Essential reading from the editor's desk

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Colorectal cancer remains the third most prevalent cancer in both females (after breast and lung cancer) and males (after prostate and lung cancer) in Belgium with incidence rates of 2809 and 2956 per 100,000 person years respectively (1). Since 2009 and 2013 a colorectal screening program was initiated in Wallonia and Flanders respectively, currently both using immunochemical fecal occult testing (2). In case of positive screening, a total colonoscopy should follow to detect high-risk lesions. Self-evidently, quality of the endoscopic procedure is a key parameter for an effective screening program. Widely accepted quality measures for screening colonoscopy include cecal intubation rate, withdrawal time, adenoma detection rate, quality of polyp resection and bowel preparation (3,4). In this edition of Acta Gastro-Enterologica Belgica Dikkanoğlu et al. compared the effect of bowel preparation explained by a secretary (control) vs. a physician (intervention) in addition to written instructions (5). Even if there were no differences in adenoma detection rate in this series of 150 patients, education by the physician resulted in significantly better bowel preparation scores compared to the standard. This study highlights the importance of proper instruction by a member of staff who is experienced with the practical aspects of bowel preparation, rather than a member of the administrative staff.

Recently, Van Overbeke et al. reported in our journal their experience with cold-snare polypectomy for large non-pedunculated polyps with excellent results (6). In the current edition of the Acta, a retrospective study by Kudo and colleagues evaluated the feasibility and safety of cold-snare polypectomy for pedunculated polyps up to 1cm (7). The procedure time, use of hemostatic clips and the incidence of delayed bleeding were significantly reduced in the cold-snare vs. hot-snare polypectomy group. However, immediate bleeding was more frequent after cold-snare polypectomy. Even if these results should be confirmed in the setting of randomized study, the results support the expanding use of cold-snare polypectomy in large non-pedunculated polyps and pedunculated polyps up to 10mm.

Nevertheless, the colonoscopy quality parameters mentioned above still represent indirect readouts of the true quality criterium, i.e. the number of missed colorectal cancers during screening colonoscopy. In the current edition of the Acta, Aerts and colleagues from the regional teaching hospital of Turnhout, Belgium, have analyzed the incidence and characteristics of post-colonoscopy colorectal cancers (PCCRC) (8). A prospective registry was started including all colorectal cancer patients diagnosed between 2014 and 2020 who had undergone a colonoscopy in the 10 years prior to cancer diagnosis. The authors identified 47 PCCRCs during this period of which half were detected more than 4 years after the index colonoscopy, suggesting new colorectal cancers. Of the remaining 23 cancers, about 70% were most likely missed during the initial colonoscopy and 30% may have resulted from an incomplete resection of a detected lesion. The 3 year PCCRC rate was 2.46%, which was well below a proposed cut-off of 3.6% based on the results of the English colorectal screening program (9). Even if the risk of patients moving to another hospital, and thereby skewing the analysis, was considered low, a national or at least regional colonoscopy registry would allow the calculation of 3y PCCRC for each center or even endoscopist. The authors suggest that the 3y PCCRC should be monitored as a quality index of lower gastrointestinal endoscopy (4).

Pancreatic lesions from another source of concern, both for patients and physicians, because of the difficulty to distinguish benign from. (pre-)malignant lesions. Vanden Bulcke et al. performed a retrospective study in 72 patients with resected pancreatic cysts and evaluated the performance of 3 frequently used guidelines in predicting the nature of the lesion (10). The European evidence-based guideline on pancreatic cystic neoplasms had the lowest number of missed malignant lesions with a negative predictive value of 83.3%. However, all guidelines had a low specificity resulting in a high incidence of surgical overtreatment. These important data highlight the need for better biomarkers to achieve a better balance between avoidance of missed malignancy and unnecessary surgery. Further in this edition, Figueiredo and colleagues describe the excellent performance of fine-needle aspiration and biopsy guided by endoscopic ultrasound in 142 patients with solid pancreatic lesions (11).

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Finally, we want to draw your attention to excellent reviews on the use of neuromodulators in chronic constipation (12) and diagnostic and prognostic scoring systems in auto-immune hepatitis (13).

The entire editorial board wishes you a pleasant reading with these highlighted and many other interesting and thought-provoking articles!

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