



### KEY INSIGHTS:

**The rise in early-onset bowel cancer is alarming, particularly as younger adults often present with more advanced stages of the disease. In response to this trend, Australian government is now considering lowering the starting age for national bowel cancer screening from 50 to 45 years, to improve early detection and enhance treatment outcomes.**

As gastroenterologists committed to advancing our understanding and treatment of gastrointestinal diseases, we are writing to share some concerning trends and insights into colorectal cancer. Specifically, there is a growing body of evidence highlighting the increased incidence of this disease in younger adults, often presenting at more advanced stages and with more aggressive disease courses *The New York Times "Colon Cancer Is Rising in Young People: What to Know About Causes and Symptoms"*.

A similar trend is evident in Australia, as highlighted in an article published in *The Guardian* in August 2023. Among the approximately 16,000 annual cases of bowel cancers in Australia each year, one-tenth are diagnosed in individuals under the age of 50. This demographic, referred to as young-onset bowel cancer patients, is typically diagnosed at an advanced stage (stage III or IV cancer).

Bowel cancer represents the deadliest form of cancer and ranks as the sixth leading cause of death for Australians aged 25–44. Annually, 1,716 Australians under the age of 50 are diagnosed with bowel cancer accounting for 11% of all bowel cancer cases nationally. Furthermore, 315 people under the age of 50 die from bowel cancer each year, representing 5.8% of all bowel cancer deaths. Alarming, the risk profile for bowel cancer has shifted over time; a 45-year-old today faces the same risk level that a 50-year-old encountered a decade ago.

In response to this trend, the updated 2023 guidelines endorsed by the National Health and Medical Research Council (NHMRC) have adjusted the recommended age for population screening from 50 to 45 years. The National Bowel Cancer Screening Program currently distributes free, at-home bowel screening test kits to Australians aged 50–74 every two years. Considering emerging data on early-onset bowel cancer and NHMRC recommendation, the Australian Government is considering lowering the starting age for eligibility in the National Bowel Cancer Screening Program from 50 to 45 years.

The emerging trends in early-onset bowel cancer are alarming and underscore the need for heightened awareness and the implementation of early intervention strategies including proactive screening within our primary care practices. According to Bowel Cancer Australia, individuals under 50 have an increased risk of developing bowel cancer if they experience one or more of the following symptoms between three months and two years prior to diagnosis: abdominal pain, rectal bleeding, diarrhoea and iron deficiency anaemia. It is imperative not to ignore any symptoms, however minor they may appear, as early detection can significantly enhance treatment outcomes and ultimately save lives.

**Southend Gastros provides early colonoscopy for symptomatic patients.**



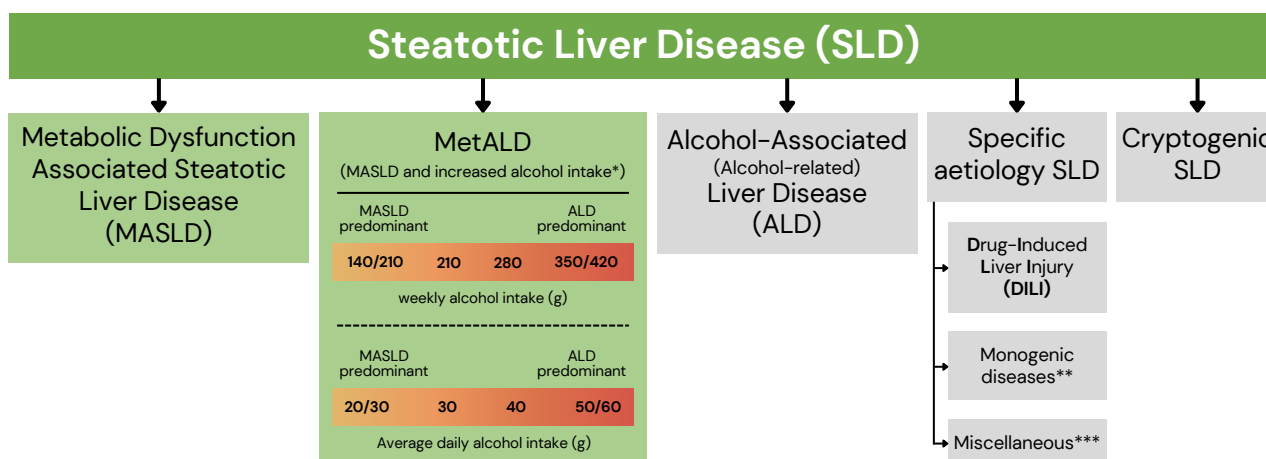
## Change in terminology: NAFLD to MASLD (Metabolic dysfunction associated steatotic liver disease) what's in the name.

Dr Madhavi Kasi (MBBS MRCP FRACP)

### KEY INSIGHTS:

The disease formerly known as Non-Alcoholic Fatty Liver Disease (NAFLD) has been renamed to Metabolic dysfunction associated steatotic liver disease (MASLD). This change reflects a more accurate description of the disease as related to metabolic dysfunction rather than alcohol use. MASLD is the most prevalent liver disease globally, affecting over 30% of the population. Diet and lifestyle modifications remain the mainstay of the treatment.

