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2nd CRC Screening Summit:

How Can Europe Tackle the High Incidence of Colorectal Cancer?

Tuesday, November 30, 2021

SUMMIT REPORT

The Second Colorectal Cancer Screening Summit

On 30 November 2021, Digestive Cancers Europe (DiCE) held a virtual Summit to discuss the current challenges and successes across Europe on colorectal cancer (CRC) screening. Given the success of last year's CRC Screening Summit, held on the same date last year, we are proud of this, our second edition of the event. So much so, that we are now planning for it to recur annually.

Why has DiCE run its second Summit on CRC Screening?

CRC is the second most frequent cancer among women and the third among men. Each year, approximately 500.000 citizens in Europe are diagnosed with CRC and approximately 250.000 die. CRC has a severe impact on patients and their families. Although CRC is the second most frequent cause of cancer-related deaths in Europe, many of the deaths and consequences of CRC could be avoided by applying preventive practices. A healthy lifestyle can contribute to reducing CRC risk. Moreover, CRC screening allows early and proven CRC detection.

If CRC is detected early (stages 1 or 2), it can be treated more effectively and there are higher chances of survival. Detection of CRC at stage 1 is associated with 90% 5-year overall survival (OS). At late disease stages (stage 4), the cancer is more difficult to treat, and the chances of survival are lowered to ~10% 5-year OS.[1] Also, on average, one might say that the difference in cost between the early stage and the late stage is probably tenfold, between 4,000€ and 40,000.[1] Data underline the fact that implementing population-based screening programmes across Europe can be lifesaving, cost-effective and cost-saving.[2]

Disparities are registered across Europe. In a few countries, such as Slovenia or The Netherlands, the active participation rate of citizens in CRC screening programmes reaches up to 65%, the desirable rate of participation as defined by a European Commission report. [3] Still, on average across Europe, only 14% of citizens between 50- and 74-year-old have the opportunity to participate in a formal population-based CRC screening. [4]

Along with this, the current COVID-19 crisis poses new challenges for European health care systems, with major consequences foreseen for cancer care and cancer patients. The COVID-19 pandemic has undoubtedly had a dramatic impact on all areas of cancer control, including screening and early detection programmes. The already existing gaps in access to screening programmes have enlarged across Europe and the most vulnerable groups have been left behind.

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[1] White Paper – Colorectal Screening in Europe. Digestive Cancers Europe, 2019.

[2] Cancer Screening in the European Union Report on the implementation of the Council Recommendation on cancer screening

[3] European Commission Guidelines For Quality Assurance in Colorectal Cancer Screening and Diagnosis, 2020

[4] The European Colorectal Cancer Road Map. Digestive cancers Europe, 2020

Inaction has a heavy price. Europe urgently needs formal population CRC screening programmes implemented across all countries to save lives! The Second CRC Summit gathered experts to share national and international experiences that can help move the implementation of quality screening practices forward across Europe.

DiCE and CRC Screening

Since 2018 Digestive Cancers Europe has established CRC screening as a strategic priority building on decades of experience from the EuropaColon organisation from which DiCE grew.

Along with running CRC related projects that input the patient voice on matters related to screening, DiCE raises awareness on screening:

- through its annual European Colorectal Cancer Awareness Month (ECCAM) campaigns. This is done together with its Member Organisations to reach the general public across Europe with the public health message centring on the value and urgency of CRC screening
- and by advocating at the policy level about the implementation of high quality and sustainable population-based screening programmes for all Europeans.

These activities led to the formation of a Thematic Network on CRC screening within the EU Health Policy Platform, which culminated in the publication of the Joint Statement: Call for Action on Colorectal Cancer Screening in the EU and the First Summit on CRC Screening in 2020. The Thematic Network has now been transformed into a Stakeholder Network on the same platform. The network and related platform, encourage its members to share knowledge and information on CRC Screening in the EU.

