### GA001

I: Okay no worries. Now I’ll move onto asking about the guidelines themselves. So um, what is your understanding of the Cancer Council Australia guidelines about using aspirin for preventing bowel cancer?

P I must admit that when you first asked me to participate, I had to look them up, to check what the guidelines actually were because I wasn’t fully aware that there was a release as far as bowel cancer prevention and aspirin usage.

I: Okay.

P: Ahh, and, the most useful website was one which ahh, I think John Smith may have co-authored; but it gave an overview of the evidence behind it.

I: Okay, okay, I have a copy if you’d like to have a look.

P: Yes.

*[Interviewer shows laminated copy of CCA guidelines to participant GA001]*

I: Is that similar to what you saw?

P: … yes, it is very similar to what I saw. What I found most useful in the site was the how many people you need to treat and for how long before you got a benefit. Because it did seem that you would need to treat quite a few people for prolonged period of time before a benefit was seen and the only other thing that didn’t come into consideration or one of the things which didn’t come into consideration was how having regular colonoscopies might impact on recommendations, etc.

I: Okay…

P: … so what I’m getting at is that gastroenterologists are a little bit biased in that a lot of their patients are already doing regular colonoscopies and that in itself with removal of polyps is preventing bowel cancer. What we don’t know is how much extra advantage is giving aspirin on top of that.

I: Okay, so what’s your opinion on the recommendations themselves?

P: Ahh, I‘ve got no problems with recommending it and I think it’s a good thing that GP’s should be discussing with their patients and considering having it. I do as I have previously discussed with you, have a slight bias in that I’ve been involved in research looking at gastric injury from aspirin and demonstrated that even low doses can predispose to GI bleeding and GI bleeding events. Ahh, and so I personally at the moment don’t on a routine basis recommend aspirin but if a patient were to ask me what they can do in addition to having their regular screening, I often discuss diet and I’m quite happy to suggest aspirin to them as well in that setting.

I: And so you mentioned talking about diet a few other things; is there anything else you routinely recommend as part of bowel cancer prevention strategies in patients.

P: Well apart from regular… you know, because I’m again, biased I start of by saying you know, “keep up the regular surveillance”. Ahhh, but diet, exercise and into my equation would come aspirin as well. Alright?

I: No worries. And um, are you aware of the benefits and harms of aspirin?

P: Yes.

I: Can you tell me a bit more about what your experiences with that have been?

P: Ahh, as far as benefits okay – so you’re impairing platelet function a little bit so there’s an increased risk of bleeding; but minimal. You know, we’re quite happy to do procedures nowadays, with people on aspirin and even take off large polyps while people are remaining on aspirin, so your risk of immediate bleeding for any intervention is pretty minimal. But your risk of a GI bleed which can be life threatening is still present. But it’s more in people who might have pre-existing ulcer disease. So, if there were a history of any pre-existing disease then I’d recommend to people that they be on a co-prescription of a medication that reduces the acid in their stomach in order to prevent any problem that may be associated with aspirin. Now, the effects of aspirin on the gut are basically two-fold. Particularly the stomach, is a direct irritating injury from direct exposure and then there’s a secondary effect from prostaglandin inhibition after absorption of the aspirin.

I: Okay… have you had experience with many of your patients being affected by the harms of aspirin.

P: Of the patients I might see who might present with bleeding; it’s usually my first encounter with him and they’ve had aspirin exposure that might have contributed. But as far as patients I’ve got that I’ve initiated aspirin, I’ve not had any significant issues with the initiation.

I: And are there particular types of patients you would or would not consider aspirin for?

P: Ahh… it’s a bit hard to say. Look if patients are already on significant anticoagulation therapy I often don’t co-prescribe, but cardiologists often do. And I’ve got no problem, but I tend to steer away from having them on too much impairment of platelet function or clotting ability. So, if they’re already on clopidogrel plus a blood thinner, I’d probably steer away from aspirin. The other situation where I would try and stop it would be if there’s recurrent GI bleeding from the small intestine and we sometimes steer them away from aspirin if we can… you know, recurrent anaemia associated with say small bowel angioectasias, so vascular lesions in the small bowel which are bleeding that we can’t control.

