infection and psychological harm and the time that participants must devote to the screening process are not generally accounted for in these evaluations.
- Although all of the published economic evaluations that CCOHTA reviewed showed that screening was cost-effective, the NCCCS[3] analysis showed that cost-effectiveness and reduction in deaths from colorectal cancer depend strongly on the assumed participation rate for the first screen (67% in the base case) and the frequency of screening. However, the participation rate that can be achieved in Canada is largely unknown.

To our knowledge, no country has implemented a population-based screening program at the national level, although several countries have undertaken pilot studies or large-scale programs. If Canada embarks on an expensive ($112 million per year, according to the NCCCS study[3]) community-based screening program for patients at average risk, then health care professionals and the general public should understand that this would be an experiment. Whether the benefits will outweigh the harms is unknown.

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In his commentary, Richard Schabas compared various tools for colon cancer screening.[1] Regarding fecal occult blood (FOB) testing, he stated that the test is "undeniably imperfect" and that "it misses almost as many cancers as it finds." He went on to say that colonoscopy is "probably a better screening tool than FOB" and "appears to be at least as cost-effective." Schabas concluded that we must start doing FOB testing and not colonoscopy in Canada because we believe in "the principles of equity and distributive justice." Instead of setting a goal of increasing the capacity to offer widespread screening colonoscopy, which could significantly reduce the incidence of and mortality associated with colon cancer, Schabas suggested that we opt for a clearly inferior test and accept our "inadequate health system capacity."

By comparison, there is no consensus on the value of mammographic screening for breast cancer, yet we are prepared to spend millions of dollars on such programs. Why should colon cancer not be regarded as at least of equal importance?

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[The author responds:]

In discussing my commentary about colorectal cancer screening,[1] Ted Mitchell is quite right to point out the importance of informed consent for cancer screening. The Cancer Care Ontario[2] and NCCCS[3] reports both emphasize this point. However, it is inappropriate to suggest that these reports do not reflect a "thoughtful weighing of the risks." Both groups included strong consumer representation and put much thought into the issue.

Mitchell is also concerned that colorectal screening will place a new burden on family doctors. However, this burden would be minimized if provincial governments introduced organized screening programs, with provisions for follow-up recall and timely colonoscopy assessment.

There are 3 problems with Bruce Brady's analysis. First, it should be remembered that an intervention with a modest clinical (i.e., individual) benefit can still have a significant population impact. The 20% reduction in mortality projected by the Cancer Care Ontario report[2] would result in about 1500 fewer deaths from colorectal cancer annually in Canada by 2015. Second, cost-effectiveness does not necessarily depend "strongly" on participation rate. In fact, a colorectal screening program would have relatively low fixed costs and high discretionary costs. Our own (unpublished) work at Cancer Care Ontario suggested that the cost-effectiveness curve is very flat above 20% participation, which is hardly a daunting target. Third, Brady refers to a national screening program as an "experiment," but it would be more appropriate to view the randomized clinical trials as the experiments. An evidence-based program emulating these randomized clinical trials would be good health policy, not just an experiment.

Brady is properly concerned about the risks of colonoscopy assessment by inexperienced operators. This is a compelling reason for offering colorectal screening through an organized program rather than on an ad hoc basis (as would be the case with simply issuing clinical guidelines).

With regard to Gordon McLauchlan's letter, there is no need to choose between starting colorectal screening with FOB testing (because we are able to do so) and building our endoscopy capacity so that some day we can replace FOB testing with endoscopy.

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