Updated Colorectal Cancer Guidelines Call for CT Scan

BY MARY ANN MOON
Contributing Writer

Updated clinical practice guidelines now call for annual CT scanning of the chest and abdomen in colorectal cancer patients who are at high risk for recurrence and who would be candidates for further resection if metastases were found.

An expert panel of the American Society of Clinical Oncology revisited the issue of stage II or III colon or rectal cancer surveillance because treatment and monitoring of the disease have changed since the previous clinical practice guidelines were issued in 2000. There have been substantial advances in tumor respectability and patient survival, "supporting more aggressive follow-up after diagnosis and treatment," the panel noted.

The previous guidelines recommended against CT surveillance based on evidence that identification of lung and liver metastases on CT did not influence survival. But the panel's review of studies published since 1999 showed a 25% lower mortality in patients with stage II or III colorectal cancer who have CT monitoring, because it can identify such metastases at an early enough stage to now allow limited but curative surgical resection.

The updated guidelines also now recommend considering annual pelvic CT scanning for surveillance of patients with rectal cancer who have unfavorable prognostic factors, especially those who were not treated with radiotherapy. The data do not justify such surveillance for lower-risk patients, according to the panel.

The guidelines have been published and are posted online at www.jco.org (J. Clin. Oncol. 2005;23: 8512-9).

Updated guidelines for patients, titled "Follow-Up Care for Colorectal Cancer," are available on the patient Web site, at www.plwc.org.

The new guidelines call for serum testing for carcinoembryonic antigen (CEA) every 3 months for at least 3 years after initial diagnosis and treatment. Colonoscopy is recommended postoperatively to document freedom from carcinomas and polyps, as well as at year 3 and at 5-year intervals thereafter.

The guidelines also address American Gastroenterological Association recommendations for more frequent colonoscopy in certain high-risk patients.

The new guidelines recommend regular primary care visits every 3-6 months for the first 3 years, every 6 months during years 4 and 5, and as often as the physician deems necessary thereafter. ■

Surveillance 5 Years After Polypectomy Deemed to Be Safe

BY BRUCE JANCIN
Denver Bureau

HONOLULU — A 5-year wait before surveillance colonoscopy following removal of a high-risk adenomatous polyp appears to be sufficient, instead of the currently recommended 3 years, Mihir Bakhru, M.D., said at the annual meeting of the American College of Gastroenterology.

Lengthening the surveillance interval in patients with such lesions from 3 to 5 years—as now looks to be safe—should free up more time for busy gastroenterologists to perform primary screening colonoscopies, added Dr. Bakhru of the Cleveland Clinic Foundation.

Current national guidelines recommend postpolypectomy surveillance colonoscopy 5 years after removal of polyps categorized as moderate risk and 3 years after clearance of high-risk polyps. But direct evidence to support the safety of the 5-year interval has been lacking.

That uncertainty was the impetus for Dr. Bakhru's study in which he compared the surveillance colonoscopy findings in 163 patients who underwent the procedure 5 years post polypectomy with an equal number of age- and gender-matched patients who underwent the procedure at 3 years.

Because these prospective but nonrandomized data were generated prior to current national guidelines, 57% of patients in the 3-year-interval group were at moderate risk, as were 49% in the 5-year-interval group, he said.

The primary study end point was the percentage of patients found to have recurrent neoplasia at surveillance colonoscopy: 49% with 3-year follow-up, a rate not significantly different from the 51% rate with 5-year follow-up. The rate of advanced neoplasia was 11% with 3-year and 10% with 5-year follow-up. Of the recurrent neoplasms detected in the 3-year follow-up group, 79% were tubular adenomas, as were 80% of those found with 5-year surveillance. No cancers were detected in either group.

Results from a multivariate analysis indicated that patients with more than two adenomas at screening colonoscopy, a polyp greater than 1 cm in size, and high-risk pathology were at more than a threefold increased risk of recurrent or advanced neoplasia at follow-up, although none of these three factors alone was predictive. Older age and nonwhite race were also predictive of recurrent or advanced neoplasia.

