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We do, however, think it is somewhat relevant. We cite a previous paper by primary care researchers which reported variable knowledge among GPs of the NICE guideline. Indeed, that finding triggered our research: we wanted to see if there was variation in practice, after others reported variation in knowledge. We set that paper on variable GP knowledge in context, saying: “discussion will often be initiated in primary care, thus leaving room for variation in care driven by variation in primary care physicians’ knowledge”. This is indeed a possibility. GPs can act as an important facilitator in referring patients, and widening the use of chemoprevention. This seems uncontroversial to us.

Dr Hopcroft suggests that CCGs should use data to monitor GP prescribing and ensure that GPs are following NICE guidance: this is exactly what we recommend. Indeed, as discussed in the paper, we produce an openly accessible tool—OpenPrescribing.net—that does exactly this, with 50,000 unique users last year. Improvements in data monitoring, audit, and knowledge dissemination can only support GPs in staying current with guidance. We do, however, think it is somewhat relevant. We cite a previous paper by primary care researchers which reported variable knowledge among GPs of the NICE guideline. Indeed, that finding triggered our research: we wanted to see if there was variation in practice, after others reported variation in knowledge. We set that paper on variable GP knowledge in context, saying: “discussion will often be initiated in primary care, thus leaving room for variation in care driven by variation in primary care physicians’ knowledge”. This is indeed a possibility. GPs can act as an important facilitator in referring patients, and widening the use of chemoprevention. This seems uncontroversial to us.

We agree that the guidance to only offer chemoprevention to women presenting, as well as variation in spontaneous presentations. We are separately concerned by the prospect that variation in use of primary prevention will be driven by variation in patients’ choices to spontaneously present, which may in turn be a driver of inequality in health outcomes; in our view this is a worthy topic for research.

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We agree that the guidance to only offer chemoprevention to presenting patients, rather than actively seeking out patients, may be another contributing factor to low rates of adoption. However, variation among practices’ prescribing data could still be driven by clinicians’ variable actions in response to patients presenting, as well as variation in spontaneous presentations. We are separately concerned by the prospect that variation in use of primary prevention will be driven by variation in patients’ choices to spontaneously present, which may in turn be a driver of inequality in health outcomes; in our view this is a worthy topic for research.

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