

# Colon Ca Rates Lower After Specialist Screening

BY DENISE NAPOLI

Patients whose previous negative colonoscopies were performed by gastroenterologists are less likely to have subsequent colorectal cancer than are patients whose screens were done by other specialists, including general surgeons, Dr. Linda Rabeneck and her colleagues reported.

Despite previous studies finding a significantly decreased risk of colorectal cancer (CRC) even 10 years after a negative colonoscopy, “a small but clinically meaningful number of incident CRCs occur,” wrote Dr. Rabeneck of the University of Toronto (Clin. Gastroenterol. Hepatol. 2010 March [doi:10.1016/j.cgh.2009.10.022]).

These cancers could include missed lesions because of poor bowel preparation, suboptimal

colonoscopy technique, incomplete polypectomy, or even truly new cancers, the authors wrote. However, “the issue of whether endoscopist characteristics, including colonoscopy volume and specialty, are important in this context has not been previously addressed in a large-scale ... population-based study that reflects usual clinical practice.”

Dr. Rabeneck and her colleagues studied 110,402 Ontario residents aged 50-80 years who had a negative complete colonoscopy between Jan. 1, 1992, and Dec. 31, 1997. Slightly more than half (55.2%) were female. Participants had no history of colorectal cancer, no past diagnosis of inflammatory bowel disease, and no colonic resection within 5 years of the index colonoscopy.

Patients were followed up for colorectal cancer diagnosis from

the date of the index negative colonoscopy through Dec. 31, 2006. During the study’s 15-year follow-up period, colorectal cancer “was diagnosed in 1,596 persons, of whom 1,426 had the index colonoscopy in a hospital [86%], and 170 had the procedure in a private office/clinic,” the authors wrote.

Among the patients who had colonoscopies performed in a hospital, 38% of endoscopists were general surgeons, 17% were gastroenterologists, and the remainder of physicians was classified as “other”: primarily internists, family physicians, and “general physicians.” Regarding these hospital-based patients, the authors wrote: “For those who had their procedures performed by a general surgeon, the risk of incident CRC was increased by almost 40% (hazard ratio 1.389), compared with those who had

their procedures performed by a gastroenterologist.”

Patients whose hospital-based colonoscopies were performed by physicians classified in the “other” category (primarily internists) also were at higher risk for a subsequent colorectal cancer diagnosis (HR 1.275).

In the office-based setting, however, “endoscopist specialty was not significantly associated with incident CRC.”

Nor was there any association between the volume of colonoscopies previously performed by the endoscopist and incident CRC in either setting, after adjustment for patient age, sex, and comorbidity.

The authors attempted to explain the disparate findings between the office and hospital settings by pointing out that patients seen in the private office/clinics were younger, more

likely to be men, and had less comorbidity. Therefore, “it is likely that the procedures in the private office/clinics were technically easier to perform,” they said.

“Having extensive formal training matters more when the procedures are more challenging to perform,” they added.

Dr. Rabeneck and her coauthors also pointed out that there is a risk that the study may not pertain “to the current era.” However, “there has been no change in endoscopy training requirements since the study period,” they wrote. “In addition, the proportion of colonoscopies performed by gastroenterologists has increased only modestly (to 26% in 2008),” compared with the 16% figure at the time of this analysis. ■

**Disclosures:** The authors reported no relevant conflicts of interest.

## Advanced Neoplasms Rare After Prior Negative Colonoscopy

BY DENISE NAPOLI

Even in patients whose last negative colonoscopy was more than 10 years before, advanced adenomas were rare, Dr. Hermann Brenner and his colleagues reported.

The finding suggests that “extension of screening intervals, which could strongly enhance acceptance and cost-effectiveness of endoscopy-based screening and reduce its discomfort, might be achieved while maintaining high levels of safety,” they wrote (Gastroenterology 2010 March [doi:10.1053/j.gastro.2009.10.054]).

