

COLORECTAL CANCER SCREENING PROGRAMME

Monitor 2015

National Monitoring of the Colorectal Cancer Screening Programme

Erasmus MC – NKI / AvL

The screening programme is proceeding as expected with high levels of participation in all steps. The programme is expected to be fully implemented by the end of 2019. The prime focus is to ensure sufficient colonoscopy capacity in all regions of the Netherlands. To achieve this, a concerted effort by all parties is required.



Summary

In the second year of the screening programme, 1,171,550 individuals were invited for colorectal cancer screening with the fecal immunochemical test (FIT). This represents 89.6% of the target population. Of those invited for the first time, 848,761 (72.6%) participated in screening – a slight increase from 2014 (71.3%). In 2015, 53,490 individuals received an unfavourable test result at a cut-off value of 47 µg Hb/g faeces. This represents a screening positivity rate of 6.4%. Of the people who received an unfavourable test result, colonoscopy reports are available for 79.4%. For participants who had a diagnostic colonoscopy in 2015, 8.7% were diagnosed with colorectal cancer. A further 48.5% were diagnosed with advanced adenoma.

The Dutch colorectal cancer screening programme is coordinated by the National Institute for Public Health and the Environment (RIVM). RIVM commissioned Erasmus MC and the Netherlands Cancer Institute (NKI)/Antoni van Leeuwenhoek Hospital to carry out national monitoring of the colorectal cancer screening programme on an annual basis. Monitoring ensures the quality of the colorectal cancer screening programme and identifies pertinent issues and bottlenecks. Monitoring is conducted using data from ScreenIT, the national information system for the colorectal cancer screening programme.

data for quality assurance (n=44) were excluded from the results, except for the total number of invitations sent.

The colorectal cancer screening programme's target population consists of men and women aged 55 to 75, who are invited for screening with a test that measures blood in the stool (faecal immunochemical test, FIT) once every two years. In the case of an unfavourable test result, i.e. when the amount of blood in their stool samples exceeds the cut-off value (47 µg Hb/g faeces), the participant is invited for a colonoscopy intake. The screening programme will be gradually implemented, with a projected roll-out of five years. In 2015, the following groups were invited to take part in the screening programme:

- first-round birth cohorts 1940, 1946, 1948, 1950 and 1952;
- 18.7% of the 2014 target population who had not yet received an invitation in 2014;
- individuals who received their first invitation during 2013 and were eligible for the second round in 2015.

MONITORING THE PARTICIPATION RATE AND RESULTS OF PRIMARY SCREENING

The target population for 2015 consisted of 1,307,775 individuals. Of these, 32,169 individuals indicated that they did not wish to participate in response to a first notification letter, before the actual invitation was sent. Although higher than in the previous year, this increase may be attributable to the extension of the period between the first notification letter and the invitation (from two to three weeks) in July 2015.

At 31 December 2015, 1,171,550 individuals had been invited - 1,169,391 first round invitations and 2,159 second round invitations (Table 1), encompassing 89.6% of the target population. The remaining individuals in the target population (10.4%) will be invited in 2016. As the number of individuals in the second round is very low, the results for this group will not be presented. From this point, all figures will be based only on individuals invited for the first round of screening.

The first round of the screening programme had an overall participation rate of 72.6% (Table 2). This percentage was higher for women (74.0%) than for men (71.1%). Women born in 1948 had the highest participation rate (76.0%). Those invitees who did not

Birth cohort	Invited*
First round	
1938	944
1939	4,879
1940	108,909
1946	197,176
1947	25,575
1948	183,615
1949	46,796
1950	177,966
1951	82,085
1952	186,306
1954	151,140
Subtotal	1,169,391
Second round	
All	2,159
Total	1,171,550

* Invited consists of all individuals with an invitation including FIT kit or a first notification letter with opt-out.

Birth cohort	Men		Women		Total	
1938	131	32.1%	166	31.0%	297	31.5%
1939	1,034	50.9%	1,354	47.6%	2,388	48.9%
1940	34,327	66.9%	37,560	65.2%	71,887	66.0%
1946	71,132	73.1%	74,657	74.8%	145,789	73.9%
1947	9,262	69.8%	10,227	71.5%	19,489	70.7%
1948	66,778	73.1%	70,114	76.0%	136,892	74.6%
1949	16,232	71.7%	17,680	73.2%	33,912	72.5%
1950	63,988	72.0%	67,633	75.9%	131,621	74.0%
1951	27,992	70.3%	31,250	73.9%	59,242	72.2%
1952	66,179	71.1%	70,542	75.7%	136,721	73.4%
1954	53,114	69.5%	57,409	74.8%	110,523	72.2%
Total	410,169	71.1%	438,592	74.0%	848,761	72.6%

participate can be divided into two groups, those who actively opt out of screening (non-participants) and those who failed to respond (non-responders). The non-responders also included individuals who were deceased or emigrated after receiving an invitation.

