Reviewer's report

Title: Sociodemographic and health-related predictors of self-reported mammogram, foecal occult blood test and prostate specific antigen test use in a large Australian cohort study

Version: 1 Date: 10 January 2013

Reviewer: Ben Hudson

Reviewer's report:

Thank you for asking me to review this large, well conducted study which adds useful data regarding uptake of screening tests. The study question is clear and the methods appropriate and well described. Data are clearly presented. The title and abstract convey the method and findings clearly. The authors provide a good discussion of the potential limitations of the study, and despite these the results remain convincing. I have a few questions regarding the discussion, but those notwithstanding, I'm happy to recommend this paper for publication.

Minor essential revisions.

1. In the Background section of the Abstract the authors state that they examined the proportions of participants who had received screening tests in the previous 2 years. However, in the Methods section it appears that participants were asked whether they had ever been screened using each of the tests in question. This apparent discrepancy should either be corrected or clarified.

2. Tables 1 and 2 include participants' psychological distress levels. It would be helpful to mention in the Methods section what instrument was used to obtain these results.

3. In paragraph 1 of the Discussion section, the authors suggest that there are “…different barriers to cancer screening depending on the test…” The word “barrier” implies that, in an ideal world, all participants would have availed themselves of both applicable tests. This assumption fails to allow for the fact that some participants may have made a valid decision not to be tested. I suggest that the authors should acknowledge this possibility and that they consider using a different word than “barrier”. Another example of this problem is in para 5 of the Discussion section, where it is noted that “…men and women who reported needing help with daily tasks because of illness or disability had low levels of screening use. This is probably explainable in terms of access issues and the ability to get to a mammography clinic/doctor, or to perform a FOBT at home.” This finding might be better explained by the fact that these participants are more likely to have immediate health problems, possibly a shorter life expectancy, and have therefore made a reasonable decision that the small long-term benefits of screening are not relevant for them.

4. In paragraph 6 of the Discussion section the authors suggest that there is a
“clear role for general practice in encouraging participation in the National Bowel Cancer screening programme…” and in the final paragraph they suggest that “Strategies aimed at using one test as a ‘teachable moment’ for promoting another…may help in closing the gap in….” These statements require further consideration. Do the authors really believe that it is for GPs (or anybody else) to encourage or promote participation in screening programmes? The fine balance of benefits and harms of screening programmes means that the decision to take part in one should be made by a well-informed individual, and that we should strive to provide the necessary information in an accessible way. There is an emerging consensus that we should be moving away from a position of promoting screening to one of providing high quality decision aids which individuals can use to make their own decisions on whether or not to participate. [1, 2]

5. In the Discussion section in para 6, the authors also suggest that “there is a clear role for general practice….inviting those not currently in the eligible age groups for the program to have a FOBT.” This could be read to mean that the authors are recommending GPs encourage ad hoc or haphazard screening outside the organised screening programme. Such haphazard screening has a number of well recognised risks: a lack of an organised system of call and recall, no agreed protocol for testing and follow up, and no programme quality control. Haphazard screening risks exposing participating individuals to screening-related harms that may exceed screening’s benefits, and may exacerbate health inequalities by directing resources away from those with greatest need, it is therefore generally discouraged. [3] I’m not clear that this is what the authors intended, perhaps this could be clarified?

6. Finally, the authors use the word “foecal” in the title and elsewhere. This may be an Australian spelling, but I don’t believe it is standard elsewhere and suggest they use either “faecal” or, if they must, “fecal”.

Discretionary revisions

1. In paragraph 2 of the Discussion section the authors suggest that “Increasing government-funded bowel cancer screening so that all people are screened biennially would go a long way towards increasing participation overall”. It’s not clear whether such a policy change would increase uptake, and the authors provide no explanation as to why they think it would. (Offering people more of something they don’t appear to want very much doesn’t seem to me a guaranteed way of encouraging them to have more of it). In any case, they then go on to rather undermine this argument in the following paragraph, where they remind us that “Barriers to cancer screening among low socio-economic groups are not limited to cost and accessibility”.

2. I wonder whether the authors could make a little more of the fascinating finding that 63% of their male participants had had a PSA test? This seems surprisingly high, especially given the RACGP and USPSTF guidance against this form of screening.[4, 5]


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

**Quality of written English:** Needs some language corrections before being published

**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.