

through the blood system) that was close to his heart.² He considered that recommendation to be part and parcel of the precautionary principle because it would have served to balance the pressures of extreme risk aversion (by regulatory bodies and health care agencies, among others) with the need to move ahead with new treatments or to respond to unanticipated challenges. It put the dignity of patients first. Regrettably, it has not been adopted.

Krever recognized that blood is not another drug but rather a complex biological product that can never be completely characterized. Given this fact, his first recommendation was remarkably prescient. As we enter the world of targeted biopharmaceuticals, more and more of our therapies begin to look like blood products in their subtle complexity. My guess is that we are going to have to revisit the issue of no-fault compensation as part of a complete re-framing of our drug development process, lest we stifle innovation or drive the costs of new drugs to unaffordable levels.

Harvey Schipper BASc(Eng) MD
Founding Member of the Board of Directors, Canadian Blood Services, Toronto, Ont.

Competing interests: None declared.

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Colorectal cancer screening

In their editorial on screening for colorectal cancer, Alan Barkun and Ken Flegel exaggerated the screening rate for this disease in the United States.¹ They cited a survey in which adults over 50 years of age were asked if they had ever undergone fecal occult blood testing, sigmoidoscopy or colonoscopy.² Sixty-three percent of the respondents replied that they had; Barkun and Flegel cited this figure as evidence of greater uptake

of screening in the United States. However, only 37% of the respondents in that study were defined as being “current for testing” (that is, they claimed to have undergone fecal occult blood testing in the past year, sigmoidoscopy in the past 5 years or colonoscopy in the last 10 years). This survey was subject to recall bias in 2 ways: some respondents might have wanted to show that they were aware of current screening recommendations (and thus they would have responded falsely that they had been screened) and some might have responded that they had been screened when in fact they had undergone these tests for investigation rather than screening purposes.

David Lieberman has estimated the rate of colorectal cancer screening in primary care in the United States to be between 26% and 32%.³ This rate is not much different from the rate in Canada and is not corrected to take into account patients without access to primary care.

Roy M. Preshaw MD
Lady Minto Hospital, Salt Spring Island, BC

Competing interests: None declared.

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[The authors respond:]

We thank Roy Preshaw for his letter in response to our editorial on colorectal cancer screening.¹ He unfortunately appears to have mixed up 2 separate rates reported in the US and Canadian studies. We correctly quoted the “ever-screened” rate in the United States as 63%²; the comparable rate in Canada is 23.5%.³ The difference between the “current-for-screening” rates in the 2 countries is similar in magnitude: 37% in the United States² and 17.6% in Canada.³

Preshaw’s assertion that colorectal

cancer screening rates in Canada and the United States are not so different is thus incorrect. In fact, no assertion could be further from the truth. There are overwhelming data showing that “current-for-screening” rates are approximately 43% to 55% in the United States^{4,5} whereas Canadian investigators have reported dismal data. For example, a “current-for-screening” rate of only 14% in Canada was recently reported.⁶

The reasons for these differences are likely multifactorial. However, a recent US study indicated that among primary care physicians and adults at average risk of developing colorectal cancer, lack of patient awareness and failure of a physician to recommend screening are key barriers to screening.⁷ We therefore reiterate our plea for Canadian physicians to actively work to close this care gap; such action will ultimately save lives.

Alan Barkun MDCM MSc
Chairholder, Douglas G. Kinnear Chair in Gastroenterology, McGill University, Montréal, Que.

Ken Flegel MDCM MSc
Senior Associate Editor, *CMAJ*

Competing interests: None declared.

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Corrections

Box 4 in the review by Warburton and colleagues¹ should have listed the for-