Earlier Colorectal Screening Urged for Key Groups

African Americans, diabetics, and female smokers are found to be at substantially above-average risk.

BY BRUCE JANCIN
Denver Bureau

HONOLULU — The possibility that earlier onset for colorectal cancer screening is warranted in selected major patient subgroups—most notably African Americans and women smokers—emerged as a recurrent theme at the annual meeting of the American College of Gastroenterology.

Current recommendations call for colorectal cancer (CRC) screening to begin at age 50 in average-risk individuals. But emerging evidence suggests that women who smoke, diabetics, and African Americans are at substantially above-average risk and may warrant aggressive screening.

A particularly strong case for an earlier start to screening can be made for African Americans. Indeed, a recent ACG position paper (Am. J. Gastroenterol. 2005;100:515-23) concluded that "current research data would favor modification of the CRC screening guidelines for African Americans to begin screening at the age of 45."

And that may not go far enough, according to a coauthor of the report. "If you look at some of the data that are coming out for prostate cancer, there really is a very strong body of evidence now that PSA screening of African Americans should begin at age 40 rather than 50. And I think GI will get there also," Dr. Frank A. Hamilton said at a press briefing.

He cited, for example, California studies showing African Americans were more than twice as likely as whites to present with advanced CRC before age 50.

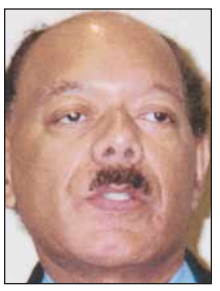
Nationwide, the overall incidence of CRC in 2000 was 20%-25% lower than in the peak year of 1985. But the incidence among African Americans was more than 12% greater than in whites during 1996-2000. The disparity was particularly disadvantageous for African American women, whose CRC incidence was 17.5% greater than in white women.

CRC is the second leading cause of cancer deaths in the United States. Survival in affected African Americans is significantly worse than in whites. Five-year survival in African Americans with CRC during 1992-1999 was 53%, compared with 63% among whites. Although not all the evidence is in, Dr. Hamilton said it appears that reduced access to screening among African Americans is the chief explanation for the disparity, rather than racial differences in tumor biologic aggressiveness.

"I think we're finding more African American patients late with the disease. It may be a question of access rather than genetic differences," added the gastroenterologist, who is branch chief at the National Institute of Diabetes and Digestive and Kidney Diseases, Bethesda, Md.

The Centers for Disease Control and Prevention recently received congressional authorization to develop model programs aimed at redressing racial health disparities, with particular focus on CRC, he noted.

Asked what sort of reception the ACG proposal for earlier CRC screening in African Americans has received among health policy officials, Dr. Hamilton said there has been concern that it's overly ambitious. After all, only about 45% of the eligible general population—that is, individuals 50 years and older—has ever had any form of CRC screening, a rate that lags behind screening for other cancers.



Elsewhere at the meeting, Dr. Anna L. Zisman, presented an analysis of gender differences in the impact of tobacco and alcohol use on CRC risk. The study population consisted of 86,582 patients diagnosed with CRC during 1993-2003 who were included in the IMPAC Medical Registry Services Cancer Information Resource, which features patient information obtained from more than 350 participating teaching and community hospitals.

Smoking and alcohol consumption are well-established CRC risk factors. But differences in how they operate in men, when compared with women, weren't appreciated until this study.

African Americans were more likely than whites to present with advanced colorectal cancer before age 50.

DR. HAMILTON

The mean age at CRC diagnosis in the study population was 68.2 years in men and 71 years in women. Women who were current smokers or drinkers were diagnosed at a younger age than those who were not. And if they were both current smokers and drinkers, the effect was magnified such that their CRC diagnosis came a mean of 9.2 years earlier than in those who hadn't used tobacco or alcohol for at least 1 year, if ever. In men, the age gap was smaller, with current smokers and alcohol users developing CRC 6.5 years younger.

A multivariate analysis showed the gender disparity was accounted for by a much greater impact of smoking on age of CRC onset in women, compared with men, as indicated by the finding that both never-smoking, current-drinking women as well as men developed CRC a mean of 4.9 years earlier than their never-smoking, never-drinking counterparts.

