PEER REVIEW HISTORY

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ARTICLE DETAILS

TITLE (PROVISIONAL)	Barriers to early presentation of self-discovered breast cancer in Singapore and Malaysia: a qualitative multicentre study
AUTHORS	Lim, Jennifer NW; Potrata, Barbara; Simonella, Leonardo; Ng, Celene; Aw, Tar-Ching; Dahlui, Maznah; Hartman, Mikael; Mazlan, Rifhan; Taib, NA

VERSION 1 - REVIEW

REVIEWER	Dr Sarah Rayne Helen Joseph Breast Care Clinic Department of Surgery Faculty of Health Sciences University of the Witwatersrand Johannesburg
REVIEW RETURNED	22-Sep-2015

GENERAL COMMENTS	This is a well-thought out and executed study, with appropriate ethical considerations, which will be a pertinent addition to the literature around factors associated with time to presentation in breast cancer. I would recommend it for publication although I have a few minor comments which may aid in clarity at the authors discretion. Introduction Paragraph 2: In Malaysia, are patients routinely risk-assessed in clinics then mammography offered? Or is the system of assessment based on presentation for co-morbidities to a doctor who incidentally recommends a mammogram? Results: If available, a response rate or details of the (approximate) clinical burden of cancer in these hospitals during recruitment would be useful in putting participant numbers in context. Table 1- Early stage breast cancer is defined as Stage 1-3A. It may therefore be a confusing term to use in the context of the separation of stage1/2 and 3/4. Separating the patients into the 4 standard stages would be better- or use a term other than 'early' and 'late'. Over 3 months has been defined as delayed presentation in a paragraph but later the last sentence of the paragraph talks about the delay to presentation of 1 day to a few years. It is not clear whether this is in all groups or just the delayed group. In addition a mean and SD is given although the upper limit is not numerical ("a few years"). In addition the early/late presenter data is duplicated- first stating % presenting early, and then the remaining percentage (late) Table 2- percentages throughout would aid clarity. Early presentation paragraph: It may be beyond the scope of the paper but eleven women had regular mammography and yet had undetected cancers despite mammography- were these interval cancers or women with failed follow-up (as discussed later in the paper). Also there is a comma which may be in the wrong place (I

	may be incorrect): "…who were aware of breast cancer, performed regular BSE and tended to seek immediate…" should rather be "…who were aware of breast cancer performed regular BSE, and tended to seek immediate…" or removed entirely. Table 3- numbers of patients describing each theme would help in contextualising how important each of these reasons are. Some of this is done in the qualitative part of the reported results but not all. The first theme "Symptom interpretation: symptom to signs of menstruation" is unclear- did patient relate symptoms to sign of menstruation? Paragraph 3 of the discussion presents interesting results concerning ignorance and poor awareness as underlying reasons for delayed presentation. These may be better presented and enumerated in the results prior to discussion. One limitation is identified in bullet form but not elaborated in the discussion, or any others. Thank you for affording me the opportunity of reviewing this work. By discovering new (and more up to date) barriers- such as online misinformation, it will add to the body of work in the area of help-seeking delay, particularly in low and middle income countries.

REVIEWER	Elizabeth Davies King's College London
REVIEW RETURNED	29-Sep-2015

GENERAL COMMENTS	Thank you for this interesting and important study which has relevance for women in Singapore and Malaysia and potentially for research on women from these and other ethnic groups in other countries around the world. While the study is clearly needed, appears well conducted and reveals new findings, particularly about the importance of perceived lack of access to services, ambiguous on line information and the fear of bringing shame on the family, there are several ways in which the description of the study, the analysis process and the discussion might be exanded and improved. Abstract and key findings: As the first thing the reader sees it would be useful to rephrase some of the terms to be more specific if possible within the word limit so that this makes sense without reference to the full body of the text. For example, 'negative influence of relatives', 'online information' and ' despite economic status' do not become clear until reading the full text. It's also not clear at this point why the pattern of presentation between the two groups 'remained unchanged'. Introduction: It would be worth mentioning other qualitative results from around the world on the experiences of groups of women with delayed presentation. And stressing why this kind of approach is particularly needed at this point. Sampling and approach to women: This needs to be described in more detail. How far were these women from their diagnosis when they were approached? This might influence what they could admit to themselves and to the interviewer? Was it emphasised that their