I: Okay. And in terms of initiating aspirin are there particular risk group patients that you’d consider it in more than in others?

P: Ahh… yeah I’m not sure how to approach that… how to answer that. In particular risk groups which I would?

I: Like um, which you would consider recommending aspirin to for example like Lynch syndrome or high family risk?

P: Look well the high family risk ones, yes, certainly. Most of my comments thus far relate to average-risk patients, so general average risk rather than the high-risk groups. Certainly, with the high-risk groups – solid family histories, Lynch syndrome, Familial Adenomatous Polyposis; I’ve got no qualms with them being on aspirin or an anti-inflammatory to reduce polyp recurrence. And we probably as a routine recommend it in that situation, but that’s a very small grouping. Ahh, and a lot of the familial polyposis or Lynch Syndromes actually come to specialty units rather than seeing gastroenterologists in private, so you’re not getting that many of that group of patients coming through. So, the bulk majority of my patients are patients with perhaps a family history but not a strong family history of colorectal cancer – brother, sister, parent with… sorry [INTERRUPTED by knock on the door].

P: Sorry about that.

I: That’s okay.

P: … so yes the high-risk groups; definitely appropriate to be having them on something that would reduce polyp recurrence. They still need to embark on their regular surveillance though as well. But the lesser risk groups, so the low-risk to moderate-risk you know, surveillance is the main thing.

I: And in terms of even the average-risk population, do you think it’s part of your role as a gastroenterologist to recommend preventative strategies?

P: I think yes. I think it can come into the discussion with the patient, but also in discussion with general practitioners as well. Absolutely.

I: And with your patients, what do you think they would feel about using aspirin preventatively?

P: A lot of them are already on aspirin and a lot of the evidence base that the recommendations are on are as a secondary spin-off from studies where it’s been used in cardiovascular prevention or stroke prevention. A lot of the patients we see are already on aspirin initiated by other specialists or by their GP as part of general prevention in those areas.

I: Okay…

P: And… Oh no you go on.

I: Oh you go on…

P: Nah I’m fine [laughter]

I: And um, how would you go about explaining the benefits and harms of aspirin to your patients?

P: Ahhh, I would outline just not only the benefits from the point of view of the bowel, but other potential benefits – cardiovascular, stroke prevention wise. What would be useful is to have… and I don’t currently have this for display for patients; is some sort of graphic which gives them an idea of how many people would need to be treated for how long to get a benefit or to prevent a problem. And there are various charts that are available that can help display that. I often find communicating risk to patients can be difficult and their understanding of what might be the potential benefit can be limited at times, so something of an audio-visual display would be helpful.

I: Okay, on that note…

P: That was unscripted [laughter]

*[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 GA001]*

I: This is research compiled, based from a few different studies. I think it’s 5-year incidence… or is it 10?

P: 10-year incidence. 5 years of aspirin use.

I: Yes 5 years of aspirin use.

P: So, you need to have 5 years of aspirin use to reduce bowel cancer risk from 131 to 99.

I: So, what’s your understanding or what do you think of this expected frequency tree?

P: I think that’s a good display. Ahh, so, this… the interpretation is that these individuals would have to be on aspirin continuously for 5 years or longer. Okay. So that sort of display would be helpful in helping to explain issues to patients. I think it would be very useful for GPs to have something like this as well.

I: And do you think you would use something like this potentially as well?

P: Ah yes, I think gastroenterologists could use it as well. But a lot of the initiation of aspirin is more in the general practice setting rather than in the gastroenterologists initiating it. Because the GP is looking hopefully at the patient in a more global perspective and considering other issues such as their cardiovascular health or their cerebrovascular health. I mean, we do consider it, but we are focused more on the gut than anything else.

I: Moving onto the last few questions.

P: Yes.

I: In terms of generally, how you implement new guidelines – if there’s a new guideline in general, how do you find out about it normally?