The 2021 CRC Screening Summit

This year’s Summit focused on three specific areas:

1. How to design and build effective and robust screening programmes
2. What the impact of COVID-19 on CRC screening has been and lessons learned
3. What needs to be done at the European level to make screening work.

The event, moderated, as last year, by Ms Tamsin Rose, saw the participation of nearly 20 experts with a wealth of expertise reflected in the topics of discussion.

Opening Messages

After the welcoming messages delivered by DiCE's CEO, Zorana Maravic, and DiCE's Acting Chair of the Board, Iga Rawicka, the Summit opened with a video message by Stella Kyriakidis, European Commissioner for Health and Food Safety. The Commissioner highlighted the important role that prevention practices, including screening, can play in reducing the loss of lives to CRC and the impact of the disease for patients and their families. As a result of the Beating Cancer Plan (BECA), CRC is currently under the spotlight and several initiatives are offering the opportunity to deal with CRC more effectively. These include the Update of the Council Recommendations on Cancer Screening, work which has already started and will be presented next year. Although currently, 20 Member States (MS) have set up population-based screening programmes, there is room for improvement and wider implementation. Moreover, the Cancer Inequalities Registry will help identify national and regional challenges and actions to guide investment and interventions to tackle inequalities within and between MS. The Commissioner referred to the challenges imposed by COVID-19, which brought additional stress to patients and their families, and that well designed CRC screening programmes recovered relatively quickly from the impact of the pandemic. Stella Kyriakides underlined the Commission's commitment to funding the health sector through the EU4Health Programme and the Recovery and Resilience Facility and supporting sustainable healthcare systems. Finally, the Commissioner emphasised the importance of collaboration to drive success.

"Multi-stakeholder involvement and engagement are crucial. And I know that I can count on your contribution and your support to offer that engagement."
Stella Kyriakides

CRC Screening – the Patient Perspective

Slovenia is currently one of the exemplary countries in Europe with one of the highest participation rates to CRC screening for people from 50–74 years of age, exceeding the 65% target of the European Council recommendations. Samo Podgornik, a patient representative from Slovenia, explained the Slovenian CRC screening programme, known as SVIT, which is based on a multi-stakeholder approach, good communication and information provision always and a relative short waiting time between a positive faecal immunochemical test (FIT) and a colonoscopy.

"I am grateful that the SVIT programme [Slovenian CRC Screening Programme] discovered my illness and the Institute of Oncology in Ljubljana cured me."
Samo Podgornik

Samo explained that being fully informed about the preparation for a colonoscopy as well as the procedure itself can help reduce people's anxiety and fear and increase participation. Samo's FIT result was positive, indicating signs of CRC. After a two-week wait, he underwent a colonoscopy, which confirmed that he had indeed CRC. He was diagnosed with stage IV CRC at the age of 52 and was treated immediately. It's been eight years since then, and Samo has become a **SVIT programme ambassador**, advocating for participation in CRC screening and its lifesaving effects.

Panel I: Designing and Building Effective and Robust CRC Screening Programmes

Panellists	
Dr Dominika Novak Mlakar	Head of the CRC Screening Programme, Slovenia
Dr Carlo Senore	Senior Epidemiologist, Piedmont Region Cancer Prevention Centre, University hospital Città della Salute e della Scienza, Turin, Italy
Prof. Ulrike Haug	Professor of Clinical Epidemiology and Pharmacoepidemiology, University of Bremen and Head of the Department of Clinical Epidemiology at the Leibniz Institute for Prevention Research and Epidemiology - BIPS, Bremen, Germany
Dr Nastazja Pilonis	Clinical Fellow in Gastroenterology, Cambridge University Hospitals NHS Foundation Trust, Cambridge, UK
Prof. Tomas Poškus	Professor of Surgery of Vilnius University and Member of the coordination committee of CRC screening program, Lithuania

The first topic of the Summit focused on **how to design and build effective and robust CRC screening programmes.**

