Letters and comments

Contributors to this section are asked to make their comments brief and to the point. Letters should comply with the Notice printed on the inside back cover. Tables and figures should only be included if absolutely essential and no more than five references should be given. The Editor reserves the right to shorten letters and to subedit contributions to ensure clarity.

Response to paper by
S Walsh, C Bruce, S Bennington, S Ravi

The fourteen-day rule and colorectal cancer

Ann R Coll Surg Engl 2002; **84**:386–8

D Smith, L Titu, D Cade

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We read with interest your experience of the effects of the fourteen-day rule on colorectal services at a district general hospital and congratulate you on meeting the requisite targets without imposing an increased wait for 'routine' referrals.[1] However, it is disheartening to see a 5-week plus delay between first out-patient appointment and final diagnosis. Your answer to this predicament, patient education or throwing increased resources toward the investigative delay,[1] but at what cost? Perhaps changing perspective and moulding the patient pathway to a more structured, patient-orientated journey could educate as well as facilitate resource allocation. This could be done without distorting clinical practice as a means to achieve government guidelines.

In a recent paper in *The Lancet*,[2] Selvachandran *et al*. described a pathway in which patients pen their own health-care record by means of patient consultation questionnaire (PCQ) linked to an electronic database. From this, weighted numerical scores (WNS) can be derived which help stratify risk for cancer. Patients not referred urgently and scoring highly can then be prioritised efficiently. The one-stop colorectal clinic is an integral link in this diagnostic chain, which bypasses the traditional clinic visit and propels patients to their diagnostic destination.

Preliminary data recorded from 3219 patients as part of an on-going prospective study since October 1999, show encouraging results. Of those studied, 144 (4.5%) had colorectal cancer and 28% of these were Dukes' A, as compared to the traditionally quoted national average of 7.1%.[3] Of the 57 colorectal cancers referred in the last 12 months, 91% had their first diagnostic test within 2 weeks of referral; for the others, the interval was within 3 weeks. Interestingly, just over half of these (34) were referred as either urgent or 2-week rule, the rest as routine. Likewise, a high proportion of inappropriate NHS guideline, fast-tracked referrals were noted, with only 11% of the 305 GP referrals actually having colorectal cancer. This is consistent with previous reports where Jones *et al*. found that at least two-thirds of fast-track referrals were inappropriate;[4] this does inevitably stretch already limited resources.

However, a dedicated referral pathway linked with a one-stop clinic can increase the detection rate for early colorectal cancers (Dukes' A). WNS can be used as an effective tool to screen the referred population and help allocate resources more efficiently. With a WNS of 40, 57% of our referred population would have to be seen to detect over 95% of the cancers. This would still lead to a detection rate for early colorectal cancer in the region of 25%.

Response to paper by KS Mainprize et al.

Dukes' staging is poorly understood by doctors managing colorectal cancer

Ann R Coll Surg Engl 2002; **84**: 23–5

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We read this article with great interest. In the survey, all the participating colorectal surgeons had got the Dukes' staging right. It is the colorectal surgeon, pathologist and oncologist who manage colorectal cancer and hence the article has failed to prove the point highlighted in the title. There have been other studies[1] which have highlighted the variations in staging colorectal cancer by those managing colorectal cancer.

Reference

1. Raraty MG, Winstanley JH. Variations in the staging of colorectal carcinoma. *Ann R Coll Surg Engl* 1998; **80**: 188–91.

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