Regarding "Stool-Based Testing for Post-Polypectomy Colorectal Cancer Surveillance Safely Reduces Colonoscopies: The MOCCAS Study"

Dear Editors:

We read the MOCCAS study with great interest, particularly its findings suggesting that stool-based tests

and contributes significantly to the ongoing debate on optimizing CRC surveillance, it would benefit from a more cautious interpretation of its findings. Specifically, the reliance on FIT sensitivity, assumptions about adherence rates, and the economic implications of false positives merit further exploration. Addressing these considerations could strengthen the case for stool-based surveillance and better inform clinical decision-making, ensuring that the benefits of reduced colonoscopy burden do not come at the cost of compromised patient outcomes.

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testing. Concerns regarding test performance relate to the suboptimal sensitivity of fecal immunochemical testing (FIT) for the detection of nonbleeding colorectal cancer (CRC) precursor lesions, particularly advanced serrated polyps (ASPs), and the assumed independence of test results. Both may lead to suboptimal effectiveness of a FIT-based surveillance program because of systematically missed lesions. In particular, sensitivity of FIT for ASP is limited. Therefore, it is important to realize the Adenoma and Serrated Pathway to Colorectal Cancer (ASCCA) model used considers ASP and advanced adenomas separately. To estimate the potential impact of the sensitivities of FIT for advanced adenoma and ASP on a FIT-based CRC surveillance program, extensive sensitivity analyses were performed, regarding, among other things, lower FIT performance (lower bounds of the CIs) and the assumption that 25% of colorectal lesions were systematically missed by stool testing. Also under those circumstances, FIT thresholds could be identified for which stool-based testing strategies were at least equally effective as colonoscopy surveillance while substantially reduced the number of

Noncontrast Magnetic Resonance Imaging vs Ultrasonography for Hepatocellular Carcinoma Surveillance: A Randomized, Single-Center Trial - Gastroenterology

Results

From June 2015 to November 2017, 416 patients were screened, and 414 were enrolled and assigned to the US (n = 207) or MRI (n = 207) group. In total, 23 participants in the US group and 25 in the MRI group were diagnosed with liver cancer by November 2022. The detection rates of BCLC stage 0 or A tumors were not different between the US and MRI groups (7% [95% confidence interval (CI), 4%–11%] vs 12% [8%–17%]). BCLC stage 0 tumors were more frequently detected in the MRI group than in the US group (8% vs 2%). The MRI group had earlier BCLC stage ($P = .014$) and lower false-positive referral rate (0.7% [95% CI, 0.4%–1.2%] vs 3.1% [2.3%–4.1%], $P < .001$) compared with the US group.

Conclusions

Noncontrast MRI is a better alternative to US for the surveillance of cirrhotic patients offering earlier stage at initial diagnosis and lower false-positive referral rate. (ClincalTrials.gov, Number: NCT02514434.)

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MICROHEMATURIA: AUA/SUFU GUIDELINE (2020, AMENDED 2025)

Guideline Panel

Daniel A. Barocas, MD, MPH; Stephen Boorjian, MD;* Ronald Alvarez, MD, MBA; Tracy M. Downs, MD; Cary P. Gross, MD; Blake Hamilton, MD; Kathleen Kobashi, MD; Robert Lipman; Yair Lotan, MD; Casey Ng, MD; Matthew Nielsen, MD, MS; Andrew Peterson, MD; Jay Raman, MD; Rebecca Smith-Bindman, MD*

GUIDELINE STATEMENTS

DIAGNOSIS AND DEFINITION OF MICROHEMATURIA

1. Clinicians should define microhematuria as ≥3 red blood cells per high-power field on microscopic evaluation of a single, properly collected urine specimen. (*Strong Recommendation; Evidence Level: Grade C*)

2. Clinicians should not define microhematuria by positive dipstick testing alone. A positive urine dipstick test (trace blood or greater) should prompt formal microscopic evaluation of the urine. (*Strong Recommendation; Evidence Level: Grade C*)

INITIAL EVALUATION

workup. (*Expert Opinion*)

FOLLOW-UP

22. In patients with a negative risk-based hematuria evaluation, clinicians should engage in shared decision-making regarding whether to repeat urinalysis in the future. (*Strong Recommendation; Evidence Level: Grade C*)

23. For patients with a prior negative hematuria evaluation and subsequent negative urinalysis, clinicians may discontinue further evaluation for microhematuria. (*Conditional Recommendation; Evidence Level: Grade C*)

24. For patients with a prior negative hematuria evaluation who have persistent or recurrent microhematuria at the time of repeat urinalysis, clinicians should engage in shared decision-making regarding the need for additional evaluation. (*Expert Opinion*)

25. For patients with a prior negative hematuria evaluation who develop gross hematuria, significant increase in degree of microhematuria, or new urologic symptoms, clinicians should initiate further evaluation. (*Moderate Recommendation; Evidence Level: Grade C*)

Efficacy of dietary interventions in irritable bowel syndrome: a systematic review and network meta-analysis

Melanie S Cuffe, MBChB [a,b,*] · Heidi M Staudacher, PhD [c,*] · Imran Aziz, MD [d,e] · Enrique Coss Adame, MD [f] · Claudia Krieger-Grubel, MD [g] · Ana Maria Madrid, MD [h] · et al. Show more

