Monitor Dutch **colorectal cancer** screening programme **2024**

Edition december 2025, version 1.1

Key findings 2024

A total of **1,503,556** individuals participated via a stool test (FIT). The participation rate was **67.1%**.

Of all participants with a valid FIT result, **4.5%** were referred for a colonoscopy intake due to an unfavourable stool test result.

Of all referred individuals, **84.7%** underwent a colonoscopy.

Colorectal cancer, an advanced adenoma, or an advanced serrated polyp was detected in **18,139** individuals. The detection rate was **1.21%**.

Note! Disclaimer: *This monitor has been carefully compiled. Where possible, outcomes from previous years have been recalculated based on the most recent data. As a result, these may differ from previously reported results. The most recent publication should always be used as point of reference.*

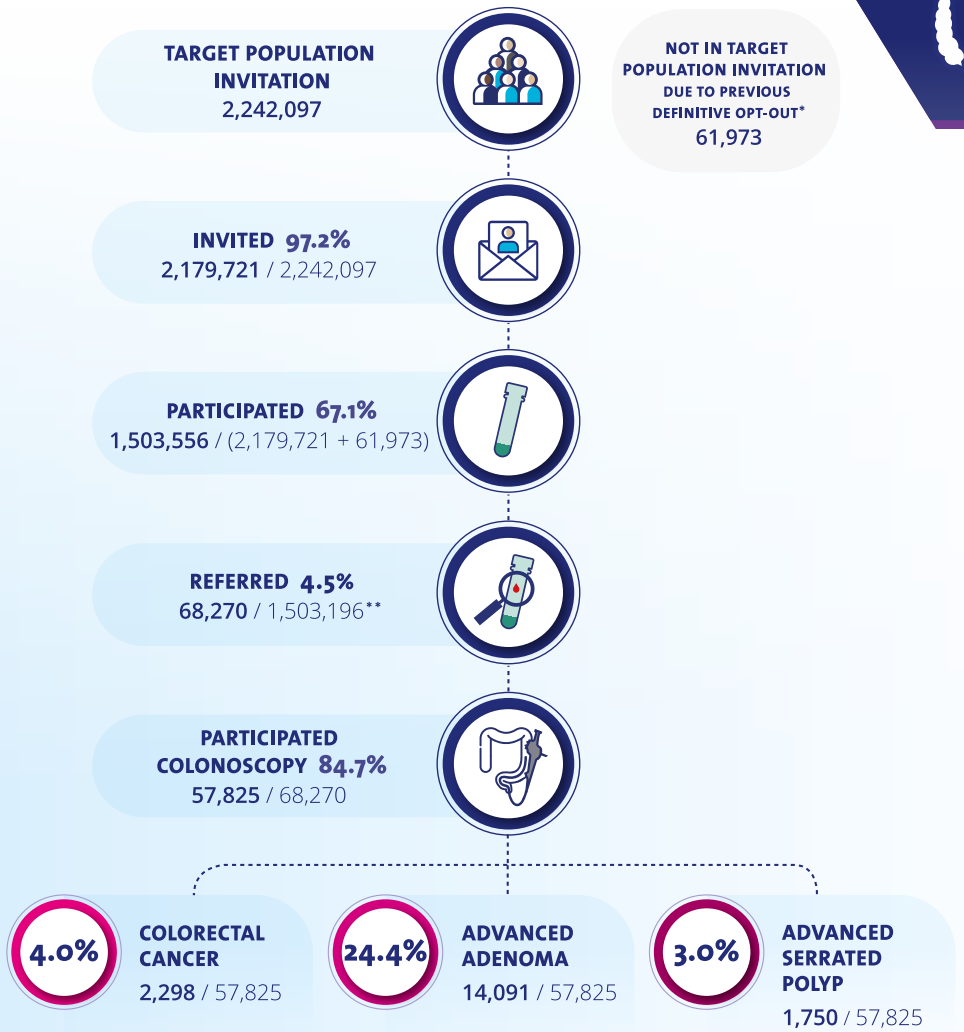

Figure 1 / **Flowchart colorectal cancer screening programme in 2024** (source: BVO NL and Palga)

* This refers to individuals who are eligible to participate in the colorectal cancer screening programme but have permanently opted out in a previous round. Because of this opt-out, they did not receive an invitation to participate in the current round. These individuals are included in the denominator of the participation rate.
** Only individuals with a valid FIT result are included in the denominator of the referral rate. Therefore, this number is lower than the total number of participants.

Erasmus MC

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1 / Invitations and participation

Introduction: **Colorectal cancer screening programme**

In the Netherlands, individuals aged 55 to 75 are biennially invited to participate in the colorectal cancer screening programme through a stool test (FIT). The presence of blood in the stool may indicate the presence of colorectal cancer or precancerous lesions (advanced adenomas). By removing precancerous lesions, colorectal cancer can be prevented. In addition, the screening programme allows colorectal cancers to be detected at an earlier stage. This increases the chances of successful treatment compared to when colorectal cancer is detected at a late stage. The ultimate goal of the screening programme is to prevent colorectal cancer as much as possible and reduce both colorectal cancer mortality and the burden for individuals with colorectal cancer.

