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Preface

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Guest Editor

Consider the war on colon cancer. Every year more than 150,000 Americans develop colon cancer, with more than 50,000 fatalities [1]. This number of fatalities per year is comparable to all the American fatalities in the decade-long Vietnam War and is more than 12 fold the number of American fatalities in the current 5 years of war in Iraq. Throughout the world more than 1 million people develop colon cancer every year, about half of whom succumb to this disease [2]. The mortality from this cancer since World War II exceeds by several fold the mortality among all the armed forces in World War II, the bloodiest war in history. In the approximately 8 minutes that it takes to read this preface, another American on average will die from colon cancer, and 10 individuals will die worldwide. Incredibly, about 1 in 18 of you, the readers of this article, will develop colon cancer within your lifetime, a risk that I, likewise, share [3].

This war aims to save lives, hundreds of thousands per year worldwide, rather than extinguish them as in conventional warfare. The armed forces in this war are colonoscopists, epidemiologists, bureaucrats, and endoscopy nurses; their guns are colonoscopes; and their ammunition is polypectomy snares. Consider the "body count" since the declaration of war. During the last 30 years the incidence of this cancer has decreased by about 20% and the mortality has declined by 40% [4]. These declines have recently accelerated, with an incredible 5% decrease in mortality in 2004 [5]. These cumulative effects have reduced American fatalities by 20,000 per year.

Although impressive, these reductions are insufficient. Fifty thousand too many Americans still die from colon cancer per year. Victory in this war is predicated on prevention by appropriate screening and polypectomy of precancerous lesions. Half of the eligible population fails to undergo any form of

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colon cancer screening [6,7]. Screening cannot save the lives of unscreened patients. Further reductions require redoubled efforts. The residual patients become harder to recruit for colon cancer screening as the more compliant patients have already undergone screening [8].

Much of the inefficiency in screening stems from insufficient knowledge by clinicians, who in turn fail to educate or refer their patients for screening. Education is thus critical for clinicians—whether internists, family practitioners, or other nongastroenterologists—to appropriately refer their patients for colonoscopic screening and surveillance. This issue is dedicated to educating the internist and general practitioner about this cancer and further educating the gastroenterologist and colon cancer researcher. I hope that this monograph functions on multiple levels—to provide the basic clinical knowledge, to comprehensively review the data, and to analyze the latest discoveries—to be useful to all these constituencies to benefit our patients.

I am delighted to offer the readers a distinguished assembly of researchers and authorities as authors. As we eliminate the straightforward, easily identifiable conventional adenomas, the more clinically obscure and less colonoscopically evident serrated adenomas assume greater importance in preventing the residual interval colon cancers after an apparent clearing colonoscopy. Jeremy Jass, the internationally renowned authority on serrated adenomas, and James East provide an important review of this rapidly evolving subject. Tusar Desai and Donald Barkel provide the perspective of academic clinicians in private practice to the complex field of syndromic colon cancer. There is much that is new and highly relevant in this review of this fast-evolving subject. Although much of the current focus on colon cancer prevention centers on removal of premalignant colonic polyps, more work is needed to prevent carcinogenesis at the earliest stages by reducing risk factors and by intervening in the molecular pathways of carcinogenesis. James Marshall comprehensively reviews the subject of colon cancer prevention through diet, drugs, and lifestyle. Anthony Miller has devoted his professional career to clinical epidemiology, especially disease prevention. He provides a terrific compilation of the complexities in applying the theory of mass screening to colon cancer.

Jack Mandel provides a thorough and timely review of the different modalities of colon cancer screening, including reviews of all the major trials of these modalities. Nurse Sue Mihalko provides a unique perspective and novel information on screening from her vast experience over 2 decades as administrator of the endoscopy unit at William Beaumont Hospital, the second largest endoscopy unit in the United States. This unit is highly efficient and is recognized for its high quality of care, user friendliness, and patient safety. She describes the principles of running an efficient, high-quality endoscopy unit and divulges many of her secrets.

CT colonography is the most controversial subject in colon cancer screening because of variable data about sensitivity, specificity, and efficacy; it is also one of the fastest-evolving areas because of rapid advances in computer technology. Susan Summerton and colleagues thoroughly review this subject to provide the

clinician and researcher the information to critically review the literature and to rationally judge its role in colon cancer screening.

Two highly academic clinicians, my colleague Mike Duffy and a second-year gastroenterology fellow, Amulya Konda, thoroughly review the complex and important subject of surveillance of patients at increased risk for colon cancer to properly refer these patients for surveillance colonoscopy. Manoop Bhutani has played a leading role in the development of endoscopic ultrasound through important clinical and research contributions during nearly 2 decades. I am delighted to present his comprehensive clinical review on endoscopic ultrasound for cancer staging.

Douglas Rex is an internationally acclaimed clinical-academic gastroenterologist who has made major contributions in improving the sensitivity of colonoscopy for polyp detection, in critically evaluating CT colonography, in the use of anesthetics for colonoscopy, and in techniques of colonoscopic polypectomy. His article is an important reference on polypectomy techniques and is essential reading for the colonoscopist.

The article by Carol Scott-Conner, an international authority on minimally invasive colon cancer surgery, and Neal Wilkinson is of great interest to the surgeon and other physicians treating patients who have colon cancer. Despite all efforts at colon cancer prevention or early diagnosis, significant numbers of patients still present with advanced cancer that requires radiotherapy or chemotherapy. John Robertson, a terrific colon cancer specialist, reviews the important clinical trials on radiotherapy for advanced colon cancer. Timothy Asmis and Leonard Saltz, dedicated oncologic researchers, comprehensively review chemotherapy for colon cancer, with a special focus on large cooperative trials.

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On a personal note, I have participated in this war from the perspective of both a practicing clinician and researcher on colon cancer. As a clinical gastroenterologist I was drafted early in this war. Ed Goldberg and I published a paper in 1992 demonstrating preliminary evidence of a decline in colon cancer mortality in America [9], findings that have been confirmed and greatly extended in the ensuing 15 years. Let us rededicate our commitment and

redouble our efforts to eradicate colon cancer entirely, like the old scourges of yore, such as small pox or bubonic plague!

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