··· LETTERS TO THE EDITOR ···

TO THE EDITOR:

I was happy to see that in the March issue your publication addressed the issue of screening for colorectal cancer in asymptomatic patients.[1] Now that the new legislation is in place, it is important that people know the facts about screening options.

The one very disappointing aspect of the article was the information on page 433. Table 1 indicates that for asymptomatic patients, the only options are fecal occult blood testing every year, flexible sigmoidoscopy every five years, and a colonoscopy for a positive screening test. This table leaves out the double contrast barium enema (DCBE) as a screening alternative. The new legislation clearly states that the only way to visualize the entire colon in asymptomatic patients is with a DCBE. A physician can order a flexible sigmoidoscopy or a DCBE, not both. Colonoscopy is not indicated for asymptomatic patients. The American Cancer Society and the US Preventive Services Guidelines include the DCBE for asymptomatic patients. For any screening program to be effective, physicians must have all the information. You do your readers a disservice by not giving all the available options.

It would be very helpful if a letter to the editor or clinical note is published informing your readers on all of the options available.

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1. Bond JH, Levin B. Screening and surveillance for colorectal cancer. *Am J Man Care* 1998;4:431-437.

AUTHOR'S REPLY:

We appreciate Mr. Carden's comments about our review,[1] and we agree that it is important that people know the facts about screening options. Mr. Carden incorrectly states, however, that the recommendations for screening for colorectal cancer of the average-risk population listed in Table 1 are the "only options for screening" provided by our review. We designed this table to present only the first-line strategy for screening that is recommended in all three of the cited evidence-based guidelines. These recommendations are supported by direct evidence in the form of either prospective randomized controlled trials or high quality case-control studies. He is correct that screening by barium enema or colonoscopy are included as options in the guidelines developed by both the GI Societies Consortium and the American Cancer Society.[2,3] He is incorrect, however, in stating that the US Preventive Services Guidelines include a recommendation for double contrast barium enema screening of asymptomatic patients.[4]

Our review does recognize the other options for screening discussed by Mr. Carden. The text that accompanies Table 1 states that "other recommended screening alternatives that currently are supported only by indirect evidence may be offered to patients as an option. These include colonoscopy every 10 years or double contrast barium enema every 5-10 years." The Secretary of the Department of Health and Human Services has ruled that Medicare will allow for double contrast barium enema screening to be substituted for the recommended flexible sigmoidoscopy in circumstances where an average-risk patient may not tolerate the latter. In these cases, a written request for the X ray alternative must be made by the patient's physician.

Our primary recommendation regarding the diagnostic evaluation of a patient with a positive screening fecal occult blood test or flexible sigmoidoscopy is also consistent with current guidelines. We recommend that this evaluation be performed "usually with colonoscopy" because that is the diagnostic procedure used in the US fecal occult blood screening trials that demonstrated a 33%-43% reduction in mortality from colorectal cancer.[5,6] In addition, studies have shown that colonoscopy is more accurate than double contrast barium enema for detecting smaller polypoid lesions in the colon, and it allows biopsy of suspicious lesions and resection of most premalignant polyps at a single sitting with a single bowel preparation.[7]

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1. Bond JH, Levin B. Screening and surveillance for colorectal cancer. *Am J Man Care* 1998;4:431-437.
2. Winawer SJ, Fletcher RH, Miller L, et al. Colorectal cancer screening: Clinical guidelines and rationale. *Gastroenterology* 1997;112:594-642.
3. Byers T, Levin B, Rothenberger D, et al. American Cancer Society guideline for screening and surveillance for colorectal polyps and cancers. *CA-Cancer J for Clin* 1997;47:154-160.
4. Guide to Clinical Preventive Services, Second Edition. Report of the US Preventive Services Task Force. Washington, DC; Department of Health and Human Services, 1995.
5. Mandel JS, Bond JH, Church TR, et al. Screening for fecal occult blood reduces mortality from colorectal cancer: Results from the Minnesota Colon Cancer Control Study. *N Engl J Med* 1993;328:1365-1371.
6. Winawer SJ, Flehinger BJ, Schottenfeld D, et al. Screening for colorectal cancer with fecal occult blood test and sigmoidoscopy. *J Natl Cancer Inst* 1993;85:1311-1318.
7. Rex DK, Rahmani EY, Haseman JH, Lemmel GT, Kaster S, Buckely JS. Relative sensitivity of colonoscopy and barium enema for detection of colorectal cancer in clinical practice. *Gastroenerology* 1997;112:17-23.

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