Subgroups May Need Earlier Colon Ca Screening

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HONOLULU — The possibility that an earlier start for colorectal cancer screening is warranted in selected major patient subgroups—most notably African Americans, diabetics, and women smokers—was a recurrent theme at the annual meeting of the American College of Gastroenterology.

Current recommendations call for colorectal cancer (CRC) screening to begin at age 50 in average-risk individuals. But emerging evidence suggests that women who smoke, diabetics, and African Americans are at substantially above-average risk and may need more aggressive screening.

A particularly strong case for an earlier start to screening can be made for African Americans. Indeed, a recent ACG position paper (Am. J. Gastroenterol. 2005;100:515-23) concluded that "current research data would favor modification of the CRC screening guidelines for African Americans to begin screening at the age of 45."

And that may not go far enough, according to a coauthor of the report. "If you look at some of the data that are coming out for prostate cancer, there really is a very strong body of evidence now that PSA screening of African Americans should begin at age 40 rather than 50. And I think GI will get there also. There's very suggestive evidence that this should be the approach," Frank A. Hamilton, M.D., said at a press briefing held to publicize the ACG report.

He cited, for example, California studies showing African Americans were more than twice as likely as whites to present with advanced CRC before age 50.

Nationwide, the overall incidence of CRC in 2000 was 20%-25% lower than in the peak year of 1985. But the incidence among African Americans was more than 12% greater than in whites during 1996-2000. The disparity was particularly disadvantageous for African American women, whose CRC incidence was 17.5% greater than in white women.

CRC is the second leading cause of cancer deaths in the United States. Survival in affected African Americans is significantly worse than in whites. Five-year survival in African Americans with CRC during 1992-1999 was 53%, compared with 63% among whites. Although not all the evidence is in, Dr. Hamilton said it appears that reduced access to screening among African Americans is the chief explanation for the disparity, rather than racial differences in tumor aggressiveness.

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DR. HAMILTON

"I think we're finding more African American patients late with the disease. It may be a question of access rather than genetic differences," added the gastroenterologist, who is branch chief at the National Institute of Diabetes and Digestive and Kidney Diseases, Bethesda, Md.

The Centers for Disease Control and Prevention recently got congressional authorization to develop model programs aimed at redressing racial health disparities, with particular focus on CRC, he noted.

When asked what sort of reception the ACG proposal for earlier CRC screening in African Americans has received among health policy officials, Dr. Hamilton said there has been concern that it's overly ambitious. After all, only about 45% of the eligible general population—that is, individuals 50 years and older—has ever had any form of CRC screening. Some say it makes better sense to find ways to boost compliance with the current recommendation to screen starting at age 50 before promoting earlier screening. The Healthy People 2010 goal is to raise the CRC screening rate in the general population to at least 60% 5 years from now.

Also at the meeting, Anna L. Zisman, M.D., presented an analysis of gender differences in the impact of tobacco and alcohol use on CRC risk. The study population consisted of 86,582 patients diagnosed with CRC during 1993-2003 who were included in the IMPAC Medical Registry Services Cancer Information Resource, which features patient information obtained from more than 350 participating teaching and community hospitals.

Smoking and alcohol consumption are well-established CRC risk factors. But differences in how they operate in men, compared with women, weren't appreciated until this study, which earned Dr. Zisman and her coinvestigators the 2005 ACG Radhika Srinivasan Gender-Based Research Award.

The mean age at CRC diagnosis in the study population was 68.2 years in men and 71 in women. Women who were current smokers or drinkers were diagnosed at a younger age than those who were not. And if they were both current smokers and drinkers, the effect was magnified such that their CRC diagnosis came a mean of 9.2 years earlier than in those who hadn't used tobacco or alcohol for at least 1 year, if ever. In men, the age gap was smaller, with current smokers and drinkers developing CRC 6.5 years younger.

A multivariate analysis showed the gender disparity was accounted for by a much greater impact of smoking on age of CRC onset in women, compared with men, as indicated by the finding that both never-smoking, current-drinking women as well as men developed CRC a mean of 4.9 years earlier than their never-smoking, never-drinking counterparts.

"We need to be looking at gender and environment interactions in designing preventive strategies. In particular, we should be looking at earlier screening in women, smokers especially," said Dr. Zisman of Evanston (Ill.) Northwestern Healthcare.

A limitation of the IMPAC registry is that it doesn't include data on amount of alcohol consumed. The current-drinker group thus included the full range.

