Recommendations for a Step-Wise Comparative Approach to the Evaluation of New Screening Tests for Colorectal Cancer

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BACKGROUND: New screening tests for colorectal cancer continue to emerge, but the evidence needed to justify their adoption in screening programs remains uncertain. METHODS: A review of the literature and a consensus approach by experts was undertaken to provide practical guidance on how to compare new screening tests with proven screening tests. RESULTS: Findings and recommendations from the review included the following: Adoption of a new screening test requires evidence of effectiveness relative to a proven comparator test. Clinical accuracy supported by programmatic population evaluation in the screening context on an intention-to-screen basis, including acceptability, is essential. Cancer-specific mortality is not essential as an endpoint provided that the mortality benefit of the comparator has been demonstrated and that the biologic basis of detection is similar. Effectiveness of the guaiac-based fecal occult blood test provides the minimum standard to be achieved by a new test. A 4-phase evaluation is recommended. An initial retrospective evaluation in cancer cases and controls (Phase 1) is followed by a prospective evaluation of performance across the continuum of neoplastic lesions (Phase 2). Phase 3 follows the demonstration of adequate accuracy in these 2 prescreening phases and addresses programmatic outcomes at 1 screening round on an intention-to-screen basis. Phase 4 involves more comprehensive evaluation of ongoing screening over multiple rounds. Key information is provided from the following parameters: the test positivity rate in a screening population, the true-positive and false-positive rates, and the number needed to colonoscop. CONCLUSIONS: New screening tests can be evaluated efficiently by this stepwise comparative approach. Cancer 2016;122:826-39. © 2016 The Authors. Cancer published by Wiley Periodicals, Inc. on behalf of American Cancer Society. This is an open access article under the terms of the Creative Commons Attribution-NonCommercial-NoDerivs License, which permits use and distribution in any medium, provided the original work is properly cited, the use is non-commercial and no modifications or adaptations are made.

KEYWORDS: colonoscopy, colorectal cancer, fecal occult blood test, molecular diagnostics, screening test.

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INTRODUCTION
New tests to screen for colorectal cancer (CRC) continue to emerge and are based on new biomarkers, new imaging modalities, or variations of existing methods. Efficient evaluation of these options presents a challenge. It has been observed that new diagnostic tests frequently enter practice without evidence of improved outcomes.1 For screening tests, the requirement for evidence is more demanding, because more than clinical test accuracy (ie, sensitivity and specificity) is required to justify adoption.1,2 Safety, public acceptability, and cost effectiveness need to be assessed even more carefully for tests that are to be applied to ostensibly healthy individuals.

The intention of a cancer screening program, or secondary prevention, is to significantly reduce the cancer site-specific mortality and burden of that disease in the target population2 through programmatic use of a test that detects neoplasia at a stage early enough for treatment to be successful and/or for incidence to be reduced.3 It has been demonstrated that certain screening tests reduce cancer site-specific mortality and/or incidence by randomized, population-based evaluation on an intention-to-screen basis,4-12 thereby limiting biases, such as lead-time, length, and self-selection, that are often present in simpler studies that use surrogate measures of mortality or intermediate endpoints. Evaluation of every new CRC screening test to the endpoint of mortality would be a huge and expensive undertaking and would markedly slow—if not prohibit—the implementation of promising new technologies. Fortunately, simpler studies using surrogate measures or intermediate endpoints can be used to evaluate new tests1 provided that a carefully validated reference standard is used and biases are minimized. To define what is justifiably required to support the use of a new test for CRC screening, we propose an efficient and rigorous method for how to compare the alternative/new (hereafter “new”) with the proven/established screening tests.

METHODS
To establish the guiding principles for comparative evaluation, including the informative endpoints and the appropriate study design, we established a consensus based on the Glaser and Delphi approaches.13 The membership was chosen from experts because of their knowledge or experience in practice or research relevant to screening for CRC. The problem was defined by using the consensus process to agree on the goal. To support the consensus process, systematic literature searches were undertaken using Medline and other relevant databases. One search string was optimized for diagnosis and screening with the inclusion of measures like sensitivity, another was optimized for cancer, and a third attempted to identify articles focused

**BOX 1:** These are the guiding principles that underpin a strategy for comparing screening tests that emerged from the consensus approach and the literature review (a discussion of each is provided in Supporting Table 1; see online supporting information):

Principle 1. Screening aims to reduce the burden of disease in the targeted population, without adversely affecting the health status of those who participate in screening, through early detection and treatment of cancer and/or through detection of precancer lesions, which reduces incidence.

