Introduction to a New Series

It has been four years since the last colorectal cancer (CRC) symposium appeared in this journal (1). Many questions posed by the expert faculty in the previous series have partial and in some cases complete answers. Nevertheless, CRC remains a problem of large magnitude with an international incidence of nearly 100,000 new cases annually (2) and a mortality of 55,000 cases annually in the United States (3). Screening for CRC precursors with removal of precancerous as well as early cancerous lesions continues to be the immediate best hope to effect reduction in these figures.

A large base of knowledge has been obtained concerning the multiple approaches that are available to effect screening. Randomized trials of fecal occult blood screening (FOBT) have indicated mortality reduction (4,5,6). The continued analysis of data from the National Colon Polyp Study (7) have clarified the recommendations for screening the average risk population as well as patients with first degree relatives with polyps or cancer. There is now a vast clinical experience with patients who have undergone screening with FOBT, flexible sigmoidoscopy barium enema, and colonoscopy alone or in various combinations. Amongst Gastroenterologists, the use of colonoscopy has emerged as the preferred approach for screening and recent feasibility trials have shown encouraging results.(8,9) Firm data supporting efficacy compared to other approaches however has not yet been obtained. The health care system has taken on support for screen-

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sent are addressed by this symposium in this and the ensuing issues of this journal.

The stage is traditionally and again set for the symposium with a landmark overview. Dr. John H. Bond of the Minneapolis VA Medical Center and the University of Minnesota directly addresses the question: “Screening for Colorectal Cancer: Is there Progress for Early Detection?” The natural history, proposed screening intervals, and choices of approach are presented on the background of agreed and emerging guidelines.

The issues of quality control for CRC screening are paramount to efficacy and cost effectiveness. Dr. David Lieberman of the Portland VA Medical Center and the Oregon Health and Science University reviews these quality control issues and provides a framework for improving quality.

The next two articles in the series provide a practical update on the use of present and emerging approaches to stool testing for screening for CRC. The time-honored office based FOBT is compared to the Immunochemical FOBTs for clinical and practical use by Dr. Graeme P. Young from the Flinders Medical Centre in Adelaide, Australia. Dr. Young’s extensive experience with the development and use of the Immunochemical techniques gives hope for improved results with this lower cost and less invasive approach as an adjunct to flexible endoscopic procedures.

As our knowledge and understanding of the genetics of CRC continues to increase at a rapid rate, so have advancements for potential specific non-invasive approaches to screening though the use of genetic based concepts. Dr. Michael Ross, Vice President of Clinical Affairs at EXACT Sciences, Inc., reviews the emerging stool DNA testing approach and its potential value for individuals who are unwilling or unable to undergo more invasive screening modalities.

The important issues of dietary and chemoprevention for CRC continue to capture the imagination and research direction of many investigators in this field. Dr. Paul Rozen from the Tel Aviv Medical Center in Tel Aviv, Israel returns to update and supplement his excellent review from the last series (1). His review of the available chemo preventive agents gives hope for future progress in prevention but places these agents in clinical perspective along with our present knowledge of the dietary approach to patients at risk.

Dr. Avrum Bluming of the University of Southern California returns as a Symposium Faculty to analyze if real progress has been made in chemotherapy for advanced disease. It is apparent that remarkable progress has been made with a variety of adjuvant therapies and newer more innovative approaches. His review serves as a practical guide for physicians working in conjunction with oncological specialists.

The symposium concludes with Dr. Charles P. Rosenbaum’s “Review of Chemotherapy for Colorectal Carcinoma,” from the perspective of the community oncologist. Managed care has provided a closer working relationship with the community oncologist in on going palliative care of these patients. The timing and route of drug administration as well as the use of adjuvants now fall to the practice of the oncologist, gastroenterologist and primary care physician.

Finally, if continued progress is to be made in the diagnosis and therapy of this and any prevalent cancers, it requires a combination of efforts that include research, education and funding. The recently organized International Digestive Cancer Alliance (IDCA) has launched with a program directed at CRC. Drs. Meinhard Classen from Munich, Germany and Sidney Winawer from New York are the Co-Chairs of this Alliance. They conclude this symposium Series with a review of the IDAC’s present initiatives, and goals.

Once again we have come full circle. I want to express my appreciation to each of the experts who have contributed to this symposium, the fifth that this journal has committed itself to. It is obvious that major strides in our understanding of this disease are reaping benefit in early detection as well as therapy.

References