

First Colonoscopy of the Day Yields More Polyps

A similar pattern emerged even when the analysis was restricted to histologically confirmed polyps.

BY ROBERT FINN
San Francisco Bureau

SAN DIEGO — Colonoscopies performed first thing in the morning yielded significantly more polyps and more histologically confirmed polyps than did those performed later in the day, according to a study presented at the annual Digestive Disease Week.

"In medicine it's well known that errors accumulate, particularly in anesthesia and surgery, as the day progresses," said Dr. Brennan M. Spiegel of the University of California, Los Angeles. "Any surgeon will tell you that he'd rather be the first case of the day if he has to go under the knife." The study he presented appears to extend these results to both surveillance and screening colonoscopy.

Dr. Spiegel and his colleagues performed a retrospective analysis of 500 consecutive patients seen at the West Los Angeles Veterans Administration Medical Center between 2006 and 2007. At that institution, colonoscopy cases begin at 7:45 a.m. and typically end at 1 p.m. The investigators divided at that time into five segments that they analyzed separately.

Colonoscopists found a mean of 2.6 polyps per patient seen before 8:30 a.m.,

2.1 polyps between 10 a.m. and 11:30 a.m., and 1.2 polyps after 1 p.m. On average, the first colonoscopy of the day found 20% more polyps than did those performed later in the day, a statistically significant difference. The trend line was also statistically significant.

The investigators noticed a similar pattern when they restricted their analysis to histologically confirmed polyps. The colonoscopists found a mean of 2.1 hyperplastic polyps during the first case of the day, 1.6 in cases between 10 a.m. and 11:30 a.m., and 1.1 in cases after 1 p.m. That trend line also was statistically significant, but there was no significant difference between the time periods in the ratio of hyperplastic to adenomatous polyps.

"We were finding fewer of all polyps, not just hyperplastic or adenomatous," Dr. Spiegel said.

The first case of the day remained a significant independent predictor of polyp yield even after the investigators controlled for a host of potential confounders in a multivariate analysis ($P = .004$). They controlled for patient-level factors such as age and body mass index, provider-level factors such as which individual colonoscopist performed the procedure and whether he or she was a fellow, and pro-

cedure-level factors such as the quality of the bowel prep and the withdrawal time.

Of those factors, the only other independent predictor of polyp yield was whether or not a fellow was participating in the procedure. Fellow participation was a strong predictor of higher yield ($P = .00001$). Dr. Spiegel suggested that one reason the presence of fellows may have improved yield is that there were, "two [sets of] eyes on the screen instead of one."

The study generated some critical comment during the question-and-answer period. During his talk, Dr. Spiegel said that patients were assigned randomly to time slots, but by that he meant that no one intentionally assigned a specific type of case to a specific time period. But one audience member said that there might be some undetected bias in appointment times, with a certain type of patient choosing earlier or later appointments.

Another physician noted that some colonoscopy centers perform many more procedures per day than does the West Los Angeles VA Medical Center, and suggested that the result might have been different if the study had been conducted elsewhere.

Another audience member commented,

"I worry that when the New York Times or the Wall Street Journal gets ahold of this paper and publishes it widely, we're going to begin to have great difficulties scheduling patients in the afternoon."

Dr. Spiegel agreed that the study should be repeated elsewhere before anyone takes it too seriously. "And whether it's the New York Times or anyone else, we have to emphasize that we have no idea that this has an impact on advanced adenomatous cancer," in terms of survival, he said.

But if the results are generalizable and colonoscopists are simply more vigilant earlier in the day, Dr. Spiegel wondered what could be done about this, "short of putting an electrical

shock in the handle of the colonoscope." He suggested that clinicians look to other industries, such as air-traffic control and long-distance trucking, that depend on constant vigilance. In those industries, strategies such as split-shift scheduling, visible prompts, and frequent reminders to be vigilant have proven to be helpful.

Dr. Spiegel acknowledged receiving consulting fees, research support, and/or other financial benefits from AstraZeneca, Ethicon, TAP Pharmaceutical, Novartis, and Procter & Gamble. ■

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Suction Technique Is Effective for Removing Flat Colorectal Polyps

BY ROBERT FINN
San Francisco Bureau

SAN DIEGO — A "suction pseudopolyp" technique is safe and effective for removing flat or nearly flat colorectal polyps, according to a study presented at the annual Digestive Disease Week.

