

## **National cancer control plans require the integration of primary care and economic evaluation.**

Dear Editor,

Romero et al. highlight a missed opportunity in cancer policy in their analysis of 158 national cancer control plans (NCCPs): the integration of strategies to identify cancer in primary care. Half (52%) of the NCCPs do not specify mechanisms to refer patients with symptoms suggesting a possible cancer diagnosis from primary care, and a quarter (27%) do not even mention primary care. The emphasis on screening is limited in its reach, as screening detects a small percentage of cancers (1), it is unavailable for most cancer sites and no optimal screening strategies exist. Romero et al. conclude that “implementation research can improve the ability of NCCPs to reduce cancer burden”. Given the majority of people present with symptoms to primary care in the year preceding their cancer diagnosis (2), implementation research should focus on primary care to improve the detection of cancer at an early treatable stage (3).

The typically non-specific and common nature of many early cancer symptoms means that sufficiently sensitive and efficient strategies to avoid missed cancers remain elusive. A doubling of referrals in response to recommendations to liberalise investigation of symptomatic patients with possible gastrointestinal cancer has further complicated meeting national endoscopy waiting time targets in the UK (4). Similar increases in testing would not be possible in low- to middle-income countries. Acknowledgment of health-system capacity is essential if NCCPs are to improve testing strategies to account for the differences in symptom burden and disease spectra observed across primary and secondary care (5, 6). Symptom-based testing strategies will need careful integration into each NCCP to optimise referral patterns in line with local infrastructure, avoid unnecessary patient anxiety, and contain costs.

But, with increased testing comes the potential for overdiagnosis. This is long accepted for some cancers, e.g. the shift towards watchful-waiting in low-risk localised prostate cancers and trials of surveillance-first strategies for ductal carcinoma in-situ. However, as testing rates increase, incidence is rising for many cancers without proportionate reductions in mortality (7). Appreciating the fine line between under- and over-testing is essential to ensure that the benefits of early detection are not eroded by the harms of overdiagnosis. A greater emphasis on primary care and economic evaluation within each NCCP is therefore essential to address the methodological challenges posed by shifting cancer testing into the primary care setting.

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Declaration of interests.

No authors have any conflicts of interest to declare.

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