According to Dr Turcotte, this program “would have no effect on the absolute risk of dying” and therefore should not be implemented because it contradicts a principle of public health practice. There is no reference to support this statement, and its rigorous application would mean the end of most of Canada’s existing public health programs. As Dr Turcotte accepts that 30% of deaths from colorectal cancer (CRC) would be eliminated through this program, it is hard to understand why we would reject a measure that could eliminate approximately 3000 premature deaths each year.

Dr Turcotte’s second point concerns the anxiety caused by false-positive screening results. He neglects to mention the anxiety and suffering experienced by those forced to live through a long and slow decline with metastasizing CRC that was diagnosed too late. He also fails to take into account the anxiety and suffering of these people’s families and friends. If any situation is as nightmarish as he says, it is surely this and not screening.

His third point concerns the misuse of public health resources. Once again, Dr Turcotte makes no mention of the cost of investigating lesions at a more advanced stage than T1N0M0 or the cost of treating them with surgery, radiotherapy, and chemotherapy. From a strictly economic point of view, 111300 potential years of life are lost to CRC. If a screening program made it possible to save 30% of those years, that would be an additional 33390 years of life. In Canada, if we chose $50000 as an acceptable threshold of health investment for each additional year of life, that would represent a total of $1700000000 (111300 x 30% x $50000). Clearly, with this amount of money, the health authorities would be able to offer every Canadian an excellent CRC screening program.

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Competing interests
None declared

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Reference

These rebuttals are responses from the authors of the debates in the April issue (Can Fam Physician 2008;54:504-6).