Important changes to the bowel cancer screening programme

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Deborah Alsina MBE, Chief Executive of Bowel Cancer UK

Over 16,000 people die from bowel cancer each year in the UK – that's one person every 30 minutes. Yet bowel cancer is both treatable and curable if diagnosed early. In fact nearly everyone diagnosed at the earliest stage will survive, compared to less than one in 10 of those diagnosed at the latest stage.

We know the best way to achieve an early diagnosis for bowel cancer is through screening. The Bowel Cancer Screening Programme is aimed at those aged 60–74 (50 in Scotland). Eligible participants are sent a home testing kit in the post every two years. The test looks for the presence of blood in poo that can't normally be seen and doesn't show up on your toilet paper or toilet pan, which could indicate that there is a polyp (non–cancerous growth) or cancer in your bowel. The aim of the programme is to prevent bowel cancer and detect it early. One year survival figures for screening are 97%, compared to just 49% for those diagnosed as an emergency.

That's why we were pleased when in 2016 the UK National Screening Committee (UKNSC) recommended the introduction of the more accurate faecal immunochemical test (FIT) to replace the current guaiac faecal occult blood test (gFOBT) in the Bowel Cancer Screening Programme.

Over the years we have proactively engaged with the Bowel Cancer Screening Programme to campaign for this change. For example in 2015 we worked with the Independent Cancer Taskforce in England to ensure the adoption of FIT was included as a recommendation in the England Cancer Strategy, and we made a strong case for change in our response to the UKNSC consultation on whether the Programme should adopt FIT. Since then Scotland have changed the screening test used in the programme to FIT in November 2017, and England and Wales have agreed to do the same in 2018, but the situation in Northern Ireland remains unresolved due to the political situation. The charity is now an active member of the FIT Implementation Groups in all three of these nations.

What is FIT?

FIT works in a similar way to the current screening test by detecting tiny amounts of blood in poo that could indicate cancer or polyps, growths that can develop into cancer. However FIT measures blood in a different way from that used by gFOBT. FIT measures the level of blood in the poo sample whereas gFOBT only indicates the presence of blood. It also specifically measures human blood, which means it's not influenced by other blood in the diet. Because of this, it is more accurate.

FIT is now used around the world including in Italy, The Netherlands, France, Ireland, New Zealand, Australia, Spain, Slovenia, Malta, Japan, parts of Canada, and Southeast Asia.

Benefits of FIT vs gFOBT

The pilot studies conducted in England and Scotland found that FIT has many practical and clinical advantages over gFOBT including picking up more cancers and improving uptake.

Increased disease detection: The English pilot found that FIT picks up twice as many cancers and four times as many advanced adenomas (tumours). This is important because the more cancers we can pick up early, the more lives we can save. We know that cancers picked up through screening are more likely to be early stage cancers. The earlier bowel cancer is detected, the easier it is to treat and the greater chance of survival.

Higher uptake rates: FIT has been shown to increase the number of people participating in the bowel cancer screening programme, particularly for previous non–responders and first–timers, as well as hard to reach groups, such as ethnically diverse and deprived groups. It's anticipated that uptake will increase by around 10% and double in people who previously haven't responded. Currently only around half of those invited take part in the Bowel Cancer Screening Programme, meaning opportunities to detect cancer early are being lost.

Realising the benefits of FIT

If the full benefits of FIT are to be achieved then it is essential the test is brought in at a more sensitive level – meaning more people will receive a positive result and be referred for a colonoscopy. However a highly sensitive FIT will have significant impact on colonoscopy services, particularly as many endoscopy units are currently struggling to cope with an increasing demand for the service. Without additional investment in colonoscopy services the opportunity to detect more bowel cancers early and save lives will be lost and people will continue to die needlessly.

There needs to be a clear, timetabled and transparent programme of action to increase capacity at screening centres to ensure that sensitivity level can be increased over time.

Increasing demand

Demand for endoscopy tests has been increasing dramatically over the last few years – a trend that is set to continue. In fact, reports estimate that nearly a million more endoscopies in England alone will be needed year on year to meet this increasing demand. This is due to a number of factors, such as an ageing population, increase in symptom awareness and roll out of new screening programmes.

But despite the increasing demand for services, this hasn't been matched with investment to increase capacity to meet this.

Capacity for high risk groups

Lack of capacity is also impacting people who are at high risk of bowel cancer, such as those with certain genetic conditions like Lynch syndrome, which can increase risk of bowel cancer by up to 80%. People with Lynch syndrome should be placed in a surveillance programme to receive regular colonoscopy every 18 months to two years to help reduce their risk of bowel cancer. However those at high risk are often made to wait unacceptable lengths of time before being seen. Our research found that 49% of respondents to our survey on Lynch syndrome had experienced delays to their planned colonoscopy appointment, with 78% of these waiting more than six weeks beyond their planned procedure date. That's why we launched a petition calling for urgent improvements to the diagnosis and management of people with Lynch syndrome.