Principle 2. The screening test is just 1 event in a process that includes engagement of the public, testing, validation, communication, and treatment.

Principle 3. Population randomized controlled trials with mortality as the primary outcome set the standard for the evaluation of new tests.

Principle 4. New tests can be assessed in parallel with an existing test all the way through the screening process, from population engagement to population outcomes/measures.

Principle 5. New screening tests might detect a different neoplasia-dependent biology; as a consequence, the value of treatment and benefit to mortality reduction might not be the same.

Principle 6. In 2-step screening, the screening test selects participants who proceed to diagnostic verification by colonoscopy, because a positive test increases the likelihood of neoplasia being present.

Principle 7. It is not ethically justifiable to proceed to study a test in the screening environment, including acceptability to invitees or other screening program outcomes, without studies indicating that the new test is of acceptable accuracy compared with a proven comparator test.

Principle 8. New tests must be clearly defined with provision of adequate technical details, quality-assurance procedures, and performance standards.
on comparison of tests. We also searched for review articles that addressed the evidence supporting screening for CRC.

A series of specific questions that focused on the definition of appropriate study designs and outcomes for the comparison of different screening tests were established by agreement. The answers to these questions were reached by consensus (requiring 75% agreement) based on dissemination of summaries of the literature searches, detailed examination of methodological articles, a series of semistructured discussions with dissemination of decisions after each critique, followed by consultation with external advisors. On the basis of these processes, progressive drafts of the recommendations were then prepared, circulated, and critiqued.

In this report, we present: 1) the underlying guiding principles that emerged from the consensus; 2) an expert opinion on the methods appropriate for evaluating a new test compared with a proven comparator test (what is needed), 3) practical guidance on how to apply these methods in a 4-step, phased evaluation (how to do it); and 4) examples of published research that exemplify these phases (how it has been done). Therefore, it will guide researchers and enable practitioners to decide whether a new test is suitable for the context in which they practice.

GUIDING PRINCIPLES

The guiding principles that emerged from the consensus approach and the literature review are outlined in Box 1, together with their key consequences for test comparison. A presentation of the reasoning underlying these principles is presented in Supporting Table 1 (see online supporting information).

With regard to Principle 3, which states that “Population randomized controlled trials (RCTs) set the standard for evaluation of new tests,” Table 1 outlines the characteristics of major screening tests known to reduce CRC mortality and/or incidence together with the type of evidence supporting their value. Such tests are ideal as a reference point against which to compare a new test.

| Detection Goal | Technology | Strongest Evidence for Benefit | Test Objective | Sensitivity Determinant | Specificity Determinants |
|----------------|------------|--------------------------------|----------------|------------------------|-------------------------|
| Fecal blood    | Guaiac-based FOBT (gFOBT) | Population RCTs—reduced incidence and mortality | Heme component of hemoglobin | Amount of fecal heme exceeds that needed to generate a positive result (fixed by manufacturer) | Dietary peroxidases; agents interfering with peroxidase reaction; bleeding nonneoplastic lesions; amount of stool in sample. |
| Fecal immunochemical test for hemoglobin (FIT) | Case-control and cohort studies—reduced incidence and mortality; comparative screening cohorts (randomized)—higher detection rates and participation compared with gFOBT | Globin component of human hemoglobin | Amount of fecal hemoglobin exceeding selected cutoff concentration (may be fixed by manufacturer or selected by end user) | Bleeding nonneoplastic colonic lesions; amount of stool in sample. |
| Endoscopic visualization of lesion | Colonoscopy | Case-control and cohort studies—reduced incidence and mortality | Visually apparent lesions (ulcerative, polypoid, or flat/depressed) suspicious of neoplasia | | |
| Sigmoidoscopy (flexible) | Population RCTs—reduced incidence and mortality | Visually apparent lesions within reach | Quality of procedure; ability to negotiate the colonic lumen with adequate views; nature of the lesion | Histopathologic clarification | |

Abbreviations: FOBT, fecal occult blood test; RCTs, randomized controlled trials.

This information is derived from several publications.5,6,14-19
Table 1 also describes the test target (which serves as an informative outcome for comparison), as discussed in Principle 5.

A FRAMEWORK FOR EVALUATING A NEW SCREENING TEST

With these principles in mind, a practical framework for evaluating a “new” test against a proven test can be built. The test of effectiveness for the proven test demands proof at the population level—hence, the context for evaluation must eventually include population outcomes and not just the testing of capacity to detect lesions.

