American Cancer Society®

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Emerging Strategies in Early Detection Webinar

Expanding the Colorectal Cancer Screening Toolbox with Blood-based Screening | July 28, 2026 - Summary, Scenarios, Q&A, and Resources

Panelists who provided evidence, context, and guidance:

Andrew M. D. Wolf, MD, MACP
Professor Emeritus of Medicine
UVA School of Medicine
Chair, Guideline Development Group | American Cancer Society

Peter S. Liang, MD, MPH
Associate Professor of Medicine and Population Health | NYU Grossman School of Medicine
Section Chief of Gastroenterology and Hepatology | VA New York Harbor Health Care System

Samir Gupta, MD, MSCS
Professor of Medicine, Division of Gastroenterology | UC San Diego
Staff Physician | VA San Diego Healthcare System

Overall Webinar Takeaways

The panel strongly agreed that:

- Colonoscopy and stool-based tests remain the preferred CRC screening options.
- Blood-based tests should be reserved primarily for individuals who decline or fail to complete preferred screenings after multiple opportunities.
- Blood tests can meaningfully increase screening participation for individuals who are unscreened and likely to remain unscreened with preferred tests.
- A positive blood test must be followed by a timely colonoscopy (preferably within six months).
- Clinician education, patient counseling, and thorough documentation are critical for appropriate use of blood-based CRC screening.

Dr. Andrew Wolf: What Primary Care Clinicians Need to Know About Blood-Based CRC Screening

Key Message: Blood-based colorectal cancer (CRC) screening tests represent an important advancement, but they are not the "holy grail" and should not currently replace preferred screening methods such as colonoscopy or stool-based tests.

Overview of New Blood Tests

- Guardant Shield (FDA approved in 2024)
- Freenome SimpleScreen (FDA approved on July 27, 2026)
- Both tests:
  - Detect circulating tumor-related DNA in blood.
  - Use AI/machine learning to generate positive or negative results.
  - Are intended for average-risk adults only
- Test Performance
  - Strengths
    - Approximately 80% sensitivity for detecting colorectal cancer overall
    - High specificity (\~90%), meaning relatively few false positives
  - Limitations
    - Only 12–13% sensitivity for advanced precancerous lesions
    - Approximately 60% sensitivity for Stage I cancers
    - Much better at detecting later-stage cancers than early-stage cancers

Roughly 80% of the long-term mortality benefit from CRC screening comes from finding and removing precancerous lesions. Because blood tests perform poorly at detecting these lesions, they are less effective than preferred screening methods at preventing cancer.

American Cancer Society Guideline Update

The American Cancer Society's updated guidance continues to recommend:

- Preferred Screening Options:
  - Annual FIT
  - Annual high-sensitivity gFOBT
  - Stool DNA tests every 3 years
  - Stool RNA tests every 3 years
  - Colonoscopy every 10 years
  - CT colonography every 5 years
  - Flexible sigmoidoscopy every 5 years

ACS Position on Blood-based Screening

- Blood-based Tests:
  - Are not preferred screening options
  - Should be used for people who:
    - Decline colonoscopy or other visual exams
    - Decline stool-based testing
    - Remain unscreened despite efforts to engage them
- Ideal Candidate for Blood Testing
  - Someone who:
    - Refuses colonoscopy or other visual exams
    - Refuses stool-based tests
    - Remains non-adherent despite repeated outreach
    - Is willing to undergo colonoscopy if the blood test is positive

Follow-Up Colonoscopy After a Positive Stool or Blood-based Test

- Requires a diagnostic colonoscopy
- Colonoscopy should ideally occur within 6 months
  - Delays beyond 6 months are associated with finding more advanced disease.

Dr. Wolf's Main Conclusion: Blood-based screening is better than no screening, but inferior to colonoscopy, CT colonography, flexible sigmoidoscopy, and stool-based screening for preventing colorectal cancer and reducing mortality.

