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HIGHLIGHTS FROM MEDICAL GRAND ROUNDS

COLON POLYPS: DIAGNOSIS, TREATMENT, SURVEILLANCE

CURRENTLY AVAILABLE screening methods for colon polyps, though far from perfect, can reduce mortality due to colon cancer, the second most common cause of cancer death in the United States. Research is beginning to reveal the genetic basis of this disease, but despite these advances, strategies for primary prevention remain uncertain. So far, antioxidant vitamins have shown no effect on polyp recurrence. Aspirin is the most promising preventive agent.

DETECTING COLON POLYPS

Colonic polyps are extremely common and their prevalence increases with age. Removal and microscopic examination is required to determine if a polyp is neoplastic. Neoplastic polyps may be benign or malignant, but even benign neoplastic polyps carry the potential for malignant degeneration to colon cancer.

Because most polyps are asymptomatic they are usually found incidentally during screening or discovered on colon studies ordered to evaluate nonspecific complaints. Polyps are most frequently diagnosed by endoscopy or barium radiography.

The American Cancer Society and the American College of Gastroenterology recommend that all persons older than 50 years have a stool test for occult blood every year, and a flexible sigmoidoscopy every 3 to 5 years, to detect cancer at its earliest, most treatable stage. A colonoscopy is recommended for high-risk patients of any age with previous cancer or a strong family history of the disease.

Stool testing for occult blood

Occult blood testing is underused, probably because physicians do not have confidence in it. The sensitivity is about 30% for adenomas and 70% to 80% for cancer, reflecting the fact that cancers do not bleed constantly and polyps rarely bleed.

Yet, a large randomized trial has indicated that yearly fecal occult blood testing reduces colon cancer mortality. Of note, testing failed to detect polyps but did detect cancer at an earlier stage. Rehydration of slides led to an unacceptably high number of false-positive tests, and 38% of the tested group underwent colonoscopy, raising the concern that colonoscopy and polypectomy accounted for the mortality reduction.

A major problem is lack of compliance on the part of both patients and physicians. Large screening programs report a return rate of only 30% to 48%. Patients should follow a diet low in red meat and then collect stools on three separate days and place smears on the testing cards. False-negative results are increased when samples are taken from water in the toilet; false-positive results may be caused when toilet sanitizers are used.

Sigmoidoscopy

Sigmoidoscopy reveals polyps in approximately 8% of asymptomatic persons older than 40 years. Unfortunately, sigmoidoscopes can view only one fourth to one third of the colonic mucosa, and approximately 40% of colon polyps occur higher up. Nevertheless, a recent case-controlled study showed a reduction in mortality from rectosigmoid cancer in a population screened by sigmoidoscopy. Patients found to have adenomas on sigmoidoscopy should undergo colonoscopy and polypectomy. Whether patients with distal hyperplastic polyps should also undergo colonoscopy is controversial, but we recommend such an approach, especially in patients involved in a preventive health program, because proximal adenomas are found in 15% to 30% of such patients.

■ Highlights from Medical Grand Rounds present take-home points from selected Cleveland Clinic Division of Medicine Grand Rounds lectures.

Air-contrast barium enema

A barium enema with a good air-contrast technique can be used in conjunction with sigmoidoscopy to evaluate the entire colon. A single-contrast barium enema has a 40% false-negative rate and is not acceptable as a screening tool.

Colonoscopy

Colonoscopy in experienced hands is the screening method of choice, but until recently its cost and manpower requirements have limited its use to populations at high risk. One proposal is to perform a colonoscopy in all persons between the ages of 50 and 60. Patients found to have adenomas would have them removed and then undergo colonoscopic surveillance; patients without adenomas could wait 10 years before undergoing colonoscopy again.

FOLLOW-UP AFTER POLYPECTOMY

The National Polyp Study published results of a randomized evaluation of the appropriate surveillance interval after adenomas have been removed. It appears safe for most patients to wait 3 years before the next examination. Once no adenomas are found, the interval can be extended to 5 years. Longer intervals may even be appropriate for persons with only one small adenoma. Patients at higher risk include those with four or more adenomas, an incompletely removed polyp, a polyp with invasive cancer, or a poorly prepared colon. These patients may be better served by an examination in 1 year and then 3 years.

CAN POLYPS BE PREVENTED?

Epidemiologic studies suggest a relationship between high-fat, low-fiber diets and colorectal cancer and adenomas. Genetic studies have elucidated loss of several tumor suppressor genes and activation of the *ras* oncogene in a stepwise progression from normal colonic mucosa to adenoma to cancer. Despite these advances, we are still not able to exert primary prevention for colon cancer.

Several large trials are investigating various supplements and medicines to prevent polyps. Supplements of vitamins A, C, and E showed no effect on polyp recurrence in a randomized, prospective, double-blind study of patients with adenomas. Calcium is currently under study, as is a metabolite of sulindac, a nonsteroidal anti-inflammatory drug. The most exciting agent under current study is aspirin; several

epidemiologic and cohort studies have shown a protective association between regular aspirin use and a reduced incidence of colon cancer.

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SUGGESTED READING

Bond MD. Polyp guidelines: diagnosis, treatment, and surveillance for patients with nonfamilial colorectal polyps. *Ann Intern Med* 1993; 119:836-843.

Mandel JS, Bond JH, Church TR, et al. Reducing mortality from colorectal cancer by screening for fecal occult blood. *N Engl J Med* 1993; 328:1365-1371.

IS FIBROMYALGIA A USEFUL DIAGNOSTIC LABEL?

FIBROMYALGIA is a hypothesis. It is a descriptor that serves many masters: it facilitates research, offers the comfort of the laying on of diagnostic labels, and serves the intellectual and administrative mandate to categorize.

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However, on close inspection, it can be seen that the label "fibromyalgia" is a contrivance that harms the patient. The diagnosis of fibromyalgia results from the reductionistic way of thinking that has dominated Western medicine for most of this century. It describes physical complaints that all humans associate with being "out of sorts" and magnifies these complaints into a full-blown syndrome. The labeling process itself is iatrogenic; it cues patients on how to perceive their problems and prompts them to change how they view themselves.

THE SYNDROME OF OUT-OF-SORTS

Everyone has bad days. Most of us realize that simply being alive means we will have some days when we feel a little indisposed. I have identified the components of a bad day, which I call the syndrome of out-of-sorts (SOOS). SOOS is characterized by at least four of the following: loss of the sense of well-being, decrease in energy, easy fatigue, heaviness in the head, stiffness and achiness, and awareness of one's bowels (*Table*). Usually, people can identify the stressors that contribute to their SOOS, and most