LETTER FROM THE EDITOR

According to recent statistics published by the American Cancer Society (ACS), an estimated 102,900 new cases of colon cancer were diagnosed in 2010, resulting in an estimated 51,370 deaths due to colon or rectal cancer (*CA Cancer J Clin*. 2010;60: 277-300). Accounting for 9–10% of all new cases of cancer and 9% of all cancer-related deaths, colorectal cancer ranks as the third most common cancer among both men and women and the third-leading cause of cancer-related death.

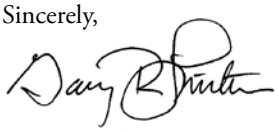
While these facts are sobering, the ACS data also include promising news. Death rates due to colorectal cancer have decreased in both men and women, with the death rate between 1990 and 2006 showing a 33% decline in men and a 28% decline in women. In addition, 5-year survival rates for colon cancer have increased from 52% in 1975–1977, to 59% in 1984–1986, to 66% in 1999–2005.

A related study looked at colorectal cancer mortality rates in different regions of the United States (*Cancer Epidemiol Biomarkers Prev*. 2011;20:1296-1302). Comparing the death rates from 1990–1994 with the rates from 2003–2007, this study found significant decreases in mortality rates in all states except Mississippi and Wyoming. Of the states that showed a change in colorectal cancer mortality, death rates declined at least 9% (Alabama), and some states showed declines greater than 33% (Massachusetts, Rhode Island, New York, and Alaska). This study also found that the decrease in colorectal cancer mortality rates correlated strongly with an increase in screening rates.

Given these trends, current screening practices seem to be having a beneficial impact, although clearly there remains room for improvement. To further reduce deaths due to colorectal cancer, we need to ensure that all patients are being screened according to recommended guidelines, which suggest that most patients over the age of 50 years should undergo a screening colonoscopy every 10 years. We should also ensure that our adenoma detection rates are within the appropriate ranges and that patients with suspicious findings receive appropriate follow-up care. Finally, we should continue to increase awareness about the importance of colorectal cancer screening in the general population—whether by talking to patients and encouraging them to spread the word, by supporting organizations that are running advertising campaigns, or by other means.

Moving on to this month's issue of *Gastroenterology & Hepatology*, I would like to highlight several interesting articles. This month's feature article by Dr. Tran discusses the challenges posed by immune tolerant hepatitis B, and an article by Drs. Rahma and Khleif gives an overview of therapeutic vaccines for gastrointestinal cancers. Our columns address the utility of interleukin-28B polymorphisms in the era of direct-acting antiviral therapy, factors to consider when preparing patients for biologic or immunosuppressant therapy, the use of cecal and terminal ileal images for verifying the completion of colonoscopy, and the management of cricopharyngeal bar and Zenker diverticulum. Finally, this month's case reports describe a patient who developed complete esophageal obstruction following endoscopic variceal ligation, as well as a Middle Eastern patient with celiac disease who presented with gait ataxia, dermatitis herpetiformis, and signs of cerebellar oculomotor dysfunction. As always, I hope you find these articles both informative and interesting.

Sincerely,



Gary R. Lichtenstein, MD, AGAF, FACP, FACG