Colon cancer

Are proximal colorectal cancers always associated with distal adenomas?

A J M Watson

Only half of proximal colon cancers are associated with adenomas in the distal colon. This has important implications for the selection of the initial investigation for colorectal cancer screening.

Of all the common cancers, colorectal cancer is the best suited to prevention through screening as it is derived from benign adenomas which can be easily detected and removed. The best screening investigation remains much debated. Many argue that colonoscopy is superior to other techniques because it has the highest sensitivity (>90%) and examines the whole colon. However, it has a number of important disadvantages. Firstly, it is potentially dangerous. Perforation rates of 1 in 1000–1 in 20 000 have been found potentially dangerous. Perforation rates are important disadvantages. Firstly, it is always associated with distal colorectal cancer.

The crucial assumption for the use of flexible sigmoidoscopy is that all proximal cancers are missed, including 17% of proximal carcinomas and carcinomas in the 2154 individuals (17% of the total screeners) who were found to have distal neoplasms. Of these, 1833 individuals were studied. Twenty one per cent of subjects had colonic neoplasms proximal to the level reached by flexible sigmoidoscopy and a further 5% of subjects had proximal advanced neoplasms (PAN) defined as high risk adenomas or carcinomas. The risk of PAN increased threefold in subjects with distal adenoma > 10 mm in diameter or containing villous components. The investigators then calculated the number of PAN that would have been missed depending on the threshold criteria for offering colonoscopy. If the threshold criteria for colonoscopy had been more than one adenoma or a single high risk adenoma (as defined by a diameter > 10 mm or villous components or showing severe dysplasia) then 38% of PAN would have been missed, including 17% of proximal carcinomas. Furthermore, the tendency to miss PAN was found to increase with the age of the subject. On the other hand, implementation of these strict threshold criteria would have resulted in 66% fewer colonoscopies being undertaken.

A particularly interesting feature of the study was that colonscopes were used to perform many of the flexible sigmoidoscopic examinations with the extent of examination limited by the degree of bowel cleansing from a single sorbitol enema. In this way the investigators were able to examine a greater proportion of the colon than is usually possible with a conventional flexible sigmoidoscope. This additional examination above that of conventional flexible sigmoidoscopy resulted in a further 3% of patients being offered full colonoscopy and three proximal carcinomas being detected in subjects who would have otherwise been misclassified as having no neoplasia. The authors conclude that the finding of any adenoma at flexible sigmoidoscopy should trigger a full colonoscopy. They recommend that the initial examination should be an unsedated examination with a colonoscope after a simple enema. This study is consistent with previous findings that 46–52% of PAN are not accompanied by distal polyps. Addition of faecal occult blood testing to flexible sigmoidoscopy does not significantly increase the detection of advanced neoplasia. One is therefore left with the conclusion that colonoscopy remains the most sensitive screening tool and, if performed by a skilled operator, is reasonably safe. No screening technique will entirely eliminate the risk of colorectal cancer. Risk reduction is all that can be achieved and this must be carefully explained to patients. Flexible sigmoidoscopy is safer, cheaper, and more convenient for patients than colonoscopy but at the cost of lower efficacy for preventing and detecting cancer.

Gut 2003;52:317–318

REFERENCES


www.gutjnl.com

Downloaded from http://gut.bmj.com/ on June 27, 2017 - Published by group.bmj.com
Liver disease

Lessons from liver transplantation: flip, flop, and why?

P C Adams

A case of hereditary haemochromatosis developing in a non-hereditary haemochromatosis recipient following transplantation of a C282Y heterozygous donor liver

