A time for change and a time for vision[1]

IT is a privilege and a challenge to edit the *Journal* of the Royal College of General Practitioners. I have enjoyed both aspects immensely over the past nine years. In this, my last editorial prior to retirement, I wish to indulge myself in a few reminiscences, look at the *Journal* in its 41st year, and risk a peep into the future.

Since January 1991 much has changed for me as Editor. Instead of the traditional library atmosphere of my office in the Georgian premises of Queen Street, Edinburgh, the *BJGP* now operates from Princes Gate in the hectic activity of a busy computerised office. Much has changed but, thankfully, much has remained the same.

From the beginning, the College wished to facilitate the publication of original scientific research from primary care. The *British Journal of General Practice* is primarily dedicated to this end. Research represents a commitment to the future of general practice. High quality care depends ultimately on the quantity and quality of research and of continuing education within general practice.[2]

As Editor I have enjoyed total independence in choosing the contents of the College *Journal*, unfettered by any political pressure whatsoever. This is a freedom also enjoyed by my predecessors[3] and does great credit to our College. Happily, we have avoided the pitfalls that have beset some other international journals.[4] It is my earnest wish that this privilege be extended to my successor. Over-pliant editorial direction inevitably jeopardises the scientific worth and academic reputation of any peer-reviewed journal.

Over the years, the content of the *Journal*, and the balance between research, discussion, education, and other material has been the subject of heated debate. An independent survey[5] showed a very high claimed readership among College members, a wish for expansion, and for greater diversity of content. This latter need is being addressed enthusiastically by our Deputy Editor, Dr Alec Logan.

Responders to the survey expressed dissatisfaction with the delay between acceptance and publication of scientific articles. Submission and acceptance dates are printed routinely when a paper is published. It is intended that aggregated performance data will also be published at regular intervals. An ideal balance between the number of papers accepted for publication and available space is not easy to achieve. Imbalance adversely affects waiting times to publication. I understand and sympathise with this expression of discontent from authors, though the responsibility must remain entirely mine. If I have been guilty of accepting too many papers, I crave indulgence. In my defence I should say that, as Editor, the most difficult thing I have had to do is reject worthwhile papers because they did not quite reach the current scientific standard for an international journal of our discipline. In accepting 'too many' articles I have preferred to sacrifice immediacy in favour of strengthening the archive and reflecting *Caritas* as well as *Scientia*.

The membership is not the only constituency that must be considered in editing a journal of international repute: the *BJGP* should also be viewed objectively for its contribution to the literature of general practice and its support for general practice as an independent academic discipline.[6] For this purpose, a more objective assessment than can be obtained from a readership survey is available. The most widely used method of bibliometric analysis is based on journal citation rankings. This is impersonal, international, and is operated externally (both to the RCGP and to the United Kingdom). Citations count the number of times research workers choose, not only to read a given journal, but to cite its work as important to their own.

Family medicine is short of journals that are recognised and ranked internationally. The Journal Citation Reports (JCR)[7] currently lists 100 journals classified under the heading 'Medicine, General and Internal'. The group includes journals such as the *New England Journal of Medicine*, *The Lancet*, and the *British Medical Journal*, ranked in terms of 'impact factor': a numerical measure of the average number of citations per paper to papers published by a journal in a two year period. Impact factor is thus an objective estimate of the strength of a journal's influence. The *BJGP* is ranked 16th worldwide, and is therefore an internationally recognised journal in its own right.

A measure of how quickly articles published in a journal are cited by other research workers is provided by the 'immediacy index'. On this measure, the *British Journal of General Practice* is the third highest British medical journal for immediacy in the General and Internal Medicine group. Among all other journals of general practice and family medicine worldwide, the *BJGP* is first in terms of both impact and immediacy. Judged objectively, the *BJGP* is therefore the most read and influential journal of general practice in the world.

Scientific journals face many challenges at the end of the 20th century.[8] These result from very rapid and accelerating technological progress combined with a steady escalation in the cost of production and distribution of paper journals. For primary care there is also the welcome, additional problem of the large-scale expansion of academic general practice and consequent rapid increase in submissions from primary care researchers.