Context 1: **Invitation and participation round**

In previous monitors, various results related to participation, referrals, and outcomes were presented by invitation round: the round in which an individual receives an invitation for the screening programme. In this monitor, however, the results related to referrals and outcomes are presented by participation round: the round in which an individual participates in the screening programme. If someone does not participate at age 55 but does participate in the next round (at age 57), this concerns the first participation round and the second invitation round. Because of this different approach, results may differ from previously reported figures. Indicators related to participation are still presented according to the invitation round.

Table 1 / **Invitations and participation** by year (source: BVO NL)

	2020	2021	2022	2023	2024
Previously definitively opted out*	66,778	66,354	65,671	63,582	61,973
Invitations sent	1,892,609	2,266,123	2,134,827	2,182,390	2,179,721
Participants stool test	1,364,272	1,608,797	1,471,955	1,494,517	1,503,556

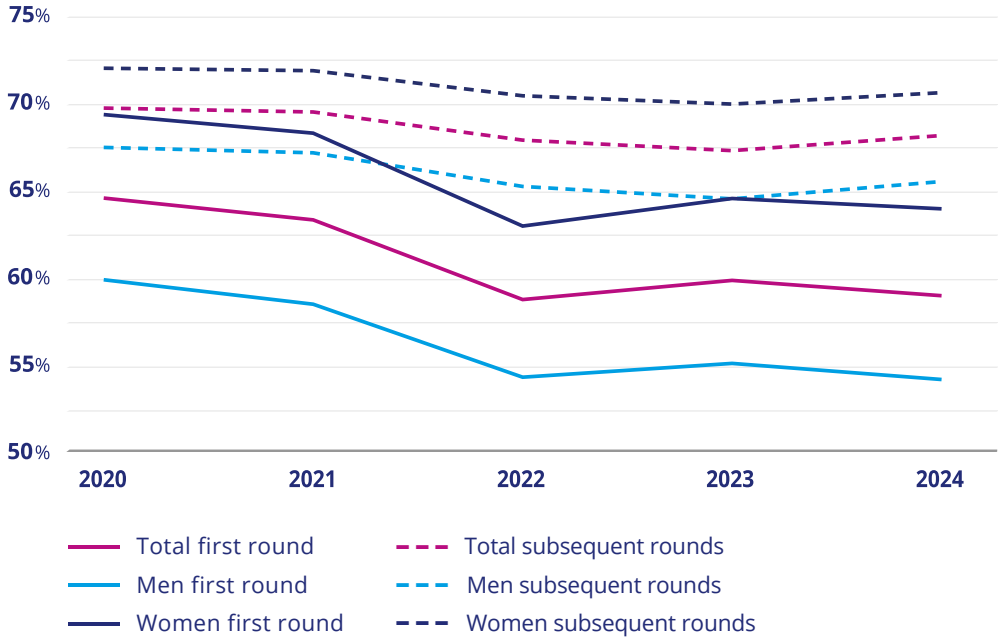
* This concerns individuals who, in principle, are eligible to participate in the colorectal cancer screening programme, but have definitively opted out during a previous round. Due to this opt-out, they did not receive an invitation to participate in the current round. These individuals are included in the denominator of the participation rate.

- Of all individuals eligible for an invitation in 2024 based on their birth year, 61,973 individuals (2.8%) were not invited because they had definitively opted out during a previous round (table 1). Additionally, 42,536 individuals (1.9%) actively opted out after receiving the invitation (non-participants), and 633,629 individuals (28.3%) have not responded to the invitation so far (non-respondents). In total, 1,503,556 individuals participated in 2024 (67.1%).
- A total of 936,190 individuals received a reminder because they had not participated six weeks after the initial invitation. Within this group, 291,067 individuals still participated (31.1%). This corresponds to 19.4% of the total number of participants.

Table 2 / **Participation rate stool test** by sex, age and year (source: BVO NL)

	2020	2021	2022	2023	2024
Men	**67.1%**	**66.2%**	**64.0%**	**63.5%**	**64.1%**
55 – 59 years	63.1%	61.4%	57.8%	57.7%	56.3%
60 – 64 years	66.5%	65.7%	63.3%	62.8%	64.5%
65 – 69 years	70.7%	70.1%	68.8%	67.7%	68.8%
≥70 jaar	69.7%	70.2%	68.7%	69.5%	70.1%
Women	**72.1%**	**71.7%**	**69.6%**	**69.5%**	**69.9%**
55 – 59 years	71.2%	70.5%	67.0%	67.3%	66.0%
60 – 64 years	72.3%	71.8%	69.6%	69.3%	70.4%
65 – 69 years	74.5%	73.9%	72.8%	71.9%	72.9%
≥70 years	70.3%	71.3%	69.4%	70.8%	71.3%
Total	**69.6%**	**69.0%**	**66.9%**	**66.5%**	**67.1%**

Figure 2 / **Participation rate stool test** by sex, invitation round and year (source: BVO NL)



- The overall participation rate in 2024 was higher than in 2023. The declining participation trend seen in previous years did not continue (table 2). This applies to both men and women.
- As in previous years, participation was lowest in the youngest age group (55-59 years). The difference in participation between this group and the other age groups was significantly greater for men than for women (table 2).
- Unlike all other age groups, a decrease in participation from 2023 to 2024 was observed for the youngest age group (table 2). Within this group, participation decreased from 57.7% to 56.3% for men and from 67.3% to 66.0% for women.
- Compared to 2023, a decrease in participation was seen for both men and women who were invited for the first time, while participation increased for those who had been invited before (figure 2).
- As in previous years, participation in 2024 was lower for men than for women (figure 2).
- Participation was lowest among men invited for the first round (54.1%) (figure 2). This aligns with the fact that younger age groups participate less often compared to older age groups (table 2).

