based Testing Brief*

- Being **updated** for an October re-release, to include:
  - The case for offering stool-based tests
  - The latest science on sensitivity/specificity for these tests
  - The importance of timely colonoscopy follow up to positive or abnormal stool-based tests



# CRC News: Ongoing Communication With Partners

We regularly share new **resources, news, webinars, and opportunities** with our members and 80% partners.

Sign up now!

Connect with us our social media channels:

- [NCCRT X \(Twitter\)](#)
- [NCCRT LinkedIn](#)
- [NCCRT YouTube](#)



American Cancer Society | NATIONAL COLORECTAL CANCER ROUNDTABLE

## CRC News

Welcome to the latest edition of *CRC News*, the [American Cancer Society National Colorectal Cancer Roundtable \(ACS NCCRT\)](#) periodic newsletter for ACS NCCRT members working toward our shared goal to reach [80% in Every Community](#).



**Nominations Open for the ACS NCCRT's National Achievement Awards!**



NATIONAL COLORECTAL CANCER ROUNDTABLE

80%

Together, we can save lives by improving colorectal cancer screening rates.  
#80InEveryCommunity

American Cancer Society | NATIONAL COLORECTAL CANCER ROUNDTABLE

## National Colorectal Cancer Roundtable (NCCRT)

A national coalition by ACS dedicated to reducing the incidence of and mortality from colorectal cancer in the U.S.

Non-profit Organizations · 852 followers · 2-10 employees

Lori & 203 other connections follow this page

Following Visit website

Home About Posts Jobs People





# Thank You!

[Emily.Bell@cancer.org](mailto:Emily.Bell@cancer.org)

[nccrt.org](http://nccrt.org)   [@NCCRTnews](https://twitter.com/NCCRTnews)   [#NCCRT2024](https://twitter.com/NCCRTnews)

# Presentation 3

---

## **CRC Screening Blood Test Research**

Dr. Rachel Issaka, MD, MAS

Associate Professor, Public Health Sciences Division  
Gastroenterology and Hepatology Clinical Research Division  
Fred Hutchinson Cancer Research Center





# Emerging Blood Tests for Colorectal Cancer Screening

Rachel Issaka, MD, MAS

Associate Professor, Public Health Sciences & Clinical Research Divisions

Associate Professor, Division of Gastroenterology, UW School of Medicine

Kathryn Surace-Smith Endowed Chair in Health Equity Research

Director, Population Health Colorectal Cancer Screening Program

October 1, 2024



UW Medicine

# Financial Disclosures/Disclaimers

**Employee:** Fred Hutchinson Cancer Center, University of Washington

**Grant Funding:** National Institutes of Health/National Cancer Institute, American College of Gastroenterology

**Advisory Board Member:** Guardant Health, Inc.

**Disclaimer:** Several non-FDA approved use of products will be discussed in this presentation



# Outline

Colorectal cancer epidemiology

cf-DNA/ct-DNA aka “liquid biopsy”

