GENERAL PRACTITIONERS IN THE 1ST LINE OF CANCER PREVENTION

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GPs at the frontline of cancer prevention

- **Primary prevention**

- **Early diagnostics** in symptomatic

- **Secondary prevention:**
  - screening programmes for high risk persons
  - screening programmes for average risk persons

- **Care for cancer patients**
Primary cancer prevention

Limited possibility….  
- Brief interventions on life style, risk factors
- Systematic checks *(Cochran 2012- no/marginal effect)*
- Individual – family – group basis

Interventions on suggestible factors with influence on cancer risk (RR):
- smoking 1.8
- diet and obesity 1.5
- red meat 1.4
- physical activity 0.6
Early diagnostics of cancer

- The principal method of identification of colorectal cancer stays *symptomatic presentation* to GPs who are source of referral to secondary care

.............................90-95% of colorectal cancers

**Key Issues:**
- Help-seeking behaviour
- GP performance
- Access to diagnostics
Early diagnostics of cancer: Help-seeking behaviour

- **Delay processes on patient’s side:**
  - **cognitive:** low recognition of seriousness of the symptom
  - **emotional:** fear of receiving a cancer diagnosis
  - **behavioural:** a reluctance to interact with the HC system

Forbes et al, Brit Jour of Cancer 2013
Simon et al, Cancer Epid Biomarkers and Prevention, 2010
Quaife et al, Brit Jour of Cancer 2014
Whitaker et al, Brit Jour of GP, 2015
Clinical decision making in primary care is based on risk estimation.

The aim is to identify in a timely way those patients with a high risk of serious disease.

Symptoms are common, but cancer is rare.

Concept of alarm symptoms (rectal bleeding, weight loss, anemia, abdominal pain, appetite loss, alteration in bowel habit).

Probability of cancer increases with a combination of symptoms.


Early diagnostics of cancer. Access to diagnostics

- capacity
- organization of referrals
- waiting times
- quality of services

- Due to increasing demand of screening colonoscopies, optimization of referrals for colonoscopy is necessary.
- Waiting times 6-12 weeks

- interdisciplinary cooperation.
Secondary prevention

- **Case finding/identification of high risk group:**
  - CRC incidence in 1st degree relatives or multiple occurrence in 2nd degree relatives
  - IBD
  - detected adenoma polyps
  - women after breast, ovarial or uterus surgery
  - hereditary nonpolyposis CRC syndrome
  - (Diabetes 2nd type or high CV risk)

- **Screening**
GPs in Colorectal Cancer Screening

Screening established in 20 from 27 EU countries. GP involvement varies according to the chosen national strategy and organization of health care:

- **Key role** in distributing and performing FOBTs (Germany, Czech R., Slovakia, France)

- **Supportive role** (Netherlands, UK, Finland, Slovenia, Spain)

- **Recruitment** for colonoscopic screening (Poland)
Time trend in colorectal cancer screening coverage

New design

Address invitation

Coverage by examination (50+)

Unsatisfactory coverage by colorectal cancer screening examinations was substantially increased (by one fifth) after first year of personal invitations.
Possible models of GP involvement in population based screening

1. Kits distributed, collected and analyzed centrally (UK, Slovenia, Netherland, Finland) **Uptake > 55-70%**

2. Kits distributed centrally, collected by GPs and then sent for central analysis (Basq country, Spain)

3. Letters inviting to GPs who distribute kits and send them for analysis to central laboratory (?)

4. Invitation to GPs who distribute, collect and analyze them in practice (CZECH, France) **Uptake > 30%**

5. Kits distributed centrally only those not-attending the screening (and then either collected by GPs or sent directly to central lab).
Which models are effective?
GP involvement Pros and Cons

**PROS**
- GP knows (symptomatic) patients
- FOBT logistic and control
- FOBT results at the site (quality aspect)
- consequences of negative and positive tests

**CONS**
- data on participation
- equity in access
- by-passing doctors
- cheaper, easy, direct
- FOBT quality aspects
Which models are effective?

GP involvement Pros and Cons

**PROS**
- GP
  - workload
  - attitudes to screening
  - may be expensive

**CONS**
- CENTRALIZED PROGRAM
  - new administration
  - a lot of mailing (quality aspects)
  - incl. of symptomatic, ethical issues
Role of GPs in population based program

- Increasing participation

- Communication of screening
  Wee 2005, Ferreira 2005

- Balanced information for informed choice (risk and benefits)

- FOBT agenda (if applicable)
- FOBT+ referrals
GPs should be educated in order to:

- understand screening
- communicate screening
- increase participation
- provide balanced information for informed choice
- perform FOBT if relevant
- deal with FOBT negative and positive
- interpret results of FOBT, colonoscopy
- support a patient in surveillance program
FOBT+ consultation

- Not expected
- Not welcome and always difficult

-“I feel OK, I do not believe that something is wrong“.

-“I don´t believe, give me another test“.

-“Doctor, you told me, that the test was just for sure…“

-“I have heard about more pleasant methods than colonoscopy…“

10% of patients disagree with colonoscopy
FOBT+ management

1. Make an appointment for FOBT+ patient sensitively.
2. Calm patient down before giving bad news.
3. Inform what FOBT+ in screening program means.
4. Learn patient about colonoscopy (use brochures, websites, webcast).
6. Support appointment for colonoscopy in specific centre, with specific physician, if possible.
7. Assess positively patient approach to his health.
8. Invite patient to come after colonoscopy.
GP performance indicators

Primary Care Data

- centrally collected (hard) data/indicators:
  - FOBT participation rate
  - FOBT positivity rate
  - compliance with colonoscopy in FOBT positives
  - regional differences
  - individual physician involvement

- primary care collected data (experimentally)
  - waiting times for colonoscopies
  - feedback on endoscopic services and follow up
Increasing prevalence of colorectal cancer patients; 12 patients per 1 GP in the Czech Republic.

- Understanding the cancer/oncological treatment and its options, incl. adverse effects
- Attention to cancer duplicity/multiplicity
- Palliative care
Colorectal Cancer
Imperatives for primary care physicians

- Promote healthy lifestyle
- Do not miss a symptomatic cancer/refer in time.
- Identify high risk patients for CRC.
- Communicate screening for CRC (and screen if applicable).
- Care your colorectal cancer patients