

Small Colorectal Polyps Show Low Malignancy Risk

BY DENISE NAPOLI

FROM CLINICAL GASTROENTEROLOGY AND HEPATOLOGY

In a cohort of more than 5,000 patients with a total of 755 colorectal polyps, 100% of malignancies were associated with polyps greater than or equal to 10 mm, Dr. Perry J. Pickhardt and his colleagues reported.

Most of the polyps were smaller, however: “6-9 mm lesions represented as much as 61% of all ... lesions,” the authors noted.

“These aggregate results suggest the potential for less aggressive management of some [computed tomographic colonography]-detected lesions,” especially those in the 6- to 9-mm range, wrote Dr. Pickhardt of the department of radiology at the University of Wisconsin-Madison.

They looked at 5,124 consecutive asymptomatic adults undergoing computed tomography colonography (CTC) between April 2004 and July 2008. Patients’ mean age was 57 years, and 2,792 were women.

“Although individuals were not excluded for a positive family history of colorectal cancer, only 1.7% (89 adults) actually had a positive history according to [American Cancer Society] guidelines,” wrote Dr. Pickhardt (Clin. Gastroenterol. Hepatol. 2010 July [doi:10.1016/j.cgh.2010.03.007]).

Included in the analysis were all CTC-detected colorectal polyps greater than 6 mm that had corresponding endoscopic and/or surgical confirmation, wrote the authors, “including lesions not prospectively identified at CTC but found at subsequent colonoscopy.” Also “mucosal-based polyps that were confirmed at colonoscopy but were lost during retrieval, fulgurated, or otherwise ablated were also excluded.”

A total of 755 lesions greater than or equal to 6 mm were found in 479 patients. This included 464 lesions (61.5%) that were 6-9 mm, 216 lesions (28.6%) that were 10-19 mm, 33 lesions (4.4%) that measured 20-29 mm, and

42 (5.6%) that exceeded 30 mm.

According to Dr. Pickhardt, “In the small polyp group (6-9 mm), the rate of advanced adenomas was 3.9% (18 of 464).” Furthermore, only two polyps in this group were found to exhibit high-grade dysplasia, and none were classified as malignant.

That is in contrast to large polyps—those greater than 10 mm. Here, “the overall rate of advanced adenomas and malignancy was significantly higher compared to the smaller polyp group, at 61.9% (180/291) and 6.9% (20/291), respectively,” wrote the authors.

This included two malignant polyps in the 10- to 19-mm group (for a prevalence of 0.9% in this group, out of 216 total polyps), and two malignancies in the 20- to 29-mm group (for a prevalence of 6.1% in this group, out of 33 total polyps—a significantly higher proportion than the 0.9% prevalence in the 10- to 19-mm group, with *P* less than .001).

The remaining 16 malignancies were all found among the group of 42 polyps that measured greater than 30 mm, for a prevalence of 38.1%.

“For CTC-detected masses measuring 3 cm or greater, the risk of cancer clearly outweighs any procedural costs or risks related to its removal,” wrote the authors. However, “For CTC-detected colorectal lesions in the 1-2 cm and 2-3 cm size categories, the need for polypectomy referral has not been questioned in the past, although our findings show that the immediate benefit may not be as great as previously assumed.”

The authors conceded that the study was limited by the fact that the cohort included “average-risk screening subjects; higher rates of important histology would be expected amongst cohorts at increased risk for colorectal cancer.” ■

Disclosures: Dr. Pickhardt and one other author on this study disclosed that they are consultants for Viatronix Inc. and Medicsight PLC, medical and CT imaging companies, and are cofounders of VirtuoCTC LLC, which publishes guidance on CTC.

Patient Self-Report of Lactose Intolerance Found Unreliable

BY DENISE NAPOLI

FROM CLINICAL GASTROENTEROLOGY AND HEPATOLOGY

Patients who identified themselves as lactose intolerant recalled symptoms experienced at home as being much more severe than symptoms following a 50-gram lactose challenge, Dr. Francesc Casellas and colleagues reported.

In addition, more than half of these self-identified lactose intolerant individuals were not, in fact, lactase deficient, based on a hydrogen breath test conducted after the lactose challenge.

