phn NORTH WESTERN MELBOURNE
An Australian Government Initiative

Enhancing Early Detection: The Latest in Cancer Screening

Wednesday 12th March 2025

The content in this session is valid at date of presentation

Australian Centre for the Prevention of Cervical Cancer

Cancer Council

Acknowledgement of Country

North Western Melbourne Primary Health Network would like to acknowledge the Traditional Custodians of the land on which our work takes place, The Wurundjeri Woi Wurrung People, The Boon Wurrung People and The Wathaurong People.

We pay respects to Elders past, present and emerging as well as pay respects to any Aboriginal and Torres Strait Islander people in the session with us today.

Victorian Cancer Screening Framework Initiative

Australian Centre for the Prevention of Cervical Cancer

Cancer Council

phn VICTORIAN-TASMANIAN ALLIANCE

An Australian Government Initiative

VICTORIA State Government

This webinar was supported by the Victorian Government.

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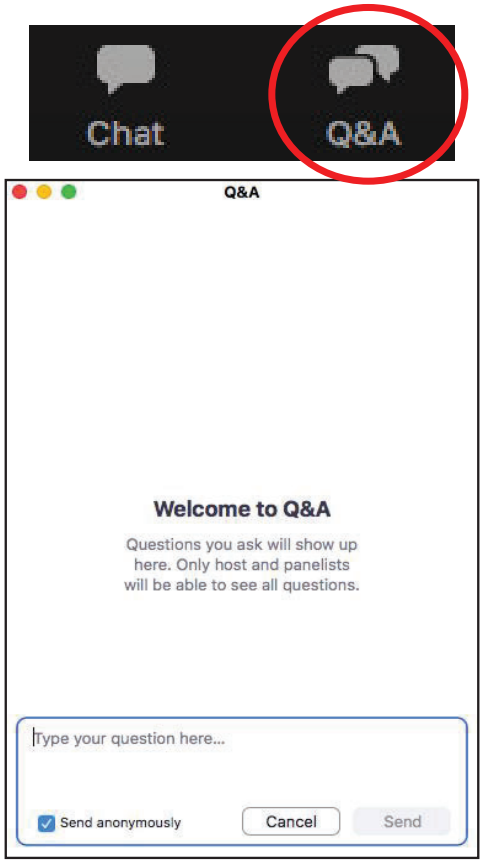

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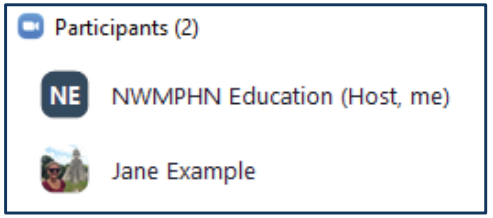


Speakers

Professor Marion Saville, Australian Centre for the Prevention of Cervical Cancer

Professor Marion Saville is an anatomical pathologist and has been Executive Director of the Australian Centre for the Prevention of Cervical Cancer since 2000. She currently chairs the working group to review Australia's Guidelines for the management of screen-detected abnormalities in the National Cervical Screening Program. Marion was appointed as a member of the Order of Australia on Australia Day 2020 for her significant service to women's health through cervical screening initiatives.

A/Prof Justin Tse, University of Melbourne

Associate Professor Justin Tse is a practicing general practitioner at Doctors of Ivanhoe and an academic specialist in the Department of General Practice and Primary Care at the University of Melbourne. He also holds appointments with the Victorian Comprehensive Cancer Centre and Cancer Council Victoria. Justin completed his research degree in prostate cancer and is involved in research with the Cancer in Primary Care Team at the University of Melbourne. He has a specific focus on bowel cancer screening, prevention and early detection.

Mr John Lee, Telstra Health

John Lee is the Head of Engagement and Communications for the National Cancer Screening Register at Telstra Health. He joined the team in 2018, bringing over 10 years' experience in the field of cancer screening health promotion and engagement in the UK and Australia. John is passionate about improving participation in cancer screening programs and integrating the broader health care ecosystem to help improve outcomes for Australians.

UPDATES TO THE NCSP GUIDELINES

Changes relevant for General Practice

Prof Marion Saville AM | Executive Director
Australian Centre for the Prevention of Cervical Cancer

12th March 2025

Australian Centre for the Prevention of Cervical Cancer

VCS Pathology

Population Health

Digital Health

compass
Future directions in cervical screening

NHMRC Centre of Research Excellence in Cervical Cancer Control

ROSE FOUNDATION · EMPOWERS WOMEN · ELIMINATES CERVICAL CANCER ·

ACKNOWLEDGEMENT OF TRADITIONAL OWNERS

SUMMARY OF THE AUSTRALIAN NATIONAL CERVICAL SCREENING PROGRAM

START
Age 25 years

SCREENING INTERVAL
5 yearly

EXIT
Age 70 to 74 years

Primary HPV test with partial genotyping (16/18) + reflex Liquid Based Cytology (LBC) triage

All sexually active women or people with a cervix - HPV vaccinated or not

Cervical Screening Test (CST)

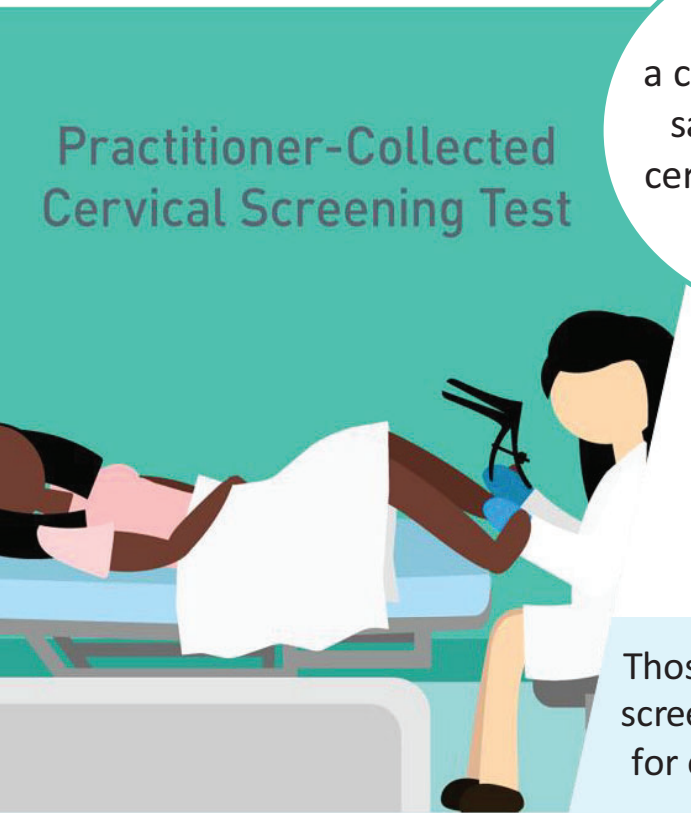
Option of self-collection

Invitation & reminders to screen: National Cancer Screening Register

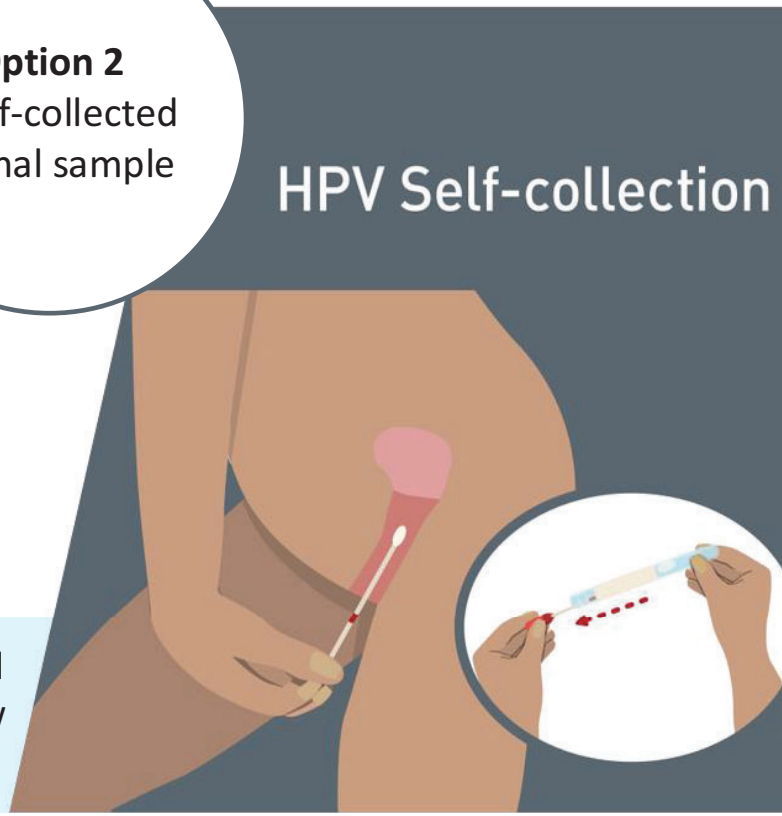
EXPANDED CERVICAL SCREENING OPTIONS

Since 1 July 2022, all routine screening participants can choose to screen using either:

Option 1
a clinician-collected sample from the cervix taken using a speculum



Option 2
a self-collected vaginal sample



Those who choose self-collection still access cervical screening through their healthcare provider, to allow for education, engagement and follow-up of results

Accurate

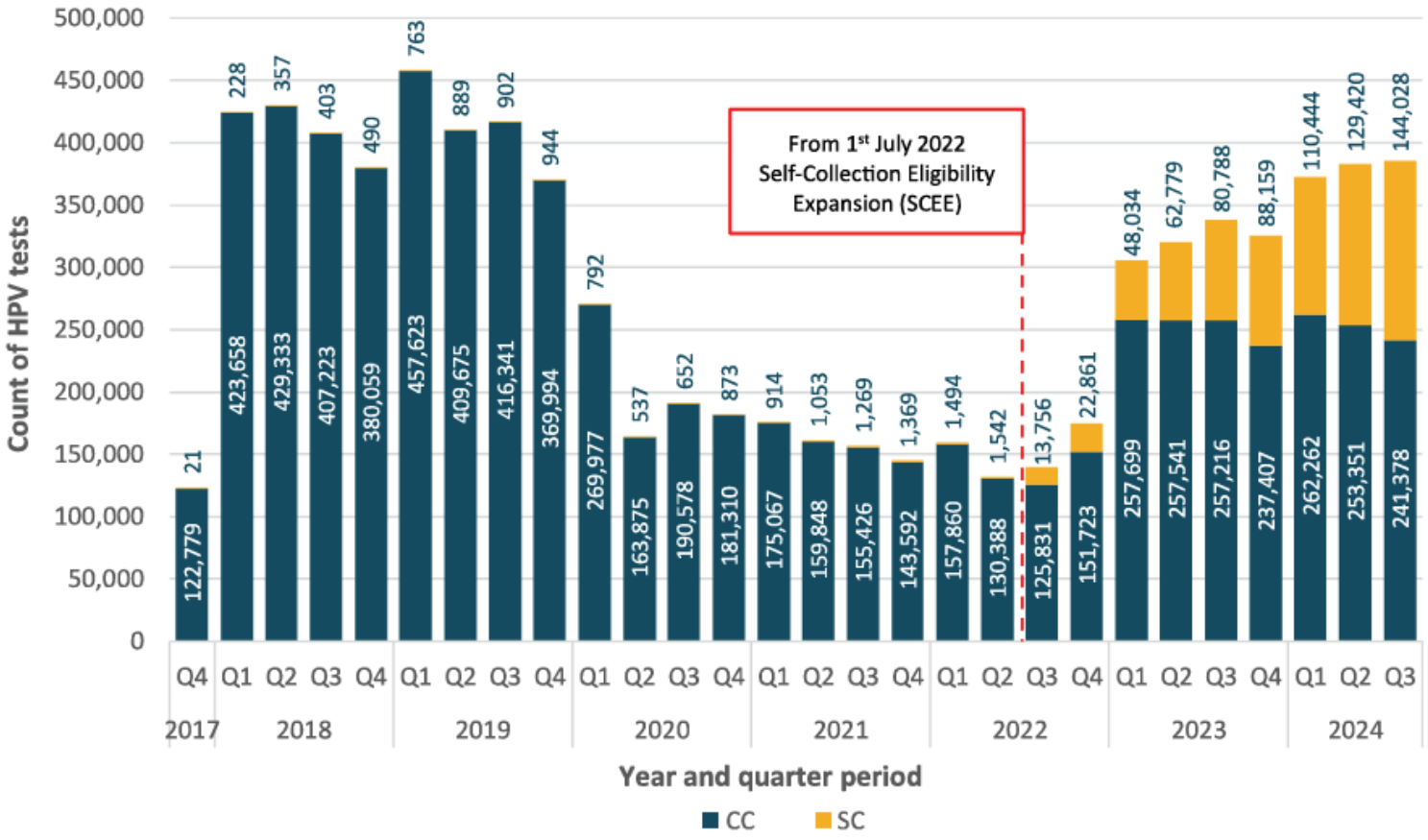
Safe

SELF-COLLECTION

Acceptable

Easy

SELF-COLLECTION TEST VOLUMES



HPV screening tests reported as self-collected and clinician-collected in each quarter Q4 2017 – Q3 2024

Source: NCSP Cervical Screening Test self-collection uptake report. 2024.

UPCOMING GUIDELINE UPDATES

April 14th 2025

New Cervical Screening Clinical Guidelines are expected to come into effect on 14 April 2025.

