### GA006

I: So, this is GA006 and it’s the 28th or March, 11.30am. So, I just want to ask you, what is your understanding of the Cancer Council Australia guidelines around using aspirin to reduce the risk of bowel cancer?

P: Um, actually I haven’t read them. So my understanding is zero.

I: So, I have a copy them here. You can have a look at them. Let me know what you’re thinking as you read them and let me know what your opinion is I guess.

*[Interviewer shows laminated copy of CCA guidelines to participant GA006]*

*[GA006 takes some time to read the guideline summary].*

P: Okay.

I: So, what is your opinion or understanding now?

P: Ah well my understanding is that the anti-cancer people are recommending it for people aged 50-70. They’re recommending a dose which is unproven; and a dose which I see a lot of complications in hospital from. So, I have some issues with that.

I: Which dose are you talking about?

P: 100mg. We see a lot of patients with anaemia, GI bleeding. Usually with something else as well as the aspirin, but it’s not a risk-free drug in my mind.

I: Can you tell me more about what sort of side effects of aspirin you’ve dealt with?

P: Well we see the GI bleeds, the upper (GI?) bleeds from it; We see a lot of unexplained anaemia where people have been on aspirin as well.

I: Okay. And do you know much about the evidence around these guidelines?

P: No, the evidence for these; no. I used to know the evidence for non-steroidals in the polyposis syndromes and I looked at a number of the trials and they actually found it very hard to prove that there was a clear benefit. And I have to admit, I haven’t had presented to me; a clear prospective study where these benefits have been shown.

I: And um, have you seen much of the benefits of aspirin or have you really only seen the harms of aspirin?

P: Well, the benefits of aspirin are actually invisible because you don’t see them. So…

I: True. Um, so when you consult your patients normally, what bowel cancer prevention strategies do you incorporate into your practice?

P: Ahh… screening strategies. I mean there’s no good evidence for dietary ones that I talked… Stopping smoking – clear risk. Keeping your weight down. And adequate screening.

I: Okay. And do you think It’s part of your role as a gastroenterologist to consider these primary prevention strategies?

P: Ahh when I’ve seen the data that convinces me, yes. But I haven’t seen that data yet.

I: And do you think anyone else plays a role in this?

P: [pause; looks confused]

I: Like any other clinicians or anyone else you think?

P: Well, if the GPs are convinced by the evidence then I don’t have a problem with them starting it.

I: Okay. And do you currently recommend aspirin to any of your patients?

P: No.

I: Okay. And are there any particular patients that you may consider aspirin; in terms of their risk stratification.

P: Well, the patients that I see – there aren’t many that who we’d call a low risk stratification. So, people with Inflammatory bowel disease; I’m not going to be recommending aspirin for them. People with end stage liver disease; I'm not going to be risking aspirin for those. They form the bulk of my population. So low risk normal people who don’t have a bowel problem which is a relative contraindication – I don’t see very many of.

I: Do you deal with anyone with Lynch Syndrome or any other high family risk of bowel cancer?

P: No the Lynch syndrome I tend to refer on to my interventional endoscopy friends because they need regular scopes. Yeah.

I: Right. And what do you think patients may feel about using aspirin preventatively if they had to.

P: Um, most of my patients are keen for a preventative medicine; as long as it doesn't involve taking pills. So diet other things like that and they're very willing to take alternative medicines all the time. But when I start talking about medicines they’re not so keen.

I: Okay and have you had any feedback from any patients who've taken aspirin?

P: No.

I: How do you think you would go about explaining the benefits and potential harms of taking aspirin to your patients.

P: Umm…. If I was going to explain it to them, I have to say there's no immediate benefit from it. This is something which is going to show up in five to ten years. It's not an absolute preventative factor. It only reduces it by 25% I think – figures usually quoted around. So, it's only a relative improvement. And in general, most of my patients have other significant risk factors which was smoking, obesity and alcohol consumption. And I'm going to be working on those much harder than I am at pushing the prophylactic aspirin.

I: And is there any supporting information that you think you might use with this?

P: *(pause)* Um…So… the only way would be to argue that it’s like hypertension in that treatment now prevents the risk of having a stroke or a heart attack long-term. There are multiple studies which demonstrate that. But the evidence I’ve seen for this is not strong enough for me to be convinced.

I: Yep fair enough. This is the expected frequency tree which came out and sort of explains things to patients. So if you don't mind having a look at it. Let me know what you think and whether you might consider using something like this to explain to patients.