The discussion started with a general overview of the Slovenian SVIT programme presented by the Head of SVIT, **Dr Dominika Novak Mlakar**, who illustrated the power of good communication in achieving high participation levels. They use and recommend regular written reminders via post. Data from 2018 show that after the implementation of four rounds of screening, CRC became the fifth most frequent cancer, while in 2007 it was the second most frequent cancer in Slovenia. Moreover, the overall survival of patients diagnosed within the CRC screening programme has improved by 30% (period of 2012–2016; group 50-74 years old). The programme's success is reflected by the high participation rates, increase in overall survival, and a decrease in new cases and mortality.

> *Since its creation in 2009, the SVIT programme's key challenge and aim have been "to achieve high quality and effectiveness of the programme and high level of trust. It is a great pleasure to know that we have succeeded."*
> ***Dr Dominika Novak Mlakar***

Ms Rose then turned to the four panellists, each from a different country in Europe, to reflect on **three key points needed to make a robust and effective screening programme**.

Dr Carlo Senore provided the Italian perspective where CRC screening programmes are organised at the regional level. He highlighted that success relies on multi-disciplinary collaboration, effective governance with a defined screening protocol, and constant monitoring of the programme's performance. He added that it is crucial that all results are always communicated back to participants.

Regarding multi-stakeholder collaboration, he proposed that avenues of communication between the endoscopist, pathologist and surgeon should be established to successfully manage people who are undergoing assessment. In addition, participants always need to be provided with the appropriate information and the flow of information needs to be managed efficiently. Thus, a multi-stakeholder approach relies on good communication between all interested parties.

Having sufficient information on different screening programmes supports the ability to monitor the activity. Data on the activity of screening provides opportunities for benchmarking and comparing key performance indicators across countries and programmes. Dr Senore concluded that networking activities at the national, and also at the European level, need to take place to provide a platform for the exchange of best practices.

Prof. Ulrike Haug focused on the German experience and underlined that the frequency of invitations to participate in the programme should be based on evidence collected around the results of the CRC screening data; this would lead to more effective and efficient programmes. A second point for successful screening programs was ensuring that participants with a positive FIT result have a follow-up colonoscopy. Finally, Prof. Haug added that monitoring of the programme should include characterisation of non-participants. This would allow understanding the drivers of low participation levels and would contribute to identifying where and how to reach non-participants.

Dr Nastazja Pilonis spoke about the need of implementing a homogeneous policy on screening at the national level, which has become very relevant in our current times, as people need to trust governments on health-related issues. She then emphasised the need for continuous quality assurance of the programme and how people are invited to undertake a FIT or a colonoscopy. As the latter is an invasive procedure, she felt its safety and efficacy must be monitored at all times.

However, for successful screening approaches to take place in different countries, it is important to acknowledge the diversity of the population in Europe, considering the huge differences in culture, fiscality and different priorities governments have. These differences should be considered when deciding the screening method to be used as well as the expected screening uptake.

Prof. Tomas Poškus highlighted the importance of having a robust national or regional system in place based on adherence to set regulations. He sees the programme as a costly initiative that must be supported by sufficient, recurrent, and stable funding, which should not be based on political outcomes. Finally, he underlined that a robust data management system will allow for the follow-up of each person during the whole screening process while keeping participants aware of this process. He agreed that the quality of the process should be monitored.

From the overall discussion, it became clear that communication via post was used for informing and engaging people about CRC screening. This led to discussing **a question posed by the audience** on **how to make CRC screening programmes more inclusive and how to reach and invite people that do not have a fixed address**, for example, undocumented migrants, homeless people or people that move around a lot.

