LETTERS

Individualised surveillance strategies for colorectal cancer in inflammatory bowel disease

We read with interest the updated guidelines for colorectal cancer (CRC) screening and surveillance in moderate and high risk groups from Cairns SR *et al*.[1] Indeed risk stratification is an important step forward for inflammatory bowel disease (IBD)-related CRC surveillance programmes. But as the authors already suggest, the adherence to these surveillance protocols is poor and, furthermore, the proposed strategy is based on risk factors originating from tertiary referral centres with high-risk patients groups. It has already been demonstrated by population-based studies that there might have been an overestimated risk of IBD-related CRC.[2] In a Dutch nested case–control study including 173 cases and 393 control patients, we identified several strong prognostic factors for IBD-related CRC in general hospitals: age, duration of primary sclerosing cholangitis (PSC) and IBD, concomitant pseudopolyps and use of anti-tumour necrosis factor or immunosuppressives.[3] We used Poisson regression of time to CRC with time-dependent covariates in these data to estimate the individual CRC risk for patient with IBD.

The different factors were weighted by their regression coefficients and subsequently assigned rounded figures. For example: 3 years of PSC and 4 years of IBD both received one point in the prediction rule (table 1). Practical use of the model is illustrated with a hypothetical 50-year-old male patient, diagnosed with IBD at age 22, extensive colitis with pseudopolyps, concomitant PSC for 10 years. According to table 1, his age score is five points, and total sum is 22 points. His probability for the development of CRC in the next year is 0.2% (figure 1).

Although this proposed model needs to be validated in an external cohort, we believe that is a first, important step towards individualised surveillance for patients with IBD and can be applied in general hospitals. According to this model we would propose to start surveillance every 3 years in patients with IBD with a predicted risk of 0.2% or higher. After further validation, this model may support physicians in deciding on starting surveillance in general hospitals.

Table 1 Prediction model flowchart

Step 1: Choose the number of points for each patient characteristic mentioned below:	
Patient's characteristics	**No. of points**
Duration of IBD	1 point for every 4 years of IBD
Duration of PSC	1 point for every 3 years of PSC
Gender	
Male	2 points
Female	0 points
Location of IBD	
Leftsided colitis (UC)	0 points
Extensive colitis (UC)	1 point
Limited CD	−3 points
Extensive CD	−1 point
Unclassified colitis	0 points
Concomitant pseudopolyps	4 points

Step 2: Choose the number of points that matches with your patient's age:			
Age	**Points**	**Age**	**Points**
0–6	−10	37–50	6
7–9	−9	51–53	7
10–12	−8	54	8
13–14	−7	55	9
15–17	−6	56	10
18–20	−5	57	11
21–23	−4	58	13
24–25	−3	59	14
26–27	−2	60	15
28–29	−1	61	16
30	0	62	18
31	1	63	19
32–33	2	64	20
34	3	65	22
35	4		
36	5		

Step 3: From figure 1 read your patient's individual risk for developing inflammatory bowel disease-related colorectal cancer within the next year

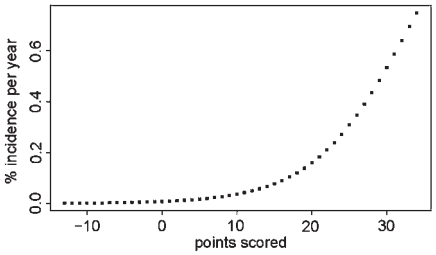

Figure 1 Individualised risk of developing inflammatory bowel disease-related colorectal cancer.

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Efficacy of azathioprine versus mesalazine in postoperative Crohn's disease—The Authors' response

We thank Dr Ford for his comments[1] on our recent paper in *Gut* entitled 'Azathioprine versus mesalazine for prevention of post-operative clinical recurrence in patients with

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