Dr. Bakhru received a 2005 ACG Auxiliary Award for his study. ■

Colonoscopy Misses Lesions Even in Experienced Hands

BY BRUCE JANCIN
Denver Bureau

HONOLULU — Roughly 2%-4% of newly diagnosed colon cancers in a busy private gastroenterology practice were missed at colonoscopy performed within the prior 36 months, John F. Johanson, M.D., said at the annual meeting of the American College of Gastroenterology.

"The implication of these data is that even in experienced hands, colonoscopy is not perfect. We all understand that. But I think it needs to be communicated to our patients. We've now actually incorporated the possibility of a missed lesion into our informed consent," said Dr. Johanson, a Rockford, Ill., gastroenterologist.

The data will also be used to develop benchmarks for quality assurance efforts.

Dr. Johanson reviewed computerized medical records for 2003 and 2004 in a private practice with 12 board-certified gastroenterologists. Each had performed at least 2,000 colonoscopies, and most had done far more than 5,000. During the study period they did 16,147 colonoscopies, leading to detection of cancer in 204 patients. Thus, 1 in 80 procedures resulted in diagnosis of colon cancer.

Eight patients had colonoscopy within 36 months prior to diagnosis. Malignant transformation of polyps is typically a slow process, so the initial assumption was that all these were missed lesions. This yielded a missed cancer rate—or as Dr. Johanson prefers to call it, a "surprise" colon cancer rate of 3.9%. There were two T-4 lesions, four T-3s, one T-2, and one T-1. They did not cluster by location or colonoscopist.

Upon examination of the detailed records of the prior colonoscopies, it became apparent that two of the eight colon cancers weren't truly missed, thus dropping the miss rate to 2.9%.

One such patient had a large rectosigmoid polyp removed and came back for another colonoscopy 1 year later, when it was found the polyp had returned. It was removed again down to the base. When the patient came back again a year later, the lesion had returned—and was now malignant.

Another patient, referred for evaluation of abdominal pain, had an incomplete colonoscopy due to technical reasons; the scope could be advanced only to the mid-transverse colon. A year and a half later the patient was back, this time with rectal bleeding—and cancer of the ascending colon.

Two other patients had cancers in the same locations as adenomas that, in hindsight, were probably incompletely removed. In the remaining four patients, there was no clear explanation for the surprise colon cancer. Dr. Johanson's study received a 2005 ACG/Olympus Award. ■

5-ASA Advocated for Long-Term Colorectal Cancer Chemoprevention

HONOLULU — Two good reasons exist for all ulcerative colitis patients to be on 5-aminosalicylate long term, Bret A. Lashner, M.D., said at the annual meeting of the American College of Gastroenterology.

One is that the drug helps maintain remission. That's common knowledge. But 5-ASA also may reduce the risk of developing colorectal cancer, said Dr. Lashner, director of the Center for Inflammatory Bowel Disease at the Cleveland Clinic Foundation.

'ASA not only prevents recurrence but might help decrease the risk of cancer.'

DR. LASHNER

Evidence for a chemopreventive effect of 5-ASA is "somewhat weak," he conceded. There have been five studies addressing the issue, all observational. Three proved positive, and two showed no effect.

But a recent metaanalysis by Fernando S. Velayos, M.D., and colleagues at the University of California, San Francisco, that included these five studies as well as four others looking at the combined end point of colorectal cancer or dysplasia, concluded 5-ASA was indeed protective against colorectal cancer. The drug was associated with a 49% reduction in relative risk. It was also associated with an identical 49% reduction in the risk of colorectal cancer/dysplasia (Am. J. Gastroenterol. 2005;100:1345-53).

"We now know from work at the University of Chicago that patients don't take this medication the way they should. Adding into your practice the advice that 5-ASA not only prevents recurrence but might help decrease the risk of cancer or dysplasia might get patients to take their medicine more often," Dr. Lashner said.

Two other agents are supported by evidence of efficacy for primary chemoprevention of colorectal cancer in ulcerative colitis patients. One is folic acid at 0.4-1.0 mg/day. Only one of three epidemiologic studies showed a statistically significant benefit, but since folic acid is safe and inexpensive, it is something that ulcerative colitis patients ought to routinely take long term, Dr. Lashner said.

The other agent is ursodeoxycholic acid, which in two studies showed efficacy in inflammatory bowel disease patients with primary sclerosing cholangitis, he said. The dose is 1,200 mg/day.

—Bruce Jancin