cf-DNA/ct-DNA colorectal cancer tests

Multi-cancer early detection tests

# Colorectal cancer (CRC) is a leading cause of cancer deaths

**2<sup>nd</sup>** leading cause of cancer deaths in the U.S.

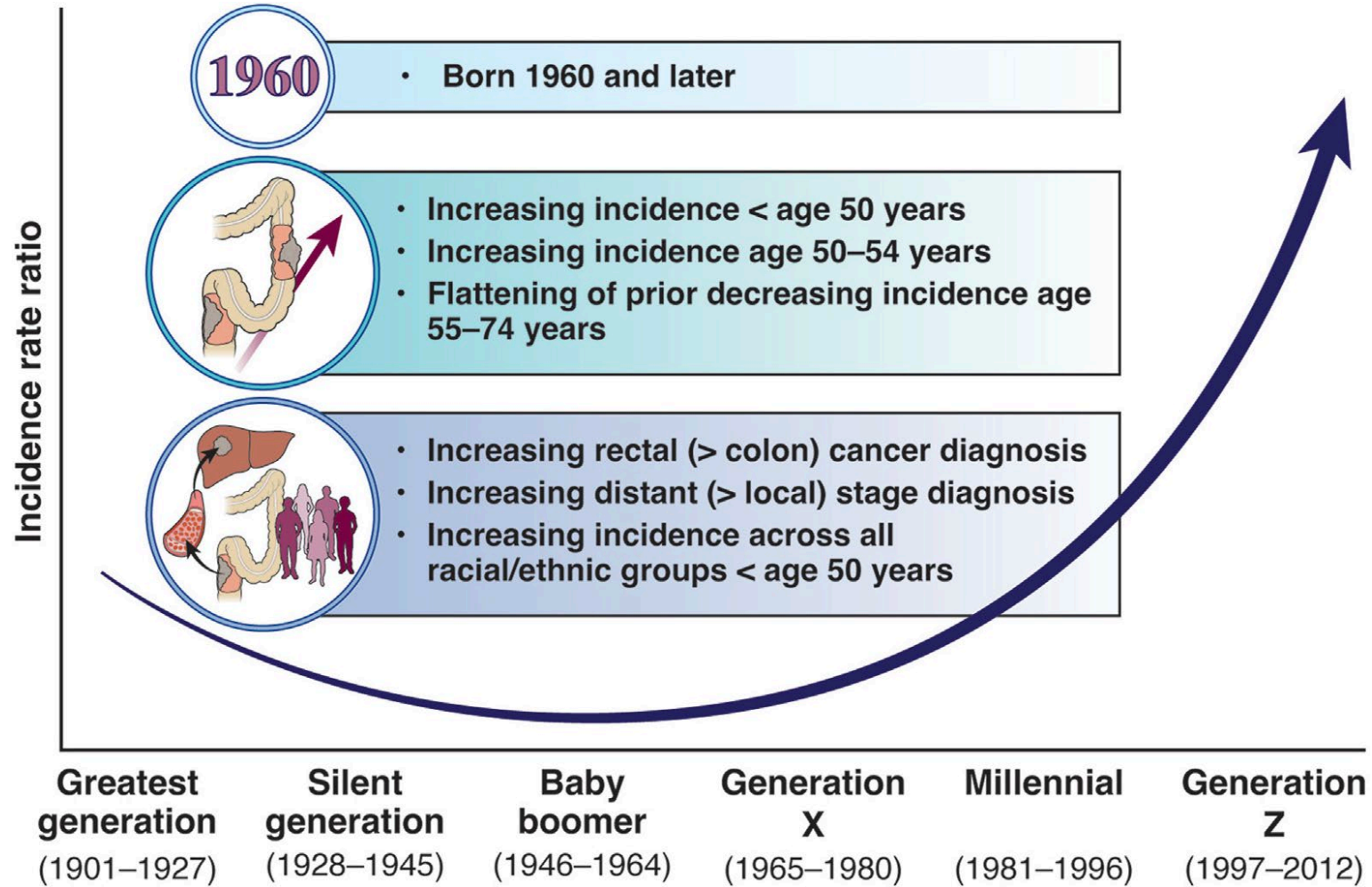
**53,000** estimated deaths in 2024

**42%** 45- to 75-year-old adults never screened

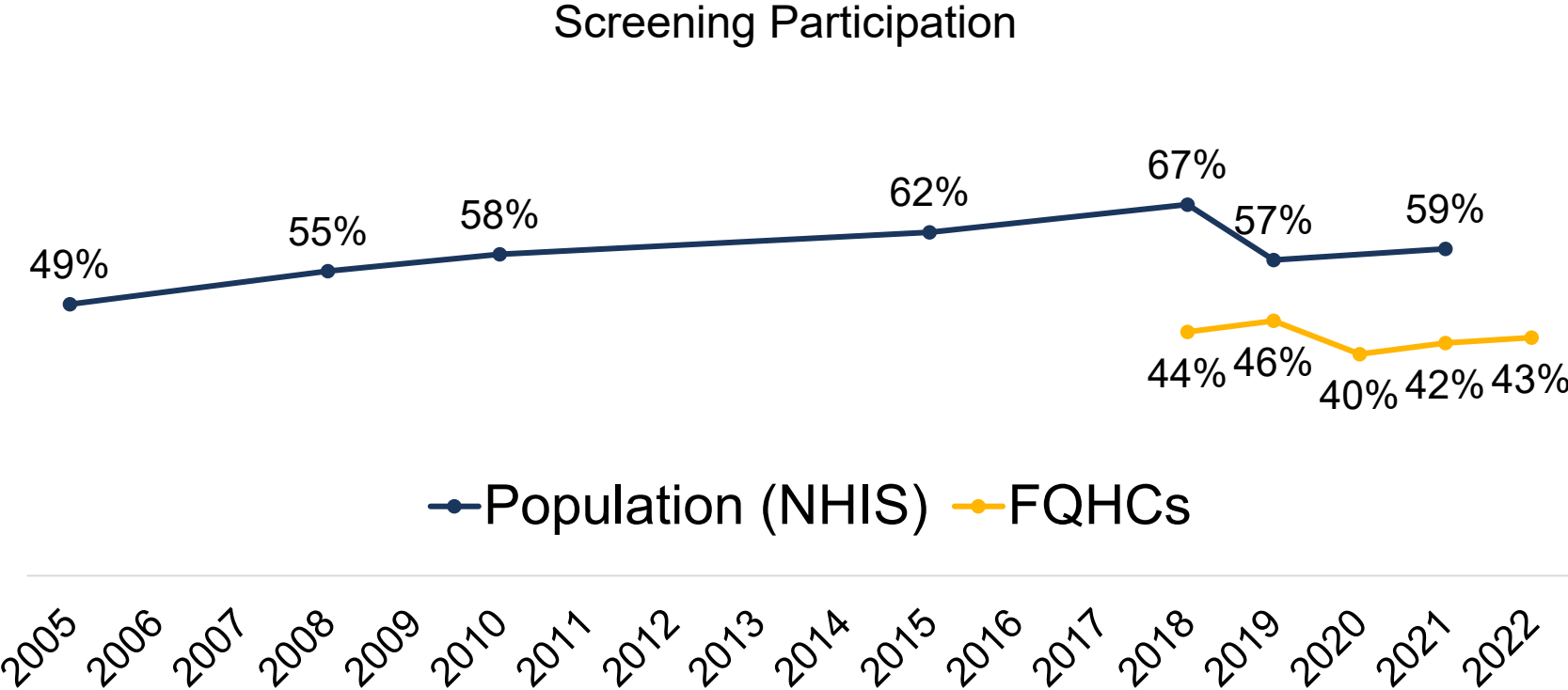
**2030** no #1 cause of cancer deaths in adults <50yo



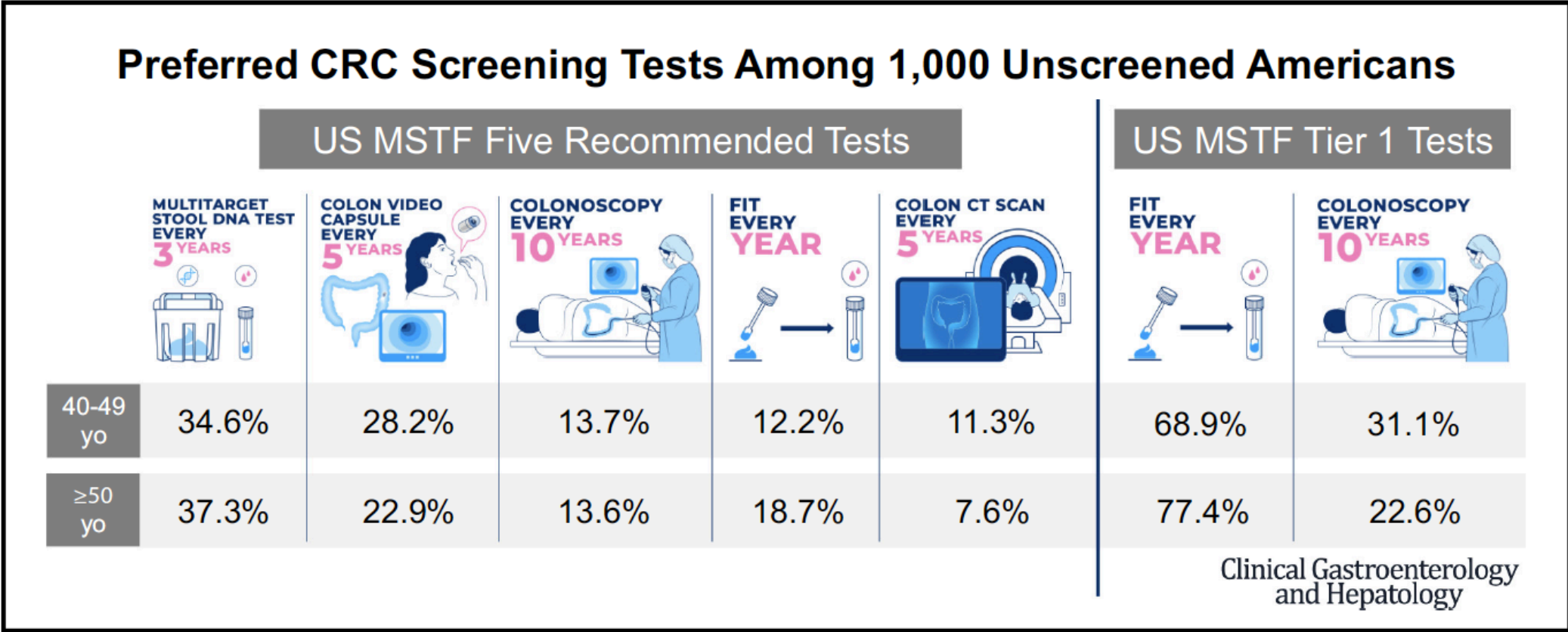
# Epidemiology of CRC is changing due to birth cohort effects