This means that “symptoms patients believe related to lactose are aggravated by the home environment or, more likely ... are not due to lactose malabsorption but to other causes,” they wrote.

Dr. Casellas of the Digestive System Research Unit at the Hospital Universitari Vall d’Hebron in Barcelona looked at 353 white

patients referred to their unit for evaluation of suspected lactose maldigestion. The cohort included 240 women, and the median age was 41 years (Clin. Gastroenterol. Hepatol. 2010 July [doi:10.1016/j.cgh.2010.03.027]).

Patients were asked to complete a questionnaire that assessed five symptoms common among lactose malabsorbers: diarrhea, abdominal cramping, vomiting, audible bowel sounds, and flatulence.

“Patients completed the validated questionnaire on lactose intolerance symptoms twice,” wrote Dr. Casellas and coauthors. The first time occurred before patients underwent a lactose hydrogen breath test: The questionnaire asked exclusively about symptoms occurring after “usual consumption of milk-based products at home,” or what the investigators referred to as “home symptoms.” The second time patients completed the questionnaire was following completion of the breath test;

this time, they were asked to rate symptoms experienced in the laboratory after they ingested a 50-gram lactose test load.

Only 164 out of the 353 patients (46%) were found to be true lactose malabsorbers following the hydrogen breath test. Among all 353 patients, at-home symptoms were ranked as being much worse than were symptoms following the lactose challenge, with the median score for home symptoms being 16 (range, 8-26) and the median score for symptoms in the laboratory being 8 (range, 2-18).

However, patients with true lactase deficiency according to the breath test reported more severe symptoms following the challenge than did patients with normal lactase levels: Malabsorbers reported

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a median of 15 for symptoms on the second, in-laboratory questionnaire (range, 7-25), compared with a median score of 4 on that survey among lactose absorbers (range, 0-11).

“These results suggest that, despite patient manifestations, symptoms experienced at home were unlikely to be directly related to lactose-containing foods,” especially among those patients without true lactase deficiency, the authors wrote. They speculated that the reported increased severity could be caused by the fact that “patients at home ingest lactose with other nutrients, such as fat, that could in themselves cause symptoms.”

In any case, “A record of symptoms does not suffice to establish lactose malabsorption,” they wrote. “Specific procedures such as the lactose breath test should be performed to confirm it.” ■

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Guidelines Suggest Colon Screening at Age 45 for Blacks

BY ALICIA AULT

FROM GIE: GASTROINTESTINAL ENDOSCOPY

In guidelines, the American Society for Gastrointestinal Endoscopy is suggesting that blacks begin colonoscopy screening at age 45.

It is a suggestion, not a recommendation, which would carry a greater weight, according to the ASGE’s Standards of Practice Committee, which developed the guidelines (Gastrointest. Endosc. 2010;71:1108-11).

The recommendations are based on literature reviews; the word “recommendations” means that the quality of evidence was greater, while a “suggestion” indicates that the quality was weaker.

The authors noted that “African Americans with colon cancer have a 20% age-adjusted increase in mor-

tality risk, compared with European Americans,” are younger at presentation, have a higher proportion of cancers presenting before age 50, and generally, are of a more advanced stage at the time of diagnosis.

Many ethnic groups have low colon cancer screening rates; the guidelines recommend a new emphasis on screening for those groups.

Although there have been no studies that assess the impact of modifying specific endoscopic standards based on ethnicity, “it is logical to assume that increased awareness of differences in disease patterns and management among different ethnic groups could have beneficial impacts on the health-related quality of life of people in these groups,” said Dr. Jason A. Dominitz, chair of ASGE’s Standards of Practice Committee, in a statement.

“At the same time, it is important to recognize that ethnic populations are not homogeneous and that additional factors, such as environment and behavior, also play important roles in disease,” he said.

The guidelines also suggest a screening esophagogastroduodenoscopy (EGD) for gastric cancer in new immigrants from high-risk regions, such as Korea, Japan, China, Russia, and South America, in particular if there is a family history in a first-degree relative.

However, screening EGD for adenocarcinoma or squamous cell carcinoma of the esophagus should be based on clinical considerations and not upon ethnicity, according to the guidelines.

The full guidelines can be found in the June issue of GIE at www.giejournal.org or on ASGE’s Web site. ■