On this point, **Dr Pilonis** shared that in Poland the screening programme allows all people 50–64 years of age to schedule a colonoscopy without a prior invitation. This provides an opportunity for people who may not have been reached by a letter invitation, to participate. However, this requires people's willingness to get screened and for this to happen people's trust needs to be in place. Trust could be built, and participation could increase if a united message underlying the safety and effectiveness of screening methods would be delivered at the European level. **Prof. Poškus** commented that this is a difficult problem to address and perhaps could be tackled by creating a "come-in screening". An additional obstacle is related to the fact that people are being contacted using the address of their medical records, which is something that not all people welcome and also needs to be GDPR compliant. **Dr Senore** added that patient organisations could contribute to the efforts to contact difficult-to-reach groups, which would lead to improving the equity of access to the programme.

Finally, the panellists were asked to provide a short response to a question asked by the audience on **how to motivate individuals who are ambivalent to screening**.

One solution to increase participation would be to offer a range of screening options or sequential options. This is because, while compliance to FIT is low, offering both the option of FIT and that of a colonoscopy leads to an increase in compliance, as shown by results of a randomised health services study performed in Poland.[1] Another important strategy is education – people need to be appropriately informed about the benefits of screening. Increasing accessibility is also crucial and the possibility of posting the test by regular mail should be considered. Finally, when offering colonoscopy, it is important to underline that this can be offered with sedation to remove the fear that many people may have towards this procedure.

Questions and Answers

Question: ***Does the SVIT programme also engage people with mental health problems and the elderly?*** Dr Novak Mlakar confirmed that the SVIT invitations include people with different types of disabilities and people who reside in care homes and the programme provides additional support if needed – for example by accompanying them for a colonoscopy. Clinicians and nurses are well prepared to manage any person who may have any type of additional need.

Question: ***How do General Practitioners (GPs) or previous participants promote screening?*** Dr Novak Mlakar said that they send GPs list of non-participants three times a year, so they are informed about non-participants. GPs are asked to contact these non-participants/their patients either by phone or by e-mail. GPs can also send a community nurse to the non-participants to help them out with communication issues or sample collection. It is also important that GPs or previous participants are invited to engage at promotional activities at community level to speak on the importance of CRC screening.

Question: ***Do you know what the coverage of the eligible population is and what percentage of the invited population that actually undertakes screening?*** Prof. Haug responded that since 2019 everybody who has health insurance receives an invitation and has full coverage. The uptake of screening and diagnostic colonoscopies in the past 10 years differs; screening colonoscopies constitute half of all colonoscopies and the 10-year prevalence for 60–74 years old is 20–23%; this goes up to 50% for all colonoscopies. In 2019, the screening method changed from FOBT to FIT, and there is still not enough data around FIT uptake. For the FOBT, the uptake was 20–30%, but could have been higher as the test is cheap and people might have used it without being reimbursed.

Panel II: CRC Screening – Lessons Learnt from the COVID-19 Panemic

Panellists	
Dr Iris Lansdorp-Vogelaar	Associate Professor at the Department of Public Health of Erasmus Medical Centre, Rotterdam, Netherlands and EU-TOPIA representative
Iris Seriese	Manager of the National Colorectal Cancer Screening Program, Netherlands
Dr Tytti Sarkeala	Director of Screening, Finnish Cancer Registry, Finland
Dr Robert Logan	King's College Hospital NHS Foundation Trust and National Clinical Adviser to the National Bowel Cancer Screening Programme, UK
Dr Maria Isabel Portillo Villares	Coordinator of the Colorectal Cancer Screening Programme, Basque Region, Spain
Prof. Dr Eric Van Cutsem	Head of Digestive Oncology, Leuven University Hospital, Belgium and Medical Director and Board Member of DiCE

The second part of the Summit explored **the impact of COVID-19 pandemic and the lessons learned from CRC screening programmes**.