After receiving the invitation or first notification letter, a total of 103,465 (8.8%) individuals opted out of screening (non-participants). Of these, 33,469 (32.3%) individuals indicated “medical reasons” for not participating and 8,759 (8.5%) individuals indicated that they had “no time or no interest”. For 61,237 (59.2%) non-participants, reasons for not participating were not specified (unknown). A total of 217,165 (18.6%) individuals failed to respond to the invitation (non-responders). Reminders were sent to 97.4% of all the non-responders without reason (i.e. no death or emigration).

Of the 842,163 individuals sending in their first FIT, 77,386 (9.2%) participants initially returned a test that was not assessable: 6,727 (0.8%) due to unreliable test results, 2,965 (0.4%) due to a FIT that was unsuitable for assessment, 55,251 (6.6%) because the materials were incomplete (missing form or missing FIT kit), and 12,443 (1.5%) because the participants had lost the kit. Some of the individuals with incomplete materials (missing form) filled in their details digitally. Finally, after (repeatedly) being sent a new FIT, 841,028 (99.1%) participants returned an assessable FIT.

3. FIT findings, first round

In 2015, all tests were assessed at a cut-off value of 47 µg Hb/g faeces (equivalent to 275 ng/ml). A total of 53,490 (6.4%) participants with an assessable FIT had an unfavourable test result (positivity rate). Of these, 32,280 were male and 21,210 were female (Figure 1 and Table 3). The positivity rate was also higher in males (7.9%) than in females (4.9%).

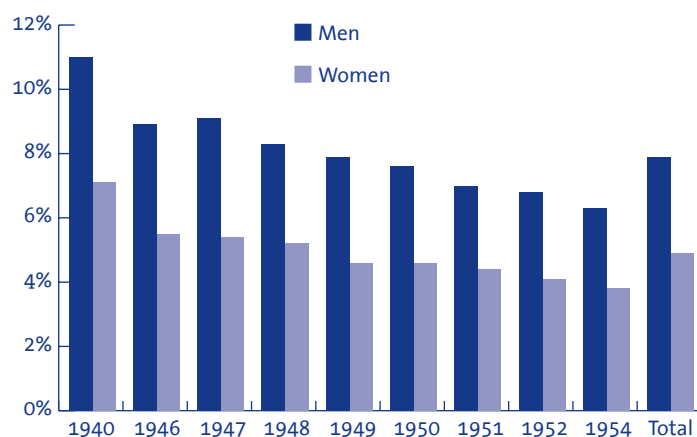


Figure 1: Positive test result (positivity rate) by birth cohort
(Source: ScreenIT)

* Birth cohorts 1938 and 1939 are not shown, due to the low numbers in this group.

Table 3: Positive test result (positivity rate) by birth cohort
(Source: ScreenIT)

Birth cohort	Men		Women		Total	
1938	14	11.4%	10	6.4%	24	8.6%
1939	111	11.0%	89	6.8%	200	8.6%
1940	3,717	10.9%	2,636	7.1%	6,353	8.9%
1946	6,286	8.9%	4,049	5.5%	10,335	7.1%
1947	837	9.1%	552	5.4%	1,389	7.2%
1948	5,489	8.3%	3,633	5.2%	9,122	6.7%
1949	1,274	7.9%	810	4.6%	2,084	6.2%
1950	4,826	7.6%	3,067	4.6%	7,893	6.0%
1951	1,948	7.0%	1,376	4.4%	3,324	5.7%
1952	4,488	6.8%	2,849	4.1%	7,337	5.4%
1954	3,290	6.3%	2,139	3.8%	5,429	5.0%
Total	32,280	7.9%	21,210	4.9%	53,490	6.4%

Part 2

MONITORING THE PARTICIPATION RATE AND RESULTS OF FOLLOW-UP DIAGNOSTICS

This section provides an overview of participation and of the most important findings at colonoscopy. The findings are based on endoscopic findings in the colonoscopy report and on the pathology reports of all participants for whom this information was available.

1. Participation intake interview

In total, 53,490 (6.4%) participants had an unfavourable FIT result. Of these, 53,477 (99.98%) individuals were invited for an intake interview for colonoscopy; the other 13 were either sent invitations after 31 March 2016 or had died or migrated before they received the invitation.

