FIGHT COLORECTAL CANCER™

PATH TO A CURE

Foreword

When Fight CRC published the first Path to a Cure report in 2021, we set a bold goal: to shift the national response to colorectal cancer by accelerating the translation of science into equity-driven care. At that time, many of the issues now commanding national attention, early-age onset, biomarker testing inequities, disparities in treatment access, were being surfaced by patient voices but still lived on the margins of mainstream cancer policy and research agendas.

Four years later, we made undeniable progress. Colorectal cancer now has a place in high-profile initiatives like Cancer Moonshot and Cancer Grand Challenges. Universal tumor testing has become a national quality metric. Immunotherapy has changed the game for some patients. And our community of advocates has grown in strength, skill, and scale.

But our work is far from done.

As this 2026 report makes clear, precision care is still not the norm. Recurrence rates remain high. Early-age onset CRC continues to rise. And too often, the benefits of science do not reach the patients who need them most. Fight CRC believes that patients are not only the reason for research but essential to its success. That's why we continue to invest in advocacy, policy change, and partnerships that bring patient priorities to the forefront.

This report reflects the voices of survivors, scientists, clinicians, and caregivers across the country and the globe. It is both a snapshot of where we are and a roadmap for where we must go.

ANJEE DAVIS, MPPA, CEO, *Fight Colorectal Cancer*

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Introduction

Colorectal cancer (CRC) research has made extraordinary progress in the past two decades—from the development of life-extending chemotherapies and immunotherapies to the discovery of actionable biomarkers and the emergence of non-invasive monitoring technologies. These advancements have fundamentally shifted how CRC is diagnosed, treated, and tracked. However, survival gains have not been equitably distributed. Early-age onset cases are rising, treatment breakthroughs often benefit only a subset of patients, and many survivors still face lifelong complications with minimal support.

Fight Colorectal Cancer (Fight CRC) is proud to present the 2026 Path to a Cure report as a national blueprint for accelerating equitable, patient-centered progress in CRC. This report is designed for medical researchers, clinicians, and policymakers who seek to align science with the real-world needs of patients.

As the leading advocacy organization focused solely on CRC, Fight CRC has long championed the belief that research should be informed by the lived experiences of those affected. Through initiatives like our Early-Age Onset CRC Think Tank, biomarker education campaigns, clinical trial navigation tools, and federal policy advocacy, Fight CRC has emerged as a trusted convener and catalyst for change. We ensure that patient priorities help shape both the science and the systems designed to deliver care.

This report synthesizes the state of CRC research and care as of early 2026, highlighting scientific momentum, exposing policy and funding gaps, and charting a clear path forward. It reflects Fight CRC's unwavering commitment to not only curing CRC, but transforming what it means to survive and thrive after diagnosis.

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Background

CRC INCIDENCE AND DISPARITIES

Colorectal cancer (CRC) remains the second-leading cause of cancer-related death in the United States and the third most commonly diagnosed malignancy in both men and women. As of 2024, over 150,000 Americans are expected to be diagnosed with CRC annually, including more than 18,000 individuals under age 50.[1] The disease burden is further compounded by marked disparities in outcomes by race, geography, and socioeconomic status. Black Americans are approximately 20% more likely to be diagnosed and 40% more likely to die from CRC than non-Hispanic whites.[2]

MOLECULAR COMPLEXITY AND SUBTYPES

The landscape of CRC has evolved significantly in the last two decades. Advances in molecular understanding have delineated key genetic subtypes—such as microsatellite instability-high (MSI-H), BRAF V600E mutations, and KRAS/NRAS status—that inform prognosis and therapeutic response. MSI-H tumors, often seen in Lynch syndrome, have shown dramatic responses to immune checkpoint inhibitors. Conversely, the majority of CRC cases are microsatellite stable (MSS), which are typically resistant to immunotherapy and represent a central focus of current translational research.[3]

EARLY-AGE ONSET CRC: AN EMERGING CRISIS

The rise in early-age onset (EAO) CRC presents a unique and urgent challenge. Incidence among adults under age 50 has increased by nearly 50% since the mid-1990s, and CRC is now the leading cause of cancer death in men and women under 50 combined in the U.S.[1] While screening age was lowered to 45 in 2021 by the U.S. Preventive Services Task Force, uptake and risk assessment remain uneven, and symptom-based diagnoses are common in this younger cohort.

ADVANCES IN TREATMENT AND TARGETED THERAPIES

Treatment advances have centered on both systemic therapies and local interventions. The use of combination chemotherapy, biologics, and targeted agents (e.g., HER2-directed therapies, BRAF inhibitors) has extended survival in metastatic CRC. Trials such as MOUNTAINEER and BREAKWATER have expanded treatment options for biomarker-defined populations. In rectal cancer, the paradigm is shifting toward organ preservation using total neoadjuvant therapy and non-operative management in select responders, especially among mismatch repair-deficient (dMMR) patients.[4]

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FIGHT CRC'S ROLE IN RESEARCH ADVOCACY

Fight Colorectal Cancer (Fight CRC) has played a pivotal role in elevating the national conversation on CRC research and patient-centered progress. As a trusted convener of leading researchers, clinicians, patients, and policymakers, Fight CRC has built platforms for research advocacy that center on the lived experiences of patients and their families. Through initiatives like the Early-Age Onset CRC Think Tank, Fight CRC has brought global experts together to identify biological drivers and gaps in care for younger patients.