# CRC screening rates are suboptimal and have plateaued

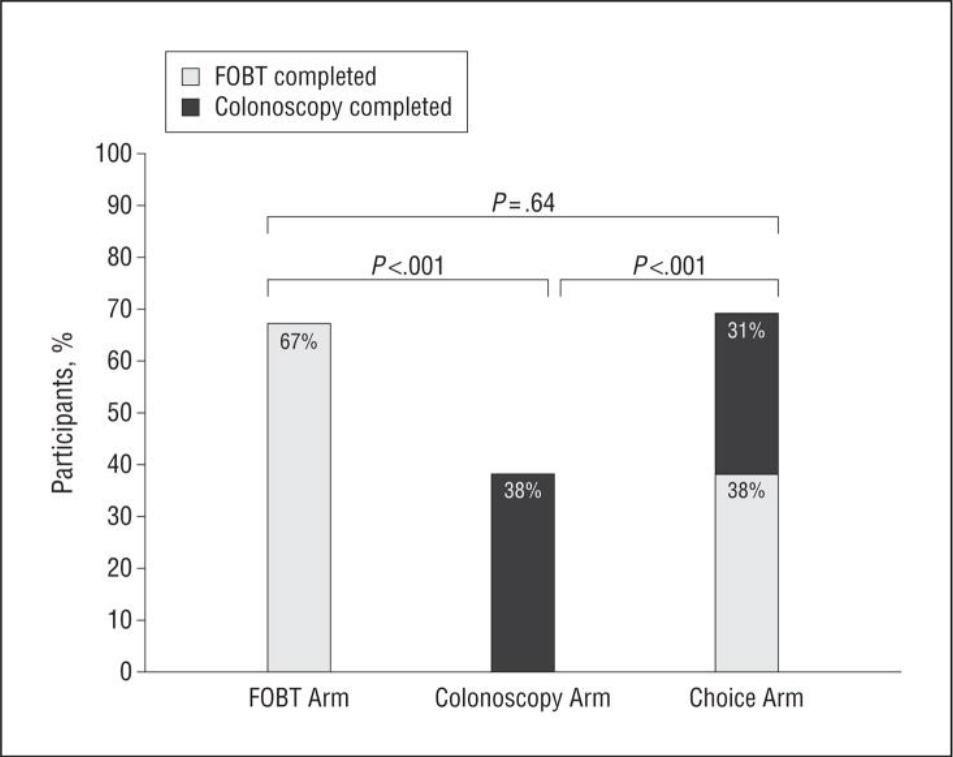


# Increased interest in non-invasive and blood-based screening

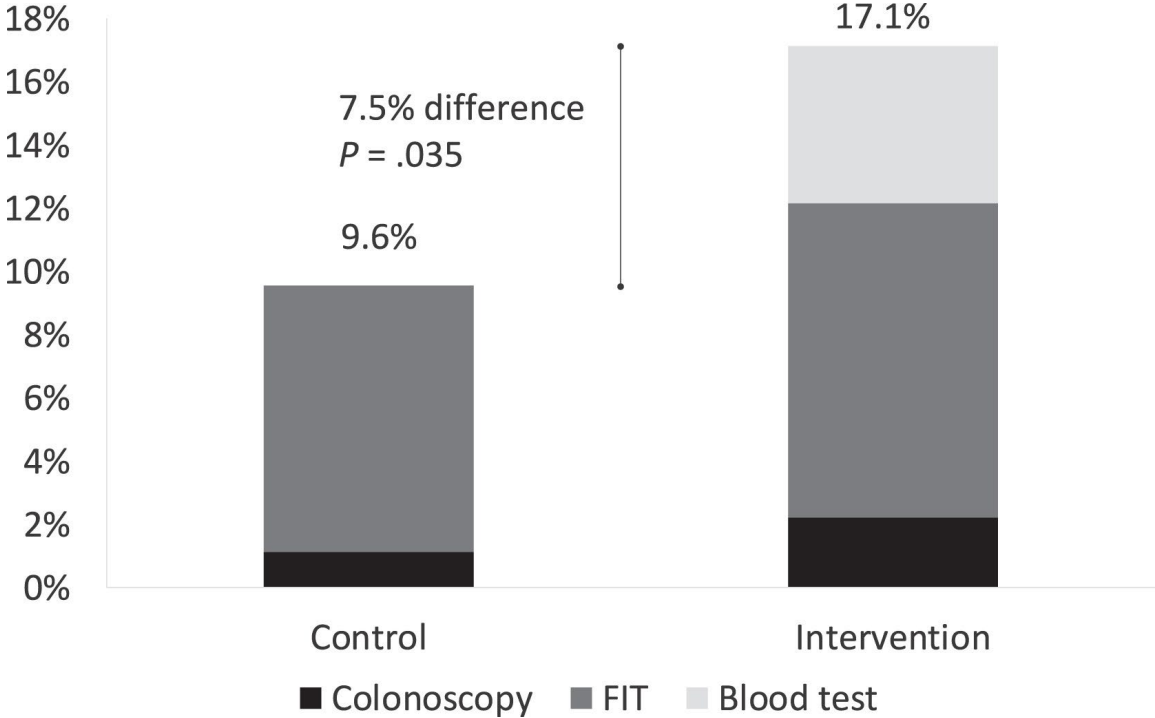


# CRC screening improves with stool and blood-based options

Offering a choice of colonoscopy and stool-based test increases screening participation



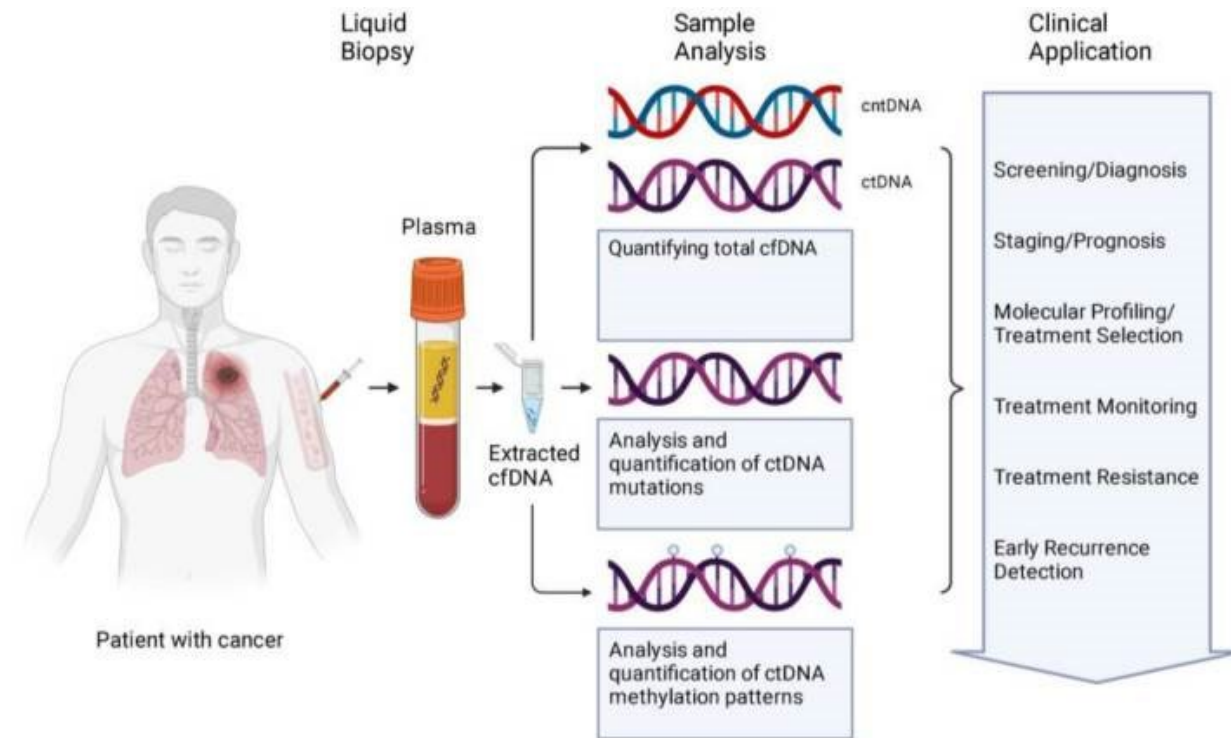
Offering a blood test after patients decline alternative options increases screening



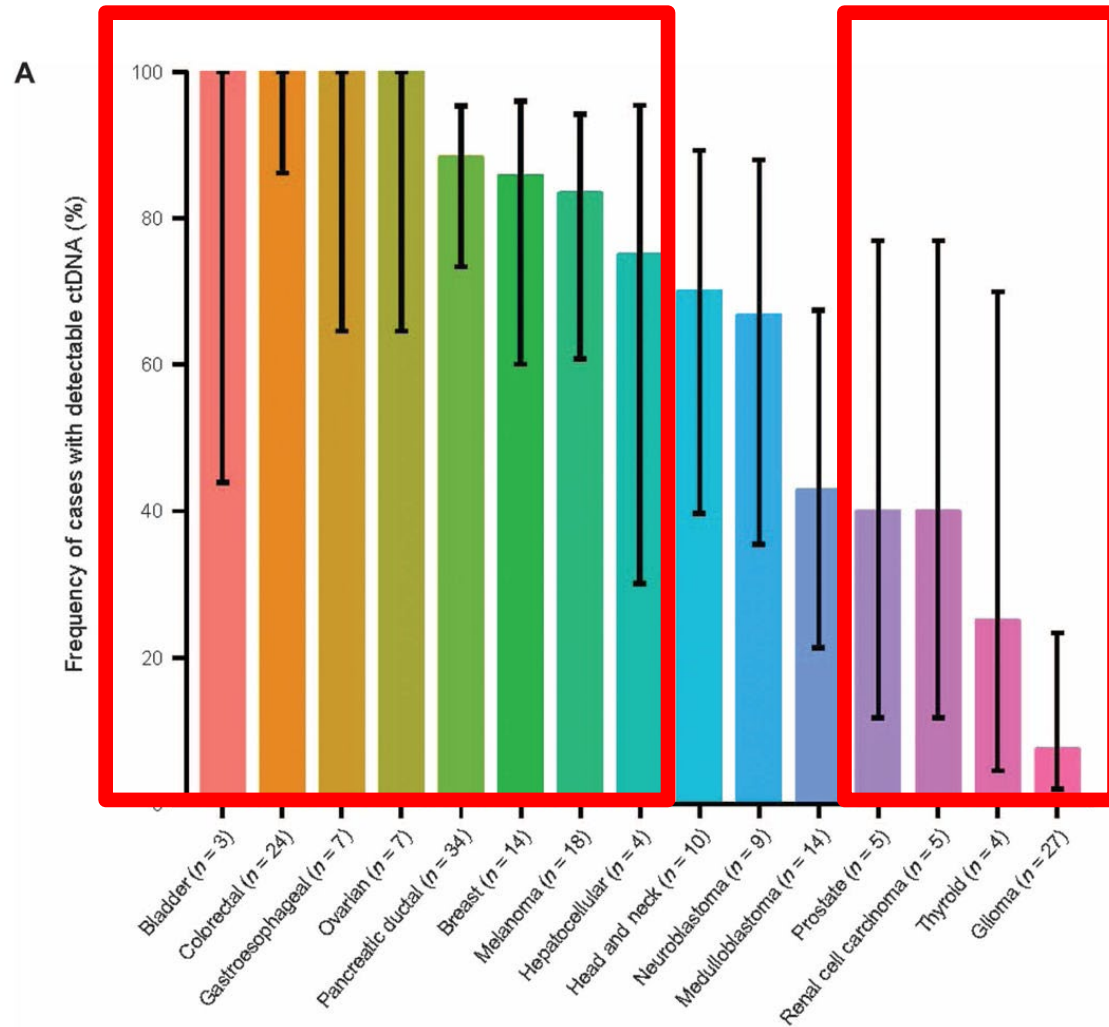


# Cell-free DNA (cf-DNA) / Circulating tumor DNA (ct-DNA)

- **Circulating cell-free DNA (cfDNA)**
  - Extracellular fragments of dsDNA (120–220 bp long)
  - Short half-life (4mins to 2hours)
  - Found in body fluids (e.g., blood, urine, CSF)
- **Circulating-tumor DNA (ctDNA)**
  - The fraction of cf-DNA that originates from tumor cells
  - From necrosis, apoptosis and active secretion
    - Normal extra tumoral cells
    - Tumor microenvironment cells
    - Neoplastic tumor cells



