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will find another link. INTRODUCTION {#s1}  
===== Colorectal cancer (CRC)  
occurs in approximately 130,000 Australians  
each year and is the second most common  
cause of cancer death \[@RJW003C1\].  
Mortality is largely a function of stage at  
presentation, and improvements in CRC  
survival can be attributed to earlier  
diagnosis \[@RJW003C2\]. The majority of  
CRC diagnoses are made by primary care  
physicians (PCPs) through a combination of  
patient symptoms, rectal examination

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findings and structural tests, including faecal occult blood test (FOBT) and flexible sigmoidoscopy (FS). The latter test detects diminutive polyps via colonoscopy, and the recommendation is to target biopsy of precancerous polyps \[[@RJW003C3]\]. There is concern that many biopsies are of unnecessary, non-precancerous lesions \[[@RJW003C4]\]. Effective screening strategies are resource intensive, limiting the number of patients who can be tested. FOBT has not been shown to reduce CRC mortality \[[@RJW003C5]\]. Population-based screening does not reduce CRC incidence; however it does reduce CRC-associated mortality \[[@RJW003C6]\]. The American Cancer Society recommends screening to individuals between 50 and 75 years of age in a 5-year cycle using FOBT or FS. Within this population, there is conflicting evidence regarding whether population-based screening reduces CRC mortality, with trials of triage of FOBT positives by FS showing no reduction in CRC-associated mortality

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\\[@RJW003C7]\\]. The current Australian screening policy also lacks support, with trial evidence not demonstrating a reduction in CRC-related mortality \\[@RJW003C8]\\]. The Australian Government funds the Australian colorectal cancer screening programme; it funds the FOBT two and FS once per annum for screening. Screening of the non-institutionalised population is performed via a mailed invitation to initiate screening. This is followed by a 2-week period in which a reminder of the invitation is sent. Following the 2 weeks there c6a93da74d

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