In parallel, the organization has helped guide federal investment by pushing for NIH Notices of Special Interest (NOSI) and dedicated budget report language prioritizing CRC disparities, treatment access, and early detection. Fight CRC advocates have testified before Congress, worked with the Cancer Moonshot and Cancer Grand Challenges, and shaped national quality metrics such as the MIPS tumor testing measure.

SURVIVORSHIP AND LONG-TERM OUTCOMES

In parallel, survivorship has gained visibility as a critical phase of cancer care. With over 1.5 million CRC survivors in the U.S., issues such as bowel dysfunction, sexual health, recurrence anxiety, and reintegration into work and family life are now recognized as key quality of life indicators. Circulating tumor DNA (ctDNA) and minimal residual disease (MRD) assays have emerged as precision tools for detecting recurrence and guiding adjuvant treatment decisions.[5,6] However, access to these innovations remains inconsistent. Fight CRC continues to push for broader insurance coverage and guideline updates to integrate these tools into standard survivorship pathways.

FEDERAL RESEARCH LANDSCAPE AND SYSTEMIC GAPS

At the federal level, progress has been uneven. While major research collaborations such as the Cancer Grand Challenges PROSPECT project[7] are exploring the microbiome and lifetime exposures in EAO CRC, the National Cancer Institute (NCI) has faced funding volatility.[8] The 11% budget cut proposed for FY2025 threatens continuity for ongoing trials and workforce stability.[9] Fight CRC has responded by mobilizing its advocate network and policy partners to protect CRC-specific funding and elevate the urgency of research tied to patient-defined needs.

FRAMING THE REPORT

This report builds on these findings to outline a national agenda for precision CRC care that closes gaps in prevention, treatment, survivorship, and research equity. Fight CRC is committed to ensuring that CRC research not only advances science but reflects the real-world needs of those affected.

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Section II: Biology & Etiology

Progress Indicator: Leveraging biological and hereditary insights to reduce late-stage colorectal cancer diagnoses.

WHY IT MATTERS

Colorectal cancer (CRC) is rising sharply among adults under age 50, with incidence increasing by nearly 50% among 20- to 49-year-olds from 1995 to 2015.[1] Deeper understanding of the cohort effect is necessary, as the effect is now extending to middle aged people. Younger patients are more likely to present with distal, aggressive tumors and advanced-stage disease and, based on changing epidemiology and racial/ ethnic minorities, are disproportionately impacted.[10] Despite breakthroughs in understanding molecular drivers such as MSI-H, BRAF mutations, and Lynch syndrome, clinical translation lags—particularly in racially diverse and underserved populations.[11,12]

RECENT PROGRESS (2021–2025)

- Global Early-Onset CRC Think Tank (2025): Fight CRC convened global experts from six continents to align on the etiologic underpinnings of early-age onset CRC. The meeting included regional presentations (e.g., North America, Asia, Europe, Africa), sessions on microbiome, biobanking, epidemiologic tool development, risk stratification, and international advocacy strategy sharing. Key experts included José Perea (Spain), Andrew Chan (Harvard/MGH), Martin Wong (Hong Kong), and Daniel Buchanan (Australia).

- The $25M Cancer Grand Challenges PROSPECT project (2024): Led by Dr. Andrew Chan and Dr. Yin Cao, the project investigates lifetime exposures and microbiome factors driving the rise in EAO CRC, with implications for prevention and treatment.

- Early-Onset CRC Research Priorities (2024): A U.S. Think Tank laid the foundation for research into symptom delays, molecular epidemiology, and hereditary testing implementation, now informing multi-institutional collaborations.

- NCI Notice of Special Interest (2023): The NIH signaled national priority status by issuing a NOSI focused on etiology, early detection, and prevention of early-age onset CRC.[13]

- Symptom Delay Research (2023): Fight CRC completed a national analysis of delayed diagnosis in early-age onset patients, incorporating Komodo claims data and patient interviews; findings are under journal review.

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RECENT PROGRESS (2021–2025) CONT.

Lynch Syndrome Integration and Research Efforts: MIPS Measure #491 (Medicare Measure for Performance 2025): Mismatch Repair (MMR) or Microsatellite Instability (MSI) Biomarker Testing- This measure is designed to promote universal MMR/MSI testing, aiding the identification of individuals at high risk for Lynch syndrome, in alignment with established guideline recommendation.