The initial intake interview was rescheduled by 23,914 (44.7%) of the participants. Appointments were moved to a different time,

date or location. Of all those invited for an intake interview, 46,561 (87.1%) individuals participated. Of the remaining invitees, 1,514 (2.8%) individuals have an intake interview scheduled, 4,354 (8.1%) opted out, and 1,048 (2.0%) failed to show up for their intake interview. Of those who opted out prior to the intake interview, 1,274 (29.3%) individuals reported advice of their general practitioner as the reason. No reason was given for the remaining 3,080 (70.7%) cancellations.

Table 4: Recommended follow-up strategy from intake interview, by birth cohort (Source: ScreenIT)

Year of birth	Colonoscopy		CT colonography		Exclusion		Postponements/On hold/Different location	
1938	17	89.5%	0	-	0	-	2	10.3%
1939	132	89.2%	1	0.7%	11	7.4%	4	2.7%
1940	4,823	90.8%	84	1.6%	269	5.1%	134	2.5%
1946	8,423	93.2%	94	1.0%	301	3.3%	217	2.4%
1947	1,133	93.5%	15	1.2%	35	2.9%	29	2.4%
1948	7,478	93.8%	76	1.0%	209	2.6%	209	2.6%
1949	1,743	94.3%	15	0.8%	55	3.0%	36	1.9%
1950	6,568	94.5%	63	0.9%	168	2.4%	149	2.1%
1951	2,701	93.0%	35	1.2%	101	3.5%	68	2.3%
1952	6,090	94.8%	53	0.8%	148	2.3%	134	2.1%
1954	4,476	94.5%	44	0.9%	108	2.3%	110	2.3%
Totaal	43,584	93.6%	480	1.0%	1,405	3.0%	1,092	2.3%

2. Recommended follow-up strategy from intake interview

Table 4 shows the recommended follow-up strategy after the intake interview. Of the 46,561 individuals who participated in the intake interview, 43,584 (93.6%) were advised to undergo a colonoscopy. A total of 480 (1.0%) individuals were advised to undergo CT colonography, 1,405 (3.0%) participants were excluded, and 1,092 (2.3%) participants were advised to postpone colonoscopy for the time being or were referred to a different colonoscopy centre.

3. Participation in colonoscopy

Of the individuals who were recommended colonoscopy during the intake interview, 42,037 (96.5%) underwent colonoscopy and have available colonoscopy reports and/or pathology reports. For 1,547 (3.5%) individuals, no colonoscopy reports or pathology reports were available.

In addition to the 42,037 participants who underwent a colonoscopy following an intake interview, an additional 428 participants without a report of the intake interview underwent colonoscopy and had colonoscopy reports and/or pathology reports available. Thus, a total of 42,465 (79.4%) participants with a positive FIT underwent a colonoscopy (Table 5). There are no colonoscopy records available for 11,565 (20.6%).

Colonoscopy participation after a positive FIT in 2014 was recently re-evaluated with data from the national pathology database (PALGA). This evaluation showed that a number of participants with an unfavourable FIT results but without colonoscopy data in ScreenIT underwent a colonoscopy outside the programme. This suggests that the true percentage of individuals that underwent a

Table 5: Percentage of participants with a positive FIT that underwent colonoscopy, by birth cohort (Source: ScreenIT)

Year of birth	Colonoscopy	None
1938	18 75.0%	6 25.0%
1939	1,34 67.0%	66 33.0%
1940	4,694 73.9%	1,659 26.1%
1946	8,219 79.5%	2,116 20.5%
1947	1,113 80.1%	276 19.9%
1948	7,276 79.8%	1,846 20.2%
1949	1,712 82.1%	372 17.9%
1950	6,368 80.7%	1,525 19.3%
1951	2,681 80.7%	643 19.3%
1952	5,900 80.4%	1,437 19.6%
1954	4,350 80.1%	1,079 19.9%
Total	42,465 79.4%	11,565 20.6%

colonoscopy after an unfavourable result is higher than reported. Based on the extrapolation of these data from 2014, this represents an increase in participation of approximately 6-8%.

4. Colonoscopy findings

Participants were classified according to the most severe abnormality found during colonoscopy. This involved the following sequence (from most severe abnormality to no abnormalities): colorectal cancer, advanced adenomas, non-advanced adenomas, serrated polyps, other malignancies and no polyps or colorectal cancer. At national and international level, colorectal cancer and advanced adenomas (collectively referred to as “advanced neoplasia”) are considered to be relevant findings within a colorectal cancer screening programme.

