In Spain we are moving from severe dissatisfaction with colorectal cancer (CRC) screening for moderate-risk individuals as implemented to moderate optimism on its future extension to the whole of the national territory. In 2000 initial experiences were obtained in Catalonia; by 2006 institutional programs were started also in Valencia and Murcia. The results of such experiences allowed to consider program extensions with guarantee of success. So much so that in 2009 the Estrategia en Cáncer approved by the Sistema Nacional de Salud (SNS) established the implementation and extension of population-wide CRC screening as their goal (1). This Strategy defined that screening –based on fecal occult blood (FOB) testing every two years, followed by colonoscopy for positive results– should be offered to all males and females between 50 and 69 years of age, with a potential subsequent extension to 74 years of age. A coverage of 50 % by 2015 and 100 % by 2020 was aimed at, and quality assessment and control was assigned to the Red de Programas de Cribado de Cáncer de España. This strategy was further supported in 2013 when the SNS Consejo Interterritorial agreed on the inclusion of such screening in the SNS common services portfolio, which was published in the Boletín Oficial del Estado (BOE) and scheduled to be in force in 2014 (2). The Órden Ministerial states that early colorectal cancer detection should be accomplished in a coordinated, protocolized manner, with a maximum period of five years to program onset in all autonomous regions (comunidades autónomas, CC. AA.), and a maximum term of ten years to 100 % coverage. This realistic view of full coverage by 2024, while delaying the Strategy’s deadline, is now a formal mandate for us all. It is important to consider that we need not wait till that date to approach the aforementioned extension, but that stragglers, those CC. AA. that are still considering or performing initial pilot experiences, must catch up with the rest of national programs by said year at the very latest. In 2013, Spanish program coverage reached 20 %, starting with a mere 4 % in 2009 –11 out of 17 CC. AA. were already reporting a program (65 %), 2 (12 %) were running pilot experiences, 3 (18 %) had committed to start in 2014, and only 1 (5 %) reported no related activities or schedules (3). Even this solitary region has just announced their own pilot experience for 2015 through specialized media.

Beyond the excellent cost-effectiveness of screening options for CRC (4), Spanish programs are now showing a direct yield that warrants the advocacy of CRC early diagnosis as a need even –and most particularly– in a time of crisis with limited resources as is now the case (5). A reliable estimation, based on national data on CRC-related costs and data from the program in the Murcia region, concludes that the necessary investment for a complete deployment of screening programs would only represent 6 % of the total direct cost estimated for CRC in Spain (5). An example that such investment is immediately profitable is found in the Murcia region, where
the treatment cost of an early detected cancer within a screening program is over one third lower when compared to a cancer identified in standard clinical practice (6). This savings-per-diagnosed cancer experience is shared by the Basque Country region, where estimations suggest that, when savings in terms of cancers prevented by adenoma resection are added, their net savings in over two years were in excess of €35 million (5).

Spanish prevention programs for CRC, as based on regular FOB screening for moderate-risk individuals, are of the highest quality. Results obtained are consistent across CC. AA., quality control is adequate as provided by the Red de Programas de Cribado de Cáncer de España, and standard processes and markers allow the reporting of nation-wide results. This is why Spain is now among countries exhibiting the most robust models, despite our late integration into the CRC screening scene. The Spanish model success relies in the excellent collaboration now developing between public health care institutions, clinicians, and civil society, as illustrated by the Alianza para la Prevención del CCR (7). In addition, research lines developing within these programs are considerably solid. A paradigmatic instance of the above is the COLONPREV study, an exclusively Spanish multicenter clinical trial that is first to compare biennial FOB screening versus direct colonoscopy at study onset. The endpoint –mortality at 10 years– has not been reached yet; however, the results from the initial two years are now reported, and show that the numbers of invasive cancers detected in both arms are similar, albeit more adenomas are logically detected in the direct colonoscopy arm (8).

In the present issue of the Spanish Journal of Gastroenterology (Revista Española de Enfermedades Digestivas) a new manuscript is reported, which reflects the quality of research as promoted by Spanish CRC screening programs (9). Most authors are included in the cancer prevention and screening team of the Valencia region. This group is particularly representative nation-wide, both for the excellence of their program and their significance and leadership within the Red de Programas de Cribado de Cáncer de España. This manuscript reports research results that will be very useful for the optimization of future strategies to help increase program effectiveness. Regarding CRC and adenomas, differences in risk according to age, gender, site, and lesion type are well known and have a considerable impact on screening program results, including a topic so much sensitive as the development of interval cancer (10). A relatively simple approach is the attribution to older women of a risk equivalent to that of men (11). An emerging, more complex element for reflection is the presence of differences in the detection and malignant potential of non-polypoid lesions between males and females (12). Whatever may be the case, such observations underly the notion that the time is likely ripe to split up screening according to gender (13). In addition to gender and age, the paper by Molina-Barceló et al. also discusses a highly interesting factor, namely social status (9). These authors had previously examined the impact of social status and gender on screening participation rates (14), and more recently participation differences according to age and gender as a part of the COLONPREV study (15); however, it is now that they clearly establish the reasons accounting for such differences. Thus, women are less likely to participate because of their intuitive dislike of screening, whereas men usually allege their lack of time, adopting the presumably differentiating social role usually attributable to males; in turn, older individuals mainly state their fear of the diagnosis, while lower-class women experience embarrassment, which also reflects the adoption of a differentiating social role by females with this social status (9). Importantly, this study lays the foundations to optimize strategies meant to increase participation rates in screening programs, not
only because of a better understanding of differences in prevalence according to age and gender, but also because of the potential improvement of the information intended to overcome social resistance as a marker of the likeliness of screening acceptance.

Our final reflection is that reasons for conservatism no longer exist regarding program extension and overt commitment to participation improvement from fear of program sustainability. On the contrary, effects will be better, both in health in financial outcomes, as participation rises and strategies become more adjusted to social perception patterns rather than just risk perception patterns. The key aspect here is staying within structured, universal, public programs that ensure quality and systematic assessments using a single set of criteria. No doubt, the best possible future will have preventive actions included in a social healthcare model devoted to obtain optimal health outcomes in the population. Meanwhile, papers like the above raise our optimism for such future.

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