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

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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.

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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.

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