ASGE issues guideline on ethnic issues in endoscopy

June 3 2010

The American Society for Gastrointestinal Endoscopy (ASGE) has issued guidelines addressing ethnicity, gastrointestinal diseases and endoscopic procedures. The guideline suggests that colorectal cancer screening should begin at age 45 for average risk African-American men and women, and that it is recommended that colorectal cancer screening be emphasized for other minority ethnic groups that have lower screening utilization rates. It is noted in the statement that weaker recommendations are indicated by phrases such as "we suggest," whereas stronger recommendations are typically stated as "we recommend." This guideline, "Ethnic issues in endoscopy," was developed by ASGE's Standards of Practice Committee and appears in the June issue of *GIE: Gastrointestinal Endoscopy*, the monthly peer-reviewed scientific journal of the ASGE.

The United States (U.S.) population is ethnically diverse and disease patterns can affect each ethnic group differently. Observations of the differences in the prevalence or presentations of disease among ethnic groups can be important keys to disease diagnosis and management. This guideline emphasizes some of the more important differences in gastrointestinal disease patterns among minority ethnic groups in the U.S. that may influence the practice of endoscopy in these patient groups.

"This guideline is not intended to serve as a comprehensive list of gastrointestinal disease profiles for various ethnic groups. Colorectal cancer screening is one example where practice recommendations have

been modified to account for differences based on patient ethnicity. Studies addressing the impact of modifying specific endoscopic standards of practice for conditions based on ethnicity are currently lacking," said Jason A. Dominitz, MD, MHS, FASGE, chair of ASGE's Standards of Practice Committee.

"However, it is logical to assume that increased awareness of differences in disease patterns and management among different ethnic groups could have beneficial impacts on the health-related quality of life of people in these groups. At the same time, it is important to recognize that ethnic populations are not homogeneous and that additional factors, such as environment and behavior, also play important
roles in disease."

The guideline addresses gastrointestinal diseases affecting the esophagus (esophageal cancer), stomach (Helicobacter pylori infection, gastric intestinal metaplasia and gastric cancer) and colon (colorectal cancer) in ethnically diverse populations.

Among the topics discussed, the guideline notes that the minority ethnic groups that are at risk for gastric carcinoma (cancer) predominantly have the "intestinal" type of gastric cancer, where intestinal metaplasia in the stomach is considered to be a precursor lesion. In one study from the southwestern United States, the prevalence of intestinal metaplasia was significantly higher in Hispanics and African-Americans combined (50 percent) compared with non-Hispanic whites (13 percent). East Asians also have a significantly increased rate of gastric carcinoma. In some Asian countries, screening of asymptomatic individuals for gastric cancer is performed, typically beginning around age 40. In accordance with recent recommendations regarding screening for gastric cancer in populations within the Asian Pacific region, endoscopic screening for gastric cancer in new (first generation) U.S. immigrants from high-risk regions around the world, such as Korea, Japan, China, Russia, and

South America, should be considered if there is a family history of gastric cancer in a first-degree relative.

Differences in colorectal cancer incidence and mortality exist between racial groups, and recognition of these differences has resulted in some experts recommending earlier screening in certain ethnic groups. African-Americans with colorectal cancer have a 20 percent stage-adjusted increase in mortality risk compared with European Americans. Furthermore, while colorectal cancer screening is recommended for average risk men and women beginning at age 50, African-Americans have a younger age at presentation with colorectal cancer than European Americans and a higher proportion of cancers presenting before age 50. Advanced cancer stage at the time of diagnosis accounts for half of the increased mortality risk in African-Americans. There are multiple possible explanations for this phenomenon, including societal issues (such as access to medical care and increased exposure to modifiable colorectal cancer risk factors), as well as possible inherent biologic differences resulting in more aggressive colon neoplasm behavior in African-Americans than in European Americans.

Early detection of colorectal cancer and removal of adenomatous (precancerous) polyps results in lower colorectal cancer incidence and lower mortality rates. Therefore, the guideline suggests that colorectal cancer screening should begin at age 45 for average-risk African-American men and women. Colorectal cancer screening should also be emphasized in other minority ethnic groups, such as Hispanics and Native Americans. Observations have shown that Hispanics and Native Americans have developed an increasing incidence of colorectal cancer compared with historical rates of the disease in their ethnic groups, as well as a trend toward later-stage disease, when compared with non-Hispanic European Americans.

RECOMMENDATIONS FROM THE ASGE

STANDARDS OF PRACTICE COMMITTEE:

The recommendations are based on reviewed studies and are graded on the quality of the supporting evidence. The strength of individual recommendations is based on both the aggregate evidence quality and an assessment of the anticipated benefits and harms. Weaker recommendations are indicated by phrases such as "we suggest," whereas stronger recommendations are typically stated as "we recommend." See the guideline for recommendation grade and an explanation of the grading system.

1. We suggest that screening esophagogastroduodenoscopy (EGD or upper endoscopy) for adenocarcinoma or squamous cell carcinoma of the esophagus should be based on clinical considerations and not upon ethnicity.

2. Screening for and treating Helicobacter pylori has the potential to reduce the risk for gastric cancer in groups with high gastric cancer risk, but we do not suggest ethnicity based deviations from usual care.

3. In patients found to have gastric intestinal metaplasia, we suggest surveillance for those at increased risk of gastric cancer due to ethnic background or family history.

4. We suggest screening EGD for gastric cancer in new U.S. immigrants from high-risk regions around the world, such as Korea, Japan, China, Russia, and South America, especially if there is a family history of gastric cancer in a first-degree relative.

5. We suggest that colorectal cancer screening should commence at

age 45 for average-risk African-American men and women.

6. We recommend that colorectal cancer screening be emphasized for other minority ethnic groups that have lower screening utilization rates.

Summary

In summary, several gastrointestinal diseases demonstrate racial and ethnic differences in their epidemiology. Practitioners should be aware of these differences, because alteration of diagnostic and management strategies may help reduce racial and ethnic disparity in healthcare outcomes.

More information: The full guideline can be found in the June issue of GIE at www.giejournal.org or on ASGE's website at www.asge.org/PublicationsProductsIndex.aspx?id=352

Provided by American Society for Gastrointestinal Endoscopy