Aspirin, NSAIDs Risky for Colorectal Ca Prevention

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Routine use of aspirin or nonsteroidal anti-inflammatory drugs should not be recommended as preventive therapy for colorectal cancer in patients at average risk for the disease, according to a statement released by the U.S. Preventive Services Task Force.

The caution against prophylactic use of these agents applies to asymptomatic adults, including those with a family history of colon cancer, but not to patients with a personal history of colon cancer or polyps, familial adenomatous polyposis, or hereditary nonpolyposis colon cancer syndromes, the statement specified (Ann. Intern. Med. 2007;146:361-4).

The USPSTF issued its recommendation based on literature reviews conducted by the Agency for Healthcare Research and Quality (AHRQ). These reviews evaluated the role of aspirin, NSAIDs, and cyclo-oxygenase-2 (COX-2) inhibitors for the primary prevention of colorectal cancer and colorectal adenoma. On the basis of the relevant literature published between 1996 and 2006, the USPSTF determined that "the harms outweigh the benefits of aspirin and NSAID use for the prevention of colorectal cancer."

The literature reviews showed that aspirin, COX-2 inhibitors, and NSAIDs reduce the incidence of colonic adenomas and that aspirin and NSAIDs reduce the incidence of colorectal cancer. However, these drugs were associated with adverse gastrointestinal outcomes and, in the case of COX-2 inhibitors, with important cardiovascular events.

But the USPSTF also said that clinicians should continue to discuss aspirin chemoprophylaxis in patients who are at increased risk for coronary heart disease, because there is "good evidence" that low-dose (less than 100 mg) aspirin therapy can reduce the risk of heart disease. ■

Fatalism Tied to Lower Colorectal Screening Rates

HOUSTON — Barriers to early detection of colorectal cancer among underserved patients include limited access to care and fatalistic beliefs about a cancer diagnosis, Aimee James, Ph.D., reported at the annual meeting of the American Society of Preventive Oncology.

"Fatalist views and myths were prevalent" in a focus-group study of 18 underserved patients. Such misconceptions included "the risk of 'going under the knife,' and dangers of exposing cancer to air," said Dr. James, of the department of preventive medicine and public health, University of Kansas, Kansas City.

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DR. JAMES

She and her associates interviewed patients at a federally funded community health center who volunteered to participate in focus group sessions. Most were unemployed, and 71% were uninsured. The study was funded by the American Cancer Society.

"Many said they knew nothing about colorectal cancer or expressed confusion about GI anatomy or what the tests might entail," Dr. James said in an interview.

In regard to access to care, the main issues were not being able afford follow-up, not knowing where to go, or not having confidence in the care they would receive. Other barriers to early detection were negative attitudes about survival. "Some told us that surgery can cause cancer to spread, and they do believe that. The health care provider needs to address these belief systems," Dr. James said.

Participants said that early detection improved outcomes, yet many doubted the effectiveness of treatment. As one patient put it, "When it's time for you to go, I don't care how many surgeries they do, how many pap smears you get, or how many times they scrape you clean, it's time to go."

—Carole Bullock

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