When an RCT establishes that a test is effective in reducing mortality, then a new test does not need to be evaluated with such rigor provided it is compared with the proven test.1 This is true provided that Principle 5 (Box 1) applies; namely, that the value of treatment and benefit in mortality are not compromised because of potential differences in the biology of detected lesions.

In applying this view, other than effects on CRC mortality and disease stage, there are 3 types of readily determined outcomes that inform the value of a new test: accuracy, acceptability, and impact on other screening program outcomes when applied in a screening context (see Phased Evaluation, below). Such intermediate/surrogate outcomes facilitate the prediction of benefit provided that the new test is directly compared with a test that has been proven to be effective on an intention-to-treat basis, ie, based on an approach that, among other things, takes into account imperfect adherence and overcomes other sources of bias.1,20,21

STUDY DESIGN FOR COMPARING TESTS

Accuracy can be assessed through case-control and cohort studies using the framework illustrated in Figure 1. This framework can be adapted to any phase of evaluation, from prescreening assessment to mass population application.

Choice of Comparator Test

The first and well characterized, noninvasive test (in terms of effectiveness) is the guaiac-based fecal occult blood test (gFOBT) Hemoccult (and variants, particularly Hemoccult II; Beckman Coulter Inc, Pasadena, Calif). The screening outcomes achieved with this gFOBT represent the minimum that needs to be achieved, because the effect of gFOBT on mortality is modest. The more advanced technology provided by fecal immunochemical tests for hemoglobin (FIT) provides better accuracy, including improved sensitivity for adenomas as well as CRCs and better acceptability when evaluated on an intention-to-screen basis. Population-based and case-control studies support the value of this technology.22-29 Further studies from the Netherlands16 confirm the value of FIT in a population RCT when analyzed on an intention-to-screen basis relative to the gFOBT Hemoccult II. This evidence has led to recommendations that FIT replace gFOBT.15,30 Therefore, a well studied FIT sets a new standard against which new tests can be judged.31 FIT technology tends to have a better capacity to detect adenomas than gFOBT, and repeated testing improves detection.32,33

Because population screening trials with flexible sigmoidoscopy (FS) have now been reported,5 this screening test will serve as a useful comparator for the detection of preinvasive lesions.

The experts concluded that colonoscopy serves to estimate the accuracy of a new test; however, without RCT intention-to-screen evidence of effectiveness, the effectiveness of a new noninvasive test cannot be deduced if it is assessed relative to colonoscopy only. However, as results emerge from the currently underway population screening trials evaluating colonoscopy, we will be able to use colonoscopy as a comparator knowing its benefit to mortality in an unbiased setting.

EVALUATION OF ACCURACY

Clinical accuracy (sensitivity, specificity, and predictive values) is crucial to whether a new test is fully evaluated in
screening. It is not appropriate to study acceptability or other screening program outcomes without having first measured accuracy. Consequently, comprehensive test evaluation must be phased (see Principle 7).

The 2 key measures of accuracy—sensitivity and specificity—are often difficult to ascertain, especially for screen-relevant lesions (i.e., the earlier stage cancers and adenomas that would be encountered in a largely asymptomatic, typical screening population). A valid estimate of these accuracy measures would require costly and time-consuming testing of an unselected screening population that included a sufficient number of participants with such lesions in which all test confounders were likely to be encountered and in which every participant, both test-positive and test-negative, underwent diagnostic verification.

Fortunately, when a comparator test is available, a paired study design (which improves statistical power) facilitates evaluation of effectiveness of the new test and estimation of the relative impact on screening outcomes. A valid estimate of these accuracy measures would require costly and time-consuming testing of an unselected screening population that included a sufficient number of participants with such lesions in which all test confounders were likely to be encountered and in which every participant, both test-positive and test-negative, underwent diagnostic verification.

Another simplification is based on the proposition that the 2 key questions concerning clinical accuracy are: 1) detection—a test that is more sensitive in practical terms returns more true-positives, and 2) the burden associated with detection—a test that is more specific in practical terms returns fewer false-positives. The assessment of these 2 parameters is achieved by a thorough diagnostic verification of every test-positive case (both comparator and new test-positives) to determine whether it is a true-positive or a false-positive.