Table 3 / **Participation patterns over two invitation rounds** by year (source: BVO NL)

Invited in:	2018+2020	2019+2021	2020+2022	2021+2023	2022+2024
Re-participation rate	91.5%	92.5%	91.4%	91.6%	93.0%
Switch non-participation to participation	19.0%	18.1%	15.1%	16.1%	20.4%

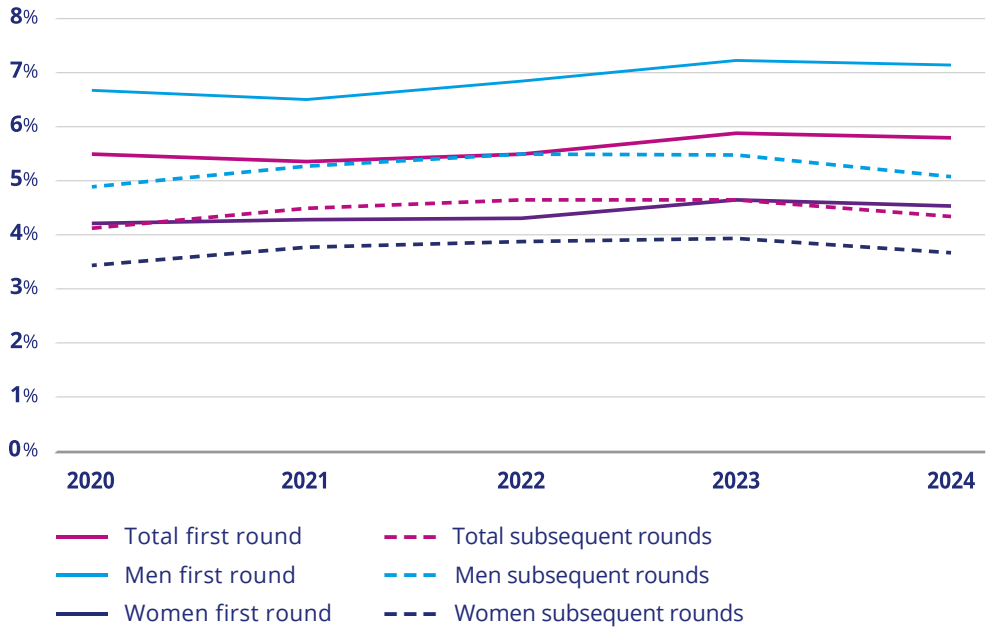
- Of all individuals who participated in the previous invitation round and were invited again in 2024, 93.0% participated again in 2024. This was higher than in 2023, when the re-participation rate was 91.6% (table 3).
- The re-participation rate was higher for the older age groups and similar for men and women.
- The increase in the re-participation rate and the switch from non-participation to participation from 2023 to 2024 was observed in all age groups, for both men and women.
- Of the individuals who did not participate in the previous invitation round in 2022 and were invited again in 2024, 20.4% participated in 2024 (table 3). This is more than in 2023, when 16.1% of individuals participated after not participating in the previous round. This percentage was higher for women (21.1%) than for men (19.7%). For both, the increase was larger for men than for women, and larger for the 60-64 age group than for the other age groups.
- The increase in the re-participation rate and the switch from non-participation to participation is reflected in the increase in participation for individuals invited for a subsequent round (figure 2).

2 / **Referrals and outcomes**

Table 4 / **Referral rate** by sex, age and year (source: BVO NL)

	2020	2021	2022	2023	2024
Men	**5.1%**	**5.5%**	**5.7%**	**5.7%**	**5.4%**
55 – 59 years	4.7%	5.1%	5.5%	5.6%	5.5%
60 – 64 years	4.8%	5.0%	5.1%	5.1%	4.8%
65 – 69 years	5.1%	5.6%	5.8%	5.7%	5.3%
≥70 years	5.9%	6.2%	6.4%	6.4%	6.0%
Women	**3.5%**	**3.8%**	**3.9%**	**4.0%**	**3.8%**
55 – 59 years	3.1%	3.4%	3.7%	3.8%	3.6%
60 – 64 years	3.3%	3.5%	3.5%	3.6%	3.4%
65 – 69 years	3.5%	3.9%	4.0%	4.1%	3.8%
≥70 years	4.2%	4.6%	4.7%	4.6%	4.5%
Total	**4.2%**	**4.6%**	**4.7%**	**4.8%**	**4.5%**

Figure 3 / **Referral rate** by sex, participation round and year (source: BVO NL)