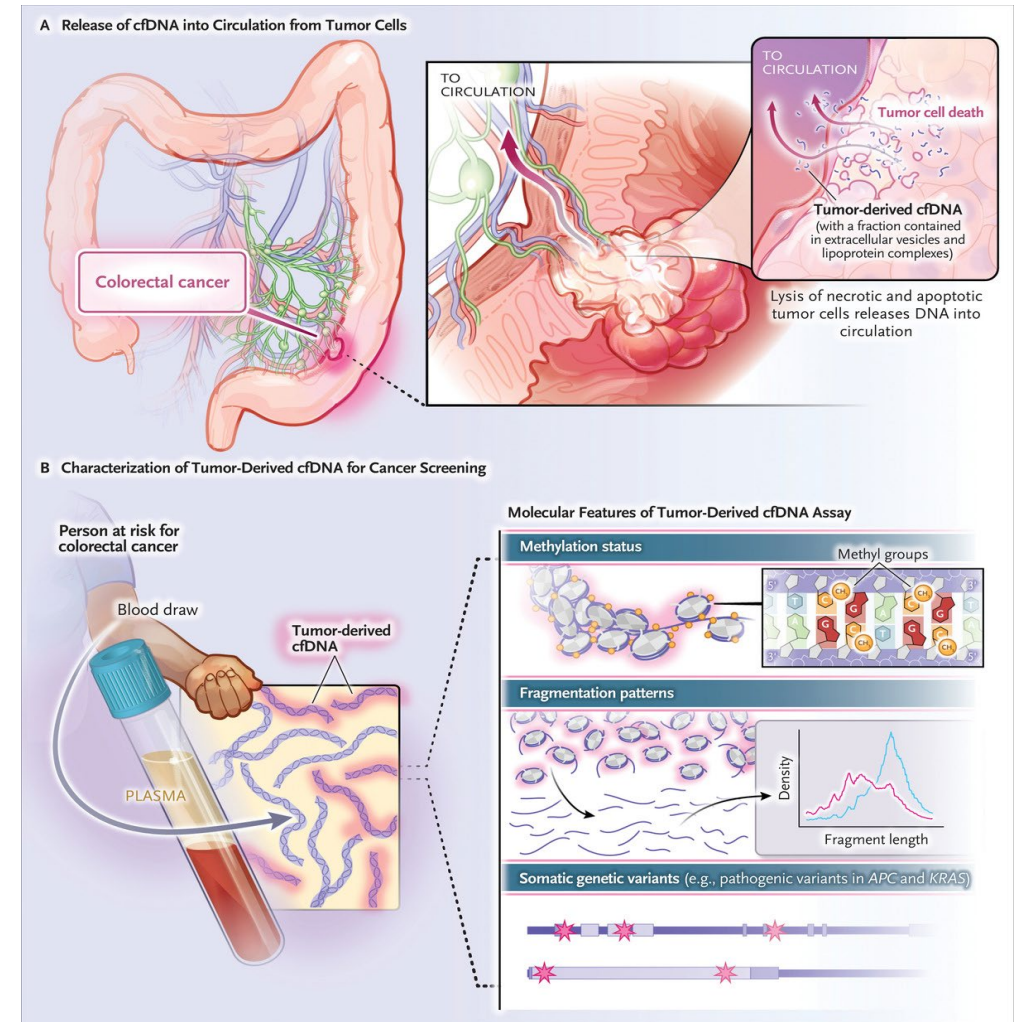
# cf-DNA/ct-DNA aka “Liquid Biopsy”



Among 206 patients with metastatic colorectal cancer, **sensitivity and specificity for detecting KRAS gene mutations was 87.2% and 99.2%, respectively**

# cf-DNA for colorectal cancer screening

- cf-DNA assays must be sensitive enough to detect low concentrations of DNA and extract DNA from blood
- cf-DNA assays must identify epigenetic signatures associated with colorectal cancer
  - Chemical or enzymatic process that converts the epigenetic signature into a genetic change (detect with DNA sequencing)
  - Binding or cleaving reagent, depending on methylation
  - Direct detection of methylation by single-molecule sequencing of the cfDNA.



# cf-DNA/ct-DNA colorectal cancer screening tests

1. cfDNA Sheild
  - Guardant Health, Inc
2. ctDNA and protein assay
  - Freenome
3. Epirocolon (mSEPT9)
  - Epigenomics

*The* NEW ENGLAND  
JOURNAL *of* MEDICINE

ESTABLISHED IN 1812

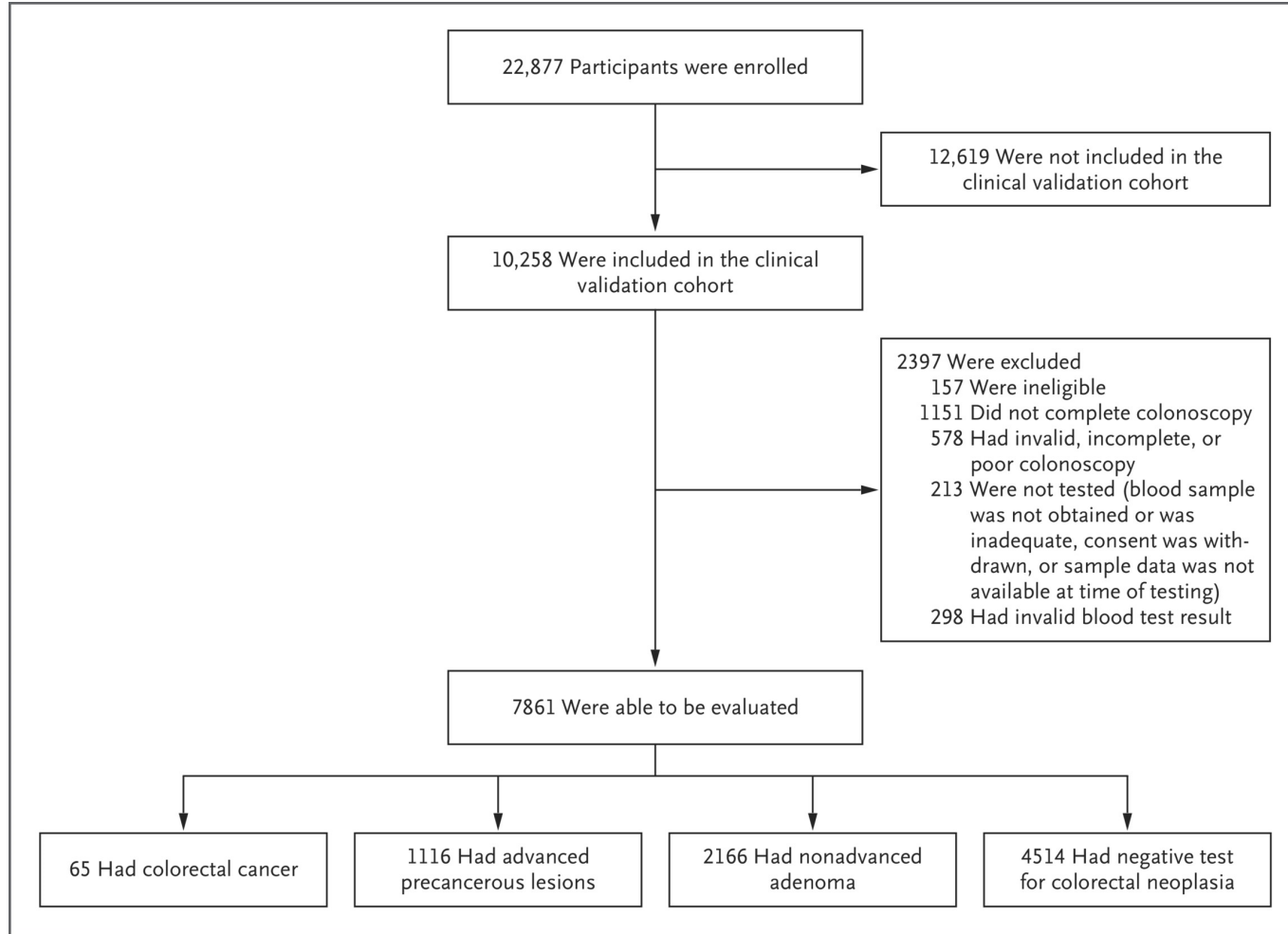
MARCH 14, 2024

VOL. 390 NO. 11

A Cell-free DNA Blood-Based Test  
for Colorectal Cancer Screening

Daniel C. Chung, M.D., Darrell M. Gray II, M.D., M.P.H., Harminder Singh, M.D., Rachel B. Issaka, M.D., M.A.S.,  
Victoria M. Raymond, M.S., Craig Eagle, M.D., Sylvia Hu, Ph.D., Darya I. Chudova, Ph.D., AmirAli Talasaz, Ph.D.,  
Joel K. Greenson, M.D., Frank A. Sinicrope, M.D., Samir Gupta, M.D., M.S.C.S., and William M. Grady, M.D.

