

Introduction

Patients with inflammatory bowel disease (IBD) are at higher risk of developing colorectal cancer (CRC).¹

Guidelines recommend periodic endoscopic surveillance to detect and manage dysplasia.¹

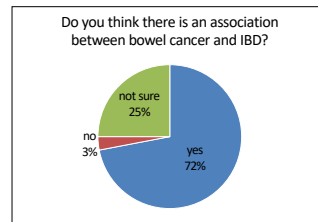
We aimed to explore patient knowledge and perceptions of CRC risk and surveillance and identify potential barriers to surveillance practice.

	n (%)
Gender	
Male	201 (48%)
Female	217 (52%)
Age (years)	
18 – 24	26 (6%)
25 – 34	77 (18%)
35 – 44	72 (17%)
45 – 54	75 (18%)
55 – 64	79 (19%)
>65	89 (21%)
Ethnicity	
Caucasian	361 (86%)
Asian	28 (7%)
Other	29 (7%)
Diagnosis	
Ulcerative colitis	266 (64%)
Crohn's disease	145 (35%)
Indeterminate colitis	7 (2%)
Years since diagnosis	
0-5	139 (33%)
5-10	102 (24%)
10-20	111 (27%)
>20	66 (16%)
Crohn's & Colitis member	
Yes	140 (33%)
No, or do not know	278 (67%)

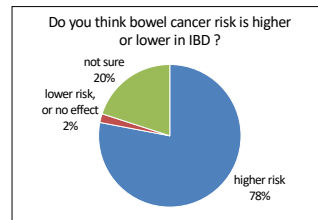
Table 1. Demographics

Methods

- A 44-item questionnaire was administered (online or postal) to IBD patients with colonic involvement attending gastroenterology clinics between July 2021 and April 2022.
- Combination of multiple-choice questions and free text responses exploring patient knowledge of complications associated with IBD, specifically dysplasia and CRC risk; and patient knowledge and perceptions of surveillance practice.



Graph 1. Patient knowledge on association between CRC and IBD.



Graph 2. Patient knowledge of CRC risk in IBD

Results

- Total 418 respondents
- Participant demographics- table 1
- Two hundred and sixty-five (66%) patients rated their IBD control moderate/good (score $\geq 7/10$).
- Three hundred and fourteen (75%) self-rated their understanding of IBD as good/excellent.
- Two hundred and thirty respondents (55%) spontaneously named CRC as a potential complication of IBD. Of these, 58% named CRC as the complication they feared most.
- Three hundred and twenty-eight patients (78%) recognized a higher CRC risk in IBD, but 90 patients (22%) believed the risk of CRC was lower in IBD or were unsure (Graph 1 and 2).
- Older age ≥ 65 years ($p=0.02$), being a Crohn's and Colitis UK (CCUK) member ($p<0.001$), patient rated IBD control ($p=0.04$) and self-rated understanding ($p=0.01$) were associated with better CRC risk awareness.
- One hundred and forty-nine (36%) respondents stated that their IBD healthcare professional (HCP) had previously discussed CRC risk with them; this was associated with better CRC knowledge ($p=0.001$).
- On multivariate analysis, CCUK membership, prior HCP discussion and age ≥ 65 years were predictive of greater CRC risk awareness (Table 2).

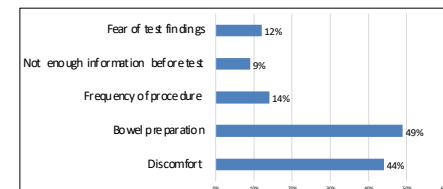
Multivariate analysis- factors predictive of greater awareness of CRC risk in IBD

CCUK membership	OR 2.75; 95% CI 1.57- 4.83; $p<0.001$
Prior HCP discussion with patient	OR 1.57; 95% CI 0.85-2.87; $p=0.01$
Age ≥ 65 years	OR 0.3; 95% CI 0.09- 0.99; $p=0.05$

Table 2. Multivariate analysis

Results

- Concerning the most appropriate screening test for dysplasia, 369 patients (88%) stated colonoscopy, but only 29 (7%) were aware that colonic surveillance should commence 8-10 years after diagnosis; and 153 (37%) recognized that optimal timing is when IBD is in remission.
- Patient reported information sources included gastroenterology HCPs (43%), patient support groups (28%), and hospital provided patient leaflets (17%).
- Bowel preparation (49%) and discomfort (44%) were factors most likely to dissuade patients from agreeing to surveillance (Graph 3). Despite this, the majority (78%) stated they would agree to have surveillance colonoscopy if advised by their HCP.



Graph 3. Factors reported by patients affecting decision to undergo surveillance practice.

Conclusions

Patient knowledge of CRC risk and surveillance practice in IBD is variable.

Modifiable factors associated with improved knowledge are discussion with HCPs and CCUK membership.

Our findings underscore the need for further patient education to aid informed decision-making between patients and HCPs and to improve patient adherence to surveillance practice.