- A white paper submitted to the Commission on Cancer advocates for universal multigene panel testing in CRC cases and in review of inclusion as a quality measure for the National Accreditation Program for Rectal Cancer.
- Ongoing ICD-10 code advocacy seeks a discrete designation for Lynch syndrome to support tracking and implementation of universal MSI-H testing and is in the final review stages with the Centers for Disease Control.

KEY BARRIERS

- Underdiagnosis of Hereditary Risk: Roughly 95% of individuals with Lynch syndrome remain undiagnosed, despite clinical guideline support for universal screening.[14]
- Racial and Geographic Disparities: African American and younger CRC patients are more likely to develop aggressive tumor types with fewer actionable biomarkers.[11]
- Emerging Etiologies Require More Research: The roles of microbiome composition, chronic inflammation, dietary exposures, and environmental pollutants in early-age onset CRC remain largely uncharacterized.[12]

2026–2028 STRATEGIC PRIORITIES

Advance Etiology Research:

- Fund large, diverse cohort studies stratified by age, ancestry, tumor biology, and geography.
- Prioritize investigation into microbiome, inflammation, and environmental exposures.
- Support global research convenings.

Implement Universal Lynch Testing:

- Advocate for inclusion in USPSTF, NCCN, and CoC accreditation frameworks.
- Mandate testing in NCI-designated centers and ensure reimbursement alignment.
- Enhance Data Infrastructure:
  - Launch national biobanks and registries focused on early-age onset and underserved populations globally.
  - Include molecular phenotype and social determinants of health in registry design.

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VACCINE RESEARCH:

- Support research for an effective vaccine for individuals with Lynch syndrome by supporting continued exploratory research, clinical trials, and collaborative efforts aimed at shifting from cancer surveillance to proactive immunoprevention.

DRIVE POLICY AND FUNDING:

- Establish dedicated NIH/DoD budget lines for early-age onset CRC research.
- Increase awareness and need of philanthropic and industry support for early onset CRC research initiatives.
- Mandate insurer coverage for multigene panel testing and counseling.

SEER STAGE	COLON 5-year relative survival rate	RECTAL 5-year relative survival rate
Localized	89%	91%
Regional	72%	72%
Distant	16%	14%
All SEER stages combined	67%	63%

CALL TO ACTION

Scientific discovery alone will not change outcomes. We need faster translation of genomic discoveries into clinical tools, broader adoption of hereditary testing, and decisive public policy to confront the rising burden of CRC in young adults. Medical researchers and policymakers alike must treat early-age onset CRC not as a trend, but as a crisis in need of urgent, unified response.

KEY METRICS AND TRACKING:

Ensure 80% of patients diagnosed with CRC undergo germline genetic testing at the time of diagnosis.[15]

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Section III: Prevention & Early Detection

Progress Indicator: Advancing colorectal cancer prevention and early detection through equitable, evidence-based strategies.

WHY IT MATTERS

Colorectal cancer (CRC) is one of the most preventable malignancies, yet screening rates remain suboptimal, particularly among medically underserved populations. Persistent gaps in access, insurance coverage, and awareness delay detection and disproportionately impact Black, Hispanic, low-income, and rural populations.[16,17] At the same time, early-age onset (EAO) CRC continues to rise, while current guidelines and practices often fail to reach this younger at-risk group.[1] CRC incidence among adults under 50 is increasing by approximately 2% annually, with mortality also rising, underscoring the urgent need for stronger early detection strategies in younger populations.[18]

RECENT PROGRESS (2021–2025)

National Policy Wins:

- Fight CRC secured report language in the FY23 federal budget urging NCI to address EAO CRC disparities and expand treatment research.
- Advocacy led to a delay in UnitedHealthcare's prior authorization policy for colonoscopy, preserving timely access to follow-up screening.
- Resources were developed to enforce ACA requirements for public and private insurers to pay for a complete CRC screening no out-of-pocket costs on follow-up colonoscopy after a positive non-invasive test (FIT/FOBT, sDNA testing).

ARPA-H and Screening Innovation:

- Advanced Research Projects Agency for Health (ARPA-H) funded precision science initiatives for multi-cancer early detection (MCED), including liquid biopsy research focused on CRC.

Public Engagement & Tools:

- Fight CRC's screening risk quiz reached over 3 million users, guiding individuals to assess risk and find appropriate providers.
- A digital patient-provider resource suite was launched to promote screening awareness and policy navigation.

White House & Cancer Moonshot Participation:

Fight CRC contributed to the President's Cancer Panel report, "Closing Gaps in Cancer Screening," including a companion brief on CRC equity strategies.[19]

Global Think Tank Integration (June 2025):

The GEOCRCTT convening included sessions on regional/global disparities in screening access and outcomes with focus on Risk Stratification and Awareness. Tools for international data sharing and comparative screening research are under development.

