



Opportunistic Screening for Bowel Cancer in Advance of an Organised Screening Programme

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Background

- Meta analysis of randomised clinical trials
 - 16% mortality reduction from bowel cancer
 - Low complication rates from diagnosis and treatment
- Many OECD (including UK and Australia) countries have commenced national screening or pilot programmes
- Implementation of screening for bowel cancer has been under consideration in New Zealand for a number years
- Bowel cancer screening pilot study recently announced (4 year programme commencing by December 2011)

Background

- Sporadic opportunistic testing for average risk people occurs throughout New Zealand (faecal occult blood testing or colonoscopy) but there is NO national data on patterns of practice
- Variable access to colonoscopy throughout New Zealand
- NZGG guidelines Surveillance and management of people at increased risk of colorectal cancer
- Variable practice with implementation of this guideline resulting in inconsistent practice throughout NZ
- Lower thresholds for access to private services
- Significant inequities particularly for Maori and Pacific Islanders

Opportunistic Screening

Opportunistic Screening is that which is not conducted as part of an organised programme of targeted population based screening.

The purpose of this indicator is to highlight the importance of only offering evidence based screening to specific individuals with a higher risk, e.g. familial polyposis risk for colon cancer.

(Aiming for Excellence RNZGP 2009)

**OPPORTUNISTIC SCREENING INCLUDES
UNORGANISED SCREENING PROGRAMMES**

Opportunistic Screening: The view points

	Patient	Primary Care Clinician	Population Health Clinician
Perspective	<ul style="list-style-type: none"> • Experience of self or loved one getting the disease. • Individual cost for private services 	<ul style="list-style-type: none"> • In daily contact with people affected. • Patient is of primary concern 	<ul style="list-style-type: none"> • Patient is whole population. • Efficient and cost effective use of resources
Interest	<ul style="list-style-type: none"> • Strong belief in screening due to popularity paradox. • Accept that side effects occur. 	<ul style="list-style-type: none"> • Strong belief in screening due to popularity paradox. • Accept that side effects occur. • Interested in benefit and harm for individual patient 	<ul style="list-style-type: none"> • Interested in balance of harm versus benefit for the whole population. • Wanting to protect the population from harm if no proof of benefits being greater than harms.
Concern about benefit versus harm	<ul style="list-style-type: none"> • Of no concern to an individual if others who have the test are harmed without any benefit. The fact that they may fall into this group is a risk they are willing to take. • They think that the benefits will outweigh the risks for them. 	<ul style="list-style-type: none"> • Belief that the benefits of screening will outweigh risks for the individual in front of them. • Belief in quality of the existing pathway of care. 	<ul style="list-style-type: none"> • Accepts that individual cases will vary and some will always benefit, but if overall harms outweigh benefits then those who benefit do so at the expense of others who experience harm.

The Popularity Paradox

People receive treatment for a problem that would never have developed if they had been left unscreened and do not realise the risk of over-diagnosis or over-treatment.

Everyone with screen-detected abnormality is offered intervention, and even if we know that say 40 have to be treated to prevent one serious outcome, we cannot know who the one is and who the 39 are. So any of those treated could have derived major benefit, and most tend to believe that they are the one.

The greater the over-diagnosis and over-treatment, the more people there are who believe they owe their health or even their life to the programme.

(Raffle and Gray 2007)

