The international conference European Digestive Cancer Days 2017 (EDCD) is an extension of the annual European Colorectal Cancer Days conference and for the first time this year extends its focus to all digestive cancers.

Digestive cancers account for four of the top ten European cancer killers, 23.4% of European cancer incidence and 30.1% of European cancer deaths but currently, of the 5 primary digestive cancers, only colorectal cancer is screened for. The primary objectives of the EDCD conference is therefore to share and promote best practice in the screening, monitoring and surveillance of digestive cancer patients; promote the standardisation of colorectal cancer (CRC) screening programmes; and promote CRC screening uptake in order to meet EU guidelines.

EDCD 2017 is co-organised by:
- United European Gastroenterology
- Institute of Health Information and Statistics of the Czech Republic
- Masaryk University, Faculty of Medicine, Institute of Biostatistics and Analyses
- Pavel Poc, Member of the European Parliament

Opening remarks

“In recent years, great progress has been made in colorectal cancer screening, but to treat any patient for any digestive cancer at an advanced stage should be seen as a failure. Over the next 30 years we should be working towards a point where treatment at the advanced stage is not necessary in any cases. There is a huge variance in screening uptake rates across Europe and this needs to change. We need better implementation and improved uptake, supported by increased funding for all digestive cancer screening.”

Professor Thierry Ponchon
Chair of UEG Public Affairs Committee

“In the case of cancer, our society fails. In fact, cancer is the main killer in the European Union. It’s the same as a hypothetical jumbo jet full of people crashing every single day, every single week, every single year. Implementing change at both a national and EU level must become a greater priority if we are to succeed in the fight against digestive cancers.”

Pavel Poc
Vice-Chair of MEPs Against Cancer

Digestive cancers account for 4 of the top 10 cancer killers in Europe

![Digestive cancers account for 4 of the top 10 cancer killers in Europe](image)
Implementing innovations in colorectal cancer screening: Transition to quantitative immunochemical testing

Professor Stephen Halloran of the University of Surrey in the UK, discussed the merits of the Faecal Immunochemical Test (FIT), and specifically the benefits of FIT testing over the guaiac Faecal Occult Blood Test (gFOBT).

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A key issue with gFOBT is that it is not a specific test, as many factors can affect the analysis, such as food stuffs or drugs. FIT on the other hand, has a marked increase in specificity and sensitivity with a smaller number of false positives. FIT is also easier for the public, as only one sample is required, rather than three, and the applicator makes it easier to collect the sample. This has had a positive impact upon uptake.

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Professor Halloran also emphasised the need to move towards a more personalised screening programme based upon personal risk assessment, taking into account factors such as age, lifestyle and hereditary risk.

To support and supplement a more personalised approach to screening, Professor Bohumil Seifert of Charles University in Prague set out the need for a shift in the role GPs play in personalised screening.

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Currently, there are no guidelines on the role GPs play when it comes to screening. GPs support, but are not active in screening programmes. More education of GPs is required, as is more communication between the GP and the patient pre- and post-screening to reap the full benefit of the screening programmes.

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Whilst the prognosis for the majority of cancers has improved significantly in recent decades, pancreatic cancer remains stuck in the past. Pancreatic cancer is the tenth most common male cancer and seventh most common female cancer and is the fourth leading cause of death by cancer in Europe. The five-year survival rate is just 3%, and between 74% and 82% of patients die within a year of diagnosis. This disease therefore poses a huge challenge throughout Europe.

Some of the fundamental issues regarding pancreatic cancer treatment in Europe were addressed by Professor Sorin Barbu.

“When it comes to pancreatic cancer, not all patients receive standardised multi-disciplinary treatment. This needs to change. There is also a failure to operate on early stage pancreatic cancer patients, especially in older and poorer patients in countries with health insurance. Ultimately, surgery is cost effective and improves survival rates and we should strive to be able to operate on more patients in the early stages. Through more research, better, more personalised treatment and standardisation and centralisation of treatment, we can move towards a position where detection and surgery are more common in the vital early stages.”

Identification in those early stages can be made easier by more effectively identifying the risks. Dr Núria Malats of the Centro Nacional de Investigaciones Oncológicas observed that:

“We need to identify the high-risk population by looking at factors such as genetics, lifestyle, diabetes, certain blood types, allergies, asthma, digestive conditions, auto-immune conditions, chronic inflammatory conditions, microbiome make-up and so on, and to use a personalised risk application based on all these factors which allows patients to monitor and self refer if worried.