The discussion started with Dr Iris Lansdorp-Vogelaar who presented the data on the impact of COVID-19 pandemic on the CRC screening programme in the Netherlands. In this country, but also all over the world, the rate of cancer diagnoses started to decrease since the first confirmed cases of COVID-19 and screening programmes were deeply impacted. Many CRC screening programmes suffered from lower capacity and/or participation and, as reflected in an informal survey, many of them suspended their activities. In the Netherlands, the number of FIT invitations for CRC screening sent out was deeply reduced during the lockdown period, with no invitations being sent out during April and May 2020. The backlog of invitations produced by that disruption period was cleared during the following months by increasing capacities. To understand the impact of the disruption period due to pandemic, the COVID-19 and Cancer Global Modelling Consortium evaluated two projects on CRC screening programmes. Using four microsimulation models they demonstrated that the longer the disruption period, the higher the number of cases of CRC and the CRC-related mortality rate. Furthermore, if the disruption period is followed by a period of reduced participation due to population fear of approaching health centres, the impact can be much larger. On the contrary, an immediate catch-up after a disruption period can be the best solution to minimise the effect of this. Therefore, in case of insufficient capacity to catch up immediately, catching up over an extended period is the best alternative.

> *"The COVID-19 and Cancer Global Modelling Consortium is a collaboration of several institutes in the field of cancer, including the UICC, the IARC, the Canadian Partnership against Cancer, the Cancer Council NSW and the International Cancer Screening Network (ICSN), which provide more informed advice to our governments in cancer control both during and after the crisis."*
> ***Dr Iris Lansdorp-Vogelaar***

Following the presentation of Dr Lansdorp-Vogelaar, Ms Rose asked the five panellists to provide the audience with the **key learnings from the experience they had in their countries**.

Iris Seriese shared the key learnings from the experience in the Netherlands. She noted that stopping the programme in solidarity during insecure times for the health care system was a good decision; this provided time to rethink how to restructure the programme when it was time to start it again. Supported by a mathematical model, when they restarted to send out invitations for screening, they decided to send them to everyone, and not any specific groups based on age, screening round or gender. They invited everyone in the same order they would have normally been invited (first out - first in principle), with a maximum screening interval of 32 months. Due to the flexibility of the IT system, they were able to invite based on the capacity that was available in colonoscopy centres. This method has led to an average screening interval of ~28 months maximum, which had resulted in the least missed yield compared to other strategies. Ms Seriese added that if the current increase in infections continued during the COVID-19 pandemic, they have planned to stop the programme again and continue more slowly.

Dr Tytti Sarkeala reported that in most piloting municipalities in Finland, invitations were on pause for two months in spring 2020 only. Thereafter, invitations were sent normally, and the delay was compensated with extra invitations in autumn. Also, participation in screening was similar from 2019 onwards and reached approximately 80%. The FIT analysis of samples worked normally throughout 2020, and there were only minor delays in colonoscopy appointments as people showed trust in the programme and wanted to participate despite COVID-19. Moreover, healthcare decision-makers and personnel consider CRC screening important. The Finnish experience in the FIT programme has so far been very good. However, this has been a pilot study and a national programme will be rolled out in spring 2022.

Dr Robert Logan commented that in the UK screening had also to be stopped completely. After starting to come out from the first pandemic wave last year, some significant changes were made in terms of the UK approach to screening. It was decided to stop the Bowel Scope Flexi Sigmoidoscopy screening component of the National Screening Programme. The crisis represented an opportunity to make this decision, which had been contemplated even before the pandemic due to problems in the delivery of this programme related to an insufficient workforce. Thus, this programme was replaced by FIT screening starting at the age of 56. Furthermore, the use of FIT in symptomatic services was implemented, recommending that everyone with any CRC symptoms had a FIT before having a colonoscopy. Finally, on account of the IT system, which gave insight into the entire clinical history of patients, it was possible to invite those patients with a higher risk of CRC for a colonoscopy, based on their profile and analysis results, thus maximizing the chances of CRC detection. As a result of these new strategies, it is now possible to detect twice as many cancers as they were two years ago in the UK.