The simple dichotomous measures of the true-positive rate (TPR) and the false-positive rate (FPR) are direct and practical measures of accuracy, sometimes referred to as test “operating characteristics,” as indicated in Table 2. They are used when undertaking receiver operating characteristic (ROC) analysis. The TPR reflects detection (sensitivity), and the FPR reflects the burden associated with detection (1-specificity). Consequently, relative sensitivity and specificity are determined by comparing the TPR and the FPR, respectively, between tests.

Comparing Test Accuracy: The Scenarios

The approach based on verification of positive tests, classifying them as true-positive or false-positive, provides a straightforward but powerful strategy for comparing the accuracy (operating characteristics) of 2 screening tests. The concepts presented apply regardless of whether the target lesion is cancer and/or adenoma.

In comparing accuracy, the targeted clinical lesion (hereafter referred to as targeted lesion), which can be cancer, and/or adenoma, or combinations thereof, needs to be clearly defined. Performance characteristics related to sensitivity and specificity need to be compared for the same clinical endpoint. Depending on the phase of evaluation and the question being addressed, the targeted lesion might be early stage cancer, or advanced adenoma, or “advanced neoplasia,” a term referring to cancer plus advanced adenoma (see Phase 2 below for definition). Tests might differ in their capacity to detect lesions at specific stages, and this needs to be explored. It should be noted that clinical accuracy depends on the presence of the biomarker that forms the basis of the test objective (see Table 1); and this, in turn, might be important to

| Test Result | Diagnostic Verification; Operating Characteristic | Corresponding Accuracy Characteristic | Issue Addressed |
|-------------|-------------------------------------------------|--------------------------------------|----------------|
| Positive    | True (i.e., target condition present); true-positive rate (TPR)* | Sensitivity (positivity rate in those with the target condition) | Detection |
|            | Positive predictive value (TPR/TPR + FPR) | Efficiency of detection |
|            | Specificity (1 – FPR) | Burden associated with detection |
| Negative    | False (i.e., target condition not present); false-positive rate (FPR)* | Negative predictive value (TNR/TNR + FNR) | Elimination/exclusion of targeted clinical lesion (stage specified) |
|            | True; true-negative rate (TNR) | Missed lesion |
|            | False; false-negative rate (FNR) | Burden of failed detection |

* A targeted clinical lesion is either cancer and/or advanced adenoma, depending on the question being asked of the test, because tests might detect these to differing degrees.

**TABLE 2. Relation Between Direct Practical Measures (Operating Characteristics) of a Screening Test Result, How Each Informs Assessment of Test Accuracy, and the Consequences of the Result for a Screening Program**
treatment response (Principle 5) (Supporting Table 1; see online supporting information).

Two simple questions, modified from Lord et al, guide assessment in a practical manner:

Is the new test better at detecting target lesions?
This is true if the TPR (which reflects sensitivity) for the target lesion is improved using the new test. It is likely that improved outcomes (reduced mortality and/or incidence) will follow from use of the new test, especially if the TPR is greater for early stage cancers.

Complexity arises if the new test is better at detection (higher sensitivity) but returns more false-positives (lower specificity) than the old test, raising concerns about cost and potential harms. Hemoccult Sensa, compared with Hemoccult II, is an example. Note, however, that a test with more true-positives and a higher initial colonoscopy rate (whether because of true-positives and/or false-positives) will make the program more expensive initially but might create longer term savings as a result of better detection. This will become clearer in formal cost-effectiveness analyses that measure the cost per quality-adjusted life year saved.

There are several ways to address such complex scenarios. The operating characteristics of the 2 tests can be plotted as an ROC curve (TPR vs FPR) as a way to judge which test has the best balance of true-positives and false-positives; overall, the test with the greatest area under the curve has the best discriminatory power. This is particularly applicable to prescreening phases in the evaluation process that focuses on accuracy (see below).

Another objective approach is to calculate the number needed to screen (colonoscope) to detect 1 target lesion using each test (the reciprocal of the positive predictive value). Calculating the number needed to colonoscopy also facilitates comparison of 2 tests when each is applied to a different cohort, although comparability of populations needs careful consideration. However, the number needed to colonoscopy should be determined only in Phase 3 studies conducted in settings that represent the natural prevalence of neoplasia and not in studies in which prevalence is biased because of recruitment processes.

