

Young patients with sporadic colorectal adenomas: current endoscopic surveillance practices and outcomes

Jae Myung Cha, MD, PhD,^{1,2} Danielle La Selva, BA,² Richard A. Kozarek, MD,² Michael Gluck, MD,² Andrew Ross, MD,² Otto S. Lin, MD, MSc²

Seoul, South Korea; Seattle, Washington, USA

Background and Aims: For young individuals (age <40 years) without strong family histories that would put them at risk for genetic colorectal cancer syndromes, it is unclear if national Multi-Society Task Force surveillance recommendations apply or if endoscopists follow these guideline recommendations when such patients are incidentally found to have adenoma(s) on colonoscopy.

Methods: We reviewed records on young (age <40 years) patients, with either no family history or only a moderate family history (1 first-degree family member with colorectal cancer at age ≥ 50), who were found to have neoplastic polyp(s) on their index colonoscopy. We assessed the pattern of endoscopist surveillance recommendations, whether endoscopist recommendations complied with national guidelines, and compliance with surveillance recommendations.

Results: One hundred forty-one subjects were included, of whom 19 (13.5%) had a moderate family history of colorectal cancer. For patients with non-high-risk findings, 27.7% were asked to repeat their colonoscopy in ≤ 3 years and 99.0% within 5 years. Endoscopist surveillance recommendation compliance rates with national guidelines were >65.0% for low-risk neoplasia but lower for high-risk (40.0%), nonpolypoid (44.2%), and serrated neoplasia (54.2%, $P < .001$ for all). Subjects whose endoscopist recommendations were noncompliant with guidelines were usually recalled too early (96%). Only 24.7% of subjects were actually compliant with endoscopist surveillance recommendations.

Conclusions: For young patients with neoplastic polyp(s) but no strong family history, most endoscopists complied with national guidelines and recommended repeat colonoscopy in 3 to 5 years. However, relatively few patients were compliant with repeat colonoscopy recommendations. For most cases that were noncompliant with guidelines, patients were recalled too early as opposed to too late. (Gastrointest Endosc 2018; ■:1-8.)

Abbreviations: CRC, colorectal cancer; MSTF, Multi-Society Task Force.

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Current affiliations: Gastroenterology Division, Kyung Hee University Hospital at Gang Dong, Kyung Hee University School of Medicine, Seoul, South Korea (1), Digestive Disease Institute, Virginia Mason Medical Center, Seattle, Washington, USA (2).

Reprint requests: Otto Lin, MD, Digestive Disease Institute, Virginia Mason Medical Center, 1100 Ninth Avenue, Seattle, WA 98101.

If you would like to chat with an author of this article, you may contact Dr Lin at otto.lin@vmc.org.

For patients with a history of colorectal neoplastic polyps, the Multi-Society Task Force (MSTF) on colorectal cancer (CRC) and the American Cancer Society endorse a risk stratification surveillance approach on the basis of baseline neoplasia characteristics. Specifically, repeat colonoscopy is recommended at 5 to 10 years for patients with 1 to 2 low-risk adenomas and at 3 years for those with high-risk adenoma findings, which includes the presence of an advanced neoplasm (adenomatous or sessile serrated polyps ≥ 1 cm in size or tubulovillous or villous adenomas) or multiple (>2) low-risk adenomas.¹ These surveillance guidelines pertain to patients over age 50 and probably are applicable to those 40 to 50 years of age. However, for very young individuals (<40 years of age) who do not have strong family histories of CRC that would put them at risk for genetic CRC syndromes, it is unclear whether MSTF surveillance intervals should be followed when such patients are incidentally found to have a neoplastic

polyp on colonoscopy. The text of the MSTF guidelines do not specify whether its recommendations apply to very young patients¹; therefore, many gastroenterologists may assume that these guidelines cover all patients regardless of age. However, currently there are few published data on surveillance in such young low-risk patients. In the original 1997 Bethesda guidelines, the presence of an adenomatous polyp discovered before age 40 was supposed to trigger an assessment for genetic syndromes.² However, this criterion was excluded from the revised 2004 Bethesda guidelines when it became clear that it was far too nonspecific and would capture large numbers of patients who were actually not at high risk for CRC development.³

To shed light on this question, we performed this study on young (age <40) patients with either no family history or only a moderate family history of CRC (1 first-degree family member with CRC at age 50 or greater), who were found to have neoplastic polyp(s) on colonoscopy. The objectives of our study were to assess the pattern of endoscopist recommendations for surveillance colonoscopy based on patient and polyp characteristics, whether or not endoscopist recommendations complied with MSTF guidelines, and patient compliance with endoscopist surveillance recommendations.

