Editor’s Comments

This article shows that the relative ease of performance of flexible sigmoidoscopy as a screening tool in symptomatic patients presenting to a surgical endoscopy clinic is greater in the male patients when compared with females. The suggestion here is that this should direct the logistic performance of an open access endoscopy clinic and its training both in terms of suite and list planning as well as in referral practice. This sort of management perspective may create a gender-based performance standard of practical significance for the conduct of such suites, however, this approach may raise more questions than it answers and in point of fact, the issues surrounding its principal benefits are quite complex. The logistics of flexible sigmoidoscopy as a screening tool in the patient presenting with rectal bleeding have been shown to be safe provided that it is selectively used in the context of the patient history. For example, rectal ‘outlet-style’ bleeding may be successfully managed in the context of a one-stop flexible sigmoidoscopy service where hemorrhoids, localized proctosigmoiditis and other benign causes of bleeding can correlate with the history of bright red post-defecatory bleeding in the absence of significant change in bowel habit, constitutional symptoms and in the absence of a positive family history of colorectal neoplasia [1]. What is evident is that flexible sigmoidoscopy will be safe and specific for the exclusion of colorectal neoplasia in low risk patients presenting with a particular type of rectal bleeding where there is an identifiable anal cause on direct examination [2].

We have known for years about the average performance time, feasibility and completeness of flexible sigmoidoscopy, [3] however, the critical thing when a programme of deliberate flexible sigmoidoscopy is to be used as a screening and management tool is the predictability in patients with designated low-risk rectal bleeding of the likelihood that serious pathology will be missed by this limited examination. This is more likely in male patients over the age of 40 years even in the absence of worrisome symptoms [4-6] where the detection of adenomatous polyps would be critical for the use of full colonoscopy and provide an advantage in screened populations for reducing the overall incidence of colorectal cancer in polypectomized cohorts [7-9]. In this context, certain pathological features, most notably, nuclear polymorphism and crowding rather than mitotic activity show prognostic value for the prediction of metachronous colorectal cancer in screened populations who already have a rectosigmoid adenoma defining those patients best served by postpolypectomy surveillance [10] where the utilization of new endoscopic-guided imaging modalities define at-risk polyps in patients where these are detected by limited endoscopy [11]. These newer approaches even when endoscopic screening is limited will have implications for polypectomy and full colonic evaluation [12] as too will first-up less invasive screening modalities which will direct either flexible sigmoidoscopy or colonoscopy [13, 14].

The authors have clearly shown gender differences in the logistic performance of flexible sigmoidoscopy which may assist them in their endoscopic list calculations; a fact which is in keeping with the reported differences in the utilization of screening modalities between men and women where the take-up rate of flexible sigmoidoscopy is generally greater in males [15]. These issues are of administrative importance, but one issue is the ability to predict those patients more likely to have positive colorectal screening which will affect the detection of higher-risk adenomatous polyps and earlier cancers where it has been shown that non-sigmoidoscopy screening influences the detection of cancers in distal as well as proximal locations [16]. We don’t as yet know what impact the newer modalities of screening will have on the importance of limited endoscopic techniques in open access units or whether we will be able to identify population-based subgroups where such a limited endoscopic approach will prove most cost-effective [17-19]. The decisions made here will have endoscopic durability where demographic risk factors can be identified, (although there is cohort selection bias), for population-based repeat take-up rates of endoscopy in those who have already undergone prior screening procedures [20]. In this respect, the predictability of colorectal adenomas increases with age (particularly in males) although this effect is lost a little as patients exceed 70 years of age [21]. The same effects are seen in younger female patients with high BMI values [22].

This view, however, should be accompanied with a recognized rate of incomplete examination for flexible sigmoidoscopy where this is employed as the principal preliminary examination; a finding more likely in older patients, females and those with a prior history of hysterectomy [23] where there is an overall reported shorter depth of instrument insertion in women which is somewhat independent of the type of endoscopist (medical versus nurse practitioner) used [24, 25]. The secondary derivative costs imposed by flexible sigmoidoscopy must be considered where this technique is used as a primary modality where we know that the relative risk (RR) for the detection of distal colorectal cancer is lower amongst those who have a negative flexible sigmoidoscopy but where the RR for proximal colonic cancer is not different in the negative flexible sigmoidoscopy population when compared with the initially unscreened cohort during follow-up [26]. It must be remembered that the benefits of flexible sigmoidoscopy can be outweighed by secondary resultant costs where demographic disease predictability and flexible sigmoidoscopic accuracy will define its value as a principal investigative modality independently of its gender-related time and turnover advantages reported here by Chand, Andrews and Nash.

References


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