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KEY BARRIERS

- **Racial, Ethnic & Geographic Disparities:** CRC screening uptake is significantly lower among non-Hispanic Black, Hispanic, American Indian/Alaska Native, and rural populations.[20]

- **Under-Screening of Young Adults:** Despite guidelines lowering the screening age to 45, many providers continue to default to age 50—overlooking patients ages 45-49. In addition, providers often miss guideline recommendations for younger individuals under 45 who are symptomatic or at increased risk.

- **Delays in Diagnosis:** A key issue leading to delays in colorectal cancer diagnosis is the presence of screening barriers—such as limited access to primary care, endoscopic screening, lack of awareness, and socioeconomic challenges—that prevent timely detection.

2026–2028 STRATEGIC PRIORITIES

1. **Advance Risk-Based and Age-Appropriate Screening:**
    a. Increase public awareness and provider adoption of age-45 screening guidelines.
    b. Expand risk-stratified tools to identify younger symptomatic and hereditary-risk patients.
2. **Policy Implementation & Equity:**
    a. Monitor and enforce ACA compliance for follow-up colonoscopies at the state and federal level
    b. Advocate for HEDIS measures capturing completion of full screening pathways.
    c. Continuing to advocate for the needs and value of the United States Preventive Task Force and demonstrated scientific rigor in representation.
3. **Innovate in Non-Invasive Modalities:**
    a. Support NCI's Cancer Screening Research Network and MCED testing to advance blood-based testing science.
    b. Fund development of oral microbiome and blood-based early detection tools.
4. **Close Screening Gaps:**
    a. Provide targeted outreach and navigation to FQHCs, Medicaid populations, and rural clinics.
    b. Collaborate with state programs and ARPA-H for MCED accessibility pilots.

KEY METRICS AND TRACKING:

- Achieve an 80% screening rate for average-risk patients.[15]
- Ensure 80% of patients with an abnormal non-invasive screening test receive a follow-up colonoscopy within 90 days (3 months).[15]

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U.S. SCREENING RATES BY RACE, INCOME & GEOGRAPHY

WHAT TO SHOW	HOW TO BUILD IT	SOURCE(S)
A. State-by-state FIT/colonoscopy uptake (adults 45-75)	Choropleth map (Datawrapper, Tableau, or ArcGIS) using 2022 BRFSS variable _CRCREC2 (up-to-date screening)	STATE CANCER PROFILESCDC
B. Racial/ethnic gap	Clustered bars (White, Black, Hispanic, Asian/PI, AI/AN) with national medians for context	STATE CANCER PROFILES
C. Income gradient	Slope-chart: <$25 k → ≥$75 k income categories vs. screening %	CDC

POLICY TIMELINE 2010-2025

Mar 23, 2010
ACA SIGNED
Preventative services with USPSTF A/B ratings must be covered by most new plans with no cost-sharing.
Effective for plan years starting ≥ Sept 23, 2010

Feb 20, 2013
FEDERAL CLARIFICATION
Polpy removal and related anesthesia during a scrrening colonoscopy are considered integral to the preventative service → no cost-sharing in private plans

May 18, 2021
USPSTF LOWERS SCREENING AGE TO 45
CRC screening recommended for average-risk adults between the ages of 45-75 (B grade).

Plan years ≥ May 31, 2022
AGE-45 COVERAGE TAKES EFFECT
Private plans must implement the new USPSTF benefit at the next plan year.

Jan 10, 2022
FOLLOW-UP COLONOSCOPY GUIDANCE (COMMERCIAL)
After a positive stool-based or direct visualization test, the follow-up colonoscopy. is part of the screening and must ve covered with no cost-sharing
Applies to ACA-compliant/commercial plans.

Jan 1, 2023
MEDICARE UPDATES
1) Medicare lowers screening age to 45 for certain CRC tests.
2) Medicare defines follow-up colonoscopy after a positive stool test as part of a complete CRC screening (i.e. preventative).

2022-2030
MEDICARE COINSURANCE PHASE-OUT:
When a screening colonoscopy includes additional procedures (e.g. polyectomy), beneficiary coinsurance phases down: 20% (2022) → 15% (2023-2026) → 10% (2027-2029) → 0% (2030+).

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FOLLOW-UP COLONOSCOPY COST-SHARING BEFORE VS. AFTER ACA ENFORCEMENT

COST-SHARING BEFORE *(what patients were seeing)*	COST-SHARING AFTER *(today's protections)*
PRIVATE PLANS pre-2013 and pre-2022 ■ **Screening colonoscopy could trigger surprise bills if a polyp was removed or if the test was a follow-up to a positive t-home test.** *HMP Global Learning Network*	**PRIVATE PLANS** ACA-compliant ■ **Polyp removal and anesthesia during a screening colonoscopy = no cost-sharing (clarified Feb 2013).** *acgdn.gi.org* ■ **Follow-up colonoscopy after a positive stool/direct-visualization test = no cost-sharing (guidance Jan 10, 2022; effective plan years ≥ May 31, 2022).** *Centers for Medicare & Medicaid Services*
MEDICARE pre-2022 ■ **Screening colonoscopies that required additional procedures were often reclassified as diagnostic → coinsurance applied (typically 20%). Follow-up colonoscopy after a positive stool test was not treated as preventative.** *Centers for Medicare & Medicaid Services*	**MEDICARE** since 2023 ■ **Follow-up colonoscopy after a positive stool test is now part of preventative screening (no cost-sharing for the screening continuum).** *Centers for Medicare & Medicaid Services* ■ **If additional procedures are done during a screening colonoscopy, coinsurance is phasing down: 15% (2023-2026) → 10% (2027-2029) → 0% (2030+).** *Centers for Medicare & Medicaid Services* **NOTE:** Grandfathered plans and some exceptions may apply; patients should confirm benefits with their insurer.