Dr Maria Isabel Portillo Villares said that, also in the Basque country, the CRC screening programme had to stop for two months, and it restarted at the end of May 2020. In their case, they resumed the invitations after the lockdown and extended the invitations to more than 70% of the target population in 2021. In addition, while previously the invitations were sent to people from 50 to 69 years of age, they extended the invitations to include those 70 years old. An information campaign was launched about the importance of participating in the screening programme with the support of patient associations and primary care physicians and nurses. The involvement of primary care health centres was key for improving participation. Overall, the participation rate was affected by a slight decrease compared to 2018/2019 but was not severely affected. The data showed that participation was lower among people younger than 60 years of age and deprived groups, showing that participation in the programme among these groups was affected more by the pandemic. The pandemic also decreased the colonoscopy capacity. A way around this has been to perform FIT tests every year (instead of every three years) to monitor patients who already had surgery for the removal of polyps or adenomas.

Prof. Dr Eric Van Cutsem explained that in Belgium every year there are 60–70.000 new cancer cases, out of which 8.000 cases are for CRC cancer. In 2020, an approximately 6% decrease in cancer diagnosis was observed compared to 2019, meaning that ~4.000 patients were not diagnosed with cancer. In the first period of 2021, the backlog decreased by 10%. Interestingly, CRC screening participation decreased only slightly compared to that in 2019 and 2020 (less than 2%), meaning that the reduction in screening was only slightly responsible for the reduction of new cancer diagnoses. Prof. Van Cutsem postulated that the small reduction in participation in CRC screening would have a low impact on the overall cancer survival rates.

Questions and Answers

Question: ***What we see is that in different countries, different strategies have been implemented to mitigate the impact of COVID-19. Do you have an understanding of what catch-up approach has been followed internationally?*** Dr Iris Lansdrop-Vogelaar said that the international cancer screening network is doing a second survey asking countries across the globe how they have dealt with the pandemic crisis. Hopefully, by the beginning of 2022, we will have more information about how people, who may have any type of cancer, need to be managed.

Question: ***What needs to happen at the European level to support national efforts to catch up and maintain continuity in CRC screening?***

- **Ms Iris Seriese** proposed that we should gain better insights on the barriers and share info about the best strategy.
- **Dr Tytti Sarkeala** said that national and international collaboration is very important for sharing information, strategies, and protocols.
- **Dr Robert Logan** responded that when the FIT test was implemented, increased participation was observed from groups of people that otherwise would have not participated. Thus, we must ensure we have as broad a participation as possible. This requires organising screening programmes as inclusive as possible while recognising that a lot of people, who are at a greater risk of having cancer, are the ones that may be less likely to participate.
- **Dr Maria Isabel Portillo Villares** said we should invest in CRC screening and communication to decrease barriers to participation. It is time to share experiences and use different strategies to increase coverage and participation of vulnerable groups. Also, we have to consider that colonoscopy capacity can be a limiting factor that determines participation. It is important to educate patients and health care professionals on the importance of combining the colonoscopy with the FIT to maximise the utility of this procedure.
- Prof. Dr Eric Van Cutsem recognised the importance of learning from each other in a work group like the one that the Summit offers. He supported the fact that DiCE and other European organisations, as well as the European Commission, can play a crucial role in delivering recommendations, sharing experiences, modelling expertise and the numbers around screening, while raising awareness.

Panel III: Making CRC Screening Work Across Europe – What Needs to Be Done?

Panellists	
Dr Partha Basu	Head of the Screening Group, The International Agency for Research on Cancer (IARC)
Prof. Luigi Ricciardiello	Associate Professor of Gastroenterology, and Coordinator of the Colon Cancer Screening Program at University Hospital of Bologna Chair, Research Committee, United European Gastroenterology
John F. Ryan	Director of Public Health DG SANTE, European Commission
Dr Tit Albreht	Head of the Centre for Health Care at the National Institute of Public Health of Slovenia

The third session of the Second CRC Screening Summit focused on actions to be implemented at the European level to improve screening program output.