If not better at detecting target lesions, does it have other advantages?
A new test might have other benefits, for instance, significantly better specificity without improved sensitivity. Comparison is made simple in this circumstance by calculating the number needed to colonoscopy to detect 1 target lesion for each test. The new test might also have programmatic benefits (see Phase 3 evaluation), such as greater acceptance by the screening population or improved technical reliability. In similar fashion, the number needed to invite to detect 1 target lesion will offer additional comparative information by capturing the product of participation and accuracy, although this approach is susceptible to the method of invitation and how the invitation is framed. It should be noted that many consider the sensitivity of gFOBT, which has demonstrated a statistically significant but only relatively small impact on CRC mortality, to be inadequate. Consequently, they would argue that there is only a place for a new test that returns a better sensitivity than gFOBT.

Study Populations
The population selected for study will depend on the question being asked and the phase of the evaluation. The testing path may involve paired testing in a single group (that comprises cases and controls) or parallel testing of randomized cohorts (see Fig. 1). Which is chosen depends on the stage of evaluation (see Box 2). The subsequent discussion on phased evaluation provides more detail.

Comparing Tests in the Screening Pathway
In addition to accuracy, it is essential that the effect of a new test on other variables in the screening pathway is determined, eg, safety, cost, feasibility, ease of use for a screening participant, and acceptability. New tests must undergo evaluation in unselected, typical screening populations, and an intention-to-screen evaluation is necessary to justify large-scale adoption.

In mass population screening, detection of target lesions is the product of participation and sensitivity; because, without participation (sometimes referred to as compliance or uptake), there can be no detection. Consequently, measuring participation with 1 test relative to another in separate cohorts randomly selected from the same population can document test acceptability, provided that framing of information is carefully balanced.

Phased Evaluation
Phased (ie, sequential) evaluation in a step-wise, increasingly complex manner is most appropriate. Initial evaluation (Phases 1 and 2) starts with a simple prescreening evaluation that addresses accuracy of the new test and proceeds, if judged appropriate, to more
thorough evaluation addressing outcomes in the population screening context (Phases 3 and 4), as indicated in Box 3. Phased evaluation takes into account the issues described in Box 3. The primary and secondary objectives and general characteristics of these phases are provided in Table 3.

The phased approach is indeed undertaken in practice. Supporting Table 2 (see online supporting information) provides selected examples of studies that have demonstrated the elements of each phase, together with their main characteristics. When tracking through these phases for tests, such as different FIT products and designs or the fecal DNA tests, it is observed that early, simple studies are followed by more complex and informative studies. There are many other possible examples—those provided serve to demonstrate the increasing complexity of each phase, design options within a phase, and information that may be gleaned from such studies.

**Phase 1: Retrospective Estimation of Ability to Discriminate Between Cancer Cases and Normal Controls**

The ability to distinguish between cancer and noncancer states is essential for a test to be useful and can initially be evaluated in individuals who have established cancer
| Evaluation | Nature | Primary Aim | Secondary Aims | Population |
|------------|--------|-------------|----------------|-------------|
| Phase 1    | Prescreening: Retrospective estimation of ability to discriminate between cancer cases and controls without neoplasia | • Test detects established cancer | 1.2 Establish the test sampling process<br>1.3 Optimize processes for quality assurance<br>1.4 Fine tune test endpoint | Individuals known to have cancer, ideally with a majority in potentially curable disease stages and including some who are asymptomatic; controls to be free of neoplasia; concordance between tests should be reported; ideally, paired testing, with all results verified at diagnostic procedure |
| Phase 2    | Detection of lesions along the neoplastic continuum; prospective clinical studies | • Test detects early neoplasia before it becomes apparent | 2.3 More reliably estimate operating characteristics<br>2.4 Information on covariates affecting test performance<br>2.5 Ascertain the number of samples and threshold (fine-tune the endpoint)<br>2.6 Test to be registrable with authorities<br>2.7 Clarify whether there are subgroups in which the test might fail to detect lesions | Cases covering all stages of colorectal neoplasia, especially early stage cancer and/or advanced adenomas, with knowledge of whether cases are symptomatic; asymptomatic where possible; controls to be free of neoplasia; results in individuals with common benign diseases and how they affect test result need ascertainment; testing undertaken before scheduled diagnostic procedure; ideally, paired testing; concordance between tests should be reported |
| Phase 3    | Initial screening evaluation; single round of screening | • Characteristics of neoplasia detected when screening; false-referral rate; acceptability | 3.3 Describe the characteristics and frequency of neoplasia detected when screening<br>3.4 Determine feasibility<br>3.5 Preliminary assessment of costs including diagnostic workload | Testing in a typical screening environment using a single prevalent screen; separate cohorts perform the new test or comparator (potentially in the form of “usual care”), and outcomes are followed from invitation to outcome of interest; only those who test positive need colonoscopy (unless direct comparison with screening colonoscopy is required); start with initial, small studies addressing simpler pathway outcomes and progress to larger programs addressing detection rates; analyze by intention-to-screen |
| Phase 4    | Screening program evaluation over multiple rounds | • Impact of screening on reducing burden of neoplasia, adverse events | 4.2 Broader benefits<br>4.3 Accurate costs<br>4.4 Participation with rescreening<br>4.5 Compliance with diagnostic follow-up<br>4.6 Treatability of lesions detected<br>4.7 Screening intervals<br>4.8 Missed cancer rate<br>4.9 Program detection rates with repeated screening<br>4.10 Diagnostic follow-up rate across all rounds<br>4.11 Number needed to screen to detect a lesion<br>4.12 Unexpected adverse events | Randomly selected from populations in which screening program is likely to be implemented; design may use historic controls or else a parallel-arm RCT with screening participants and alternatively screened population; intention-to-screen analysis required |