# Enrolled participants and histopathology definitions



Colonoscopy Outcome	Histopathology Definition
CRC	CRC
Advanced Precancerous Lesion	Carcinoma in situ High Grade Dysplasia Villous architecture >25% Tubular Adenoma > 10mm Sessile Serrated Lesion > 10mm
Non-advanced precancerous lesion	Adenoma and sessile serrated lesion < 10mm
Negative for colorectal neoplasia	Negative colonoscopy Hyperplastic polyps

# Enrolled study population was racially and ethnically diverse

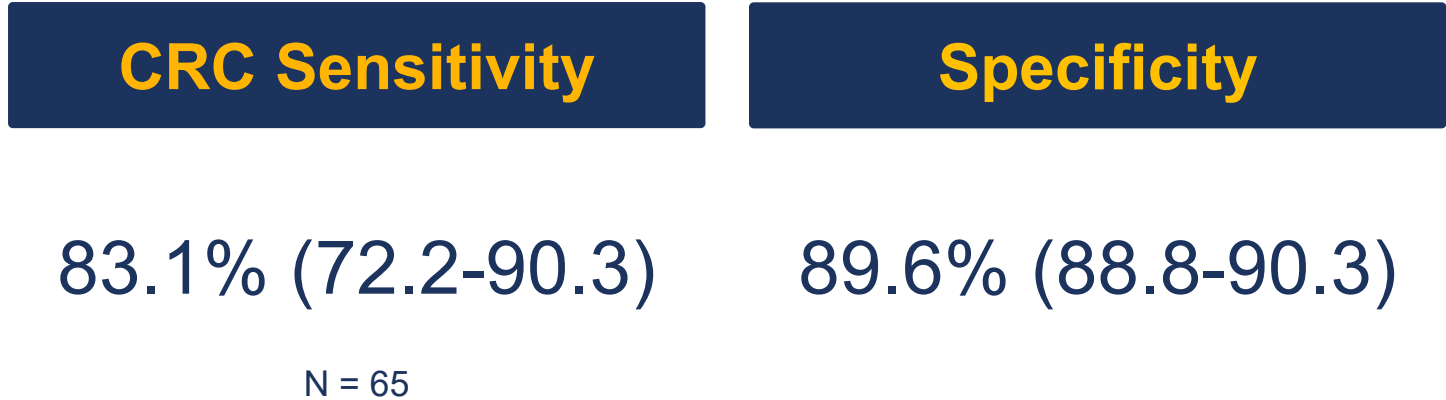
Characteristic	Clinical Validation Cohort (N=10,258)	Evaluable Subjects (N=7,861)
<b>Age (years)</b>		
Mean (SD)	60.6 (9.13)	60.3 (9.14)
Min, Max	45, 90	45, 84
<b>Age Group (years)</b>	N (%)	N (%)
45-49	776 (7.6)	640 (8.1)
50-69	7,161 (69.8)	5,495 (69.9)
70+	2,321 (22.6)	1,726 (22.0)
<b>Sex</b>		
Female	5,493 (53.5)	4,218 (53.7)
<b>Race</b>		
American Indian or Alaska Native	19 (0.2)	14 (0.2)
Asian	685 (6.7)	560 (7.1)
Black or African American	1,353 (13.2)	931 (11.8)
Native Hawaiian or Other Pacific Islander	24 (0.2)	19 (0.2)
White	7,939 (77.4)	6,167 (78.5)
Other / Multiple / Missing	238 (2.3)	170 (2.2)
<b>Ethnicity</b>		
Hispanic or Latino	1,561 (15.2)	1,044 (13.3)

>200 rural and urban sites, including community hospitals, private practices, GI clinics and academic centers



34 states across geographic regions

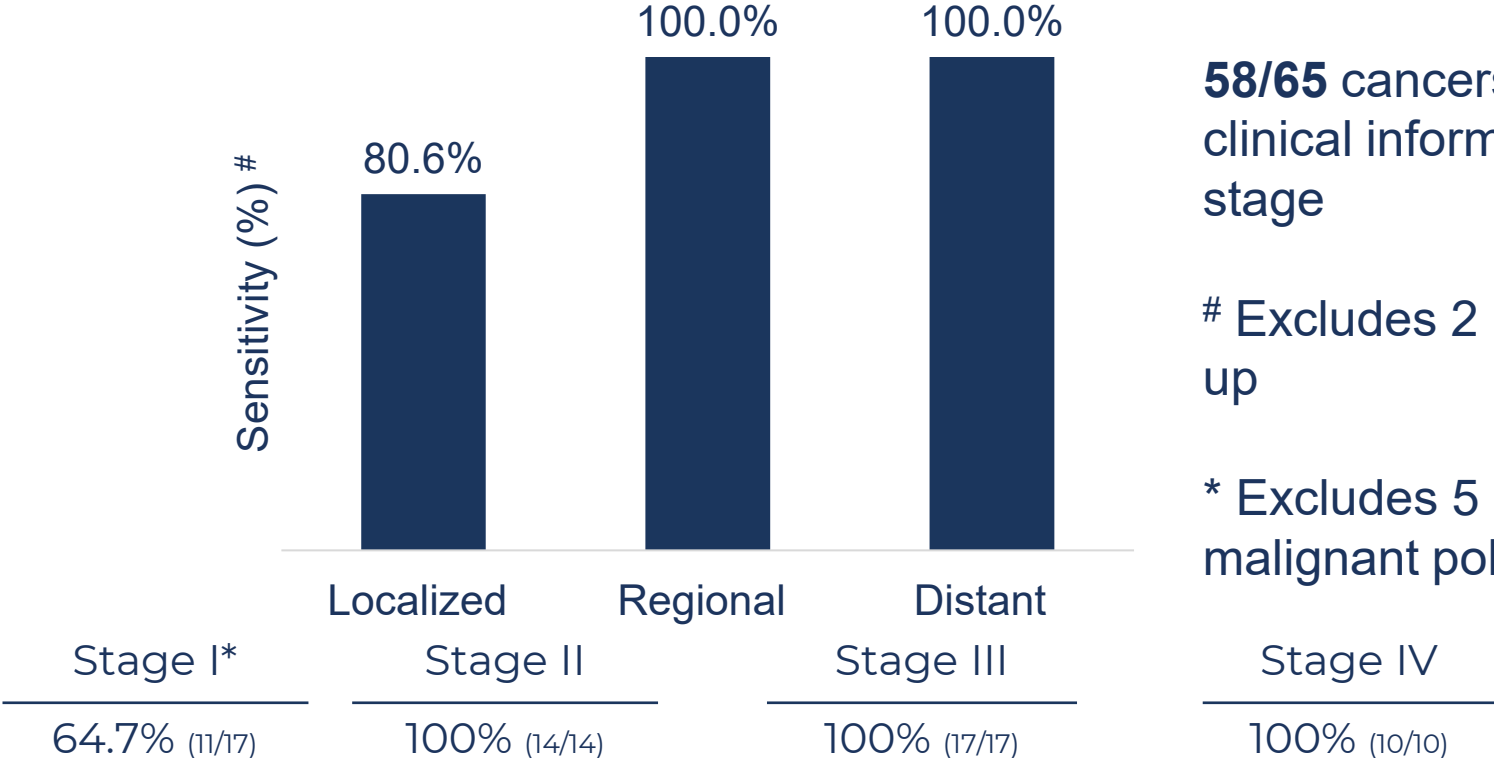
# ECLIPSE met co-primary endpoints





# Stage specific colorectal cancer sensitivity

Overall CRC Sensitivity: 83.1%



**58/65** cancers had complete clinical information to accurately stage

# Excludes 2 lost to clinical follow-up

\* Excludes 5 incompletely staged malignant polyps

# Advanced precancerous lesion detection

	Most advanced finding on Colonoscopy	Positive Results	Sensitivity
Advanced Lesions	1116	147	13.2% (11.3-15.3)
High Grade Dysplasia	31	7	22.6% (11.4-39.8)

- No significant differences in APL sensitivity based on key clinical characteristics
- Sensitivity for more advanced pathology trended higher

# Conclusions

- This cf-DNA blood-based test d screening
- The ECLIPSE study enrolled a population in the US
- This cf-DNA assay is the **first b recommended non-invasive c**
- Combined with improved adher potential to have a significant in. pact on CRC screening in the population.