A previous case-control study, also led by Dr. Brenner of the division of clinical epidemiology and aging research at the German Cancer Research Center in Heidelberg, Germany, found a significant 67% reduction in risk of colorectal cancer among people who had a negative colonoscopy between 10 and 19 years prior, and a nonsignificant 54% reduction in risk among people whose negative screening was 20 or more years before (Gut 2006;55:1145-50). However, that study had been restricted to colorectal cancer and had not looked at adenoma rates.

“The current study provides evidence that a similarly very low risk is also seen if advanced colorectal adenomas are included in a combined end point of advanced neoplasms,” the authors wrote. “Taken together, these patterns support suggestions that a very low risk of clinically relevant colorectal neoplasms prevails far beyond 5 or 10 years after a negative colonoscopy, the most commonly recommended intervals for endoscopic screening examination of the large bowel.”

In the current study, Dr. Brenner and his colleagues looked at 2,701 patients who had never had a colonoscopy, as well as 533 patients with a history of one or more prior

negative colonoscopies. “Three-quarters of participants with previous negative colonoscopies had just one previous colonoscopy, almost 20% had two previous colonoscopies, and only 5% had three or more previous colonoscopies,” the authors wrote.

All of the participants were age 55 or older. In the colonoscopy-naïve group, the mean age was 63.8 years and about half of the participants were female. In the group with a history of negative colonoscopy, there were a slightly greater proportion of women (57.6%) and the mean age was slightly older (65.1 years). The mean time since last colonoscopy was 11.9 years.

“Among participants without previous colonoscopy, the most advanced finding at screening colonoscopy was colorectal cancer in 41 cases (1.5%), advanced adenoma in 267 cases (9.9%), and other adenoma in 494 cases (18.3%),” the authors wrote.

In patients with a previous negative colonoscopy, no patients had colorectal cancer, and 25 (4.7%) had advanced neoplasm.

“These numbers are far and significantly below the numbers that would have been expected based on the age- and sex-specific prevalences in participants undergoing first-time colonoscopy,” wrote the authors—8.4 cases for colorectal cancer and 59.4 for advanced neoplasm, in a cohort of this size.

Additionally, “among those with a negative colonoscopy more than 15 years ago, the prevalence was still more than 40% lower than among those with no previous colonoscopy, even though this difference failed to reach statistical significance,” they added. ■

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## Bowel Prep Affects Interval To Next Colonoscopy

BY SHERRY BOSCHERT

SAN DIEGO — Poor bowel preparation before colonoscopy influenced physicians to recommend follow-up colonoscopies 17 months sooner than they suggested for patients with adequate bowel preparation in a retrospective cohort study of 788 patients.

A 17-month shortening of the follow-up interval also occurred



**The quality of bowel preparation was seen as important for determining the follow-up interval.**

DR. KARASEK

when colonoscopists found an adenoma, suggesting that colonoscopists considered the quality of bowel preparation to be an important factor when determining the follow-up interval, Dr. Veronika Karasek said in a poster presentation at the annual meeting of the American College of Gastroenterology.

The retrospective study included 788 patients with a mean age of 62 years and an average follow-up interval of 60 months. The follow-up interval was shortened by 2.5 months on average for each polyp found, and by 17.2 months on average if an adenoma was found, reported Dr. Karasek of the Veterans Affairs Medical Center, Phoenix and her colleagues. Adenomas

were found in 42% of cases, and polyps were found in 60%. Colonoscopy detected a mean of 1.7 polyps per patient.

Bowel preparation was reported as adequate in 75% of colonoscopies. If bowel prep was inadequate, “17.1 months were subtracted from average follow-up time,” the authors said.

Good bowel preparation became more challenging in December 2008 when the Food and Drug Administration removed a commonly used, over-the-counter bowel preparation method containing Phospho-soda from the market.

In a separate poster at the meeting, two non-Phospho-soda bowel preparations for colonoscopy—an over-the-counter magnesium citrate solution or 2 L of polyethylene glycol plus ascorbic acid (MoviPrep)—provided good to excellent colon cleansing in a randomized pilot study of 87 patients.

The adequacy of bowel preparation was rated higher in patients who got the split-dose regimen, compared with whole-dose administration, reported Dr. Ron Palmon of Mount Sinai School of Medicine, New York, and his associates. ■

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