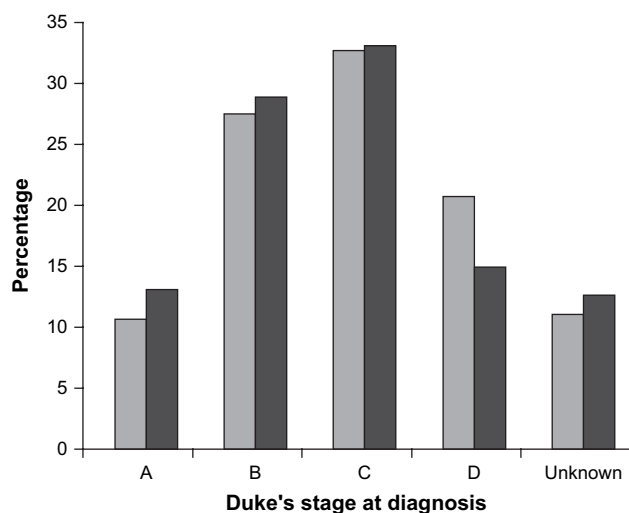


Dear Editor,

**The influence of language spoken on colorectal cancer diagnosis and management**

Multiple studies have reported clearly inferior cancer-related outcomes in minority populations.<sup>1</sup> Stage at diagnosis and differences in treatment have been cited as the most important explanatory factors. Some research has evaluated the psychosocial elements of this association; however, the influence of language has not previously been evaluated.<sup>1</sup> Patients who do not have English as a preferred language make up a significant minority in Australian public hospitals and although interpreters are available, or family members may act in this capacity, the effect on patient outcomes has not been reported.

To assess the influence of language spoken, we queried a prospective colorectal cancer database at Western Hospital, established in 1998 and matched this with data from the hospital's central information system, which records patient preferred language. Of the 1114 patients on our database, 215 (19%) described a language other than English as their preferred language.

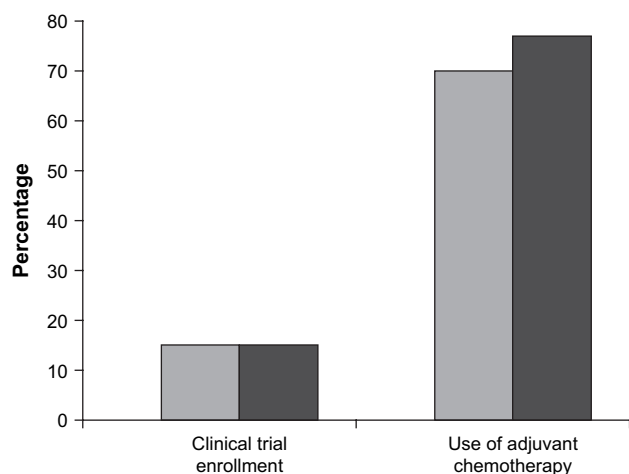


**Fig. 1.** Distribution of stage of colorectal cancer at diagnosis. Patients with rectal cancer who received preoperative chemoradiation make up the vast majority of the unknown group. ■, English ( $n = 899$ ); ■, Non-English ( $n = 215$ ).

Tumour stage at presentation was similar in the English preferred (EP) and non-English preferred (NEP) patients (Fig. 1) indicating there are no barriers to initially accessing care and no increase in delayed diagnosis. The rate of screen-detected cancers (2% in both groups) also suggests that screening colonoscopy is being carried out at a similar rate in both groups.

Discussion of adjuvant therapy requires consideration of the patient prognosis following surgery, the potential benefits of chemotherapy, the potential risks of chemotherapy and the practical aspects of chemotherapy administration. This scenario is more complicated if the oncologist is communicating with the patient through an interpreter. For the subset of patients with stage III colon cancers in our study, adjuvant chemotherapy was given to 67% of EP and 74% of NEP patients (Fig. 2).

Discussing complicated research protocols with patients is challenging and there could be a temptation in a busy outpatient



**Fig. 2.** Enrolment of patients in clinical trials and use of adjuvant chemotherapy according to preferred patient language. ■, English ( $n = 899$ ); ■, Non-English ( $n = 215$ ).

clinic to offer NEP patients standard care as the only option, rather than undertaking a prolonged discussion of a trial in challenging circumstances. Another factor impeding accrual of non-English speaking patients is the increasing number of clinical trials incorporating quality of life assessments available in a limited number of languages. Overall, 134 of the 1114 colorectal patients (12%) included in our database had been enrolled in a clinical trial, including 16 (11.9%) of the NEP patients (Fig. 2).

Our results indicate that patients seen at the Western Hospital that are NEP receive the same quality of care as EP patients, despite potential barriers in communication. As NEP patients often are of lower socio-economic status, this suggests that the universal access to medical care available in Australia through our public hospital system is providing consistent quality of care to all patients, but this requires further study.

## REFERENCE

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