SOCIEDAD INTERAMERICANA DE ENDOSCOPÍA DIGESTIVA

Clarifications regarding the NordICC study and its media dissemination.

TECHNICAL POSITION STATEMENT · May 2026

Executive Summary

In response to media reports across the Americas following the results of the NordICC study, this SIED document seeks to clarify its true interpretation within the context of the rising incidence of colorectal cancer in Latin America. Far from questioning the value of colonoscopy, the study primarily reflects problems with adherence to and implementation of screening programs. In a region where late diagnosis remains common, strengthening screening programs is essential to prevent advanced disease and reduce mortality. The central message is clear: screening saves lives when it is accessible, high-quality, and supported by effective participation.

1. Introduction

On May 8, 2026, The Lancet published the 13-year results of the NordICC study, a randomized, multicenter clinical trial that evaluated the impact of colonoscopy as a primary screening tool for colorectal cancer in Norway, Poland, and Sweden. Within hours, media outlets throughout the region (from Mexico to Argentina) reproduced versions of the same alarmist headline.

The Inter-American Society of Digestive Endoscopy (SIED), which brings together the 22 main scientific societies of gastroenterology and endoscopy in Latin America, the Caribbean and North America, considers it essential to respond accurately, with scientific rigor and with a perspective that reflects the reality of the continent.

According to GLOBOCAN 2022 data, colorectal cancer ranks third in incidence and second in mortality in Latin America and the Caribbean, with a trend toward increasing mortality at the regional level. Projections indicate that the incidence of colorectal cancer in the region could increase by up to 60% by 2030. In contrast to what is happening in high-income countries in Northern Europe and North America (where mortality is declining thanks to decades of organized screening programs), in Latin America this reduction has not yet materialized in most countries.

A systematic review published in JAMA Network Open in 2024 (Montalvan-Sanchez et al.) confirmed that colorectal cancer screening is feasible in middle- and upper-income countries in Latin America, with detection rates comparable to those in high-income regions. However, most countries in the region still lack organized and systematic screening programs. This is the real gap that defines our regional agenda.

In this context, the statement we present below has a dual purpose: first, to provide a technically sound response to the headlines generated by NordICC, so that professionals and the entire community have accurate information for a proper interpretation of the results of said study.

Second, to reaffirm SIED's commitment to colorectal cancer screening as a public health imperative in the Americas, beyond the methodological particularities of any individual study.

2. Media coverage

In the hours following the publication of the study, widely circulated regional media outlets published articles with titles such as "A 13-year study casts doubt on whether colonoscopy reduces death," "The Lancet questioned the effectiveness of colonoscopy," or "Colonoscopy may be less useful than was believed for decades."

These coverages share a pattern that deserves to be pointed out: they reproduce the main finding of the study, that the reduction in mortality was not statistically significant, without the methodological, epidemiological and clinical context indispensable for interpreting it correctly.

Common errors identified in media coverage:

- ✗ Omitting that only 42% of those invited actually underwent a colonoscopy.
- ✗ Failing to report that mortality in the group without screening was almost half of what the authors projected when designing the study.
- ✗ Ignoring that the per-protocol analysis (those who did undergo a colonoscopy) showed a 45% reduction in cancer incidence.
- ✗ Failing to clarify that the study evaluated a single colonoscopy in the participant's lifetime, not a periodic screening program.
- ✗ Failing to distinguish between colonoscopy as primary screening and colonoscopy as confirmation after a positive FIT (the dominant strategy in the region).
- ✗ Failing to cite the robust evidence supporting FIT screening.

A misleading headline can lead to the abandonment of life-saving controls. That's why we're presenting solid information here to be used when and how appropriate.

3. What did NordICC study and what did they not study?

The NordICC study included 84,583 people aged 55 to 64 in Norway, Poland, and Sweden, who were randomly assigned to receive an invitation to undergo a screening colonoscopy or to receive no intervention. The objective was to measure, after 13 years, whether the group invited to screening had a lower incidence and mortality rate from colorectal cancer.