Table 6: Colonoscopy yield by birth cohort (Source: ScreenIT)

Year of birth	Colorectal cancer	AAD	NAAD	Serrated	No polyps or tumours
1938	3 16.7%	11 61.1%	2 11.1%	0 -	2 11.1%
1939	17 12.9%	61 46.2%	28 21.2%	4 3.0%	22 16.7%
1940	501 10.7%	2,146 45.9%	1,061 22.7%	152 3.3%	814 17.4%
1946	747 9.1%	4,000 48.8%	1,787 21.8%	344 4.2%	1,320 16.1%
1947	107 9.6%	512 46.1%	221 19.9%	45 4.1%	225 20.3%
1948	631 8.7%	3,553 49.0%	1,465 20.2%	339 4.7%	1,268 17.5%
1949	165 9.6%	818 47.8%	344 20.1%	81 4.7%	303 17.7%
1950	504 7.9%	3,190 50.3%	1,220 19.2%	310 4.9%	1,122 17.7%
1951	233 8.7%	1,267 47.3%	526 19.6%	138 5.2%	512 19.1%
1952	485 8.2%	2,907 49.3%	1,092 18.5%	294 5.0%	1,110 18.8%
1954	299 6.9%	2,071 47.8%	831 19.2%	273 6.3%	861 19.9%
Total	3,692 8.7%	20,536 48.5%	8,577 20.2%	1,980 4.7%	7,559 17.8%

* Abbreviations: AAD (advanced adenomas), NAAD (non-advanced adenomas).

Table 6 summarises colonoscopy yield by birth cohort. During colonoscopy, colorectal cancer was found in 3,692 (8.7%) participants. In 20,536 (48.5%) participants, the most important finding was an advanced adenoma. The positive predictive value of FIT, that is the percentage of participants with unfavourable test results who underwent a colonoscopy and were diagnosed with colorectal cancer and/or advanced adenomas, was 57.2% (8.7% + 48.5%).

A further 8,577 (20.2%) participants were diagnosed with a non-advanced adenoma, while 1,980 (4.7%) participants had a serrated polyp. In addition, colonoscopy revealed that 15 (0.04%) participants had other malignancies. In 7,559 (17.8%) individuals, no tumours or polyps were found. In 3,609 out of the 42,359 (8.5%) individuals, the diagnosis was not confirmed by pathology. In 106 individuals, no diagnosis could be made on the basis of the gastroenterology and/or pathology report.

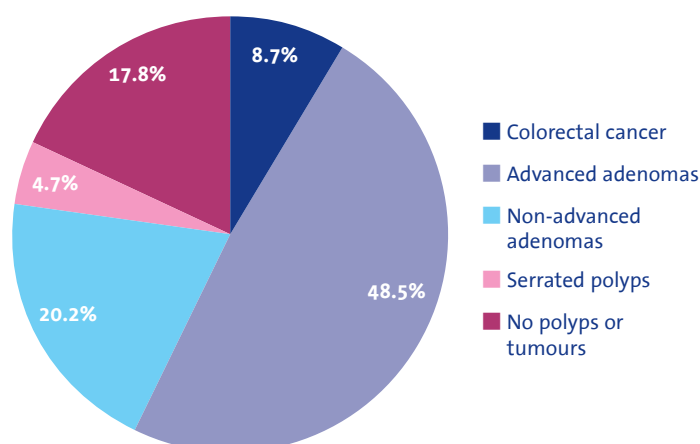


Figure 2: Colonoscopy yield

5. Detection rate of the screening programme

Colorectal cancer or advanced adenomas were found in 24,228 of the 848,761 participants. This corresponds to a detection rate of 28.5 per 1,000 screened individuals. Table 7 shows the difference between the detection rates by birth cohort.

6. Stage distribution of screening-detected cancers in 2014

Colorectal cancer has several stages, depending on the extent of the tumour and the presence of metastases. This classification has five stages: 0, I, II, III and IV. Stage 0-I concerns a tumour confined to the intestinal wall; stage II concerns a tumour which extends beyond the intestinal wall; stage III concerns a tumour which extends beyond the intestinal wall with metastasis to local lymph nodes; and stage IV concerns a tumour which extends beyond the intestinal wall with metastasis to other organs.

For the 2014 target population (2014 monitor), the stage distribution of the detected cancers was requested from PALGA (Table 8 and Figure 3). Of the 2,922 colorectal cancers, the stage distribution for 1,499 (51.3%) cancers was recorded in PALGA according to standard protocol and these data have been analysed. The stage distribution of the cancers recorded in PALGA is expected to be representative of all cancers registered in PALGA. Comparison of this stage distribution of detected cancers in 2014 to the stage distribution of all cancers in 2012 (before the screening programme was implemented) shows a significant change, with more early-stage cancers detected among the participants in the screening programme.