Dr. Peter Liang: Research from the Veterans Administration and Kaiser Permanente

Purpose of Research | Dr. Liang addressed two primary questions:

- Do blood tests increase CRC screening participation?
- Do blood tests decrease use of preferred screening methods?

VA Randomized Controlled Trial

Population

- Veterans who had previously declined colonoscopy and FIT

Intervention | Patients received:

- Letter outreach
- Up to five phone calls
- The intervention group was additionally offered a blood test.

Results | Screening completion increased:

- Control: 9.6%
- Blood-test group: 17.1%
- Absolute increase: 7.5%

Effect on Preferred Tests | Offering blood testing did not reduce use of:

- Colonoscopy
- FIT

This was an important finding because there had been concern that blood tests could divert patients away from more effective screening options.

Kaiser Permanente Northwest Study

Population | Adults who:

- Previously declined FIT (either in clinic or did not return mailed FIT kits)
- Results | Screening increased:
  - Usual care: 13%
  - Blood-test outreach: 30.5%
  - Absolute increase: 17.5%

Effect on Preferred Tests | Offering blood testing did not lead to a statistically significant decrease in use of:

- Colonoscopy
- FIT

Follow-Up Colonoscopy After Positive Blood Tests

Dr. Liang emphasized that screening is not complete without colonoscopy following an abnormal result.

Findings | Follow-up colonoscopy rates were disappointing:

- VA Trial:
  - 2 positive blood tests
  - Only 1 completed colonoscopy
- Kaiser Trial:
  - 22 positive blood tests
  - 11 completed colonoscopies
- Approximately 50% follow-up completion in both studies.

Dr. Liang's Main Conclusion

Blood tests:

- Increase screening participation among people who otherwise refuse screening.
- Do not appear to reduce use of preferred screening methods.
- Still face major challenges with follow-up colonoscopy completion.

Dr. Samir Gupta: Clinical Perspective and Screening Uptake

Key Messages from Dr. Gupta:

Screening participation is suboptimal.

Screening Opportunity Matters

- Rising rates of CRC among younger and middle-aged adults.
- The importance of engaging patients who are overdue for screening.
- Every encounter should be used as an opportunity to encourage screening.

Dr. Samir Gupta: Clinical Perspective and Screening Uptake (Continued)

Colonoscopy Provides Valuable Risk Information

- A normal colonoscopy at ages 55–60:
- Predicts low future CRC risk.
- Provides valuable long-term risk stratification.

Preliminary Results from a Randomized Trial Suggest a blood best can increase screening without reducing participation in other tests:

- In a randomized trial including over 330 patients served by a Federally Qualified Health Center in San Diego, offering the option of an in clinic cfDNA together with an at home FIT, in addition to usual care options for screening, was associated with markedly higher screening participation, compared to only offering the usual care options of FIT and colonoscopy.
- Participation in preferred tests such as FIT and colonoscopy were not lower in the group offered the blood test option compared to those offered only usual care.

Blood Tests Have a Role

- Dr. Gupta agreed blood tests are appropriate when:
  - Preferred tests have been declined.
  - Patients remain persistently unscreened.
- Concern About Follow-Up Colonoscopy:
  - Dr. Gupta raised an important unresolved question: Should clinicians require commitment to follow-up colonoscopy before ordering a blood test?
  - He acknowledged this is challenging because:
    - Patients may initially reject colonoscopy.
    - A positive blood result may later motivate them to proceed.

PRACTICE SCENARIOS

Scenarios were created by practicing primary care clinician volunteers of the American Cancer Society Primary Care Clinical Champion Corps.

Scenario 1: The Patient Requesting a Blood Test After Seeing Advertising

Patient Profile

- 50-year-old average-risk adult
- No prior colorectal cancer screening
- Comes in specifically asking for a blood test after seeing TV commercials
- No contraindications to colonoscopy or stool-based screening

Expert Guidance From Panelists:

Dr. Wolf

- Educate the patient that blood tests are less effective at finding precancerous lesions and early cancers.
- Review all available screening options.
- Blood testing can be offered after informed discussion.

