Cynulliad Cenedlaethol Cymru
Y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon
Ymchwiliad i wasanaethau Endosgopi
HSCS(5) E02
Ymateb gan unigolyn

National Assembly for Wales
Health, Social Care and Sport Committee
Inquiry into Endoscopy Services

Evidence from an individual

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 xxxx, aged xx, I noticed a change in bowel habit and a number of other unusual symptoms and went to my GP in xxxx. 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 xxxx, with my symptoms continuing, he referred me to a consultant enterologist.

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

My symptoms continued and in xxxx 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 xxxx, following the meeting with the consultant the previous xxx, 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 xxxx to xxxx 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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