GENERAL PRACTITIONERS IN THE 1ST LINE OF CANCER PREVENTION

Bohumil Seifert

Dpt. Of General Practice 1st Faculty of Medicine

Charles University in Prague

May, 29, 2015

European Colorectal Cancer Days, Brno 2015

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 p.

- **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 obezity 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 recieving 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

Early diagnostics of cancer. GP performance

- 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

Winkens et al. BMJ 2002, Elstein et al, BMJ 2002

- Symptoms are common, but cancer is rare.
- Concept of alarm symtoms (rectal bleeding, weight loss, anemia, abdominal pain, apetite loss, alteration in bowel habit).
- Probability of cancer increases with a combination of symptoms.

Jellema et al, BMJ 2010, Astin et al, BJGP 2011, Olde Bekkink et al, BJC 2010

Early diagnostics of cancer. Access to diagnostics

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

- Due to increasing demand of screening colonoscopies **optimalization 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 occurence 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**

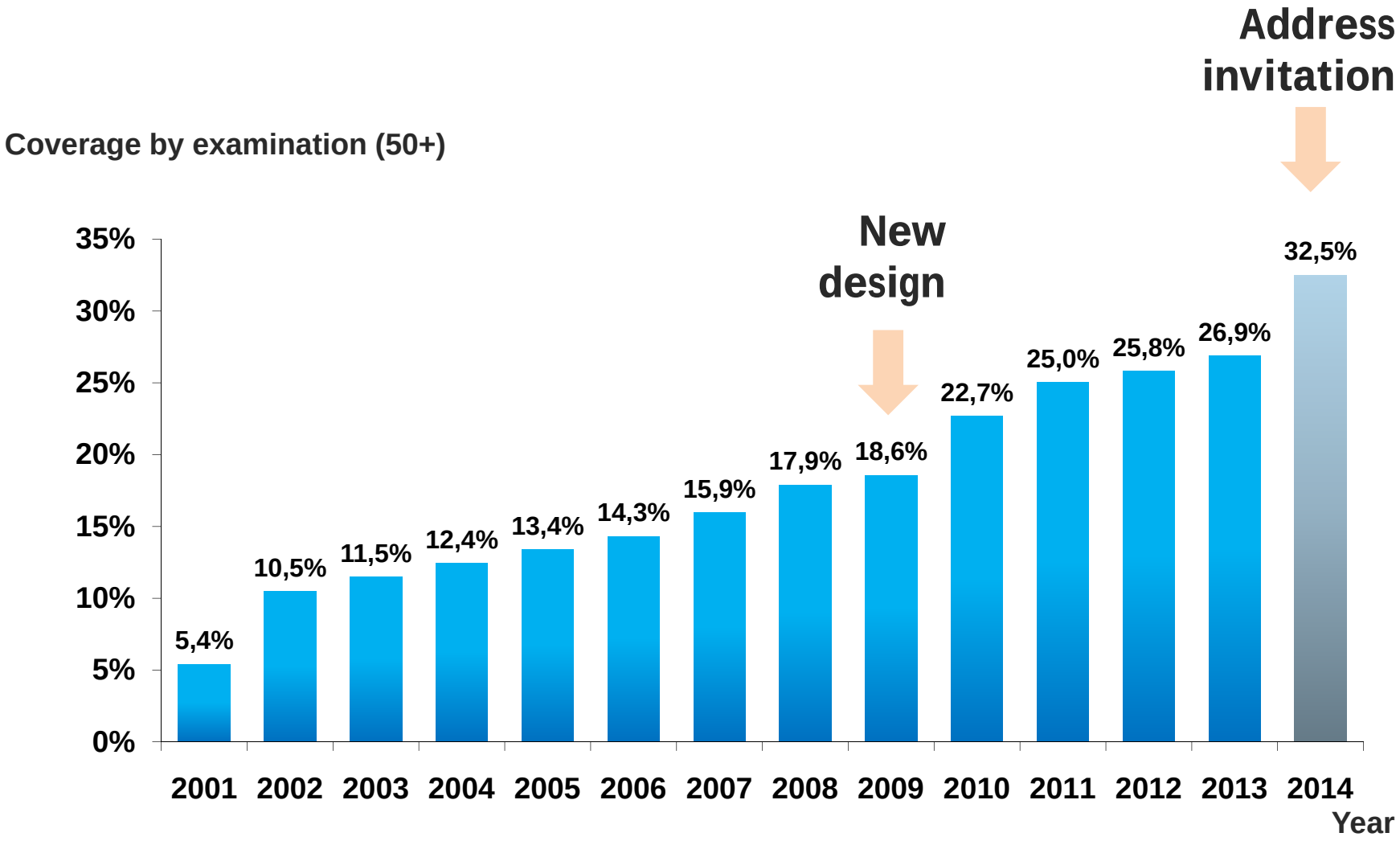
GPs in Colorectal Cancer Screeening

Screening established in 20 from 27 EU countries.

GP involvement varies according to the chosen national stratégy 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



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, c… …ntrally (UK, Slovenia, N…
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** … …ect them and analyse them… …rance)
5. Kits distributed centraly only those not-attending the screening (and then either collected by GPs or sent directly to central lab).

Uptake > 55-70%

Uptake > 30%

Which models are effective?
GP involvement Pros and Cons

PROS

- data on participation
- equity in access
- by-passing doctors
- cheaper, easy, direct
- FOBT quality aspects

CONS

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

Which models are effective?
GP involvement Pros and Cons

PROS

CONS

GP

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

CENTRALIZED PROGRAM

- **new administration**
- **a lot of mailing (quality aspects)**
- **incl. of symptomatic, ethical issues**

Role of GPs in population based program

- Increasing participation

Harris 2000, Brawarsky 2004, Seifert 2007, Hewitson 2011

- Communication of screening

Wee 2005, Ferreira 2005

- Balanced information for informed choice (risk and benefits)

O´Connor 1999, Jepson 2005, Wegwarth 2013

- 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
- interprete 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).
5. **Explain** preparation/prescribe preparation.
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 differencies
- individual physician involvement

- **primary care collected data (experimentally)**

- waiting times for colonoscopies
- feedback on endoscopic services and follow up

GP: Cancer patient care, tertiary and quartery prevention

- 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 life style
- 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