Risks of Unorganised Screening

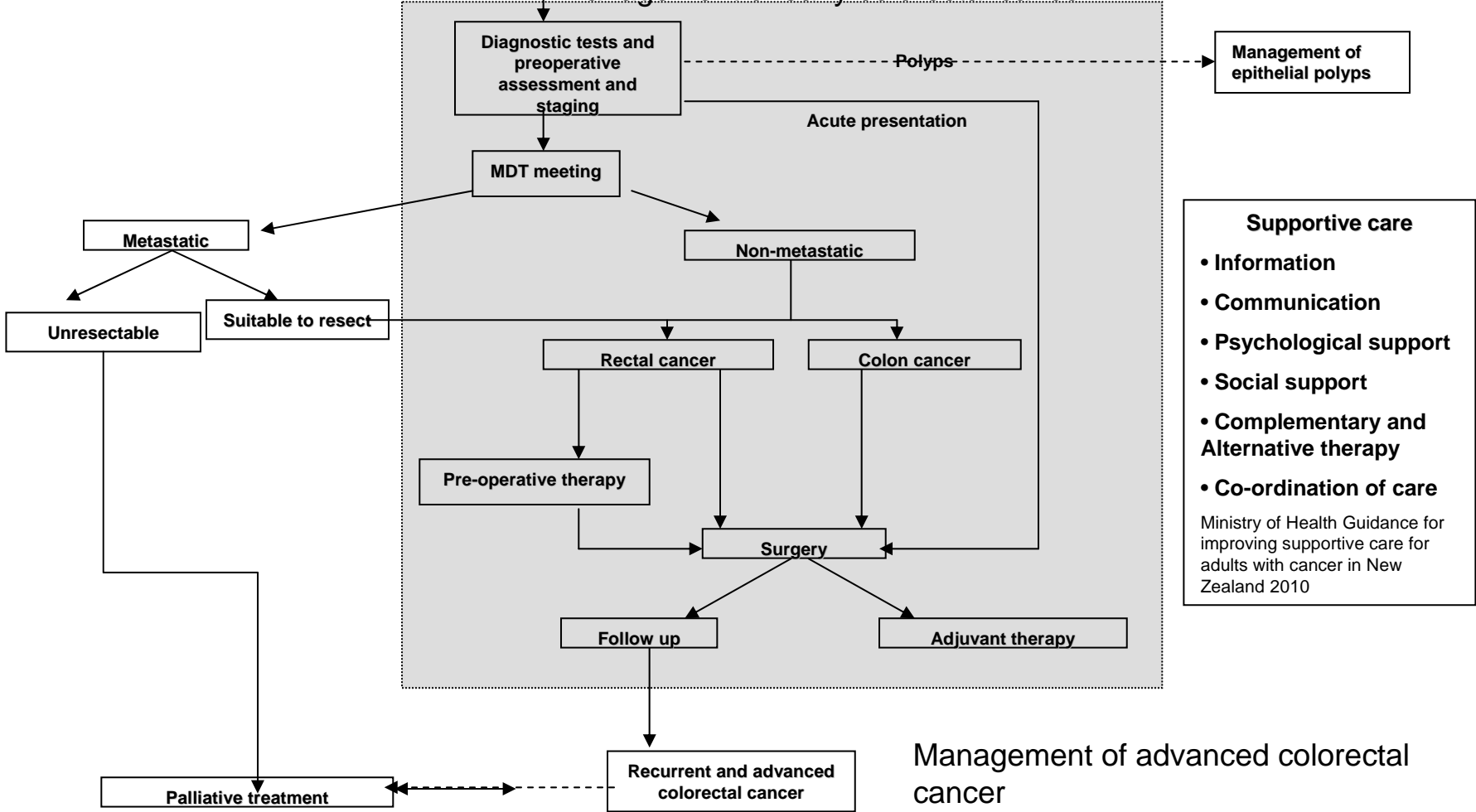
Problem	Result
Inequalities	Those at lowest risk of the disease may be more likely to be screened and those with the highest risk may be less likely to be screened. There may also be inequities at all steps of the screening programme from invitation, testing, and access to and quality of treatment. Inequities may not be measured so they may not be recognised and actions may not be taken to mitigate them.
No consistency of the screening pathway	Risk of under investigation and treatment. People with a true positive screening test may not receive timely or appropriate investigation or treatment. People falling through the gaps.
Lack of quality standards and training	Participants may be exposed to harmful practices such as investigation or treatment that of less than optimal quality. Variable quality standards in place.
Lack of consistent national guidance	Risk of over-diagnosis, over-investigation and over-follow-up because clinicians manage on the side of caution so that they do not miss a case.
Cost inefficiencies	Over screening, over investigation and over-treatment use resources which could be used elsewhere to gain greater health benefit.

Groups at high risk for colorectal cancer
 New Zealand Guidelines Group Surveillance and Management of Groups at Increased risk of colorectal cancer 2004

