achieved if quality is optimal at every step in the screening process, from information and invitation of eligible target population, to performance of the screening test and follow-up, and, if necessary, treatment of women with screen-detected abnormalities'.[14]

Overall, the ACOG guidelines are a significant step in the right direction, but we feel it is important to point out that these are not fully 'evidence-based' guidelines. In particular we know of no evidence to prefer the ACOG guidelines to the generally less intensive guidelines of the organized European cervical screening programmes.

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Colorectal cancer prevention through screening: population acceptance of flexible sigmoidoscopy

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The latest UK figures show that 37,514 people were diagnosed with colorectal cancer (CRC) in 2006 and 16,259 died from the disease, putting CRC second only to lung cancer as a cause of cancer death.[1] In 2006, the National Bowel Cancer Screening Programme was initiated, offering biennial faecal occult blood testing (FOBT) starting at age 60, with the aim of detecting CRC at an earlier stage when treatment is likely to be more effective.[2]

An even greater prize than finding early stage disease is to identify the precursor lesions and prevent cancer developing. This avoids the human and financial costs associated with surgery, chemotherapy and radiotherapy. The Cervical Screening Programme is an example of screening for precursor lesions. The primary test examines a sample of cervical cells; if neoplastic changes are observed, the woman is referred for a colposcopic examination during which the affected area of the cervix is removed under local anaesthetic. This programme is estimated to prevent thousands of cases of cervical cancer a year.[3]

Prevention of colorectal cancers through detecting and removing the precursor lesions (adenomatous polyps) may also be within reach. In the UK Flexible Sigmoidoscopy (FS) Trial, adults aged 55 to 64 years were randomized to either a single FS examination or usual care (no CRC screening was offered at that time in the UK). The 11-year follow-up results have just been published and showed a 43% reduction in CRC mortality and a 33% reduction in incidence among those attending for the test.[4] This is one of the most impressive cancer preventive outcomes ever reported in a trial, and the results will get better still if CRC incidence remains low in the screened group while continuing to rise with age in the controls.

Crucial to delivery of this protective effect at a population level is high uptake of FS. This is likely to be a challenge outside the trial context. Apart from the test itself, participants need to complete the bowel preparation at home because of the difficulty of doing it in a high-volume screening clinic. In the FS Trial, participants were sent an enema to

self-administer around one hour before leaving home to have the test,[5] and then attended a specialist screening endoscopy clinic in the local hospital.

Estimating the likely population uptake if the test were to be delivered as a screening programme in the UK is difficult because the FS Trial used a two-stage recruitment. Potential participants were sent brief information along with a questionnaire asking whether they would be likely to accept an invitation for the test. Only those who returned the questionnaire and indicated that they would 'definitely' or 'probably' accept the invitation (~53% of the 368,000 contacted) were eligible to be randomized. Uptake rates of over 70% were achieved in the screening arm, but this is likely to be a reflection of the selection at Stage 1.

This issue of *Journal of Medical Screening* reports results from a pilot study in which FS screening was delivered as if it were a screening programme.[6] The programme was offered in two London boroughs; one socioeconomically deprived and both ethnically diverse. Patients aged 58 and 59 ($n = 2260$) who were registered with the 34 participating general practices, were invited to have the FS test carried out by a specialist endoscopy nurse at the local hospital. As in the FS Trial, a self-administered enema was sent with the screening appointment, followed by a reminder after two weeks to those who hadn't contacted the clinic to confirm or decline the appointment. 45% attended, 5% accepted but were unable to attend within the time-frame of the study, 5% accepted but failed to attend, 7% declined, 27% did not respond, and 11% were ineligible or the invitation was returned unopened. Among those eligible to be screened, uptake was 51%. There were no gender differences in uptake, but rates were substantially higher in affluent (63%) than deprived areas (38%).

Comparisons with FOBT uptake are interesting. Despite FS requiring bowel preparation, a visit to the hospital, and a more invasive test, uptake rates for the two tests seem surprisingly similar. Data from the London Screening Hub show FOBT kit return rates of 47% in Harrow and 40% in Brent,[7] which are very close to the raw uptake rates of 53% and 39% in these two boroughs in the FS pilot. Differences by deprivation were also similar. This suggests that the barriers to CRC screening are likely to lie not in the specifics of the test but in the public's lack of awareness of the high incidence of CRC or the potential value of screening.[8] This is encouraging for ultimately achieving uptake rates comparable to those in the established cancer screening programmes. Successful implementation of FS as part of a population-based screening programme holds out the prize of dramatically reducing the incidence of colorectal cancer.

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