Access the cervical screening guidelines via the Cancer Council Australia website, or directly via the MAGICapp platform:

www.cancer.org.au/clinical-guidelines/cervical-cancer/cervical-cancer-screening

SUMMARY OF CHANGES IN 2025

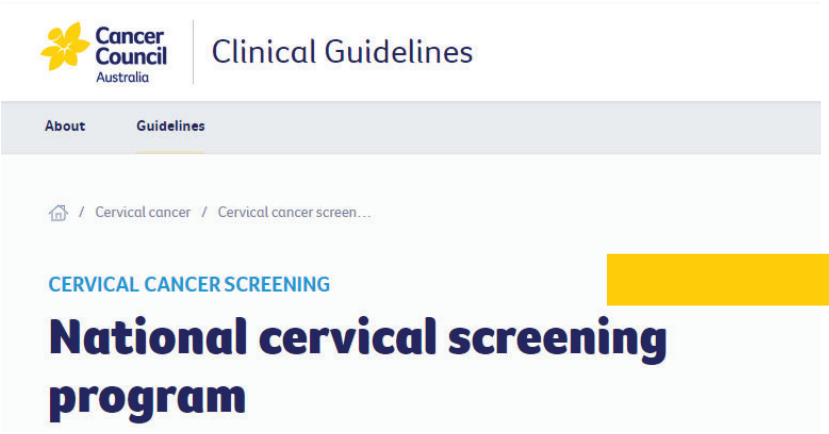
National Cervical Screening Guidelines

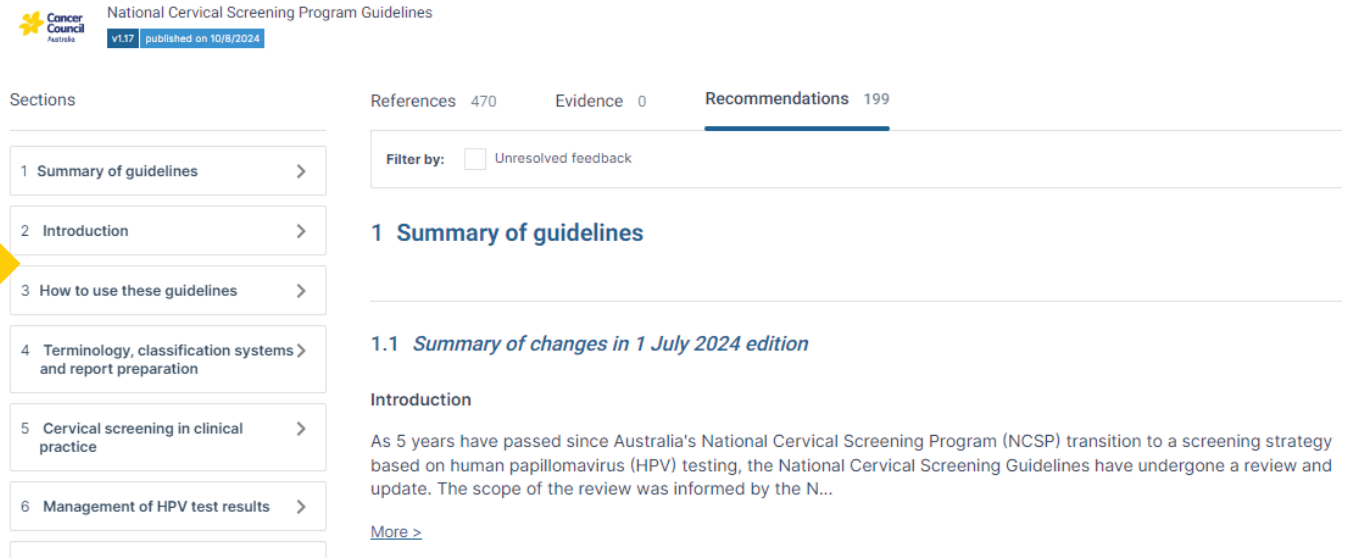
1. Guidelines shifted to MagicAPP platform, creating a more user-friendly experience
2. New chapter ‘Cervical screening in clinical practice’ which includes links to resources
3. Changes to post-treatment management for people who have been treated for HSIL
4. Categories of people considered immune-deficient clarified and expanded
5. Change in recommendation for screening participants with HPV (not 16/18) detected on a self-collected sample who do not return for cytology until 9 months or more after the HPV test
6. Screening after total hysterectomy (where indicated) simplified to annual testing
7. Changes to surveillance following treatment of AIS

1. CHANGE TO MAGICAPP PLATFORM

- Improved structure and format to support ease of navigation for healthcare providers
- MAGICapp supports many clinical guidelines both in Australia and globally
- You can still access this through the existing Cancer Council Australia website link. Make sure to bookmark it!

https://www.cancer.org.au/clinical-guidelines/cervical-cancer/cervical-cancer-screening

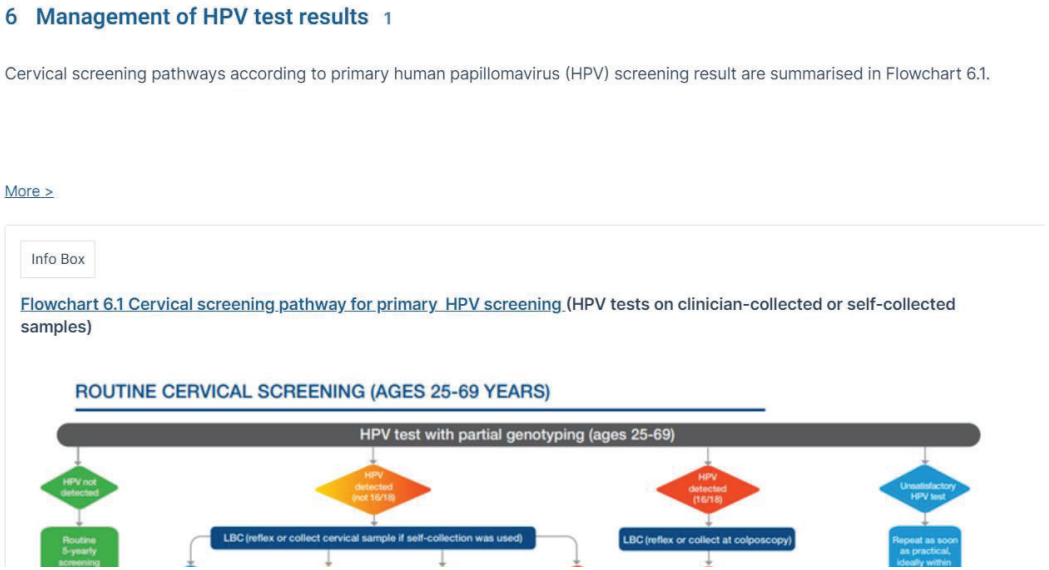




NAVIGATING THE MAGICAPP PLATFORM

MAGICapp Layers of Information enables an online multilayered format, designed to allow end-users to find the most relevant information first and then drill down to find more detail:

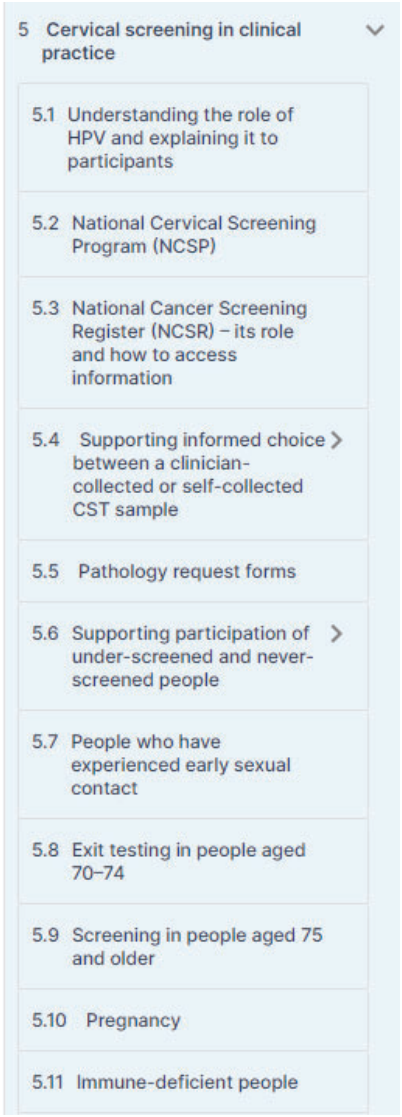
- **All Recommendations, Good Practice Statements and Decision Flowcharts are displayed on the front page (first layer) of each chapter.**



2. NEW SECTION

Chapter 5: Cervical screening in clinical practice

- Brings together into one location the most important concepts and information for those performing cervical screening, particularly in the primary care setting.
- Also links to other specific sections, such as ‘Management of HPV test results’ and ‘Screening and management in specific populations’,
- Also links to NCSP and other updated resources including the NCSP Healthcare provider toolkit, which supports healthcare providers in engaging under-screened and never-screened people in cervical screening.



3. SCREENING OF PEOPLE WITH IMMUNE DEFICIENCY

‘**Immune-deficiency**’: groups with severe acquired or congenital immune deficiency deemed to have or be at substantially higher risk of cervical precancer and cancer

Most evidence references transplant patients and PLHIV; advice on other conditions extrapolated from these studies

Immune-deficient participants assessed as being at substantially increased cervical cancer risk:

- should be screened every 3 years
- should be referred for colposcopy by an experienced colposcopist or in a tertiary centre if HPV (any type) is detected

SCREENING OF PEOPLE WITH IMMUNE DEFICIENCY

Categories have been clarified and expanded. The following list of examples is not exhaustive:

3-YEARLY SCREENING

Recommended	Should be highly considered

• Living with HIV
• Solid organ transplant with immunosuppressive therapy
• Active haematological malignancy
• Haematopoietic stem cell transplant recipients
• Primary immunodeficiency
	• Long term haemodialysis (>6 m)
	• Long-term treatment (>6 m) with highly immunosuppressive therapies
	  ➢ high-dose corticosteroid treatment
	  ➢ selected conventional and targeted synthetic disease-modifying anti-rheumatic drugs
	  ➢ biologic therapies that deplete T cells
	  ➢ multiple immunosuppressants

4. CHANGES TO TEST OF CURE

Test of Cure refresher

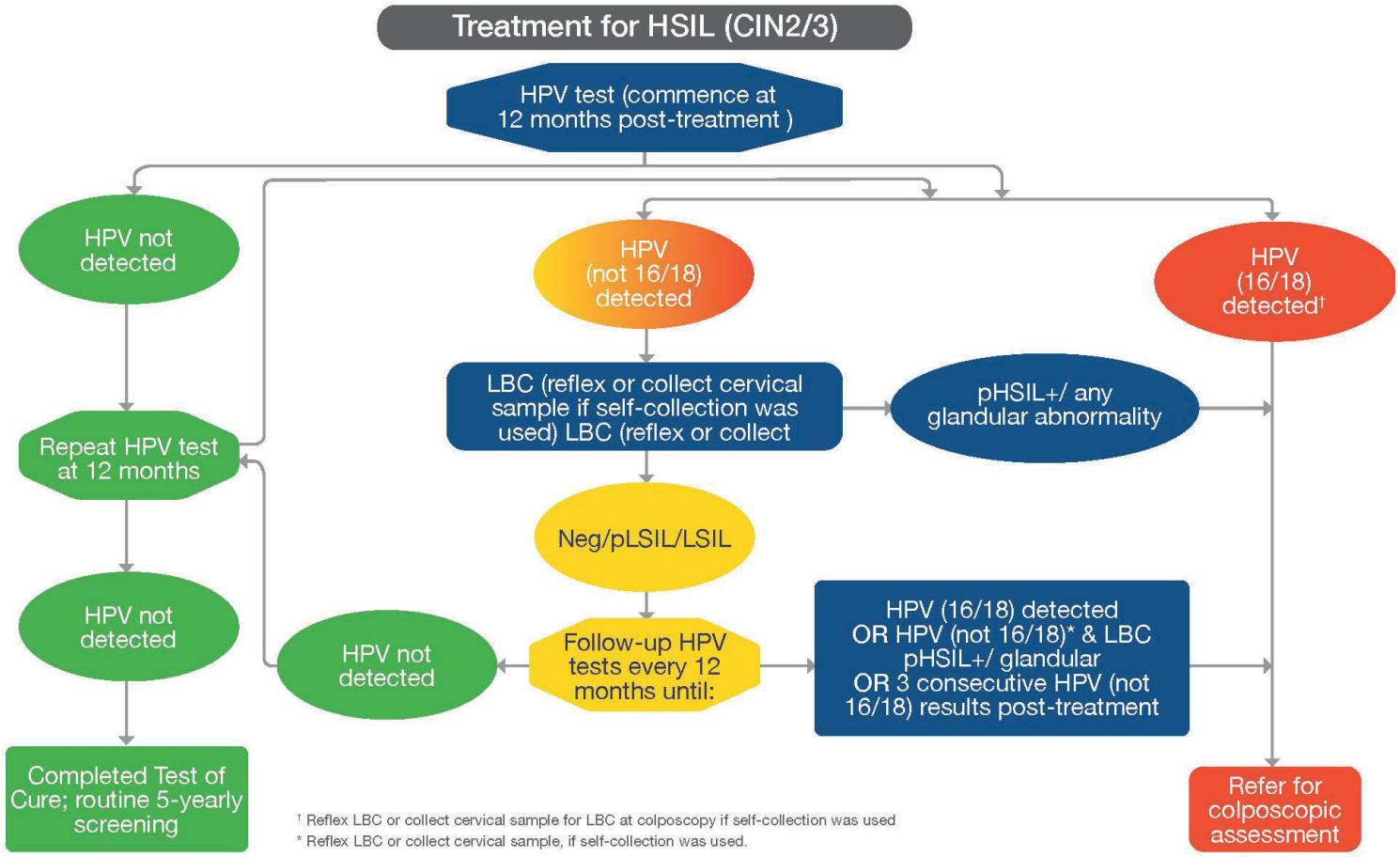
The risk of recurrence and invasive cervical cancer remains elevated for 10–25 years in people who have been treated for HSIL [CIN2/3]	Post-treatment surveillance ('Test of cure') is important to detect residual or recurrent disease
'Test of cure' following treatment for HSIL involves annual testing, until:	2 x negative tests
	1 year apart (consecutive tests)
	Before they are considered 'baseline' risk and can return to 5 yearly screening

CHANGES TO TEST OF CURE

Following treatment for HSIL

	2024 (CURRENT)	2025 (NEW GUIDELINES)
Recommendation	Annual **co-tests** until 2 x consecutive negative tests (negative HPV and LBC)	Annual **HPV tests** until 2 x consecutive test with HPV not detected
Self-collection an option?	✗	✓

TEST OF CURE FOLLOWING TREATMENT FOR HIGH-GRADE SQUAMOUS ABNORMALITIES



Suggested citation: Cancer Council Australia Cervical Cancer Screening Working Party. Clinical pathway: Test of Cure following treatment for high-grade squamous abnormalities. *National Cervical Screening Program: Guidelines for the management of screen detected abnormalities, screening in specific populations and investigation of abnormal vaginal bleeding*. CCA 2024. Accessible from http://wiki.cancer.org.au/australia/Guidelines:Cervical_cancer/Screening

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REC 9.17
Abnormal Test of Cure results: HPV (not 16/18) detected with LBC negative, pLSIL or LSIL

- continue annual HPV tests until HPV not detected at two consecutive tests.
- if HPV (not 16/18) detected (LBC negative or pLSIL/LSIL) on three consecutive annual tests → refer for colposcopy.

5. REPEAT SELF-COLLECT AT 9 MONTHS

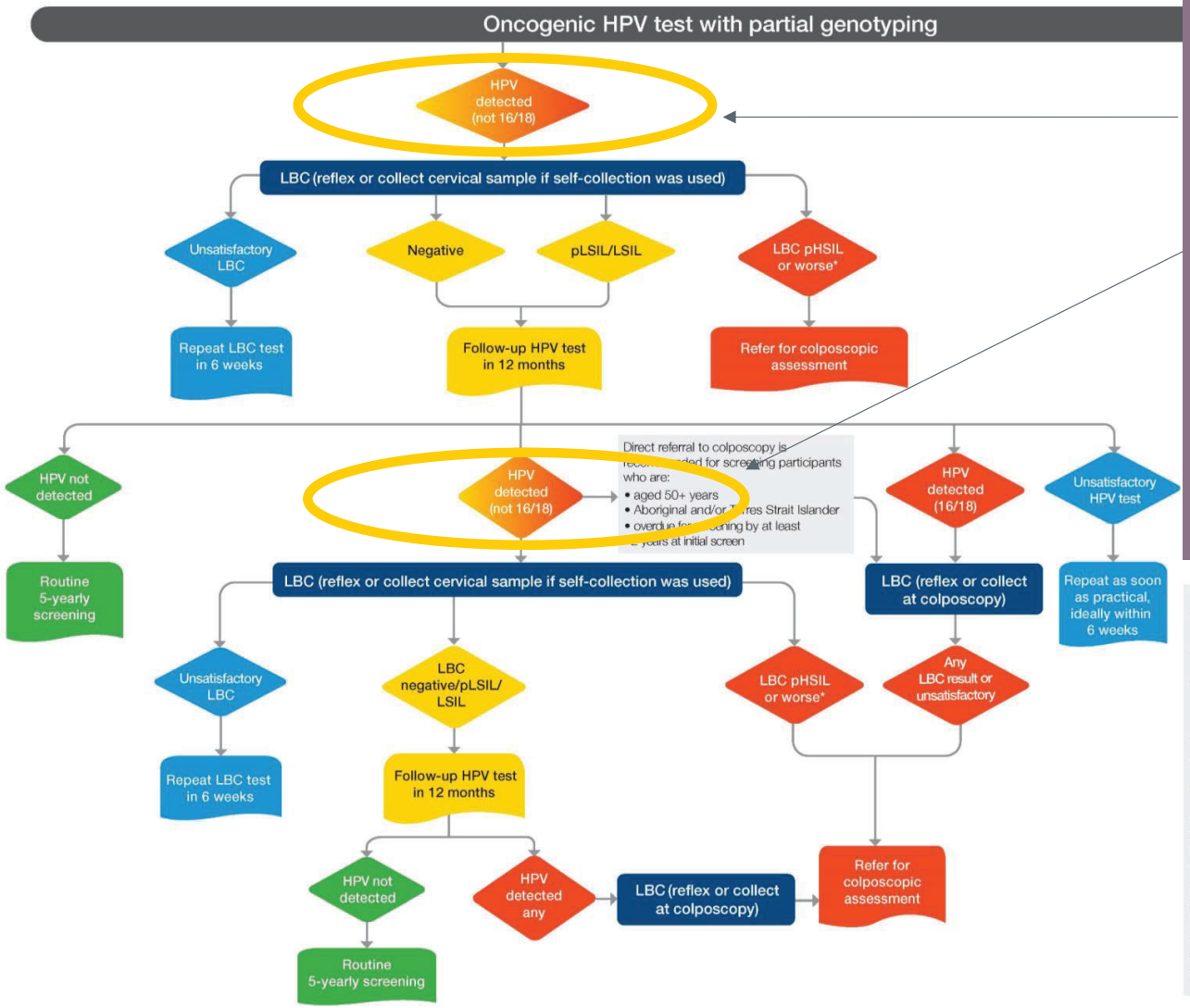
If have not returned for cytology after HPV (not 16/18) detected