Underpinning the need for earlier identification and more effective treatment in the early stages is a need for increased funding. Less than 2% of EU health funding is currently allocated to pancreatic cancer and the salience of this point was emphasised by Ali Stunt, pancreatic cancer survivor and Chief Executive of Pancreatic Cancer Action:

“Funding is simply so much better for all other cancers. It needs to be proportionate to mortality and survival rates if we are to see an improvement in the pancreatic cancer landscape.”
PANCREATIC CANCER: THE MAIN CHALLENGE

Pancreatic cancer patients lose 98% of their healthy life expectancy at the point of diagnosis.

The median 5 year survival rate for pancreatic cancer across Europe is 3%.

The number of people dying each year from pancreatic cancer has risen continuously over the last 40 years.

Professor Jonas Rosendahl of the Martin Luther University of Halle-Wittenberg asserts that surveillance of chronic pancreatitis (CP) patients would help to identify potential cancer patients.

"The risk of CP developing into pancreatic cancer is higher in the first year and reduces over time, while the risk of CP developing into pancreatic cancer with at-hereditary risk patients increases with age amongst those who are over 50, while smoking brings this down to age 30. Screening with MRI has been advocated but it is not easy to detect all tumours in an MRI image. We require more studies on screening of CP patients to qualitatively and quantitatively assess effectiveness."
OTHER DIGESTIVE CANCERS: NEXT TO BE SCREENED?

Barrett’s Oesophagus

There is strong evidence to demonstrate that screening for CRC reduces incidence and mortality rates. But how effective can screening prove to be for other digestive cancers?

Professor Thierry Ponchon discussed the merits of endoscopy screening for Barrett’s Oesophagus, citing three alternatives: Nasogastroscope, oesophageal capsule and Cytosponge. “Screening with endoscopy is cost effective for low and high-grade dyspepsia but there are question marks over whether endoscopy screening for Barrett’s Oesophagus is cost effective, especially as the risk of Barrett’s is not high; affecting around 1 in 400 patients per year. We therefore need a low-cost screening method which, endoscopy certainly isn’t”

Each of the three alternative screening options put forward by Professor Ponchon also have their pitfalls. The most cost-effective option is the oesophageal capsule, but it is difficult to identify Barrett’s Oesophagus from the images collected, and a separate biopsy procedure is required to determine whether the patient has Barrett’s Oesophagus, which is costly.

Nasogastroscope on the other hand is well accepted by patients but expensive to administer, and the Cytosponge, though promising, is still in the study phase and thus far is only effective in detecting Barrett’s Oesophagus longer than three centimetres in length.

Hepatocellular Carcinoma

With hepatocellular carcinoma (HCC) screening, ultrasound is the most widely accepted, but expensive tool. Though surveillance of high risk patients is recommended, Professor Patrizia Burra of the Padua University Hospital explained that difficulties still exist around this issue. “The evidence of links to Hepatitis C, Hepatitis B, alcohol, hereditary factors, non-alcoholic fatty liver disease (NAFLD) and non-alcoholic steatohepatitis (NASH) make surveillance of high risk patients necessary, but the difficulty lies in assessing over how often to monitor high risk patients and the subsequent costs of this.” Professor Burra’s recommendation for the most cost-effective and patient beneficial approach is to combine all risk factors when assessing a patient, to enable stratification of overall risk.

Gastric Cancer

Early stage diagnosis is particularly vital with regards to gastric cancer, and could increase survival from one to five years. Endoscopy is currently the preferred screening method by patients, though some lesions in the stomach can be missed by endoscopy screening. “Standalone screening is not deemed cost effective” says Professor Mário Dinis-Ribeiro of the Instituto Português de Oncologia do Porto “but alongside colonoscopy for CRC, research indicates that it could be cost effective in countries where the incidence of stomach cancer is more than 10 in 100,000 population. Eastern European countries fall into this category. Of course, further research is required to determine the effectiveness of gastric cancer screening on a large scale, and particularly to confirm whether or not it can be effective in those countries who fit the stomach cancer incidence parameters.”
Western Europe
All countries in Western Europe have some form of screening programme. Some are more organised than others and there is still much to do to get those countries lagging behind in line with EU guidelines and best practice.

Currently leading the way is the Netherlands, who, following an eight-year planning period, commenced the nationwide roll-out of their population based screening programme in 2014. It is now the most successful programme in Europe in terms of uptake at 70%. Professor Evelien Dekker, a gastroenterologist at the Academic Medical Center in Amsterdam explained the impact of the Dutch programme’s success. “The success of the programme initially resulted in a higher than originally planned requirement for colonoscopies, resulting in significant waiting times. To compensate for this, we had to increase the cut-off threshold, in order to reduce referrals but with minimal impact on patient risk. Real-time monitoring has proved to be critical to the success of the programme, allowing for quick adjustments and no damage to the reputation and confidence in the programme.”

