

Colorectal cancer screening awareness in European primary care[☆]

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Abstract

Background: Adjustment for stage at diagnosis markedly reduces USA versus European colorectal cancer survival differences and a screening bias was therefore suspected. Moreover, little is known about colorectal cancer screening habits in European primary care and the history of guidelines implementation. The purpose of the study was to index the overall colorectal cancer screening attitudes of European physicians involved in primary care activities. **Methods:** A systematic literature-search was performed in three major medical libraries: PubMed/MEDLINE, ISI web of science, and COCHRANE. **Results:** We found only five eligible studies, but valuable data were presented only in four. Colorectal cancer screening was recommended by 65–95% of physicians, but the major part of them implemented it only among high-risk individuals; stool occult blood testing was advised by 42–83% and prescription of screening endoscopic modalities was inconsistent. Most European reports found were not eligible and were mainly focused on diagnostic delay in symptomatic subjects rather than on screening procedures among asymptomatic individuals. **Conclusion:** In comparison with European practice, colorectal cancer screening habits of American physicians are to a greater extent rational, evidence-based and well monitored and have a longer tradition in medical care thus allowing better prevention services for asymptomatic individuals.

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1. Introduction

Colorectal cancer survival in the United States of America (USA) is higher than in Europe but adjustment for stage at diagnosis markedly reduces survival differences. Considering both the different proportion of adenocarcinomas in polyps and the distribution by stage

at diagnosis in the two continents, screening differences were suspected to be a possible explanation for such a phenomenon but no study has satisfactorily analyzed this hypothesis [1].

The survival benefit derived from screening procedures in colorectal cancer had been strongly documented by randomized-controlled trials [2–5] and a meta-analysis [6]. Appropriate colorectal cancer screening (CCS) is therefore counseled by public-health authorities [7–10].

Due to different public health policies, screening practice in USA is mainly based on spontaneous screening recommended by general practitioners (GPs) while in Europe it is principally endorsed with active invitations by the national health services.

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Physicians involved in primary care have a key role in colorectal cancer screening among asymptomatic individuals for both policies: in USA for screening recommendations and in Europe for either implementation of programs with active invitation [11] or recommendation where invitation programs are lacking. Still, little is known about European primary care physician screening habits.

Considering the important role of primary care physicians in screening activities we performed a systematic research of peer-reviewed medical literature in order to identify reports indexing the colorectal cancer screening attitudes of European physicians, and we evaluated the proportion of European physicians recommending or believing in colorectal cancer screening procedures among asymptomatic adult individuals. Data obtained were thereafter compared with USA data.

Furthermore, since physicians' attitudes may be influenced by the implementation of guidelines, their dissemination, their cultural re-elaboration and the process of putting them into practice; and considering that these variables are time-dependent, we briefly overviewed the history of guideline implementation for both Europe and USA, in order to provide balanced evaluations in data comparison.

2. Material and methods

2.1. Identification of eligible studies

We searched PubMed/MEDLINE, ISI, and COCHRANE libraries with the algorithm [(cancer screening OR colorectal screening OR colorectal cancer screening OR stool occult blood test OR fecal occult blood test OR colonoscopy OR digital rectal examination OR sigmoidoscopy OR flexible sigmoidoscopy) AND (primary care OR primary care physicians OR primary care physician OR pcp OR general medical practitioners OR general medical practitioner OR gmp OR general practitioner OR gp OR general practitioners OR family doctors OR family doctor) AND (practice OR prescription* OR recommend* OR advis* OR perception* OR knowledge OR habits OR habitudes OR belief OR attitude* OR periodic health examination)].

We set no year and no language restriction. We also hand searched the volumes of three European Journals that were likely to publish eligible reports, for the last 4 years to ensure that electronic searches would not miss any [12].

All studies coming from any of the following countries were considered eligible: Albania, Austria, Belarus, Belgium, Bulgaria, Croatia, Czech Republic, Denmark, England, Estonia, Finland, France, Fyrom, Germany, Greece, Holland, Hungary, Iceland, Ireland, Italy, Latvia, Lithuania, Luxembourg, Malta, Netherlands, Norway, Poland, Portugal, Republic of Moldova, Rumania, Russia, Slovakia, Slovenia, Spain, Sweden, Switzerland, Turkey, United Kingdom, Ukraine and Yugoslavia.

With the aforementioned algorithm we also retrieved USA data. Due to the large amount of American reports

available, and in order to provide a comparison with European evidence, we performed a random selection of 20 possible eligible USA reports. Randomization was executed by table of random numbers and it was performed over the same periods (publication-years) in which eligible European studies were available.

Last MEDLINE search was performed on the 14 June 2005, while ISI and COCHRANE search were perused on the 16 June 2005.

2.1.1. Eligibility criteria

We considered eligible all peer-reviewed studies providing information on the proportion of primary care physicians using OR recommending OR prescribing OR believing OR advising any colorectal cancer screening activity (*stool occult blood test, flexible sigmoidoscopy, colonoscopy, digital rectal examination*) among asymptomatic individuals. We evaluated all relevant studies, regardless of whether the corresponding proportion was a primary endpoint or not.

We excluded all qualitative research reports, since their sampling method and stopping rules do not ensure a representative sample, and because the thematic coding of the main findings is formulated *post hoc* by the researchers. Physicians with specialties that are usually encountered in non-primary care setting were excluded from the calculations unless it was clearly stated that they were indeed primary care oriented.

In studies with one or more interventional arms (e.g. cost–benefit education workshops, conferences, educational meetings) where the CCS activity was estimated in interventional group VS a control group (not exposed to the educational program), only the control group of primary care physicians was considered eligible. Similarly, in interventional studies where screening were evaluated among the same physicians before (control arm) and after the educational intervention (interventional arm), we considered eligible only the evaluations prior to educational interventions. Reports purely dedicated to genetic counseling were excluded from the study.

2.1.2. Data extraction and outcomes

Two investigators separately extracted the relevant studies by abstract or by title (when the abstract was not available). Full papers were further retrieved and data consensus should have been reached on all outcome items. In case of suspicion that useful data included in the original studies were not reported in the retrieved articles (and therefore might be available in an unpublished form) the authors were personally contacted.

From each eligible study we recorded author's name, journal and year of publication, place and country of origin, year of patient enrollment, number of physician surveyed (involved in the study), number of eligible physicians for data analysis, eligibility response rate (defined as number of physicians surveyed VS eligible), ordering rate for any CCS test (digital rectal examination, sigmoidoscopy, colono-

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