	care would not be affected if they declined. How many did decline? To what extent was the sampling purposive in terms of presentation, ethnic group, age, socioeconomic group? Did an effort need to be made to reach any particular group. Were women interviewed alone or with relatives? Were the interviews distressing? What aspects did the standard protocol consider? Interview method: Was an attempt made to allow women to tell their story using the topic guide or were all women asked the same questions in the same order? Did analysis proceed alongside data collection and if so were themes that emerged explored in more detail to understand them by, for example, seeking to confirm or disprove them in subsequent interviews? Analysis: The way this was conducted needs more description. Who did the majority of the coding? Was this performed by a one or two members of the team alone or together and then checked by the larger group? Who decided and how on what was an important theme? How was agreement reached about these? And how was any decision that data saturation had been achieved made? Who carried out the translation? Presentation of results: It would be good to include the age of each woman as well as her ethnic group and possibly how she presented. As the sample is purposive including percentages does not really make sense as they are not representative of a reproducable larger group. It would be better to use the numbers alone here to describe the sample rather than to try and prove that something was more common in one than another group. Discussion: Women's awareness of causes of cancer and their own risk of it is discussed here but not in the results. If this is a finding of the study, it would be best to consider this in the results as a further an influence on presentation. It would be useful to restructure the discussion into sections that consider 1) A summary of the main findings 2) How these compare to previous studies around the world ie what is new and what is similar to work on other currently groups of women eg chinese in US or UK and what is new for Singapore and Malaysia. Are some of these findings a function of low awareness in general and have been found in other ethnic groups or are they possibly specific to these groups? 3) Limitations of the study 4) Implications for research, practice and policy. It might also be useful to have the revised manuscript reviewed by someone outside the team just to check on grammar for example that 'the' is used where it's needed before nouns.

VERSION 1 – AUTHOR RESPONSE

Reviewer: 1

Introduction Paragraph 2: In Malaysia, are patients routinely risk-assessed in clinics then mammography offered? Or is the system of assessment based on presentation for co-morbidities to a doctor who incidentally recommends a mammogram?

We have provided this information in paragraph 2, p. 3 under section ‘INTRODUCTION’.

Results: If available, a response rate or details of the (approximate) clinical burden of cancer in these hospitals during recruitment would be useful in putting participant numbers in context.

At least 75% response rate. This is stated in paragraph 1 under section 'RESULTS'

Table 1- Early stage breast cancer is defined as Stage 1-3A. It may therefore be a confusing term to use in the context of the separation of stage1/2 and 3/4. Separating the patients into the 4 standard stages would be better- or use a term other than 'early' and 'late'.

In the context of public health and presentation of disease, a separation of stage 1/2 vs stage 3/4 is important on the basis of the T staging as that would be related to symptoms. Stage 3a although has better prognosis than stage 3b, it may not be meaningful in T staging.

Over 3 months has been defined as delayed presentation in a paragraph but later the last sentence of the paragraph talks about the delay to presentation of 1 day to a few years. It is not clear whether this is in all groups or just the delayed group. In addition a mean and SD is given although the upper limit is not numerical ("a few years"). In addition the early/late presenter data is duplicated- first stating % presenting early, and then the remaining percentage (late)

These have been corrected.

Table 2- percentages throughout would aid clarity.

These are now added.

Early presentation paragraph: It may be beyond the scope of the paper but eleven women had regular mammography and yet had undetected cancers despite mammography- were these interval cancers or women with failed follow-up (as discussed later in the paper).

We apologise for this mistake. This is now deleted.

Also there is a comma which may be in the wrong place (I may be incorrect):
"…who were aware of breast cancer, performed regular BSE and tended to seek immediate…"
should rather be
"…who were aware of breast cancer performed regular BSE, and tended to seek immediate…" or removed entirely.

Corrected.

Table 3- numbers of patients describing each theme would help in contextualising how important each of these reasons are. Some of this is done in the qualitative part of the reported results but not all.
The first theme "Symptom interpretation: symptom to signs of menstruation" is unclear- did patient relate symptoms to sign of menstruation?

The additional information are now added.

Paragraph 3 of the discussion presents interesting results concerning ignorance and poor awareness as underlying reasons for delayed presentation. These may be better presented and enumerated in the results prior to discussion.

This information is moved to RESULTS section.

One limitation is identified in bullet form but not elaborated in the discussion, or any others.
This is deleted.

Reviewer: 2
Reviewer Name: Elizabeth Davies

Abstract and key findings: As the first thing the reader sees it would be useful to rephrase some of the terms to be more specific if possible within the word limit so that this makes sense without reference to the full body of the text. For example, 'negative influence of relatives', 'online information' and ' despite economic status' do not become clear until reading the full text. It's also not clear at this point why the pattern of presentation between the two groups 'remained unchanged'.