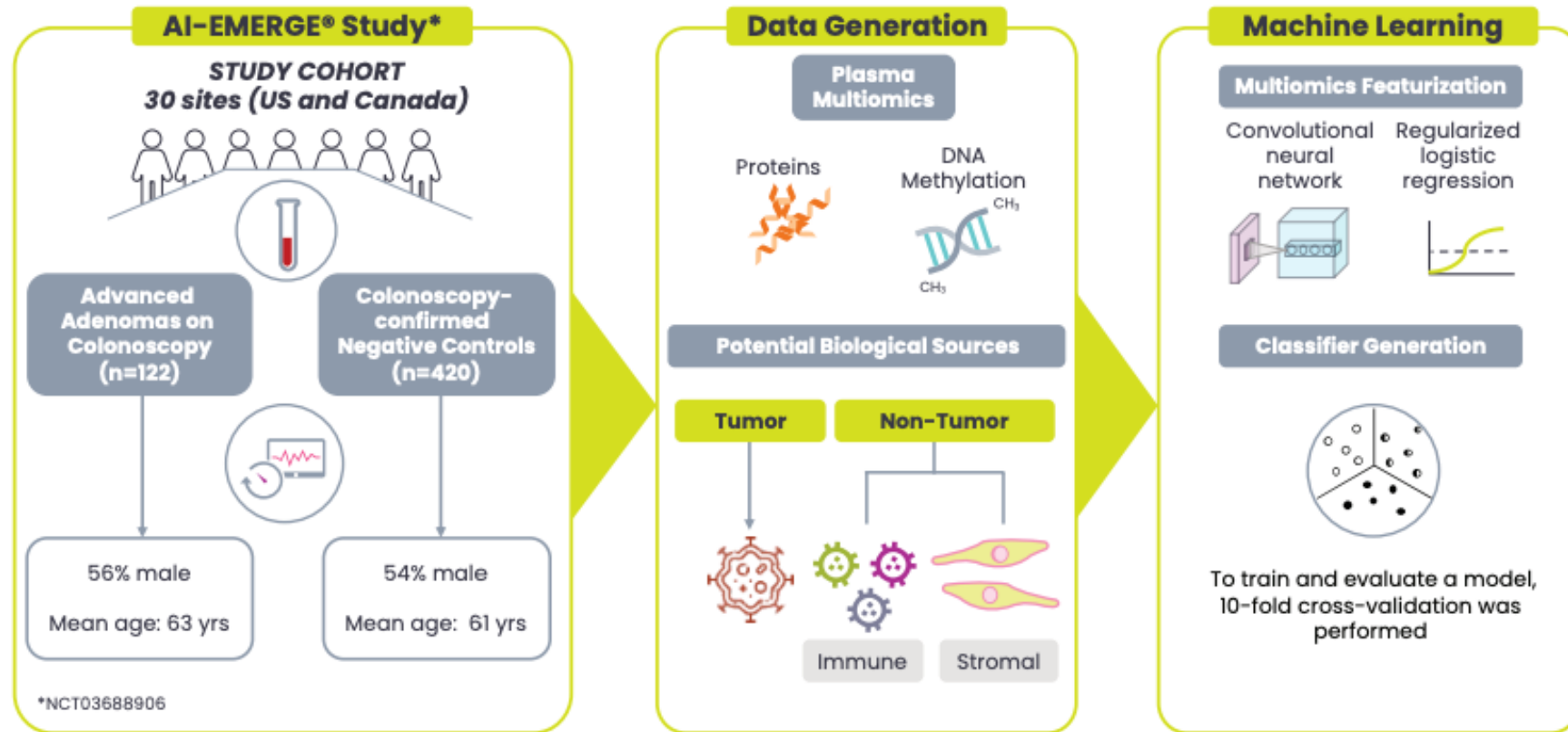
•y in average-risk CRC

•hics of the intended use

• to **current guideline-**

sed testing strategy has the

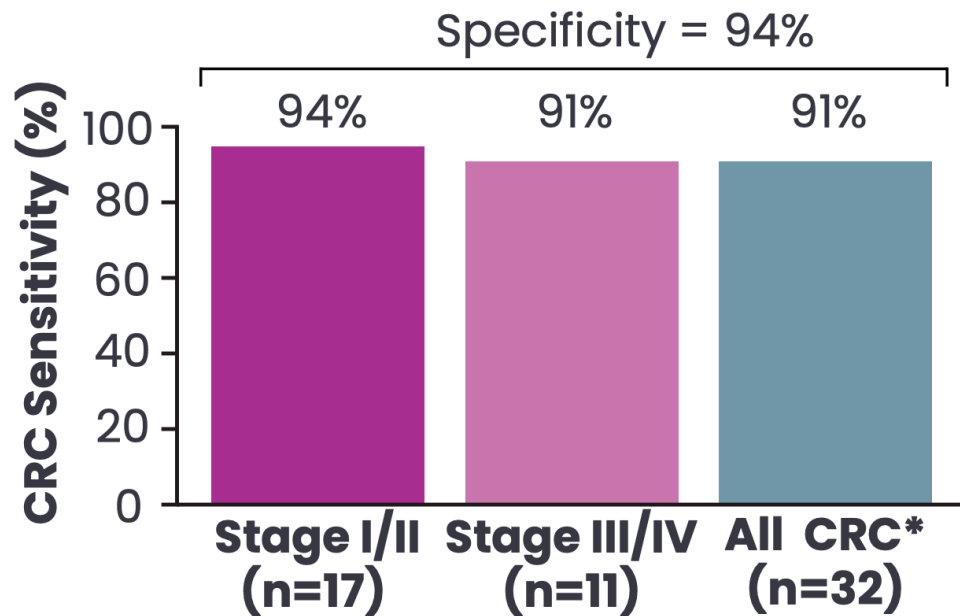
# ct-DNA + protein blood colorectal cancer screening assay



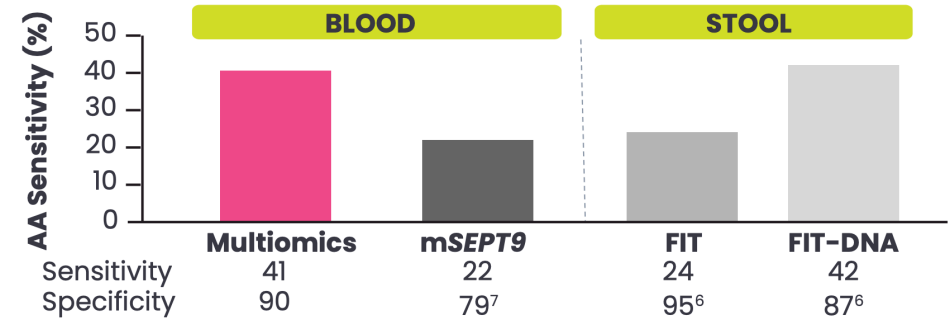
# ct-DNA + protein blood colorectal cancer screening assay

