Low Literacy Can Impede Colorectal Ca Screening

Provider education and feedback boosted screening rates in a randomized study.

BY JENNIFER LUBELL
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WASHINGTON — Physician-directed interventions can increase rates of colorectal cancer screening in patients with low literacy skills, Dr. Charles Bennett reported at a conference on health literacy sponsored by the American College of Physicians Foundation.

Patients with limited literacy "may not be able to understand basic cancer screening information and educational materials, many of which are written at a literacy level above that of a significant portion of the American population," noted Dr. Bennett, a hematologist/oncologist who is an associate director for the Veterans Administration Midwest Center for Health Services and Policy Research.

In a randomized, controlled trial among veterans age 50 years and older seen in two general primary care clinics, the use of provider-directed interventions led to a 26% increase in screening completion among patients with low literacy skills, he said.

No prior study has evaluated the cost effectiveness of health-promotion efforts for colorectal cancer (CRC), but successful interventions have been shown to improve breast and cervical cancer screening rates, he said.

CRC is the third most common cancer in the United States, with the third highest mortality. The American Cancer Society predicts that more than 145,000 adults will be diagnosed with colorectal cancer in 2005 and that 56,000 will die from the disease.

Screening can reduce CRC-related mortality by detecting early-stage CRC. Screening strategies available include the fecal occult blood test (FOBT), flexible sigmoidoscopy, colonoscopy, and double contrast barium enema.

The U.S. Preventive Services Task Force recommends CRC screening for average-risk individuals age 50 years and older, yet less than 53% of the eligible U.S. population has been screened for CRC. "Physician recommendation is the largest predictor of CRC screening guidance," Dr. Bennett said.

The VA health care system measures screening rates at monthly intervals as part of its quality-enhancement research initiative. Of the 17 measures evaluated in this program, CRC screening has the lowest performance rates, he said. VA studies have not shown racial or ethnic differences in CRC survival rates, but African Americans insured by Medicare or private health insurance have lower 5-year survival rates than whites with the same insurance, Dr. Bennett said.

Veterans who use the VA health care services have especially low levels of health literacy. At the Jesse Brown VA Medical Center in Lakeside, Ill., only 42% of hospitalized VA patients have health literacy skills above the ninth-grade level, he said.

The trial to test health care provider–directed interventions took place at two primary care clinics at the Jesse Brown center from May 2001 to June 2003. One clinic served as the control site and the other was the intervention clinic. Each had three attending physicians and a staff of nurse practitioners and medical residents. Patients had to be at least age 50 years and be scheduled to be seen in one of the two outpatient clinics. Individuals were excluded if they had a personal or family history of polyps, CRC, or inflammatory bowel disease; had completed a FOBT in the preceding year; or had a flexible sigmoidoscopy or colonoscopy in the preceding 5 years.

In the intervention clinic, providers attended quarterly feedback sessions, focusing on individual and group feedback on CRC screening recommendation rates and patient adherence to recommended tests. The physicians and staff also received an overview of CRC screening guidelines as well as practical strategies to communicate with patients who have limited literacy skills. The "continuous quality improvement" (CQI) process—which applies scientific methods to the practice of medicine to help ease a physician's workload, increase patient satisfaction, and reduce malpractice exposure—was introduced to the participants.

Screening recommendation and completion were assessed by a review of electronic health records by research assistants.

Overall, the health care provider–directed intervention resulted in a 7% absolute increase in the rates of CRC screening recommendations, and a 9% absolute increase in the rates of CRC screening completion, Dr. Bennett reported.

Providers who attended at least one feedback session were more likely than those who attended no sessions to make a CRC screening recommendation. In addition, patients of providers who attended at least one feedback session were more likely than those who attended no sessions to adhere to CRC screening recommendations.

Respondents with limited literacy skills were more likely than others to be unfamiliar with CRC and other screening tests for CRC. They also appeared to be more skeptical about the screening process, complaining that an FOBT was inconvenient and messy, and stating they would not use an FOBT even if recommended by their physician. But they were more likely to believe that they were at average to high risk of developing CRC than higher literacy patients, Dr. Bennett said.

Among the patients with low literacy, the provider-directed intervention was associated with a 26% increase in screening completion, he reported.

"If information technology support could facilitate downloading of provider-specific CRC screening rates directly from the electronic medical records of the VA, then the intervention costs would substantially decrease," Dr. Bennett said.