LBC must be performed when HPV (not 16/18) detected to determine risk and further management

If self-collected → return within 6 weeks for LBC

However, for those **who do not return until 9 months** or more after the HPV test:	offer a follow-up self-collected HPV test, rather than LBC
	this will determine if the HPV infection has now been cleared and the person can return to routine screening

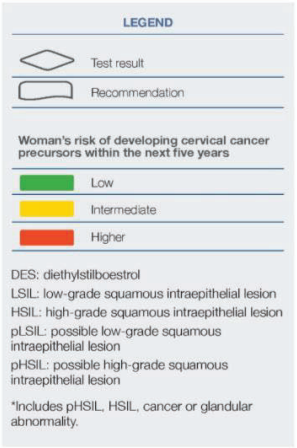
CERVICAL SCREENING PATHWAY (CLINICIAN COLLECTED OR SELF-COLLECTED)



For those **who do not return until 9 months** or more after the self-collected HPV test:

offer a follow-up self-collected HPV test, rather than LBC

this will determine if the HPV infection has now been cleared and the person can return to routine screening



Cancer Council Australia Cervical Cancer Screening Working Party. Clinical pathway: Cervical screening pathway. National Cervical Screening Program Guidelines for the management of screen detected abnormalities, screening in specific populations and investigation of abnormal vaginal bleeding. Accessible from http://wiki.cancer.org.au/australia/GuidelinesCervical_cancer/Screening. Updated Dec 2020.

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CASE STUDY

Samiha is 35 years old and booked her first ever CST

Her results have returned HPV (not 16/18)

Follow-up appointment within 6 weeks for LBC

Samiha does not return for the follow-up appointment

Samiha returns 10 months later, at which:

LBC must be taken

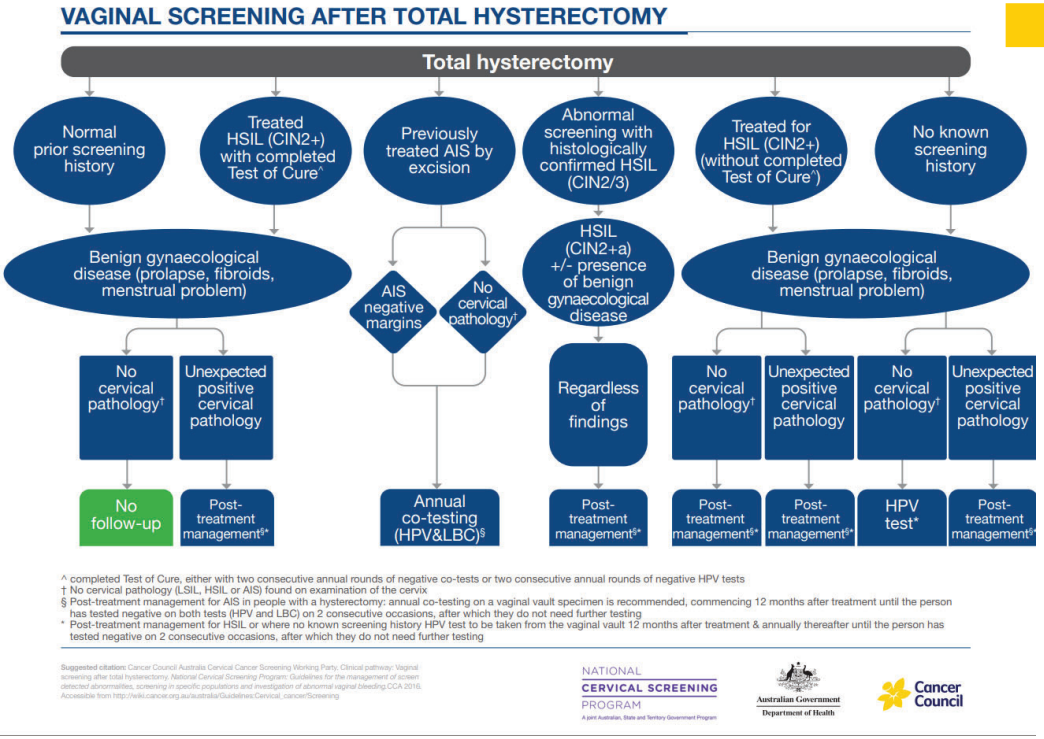
Samiha can collect her own sample again

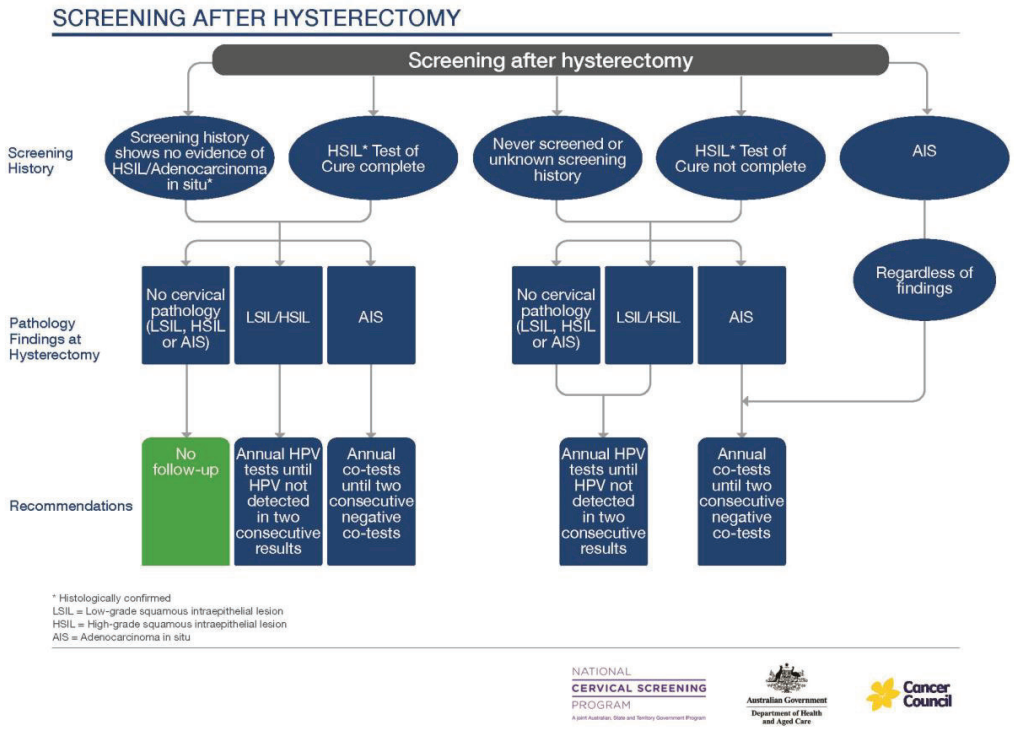
6. SCREENING AFTER HYSTERECTOMY

- Simplified to **annual testing**
- co-test or HPV test depending on cervical pathology and history

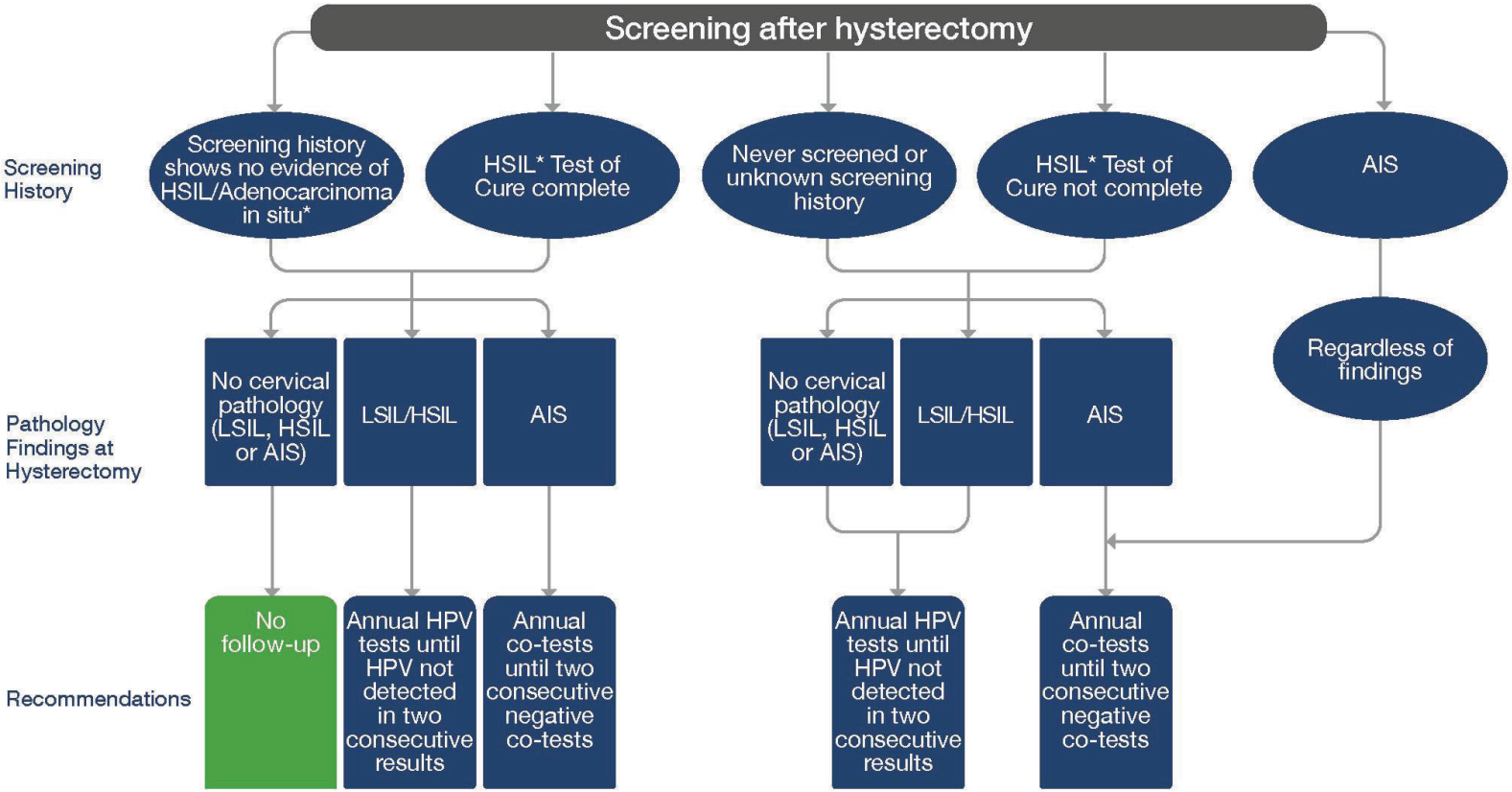
- until 2 x negative tests on 2 x consecutive occasions

SCREENING AFTER TOTAL HYSTERECTOMY





SCREENING AFTER HYSTERECTOMY



* Histologically confirmed
LSIL = Low-grade squamous intraepithelial lesion
HSIL = High-grade squamous intraepithelial lesion
AIS = Adenocarcinoma in situ

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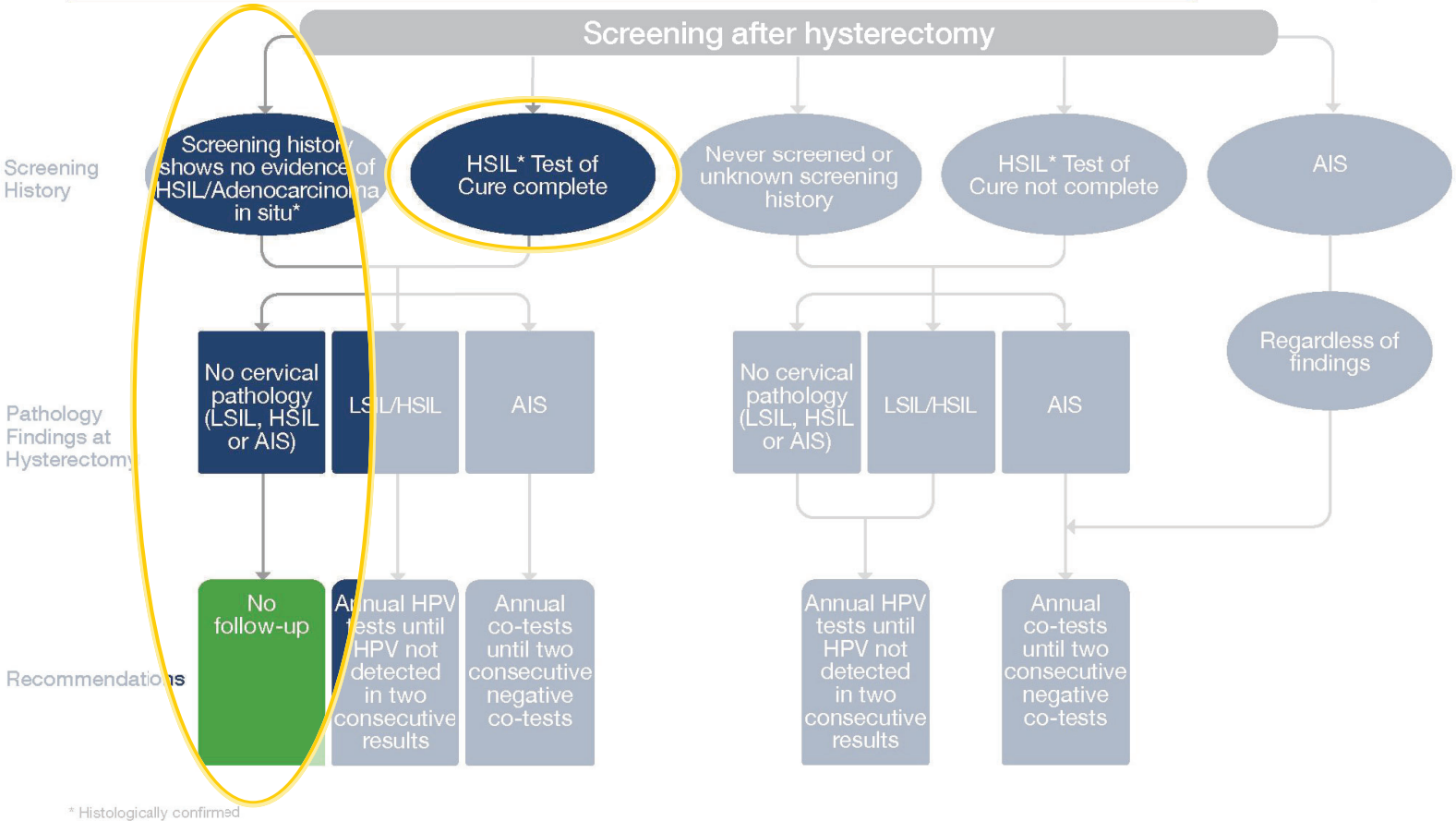
SCREENING AFTER HYSTERECTOMY