Stage distribution can only be requested after completion of the annual monitor, so it is not possible to present the stage distribution of cancers of the 2015 target population. The data from 2014 provide insight into the stage distribution of the screen-detected cancers in the Dutch colorectal cancer screening programme. However, stage IV may be underestimated, because not all metastases have been registered in PALGA. The most probable shift would be between stage III and IV.

7. Complications during or after colonoscopy

The number of participants for whom a complication was recorded during or after colonoscopy is shown in Table 9. This concerns complications from the endoscopy report and complications entered manually. In total, 1 (0.002%) fatal complication (i.e. death of the individual) and 40 (0.10%) serious complications (i.e. hospitalisation for more than 10 days) were recorded. In 15 (0.04%) individuals, the complication concerned bleeding, and in 23 (0.05%) individuals it concerned a perforation.

The reported colonoscopy complications only include the fatal and serious complications because the data concerning moderate and minor complications are unreliable. This is because these two sub-groups also include procedural complications that were properly managed immediately, such as a minor bleed during polypectomy that was successfully treated during the procedure. This has no impact on the patient's treatment or subsequent health status. Therefore, in accordance to national and international guidelines, it cannot be defined as a colonoscopy complication.

Table 7: Detection rates per 1,000 participants by birth cohort (Source: ScreenIT)

Birth cohort	Colorectal cancer	AAD	NAAD	Serrated polyps
1938	10.1	37.0	6.7	-
1939	7.1	25.5	11.7	1.7
1940	7.0	29.9	14.8	2.1
1946	5.1	27.4	12.3	2.4
1947	5.5	26.3	11.3	2.3
1948	4.6	26.0	10.7	2.5
1949	4.9	24.1	10.1	2.4
1950	3.8	24.2	9.3	2.4
1951	3.9	21.4	8.9	2.3
1952	3.5	21.3	8.0	2.2
1954	2.7	18.7	7.5	2.5
Total	4.3	24.2	10.1	2.3

* Abbreviations: AAD (advanced adenomas), NAAD (non-advanced adenomas).

Table 8: Stage distribution of screening-detected cancers in invitation year 2014

Stage	N	Percentage (%)
1	665	44.4
2	444	29.6
3	322	21.5
4	68	4.5*
	1,499	

* Stage IV may be underestimated, because not all metastases were registered in PALGA.

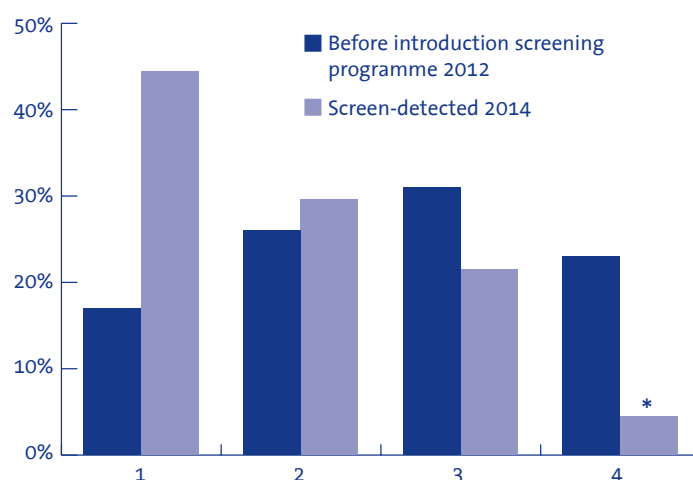


Figure 3: Comparison of stage distribution of colorectal cancers before introduction of the screening programme and screen-detected cancers (Source: PALGA; Elferink, NTVG, 2014 (Netherlands Comprehensive Cancer Organisation, IKNL))

* Stage IV may be underestimated, because not all metastases were registered in PALGA.

Table 9: Participants with recorded fatal and serious colonoscopy complications (Source: ScreenIT)

Type	Fatal	Serious
Bleed	0 -	15 0.04%
Perforation	0 -	23 0.05%
Other	1 0.002%	2 0.005%
Total	1 0.002%	40 0.095%

* The colonoscopy complications reported here only include the fatal and serious complications, because the data concerning moderate and minor complications are unreliable.

** A fatal complication is death within 30 days of colonoscopy, and a serious complication is hospitalisation of more than 10 days within 30 days of colonoscopy.

There are indications that the colonoscopy complications recorded in ScreenIT may differ from the complications that actually occur:

- Some endoscopists only register complications in the Dutch Association of Gastroenterologists (NVMDL) complications registry and not in ScreenIT. However, after quality audits, a number of endoscopy centres retroactively entered this data in ScreenIT.
- The complications in ScreenIT have not always been registered consistently, potentially resulting in registration of complications that, according to Dutch and international definitions, are not considered complications. As a result, it was decided that moderate and minor complications would not be reported.

