Cost benefits of hemoccult screening for colorectal carcinoma
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Record Status
This is a critical abstract of an economic evaluation that meets the criteria for inclusion on NHS EED. Each abstract contains a brief summary of the methods, the results and conclusions followed by a detailed critical assessment on the reliability of the study and the conclusions drawn.

Health technology
Hemoccult screening.

Type of intervention
Screening and treatment.

Economic study type
Cost-effectiveness analysis.

Study population
Persons aged 45 years and over.

Setting
Medical centre. The study was carried out in the USA.

Dates to which data relate
The analysis is based on the detection rate at a medical centre in 1979/80, extrapolating outcomes from a 5 year follow-up of patients identified in 1974. The price date was 1980.

Source of effectiveness data
Single study.

Analysis of effectiveness
Main outcome was the detection rate.

Effectiveness results
Twelve cases were detected at screening, from 112 positive test from 10255 returns from 14041 mailed kits.

Modelling
Epidemiological cohort model (model of survival and disease).

Measure of benefits used in the economic analysis
Life-years gained.
**Direct costs**
Direct costs were to the health service: Hemoccult II slides, laboratory analysis, diagnosis (sigmoidoscopy, barium enema, and colonoscopy [37.2% of cases]), treatment for carcinoma, mailed kits. Price related to 1980.

**Currency**
US dollars ($). In the DH Register of Cost-Effectiveness Studies, the original results were converted to UK pounds sterling (£) using GDP purchasing power parities and reflated to 1991 using the NHS pay and prices index.

**Sensitivity analysis**
No sensitivity analysis was carried out.

**Synthesis of costs and benefits**
Outcome duration was life long. Cost duration was less than 1 year. The incremental cost per life year was 928 (costs and benefits were not discounted).

**CRD Commentary**
(This commentary was not written by CRD, but by the authors of the DH Register.)

1) There is only a 13% difference in costs between treatment and control. 2) Variations in compliance, use of diagnostic tests and less than 100% progression of disease could alter the CE ratio significantly. 3) The analysis has correctly stratified survival and cost by stage of disease

**Bibliographic details**

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**Indexing Status**
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**MeSH**
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