Abbreviations: FPR, false-positive rate; RCT, randomized controlled trial; TPR, true-positive rate.

aDiscussions of group sizes and approximate costs for each phase are included in the text.
(cases) compared with those who are free of neoplasia (controls). Although they initially guide evaluation, the accuracy measures obtained in this way may be biased, and the cases used are not necessarily representative of preclinical cancer, the critical target of any screening program.

**Cases and controls**

An initial indication can be obtained comparing individuals who have established cancer (cases) with those who are free of neoplasia (controls). For cases, it is helpful to have a range of different histologic features and stages, meaning that all must have had diagnostic colonoscopy.

**Intervention**

Design should follow that charted in Figure 1, with cases and controls performing both the new tests and the comparator tests: ie, “paired-testing.” The individuals who are developing the test sample should be blinded with respect to participants’ status. If the test requires collection of biologic samples, then it needs to be ensured that the sampling process and preanalytic conditions are exactly the same for cases and controls (such as time interval from the colonoscopy, setting of the examination, conditions of sample storage, and so on).

**Outcomes and sample size**

A sample size of 60 pairs has approximately 80% power to detect a difference in the TPR of 20% when the proportion of discordant pairs is expected to be 30% in cases affected by the cancer; such conditions may be encountered.47 “Discordant pairs” refers to those cases who are positive on 1 or the other test but not on both tests. The minimum standard approach and its analysis is described in detail by Pepe et al.3 Basic considerations in measuring power when the TPR and the FPR are the main outcomes and when the design is not paired have been provided.3

For studies on marker combinations that require training before validation, if the training and validation cases are drawn from the same population, then the sample size requirements should be fulfilled by the validation set independent of the training set.

The proportions of individuals with lesions in which both the new test and the comparator test are positive and in which only 1 or the other test is positive should be reported. This clarifies concordance between the tests and addresses Principle 5.

To compare tests in a paired design, calculation is simply performed by determining the confidence interval of the difference in test positivity8 or by using the McNemar test. Fine-tuning the test endpoint, ie, the threshold set for positivity (the criterion value), is crucial for those tests that have a quantitative or semiquantitative endpoint. An ROC curve should be constructed and analyzed.3,39 For each cutoff selected for positivity in the ROC curve, the confidence interval of the difference in positivity rates between the new test and the comparator test can be calculated.47

If the new test is at least comparable to the comparator test, then it is justified to proceed to a Phase 2 evaluation. In exceptional circumstances, skipping phases before Phase 3 might be justifiable, especially if screen-detected cases were included.

**Phase 2: Detection of Neoplasia Across the Oncogenic Continuum—Prospective Clinical Studies**

Paired testing is undertaken prospectively in participants before they undergo the diagnostic procedure: ie, before they are identified as cases or controls. Test operating characteristics need to be understood across the spectrum of stages of oncogenesis, with the particular interest being performance in the earlier stages, when treatment is more likely to be successful. This is especially important if the new test has a different objective (ie, it detects a different biology) than that of the proven comparator. The risk in practice is that seeking a higher detection rate for early stages or preinvasive neoplasia (adenomas) raises the possibility of a higher FPR and overdiagnosis (detection of inconsequential colorectal neoplasia).48

There are 2 clinical targets of particular interest. One is a shift to earlier stage cancer, because CRC screening RCTs demonstrate that reduced mortality is linked to earlier detection. This can only be examined in very large screening studies,49 but a surrogate measure is provided by estimating sensitivity for earlier stage cancer. The second target is that of preinvasive neoplasia, particularly advanced adenomas (size >9 mm, villous component >25%, high-grade dysplasia, or >2 of any characteristic), because the detection of adenomas by screening FS is beneficial,5,50,51 and advanced adenomas are more likely to progress to cancer.

