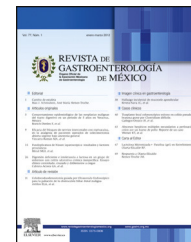




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EDITORIAL

Should we forget about rectosigmoidoscopy for the diagnosis of advanced colorectal neoplasia? ☆, ☆ ☆



¿Debemos olvidar la rectosigmoidoscopia para el diagnóstico de neoplasia avanzada colorrectal?

There is a rising trend in colorectal cancer worldwide and despite the advances in medicine and the fact that the important risk factors of age above 50 years, male sex, a family history of the disease, smoking, obesity, and diabetes mellitus are recognized, it has not been possible to determine a factor in the general population that can identify with absolute certainty the population at risk for developing this neoplasia.¹

In the year 2002 in Mexico, a total of 108,064 new cases of cancer with histopathologic diagnoses² were registered. Of that total, 3,791 (3.5%) cases corresponded to colorectal cancer, specifically 2.3% to cancer of the colon and 1.2% to cancer of the rectum, situating colorectal cancer among the first 10 causes of morbidity due to malignant neoplasias. In 2006,³ 4,550 new cases (4.19%) were reported, 2.80% of which corresponded to cancer of the colon and 1.39% to cancer of the rectum, showing that there is also an increasing trend of this neoplasia in our country.

The majority of cases of colorectal cancer (CRC) derive from adenomatous polyps and new cases can be prevented and/or reduced through the detection and removal of those polyps through colonoscopy. Survival can also increase if CRC is diagnosed in the early stages of the disease. However, not all adenomas present with the same risk for transforming into cancer. Two risk groups are currently distinguished based on their transformation probability, and they are classified as low-risk and high-risk adenomas. The low-risk category is defined as 1 or 2 adenomas smaller than 10 mm.

Adenomas are considered high-risk when they are larger than 10 mm or there are 3 or more polyps, when there is a villous component, or there is the presence of high grade dysplasia.

The same associated factors have been described for both CRC and advanced neoplasia (AN), given that the precise factors related to the latter are not known. The study by Parra-Pérez et al.⁴ evaluated the factors associated with AN and proximal AN (PAN) in colorectal cancer in a Latin American population. They conducted an observational, cross-sectional analysis that included 846 patients. AN was detected in 108 of the patients and PAN in 55. The most striking fact for the authors was that of those 55 patients, 42 had no neoplasia in the distal colon. They concluded that the factors related to AN were an age of 50 years or older and male sex, and the factors related to PAN were an age of 60 years or older, the presence of advanced distal neoplasia, or the presence of ≥ 3 non-advanced distal neoplasias, increasing the risk almost 2.5-fold. Another conclusion of the study was that 75% of the PANs remain undiagnosed if complete colonoscopy is not performed, having a direct impact on the morbidity and mortality of CRC. In their study, they were not able to identify additional risk factors for detecting AN, but they were able to determine that distal AN was an important risk factor for the presence of PAN, concurring with that reported in the literature.

As the authors state in their study, the most important aim in the detection of AN is to reduce CRC mortality and the method of choice should be complete colonoscopy, with the quality criteria previously described.⁵ The current endoscopic screening methods for CRC detection are sigmoidoscopy and colonoscopy. The observation has been made that there are increasingly fewer sigmoidoscopies⁶ and more colonoscopies being carried out due to various factors. However, this is not a generalized practice and sigmoidoscopy continues to be performed in many places, but, as the study points out, in the absence of complete colonoscopy, 6 to 75% of cases of PAN will not be diagnosed.⁷⁻⁹ The recent

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increase in diagnoses of serrated sessile adenomatous polyps is noteworthy.¹⁰ They are more frequently located in the proximal colon and the best method for diagnosing them is complete colonoscopy, adding another reason for discontinuing flexible sigmoidoscopy, especially in symptomatic patients or in those being screened.

The primary aim of this study was to determine the risk factors for AN and PAN. Unfortunately, no factor has yet been identified that can have a direct impact on the quality of care for this population. We depend on the factors mentioned above, together with our clinical judgment, to make the decision to perform a screening procedure for CRC. It is a well accepted fact that the most important goal in the detection of AN is to reduce the mortality caused by CRC. Therefore it is necessary to continue to conduct studies that distinguish the risk factors in the population at average risk for CRC, as well as to define the current role of sigmoidoscopy as a screening method for CRC, given the increasing number of proximal colorectal neoplasias reported. For now, taking into account the present conditions in Mexico, which are similar to those in all Latin America, it is very likely that sigmoidoscopy will continue to be a useful and utilized method for CRC screening, a circumstance that is still supported by results reported in the national and international literature.

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Conflict of interest

The author declares that there is no conflict of interest.

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