Dr. Liang

- Preferred tests should be discussed first.
- Use decision aids to compare:
  - Effectiveness
  - Preparation requirements
  - Convenience

Dr. Gupta

- Commend the patient for seeking screening.
- Stress that screening is timely and potentially lifesaving.
- Present all screening choices.

Note from Clinical Champion Corps: Many patients asking about blood tests ultimately choose colonoscopy or stool-based screening once the strengths and limitations are explained.

PRACTICE SCENARIOS (Continued)

Scenario 2: The Repeatedly Nonadherent Patient

Patient Profile

- 58-year-old average-risk patient
- Colonoscopy recommended multiple times over several years
- Two stool test kits (FIT or Cologuard) were ordered but never completed
- Continues to remain overdue for screening

Expert Guidance From Panelists:

Dr. Wolf

- Explore barriers and reasons for non-completion.
- If repeated opportunities have failed, blood testing becomes appropriate.
- Confirm willingness to undergo colonoscopy if blood test is positive.

Dr. Liang

- Ensure prior education truly occurred.
- If informed refusal of preferred tests persists, blood testing is reasonable.
- Screening with a blood test is better than no screening.

Dr. Gupta

- Emphasize that risk increases significantly after age 60
- Reinforce benefits of colonoscopy, particularly for unscreened adults approaching age 60
- If blood testing is the only acceptable option, proceed with it.

Documentation Recommendations from the Panel

The experts recommended documenting:

- Screening options discussed
- Colonoscopy and stool tests offered and patient's refusal of preferred options
- Counseling about test performance – strengths and limitations
- Patient's reasons for declining preferred tests when known
- Selection of blood-based testing after informed discussion
- Counseling regarding the need for follow-up colonoscopy after a positive result

Drs. Wolf and Gupta specifically noted that documentation helps:

- Support continuity of care
- Reduce medicolegal risk
- Facilitate follow-up if a blood test is positive

Failure to document these conversations could create medicolegal risk if cancer is later diagnosed.

QUESTIONS & ANSWERS

Q: Why are some physicians recommending a Blood-based stool test in spite patients have a negative colonoscopy? Is this a best practice for Family Practice Doctors?

A: Blood based screening, or screening with any non-invasive test should not be performed within 10 years of a normal colonoscopy for purposes of screening. *Answered by: Samir Gupta, MD, MSCS, AGAF*

Q: How does Galleri testing fit into the equation at this time? And how do you explain it to patients? It has been confusing to talk to the public about, because many think they just need the blood test and they will be fine.

A: Galleri testing is not adequate for colorectal cancer screening. However, a person with a positive Galleri test, depending on the specifics of the result, might be at increased risk for colon cancer and may need follow up colonoscopy. In general, we should be clear in telling patients that Galleri has not been specifically studied or approved for the specific purpose of colon cancer screening. *Answered by: Samir Gupta, MD, MSCS, AGAF*

Q: Can you speak to the uptake of the blood test in FQHCs? My understanding is that there is hesitancy to adopt because of UDS reporting.

A: I hear this concern and anticipate that this will remain a barrier to use unless/until the blood test is included as part of quality metrics such as UDS. *Answered by: Samir Gupta, MD, MSCS, AGAF*

Q: If after educating a patient about options and they still want to do blood test, can the blood test be done that day or does it require a follow-up visit?

A: It can be done the same day. *Answered by: Samir Gupta, MD, MSCS, AGAF*

QUESTIONS & ANSWERS (Continued)

Q: Was there any research on performing the blood-based tests annually? Would an annual blood based test have better sensitivity for adenomas?

