



## Colon cancer screening

I am a bit perplexed about the cost-effectiveness analysis of CRC screening by Steven Heitman and associates.<sup>1</sup> First, it does not compare CT colonography with a “do nothing” approach nor does it take into consideration the recommendations of the Canadian Task Force on Preventive Health Care.<sup>2</sup> What is the predicted cost-effectiveness, in Canada, of CT colonography as the alternative to doing nothing?

Second, the analysis seemingly presumes that either CT colonography or colonoscopy will be used exclusively. The authors indicate that current population screening rates are less than 20% but that a recent study has shown that up to 28% of the population would be willing to submit to CT colonography. The analysis should have included a population perspective on the benefits and costs of offering CT colonography to patients willing to submit to this strategy who would otherwise refuse screening altogether. Offering several screening methods may be the only way to increase population-wide adherence.

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### REFERENCES

1. Heitman SJ, Manns BJ, Hilsden RJ, et al. Cost-effectiveness of computerized tomographic colonography versus colonoscopy for colorectal cancer screening. *CMAJ* 2005;173(8):877-81.
2. Canadian Task Force on Preventive Health Care.

Colorectal cancer screening: Recommendation statement from the Canadian Task Force on Preventive Health Care. *CMAJ* 2001;165(2):206-8.

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The article by Steven Heitman and colleagues<sup>1</sup> ignores health human resource realities in Canada. The only logical strategy for people aged 50–74 years at average risk of developing colorectal cancer (CRC) is to start with computerized tomographic (CT) colonography and proceed to full colonoscopy with polypectomy on the same day when polyps greater than 5 or 10 mm in diameter are found.

The Canadian health care system does not have the capacity to offer colonoscopies to everyone aged 50–74 years who is at average risk. Access to gastrointestinal specialty care is limited in many parts of Canada.<sup>2</sup> In 2001, only 3857 colonoscopies were performed per 100 000 Ontarians aged 50–74 years.<sup>3</sup> From 1992 to 2001, only 15.7% of Ontarians aged 50–74 years had at least one colonoscopy; 16.7% underwent double-contrast barium enema.<sup>3</sup>

There are resource planning advantages to a “CT colonography first” strategy. It takes 15 min for an experienced endoscopist to perform a full diagnostic colonoscopy and an additional 5–10 min for a polypectomy. For 100 000 people undergoing CRC screening (27.2% of them will have polyps greater than 5 mm in diameter), the “CT colonography first” strategy will require 3692 endoscopy days.

A colonoscopy for the people in this group who are found to have polyps will use only 1417 endoscopy days.

There are 2 questions that need to be addressed with regard to CRC screening programs. The first is whether CT colonography should replace double-contrast barium enema as a screening tool. The second concerns the optimal interval for repeating CT colonography.

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2. Leddin D, Hunt R, Champion M, et al; Canadian Association of Gastroenterology and the Canadian Digestive Health Foundation: guidelines on colon cancer screening. *Can J Gastroenterol* 2004;18(2):93-9.
3. Vinden C, Schultz SE, Rabeneck L. *Use of large bowel procedures in Ontario: an ICES research atlas*. Toronto: Institute for Clinical Evaluative Sciences; 2004.

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[Four of the authors respond:]

These authors have raised several important issues. Dr. Kiberd suggests that our model should have included comparison to fecal occult blood testing

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