Author's response to reviews

Title: Knowledge, attitudes, and preventive practices about colorectal cancer among adults in an area of Southern Italy

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Author's response to reviews:

I am submitting the revised manuscript entitled “Knowledge, attitudes, and preventive practices about colorectal cancer among adults in Italy” and we have fully addressed the reviewers’ concerns and below we have indicated all the revisions made. As suggested, we have also included a copy of the questionnaire as an additional file with the revised manuscript.

Reviewer 1
1. As suggested, we have specified that in Italy a population based organized screening for colorectal cancer is under implementation and we have added appropriate reference.
2. As suggested, we have specified the meaning of “screening”.
3. As suggested, the title has been modified in “Knowledge, attitudes, and preventive practices about colorectal cancer among adults in an area of Southern Italy”.
4. As suggested, we have included mortality and incidence in Italy and we have added appropriate reference.
5. As suggested, we have included the European and the Italian recommendations and we have added appropriate references.
6. As suggested, we have specified that pilot study and pretest were carried out with a sample of 25 adults from the same source and similar to those included in the final study in order to evaluate the comprehensibility of the wording and internal validity of each question and that feedback was incorporated into the survey prior to the initial delivering.
7. As suggested, we have clarified the meaning of “having correctly undergone or not undergone FOBT” and we have indicated those who were eligible.
8. As suggested, we have corrected the percentage in the results and discussion sections regarding those who never participated in colorectal cancer screening.
9. As suggested, we have compared the principal socio-demographic characteristics of the respondents with those of the general population in the same area. None of the between-group comparison was statistically significant and, therefore, the sample may be considered representative.

Reviewer 2

1. In response to the point regarding the aim of the study, we are confident that our sample of subjects with a mean age of 44 years (range 31-67) perfectly reflects the aim of the study that was to characterize the levels of knowledge, attitudes, and preventive practices about colorectal cancer in adults. As suggested, we have clarified that the study has been conducted in an area of Southern Italy.

2. As suggested, we have included the Italian recommendations for colorectal cancer screening, we have added appropriate references, and we have modified the results according to these recommendations.

3. In response to the point regarding the screening program in our country, we have specified that in Italy a population based organized screening for colorectal cancer is under implementation and we have added appropriate reference.

4. In response to the point regarding the age of the sample selected, we did not expect greater knowledge or intention to screen in the younger people, but, as we have already indicated in the manuscript, in our opinion it was important to analyze a “young” population since we felt that special attention should be paid to them because we are confident that prior behaviors in targeting promotion and information may have important public health implications in order to further increase understanding of colorectal cancer and performing appropriate preventive practices.


6. In response to the point regarding how the questions about risk factors and screening tests were developed, they were developed in accordance to the literature.

7. In response to the point regarding the pilot testing of the questionnaire, as already indicated a pilot study was conducted. In the revised version, we have specified that pilot study and pretest were carried out with a sample of 25 adults from the same source and similar to those included in the final study in order to evaluate the comprehensibility of the wording and internal validity of each question and that feedback was incorporated into the survey prior to the initial delivering.

8. In response to the point regarding the test-retest reliability of self-reported height and weight, we have not assessed the reliability but we have indicated in
the methods section that it has been demonstrated that such self-reported was reliable with test-retest analyses. In order to avoid misunderstanding we have added appropriate references.

9. In response to the point regarding the reason for treating education as a continuous variable, we have compared the two logistic models, through the likelihood ratio test, using the variable as a continuous and as categorical and the continuous one best contributed to the models. Therefore, we have included the education as a continuous variable.

10. In response to the point regarding the reason for treating the perception of health status as a continuous variable, as already described in the methods section the self-rated health was assessed on a ten-point Likert-type scale, with responses ranging from 1 (poor) to 10 (excellent). Our hypothesis was that the increasing or decreasing perception of health status may influence the level of knowledge on the main modifiable risk factors and screening tests for colorectal cancer, the positive attitude towards the utility of screening, and for correctly undergone or not undergone screening tests. Therefore, we have used the perception of health status as a continuous variable.

11. As suggested, in Model 4 the variable personal and familial history of precancerous lesion or colorectal cancer has been modified by excluding the respondents with colorectal cancer (one subject). The new variable is personal history of precancerous lesion and familial history of precancerous lesion or colorectal cancer.

12. As suggested, in the statistical analysis section we have described the bivariate analysis before the multivariate analysis and we have clarified the four primary outcomes of interest.

13. In response to the point regarding why certain variables were or were not included in the models, we have clarified that in the model building strategies we have conducted a careful univariate analysis of the variables potentially associated with the different outcomes of interest. For this reason, a group of variables, such as for example the socio-demographics, have been tested for inclusion in all models, whereas another set of variables have been tested for inclusion in each of the different models.

14. As suggested, in the results section we have described each part of the questionnaire, such as knowledge, attitudes, and practices, followed by the results of the related statistical analysis.

15. In response to the point regarding the potential bias for the response rate achieved, we compared the principal socio-demographic characteristics of the respondents with those emerging from the general population of the same geographic area. None of the between-group comparison was statistically significant and, therefore, the sample may be considered representative.

16. In response to the point regarding the missing data, we did not have missing answers on the knowledge and attitudes questions. This is not uncommon since it was similar to many other studies recently conducted by some of us (European Journal of Pediatrics 2005;164:207-11; Journal of Paediatrics and Child Health 2005;41:260-4; Cephalalgia 2005;25:767-75; Journal of Infection

17. As suggested, in Table 3 we have included in the logistic regression models the reference group for each Odds Ratio.

18. As suggested, we have corrected the discrepancies between the percentages reported in the results and discussion sections.

19. In response to the point regarding additional literature, no previous studies have been conducted in our country or in other Mediterranean countries.

We are confident that these changes fully address the concerns raised therein and that the paper is publishable in BMC Cancer.

Yours sincerely,

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