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# 3g mesalazine granules are superior to 9mg budesonide for achieving remission in active ulcerative colitis: A double-blind, double-dummy, randomized trial.

*Lakatos PL, David G, Pandur T, Erdelyi Z, Mester G, Balogh M, Szipocs I, Molnar C, Komaromi E, Kiss LS, Lakatos L.*

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Colorectal cancer (CRC) and small bowel adenocarcinoma (SBA) are severe complications of inflammatory bowel diseases (IBD) and represent a major concern in the follow-up of these patients. The association between CRC and ulcerative colitis has been well established since the first case was described in 1925, whereas conflicting data about the risk of CRC in Crohn's disease (CD) have been reported in the literature. A strong association between CD and small bowel cancer has been established without any reduction of this risk in recent decades. The risk of CRC in CD is less clear. An increase in risk of about 2.5-fold has been reported in several studies, including two recent meta-analyses, whereas other studies reported no increased risk of CRC in the CD population. The well-established risk factors for CRC in IBD are disease duration, an early age at diagnosis (usually associated with long disease duration), the disease location (colonic location and extensive disease), a familial history of CRC, concomitant primary sclerosing cholangitis and male gender. Environmental, dietary and genetic factors can influence the risk of CRC and small bowel adenocarcinoma. Geographic variations have been reported, with an increased risk in North America and the United Kingdom.

| New findings | Findings confirming previous data |
|---|---|
| No increased risk of SBA in CD | No increased risk of CRC in CD |
| Stricturing disease at diagnosis = risk factor for CRC in CD | Male gender = risk factor for CRC in CD |
| CRC during first decade of CD | Early age at diagnosis = risk factor for CRC in CD |
| Disease duration ≠ risk factor for CRC in CD | |
| Disease location ≠ risk factor for CRC in CD | |

### *Interst of this work*

This is an interesting paper studying a large number of CD patients during a long follow-up and providing data from a part of Europe for which data have been completely missing. The authors establish the risk of CRC and SBA in their CD population, confirm several risk factors previously identified and, interestingly, demonstrate some new ones.

The authors nicely studied more than 500 CD patients from different centres of Hungary with a median follow-up of 10.9 years. Some of the data were collected prospectively. Interestingly, no case of SBA was described. Only five cases of CRC were diagnosed. This corresponded to an annual rate of 0.09%, which is comparable to that in the general population. CRC was usually diagnosed during the first decade of the disease, although disease duration is generally a well-established risk factor. Early age at onset of the disease and male gender were confirmed as CRC risk factors in this study, whereas disease location was not. Interestingly, all the cases of CRC occurred in patients with stricturing disease at diagnosis. However, the small number of cases of CRC diagnosed in this cohort may have prevented the identification of other important risk factors.

### *Summary*

No increased risk of SBA or CRC was demonstrated in this study despite the long follow-up and the large number of patients. Young age at diagnosis, male gender and stricturing disease at diagnosis were identified as possible risk factors. This suggests that young males with CD should be monitored more carefully from the start, independent of disease location.