In this landmark study by Benitez Majano et al., the authors use linked primary care data to study pathways to diagnosis and diagnostic delay and the association with mental health conditions. Unsurprisingly, patients with a coexistent mental health diagnosis experienced diagnostic delay. However, the delay was not merely a statistical delay of little clinical significance. The authors concluded that diagnostic delays were “prognostically consequential,” in other words, delays that were likely to be associated with reduced 5-year and 10-year cancer survival rates.

What is more surprising is that a study of this type has not been previously conducted, even though in the everyday experience of primary care physicians, mental health symptoms so commonly coexist with symptoms that may be an early warning signal associated with cancer or explicit red-flag symptoms. Disentangling this web of symptoms and determining when to consider diagnostic testing and referral is a continually challenging task of primary care. This research and this study are long overdue. These findings will confirm and quantify long-held concerns of primary care physicians that mental health conditions may detract and distract from a diagnosis of bowel cancer and likely other cancers, as well.

Although not a primary outcome of this study, the findings concerning diagnostic delay after presentation with red-flag symptoms should be of great concern to primary care physicians. In this study, it took more than 4 months (133 days) between a primary care record of a new-onset red-flag symptom and colon cancer diagnosis in patients without a mental health diagnosis and a disturbing delay of almost 1 year (326 days) delay in those with a mental health diagnosis. That these delays need to be drastically reduced is self-evident.

How can delay be reduced, however? For all the talk about integrated care and educational programs, these delays continue and are clearly the reality for a large number of patients. Urgent referrals for suspected cancer in England have more than doubled in the past 10 years, to more than 2 million referrals per year, including more 400,000 referrals for suspected bowel cancer per year. However, while increasing symptomatic referral has been associated with improved outcomes, including stage at diagnosis for many cancers, this seems less the case for bowel cancer. Ultimately, to make a large difference to colon cancer survival rates, diagnosis may need to be made before symptom onset and certainly before recurrent red-flag symptom presentations. The rollout and uptake of fecal immunochemical test (FIT) for the triage of symptomatic presentations and in screening has the potential to improve early detection rates and prioritize use of stretched and expensive endoscopy capacity. With FIT requiring 1 small sample, ease of use and acceptability may be improved.

The UK recently introduced a national bowel cancer-screening program involving use of FIT. Bowel cancer mortality reductions of 41% were reported in an observational study that screened participants using FIT, which compares with a 16% reduction in patients using previous fecal occult blood screening. In the UK, 2-year bowel cancer screening using FIT currently begins at age 60 years, with the aim to reduce the eligibility age to include all adults aged 50 years and older. A further reason for putting more faith in bowel cancer-screening programs is that 50% of colorectal cancers have no red-flag symptoms.

The very real difficulty faced by primary care physicians is that all bowel symptoms have poor sensitivity and specificity for bowel cancer. It is now clear that sensitivity and specificity for bowel cancer may be even worse in individuals with concurrent mental health symptoms. Although FIT screening promises gains in early diagnosis and reduced mortality, primary care physicians will always...
have to remain clinically alert for possible and probable bowel cancer symptoms. This is because, in reality, universal screening is unlikely to be acceptable to all people; screening uptake is lower in individuals with mental health conditions, potentially widening health inequalities; and national screening programs are at present unlikely to screen at ages younger than 50 years.

Even FIT screening or use in patients who are symptomatic, although it has high sensitivity, will miss some cancers, with up to 10% of patients with bowel cancer having a false-negative FIT result. It is therefore crucial to not completely rule out the possibility of cancer with a negative FIT result, and in individuals with red flags or recurrent symptoms, it is crucial to arrange further diagnostic workup for those with unexplained anemia, for example.

Increased screening may over time be associated with fewer diagnoses based on clinical presentation, but this will not remove the need for clinical vigilance, enhanced safety netting, and triage testing and appropriate referral. As we now know, this is even more applicable for patients with concurrent mental health problems, who may need specific targeted interventions to improve screening uptake and symptomatic presentation to primary care.