MASLD, formerly known as NAFLD, is now recognized as the most prevalent liver disease globally, affecting more than 30% of the world's population. This renaming followed a universal agreement facilitated by the collaboration of various societies and organizations, culminating in the Multi-Society Delphi Consensus.



\*Weekly intake 140–350g female, 210–420g male (average daily 20–50g female, 30–60g male)

\*\*e.g. Lysosomal Acid Lipase Deficiency (LALD), Wilson disease, hypobetalipoproteinemia, inborn errors of metabolism

\*\*\*e.g. Hepatitis C Virus (HCV), malnutrition, celiac disease

MASLD encompasses patients who exhibit hepatic steatosis and have at least one of five cardiometabolic risk factors. These factors include obesity with a BMI >25, fasting blood glucose level >5.6 or a history of DM, hypertension, hypertriglyceridemia, plasma HDL <1 or the use of lipid lowering agents.

The most widely used detection modality for the presence of steatosis is ultrasonography. If available, liver stiffness should be measured by elastography. Fibrosis staging can be performed by using a combination of non-invasive liver scores (e.g. Fibrosis-4 [FIB-4] and NAFLD Fibrosis Score [NFS]).

Diet and lifestyle modifications remain the key for the management of MASLD. Calorie restriction and increased physical activity with resulting weight loss can lead to significant improvements in MASLD. Foods rich in saturated fats, cholesterol, refined carbohydrates, sugary beverages, red meat, and highly processed foods, which are energy-dense or have inflammatory potential, are closely associated with the development of MASLD or MASH. Physical activity plays a significant role in managing MASLD, with exercise demonstrating a dose-effect relationship with vigorous physical activity demonstrating a stronger positive impact than moderate exercise.

Resmitron (oral liver THR agonist) became the first medication approved for treatment of MASLD by FDA. Incretin mimetics, which are glucagon-like peptide-1 receptor (GLP-1R) agonists, hold promise for the treatment of MASH. Other pharmacological agents such as PPAR agonists and FXR agonists are being studied in Phase III trials, with promising outcomes.

Southend Gastros provide consultation and dietary evaluation for MASLD patients.

REFERENCE AVAILABLE UPON REQUEST



# Evaluation of iron deficiency anaemia: a summary of current guidelines.

Dr. Jeevithan Sabanathan (MBBS, FRACP, AFRACMA)

## KEY INSIGHTS:

**Iron Deficiency Anemia (IDA) remains the most common cause of anaemia worldwide, often serving as a crucial indicator of more severe health issues such as gastrointestinal malignancies. Updated guidelines recommend thorough investigations for IDA, including bidirectional endoscopy for certain at-risk groups to ensure comprehensive evaluation and management of this condition.**

Anaemia is a common presentation in clinical practice, and iron deficiency is the most common cause of anaemia worldwide. Iron deficiency anaemia (IDA) may be the first presenting manifestation of colonic or oesophago-gastric carcinoma, highlighting the importance of swift and complete investigation. To guide the management of IDA, several gastroenterological societies have developed and published guidelines. Several society guidelines have been published on the management of iron deficiency anaemia including the American Gastroenterology Association (AGA) in 2020<sup>1</sup>, British Society of Gastroenterology (BSG) in 2022<sup>2</sup>, and Gastroenterological Society of Australia (GESA) in 2022<sup>3</sup>.

In adults, anaemia is defined by specific haemoglobin thresholds; <130 g/L in men, <120 g/L in non-pregnant women, and <110 g/L in pregnant women. In patients with anaemia, the BSG and GESA recommend using a ferritin threshold of <30 ug/L to diagnose iron deficiency. However, caution should be exercised in patients with inflammatory conditions or chronic kidney disease in whom the ferritin may be artificially elevated. In such scenarios, transferrin saturation can be used as an adjunct, and is generally below 20% in patients that are truly iron deficient.

The aetiology of IDA includes suboptimal oral intake, poor absorption of oral iron, and/or chronic blood loss from gastrointestinal and other sources. When evaluating a patient with IDA, potential non-gastrointestinal sources such as nutritional deficiency due to a vegan or vegetarian diet, frequent blood donation, or non-gastrointestinal blood loss due to menorrhagia or haematuria should be considered. In the absence of such factors, evaluation of the gastrointestinal tract for a source of chronic blood loss or a malabsorptive process is indicated. While gastrointestinal malignancy remains the primary concern, other conditions such as peptic ulcer disease, coeliac disease, inflammatory bowel disease, and benign vascular lesions also significantly impact patient care and quality of life.

The AGA and BSG both recommend non-invasive testing for *Helicobacter pylori* infection and coeliac disease in patients with IDA.

The AGA also recommend bidirectional endoscopy in postmenopausal women and men with iron deficiency anaemia. This recommendation is based on a pooled analysis which revealed that lower gastrointestinal malignancies were detected in 8.9% of patients, and upper gastrointestinal malignancies were identified in 2% of this cohort. In pre-menopausal women the AGA once again recommends bidirectional endoscopy over iron replacement only.

Finally, the AGA recommends a trial of initial iron supplementation in patients with negative bidirectional endoscopy over routine video capsule endoscopy (VCE).

**Southend Gastros provides comprehensive management of patients with IDA including consultation, gastroscopy, colonoscopy, and capsule endoscopy.**

REFERENCE AVAILABLE UPON REQUEST



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