Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

COVID-19: Colorectal cancer endoscopic surveillance in IBD

We commend the Article by Alexander Ho and colleagues[1] detailing the backlog of endoscopic procedures in England during the COVID-19 pandemic. Several strategies are proposed to manage this backlog including high-level triage, use of quantitative faecal immunochemical test (qFIT), and alternatives to endoscopy such as radiological imaging and colon capsule.

Ho and colleagues'[1] data suggest that surveillance procedures—eg, for high-risk populations such as those with inflammatory bowel disease—have been slower to recover. This trend could have been compounded by the tools mentioned being less applicable in inflammatory bowel disease. For instance, qFIT detects degraded human haemoglobin and is used relatively infrequently in inflammatory bowel disease. A qFIT of more than 100 ng/mL (equivalent to >20 µg/g) is associated with a Mayo endoscopic subscore of more than 1, suggesting that qFIT can detect active colonic inflammation.[2] In the UK, a higher qFIT score at greater than 10 µg/g (in symptomatic cohorts) and more than 80 µg/g (bowel cancer screening population)[3] is likely to detect colonic inflammation, confounding its use as a risk stratification tool in inflammatory bowel disease surveillance. Furthermore, CT colonography and colon capsule are unlikely to be useful alternatives when screening for flat dysplasia or subtle mucosal abnormalities.

Before the COVID-19 pandemic, the rates of post-colonoscopy colorectal cancer in inflammatory bowel disease were unacceptably high.[4] The absence of a suitable alternative to endoscopic surveillance and the high demand on endoscopy capacity could result in delayed cancer diagnoses. Non-invasive stool testing for DNA methylation markers has shown promising results[5] and once validated could prioritise patients awaiting surveillance procedures.

It is crucial to use available endoscopic resources effectively. Currently, there is no clear exit strategy for patients with inflammatory bowel disease at low risk of developing colorectal cancer, who undergo surveillance colonoscopy at 5 yearly intervals. In a study of 775 patients with colonic inflammatory bowel disease (excluding those in the highest risk category), Ten Hove and colleagues[6] that two consecutive negative colonoscopies predicted a low risk of future colorectal cancer. The median interval between the colonoscopies was 2·2 years and the longest follow-up from first surveillance was 6·1 years.[6] Surveillance intervals are likely to be longer in the UK and, for patients perpetually in the low risk 5-year interval, stopping surveillance might be a valid strategy, although longer term data is needed. Cessation of surveillance requires appropriate safety-netting; however, this approach could help to mitigate the overall burden on endoscopy services. There are currently no good alternatives to endoscopic surveillance for colorectal cancer in inflammatory bowel disease and the restarting of surveillance procedures is an urgent priority for health-care providers.

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