The case for investment is clear

Given the wide ranging impact that increasing demand and a lack of capacity is having on ability to provide services for bowel cancer, the case for urgent investment is clear. Investing in services that can diagnose bowel cancer is critical to ensuring units have sufficient workforce and infrastructure to carry out endoscopy and that all units are working as efficiently as possible. We need to do more than just papering over the cracks. We need to ensure diagnostic services for bowel cancer are fit for the challenges of the 21st century.

We've been raising this issue with key decision–makers for many years, published two reports highlighting the challenges and solutions and launched the right test, right time campaign. As part of this campaign we've been calling for a national endoscopy strategy and a training programme as a solution to the mounting pressure on endoscopy units. We hope to work with Government, the NHS and clinicians to ensure a sustainable endoscopy service that has the capacity to meet future demand.

Useful information

England will be rolling out FIT in 2018 and Wales in 2019. Northern Ireland is still yet to approve the new test. No matter which bowel screening test you receive in the post, completing and returning it could save your life.

Find out more about screening at **bowelcanceruk.org.uk/screening**

For more information call the bowel screening helpline for your country:

England: **0800 707 6060**
Scotland: **0800 0121 833**
Wales: **0800 294 3370**
Northern Ireland: **0800 015 2514**

What else is Bowel Cancer UK doing?

Last year, we launched our five year research strategy 'Unlocking the Key to the Cures'. Following extensive consultation with leading research experts, we've chosen four priority areas of focus for the next five years. One of them is 'to improve the prevention, early detection and treatment of bowel cancer.' We are determined to prevent as many bowel cancers as possible, diagnose earlier and improve treatment and care for all patients. We will specifically focus on:

1. Identifying ways of preventing bowel cancer.
2. Improving bowel cancer screening.
3. Understanding and identifying people at high risk of bowel cancer.
4. Understanding bowel cancer in the under 50s.
5. Ensuring best treatment and care for bowel cancer patients.

You can read more about our research strategy on Bowel Cancer UK's website

Another key part of our work is educating patients, the public and healthcare professionals about bowel cancer, in particular the importance of early diagnosis and screening. One of the ways we do this is through our health promotion volunteer programme, which has been recognised by the Royal Society of Public Health. Up and down the UK, hundreds of volunteers give talks to their local community about bowel cancer, raising awareness of the screening programme, how they can reduce their risk and the symptoms of the disease. Our expert team also runs study days and bespoke training events for public health and healthcare professionals.

How you can get involved

We are determined to save lives from bowel cancer but we can't do it without people like you.

- Sign up to our monthly e–newsletter.
- Share your story to help raise awareness and let others know they're not alone.
- Become a campaign supporter and take action to stop bowel cancer.
- Volunteer for us.
- Book a talk for your workplace or community group.

bowelcanceruk.org.uk

We would like to thank Deborah Alsina of Bowel Cancer UK for submitting this informative article. Obviously, regular screening for bowel cancer is vital for ostomates too, so we contacted Professor Richard Logan (Director of the Eastern Hub of the Bowel Cancer Screening Programme) to ask whether the FIT test was suitable for people with stomas. We encourage you to read his response (below) as it contains important information:

'...for people with a stoma anything that could produce a small amount of bleeding from the edges of the stoma or from the lining of the bowel just within the stoma will quite likely result in the FIT showing blood. As this would be fresh blood as opposed to blood that had arisen from further round the bowel it is quite likely to give a high FIT result. I would imagine that managing the stoma with irrigation could produce some bleeding. However we have no evidence yet as to what would happen in practice when a FIT is used. We do get reports on our Helpline from ostomates who say that they often see small amounts of bleeding from around the stoma.

My advice therefore to ostomates sent a screening test would be to firstly check whether it is appropriate for them to do the test. I don't know what proportion of ostomates have had their stoma created for cancer. For those who have had their stoma for cancer they should be being followed up by a surgical unit or hospital where it was done or where they now live. The current recommended follow up is a colonoscopy at 5 years and another at 10 years as well as at 1 year for those people who did not have a colonoscopy for the diagnosis of their cancer. If an ostomate has had a colonoscopy at these intervals and nothing serious found there is little to be gained by them completing a screening test whether it is the guaiac FOB test or the FIT when it is introduced.

For those who have had their stoma created for other conditions or who had a stoma created for cancer before the age of 50 then they should collect the samples much in the way that the excellent article you sent proposes. (Prof Logan is referring to our article on bowel cancer screening that appeared in the Spring 2013 edition of *Tidings*. You can download this edition free from our website. Alternatively please call the helpline and we will send you a copy of the article.)