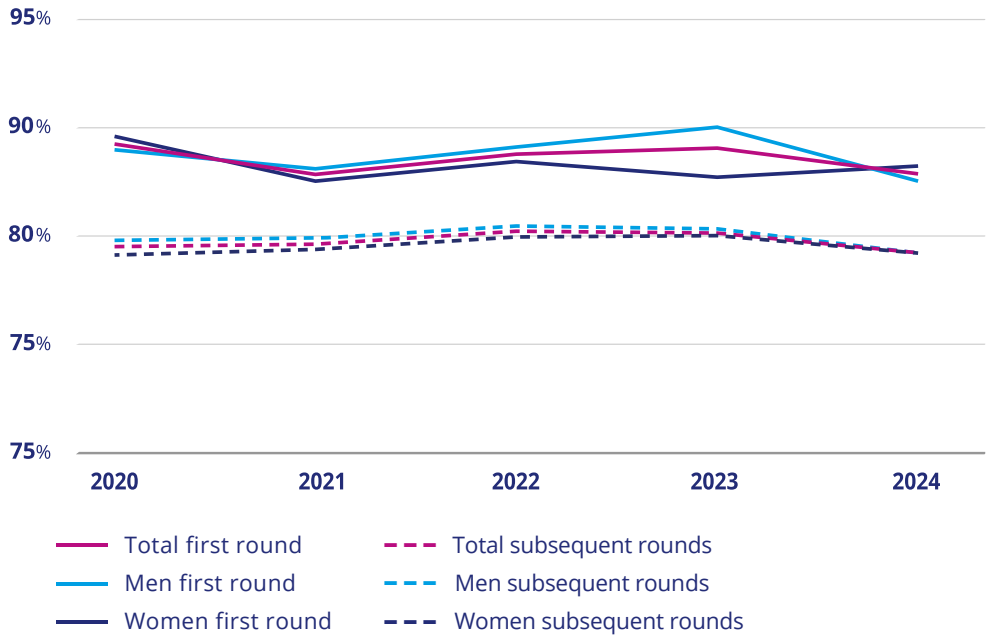


- In 2024, 68,270 individuals received an unfavourable stool test result, after which they were referred for a colonoscopy intake. The referral rate was 4.5% (table 4).
- As in previous years, in 2024 men more often received an unfavourable stool test result (5.4%) than women (3.8%) (table 4). The referral rate was highest for men participating for the first time (7.1%) (figure 3).
- For 63,100 individuals, it is certain that they had an intake. Of these individuals, 59,203 (93.8%) were advised to undergo a colonoscopy. 657 individuals (1.0%) were advised to undergo a CT colonography. The remaining individuals (5.1%) were advised not to undergo any colorectal examination.
- The intake appointment for the colonoscopy was scheduled within the set norm of fifteen working days after the unfavourable stool test result for 96.1% of the individuals.

Table 5 / **Participation rate colonoscopy** by age and year (source: BVO NL)

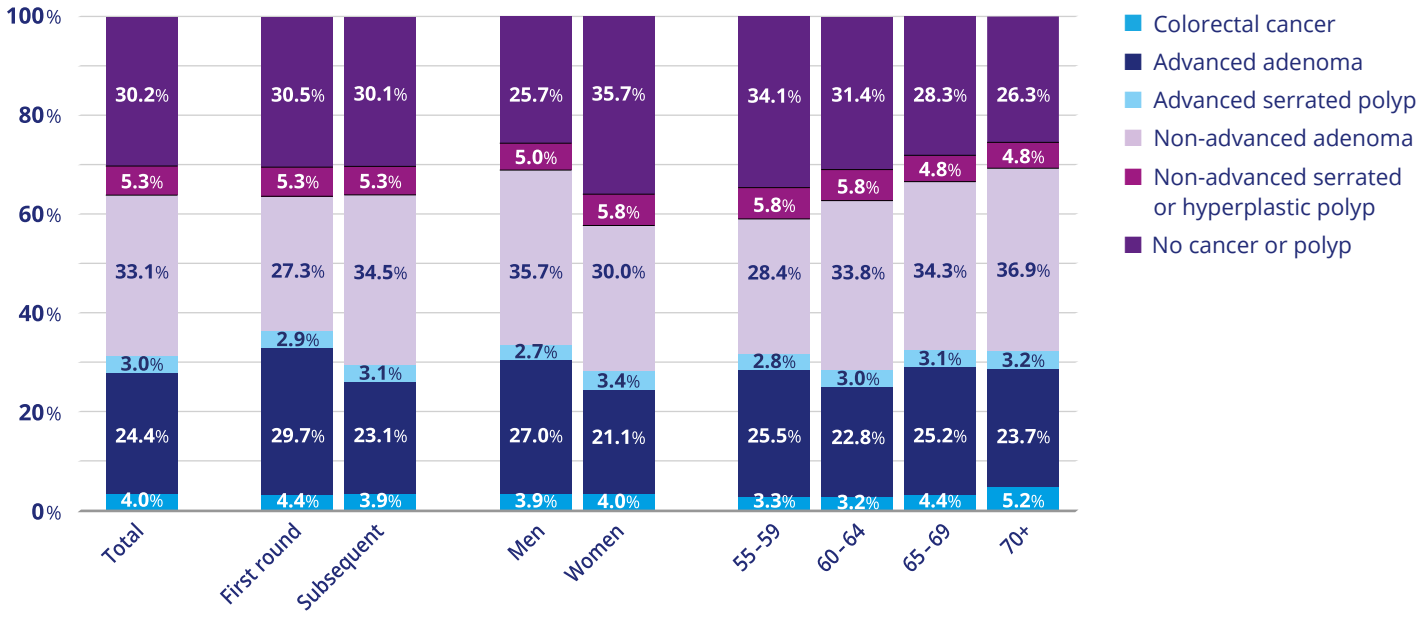
	2020	2021	2022	2023	2024
55 – 59 years	88.0%	87.6%	88.8%	88.7%	87.3%
60 – 64 years	86.0%	86.7%	86.9%	87.0%	86.2%
65 – 69 years	84.2%	84.8%	85.4%	85.0%	83.9%
≥70 years	81.1%	81.4%	81.7%	82.1%	81.3%
Total	**84.8%**	**85.0%**	**85.8%**	**85.7%**	**84.7%**

