Adjuvant treatment for colorectal cancer

Reducing avoidable delays in establishing the diagnosis is also important

EDITOR,—In patients with colorectal cancer,¹ any measures that reduce the delay to diagnosis should, hopefully, improve surgical cure rates and reduce the need for adjuvant treatment. There is good evidence from studies^{2,3} and from epidemiological publications⁴ to suggest that better application of proved methodologies would improve the detection of colorectal cancer at an early and more favourable stage.

We recently completed a study of the diagnostic delays for all colorectal cancers presenting to our institution in 1993. Ninety three new colorectal cancers were diagnosed during the year. Seventeen patients presented as emergencies. When these patients were excluded the median delays were: time from onset of symptoms to presentation to the general practitioner, 60 days; from dispatch of letter to hospital review, 16 days; and from hospital review to histological confirmation, 15 days. Diagnosis was established at rigid sigmoidoscopy performed at the hospital clinic in 33 cases. The initial delay of 60 days could have been reduced to almost zero in these 33 patients if sigmoidoscopy were performed in primary care or if rapid open access to sigmoidoscopic services were available. The presence or absence of rectal bleeding made no difference to the likelihood of sigmoidoscopic abnormality in this group of patients.

The importance of rectal examination has been emphasised in a study of 178 patients from Finland, in which information on initial rectal examination was not found in the hospital notes

of 58% of patients subsequently confirmed to have colorectal cancer and 24% of the cancers were diagnosable by this simple examination.⁵ This study showed similar delays to those in our study, with 83 days to the first hospital assessment from the start of symptoms.

Avoidable delays in establishing a diagnosis of colorectal cancer in symptomatic patients still occur. The maximum potential reduction in time to diagnosis in our study was 60 days—a short period compared with the total time for which the tumour had been present. Thus the impact on outcomes of diagnosis at an earlier stage is difficult to assess. Nevertheless, symptomatic patients should be offered the most effective and rapid diagnostic interventions. It seems appropriate to encourage the better use of simple diagnostic resources to achieve earlier diagnosis as well as highlighting the benefits of adjuvant treatment for advanced disease.

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Concerns about chemotherapy are legitimate

EDITOR,—Maurice L Slevin's editorial on adjuvant treatment in colorectal cancer reflects the prevailing conviction among oncologists about the beneficial effect of chemotherapy on survival in this disease.¹ Unfortunately, Slevin probably overestimates the real effect because he selectively emphasises particular trials that have reported a survival benefit while ignoring other studies, testing identical regimens, in which no benefit was apparent (N Wilking, Stockholm colorectal cancer symposium, Stockholm, 12-13 Oct 1995).^{2,3} Moreover, even in those trials cited, the reported improvements in survival are only moderate, the confidence limits are wide, and the apparent effect is restricted to patients with positive nodes (type C disease).

The proportional reductions in the risk of dying, as used by Slevin, give a misleadingly optimistic view of the benefits in terms of absolute survival. It is more appropriate here to use the "number needed to treat" method.⁴ In the non-adjuvant "therapeutic desert" referred to by Slevin 100 patients with Dukes's type C cancer undergo radical surgery alone to achieve cure in about 30—or three patients need to be treated to avoid one death. If 100 such patients were then to undergo one year of postoperative adjuvant therapy between one and 10 might be cured by it (the wide confidence intervals in published trials preclude a tighter estimate). Looked at the other way round—in the most

nihilistic light, to use Slevin's word—between 90% and 99% of patients would accrue no benefit from chemotherapy. This is important if it is remembered that most patients are elderly and that the chemotherapy is sufficiently toxic for one third of patients to drop out because of unacceptable side effects. Thus, although the oasis beyond the desert is there, for most patients—whose outcome is unchanged—it might as well be a mirage.

Progress has been made in recent studies, and experience indicates that further progress will be built on critical appraisal and further study. The hype that accompanied the publication of the early results of the American trials led to the premature closure of other trials in colorectal cancer with "no treatment" arms in the United States and elsewhere. Fortunately, in Europe cautious realism and hopeful expectation rather than unbridled optimism have generally been the rule. Large numbers of patients are still being randomised into trials with "no treatment" arms, and these studies should produce the reliable data that we must have so that patients can be informed clearly and realistically. To describe legitimate concerns about the reliability of available data on chemotherapy as nihilistic is to miss the point.

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Author's reply

EDITOR,—Richard Gray and John Northover criticise my editorial on the grounds that I reviewed the literature selectively. In fact, I reviewed all the available literature on trials of adjuvant chemotherapy in Dukes's type C colon cancer, either published or available as an abstract, since Laurie *et al.*'s publication of 1989¹ and did not apply any selection. The trials that Gray and Northover quote (N Wilking, Stockholm colorectal cancer symposium, Stockholm, 12-13 Oct 1995)² are in progress and therefore cannot be reviewed.

Caution needs to be exercised in assessing preliminary unpublished results as the details are critical. For example, the breakdown of patients with Dukes's type B and C disease is critically important as a survival advantage has been consistently shown only in patients with type C colon cancer; thus large numbers of patients with type B disease will have a dilutional effect, making it difficult to detect a survival advantage associated with chemotherapy in the whole group. This is a particular problem with studies started after 1989

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