



## Is 35 the new 50? Challenges in determining colonoscopy surveillance recommendations for young patients with incidentally detected adenomas

There has been significant publicity recently regarding increasing rates of colorectal carcinoma (CRC) in young patients aged 20 to 45 years. Last year in the *Journal of the National Cancer Institute*, a publication by Siegel et al<sup>1</sup> entitled “Colorectal cancer incidence patterns in the United States, 1974-2013” demonstrated that young adults now have double the risk for the development of colon cancer and quadruple the risk for the development of rectal cancer, compared with their age-matched counterparts born in 1950. Headline articles followed in leading American newspapers such as the *New York Times*<sup>2</sup> and the *Washington Post*,<sup>3</sup> creating the perception among the general public of an apparent emerging epidemic of early-onset CRC. These articles stimulated discussion internationally about the specter of younger individuals presenting with CRC in the average-risk population and challenged the medical community to contemplate whether current screening recommendations are adequate.

Internationally, CRC screening programs are increasingly being adopted, with a majority commencing screening for average-risk patients at age 50.<sup>4</sup> Individuals below age 50 are eligible for screening if they have a significant family history of CRC, a familial colorectal genetic syndrome, or a specific risk factor such as inflammatory bowel disease, or if they come from a population at higher risk such as African Americans.<sup>5</sup> These programs vary in the details of their protocols; however, none accommodate for the increasing cancer incidence in patients too young for inclusion in national bowel cancer screening programs.

In the context of these findings, some researchers have proposed reducing the age for beginning bowel-cancer screening programs for average-risk patients.<sup>6</sup> However, data to support this notion are currently insufficient to make strong recommendations. Even though an increasing relative risk of CRC has been shown, the absolute risk still remains low in this younger age group. Furthermore, implementation of a screening program requires more than merely an increasing disease incidence in a specific population.<sup>7</sup> Other factors such as test sensitivity and specificity, safety, cost, acceptability to patients, and resource availability must also be present.

The latter is particularly relevant when endoscopic services are already overburdened in many health services.

Therefore, because it remains unlikely that there will be any change to the age of beginning CRC screening programs for the foreseeable future, consideration must be given to the optimal approach for younger patients in whom incidental colorectal adenomas are found. Consensus guidelines such as the U.S. Multi-Society Task Force (MSTF) document are available to guide decision making when adenomas are identified in adults of screening age (ie,  $\geq 50$ )<sup>8</sup>;

**Factors associated with surveillance noncompliance in young patients have not been well studied, and thus the reasons for the low compliance cannot be known with certainty. However, it may be postulated that, potentially, young adults do not consider themselves at significant risk of a cancer diagnosis and thus do not appreciate the need to adhere to surveillance recommendations.**

however, these guidelines have not been validated in younger patients. Younger patients generally have colonoscopies to investigate symptoms; thus, adenomas are considered incidental. Once identified, however, they must be removed and appropriate surveillance advice dispensed.

This issue is also increasingly relevant because of the rising rates of colonoscopies being performed for younger patients. Recent reports have revealed a doubling in the number of colonoscopies performed for adults aged 40 to 49 years over the past 10 years.<sup>1</sup> This has led to an increasing likelihood of identifying incidental adenomas in young adults without clear guidance regarding how to manage their surveillance. Although the progression from adenoma to carcinoma is well understood in general, predicting which individuals are at greatest risk for CRC, and thus require more intensive surveillance, is challenging. Polyp histopathologic features, overall polyp burden, and a thorough family history, in addition to genetic testing in certain cases, can be used to guide

stratification of neoplasia risk in some individuals. However, there will remain a majority of young adults with incidental adenomas for whom surveillance decisions are required in the absence of these risk factors. Compounding the difficulty of making management decisions relating to neoplasia risk is the reality that despite known risk factors, most CRCs are sporadic regardless of patient age.

Therefore, what is the best approach to determining surveillance colonoscopy intervals for young patients with incidentally detected adenomas? At one extreme, some may argue that despite the identification and removal of an incidental adenoma, this population remains at sufficiently low risk for malignancy that surveillance is not required until they reach the entry age of national bowel cancer screening programs. At the other extreme, some may argue for more aggressive surveillance than would be suggested for older patients, based on the assumption that the presence of an adenoma in a young adult is suggestive of a significant predisposition to colonic polyps and potential for progression to CRC. Indeed, perhaps it is this very population who are the explanation for the increasing incidence of young-onset colorectal malignancies in the study by Siegel et al.<sup>1</sup> The middle ground is held by those who believe that the standard surveillance guidelines, such as those by the MSTF, should also be applied to these younger patients, despite not being validated for this population. The lack of evidence to guide surveillance practice for younger patients results in a lack of consensus in management. Clearly, further investigation in this area is required.