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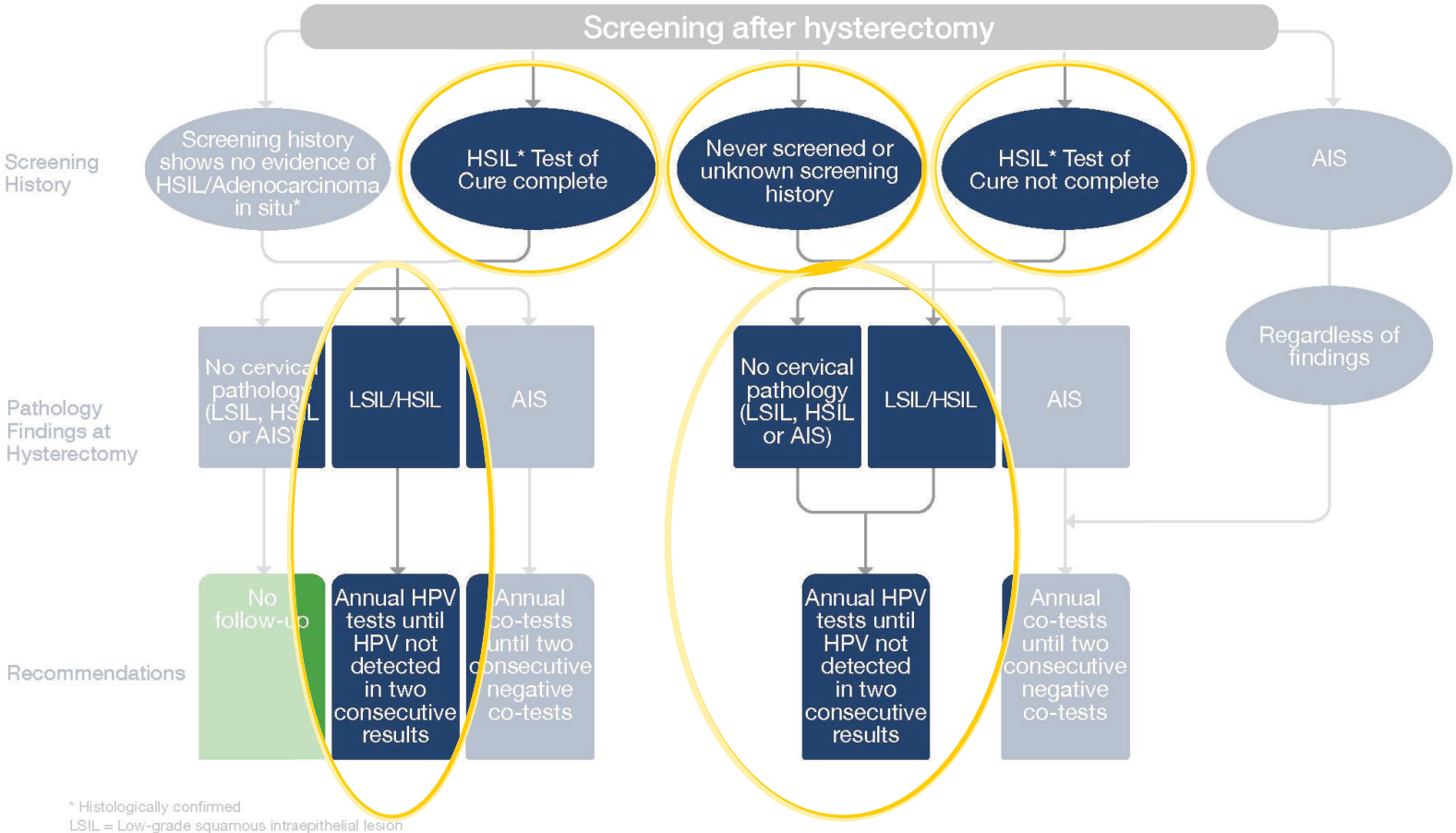
No follow-up follow-up required if:

1. No history of HSIL / AIS and no cervical pathology findings at hysterectomy
2. History of HSIL with Test of Cure complete and no cervical pathology findings at hysterectomy

SCREENING AFTER HYSTERECTOMY



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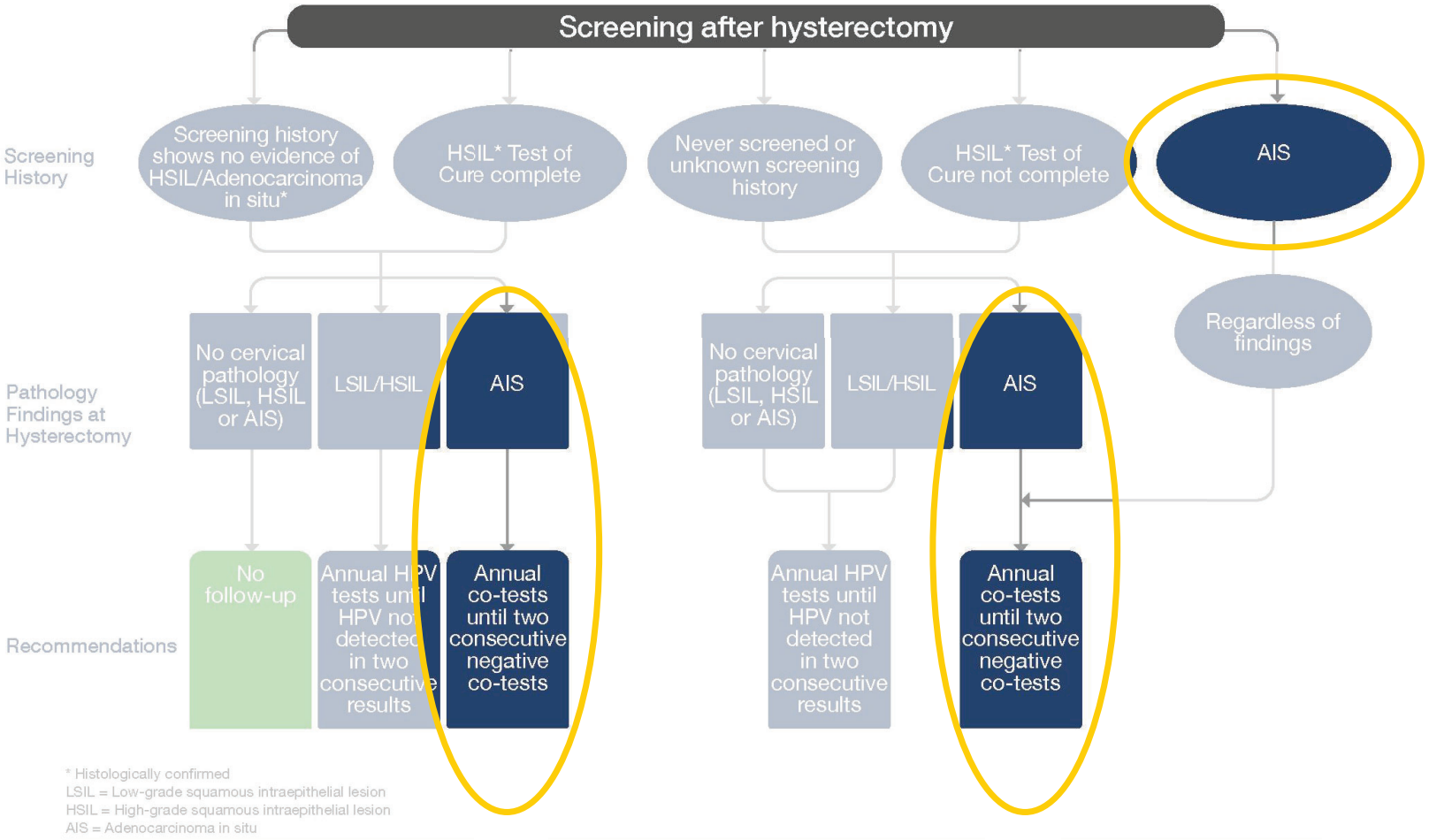
Annual HPV tests if:

P/Hx of HSIL, Test of Cure complete but LSIL/HSIL pathology findings at hysterectomy

P/Hx of HSIL with Test of Cure incomplete, regardless of pathology findings

Or if never screened or unknown screening history, regardless of pathology findings

SCREENING AFTER HYSTERECTOMY



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Annual co-tests tests if:
Pathology findings AIS
PHx of AIS
Testing can cease when co-tests are negative on two consecutive occasions

7. CHANGES TO SURVEILLANCE FOLLOWING TREATMENT OF AIS

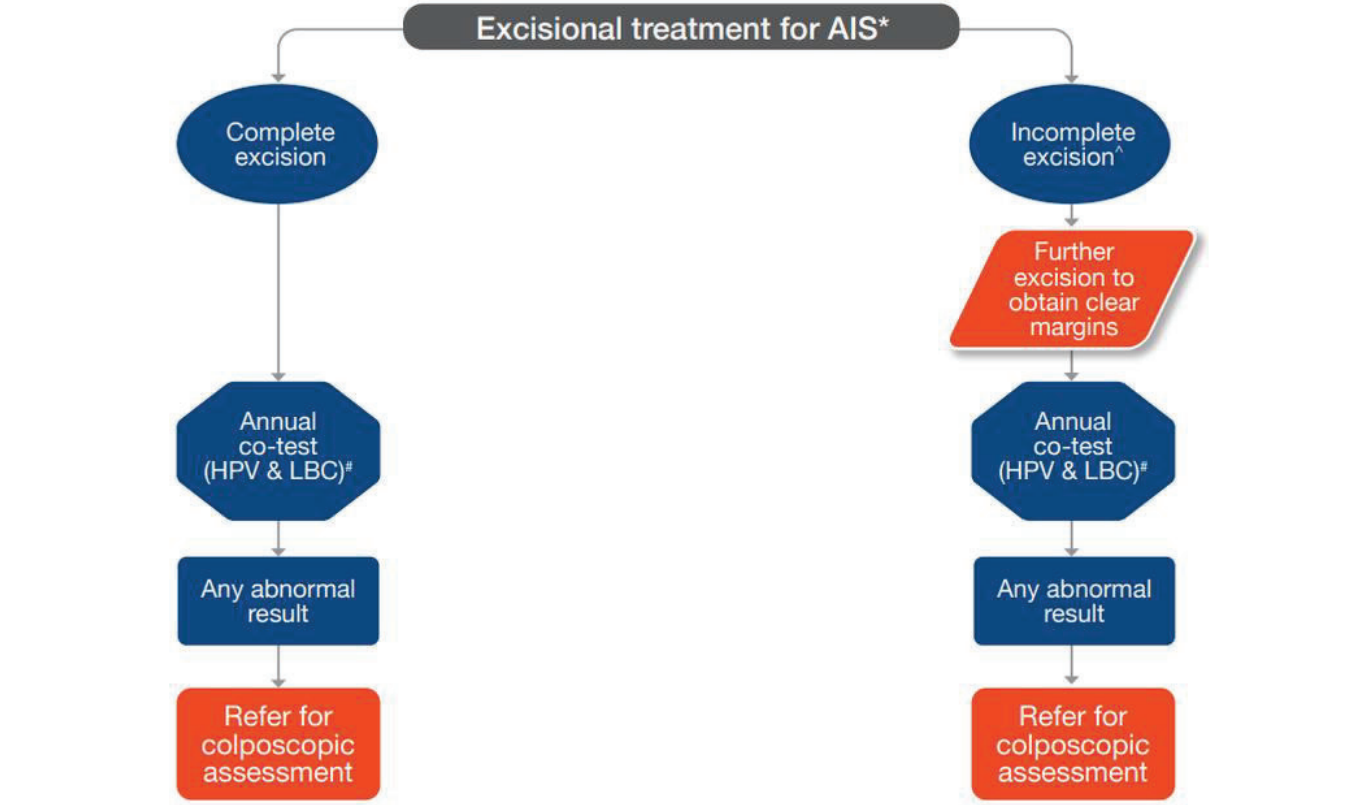
AIS refresher

Adenocarcinoma in situ (AIS) is an HPV-associated precancerous lesion of the glandular cells of the endocervix and the precursor to endocervical adenocarcinoma.

Histological confirmation of adenocarcinoma in situ (AIS) lesions often occurs as the result of a diagnostic excisional biopsy, usually a cold knife cone biopsy, which may or may not have completely excised the lesion.

Current guidelines (prior to 14 April) require **annual co-tests indefinitely**

FOLLOW-UP AFTER EXCISIONAL TREATMENT FOR AIS



* AIS = Adenocarcinoma in situ
# If all testing has been negative for 5 years, surveillance testing can be extended to every 3 years. If surveillance tests have been done for 25 years or more since the time of treatment and all tests are negative, people can be returned to routine screening. If they have already had a negative co-test when aged 70 years or older they can exit screening.
^ If margins are equivocal, review at MDT

Suggested citation: Cancer Council Australia Cervical Cancer Screening Working Party. Clinical pathway: Follow-up after excisional treatment for AIS. *National Cervical Screening Program: Guidelines for the management of screen detected abnormalities, screening in specific populations and investigation of abnormal vaginal bleeding*. CCA 2024. Accessible from http://wiki.cancer.org.au/australia/Guidelines:Cervical_cancer/Screening

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Annual co-tests
Refer for colposcopy if any abnormal result
Interval can be extended to **3 years** if **all co-tests negative for 5 years**
If all tests negative for 25 years: - return to routine screening (if <70yo) - exit the program (if >70yo)