An important purpose of Phase 2 can be to determine the final test format (ie, criterion endpoint fine-tuning), before the population evaluation in Phase 3. The operational nature of the test (eg, in the case of a laboratory test, the assay details and analyte) should be carefully defined (see Principle 8), and a provisional threshold should be set for positivity: ie, the characteristic that would direct that individual to undergo diagnostic evaluation. For tests requiring a biologic sample, the sampling process must be clear; information on stability of the
analyte and robustness of the sampling method regarding preanalytic variations should be published. If any of these matters remain uncertain, then simple pilot studies in typical screening populations should be undertaken. Although a new test might detect lesions at an earlier stage, it also might fail at certain stages, or it might detect a different type of neoplastic lesion. Ideally, Phase 2 studies would indicate whether these outcomes are likely.

**Cases and controls**
Individuals who are scheduled for colonoscopy for any reason are informative, but they are more so if asymptomatic.

**Intervention**
Evaluation parallels that for Phase 1, with individuals undergoing paired testing before colonoscopy. Participants should be classified according to stage of oncogenesis and presence(58,709),(904,863)(58,863),(904,997).
participatory (per-protocol) outcome, and the outcome being addressed. For instance, test positivity or participation rates are often the initial outcomes of interest in Phase 3 studies and are easily estimated. With study group sizes of $n = 376$, a 2-group chi-square test with a .05 two-sided significance level has 80% power to detect a 10% change in participation, where participation in the reference group is 30%. When the ultimate consideration is the difference in detection rates of cancer, if a difference in detection rates of cancer of 3 per 1000 invitees is expected, then the sample size should be at least 6083 if a gFOBT comparator is expected to detect 2 per 1000.

Therefore, it is sensible within Phase 3 studies to progressively stage evaluation, starting with smaller study groups of, say, 400 to 500 to measure the overall test positivity rate (which estimates the number of colonoscopies required to be) and participation rates and to gain further estimates of the TPR and FPR and associated covariates. This informs sample sizes for larger studies that then address detection rates. Modeling cost effectiveness is an important element of Phase 3, because it provides real-world estimates of test positivity rates and participation, variables that are important to accurate cost modeling. Indeed, as outcomes are accumulated, extensive modeling can be undertaken using models like MISCAN (Microsimulation Screening Analysis) to predict impact and thus enable the adjustment of programs to maximize the likely benefit.

**Phase 4: Screening Program Evaluation**

The objective of screening is to reduce the burden of disease by reducing CRC mortality at the population level. It is important that it does not adversely affect the health status of those who choose to participate. A new test might be associated with some unexpected adverse events that would counterbalance mortality benefits predicted by better detection and/or participation; Phase 4 studies conducted over multiple rounds would identify these events. Comparing new CRC screening tests using CRC mortality as the endpoint will probably never be feasible on the grounds of size, time, and cost. Phase 4 evaluation is not so much about the comparison of tests but about monitoring how the new test performs when applied to a large, unselected population, ideally over repeated rounds of screening. Measures like a shift to an earlier disease stage and interval (missed) cancers are ascertainable, as well as unexpected adverse events. Knowledge of these will improve cost-effectiveness determinations. Consequently, Phase 4 evaluation would normally proceed as a process of careful evaluation of an organized screening program applied to a large population and monitored over a considerable time, often involving multiple rounds of screening.

**Outcome measures that demonstrate benefit**

In considering what to measure to assess health benefits in screening programs, intermediate measures associated with demonstrated RCT effectiveness can be informative. The gFOBT RCTs demonstrate that a shift to an earlier stage of cancer in a program that involves repeated screening offers is associated with reduced mortality. Thus earlier detection by a new test to at least a comparable degree is highly desirable; for instance, it has now been demonstrated that screening with FIT leads to earlier detection.

The association of adenoma detection and removal in screening with the reduction of CRC incidence and mortality is now proven by the RCTs of FS screening. Thus FS is an expeditious comparator for evaluating new tests that target preinvasive lesions, because a potential surrogate measure for predicting a reduction in incidence is the detection (the TPR) of those lesions considered to be at high risk of progressing to CRC.

