## PEER REVIEW HISTORY



## ARTICLE DETAILS

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| **TITLE (PROVISIONAL)** | Eliciting symptoms interpreted as normal by patients with early stage lung cancer – could GP elicitation of normalised symptoms reduce delay in diagnosis?: Cross sectional interview study |
| **AUTHORS** | Brindle, Lucy; Pope, Catherine; Corner, Jessica; Leydon, Geraldine; Banerjee, Anindo |

## VERSION 1 - REVIEW

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| **REVIEWER** | Sara Macdonald<br>Lecturer in Primary Care<br>Institute of Health & Wellbeing<br>University of Glasgow |
| **REVIEW RETURNED** | 05-Sep-2012 |

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| **THE STUDY** | Those areas not relevant for qualitative work. |
| **RESULTS & CONCLUSIONS** | The results can feel confusing at times. If they were presented in a more structured fashion they would, I feel have more significant impact. |
| **GENERAL COMMENTS** | This is an extremely important area and one which would undoubtedly benefit from additional evidence. The UK is especially poor in terms of lung cancer survival and 'delays' to diagnosis are worthy of investigation. There is obvious value in focusing on patient presentation behaviour and help-seeking.<br><br>Both abstract and Introduction are reasonable and well written.<br><br>Method – I wonder if it is enough to say 'We combined thematic analysis with discourse analysis to explain normalisation and non-presentation of symptoms'? How? Why was it necessary to use two approaches? The results do not appear to outline whether results were different with two individual analytic approaches.<br><br>On page 7, Line 7 para beginning 'The results .... . My feeling is that this would be better coming in the results section, though this is personal preference. That said, I think this paragraph is a little confusing and the presentation of the themes/findings could be clearer.<br><br>Results<br><br>As with the previous paragraph, I think that the results might be presented more clearly. I found it a little confusing that the symptom type was first flagged up but then rarely referred to? If the reasons |

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| | for non-presentation were largely due to normalisation of symptoms then there seems little value in distinguishing between the two. Reasons for presentation were merely alluded to.<br><br>Perhaps more headings or signposting would help?<br><br>Table 1 – Patient characteristics, outlines a range of differences between patients – age, smoking status, deprivation status – yet none of those are discussed. Were current smokers for example, more likely to normalise breathlessness? Were there differences between symptom appraisal and SES?<br><br>Discussion<br><br>The section on 'hidden symptoms' is welcome. However I wonder if it just worth mentioning that in large scale cancer awareness studies people are more likely to respond to closed questions. Also, awareness of some symptoms highlighted by Robb et al (your ref 28) e.g. breast lump is high – so it may be that people do not recognise the significance of breathlessness? Bleeding appeared to prompt help-seeking.<br><br>Page 11 line 42 – I think it's a rather bold statement to say 'Nice referral guidelines are based upon a weak evidence base'!<br><br>This is an important paper that gives further understanding of presentation behaviour in lung cancer. |

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| **REVIEWER** | Professor Angela Mary Tod<br>Centre for Health and Social Care Research<br>Sheffield Hallam University<br>England |
| **REVIEW RETURNED** | 05-Sep-2012 |

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| **THE STUDY** | Methods: Generally well described but more information about discourse analysis approach are required<br>Outcome measure and statistical methods: not appropriate as a qualitative study |
| **GENERAL COMMENTS** | This is a well written and useful article that takes forward the evidence on lung cancer diagnostic delay. It extends understanding or mormalisation of symptoms and non-presentation to GPs. The insight regarding non-disease related terminology is particularly helpful, especially with the popularity of interventions such as patient clinical decision decision support aids.<br>The paper is concise and yet includes all relevant literature in the intorduction and discussion<br>I have two suggestions for improving the quality of the paper.<br>A bit more detail regarding discourse analysis would be helpful. There are different DA approaches and techniques and it would be useful to know which specilic approach was adopted here.<br>Second, the samole characteristics table (1) is helpful. i wonder if it would be better to provide a table by individual participant and inidcating each participants characteristics e.g. age group, socio-econimic status, , co-morbidity, smoking status, diagnosis route. |

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| | This would give a clearer profile of each participant. |

**VERSION 1 – AUTHOR RESPONSE**

Reviewer comments:
" I wonder if it is enough to say 'We combined thematic analysis with discourse analysis to explain normalisation and non-presentation of symptoms'? How? Why was it necessary to use two approaches? The results do not appear to outline whether results were different with two individual analytic approaches."