The widespread application of liver transplantation has been the single most important therapy to extend long term survival in patients with a variety of acute and chronic liver diseases. A fringe benefit of liver transplantation has been identification, confirmation, and cure of the metabolic basis of diseases.1 Haemophilia patients transplanted for chronic hepatitis C are cured of their clotting disorder, and patients transplanted for Wilson disease show no signs of copper accumulation following transplantation. Although many transplant recipients have mild to moderate iron overload at the time of transplantation, liver transplantation has been uncommon in homozygotes for the C282Y mutation of the HFE gene for haemochromatosis, and the metabolic effects on iron metabolism have not been clearly established.2 Studies in which C282Y homozygous donors have been transplanted into normal recipients have usually demonstrated a return to normal liver iron concentrations over time, and transplantation of a C282Y homozygous liver and intestine into a normal recipient has led to iron accumulation necessitating venesection therapy.2 These studies have suggested that the intestine is the major organ involved in the pathogenesis of haemochromatosis although systemic abnormalities in macrophage and lymphocyte function have been described. A major unresolved issue in haemochromatosis is why some C282Y homozygotes have cirrhosis and other organ damage while as many as 50% of C282Y homozygotes will have no biochemical abnormalities of transferrin saturation or ferritin.3

In this issue of Gut, Wigg and colleagues4 describe a fascinating case of iron accumulation following liver transplantation [see page 433]. The 44 year old female donor was a C282Y heterozygote or carrier with a slight elevation in hepatic iron concentration. The recipient had mild iron overload secondary to alcoholic siderosis and was found to have a new polymorphism in the HFE gene (R6S). Four years later the recipient was found to have severe hepatic siderosis. The tantalising aspect of this unusual case report is the suggestion that two independent mutations could be synergistic to result in iron overload. This concept has been studied in haemochromatosis as several investigators have searched for concomitant mutations in non-HFE iron transport genes such as DMT1 and transferrin receptor genes. The hypothesis could be that the C282Y homozygote without any other coexisting mutations would be unaffected. In the presence of another common mutation (since >50% of C282Y homozygotes have iron abnormalities), iron accumulation would occur and would lead to organ dysfunction. This “two hit” hypothesis has been proposed in other diseases such as α1-antitrypsin deficiency and non-alcoholic steatohepatitis. However, if expression of haemochromatosis is dependent on co-modifying genes, pedigrees of non-expressing cases would be more common than currently reported. As females are significantly less affected than men, and alcohol worsens the disease severity in haemochromatosis, expression of haemochromatosis could also be an example of a gene–environmental interaction.

There are several unexplained aspects to the current report. A simple C282Y heterozygote would presumably express this defect in the liver and intestine and yet most C282Y heterozygotes have normal iron studies, and significant iron overload in simple heterozygotes is extremely rare. Transplantation using C282Y heterozygous donors and recipients has been reported.5 At our centre, we have transplanted three C282Y heterozygous livers into three C282Y heterozygous recipients without the apparent development of iron overload.

The presence of a base pair change (R6S) is not synonymous with a major metabolic effect on iron metabolism. Further studies will be required on this polymorphism to determine if functional changes occur in the HFE protein, and it would be uncommon for heterozygotes of any HFE mutation to have significant changes in iron metabolism. For example, the H63D mutation does not lead to iron overload in H63D heterozygotes.

To further complicate the clinical picture, recently a ferroportin mutation has been described leading to severe iron overload in patients. Many of the patients in the original report had a normal transferrin saturation and ferritin.6 If iron tests cannot predict the development of iron overload, there may be cases of occult iron overload in the general population or post liver transplant that have not come to medical attention. The unusual case described in this report may never occur again but this and other cases resulting from inadvertent experiments in transplantation will continue to stimulate ideas and insights into the mysteries of iron metabolism.

Gut 2003;52:317–318

REFERENCES

Lessons from liver transplantation: flip, flop, and why?

P C Adams

Gut 2003 52: 318
doi: 10.1136/gut.52.3.318

Updated information and services can be found at:
http://gut.bmj.com/content/52/3/318

These include:

References
This article cites 8 articles, 2 of which you can access for free at:
http://gut.bmj.com/content/52/3/318#BIBL

Email alerting service
Receive free email alerts when new articles cite this article. Sign up in the box at the top right corner of the online article.

Notes

To request permissions go to:
http://group.bmj.com/group/rights-licensing/permissions

To order reprints go to:
http://journals.bmj.com/cgi/reprintform

To subscribe to BMJ go to:
http://group.bmj.com/subscribe/