Interval cancers, ie, missed or new cancers, occur in programs, and monitoring these for each test would be valuable; although, to obtain valid and accurate comparative data, an adequate follow-up time and a very large sample size are required. Nonetheless, interval cancer rates need to be determined, especially when the earlier phases of evaluation have focused primarily on assessment of test-positive cases (ie, an endoscopic method is not routinely undertaken in test-negative participants).

Comparing tests over multiple rounds is also an important goal of Phase 4 testing and will require prolonged follow-up. Cumulative detection rates should be considered when the stipulated screening interval of the tests being compared is different. Also, methods for reporting participation over multiple rounds of screening have not been well applied to CRC screening; however, as long as repeated participation is required to achieve the expected screening benefit, this represents a relevant indicator to be assessed. Participation in screening—a central performance indicator for population screening—can vary across the population, and it is important to monitor not only the effect of a new test on overall uptake but also its acceptability to all socioeconomic and ethnic groups to avoid widening the inequalities gap.

**Phase 4 study design**

Studies should follow the design outlined for Phase 3 evaluation but should also include multiple rounds of...
New Biomarkers

The discovery of new biomarkers, such as fecal or blood tests for DNA, RNA, or protein, adds complexity. Initial research usually precedes Phase 1 as we describe it but also requires fine-tuning the test endpoints in Phases 1 and 2. This is especially true if a panel of markers is being used.

The process of discovery starting with tissue banks has been discussed in detail elsewhere. Sophisticated, retrospective molecular analyses of material in biospecimen banks can serve to identify candidate biomarkers that might become the objective of the screening test.

If such laboratory research identifies a promising biomarker, then it can be initially evaluated as for Phases 1 and 2 by a simple study in cases and controls. Doing this, however, may assume that the retrospective biospecimen banks are adequate to identify the best candidate. Usually, this is not the case, because discovery is often undertaken on limited numbers of samples obtained from strictly categorized materials that often are not typical of screen-detected lesions. A further technological challenge arises if resected tissue specimens are used to identify the biomarker; however, use of the biomarker in screening involves measurement in a biologic sample, such as blood or feces. Many factors may influence the appearance of the biomarker in the biologic sample, and there is a chance that it might not be of the same molecular structure in blood or feces as in tissue, because degradation or other processing might occur.

This makes it likely that the best discovery process first develops a putative panel of markers and then uses clinical studies set up in such a way that the panel can be explored in clinical specimens as part of Phase 1 or 2 studies, or perhaps even Phase 3 studies. Indeed, access to the appropriately characterized population with biologic samples, which serve as a source of materials for discovery of potential biomarkers, may be very useful. The usefulness of panels of multiple markers can then be explored, ie, “validated,” in Phase 1, 2, and 3 studies.

Discussion

This phased approach provides an efficient method for evaluating a new screening test that increases in cost and complexity only if key attributes are worthwhile. It assesses both accuracy and acceptance, because screening of a general population requires good participation as well as good detection, and the same principles can be applied to adenoma detection.

Study costs increase considerably with each phase. The high cost of undertaking Phase 3 studies might be reduced by obtaining government regulatory approval for the use of a test on the basis of Phase 2 studies. Some authors suggest that this can wait until Phase 4 studies have been undertaken, although that seems impractical, because no commercial entity would proceed with test development under such circumstances. Using the logistics and infrastructure of existing screening programs can also help reduce costs of such studies. Expensive studies have included the evaluation of new, noninvasive tests in colonoscopic screening participants. Although useful, this fails to provide comparison with a test known to reduce mortality on an intention-to-screen basis.

The final issue is what justifies progression from 1 phase to the next. Although our proposal sets the principles for the phased evaluation of new tests, researchers, in collaboration with health service providers, should agree on hurdle values before embarking on a study. It is noteworthy that criteria for equivalence or superiority should be agreed at commencement. Phase 1 studies can be considered as exploratory and of value in helping to determine necessary power and likely outcomes in Phases 2 and 3. What constitutes an acceptable hurdle value will vary with the test and how the test will be used within the health care system.

We consider that this process of comparative, phased evaluation provides a rational, efficient, and useful process for evaluating new tests and for progressing a test to a stage at which the considerable degree of evidence needed for its inclusion in population screening is obtained. Health providers will be able to adopt a test that is soundly based on scientific objectivity and the fundamental principles of screening.
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