A1: To my knowledge, prospective data for annual use of either cfDNA test have not been published. I need to check if any of the modeling studies modeled outcomes with annual use - that might offer some helpful information. *Answered by: Samir Gupta, MD, MSCS, AGAF*

A2: Meester and colleagues published a modeling study in 2026 providing interval comparison for both Shield and SimpleScreen in Table S13 (Meester et al., 2026). Ebner and colleagues published a modeling study comparing intervals for both Shield and SimpleScreen in Table S2 (Ebner et al., 2025). *Answered by: Molly Black*

A3: Note that the Meester study only compared different strategies involving the two blood-based tests, while the Ebner study compared the blood-based tests to stool-based tests. In these latter comparisons, both annual and every 3 year blood-based testing strategies yielded fewer life-years gained for the number of colonoscopies required compared to currently recommended stool-based strategies. *Answered by: Andrew M. D. Wolf, MD, MACP*

Q: Which test has the best adherence in clinical settings?

A: The evidence continues to show offering choice is the most effective strategy to increase patients who were up-to-date with colorectal cancer screening. The decision making process should match the patient's preferences as well as the individual's likelihood of adherence. The adherence varies drastically among different patient populations. (Inadomi et al., 2012)(Ebner et al., 2024)(Mehta et al., 2024) *Answered by: Molly Black*

Q: If the blood tests have only about 83% sensitivity for CRC overall, that means that 17% (almost 1 in 5 people) who have a cancer will be mislead into thinking they don't have cancer. The false-negative rate is often not mentioned in these conversations. Thoughts from the panel?

A: Yes patients for sure need to understand both sensitivity and false negative - I feel like different patients process information on "miss rates" in different ways. *Answered by: Samir Gupta, MD, MSCS, AGAF*

AMERICAN CANCER SOCIETY RESOURCES

Patient Education & Activation Resources

- ACS Colorectal Cancer Screening Guideline w/2026 Update flyer | LINK - *Ask Your ACS Staff for Spanish*
- ACS CRC Guideline Patient Page (2026) | LINK
- 7 Things to Know About Getting a Colonoscopy *flyer*
  - English | Arabic | French | Haitian Creole | Hindi | Korean | Polish | Portuguese | Russian | Simplified Chinese | Somali | Spanish | Tagalog | Ukrainian | Vietnamese
- Colorectal cancer: Catch it Early and Reduce Your Risk
  - English | Arabic | French | Haitian Creole | Hindi | Korean | Polish | Portuguese | Russian | Simplified Chinese | Spanish | Tagalog | Ukrainian | Vietnamese
- You Can Prevent Colorectal Cancer *flyer:*
  - English | Arabic | French | Haitian Creole | Hindi | Korean | Polish | Portuguese | Russian | Simplified Chinese | Spanish | Tagalog | Ukrainian | Vietnamese - *Ask Your ACS Staff for Hebrew, Yiddish*
- Getting Screened for Colorectal Cancer *booklet:* English | Navajo
- Cancer Screening Reminder *cards & flyers (English & Spanish)* | *Ask Your ACS Staff*
- Colorectal Cancer Fact Sheet for Patients | LINK
- ACS Cancer Screening Resources for Patients | LINK
- ACS CancerRisk360™ Learn More | LINK
- ACS Get Your Tests flyer/poster: English | Arabic | Chinese | French | Haitian Creole | Hindi | Korean | Polish | Portuguese | Russian | Spanish | Tagalog | Ukrainian | Vietnamese

Practice Resources

- ACS Colorectal Cancer Screening Guideline Update (2026) | LINK
- ACS Colorectal Cancer Screening Guideline (2018) | LINK
- Colorectal Cancer Fact Sheet for Health Care Professionals | LINK
- ACS NCCRT's Steps for Increasing Colorectal Cancer Screening Rates: A Manual for Primary Care Practices | LINK
- ACS NCCRT's Clinician's Reference: Stool-Based Tests for Colorectal Cancer Screening (2025) | LINK
- ACS NCCRT's The Dos and Don'ts of Colorectal Cancer Screening | LINK
- ACS NCCRT's Lead Time Messaging Guidebook | LINK
- cancer.org/hcp for healthcare professionals website | LINK
- ACS Community Health Center Cancer Screening Resources for Health Care Professionals | LINK
- ACS Cancer Screening Disparity Atlas | LINK

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