Figure 4 / **Participation rate colonoscopy** by sex, invitation round and year (source: BVO NL)



- Of the 68,270 individuals with an unfavourable stool test result, 57,825 underwent a colonoscopy. The participation rate for colonoscopy was 84.7% (table 5).
- Colonoscopy participation was lower in 2024 than in 2023 for all age groups (table 5). This decrease in participation was observed for both men and women and was strongest among men aged 55–59.
- Participation in colonoscopy was higher in the first round (87.9%) than in the subsequent rounds (84.2%) and was higher for the younger age groups than for the older age groups (figure 4 and table 5). This can partly be explained by the fact that older age groups were more often advised not to undergo colorectal examination (3.3% in the 55-59 age group versus 6.6% in individuals aged ≥70).
- Although there was a general decrease in colonoscopy participation, participation for women invited for the first round in 2024 (88.3%) was higher than in 2023 (87.8%) (figure 4).

Figure 5 / **Outcomes colonoscopy after unfavourable stool test in 2024*** by participation round, sex and age (source: BVO NL and Palga)



* Figures cannot be directly compared with previous years (see context 2).

- In 2024, 2,298 colorectal cancers (4.0%), 14,091 advanced adenomas (24.4%), and 1,750 advanced serrated polyps (3.0%) were detected during colonoscopy (figure 5). In total, a relevant finding was found in 31.4% of individuals who underwent a colonoscopy following an unfavourable stool test result. This is called the positive predictive value.
- The positive predictive value for colorectal cancer, advanced adenomas, and advanced serrated polyps combined was higher for the first participation round (37.0%) than for the subsequent participation rounds (30.1%) (figure 5). Because colorectal cancers, advanced adenomas, and serrated polyps are already detected in the first round, the chance of detecting them in subsequent rounds is lower.
- The positive predictive value for colorectal cancer was similar for men (3.9%) and women (4.0%) (figure 5).
- For advanced adenomas, the positive predictive value was higher for men (27.0%) than for women (21.1%) (figure 5).
- The positive predictive value for advanced serrated polyps was higher for women (3.4%) than for men (2.7%) (figure 5).

Context 2:
Definition relevant findings

In this monitor, relevant findings are defined differently than in previous years. Whereas previously only colorectal cancer and advanced adenomas were considered relevant findings, advanced serrated polyps are now also included in this category. This change affects the detection rate and the positive predictive value. All results presented in this monitor have been recalculated based on this new definition. As a result, figures may differ from previously reported results.

Table 6 / **Detection rate colorectal cancer (CRC), advanced adenomas (AA) and advanced serrated polyps (ASP) in 2024** by participation round, sex and age (source: BVO NL and Palga)

	CRC (n)	Detection rate CRC	AA (n)	Detection rate AA	ASP (n)	Detection rate ASP	Detection rate total
Total	**2,298**	**0.15%**	**14,091**	**0.94%**	**1,750**	**0.12%**	**1.21%**
Participation round							
First round	477	0.21%	3,235	1.43%	318	0.14%	1.78%
Subsequent rounds	1,821	0.14%	10,856	0.85%	1,432	0.11%	1.10%
Sex							
Men	1,257	0.18%	8,642	1.23%	875	0.12%	1.53%
Women	1,041	0.13%	5,449	0.68%	875	0.11%	0.92%
Age category							
55 – 59 years	535	0.13%	4,121	0.99%	459	0.11%	1.23%
60 – 64 years	424	0.11%	3,056	0.80%	405	0.11%	1.02%
65 – 69 years	646	0.16%	3,739	0.95%	454	0.12%	1.24%
≥70 years	693	0.22%	3,175	1.00%	432	0.14%	1.36%

- Of all participants, 0.15% were diagnosed with colorectal cancer, 0.94% with an advanced adenoma, and 0.12% with an advanced serrated polyp (table 6). The total detection rate was 1.21%.
- The detection rate for colorectal cancer, advanced adenomas, and advanced serrated polyps combined was higher for the first participation round (1.78%) than for the subsequent rounds (1.10%) (table 6).
- The detection rate for colorectal cancer was higher for men (0.18%) than for women (0.13%) (table 6). This also applies to the detection rate for advanced adenomas, which was 1.23% for men and 0.68% for women. The difference was smaller for advanced serrated polyps, with a detection rate of 0.12% for men and 0.11% for women.
- Within the different age groups, the detection rate for colorectal cancer, advanced adenomas, and advanced serrated polyps was highest for individuals aged 70 and older (1.36%) (table 6).

