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Socioeconomic differences in help seeking for colorectal cancer symptoms during COVID-19

We read with interest the paper by Ip *et al* exploring socioeconomic differences in help seeking for colorectal cancer symptoms during COVID-19.¹ While we agree with the importance of this topic, the study has significant weaknesses that limit its validity.

We felt it should have been clear from the title onwards that the study is about participant-reported help seeking associated with educational attainment. The latter is a poor indicator of socioeconomic status,² whereas a measure, such as the Index of Multiple Deprivation (IMD),³ that considers several factors which contribute to socioeconomic status would have been more appropriate.

Participant recruitment was conducted through a 'Market Research Participant Recruitment Agency' (<https://www.sarosresearch.com/>). The authors state that participant screening was conducted by the company based on symptoms relating to bowel cancer. However, they do not report in this paper the symptoms that the chosen participants were reported as having, the duration of these symptoms, and the subsequent diagnosis (and if it was indeed bowel cancer). The only indication of their symptoms was provided in the quote captions; however, some of these were non-specific, such as 'extreme tiredness', which are not in themselves necessarily indicative of colorectal cancer. Details of the inclusion criteria that were used to identify participants should have been reported, together with any eligibility checks undertaken.

We note that sadly the patient contributor died during the study. It would have been helpful to understand the extent of their involvement in the research design or methods, as this detail was missing.

Some of the conclusions and recommendations are not relevant to the findings reported; for example, the recommendation to 'ensure infection control measures for COVID (and wider) are

overt and embedded into NHS services' is unrelated to the aims of the study.

Finally, it is regrettable that this study did not include general practices or their patients.

As such, we feel that this paper's conclusions and recommendations should be regarded with considerable caution.

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DOI: <https://doi.org/10.3399/bjgp22X720233>

Author response

We welcome the opportunity to respond to Atherton *et al* and to provide reassurance of the methodological validity of our study.¹

We include details of other socioeconomic status (SES) indices (included in the Index of Multiple Deprivation [IMD]) in

the supplementary file. Furthermore, the paper cited in the eLetter also states that education is a frequently used indicator of socioeconomic status because it is relevant to people regardless of age.

The symptoms we report in our paper are supported by robust sources, for example, Bowel Cancer UK, and were agreed with our co-authors, including a GP and those specialising in diagnosing and treating colorectal cancer. Our participants' eventual diagnosis was outside the scope of the study – we were interested in how people made sense of and sought help for symptoms. In doing so, this adds important information to a broader picture about how inequalities were exacerbated.

Our patient representative who sadly died was involved in the study design and early analysis discussions. Julie Callin (our other patient representative) is a co-author on the paper and was involved in the entire research process.

The recommendation regarding infection control is relevant because reticence to seek help due to fears about COVID infection was reported particularly in lower SES groups.

Finally, this study is based on patient accounts of help seeking during the pandemic, so it is incorrect to suggest that we did not include patients from general practices. We are pleased to share that we have recently completed a related study that gathers views of healthcare professionals across the cancer care trajectory (including GPs).²

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