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We identified 28 eligible randomised controlled trials (comprising 2338 patients) of 11 different dietary interventions compared with four control interventions, of which six (low FODMAP diet, British Dietetic Association/National Institute for Health and Care Excellence [BDA/NICE] diet, lactose-reduced diet, starch-reduced and sucrose-reduced diet, a personalised diet, and a Mediterranean diet) were studied in more than one trial. For global IBS symptoms, assessed in 28 randomised controlled trials and when considering only the dietary interventions studied in more than one trial, a starch-reduced and sucrose-reduced diet ranked first (RR of global IBS symptoms not improving 0·41 [95% CI 0·26–0·67]; P-score 0·84; two trials), a low FODMAP diet ranked fourth (0·51 [0·37–0·70]; P-score 0·71; 24 trials), and a BDA/NICE diet ranked tenth (0·62 [0·43–0·90]; P-score 0·44; eight trials), versus a habitual diet. For abdominal pain, assessed in 26 trials and when considering only the dietary interventions studied in more than one randomised controlled trial, a starch-reduced and sucrose-reduced diet ranked second (RR of abdominal pain not improving 0·54 [95% CI 0·33–0·90]; P-score 0·73; two trials), and a low FODMAP diet ranked fifth (0·61 [0·42–0·89]; P-score 0·64; 23 trials), versus a habitual diet. For abdominal bloating or distension, assessed in 26 trials and when considering only the dietary interventions studied in more than one randomised trial, only a low FODMAP diet (RR of abdominal bloating or distension not improving 0·55 [95% CI 0·37–0·80]; P-score 0·64; 23 trials) was superior to a habitual diet and ranked fourth. For bowel habit, assessed in 23 randomised trials, none of the dietary interventions was

DBT yields promise for women with family history of breast cancer

Amerigo Allegretto
May 22, 2025

Digital breast tomosynthesis (DBT) has its advantages over conventional mammography in women with a family history of breast cancer, suggest findings published in *JAMA Oncology*.

Latest in Womens Imaging

APBI leads to successful outcomes for DCIS cases

JAMA Oncology | Original Investigation

Tomosynthesis vs Digital Mammography Screening in Women with a Family History of Breast Cancer

Tong Li, PhD; Yu-Ru Su, PhD; Janie M. Lee, MD; Ellen S. O'Meara, PhD; Diana L. Miglioretti, PhD; Karla Kerlikowske, MD; Louise Henderson, PhD; Nehmat Houssami, PhD

IMPORTANCE Evidence on screening outcomes with digital breast tomosynthesis (DBT) vs digital mammography (DM) in women with a family history of breast cancer is limited.

OBJECTIVE To compare the performance of DBT and DM screening in women with a family history of breast cancer overall and subdivided by breast cancer family history category, breast density, age group, screening interval, and screening round, and to describe characteristics of cancers detected on screening vs interval cancers.

DESIGN, SETTING, AND PARTICIPANTS In this comparative cohort study at imaging facilities affiliated with the Breast Cancer Surveillance Consortium, adult women 18 years and older with a self-reported family history of breast cancer who underwent DBT or DM from 2011 to 2018 were included, with a 1-year follow-up for breast carcinoma. Data analysis was performed between November 2023 and August 2024.

EXPOSURES DBT or DM.

MAIN OUTCOMES AND MEASURES The main outcomes were absolute risk difference (ARD) between DBT and DM for recall rate, cancer detection rate, interval cancer rate, advanced cancer rate, biopsy rate, positive predictive values, sensitivity, and specificity, with inverse probability of treatment weighting.

RESULTS A total of 208 945 women with a family history of breast cancer undergoing 502 357 screening examinations were included in the sample. Median (IQR) age was 58 (50-66) and 57 (49-66) years for the DBT and DM groups, respectively. Adjusted ARDs (DBT vs DM) were significant for recall rate (−1.51%; 95% CI, −2.42% to −0.59%) and specificity (1.56%; 95% CI, 0.65%-2.46%) In the overall cohort of 121 698 DBT and 380 561 DM examinations and among women with 1 first-degree relative (recall rate ARD, −1.72%; 95% CI, −2.70% to −0.74%; specificity ARD, 1.75%; 95% CI, 0.81%-2.69%). Among those with only second-degree relatives, the biopsy rate for DBT was significantly higher (ARD,

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Original Article

Diagnostic Performance of Ultrasound for Differentiating Malignant From Benign Cervical Lymphadenopathy in Children

A Systematic Review and Meta-Analysis

Results

Ten articles (1077 children) were included. Among the retrieved US features, abnormal vascularity, heterogeneous echogenicity, abnormal hilum echogenicity, and long-axis/short-axis (L/S) ratio were significantly associated with malignant lymphadenopathy, with pooled diagnostic odds ratios of 36 (95% confidence interval [CI]: 14–92), 17 (3–91), 16 (5–54), and 7 (5–9), respectively. The most sensitive US features were abnormal hilum echogenicity (0.86, 95% CI: 0.66–0.95) and heterogeneous echogenicity (0.84, 95% CI: 0.25–0.99). Abnormal vascularity (0.91, 95% CI: 0.82–0.97) was the most specific. Substantial heterogeneity was found in both sensitivity and specificity ($I^2 > 50\%$; $P < .01$), although the source was not revealed.

Conclusion

Among US features, abnormal vascularity, heterogeneous echogenicity, abnormal hilum echogenicity, and L/S ratio are useful for differentiating malignant from benign cervical lymphadenopathy in children, showing good diagnostic performance. These findings should be carefully interpreted due to unexplained heterogeneity, which may lower the validity of the pooled estimates.

THE END