In an effort to make the registration of complications more uniform and consistent, ScreenIT and the NVMDL's complications registry will be linked in the future. To accommodate complete registration, non-gastroenterologists who perform colonoscopies will also get access to this registry. From 1 January 2017, this link of databases will avoid duplication of effort, and ensure that complications are registered in a uniform manner.

Part 3

MONITORING PROCESSING TIMES

The various processing times are displayed as averages (in calendar days), the first (Q1) quartile, median (Q2) and third quartile (Q3). The first quartile (Q1) indicates the maximum processing time for the first 25% of individuals, the median (Q2) is the processing time for half of the individuals, and the third quartile (Q3) corresponds to the processing time for the first 75% of individuals.

- The **return period** (the interval between the self-sampling date and the date on which the letter with the FIT result was sent back to the participant) was 2.5 days on average (Q1: 1 days, Q2: 2 days, Q3: 4 days). *Target value: 7 week days*

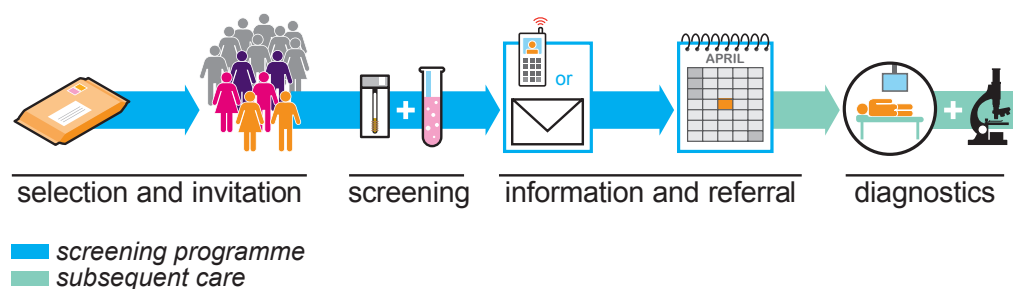
- The **waiting time for an intake interview** (the interval between sending the letter with the FIT result and the date of the initial scheduled intake interview) was 23.6 days on average (Q1: 19 days, Q2: 24 days, Q3: 28 days). *Target value: 42 week days (temporarily extended due to limited colonoscopy capacity)*

- The **average travel distance to the initial scheduled intake interview location** (the distance between an individual's home address and the intake location) was 21.1 km on average (Q1: 9.0 km, Q2: 17.9 km, Q3: 27.6 km). *Maximum limit: 40 km*

The average return period, waiting time and travel distance are all within the defined target values.

PRIMARY PROCESS

Schematic representation of the bowel cancer screening programme, including subsequent care



Part 4

NATIONAL INCIDENCE AND MORTALITY

The incidence of colorectal cancer increased between 2013 and 2015 (Figure 5). In 2013, there were 77.6 new cases (crude incidence rates per 100,000). These rates increased to 89.3 in 2014 and to 91.5 in 2015.

In 2015, the increase (compared to 2014) was most pronounced in the age groups 60-64 years (38.3%) and 65-69 years (24.1%). These

are the age groups that were invited for screening in 2015. As screening detects cancers earlier, more cases of colorectal cancer were discovered in these age groups.

At the time the monitor was submitted for publication, mortality rates for 2015 had not yet been published. In 2013, the mortality rate was 29.4 per 100,000 individuals, while in 2014 it was slightly lower at 29.1 per 100,000 individuals.

