Colorectal Screening: Progress, Not Perfection

BY BETSY BATES
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Las Vegas — There's good news and bad news about the state of colorectal cancer screening, and both took center stage at the annual meeting of the American College of Gastroenterology.

First the good news: More Americans are being screened and having precancerous polyps removed. Age-adjusted rates of colon cancer fell from 42.81 per 100,000 in 1988-1990 to 38.59 per 100,000 during 2000-2002, according to the Nationwide Inpatient Sample (NIS), reported Dr. Mazen M. Jamal and Dr. Eugene J. Yoon of the Long Beach (Calif.) Veterans Affairs Medical Center and the University of California, Irvine, Medical Center.

Similar trends were seen in the Surveillance Epidemiology and End Result (SEER) database during the same time period, the authors noted.

"This may be the first sign that we're making an impact," said Dr. Mark B. Pochapin, chief of gastrointestinal endoscopy at Cornell University/New York–Presbyterian Hospital, New York, speaking at a press briefing at the meeting.

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More good news came from the Clinical Outcomes Research Initiative (CORI), an ongoing study of 75 representative U.S. gastroenterology practices serving 600,000 patients. Dr. David Lieberman, chief of gastroenterology at Oregon Health and Science University, Portland, announced CORI results showing that in 2005, 30.7% of colonoscopies performed in "real-life clinical practice" were for screening, vs. 9.7% in 2000-2002. "Clearly this shows a dramatic change in the use of colonoscopy in just over a few years," he said.

"Overall, it appears that we are finally approaching 50% of patients who are age-eligible receiving at least some form of colon cancer screening," Dr. Lieberman continued. "This is not as good as we would like—the rate is 70% for mammography—but it is an upward trend."

But there was bad news as well.

Dr. Lieberman noted that more than 50% of endoscopists are recommending more frequent surveillance than expert guidelines recommend for patients with a low recurrence risk, including those with small tubular adenomas.

This trend will "use up a lot of our resources," and reduce the rate of gains being achieved by initial screening of appropriate candidates, he said.

In the meeting's Emily Couric lecture, Dr. Douglas Rex, professor of medicine at Indiana University, Indianapolis, spotlighted two of the key shortcomings of colonoscopy: injuries to patients, including perforations that occur during the removal of small polyps, and detection rates that are highly variable and operator-dependent.

Medicare population data show a perforation rate of 1 in 1,000 patients during screening colonoscopy.

Many experts for years have advocated use of cold techniques rather than use of hot snaring equipment or hot forceps to reduce this perforation rate, but "people really aren't listening," Dr. Rex said.

The problem of variable detection rates could be targeted by moving toward improved technology such as wide-angle views and flexible endoscopes capable of viewing the back sides of folds within the colon. But individual endoscopists must get engaged in changing practice, he said.

Two recent studies found 4-fold to 10-fold differences in adenoma detection rates by experienced endoscopists in controlled studies, including one study performed at Dr. Rex's institution. These differences extend even to detection of large adenomas.

Individual endoscopists should begin tracking their own adenoma detection rates to see if they match or exceed a general prevalence figure of 25% in men and 15% in women over age 50 undergoing screening colonoscopy, he said.

"If those numbers are low, then the first thing to look at is probably withdrawal time, since withdrawal time in seven studies has been associated with adenoma detection rates," he said. The ideal withdrawal time for maximum detection of adenomas is unknown, but current data suggest it should be at least 6-7 minutes.■