Colorectal Cancer
Health Check Barometer 2017

Contributing countries: Belarus, Belgium, Bulgaria, Cyprus, Estonia, Finland, France, Germany, Greece, Hungary, Israel, Latvia, Lithuania, FYR Macedonia, Malta, Netherlands, Portugal, Romania, Russia, Serbia, Slovakia, Slovenia, Spain, Turkey, United Kingdom.

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Introduction
This is the 3rd Health Check Barometer published by EuropaColon. We acknowledge the support from our Affiliate and Associate partner groups, from published sources plus organisations and companies in Europe. The purpose of the report is to provide an overview of issues relevant to colorectal cancer (CRC) patients and the delivery of their care. It also aims to offer a tool for meaningful engagement with the EU Commission, MEPs, and National Governments.

Colorectal Cancer
CRC is the name given to the cancer of the large intestine and rectum. CRC is the 3rd most common cancer in men and 2nd in women with over 425,000 new cases every year and about half dying each year in Europe.

Enough is known about CRC to be confident that cases can be prevented and many successfully treated if detected early. This depends on effective prevention and early detection strategies being implemented in all European countries. Early and well managed interventions can save thousands of lives alongside considerable savings in treatment costs every year.

Estimated age-standardised rates (World) per 100,000

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<th>Region</th>
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A NCCP should look at the equity of cancer care delivery within the whole country, especially areas where access to a centre of excellence is not routine. Any review should include access to diagnostics, medicines, treatment and care in relation to access and delivery in bordering countries.

EuropaColon believes a NCCP should be reviewed at least every 5 years. Such review should involve all clinical and non-clinical partners who are stakeholders in the provision of diagnosis, treatment, care and support of cancer patients. It is essential that discussions should include patient representatives or patient organisations.

Colorectal Cancer Screening
In 2011 the EU Commission published the European Guidelines for Quality Assurance in Colorectal Cancer Screening and Diagnosis. This comprehensive publication sets the standard for improving early diagnosis with the intention to reducing mortality from CRC with the introduction of a Formal Population Screening Programme (FPSP). Not only is progress well documented but its cost effectiveness has been established beyond doubt.

Perhaps we need to define FPSPs to avoid confusion. These are centralised programmes managed under the auspices of the Health Ministry whereby every eligible citizen between the ages of 50 and 74 is invited to complete a screening test. In some countries a ‘programme’ is operating where citizens refer themselves, or by a GP, for screening. This is not FPSP, uptake will be poor, quality inconsistent and oversight of the process difficult if not impossible. Such activity should not be described as national screening when reviewing screening arrangements as it both confuses and misleads further analysis.

Early CRC screening offered citizens the gFOBT (guaiac Faecal Occult Blood Test) but FIT (Faecal Immunochemical Test) is markedly more effective and is recommended in the 2011 Guidelines. It is reassuring progress that many Member States have or are converting to FIT-based screening programmes. This test is more sensitive, easier to use and achieves higher compliance rates. However the clinical
effectiveness of FIT-based screening will depend on the threshold adopted for referral for colonoscopy.

A major benefit of the FIT test is the increased ability to identify early cancers and advanced adenomas likely to become cancers.

The EU Commission recently published a new report⁴ that reviews screening in MS. The report concludes that while much progress is being made “… significant efforts need to be made by the MS to improve the organisation of their programmes to further increase the coverage as well as to improve the performance”. The report is also clear that coverage needs to expand to reduce inequalities in access and extend the benefits to all eligible citizens.

While this new report gives a more detailed picture of screening in MS, the data is incomplete, making it difficult to draw accurate comparisons between countries. Considerable discrepancies exist in MS approaches to screening; stages of roll-out; age offered for screening and how uptake or compliance is recorded.

A fully functional organised population-based screening programme is a robust system of screening which will reach all of the eligible subjects, gain good compliance, provide consistent high quality FIT testing, colonoscopy and pathology diagnosis. Such programmes continually monitor performance and correct failings including taking measures to raise national awareness of the programme and focusing campaigns on groups with poor compliance. Aspects of the recent report suggest greater national compliance in meeting EC screening quality standards than are known to apply.

EuropaColon has determined that EIGHT countries are making good progress but with some deficiencies – Belgium (not to the whole of the country), France (compliance is low), Republic of Ireland (limited population invited), Italy (poor coverage in southern Italy), Netherlands (early roll-out but with exceptional compliance), Malta (very limited age range), Slovenia (full roll-out with good compliance), UK (high quality, currently gFOBt, all countries cover 60-75, Scotland include 50-59).

Whilst comprehensive coverage (invitations to all of the eligible population) is an essential element of screening, good compliance is also a key and more difficult to attain. Presently there is huge variation between countries with many where it is very low. Compliance depends on continued efforts to raise public health awareness of screening and the benefits of the programme.

EuropaColon believes that cutting prevention or public health budgets at a time when we have cost saving programmes that will save lives does not make sense.

