

pathogenesis of the malformations, it was found that thalidomide is an immunosuppressant.³ The use of two different ¹⁴C-labelled thalidomide preparations showed that a portion or the whole of the glutarimide molecule binds to the DNA of rabbit embryos.⁴

In Britain and Ireland, 480 thalidomide-affected infants survived. Of these, 25 died before reaching the age of 40 years. The causes of death were cancer (4), heart disease (4), diabetes (3), hypertension and renal failure (3), motor accidents (3), and substance misuse or suicide (8) (M Johnson, Director, the Thalidomide Trust [United Kingdom], personal communication).

Four deaths from cancer before the age of 40 years in a cohort of 480 is an incidence of 0.83%. The death rate from cancer in England and Wales before the age of 40 is

Surgeons' views about colorectal cancer screening before and after national guidelines

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TO THE EDITOR: In November 1999, the National Health and Medical Research Council (NHMRC) released *Guidelines for the prevention, early detection and management of colorectal cancer*.¹ One chapter addressed screening for colorectal cancer

(CRC), citing Level 1 evidence in support of faecal occult blood testing (FOBT) as the preferred modality for population-based CRC screening. Colonoscopy and sigmoidoscopy were not recommended. In a postal survey conducted in 1998, before release of these guidelines, we found mixed views among Australian surgeons about CRC screening.²

In February 2001, we conducted a follow-up (post-guidelines) survey which included three questions about CRC screening that had been asked in the pre-guidelines survey. Using a pre-post design, we evaluated the impact of the NHMRC guidelines on surgeons' views.

Of the 172 surgeons confirmed still to be in active practice at the time of follow-up, 114 (66%) returned questionnaires. One hundred and three (90%) agreed to matching of their baseline and follow-up responses. Of these, 101 (98%) provided valid responses to each of the three questions on both occasions.

Surgeons' views about population-based CRC screening by FOBT changed significantly between the surveys (Box). At baseline, half "strongly agreed" or "agreed" that population-based FOBT should be introduced for all Australians over the age of 50 years. At follow-up, the proportion had increased significantly to more than two-thirds (McNemar's $\chi^2 = 13.0$; $P < 0.001$). There was no significant change in the percentage of

Surgeons' views about screening for colorectal cancer before and after publication of national guidelines¹ ($n = 101$)

		Strongly agree	Agree	Neutral	Disagree	Strongly disagree
Population-based screening by FOBT should be introduced for all Australians over 50 years of age	Before	17%	34%	28%	18%	4%
	After	26%	44%	23%	8%	0
Colonoscopy is preferable to FOBT as a population-based screening method	Before	6%	23%	21%	42%	9%
	After	7%	28%	22%	37%	7%
Sigmoidoscopy is preferable to FOBT as a population-based screening method	Before	2%	23%	13%	55%	8%
	After	1%	13%	23%	55%	9%

FOBT=faecal occult blood testing. Due to rounding, row percentages do not necessarily sum to 100%.

surgeons who "strongly agreed" or "agreed" that colonoscopy is preferable to FOBT (McNemar's $\chi^2 = 0.9$; $P = 0.3$). In contrast, there was a significant decrease in the percentage who "strongly agreed" or "agreed" that sigmoidoscopy is preferable to FOBT (McNemar's $\chi^2 = 4.4$; $P = 0.04$).

Although the influence of events unrelated to the NHMRC guidelines cannot be entirely excluded from uncontrolled evaluation designs such as this, our data provide some reassurance that the guidelines have had an impact. However, as argued elsewhere,³ substantially more effort is required to ensure that patients with CRC detected through screening receive evidence-based management.

More rigorous study designs with control groups are recommended to identify strategies effective in changing surgical practice. Finally, surgeons' increased enthusiasm for CRC screening contrasts with public hesitancy.⁴

1. National Health and Medical Research Council. Guidelines for the prevention, early detection and management of colorectal cancer. Canberra: AGPS, 1999.
2. Gattellari M, Ward JE, Solomon MJ. Are Australian surgeons convinced about colorectal cancer screening? [letter] *Med J Aust* 2000; 173: 333.
3. Thomas RJS, Spigelman AD, Armstrong BK. Large bowel cancer: guidelines and beyond [editorial]. *Med J Aust* 1999; 171: 284-285.
4. Young JM, Bruce T, Ward JE. Is support among patients for colorectal cancer screening susceptible to "framing effect"? A GP-based study. *Health Promot J Aust* 2002. In press. □

Correction

Re the letter "Guidelines for the management of gestational diabetes mellitus revisited", by David S Simmons, Barry N J Walters, Peter Wein and N Wah Cheung, on behalf of the Australasian Diabetes in Pregnancy Society, published in the 1 April issue (*Med J Aust* 2002; 176: 352), in which the American College of Obstetricians and Gynecologists criterion for diagnosing gestational diabetes mellitus of a 1-hour fasting plasma glucose level of ≥ 10.0 mmol/L was mistakenly placed in the adjacent Australasian Diabetes in Pregnancy Society column. The entire corrected table is reprinted below.

Differences between management guidelines for gestational diabetes mellitus (GDM) from the Australasian Diabetes in Pregnancy Society (ADIPS, 1998) and the American College of Obstetricians and Gynecologists (ACOG, 2001)

	ADIPS	ACOG
Universal versus selective screening by blood test	Universal unless low GDM incidence or resources limited	No recommendation. States that "many physicians elect to screen all pregnant patients as a practical matter"
Differences in definition of low risk for GDM	Age < 30 years, obesity, family history of diabetes	Age < 25 years, body mass index < 25 kg/m ² . No known diabetes in first-degree relative
Oral glucose tolerance test used	75 g, 2-hour, 2-point blood sampling	100 g, 3-hour, 4-point blood sampling
Criteria for diagnosis of GDM	Plasma glucose level: Fasting, ≥ 5.5 mmol/L and/or 2-hour, ≥ 8.0 mmol/L (Australia)	Plasma glucose level: Fasting, ≥ 5.3 mmol/L; 1-hour, ≥ 10.0 mmol/L; 2-hour, ≥ 8.6 mmol/L; 3-hour, ≥ 7.8 mmol/L (2 or more time points need to be elevated)
Insulin therapy commenced after medical-nutrition therapy	Plasma glucose level: Fasting, ≥ 5.5 mmol/L and/or 1-hour postprandial, ≥ 8.0 mmol/L and/or 2-hour postprandial, ≥ 7.0 mmol/L	Plasma glucose level: Fasting, ≥ 5.3 mmol/L and/or 1-hour postprandial, ≥ 7.2 -7.8 mmol/L and/or 2-hour postprandial, ≥ 6.7 mmol/L