

Colorectal Cancer-is it Avoidable?

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Editorial

Bowel cancer remains one of the commonest causes of cancer death in the western world [1]. The pathways for colorectal carcinogenesis via the classical polyp-cancer sequence and also through family cancer syndromes and other genetic and environmental influences are increasingly understood, such that appropriate intervention at a premalignant phase (adenomatous polyp) via endoscopic or surgical polypectomy can prevent colorectal cancer and the sequelae of the disease [2].

Screening trials (Fecal Occult Blood testing, Flexible Sigmoidoscopy) have been shown to lower mortality from colorectal cancer and have led to screening programmes being increasingly adopted across the world [3]. Ideally, a screening programme should pick up and intervene on a common condition before it reaches the point where carcinogenesis has occurred e.g. cervical screening and CIN.

Presently colorectal screening programmes are diagnosing cancer at an earlier stage and also picking up polyp and polyp cancers that can be removed endoscopically [4]. Most of the significant costs for colorectal cancer care are for oncology treatment, which after screening is often un-necessary, complex surgery which can be minimized via screening and of course it's associated burden of ITU and rehabilitation [5]. Whilst surgery will always be necessary its' use can be minimized if we are to somehow target our expenditure on screening patients at an appropriate age. This calls into question what age is appropriate as many programmes are being undertaken later in life when patients gain more comorbidity [6].

This might also lead to more elderly patients being turned down for intervention which they might have undergone earlier whilst they were fitter, thus shifting the stage of disease and further minimizing costs. It might be simpler to move the goalposts forward and thus screen at an earlier age however this would need more endoscopic resources. It is likely that Faecal Immunochemical Testing (FIT) will further increase the requirement for colonoscopy; however simple colonoscopic polypectomy will always be easier for patients than colorectal cancer resection. [7]

In symptomatic disease, we need to remove the stigma associated with seeking help from doctors and attending for investigation [8]. It is

commonplace that even healthcare staff will seek opinion outside their own institution due to embarrassment of meeting their colleagues with bowel symptoms, even though their organization provides good treatment. However, those same colleagues might have no issue undergoing dental treatment in the same organization as this is perceived as less embarrassing. Similarly, patients may not attend as they perceive that symptoms are due to benign diseases such as haemorrhoids; this could be looked at in the same light as patients not stopping smoking as they have no symptoms or only a cough though when educated regarding the risks of major quality of life risks such as amputation they may quit smoking due to the shock of this information [9].

In essence, colorectal cancer remains avoidable, largely through screening at the correct age and educating the public to attend for assessment when they have symptoms; stigma and fear of investigations needs to be eased and education on how screening can prevent need for more radical treatment in future would assist this.

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