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Short-Interval Repeat Colonoscopy in Four African American Patients: A Case Series on Indication-Specific Assessment and Documentation Gaps

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Abstract

Repeat colonoscopy within 12 months can be appropriate after inadequate bowel preparation, piecemeal or incomplete resection, colorectal cancer (CRC) resection, or new or persistent symptoms, but its appropriateness is often difficult to establish retrospectively.

We describe four African American patients older than 50 years, drawn from a five-patient institutional review of repeat colonoscopy within one year, who each had at least one repeat examination within 12 months. Each index-repeat pair was assigned an indication category and assessed against the U.S. Multi-Society Task Force (USMSTF) guidance in effect when it was performed, with the 2020 guidance used only as a secondary comparison, and was classified as supported, indeterminate, or not clearly supported. The qualifying repeats in Case 2 (six months) and Case 3 (seven months) followed index examinations with documented suboptimal preparation or poor visualization and were classified as supported. The qualifying repeat in Case 1 (nine months), which occurred during post-CRC surveillance, and the four repeats within 12 months in Case 4 (one, three, five, and seven months), which followed an index examination with two adenomas containing high-grade dysplasia, were classified as indeterminate because preparation quality, resection completeness, and procedural rationale were not linked to the specific examinations. Advanced histology alone did not justify an interval shorter than 12 months under any applicable guideline. In this small, selected series, the main barrier to judging appropriateness was the absence of examination-level documentation. These observations cannot estimate the frequency of low-value colonoscopy or address racial differences in surveillance practice.

Categories: Pathology, Internal Medicine, Gastroenterology
Keywords: african american health, bowel preparation, colonoscopy, colonoscopy surveillance, colorectal adenoma, colorectal cancer, healthcare quality improvement, short-interval repeat colonoscopy

Introduction

Colonoscopy remains the gold standard for colorectal cancer (CRC) screening and for evaluation of gastrointestinal (GI) symptoms. Surveillance guidelines, including the 2020 U.S. Multi-Society Task Force (USMSTF) update, recommend follow-up intervals based on polyp size, number, histology, and completeness of resection, assume a complete examination with adequate bowel preparation, and reserve intervals of one year or less for a few specific circumstances [1]. Despite these recommendations, both underuse and overuse persist in CRC screening and surveillance. A systematic review estimated that 17.0%-25.7% of US screening colonoscopies are non-indicated, either because they are performed at shorter intervals than recommended or in patients outside recommended age ranges [2], and both underuse and overuse of repeat screening and surveillance colonoscopy have been documented in the Veterans Health Administration [3]. Overuse may expose patients to avoidable procedural risks, including sedation-related complications, perforation, and bleeding, while also straining endoscopy capacity and increasing healthcare costs without clear improvement in outcomes.

Interval CRCs, defined as CRCs diagnosed after a negative colonoscopy but before the next recommended examination, have highlighted the importance of colonoscopy quality rather than surveillance frequency alone [4]. Current quality targets include an adenoma detection rate (ADR) of at least 35%, adequate bowel preparation in at least 90% of outpatient examinations, a cecal intubation rate of at least 95%, and a mean withdrawal time of at least eight minutes in normal examinations [5]; higher ADR has been associated with lower risks of interval CRC and CRC death [6]. Inadequate bowel preparation increases adenoma miss rates [7], and fair or worse preparation has been associated with a higher risk of post-colonoscopy CRC death [8].

African American patients bear a disproportionate burden of CRC; during 2015-2019, CRC incidence was 41.7 per 100,000 among Black individuals compared with 35.7 per 100,000 among White individuals, with higher mortality among Black individuals [9]. These disparities reflect factors operating at multiple levels, including differences in risk-factor exposure, access to screening and follow-up of abnormal results, and access to high-quality treatment [10]. African American adults have also been more likely than White adults to report lack of a provider recommendation as the main reason for not undergoing screening [11]. In this population, both missed surveillance and repeat procedures that add risk without benefit have consequences.

Analyses of large administrative databases show that some patients undergo repeat colonoscopy at intervals inconsistent with recommendations, but they lack the patient-level detail needed to determine why [3,12]. In a patient-level review of 110 patients who underwent repeat colonoscopy within one year, Songtanin et al. identified four main indications: poor bowel preparation with incomplete examination, incomplete polyp resection, multiple polyps raising concern for missed lesions, and new GI symptoms [12]. These indications are clinically distinct and are governed by different guidance, yet early repeat examinations are often evaluated collectively against a single post-polypectomy surveillance framework. This case series describes the clinical indications and documentation associated with short-interval repeat colonoscopy in four African American patients. Each qualifying index-repeat pair was categorized as post-polypectomy surveillance, diagnostic evaluation of new or persistent symptoms, repeat examination after inadequate bowel preparation, follow-up of piecemeal or suspected incomplete resection, or post-CRC surveillance, and was assessed against the guidance in effect when it was performed.