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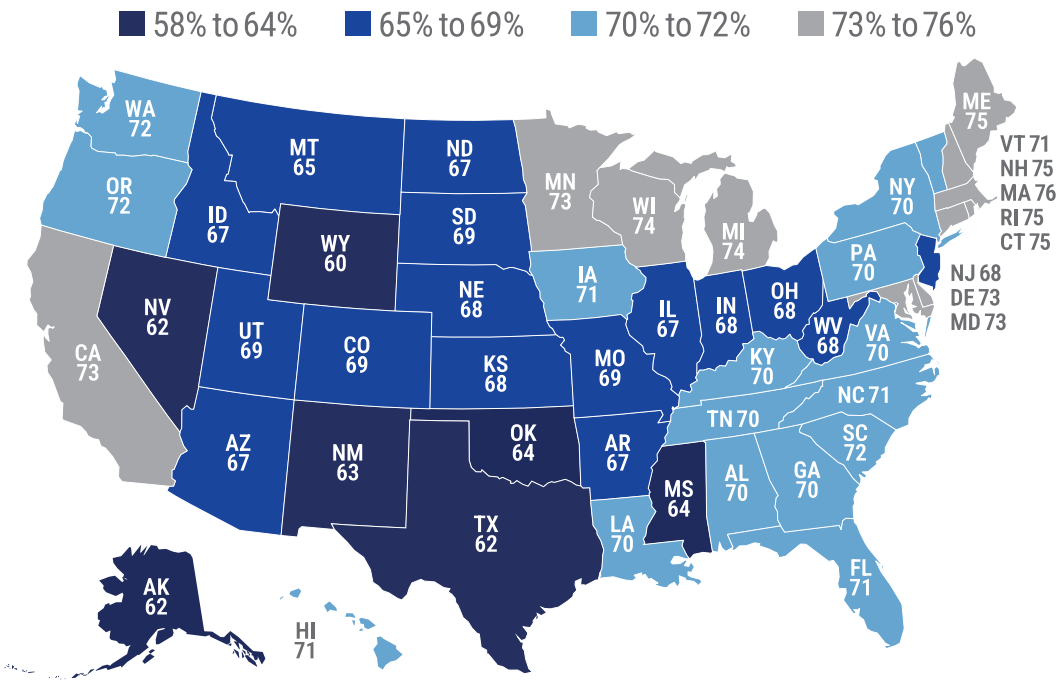
COLORECTAL CANCER SCREENING TEST USE*

(%) adults 50 and older by state 2018.

*Blood stool test, sigmoidoscopy, or colonoscopy, in the past 1, 5, and 10 years, respectively.
Note: Estimates are age-adjusted to the 2000 U.S. standard population and do not distinguish between examinations for screening and diagnosis.
Source: American Cancer Society. Colorectal Cancer Facts & Figures 2020–2022. Atlanta: American Cancer Society; 2020.



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CRC SCREENING GUIDELINE COMPARISON

COUNTRY	START AGE / FREQUENCY	TEST OF CHOICE	SOURCE
U.S.	45 yrs – 75 yrs, FIT q1y / colonoscopy q10y	USPSTF	USPSTF
Canada	50-74, FIT q2y	Canadian Task Force	Government of Canada
U.K.	54-74 (rolling to 50 by 2025), FIT q2y	NHS BCSP	nhs.ukvillamedicalcentrewirral.nhs.uk
Australia	45-74, FIT q2y (NB: 45-49 on request since 1 Jul 2024)	National BCSP	Health.gov.auHealth.gov.au
Japan	40+ yrs, FIT q1y (colonoscopy follow-up)	MHLW guideline	Oxford Academic

CALL TO ACTION

Prevention must be precision-based, policy-backed, and patient-centered. To truly close the gaps, health systems must move beyond guidelines to measurable, enforced implementation. Policymakers must guarantee access, while researchers must advance non-invasive tools to catch CRC earlier—and in more people.

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Section IV: Treatment

Progress Indicators:

1. Advancing precision therapies for colorectal cancer.
2. Addressing systemic barriers to improve outcomes for all colorectal cancer patients.

