Bowel cancer continues to be a leading cause of mortality and morbidity in New Zealand. Around 3,000 new cases of bowel cancer are diagnosed in New Zealand each year. Bowel cancer has the second highest cancer mortality rate in New Zealand, and is the cause of over 1,200 deaths annually; 1,252 deaths in 2013.

The stage of bowel cancer at diagnosis is the most important determinant of prognosis. Screening programmes are a crucial part of any programme aimed at reducing the impact of bowel cancer. They help detect cancers at an earlier and more treatable stage, and can also prevent cancers entirely through polypectomy. After years of advocating for a national bowel screening programme, Bowel Cancer New Zealand welcomed the Government's announcement earlier in 2016 to implement a national screening programme. As details of the proposed programme emerge, Gandhi and colleagues have appropriately pointed out that the question has shifted to how and who we should screen.

The Waitemata DHB Bowel Screening Pilot Programme included people aged 50–74 years, screened with faecal immunochemical tests (FIT) at two-yearly intervals. However, the national programme will only be available to people aged 60–74 years as it rolls out. This is a concern for various reasons.

Firstly, New Zealand has a higher proportion of patients diagnosed with metastatic (stage IV) colon cancer (24%) and rectal cancer (19%) than both Australia (19% and 17% respectively) and the UK (17% for both cancers). Secondly, provisional cancer registration data indicates that of 9,513 new diagnoses of bowel cancer in 2013–2015, 39% occurred in individuals aged 60–74; and 12% occurred in people aged 50–59 years. In 2014 alone, there were 120 deaths from bowel cancer in the 50–59 year age group. In view of these statistics, and the fact that screening has the potential to shift the stage at diagnosis, we urge planning for New Zealand’s national bowel cancer screening programme to include people aged 50–59 years.

A further justification for extending the eligible screening age is the Government's commitment to reducing inequities in outcomes between Māori or Pacific people and non-Māori/non-Pacific people. While 12% of all bowel cancer occurs in people aged 50–59 years, among Māori diagnosed with bowel cancer the proportion in the 50–59 year age group is 22%, and among Pacific people the proportion is also high. Māori and Pacific New Zealanders are younger at time of bowel cancer diagnosis, yet they are also more likely to be diagnosed with stage III or stage IV cancer. Restricting the screening programme to people aged 60–74 years is inconsistent with the Government's aim of reducing inequity in bowel cancer outcomes between different ethnic groups.

A recent study summarising international bowel cancer screening programmes indicates that the many organised, population-based, colorectal screening programmes across the globe begin screening from age 50. We are told by representatives of the Ministry of Health's Bowel Cancer Working Group that ‘hard calls’ are required in New Zealand’s screening programme as our DHBs do not have the colonoscopy workforce to cope with the projected volume of colonoscopies required after positive FIT screening test results. Initiatives to address this workforce shortfall have repeatedly stalled, and too little has been done to address the problem.

Given that New Zealand has among the highest incidence of bowel cancer worldwide and poorer survival outcomes compared to Australia, we believe plans to properly resource New Zealand’s DHBs and to extend the national programme to those aged 50–59 years are required urgently. To address known inequities, Māori and Pacific people in the 50–59 year age range should be eligible for inclusion in the screening programme now.
Competing interests:
Nil.

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