This design is conceptually different from studying the FIT (the most widespread strategy in Latin America), as well as from evaluating periodic screening programs or colonoscopy as a diagnostic step after a positive FIT. Specifically, it involves colonoscopy as the first and only screening step, performed only once in the participant's lifetime.

It is also relevant to point out that the countries in the study (Norway, Poland and Sweden) did not have organized colorectal screening programs at the start of the trial, which makes them epidemiologically and health-wise different from the contexts where programs are implemented or promoted today in our region.

4. The main findings in plain language

What the study found

After 13 years of follow-up, the group invited to participate in the screening showed a statistically significant 19% reduction in the incidence of colorectal cancer compared to the non-screened group. This means that colonoscopy, when performed, prevents cancers from developing, primarily because it detects and removes the polyps that cause them.

The reduction in disease-specific mortality was 12% in favor of screening, but this result did not reach statistical significance. However, a 12% reduction does not indicate a lack of benefit; it is a benefit that the study size and current conditions did not allow to be statistically confirmed.

Why the mortality rate was not significant (the fact that the media ignored).

When designing the study nearly 20 years ago, researchers projected that 0.82% of people in the unscreened group would die from colorectal cancer. The observed rate was just 0.47%, nearly half of what was expected, even among those who were not screened.

Why? Because colorectal cancer treatment has improved dramatically in two decades: new surgical techniques, more effective chemotherapy, precision radiotherapy, and immunotherapy. When baseline mortality falls so significantly, any preventive intervention will have greater difficulty demonstrating a further statistically significant reduction. This does not invalidate screening; on the contrary, it complements it.

The difference between intention-to-treat and per-protocol análisis

Only 42% of those invited actually underwent the colonoscopy. When those who did complete the procedure are analyzed (protocol analysis), the reduction in the incidence of colorectal cancer rises to 45%.

This illustrates a fundamental clinical and public health principle, especially relevant in our region: screening only works if it is done.

5. The Latin American reality: where risk grows and access is lacking

The region faces a scenario of double inequity: the incidence and mortality of colorectal cancer are on the rise, with mortality growing at an annual rate of 2.48% according to GLOBOCAN 2022, while the coverage of organized screening programs remains low or non-existent in most countries.

An assessment of 27 CELAC countries published in the International Journal of Cancer (Mosquera et al., 2024) identified multiple systemic barriers to cancer screening in the region: limited availability of services, economic and geographic access barriers, low cultural acceptability, insufficient training among health providers, and absence of effective follow-up systems.

In this context, misinformation generated by media coverage without in-depth analysis and alarmist headlines has a particularly serious impact: in populations where the culture of screening is still under construction, a negative headline about colonoscopy can set back years of progress in adherence.

SIED member societies have observed, in their respective national contexts, how distrust in preventive procedures and fear of diagnosis remain greater barriers than economic barriers.

Colorectal cancer, unlike many others, is one of the few cancers that can be prevented. Detecting and removing adenomatous polyps before they become malignant is a unique therapeutic opportunity that exists in almost no other common cancer.

Ignoring it in a continent where the incidence is growing is a mistake that has measurable consequences in human lives.

6. Screening strategies in the region

Latin America is not a homogeneous bloc. The countries of the region have different healthcare systems, varying levels of endoscopic resources, different follow-up capacities, and different epidemiological realities. That is why SIED does not promote a single screening model, but rather a set of evidence-based principles that each member society can adapt to its own context.

The fecal immunochemical test (FIT) is the most scalable strategy in settings with limited endoscopic resources, with high patient acceptability and strong evidence of mortality reduction. Four classic randomized trials demonstrated mortality reductions of between 15% and 30% with fecal occult blood testing. The COLONPREV trial (The Lancet, 2025), with more than 50,000 participants and 10 years of follow-up in Spain, demonstrated that biennial FIT was non-inferior to colonoscopy in terms of colorectal cancer mortality, with greater participant acceptance.

Colonoscopy remains the diagnostic and therapeutic gold standard in the screening chain: as diagnostic confirmation after a positive FIT, as a post-polypectomy surveillance tool, and as a screening procedure in contexts with installed capacity and projected high adherence.