Case Presentation

Case identification and assessment

The medical records of five patients who underwent repeat colonoscopy within one year of a prior colonoscopy at a single academic hospital-based endoscopy unit were retrospectively reviewed. Four of the five were African American and older than 50 years; the fifth patient, who was not African American, was excluded to match the focus of this series. The five patients were identified by the clinical team rather than through a systematic search of all eligible procedures, so the number of eligible patients and the total number of colonoscopies performed during the period are not known. The cases are therefore neither consecutive nor representative and are reported for illustrative purposes only. The colonoscopies described were performed between 2010 and 2021.

The unit of analysis was the index-repeat pair, defined as a colonoscopy (the preceding examination) and the next colonoscopy performed within 12 months. For Cases 1-3, the qualifying pair is the pair through which the patient met the inclusion criterion; for the remaining examinations in these patients, the documented number of examinations and range of intervals are reported. For Case 4, intervals and histologic findings were available for every examination, and all four pairs separated by less than 12 months were assessed.

Each pair was assigned to one of five indication categories: post-polypectomy surveillance, diagnostic evaluation of new or persistent symptoms, repeat examination after inadequate bowel preparation, follow-up of piecemeal or suspected incomplete resection, and post-CRC surveillance. Each pair was assessed primarily against the guidance in effect at the time of the preceding examination: the 2006 USMSTF and American Cancer Society post-polypectomy guidance for procedures before September 2012 [13], the 2012 USMSTF guidance from September 2012 to February 2020 [14], and the 2020 USMSTF guidance thereafter [1]. Post-CRC surveillance was assessed against the 2006 and 2016 post-resection guidance [15,16], and repeat examination after inadequate preparation was assessed against the 2014 USMSTF bowel-preparation recommendations [17]. These recommendations postdate the index examinations in Cases 2 and 3 and were applied retrospectively to those pairs; the 2006 and 2012 intervals assume an adequately prepared examination [13,14]. The 2020 guidance was used only as a secondary contemporary comparison. Post-polypectomy surveillance guidance was not applied to symptom-driven diagnostic examinations.

A pair was classified as supported when the record documented, at the preceding examination, an indication that the applicable guidance recognizes as warranting repeat colonoscopy within 12 months (inadequate preparation, piecemeal or incomplete resection, more than 10 adenomas (2020 guidance only), or the scheduled post-CRC examination) or a documented diagnostic indication for the repeat examination; as not clearly supported when documentation was adequate and no such indication was present; and as indeterminate when the available documentation did not allow either determination. Advanced histology (an adenoma ⩾10 mm, villous features, or high-grade dysplasia (HGD)) after complete resection was not, by itself, considered an indication for repeat colonoscopy within 12 months, because each guideline recommends a three-year interval in that setting [1,13,14].

Bowel preparation is reported as described in the procedure records; Boston Bowel Preparation Scale (BBPS) scores and withdrawal times were not consistently documented. Colorectal outcomes are limited to findings at the reported colonoscopies; interval cancers were not systematically ascertained, so no inference is made about the safety or effectiveness of any surveillance interval. This case series was prepared with reference to

the CARE reporting guidelines [18]. Institutional Review Board approved this retrospective review and waived the requirement for individual informed consent.

Case 1

A 62-year-old African American woman with overweight (body mass index (BMI) 29 kg/m^2), hypertension, diabetes mellitus, and a prior history of breast cancer presented with GI bleeding and altered bowel habits (Table *1*). She also had a history of smoking and alcohol use. She additionally had a history of CRC treated with right hemicolectomy. Twelve colonoscopies were documented from 2013 onward, with intervals ranging from seven months to five years. Her index and subsequent examinations revealed multiple tubular adenomas (TAs), several greater than 10 mm, as well as recurrent adenomas with HGD on histopathology (Figure *1*). Poor bowel preparation was documented as a contributing factor to shortened surveillance intervals, and other findings included recurrent sessile serrated adenomas/polyps (SSAs/SSPs), evidence of incomplete resections, and repeated short-interval follow-up examinations at 7-12 months. The qualifying index-repeat pair was separated by nine months (Table *2*). The case data did not specify the preparation quality, resection status, or documented indication for the examination preceding this pair.

