PERSONALIZED COLORECTAL CANCER SCREENING STRATEGIES:

INFORMATION NEEDS OF THE TARGET POPULATION

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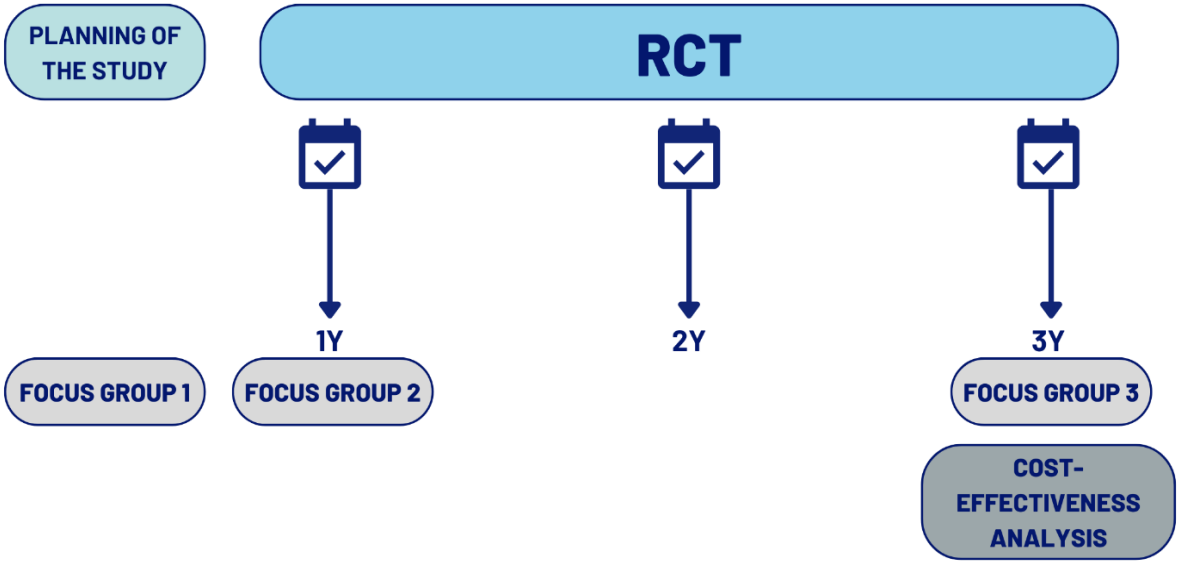
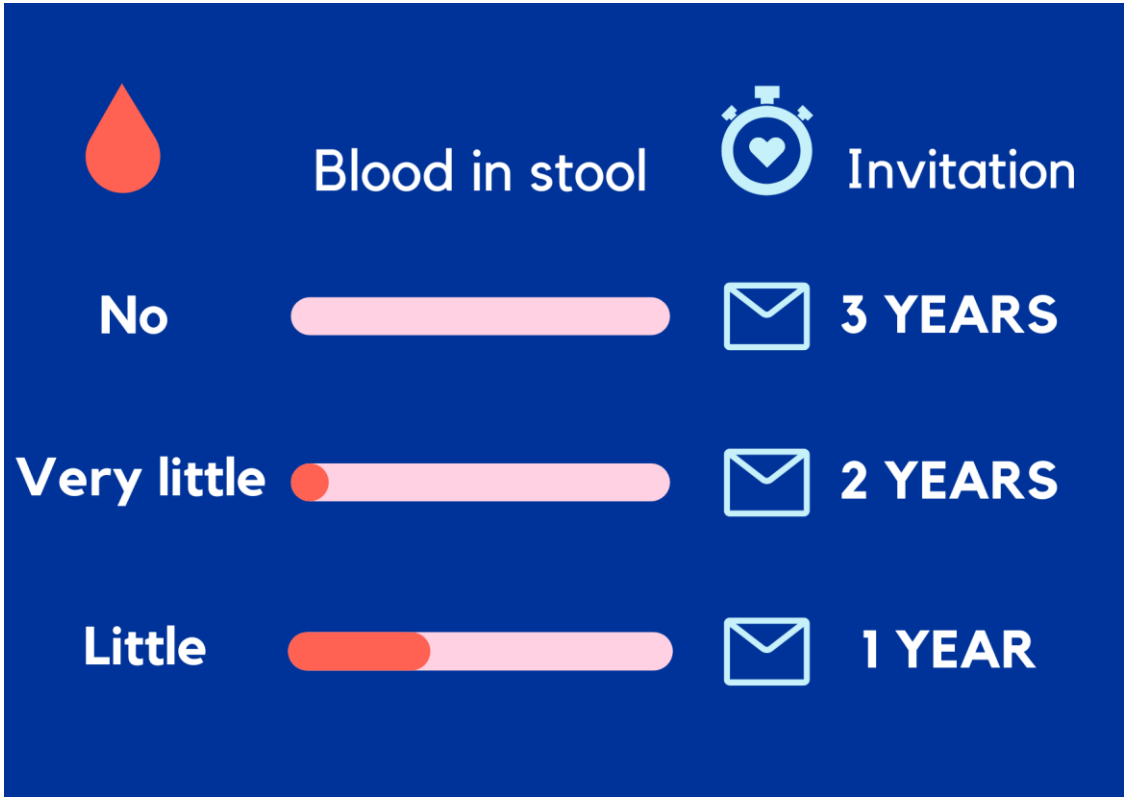
PERFECT-FIT STUDY