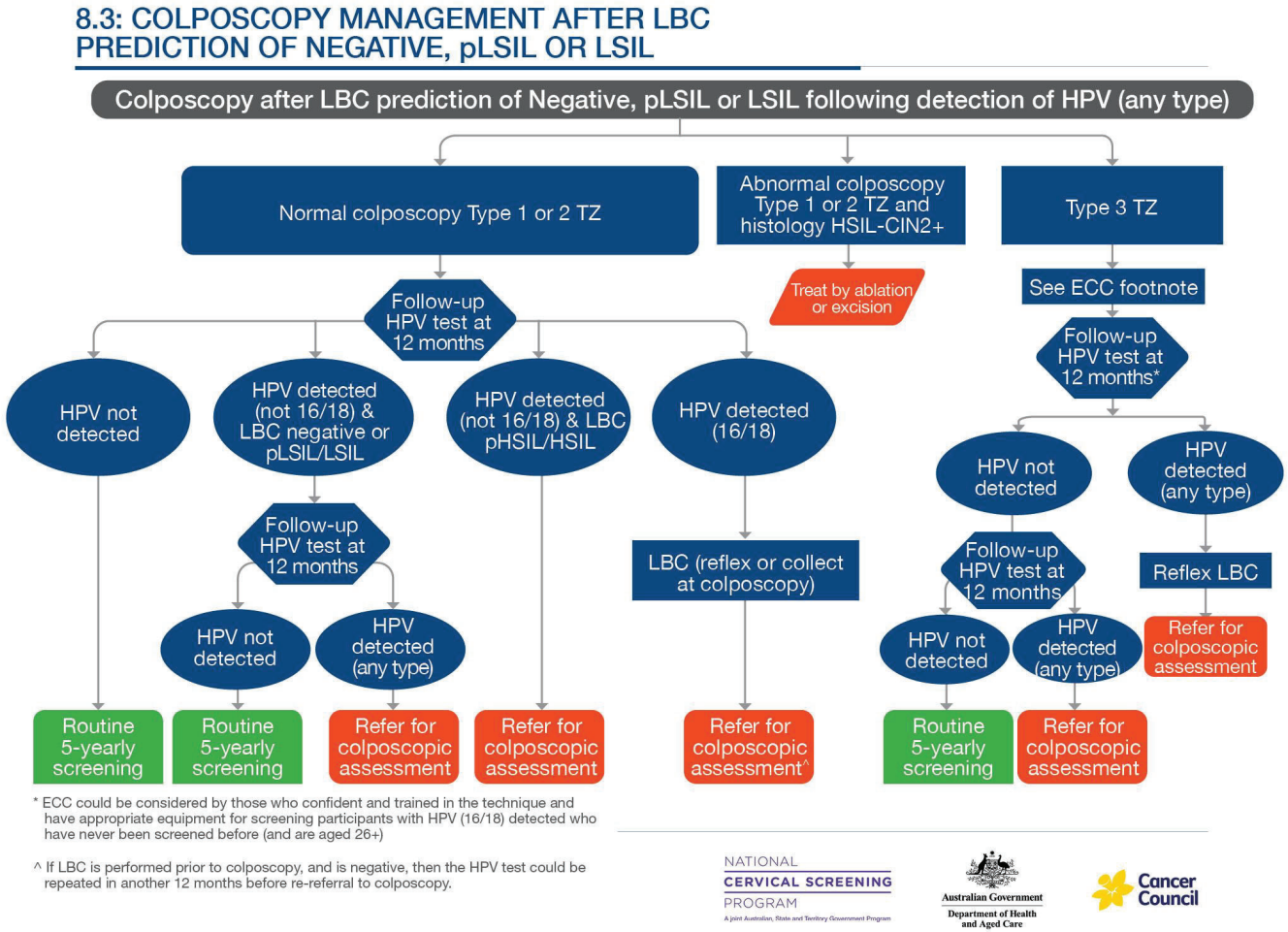
COLPOSCOPY RELEVANT CHANGES

- Option to **defer re-referral** for those with HPV (16/18) detected, LBC report of negative, and normal colposcopy, if 12-month follow-up results are again HPV (16/18) detected and negative LBC
- Repeat HPV test in another 12-months, rather than immediate referral to colposcopy

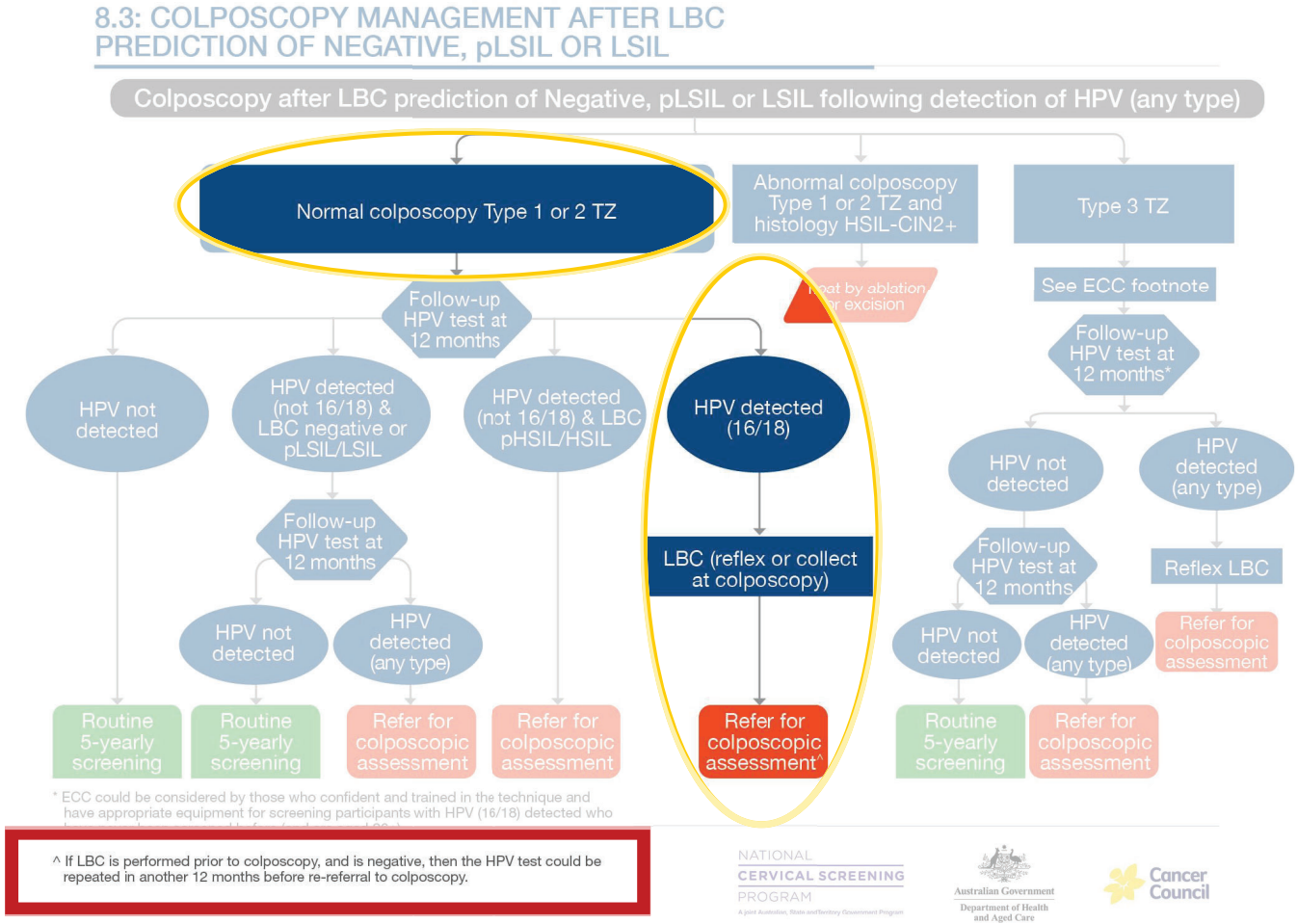
- Laboratories should recommend that patients be referred to colposcopy
- Colposcopists who wish to defer return to colposcopy will need to advise the NCSR

See NCSP Guidelines section 8.21 for more information

COLPOSCOPY RELEVANT CHANGES



COLPOSCOPY RELEVANT CHANGES



If LBC is performed prior to colposcopy, and is negative, then the HPV test could be repeated in another 12 months before re-referral to colposcopy

NEW RESOURCE AVAILABLE

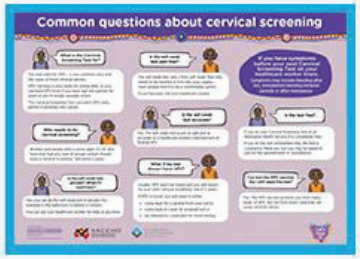
Summary of the guideline updates

New resource is now available summarising the updated guidelines. Download a copy for your clinic today!

https://acpcc.org.au/wp-content/uploads/2025/02/updated-CS-guidlines-April-2025.pdf

NEW AND UPDATED RESOURCES AVAILABLE

on the ACPCC resource hub



Common Questions

How to take your own cervical screening test

Information for your next Cervical Screening Test

How to take your own cervical screening test – English

Supporting your patients to make the choice

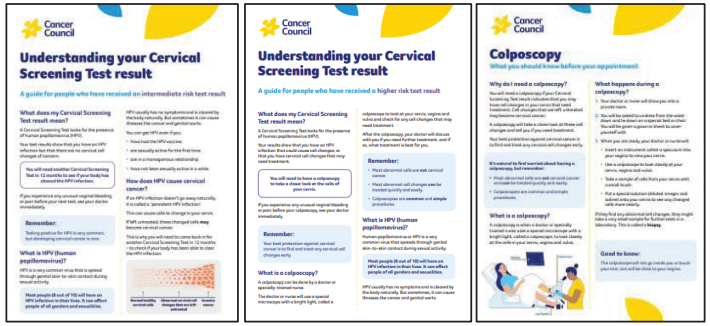
National Cervical Screening Program Quick Reference

HPV and cervical screening resource

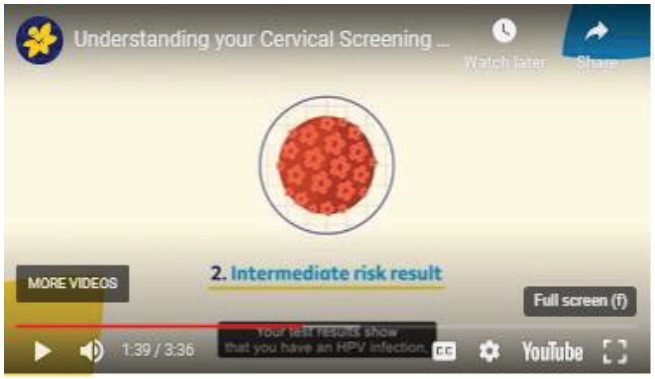
Cervical screening during pregnancy

CANCER COUNCIL VICTORIA RESOURCES FOR PATIENTS

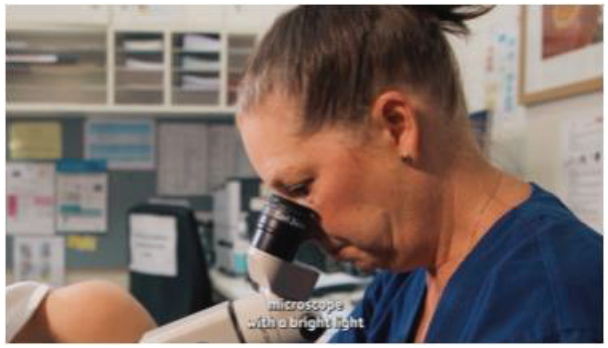
Fact sheets



Animation – Understanding your CST results



Patient education video about colposcopy



Patient stories

Lucinda, 31

In 2019, Lucinda went to her local GP for her routine Cervical Screening Test – her first in Australia since having recently moved from Ireland.

When her test came back as abnormal, Lucinda was advised to come back in 12 months to have another Cervical Screening Test. The follow-up test again came back abnormal, and Lucinda was referred to have a colposcopy.

As a midwife, Lucinda was familiar with the procedure, but this didn't stop her feeling

Daniella, 53

After experiencing some unusual vaginal bleeding at age 30, Daniella went to see her local doctor to get it checked out.

Her doctor completed a Pap test (now called the Cervical Screening Test), which came back with abnormal results. When the second test came back abnormal again, Daniella was referred to see a Gynaecologist to have a colposcopy.

Never having heard of a colposcopy before, Daniella said she was worried but that she knew it was an important step she needed to take for her health.

CONTACT US FOR FURTHER SUPPORT

We’re here to help!

education@acpcc.org.au

Clinical advisory service
Phone: (03) 9250 0309

THANK YOU!

Australian Centre for the Prevention of Cervical Cancer

VCS Pathology

Population Health

Digital Health

NHMRC Centre of Research Excellence in Cervical Cancer Control

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HealthPathways Melbourne

Enhancing Early Detection: The Latest in Cancer Screening

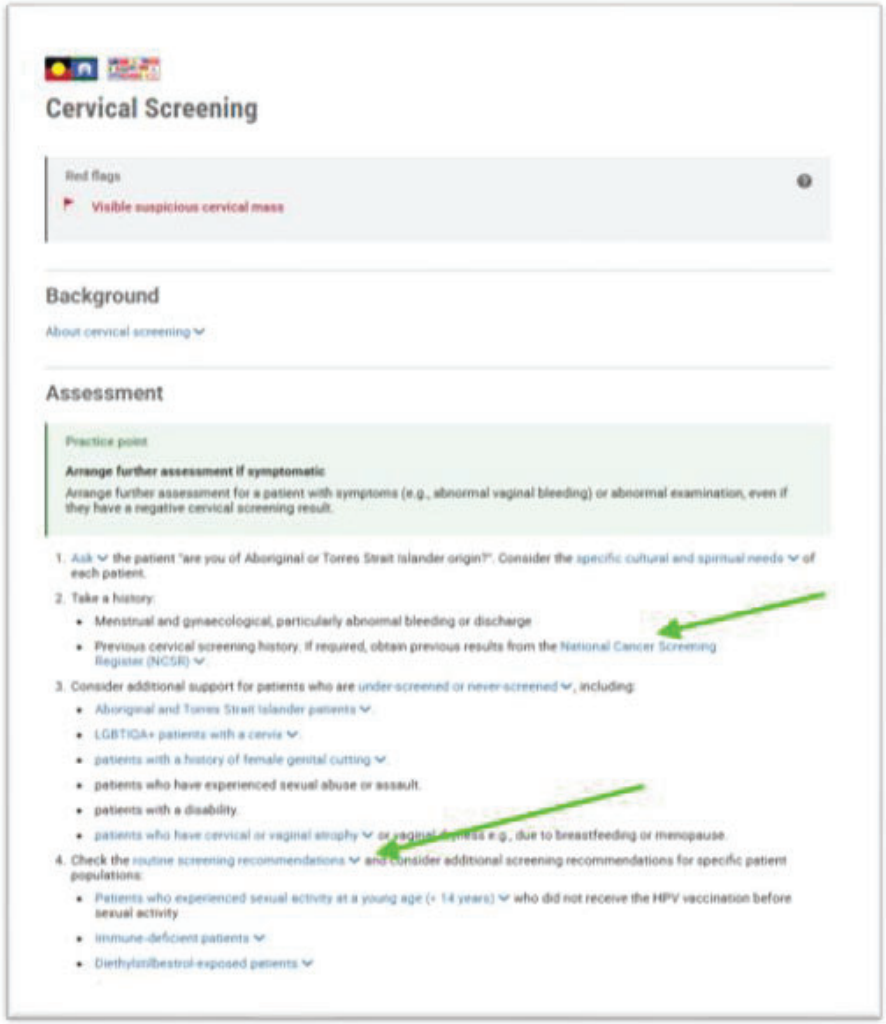
12 March 2025

Pathways are written by GP clinical editors with support from local GPs, hospital-based specialists and other subject matter experts

- clear and concise, evidence-based medical advice
- Reduce variation in care
- how to refer to the most appropriate hospital, community health service or allied health provider.
- what services are available to my patients

HealthPathways- Cancer Screening Pathways

HealthPathways- Cancer Screening Pathways



Cervical Screening

Red flags

Visible suspicious cervical mass

Background

About cervical screening

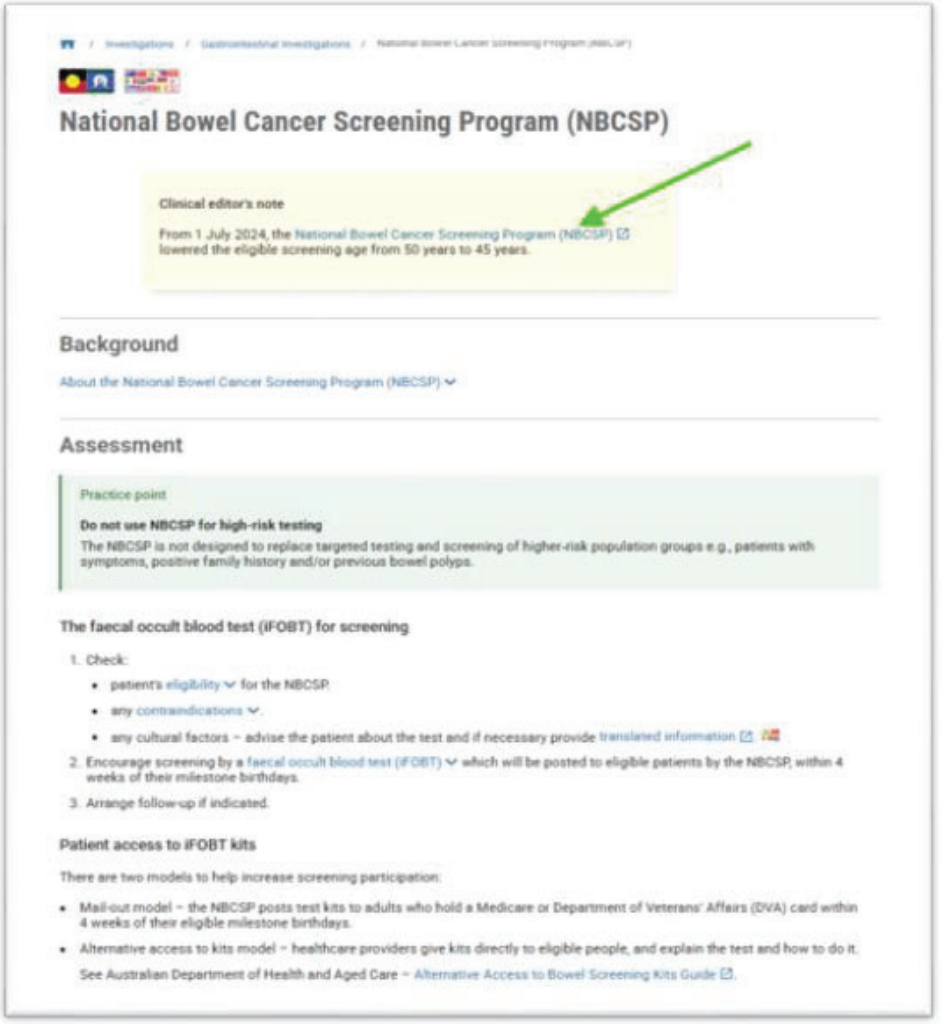
Assessment

Practice point

Arrange further assessment if symptomatic

Arrange further assessment for a patient with symptoms (e.g., abnormal vaginal bleeding) or abnormal examination, even if they have a negative cervical screening result.

