Colorectal cancer screening in “closed communities”: A European experience

UNITED EUROPEAN GASTROENTEROLOGY FEDERATION

UNITED EUROPEAN GASTROENTEROLOGY ueg

Prof. Reinhold W. Stockbrugger

Emeritus Professor Internal Medicine, Gastroenterology and Hepatology, University of Maastricht/NL
Contract Professor Internal Medicine, University Ferrara/I
Editor European Journal of Gastroenterology & Hepatology
Chairman Public Affairs Committee UEG

rstockbrugger635@gmail.com

Universiteit Maastricht

università di ferrara

It all started here …

Epidemiology of polyps in the rectum and sigmoid colon. Design of a population screening study.

Hoff G, Vatn M, Gjone E, Larsen S, Sauar J.
Scand J Gastroenterol. 1985 Apr;20(3):351-5.

- **400 persons (200 + 200) in Telemarken**
- **Newspaper, radio and TV advertising**
- **81 percent acceptance of sigmoidoscopy**

… and it was getting stronger every day!

Colorectal cancer screening in a hospital environment

Armbrecht et al.

Acceptance and outcome of endoscopic screening for colorectal neoplasia in patients undergoing clinical rehabilitation for gastrointestinal and metabolic diseases.

Z Gastroenterol 1994; 32: 3-7

1985 - 1990

1166 patients

57% acceptance of sigmoidoscopy and simultaneous FOBT

23% had adenomatous polyps and one a carcinoma

Adenomas > 10 mm only in men (n=25)

78% of the adenoma patients (n= 116) accepted colonoscopy

In 34% of these further (also multiple) polys

The FOBT was positive in only 10/658 patients, including the carcinoma, but only 4/25 polyps > 10 mm

Same procedure (or nearly) in Maastricht:

Digestion. 2011;84(4):281-8. Opportunistic screening of hospital staff using primary colonoscopy: participation, discomfort and willingness to repeat the procedure.
Khalid-de Bakker CA, Jonkers DM, Hameeteman W, de Ridder RJ, Masclee AA, Stockbrügger RW.

- 1.090 employees (50-65 yrs) invited for primary screening colonoscopy
- 41% accepted
- Bowel preparation “somewhat to very uncomfortable”: 79.5%
- Colonoscopy “somewhat to very uncomfortable”: 21.9%
- Outcome:
-- advanced adenomas in 11.8% of 329 screenees
-- sensitivity of a simultaneous FIT: 15.8%
-- sensitivity of “virtual” sigmoidoscopy: 73.7%

96.3% of the participants were willing to repeat the procedure if necessary!

What is there?

A decision of the European Council in 2003 (2003/878/EC)

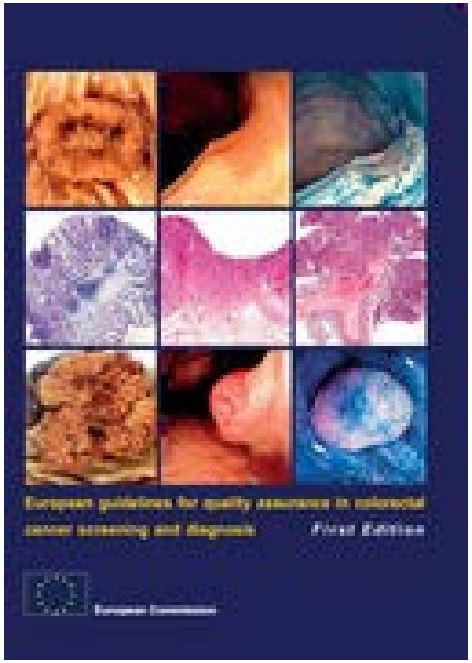
Many conferences, stakeholders, pro's and con's

In 2010, excellent "European guidelines for quality assurance in colorectal cancer sceening and diagnosis" by Nereo Segnan, Julietta Patnick and Lawrence von Karsa + 99 co-authors from Europe and the rest of the world.

The recommendation:

Population-based CRC screening!

- **public**
- **democratic**
- **affordable**
- **administration-controlled**



“Opportunistic” CRC screening: what is this?

Target individuals are not always personally invited

The screening method is not decided by a general law

The costs might not be covered by the public (but they can!)