**Figure 1. Multiomics blood test detects early-stage CRC<sup>1</sup>**

Previously presented data

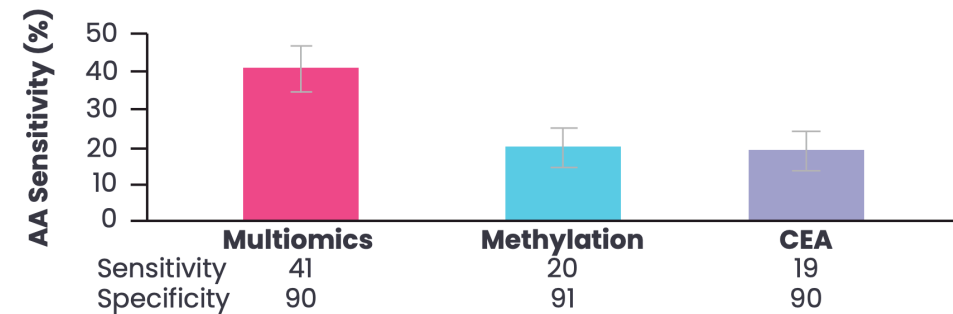


**Figure 5. Multiomics blood test achieved 41% AA sensitivity at 90% specificity**



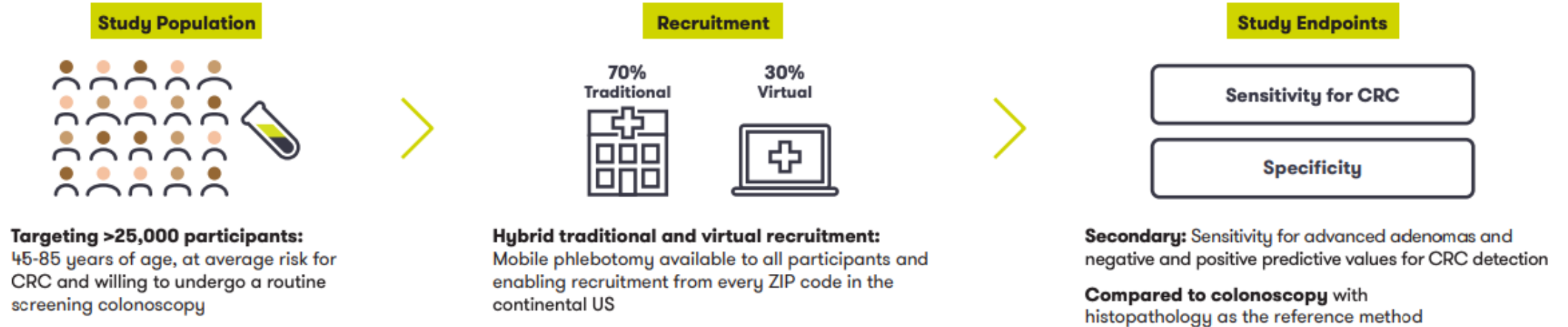
- AA sensitivity was greater than mSEPT9, the only blood test for CRC screening currently available
- AA sensitivity was much higher than FIT and comparable to FIT-DNA

**Figure 7. Multiomics detected twice as many AAs as cfDNA methylation or CEA only**



# The PREEMPT colorectal cancer trial (Freenome)

Prospective, Blinded, Multi-center Registrational Study (NCT04369053)



In a 4/2/24 press release, Freenome announced that in a diverse population of **48,995 participants**, study met all primary endpoints, including **79.2% sensitivity for CRC** and **91.5% specificity for non-advanced colorectal neoplasia**

# Conclusions

- The novel multiomics blood test **detected colorectal advanced adenomas (AA)** from a predominantly average-risk, prospectively collected study and achieved **sensitivity of 41%** at a **specificity of 90%**
- This AA performance is comparable to that of existing stool-based tests
- AA **sensitivity improved with increasing lesion size** and was consistent across location and histology (except for serrated lesions)
- By combining signatures from both tumor and non-tumor (e.g., immune) derived sources, **this multiomics test detected approximately twice as many AAs as methylation-only or single-protein approaches**

# CRC performance in a MCED training cohort (Exact Sciences)

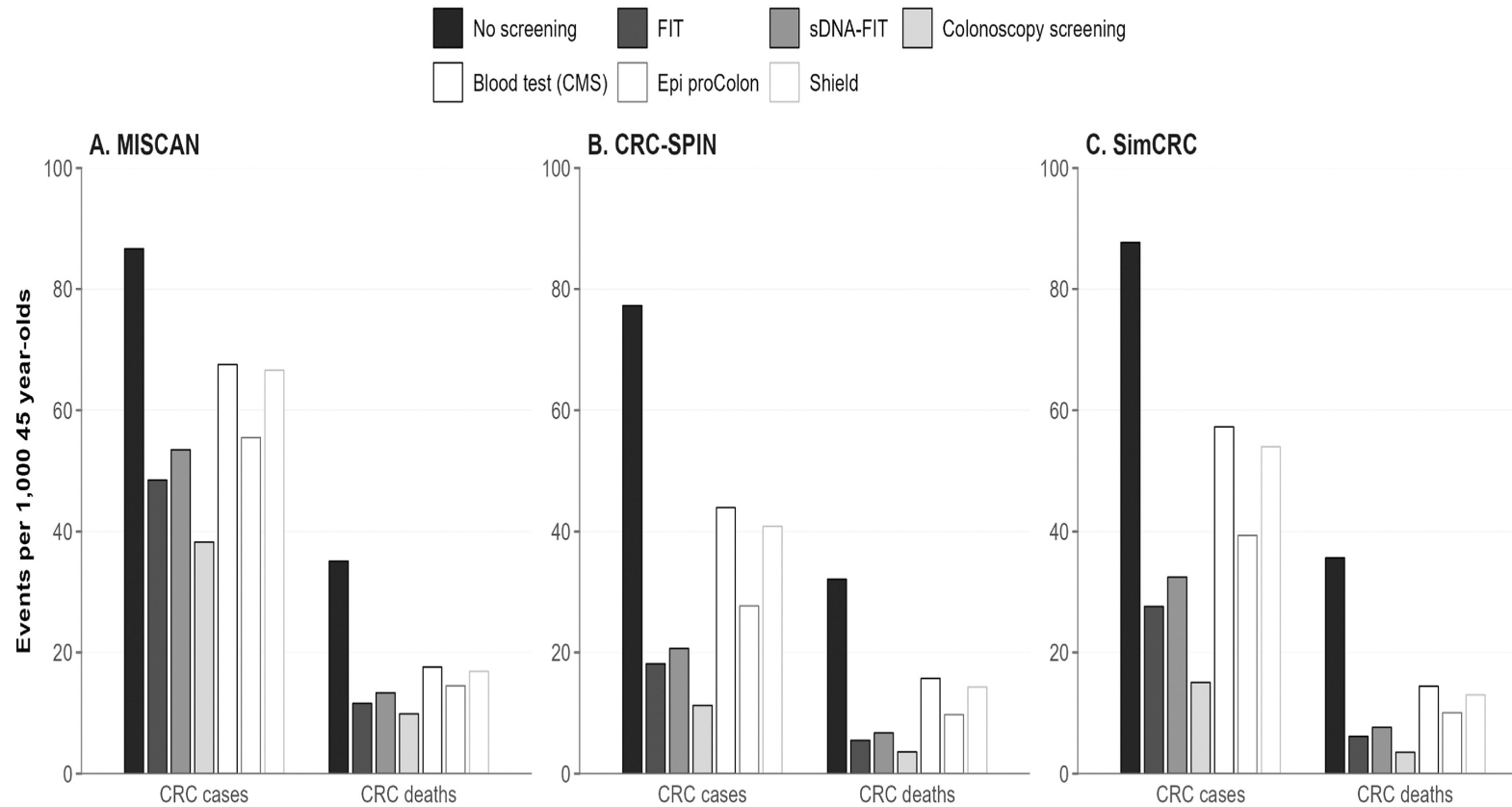
Two assays containing\* a subset of MCED-derived markers, one included a novel biomarker panel, were used to train a CRC-specific algorithm using cross validation at a target specificity of 90.9%

Marker Configuration	Specificity (95% CI) (N=2,881)	APL Sensitivity (95% CI) (N=93)	CRC Sensitivity (95% CI) (N=60)
MCED Subset 1	90.0% (88.9-91.1)	19.4% (12.6-28.5)	83.4% (72.0-90.7)
Novel Biomarker Panel	90.1% (88.9-91.1)	31.2% (22.7-41.2)	88.3% (77.8-94.2)

APL, Advanced precancerous lesion; \*Methylation testing based on TELQAS



# cf-DNA not cost-effective compared to established strategies



# Multi-Cancer Early Detection Tests (MCED)

1. CancerGuard™ (CancerSEEK)
  - Thrive/Exact Sciences
2. Galleri™
  - Grail/Illumina
3. MCED test-“anchor” indications
  - Guardant Health, Freenome, etc
4. Other companies with MCED tests in development:
  - Foundation Medicine, AnchorDx, Burning Rock Biotech, GENECAST, Singlera Genomics, Laboratory for Advanced Medicine

# There are several ongoing early-phase studies for blood-based tests

**Table 3. Emerging noninvasive, lab-based strategies for CRC screening.**

Study	Specimen source	Assay/approach	Study design	Enrolled subjects (n)	Test characteristics
<b>Later phase, large-scale prospective studies</b>					
Evaluation of the ctDNA LUNAR Test in an Average Patient Screening Episode (ECLIPSE) (52)	Blood	Measurement of ctDNA	Observational study of average-risk patients ages 45–84 years old, undergoing routine CRC screening	22 877	CRC sensitivity: 83%, CRC Specificity: 90%, AA Sensitivity: 13% <sup>a</sup>
Prevention of Colorectal Cancer Through Multiomics Blood Testing (PREEMPT CRC) (53)	Blood	Measurement of tumor and nontumor-derived signals from ctDNA, epigenetic, and protein biomarkers	Observational study of average-risk patients ages 45–85	>30 000	Not published yet, prior data from earlier trial shows CRC sensitivity: 94%, CRC Specificity: 94% <sup>a</sup>
<b>Early phase studies</b>					
Sample Collection Study for the CellMax Life Circulating Tumor Cell and Circulating Tumor DNA Platforms for the Early Detection of Colorectal Cancer and Adenomas (56)	Blood	Evaluation of aberrations in ctDNA via NGS, detection of circulating epithelial cells	Observational study of average-risk patients ages 45–80	1038	CRC sensitivity: 92.1%, AA sensitivity: 54.5%, AA specificity: 91% <sup>a</sup>
Collection of Samples USOPTIVAL Study (57)	Blood	Evaluation of cell-free DNA methylation and fragmentation characteristics, tumor-derived	Observational study of patients between the ages of 45 and 84 who were either average risk or had	997	CRC sensitivity: 93%, AA sensitivity 54%, AA specificity: 92% <sup>a</sup>
Noninvasive Identification of Colorectal Cancer and Adenomas in Early Stages (NICE) (58)	Blood	InterVenn Glycoprotein test	Prospective, multisite study using glycoproteomic testing for early detection of advanced adenoma and CRC for average-risk patients undergoing routine screening colonoscopy	575	Not available

Data from the above clinical trials were cited from multiple sources (52, 53, 55–59).  
 MTs-DNA, multitarget stool DNA; AA, advanced adenoma; NGS, next-generation sequencing.  
<sup>a</sup>Data available from abstracts only.