Case	Age/sex	BMI (kg/m²)	Comorbidities and relevant history	Presenting indication	Colonoscopies documented; period	Range of intervals
1	62/F	29	HTN, DM, prior breast cancer, prior CRC treated with right hemicolectomy; smoking, alcohol use	GI bleeding, altered bowel habits	12; 2013 onward	7 months to 5 years
2	70/F	32	HTN, obesity, breast cancer treated with partial mastectomy (chemotherapy recorded); tobacco, alcohol use	GI bleeding, abdominal pain	5; 2011-2017	Not available*
3	60/F	22	HTN, DM, regular aspirin use	Weight loss, altered bowel habits	11 (index plus 10 subsequent); 2010-2019	2 months to 2 years
4	65/M	Normal (value not available)	HTN; smoking, alcohol use	Persistent abdominal pain	8; 2014-2021	1 month to 2 years

TABLE 1: Clinical characteristics of the four patients.

*Only the qualifying six-month interval was available for Case 2.

HTN, hypertension; DM, diabetes mellitus; CRC, colorectal cancer; GI, gastrointestinal; BMI, body mass index

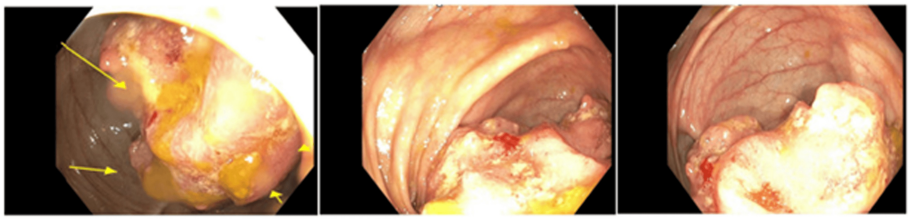

FIGURE 1: Endoscopic images (left to right) of polypoid colonic lesions (Case 1).

Arrows in the left image indicate lesions.

Case	Interval	Preceding examination: findings and documented quality	Indication category	Guidance in effect (contemporaneous recommendation); 2020 comparison	Classification and basis
Case 1; qualifying pair (2013 onward)	9 months	Multiple TAs (several >10 mm), recurrent HGD, and SSA/SSPs across the series; poor preparation and incomplete resections documented across the series but not specified for this examination	Post-CRC and post-polypectomy surveillance	Post-CRC: colonoscopy 1 year after resection, then 3 and 5 years; shorter intervals if indicated by adenoma findings [15,16]. Inadequate preparation: repeat within 1 year [17]. 2020: HGD after complete resection, 3 years [1]	Indeterminate: indications that could support a <12-month repeat were documented for the patient but not linked to this pair
Case 2; index to first repeat (2011)	6 months	Multiple TAs (some >10 mm); suboptimal bowel preparation	Repeat after inadequate preparation	2006 and 2012 intervals assume an adequately prepared examination [13,14]; repeat within 1 year after inadequate preparation [17]. 2020: same [1]	Supported: documented suboptimal preparation at the preceding examination
Case 3; 2010 index to first repeat	7 months	TAs and TVA with HGD; poor visualization	Repeat after inadequate preparation	2006: 3 years after an advanced adenoma, assuming a complete, adequately prepared examination [13]; repeat within 1 year after inadequate preparation [17]. 2020: same [1]	Supported: documented poor visualization; advanced histology alone would have supported a 3-year interval
Case 4; examination 1 (2014 index) to 2	1 month	Two TAs with HGD (one >10 mm) and two TAs without HGD; preparation and resection completeness not recorded	Uncertain: possible incomplete resection, inadequate preparation, or diagnostic evaluation of abdominal pain	2012: 3 years after an advanced adenoma or 3-10 adenomas [14]; 2006: 2-6 months after piecemeal resection of a large sessile adenoma [13]; within 1 year after inadequate preparation [17]. 2020: HGD, 3 years; piecemeal resection ≥20 mm, 6 months [1]	Indeterminate§
Case 4; examination 2 to 3	3 months	Four TAs without HGD and one TA >10 mm with HGD; not recorded	Uncertain	2012: no <12-month interval after an advanced adenoma unless resection was incomplete or preparation inadequate [14,17]	Indeterminate§
Case 4; examination 3 to 4	5 months	One HP; not recorded	Uncertain: surveillance or diagnostic	2012: surveillance intervals after prior advanced adenomas are 3 years or longer [14]	Indeterminate§
Case 4; examination 5 to 6	7 months	Two TAs without HGD; not recorded	Uncertain: surveillance or diagnostic	2012: surveillance intervals after prior advanced adenomas are 3 years or longer [14]	Indeterminate§

TABLE 2: Assessment of each index-repeat pair separated by less than 12 months.

§The case data did not record preparation quality, resection completeness, or indication for the preceding examination, so a guideline-recognized short-interval indication could be neither confirmed nor excluded.

