Those who have colonoscopy performed by GIs less likely to develop colorectal cancer

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Following a negative complete colonoscopy, those who had their colonoscopies at a hospital and had their procedures performed by a non-gastroenterologist may be at a significantly increased risk of developing subsequent colorectal cancer (CRC), according to a new study in *Clinical Gastroenterology and Hepatology*, the official journal of the American Gastroenterological Association (AGA) Institute.

"The overall incidence of colorectal cancer is reduced for at least 10 years following a negative colonoscopy, compared with the general population. However, colorectal cancers do occur in individuals following a negative colonoscopy," said Linda Rabeneck, MD, MPH, of the University of Toronto and lead author of this study. "For this reason, having extensive formal training matters, especially when procedures are more challenging to perform. We found that among those physicians who perform colonoscopy in the hospital setting, gastroenterologists are more proficient at colonoscopy than other physicians, including general surgeons. This may reflect the considerable formal training in endoscopy that forms part of gastroenterology core training requirements in the U.S. and Canada."

AGA considers colonoscopy to be the gold standard for detecting and removing adenomas, and colonoscopic polypectomy is associated with a reduced incidence of CRC. Colonoscopy is endorsed as an option for CRC screening by the U.S. Multi-Society Task Force on Colorectal Cancer and the U.S. Preventive Services Task Force.

"March is National Colorectal Cancer Awareness Month, which provides the perfect reminder to patients aged 50 and older that they need to be screened for colorectal cancer," said Gail A. Hecht, MD, MS, AGAF, president of the AGA Institute. "Colorectal cancer is the third leading cause of cancer death, but it is one of the most preventable cancers when caught earlier. We cannot emphasize strongly enough that screening saves lives. Patients should talk to their doctors to discuss all of their colorectal cancer screening options."

Study Results

Doctors identified a cohort of 110,402 Ontario residents, 50 to 80 years old, who had a negative complete colonoscopy between Jan. 1, 1992, and Dec. 31, 1997. Cohort members had no prior history of CRC, inflammatory bowel disease or a recent colonic resection. Each individual was followed through Dec. 31, 2006, and those with a new diagnosis of CRC were identified.

During the 15-year follow-up period, 1,596 (14.5 percent) developed CRC. There was no association between the average number of colonoscopies performed and a diagnosis of CRC. Among those who had their colonoscopies at a hospital, which was the majority (86 percent), those who had their procedures performed by a non-gastroenterologist, e.g., general surgeon, internist or family physician, were at significantly increased risk for developing subsequent CRC. For those who underwent their colonoscopies in a private office/clinic, endoscopist specialty was not significantly associated with incident CRC. These study findings suggest that endoscopist specialty is an important determinant of the effectiveness of colonoscopy in usual clinical practice.

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