### GA011

I: I think you answered like the general demographic questions via email and I am going to skip them. I would just like to confirm how old you are.

P: 60

I: Moving on to the guidelines themselves, what is your understanding of the Cancer Council guidelines around using aspirin.

P: I have no idea of the guidelines.

I: Okay okay. I have a copy of it over here. Take a look and let me know what you think.

*[Interviewer shows laminated copy of CCA guidelines to participant GA011]*

*[reading the guidelines – thinking out loud]*

P: “Aspirin should be actively considered in those at average risk of colorectal carcinoma Aspirin should be actively considered to prevent colorectal cancer for people aged 50 or 70 where at average risk. A low dose one under 300 is recommended for at least 2.5 years. Benefits for cancer prevention is evident only after 10 years so life expectancy should be considered when recommending aspirin.”

P: “Recommendation for those at high risk.” Do you want to talk about the first bit first?

I: Yea yea yea

P: Okay fine. So, what strikes me here as strange, very strange, is that why recommend 300 when 100 is acceptable - 300 has more side effects and it's confusing a low dose of 100 to 300mg. Put everyone on the same dose at 100, why even put 300 in the equation? The other thing is 100 milligram aspirin is incredibly cheap. I take 100 milligrams myself and the most amazing thing is it's the cheapest medication ever. I get four months-worth for $2.99 at Chemist Warehouse and not a proprietary brand… not a generic but the real McCoy. $2.99 for four months! There is no better bargain in the entire pharmacy. I don't have a problem with people 50 years of age being on aspirin. I know that some studies are now wondering whether it's safe for the average risk person to be on there but I'm not convinced that it's a problem.

I: Ah okay

P: This is also very strange this business of being on it for 2.5 years. It's not clear what they mean by that. Does that mean that they should be on it 2.5 or we can stop it afterwards or not, don’t know what it means?

P: Okay sure talk about the others?

I: Yea sure

P: “Recommendations for those at high risk of colorectal carcinoma. Those with high risk due to Lynch Syndrome carrier status should be advised to begin aspirin when they begin colonoscopy. Usually age 25. Non-syndromic familial cancer patients should be at least considered for aspirin, bearing in mind the possibility of adverse events. 600 milligrams per day has been shown to be effective but lower doses may be as effective.” So what I think about that…

*[PAUSE]*

P: Because Lynch has an 80 percent chance of getting cancer. I must admit, my Lynch patients don't seem to have that chance of cancer but because theoretically, then I think it should be on a maintenance agent. And the idea of non-syndromic, that just means people who haven't been able to prove that a lot of these people actually might have Lynch and they just don't have picked up the right genetic marker. So there some of them are not that different to the other group. And I think they really need to get an answer to whether you do 100 or 600. And again, I don't like the uncertainty. You've got guidelines you have to tell me you can't say six hundred maybe a hundred, you have to say what you want in a guideline. This is wishy washy.

P: Next one, “should be avoiding those with uncontrolled hypertension” - Agree. “Helicobacter. Breath test and treatment for those who test positive can also be considered as gastrointestinal toxicity from aspirin is enhanced in the presence of Helicobacter pylori” - That's really interesting. A study just came out by Neville Yeomans, Professor of Medicine who used to be at this hospital, did a meta-analysis of exactly that question in the ‘Journal of Gastroenterology and Hepatology’ this month. Nice meta-analysis and he had not come in with the figures but he did show that you get with aspirin, with aspirin or NSAIDs, no it was with aspirin, more peptic ulcers if you actually have HP.

“Current dyspepsia in the history of peptic ulcer. Aspirin allergy…”, well some of these are obvious, aren’t they? “Increased risk of gastrointestinal such associated oral anticoagulants or any platelet agents.” Yes - so these are mostly obvious. If you're on an oral anticoagulant or another anti platelet, you wouldn't be an aspirin you don't need to be on aspirin and it's all high risk.

P: Okay. What's the next question?

T: So, are you aware of the potential benefits and harms of using aspirin to prevent bowel
 cancer?

P: The only harm I'm aware of is gastrointestinal bleeding. I mean that must account for 99.9% percent of the side effects people get with aspirin. And the benefits... well I don't know if the literature supports it. I'm guessing if these guidelines say to do there must be some literature that supports it but I'm not personally aware of it.

I: So you don't know much about the evidence around the guidelines?

P: Absolutely not. You know the current guidelines I printed off because I want to read them, the current ones that came out about a week or two ago. They were… there must have been about two or three hundred pages. Two or three hundred pages; that thick - put it aside for my next vacation to read it. So how could anyone know the evidence stuff, that's how thick it was. Yep. And again, you want to simplify things. Okay.

I: And do you have clinical experience with the harms of using aspirin?