Electronic versions of many major biomedical journals are already available on-line, and primary electronic journals are beginning to appear. The electronic version of a paper journal need not simply copy text to a less legible screen but, freed from space limitations, can include appendices to papers published in the printed version, more data, references, and now links to other electronic resources.[9] Readers of a printed short version of a review paper could now also view updates on the website as new information becomes available and is assessed by the original authors. In an electronic update, subscribers could click on a reference to access the original article and to link with relevant material from other journals on the same topic. For editors, an electronic journal opens possibilities for processing emailed submissions more rapidly, for electronic and perhaps more open peer review,[10] and, above all, interactivity with readers.

While on-line publication offers advantages for both journals and their readers, it is premature to announce the demise of the paper journal. Despite ever faster computer chips and high speed ISDN lines, 'browsing' an on-line journal is scarcely comparable to browsing the paper version in the surgery, at the fireside, or on the train. For some time yet, those seeking a synoptic clinical update will prefer the reader-friendly format of the printed page to that of the computer or palmtop display. A journal that aims to help the busy clinician 'keep in touch' must respect the feel and convenience of the printed page as well as the efficiency of electronic documentation. The vigorous expansion of the World Wide Web has pushed traditional journal publishing to a crossroads. It is always risky to predict the future in a time of rapid change but it is not possible to stand still.

The Journal of the College of General Practitioners[11] was launched in 1958[12] to enable publication of new research relevant to general practice. Successive editors, through two changes of journal name, have striven for the best scientific quality standards and for the most relevant work for primary care, irrespective of authorship. The need to publish original scientific research from general practice remains undiminished as the *Journal* approaches its 50th volume in the year 2000. Journals will survive, though their role will change, as a result of technical advance, to serve more effectively the needs, not only researchers, but of computer-literate clinicians. Our readers call for '…an open debate on the future content and direction of the *Journal*',[13] for electronic access to the *Journal*'s archive, and for 'not merely an electronic version of the paper journal, but a rich new medium for inter-professional communication'.[14]

For the *Journal* of the Royal College of General Practitioners, I would hope for a happy symbiosis of screen and printed page; for experimentation with new ways to improve peer review and new systems of disseminating research without sacrificing quality or the seal of approval that acceptance for publication brings. The challenge for the *BJGP* is to be ready to grasp the opportunities of the new media and for the College it is to cherish and adequately nurture its international journal. Approaching the 'brave new world' with confidence calls, above all, for vision, for 'without vision the people perish'.[15]

ALASTAIR F WRIGHT

Former editor of The British Journal of General Practice

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The early detection of colorectal cancer in primary care

COLORECTAL cancer (CRC) is a major public health problem that continues to present real challenges in primary and secondary care. There are around 24 000 new cases of CRC each year in England and Wales (rather less than one per general practitioner per year) and approximately 19 000 deaths.[1] The outcome of CRC is related directly to the histological stage of the condition at diagnosis; patients with Duke's A lesions, where the cancer is localised to within the bowel wall, can expect a five-year survival of over 83%, but the outlook is grim when the malignancy has spread to lymph nodes (38%) and when there are distant metastases (3%). There is, fortunately, some evidence of improving five-year survival rates during the past two decades; for men, overall five-year survival rose from 32% in 1981 to 38% in 1989, while in women the rates rose from 32% to 40% over the same period.[2]

Primary care has an important role to play in the early detection of this disease, which can be best considered under three headings: accurate evaluation and diagnosis of patients with lower bowel symptoms or unexplained anaemia, selective screening of high-risk patients, and population screening.

Patients with lower bowel problems are common in general practice and account for about 4% of all consultations. A change in bowel habit, lower abdominal pain, rectal bleeding, and microcytic anaemia can be early warnings of serious disease, yet full investigation of all such patients is clearly inappropriate. There are few data on the predictive value of lower bowel symptoms and their natural history in primary care,[3-5] but current recommendations are that the persistence of any of these symptoms, particularly in patients over the age of 45 years, warrants investigation beyond a careful physical examination and digital rectal examination. The yield of lower bowel abnormalities in symptomatic general practice patients is remarkably high, yet many patients who clearly fall into a high-risk group are sometimes treated symptomatically for far too long.[6] Only a minority of general practitioners use rigid or flexible sigmoidoscopes in their surgeries, and direct access to lower bowel endoscopy is by no means universal. 'Fast-track' services for rectal bleeding and suspicious lower bowel symptoms have been established, and formal evaluations will soon be published. Primary care groups (PCGs) will need to work with gastroenterologists to determine the most appropriate model of service provision for the timely investigation of worrying lower bowel symptoms.

