Transcript Details
This is a transcript of an educational program. Details about the program and additional media formats for the program are accessible by visiting: https://reachmd.com/programs/clinicians-roundtable/postcolonoscopy-colorectal-cancer-optimizing-quality-to-reduce-risk/36552/

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Postcolonoscopy Colorectal Cancer: Optimizing Quality to Reduce Risk

Announcer:

This is *Clinician's Roundtable* on ReachMD. On this episode, we'll hear from Dr. Aasma Shaukat, who will be discussing her recent research on post-colonoscopy colorectal cancer in fecal immunochemical test-positive individuals. Dr. Shaukat is the Robert M. and Mary H. Glickman Professor of Medicine and a Professor in the Department of Population Health at NYU Grossman School of Medicine. She also serves as the Director of Outcomes Research in the Division of Gastroenterology and Hepatology at NYU Langone Health.

Here's Dr. Shaukat now.

Dr. Shaukat:

As colon cancer screening becomes more and more widely used, we are looking for noninvasive modalities and stool-based testing. Particularly, fecal immunochemical testing has a big role in being one of the tests that we use. However, a positive or abnormal FIT should lead to a colonoscopy. And it is unclear that after that colonoscopy is done, and if the colonoscopy doesn't find anything, what is an individual's risk of having future colorectal cancer? So that was the question that we were primarily seeking, because we thought it could help shed light on whether our follow-up intervals are properly spaced and are there lesions that turn up as missed cancers that we should be targeting.

Quality in colonoscopy is extremely important because colonoscopy is a very operator-dependent procedure, and hence, the quality of the procedure really determines its outcome. And our aim should be a high-quality colonoscopy, which would inspire confidence in the lesions that we found that we were able to completely remove and give our patient an interval that's adherent to current guidelines. When colonoscopy quality falls short, then we worry about consequences, and our biggest concern is the risk of missed colorectal cancers. And the definition of these is cancers that could occur after a complete and clearing colonoscopy has been done, but they appear at an interval shorter than one would expect them to appear. So, for instance, if an individual has been given a 10-year interval after colonoscopy at which nothing was found, an interval cancer or a post-colonoscopy colon cancer occurring at year three or five would be a concern, and we would want to know whether there were lapses in the quality of the initial colonoscopy that led to that cancer.

What our study showed is most of the cancers that are missed are missed because they just weren't seen during the colonoscopy, so the implication there is slowing down, taking our time, and using all the different maneuvers and techniques we have to expose colonic mucosa and getting a very thorough look. Some of it is increasing our withdrawal time and having adequate inspection technique. A second area of improvement is improving our polypectomy technique. It appears that we leave tissue behind when we try to resect polyps, and that tissue can very quickly turn into a preneoplastic lesion, so it is really important to have correct polypectomy techniques. We've written a lot of different guidelines on the topic, so it's really important that our polyp removal technique is up to the recommended standards currently. And the third important aspect is telling the patient what their risk might be, so correct risk stratification, so that we don't give patients intervals that are either too long or don't make sense based on their baseline risk of having future cancer.

Announcer:

That was Dr. Aasma Shaukat talking about how we can improve quality and consistency of colonoscopies to prevent later incidences of colorectal cancer. To access this and other episodes in our series, visit *Clinician's Roundtable* on ReachMD.com, where you can Be Part of the Knowledge. Thanks for listening!