



Study of Compliance, Practice Patterns, and Barriers REgarding Established National Screening Programs for Barrett's Esophagus among Primary Care Providers (PCPs): SCREEN-BE

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Introduction

- The incidence of esophageal adenocarcinoma (EAC) has increased six fold in the United States
- Barrett's esophagus is the primary risk factor for EAC
- Esophageal adenocarcinoma has a 18% 5 year survival
- Those with localized disease have a better survival rate
- Less than 10% of those diagnosed with EAC are known to have BE

Aims

- To optimize BE screening to reduce the incidence, morbidity, and mortality of EAC
- To study shortcomings of the current BE screening in the referral process in the United States
- To define provider-level knowledge, attitudes, and barriers to BE screening.

Methods

- Included primary care providers at UCH, Denver Health, and Rocky Mountain Veterans Affairs Hospital
- Developed surveys to look at
 - Provider demographics
 - Provider attitudes
 - Perceived barriers to BE screening
- 9 clinical vignettes were designed to categorize provider responses to BE screening
- Distributed via anonymous REDCap internet surveys

Responses

Please indicate whether you agree or disagree with the following statements about Barrett's esophagus screening. (n=102)

I have difficulty knowing who should be referred for upper endoscopy for Barrett's esophagus screening.

Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
1 (0.98%)	17 (16.7%)	20 (19.6%)	47 (46.1%)	17 (16.7%)

I know the current guideline recommendations related to screening Barrett's esophagus.

8 (7.8%)	48 (47.1%)	30 (29.4%)	14 (13.7%)	2 (1.96%)
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Screening for Barrett's esophagus is the responsibility of gastroenterologists and not primary care providers.

17 (16.7%)	68 (66.7%)	13 (12.8%)	3 (2.9%)	1 (0.98%)
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Primary care providers should order Barrett's esophagus screening based on recommendations from gastroenterology society guidelines

2 (1.96%)	10 (9.8%)	42 (41.2%)	44 (43.1%)	4 (3.9%)
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Primary care providers should not order Barrett's esophagus screening based on lack of recommendation from the US Preventive Services Task Force.

3 (2.9%)	17 (16.7%)	50 (49.0%)	28 (27.5%)	4 (3.9%)
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I discuss the benefits and harms of Barrett's esophagus screening in detail with patients who have chronic GERD.

15 (14.7%)	43 (42.2%)	18 (17.7%)	23 (22.6%)	3 (2.9%)
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Competing patient clinical issues prevent me from addressing screening for Barrett's esophagus.

6 (5.9%)	26 (25.5%)	28 (27.5%)	30 (29.4%)	12 (11.8%)
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I do not have enough time in clinic to discuss Barrett's esophagus screening with patients.

4 (3.9%)	34 (33.3%)	29 (28.4%)	31 (30.4%)	4 (3.9%)
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I am unsure if upper endoscopy as screening for Barrett's esophagus would be covered by insurance.

5 (4.9%)	31 (30.4%)	23 (22.6%)	38 (37.3%)	5 (4.9%)
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Not performing Barrett's esophagus screening poses malpractice liability.

2 (1.96%)	16 (15.7%)	58 (56.9%)	24 (23.5%)	2 (1.96%)
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Patients have difficulty understanding information I present about Barrett's esophagus screening.

3 (2.9%)	41 (40.2%)	41 (40.2%)	15 (14.7%)	2 (1.96%)
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Patients do not want to discuss Barrett's esophagus screening.

6 (5.9%)	57 (55.9%)	33 (32.4%)	6 (5.9%)	0 (0%)
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Patients have difficulty understanding information I present about Barrett's esophagus screening.

3 (2.9%)	41 (40.2%)	41 (40.2%)	15 (14.7%)	2 (1.96%)
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Would this demographic/clinical factor increase the likelihood that you would order BE screening? (n=102)

	Yes	No
Age >50 years	90 (88%)	12 (12%)
White race	24 (24%)	78 (76%)
Male gender	51 (50%)	51 (50%)
Smoking	89 (87%)	13 (13%)
Abdominal obesity with BMI >30	39 (38%)	63 (62%)
Family history of BE or EAC	83 (81%)	19 (19%)
Chronic GERD symptoms unresponsive to acid suppressive medications	101 (99%)	1 (1%)
Alarm symptoms (weight loss, anemia, dysphagia)	99 (97%)	3 (3%)

Discussion

- PCPs recognize the lack of knowledge with screening guidelines and factors that increase risk of BE
- Future efforts should focus on educational interventions
- PCPs would also benefit from built-in reminder systems to incorporate BE screening during visits

Future Directions

- Future studies should look at the impact of patient knowledge, attitudes, and barriers on screening
- Expanding this study to include other geographic areas and hospital systems
 - Hospital of the University of Pennsylvania, Penn Presbyterian Hospital, Pennsylvania Hospital, University of Texas Southwestern Medical Center, 77 Health and Hospital System and University of California Irvine

Acknowledgements

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Provider Characteristics	N (%)
Gender	
Male	41 (40.20%)
Female	55 (53.92%)
Non-binary	1 (0.98%)
Prefer not to specify	5 (4.90%)
Race/ethnicity	
Asian	13 (12.62%)
Black	1 (0.97%)
White	77 (74.76%)
Other/prefer not to specify	12 (11.65%)
Hispanic/Latino	3 (2.94%)
Type of practitioner	
MD/DO	95 (93.14%)
Nurse practitioner	4 (3.92%)
Physician assistant	3 (2.94%)
Years in practice	
≤5	23 (22.55%)
6-10	19 (18.63%)
11-15	12 (11.76%)
16-20	23 (22.55%)
21+	25 (24.51%)
Practice Characteristics	
Number of patients/week	
<25	30 (29.41%)
26-50	33 (32.35%)
51-75	32 (31.37%)
76+	7 (6.86%)
Number of patients/week with GERD	
0-1	8 (7.84%)
2-10	69 (67.65%)
11-25	21 (20.59%)
26+	4 (3.92%)

