

APPENDIX 2: INTERNATIONAL RECOMMENDATIONS ON CRC SCREENING

A number of overseas organisations have published positions or policies on screening for CRC, summarised below. The first five reports were published after the December 1996 publication of results from the Nottingham and Funen RCTs.

Reports published 1997 and later

The Cochrane Collaboration

A systematic review of the effects of screening for CRC using FOBTs. The findings were that: 'Although benefits of screening are likely to outweigh harms for populations at high risk of colorectal cancer, more information is needed about the harmful effects of screening, the community's responses to screening, and costs of screening for different healthcare systems before widespread screening can be recommended.'¹

National Cancer Institute

The Institute found evidence to support the following:

- Screening with guaiac-based FOBTs, either annually or biennially, in people aged 50 to 80 decreases mortality from CRC.
- Regular screening by sigmoidoscopy in people over 50 years may decrease mortality from CRC; however, there is insufficient evidence to determine the optimal interval for such screening.²

American Gastroenterological Association

Endorsed by American Cancer Society, American College of Gastroenterology, American Gastroenterological Association, American Society of Colon and Rectal Surgeons, American Society of Gastrointestinal Endoscopy, Crohn's and Colitis Foundation of America, Oncology Nursing Society and the Society of American Gastrointestinal Endoscopic Surgeons. Recommendations for people at average risk for CRC (asymptomatic, age 50 years, no other risk factors):

- Screening: offer FOBT screening each year.
- Diagnostic work-up of positive FOBT: average-risk people with a positive test with any sample should have an examination of the entire colon and rectum by colonoscopy. An alternative is DCBE, preferably with flexible sigmoidoscopy.

Recommendations were also made about screening average-risk people with flexible sigmoidoscopy, DCBE and colonoscopy.³

Agency for Health Care Policy and Research

An evidence-based review of approximately 3,500 citations, published between 1966 and 1994, on screening for CRC and adenomatous polyps in asymptomatic persons at average risk for CRC, subsequent follow-up procedures in those with positive screening tests, and surveillance of those with CRC. The review identified a number of areas that require further research, including:

- the optimal screening intervals for the currently available screening tools
- the effect of CRC screening and subsequent diagnostic evaluation on patient quality of life
- the effectiveness of screening flexible sigmoidoscopy, colonoscopy and barium enema, ideally with RCTs.⁴

Australian Health Technology Advisory Committee

- On the basis of published evidence, and subject to favourable preliminary testing, it was recommended that Australia develop a programme for the introduction of population screening for CRC by FOBT for the average-risk population (well population aged over 50).
- Given the uncertainties relating to the most effective means of implementing such a programme and to the feasibility, acceptability and cost-effectiveness of such a programme in the Australian setting, the screening programme should commence with preliminary testing involving a number of pilot and feasibility studies.⁵

Reports published up until the end of 1996

World Health Organization

Guidelines from the WHO Collaborating Centre for the Prevention of Colorectal Cancer on the primary prevention of CRC, the screening of average-risk individuals, the screening of relatives of patients with CRC, and the surveillance of patients with colorectal polyps and ulcerative colitis. WHO found that there were strong data to support the effectiveness of screening of average-risk individuals with FOBT and sigmoidoscopy, and colonoscopic polypectomy for patients with polyps.⁶

US Preventive Services Task Force

Screening was recommended for those 50 years and older with either annual FOBT or sigmoidoscopy, or both; however, insufficient evidence was found to determine which screening modality is preferable or whether the combination of FOBT and sigmoidoscopy produces greater benefits than does either test alone.⁷

American College of Physicians

The ACP recommended offering a variety of screening options to people aged 50 to 70, depending on local resources or patient preferences:

- Screening was recommended with flexible sigmoidoscopy, colonoscopy and air-contrast barium enemas, repeated at 10-year intervals.
- Annual FOBT should be offered to persons who decline the screening tests mentioned above.
- Screening should start at age 50 and conclude at 70 years.⁸

US Office of Technology Assessment

A cost-effectiveness study of screening for CRC. Screening in average-risk individuals beginning at the age of 50 was found to be a 'relatively good investment for society'. The choice of screening strategies was not clear, however: strategies that involved either flexible sigmoidoscopy or DCBE (but not both) appeared to be comparable and were also more cost-effective than other screening modalities.⁹

Canadian Task Force on Periodic Health Examination

The CTF found 'insufficient evidence to support the inclusion or exclusion of faecal occult blood, sigmoidoscopic or colonoscopic screening of asymptomatic individuals over the age of 40.' It recommended that 'efforts directed at identification of different risk groups and development of different strategies for these groups may be appropriate.'¹⁰

European Group for Colorectal Cancer Screening

It was found that mortality from CRC could be reduced in people screened using guaiac-based FOBT or sigmoidoscopy. Ongoing trials in Britain, Denmark, Sweden and France would indicate the extent of mortality reduction that can be achieved with FOBT population screening.¹¹

Italian National Committee for Colorectal Cancer Prevention

The NCCCP concluded that there was no convincing evidence to support population screening; instead, it recommended a centrally coordinated intervention programme to evaluate the clinical effectiveness of various screening modalities, whether screening was cost-effective, and the impact of screening upon the Italian health system.¹²

Royal Australian College of General Practitioners

For average-risk people, the best option was uncertain. FOBT should not be used for investigation of rectal bleeding, and was not currently recommended for screening in Australia.¹³

Gastroenterology Society of Australia, Australian Gastroenterology Institute & Australian Cancer Society

Endorsed by the Australian Cancer Network. Recommendations included the following:

- Funding should be made available for high-quality exploration of the implications and mechanisms of introduction of screening for CRC in Australia.
- Routine screening for people aged 50 years or over who have no symptoms and no special risk factors is not recommended.¹⁴

Colorectal Surgical Society of Australia & The Gut Foundation

A guide for medical practitioners on the prevention, diagnosis and treatment of CRC. Findings included:

- Although selective screening of high-risk groups of patients was feasible and should reduce mortality and morbidity from CRC, screening the entire population by colonoscopy was not practical.
- Colonoscopy was seen as the procedure of choice for detecting adenomatous polyps proximal to the splenic flexure.
- As up to 50 percent of adenomatous polyps occur beyond the reach of the flexible sigmoidoscope, it was recommended that the discovery of any polyps in the left colon should be followed by complete colonoscopy.
- Average-risk individuals should be screened by FOBT annually from 40 years of age.
- All positive tests need investigation, preferably with colonoscopy.
- GPs should consider screening with flexible sigmoidoscopy beginning at 50 years of age, repeating every three to five years in conjunction with annual FOBT.¹⁵

References

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