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San Jose Gastroenterology

2340 Montpelier Drive
San Jose, CA 95116

231 O'Connor Drive
San Jose, CA 95128

Phone: (408) 347-9001
Fax: (408) 347-9004
www.sjgi.com

- Eduardo da Silveira, M.D.
- Ruel T. Garcia, M.D.
- Brian S. Levitt, M.D.
- Huy A. Nguyen, M.D.
- Khanh K. Nguyen, M.D.
- Huy N. Trinh, M.D.
- Amanda LaPointe, PA-C

GI Focus is a professional letter focusing on the topics that physicians encounter in daily practice. This letter is printed periodically by San Jose Gastroenterology. The sources of this letter were adapted from Gastroenterology Journals for informational purposes and for communication with our colleagues. We will provide references for our sources if requested.

To sign up for email of GI Focus, to provide comments, or make other requests, please email us at GIfocus@sjgi.com

March is Colorectal Cancer Awareness Month. Therefore, we reviewed some of the important guidelines from the major scientific societies. For more information, please visit sjgi.com, where some of these topics were reviewed in prior issues.

When to Begin Screening?

If colorectal cancer or adenomatous polyp(s) in a 1st-degree relative ≤ 60 years of age:

- First colonoscopy at age 40, then every 5 years

If colorectal cancer or adenomatous polyp(s) in a 1st-degree relative >60 years of age:

- First colonoscopy at age 40, then every 10 years

If colorectal cancer or adenomas in *two* second-degree relatives:

- First colonoscopy at age 40, and then every 10 years¹

Guidelines for Surveillance

Repeat colonoscopy in 5 -10 years if:

- 1 or 2 tubular adenomas <1 cm

Repeat colonoscopy in 3 years if:

- 3 adenomas of any size
- A single polyp ≥ 1 cm
- Tubulovillous histology
- High-grade dysplasia

Key Quality Measures

• Cecum-to-anus withdrawal time needs to be >6 minutes.

• Cecal intubation should be documented and identified by cecal landmarks (appendiceal orifice and/or ileocecal valve, or entry into the terminal ileum).

• The quality of bowel preparation should also be documented.

1 Levin B et al. Screening and surveillance for the early detection of colorectal cancer and adenomatous polyps. *Gastro* 2008;134:1570-1595.

At sjgi.com, we will soon share our practice's statistics for polyp detection rate and cecal intubation rate, as compared to published criteria. These data are important for you and your patients to know, so you can be sure they receive colon cancer screening of the highest quality. Please look for this on sjgi.com

Colonoscopy Underuse? Overuse?

There has been interesting and thought-provoking data presented recently¹. Schoen et al evaluated 3627 participants in the Prostate, Lung, Colorectal and Ovarian (PLCO) cancer screening trial. This is a National Cancer Institute study that included patients from 10 diverse US centers.

Patients were enrolled after a polypoid abnormality was noted on screening flexible sigmoidoscopy. All patients had a colonoscopy examination. Patients were then stratified based on colonoscopic findings and subsequent surveillance colonoscopy practices were documented. Findings were stratified as follows:

- Patients with no adenoma
- Patients with non-advanced adenoma
- Patients with advanced adenoma

The results showed that within 5 years of the diagnostic colonoscopy:

- 26% of patients with no adenoma had a second colonoscopy at a median of 3.9 years after the first; 45% had a second colonoscopy within 7 years [overuse]
- Only 57% of patients with ≥ 3 adenomas had a surveillance colonoscopy [underuse]
- Only 31% and 58% of patients with an advanced adenoma had a surveillance colonoscopy at 3 years and 5 years, respectively [underuse]

The reasons for overuse were not associated with a lack of cecal intubation, inadequate bowel preparation, or any other identifiable cause on initial colonoscopy.

In 67% of 162 asymptomatic subjects with no adenoma at baseline or first surveillance examination, a *second* surveillance examination was performed by the same physician. This shows that overuse in this sample is not due to a possible effect of multiple physician examiners, incomplete knowledge of prior findings, etc.

The reason for underuse in the cohort of patients with advanced adenoma is not clear. More significant medical comorbidity was not proven significant.

These data show there is a significant overuse and underuse of colonoscopy. This serves to remind all of us to adhere to the published guidelines in order to maximize the health of our patients.

1 Schoen RE et al. Utilization of surveillance colonoscopy in community practice. *Gastro* 2010;138:73-81.