In a poster presentation, Donald Garrow, M.D., showed data on 226,953 American adults who participated in the National Health Interview Survey during 1997-2003. Among the 5.9% with diabetes, 1.34% had a history of CRC, nearly three times the 0.47% rate in nondiabetic subjects. After controlling for potential confounders, a history of diabetes mellitus was associated with a 40% increased odds of having CRC, said Dr. Garrow of the Medical University of South Carolina, Charleston. His study was partially funded by the Health Resources and Services Administration. ■

CLINICAL CAPSULES

Tegaserod for IBS in Women

A large, international trial has shown that tegaserod is significantly more effective than placebo for irritable bowel syndrome with constipation.

Jan Tack, M.D., of the Centre for Gastroenterological Research, University of Leuven (Belgium), and coauthors worked with physicians from 20 countries to randomize 2,660 female patients; 2,135 received tegaserod (6 mg twice daily) and 525 took a placebo for the initial treatment phase of 1 month.

After a treatment-free interval, the researchers rerandomized 983 patients (488 tegaserod, 495 placebo) who qualified for repeated treatment because they responded to the first treatment and then they had recurrence of IBS symptoms (Gut 2005;54:1707-13).

The patients treated with tegaserod had better work productivity and quality of life than did placebo patients during both the initial therapy and the repeated treatment. The drug, marketed as Zelnorm by Novartis, was initially approved in 2002 for IBS with constipation in women. Due to subsequent concerns about overuse, the label advises physicians and patients to "periodically assess the need for continued therapy."

Nicotine Enemas in Ulcerative Colitis

Nicotine enemas are no more effective than placebo enemas for patients with active ulcerative colitis, according to a randomized, double-blind study.

In the study by John R. Ingram, M.D., of the department of gastroenterology at Cardiff (Wales) and Vale National Health Services Trust, and his colleagues, 104 patients were given enemas containing 6 mg nicotine or placebo daily for 6 weeks. Patients who had been receiving oral therapy for ulcerative colitis continued on their medications. The nicotine enemas were well tolerated and 14 of 52 patients who received them achieved remission of their ulcerative colitis, as did 14 of the 43 patients who received placebo enemas—a nonsignificant difference (Clin. Gastroenterol. Hepatol. 2005;3:1107-14).

A previous study at the University Hospital of Wales in Cardiff had concluded that nicotine enemas might be more effective than transdermal delivery (Aliment. Pharmacol. Ther. 1997;11:859-63).

A Century of Family G's Genetics

Molecular diagnostic testing has transformed the care offered to families with a mutation for Lynch syndrome, according to an historical cohort study of the 929 known descendants of a German immigrant to America, known as "family G."

In their prospective analysis of living descendants within family G, Julie A. Douglas, Ph.D., of the University of Michigan, Ann Arbor, and her colleagues tested frequencies and types of cancers, ages at diagnosis, and the presence of the T to G transversion of certain cancer-gene mutations in 40 members of the family (JAMA 2005;294:2195-202).

The family's unusually high incidence of colorectal, stomach, and endometrial cancers has come to be known as Lynch syndrome. The original documentation of family G was in 1913 by Aldred S. Warthin, M.D., based on observations he started in 1895. The most recent update prior to the current study was in 1971 by Henry T. Lynch, M.D., for whom the syndrome subsequently was named.

Molecular diagnostic testing has shown that 5 of the 40 tested members of family G carry the T to G mutation. Among the living relatives of those 5, a total of 15 are at increased risk of developing one or more colorectal or Lynch syndrome–associated cancers, and another 97 can now be excluded as mutation carriers.

Wireless Esophageal pH Monitoring

A catheter-free wireless capsule shows promise as a reliable device for monitoring esophageal pH in the diagnosis of gastroesophageal reflux disease, researchers said based on a prospective study.

S. Bruley des Varannes, M.D., of Hôpital Hôtel Dieu, Nantes, France, and colleagues compared the new Bravo pH monitoring system (Medtronic) with a conventional pH measurement system (CPHMS) by simultaneously recording data with both devices for 24 hours in 36 patients, then continuing for another 24 hours with Bravo only (Gut 2005;54:1682-6).

The Bravo system uses a radiotelemetric capsule that attaches to the esophageal wall and transmits pH data to a small receiver on the patient's belt. The CPHMS with an antimony catheter remains free in the esophageal lumen. Although the Bravo device recorded less acid exposure than did the CPHMS on the first day, the researchers discounted this due to mitigating circumstances such as the capsule's lower sample rate (6 seconds vs. 4 seconds for CPHMS) and presence of the pH catheter on the first day.

R.H. Holloway, M.D., said in an editorial that because patients can undergo recordings with less disruption of their daily activities with the capsule, its use "will provide more meaningful data for evaluation of patients and, hopefully, more discriminative diagnosis"(Gut 2005;54:1672-81).

—Randall Frey