Table 7 / **Detection rates and positive predictive values** by participation round and year (source: BVO NL and Palga)

	2020	2021	2022	2023	2024
Detection rate colorectal cancer	**0.18%**	**0.18%**	**0.16%**	**0.16%**	**0.15%**
First round	0.28%	0.23%	0.22%	0.22%	0.21%
Subsequent rounds	0.16%	0.17%	0.15%	0.15%	0.14%
Detection rate colorectal cancer, advanced adenomas, and advanced serrated polyps	**1.33%**	**1.33%**	**1.32%**	**1.28%**	**1.21%**
First round	1.98%	1.77%	1.80%	1.82%	1.78%
Subsequent rounds	1.24%	1.26%	1.24%	1.19%	1.10%
Positive predictive value colorectal cancer	**4.86%**	**4.49%**	**3.99%**	**3.91%**	**3.97%**
First round	6.12%	4.39%	4.64%	4.45%	4.37%
Subsequent rounds	4.66%	4.64%	3.87%	3.80%	3.88%
Positive predictive value colorectal cancer, advanced adenomas, and advanced serrated polyps	**36.8%**	**34.2%**	**32.4%**	**31.1%**	**31.4%**
First round	43.9%	38.9%	37.8%	36.2%	37.0%
Subsequent rounds	35.7%	33.2%	31.3%	30.1%	30.1%

- The detection rate for colorectal cancer, advanced adenomas, and advanced serrated polyps was slightly lower in 2024 than in previous years (table 7). This decline was mainly observed for the subsequent rounds.
- The positive predictive value for colorectal cancer decreased from 2020 to 2022 and has been relatively stable since then (table 7).
- For the positive predictive value for colorectal cancer, advanced adenomas, and advanced serrated polyps combined, a decline was also observed over recent years (table 7). This decline appears to have been stabilized since 2023.

Table 8 / **Complications within 30 days of colonoscopy in 2024*** (source: BVO NL and DRCE)

	Grade I		Grade II		Grade IIIa		Grade IIIb		Grade IV		Grade V**	
Perforation	1	<0.01%	4	0.01%	2	<0.01%	8	0.01%	0	<0.01%	0	<0.01%
Bleeding* **	36	0.06%	35	0.06%	68	0.11%	0	<0.01%	0	<0.01%	0	<0.01%
Other* **	12	0.02%	10	0.02%	2	<0.01%	1	<0.01%	0	<0.01%	2	<0.01%
Unknown	7	0.01%	0	<0.01%	1	<0.01%	1	<0.01%	0	<0.01%	0	<0.01%
Total	**56**	**0.09%**	**49**	**0.08%**	**73**	**0.12%**	**10**	**0.02%**	**0**	**<0.01%**	**2**	**<0.01%**

* Complication rates are calculated based on the total number of colonoscopies performed in 2024 following an unfavourable stool test (regardless of the invitation year). An individual may have undergone multiple colonoscopies. The severity of complications is presented according to the AGREE classification.
** The two fatal complications have been reported to BVO NL but are not yet registered in the DRCE.
*** The severity of two bleeding complications and two other complications is unknown.

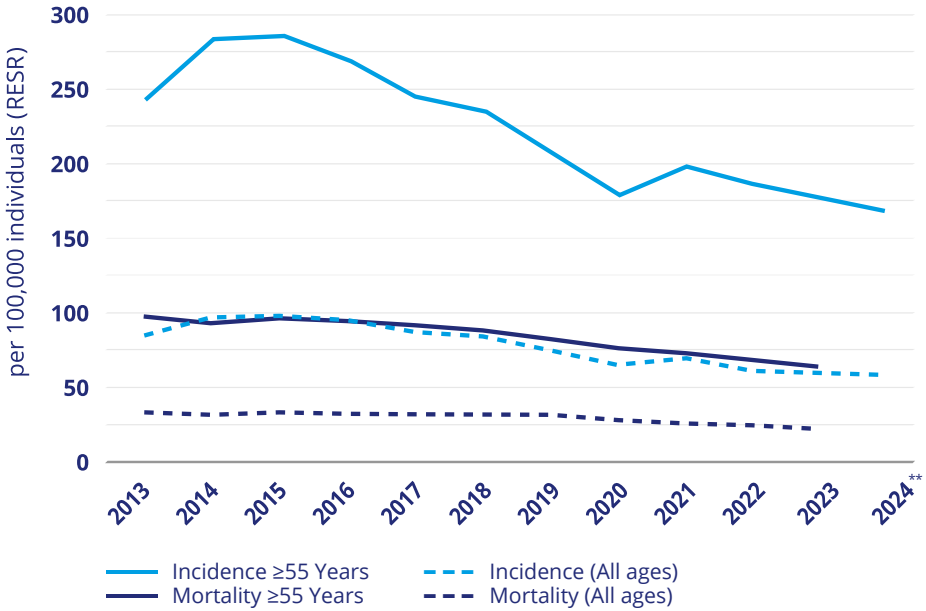
Table 9 / **Sensitivity (colorectal cancer), specificity (colorectal cancer) and interval cancers after favourable stool test** by year (source: BVO NL and NCR)