1. Ask the patient "are you of Aboriginal or Torres Strait Islander origin?". Consider the specific cultural and spiritual needs of each patient.
2. Take a history:
   - Menstrual and gynaecological, particularly abnormal bleeding or discharge
   - Previous cervical screening history. If required, obtain previous results from the National Cancer Screening Register (NCSR)
3. Consider additional support for patients who are under-screened or never-screened, including:
   - Aboriginal and Torres Strait Islander patients
   - LGBTIQA+ patients with a cervix
   - patients with a history of female genital cutting
   - patients who have experienced sexual abuse or assault
   - patients with a disability
   - patients who have cervical or vaginal atrophy or vaginal dryness e.g., due to breastfeeding or menopause
4. Check the routine screening recommendations and consider additional screening recommendations for specific patient populations:
   - Patients who experienced sexual activity at a young age (< 14 years) who did not receive the HPV vaccination before sexual activity
   - Immune-deficient patients
   - Diethylstilbestrol-exposed patients



National Bowel Cancer Screening Program (NBCSP)

Clinical editor's note

From 1 July 2024, the National Bowel Cancer Screening Program (NBCSP) lowered the eligible screening age from 50 years to 45 years.

Background

About the National Bowel Cancer Screening Program (NBCSP)

Assessment

Practice point

Do not use NBCSP for high-risk testing

The NBCSP is not designed to replace targeted testing and screening of higher-risk population groups e.g., patients with symptoms, positive family history and/or previous bowel polyps.

The faecal occult blood test (iFOBT) for screening

1. Check:
   - patient's eligibility for the NBCSP
   - any contraindications
   - any cultural factors – advise the patient about the test and if necessary provide translated information
2. Encourage screening by a faecal occult blood test (iFOBT) which will be posted to eligible patients by the NBCSP, within 4 weeks of their milestone birthdays.
3. Arrange follow-up if indicated.

Patient access to iFOBT kits

There are two models to help increase screening participation:

- Mail-out model – the NBCSP posts test kits to adults who hold a Medicare or Department of Veterans' Affairs (DVA) card within 4 weeks of their eligible milestone birthdays.
- Alternative access to kits model – healthcare providers give kits directly to eligible people, and explain the test and how to do it.

  See Australian Department of Health and Aged Care – Alternative Access to Bowel Screening Kits Guide.

HealthPathways – Relevant and Related Pathways

Cervical cancer screening relevant and related pathways

- Cervical Screening
- Women's Health
- Cervical Cancer
- Cervical Polyps
- Gynaecology
- Endometrial Cancer
- Ovarian Cancer – Established
- Ovarian Cancer Follow-up
- Colposcopy Referral
- Fertility Specialised Referral
- Acute Gynaecology Referral or Admission (Same-day)
- Non-acute Gynaecology Referral (> 24 hours)

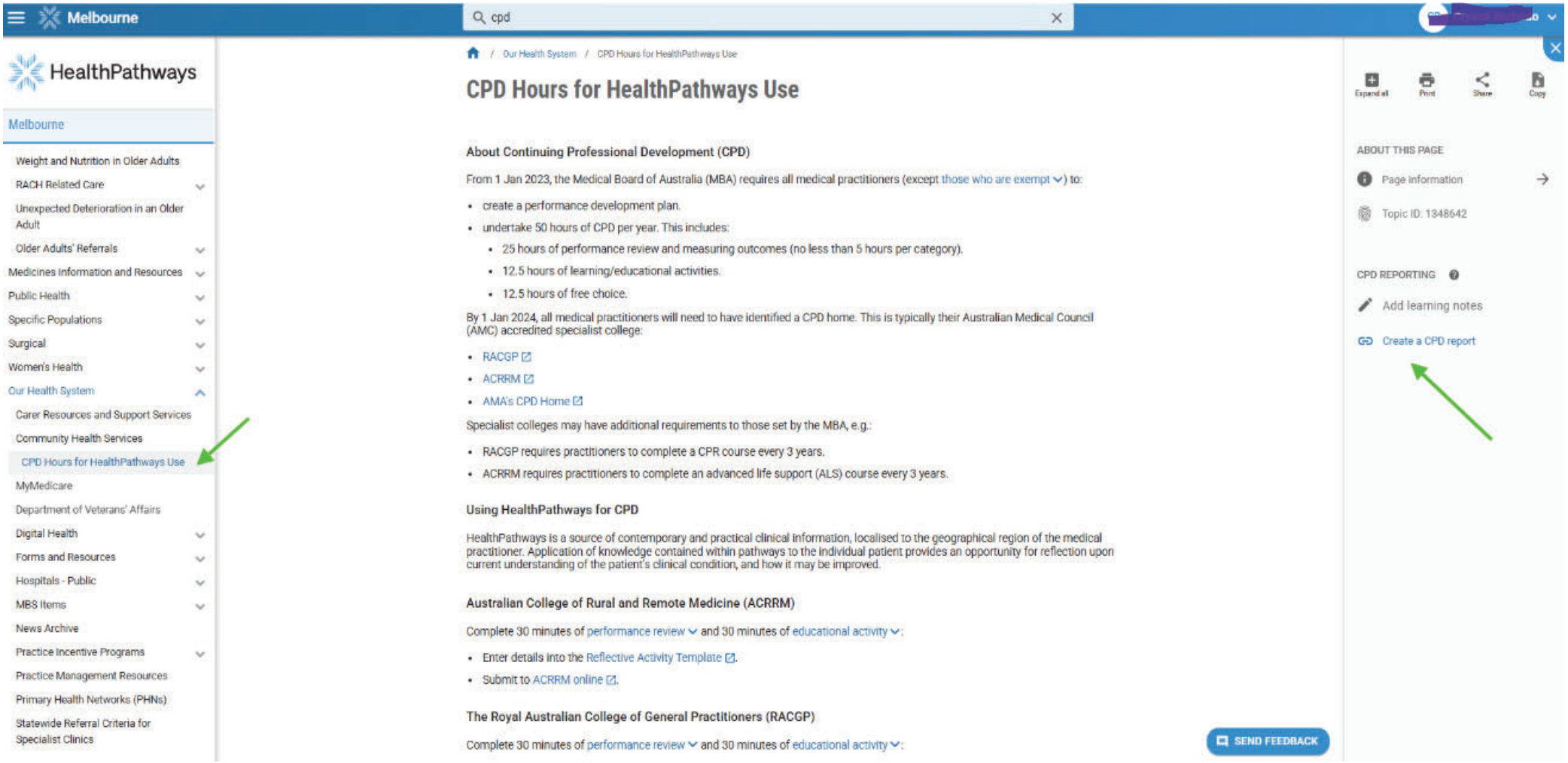
Other related Pathways

- Guide to MBS Items
- Statewide Referral Criteria for Specialist Clinics
- CPD Hours for HealthPathways Use

Bowel cancer screening-relevant and related pathways

- National Bowel Cancer Screening Program (NBCSP)
- Bowel Cancer
- Bowel Cancer Risk Categories and Screening
- Colorectal Symptoms - Suspected Colorectal Cancer
- Past Colorectal Cancer Colonoscopy Surveillance
- Positive Faecal Occult Blood Test (FOBT)
- Colorectal Symptoms – Suspected Colorectal Cancer
- Gastrointestinal Investigations
- Acute Gastroenterology Referral or Admission (Same-day)
- Non-acute Gastroenterology Referral (> 24 hours)
- Acute Colorectal Surgery Referral or Admission (Same-day)
- Non-acute Colorectal Surgery Referral (> 24 hours)

HealthPathways – CPD Hours for HealthPathways Use

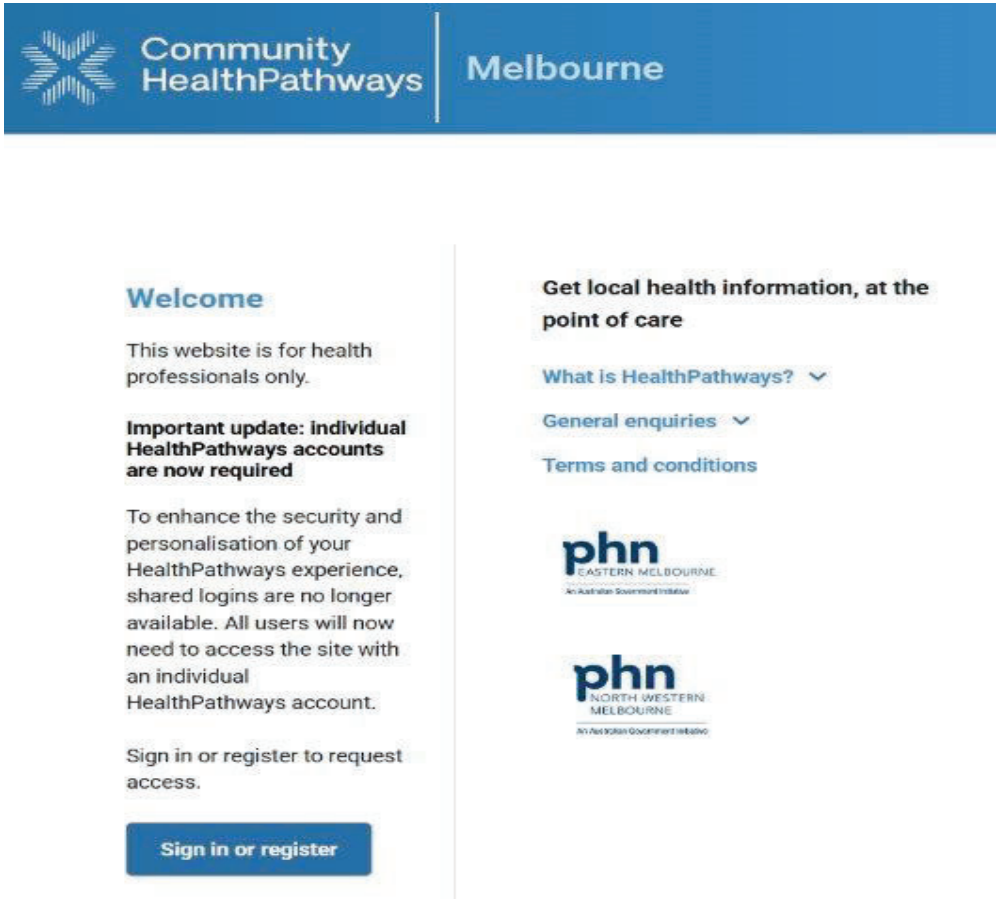


Accessing HealthPathways

Please click on the **Sign in or register** button to create your individual account or scan the QR code below.

If you have any questions, please email the team info@healthpathwaysmelbourne.org.au.

melbourne.healthpathways.org.au



THE UNIVERSITY OF MELBOURNE

PHN Cancer Screening Webinar

National Bowel Cancer Screening Program

A/Prof Justin Tse

Melbourne Medical School

Acknowledgement of Country

We acknowledge the Wurundjeri people who are the traditional custodians of the land on which we meet today and acknowledge and pay our respects to their Elders past and present.

We acknowledge those who are meeting on other first nation lands and pay respect to their Elders past and present.

Cancer Screening Webinar – Colorectal Cancer

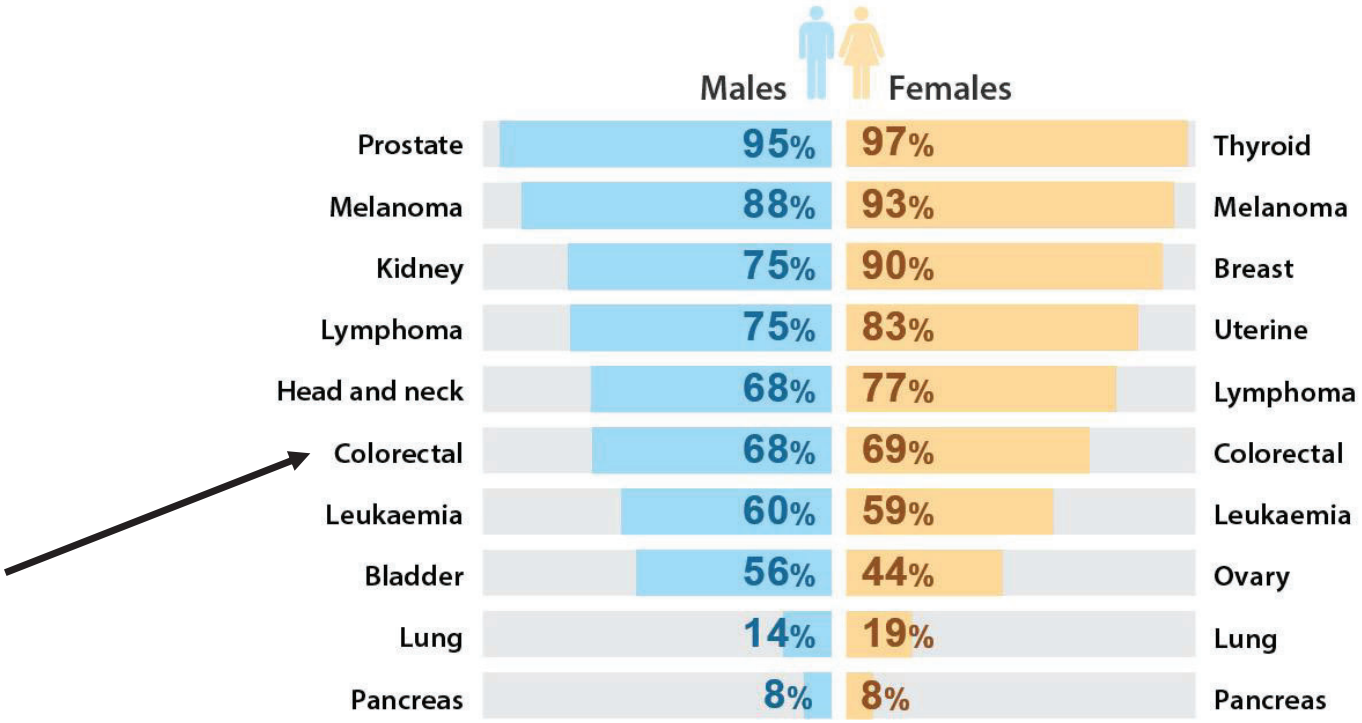
Objective 1

Identify changes to the National Bowel Cancer Screening Program Guidelines and evidence supporting them

Objective 2

Discuss changes required in clinical practice as a result of cervical and bowel screening guideline updates

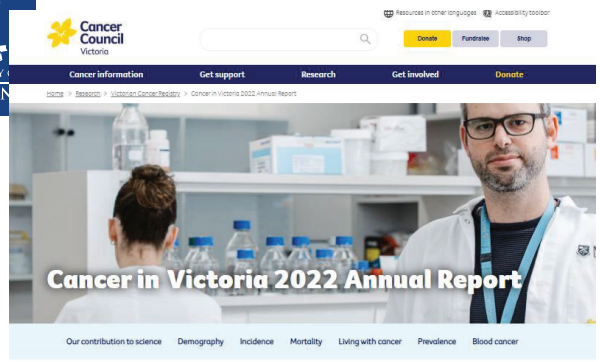
Cancer in Australia = 5-year survival rates



Source: AIHW Australian Cancer Database 2013.

