



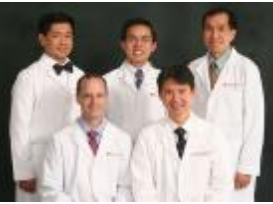
GI Focus



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

Greetings!

San Jose Gastroenterology is pleased to announce the inaugural issue of *GI Focus*. This is a quarterly newsletter focusing on gastrointestinal and hepatology issues for primary care physicians. With the advent of the information age, there is a massive amount of new information and knowledge that physicians must try to master and incorporate into their practice. Our primary goal will be to focus on most relevant issues for the primary care physician, sift through the literature, and condense the information into small, easy-to-remember "pearls." We will make an effort to discuss one GI and one hepatology topic per issue. Our secondary goal is to continually communicate information and services offered by SJGI to our referring physicians.

March Is National Colorectal Cancer Awareness Month.

Colorectal Cancer (CRC) is the third most common cancer and the second leading cause of cancer death in the United States. In 2008, it is estimated that 148,810 people will be diagnosed with CRC and 48,960 will die from the disease in the US. Fortunately, most CRC can be prevented by the detection and removal of adenomatous polyps. Survival from CRC is also increased if diagnosed at an earlier stage.

HOT OFF THE PRESS: NEW 2008 CRC GUIDELINES

On March 5, 2008, the American Cancer Society, the US Multi-Society Task Force on Colorectal Cancer (USMSTF), and the American College of Radiology issued a joint guideline for the screening and surveillance of CRC and premalignant adenomatous polyps in asymptomatic average risk adults¹. This is an update on the last guideline issued by the USMSTF which was in 2003. Average risk adults are men and women over the age of 50, without any family history of CRC and with no symptoms.

Acceptable options for the early detection of CRC and adenomatous polyps include 2 categories of tests:

Invasive tests that detect CRC and adenomatous polyps (CRC detection and prevention)

- Flexible sigmoidoscopy every 5 years
- Colonoscopy every 10 years
- Double-contrast barium enema every 5 years
- Computed tomographic colonography every 5 year

Noninvasive tests that primarily detect CRC (CRC detection only)

- Yearly guaiac-based fecal occult blood test
- Yearly fecal immunochemical test
- Stool DNA test – but interval is uncertain

The first category of tests has a greater potential for cancer prevention with the detection and removal of premalignant adenomatous polyps. When using noninvasive tests, the provider must understand that there are limitations. These tests are less likely to prevent cancer than the invasive tests. These tests must be done at regu-

lar yearly intervals in order to be effective. If the test is abnormal, a colonoscopy will be needed. When using invasive tests other than colonoscopy, an abnormal test will also require a follow-up colonoscopy.

What is new in this guideline is the strong emphasis on **CRC prevention** rather than just CRC detection. Therefore, tests to detect both CRC and adenomatous polyps should be encouraged if the resources are available.

The addition of CT colography (CTC) "virtual colonoscopy" to the list of options is also a new feature of the guidelines that will undoubtedly attract doctors' and patients' attention. CTC requires the same bowel preparation and restricted diet as colonoscopy, requires the insertion of a tube into the rectum and insufflation of air or gas into the colon while the patient is awake. It does not provide the opportunity to remove polyps; therefore suspicious lesions will require a follow-up colonoscopy. There are still unresolved issues for CTC. Medicare reimbursement is still only approved for the indication of incomplete colonoscopy and not screening colonoscopy. Standardization of protocols for performance of CTC is new, and may not be universally followed by radiology centers. There is still some controversy over the long-term potential harms associated with radiation dose. There is also the concern about finding incidental extracolonic lesions during CTC. Although there may be benefits to finding such incidental lesions, it may also lead to unnecessary and potentially harmful evaluation of false positive or benign lesions. The technology of CTC is rapidly progressing, and in near future, as these issues are resolved, CTC will likely become a more utilized test.

¹Levin, B. Screening and Surveillance for the Early Detection of Colorectal Cancer and Adenomatous Polyps, 2008: A Joint Guideline from the American Cancer Society, the US Multi-Society Task Force on Colorectal

Cancer, and the American College of Radiology. *CA Cancer J Clin* 2008;58,3.