P: Yes. Yeah. I've been a gastroenterologist since 1993. I'm on call this week and I'll be doing emergency scopes and guess what? Some of them will be GI bleeds from aspirin. Although most of the people on aspirin are for good reason; they’re usually people who have ischaemic heart disease or whatever. I must admit I don't… you know it's interesting. I've seen a lot of people who have peptic ulcer disease from aspirin who have a great reason to be on it. You know, they have ischemic heart disease, a stroke, TIA whatever. I cannot remember someone getting, and it's a lot of people healthy people like me who take aspirin 100 milligrams. I never remember seeing peptic ulcer disease in there and that would be an interesting study to see although we say that aspirin has a certain increase, is it different for people who have a good reason to be on it or people like me who don't? Because the other group we see is other NSAIDs in healthy people. And healthy people aspirin, I don’t know, maybe they're just more resilient they don't actually come in with peptic ulcers like the old geezers. And so that's the answer.

I: And when you consult with patients, what bowel cancer prevention strategies do you incorporate into the consultation?

P: I must admit. I don't. Other than regular colonoscopy.

I: Do you think it's part of your role as a gastroenterologist to consider these kind of things?

P: 100%, if someone could show me there was decent evidence that did support these guidelines then I would tell all the people who…well when you say for average risk people, I mean I don't see average risk people, I only see people with polyps, because the average risk people are not seen by gastroenterologists. They don't ever come to one. They are just seen by their regular GP for the yearly checkups. So really the question should be for GPs. The question for us is when someone has had polyps before, do we put them on aspirin? Well according to these guidelines if it's good for an average risk person, that’s probably someone without a polyp; then it probably is good for someone with a polyp but again, we would want the evidence. Because you've talked here about average risk and then high risk. But the intermediate which is the ones we see every three years or five years for polyp follow up - that's not really addressed by these which is interesting. That's a big gap. And that's the only ones a gastro sees.

I: Yea that’s something to look at.

P: I mean look, we see a few lynch people but there's not much, mostly just the sporadic polyps.

I: Mm hmm. And you mentioned that GP is also play a role in this?

P: Well when they talk about average risk people, 50 to 70, they’ll all be seen by the GP they have no reason to see a gastroenterologist.

I: Ahh okay. And do you currently recommend aspirin any of your patients?

P: Not for… I haven't recommended yet for the for prevention of polyps or prevention of colorectal carcinoma except for those people have syndromes I've been recommending but I just don't have many, I mean none of us have many people with Lynch. It's rare. For them I recommend it but not any of my other polyps or any of my other normal family history of colon cancer.

I: And what do you think of patients who feel about using aspirin preventively?

P: Well that’s hypothetical. “What would they think?” You know, I think the people who already take tablets for something find it quite easy to beguile an extra tablet. So, someone's already on a cholesterol tablet, they're on a high blood pressure tablet, it's easy for them to add aspirin to that. But for someone who's on no tablets and some of these average risk people, then it's hard for them to start with the doubt that they're not used to it they won't remember. They'll give up after a while. So that's my answer.

I: Okay

P: I'll tell you one tiny thing which I think is acceptable for that machine. I had a patient the other day and the woman was like this she was average risk and she was on aspirin. I said: “How come you on aspirin, on low dose aspirin?” And she said “Well doctor I'll tell you why. Because my husband he's had a heart attack and he needs to be on half an aspirin a day. So, I break in half and I do not want to waste the other half.” So obviously she didn't mind but your average person may find it difficult. *(Laughter)*

I: And have you had any feedback from your patients who are on aspirin?

P: As I said my only patients on aspirin those who are the ones who have who have high risk polyps - Lynch syndrome and so on. And no, there's only a few of them I don't recall having feedback and I don't recall any of them getting into problems and I in all my gastro time have never seen someone who was on aspirin for polyps who came with the bleed. As I said the people who come into those who seem to have had heart attacks and stents and have a really good reason to be on it and you wouldn't want them off it.

I: And how would you go about explaining the potential benefits and harm to aspirin to your patients?

P: Just as I've explained to you that the main side effect of aspirin is causing ulcers and bleeding and it can be severe of cause you to end up in hospital with a life threatening bleed and the benefit is that it prevents the formation of polyps which prevents the formation of bowel cancer. And the scientific studies have shown that on a risk benefit analysis, it's probably safer to take the aspirin although it's always possible to get side effects.

P: Ah okay. And is any information you'd use to help put this?

P: You mean like visual guides and DVD and, you know, if this became widespread it would be great to have a little video you could tell a person “Go and watch the video” and it’d give a better explanation than me and will save me time. So yep. Why not, if it became widespread.

I: Would something like this be useful?

*[Interviewer shows ‘expected frequency tree showing the effects of aspirin on the incidence of events over 10 years of taking aspirin for at least five years in Australian men and women aged 50–70 years’ to participant GA011]*

P: Oh you've already done something… Nooooo, I can't even understand this! (*immediately*) OK. I guess firstly. “Expecting frequency tree…” Nah, this is for scientists.

I: Too much information?

P: “Expected frequency…” I've never even heard the word frequency tree before, I think I know what you mean but… “showing the effects of aspirin on the incidence of events over 10 years of taking aspirin for at least five years and Australia...” Noo. At this time of the day; I'm struggling to understand it.

