embrace the potential of these genomic technologies in primary care.

Will RH Evans,

GP and NIHR In-Practice Fellow, Division of Primary Care, NIHR School for Primary Care Research, University of Nottingham, Nottingham.
Email: William.Evans1@nottingham.ac.uk

REFERENCES

1. Laforest F, Kirkegaard P, Mann B, Edwards A. Genetic cancer risk assessment in general practice: systematic review of tools available, clinician attitudes, and patient outcomes. *Br J Gen Pract* 2019; DOI: https://doi.org/10.3399/bjgp18X700265.
2. NHS to offer paid-for DNA tests if patients share data. *BBC News* 2019: **26 Jan:** https://www.bbc.co.uk/news/uk-47013914 (accessed 5 Mar 2019).
3. Rafi I, Qureshi N, Lucassen A, *et al.* 'Over-the-counter' genetic testing: what does it really mean for primary care? *Br J Gen Pract* 2009; DOI: https://doi.org/10.3399/bjgp09X395021.
4. Westwood G, Pickering R, Latter S, *et al.* A primary care specialist genetics service: a cluster-randomised factorial trial. *Br J Gen Pract* 2012; DOI: https://doi.org/10.3399/bjgp12X630089.

DOI: https://doi.org/10.3399/bjgp19X702161

Faecal immunochemical (rule-in) testing in general practice

D'Souza and colleagues underestimate GPs' clinical judgement in selecting patients for a faecal immunochemical test (FIT).[1] NICE may recommend FIT for 'low-risk' symptomatic patients *'without rectal bleeding who have unexplained (abdominal) symptoms but do not meet the criteria for a suspected cancer'*,[2] but this has not led to the 'deluge' of referrals or worsening of the 'endoscopy capacity crisis' in the centres where FIT has been adopted.[3]

The majority of the estimated 10% of consulting patients with abdominal complaints will not be referred for colonoscopy.[1] GPs conduct a careful triage using history and examination, an understanding of their patients' consulting patterns and comorbidity, preferences for testing, and by deciding when to respond to a positive result. Only a highly selected group of those tested and with a positive FIT are referred.

The NICE positive predictive value (PPV) threshold to rule in patients for urgent referral is 3%: the PPV for a low-risk symptom such as abdominal pain is 2% (increasing with age) compared with 5% for rectal bleeding.[4] The PPV of a positive FIT in the low-risk symptomatic population is estimated at 13%.[5] If FIT is positive, referral is uncontroversial; if negative, the PPV falls to <1%, making colonoscopy non-referral reasonable. FIT is more likely to result in a reduction of unnecessary (routine) endoscopy referrals for low-risk symptoms.

The UK's routes to diagnosis data, cited by D'Souza, show us that a higher proportion of cancers are diagnosed at early stage when GPs investigate patients who do not meet 2WW criteria: those eligible for FIT. In order to achieve our nationwide target of 3 in 4 cancers diagnosed at an early stage by 2028,[6] offering early investigation (and where necessary, referral) to the correct patients is crucial before more serious symptoms develop.

As a rule-in test for patients with low-risk symptoms, FIT enables the timely detection of cancer and other bowel disease in primary care. It may also play a role as a rule-out test for patients with high-risk symptoms, or in the future replace routine post-polypectomy colonoscopy surveillance. Introducing FIT may have been the most important change in the whole of NG12.[4]

Sarah ER Bailey,

Research Fellow, College of Medicine and Health, University of Exeter, Exeter.
Email: S.E.R.Bailey@exeter.ac.uk

Marije A van Melle,

Research Associate, Department of Public Health and Primary Care, University of Cambridge, Cambridge.

Brian D Nicholson,

GP Clinical Researcher, Nuffield Department of Primary Care Health Sciences, University of Oxford, Oxford.

REFERENCES

1. D'Souza N, Brzezicki A, Abulafi M. Faecal immunochemical testing in general practice. *Br J Gen Pract* 2019; DOI: https://doi.org/10.3399/bjgp19X700853.
2. National Institute for Health and Care Excellence. *Quantitative faecal immunochemical tests to guide referral for colorectal cancer in primary care. DG30.* 2017. https://www.nice.org.uk/guidance/dg30/chapter/1-Recommendations (accessed 3 Mar 2019).
3. Nicholson BD, James T, East JE, *et al.* Experience of adopting faecal immunochemical testing to meet the NICE colorectal cancer referral criteria for low-risk symptomatic primary care patients in Oxfordshire, UK. *Frontline Gastroenterol* 2018; DOI: 10.1136/flgastro-2018-101052.
4. National Institute for Health and Care Excellence. *Suspected cancer: recognition and referral. NG12.* 2015. http://www.nice.org.uk/guidance/NG12 (accessed 3 Mar 2019).
5. Juul JS, Hornung N, Andersen B, *et al.* The value of using the faecal immunochemical test in general practice on patients presenting with non-alarm symptoms of colorectal cancer. *Br J Cancer* 2018; DOI: http://dx.doi.org/10.1038/s41416-018-0178-7.
6. Alderwick H, Dixon J. The NHS long term plan. *BMJ* 2019; **364:** l84.

DOI: https://doi.org/10.3399/bjgp19X702173

Correction

In the Editorial by Nicholson BD, Perera R, and Thompson MJ. The elusive diagnosis of cancer: testing times. *Br J Gen Pract* 2018; DOI: https://doi.org/10.3399/bjgp18X699461, Rafael Perera's affiliation and funding information was incomplete. The affiliation should have been: Rafael Perera, Professor of Medical Statistics, Nuffield Department of Primary Care Health Sciences, University of Oxford; NIHR Oxford Biomedical Research Centre, Oxford University Hospitals NHS Foundation Trust Oxford, UK. Additional funding information is: Rafael Perera is supported by the NIHR Oxford Biomedical Research Centre.

DOI: https://doi.org/10.3399/bjgp19X702185