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## **HIGHLIGHTS FROM THE JUNE ISSUE OF *GIE: GASTROINTESTINAL ENDOSCOPY***

**DOWNERS GROVE, Ill. – June 23, 2014** – The June issue of *GIE: Gastrointestinal Endoscopy*, the monthly peer-reviewed scientific journal of the American Society for Gastrointestinal Endoscopy (ASGE), features a study reporting that the annual incidence rate of esophageal cancer among patients with Barrett’s esophagus with low-grade dysplasia is 0.54 percent; a study showing that metabolic syndrome and smoking heighten concerns regarding colorectal cancer screening in men with these risk factors; and a new ASGE guideline on endoscopy in patients with lower gastrointestinal bleeding.

### **“Incidence of esophageal adenocarcinoma in Barrett’s esophagus with low-grade dysplasia: a systematic review and meta-analysis”**

Barrett’s esophagus is a condition in which the lining of the esophagus changes and becomes more like that of the small intestine. It is believed that Barrett’s esophagus (BE) occurs because of chronic inflammation resulting from long-standing gastroesophageal reflux disease (GERD). Barrett’s esophagus is the most significant risk factor for the development of a certain type of cancer called esophageal adenocarcinoma (EAC). In some patients with BE, further precancerous change in the tissue, called dysplasia, will develop. Those patients that develop dysplasia, especially high-grade dysplasia (BE-HGD), are significantly more likely to develop esophageal cancer. However, most patients with Barrett’s esophagus will not develop EAC.

The natural history of how low-grade dysplasia (LGD) in patients with Barrett’s esophagus progresses to BE-HGD or EAC is unclear. Researchers performed a systematic review and meta-analysis of cohort studies that reported the incidence of EAC and/or BE-HGD among patients with BE with LGD (BE-LGD) with follow-up of  $\geq 2$  years. The main outcome measurements were pooled incidence rates of EAC and/or BE-HGD.

Researchers identified 24 studies reporting on 2,694 patients with BE-LGD, with 119 cases of EAC. Pooled annual incidence rates of EAC alone and EAC and/or HGD in patients with BE-LGD were 0.54 percent and 1.73 percent. The results were stable across study setting and location and in high-quality studies. Substantial heterogeneity was observed, which could be explained by stratifying based on LGD/BE ratio as a surrogate for quality of pathology; the pooled annual incidence rates of EAC were 0.76 percent for LGD/BE ratio  $< 0.15$  (surrogate for high-quality pathology) and 0.32 percent for LGD/BE ratio  $> 0.15$  (surrogate for low-quality pathology). The annual rate of mortality not related to esophageal disease in patients with BE-LGD was 4.7 percent.

### **“Metabolic syndrome and smoking may justify earlier colorectal cancer screening in men”**

Despite the overall decline in the incidence of colorectal cancer (CRC) in the United States and the associated mortality resulting from broadly promoted screening programs, there has been an increase in the incidence of CRC in subjects younger than 50 years of age (the recommended screening age for

average risk individuals), especially in those aged 40 to 49 years. The cause of such an increase in younger adults remains unclear, but some evidence links it to the increasing prevalence of obesity and metabolic syndrome. Metabolic syndrome (MetS) is characterized by central obesity, high blood pressure, hyperglycemia and dyslipidemia. Because of the adoption of Western dietary habits and lifestyle, many developed Asian countries have witnessed a substantial increase in the prevalence of obesity and MetS over the past few decades.

Gender, smoking and metabolic syndrome are important risk factors of colorectal neoplasm. Whether the presence of these factors warrants earlier screening remains unclear. This study's aim was to compare age- and gender-specific risk of colorectal neoplasms in association with smoking and MetS under endoscopic or stool-based screening. It was a cross-sectional observational study at a screening center in a university hospital in Taiwan. A cohort of 10,884 average-risk individuals 40 years of age or older who received concurrent screening colonoscopy and fecal immunochemical testing (FIT) participated in the study. The main outcome measurements were first, the prevalence of colorectal neoplasms and positive predictive value of FIT relative to age, gender, smoking and MetS. The second outcome measurement was the number of colonoscopies needed with different strategies to detect one advanced neoplasm (defined as lesions larger than 10 mm, and those containing a villous component, severe dysplasia or invasive cancers).

The researchers found that male smokers aged 40 to 49 years had a significantly higher prevalence of advanced neoplasms and positive predictive value of stool tests than nonsmoking counterparts. The prevalence of advanced neoplasms was higher among men aged 40 to 49 years with concurrent MetS and smoking (6.2 percent) or smoking alone (3.8 percent) than that of average risk women aged 50 to 59 years (2.1 percent). The number of colonoscopies needed to detect one advanced neoplasm in men aged 40 to 49 years with concurrent MetS and smoking, smoking, MetS and women aged 50 to 59 years was, respectively, 14.6, 24.8, 39.8 and 47.4 in the colonoscopy scenario and 1.7, 4.6, 5.7 and 8.3 in the FIT scenario. The researchers concluded that MetS and smoking significantly impact both the prevalence of colorectal neoplasms and the diagnostic yields of screening tests in men aged 40 to 49 years. Whether the findings justify earlier screening in this subgroup requires further study.

#### **“The role of endoscopy in the patient with lower GI bleeding”**

ASGE has published a new guideline, “The role of endoscopy in the patient with lower GI bleeding.” The guideline was prepared by the ASGE Standards of Practice Committee and appears in the journal's June issue and online at [www.giejournal.org](http://www.giejournal.org).

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#### **About the American Society for Gastrointestinal Endoscopy**

Since its founding in 1941, the American Society for Gastrointestinal Endoscopy (ASGE) has been dedicated to advancing patient care and digestive health by promoting excellence and innovation in gastrointestinal endoscopy. ASGE, with more than 13,000 members worldwide, promotes the highest standards for endoscopic training and practice, fosters endoscopic research, recognizes distinguished contributions to endoscopy, and is the foremost resource for endoscopic education. Visit [www.asge.org](http://www.asge.org) and [www.screen4coloncancer.org](http://www.screen4coloncancer.org) for more information and to find a qualified doctor in your area.

#### **About Endoscopy**

Endoscopy is performed by specially-trained physicians called endoscopists using the most current technology to diagnose and treat diseases of the gastrointestinal tract. Using flexible, thin tubes called endoscopes, endoscopists are able to access the human digestive tract without incisions via natural orifices. Endoscopes are designed with high-intensity lighting and fitted with precision devices that allow viewing and treatment of the gastrointestinal system.