WHY IT MATTERS

Colorectal cancer (CRC) treatment is evolving, with immunotherapy, organ-preservation techniques, and biomarker-driven strategies offering hope for durable control of both localized and advanced CRC. Opportunities for continued improvement and advancement remain.

- Most CRC cases are microsatellite stable (MSS), a subtype largely resistant to current immunotherapies.
- Early-age onset (EAO) CRC patients and underserved populations face barriers to cutting-edge care, despite no major biological differences in CRC between those younger and older than 50.
- Rectal cancer—associated with higher recurrence risk, distinct anatomy, and poorer prognosis—often requires different treatment from colon cancer. **It is now more commonly diagnosed than colon cancer in younger populations, especially those under 40.**
- Budget and workforce disruptions at the National Cancer Institute (NCI) and other federal agencies now threaten the progress made in CRC research and innovation.

RECENT PROGRESS (2021–2025)

Checkpoint Inhibitor Successes

- **Localized MSI-H/dMMR rectal cancer:** The NCT04165772 trial (Memorial Sloan Kettering) demonstrated that PD-1 blockade with dostarlimab achieved a 100% complete clinical response in patients with mismatch repair-deficient (dMMR) locally advanced rectal cancer, eliminating the need for chemotherapy, radiation, or surgery.[4]

- **Localized MSI-H/dMMR colon cancer:** PD-1 blockade alone or with anti-CTLA4 blockade has been associated with complete clinical and/or pathologic responses in ~2/3 patients.[21-23]
  Unresectable MSS metastatic CRC: Immunotherapy combinations such as botensilimab plus balstilimab showed disease control (response or stable disease) in about 61% of heavily pretreated patients in the phase I trial—notably, results were particularly favorable among those without active liver metastases—expanding hope for this historically resistant population.[24]

- **Unresectable MSI-H/dMMR metastatic CRC:** cite CHECKMATE 8HW showing nivo+ipi as new SOC and FDA approved.

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Organ Preservation Strategies

The OPERA trial demonstrated that adding contact X-ray brachytherapy to standard chemoradiotherapy significantly improved organ preservation in early rectal adenocarcinoma, reducing the need for life-altering surgery without compromising patient outcomes.

Targeted Therapies by Biomarker

- The BREAKWATER study reported a median overall survival of 30.3 months for patients with BRAF V600E-mutant metastatic CRC treated with encorafenib (Braftovi), cetuximab (Erbitux), and chemotherapy.[25] This regimen became FDA-approved in May 2025 as a frontline therapy for this subpopulation of patients.

- Emerging KRAS G12C inhibitors such as adagrasib and sotorasib are now FDA approved for patients with a KRAS G12C mutation (roughly 4% of the patients diagnosed with metastatic colorectal cancer).

Circulating Tumor DNA (ctDNA) Utilization

ctDNA is now being used in trials to tailor adjuvant chemotherapy in stage II/III disease, reduce overtreatment, and detect minimal residual disease (MRD), identifiable as a blood-based biomarker for inevitable CRC recurrence earlier than imaging.

KEY BARRIERS

- **Federal Funding Cuts:** The NCI faces an 11% budget cut in FY2025, disrupting trials and research momentum.[26]

- **Workforce Disruptions:** Layoffs at NCI and related agencies reduce capacity to support CRC clinical innovation.

- **Rural Urban Divide:** Lack of access to cutting edge treatment and clinical trials for rural regions.

- **Access Disparities:** Biomarker testing and clinical trial participation remain lowest in minority, rural, and low-income populations.

- **Implementation Gaps:** Despite guidelines, many patients do not receive full molecular profiling due to lack of EMR prompts or insurance coverage. With promising therapies moving to the frontline setting for patients with previously untreated metastatic CRC, identification of actionable biomarkers at the time of stage IV diagnosis is becoming increasingly more important.

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2026-2028 STRATEGIC PRIORITIES

1. Restore and grow federal funding for CRC research, especially MSS-focused trials.
2. Institutionalize biomarker testing as standard of care with reimbursement protections.
3. Expand ctDNA and MRD platforms to personalize treatment across all stages.
4. Incentivize EAO and underserved population enrollment in clinical trials.
5. Develop policy mechanisms to protect the CRC research workforce.

TABLE 1: CLINICAL TRIAL RESPONSE BY BIOMARKER TYPE

BIOMARKER	THERAPY	OUTCOME (RESPONSE/SURVIVAL)	TRIAL/STUDY NAME
MSI-H/dMMR	Dostarlimab (PD-1 blockade)	100% cCR; organ preservation	NCT04165772
MSS	Botensilimab + Balstilimab	61% tumor shrinkage or stability	NEST-1
BRAF V600E	Braftovi + Erbitux + chemo	Median OS: 30.3 months	BREAKWATER
KRAS G12C	Adagrasib Sotorasib(in trials)	Ongoing	KRYSTAL-10, CODEBREAK
NTRK fusions	Larotrectinib	Durable response in solid tumors	NAVIGATE
RET fusions	Selpercatinib	Approved in multiple tumor types	LIBRETTO-001
HER2	Trastuzumab + Tucatinib	Recently FDA Approved	MOUNTAINEER CRC