The session opened with Dr Partha Basu presenting the results from a recent publication of *The Lancet Oncology* looking at the impact of CRC screening in Europe in the last 20 years. Countries such as Germany and Austria, which implemented CRC screening programmes almost 20 years ago, are now experiencing a reduction in the disease incidence and mortality of approximately 2% and more than 3% respectively. Mortality reduction reached 3.9% in the Czech Republic. Furthermore, data shows that CRC screening programmes produce a rapid reduction in disease incidence and mortality.[5] Unfortunately, there is huge variability in the CRC screening coverage and participation rate across the different European countries. Also, gaps are recognised in the collected and shared information.[6] The disruption in CRC screening programmes caused by the COVID-19 crisis had huge consequences causing the largest excess of mortality, although strategies, such as catch-up after the stop period or extending the upper cut-off age by the same extent of the disruption period, could reduce the impact of the crisis.

> *"Until and unless we have a strong health information system, collecting data across the full continuation of cancer screening, it is extremely difficult to ensure quality of cancer screening."*
> ***Dr Partha Basu***

> *"Having more organised screening programmes is havaving more organised and resilient health systems."*
> ***Dr Partha Basu***

Following the presentation from Dr Basu, Ms Rose invited the three-panel participants to provide the audience with the **key action points to be considered to improve CRC screening programmes**.

Prof. Luigi Ricciardiello underlined that there are <u>significant differences across European countries</u> and regions. He said that we should make sure that the European organisations work together with

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[5] Cardoso R, et al. Colorectal cancer incidence, mortality, and stage distribution in European countries in the colorectal cancer screening era: an international population-based study. Lancet Oncol. 2021 Jul;22(7):1002-1013. doi: 10.1016/S1470-2045(21)00199-6.

[6] Senore C, et al. Performance of colorectal cancer screening in the European Union Member States: data from the second European screening report. Gut. 2019 Jul;68(7):1232-1244. doi: 10.1136/gutjnl-2018-317293.

patient organisations and provide the bulk of information that CRC screening reduces mortality. He added we should prioritise prevention programmes, such as screening programmes, in high-impact diseases like CRC. There is a need for more funds for cancer prevention, particularly for CRC. This can only happen if we support programme sustainability in countries where the incidence is increasing. Prof. Ricciardiello highlighted the need for unified efforts as this is a European and not a country-based problem. The involvement of GPs can help to boost adherence to cancer screening programs in each country. He concluded that we now have new technologies that we should use to target people with increased cancer risk to reduce the burden of colonoscopy.

Mr John F. Ryan said that the European Commission has worked to gather all the ideas relevant for the Europeans Beating Cancer Pan during a long consultation phase and then has developed initiatives and actions which should address the issues for which people had advocated. The plan was adopted this year and in the last few weeks, the European Commission published an Implementation Roadmap, specifying the "*When?*" and "*By whom?*" for each action - a transparency effort from the Commission. A second point is that a system has been created in which all the Commission departments can come together to follow the implementation of the plan; there is a similar group with the participation of Member States. He pointed out that since the EU Council of Ministers' position on screening launched in 2003, 20 EU Member States introduced population-based screening programmes for CRC in their National Cancer Control Plans by 2020. Mr Ryan added that although we have grown a lot since 2003, we can go much further. The Commission is currently revising the scientific basis of the 2003 recommendations, incorporating new cancer screening techniques and evidence, and is working to update the European Code Against Cancer, which is also signed by IARC. Finally, Mr Ryan underlined that sharing experiences across countries, at the regional and national level, is another way forward.