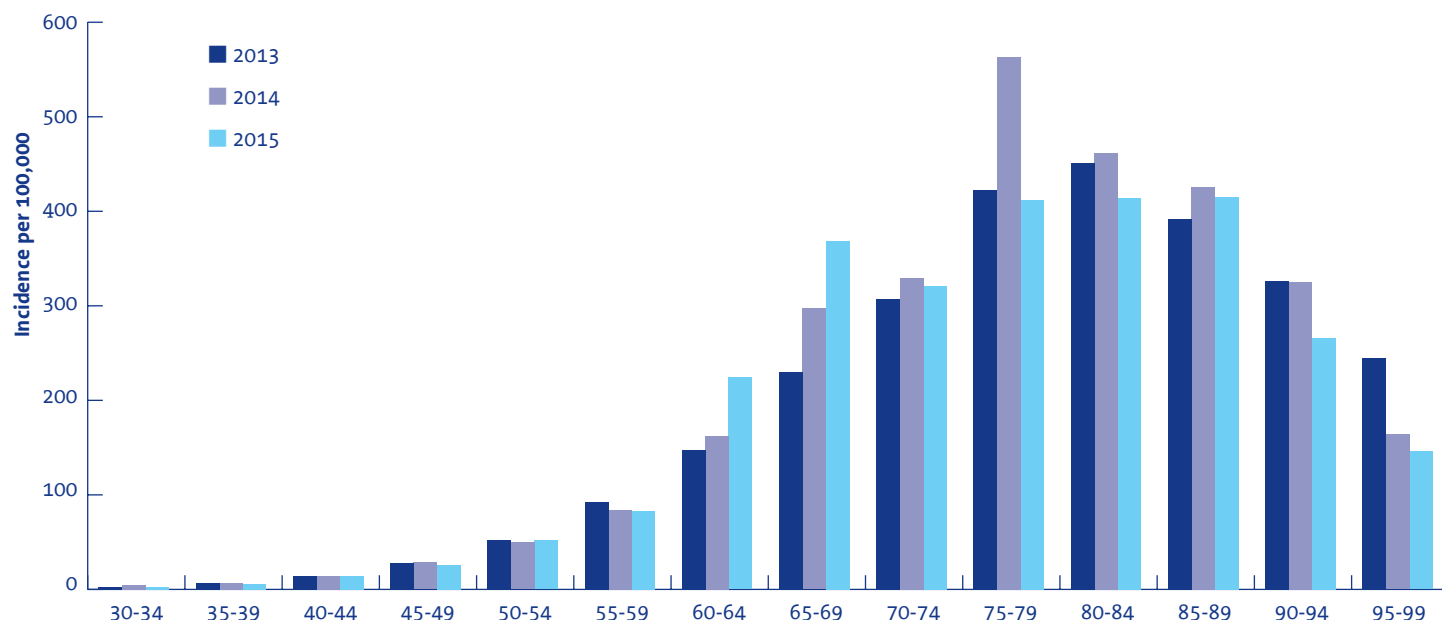


Figure 5: Incidence per 100,000 individuals by age group (Source: IKNL)

Part 5

TOTAL SCREENING PROCESS

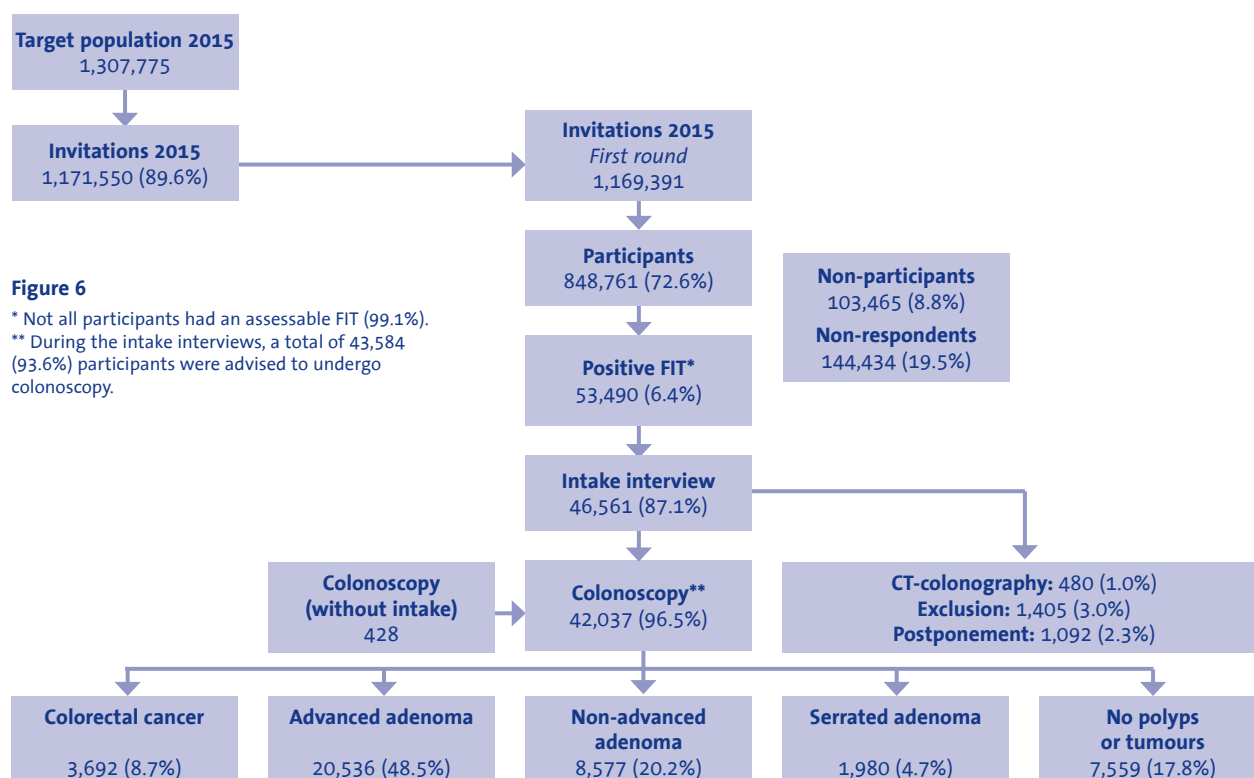


Figure 6

* Not all participants had an assessable FIT (99.1%).

