infection and psychological harm and the time that participants must devote to the screening process are not generally accounted for in these evaluations.

• Although all of the published economic evaluations that COCOHTA reviewed showed that screening was cost-effective, the NCCCS' analysis showed that cost-effectiveness and reduction in deaths from colorectal cancer depend strongly on the assumed participation rate for the first screen (67% in the base case) and the frequency of screening. However, the participation rate that can be achieved in Canada is largely unknown.

To our knowledge, no country has implemented a population-based screening program at the national level, although several countries have undertaken pilot studies or large-scale programs. If Canada embarks on an expensive ($112 million per year, according to the NCCCS study) community-based screening program for patients at average risk, then health care professionals and the general public should understand that this would be an experiment. Whether the benefits will outweigh the harms is unknown.

Bruce Brady
Health Economist
Canadian Coordinating Office for Health Technology Assessment
Ottawa, Ont.

References

The author responds:

In discussing my commentary about colorectal cancer screening,1 Ted Mitchell is quite right to point out the importance of informed consent for cancer screening. The Cancer Care Ontario2 and NCCCS3 reports both emphasize this point. However, it is inappropriate to suggest that these reports do not reflect a “thoughtful weighing of the risks.” Both groups included strong consumer representation and put much thought into the issue.

Mitchell is also concerned that colorectal screening will place a new burden on family doctors. However, this burden would be minimized if provincial governments introduced organized screening programs, with provisions for follow-up recall and timely colonoscopy assessment.

There are 3 problems with Bruce Brady’s analysis. First, it should be remembered that an intervention with a modest clinical (i.e., individual) benefit can still have a significant population impact. The 20% reduction in mortality projected by the Cancer Care Ontario report2 would result in about 1500 fewer deaths from colorectal cancer annually in Canada by 2015. Second, cost-effectiveness does not necessarily depend “strongly” on participation rate. In fact, a colorectal screening program would have relatively low fixed costs and high discretionary costs. Our own (unpublished) work at Cancer Care Ontario suggested that the cost-effectiveness curve is very flat above 20% participation, which is hardly a daunting target. Third, Brady refers to a national screening program as an “experiment,” but it would be more appropriate to view the randomized clinical trials as the experiments. An evidence-based program emulating these randomized clinical trials would be good health policy, not just an experiment.

Brady is properly concerned about the risks of colonoscopy assessment by inexperienced operators. This is a compelling reason for offering colorectal screening through an organized program rather than on an ad hoc basis (as would be the case with simply issuing clinical guidelines).

With regard to Gordon McLauchlan’s letter, there is no need to choose between starting colorectal screening with FOB testing (because we are able to do so) and building our endoscopy capacity so that some day we can replace FOB testing with endoscopy.

Richard Schabas
Chief of Staff
York Central Hospital
Richmond Hill, Ont.

References
1. Schabas RE. Colorectal cancer screening in Canada: It’s time to act [editorial]. CMAJ 2003;
Drug supply and drug abuse

The article by Evan Wood and colleagues1 suggesting that the seizure of 100 kg of heroin made no difference to heroin abuse in Vancouver is interesting, but its conclusions are open to doubt and its implications are cause for concern.

In Australia over the past 2 years, there has been a significant decrease in heroin overdoses (and subsequent deaths) in association with a decrease in heroin abuse in Vancouver2 and subsequent decreases in heroin overdoses (and subsequent deaths) in association with a decrease in heroin abuse in Vancouver,3 but its conclusions are open to doubt and its implications are cause for concern.

In our study, we moved beyond speculation and looked retrospectively at interviews with addicts regarding the availability of heroin after a record seizure.1 Instead of this post hoc analysis being a limitation, as suggested by Copeman, our approach reduced the potential for bias because the subjects and interviewers were blinded to this eventual use of the data. With regard to the time frame of our analyses, Fig. 1 of our original study1 presents data as far ahead as 3 months after the seizure. Furthermore, even if storage were a factor, basic economic theory predicts that any significant impact on supply should immediately affect price, regardless of storage.4

We believe that the ideal case study of interdiction and enforcement efforts comes from the United States, where the resources directed to this approach dwarf what is spent in other nations such as Australia and Canada. For instance, in the United States the number of nonviolent drug offenders in prison exceeds by 100 000 the total incarcerated population in the European Union (EU), despite the fact that the EU has 100 million more citizens.5 Nevertheless, US drug supply and purity have reached an all-time high.6

We agree that the implications of our study are of concern, especially since the vast majority of resources spent on the drug problem continue to be directed to enforcement.7 We hope that the politicians charged with protecting public health take a closer look at the wealth of studies showing the failure of this approach8,9 and at the evidence supporting more effective alternatives.10

References

Michael Copeman
Visiting Pediatrician
Manly Hospital
Sydney, New South Wales
Australia

We thank Michael Copeman for his interest in our study.1 While Weatherburn and associates2 speculated that interdiction efforts might have led to a heroin drought in Australia in early 2001, they also found no reduction in crime and a concomitant rise in cocaine injection. It is also noteworthy that others3 have speculated that the drought may have been due to factors other than interdiction.

In our study we moved beyond speculation and looked retrospectively at interviews with addicts regarding the availability of heroin after a record seizure.1 Instead of this post hoc analysis being a limitation, as suggested by Copeman, our approach reduced the potential for bias because the subjects and interviewers were blinded to this eventual use of the data.

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Evan Wood
Mark W. Tyndall
Martin T. Schechter
British Columbia Centre for Excellence in HIV/AIDS
St. Paul’s Hospital
Vancouver, BC

References

Emergency docs or family physicians?

I am concerned that Benjamin Chan’s research letter1 dealing with the practice patterns of physicians with emergency medicine certification (CCFP [EMJ]) from the College of Family