Letters

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Colorectal cancer risk

The study by Ellis *et al*[1] in the December 2005 issue of the *BJGP*, raises several issues ranging from failure to assess the importance of other risk factors associated with colorectal cancer to misleading statistics and incomplete investigations. When evaluating rectal bleeding, it is essential to look at other risk factors such as unexplained anaemia, family history of colorectal cancer and previous history of removal of adenomatous polyps. They mentioned no laboratory investigations.

Colonoscopy should be the diagnostic procedure of choice and gold standard in evaluating the possibility of cancer. There was no mention why 37 patients had barium enema.

In Table 1, page 952, I read in the first row sensitivity 100. This means that all patients presenting with rectal bleeding and change in bowel habit will have colorectal cancer! Page 954 stated that all patients with cancer had an associated change in bowel habit. This is their explanation of 100% sensitivity. Their analysis included 219 patients having flexible sigmoidoscopy and 47 patients filling in a questionnaire. The assessment of a questionnaire will neither exclude nor confirm colorectal pathology. Despite 53 patients declining participation, Tables 1–3 included them in quantifying the ratio of pathology. Their presentation is misleading.

Not every individual with rectal bleeding needs a colonoscopy. But if their aim is to evaluate the diagnostic power of symptoms in the assessment of cancer, then the gold standard colonoscopy should be used. The authors gave no details of duration of various symptoms and no explanation of selection criteria for performing barium enema or colonoscopy.

I read in the second column of page 953 in the last paragraph: 'As it has been shown that flexible sigmoidoscopy'. Their statement is inaccurate because the flexible sigmoidoscopy to 60 cm would detect the majority of colorectal cancer. It will miss 20–30% of significant proximal neoplasms[2] leading to missed diagnosis, false reassurance, progression of the disease, suffering and death. I am concerned about the method of recruiting patients to the study offering three options: flexible sigmoidoscopy; if not accepted postal questionnaire; or neither. A consultation should be offered without the obligation to participate in the study.

The authors stated that physical examination was carried out at the time of flexible sigmoidoscopy. This means that 47 patients filling the questionnaire and 53 declining flexible sigmoidoscopy and a questionnaire had no clinical examination. If patients decline a procedure, you still have the duty to offer them alternative options such as clinical examination, laboratory investigations and follow up after a reasonable time. This paper adds nothing new to the various guidelines on criteria for high risk of bowel cancer.

Competing interests

The author has stated that there are none.

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Authors' response

We will answer Dr Nader Al-Hassan's points in turn:

1. In this series of cases, no patient had an iron deficiency anaemia (IDA).

2. The new NICE guidelines for referral of patients with symptoms suspicious of bowel cancer specifically says that a family history in a symptomatic patient is of no proven value in identifying a higher risk patient.

3. In Portsmouth patients, who have had significant polyps will already be on a colonoscopic follow-up programme. No such patient was in our series.

4. Colonoscopy is used in Portsmouth if the patient is found to have a significant adenomatous polyp.

Barium enema is usually reserved for patients with an IDA or an easily palpable abdominal mass.

In patients presenting with rectal bleeding having a normal flexible sigmoidoscopy to 60 cm the residual risk of cancer is 1:500. In patients with this pre-test probability of cancer the difference in the value of barium enema and colonoscopy is small. Where resources for colonoscopy are restricted to those patients most likely to benefit, as is mainly in the UK, then a barium enema may be acceptable particularly in patients in whom the bleeding has stopped.

5. The sensitivity of the symptom combination for cancer was 100% as all the patients in this small series presenting with rectal bleeding had an associated change in bowel habit.

6. The total number of patients developing cancer in this cohort was determined by follow-up at 18 months. This is essential because even colonoscopy misses cancers. This is an acceptable technique to determine the prevalence of cancer in patients not having investigation. We had 100% follow-up of these patients at 18 months.

7. Our gold standard was 18 month follow-up to catch all cancers from all groups including those having colonoscopy.

8. We can give the data about the duration of the symptoms, but again in this small group of patients this did not affect cancer risk, although this might become apparent in a larger group of patients.

9. The number of patients that flexible sigmoidoscopy will miss depends on the epidemiology of patients referred to the clinic. In our clinic in Portsmouth only 12% of all cancers referred are proximal to the sigmoid colon, probably because proportionately more right-sided lesions compared with cancers in the sigmoid and rectum present as emergencies not to Outpatients or with a significant IDA to

other clinics. Of those right-sided lesions in our clinics the majority either have an associated IDA or a palpable abdominal mass, which means that any patients who present to our clinic with symptoms, but no IDA or an abdominal mass with a normal flexible sigmoidoscopy to 60 cms only very small numbers of patients have cancer. But this was not the subject for discussion in this paper. This is a stage after GP referral, and was not addressed by the data in this paper, but it does explain why our experience over the last 15 years in Portsmouth that flexible sigmoidoscopy alone in patients without an IDA or an abdominal mass is a powerful way of identifying most of the cancers which attend our clinic.

