

Introduction:

I am submitting this account as evidence to the Health, Social Care and Sport Committee as part of the consultation on endoscopy purposes.

Background:

I am a bowel cancer patient (Stage 3). I am currently in remission (2 years). Approximately 50% of patients diagnosed with bowel cancer at this stage do not survive a further 5 years.

This is a personal account relevant to the consultation and is by no means unique in nature – I have since come across many people whose diagnosis was delayed and whose prognosis was worsened as a result of failings of the current system.

Account:

In the summer of [REDACTED], aged [REDACTED], I noticed a change in bowel habit and a number of other unusual symptoms and went to my GP in [REDACTED] [REDACTED]. He examined me and took a blood sample but was unable to give a definitive diagnosis. Due to my age and other lifestyle factors, he thought it very unlikely that I had bowel cancer.

In [REDACTED], with my symptoms continuing, he referred me to a consultant enterologist.

I was seen by the consultant in [REDACTED]. He thought I should have a colonoscopy and placed me on the waiting list.

My symptoms continued and in [REDACTED] worsened. In early September, my GP was sufficiently concerned to send me to hospital as an emergency case. I was admitted and given an emergency colonoscopy which revealed a tumour which had grown to block my colon. I underwent surgery and spent 15 days in hospital. My surgeon told me I would not have survived a further 2 or 3 days without intervention.

Two weeks later, while recovering at home – in late September - I received an appointment letter from the endoscopy department of the [REDACTED], following the meeting with the consultant the previous [REDACTED], inviting me to have a colonoscopy – 9 months after being referred by my GP; 6 months after seeing a consultant; a month after undergoing surgery to save my life.

Tests showed the cancer had spread to the lymph nodes in my groin. I spent several months off work recovering at home and from [REDACTED] to [REDACTED] underwent

chemotherapy. I have a stoma which, because of the extent of the surgery, is permanent. I am at a higher risk of developing cancer in future.

Despite this, I consider myself fortunate – others in a similar position have undoubtedly died and will continue to do so.

Finance / resources:

From a resource perspective, my emergency care and subsequent chemotherapy cost the health service many thousands of pounds. My lifelong aftercare (stoma) continues to cost the health service several hundred pounds a month.

These are preventable costs. Bowel cancer, more prevalent in older people but a growing issue among younger people, is preventable and curable if caught early. More than 90% of those with Stage 1 bowel cancer survive more than 5 years. Even better: pre-cancerous polyps can be removed if they are detected by a colonoscopy.

Early detection is cost-effective. Additional resources need to be targeted at this, thus avoiding the often huge costs involved with treating cancer in its later stages – and the human (patient) advantages are obvious.

Conclusions:

I would urge the committee to consider recommending:

- Fully introducing the faecal immunochemical test (FIT) at a low threshold – certainly no higher than elsewhere in the UK.
- Ensuring the health service can cope with FIT testing at a lower age – 50
- Increased awareness for GPs about bowel cancer, particularly in relatively young patients, and the ability for GPs to short-circuit the diagnostic process.
- Significant investment in endoscopy services to be able to cope with the inevitable increase in the demand on diagnostic resources.

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