A change in focus in colorectal cancer in New Zealand: not should we screen, but who and how should we screen?

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New Zealand’s rate per capita of colorectal cancer is among the highest in the world, with a median annual age standardised rate per 100,000 for males of 55.2 (range 50.8 to 56.2) and for females 44.1 (range 42.5 to 45.0).1 Colorectal cancer was the third most commonly diagnosed cancer in New Zealand in 2012 with 3,016 cases, behind only breast cancer (3,054) and prostate cancer (3,129).2 It was the second most common cancer for both males and females in New Zealand, behind prostate and breast cancer respectively, and had the second highest number of deaths from any cancer (1,283 in 2012), with only lung cancer leading to more deaths (1,628).3

Despite this significant burden of disease, single institutional data suggests that the outcome from colorectal cancer has steadily improved over the last 20 years3 but still lags behind similar countries such as Australia. Given that the prognosis of colorectal cancer is related primarily to stage at diagnosis, screening can play a major role in improving outcomes and has been implemented in many countries. With such a burden of disease, the lack of a bowel cancer screening programme in New Zealand has been of huge concern. The New Zealand Government has now, finally, after 17 years of avoiding doing so, announced the roll-out of a national colorectal cancer screening program over the next three years. This has shifted the debate from should we screen to how and who we should screen. Two articles published in this edition of the NZMJ further enlighten these aspects of the debate.4,5

Firstly, the PIPER study6 has demonstrated what is really happening in New Zealand to patients with colon and rectal cancer. The PIPER study is a comprehensive description of the outcome and management of New Zealanders with colorectal cancer and its methodology is described in this issue of the journal.4 It is a national retrospective cohort study of a selected sample of New Zealand residents diagnosed with colorectal adenocarcinoma in New Zealand from 1 January 2007 to 31 December 2009. The researchers identified 5,667 eligible patients. A full copy of the results can be found on the University of Auckland Faculty of Medical and Health Services website.

The PIPER study6 found 4,193 (74%) patients were diagnosed with colon cancer, and 1,401 (25%) with rectal cancer. Most patients were of European extraction, with 8% recorded as Māori, 3% as Pacific, and 2% as Asian. The mode of first presentation was to the emergency department (ED) for 34% of patients with colon cancer in New Zealand has been of huge concern. The New Zealand Government has now, finally, after 17 years of avoiding doing so, announced the roll-out of a national colorectal cancer screening program over the next three years. This has shifted the debate from should we screen to how and who we should screen. Two articles published in this edition of the NZMJ further enlighten these aspects of the debate.4,5

As discussed, the stage of CRC at diagnosis is the single most powerful prognostic variable and is the principal determinant of treatment. PIPER confirmed New Zealand has a relatively higher proportion of patients diagnosed with stage IV (metastatic) disease than other countries—
Australia has 19% and 17% stage IV for colon and rectal cancer respectively, and the UK has 17% for both stage IV colon and rectal cancer. Higher proportions of metastatic disease were seen in Māori and Pacific patients; the proportions diagnosed with stage IV colon cancer were 32% and 35% for Māori and Pacific respectively, and for rectal cancer were 29% and 22% respectively.6

These outcomes highlight one of the important challenges for management of CRC in New Zealand, which is how to reduce inequities in cancer-related outcomes. Colorectal cancer is one of the few cancers for which incidence rates are lower among Māori, but rates among Māori are tending to increase towards those of non-Māori. Māori patients tend to be younger at diagnosis and have more comorbidities. There is evidence relating to health service factors that contribute to poorer colorectal cancer survival among Māori. Fewer Māori are referred to oncologists in comparison to non- Māori; fewer are offered chemo and of those who are referred, fewer get chemo started within 8 weeks.10

The Ministry of Health’s document on Standards for Service Provision for Patients with Bowel Cancer in New Zealand11 provides a starting point for ensuring there is harmonisation of best practice in the care of patients with colorectal cancer. The objective of the standards is to promote nationally coordinated and consistent standards of service provision across New Zealand, with a focus on equity. These standards, however, are still being implemented, and many aspects are yet to be fully applied especially aspects around equity.

The inequities identified in PIPER and previous research need to be carefully considered in the roll-out of a national screening programme. Screening is typically taken up by the white middle class, especially females. In the pilot, while 56.8% of the target population took up the screening trial, only 46% of those who identified as Māori and 30% of Pacific Islanders. This compared with 59.7% that identified as of European descent.12 Previous work on this13 has shown participants were largely positive about potential colorectal screening; however, various access barriers exist. These include patient-clinician engagement and communication; lack of provision for patient’s privacy during screening; and patients feeling discouraged to take part in screening. Factors enabling screening include having an established relationship with their general practitioner; screening clinicians taking time to build rapport, answer questions and share information; screening practices that were inclusive of Māori cultural norms; and possessing high health literacy.

In addition to engaging different populations in CRC screening, now that a national programme has finally become a reality, another focus of debate has reignited on how to most appropriately screen the population.14 Multiple options exist, ranging from faecal occult blood tests, through radiological investigations, to flexible sigmoidoscopy and colonoscopy. In the second CRC-focused paper in this issue, these options are outlined and discussed. Safarti et al5 conclude that the proposed national population-based biennial FIT-based programme is consistent with international evidence and entirely in line with similar decisions made in countries with similar health care systems and resource constraints.

It is reassuring that a national bowel cancer screening programme is now within our grasp and that the chosen test is appropriate to maximise the impact on bowel cancer outcomes. The challenge for the programme will be to ensure these outcomes are maximised across all New Zealanders, in particular Māori and Pacific peoples.
REFERENCES:


