

OMED COLORECTAL CANCER SCREENING COMMITTEE MEETING

Saturday, May 1, DDW New Orleans, 2010

Presenter: Michael Bretthauer



What should the adenoma target in screening be?

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Are adenomas the target?

- Two different approaches in CRC screening
 - Early detection
 - Prevention
- Evidence
- Complications
- Overdiagnosis



To be considered

- Overdiagnosis
 - Many adenomas, few cancers
- Complications
 - C'scopy complication rate: 0.1-0.6% (1/400-1/1000)
 - Levin et al, GASTRO '08: "small polyp bleeds are more numerous than large polyp bleeds because small polyps are so numerous."

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Adenoma detecting methods (prevention)

- Guidelines:
 - Adenomas
 - Advanced adenomas
 - Significant adenomas
 - ...
- Paradox:
 - Defining risk at screening
 - Defining future risk



Paradox

Levin et al, AGA++ guidelines, GASTRO 2008

(in CTC para):

”Such polyps [under 9mm]are routinely removed if found at OC because of the opportunity and the risk, albeit low, of advanced neoplasia”

” There is general agreement that the risk of advanced features in patients whose largest polyp is 5 mm is very low.”



The adenoma-carcinoma- sequence

1. Forward

- CRC arises from adenomas
- small adenoma – large adenoma –CRC

2. Flipped around

- Adenomas grow into CRC
- CRC – large adenoma – small adenoma

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The issue of time

- From small adenoma to CRC: 10 years
- From small adenoma to advanced adenoma: 5 years?



As a consequence...

1. For screening tests performed infrequently:
 - All adenomas are the target
2. For frequently performed tests:
 - Advanced adenomas are the target



Conclusions

- Are adenomas the target?
- If they are:
 - All adenomas should be the target
 - Two major problems arise
 - Overdiagnosis
 - Complications
