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# The Place of Screening in a National Cancer Strategy

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# Opening comments

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- Screening should form a significant part of any national cancer strategy
- Screening programmes and technologies should change over time in response to developments in the evidence base
- The appropriateness of specific programmes and technologies may well vary between countries, depending on incidence/mortality and on affordability
- I am not an expert on screening, but fortunately I have excellent advice!

# Cancer control reports/strategies in England

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1. The Calman-Hine report (1995)
  - Emphasis almost exclusively on services for symptomatic patients
  - Multidisciplinary teams and networks of care
2. NHS Cancer Plan (2000)
  - First comprehensive cancer strategy
  - Covered all aspects from prevention to palliative care
  - Multiple commitments/targets and increased funding
3. Cancer Reform Strategy (2007)
  - Updated the NHS Cancer Plan
  - More emphasis on awareness and early diagnosis and on survivorship following treatment

# Broad commitments on screening

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- NHS Cancer Plan (2000)

“Where screening programmes are effective they will be extended and new programmes rolled out ...”

- Cancer Reform Strategy (2007)

“Early diagnosis is vital if we are to achieve a genuinely world-class service” (Foreword by Prime Minister)

“We will extend and widen our existing screening programmes and continue to investigate opportunities for new screening programmes for other cancers”

## What has this meant in practice for breast cancer?

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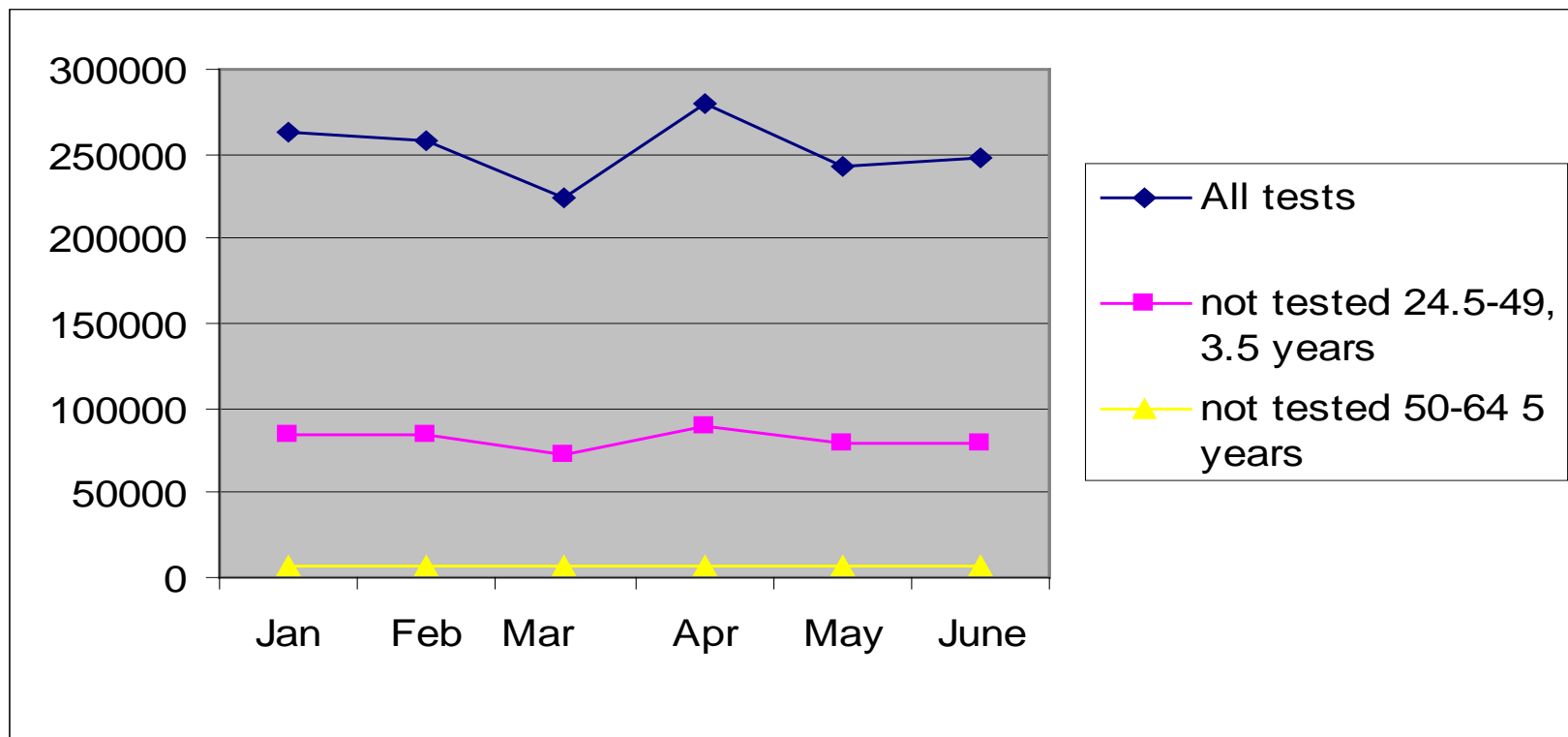
- 1998 onwards: 3 yearly mammography for women aged 50-64 years (i.e. 5 rounds per woman)
- 2000 onwards: Extension to include women aged 65-70 years (i.e. 7 rounds per woman) and 2 view mammography at all visits.
  - This required major expansion of the service
  - Radiographers (non-medical) took on new roles
  - The number of women screened pa is now over 2 million
  - The number of cancers detected has more than doubled to over 14000 cases pa
- 2007 onwards: Plans to extend breast screening to women aged 47-73 and to introduce digital mammography across the whole country
- The age extension will be introduced as a randomised trial to give robust information on the additional benefits of extra screening rounds