Patients at increased risk of CRC, among whom CRC surveillance should be considered, include those with a positive family history of the disease and also patients with long-standing inflammatory bowel disease.

The background prevalence of CRC is around 1:50, with a 1:37 chance of dying from it. With one first-degree relative, the risk of having the disease rises to 1:17, and with two first-degree relatives the lifetime risk of CRC is greater than 1:10.[7,8] Such patients should be referred at an age 10 years younger than the youngest affected relative to a centre with an interest and exper-

tise in CRC screening; the local clinical genetics department should also be able to provide advice. Patients with a family history of polyposis coli should always be referred to a geneticist for DNA testing after the age of 15 years, and those testing positive should enter a programme of endoscopic surveillance. Patients in hereditary non-polyposis colon cancer families (suspected when there is a history of three cases of CRC or adenocarcinoma of the uterus in the family), should be referred for clinical screening at the age of 25 years. DNA testing is not practicable in these patients at present. Overall, genetic factors play a part in about 15% of patients with CRC, emphasising the importance of taking a careful family history from patients registering in general practice. Computerised decision support systems are being developed to enable an individual patient's level of cancer risk to be calculated on the basis of a completed family history.[9]

The arguments in favour of a national programme of screening for CRC are strong, and general practice and primary care are likely to have an important part to play in the event that such a programme is established. Guaiac-based faecal occult blood (FOB) testing was originally used as the screening modality. The sensitivity of FOB testing is high but its specificity is relatively low, so that follow-up testing with dietary exclusion is necessary to reduce false-positive rates. Patient compliance with offers of FOB screening is reasonable, and two large randomised controlled trials of Haemoccult screening, conducted in Nottingham, United Kingdom, and Funen, Denmark, have both demonstrated a reduction in overall mortality of about 15%.[10,11] However, further work is now being conducted into the use of once-only flexible sigmoidoscopy, undertaken in patients aged between 50 and 60 years, as an alternative screening modality. Preliminary cost-effectiveness analyses have indicated that this is likely to be no more expensive than a FOB testing programme, and early results of the acceptability of flexible sigmoidoscopic screening have been encouraging.[12-15] We will have to wait for several years before the impact of a screening programme of this kind on survival and morbidity can be assessed. However, the department of new technology may outstrip the pace of research; virtual colonoscopy using sprial CT or MRI scanning could well assume a key role in screening for colorectal cancer.[16]

Other technologies have, so far, proved disappointing in the early detection of CRC. Tumour markers such as carcinoembryonic antigen and OVX1 are imprecise, and other molecular and genetic markers — serological and faecal — have yet to find a place in early detection of CRC.[17] Gene therapy in CRC, still at a very early stage, is under evaluation.[18]

Environmental factors associated with CRC include high dietary intakes of beef and animal fat and ethanol, with a low fibre intake; these factors interact with family history in determining CRC risks and may be modifiable.[19] More futuristically, chemoprevention for CRC has now appeared on the agenda, following the discovery that aspirin and non-steroidal anti-inflammatory drugs appear to protect against the development of the disease, possibly by interrupting prostaglandin pathways and inducing colon cell apoptosis. Currently, sulindac, aspirin, calcium, and selenium supplementation are being recommended to high-risk patients in some centres, although the evidence for this approach is controversial.[20]

Colorectal cancer is one of the leading causes of cancer death in the developed world, and it appears that population screening is capable of reducing the death toll from the condition. Evidence on screening needs to be accepted and implemented by central government; meanwhile, general practice can make its contribution by ensuring that patients with persistent lower bowel symptoms are carefully examined and investigated, that the level of risk for CRC in asymptomatic patients is accurately assessed, and that high-risk patients are appropriately referred. Close liaison between PCGs, medical and surgical gastroenterologists, and geneticists will be required to ensure that the early detection of CRC in primary care is maximised.

ROGER JONES

Woolfson professor in general practice, Guy's, King's and St Thomas's School of Medicine

TOM KENNEDY

Lecturer in general practice, Guy's, King's and St Thomas's School of Medicine

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Address for correspondence

Professor Roger Jones, Department of General Practice and Primary Care, Guy's, King's and St Thomas's School of Medicine, 5 Lambeth Walk, London SE11 6SP. E-mail: roger.jones@kcl.ac.uk