"We need to be looking at gender and environment interactions in designing preventive strategies. In particular, we should be looking at earlier screening in women, smokers especially, who are more likely to have earlier onset," said Dr. Zisman of Evanston (Ill.) Northwestern Healthcare. ■

Family MDs Veer Off Constipation Guidelines More Than Pediatricians

BY SHERRY BOSCHERT
San Francisco Bureau

SALT LAKE CITY — Pediatricians and family physicians choose different treatments for constipation in infants and children, a survey of 328 physicians found.

Of the 143 family physicians who responded to the mailed questionnaire, 53% treated constipation for longer than 3 months, compared with 84% of the 185 surveyed pediatricians, Dr. Douglas G. Field said. Only 1% of pediatricians treated for less than 1 month, compared with 13% of family physicians.

He presented the findings in a poster at the annual meeting of the North American Society for Pediatric Gastroenterology, Hepatology, and Nutrition (NASPGHAN), which has published guidelines for managing pediatric constipation (J. Pediatr. Gastroenterol. Nutr. 1999;29:612-26).

Many children with constipation need long-term therapy to maintain a regular bowel pattern, studies have shown, so a child should be weaned from medication only after he or she has been having regular bowel movements without difficulty, said Dr. Field of Penn State Children's Hospital, Hershey, Pa., and his associates.

The difference between specialties in treatment length might explain the higher success rate reported by the pediatricians surveyed, he added. Only 4% of pediatricians referred more than 25% of their patients with constipation to pediatric gastroenterologists, compared with 31% of family physicians.

The main reason for referral by both primary care specialties was lack of response to therapy (in 65%-69% of referrals).

Most pediatricians and family physicians used suppositories and prune juice to disimpact infants with constipation, practices supported by the NASPGHAN guidelines.

Many children with constipation need long-term therapy to maintain a regular bowel pattern.

DR. FIELD

For children, the most commonly used rectal treatments were enemas or suppositories, and the most common oral treatments were polyethylene glycol (by pediatricians) or mineral oil (by family physicians), again supported by the guidelines.

Family physicians veered from the guidelines, however, by using mineral oil in infants—for disimpaction in 7% of infants and for maintenance therapy in 9% of infants.

Pediatricians used mineral oil in 1% of infants for disimpaction and in 1% for maintenance therapy. ■

Colorectal Cancer Risk Not Tied To Dietary Fiber, Studies Show

Dietary fiber intake showed no effect on the risk of colorectal cancer in an analysis that pooled data from 13 prospective cohort studies, reported Dr. Yikyung Park of Harvard School of Public Health, Boston, and associates.

Pooling the results of studies netted 8,081 cases of colorectal cancer, giving the analysis a level of statistical power such that "a substantial effect of fiber is unlikely to have been missed," the researchers said (JAMA 2005:294:2849-57).

The pooled analysis was undertaken because the results of many epidemiologic studies and randomized clinical trials have been conflicting, and there is still much debate over whether dietary fiber decreases colorectal cancer risk.

Each of the 13 prospective cohort studies Dr. Park and associates identified for their analysis included at least 50 cases of colorectal cancer and adequately assessed dietary fiber intake. The data yielded over 7,300,000 person-years of follow-up (6-20 years of follow-up across the studies), and included incident colorectal cancer cases in 2,776 men and 5,305 women.

The initial age-adjusted analysis showed a significant link between fiber intake and colorectal cancer, with the highest levels of intake associated with a 16% lower risk than the lowest levels. However, after the data were adjusted for potentially confounding risk factors including nondietary factors, milk and red meat intake, and alcohol consumption, "only a nonsignificant weak inverse association was found," they said.

The findings were similar after the studies were combined and analyzed as a single data set. Likewise, dietary fiber showed no effect on cancer risk when the data were analyzed by subjects' body mass index and by sources of fiber.

Although the findings indicate that dietary fiber "may not have a major effect on the risk of colorectal cancer," a diet rich in whole plant foods can still be advocated because it may reduce risks of other disorders. "A true association between dietary fiber intake and risk of colorectal cancer may be underestimated in our study" because the analysis was limited by possible errors in measuring fiber intake, they noted.

—Mary Ann Moon

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