In this context, the present study by Cha et al,<sup>9</sup> entitled “Young patients with sporadic colorectal adenomas: current endoscopic surveillance practices and outcomes,” is both timely and very relevant to contemporary colonoscopy practice. The authors aimed to evaluate real-world endoscopy practice pertaining to surveillance of young adults with incidental adenomas, and the rates of adenoma detection at surveillance colonoscopy. It offers an insight into the surveillance practices of endoscopists in a cohort for whom evidence-based surveillance guidelines are not available.

This retrospective analysis from a single center in the United States reviewed surveillance practices in a population of adults under the age of 40 years. Excluded from the analysis were patients with CRC, large adenomas, a polyp with high-grade dysplasia, multiple ( $\geq 8$ ) synchronous polyps at index colonoscopy, known familial polyposis syndrome, history of inflammatory bowel disease, or a strong family history of CRC. This was defined as having 2 or more first-degree relatives with CRC or at least 1 first-degree relative with a diagnosis of CRC before the age of 50, or who fulfilled the modified Amsterdam criteria or revised Bethesda guidelines for hereditary nonpolyposis CRC. Excluding these high-risk patients was designed to ensure that only patients at average or slightly above average risk for CRC, in whom an incidental adenoma was found, were included in the study.

The primary outcomes were to evaluate whether the surveillance recommendations made by endoscopists were in accordance with the MSTF guidelines and to determine the percentage of patients who underwent their surveillance colonoscopy at the recommended interval (with up to a 6-month delay being allowed). The secondary outcomes were to evaluate whether a moderate family history or polyp characteristics influenced the initial surveillance recommendation and to review the findings at surveillance colonoscopy.

The surveillance recommendations by 14 endoscopists with a minimum of 5 years endoscopic experience were analyzed. One hundred forty-one patients undergoing colonoscopy over a 5-year period from 2009 to 2014 met both the inclusion and exclusion criteria and were included in the study. The mean ( $\pm$  standard deviation [SD]) age was  $34.2 \pm 4.9$  years, and 48.9% of the patients were male. Only 13.5% had a “moderate” family history of CRC (1 first-degree relative received a diagnosis of CRC at age  $\geq 50$ ), indicating that most patients truly had sporadic adenomas. Just under three-quarters of colonoscopies were performed for diagnostic purposes, with the remainder being performed either as screening procedure because of a moderate family history of CRC or as surveillance. Of the adenomas identified, the mean size ( $\pm$  SD) was  $6.3 \pm 5.4$  mm; just over half were in the right side of the colon, and almost one-quarter of patients had either 1 advanced adenoma or at least 3 nonadvanced adenomas. Interestingly, 37.6% had  $\geq 1$  sessile serrated polyp(s).

With regard to surveillance recommendations, MSTF guidelines were generally adhered to for low-risk adenomas (68.3%), small adenomas (66%), and polypoid lesions (73.4%). Guideline adherence was much lower for high-risk adenomas (40%), adenomas  $\geq 10$  mm (36.7%), nonpolypoid lesions (44.2%), and serrated polyps (54.2%). In cases where guidelines were not adhered to, 96% of these patients were recommended to undergo earlier surveillance than recommended by the MSTF guidelines. Regarding compliance with surveillance colonoscopy recommendations, only 24.7% of the cohort were compliant with the recommended surveillance interval, resulting in limited surveillance data for analysis. Of the 24 surveillance procedures performed, 20 patients did not have any polyps detected, and no patient had cancer or high-grade dysplastic lesion detected. Furthermore, no patients had more than 2 nonadvanced neoplastic lesions at the surveillance colonoscopy.

The findings of this study demonstrated that, generally, endoscopists made recommendations in line with the MSTF guidelines when advising younger patients of the appropriate surveillance interval, particularly after detection and removal of lower-risk lesions. Nonetheless, significant variation was observed among the endoscopists' recommendations, even within a single health care center, and thus it is likely that even greater variability exists among endoscopists internationally. When their

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