The initiative is by individual community-based providers

Good will, ambition and fantasy govern more than uniform administration

Most CRC screening actions started “opportunistic” (see Geir Hoff), some still are: US, Germany, Poland, et al.

Is opportunistic screening needed in a rich continent like Europe? Yes!!!

CRC Screening in the European Union on 05-05-2012

“population-based” **N= 9**

B, DK, ES, F, GB, I, NL, SF, SV

Coverage between 10 and 100 per cent

“opportunistic” **N= 7**

A, CZ, D, GR, L, P, PL

Coverage (per definition) 100 per cent, per reality 10 and 100 per cent

“pilot” **N= 2**

IRL, S

“not yet; unknown” **N= 9**

BG, CY, EST, H, LT, LV, M, R, SK

NW

SE

What are “closed communities”?

Everything where people are:

- **living a/o working close together or having frequent and easy communication with each other such as:**
  - **Companies, factories, educational institutions, associations, healthcare institutions, sports clubs**
  - **But also customers of publications, information, services**

What makes them prone to promote prevention such as cancer screening?

- **Good will, altruism (Africa at your own door!)** EXAMPLES >
- **Egoism, career, fame: “leaving something behind” (Bono et al)**
- **The combination of both**
- **Own experiences and the will to spend time a/o intelligence a/o money**

Precautions for intestinal cancer in the workplace. An initiative for secondary prevention in the BASF joint-stock company.

Weberndörfer et al. Dtsch Med Wschr 2004; 129: 239-43

- 3732/13265 eligible employees (28%) accepted questionnaire and FOBT
- Colonoscopy recommended to 688; 323 (47%) accepted
- 9 screenees had CRC (6/9 with early stage)
- 61 had adenomas (all excised)
- Cost/benefit relation for the company: 1:10; for the local healthcare: 1:14

Boehringer Ingelheim
125 years more health

Schneider et al. Dtsch Med Wochenschr 2011; 136: 1047-52

… but also:

BMW Group

E.ON Ruhrgas

Allianz AG

EADS Deutschland GMBH

Thyssen

FELIX BURDA STIFTUNG

Betriebliche Darmkrebsvorsorge

Handlungsleitfaden zur Planung und Umsetzung

2. Auflage

Other ‘closed communities’ to be considered:

- **a village + his General Practitioner + their hospital**
- **the winner of a lottery and all his friends above 50 years**
- **You yourself and your family members (instead of going to Mallorca!)**
- **an insurance company**
- **The Members of the European Parliament and their friends from the UEG**

Why does screening in closed community work so well?

- **The promotors and organisers are profoundly convinced before they start**
- **They know their “folks” and can speak to them**
- **They invest their own spirit, time and money and want to see success**
- **They gather enthusiastic people to perform with them**
- **They stay in contact with their screenees**

Are there disadvantages? Yes, there might be!

If the opportunistic screening works too well (see US, Germany, Poland), it might become difficult to adapt to the slow pace of populations-based mechanisms! In this case, why not have them both in parallel?

There has to be public control on the quality of opportunistic screening; otherwise financial misuse is around the corner! (Germany vs. US)

One has to avoid all screening measures, when a therapeutic and control follow-up is not granted.

When could/should opportunistic CRC screening be considered?

- **In all countries/regions with yet not established CRC screening**
- **In all countries, where CRC screening is still on trial or in a pilot phase**
- **In every country with a present or potential feature of “beneficial foundations” by wealthy individuals, companies, or communities (US until Obama!)**
- **When you – as a political community – want to have sufficient people trained in the screening methods and all problems of “live” experience**

I learned my way with two relatively “small” own studies and not by kilograms of literature!

My conclusions

CRC screening saves life, quality of life and personal and community money

Start earning … immediately!

Crises, politics, problems, rumours, etc, are ready excuses for inactivity

Stop being an ostrich … now!

For CRC screening, you need doctors for motivation and endoscopists for examinations

They do not drop from the sky, train them … now!

As a single person you might be weak; in a ‘closed community’, you are stronger!

Take up the fight for your health and luck, … and for that of your friends!

Make your choice>

This is the choice!

Thank you for your patience!