Dr Monique van Leerdam of the Netherlands Cancer Institute outlined the details of the other CRC screening programmes throughout Western Europe, which ranged from organised, population based programmes to opportunistic gFOBT/FIT based, and colonoscopy based programmes. Across Western Europe, the implementation of CRC screening programmes has already had a proven effect on CRC incidence, and Dr van Leerdam concluded that the future aim should be for population based screening programmes across Europe, in the near future.

Cost Effectiveness
Resources are scarce throughout Europe and cost effectiveness is a key consideration in the current economic environment. Assistant Professor Iris Lansdorp-Vogelaar, from the Dept. of Public Health, Erasmus MC, Rotterdam outlined the techniques available to analyse cost effectiveness of screening vs no screening and how to compare alternative screening strategies using quality of life years (QALY) as a standard measure of success. She also called for a greater emphasis on cost effectiveness analysis to ensure we save the most lives possible with the resources available to each country.

“Screening has a high upfront cost but savings in long-term hospital and patient care costs, as a result of less late stage cases, mean it is generally assumed that screening is cost effective, especially as long-term care costs are rising. In the Netherlands, we work on a model of $20,000/QALY gained. Various studies show different cost effectiveness outcomes for different screening strategies so as yet, there is no indication for the best screening strategy. With more research, we will have more clarity on the most effective screening strategy to proceed with.”

Eastern Europe
Dr Marcis Leja of the University of Latvia paints a picture of a different story in Eastern Europe. Many Eastern European countries still do not have population-based invitations for screening. Latvia, Lithuania, Slovakia, Hungary, Bulgaria and Romania have no invitation process in place, whereas Estonia and the Czech Republic have only implemented population-based invitations in 2016 and 2014 respectively.

“Eastern European governments are not making screening programmes a priority, quality assurance mechanisms are not effective and EU guidelines are not always being followed. Participation rates are low, just 11% in Latvia for example, and attendance at colonoscopy referral appointments following a positive test result is also poor. Some countries are planning and piloting organised programmes, so we should see national implementation in a few years, but more needs to be done.”
Tackling Inequalities
Professor Halloran outlined evidence from the UK of variances in CRC screening uptake due to a variety of social and economic issues “Screening programmes must reach the whole target population, and continuous screening programmes are required to achieve this” he says “With outreach, as with screening, one size does not fit all. A personalised approach to engagement and communications with non-participating groups is needed to effectively engage them. Male uptake, for instance, is lower than female uptake in all countries, and there is also a poor level of uptake amongst lower income and inner-city groups. We need to score participants based on social and cultural factors and develop the most appropriate messaging, materials and style for each score group to engage them in the programme.”

Influence of the Message
Health communications consultant, Justin Wilkes, outlined some of the evidence around the impact of messaging upon screening uptake and highlighted that “A wide range of complex social, cultural, emotional and contextual factors affect people’s willingness to participate, so communication and messaging are critical to the success of any screening programme. The overall tone of information to help increase screening uptake should be simple, emotive and factual but the tone cannot be unique due to variances in audience. In the current environment there is a global change in first world attitudes towards, and trust in, governments and government institutions and we need to think about who is providing the screening message and whether it is still appropriate for governments and health authorities to use existing content and channels to engage with the modern world and certainly the next generations”. He also outlined the need for greater use of targeted social and digital communication to engage with hard to reach groups and non-participants.

GP Endorsement
GP’s can play a key role in helping to increase screening uptake and follow up, as Frédéric de Bels, National screening department, INCA points out:

“GP’s have the benefit of knowing their patients best and can give tailored information and guide them through the screening process. They also have the power of conviction, and the ability to support non-participants and encourage attendance. Increased GP involvement and endorsement is central to optimising participation throughout Europe.”

Patient Association Impact
Patient organisations play a crucial role in education and awareness campaigns and mobilising patient and public communities. Dr Luc Colemont, founder of the Belgium based foundation, Stop Darmkanker, provided evidence of the impact that his organisation has had over the past few years:

“The power of social media to spread messages and gather support is essential and has proven to be very successful. A creative and proactive approach to engagement and communication is required and digital media potentially holds the key to greater success. There are many opportunities out there to engage, communicate and educate and it just requires dedication and action rather than discussion.”
UEG is a professional non-profit organisation combining all the leading European societies concerned with digestive health. Its members represent over 22,000 specialists, working across medicine, surgery, paediatrics, GI oncology and endoscopy. Visit www.ueg.eu to find out more.