Clinical trial registration
NCT05423886


Blood in stool
Invitation
No
3 YEARS
Very little
2 YEARS
Little
1 YEAR

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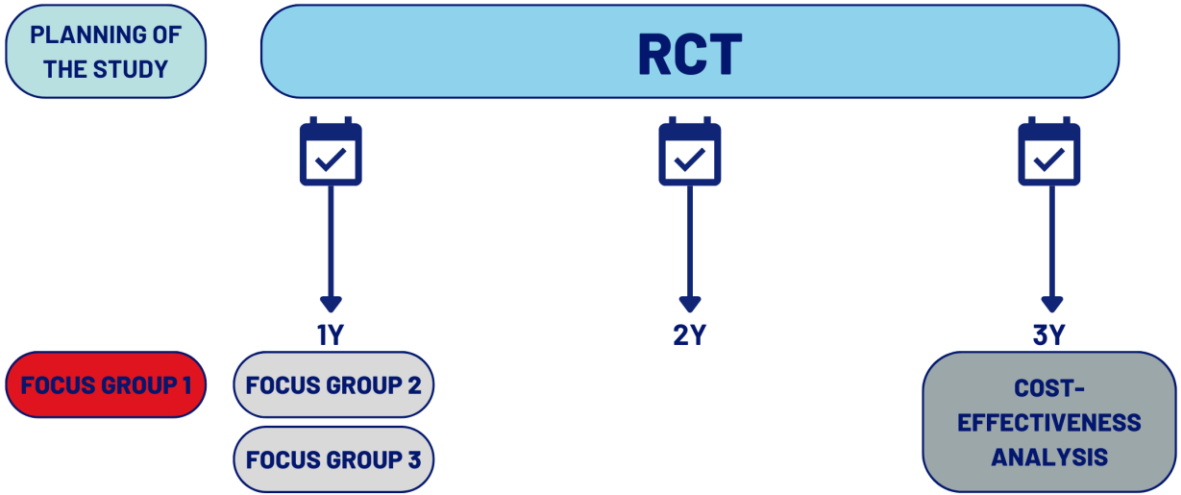

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- Risk stratification is acceptable by the public **if**:
  - Rationale behind the strategies is explained;
  - Public can see that strategies result in greater benefit to the population as a whole

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But what is understandable to the target population?

Especially for those receiving less-intensive screening, clear communication appears to be crucial

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To gain **insight** into **information needs** to make a well-informed decision to participate in **personalised colorectal cancer screening**

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- **3** semi-structured (online) focus groups
- People eligible for CRC screening (i.e. men and women aged 55 to 75) in the Netherlands;
- **Thematic analysis** was used to analyse the interviews

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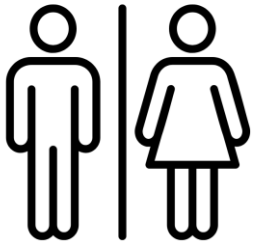
Study population – 14 participants



50% 50%

79% 21%

69% 36%

Views on CRC screening in general

- Benefits
- Harms and barriers

Engagement target population

- Information letter
- Communication channels

Information need personalized CRC screening

- Relevant information
- Presenting information
- Role of GP
- Impact of information on views on personalised screening

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Relevant information - risk communication

- Preferred relevant information **varied substantially**
- **Impossible** to address everyone's need
- All were **unaware** that negative FIT ≠ no blood in stool
  - one person felt misled

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Relevant information - risk communication

*“I wonder if you need to give such an explanation. What I would suggest is **when you test negative two or three times, you say the interval will be extended**. That you can determine that based on your **personal details**. But I **will not** start saying you have a little bit blood”*

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Relevant information - risk communication

*“I think that if there is blood found in the stool during the population screening, but not to such an extent that it is alarming, **I am shocked not to report it**, I think that is a bit **misleading**. You could say in the result letter that there is indeed blood in your stool. **It is not yet necessary to do a colonoscopy**, but monitor it for such and such reasons”*

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Relevant information - risk communication

*“I have the feeling that you will **never please everyone**, **no matter what you write down**. One will think that he gets too much information, the other will think that he gets too little information. One person wants that research earlier, the other wants it later. We are, of course, a country of experts”*

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Relevant information - costs

- Rationale of the study was unclear
- Some thought it was cost-driven

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Presenting information

- Use **figures** or **infographics** to communicate risk profiles
- Use **layered information** – particularly about the amount of blood
- Raise **public awareness**

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Role of the general practitioner

- General Practitioner can:
  - Communicate information that is **relevant** to an individual based on their medical condition
  - Communicate this in a way that is most likely to be **understandable** to individuals

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Impact of information on views on personalised screening

*“I think that at some point people are **willing to participate** in screening, that they will take the risk of that tension. And then it makes **absolutely no difference** whether that is every three years or every two years”*

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1) **Preferences** in risk **information varied widely** among the target population;
    i. A **layered approach** to deliver information on individual's CRC risk;
2) Risk information may have **minimal impact on the decision to participate** in personalised cancer screening;
3) Careful communication of **the rationale for the strategy**.

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Thank you!

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