

## Increase in Colonoscopy Utilization Resulted in Risk of Colorectal Cancer

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### Abstract

The first contains specific recommendations for screening and surveillance in people at average and at high risk for colorectal cancer. The second section describes the evidence used to develop the recommendations. Screening, diagnostic evaluation, and surveillance strategies are presented as options that the panel thought were acceptable, based on the evidence. The options differ in strength of evidence, size of benefit, clinical performance, and effectiveness in preventing colorectal cancer, simplicity, safety, patient acceptance, cost, and cost-effectiveness.

### Introduction

Interpreting the precise decrease in cancer incidence reported is challenging. The statistical validity of comparing this population with documented adenomas with repeated colonoscopy over time with those in whom cancer developed in the broader U.S. population is inherently problematic [1]. Of course, this adenoma-bearing population is a high-risk one and one might expect a significantly higher rate of subsequent Colorectal Cancer. That being said, this population has undergone repeated colonoscopies with removal of all visualized adenomas, a practice that we think significantly decreases cancer risk [2]. Moreover, this study population likely differs from the general U.S. population in other important ways that may bias the results in favour of finding a significant reduction in risk [3]. For example, all subjects consented to participate in a trial to assess the effectiveness of diet in colorectal adenoma prevention and were likely more health conscious in other ways [4]. Finally, one might expect that the quality of colonoscopy initially performed as part of a clinical trial was quite good [5]. Irrespective of the precise reduction in cancer risk reported in this study, the fact remains that a significant amount of on-going cancer occurred despite repeated colonoscopy and polypectomy as necessary. So what clinical messages should be drawn from this work? First, we should strive to improve the practice of colonoscopy [6]. Although some of these cases were likely unavoidable, certainly some were potentially preventable. As gastroenterologists, our goal should be to strive to optimize mucosal inspection by meticulous colonic examination including adequate time for withdrawal and careful cleaning of mucosal surfaces [7]. As investigators, we should aim to identify those factors that are associated with missed and incomplete resection of lesions and develop strategies to minimize such occurrences [8]. Second, these cases of interval cancer despite repeated colonoscopy remind us that we are not going to eradicate CRC with colonoscopy. The individuals found with cancer in this study had undergone at least 3 previous colonoscopies, and CRC still developed. One interpretation might be that all adenoma-bearing patients require even more colonoscopy surveillance [9]. That would likely be a mistake. There is already good evidence that the practice of surveillance is overdone, and it would be unfortunate if the results of an article like this drove more early surveillance in all adenoma-bearing patients [10]. However, there may be some subgroups of individuals with adenomas who are at particularly high risk who do merit closer follow-up. For example, in both this article and one other describing long-term follow-up in patients undergoing surveillance, a history of advanced adenoma at any time in the past appears to be an important risk factor for subsequent advanced adenoma formation and cancer. But for most patients with few low-risk adenomas, lengthening, not shortening, surveillance intervals are likely the best course. Is colonoscopy fulfilling the promise? Comparative effectiveness trials will be required to definitively determine its benefit in cancer prevention

and a call for such work has recently been made. In the absence of trials to definitively determine such effectiveness, we will need to rely on cohort data such as these to understand the performance of this procedure. Although a negative colonoscopy seems to be a fairly strong predictor of subsequent CRC-free survival, the same cannot be said for those undergoing colonoscopy with polypectomy. Careful attention to the practice of quality colonoscopy while developing strategies to better stratify adenoma-bearing patients by using either clinical epidemiology or biology will be required to further reduce the CRC burden in this population.

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### Conflict of Interest

None

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