Reviewer's report

Title: CanPrevent: A telephone-delivered intervention to reduce multiple behavioural risk factors for colorectal cancer.

Version: 4 Date: 3 September 2012

Reviewer: Annie Anderson

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Major comments (responses need to previous queries)

1. Response rate is very small considering the incidence of CRC. It is unclear why 28 were approached and what the number 28 is based on. It is unclear what the study period was.

This number was sufficient for a small feasibility and short-term effectiveness trial which has been indicated in the text (para 4, page 4; para 2, page 10).

ON WHAT GROUNDS WAS THIS NUMBER DEEMED SUFFICIENT? (Note also few men were actually recruited)

2. Assessment methods

All results are self-reported and whilst reported as being derived from valid and reliable measures are they all tested in this age group and tested for longitudinal validity? In cross sectional analysis there is less need to worry about social bias in reporting, but when an intervention has taken place, social bias in follow up may well be increased.

This intervention aimed to primarily improve health behaviours (e.g physical activity, diet) as a wide range of studies have demonstrated that improvements in health behaviours can improve health outcomes and reduce risk of colorectal cancer. Further, the intervention was telephone-delivered so it was available to all people at risk of colorectal cancer across the state of Queensland, Australia. Consistent with this delivery method, data were also collected by telephone interview. Therefore, data were self-reported and this is included as
a study
limitation (para 2, page 14). Further, we have noted where measures have been used
previously in cancer patients (pages 5-7).

CAN THE AUTHORS PROVIDE INFORMATION ON THE VALIDITY AND
RELIABILITY OF THE ITEMS USED DELIVERED BY TELEPHONE
METHODOLOGY. THE REFERENCE THEY CITE IS NOT AVAILABLE ON LINE

3. There is much in the literature about under reporting body weight (and indeed
over reporting height in the elderly) which makes attaining valid BMI measures challenging.
As mentioned above, we have acknowledged the limitations with self-reported data in the
study limitations section (para 2, page 13). Further, participants were instructed on how to
measure height and weight and this has been detailed in the text (para 4, page 6).
Waist circumference is known to vary considerably through measurement error in finding the correct part of the body to measure and repeating it in the same place some weeks later. There is no mention of specific instruction being provided to participants e.g. photographic instructions etc.
Participants were provided with an instruction sheet prior to the telephone interview with
clear instructions on how to measure their waist. The telephone interviewers also assisted if
necessary. This has been detailed in the text (para 5, page 6).

IT WOULD BE WISE TO QUOTE A REFERENCE TO SHOW THAT SELF
REPORTED WEIGHT IS ACCURATE AFTER AN INTERVENTION (THERE
ARE SEVERAL CROSS SECTIONAL REPORTS BUT THE INTEREST HERE IS
POST INTERVENTION TO ALLOW FOR SOCIAL BIAS IN REPORTING)
THE DECREASE IN WAIST IS LARGE AND A COMMENT ON THE
RELIABILITY OF SELF REPORTED WAIST MEASUREMENT IS NEEDED

Level of interest: An article whose findings are important to those with closely related research interests

Quality of written English: Acceptable

Statistical review: No, the manuscript does not need to be seen by a statistician.
Declaration of competing interests:

'I declare that I have no competing interests'