# Summary

- cf-DNA CRC screening assays appear to have sensitivity for CRC similar to other stool-based CRC screening tests
- Current cf-DNA CRC screening tests will likely have lower sensitivity for colon adenomas and serrated polyps than stool-based tests or colonoscopy
- ctDNA based MCED assays and CRC screening
  - Technical performance of the assays is promising but more data is needed to determine role in CRC screening.
  - It is unclear how to best evaluate the performance of MCED tests
- Several unresolved issues, including cost-effectiveness under current assumptions, harms caused by unnecessary procedures, uncertain impact on cancer-mortality and more



# Thank you

**Drs. Grady, Chung & Gupta**

## **Funding Sources**

- American College of Gastroenterology
- Fred Hutchinson Cancer Center
- Carl Hansen Family Fund
- NIH/NCI K08 CA241296
- NIH/NCI P50 CA244432
- Kathryn Surace-Smith Endowment
- UW Medicine

**Contact:** [rissaka@fredhutch.org](mailto:rissaka@fredhutch.org)



UW Medicine

# NW CRC Communication Workgroup Updates

---

- CRC Task Force communication workgroup meets monthly for one hour to plan and develop communication campaign materials, implement and coordinate related activities
- Currently working on- Roadshow Presentation for more outreach
- Upcoming projects:
  - Training for Community Health Workers
  - 2025 CRC Awareness Month Campaign Preparation
- If you are interested in working on these projects feel free to reach out

- Outreach and Recruitment
- Feel free to share the flyer colleagues or people who might be interested in joining this Task Force
- Previous year campaign materials:
  - [Northwest Colorectal Cancer Task Force | Healthier Washington Collaboration Portal \(waportal.org\)](#)

# NORTHWEST COLORECTAL CANCER TASK FORCE



## MISSION & GOALS

To reduce the burden of colorectal cancer and related health inequities in the Northwest region by improving cancer screening rates and outcomes. We strive to reduce the burden of colorectal cancer in the state through collaborative efforts and fostering partnerships with diverse populations and organizations working across cancer care continuum to:

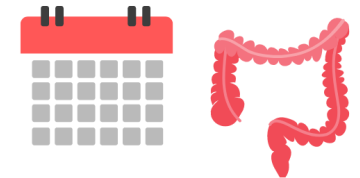
- Increase prevention efforts
- Promote screening
- Improve access to care
- Bolster survivorship support
- Spread Awareness

Scan this QR code to learn more about the NW CRC Task Force:



## WHEN AND WHERE

### Quarterly 2-hour Meetings on Zoom



## WE PROVIDE:

- Data
- Education
- Training
- Latest Research
- Resources & Materials
- Networking with Peers
- Coordinate efforts, overcome challenges & accomplish goals together

Interested in becoming involved or to get more information, contact :  
Char Raunio, ACS State Partnerships at [Char.Raunio@cancer.org](mailto:Char.Raunio@cancer.org).



# ***New NW Colorectal Cancer Teams Channel***



- A new Teams Channel has been established for the Task Force
  - ***Northwest Colorectal Cancer Task Force***
- *Task Force members can chat with members, ask questions, update on CRC activities, events, and share materials*
- *In the next couple of weeks, everyone will be added to the channel.*  
*The invitation will come from Char Raunio, ACS*
- *Please make sure to pin the Channel and check regularly for updates*
- *If you have questions or issues: reach out to:*  
*Char Raunio – [Char.Raunio@Cancer.org](mailto:Char.Raunio@Cancer.org)*



# NW Colorectal Cancer Task Force Teams Channel

The screenshot displays the Microsoft Teams interface for a channel named 'General' (NC) within a team. The left sidebar shows the 'Teams' section with a yellow highlight around the 'Teams' icon and the 'General' channel card. The main content area shows a 'Test Post' by Char Raunio from 9/12 1:24 PM, with a message: 'Hi All, wanted to see if you received the new NW CRC Task Force Teams Channel. Let me know if you can access the Channel.' Below the post are reaction icons for 3 hypes, 1 like, and 1 neutral face. Other messages include a guest user 'zebroski' (9/12 4:14 PM) saying 'Hello! This worked well on my end...' and 'Thekke Edivettiyakath, Sahla Suman (DOH) (Guest)' (9/13 10:16 AM) saying 'Hi Char! This is working on my end as well!'. A 'Reply' button is visible at the bottom of the post area. The right sidebar shows 'In this channel' with 8 people listed and a description: 'Members of the Task form can use the channel to share ideas, items, conversations with other Task Force members. Channel will also be used to share pertinent documents and materials.'

**Teams** Discover

**General** Posts Files Notes

**General** EXT:WER Return To Screening Learning Collaborat...

**General** Patient Support-Partnerships & Capacity

**Associate Directors Salesforce Updat...** Regional Community Impact Salesforce

**NOR Community Impact Fun Times** Patient Support-Community Impact NOR

**State Partnerships** Patient Support-Community Impact NOR

**Cancer Support NOR** Patient Support-Partnerships & Capacity

**General** EXT:Northwest Colorectal Cancer Task Force

**Your teams**

- Patient Support-Community Impa...**
- Patient Support-Partnerships & C...**
- Clinical Interventions**

**Test Post**

Char Raunio 9/12 1:24 PM

Hi All, wanted to see if you received the new NW CRC Task Force Teams Channel. Let me know if you can access the Channel.

3 1

zebroski (Guest) 9/12 4:14 PM

Hello! This worked well on my end. I was even able to initially access it via the app on my work phone.

2

Thekke Edivettiyakath, Sahla Suman (DOH) (Guest) 9/13 10:16 AM

Hi Char! This is working on my end as well! I had some trouble accessing it initially, but I think it was because of the pending software updates on my laptop.

1 1

Treend, Katie P (DOH) (Guest) 9/16 3:50 PM

Works for me too!

1

Reply

**In this channel**

People (8)

See all

**Description**

Members of the Task form can use the channel to share ideas, items, conversations with other Task Force members. Channel will also be used to share pertinent documents and materials.

Edit description

**Options**

- Find in channel
- Manage channel
- Channel notifications

**Updates**

kkenyon (Guest) joined the team.

Thekke Edivettiyakath, Sahla Suman (DOH) (Guest) joined the team.

# NW Colorectal Cancer Task Force Teams Channel

The screenshot shows the Microsoft Teams interface for a channel named "General" (NC). The "Files" tab is selected and highlighted with a yellow box. The toolbar includes options for "New", "Upload", "Edit in grid view", "Share", "Copy link", and "Sync". Below the toolbar, a table of documents is displayed:

Name	Modified	Modified By	+ Add column
CRC Task Force Recruitment Flyer Final.pdf	12 minutes ago	Char Raunio	
NW Colorectal Cancer Task Force Mission S...	A few seconds ago	Char Raunio	

# Next Steps

---

- Setting up the Task Force Teams channel & check the channel for updates
- Roadshow Presentation
- 2025 CRC Awareness Month Campaign Preparation
- 2025 Quarterly meetings
  - February 18th, 2025 (Tuesday), 9:00 am- 11:00 am
  - June 3rd, 2025 (Tuesday), 9:00 am- 11:00 am
  - October 7th, 2025 (Tuesday), 9:00 am- 11:00 am

# Contacts



Sahla Suman

---

[Sahla.Suman@doh.wa.gov](mailto:Sahla.Suman@doh.wa.gov)

360-742-1467



Daniel Padron

---

[dpadron@fredhutch.org](mailto:dpadron@fredhutch.org)



Derrick Zebroski

---

[zebroski@ohsu.edu](mailto:zebroski@ohsu.edu)

503-260-9050