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Characterisation of incident cases of cancer in inflammatory bowel disease: A prospective multicenter matched-pair IG-IBD study
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Background: Concern still exists about the cancer risk using thiopurines (IMM) and/or anti-TNFs in Inflammatory Bowel Disease (IBD). In a prospective, multicenter case-control study, we aimed to characterize incident cases of cancer in IBD. The possible role of characteristics of IMM vs IMM and/or anti-TNFs use in determining the frequency of any cancer was also investigated.

Methods: From January 2012 to October 2013, characteristics of all incident cases of cancer in IBD patients (pts) referring to 15 IBD centers were recorded in a common database. In each center, each IBD pt with a new diagnosis of cancer (IBD-K) was matched with 2 IBD pts with no cancer (IBD-C) for: IBD type (CD/UC), gender, age (±5 yrs). Statistical analysis: Data reported as median (range); Chi-squared, T test, univariate analysis used as appropriate.

Results: Incident cases of cancer were reported in 89 IBD pts (43 M), age 59 yrs (16–85). The frequency of cancer was higher in CD (CD-K) (n = 53; 60%) than in UC (UC-K) (n = 36; 40%; p = 0.007). Controls included 178 IBD-C with no cancer (86 M, age 52 yrs). IBD duration was comparable between the 89 IBD-K pts and their matched 178 IBD-C (12 yrs, 0–50 vs 11 yrs, 0–50; p = ns). Among the 89 IBD-K pts, cancer more frequently involved the GI tract (35%), followed by the genitourinary tract (21%), skin (9%), breast (8%), lymphoma (5%) (others 14%). In particular, cancer involved: the GI tract (n = 34; 14 CD, 20 UC), genitourinary tract (n = 20; 11 CD, 9 UC), skin (n = 9; 7 CD, 2 UC; in CD 3 melanoma: 2 no IMM no anti-TNFs, 1 IMM, no anti-TNFs; 4 NMSC: 3 IMM + anti-TNFs, 1 IMM, no anti-TNFs; in UC 1 melanoma, 1 Kaposi: both no IMM, no anti-TNFs); lung (n = 7; 4 CD, 3 UC), breast (n = 8; 6 CD, 2 UC), lymphoma (n = 5; 5 CD, 5 M, 2 IMM + anti-TNFs, 1 IMM, 2 no IMM/ no anti-TNFs), others (n = 14; 10 CD; 4 UC). GI cancers were more frequent in UC (55%) than in CD (26%; p = 0.001), while lymphoma and skin cancers were more frequent in CD vs UC (9% vs 0%; p = 0.006; 13% vs 5%; p = 0.084). Incidence of any cancer in UC was higher in pancolitis (n = 20; 55%) vs distal UC (n = 12; 33%; p = 0.003) or subtotal UC (n = 4; 11%; p = 0.001). In CD, there were no differences between stricturing (36%), fistulizing (28%) or inflammatory CD (36%; p = ns). IMM and anti-TNFs use was observed in a comparable proportion of IBD pts (CD, UC) developing or not cancer (IBD: IMM: IBD-K vs IBD-C: 35% vs 39%; Anti-TNFs: IBD-K vs IBD-C 31% vs 39%; p = ns).

Conclusions: In a prospective multicenter matched-pair study, incident cases of cancer were more frequent in CD than in UC. GI cancer was more frequent in UC, while skin cancer and lymphoma in CD. IBD phenotype (CD) and UC extent appeared to influence the frequency of any cancer, while IMM and/or anti-TNFs use the frequency of specific cancer histotypes (lymphoma, skin cancer).

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Cancer in elderly-onset inflammatory bowel disease: A population-based study
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Background: The ageing of the population makes elderly-onset inflammatory bowel diseases (IBD) a rising problem. Risk of cancer is unknown in this population. We studied this risk in a population-based cohort of patients with IBD.

Methods: In a French population-based cohort, we identified 841 IBD patients >60 years of age at diagnosis from 1988 to 2006, including 367 Crohn’s disease (CD) and 472 ulcerative colitis (UC) [1]. We compared incidence of cancer among patients with IBD with that observed in the French Network of population-based Cancer Registries (FRANCIM). Only cancers occurring after IBD diagnosis were taken into account. Confidence interval (CI) was estimated assuming a Poisson specific law for rare events. Results were expressed using the standardized ratios of incidence (SIR) and their 95%CI.

Results: After a median follow-up of 6 years [2–11], 103 (12.3%) patients with IBD including 42 CD and 61 UC developed a cancer corresponding to a SIR of 1.00 [0.83–1.21]. Eleven patients (1.3%) developed at least 2 cancers. There was no increased risk of colorectal cancer in IBD (SIR = 1.06 [0.65–1.72], CD SIR = 1.15 [0.54–2.40] and UC SIR = 0.99 [0.52–1.91] without significant protective role of 5-ASA (HR = 0.7 [0.2–2.6]). An increased risk of malignant lymphoproliferative disorders was found in IBD (SIR = 2.71 [1.41–5.20] and in UC (SIR = 3.05 [1.37–6.79]) but not in CD (SIR = 2.21 [0.71–6.86]). An increased risk of extraintestinal tumors was observed only for the liver in CD (SIR = 3.25 [1.04–9.07]). Immunomodulator exposure (n = 26) was not associated with an increased risk of cancer (SIR = 0.75 [0.43–1.29]) nor with any specific risk including malignant lymphoproliferative disorders (SIR = 1.89 [0.26–13.44]). Only 2 patients of this cohort received biological therapy.

Conclusions: There is no increased risk for developing intestinal cancer among patients with elderly-onset IBD in this population-based cohort. There is an increased risk of developing malignant lymphoproliferative disorders in UC and an increased risk for developing liver cancer in CD. These data reinforce the peculiarity of elderly-onset IBD as compared with younger age at onset IBD [1].

Reference(s)