NOT ALL COLONOSCOPIES ARE CREATED EQUAL

Colonoscopy remains a very effective tool for CRC detection and prevention and has become the preferred screening method recommended by gastroenterologist. And yet, it must be recognized that the effectiveness of colonoscopy depends heavily on the quality of the examination. A recent study published in the *New England Journal of Medicine* showed that longer mucosal examination times led to increased adenoma detection rates². Specifically, cecum-to-anus withdrawal time >6 minutes had an adenoma detection rate of 28.3% vs. 11.8%. Therefore, this is an important indicator of quality of colonoscopy. Gastroenterologist need to spend enough time examining the colon to detect polyps, many of which may be small, flat, hidden behind folds or covered by stool.

SJGI recommends that when critically reading a colonoscopy report, a physician should pay attention to the following quality indicators:

- Cecum-to-anus withdrawal time should be >6 minutes.
- Reaching the cecum should be documented and identified by cecal landmarks (appendiceal orifice and/or ileocecal valve, or entry into the terminal ileum). Photodocumentation of the cecum should also be obtained.
- The quality of bowel preparation should also be documented. If not "excellent", "good" or "adequate", the potential for missed polyps or cancer is increased.

²Barclay, RL et al. Colonoscopic withdrawal times and adenoma detection during screening colonoscopy. *NEJM* 2006;355:2533-41.

HEPATITIS B: A SILENT EPIDEMIC IN THE ASIAN-AMERICAN COMMUNITY

It is well-known that chronic hepatitis B virus (HBV) infection is common among Asians. Numerous journal articles and our own experience verify this. Unfortunately, screening and vaccination for HBV among the Asian-American population is still lacking.

A recent article published in the journal *Hepatology* highlights this issue³. Researchers in the San Francisco Bay area offered free HBV serological testing and surveyed 3,163 Asian American adult volunteers in the SF Bay area. The results were alarming. Of those screened, 8.9% were chronically infected with HBV. Among Asians born in Asia, the number was even higher: 10.7%. Even more concerning, 65% of the chronically infected were unaware that they were infected.

HBV vaccination among Asian Americans is also a problem. Among people without chronic infection, 44.8% lacked protective antibodies

(HBsAg negative, anti-HBs negative). Among patients who reported that they had received HBV vaccination, 5.2% were actually already chronically infected, and 20.3% did not have protective antibodies.

This report is especially significant for our San Jose community since this study was conducted in the Bay area. These results can be readily generalizable to our community.

The American Association for the Study of Liver Diseases (AASLD) recommends HBV screening for the following high risk groups⁴:

Individuals born from high and intermediate prevalence rates for HBV:

- Asia: all countries except Sri Lanka
- Africa: all countries
- South Pacific Islands: All countries except non-indigenous populations of New Zealand Australia
- Middle east: All countries except Cyprus
- Western Europe: Greece, Italy, Malta, Portugal, Spain
- Eastern Europe: All countries except Hungary
- The Arctic: All indigenous people
- South America: Argentina, Bolivia, Brazil, Ecuador, Guyana, Suriname, Venezuela, and Amazon region of Columbia and Peru
- Central America: Belize, Guatemala, Honduras, and Panama
- Caribbean: Antigua and Barbados, Dominican Republic, Grenada, Haiti, Jamaica, Puerto Rico, St. Kitts and Nevis, St Lucia, St Vincent and Grenadines, Trinidad and Tobago, and Turks and Caicos

Other higher risk groups recommended for screening:

- Household and sexual contacts of HB surface antigen positive persons
- Persons who have ever injected drugs
- Persons with multiple sexual partners or history of sexually transmitted disease
- Men who have sex with men
- Inmates of correctional facilities
- Individuals with chronically elevated ALT or AST
- Individuals infected with HCV or HIV
- Patients undergoing renal dialysis
- All pregnant women

³Lin, SY, et al. Why we should routinely screen Asian American adults for hepatitis B: a cross-sectional study of Asians in California. *Hepatology* 2007; 46: 1034-1040.

⁴Lok, ASF. AASLD Guidelines. Chronic hepatitis B. *Hepatology* 2007; 45: 507-539.

Administrator Corner

1. Effective February 11, 2008, SJGI began seeing patients for Dr. Joel Siegel, who recently retired after many years of excellent patient care.
2. In addition to accepting most medical insurance, we are also proud to serve Valley Health Plan (VHP) patients. If you would like us to see your VHP patients, please do not hesitate to make a referral and have your patients call us for appointment.