EuropaColon is optimistic that further progress will be made in screening since its efficacy is widely appreciated, the benefits of FIT are well understood and we have exemplars of good screening within Europe. Much more work is needed if high quality population-based programmes are to reach all eligible national populations. Whilst we know that screening can be both life and cost saving it still requires political commitment to make it happen!

A more realistic approach to Public Health needs to be adopted in the light of deaths from inaction

Biomarkers for Colorectal Cancer

Medicine is moving more and more towards personalising treatments for individual patients and this will eventually affect every aspect of cancer care from diagnosis to palliation. Personalised medicine will only achieve its true potential if patients understand their treatment options. To achieve this they need to ask questions of their doctors and nurses so that they fully appreciate their choices and their role in the delivery of their care. This will take encouragement from the whole clinical team.

RAS (the primary biomarker test for CRC) testing in Europe has improved significantly since the first Barometer in 2015 being now established in most Member States. The test identifies if the patient will respond to a particular medicine of which there are two that target the EGFR gene. Without test a patient might be offered a medicine less likely to have clinical benefit against the tumour. Recent research has shown that in some of the larger MS these tests only became routine during 2015, despite the test being a recognised marker for some years. We must assume that the trend will continue and soon all patients will receive the appropriate test before a medicine is prescribed in all countries in the EU⁵.

A current difficulty is the turn-around time between ordering the test and receiving the results. This can vary from more than two weeks in France to less than one week in other countries (e.g. Germany). The concern is that as the number of required biomarker tests increases (i.e. BRAF, MSI, CMS, etc) this will further contribute to delays. It will be especially noticeable when BRAF and RAS testing are done sequentially and not simultaneously which occurs in some countries. It is inevitable that the number of biomarker tests will continue
to grow as research into the molecular mechanisms of cancer expands.

A positive recent development is liquid biopsy RAS testing in mCRC. Traditionally most biomarker testing was performed on tumour tissue obtained either via biopsy or surgical resection. Today a number of technologies enable analysis of tumour DNA in blood, with several benefits to patients. This simple test is minimally invasive, can deliver faster results, leading to quicker commencement of treatment plus identifying RAS mutation-status in real time.

**EuropaColon welcomes these new developments as we move away from one-size fits all treatment. The cost effectiveness of biomarker testing was proven by the French Cancer Institute, they showed that testing prior to prescribing a medicine makes considerable savings.**

Increasingly biomarker testing will be required for all cancers. EuropaColon recommends that Member States develop the adequate infrastructure, both diagnostic and treatment facilities, to enable biomarkers to be fully integrated into clinical practice.

### Essential Requirements for Quality Cancer Care

In 2016 the European CanCer Organisation (ECCO), in order to promote good practice and multidisciplinary cancer care, undertook the first of a series of reports to establish the Essential Requirements for Quality Cancer Care. Colorectal Cancer\(^7\) and Bone and Soft Tissue Sarcomas\(^8\) formed the first reports.

25 members from European Societies attended two meetings – included were medical oncologists, radiologists, surgeons, patient advocates, representatives of oncology institutes, nurses, pharmacists and psychologists. At these meetings the first steps were set out and then finalised before submitting for publication in January 2017.

The ERQCC projects aims to:

- Improve outcomes for cancer patients in Europe through the adoption and implementation of Essential Requirements for Quality Cancer Care in Europe;
- Complement existing clinical guidelines and improve their efficacy
- Shape the policy environment at European and national levels to improve the quality of cancer care and decrease inequalities in cancer outcomes across Europe.

The ERQCC paper describes the essential requirements for quality care:

- CRC is the second most common cause of death in Europe and has wide variation in outcomes among countries. Increasing numbers of older people are contracting the disease and treatments for advanced stages are becoming more complex. A growing number of survivors also require specialist support.
- High-quality care can only be carried out in specialised CRC units or centres which have both a core multidisciplinary team and an extended team of allied professionals, and which are subject to quality and audit procedures. Such units or centres are far from universal in all European countries.
- It is essential that, to meet European aspirations or comprehensive cancer control, healthcare organisations implement the essential requirements in this paper, paying particular attention to multidisciplinary and patient-centred pathways from diagnosis, to treatment, to survivorship.
- The ECCO expert group is aware that it is not possible to propose a ‘one size fits all’ system for all countries, but urges that access to multidisciplinary units or centres be guaranteed for all those with CRC\(^6\).

In order to measure the delivery and effective delivery of these requirements an agreed set of indicators will be determined. These will be followed up in future Barometers to determine which hospitals provide the essential service to give patients the confidence they are getting the best treatment.

**EuropaColon, in collaboration with ECCO, will report on these indicators in future Barometers, showing how the Essential Requirements are being met.**

### References

1. Epidemiology of colorectal cancer in Europe. Source: GLOBOCAN 2012 [1].
2. GLOBOCAN 2012 (IARC) . Section of Cancer Surveillance (15/1/2017
6. Poster: Patterns of KRAS, NRAS, BRAF testing amongst patients with mCRC in the EUS, Xin Niu et al, ASCO 2015