Classification categories are defined in the case identification and assessment section.

TA, tubular adenoma; TVA, tubulovillous adenoma; HGD, high-grade dysplasia; SSA/SSP, sessile serrated adenoma/polyp; HP, hyperplastic polyp; CRC, colorectal cancer

Case 2

A 70-year-old African American woman (BMI 32 kg/m²) with obesity, hypertension, and a history of tobacco and alcohol use underwent colonoscopy for GI bleeding and abdominal pain (Table *1*). She also had a history

of invasive ductal carcinoma of the left breast treated with partial mastectomy, with no evidence of recurrence; chemotherapy was also recorded, but its timing relative to the colonoscopies was not specified in the case data. From 2011 to 2017, she underwent five colonoscopies; the index examination and the first repeat examination, which met the inclusion criterion, were separated by six months (Table 2). Findings included multiple TAs, some greater than 10 mm, recurrent polyps, and adenomas with HGD on histopathology on several occasions (endoscopic images in Figure 2). The index examination was additionally limited by suboptimal bowel preparation, which reduced visualization.



FIGURE 2: Endoscopic images (left to right) of colonic polyps in the cecum.

Arrows (left panel) indicate multiple adjacent polyps.

Case 3

A 60-year-old African American woman with a normal BMI (22 kg/m^2) and multiple cardiometabolic comorbidities, including hypertension and diabetes mellitus, underwent colonoscopy after presenting with unexplained weight loss and a change in bowel habits (Table 1). She also reported regular aspirin use. She had no documented history of CRC. The index colonoscopy in 2010 revealed TAs and a tubulovillous adenoma (TVA) with HGD (Figures 3-4), and visualization was documented as poor. The qualifying repeat colonoscopy followed seven months later (Table 2). By 2019, she underwent 10 subsequent colonoscopies (Figure 5) at an average interval of 10 months (range, two months to two years). Findings on follow-up examinations included TAs without HGD, a villous adenoma with HGD, multiple TAs without HGD, and several examinations with only mild dysplasia or benign findings. Episodes of suboptimal bowel preparation were documented during follow-up.

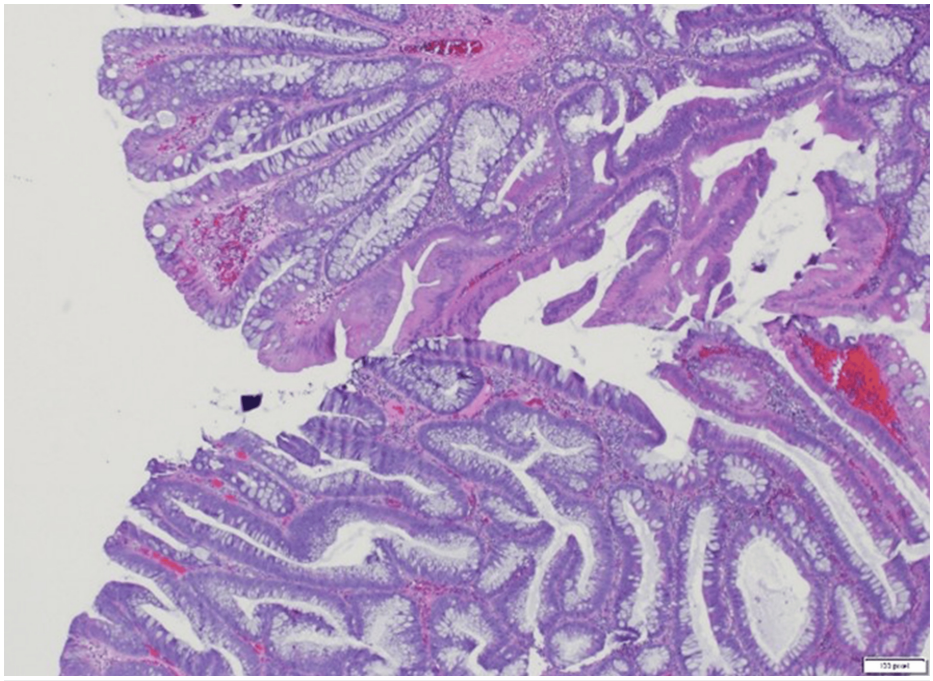

FIGURE 3: Tubulovillous adenoma with high-grade dysplasia, sigmoid colon (hematoxylin and eosin (H&E), original magnification ×20) (Case 3).

