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EDITORIAL

Special Issue Introduction
March Colorectal Cancer Awareness Month

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This month's issue of *Evidence-Based GI: An ACG Publication* (EBGI) is dedicated to clinical research about colorectal cancer (CRC) screening and prevention in honor of Colorectal Cancer Awareness Month. Generally, CRC Awareness Month activities focus on educating individuals about CRC prevention through screening and reaching out to underserved communities to improve adherence to screening. However, as gastroenterologists, our primarily role is to prevent CRC through the performance of high-quality colonoscopy, which has been a focus of EBGI since its inception!

In this issue, we summarize that most post-colonoscopy CRCs (PCCRC) occur within 4 years of an index colonoscopy and are due to missed polyps. Conversely, as long as a high-quality and complete colonoscopy is performed by an endoscopist with an acceptable adenoma detection rate (ADR), then repeat screening colonoscopy at 10+ years demonstrate very low rates of advanced adenomas. High-quality colonoscopy also emphasizes complete polyp resection with low adverse events. Another summary from this issue reviews the first randomized controlled trial to demonstrate that cold snare polypectomy of small polyps decreases severe post-polypectomy bleeding versus hot snare polypectomy. Finally, endoscopists should

strive to identify under-diagnosed Lynch Syndrome and ensure that all CRCs are tested for deficient mismatch repair proteins with immunohistochemistry.

Ultimately, the first 18 months of EBGI highlight multiple clinical research studies about high-quality colonoscopy for CRC screening. Screening colonoscopy is not beneficial in individuals >75 years old if they have concurrent cardiovascular disease or multiple co-morbidities[1], and intervals for surveillance colonoscopy should be extended to 7-10 years if only 1-2 small adenomas are found.[2] Adenoma detection rates up to 40% are associated with lower rates of PCCRC[3] and even higher ADRs lower PCCRC in fecal immunochemical test-positive (FIT+) patients.[4] Endoscopists should strive to achieve higher ADRs through multiple interventions, including computer-aided detection systems (e.g., GI Genius)[5] and extending withdrawal times to 9 minutes[6], but this process starts with the audit and feedback of endoscopists.[7] These aspirational increases in ADR are appropriate even as we screen 45-49 year olds[8], and don't forget that proximal serrated polyp detection rates are also inversely associated with PCCRCs.[9] Optimizing polypectomy technique is crucial to high-quality colonoscopy since incomplete polyp resection contributes to PCCRCs.[10] A 1-2 mm rim of normal mucosa should be obtained when performing cold snare polypectomy[10], but it's okay to use jumbo forceps for resection of "tiny", 1-2 mm polyps when their position is not amenable to cold snare polypectomy.[11] As discussed above, cold snare polypectomy reduces severe delayed post-polypectomy bleeding in small polyps while also being suitable for piecemeal polypectomy of larger polyps.[12] By following these practices, gastroenterologists optimize the value of colonoscopy for CRC screening and provide the evidence-based practices needed to allay concerns about its efficacy.[13]

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