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TABLE 2: KEY MILESTONES IN PRECISION CRC TREATMENT, 2020–2025

YEAR	MILESTONE
2020	FDA approvals of larotrectinib and selpercatinib in solid tumors
2021	CAP/ASCO guidelines updated: universal MSI/MMR testing recommended
2022	ctDNA escalated to guide adjuvant chemo decisions in stage II CRC
2023	Launch of Cancer Grand Challenges PROSPECT project
2023	NCCN guideline updates: HER2 testing included in metastatic CRC workup
2024	NCT04165772 trial: 100% cCR with dostarlimab in dMMR rectal cancer
2024	OPERA trial shows improved organ preservation with contact X-ray therapy
2025	BREAKWATER study: OS milestone for BRAF-mutant mCRC with triplet therapy

KEY METRICS AND TRACKING:

Ensure 80% of patients initiate treatment within six weeks of a CRC diagnosis.[15]

CALL TO ACTION

The promise of precision oncology in colorectal cancer is real, but fragile. Without decisive investment, equitable access, and policy follow-through, many patients will be left behind. We must ensure that breakthroughs in tumor biology translate into outcomes for all.

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Section V: Survivorship & Recurrence

Progress Indicator: Enhancing physical and mental health, surveillance, and recurrence prevention strategies for CRC survivors.

WHY IT MATTERS

More than 1.5 million people in the U.S. are living after a colorectal cancer (CRC) diagnosis. For many, surviving cancer marks only the start of a lifelong journey. Survivors often face challenges that extend far beyond monitoring for recurrence—such as chronic bowel dysfunction, fatigue, depression, fear of recurrence, and employment discrimination. Early-age onset (EAO) survivors often carry these burdens into the prime of their working and parenting years. Across all ages, one of the greatest issues in survivorship is the bridging of care from oncology to primary care, which includes ensuring clear communication and proper tracking of health records. Fight CRC recognizes survivorship as a continuation of care, not an afterthought, and is working to close gaps that affect quality of life, access, and equity.

RECENT PROGRESS (2021–2025)

Precision Monitoring and Recurrence Detection

- ctDNA Integration: Multiple trials (e.g., CIRCULATE, COBRA) validated the use of ctDNA as a predictor of recurrence, outperforming imaging in many stage II/III patients.[27]
- Minimal Residual Disease (MRD): FDA-approved MRD testing platforms are guiding treatment decisions post-surgery, enabling risk-adapted surveillance and reducing unnecessary chemotherapy.

Survivorship Care Advancements

- **Commission on Cancer (CoC) Survivorship Guidelines Updates (2025):** More continuous survivorship services; targeted reporting requirements; clearer non-duplication of documentation.[28]
- **National Comprehensive Cancer Network (NCCN):** Stronger emphasis on multidisciplinary support teams and promotion of healthy lifestyle behaviors.[29-31]
- **ASCO Survivorship Guidelines (2023–2024):** Expanded recommendations emphasize integrated symptom management, mental health, and long-term physical care.[32-33]
- **Navigation and Telehealth Models:** Programs piloted at NCI-designated centers, with Fight CRC involvement, show virtual survivorship navigation can improve adherence and reduce anxiety.

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Addressing Quality of Life and Equity

- **Patient-Reported Outcomes (PROs):** Standardized PROs including fatigue, bowel and sexual function, and mental health status are increasingly used to guide care decisions.
- **Mental Health Inclusion:** Distress screening is required by American College of Surgeons Commission on Cancer.
- **Fight CRC Advocacy:** Focused on Medicare coverage for MRD, survivorship benefit standards, and equity in post-treatment care across underserved populations.

Stronger Partnerships and Collaborative Networks:
The **Office of Cancer Survivorship (OCS**) at National Cancer Institute (NCI), founded in 1996, leads research and policy efforts to improve both the quality and length of life for cancer survivors. It funds survivorship science, advances care models, and recently launched **National Standards for Cancer Survivorship Care**, with priorities in primary care integration, underserved populations, and long-term survivorship with a stronger push in 2025 for integration.

The **Cancer Survivorship & Supportive Care Professionals Network (CSPN)**, established in 2014, is a national peer network for providers across 40+ states. It offers education, expert forums, and a new online platform (2025) to share resources and support collaboration.[34] The network sustains its work through donations and optional memberships, with the goal of strengthening survivorship care nationwide.

KEY BARRIERS

- **Insurance Limitations:** Many MRD and navigation services are still not reimbursed, disproportionately impacting rural, uninsured, and Medicaid-covered patients.[35]
- **Inconsistent Surveillance & Support:** Survivorship care varies widely based on location and provider, especially for EAO CRC survivors.
- **Data Deficits:** Long-term tracking of psychosocial outcomes and recurrence patterns is not uniformly collected or reported.