Victoria – 2023
Bowel Cancer – *Stage 1* diagnosis – over 90% (5-year survival rate)

Overall 5-year survival rate – now at 73% for Bowel Cancer



The Victorian Cancer Registry: Our contribution to science

Cancer Council of Victoria – Registry report 2022 - link

Relative survival rate – high for Breast, Prostate, Melanoma and Bowel Cancer

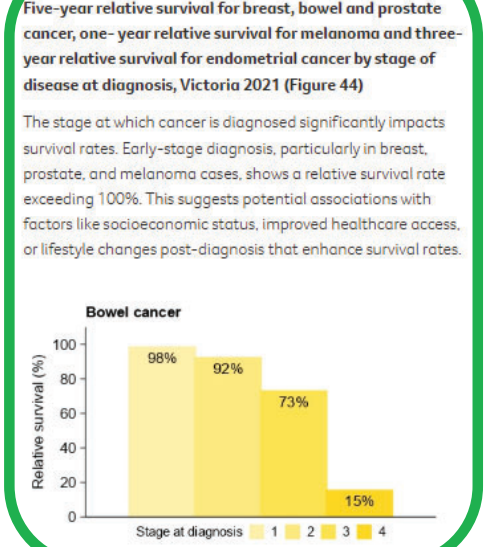
Living with cancer

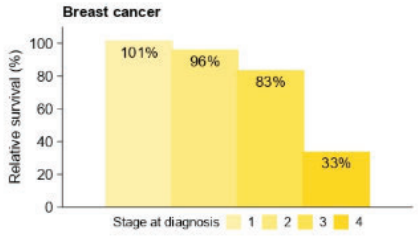
A snapshot of cancer survival in Victoria in 2022:

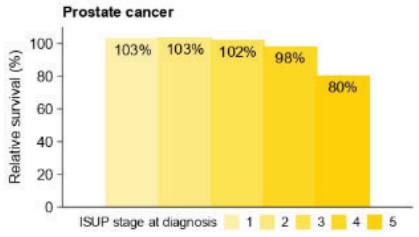
- The 5-year survival rate for Victorians diagnosed with cancer has increased 48% over the past 30 years.
- Across all cancers, the 5-year survival rate is 73% for females and 70% for males.
- Survival rates vary significantly across cancer types and are also impacted by a person's age, whether they identify as Aboriginal or Torres Strait Islander, where they live, and the stage of cancer at diagnosis.

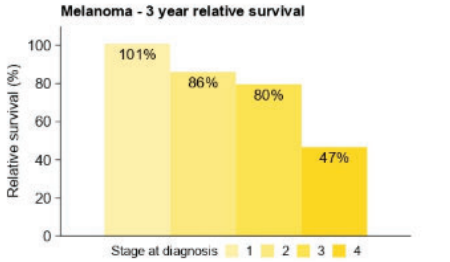
Five-year relative survival for breast, bowel and prostate cancer, one- year relative survival for melanoma and three-year relative survival for endometrial cancer by stage of disease at diagnosis, Victoria 2021 (Figure 44)

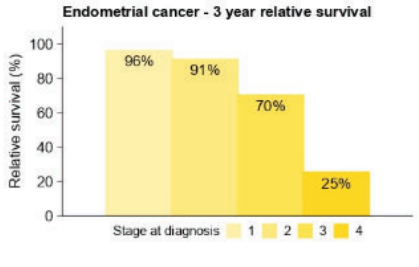
The stage at which cancer is diagnosed significantly impacts survival rates. Early-stage diagnosis, particularly in breast, prostate, and melanoma cases, shows a relative survival rate exceeding 100%. This suggests potential associations with factors like socioeconomic status, improved healthcare access, or lifestyle changes post-diagnosis that enhance survival rates.











The symptomatic patient

Screening programs for CRC are targeted for *asymptomatic* patients

- If a patient presents with *symptoms or signs, the Optimal Care Pathways suggest the following ->*

Current colorectal cancer OCP guidance for Step 2: Presentation, initial investigations and referral

The following signs, symptoms and results should be investigated

- Positive iFOBT
- Passage of blood with or without mucus in faeces
- Unexplained iron deficiency anaemia
- Change in bowel habit (loose stools or constipation), especially a recent one
- Undiagnosed abdominal pain or tenderness
- Unexplained rectal or abdominal mass
- Unexplained weight loss
- Lethargy

Initial investigations include

- Detailed family history for patients presenting with possible symptoms of colorectal cancer
- Physical examination
- Digital rectal examination
- Full blood examination and iron studies

Referral options

At the referral stage, the patient's GP or other referring doctor should advise the patient about their options for referral, waiting periods, expertise, if there are likely to be out-of-pocket costs and the range of services available. This will enable patients to make an informed choice of specialist and health service.

Communication

The GP's responsibilities include:

- explaining to the patient and/or carer who they are being referred to and why
- supporting the patient and/or carer while waiting for specialist appointments informing the patient and/ or carer that they can contact Cancer Council on 13 11 20.

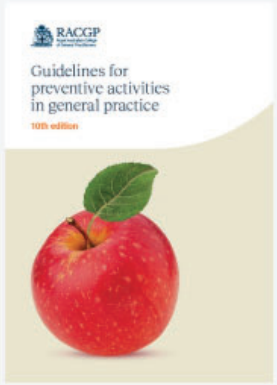
Timeframe

Test results should be provided to the patient within 1 week of testing. If symptoms suggest colorectal cancer, patients should be referred and colonoscopy completed within 4 weeks. Patients should see a surgeon within 2 weeks of GP referral following a positive diagnosis of colorectal cancer via colonoscopy.

The RACGP Red Book Guidelines

RACGP Education Clinical resources Running a practice Advocacy News Search LOGIN / JOIN

Colorectal cancer



DOWNLOAD PDF

Table of contents

- Table of Abbreviations
- About the Red Book
- Screening, case finding and prevention principles
- Structure of the Red Book

Search guideline

Cancer | Colorectal cancer

Screening age bar (average risk)

0-9	10-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79	≥80

> Prevalence and context of the condition

Table of recommendations

Screening — Recommended as of: 28/06/2024

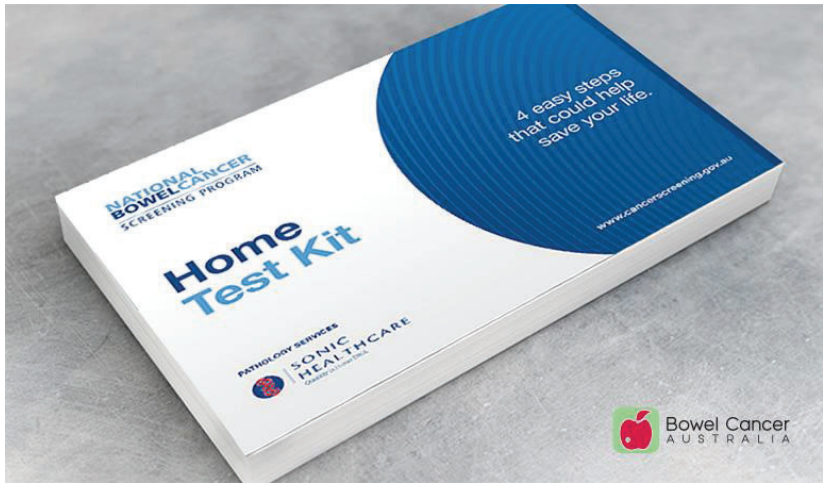
Screening

Recommendation	Grade	How often	References
Immunochemical faecal occult blood testing (iFOBT) every 2 years is recommended starting at age 45 years and continuing to age 74 years for those at average risk of colorectal cancer.	**Conditionally recommended**	Every 2 years	5
Colonoscopy is not generally recommended for screening people at average or slightly increased risk according to their family history.	**Generally not recommended**	N/A	6,7,8

The National Bowel Cancer Screening Program

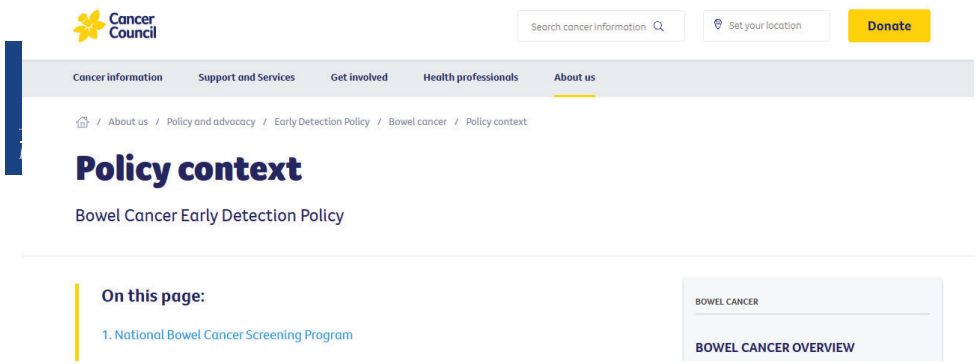
National program – started in 2006 with expansion of age range in 2014 to 50–74-year-old

2024 – new age range 45–74-year-old



The rationale ->

- Evidence that early detection improves 5-year survival rate iFOBT. Safe and reliable test. Easy to use.
- iFOBT can reduce deaths from the disease by 36 per cent
- Still low uptake rate – 40% of eligible population
- Completed every two years



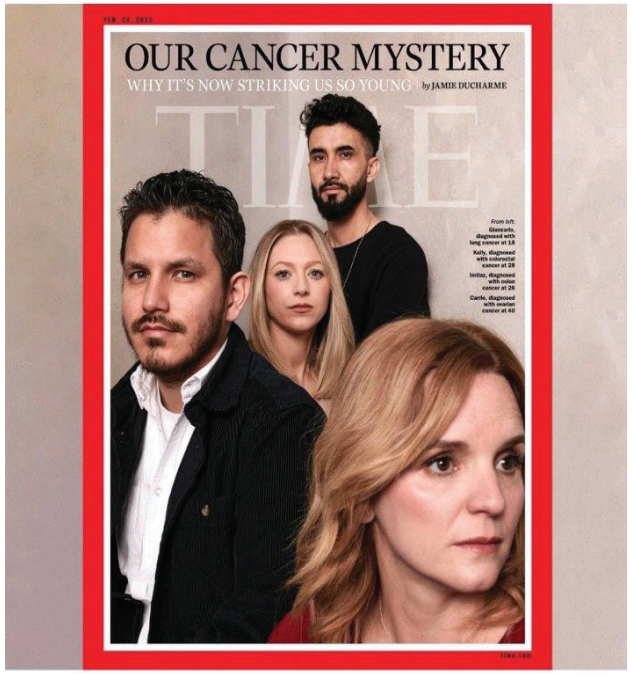
Cost-effectiveness

A range of studies have found population-based bowel cancer screening with iFOBT once every 2 years in people aged 50-74 years is cost-effective as discussed below.

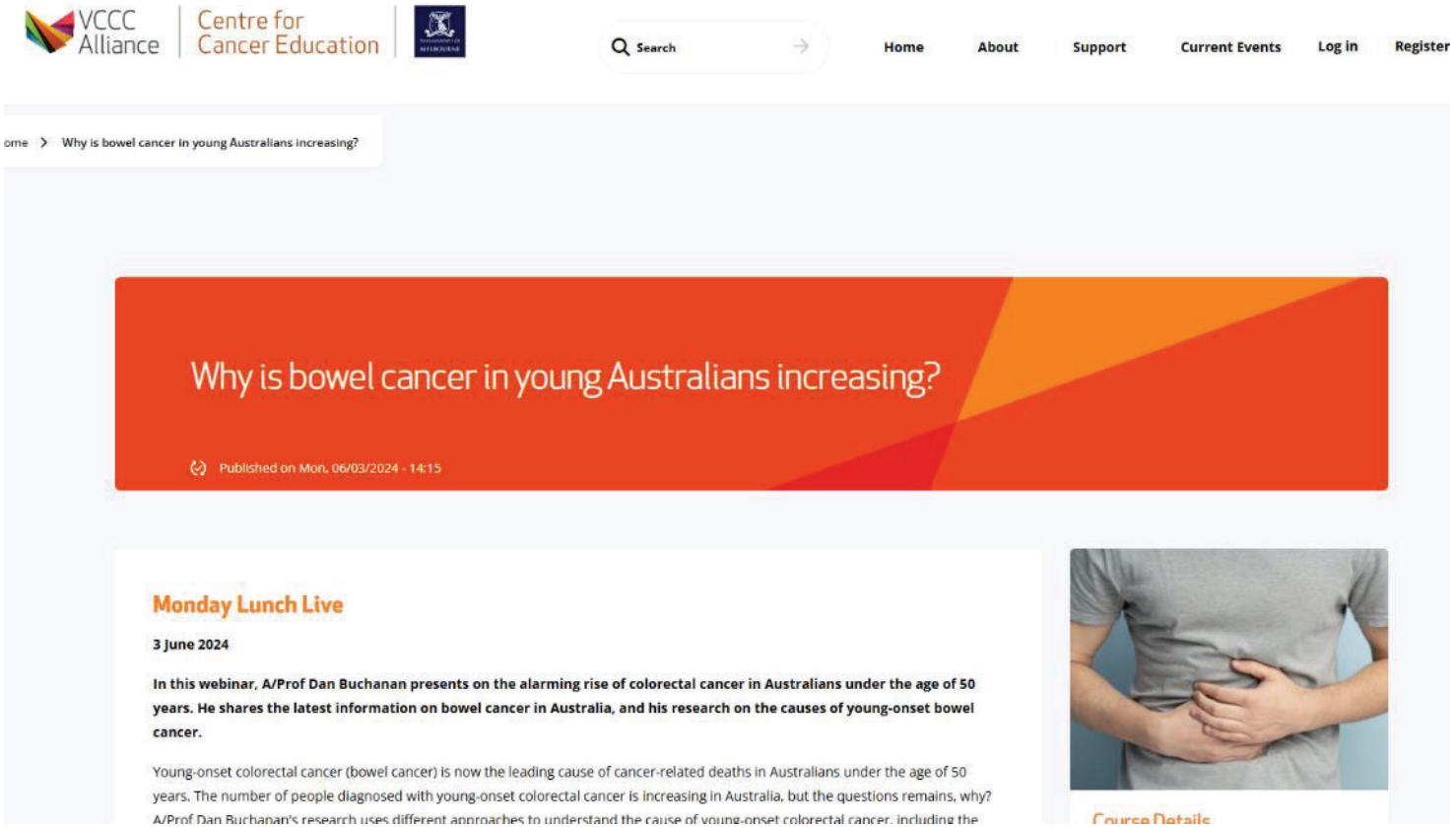
A preliminary cost-effectiveness study of the NBCSP found that, over the lifetime and relative to no screening, the program was predicted to save 1,265 life years, prevent 225 bowel cancer cases and cost an additional $48.3 million, equivalent to a cost-effectiveness of $38,217 per life-year gained (LYG) at current participation levels. An analysis assuming full participation improved this to $23,395 LYG.[14]

A 2017 cost-effectiveness study of the NBCSP found that biennial iFOBT screening is highly cost-effective and was predicted to be associated with a cost-effectiveness ratio of $2,693-$3,048 per life-year saved compared with no screening.[15] The fully implemented NBCSP is estimated to reduce bowel cancer incidence by 23% and mortality by 36%.[15] A subsequent study concluded that in comparison to other screening approaches (including no screening, colonoscopy, computed tomographic colonography, faecal DNA test, plasma DNA test and flexible sigmoidoscopy), the biennial iFOBT is highly cost-effective and the most cost-effective approach of all the screening scenarios considered.[16]

Dan Buchanan – VCCC Monday Lunch Live (link)



13th Feb issue - TIME (link)



Dan Buchanan – VCCC Monday Lunch Live (link)

Why is bowel cancer in young Australians increasing?