	2017	2018	2019	2020	2021
Number of interval cancers after favourable stool test	1,347	1,386	1,299	972	1,143
Percentage of interval cancers after favourable stool test	0.10%	0.09%	0.09%	0.07%	0.07%
Sensitivity	78.3%	74.3%	72.7%	73.0%	73.1%
Specificity	95.3%	95.8%	95.9%	95.9%	95.6%

- In 2024, 59,576 colonoscopies were performed as part of the colorectal cancer screening programme, of which 194 colonoscopies had a registered complication (0.33%) (table 8).
- A total of 83 complications were recorded that required an endoscopic or radiological intervention (grade IIIa) or surgical treatment (grade IIIb) (0.14%) (table 8).
- Two fatal complications (grade V) were identified (<0.01%) (table 8).
- The most common complication was a bleeding, which was registered 141 times (0.23%) (table 8).
- Of all individuals who participated following an invitation in 2021 and received a favourable stool test result in that round, 0.07% were diagnosed with colorectal cancer before they were invited again for screening (table 9). The percentage of interval cancers was in line with previous years.
- The sensitivity of the screening programme was 73.1% in 2021 (table 9). This is similar to the sensitivity in 2020 (73.0%).

3 / Incidence and mortality

Figure 6 / **Incidence and mortality rates colorectal cancer in the Netherlands from the year before the implementation of the national screening programme in 2014*** by age and year (source: NCR (incidence) and CBS (mortality))



* This concerns all colorectal cancers in the Netherlands, regardless of whether they were detected within or outside of the screening programme. For incidence, results are presented for colon and rectal cancer only. For mortality, appendix cancer is also included because more detailed data was not available.
** Data for 2024 is provisional (incidence) or not yet available (mortality).

Table 10 / **Incidence and mortality colorectal cancer in the Netherlands*** by year (source: NCR (incidence) and CBS (mortality))

	2020	2021	2022	2023	2024**
Incidence colorectal cancer per 100,000 individuals (RESR)					
≥ 55 years	176.68	197.90	179.80	173.16	169.04
All ages	63.92	71.11	64.91	62.95	61.89
Mortality colorectal cancer per 100,000 individuals (RESR)					
≥ 55 years	77.31	74.57	72.98	69.74	-
All ages	26.61	25.75	25.12	24.12	-
Colorectal cancer mortality relative to 2013**					
≥ 55 years	-21.9%	-24.6%	-26.3%	-29.5%	-
All ages	-20.5%	-23.1%	-25.0%	-28.0%	-

* This concerns all colorectal cancers in the Netherlands, regardless of whether they were detected within or outside of the screening programme. For incidence, results are presented for colon and rectal cancer only. For mortality, appendix cancer is also included because more detailed data was not available.
** Data for 2023 are preliminary (incidence) or not yet available (mortality).
*** Year prior to the nationwide implementation of the colorectal cancer screening programme in 2014.

- In 2024, 169.04 individuals per 100,000 individuals aged 55 years or older were diagnosed with colorectal cancer (Figure 6 and Table 10). This shows a continued decline in incidence, although the sharp decrease seen in previous years appears to have leveled off.
- Colorectal cancer mortality was lower in 2023 than in 2022 (Figure 6 and Table 10), continuing the downward trend. The colorectal cancer mortality rate for individuals aged 55 and older decreased from 98.96 per 100,000 in 2013 to 69.74 per 100,000 in 2023, representing a relative decline of 29.5%.

Context

Context 1 and 2 are presented elsewhere in the document.

Context 3: **Data and monitoring**

The National Institute for Public Health and the Environment (RIVM) coordinates the colorectal cancer screening programme in the Netherlands on behalf of the Ministry of Health, Welfare and Sport (VWS). Monitoring of the screening programme is carried out by the Erasmus MC on behalf of the RIVM. The goal of this monitoring is to map the progress of the screening programme and to identify important trends. This report presents results for individuals invited to participate in the colorectal cancer screening programme in 2024, as well as results from previous years.

The majority of the data presented in this report is derived from the Dutch screening organisation (BVO NL) and the Pathological-Anatomical Nationwide Automated Archive (Palga), with a reference date of July 10, 2025. Information regarding complications from colonoscopies is additionally sourced from the Dutch Registration of Complications in Endoscopy (DRCE), collected in September 2025. Finally, information on incidence and mortality is available from the Netherlands Cancer Registry (NKR) and Statistics Netherlands (CBS), with a reference date of January 27, 2025 (retreived September 2025).

Because data from 2023 and earlier years have been recalculated based on the most recent data, figures may differ from previous publications.