## What has this meant in practice for cervical cancer?

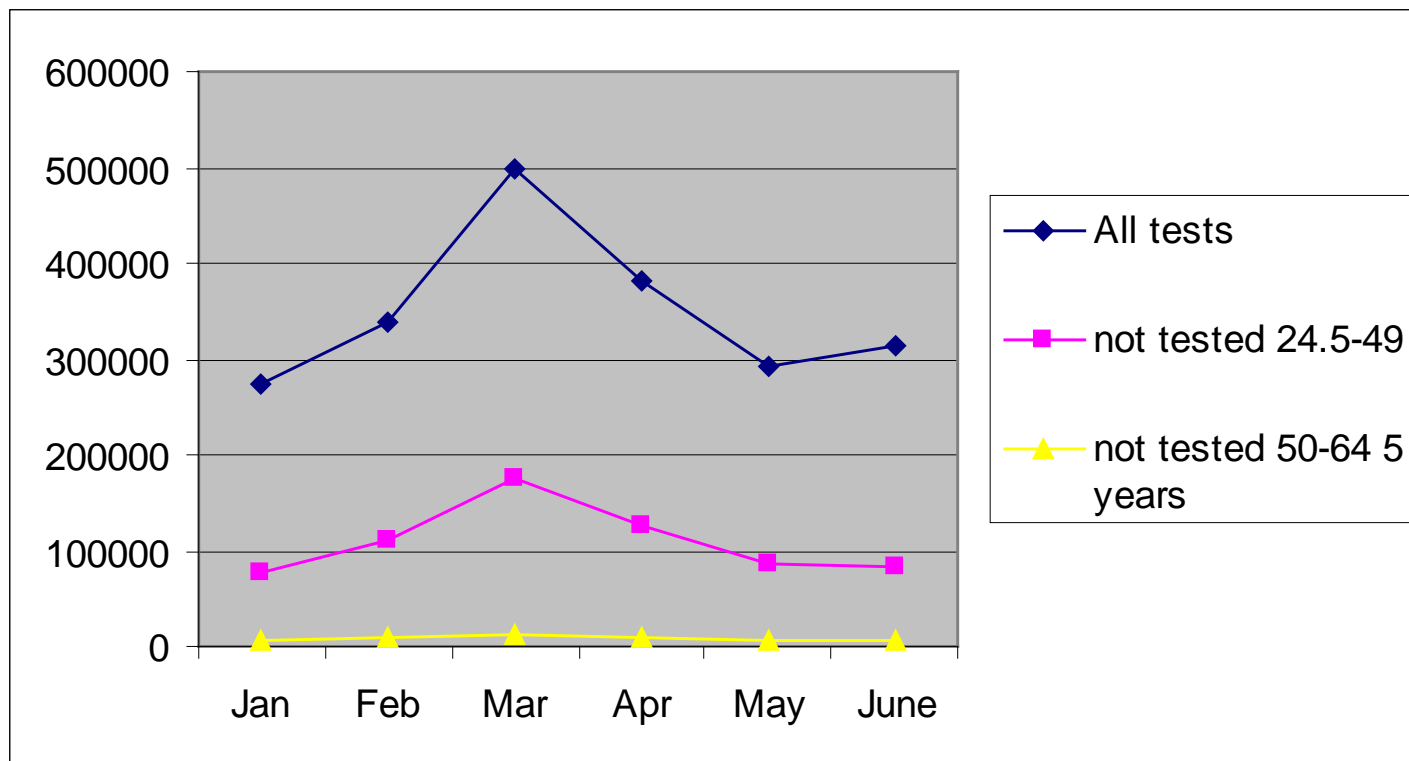
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- We have a longstanding cervical cytology programme, which underwent a major upgrade around 20 years ago. It is estimated to save around 4500 lives pa
- Developments over the past 5-7 years
  - Introduction of liquid based cytology, leading to major reductions in women being recalled because of inadequate smears (from almost 10% to around 2%)
  - Standardisation of age range (25-65) and screening intervals
  - Service redesign to reduce ‘turnaround times’ to a maximum of 2 weeks
  - Work to reduce variations in coverage and falling participation in younger women
  - Handling of the “Jade Goody” effect. Jade Goody was a reality TV (Big Brother) star diagnosed with cervical cancer in August 2008 who died in March 2009