10. The method of recruitment to the trial was not on the basis as is stated, but was offered to all patients presenting with rectal bleeding. The group was divided up into those that accepted a flexible sigmoidoscopy, those that simply filled out a questionnaire and the third group that refused both. It was interesting that 40% of patients refused a flexible sigmoidoscopy.

11. Patients refusing referral to hospital and examination were indeed followed up after a reasonable time to check that they came to no harm.

12. It is interesting that our conclusions fall completely in line with the National Institute of Clinical Excellence Guidelines for referral of patients suspected of cancer recently published in the UK.

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Quite an eyefull

Unilateral conjunctival and lid infections are often treated in general practice. They are more likely to be related to trauma or foreign body irritation and it has always been debatable as to how long these infections should be treated in primary care before referral to a hospital ophthalmic clinic.

A 53-year-old bank service manager presented with a chronically irritable left eye, intermittent discharge, slight swelling of the eyelid and mild erythema. There was no loss of vision. His symptoms were managed in primary care for 1 year by his GP, optometrist and a local primary care eye clinic. There was poor response to a variety of antibiotics and bacterial swabs, including testing for chlamydia, were negative. As a result, he was referred to the regional ophthalmology department.

Examination at the ophthalmology department of the affected eye revealed mild blepharitis of upper and lower lids, mild erythema and moderate swelling and induration of the left upper eyelid. Eversion of the left upper eyelid revealed a deeply embedded contact lens in the tarsal plate with conjunctivalisation of the lens and a surrounding area of inflammatory granulomatous tissue. At the slit lamp, the contact lens was removed leaving an indentation in the tarsus of similar shape and size to the lens. The contact lens was sent to microbiology, which did not grow any organisms including testing for acanthomoeba.

Further questioning revealed that the patient had lost a gas permeable contact lens 14 years ago. Since 1980, there have been published cases reporting retained contact lenses in the eye for several years. Hard gas permeable contact lenses seem to be the main culprits in all of these cases, usually migrating and settling in the upper eyelid. Patients were more likely to present with inflammation or a mass in the eyelids rather than infection.

We wish to highlight the need to perform eversion of the upper eyelid in cases of prolonged and non responsive ophthalmic infection and inflammation. This is also essential where there is unilaterality of signs and negative laboratory tests. While this remains an unusual scenario it serves to remind clinicians not to overlook this simple and necessary step towards complete ophthalmic examination.

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Euthanasia

Pasterfield *et al*, looking at GPs' views on changing the law on physician-assisted suicide and euthanasia, end with a question.[1] Why are most GPs opposed to changing the law whereas patients largely are seen to support such a measure? To this I would add a further question. Why are a larger percentage of palliative care doctors opposed to such a change than GPs?[2,3] If one sees these two questions as being linked, an obvious hypothesis emerges. The hypothesis is that increasing experience of good palliative care is associated with the belief that legally allowing euthanasia is unnecessary and potentially dangerous.

Many of us will remember cases of appalling palliative care while in our house officer years. Hearing comments of families in the lead up to the Joffe Bill debate illustrates that many such bad stories are also in the public domain. As a GP, the benefits of good palliative care to my patients and their families rapidly became apparent. These good stories, however, are not media big sellers. As a result, a balanced view on end of life care is only available to a privileged few. We as GPs are able to experience this to a degree, often depending on how well resourced our local palliative care services are. Palliative care clinicians, on the other hand, live these stories with their patients on a daily basis.

As doctors we have a unique insight into the dangers of legalising euthanasia. Many of us will have been in a position where we have been directly or indirectly asked to end a patient's life. However, once the reason behind the request has been identified and addressed, the request is usually withdrawn. Palliative care clinicians, who meet these requests more frequently, tell me that their most common experience is the same. As GPs and palliative care clinicians we see errors in prognosis and diagnosis. We see the use of time as a therapeutic tool: patients who once wished themselves dead, are glad to be alive. We see how tired families can become caring for a loved relative, so that death can seem like a welcome release, not so much for the patient, but for the family.

Does exposure to good palliative care result in opposition to legalised euthanasia? Is it worth further research? I think so.

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