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Editorial

# Interval Cancer, a Challenge yet to Be Solved

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Defining interval cancer, also called missed or post-endoscopy cancer—for both gastric and colorectal cancers—presents a complex challenge. Consequently, the Interval Colorectal Cancer Expert Working Group from the World Endoscopy Organization's (WEO) Colorectal Cancer Screening Committee[1,2] defines it as a cancer diagnosed after a colorectal screening exam where no cancer was found, and before the next recommended screening. This term is broadly used to denote cancers of the gastrointestinal tract identified in the interval between an endoscopically reported normal study and the next scheduled follow-up examination. For gastric cancer, the interval cancer rate stands at 9.4% (95% confidence interval [CI]: 5.7-13.1%)[3], aiming for an ideal rate below 5% as per WEO standards; whereas, for colorectal cancer, the incidence rate of interval cancer is a matter of debate, ranging between 5.25% and 9.3%[4,5]. The importance of understanding interval cancer spans diagnostic, therapeutic, ethical, legal, and public health concerns, especially considering these represent the two most prevalent digestive neoplasms in our society.

Dr. Castaño and colleagues[6] offer a compelling analysis aimed at determining the rate of interval cancer in both gastric and colorectal cancers by comparing the two. They delve into the local tumor incidence rates, addressing the lack of data on this phenomenon in our context, with the goal of sparking interest in acquiring specific local data among the journal's readership.

The etiology of these neoplasms is multifactorial, with the highest risk stemming from overlooked or incompletely excised lesions. There is no consensus in the literature regarding whether interval colorectal cancers are inherently more aggressive due to molecular composition changes[7]. Colorectal cancer itself is recognized as a heterogeneous disease, with different molecular entities involved in oncogenesis, potentially contributing to the development of interval colorectal cancer. Evidence suggests the sessile serrated neoplasia pathway might accelerate carcinoma development post-screening colonoscopy. Nonetheless, the overall survival rates for interval colorectal cancers are comparable to those detected within the screening process[7]. Flat neoplastic lesions pose a significant challenge for both endoscopists and pathologists[7]. In our context, factors such as schedule overloads, preparation difficulties (refer to Aponte and colleagues)[8], endoscopist haste, and the lack of appropriate technology in various settings are among the numerous determinants of the quality in diagnostic and screening endoscopy[9,10].

Enhancements in the quality of endoscopic procedures, through endoscopist education, procedure quality surveillance systems, risk-stratified screening, and the integration of technologies such as chromoendoscopy and artificial intelligence, could significantly influence this situation[7].

 

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