"A bit more detail regarding discourse analysis would be helpful. There are different DA approaches and techniques and it would be useful to know which specific approach was adopted here."

Response:
The methods section now distinguishes more clearly between the contribution made by discourse analysis and thematic analysis. The type of discourse analysis is also described.

Reviewer comment:
"On page 7, Line 7 para beginning 'The results .... . My feeling is that this would be better coming in the results section, though this is personal preference. That said, I think this paragraph is a little confusing and the presentation of the themes/findings could be clearer."

Response:
The paragraph that began 'The results…' has been moved to the results section and revised to more clearly link the tables with the statements that they support.

RESULTS
Reviewer comment:
"Perhaps present individual socio-demographic characteristics, rather than summary statistics"

Response:
Socio-demographic information is often presented as summary statistics in qualitative papers in clinical journals. Whilst acknowledging benefits of presenting individual characteristics, summary statistics avoid the linkage of information that might identify participants. Furthermore, summary statistics facilitate the comparison of this population with others. As the results did not appear to differ by socio-demographic characteristics, presentation of individual characteristics would not enhance interpretation of data in this case.

Reviewer comment:
"As with the previous paragraph, I think that the results might be presented more clearly. I found it a little confusing that the symptom type was first flagged up but then rarely referred to? If the reasons for non-presentation were largely due to normalisation of symptoms then there seems little value in distinguishing between the two (symptoms of disease/symptoms of normal processes). Reasons for presentation were merely alluded to. Perhaps more headings or signposting would help?"

Response:
The paragraph that began 'The results…' has been moved to the results section and revised to more clearly link the tables with the statements that they support. (see above)

No change has been made regarding symptom type. Some symptoms might be more strongly associated with normal processes by participants than others. For example, those with breathlessness appeared more likely to normalise their symptom than those with cough. However,

cough and breathlessness were both normalised, and all participants, except those providing narratives of decline, experienced potential LC symptoms which they normalised (see table 3). Therefore, the improved elicitation of normalised symptoms emerges as of potential value in improving earlier cancer diagnosis within primary care. Any apparent differences between symptoms would require confirmation within a larger sample and quantitative study design.

It is not possible to also discuss symptoms of disease/concern accounts in detail in a short paper. However, in order to demonstrate exceptions to the normalisation of symptoms, it is necessary to report the occurrence of 'symptoms of disease' accounts within the paper.

Reviewer comment:
"Table 1 – Patient characteristics, outlines a range of differences between patients – age, smoking status, deprivation status – yet none of those are discussed. Were current smokers for example, more likely to normalise breathlessness? Were there differences between symptom appraisal and SES?"

Response:
The paper now reports that there were no discernible differences according to table 1 characteristics. Participants experienced symptoms not presented to GPs, and produced normalised accounts of these non-presented symptoms, irrespective of patient socio-demographic characteristics and smoking status. Exceptions appeared to arise only in the case of participants providing narratives of declining health.

DISCUSSION
Reviewer comment:
"However I wonder if it just worth mentioning that in large scale cancer awareness studies people are more likely to respond to closed questions."

Response:
Our findings refer to the characteristics and content of the interview response, rather than whether or not participants respond (interview participants responded to closed and open questions). The observation about large scale cancer awareness studies is likely to be relevant to questionnaire responses generally (less effort is required to answer a closed question), rather than responses to questions about cancer symptoms specifically.

Reviewer comment:
"Also, awareness of some symptoms highlighted by Robb et al (your ref 28) e.g. breast lump is high – so it may be that people do not recognise the significance of breathlessness? Bleeding appeared to prompt help-seeking."

Response:
This possible interpretation of our data has now been discussed.

Reviewer comment:
"I think it's a rather bold statement to say 'Nice referral guidelines are based upon a weak evidence base'!"

Response:
A change has been made to specify NICE guidelines for lung cancer referral. The NICE referral guidelines acknowledge that the evidence base is weak for lung cancer referral. The recommendations for urgent CXR referral are based upon evidence categorised as level D.

**VERSION 2 – REVIEW**

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| **REVIEWER** | Sara Macdonald<br>Lecturer in Primary Care<br>Institute of Health & Well-being<br>University of Glasgow |
| **REVIEW RETURNED** | 10-Oct-2012 |

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| **THE STUDY** | Not relevant in qualitative work. |