



Europe against Colorectal Cancer

Declaration of Brussels

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Preamble: Colorectal cancer screening in Europe 2007

Every year, more than 400,000 people in Europe are newly diagnosed with the disease while 212,000 Europeans die from it. Cancers of the colon and rectum (CRC) are the second most common malignant tumours in Europe and also rank second in mortality. To date, every other patient dies from the disease, although no other cancer – with the exception of skin and cervical cancer – provides similarly excellent early screening and prevention opportunities. In theory, virtually all colon and rectal cancers can be either prevented or cured by removal of adenomas and by detection and subsequent removal of the cancers in their early stages – a fact which is reflected by the EU Commission's cancer screening recommendations from 2003 which have advised the member states to launch comprehensive CRC screening programmes on a national scale.

Until now, no more than about half of the member states have followed with this recommendation, either by introducing a national screening programme or by conducting preliminary studies for its eventual launch. Scope and quality of the existing programmes vary widely as do their success rates. In several countries, too few people have made use of the screening opportunities provided to make a significant impact on the incidence and mortality rates of CRC. Participation numbers have been highest where a central agency and a call/recall system were established to target people from all walks of life and socio-economic backgrounds. In some countries, the performance of the screening test in a decentralized and non-standardized fashion has generated significant error rates. Experience clearly shows that error rates are smallest in countries that have evaluated their tests in a central laboratory facility in compliance with defined quality standards. In other countries, screening results have not been centrally compiled and evaluated, making it impossible to judge the effectiveness of the screening programme.

Nearly all existing screening programmes have failed to make specific arrangements for an evaluation of the high-risk groups of people with an inherited susceptibility (familial and hereditary) to CRC which would allow to refer family members to genetic counselling. Since members of the high-risk groups who make up 15 to 20 % of all CRC cases are at increased risk of contracting the disease at an earlier age than the members of the general population, it is important to identify these families and to make sure that the people concerned take steps that are appropriate to their inherited susceptibility. There is an urgent need for a standardized European approval.

It seems safe to say that most of those member states which have so

far failed to show any interest at all in a CRC screening programme have also failed to realize the huge importance and potential impact of this issue on their populations which is why they have opted for different health policy priorities. Several of these countries also seem to think – wrongly, as it happens – that the effectiveness of colon cancer screening programmes has not yet been sufficiently established. On the other hand, uncontrolled screening with poorly documented modalities would subject the national health services to substantial levels of stress and can therefore not be recommended. Pre-screening trials on a national or regional basis are urgently needed.

Although the EU Commission has no real power to enforce the implementation of screening programmes in the individual member states, it can issue practical recommendations – complementing the public health policies of the individual member states – capable of improving the general health of the European citizens and of combating widespread serious illnesses. Over the past few years, the Commission has already made effective use of these powers in its attempts to combat breast cancer, supporting supranational research initiatives, European networks and the drafting of a European guideline for the implementation of national screening programmes. The successful outcome of this approach has demonstrated the potential normative effect of European Council recommendations on public health policies.

The signatories of this Declaration call upon the European Commission to use its powers and authority in equal measure to launch trials on alternative screening processes and to implement quality-assured CRC screening programmes, having already done so for the implementation of quality-assured breast cancer screening programmes. The following list of our requests identifies the required elements of any future EU action plan meant to provide a solid European basis for the fight against a major European health issue.

The requests:

1. The European Commission should set up a European action plan 'Europe against Colorectal Cancer'. The Commission should make the prevention of CRC and the implementation of national screening programmes a priority for action on the European healthcare agenda for years to come. The health ministers of the individual member states should be called upon to provide the necessary human and financial resources.

2. The European Commission should provide the European health ministers as soon as possible with a European guideline for CRC screening. This guideline should follow best practice and provide the individual European countries which have embarked upon an introduction of quality-assured national screening programmes with support on all levels. The aim should be to improve screening processes and to ensure that the effects of CRC screening and management are better understood.

3. The European guideline on CRC should include practical assistance in the detection and management of the high-risk groups. Strategies are needed to identify, instruct and supervise high-risk groups with an increased familial and hereditary risk of contracting CRC.

4. European guideline for CRC screening should include a demand for the provision of all target groups with adequate information. People participating in the national colon cancer screening programme should be fully informed about the benefits and risks of the screening procedures. Migrants must be approached in their native languages. All member states should have quality-assured information available which they can then use to instruct the individual target groups.

5. The European guideline should recommend to implement any national screening programme by issuing invitations to the persons entitled to screening through a central agency. CRC screening programmes are successful when incidence and mortality rates fall. This requires the maximum possible participation of the target group. Experience has taught us that higher participation rates can be achieved by using central invitation procedures in combination with a call/recall system which targets people from all socio-economic backgrounds. Research to increase participation in particular from lower socioeconomic levels is urgently needed.

6. The European guideline should recommend to implement any national screening programme on the basis of a quality-assured and quality-controlled infrastructure. Whether or not CRC screening programmes are ultimately successful is also contingent upon the consistent use of common quality standards in the identification of the target population, in the evaluation of tests, the quality and timely implementation of the further diagnostic and therapeutic measures, the standardisation of central data collection strategies and the monitoring as well as the scientific analysis of the screening results.

7. The European guideline should advise the member states to facilitate the provision of appropriate training to the personnel involved

in the screening itself, the processing of its results and subsequent treatment of patients. It is important that the general practitioners who provide their patients with advice in CRC screening matters are familiar with the potential risks and benefits of the different screening methods. They must also be capable of identifying patients from high-risk groups and of providing them with advice which complies with the guideline. Each of the individual countries will have to make sure that sufficient contingents of appropriately qualified epidemiologists, health officials and doctors (gastroenterologists/ pathologists/oncologists/surgeons) are available to meet the required performance indicators on all levels, in particular colonoscopy, in order to guarantee the delivery of high-quality screening.

8. The European Commission should establish and fund designated research programmes for the development and evaluation of suitable methods and programmes for CRC screening. Screening tools, both conventional and those under development, require an evidence-based proof. Most methods – except the gFOBT – have not been tested for sufficiently long periods of time and with sufficiently large numbers of subjects to demonstrate their actual potential of decreasing the incidence and mortality rates of CRC. In some European regions, trials to study the immunological FOBT, flexible sigmoidoscopy and colonoscopy are currently under way. Due to a lack of available funds, however, urgently required regional trials in line with all scientific requirements cannot be realized. New blood and stool tests and imaging procedures (CT and MR colonography etc) require intensive research and might well become primary screening methods in some EU countries. Existing or planned screening programmes should be followed-up while their effect on incidence, mortality and health cost expenses should be studied across the individual countries or regions. An unbiased approach is required to establish the separate effects of screening and treatment on the aforementioned variables.

9. The European Commission should use the Brussels conference as a platform for its own establishment of a 'Pan-European Network Against Colorectal Cancer'. Such a network should feature scientists, politicians and representatives of health insurance providers and other policy makers, high-risk groups and patients' organisations from different European countries. The network should create synergies between the individual stakeholders involved in the national screening programmes by enhancing collaboration and the exchange of best practice. We firmly believe that this is the only way of levelling the considerable EU-wide differences of national CRC incidence and mortality rates in the foreseeable future.