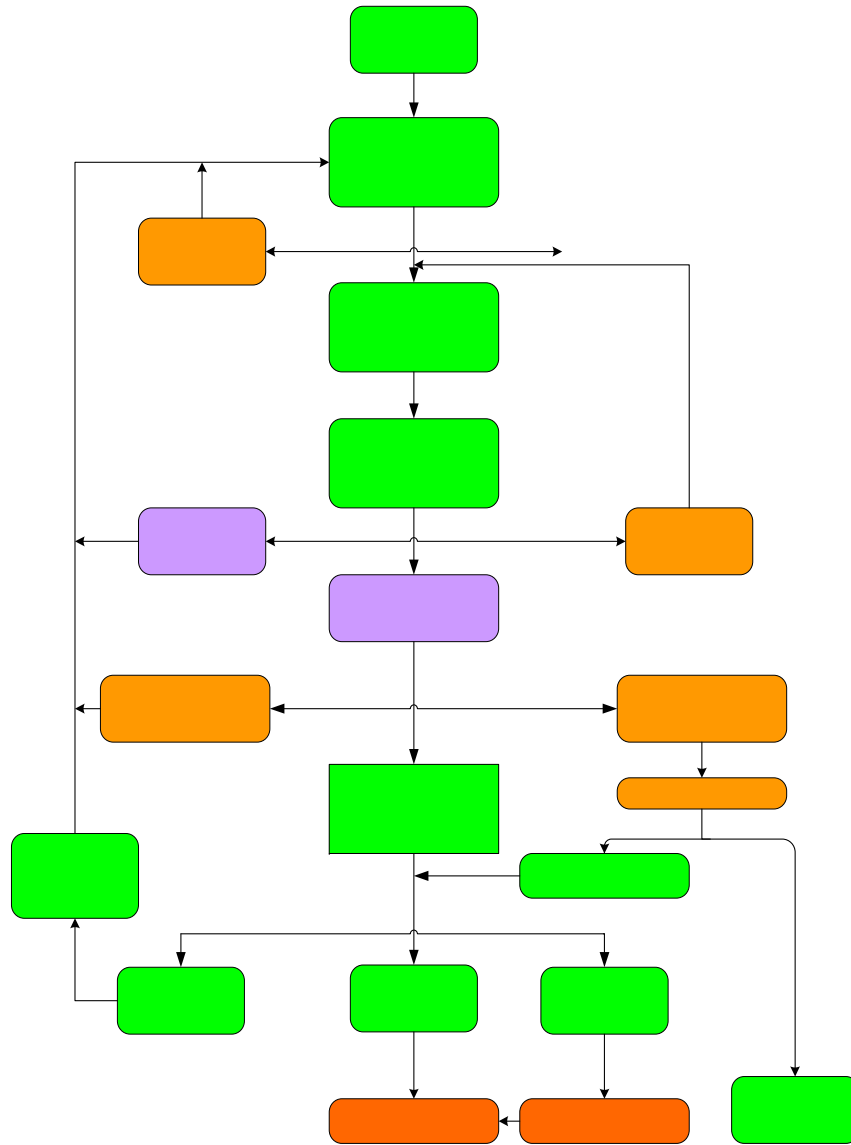
Population screening
 Ministry of Health bowel cancer screening pilot 2011-2015 (1%)

Patients presenting with symptoms
 New Zealand Guidelines Group Suspected Cancer in Primary Care 2009

Management of early colorectal cancer



Bowel Cancer Screening Pathway



Unorganised Screening

“A screening programme will cause net harm if it is not properly set up as a national programme with appropriate resources, and stringent quality control measures”

(Raffle and Gray 2007, p207).

Informed Consent

- Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including:
 - an explanation of his or her condition; and
 - an explanation of the options available, including an assessment of the expected risks, side effects, benefits, and costs of each option.

(HDC Code)

- Informed consent is relatively new to the screening world. Previously it was considered that everyone should be screened for their own good and informed consent was not seen as important

(Raffle and Gray 2007)



Informed Consent

- Informed consent is highly relevant to the current situation where good evidence exists for benefit over harm but quality of care and resources cannot be guaranteed.

Indicator Criteria for Opportunistic Screening

(Aiming for Excellence RNZGP 2009)

- Practice processes for opportunistic screening are evidence based
- Clinical team members can describe their role in providing opportunistic screening
- There is evidence of linking screening activity with interventions
- Clinical team members document discussing contentious screening tests with eligible patients in relation to harm versus benefit
- The practice annually reviews its opportunistic screening process

Improving Current Practice

- Improving awareness for early investigation and referral of people with bowel symptoms (Suspected Cancer in Primary care Guideline NZGG)
- Having a low threshold for investigating and referring people with symptoms who have a slightly above average risk
- Improving the consistency of access to surveillance of people who have high and moderate risk for bowel cancer (Surveillance and management of Groups at increased risk of colorectal cancer NZGG)
- Improving local pathways for these groups (Cancer Programme Improving Services for Bowel Cancer)
- Providing good information for those requesting faecal occult blood testing
- Circumspect about invitation for faecal occult blood testing

Questions and discussion

