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Follow-up after colon cancer treatment in the Netherlands; a survey of patients, GPs, and colorectal surgeons

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Abstract

Introduction: Follow-up to detect recurrence is an important feature of care after colon cancer treatment. Currently, follow-up visits are surgeon-led with focus on recurrence. To date, there is increasing interest for general practitioners (GPs) providing this care, as GPs might provide more holistic care.

The present study assessed how surgeons, GPs, and patients evaluate current surgeon-led colon cancer follow-up and to list their views on possible future GP-led follow-up.

Methods: The study consists of a cross-sectional survey including colorectal surgeons, patients who participate or recently finished a follow-up programme, and GPs in the Netherlands.

Results: Eighty-seven out of 191 GPs, 113 out of 238 surgeons, and 186 out of 243 patients responded. Patients are satisfied about current surgeon-led follow-up, especially about recurrence detection and identification of physical problems (94% and 85% respectively). However, only 56% and 49% of the patients were satisfied about the identification of psychological and social problems respectively. Only 16% of the patients evaluated future GP-led follow-up positively. Regarding healthcare providers, surgeons were more positive compared to GPs; 49% of the surgeons, and only 30% of the GPs evaluated future GP-led follow-up positively ($P = 0.002$). Furthermore, several reservations and principle requirements for GP-led follow-up were identified.

Discussion: The results suggest an unfavourable view among patients and healthcare providers, especially GPs, regarding a central role for GPs in colon cancer follow-up. However, low satisfaction on psychosocial aspects in current follow-up points out a lack in care. Therefore, the results provide a justification to explore future GP-led care further.

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Introduction

It is expected that in 2015 more than 14.000 patients will be diagnosed with colorectal cancer in the Netherlands.[1,2] In more than three-quarter of newly diagnosed cases the tumour is confined to a portion of the bowel and regional lymph nodes enabling curative resection followed by adjuvant chemotherapy when indicated. In spite of this intended curative treatment approximately 30—40% of the patients develop recurrent disease in the following years.[1,3—5] After curative treatment patients are included in a surgeon-led follow-up programme with the focus on detection of recurrence and metachronous tumours in the Netherlands. Nevertheless, patients have additional needs, including cancer and treatment related physical consequences, psychological and social problems, revalidation, and other questions relating to functional impairments which are in many cases insufficiently highlighted during these visits.[2,4,6—10]

Concerning different follow-up strategies to detect recurrent disease, intensive follow-up compared to minimal follow-up results in a significant survival benefit favouring intensive follow-up.[4,11] However, there is a large variety in

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follow-up strategies described in literature, each combining a number of different components including frequency and type of clinical assessment and tests.[4,11] Furthermore, there is no consensus about the setting in which follow-up should be conducted; should follow-up take place in the hospital conducted by an oncological surgeon which is common, non-evidence based, practice or is it possible in primary care?

Few studies report on primary versus secondary care follow-up of breast and colon cancer patients.[12,13] These studies show no statistically significant difference for quality of life, recurrence rate, and other outcomes. Furthermore, GP-led cancer follow-up might be more cost-effective mainly due to a difference in organization and physician costs.

It is therefore hypothesized that GP-led follow-up of patients with colon cancer seems safe with equal detection of recurrences and subsequently equal number of resections of recurrences with curative intent. GP-led follow-up might also be more cost-effective. Furthermore, the care that GPs offer might result in more attention for psychological and social aspects increasing patients' quality of life. GP's also argue that continuity of care might be better, as they are often involved in the diagnostic process and palliative care, but not in the chronic stadium of the disease. Nevertheless, in the Netherlands it is unknown to what extent surgeons, GPs, and patients with colon cancer are willing to replace current surgeon-led by GP-led follow-up. Therefore the aim of the present study is to assess how surgeons, GPs, and patients evaluate current surgeon-led and possible future GP-led follow-up.

Patients and methods

The study consists of a cross-sectional survey in the period June–August 2012, including colorectal surgeons, patients who participate in a follow-up programme or recently finished their follow-up after they were operated on for colonic cancer, and GPs. All GPs in the region of the Academic Medical Centre Amsterdam and Almere ($n = 191$) were included. All Dutch hospitals were asked which surgeon(s) operate on colonic malignancies and/or are involved in follow-up. All these (colorectal)surgeons ($n = 238$) were included. The group of patients consists of patients who participated in the LAFA trial (LAparoscopy and/or FAst track multimodal management versus standard care, ISRCTN:79588422), were alive in June 2012 and were willing to participate in future research ($n = 243$).[14] Patients were treated in 9 Dutch hospitals (3 university hospitals and 6 teaching hospitals) and were eligible if they were between 40 and 80 years of age, had an American Society of Anaesthesiologists (ASA) grade of I, II, or III, were to undergo elective segmental colectomy for histologically confirmed adenocarcinoma, and without evidence of metastatic disease. For the present study ethics approval was obtained from the Medical Ethics Committee of the Academic Medical Centre in Amsterdam.

Survey instruments

Separate questionnaires were developed for the different healthcare providers (*i.e.* colorectal surgeons and GPs) and patients. Initially, question lists were developed by collecting and extracting information from literature. The questions were than evaluated by a consensus process by four of the authors followed by a critical evaluation by a psychologist specialized in developing questionnaires. Finally, the questionnaires were pilot tested on GPs ($n = 8$), and surgeons ($n = 5$) at our institution and patients ($n = 7$) who had been operated on for a colon cancer. All the questionnaires included questions on socio-demographic characteristics, how several aspects of current follow-up and possible future GP-led follow-up are rated, questions on possible inclusion and exclusion criteria for GP-led follow-up (*e.g.* hereditary cancer, first follow-up period versus later years with a lower recurrence rate). The questionnaires contained identical as well as specialty(patient)-specific questions to facilitate comparisons across groups. All questionnaires contained some open questions, most questions had answer options according to the five-level Likert-scale.

The patients were contacted with a postal survey, the GPs and surgeons were approached by e-mail in which they found a link to an online questionnaire (online survey software by Survey Gizmo, www.surveygizmo.com).

Data analysis

Participants were asked to react using a 5 point Likert scale with 1 being "strongly disagree" and 5 being "strongly agree"; 4 ("agree") and 5 ("strongly agree") were considered as positive responses, 1 ("strongly disagree") and 2 ("disagree") were considered as negative responses. Descriptive statistical methods were used to analyse the data by using SPSS v.18.0 package (SPSS, Chicago, IL, USA). The Pearson Chi-square test was used to explore univariate associations.

Results

Respondents

In Table 1 the characteristics of the respondents are shown. For patients surgery was minimum 3 and maximum 7 years ago (mean 4.5 ± 1.1) resulting in 118 (63%) patients who were in the first five years after surgery and still included in the scheduled follow-up programme. Surgeons had on average 101–150 patients who were curatively treated for colon cancer in follow-up, GPs on average 1–5 patients. GPs practice size ranged between 330 and 5000 patients (mean 1854 ± 699).

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