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2026–2028 STRATEGIC PRIORITIES

1. Secure universal coverage for MRD testing, ctDNA surveillance, and navigation support.
2. Standardize survivorship care plans (SCP)—including mental health screening—across NCCN and CoC-accredited sites. If SCPs are not possible, foster or promote connection with primary care to include health maintenance priorities such as cholesterol, vaccines and recommended cancer screening.
3. Encourage stronger education and capacity building efforts in primary care to help support colorectal cancer survivors.
4. Scale digital navigation and tele-survivorship programs through public-private partnerships.
5. Fund multi-site research into quality of life by age, race, gender, and geographic region.
6. Expand the definition of survivorship to include social and economic reintegration.
7. Share the survivor voice to highlight the importance of family history, need for screening, advocate for treatment options, and support long-term side effect management.

TABLE 3: PRECISION TOOLS IN CRC RECURRENCE MONITORING

TOOL/PLATFORM	PURPOSE	CLINICAL IMPACT	STATUS
ctDNA (Signatera, Guardant Reveal)	Detect MRD, assess recurrence risk	Improves early recurrence detection	Validated in trials (CIRCULATE, COBRA)
MRD Testing	Guide adjuvant chemo decisions	Supports treatment de-escalation or intensification	FDA approved for specific settings
PRO Dashboards	Track physical and emotional symptoms	Enhances engagement, triggers intervention	In pilot use

PATH TO A CURE

TABLE 4: COMMON CRC SURVIVORSHIP CHALLENGES AND SOLUTIONS

CHALLENGE	INTERVENTION / TOOL	ADOPTION STATUS
Bowel dysfunction	Pelvic floor therapy, low-residue diet	Limited to tertiary care centers
Diet and exercise	Established guidelines and recommendations during treatment, surgery, and ongoing lifestyle integration	Recommended by American Cancer Society and National Cancer Institute
Ostomy and Surgical Care	Education, psychosocial support, supply access, and coordinated clinical follow-up	Varied but recommended by ASCO and NCCN
Care Coordination	Shared care models between primary care, oncology, and specialty providers for survivorship care planning	NCCN and CoC recommended
Fatigue / cognitive burden	Lifestyle counseling, exercise plans	ASCO-recommended, underused
Fear of recurrence / anxiety	Mental health screening + counseling	Included in recent NCCN updates
Surveillance	Cancer screening for second primaries	Recommended by all major professional guideline groups
Sexual dysfunction	Specialized rehab / hormonal support	Often unaddressed and lacking standardization, but identified as a need by ASCO, NCCN and CoC
Employment hardship	Legal aid, social work navigation	Fight CRC advocacy priority and National Coalition for Cancer Survivorship (NCCS)

KEY METRICS AND TRACKING:

Ensure 80% of patients initiate treatment within six weeks of a CRC diagnosis.[15]

PATH TO A CURE

CALL TO ACTION

Survivorship is the final stage of precision care—and one of the most neglected. CRC survivors deserve whole-person care that addresses not only recurrence risk but also bowel health, body image, family life, and economic stability. With stronger data, equitable reimbursement, and a broader definition of success, we can improve the lives of survivors and reduce preventable suffering.

COLLECTIVE ACTION & VISION FORWARD

The evidence assembled in Path to a Cure 2026 confirms that breakthroughs are possible when science, policy, and patient experience align. Fight CRC commits to driving this alignment through three overarching priorities:

1. **Champion Patient-Defined Research Priorities**
   - Expand the Early-Age Onset Think Tank into a recurring global consortium.
   - Advocate for dedicated NIH and DoD funding streams focused on MSS biology, survivorship quality-of-life science, and health-equity implementation studies.
2. **Translate Discovery into Equitable Care**
   - Push for universal biomarker and ctDNA coverage across public and private payers by 2027.
   - Partner with NCCRT, ACS, and federal agencies to reach the next screening milestone—"90% by 2030"—with special emphasis on rural, Black, Latino, and Medicaid populations.
3. **Elevate Survivorship as a Standard of Excellence**
   - Embed mental-health screening, PRO dashboards, and MRD testing into NCCN and CoC survivorship standards.
   - Launch a Fight CRC Survivorship Innovation Lab to pilot virtual navigation, employment support, and symptom-tracking tools.

PATH TO A CURE

KEY METRICS WE WILL TRACK

DOMAIN	2026 BASELINE	2028 TARGET
Universal MSI/MMR testing	78% of new CRC cases	≥ 95%
ctDNA/MRD coverage (commercial)	30% of eligible plans	≥ 80%
Screening uptake ages 45–49	27%	50%
Trial accrual of racial/ethnic minorities	12%	20%
Survivorship care plans delivered	45% of stage I–III survivors	75%

CALL TO COLLABORATION

We invite researchers to co-design studies with our advocate network; industry partners to align access programs with equity goals; and policymakers to sustain robust funding for CRC science. Together, we can turn precision breakthroughs into population-level cures.

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