Because CRC screening rates have scored so low in the past within the VA, information technology improvements within the system are likely in the near future, he said. ■

Colectomy Not a Final Cure for Ulcerative Colitis, Data Show

BY BRUCE JANCIN
Denver Bureau

HONOLULU — The widely held view that surgery is the "curative" option in patients with severe ulcerative colitis could not be further from the truth, according to the results of a large, population-based study presented at the annual meeting of the American College of Gastroenterology.

The findings show the importance of early, aggressive medical intervention in ulcerative colitis.

DR. DHILLON

Indeed, colectomy wasn't the end of the story for the majority of ulcerative colitis patients who underwent the procedure in Olmsted County, Minn., during 1940-2001. The cumulative risk of additional gut surgery that wasn't part of a planned multistage procedure was 28% within the first year following colectomy, 53% at year 10, and 63% at year 20, reported Dr. Shamina Dhillon of the Mayo Clinic, Rochester, Minn.

Since 98% of all residents in largely rural Olmsted County receive their health care through the Mayo Clinic and centralized records are kept, it was possible for Dr. Dhillon to study the natural history of ulcerative colitis in the 378 patients diagnosed there with the disease during the study period. The total follow-up amounted to 6,360 patient-years.

The cumulative risk of colectomy following diagnosis of ulcerative colitis was 3% within 1 year, 16% at 10 years, 22% at 20 years, and 28% at 30 years. Also, 3% of patients underwent surgical lysis of adhesions within the first year after colectomy; the figures were 14% by year 10 and 17% by year 20.

Among the 35 patients who underwent ileal pouch–anal anastomosis, the cumulative 10-year rate of any subsequent surgery was 53%. Conversion to permanent ileostomy or diverting ileostomy after initial takedown occurred at a cumulative rate of 18% at year 10.

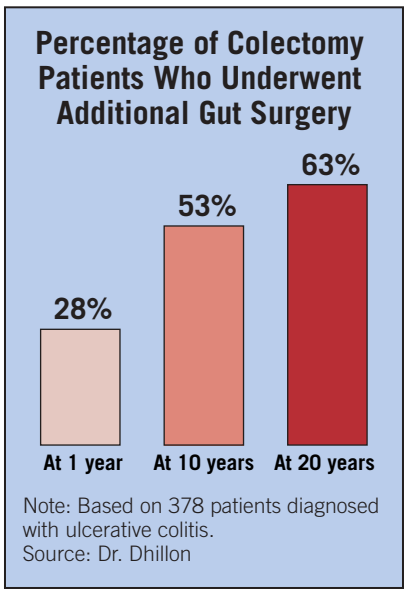
Patients who underwent proctocolectomy with Brooke ileostomy had a 17% risk of stomal revision by year 10, climbing to 27% at year 20. The cumulative risk of a stomal hernia repair was 9% at year 10 and 20% at year 20.

The few other large population-based studies addressing what happens to patients after diagnosis of ulcerative colitis have shown similarly high rates of multiple surgeries. The Stockholm (Sweden) County Registry, for example, showed a cumulative colectomy rate of 45% at 25 years following diagnosis of ulcerative colitis.

Within 15 years after colectomy, 22% of patients underwent additional surgery to relieve obstruction of the small intestine, Dr. Dhillon said.

The experiences in Stockholm and Olmsted counties underscore the importance of early and aggressive medical intervention in ulcerative colitis in order to help affected patients avoid undergoing surgery not once, but on multiple occasions, she added.

Her study received the 2005 ACG/Centocor Inflammatory Bowel Disease Abstract Award.



Many audience members expressed surprise at the high rate of unplanned repeat surgery, particularly in light of the Mayo Clinic's longstanding reputation for outstanding-quality medical and surgical management of inflammatory bowel disease.

Dr. Dhillon's study coinvestigator, Dr. William J. Sandborn, provided some additional perspective. "I think surgery is increasingly becoming a treatment of last resort. It's not curative," said Dr. Sandborn, professor of medicine at the Mayo Medical School.

"Half of the patients with ileoanal anastomosis get pouchitis, and 10%-20% get permanently or temporarily rediverted after their initial surgery," Dr. Sandborn continued.

"The median stool frequency in 24 hours in our study was eight, which means half of the patients who didn't have pouchitis had more than eight stools in 24 hours.

"Fecundity in young women—the ability to get pregnant without in vitro fertilization—is reduced by as much as 80%. So this is not a cure. It's a last-ditch effort to have something besides a stoma if no medicines work." ■