

Support Grows for Earlier Colonoscopy in Blacks

BY MICHELE SULLIVAN

FROM THE ANNUAL DIGESTIVE DISEASE WEEK

NEW ORLEANS — Screening colonoscopy in asymptomatic black patients found a 4.5% rate of high-grade dysplastic polyps in those aged 45-49 years, according to the findings of a retrospective review.

The findings suggest that blacks should have their first colonoscopy before they reach age 50, said Dr. Frank Friedenberg, a professor of medicine at Temple University Hospital, Philadelphia.

About a month after the meeting, the American Society for Gastrointestinal Endoscopy issued separate guidelines suggesting that blacks begin screening colonoscopy at age 45. Developed by the ASGE's Standards of Practice Committee, the guidelines on ethnicity, gastrointestinal diseases, and endoscopic procedures appear in the June issue of *GIE: Gastrointestinal Endoscopy* (2010; 71:1108-11). The document is available at www.giejournal.org and www.asge.org.

The guidelines, which are based on literature reviews, include "recommendations" as well as "suggestions," with the latter term indicating that the quality of evidence is weaker.

The ASGE suggestion regarding screening for black patients reflects several risk factors: "African Americans with colon cancer have a 20% stage-adjusted increase in mortality risk, compared with European Americans," are younger at presentation, have a higher proportion of cancers presenting before age 50, and generally more advanced stage at the time of diagnosis, the authors of the guidelines noted.

Many ethnic groups have low colon cancer screening rates; the guidelines support an increased emphasis on screening for those groups.

No studies have assessed the impact of modifying specific endoscopic standards based on ethnicity, but "it is logical to assume that increased awareness of differences in disease patterns and management among different ethnic groups could have beneficial impacts on the health-related quality of life of people in these

groups," said Dr. Jason A. Dominitz, chair of ASGE's Standards of Practice Committee.

"It is important to recognize that ethnic populations are not homogeneous and that additional factors, such as environment and behavior, also play important roles in disease," Dr. Dominitz added in a statement.

In presenting his findings at Digestive Disease Week, Dr. Friedenberg noted that "several lines of evidence suggest we should be looking at screening blacks at an earlier age."

"National data suggest that colorectal cancer is actually increasing in blacks, while it's declining in the general population. Blacks also seem to have a predilection for proximal colorectal neoplasia, suggesting that flexible sigmoidoscopy is not an appropriate screening tool.

"Finally, patients younger than 50 who develop colorectal cancer are twice as likely to be black as white. All these are very compelling reasons to think about earlier screening," he said.

Dr. Douglas K. Rex, distinguished professor of medicine at Indiana University, Indianapolis, and director of endoscopy at Indiana University Hospital, commented in an interview that "the approach of screening colonoscopy starting at age 45 in African Americans was endorsed by the American College of Gastroenterology, but has been controversial. This study lends support to the ACG recommendation, but is unlikely to resolve the controversy."

Dr. Friedenberg and his colleagues reviewed the charts of 109 black patients aged 45-49 years matched with 226 black patients aged 50-59 years, all of whom underwent a screening colonoscopy. All of the patients were asymptomatic, and none of them had a family history of colorectal cancer. The groups were well-matched in terms of gender and body mass index (mean, 31 kg/m²).

The older patients were significantly more likely than the younger patients to smoke (48% vs. 37%), drink alcohol (43% vs. 21%), and use aspirin regularly (26% vs. 15%).

Polyps were found in 22% of the younger group and

20% of the older group, not a significant difference. Thirty percent of each group had more than one polyp. The polyps were on the right side of the colon in about half of each group. "This is much more than you would expect, lending credence to the observation that blacks have a predilection for right-sided lesions," Dr. Friedenberg said.

Significant differences emerged in polyp histology. High-grade dysplastic lesions occurred in 4.5% of the younger group and 0.4% of the older group. "Theoretically, this means that there were several younger individuals who, if they had waited until their 50s to have a colonoscopy, could have had a colon cancer by then," Dr. Friedenberg said.

The significantly higher use of aspirin in the older group may have exerted a protective influence against high-grade lesions, he said, "although since that group smoked significantly more, it might have balanced out the risk."