In a case series involving 101 patients with a total of 126 small- and medium-sized flat polyps, the investigators were able to remove every polyp and retrieve 125 (99.2%) for histopathologic examination, said Dr. Venessa Pattullo of Westmead Hospital, Sydney, Australia.

The histology was definitive in all of the polyps that were retrieved, and the patients experienced no immediate or delayed complications, such as bleeding, perforation, or pain.

The pseudopolyp technique employs the suction channel of the colonoscope. Dr. Pattullo first aligns the suction channel with the center of the lesion. She then aspirates the lesion into the channel, maintaining continuous suction for 5 seconds as she withdraws the colonoscope a distance of 2-4 cm.

The result is a pseudopolyp containing both the flat lesion and some surrounding

healthy tissue, all of which can easily be ensnared and removed with diathermy. This typically leaves clean cauterized edges and a clear margin, and carries little risk of transcolonic injury.

To be included, the patient's polyps had to fit into Paris classification 0-IIa (superficially elevated lesions) or 0-IIb (truly flat lesions). Patients were 18-80 years old, and the polyps were all less than 10 mm in diameter. The

The histology was definitive in all of the retrieved polyps, and the patients had no complications, immediate or delayed, such as bleeding, pain, or perforation.

101 patients and 126 flat polyps were part of a larger group of 2,640 colonoscopies during which 1,376 polyps were removed from 1,245 patients over a 12-month period.

Flat polyps are typically difficult to ensnare because there is no protuberant tissue to grab onto, Dr. Pattullo said. The traditional methods used to remove flat polyps have a number of shortcomings. For example, hot biopsy with electrocautery has been associated with a 16% complication rate.

Cold biopsy often leaves residual adenoma.

Some colonoscopists "discount these diminutive lesions as clinically insignificant and [do] not attempt to remove them at all," Dr. Pattullo said, describing this as an "unsatisfactory alternative."

Dr. Pattullo said she had no conflicts of interest associated with her presentation. ■

NEW & APPROVED

Aciphex

BY DAMIAN McNAMARA, MIAMI BUREAU

Aciphex

(rabeprazole sodium, Eisai Corporation)

The Food and Drug Administration approved an adolescent indication for Aciphex (rabeprazole sodium) 20 mg for short-term treatment of gastroesophageal reflux disease in patients 12 years and older.

► **Recommended Dosage:** A 20-mg oral dose daily for up to 8 weeks is recommended for adolescents aged 12 years and over. The tablets can be taken with or without food.

► **Special Considerations:** Headache and nausea were adverse effects that occurred in 2% or more of 111 adolescent patients treated with Aciphex. There were no adverse events not previously reported in adult studies (pain, pharyngitis, flatulence, infection, and constipation).

Closely monitor patients for drug interactions, especially if they are taking warfarin, cyclosporine, or clarithromycin.

► **Comment:** Safety and efficacy are based on a multicenter, randomized, open-label study of 111 patients aged 12-16 years treated with 10 mg or 20 mg of Aciphex for up to 8 weeks. Severity and frequency of gastroesophageal reflux disease (GERD) symptoms were reduced at 8 weeks, compared with

baseline, according to a news release. Use in adolescents also is supported by extrapolation of data from previous adult clinical studies. The FDA has approved a number of indications in adults since August 1999.

"GERD is becoming a much more common problem—in general and especially among adolescents. We are seeing more in the younger age group with dietary indiscretions and obesity," Dr. Stephen Brunton, a family physician in private practice in Charlotte, N.C., said.

"It is very reassuring for clinicians to know the studies have been done and the FDA has given its ... seal of approval," Dr. Brunton said.

Aciphex blocks gastric acid secretion and is a member of the class of substituted benzimidazole proton pump inhibitors, which also includes esomeprazole (Nexium), pantoprazole (Protonix), lansoprazole (Prevacid), and omeprazole (Prilosec).

"It's a very safe class of medications, the most potent acid blockers, and can be used first line in our patients with GERD," Dr. Brunton said.

"There are subtle differences between the newer agents, and the choice depends on a person's experience," added Dr. Brunton, who disclosed he is a consultant for Eisai Corporation. ■