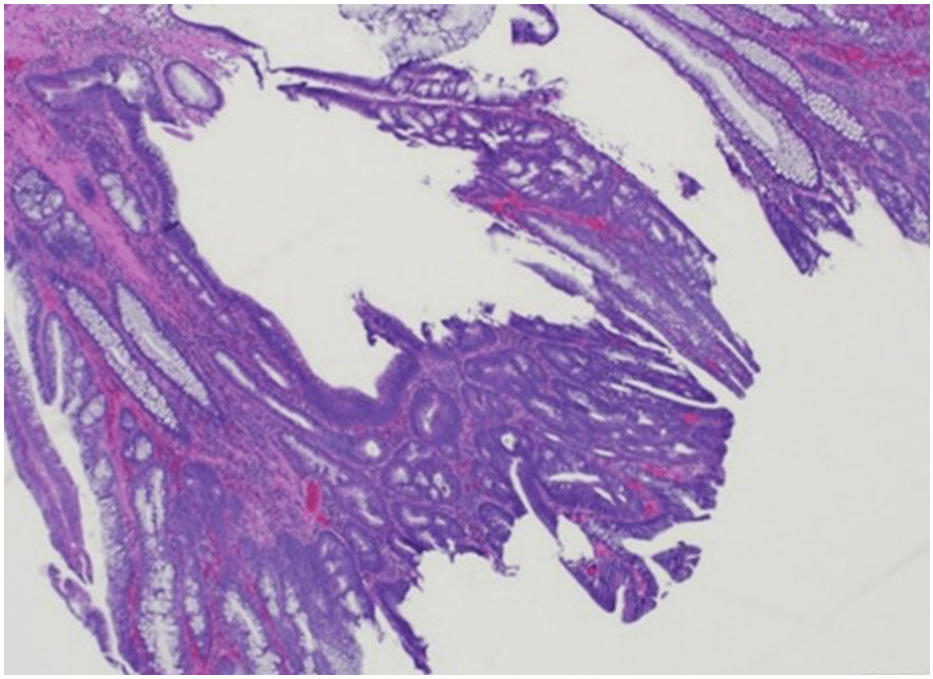

FIGURE 4: Tubulovillous adenoma, sigmoid colon (H&E, original magnification ×20) (Case 3).



FIGURE 5: Endoscopic images of polyps in the rectum (Case 3), a site separate from the sigmoid lesions shown in Figures 3-4.

Case 4

A 65-year-old African American man with a normal BMI and hypertension, with a history of smoking and alcohol use but no diabetes, malignancy, or immunosuppressive conditions, underwent colonoscopy for persistent abdominal pain (Table *1*). Between 2014 and 2021, he underwent eight colonoscopies at intervals ranging from one month to two years (Table *3*). The index colonoscopy in 2014 identified two TAs with HGD, one larger than 10 mm, and two TAs without HGD (Figures *6*-*7*). Repeat colonoscopy one month later identified four TAs without HGD and one TA larger than 10 mm with HGD (Figure *8*). Subsequent examinations were followed after three months (one hyperplastic polyp (HP)), five months (one TA without HGD), 15 months (two TAs without HGD), seven months (two TAs without HGD), and two years (three TAs without HGD). Suboptimal bowel preparation was documented as a recurring problem, and ongoing GI symptoms were recorded during follow-up, but preparation quality, resection technique and completeness, and the indication were not recorded for individual examinations in the case data.

Examination	Interval from preceding examination	Histologic findings
1 (index, 2014)	-	Two TAs with HGD (one >10 mm); two TAs without HGD
2	1 month	Four TAs without HGD; one TA >10 mm with HGD
3	3 months	One HP
4	5 months	One TA without HGD
5	15 months	Two TAs without HGD
6	7 months	Two TAs without HGD
7	2 years	Two TAs without HGD
8 (2021)	2.5 years	Three TAs without HGD

TABLE 3: Examination timeline for Case 4.

Bowel preparation quality, resection technique and completeness, and the documented indication were not recorded for individual examinations; suboptimal preparation was documented as a recurring problem.

