

## **IMPLEMENTATION OF COLORECTAL CANCER SCREENING IN FRANCE**

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In 2000, the Advisory Committee on Cancer Prevention of the European Commission, on the basis of the data available in Denmark, England and France recommended that EU countries set up colorectal cancer screening programmes. This recommendation led to the inscription of colorectal cancer screening in the European Code Against Cancer and to a statement from the European Commission itself. In the absence of any reaction from the French Health Authorities, the French Society of Gastroenterology decided to launch a press campaign directed towards the Public Health Authorities. Under this strong pressure, the then Minister of Health, Bernard Kouchner, announced in April 2001 the implementation of pilot studies. However, technical problems and opposition, in particular opposition from the National Health Service remained. It was only after another decision from the next Minister of Health, Jean-François Mattéi that the programme started. After a call for proposals, 22 geographic areas called *departements*, were selected. In light of the preliminary results, the following Minister of Health, Philippe Douste Blazy announced in April 2005 the progressive generalisation of colorectal cancer screening. It is a reality since the end of 2008.

### **ORGANISATION OF COLORECTAL CANCER SCREENING IN FRANCE**

Cancer screening is coordinated at the national level by a strategic committee associating experts and representatives of the different health authorities. The Ministry of Health, the National Cancer Institute (INCa), the National Health Insurance and the National Public Health Institute (InVS) are particularly involved.

The practical organisation is decentralised. At the level of each district including any overall population of about 500,000 to 1,000,000, a coordinating centre is in charge of organising breast and colorectal cancer screening. A structured organisation with a rigorous call-recall system and quality assurance evaluation is necessary for effective screening. From the administrative point of view, the coordinating centre is a non-profit organization with an administrative council and two scientific committees: one for breast cancer, one for colorectal cancer. The coordinating centre is directed by a public health doctor assisted by technical staff. This structure is in charge of the organisation and the evaluation of the screening campaigns. Its responsibilities include training GPs, informing health professionals, informing the population and inviting the target population to

be screened, ensuring the practical organisation of screening campaign and collecting data to evaluate the screening campaign. They report annual statistics to the national health authorities.

Faecal occult blood screening (with a guaiac test) is recommended every two years to asymptomatic subjects aged 50 to 74. Certain subjects are excluded from this screening strategy, namely those with newly appeared digestive symptoms requiring a colonoscopy, subjects with a previous history of colorectal cancer or of adenoma followed-up by colonoscopy, first degree relatives of an index case who had colorectal cancer before 65, as they are systematically invited to have a screening colonoscopy, subjects with a normal colonoscopy performed within the previous 5 years and subjects with other severe illness. Excluded individuals represent 10 to 15% of the overall population.

### **INVITATION STRATEGY**

At the beginning of every screening round, an information letter is sent to each target subjects along with a 4-page information brochure. The invitation process is based on nominative lists of citizens with national health insurance provided by health insurance organisations. Only 0.4% of people do not have health insurance. During the first 6 months of the screening round, GPs and doctors in occupational medicine offer the test free of charge to eligible patients seen at their practices. A reminder is sent after 3 months to non-participants. For patients who do not consult their GPs during the medical phase, the coordinating centre subsequently mails the test and when necessary a reminder letter 1 month later. The entire population involved is invited to participate in the successive rounds.

Individuals who accept the test take 2 samples of three consecutive stools and send the completed cards, in a prepaid envelope, to the central analysis laboratory. No diet restriction is required. The three cards are processed without rehydration, according to a standardized procedure. One positive field is enough to call a test positive. In the case of a positive test, the subject is invited by letter to consult his GP (who has been previously informed by the analysis laboratory). The latter has to prescribe a full colonoscopy. The appointment is made directly by the patient. In the case of negative test results, subjects are informed of the test's limitations and the need to consult if digestive symptoms appear. They are also informed that the test needs to be repeated within 2 years. In all cases the result is sent by the biologist of the analysis centre.

### **AWARENESS CAMPAIGNS AND INFORMATION TO HEALTH PROFESSIONALS**

In France the active participation of primary care physicians was found to be crucial to obtain a high participation rate. The key role of GPs is to identify persons who should be excluded for medical reasons, to explain and give the test and to explain the whole screening process. So GP

training is an essential part of the programme. Inviting GPs to participate in a short training session a few days before the start of the screening campaign is not sufficient and specific actions are required to motivate them. Our experience suggests that meeting in small groups encourages active participation. Regular feed back on the development of the screening programme is also important. GPs who do not attend the training sessions receive individualized training. When this strategy was used, more than 90 % of the GPs took part. Offering the test during a routine consultation resulted in an average participation rate of 90%. This data suggests that in France, and probably in all Latin European countries, it is essential to have GPs participate in the screening programme. However mailing the test is helpful in reaching those who are not in contact with primary care physicians during the 6-month free-consultation phase. A small fee is paid to GPs according to the number of patients who do the tests.

GPs provide administrative data on the subjects involved in screening and information about medical exclusion criteria. Gastroenterologists transmit the data on the colonoscopy and on the characteristics and treatment of detected lesions.

## **PRELIMINARY RESULTS CONCERNING COLORECTAL CANCER SCREENING IN FRANCE**

A preliminary evaluation was performed by the National Public Health Institute (InVS). The overall participation rate among the 19 districts ("departments") covering a population of nearly 4 million people aged 50 to 74 was 42%, varying by district from 31% to 54%. It was 48% and above in 7 districts, between 40% and 48% in 4 districts and between 31% and 39% in 8 districts. The overall positivity rate was 2.7% and colonoscopies were performed in 86% of subjects with a positive test. Among them 9.2% of subjects had colorectal cancer and 31.1% had adenomas. Among the latter group, 49.2% had an adenoma larger than 1cm [six cases of perforation resulting from colonoscopy (0.84 p 1000 examinations)]. Mass screening with FOBT reproduces the results of the French controlled trial in some areas. However, it was not the case everywhere. Some improvements are still necessary.

## **CONCLUSION**

Following EU recommendations, a national policy for colorectal cancer screening was implemented in France. The strategy is based on faecal occult blood testing in asymptomatic subjects aged 50 to 74. A structured organisation with a rigorous call-recall system and quality assurance was set up in each administrative area. Since the end of 2008, colorectal cancer screening is offered to the whole target population.