METHODS

Subjects

Virginia Mason Medical Center maintains an ongoing, prospectively updated quality control database of colonoscopies, which was used to retrospectively identify potentially eligible subjects whose electronic medical records were then manually reviewed. We enrolled only young patients with early-onset colorectal neoplastic polyps who had no family history or only a moderate family history of CRC. Such patients were defined as those younger than age 40 years who were found to have 1 or more colorectal neoplasia during the index colonoscopy; subjects were divided into those with no family history (no first-degree relatives with CRC) or only a moderate family history (1 first-degree relative with CRC occurring at age 50 or older).

The following types of patients were excluded: (1) patients with a history of large (≥ 1 cm) adenomas, high-grade dysplastic lesions, or CRC (because the target of the study was the young patient without any known propensity for CRC before the index colonoscopy); (2) patients with 8 or more synchronous colorectal neoplasia on the index colonoscopy, or a lifetime total of 20 or more colorectal neoplasia; (3) patients with a diagnosis of inflammatory bowel disease or indeterminate colitis; (4) patients with confirmed or suspected familial adenomatous polyposis, attenuated familial adenomatous polyposis, Lynch syndrome, or other types of inherited cancer

syndromes; and (5) patients with a “strong” family history of CRC, defined as 2 or more first-degree relatives with CRC, or at least 1 first-degree relative who developed CRC before the age of 50, or fulfillment of the modified Amsterdam criteria or revised Bethesda guidelines.

Data abstraction

To screen for eligible patients, the medical records were extensively reviewed. In addition, each patient’s “family history” module, which lists all first- and second-degree relatives with CRC and other cancers (including other Lynch syndrome cancers), was reviewed. Microsatellite instability testing was not routinely performed before the index colonoscopy because our subjects, by definition, did not have a personal history of CRC or advanced neoplasia.

We abstracted the following data: (1) patient demographics and American Society of Anesthesia class; (2) indication for colonoscopy (diagnostic vs screening); (3) the number, histology, size, distribution, and shape characteristics of neoplastic polyps found on the index colonoscopy; (4) family history of CRC (if any); (5) quality of bowel preparation, completion rate, and adverse events; and (6) the number, histology, size, distribution, and shape characteristics of neoplastic polyps found on repeat surveillance colonoscopy, if already performed at the time of this study.

The primary study endpoints were as follows: (1) endoscopist recommendations for repeat surveillance colonoscopy, as derived from the procedure note, subsequent clinic notes, or phone messages or letters to the patient, and whether such recommendations complied with MSTF guidelines; and (2) percentage of patients who had actually undergone repeat surveillance colonoscopy within 6 months of the time recommended by the endoscopist who had performed the index colonoscopy (compliance). The secondary study endpoints were as follows: (1) association between moderate family history of CRC and endoscopist surveillance recommendations; (2) association among polyp size, number, histology, and shape on the index colonoscopy and endoscopist surveillance recommendations; and (3) findings on repeat surveillance colonoscopy, if available.

This study was approved by the institutional review board of Virginia Mason Medical Center (IRB 18-001). Because of the study’s retrospective nature, requirements for individual informed consent were waived.

Colonoscopy

The 14 endoscopists involved in the study were all board-certified attending gastroenterologists with at least 5 years’ experience performing colonoscopy. All satisfied American Society for Gastrointestinal Endoscopy quality benchmarks, such as adenoma detection rates, colonoscopy withdrawal times, adverse event rates, and adequate bowel preparation rates. Endoscopist surveillance recommendations were communicated orally to the patient and his or her family immediately after the procedure by the

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