

The risk of colon cancer is not greater in a younger person with a benign source of rectal bleeding

Other strategies for evaluating rectal bleeding in younger patients

To the editors:

If I was a man younger than 50 years old (and this is in fact the case), and I had a mild episode of rectal bleeding (nonurgent, without alarm symptoms or signs), I would not want to end up undergoing a full colonoscopy. However, from the recent retrospective study from Wong et al (“Consider colonoscopy for young patients with hematochezia,” *J Fam Pract* 2004; 53:879–884), I would get one if their conclusions are correct, as they “strongly recommend it” in their conclusion. If I went to my family practitioner, however, I probably would not have a colonoscopy. Why is this?

Wong et al evaluated medical records from young patients (aged <50 years) with rectal bleeding in a tertiary referral medical center. Following the records retrospectively in time, they found a number of colon cancers. Based on available evidence, they strongly recommend consideration of colonoscopy in this population. However, as the authors themselves state, there are several limitations that impede arriving to such a conclusion.

Clinical and epidemiological studies based on referrals from primary to secondary or tertiary care centers may suffer from important and unpredictable selection bias.² Patients included in this study have been inevitably filtered along the diagnostic process; this bias is mentioned but overlooked by the authors. An undetermined number of patients with mild rectal bleeding do not seek consultation, and many are treated in primary care for symptomatic

hemorrhoids or anal fissure, among other causes. This is by far the most common etiology in primary care, and these patients do not arrive to tertiary centers.^{3,4} Thus, the design of this study does not allow us to make strong inferences about young patients (<50 years) in primary care.

On the other hand, its retrospective design and small sample size adds limitations to the conclusions; therefore, its results are probably overestimating the true diagnostic value of colonoscopy. The fact is that the risk of colon cancer in a younger person with an objective benign source of anal or rectal bleeding (anal fissure or hemorrhoids) might not be higher than the risk from a random person of the same age but without rectal bleeding. Data from screening studies in this younger population show very similar risks to the ones found in this study.⁵

An optional (and as reasonable) approach is to investigate using a simple anal and rectal examination, with the help of an anoscope, looking for an active bleeding source such as a hemorrhoid or an anal fissure.⁶ This simple procedure will allow us to assess in our office most of the non-urgent bleedings.⁷ In the case, if there is not an obvious reason for the bleeding, a complete evaluation of the rest of the colon is warranted. If hemorrhoids are found, they can be treated, and the patient is then followed to check that the bleeding disappears in parallel with the symptomatic bleeding hemorrhoids. If the hemorrhoids stop bleeding and there is still rectal bleeding, a colonoscopy is again necessary. Some working groups on gastroenterology consider this a safe strategy, and it has been endorsed in national evidence-based clinical practice guidelines.⁸

Until prospective trials that compare the main diagnostic strategies available (eg,

flexible sigmoidoscopy, colonoscopy, or anoscope) in primary care are not available, we can only, as the authors acknowledge in their paper, speculate about the true underlying value of these diagnostic strategies.

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Drs Wong and Kuwada respond:

In response to the letter by Dr. Alonso-Coello, we acknowledge some limitations of this study; however, we would like to further address some of his comments.

We agree that the importance of referral bias cannot be overlooked. Since we included only patients referred by primary care physicians, we do realize that our analysis includes a select group of patients. However, our study population is not dissimilar to the patients commonly seen in community practice. Both hospitals included in the study have open-access endoscopy systems and the majority of patients undergo endoscopy without seeing a gastroenterologist first. In other words, the primary care physician is generally making the decision to perform colonoscopy. We think this limits the referral bias typically attributed to tertiary referral centers. Also, we excluded patients with a strong family history of colorectal cancer in order to decrease including those with hereditary colorectal cancer predisposition. Regardless, we still exclude a portion of the population, as Dr. Alonso-Coello points out.

We disagree that our findings may represent a cross-section of the young, asymptomatic population. In the study by Imperiale et al, in nearly 900 asymptomatic patients between the ages of 40 to 49 years, none had a colorectal cancer compared to our finding of almost 2%. We do not think this can be fully attributed to referral bias. Our study raises the question of whether physicians can comfortably bypass colonoscopy in young patients with non-urgent rectal bleeding. To do so, they have to accept missing a colorectal cancer

in 2% of patients. Is this acceptable given the costs, risks and resource utilization of colonoscopy? As pointed out in our discussion, a cost analysis by Lewis et al would support performing colonoscopy.

Dr Alonso-Coello also provides an alternative strategy to evaluate rectal bleeding other than colonoscopy. Our study was not designed to specifically answer whether anoscopy would suffice in this population. However, over a quarter of the patients had coexistent colorectal pathology, including adenomas and colitis, in addition to hemorrhoids. Chronic colitis may result in chronic bleeding that would warrant further diagnostic approaches after treatment of hemorrhoids. However, we doubt that the majority of adenomas would present with persistent bleeding and would subsequently be missed in the more conservative approach suggested by Dr Alonso-Coello.

We appreciate the thoughtful comments by Dr Alonso-Coello and concur with his conclusion that a prospective study is necessary to further address some of these important issues.

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In bypassing colonoscopy for young patients with nonurgent rectal bleeding, we would have to accept missing colorectal cancer in 2% of patients

Intrathecal analgesia and the cesarean rate

To the editor:

A POEM in your June issue (“Early intrathecal analgesia does not increase cesarean sections,” *J Fam Pract* 2005; 54:500) concludes that intrathecal analgesia does not increase the cesarean section rate. The reported *New England Journal of Medicine* study was of “neuraxial analgesia,” an obfuscating term. The author,¹ the editorialist,² and the press reported that women need not worry that an early epidural will lead to an increased likelihood of cesarean section.

This claim is unjustified by the research reported. This trial was not about early epidural use. It was about 2 methods of helping women with the pain of early labor. In the so-called epidural arm, at first request for analgesia, women got intrathecal fentanyl; in the narcotic arm, hydromorphone. And at that point women in both arms already had a 75% utilization rate of oxytocin augmentation—so high as to be non-generalizable to usual settings. On second request for pain relief, two thirds of the women in both arms were ≥ 4 cm dilated or in the active phase of labor. At this advanced state, in the intrathecal-“epidural” arm they received a low-dose epidural. In the narcotic arm, they got hydromorphone intramuscularly. This trial is misleading because it fails to emphasize that most women in were in the active phase of labor at randomization. This study, like the others randomizing late,^{3,4} has shown only that when women’s early or latent phase pain is managed with intrathecal narcotic or other pharmacological or nonpharmacological means, an epidural in the active phase of labor does not increase the cesarean section rate. The role of intrathecal analgesia or early epidurals in contributing to cesarean increase has yet to be studied in a controlled trial, though when early epidurals

are studied as a separate stratum from within the Cochrane meta-analysis of epidural vs narcotic,³ epidural given early (<4 cm) increase the cesarean section rate by an odds ratio of 2.59 (95% confidence interval, 1.29–5.23).

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