The study suggests that screening colonoscopy should begin earlier in black patients, Dr. Friedenberg said. "We are already swamped with colonoscopies, and to begin screening years earlier in this population would be a financial challenge," he said. "Still, it is something that needs to be looked at on a larger scale."

Dr. Rex added that "some have argued that an early screening recommendation for African Americans would have the added benefit of educating both patients and primary care physicians that there is higher risk in this group, but there are also lower rates of screening adherence, so special efforts are needed to ensure that screening in African Americans takes place."

The ASGE guidelines also suggest a screening esophagogastroduodenoscopy (EGD) for gastric cancer in new immigrants from high-risk regions, such as Korea, Japan, China, Russia, and South America, in particular if there is a family history in a first-degree relative.

However, screening EGD for adenocarcinoma or squamous cell carcinoma of the esophagus should be based on clinical considerations and not on ethnicity, according to the guidelines. ■

Disclosures: Dr. Friedenberg had no relevant financial disclosures.

Alicia Ault contributed to this report.

Blacks with colon cancer have a 20% higher mortality risk than whites, are younger at presentation, and have a higher proportion of cancers presenting before age 50.

Diminutive Polyps Not Likely to Become Cancerous

BY CAROLINE HELWICK

FROM THE ANNUAL DIGESTIVE DISEASE WEEK

NEW ORLEANS — Diminutive polyps have a very low risk of advanced histology and virtually no risk of cancer, and therefore clinicians should balance the small potential benefit of removing them against potential harms posed by polypectomy, Dr. Thomas F. Imperiale said.

In an invited lecture on the management of diminutive polyps, Dr. Imperiale acknowledged that endoscopists often elect to remove these polyps, but he said they should consider several factors first.

Diminutive polyps (less than or equal to 5 mm) constitute at least 80% of all colorectal polyps and have been identified in 44% of persons undergoing colonoscopy for any indication, he said.

Nearly half occur in the sigmoid colon and rectum, and the remainder are fairly evenly distributed throughout the colon. Diminutive polyps are

neoplastic in 35%-50% of cases, with the risk of neoplasia increasing in accordance with polyp size. The highest risk occurs in the ascending colon and cecum, said Dr. Imperiale, professor of medicine, Indiana University Medical Center, Indianapolis.

The clinical importance of diminutive polyps is not great, as cancer is uncommon (less than 1%). In a recent systematic review of four studies involving more than 20,000 patients, the frequency of advanced lesions among patients whose largest polyp was diminutive was 0.9%, but it rose dramatically to 73.5% when the polyp was 10 mm or larger (*Aliment. Pharmacol. Ther.* 2010;31:210-7).

Furthermore, these lesions grow slowly, generally less than 0.5 mm per year. Hyperplastic polyps appear to have an even slower rate of growth, he added.

Like the cancer risk, the benefit of removing polyps is proportional to their size. The number needed to resect to prevent one advanced adenoma or

colorectal cancer, therefore, varies widely.

"The prevention of one cancer in a person with a diminutive polyp is associated with a cost-effectiveness ratio that is 5-10 times the established cost-effectiveness threshold," he pointed out. "For large polyps, however, resection is cost saving."

Polypectomy is probably overutilized for diminutive polyps and conveys more harm than benefit, he maintained, noting that it increases the risk for major complication and, when incompletely performed, is responsible for 30% of interval cancers.

In vivo histologic assessment has a potential role in the management of diminutive polyps. With this, the clinician can avoid removing non-neoplastic polyps, especially distal ones, thus reducing costs and risks; can resect and discard small adenomas, reducing pathology costs; and can identify cancer via real-time histology, which improves treatment selection, Dr. Imperiale said.

Although in vivo histology could be

used to avoid the removal of non-neoplastic polyps, it also means that adenomas are left intact and the surveillance interval could prove to be too long (which raises the risk of cancer) or too short (which increases risk from needless polypectomy), he said.

Several recent studies have evaluated the effect of optical diagnosis without pathology on surveillance intervals, essentially concluding that adenomatous and hyperplastic polyps can be adequately identified and that this approach might be acceptable for diminutive targets.

Before such techniques are implemented, he said, "we need more real-time data. We need to identify optimal techniques. And we need to quantify the effects on surveillance and estimate the downstream effects, which would be the incidence of colorectal cancer, complications, and costs." ■

Disclosures: Dr. Imperiale has no relevant financial disclosures.