We have attempted to provide more clarity to these points in the Abstract.

Introduction: It would be worth mentioning other qualitative results from around the world on the experiences of groups of women with delayed presentation. And stressing why this kind of approach is particularly needed at this point.

We have added 2 new paragraphs (paragraphs 5 and 6) on these points in the section 'INTRODUCTION'.

Sampling and approach to women: This needs to be described in more detail. How far were these women from their diagnosis when they were approached? This might influence what they could admit to themselves and to the interviewer? Was it emphasised that their care would not be affected if they declined. How many did decline? To what extent was the sampling purposive in terms of presentation, ethnic group, age, socioeconomic group? Did an effort need to be made to reach any particular group. Were women interviewed alone or with relatives? Were the interviews distressing? What aspects did the standard protocol consider?
We abode by the principles of qualitative research in conducting this study. We have added the required information in the section 'METHODS AND MATERIALS'.

Interview method: Was an attempt made to allow women to tell their story using the topic guide or were all women asked the same questions in the same order? Yes

Did analysis proceed alongside data collection and if so were themes that emerged explored in more detail to understand them by, for example, seeking to confirm or disprove them in subsequent interviews?

The approach described is the Grounded Theory approach. We did not apply this approach in our study. We analysed the data after we completed the interviews.

Analysis: The way this was conducted needs more description. Who did the majority of the coding? Was this performed by a one or two members of the team alone or together and then checked by the larger group? Who decided and how on what was an important theme? How was agreement reached about these? And how was any decision that data saturation had been achieved made? Who carried out the translation?

We added this information in the Section 'METHODS AND MATERIALS'.

Presentation of results: It would be good to include the age of each woman as well as her ethnic group and possibly how she presented. We have added the extra data suggested in the at the end of all quotations

As the sample is purposive including percentages does not really make sense as they are not representative of a reproducable larger group. It would be better to use the numbers alone here to describe the sample rather than to try and prove that something was more common in one than another group.

We kept the percentage as some authors find this information useful such as reviewer 1.

Discussion: Women's awareness of causes of cancer and their own risk of it is discussed here but not in the results. If this is a finding of the study, it would be best to consider this in the results as a further an influence on presentation.

This has been moved to RESULTS section as suggested.

It would be useful to restructure the discussion into sections that consider 1) A summary of the main findings 2) How these compare to previous studies around the world ie what is new and what is similar to work on other currently groups of women eg chinese in US or UK and what is new for Singapore and Malaysia. Are some of these findings a function of low awareness in general and have been found in other ethnic groups or are they possibly specific to these groups? 3) Limitations of the study 4) Implications for research, practice and policy.

This is the structure of our discussion.
We did not compare our findings to other Chinese group in the US or UK because this comparison is not meaningful given the differences in cultural background and health system experience between the Chinese in USA, UK and Malaysia and Singapore.

It might also be useful to have the revised manuscript reviewed by someone outside the team just to check on grammar for example that 'the' is used where it's needed before nouns.
The manuscript was proof read by Steve Harrison, a retired professor.

VERSION 2 – REVIEW

REVIEWER	Sarah Rayne Specialist Surgeon and Lecturer, Department of Surgery, Helen Joseph Hospital, Faculty of Health Sciences, University of the Witwatersrand, Johannesburg, South Africa
REVIEW RETURNED	13-Nov-2015

GENERAL COMMENTS	The changes made have substantially improved the readers ability to engage with the work. Thank you. Can i ask that the T=tumour S=stage clarified the first time it is used in the quotes or in the methods- it took me time to work out that was what it meant.

REVIEWER	Elizabeth Davies King's College London
REVIEW RETURNED	10-Nov-2015

GENERAL COMMENTS	Thank you. I am happy that the questions about the method have been addressed. The discussion is easier to read and the paper much improved overall. I think the abstract could still be expanded to include more detail about the sample but I defer to editorial policy here. There are minor typographical errors that remain throughout the manuscript eg lower case 'i', changes in format, or missing stage info in the quotes, and transcription errors in the reference list. Maybe one final proof read would detect and correct these.

VERSION 2 – AUTHOR RESPONSE

Reviewer 1: I have included information of the cancer staging (Stages and Tumour size) in pages 6 and 7 (Table 1).

Reviewer 2: I have corrected the formatting errors, amended the 'i' to 'I, added information on staging in the quotes. I have also proof-read and corrected the identified errors in the text.'. In the Abstract, additional details are added to describe the participants.