*[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 GA006]*

P: No *(immediately).* Far too complicated. My patients sort of... probably something like 60 percent of my patients, English is their second language. Even with English as my first language, I'm struggling to work out what this means. At best I like the frequency diagrams where you have a thousand patients on one side and six of them get this and one hundred and twenty get it on the other side. I can see this but this has got three or four different complications and under that and we have to balance up the risk between them and to me; not many of my patients would find it useful.

I: Do you think there’s too much going on?

P: Yes, there’s too much information on it.

I: Okay thank you. And last section’s just a few general questions. So generally, when there is a new guideline, how would you find out about it?

P: We have a presentation at our meetings and discuss it or in one of the journal clubs I go to.

I: And how do you go about incorporating new guidelines into your practice?

P: It depends how central they are to my practice. So, if there's something I'm doing all the time and they have a direct impact - it's relatively easy to incorporate them and do them. If there's something like this which I consider peripheral to my practice and not appropriate to the vast majority of my patients; until someone hammers me repeatedly about it, it doesn't happen.

I: Okay. And have you had any challenges when you try to incorporate guidelines into your practice?

P: *Pause as he thinks…* No, the challenge is my mental status making sure I remember to do it when it's a change in practice from what I’ve done before.

I: And any difference between private and public in that regard when you try and incorporate guidelines?

P: Ah, the patients we see, none... I can't think of a patient in our patients whom I would have even considered about prophylactic for because they’re always in with major problem. So, it’s quite irrelevant to the hospital practice.

I: Okay. So maybe more in private potentially?

P: Well, again the vast majority of what I see in private - they're not the right patients. This sort of thing has to be done through the primary care, in my mind.

I: And lastly would you say you're an early adopter or a late adopter of guidelines?

P: I’m not sure about guidelines; in terms of new treatments - I'm an early adopter and pusher. I go to the meetings and find out and bring them back and present them. But I push people to change or not change.

I: Okay. That’s all the questions I had, is there anything else you think about this

P: No. *(Talking about the EFT)* This would not go down well in the population. I'd say it's far too complicated in terms of colour-coding. You have the same colour of benefits and complications. And so, it's hard to work out what’s good and bad. I'm going up there and... I'm going to say I was brought up in the time that they were pushing that we should all be put onto a beta blocker, a statin and aspirin. And, I favoured that in talking to people and talking about education about those; but not for bowel cancer.

But then when the big study came out last year looking for any clear benefit of aspirin in the population and they couldn't show it. Actually, I got seriously depressed because we see so many patients who are on triple therapy, anti-platelets with aspirin and bleeding from that so it biases...

I: Is this the ASPREE study?

P: Yeah

I: I’ve got a summary of that here if you’d like to have a look.

*[Interviewer shows the summary of ASPREE study to participant GA006]*

I: Some people often get that confused with these guidelines. I think that was an older population and the follow-up period was about 4.7 years.

P: Yeah you mentioned the life survival, you’re meant to be surviving for about 10 years for this. *(pause whilst he reads).* But, if the trend at this time after 5 years, or 4.7 years is against the trend that you want that's unlikely in my mind you're going to find a trend in the right direction by following it for longer. So, I have to admit I haven't gone back and read the original studies that this is based on But, 20 years ago when the first work came out and they were looking very strong and at the use of non-steroidals and aspirin in the multiple polyposis syndrome, I know they were finding it very hard to get a clear benefit. So… but then obviously I haven't followed the evidence strongly enough to know how strongly based these are.

As a science-based person, yes, it's something I'm happy to present to the public but I want to roll up the confidence limits - how many studies are behind this, what sort of population size, what are the exclusions and that data; so presenting this to me, is saying… You're just another stumblebum coming into the system. Actually, what is this based on three trials? five trials? based on 5,000 people? based on total 220,000 people? What are your confidence limits? The shifts? What patients were excluded in the baselines? [Would like to know this information] So they *(population)* know about that.

I: Thanks a lot for your time. I really appreciate it. Thank you.

*Field notes: He was nice. Also skeptical about using 100mg aspirin - well averse to the side effects and skeptical about the evidence. Not a fan of the EFT - think it will be too complicated for his patients (many NESB). He deals with a different patient demographic, so aspirin prescription is not that relevant for him. He also brought up ASPREE. Overall, despite having his doubts, he was welcoming of the study / research into this topic.*