## Women screened Jan-Jun 2008



# Women screened Jan-Jun 2009





## What has this meant in practice for colorectal cancer?

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- Large scale pilot of the feasibility and acceptability of routine FOBT completed in 2002
- July 2006 onwards: Rollout of FOBT for men and women aged 60-69 years
  - 5 “Hubs” and around 100 “Centres”
  - Centres had to demonstrate that endoscopy services met quality and timeliness standards before being accepted into the programme
  - Acceptance rate 53%
  - 5.5 million invited; 3.2 million kits returned; over 50,000 colonoscopies; over 5000 cancers detected and over 20,000 polyps removed
- Now: Extending the programme to people aged 70-75 years

## What has this meant in practice for prostate cancer?

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- No formal screening programme (i.e. involving routine invitations being sent to men)
- PSA testing is available from GPs, subject to informed choice
- Results (2009) of RCTs are being carefully considered, especially in relation to the problem of over diagnosis

## Where next on screening in England? (1)

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Several developments are currently being considered:

- Cervical screening
  - HPV triage?
  - Primary HPV screening?  
(NB link to HPV vaccination programme)
- Colorectal screening
  - Immunochemical FOBT?
  - Flexible sigmoidoscopy (e.g. at age 55)?

## Where next on screening in England? (2)

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- Greater linkage between screening and the broader National Awareness and Early Diagnosis Initiative (NAEDI)
  - 95% of all cancers are diagnosed symptomatically
  - We estimate that around 10,000 deaths could be avoided each year through earlier diagnosis of symptomatic cases
- How? Local and national campaigns to encourage uptake of screening and to promote earlier presentation with symptoms
- We are piloting a one-to-one intervention in women at their final routine screen. This has been shown to increase awareness

## Making the case for screening in a national cancer strategy (1)

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- Breast, cervical and colorectal cancer screening programmes undoubtedly save lives (with a potential to save over 7,500 lives pa in England)
- Screening is generally highly cost effective in comparison with other cancer interventions (e.g. new drugs)

## Making the case for screening in a national cancer strategy (2)

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- Political and public support for screening has been and remains strong in this country
- But ...
  - We face severe financial constraints
  - There are multiple (and often vocal) demands on the cancer budget
  - We need ongoing public/patient advocacy
  - We have not convinced all GPs of the benefits of screening, possibly due to publicity in the British Medical Journal

# Summary

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- Screening is central to the national cancer programme in England, and is saving thousands of lives each year
- We can and we must do more, even at a time of financial constraint