TA, tubular adenoma; HGD, high-grade dysplasia; HP, hyperplastic polyp

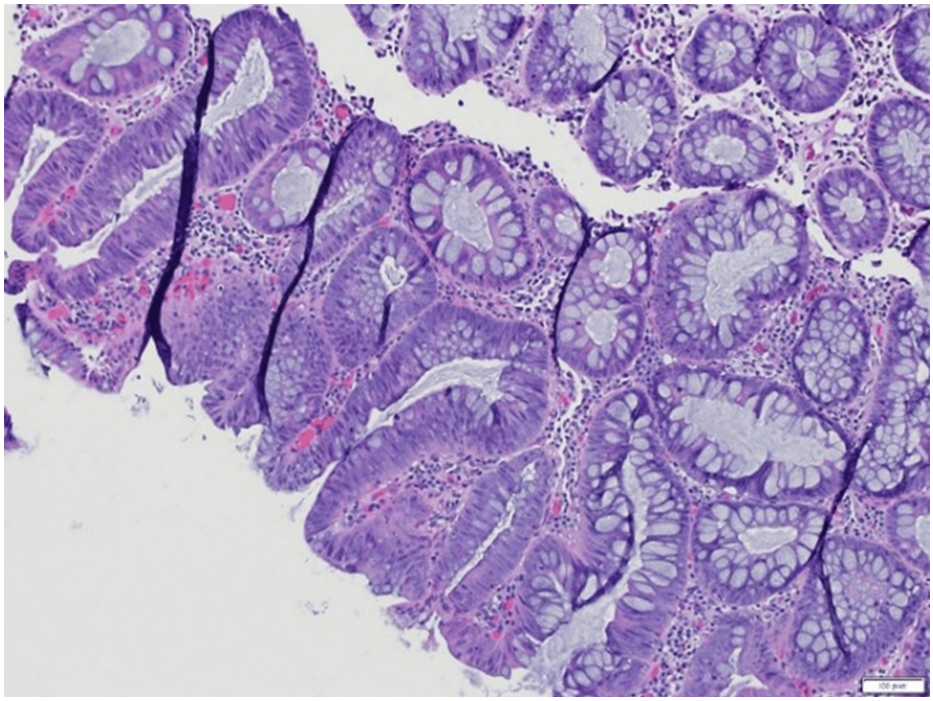

FIGURE 6: Tubular adenoma without high-grade dysplasia, transverse colon, from the 2014 index colonoscopy (H&E, original magnification ×20) (Case 4).

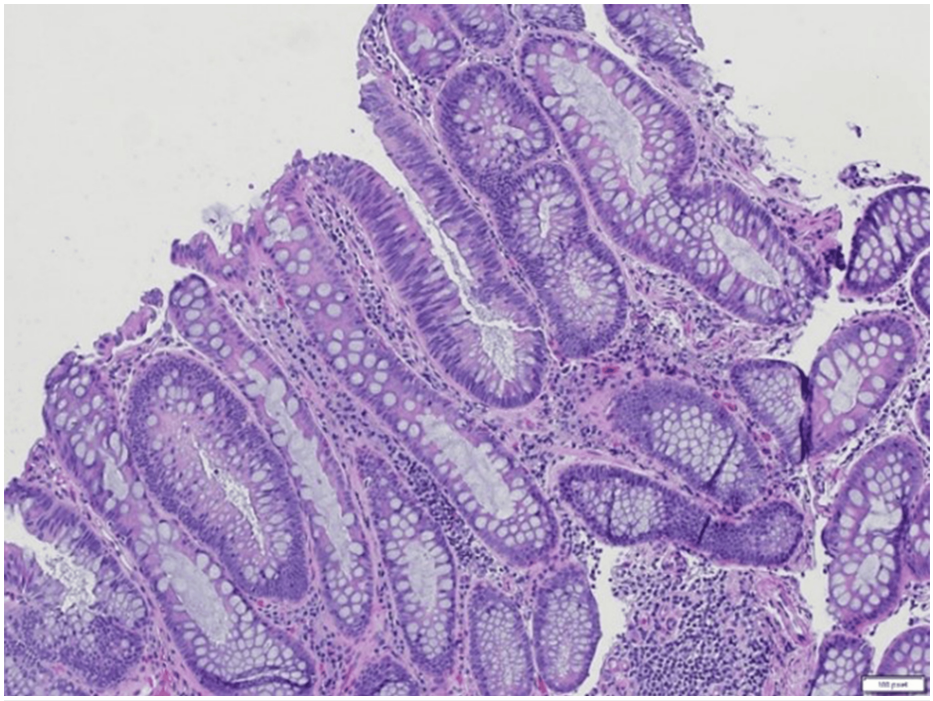

FIGURE 7: Second tubular adenoma without high-grade dysplasia, transverse colon, from the 2014 index colonoscopy (H&E, original magnification ×20) (Case 4).

