

 CORRESPONDENCE

## Evidence-Based Follow-Up for Adults With Cancer

by Prof. Dr. med. Ulrich Dührsen, Dr. med. Karl-Matthias Deppermann, PD Dr. med. Christian Pox, and Prof. Dr. med. Axel Holstege in issue 40/2019

### Misleading Conclusion

We very much welcomed the article on follow-up for cancer patients and consider it an important overview (1).

We do, however, feel obliged to point out a misinterpretation in the section about follow-up for patients with lung cancer.

In a subitem to the current follow-up recommendations, the authors explain the studies of follow-up for patients with lung cancer that are cited in the current German clinical practice guidelines for lung cancer (2). But they then recommend annual, low-dose computed tomography (CT) screening for the detection of recurrences or secondary cancers (i.e. secondary prevention) in high-risk patients with curatively treated cancer. They refer to a mortality reduction observed in participants of the National Lung Screening Trial (NLST) receiving a CT scan as compared to those who underwent a chest X-ray. The NLST is a large primary prevention study (3).

In our opinion, this conclusion can be drawn only for the risk group defined in the NLST. We are not aware of any study showing a survival benefit as a result of annual low-dose CT screening in curatively treated lung cancer patients.

In the NLST, three annual low-dose CT scans were undertaken in study participants who had not had lung cancer to date—pre-existing lung cancer, surgery to the lung, or a CT scan 18 months prior to inclusion in the study were exclusion criteria for participation in the NLST (4).

The existence of a further risk factor—such as a history of lung cancer or other tumors associated with

smoking, exposure to asbestos, chronic obstructive pulmonary disease, or lung fibrosis—probably increases the risk for lung cancer, but the benefit in terms of a significant reduction in mortality as a result of low-dose CT screening has thus far not been confirmed.

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### References

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### Conflict of interest statement

Professor Wirtz received consultancy fees from MSD, Roche, and Boehringer Ingelheim. He was reimbursed for conference registration fees by Boehringer Ingelheim. He received lecture honoraria from MSD, Boehringer Ingelheim, Roche, and Astra Zeneca. He received funding from Roche for a study project he himself initiated. For conducting clinical studies he received honoraria from MSD.

Dr. Frille declares that no conflict of interest exists.

### In Reply:

We thank Frille and Wirtz for their comments on our article on follow-up for adults with cancer (1). An ideal follow-up strategy for patients after complete resection of lung cancer in the early stages is not available to date since large randomized trials for this group of patients are lacking. The colleagues draw attention to the fact that “low dose” computed tomography (CT) scanning in the National Lung Screening Trial was tested for primary screening of patients with the risk profile nicotine (30 pack years) and age (55–75 years) and can thus not simply be generalized to patients with resected lung cancers. That is undoubtedly true. However, several

arguments support the integration of CT scanning into follow-up:

- Randomized trials in this group of patients are currently not available and are not to be expected in the next few years.
- The risk of developing a recurrence or secondary cancer is notably greater in the group of patients who have had lung cancer surgery than in the risk group studied in the National Lung Screening Trial.
- Other international guidelines (European Society for Medical Oncology [ESMO], National Compre-

hensive Cancer Network [NCCN]) have integrated CT scanning into follow-up investigations (2, 3).

- A large recently published study underlines the importance of computed tomography in follow-up care (4). DOI: 10.3238/arztebl.2020.0145b

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Prof. Dührsen declares that no conflict of interest exists.

**CLINICAL SNAPSHOT**



**Recurrent Ileal Invagination in Crohn’s Disease**

EA 24-year-old woman with known Crohn terminal ileitis in remission presented to the emergency department with pain in the right lower abdomen. The region was sensitive to pressure on physical examination, and clinical chemistry disclosed only a slightly elevated CRP level. Sonography showed a conglomerate of thickened small bowel loops. In view of the patient’s young age, the radiologists agreed to perform immediate magnetic resonance imaging to exclude complications of Crohn’s disease (*Figure*). This revealed a preterminal cockade with ileo–ileal invagination. Explorative laparotomy was carried out and the invagination was mechanically released. Seven days later the patient returned with renewed abdominal pain and nausea. The blood count showed mild leukocytosis, and sonography revealed a cockade of thickened ileal loops with renewed invagination. On repeat laparoscopy the recurrent invagination was confirmed and the affected segment of the ileum resected. Invagination has seldom been described in patients with Crohn’s disease, either postoperatively or in the presence of small bowel tumors. The detection rate is high with sonography and MRI.

Invagination should always be considered as a possible cause of acute abdominal pain.

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