Classification colonoscopy findings

The colonoscopy findings are mainly based on pathology reports. However, if no pathology report is available, the GI report is used. According to the current Colonoscopy Surveillance guideline, the categories colorectal cancer, high-risk profile, low-risk profile, and no cancer or polyps are recorded within the GI report from the end of 2022. A high-risk profile is registered in the case of advanced adenomas, advanced serrated polyps, or at least five non-advanced adenomas. A low-risk profile is registered in the case of non-advanced serrated polyps or fewer than five non-advanced adenomas. Because there is insufficient information available to correctly classify the high- and low-risk profiles without pathology reports (respectively 897 and 2926 for 2024) in accordance with the classification used in this monitoring report, all high- and low-risk profiles without pathology reports are respectively classified as advanced adenomas and non-advanced adenomas. Figures may therefore differ from reality. In cases where multiple abnormalities are present, only the highest-ranked abnormality is recorded. The classification, from highest to lowest, is as follows: colorectal cancer, advanced adenomas, advanced serrated polyps, non-advanced adenomas, and non-advanced serrated or hyperplastic polyps.

Objection

All individuals had the right to object to the use of their data. The number of individuals who exercised this right from 2020 through 2024 is described in Table 11. Data from these individuals is not included in this monitoring report.

Table 11 / **Number of individuals who objected to the use of their data**, by year (source: BVO NL)

	2020	2021	2022	2023	2024
Objection	2,669	2,606	2,553	2,489	2,409

Glossary

Advanced adenoma (AA): advanced polyps, a precursor lesion of colorectal cancer.

Advanced serrated polyp (ASP): a type of advanced polyp, a precancerous stage of colorectal cancer.

AGREE: Classification system for reporting colonoscopy complications. *Grade I*: Deviation from the standard course after colonoscopy without requiring medication, endoscopic, radiological, or surgical treatment; *Grade II*: Complications requiring medication, blood transfusion, or hospital admission of more than 24 hours; *Grade III*: Complications requiring endoscopic, radiological, or surgical intervention; *Grade IV*: Complications requiring admission to the intensive care unit; *Grade V*: death of the patient.

BVO NL: Dutch screening organisation.

CBS: Statistics Netherlands.

Colonoscopy: endoscopic examination of the colon and rectum.

CT colonography: CT scan of the colon.

Colorectal cancer (CRC): cancer in the colon and/or rectum.

Detection rate: number of participants with colorectal cancer, an advanced adenoma and/or an advanced serrated polyp relative to all participants (%).

DRCE: Dutch Registration of Complications in Endoscopy.

FIT: Fecal Immunochemical Test; also called stool test.

GI-report: report in which the gastroenterologist (GI specialist) records a diagnosis based on findings during the colonoscopy.

Interval cancer: colorectal cancers that are detected in the period between a favourable stool test result and the invitation for the next screening round, or within two years after a favourable result in the last invitation round of the screening programme.

Invitation round: round in which an individual is invited to participate in the screening programme. A distinction is made between the round in which an individual is invited for the first time (first round) and the subsequent rounds (subsequent rounds).

NCR: Netherlands Cancer Registry.

Non-participants: number of invited individuals who actively opted out during the current invitation round relative to the total number of invitees (%).

Non-respondents: number of invited individuals who did not participate without opting out, relative to the total number of invitees (%).

Palga: Pathological-anatomical national automated archive.

Participation rate colonoscopy: number of individuals who underwent a colonoscopy relative to all individuals with an unfavourable stool test (%).

Participation rate stool test: number of individuals from whom a stool sample was received at the laboratory following an invitation in the reporting year, relative to all individuals who were invited or who were not invited due to a definitive opt-out in a previous round (%).

Participation round: round in which an individual participates in the screening programme. A distinction is made between the round in which an individual participates for the first time (first round) and the rounds hereafter (subsequent rounds).

Pathology report: report in which a diagnosis is recorded based on the pathological analysis of tissue collected during the colonoscopy.

Previous definitive opt-out: number of individuals who definitively opted out prior to the current invitation round.

Positive predictive value: number of participants diagnosed with colorectal cancer, an advanced adenoma, and/or an advanced serrated polyp relative to the total number of participants with an unfavourable stool test result who underwent a colonoscopy (%).

Referral rate: number of participants with an unfavourable stool test result who were referred, relative to the total number of participants with an evaluable stool test result (%).

Re-participation rate: number of individuals who participated in the current invitation round (in the reporting year) relative to all individuals who participated in the previous round and were re-invited in the current round (%).

RESR: Revised European Standardised Rate; revised measure used to present incidence and mortality rates, standardised for the European standard population.

RIVM: National Institute for Public Health and the Environment.

Sensitivity: number of colorectal cancers detected through the screening programme relative to the sum of the number of interval cancers and colorectal cancers detected by the screening programme (%).

Specificity: number of participants who were rightly not referred (rightly favourable stool test result) relative to all participants without a colorectal cancer diagnosis before the invitation to the next screening round (%).

Switch non-participation to participation: number of individuals who participated in the current invitation round (in the reporting year) relative to all individuals who did not participate in the previous invitation round and were re-invited in the current round (%).

Target population invitation: number of individuals who, according to the programme guidelines, should receive an invitation for the screening programme in the reporting year and who have not permanently opted out.

VWS: Ministry of Health, Welfare and Sport.