**LAUNCH OF THE NATIONAL CANCER PLAN 2011-2015**  (8TH FEBRUARY 2011)

Proceedings of Discussion Group 2: Screening and Early Diagnosis

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| **A. Faecal Occult Blood Testing (FOBT)** | • Participants will receive an FOBT card/kit at home together with detailed instructions of how to take the test. The nature of the FOBT kit has yet to be decided upon. They will subsequently be contacted and informed about the result.  
• Some of the attendees expressed concern at the cooperation of the public to such a screening test as it may be too complicated.  
• Positive results need to be communicated to the patients in a sensitive and professional manner so as to avoid any unnecessary distress. Qualified staff should contact the patient by phone in order to provide the necessary assistance, answer any queries about the communicated result and set a follow up appointment during which the patient will be provided further details about additional investigations and endoscopy. This requires the set up of a dedicated team to support and guide patients throughout the process.  
• Screening programmes will be accompanied by a marketing campaign so as to increase public awareness and increase the response rate.  
• FOBT is an appropriate test to use for screening; however the type of FOBT used (guaiac or immunochemical FOBT) will have a resulting impact on the cost, detection of colon cancer and follow up.  
  − Immunochemical FOBT is more expensive than guaiac FOBT (6 euros and 50 euro cents respectively per kit) but has a considerably higher detection rate owing to its higher sensitivity and specificity. Moreover, immunochemical FOBT does not require participants to undergo a preparation diet and only a single smear is required instead of 3 consecutive smears as with the guaiac test. Therefore, the use of immunochemical FOBT, though more expensive, would lead to a greater participation rate.  
  − As immunochemical FOBT are heat sensitive their use necessitates the adoption of alternative methods of transport and storage or withholding of screening during the summer months.  
• It was suggested that, in order to reduce expenses, participants should be contacted by phone prior to the delivery of the FOBT kits. Only those participants who agree to undergo an FOBT test and submit samples should have the FOBT kit delivered at home. |
• Need for proper guidelines to guide the screening process. Guidelines are required, amongst others, for the effective and consistent interpretation of results such and to determine the cut off point for a positive and a negative result.

• Individuals with a strong family history of colon cancer should be eligible for screening even though they would not fall into the selection criteria for screening, which is based on age groups.

• Colon cancer screening would only be offered to asymptomatic people as patients who are already symptomatic should be fast tracked through appropriate clinical channels. Discussions are currently underway to evaluate the screening in terms of risk based on family history and not just age groups.

1. Follow up Endoscopy

• Importance of ensuring adequate capacity for the increase in the number of endoscopies and consequent surgeries as a result of the colon cancer screening programme. As the demand for endoscopies is already high and hospital resources are already stretched to their limit a dedicated clinic must be set up for endoscopic investigations. This would require training of new staff and endoscopists and the identification of quality indicators and criteria.

• The recently published EU quality assurance guidelines will be used to implement and safeguard quality standards throughout the screening process.

• It is has been calculated that the initial stages of the screening programme will result in an average of 300 endoscopies annually, which corresponds to 2 endoscopy sessions weekly.

• The same issues were encountered and tackled successfully in the set up of the breast screening programme. It may also be beneficial to open posts for endoscopy technicians in order to ensure successful service delivery.

• Staff can be trained to carry out endoscopies; in fact, the UK already has a very active training programme for clinicians and technicians. Screening is also shifting from the use of FOBT and endoscopies following a positive reading to screening using flexible sigmoidoscopy by trained staff.

• Interested general practitioners should also be offered training to carry out flexible sigmoidoscopies.

2. Additional logistic issues and support framework for colon cancer screening

• General practitioners have a key role in filtering patients thus preventing an overload of suspected cases. The involvement and participation of family doctors in screening programmes is essential in order to build an efficient and robust screening system.

• The Breast Screening Programme has established a formal communication link with family doctors and a series of information events are being planned to strengthen this link.

• Gastrointestinal symptoms are very common and in the absence of proper investigations, it is difficult to exclude any serious underlying causes. In order to assist general practitioners in referring patients for additional investigations, an online Proforma could be developed, which the general practitioners would be encouraged to complete, highlighting the main
- The introduction of triage for vetting of referrals, as is being done in the Department of Dermatology would allow for fast tracking of urgent cases and improves the service provided to patients.
- Identification of dedicated clinics for gastrointestinal symptoms would aid in the proper investigation of such symptoms at primary care level.
- Screening involves asymptomatic patients as patients who present with symptoms are fast tracked through the clinical channel. The introduction of a screening programme and the set up of standards will also result in an improvement in the standards at the clinical symptomatic service provision level.
  - A total of 10 million euros are dedicated to the National Cancer Plan for a period of 5 years. This includes all the resources, consumables and implementation costs.
- Such a sum may not support all the plans and actions listed for screening services, especially since HPV vaccination is expensive.
- Collaboration with the private sector should be explored in order to support such screening programmes and the associated increase in workload. Moreover it is essential to invest in human resources in order to support a longstanding programme.
### B. HPV Vaccination and Cervical Screening

- Cervical screening is the most popular and easily available screening test locally. According to the recent Health Interview Survey, 65% of women claimed to have done a smear test. Screening is done both at private and public sector level. The cervical screening service available at primary care level accounts for approximately a third of all the cervical screening tests carried out in Malta. This opportunistic screening service should be extended and organised to become a national screening service.
  - Well-woman clinics should serve not only for the administration of HPV vaccination and cervical screening, but such an opportunity must also be utilised to examine and test women for other co morbidities.
  - It is important to inform and educate the public that administration of HPV vaccination still necessitates the use of regular cervical screening and tests.
  - The logistics and maintenance of quality standards poses the greatest challenge for a national cervical screening programme. It is important to safeguard quality standards at all stages of the screening process, ranging from the conduction of smear test at physician/primary care level up to analyses and testing at laboratory level.
- General practitioners may require adequate training in conducting smear tests if they are to contribute in the national screening programme.
- For professionals to become accredited to carry out cervical smear test they must be adequately trained and must have conducted a predefined number of screening tests. Efforts must be focused to restructure and bring the existent cervical screening service up to standard in line with the Quality Assurance guidelines.

### C. Multidisciplinary teams

- Multidisciplinary teams (MDT) are very beneficial, however, the limited number of human resources as well as time constraints make multidisciplinary team approach to managing patients very hard to achieve.
- The biggest challenge to MDT is lack of time and resources.
- A multidisciplinary approach is fundamental to the screening process and in line with established guidelines, making MDT a fundamental requirement of not just screening, but also cancer diagnosis and care. The breast MDT is functioning well and can serve as a model for other modalities.