Discouraging colonic polyps

The old adage ‘no smoke without fire’ is untrue, as any cook or electrician will testify, but it is wise to investigate. There is growing support in the literature that non-steroidal anti-inflammatory drugs (NSAIDs), sulindac in particular,1–3 discourage intestinal polyps as well as other tumours. Matsuhashi et al (see page 344) join the bandwagon, but whether their contribution adds much substance is debatable. They correctly criticise a previous American study on nine adenomatous polyps as being small, but then try to make statistically significant conclusions from their own study of only twenty adenomas (in 15 patients). Their methods are not beyond criticism either, quite apart from the inherent limitations of any ‘before and after’ study of heterogeneous lesions such as polyps in a variable organ such as the colon. It is good that they took a prior biopsy specimen of each polyp, but can they then be certain that trauma alone had no subsequent effect? Could the disappearance of a 1 cm polyp have been infarction rather than a “regressive effect of sulindac” in a four month period? Are they sure that the 2-8 cm polyp shown fuzzily in close up in Fig 1B really reduced to 8 mm in the same time period – the distorting effects of the wide-angle ‘fish eye’ lens of a modern endoscope, coupled with the contractile nature of the bowel lumen, make endoscopic judgements of size subjective in the extreme (and barium enema measurements not much better because of the magnification factors involved). Even though the lesions were ‘photographed with the open biopsy forceps beside’ there is potential for ‘methodological inexactitude’; were the images assessed blind and by independent observers? Did all of the (nine) small polyps that ‘disappeared’ really do so, or were some of them simply not seen? It is possible to mark the colon surface by tattooing, but otherwise notoriously difficult for the endoscopist to locate small lesions, with a significant inherent miss-rate.4

Surprisingly, Matsuhashi et al do not refer to other studies where at least a proportion of ‘polyps’ regressed or disappeared on no therapy at all. Hofstad et al5 reported recently that they could not find 15% of 22 small polyps observed endoscopically for a year with no intervention, and during this period noted a significant decrease in the size of those polyps between 5 and 9 mm without any intervention. Knoerschild6 similarly reported that a percentage of sigmoidoscopically observed small polyps (of uncertain histology) disappear. As the potential for NSAID or sulindac treatment has been around for over a decade and adenomas are common, there seems no reason why a larger series could not have been undertaken. Furthermore, precisely because of the vagaries of nature and of those who investigate its mysteries, the principle of randomised, double blind, controlled trials is accepted as paramount in assessing the effects of a particular treatment. The preliminary report of Matsuhashi et al is a further flicker of light on the matter of NSAID efficacy, but scarcely clarifies the situation. Adenomas themselves, after all, only matter in so far that their removal may prevent cancer. If their musings Matsuhashi et al suggest that reducing adenoma size could be useful in ‘reducing risks associated with polypectomy’. They could perhaps argue that this is relevant in hospitals such as theirs where barium enema apparently precedes colonoscopy, or if colonoscopy is unavailable or impossible, but it is absurd in the majority of cases where colonoscopy is the first investigation of patients at risk or performed early when polyps are identified. Polypectomy is generally a trivially easy and very safe procedure, except for the largest and most sessile polyps. The challenge comes after removal of the polyp, where minimising the logistics and expense of follow up would be desirable, while maximising the patient’s long term safety from colorectal cancer. For those patients at higher risk (with large or multiple adenomas initially or notable family history, or both) there could be benefits from treatment with NSAIDs – but these must be proven, and convincingly. The question of side effects must be also be considered, for these have been a serious problem in recent studies,7 although not mentioned in Matsuhashi et al’s series. What is clearly needed is a properly designed drug trial, which probably only makes clinical sense after initial polypectomy has been performed. Such large scale trials are already under way.

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Gut 1997 40: 430
doi: 10.1136/gut.40.3.430

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