Early-onset Colorectal Cancer is now a global problem

Incidence of EOCRC is increasing in US[1] and high-income countries[2].

>10% of all new CRC diagnoses are EOCRC

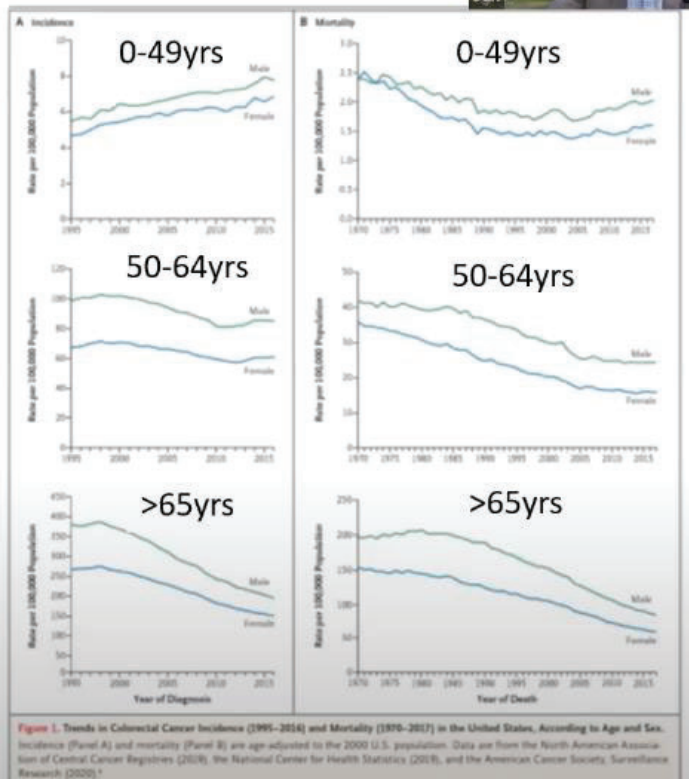
11% of colon cancers and 23% of rectal cancers by 2030[2]

EOCRC is #1 cause of cancer-related death in US in men and #2 in women[1]

EOCRCs have more advanced stage at presentation and more cancer in distal (left-sided) colon and rectum[1,2]

The cause of the increasing incidence is unknown…

- Birth cohort effect from 1950s



MORE VIDEOS

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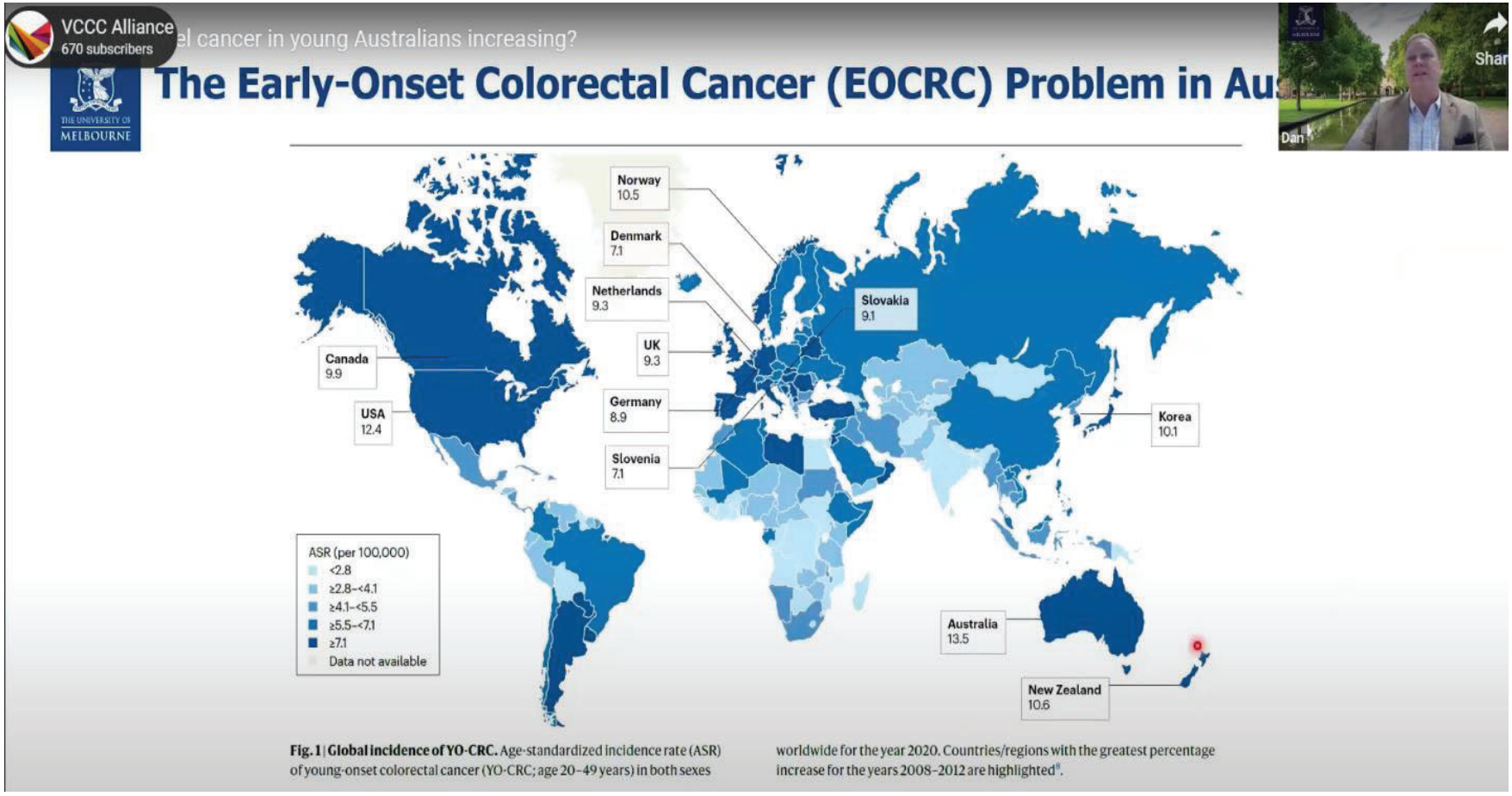
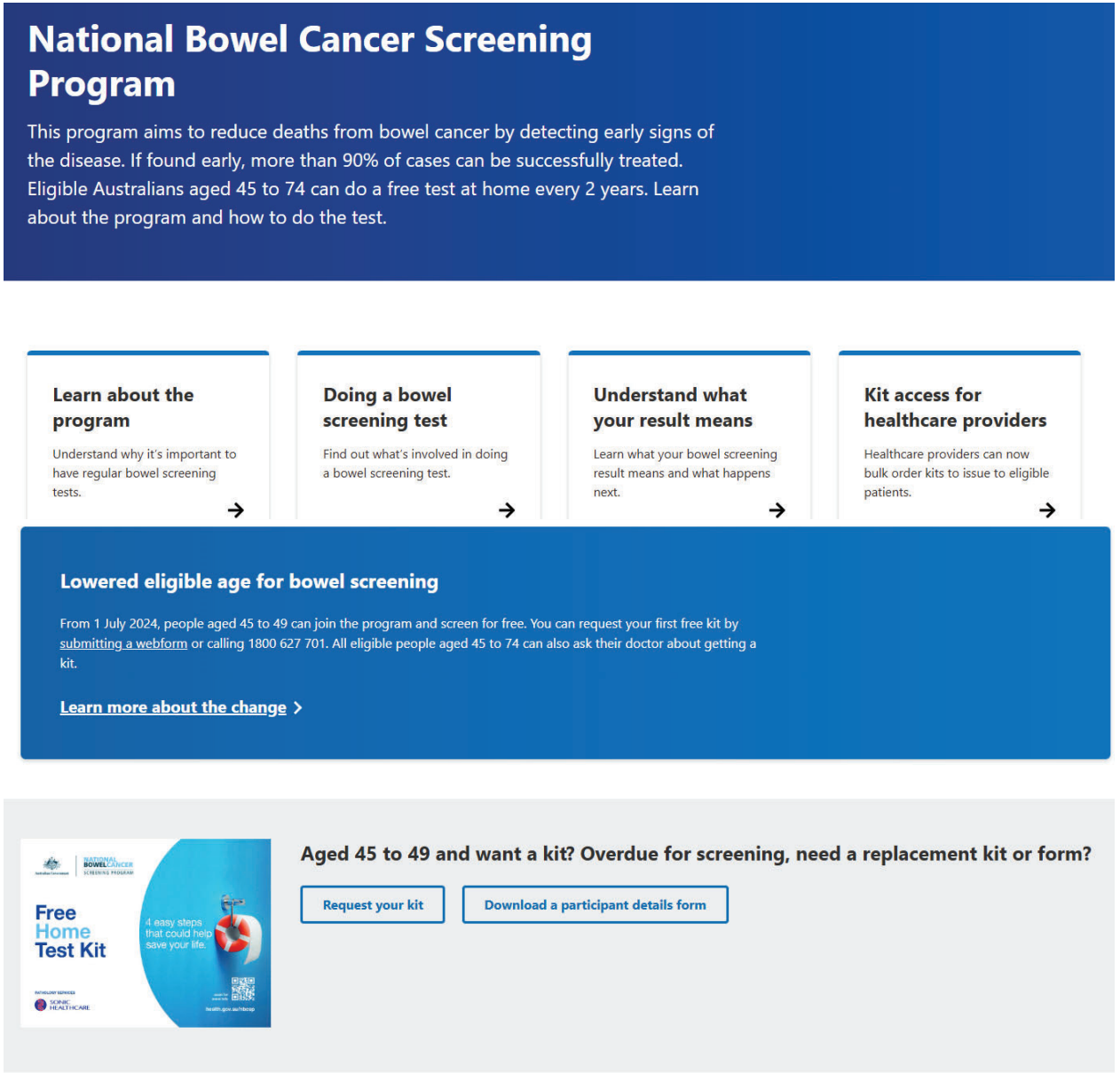


New age range – 45 to 74 years old

National Bowel Cancer Screening Program | Australian Government Department of Health and Aged Care - link

- Phone 1800627701 / web-form
- 45–49-year-old – must call up



Pause

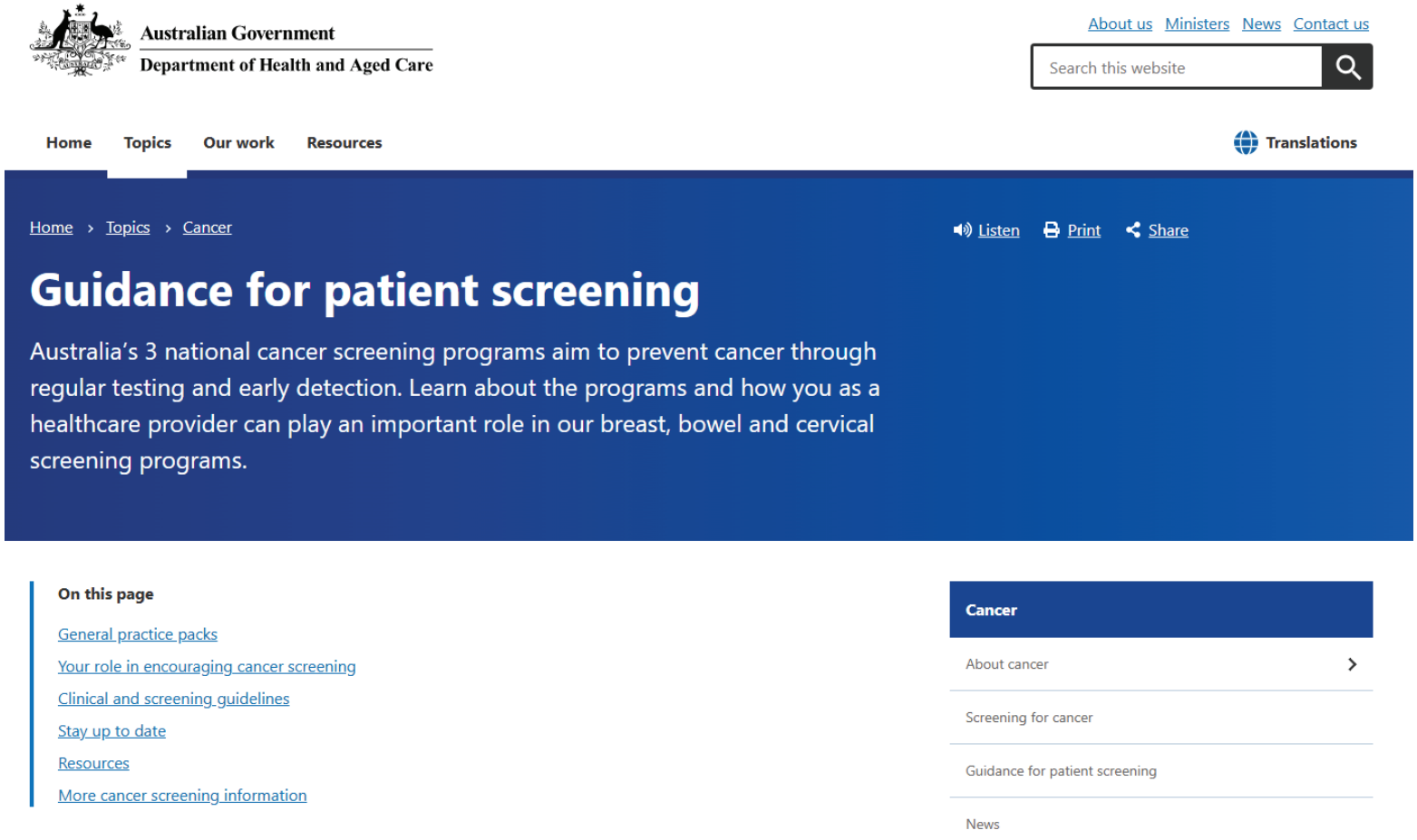
Reflection

As a primary care doctor

- Are we proactive in cancer screening in all cancers including colorectal cancer?
- If the participation rate is 40%, what can my clinic to do to increase this participation rate?
- How can we encourage prevention and early detection in the 40–50-year-old age group of cancer and other conditions?

Fact – Cancer Council of Victoria states there will be 30,000 undiagnosed cancers by 2028 in Victoria due to a fall in screening rates post COVID pandemic

General Practice pack - online access to information



Guidance for patient screening | Australian Government Department of Health and Aged Care **(LINK)**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