Is it time to pay the PIPER?
Frank Frizelle

The recently realised results of the PIPER study are a tremendous insight into the journey of patients with colorectal cancer in New Zealand. The PIPER study should force us to acknowledge and accept the unpleasant consequence of our present inadequate management of patients with colon and rectal cancer (CRC). The results should be considered a call to do better. A full copy of the report can be found on the University of Auckland Faculty of Medical and Health Services website, while the study is briefly summarised below.

The PIPER study is a comprehensive study of the outcome and management of New Zealanders with colorectal cancer. This study was a national retrospective cohort study of selected sample New Zealand residents diagnosed with colorectal adenocarcinoma in New Zealand from 1 January 2007 to 31 December 2009. The researchers hand-searched the medical records of 6,387 patients, resulting in 5,667 eligible patients. The process of data collection took over 9,000 hours and recorded over 960,000 individual data points.

They found 4,193 (74%) were diagnosed with colon cancer, and 1,401 (25%) with rectal cancer. Most patients were of European extraction, with 8% recorded as Māori, 3% as Pacific, and 2% as Asian. The proportion of colon cancers that were right-sided (located proximal to the splenic flexure) was 51% and the proportion that were left-sided was 48% (sidedness was unknown for 1%). Females were more likely to have a right-sided colonic tumour (57%). While males were more likely to have a left-sided tumour (54%).

The mode of first presentation was to the emergency department (ED) for 34% of patients with colon cancer, with 44% for Māori and 51% for Pacific patients. In the UK, 21% of CRC patients have this mode of admission. For patients with rectal cancer, the mode of first presentation was to the ED for 14% of patients, 21% for Māori and 24% for Pacific patients. While 8% of patients with colorectal cancer presented with a bowel obstruction.

The stage of CRC at diagnosis is the single most powerful prognostic variable, and is the principal determinant of treatment. New Zealand has a relatively higher proportion of patients diagnosed with stage IV (metastatic) disease than other countries—Australia has 19% and 17% stage IV for colon and rectal cancer respectively, and the UK has 17% for both stage IV colon and rectal. Higher proportions of metastatic disease were seen in Māori and Pacific patients: the proportions diagnosed with stage IV colon cancer being 32% and 35% for Māori and Pacific respectively, and for rectal cancer being 29% and 22% respectively.

The PIPER study can only describe what has been—it does not tell us what can be done to improve the outcome of patients with colorectal cancer. Since the publication of this study, the media have asked what we can do to improve the outcome, and this focus has understandably and clearly been on the absence of colorectal cancer screening in New Zealand, however besides screening, population eduction of symptoms and early investigation may also help.

The background of colon cancer screening in New Zealand has previously been discussed in the Journal. The benefit for colorectal cancer screening is well established, and the plan to repeat a trial in New Zealand was another unnecessary Government delaying tactic. The results are very similar to most other studies, only more polyps and cancers were found—not really a surprise in a country with one of the highest rates of colorectal rectal cancer in the world.
EDITORIAL

We have been hearing about the lack of resources for colonoscopy since the 1998 report into population colorectal cancer screening in New Zealand. That report stated that the benefit of colorectal screening was likely to be similar to breast screening, however there were significant differences regarding risks and benefits to the screening tools. Resources (access to colonoscopy) were identified as a major issue, and the report suggested providing more colonoscopy services in the public sector.

The response by those in charge as to why screening is still delayed has been to state that though it is recognised that colorectal cancer screening is inevitable, their need was for adequate planning, resource allocation and provision for infrastructure prior to the roll-out of national screening. Little changed in 17 years.

Another news item on colorectal cancer this week, gives insight into the minds of those behind the screening fiasco. It was reported that if a patient buys a FOBT (faecal occult blood test) screening kit themselves which gives a positive result, then the patient will not get a government-funded colonoscopy because—and I quote—“This type of screening does not include a systematic approach to the screening test, diagnosis and treatment, or consistent support for people who purchase these FOBT kits”. Such comments by those empowered to advance colorectal cancer screening does not give us much hope of any action soon.

For 17 years, the same people have been making the same claims: not enough resources. The PIPER study shows what impact these delays have had on patients. We need to acknowledge and accept the unpleasant consequence of our current inadequate management of patients with CRC. Colorectal cancer screening should be progressed with reasonable speed. While the cornerstone features need to be put in place, many of the details can be resolved with good management, as details are quickly adapted as needed with the rollout. In that way we can correct the awful state of affairs the PIPER study has confirmed, and put an end to the years of talk and relative inaction.

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