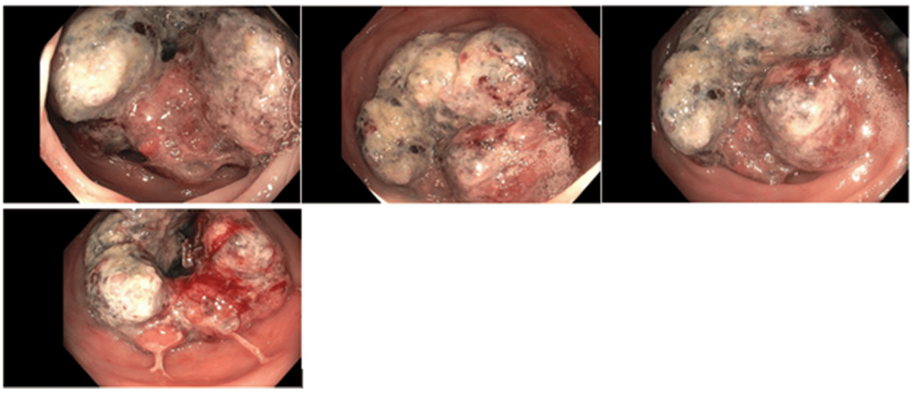

FIGURE 8: Endoscopic images of polypoid lesions in the transverse colon from repeat colonoscopy one month later; histology of the corresponding specimens showed tubular adenomas without villous features, high-grade dysplasia, or malignancy (Case 4).

Discussion

Taken together, these four cases show that the appropriateness of short-interval repeat colonoscopy cannot be judged from a patient's pathology history alone. Every patient had advanced neoplasia at some point, yet under each applicable guideline, a completely resected advanced adenoma warrants a three-year interval [1,13,14]. Whether a specific early repeat was justified therefore depended on information about the preceding examination, namely the indication, preparation quality, resection technique and completeness, and recommended interval, that was documented for only some examinations. Of the seven index-repeat pairs assessed, two were supported by documented inadequate preparation or poor visualization at the preceding examination and five were indeterminate; none could be classified as not clearly supported, because the documentation needed to exclude a guideline-recognized indication was unavailable (Table *2*). These counts describe the pairs reported here and are not estimates of the frequency of appropriate or low-value colonoscopy.

Surveillance guidelines emphasize risk stratification based on polyp size, histology, and examination quality, and the applicable guidance changed during the period covered by these cases. The 2006 guidance recommended 5-10 years after one or two small TAs and three years for 3-10 adenomas, an adenoma ⩾10 mm, villous features, or HGD [13]; the 2012 update retained a three-year interval for 3-10 adenomas and for advanced adenomas [14]; and the 2020 update lengthened the interval to 7-10 years for one or two TAs <10 mm and to 3-5 years for three or four [1]. Applying the 2020 intervals to earlier procedures would overstate the discordance of practice that was concordant at the time, which is why each pair in this series was assessed against the guidance then in effect (Table *2*).

Case 4 illustrates how examination-level review changes the interpretation of an apparently intensive surveillance pattern. Although most of his examinations showed only non-advanced TAs, the index colonoscopy showed two adenomas with HGD, one larger than 10 mm, and the repeat examination one month later identified a further HGD adenoma larger than 10 mm (Table *3*). Under the 2012 guidance in effect, completely resected advanced adenomas would warrant a three-year interval, whereas inadequate preparation or piecemeal or incomplete resection would support a much shorter one [13,14,17]. The detection of an additional large HGD adenoma at one month is consistent with an incomplete index examination, but this remains a hypothesis because preparation quality and resection completeness were not recorded for that examination. The subsequent intervals of three, five, and seven months followed examinations showing an HP or non-advanced TAs; they may reflect concern about earlier incomplete examinations, persistent symptoms, or clinician preference, and the case data do not allow these explanations to be distinguished.

Case 1 shows that post-polypectomy guidance is not the only relevant framework. After curative CRC resection, the USMSTF recommends colonoscopy one year after surgery (or after the clearing examination), followed by examinations after a further three years and then five years, and both the 2006 and 2016 post-resection guidance state that adenoma findings may indicate shorter intervals [15,16]. Her recurrent HGD, adenomas larger than 10 mm, documented poor preparation, and incomplete resections make a supporting indication plausible for several of her short intervals, but the qualifying nine-month pair could not be linked to a specific indication and was therefore classified as indeterminate.

Symptoms further complicate retrospective assessment. All four patients presented with GI symptoms, and Case 4 had ongoing symptoms recorded during follow-up. Post-polypectomy guidance sets surveillance intervals after polyp removal [1]; diagnostic colonoscopy for new or changing symptoms is a separate indication. Songtanin et al. found that new GI symptoms were one of four principal reasons for repeat colonoscopy within one year, and that 11 of 28 patients with no polyps at the index examination had new endoscopic findings at the repeat examination [12]. Their patient-level review, like ours, showed that early repeat examinations arise from heterogeneous indications that administrative data cannot separate. In Case 4, the timing, severity, and evolution of symptoms and any other investigations were not documented in the case data, so the short intervals could not be attributed to either a surveillance or a diagnostic indication.

