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Detecting people at higher risk for colorectal neoplasia in a community-based screening program

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TO THE EDITOR: The burden of colorectal cancer can be minimised, firstly, by early and appropriate investigation of symptoms; secondly, by screening those at higher-than-average risk without symptoms; and thirdly, by community-based screening of asymptomatic people aged over 50 years who are at average risk. Major screening programs using faecal-occult-blood testing (FOBT)¹⁻³ or flexible sigmoidoscopy⁴ have not necessarily made this differentiation. These tests lack the sensitivity of colonoscopy, which is generally indicated for those with symptoms or a strong family history of colorectal cancer.

In our recent community-based screening program in which we used virtual colonoscopy, we excluded those at higher than average risk for colon cancer (that is, they were symptomatic or had at least one first-degree relative with colon cancer), as our standard of care for these patients is colonoscopy. They were given verbal and written advice to see their general practitioner, with the expectation that most should have colonoscopy. They were followed up an average of 12 months (range, 6–15 months) later, by letter and telephone, to determine the outcome of this advice.

Of 2000 participants aged 50–69 years who were offered screening, 90

(4.5%) described having symptoms or a first-degree relative with bowel cancer, but had not undergone investigation. Follow-up information obtained from 71 of these people indicated that 21 had a relevant family history and 50 described recent bowel symptoms. Only 35 (49%) had discussed further investigations with their GPs — 19 (27%) had undergone colonoscopy, and five of these (26%) had advanced colorectal neoplasia (CRN). One had tubular adenoma (> 1 cm), one showed villous architecture, one had intramucosal carcinoma, and two had cancer. Four other participants had had negative results on other investigations. These were FOBT alone in three (two symptomatic, one with family history) and barium enema in one who had bleeding. Common reasons for not consulting their GPs were because of good health (15 participants), resolution of symptoms (12), and perceived lack of need for tests (10).

These data have important implications for CRN screening programs, including recently commenced Australian pilot programs (www.cancer-screening.gov.au). Firstly, there is likely to be an improved yield of advanced CRN when a previously uninvestigated high-risk group is identified within a screening program. Secondly, people identified as having higher-than-average risk for CRN need special attention to ensure there is adherence to advice on appropriate follow-up. Thirdly, procedures are required to ensure colonoscopy is appropriately undertaken when participants do consult their GPs. Accordingly, rather than adopting an exclusion policy within a screening program based on FOBT or flexible sigmoidoscopy, we believe it is appropriate that people at greater risk for

CRN are identified and offered colonoscopy within that program.

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Socioeconomic disadvantage and use of general practitioners in rural and remote Australia

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TO THE EDITOR: Studies investigating the relationship between socioeconomic status (SES) and use of healthcare services suggest that, in metropolitan regions, low-SES groups consult general practitioners more frequently than high-SES groups.¹ The primary reason is their poorer health and hence greater medical need (however, distributional, operational and financial factors associated with the provision of general practice services are also important).

Is a similar relationship found between SES and GP use in non-

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