# Report on the Belgian consensus meeting on Colorectal cancer screening

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## Abstract

**Screening and prevention of colorectal cancer must be a public health priority. It is the most frequent malignancy in Europe, the second leading cause of cancer death, including Belgium where more than 6.000 new cases occur per year. Various screening modalities, from non invasive to invasive are available and currently in use and they are all cost-effective in comparison with no screening. The decision as to which screening test to use should be made by the patient and clinician. Consensus documents prepared by the Belgian scientific community appear in this issue of Acta Gastroenterologica Belgica, summarizing the scientific evidence in favour as well as the limitations of fecal occult blood tests, flexible sigmoidoscopy, videocolonoscopy and virtual colonoscopy.** (Acta gastroenterol. belg., **2005**, 68, **239-240**).

Screening and prevention of colorectal cancer (CRC) is a public health priority. Indeed it is the most frequent malignancy in Europe (1), its lifetime risk is 2.5 to 5% in the general population, and, despite the availability of various screening methods, death occurs in half of the patients diagnosed with this cancer. Except deaths from lung cancer, CRC is the most common cause of cancer death for men and women combined (2). Colorectal cancer screening can prevent mortality (3), and there are a number of screening methods, ranging from non-invasive to highly invasive. It is an ideal target for population screening because it is a prevalent disease with an identifiable precursor lesion that, when treated, favourably alters the natural history of the disease. Unfortunately, offering an array of options has not increased screening utilization, which continues to lag behind that of other common cancers (4).

Although recommendations have been widely disseminated in the media and scientific journals (4-9), screening usage is low and there is still a lack of agreement about which routine screening strategy should be adopted. Lack of knowledge of the public, physicians (general practitioners and specialists including gastroenterologists) about CRC and the methods available to detect it at an early stage and lack of economic or political incentives from the politics responsible for the health care system are some of the barriers to screening that may contribute to its underutilization. A recent study done in 21 European countries (10) has clearly emphasized the lack of public awareness of CRC. In Belgium, 65% of the population are not aware of the importance of CRC, 50% ignore that simple procedures can help to identify the early or premalignant stage of bowel cancer and 50% mention embarrassment to speak on bowel problems as a barrier to early diagnosis (11).

Nowadays, the decision to choose one colorectal screening strategy over another is based on the availability of screening modalities, patient and provider preferences, and associated adherence to screening recommendations. Assessment of preference and development of interventions to increase adherence to screening should be a focus of research in the future. A population screening for CRC should be implemented in Belgium, which should be in line with current national a European cancer screening programmes (12).

The Belgian scientific community decided to organize a consensus development meeting which took place during a pros and contras type of debate for each of the screening methods available was presented by experts in the field. A summary of their presentations are reported followed by a consensus document for each screening method with their benefits and limitations, prepared by a Belgian workgroup consisted of 12 members including gastroenterologists from academic and non academic hospitals, a primary care general practitioner involved in a scientific association and an academic radiologist. The recommendations and guidelines based on risk stratifications will be presented to the Belgian health authorities.

## References

1. Keighley MRB. Gastrointestinal cancers in Europe. Aliment Pharmacol Ther 2003 ; 18 : 7-30.
2. Feur EJ, Wun LM. DEVCAN : Probability of developing or dying of cancer. Software, Version 4.0 Bethesda, MD. Nat Cancer Institute 1999.
3. Colorectal cancer screening use among persons aged ≥ 50 years. USA 2001 MMWR Morb Mortal Wkly Report 2003 ; 52 : 193-196.

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4. Pignone M, Rich M, Berg A, Teutsch S, Lohr K. Screening for colorectal cancer : systematic review for the US Preventive Services Task Force. Ann Int Med 2002 ; 137 : 132-141.
5. Prévention, dépistage et prise en charge des cancers du colon. Texte de consensus. Gastroenterol Clin Biol 1998 ; 22 : S1-S295.
6. Winawer S, Fletcher R, Rex D, Bond J, Burt R, Ferrucci J. Colorectal cancer screening and surveillance : clinical guidelines and rationale update based on new evidence. Gastroenterology 2003 ; 124 : 544-560.
7. Leddin D, Hunt R, Champion M, *et al*. Canadian Association of Gastroenterology and the Canadian Digestive Health Foundation. Guidelines on CCR screening. Can J Gastroenterology 2004 ; 18 : 93-99.
8. Rhodes JM. Colorectal cancer screening in the UK : Joint Position Statement by the British Society of Gastroenterology, the Royal College of Physicians, and the Association of Coloproctology of Great Britain and Ireland. Gut 2000 ; 46 : 746-748.
9. de Visser M, van Ballegooijen M, Bloemers SM, *et al*. Report on the Dutch consensus development meeting for implementation and further development of population screening for colorectal cancer based on FOBT. Cell Oncol 2005 ; 27 : 17-29.
10. Keighley MRB, O'Morain C, Giacosa A. Public aware of risk factors and screening for colorectal cancer in Europe. Eur J Cancer Prev 2004 ; 13 : 257-262.
11. Buset M. Primary prevention of colorectal cancer. Acta Gastroenterol Belg 2003, 66 : 20-21.
12. Colin JF, Vanheuverwzyn R. Colorectal cancer screening. Acta Gastroenterol Belg 2001, 64 : 255-257.