Inadequate preparation was the only guideline-recognized short-interval indication that could be linked to a specific pair in this series (Cases 2 and 3). Up to 20%-25% of colonoscopies have inadequate bowel cleansing, and the USMSTF recommends repeat examination within one year when preparation is inadequate, with shorter intervals when advanced neoplasia is detected [17]. Fair bowel preparation has been associated with a 2.56-fold higher hazard of post-colonoscopy CRC death [8]. In both cases, however, preparation was described qualitatively rather than with a validated scale such as the BBPS [19]. Because some procedures predated widespread use of the BBPS, absence of a BBPS score should not be interpreted as absence of bowel preparation assessment. Nevertheless, a qualitative descriptor makes it difficult to distinguish preparation that was inadequate to detect lesions larger than 5 mm, which warrants early repeat examination [17], from preparation that was fair but adequate, which may not.

Under the guidance applicable to these cases, the circumstances that support repeat colonoscopy within approximately one year are inadequate bowel preparation, piecemeal resection of a large lesion (⩾20 mm in the 2020 guidance) or other concern for incomplete resection, more than 10 adenomas (one year in the 2020 guidance), and the first examination after CRC resection [1,13-17]. HGD is not among them when the lesion has been completely removed during a high-quality examination; it warrants a three-year interval [1,14]. Recording, for each examination, the indication, a validated preparation score, cecal intubation, withdrawal time, the number, size, location, and morphology of lesions, the resection technique and completeness, and the recommended interval with its rationale would allow clinicians and quality programs to determine whether an early repeat meets one of these criteria [5,17].

African American patients experience disproportionately higher CRC incidence and mortality [9], which motivated our focus on this population. However, this series included no comparison group and was not designed to assess whether race influenced surveillance recommendations or the threshold for repeat colonoscopy, and these observations should not be interpreted as evidence of racial differences in surveillance practice.

These observations are consistent with broader evidence that surveillance practice diverges from guidance in

both directions [2,3]. In a prospective observational analysis comparing endoscopist recommendations with the 2012 and 2020 USMSTF guidance, adherence was lower for recommendations made under the 2020 guidance, for both low-risk and high-risk adenomas, and recommended intervals were more often shorter than advised [20]. Our cases suggest a complementary problem: even when an early repeat may have been appropriate, the reason was often not recorded in a way that allowed later verification.

This series has important limitations. The four patients were drawn from a small, non-systematic institutional review rather than a defined population, so selection bias is likely, and no denominator of eligible patients or procedures was available; the findings therefore cannot estimate the prevalence of short-interval or low-value colonoscopy. Examination-level documentation of preparation quality (including BBPS scores), withdrawal time, resection technique and completeness, endoscopist, and recommended interval was incomplete; outside procedural records were not consistently available, and complete examination-level timelines could be presented only for Case 4. Procedures spanned more than a decade and three generations of surveillance guidance, and assessments relied on documentation that was not created for this purpose. No comparison group was included, interval cancers were not systematically ascertained, and no causal inferences can be drawn about the drivers of repeat colonoscopy.

Conclusions

In this descriptive series of four African American patients, the appropriateness of short-interval repeat colonoscopy could not be determined from pathology risk alone. Assessment required the indication, preparation quality, resection technique and completeness, and recommended interval for the specific preceding examination, and incomplete documentation of these elements left most index-repeat pairs indeterminate. Standardized examination-level documentation may improve both surveillance decisions and the ability to evaluate them. Because the cases were selected and no comparison group was included, this series cannot estimate the frequency of low-value colonoscopy or assess racial differences in surveillance practice.

Additional Information

Author Contributions

All authors have reviewed the final version to be published and agreed to be accountable for all aspects of the work.

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Acquisition, analysis, or interpretation of data: Hassan Ashktorab, Rabia Zafar, Babak Shokrani, Hassan Brim, Ali Ramadan, Zaki Sherif

Critical review of the manuscript for important intellectual content: Hassan Ashktorab, Hassan Brim, Ali Ramadan, Zaki Sherif, Adeyinka Laiyemo

Drafting of the manuscript: Rabia Zafar, Babak Shokrani, Hassan Brim, Wardah Bajwa, Muhammad Ahmad Imran, Somtochukwu Abazu

Disclosures

Human subjects: Informed consent for treatment and open access publication was obtained or waived by all participants in this study. Howard University Institutional Review Board issued approval 12-CMED-76. **Conflicts of interest:** In compliance with the ICMJE uniform disclosure form, all authors declare the following: **Payment/services info:** All authors have declared that no financial support was received from any organization for the submitted work. **Financial relationships:** All authors have declared that they have no financial relationships at present or within the previous three years with any organizations that might have an interest in the submitted work. **Other relationships:** All authors have declared that there are no other relationships or activities that could appear to have influenced the submitted work.

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