The NordICC study does not compare these two strategies with each other, nor does it evaluate colonoscopy as part of a FIT → colonoscopy pathway. Its findings say nothing about the effectiveness of FIT, which is the priority strategy for most health systems in our region.

7. The evidence supporting FIT screening: strong and independent

The scientific basis for screening with fecal occult blood tests is robust and has been accumulated over more than three decades:

- Minnesota (Mandel et al., NEJM 1993), Nottingham (Hardcastle et al., Lancet 1996), Denmark (Kronborg et al., Lancet 1996) and France (Faivre et al., Gastroenterology 2004): four randomized trials that demonstrated reductions in colorectal cancer mortality of between 15% and 30%.
- Doubeni et al. (JAMA Network Open, 2024): In an observational study with tens of thousands of people in two large health systems, having at least one screening FIT was associated with a 33% reduction in the risk of dying from colorectal cancer.

- COLONPREV (The Lancet, 2025): Biennial FIT non-inferior to colonoscopy in CRC mortality, with greater population adherence.
- Montalvan-Sanchez et al. (JAMA Network Open, 2024): systematic review that confirms the feasibility of FIT screening in middle-to-high-income countries in Latin America, with neoplasm detection rates comparable to high-income regions.

In summary: the available evidence strongly supports that FIT screening, when properly implemented and followed by colonoscopy when appropriate, reduces the incidence and mortality of colorectal cancer. The NordICC study does not alter this conclusion.

8. Limitations of the study that media coverage omitted

- The study offered only one colonoscopy in the participants' lifetime. Modern screening programs include periodic repeat screenings, which multiplies the cumulative preventive benefit.
- The participation rate was 42%, significantly lower than that of effective population-based programs. The per-protocol analysis (of those who were screened) showed a 45% reduction in incidence.
- The study did not include a FIT screening arm, so no comparison between the two strategies can be inferred.
- The countries in the study (Norway, Poland, Sweden) did not have organized screening programs at the start of the trial, an epidemiological and health scenario different from that of modern programs in Latin America.
- Mortality from colorectal cancer has fallen dramatically in recent decades due to therapeutic advances, making it statistically more difficult to demonstrate further reductions with preventive intervention, without invalidating screening.
- The Society of American Gastrointestinal and Endoscopic Surgeons (SAGES) explicitly stated (when analyzing this same study worse than at 10 years) that the finding of lesser benefit in mortality should not impact national screening recommendations, and that the reduction in incidence is the most important outcome.

9. Message to the community, professionals and the media

Colorectal cancer is the second leading cause of cancer death in Latin America. Most cases develop from benign polyps that, when detected early, can be safely and permanently removed. In a region where late diagnoses are still common, screening is not a secondary option: it is the most powerful tool available to reduce the burden of this disease.

The NordICC study provides valuable information on the actual limitations of colonoscopy as the sole screening step in a specific European context. It is not a study that questions screening in general, nor the FIT in particular. Interpreting its results as an argument against screening would be a mistake with serious clinical consequences and a particularly high human cost in a region where a culture of prevention is still developing.

We urge media outlets throughout the Americas to thoroughly analyze this issue and avoid alarmist headlines before publishing highly sensitive health information. Health misinformation has a cost, and in the case of colorectal cancer, that cost is measured in lives.

We also urge the governments and health systems of the region not to use this study as justification for postponing or weakening screening programs. The evidence in favor of screening is strong.

Screening saves lives.

Colonoscopy and FIT are complementary tools, not rivals. Getting tested is always better than not getting tested.

In Latin America, increasing screening is the only right direction.

10. For SIED member scientific societies

This statement has been prepared as a regional reference document and may be adapted, endorsed, or reproduced by SIED member societies in their respective national contexts. SIED makes its institutional communication channels available to its members to amplify this message in a coordinated manner across the continent.

In response to inquiries from the media, patients, or health authorities, member societies can use this document as a technical basis and contact the SIED Secretariat for additional communication support.

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