P: Often at clinical meeting. So, where they might be an overview of guidelines which are presented or in the literature - you know, certainly gastroenterology literature where they may be re-printed in the journals that we read. So, they’re the two main areas. It is very rare for us to get a post out related to a new guideline. And that’s something that I think, which might be of assistance. But I can’t recall having a post out of a guideline. But what would be useful in addition to this is what I talked to you about before. It would just be having a reference or weblink to a page like NHMRC where the evidence behind all these is discussed. And that the doctor at his leisure can easily go to that site and just go through the information that’s involved.

I: And how would you go about incorporating new guidelines normally?

P: Ahh, look I take them on board. You know, I appreciate they’re guidelines and they’re not mandatory, and if it fits in with the way I would practice, I’m happy to sort of incorporate them into what I do. Ahh, certainly. But part of the problem is awareness – you’ve got to be aware of the guidelines as well.

I: And have you had any challenges when you tried to implement the guidelines, at different hospitals for example?

P: No, there’s usually not too much trouble with implementation. But whether there’s a perceived extra advantage in some of them. And what I was getting at with before, yes, we’re reducing bowel cancer risk, but how does that… if you’re already surveilling patients. We’re looking at a select group of patients – how much extra advantage is there? And that question is not answered. Say in this graphic, this is sort of taking the population as a whole, whereas we’re dealing with a more select group of patients. So, some gastroenterologists may be harder to convince.

I: Lastly, are you likely to be an early or late adopter of new guidelines?

P: I would hope I’m relatively early, but that’s a biased question almost isn’t it? [Laughter]. Cos you don’t want to think you drag behind everybody else.

I: So do you usually wait for other people to implement them first or…?

P: No no no look, I’m happy to sort of try and be, in most instances, near the front. Ahhh, not right at the front, no, but near. You know, you want to be trying to do what would be considered to be best for your patients. And some of that means, following guidelines, if they present good evidence. Ahh, so yea.

I: Well, I think that’s all of the questions I had. Is there anything else you’d like to add?

P: No, I think you’ve covered things very well. You asked the questions very well and that was good.

I: Thanks.

S: Can I just… the thing that’s really interesting because we do a lot work with general practice obviously; so it’s really interesting - that difference with the aspirin initiation and the obviously context that you’re using it in is with people who’ve already come to you with something as opposed to…

P: I’ve previously never seen it as my role to initiate aspirin and always had a… well, you know it’s a research bias, is you have a negative view of aspirin from a gut perspective okay. Because of the bleeding issues and when we admit problem patients, they’re often admitted with bleeding and aspirin may be a contributing component. So, we have a negative bias there.

S: Yes.

P: Yes, we’re well aware of the literature related to anti-inflammatory drugs and reduction in polyp incidence in Lynch syndrome. Ahh… but, we’ve never been initiators of aspirin at all. We’ve left it to the cardiologists where the evidence is fairly strong, and the neurologists – so for stroke and cardiovascular disease where this very solid evidence. But to convince gastroenterologists you need to say “but look, over and above your regular surveillance; you’ve got this extra advantage”. But the trouble is that all the studies are actually studies where aspirin use in bowel cancer prevention has not actually been the primary aim of the study.

S: And also if somebody is having polyps removed?

P: That hasn’t come into it… into the equation. You can’t sieve that out. You can’t separate that. So, you don’t know. And when you think personally, okay “do you want to take aspirin every day for 5 years or more before you start to see a benefit?”. It’s a fair while to take aspirin.

S: Terrific. I think we probably won’t hold you up. That’s been good, you’ve done it in well under half an hour.

P: [*Talking about* EFT] But that’s the sort of thing you need to display to patients. You know, 10,000 people treated for X period of time. You know, so that needs to be clarified; that that’s your reduction, but that’s not taking into account surveillance.

S: Yep.

P: But that’s general population.

S: Fantastic.

P: *[Still reading and talking about EFT]* Yep. Yes, current dyspepsia, that’s sort of what I was getting at. ‘Uncontrolled hypertension’. See I don’t really see the uncontrolled hypertension.

S: That’s great.

P: Alright.

S + T: Thanks.