Fifteen years of bowel cancer screening policy in Australia: putting evidence into practice?

Margo H Saunders and Anita Peerson

To the Editor: Flitcroft and colleagues' discussion of the National Bowel Cancer Screening Program provides a useful reminder of how political, institutional and financial issues can affect evidence-based policy.[1] Bowel cancer is second to prostate cancer as the biggest cause of cancer death in Australian men, and men are more likely than women to be diagnosed with bowel cancer. There are no indications, however, that the screening program has sought to engage men as a target group.

Men and women think about and act on their health in different ways and respond differently to messages, sources of information and modes of information delivery.[2] Men are less likely than women to undergo preventive screening and are more likely to seek treatment at a later stage in a disease. A report for the Australian Government noted that, before receiving the Bowel Cancer Screening Pilot Program material, men were less likely to have been aware of preventive or pre-emptive behaviours "unless their GP had actually raised the subject with them, or

a close friend had suffered, bringing the issue to a more personal level".[3] Further evidence indicated that fewer than one-third of men participated in the screening from mid 2006 to mid 2007, despite men aged 55 and 65 years being more likely than women to return positive results; among men aged 55 years, only 28% chose to participate.[4] Participation rates during the 2-year screening period ending August 2008 were estimated to be 39.2% for men and 46.7% for women.[5]

Despite the considerable evidence that the "doing of health" is a highly sex-dependent activity, a population-based, "one size fits all" approach appears to have been adopted. Adding further insult to injury, men were blamed for their lower participation rate and for failing to understand "that screening for cancer saves lives".[6] A disappointing response to a free breast cancer screening initiative, on the other hand, prompted an investigation into the relationship between the wording of the screening invitation letter and the level of screening attendance.[7]

With around one in 19 men predicted to develop bowel cancer before the age of 75 years, men's under-representation in bowel cancer screening is a serious problem. There is a need for more attention to be given to men's attitudes and beliefs about risk and prevention, with a view to developing specific approaches to increase men's participation in screening.[8]

It should not be too much to expect that Australia's first National Men's Health Policy, and an updated National Women's Health Policy, will result in sex being taken into account in the design and implementation of national health initiatives.

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1 Flitcroft KL, Salkeld GP, Gillespie JA, et al. Fifteen years of bowel cancer screening policy in Australia: putting evidence into practice? *Med J Aust* 2010; 193: 37-42.
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To the Editor: Flitcroft and colleagues' historical report of bowel cancer screening in Australia is helpful to those new to this internationally accepted life-saving practice.[1]

One inaccuracy needs correcting. Lung cancer is the leading cause of cancer *death* in Australia — not prostate or breast cancer. Flitcroft et al appear to have quoted the Australian Institute of Health and Welfare data for new diagnoses, not cancer deaths.[2] This error reflects the general lack of community focus or interest in the more than 7000 Australians who die each year from smoking-related lung cancer.[3]

An update is also warranted. Since submission of their article, once-only flexible sigmoidoscopy screening has joined faecal occult blood test (FOBT) screening in having randomised controlled trial evidence. Results of a recent British study point to the necessity of looking for this occult disease with flexible colorectal endoscopy.[4] The study showed a massive 43% reduction in colorectal cancer mortality and a 50% reduction in incidence of invasive rectal cancer, owing to early flexible sigmoidoscopic diagnosis of colonic polyposis followed by polypectomy performed at subsequent colonoscopy. These techniques save thousands of lives worldwide each year.

Flitcroft et al state that "A staged roll-out is a sensible approach", but many of us who perform colonoscopic polypectomies on a weekly basis strongly disagree. Which is better — to be on a waiting list for a colonoscopy with a positive FOBT result, or to be ignorant of the possibility of a growing cancer in the colon? It is time to give people the opportunity of FOBT with or without further investigations.

Flitcroft et al rightly point out that the National Health and Medical Research Council recommended that we should have at least biennial FOBT screening for individuals over 50 years of age.[5] Australians have been very tardy in terms of adopting this recommendation. We don't need an "age-specific cost-effectiveness analysis". The argument should be about introducing flexible sigmoidoscopy. Like Semmelweis and hand washing back in 1847, history will judge our current generation harshly for ignoring the original life-saving FOBT research that was published in 1993[6] and allowing thousands of Australians to die unnecessarily from bowel cancer since then.

It is time for us to take our heads out of the sand and introduce a proper national bowel cancer screening program. Thank you to Flitcroft and colleagues for helping us take another step in this direction.

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