I: Fair enough

P: …I have just finished clinic, but you understand what I mean right? The average patient won’t get it. No, there's other more effective ways of doing it. I just when I got thinking when you mentioned - would video-aids help? I think in a way video would. When we explain things to people, we generally go through the same line of reasoning I did, that aspirin can cause these particular side effects and aspirin can lead to this particular benefit and scientific studies showing that actually the benefits more than the risk. And if you'd like to do it that's fine, you just have to understand that there is that small risk but the risk is thought to be less than the risk of getting bowel cancer. A little video just for two minutes is better than a still because that's a still there and it's still different to get it. We used to it as scientists to understand it an abstract from an article, but not patients.

I: Yea definitely. Two general questions to finish up. Generally, when there is a new guideline head. How would you find out about it?

P: Okay, so this particular guideline *(colonoscopy surveillance intervals for polyps)* came to me with the GE Society of Australia, was fantastic. I don't always read their stuff but they they can say a new… they've actually sent out a special email saying the guidelines came out and that interests me because I'm interested in luminal gastro and then they send out ones that sorry we made a mistake, it won’t come out till next week. So, it really got my interest up. Maybe that was a ploy. And then when it came out next week I was really interested. Now as I said I actually downloaded the 200-300 pages which is wrong for the environment, but I couldn't read it on the screen and really wanted to digest the information. So, for me, I don't know if all gastroenterologists get emails from the GE society, and I don’t know if they read them, but that’s how it got to me.

P: Okay. And was this recently?

P: Oh yeah. These guidelines came out like two weeks ago max, wasn't even three weeks you’re hot off the press. If we're talking about the same guidelines? Are we talking about same guidelines, they became official two weeks ago?

I: Yeah.

P: It wasn't released through just two weeks ago Max. Okay. So, it's hot off the press and I don't know how else they are sending info to people.

I: And how do you incorporate new guidelines into your practice.

P: We've got to read him first. I won't have to worry about incorporating because a lot of what they say becomes institutional. What I mean is, they're not going to reimburse colonoscopies unless they fit with the guidelines, as not a matter of we're thinking if. I'm going to have to because the government's not going to reimburse people that don’t fit in with the guidelines in the near future. So that's one way of making us do it. It's quite heavy handed but it’s one way.

I: And have you had any challenges when you’ve tried to incorporate guidelines?

S: You know, you have challenges exactly the same challenges every single day of medicine. I've been in clinical this afternoon and there's been two people, who I said “This is what I would recommend” But they’ve been like “Nah Nah. But I want to do it the other way.” You only need gastroscopy every two years now. “But I'm worried I won't have it every year.” But really, it's hard to justify because “I really won't have it every year.” It's a given with guidelines. The other thing is that people have been told one thing in the past and unlike doctors, they don’t understand that scientific knowledge changes. Someone's said “You have to have a colonoscopy every two years”. It's very hard when someone’s convinced them to do something different, with guidelines. The guidelines talk about a lot about intervals of colonoscopy. When someone has been told something before, they actually love to continue doing it. On the other hand, some people, not many like that at all, “God only every five. It’s fantastic I had to come every two years.” Most people actually stick to what they've been doing as some doctor told them and they don't think the knowledge changes

I: And do these challenges vary between your private vs. public practice?

P: ummm no I can’t, I don’t know. Both have these things where patients think differently to you.

I: And finally, would you say you're more likely to be an early or late adopter of guidelines?

P: Well, as I mentioned, in this particular case I'm going to be an early adopter because it's an interest of mine. I don't know who else downloaded it within four days of it coming to read it. I have an interest in it and will be doing it. Although I hope they’re simple enough. Like what I'm saying is, if there's 100 categories it's it's… we're looking at a patient you think where the bloody hell do they fit into this category? - you don't know. So, I will adopt them because I want to, only if they're actually simple to do. And hopefully they've done them that way. I haven’t had the chance to digest the material. It's all about simple enough to use.

I: That's all the questions I had in anything and learned about this now?

P: No.

I: Thank you so much for your time I really appreciate it.

P: Most welcome. I certainly hope you de-identify that one.

*Fields notes: He was very welcoming and friendly. He had recently looked at the guidelines following an email from GESA. He is accepting of them, but with a few questions --> 1. on ambiguity of dose (100-300mg) and 2. how 2.5 year of taking aspirin provides benefits after 10 years. He is unsure of the evidence but happy to read more - however, he lacks the time to do so. He is aware of the pros and cons. He currently recommends aspirin to high-risk patients, but doesn’t' have many such patients, nor does he see average risks. He mainly sees 'intermediate risk' patients whom have had polyps removed and are under surveillance. He would like to see guidelines on this at it is more relevant to him. He does not do much for routine prevention of CRC but believes GPs play a role here. He found the EFT to be hard to interpret / understand. He suggested that a short 'video' explanation might be a better option. Overall, was very patient after outpatient’s clinic and welcoming of the guidelines; however, wants more concrete evidence.*