Dr Tit Albreht commented that he believes the Beating Cancer Plan represents a good opportunity to try to streamline efforts in terms of screening. He added that there is high variability in the response to screening programs. The burden of the pandemic can best be offset by supporting the Member States with different efforts to launch intense screening programs once the pandemic is over. This would be particularly important for countries that have not launched a proper population-based screening programme yet. There is a lot of funding that can be mobilised to support these Member States that otherwise can find challenges in implementing these programmes. Moreover, Europe, with the support of the Cancer Knowledge Centres and other institutions, should strive to improve quality. He sees evidence of uneven quality. To combat this, he sees a need to secure interlinks across systems to support better data flow and the proper analytical work needed to help provide robust quality and efficient screening programs. Again, he noted that national screening programmes rely on national funds, that each nation should build them based on their priorities and possibilities and that this needs to be taken into consideration. Finally, he mentioned the need also for taking into contemplating cultural barriers and the need for trying to reach the most vulnerable groups of the population.

Questions and Answers

***Question*: What are your thoughts about screening becoming available for the population under 50?**
- **Dr Partha Basu** responded that there are specific screening programmes for young populations at a higher risk for CRC, for example, for individuals affected by Lynch Syndrome symptoms. Unfortunately, the incidence of CRC is increasing among the younger population because of high-risk behaviours. Dr Basu mentioned that the *Code Against Cancer* is a great educational tool for the population and an advocacy tool for the policymakers to make sure that people have access to education and preventive programmes, for example, access to facilities for physical activities and better urban planning that can create space for cycling.
- **Prof. Luigi Ricciardiello** affirmed that early onset CRC is already an issue in the United States. For this reason, they have lowered the CRC screening, starting at 45 years of age. In Europe, this information is not currently available and there is a need to educate GPs to make them aware that this is an issue that potentially can be important. GPs need to be able to recognise symptoms and their role will be key in this issue.

Question: ***Can you provide advice to DiCE? What do you think is the role of patient organisations?***
- **Prof. Luigi Ricciardiello** suggested that DiCE should make the population aware that CRC is a real problem. "We need to keep working with the European population, boosting campaigns and making sure that policymakers, the local governments, the EU Commission, everybody understand this is a priority."
- **Dr Tit Albreht** responded that cancer did not disappear because of COVID-19 and after almost two years we are facing additional problems. DiCE can act in two ways: at the national level by supporting patient groups and patient advocates in countries and by continuing exerting pressure towards international organisations. The NGOs working together with the European Commission and IARC can convince politicians to implement measures to improve health not only for the immediate future but also for the overall future of the European population.

Closing Remarks

The Role of Patient Organisations and Citizen Groups in Shaping the Way Forward

Zorana Maravic thanked the speakers and audience for the lively discussion and their passion to improve CRC screening in Europe. Ms Maravic acknowledged the great work that has been put into the BECA plan, led by great champions including Health Commissioner Kyriakides and Mr Ryan, and underlined the need to have formal population programmes implemented properly in all Member States that will help reduce CRC mortality rates. To achieve this, it is key to empower patient organisations, as, using their expertise and knowledge, they can play a central role in and work all together towards achieving this ambitious goal. A second key point is to work with local politicians to ensure there is enough funding to run robust and long-lasting prevention programmes. Finally, it is important to run campaigns to raise awareness on screening and increase participation rates. Ms Maravic commented that DiCE along with the Member Organisations will be leading the European Colorectal Cancer Awareness Month campaign in March 2022, highlighting the need for a unified effort. Finally, she concluded that DiCE will be looking forward to the Council's updated recommendations on screening, which will be published next year and promised that DiCE will continue to participate and hold similar events. She concluded by inviting all to the third edition of the CRC Screening Summit in 2022.

Summit Closure

Tamsin Rose summarised some of the key points discussed during the Summit, which included:

- The vital role of patients, patient groups and advocates, is instrumental for increasing screening participation.
- The diverse barriers to CRC screening, which can be:
    - cultural or behavioural
    - legal and administrative
    - technical
    - financial or institutional
- The need for a focus to help address the gap between CRC screening and CRC diagnosis caused by the COVID-19 pandemic.

Ms Rose invited the audience to next year's event and closed the Summit.