

## Colorectal screening: Don't start too early

I disagree with statements made in “What’s the most effective way to screen patients with a family history of colon cancer?” (Clinical Inquiries, *J Fam Pract.* 2010;59:176-178). Patients with a first-degree relative diagnosed with colorectal cancer (CRC) or adenomatous polyps (AP) after the age of 60 have an increased risk and should start screening at 40 years of age, the article recommends.

That recommendation is at odds with the most recent colorectal screening guidelines from the American College of Gastroenterology (ACG), issued in 2008, which state: “Individuals with a single first-degree relative with CRC or advanced adenomas diagnosed at  $\geq 60$  years can be screened like average-risk persons.”<sup>1</sup> The guidelines further note that a family history of small tubular adenomas in a first-degree relative is not associated with an increase in risk—a statement that applies even to patients whose family member had a tubular adenoma before the age of 60.

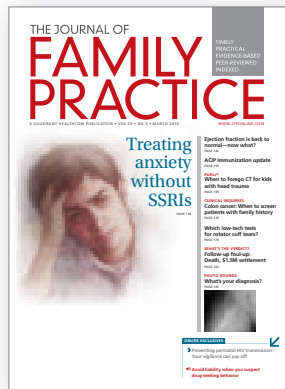
This is an important distinction. We should not be pushing people to have colonoscopies, which are invasive and expensive, without providing the most current recommendations from a specialty organization whose members include the doctors who make money from performing this procedure. Presenting this as an “evidence-based answer,” I believe, is dangerous and misleading.

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1. Rex DK, Johnson DA, Anderson JC, et al. American College of Gastroenterology guidelines for colorectal cancer screening 2008. *Am J Gastroenterol.* 2009;104:739-750.

## The author responds:

The referenced ACG guidelines are the only guidelines that do not recommend early screening for patients with a relative older than 60 with CRC or AP. It is also important to note that the authors of the ACG guidelines state that there is evidence of increased risk in this population. But presumably—in their view—the



increased risk is not large enough to warrant early screening.

Other guidelines, specifically from the American Society of Gastrointestinal Endoscopists (ASGE)<sup>1</sup> and the US Multi-Society Task Force (USMSTF),<sup>2</sup> do recommend screening at age 40 for such patients. Interestingly, the USMSTF guidelines were published just 1 year prior to the ACG guidelines, and the

USMSTF is composed of a broad range of organizations—including the ACG, the American Gastroenterological Association, the ASGE, the American College of Radiology, and the American Cancer Society. What’s more, 2 of the authors of the ACG guidelines were also primary authors of the USMSTF guidelines. Such contradictory recommendations highlight the fact that there is limited solid evidence to guide practitioners.

With regard to the level of evidence, there are a limited number of randomized controlled trials addressing this question, especially regarding the circumstance of relatives over the age of 60 with CRC or AP. Most of the recommendations, which are primarily based on consensus, suggest screening early.

Moreover, many gastroenterologists do not closely adhere to published guidelines for surveillance intervals; they often recommend more frequent or aggressive surveillance. Under the circumstances, the argument in favor of changing screening recommendations is shaky at best.

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1. Davila RE, Rajan E, Baron TH, et al. ASGE guideline: colorectal cancer screening and surveillance. *Gastrointest Endosc.* 2006;63:546-557.
2. Levin B, Lieberman DA, McFarland B, et al. Screening and surveillance for the early detection of colorectal cancer and adenomatous polyps, 2008: a joint guideline from the American Cancer Society, the US Multi-Society Task Force on Colorectal Cancer, and the American College of Radiology. *CA Cancer J Clin.* 2008;58:130-160.

## Treat generalized anxiety with CBT

We thank Drs. Zoberi and Pollard for their update on therapeutic options for generalized anxiety disorder (GAD) (Treating anxiety without SSRIs, *J Fam Pract.* 2010;59:148-154). Our only critique is that they focused almost exclu-

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➤ It is not reasonable to withhold needed treatment, whether it be contrast dye, anesthesia, or any drug, for fear of a potential reaction—particularly in an emergency situation like the case in question.

sively on pharmacologic and herbal options. Although cognitive behavioral therapy (CBT) was mentioned as an adjunct therapy in 1 clinical trial, the opportunity to more fully discuss its effectiveness both as monotherapy and in conjunction with other therapies was missed.

A recent Cochrane review on psychological treatments for GAD singled out CBT as being an effective short-term intervention.<sup>1</sup> Also, the British National Institute for Health and Clinical Excellence guideline for anxiety suggests that primary care be the point of entry for those with GAD, and CBT—for which there is evidence of the longest duration of effect—be a first line of treatment.<sup>2</sup>

In the era of the patient-centered medical home and heightened awareness of behavioral health in family medicine, CBT's importance as a treatment option for GAD should have been more thoroughly explored.



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*The opinions expressed here are those of the authors and do not necessarily reflect the position of the Navy Medical Department or the naval service at large.*

1. Hunot V, Churchill R, Teixeira V, et al. Psychological therapies for generalized anxiety disorder. *Cochrane Database Syst Rev*. 2009;(1):CD001848.
2. National Institute for Health and Clinical Excellence. Anxiety: management of anxiety (panic disorder, with or without agoraphobia, and generalized anxiety disorder) in adults in primary, secondary, and community care. London, England: National Institute for Health and Clinical Excellence; 2007. Clinical Guideline 22 (amended).

### Shellfish-iodine nexus is a myth

I read with interest the Florida case with the \$4.7 million verdict (Iodine contrast media kills man with known shellfish allergy, What's the Verdict? *J Fam Pract*. 2010;59:244). As a dermatologist who deals with many allergy issues, I was surprised that the verdict was based on the "supposed" cross-reaction of a shellfish allergy with contrast iodine material. Unfortunately, this is a medical myth that has been propagated for many years.

An excellent review on this subject recently appeared in the *Journal of Emergency Medicine*.<sup>1</sup> The authors surveyed 231 physicians at 6 academic medical centers and found that 89% of cardiologists and two-thirds of radiologists routinely ask their patients if they are allergic to shellfish before administering an iodinated contrast agent. They also noted that 35% of radiologists and 50% of car-

diologists would withhold radiocontrast or pre-medicate patients with shellfish allergies.

When an individual has a seafood or shellfish allergy, it is the protein in the animal that the individual is allergic to. The allergens from fish and shellfish are actually 2 different types of proteins, and have absolutely nothing to do with iodine. Iodine is an essential element that is found throughout the body and is essential to the production of thyroid hormone and various amino acids in the body. One could not survive without iodine. It is, therefore, impossible to have a true allergy to iodine. Although an individual could react to the various allergens contained in iodine skin preps, it is not the iodine that is causing the allergy.

It is the general opinion of experts in the fields of radiology and allergy/immunology that any "allergic" individual has a 3-fold increase in the likelihood of an allergic reaction to radiocontrast material, and more than 55% of individuals have at least 1 or 2 allergies. It is not reasonable to withhold needed treatment, whether it be contrast dye, anesthesia, or any medication, for fear of a potential reaction—particularly in an emergency like the case in question, in which the procedure was done in an attempt to save the life of a 41-year-old patient. The risk of dying from cardiac arrest is great, while the risk of death from contrast dye is miniscule.

Propagating the myth of the seafood-iodine-contrast material connection not only disseminates misinformation, but also breeds multimillion dollar lawsuits.

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1. Schabelman E, Witting M. The relationship of radiocontrast, iodine, and seafood allergies: a medical myth exposed. *J Emerg Med*. 2009; Dec. 31 [E pub ahead of print].