** During the intake interviews, a total of 43,584 (93.6%) participants were advised to undergo colonoscopy.

Part 6

COMPARISON BETWEEN 2014 AND 2015

A comparison between the first two years of the screening programme provides insight into the continuity and quality of the programme (Table 10 and Figure 7). The comparison shows the results of important indicators such as participation in FIT, intake referral percentage, colonoscopy participation, positive predictive value and detection rate. The comparison only includes individuals from the

Table 10: Comparison between results of 2014 and 2015 monitor
(Source: ScreenIT)

	2014	2015
Participation	71.3%	72.6%
Referral percentage (275 ng/ml)	6.3%	6.4%
Detection rate		
• colorectal cancer	4.0 per 1,000	4.3 per 1,000
• colorectal cancer and advanced adenoma	19.6 per 1,000	28.5 per 1,000
PPV		
• colorectal cancer	8.2%	8.7%
• colorectal cancer and advanced adenoma	48.5%	57.2%

Abbreviations: PPV (Positive predictive value of an unfavourable FIT)

* Detection rate per 1,000 participants

2014 monitor, who were assessed with the same FIT cut-off value as the present report (275 ng/ml or 47 µg Hb/g faeces). The results for both years are comparable, with a slight increase in participation, positive predictive value and detection rate observed in 2015. The two target populations had a slight difference in age composition, with the 2015 target population being younger on average.

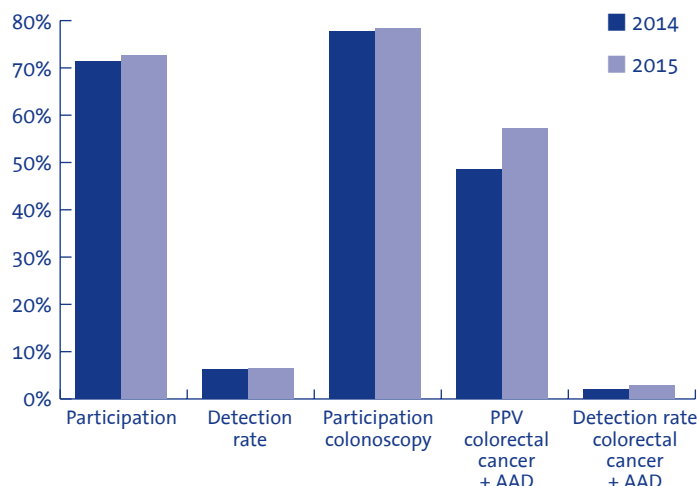


Figure 7: Comparison between results of 2014 and 2015 monitor
(Source: ScreenIT)

Abbreviations: PPV (Positive predictive value of an unfavourable FIT), AAD (advanced adenoma))

Part 7

TERMINOLOGY

Cut-off value = concentration of haemoglobin in the faeces above which participants are referred for diagnostic colonoscopy (unfavourable test result). Represented according to the international standard in 47 µg Hb/g faeces.

Detection rate = number of abnormalities found per 1,000 screened individuals.

FIT = faecal immunochemical test; primary test used in the colorectal cancer screening programme

Intake interview = clinic visit in which the consequences of a positive FIT are explained and information about the follow-up procedure is provided.

NVMDL complications registry = complications registration system of the Dutch Association of Gastroenterologists.

Unassessable FIT = FIT which cannot be interpreted by the lab, for example because the barcode is unreadable or because the kit contains too much stool material.

Unreliable FIT test result = FIT whose expiry date has elapsed or for which the period between stool collection and analysis in the lab exceeded 7 days, with a result below the cut-off value.

PAIGA = *Pathologisch Anatomisch Landelijk Geautomatiseerd Archief* (national pathology registry), a nationwide computer network and registry of all pathology laboratories in the Netherlands.

Positivity rate = percentage of participants with unfavourable test results (above the cut-off value).

Positive predictive value = Number of participants with advanced neoplasia divided by the number of participants who underwent a colonoscopy.

ScreenIT = nationwide information system for the colorectal cancer screening programme.