statistical analyses were performed using SAS version 9.4. \( P \) values were 2-sided, and \( P \) values of <.05 were considered statistically significant.

In the cohort, 39,346 patients were included; 2003 had CRC, of whom 445 had advanced stage CRC. The majority completed the diagnostic colonoscopy within 3 months. The overall prevalence rates for any adenoma, advanced adenoma, any CRC, and advanced CRC were 47.6\%, 13.9\%, 5.5\%, and 1.1\%, respectively. The prevalence rate for any CRC at 1–3 months was 50 per 1000 patients, at 6–9 months was 68 per 1000 patients, at 9–12 months was 74 per 1000 patients, and >12 months was 98 per 1000 patients, demonstrating significantly increasing rates when colonoscopy was delayed by >6 months. Risk factors associated with the development of CRC were older age, male sex, first screening, and higher fecal hemoglobin concentration. Notably, 59,783 patients did not undergo diagnostic colonoscopy after their positive FIT result. Among them, 2485 cases of CRC and 1124 cases of advanced stage CRC were reported.

The authors concluded that patients who waited >6 months to have a diagnostic colonoscopy after a positive FIT had a higher risk of having any CRC or advanced stage CRC.

Comment. Obtaining a timely diagnostic colonoscopy after a positive FIT test is a vital step in the screening process. European guidelines recommend performing the diagnostic colonoscopy within 1 month of a positive FIT result (Endoscopy 2012;44[Suppl 3]:SE88–105), whereas Canadian Guidelines recommend it being performed within 2 months (Can J Gastroenterol 2006;20:411–423). There are currently no United States guidelines specifying the time within which a diagnostic colonoscopy should be performed. This may be due to the varying evidence showing when patients may begin to be at an increased risk for CRC after a positive result. For example, in the study performed by Corley et al, patients who obtained a diagnostic colonoscopy after 10 months from their positive FIT result had higher CRC risk compared with the baseline of 8–30 days (JAMA 2017;317:1631–1641). Although the time points are different, both the current study and the Corley study showed that after a certain time has passed from the point of the positive FIT result, the risk for having CRC and possibly advanced stage disease begins to increase. Practitioners must be aware of these risks and should facilitate timely referrals.

A sizeable number of patients in this study did not undergo colonoscopy after their positive FIT result. The cause for this was not reported. Other studies investigating the barriers to obtaining a diagnostic colonoscopy after a positive FIT have included patient, physician, and systemic factors (Am J Med 2017;130:93.e1–e7). May et al reported on patient barriers to screening, stating that the most common reason their population did not obtain a diagnostic colonoscopy was patient refusal of the procedure (Clin Gastroenterol Hepatol 2019;17:469–476). Another study correlated low patient comprehension of the necessity to have a diagnostic colonoscopy after a positive FIT to poor adherence (Cancer Control 2019;26:1073274819825828). As for physician barriers, Issaka’s study reported that 13% of FIT positive patients were not referred to gastroenterology and of these 49% lacked documentation that addressed their abnormal result (Am J Gastroenterol 2017;112:375–382). The implementation of system-level strategies that address barriers to diagnostic colonoscopy follow up has had a good impact, namely tracking FIT-positive patients and early telephone contact for direct scheduling (Clin Transl Gastroenterol 2019;10:e00010). Although we do not know why some patients in the current study failed to undergo a diagnostic colonoscopy, the data revealed that patients will remain at risk for CRC and advanced stage CRC over time.

Limitations of the study included confounding factors that were not able to be evaluated in the study, such as smoking and possible inclusion of symptomatic patients. In addition, the authors were not able to assess whether those who had a high risk of CRC were associated with higher mortality.

In conclusion, screening for CRC via FIT is a highly effective method that is contingent on following up a positive result with a diagnostic colonoscopy. As shown in this study, the longer a patient waits to get this done, the greater the risk for any CRC and advanced CRC, especially after 6 months. Ensuring that all of the steps necessary in the screening process are completed in a timely manner should be a priority among patients as well as physicians.

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**REVIEWER RATING**

| Coverage of relevant topics | ★★★★★ |
| Improvement over previously available media | ★★★★  |
| Style of presentation and formatting | ★★★★  |
| Quality of figures | ★★★★  |
| Overall | ★★★★  |
Professors Wallace, Fockens, and Sung have recently published their third edition textbook in gastrointestinal endoscopy entitled, *Gastroenterological Endoscopy*. In collaboration with Thieme Publishers, the editors have expanded upon the two previous editions published by the founding editors, Professors Classen, Tytgat, and Lightdale. For those unfamiliar with this book, it is unlike any other in the field of endoscopy. This enormously comprehensive text (with multiple videos accompanying several of the chapters) clearly achieves its goal of literally tackling everything endoscopy. First, the book’s team of associate editors is represented by the world’s masters in gastrointestinal endoscopy, including Todd Baron, Nick Shaheen, Michael Bourke, Nagy Reddy, and the late Lauren Gerson. Individual chapters call on the expertise of >75 contributing authors from around the globe, most of whom are internationally recognized champions in the field.

Although the table of contents is officially broken down into seven separate sections, *Gastroenterological Endoscopy* is essentially comprised of 3 main themes: (1) the patient and endoscopy, (2) procedures and techniques, and (3) gastrointestinal disease states. One of the most interesting aspects of the book is the first section on patients and endoscopy. This area addresses several unique topics that are seldom covered in books of this nature. Examples include chapters on endoscopy suite design, scope disinfection, quality assurance in endoscopy, anticoagulation, and endoscopic complications. Next, the text dives into the nitty gritty of specific endoscopic procedures and techniques, both diagnostic and therapeutic. For example, in the chapter on deep enteroscopy (co-authored by Yamamoto himself), there is initially an in-depth discussion on the anatomic characteristics of the small intestine and the principals of device-assisted examinations. Together with well-depicted diagrams, the chapter covers the various techniques of single-balloon, double-balloon, and spiral enteroscopy. Up-to-date references support the subsections on the various indications for deep enteroscopy, training requirements, and the necessary accessory devices including the role of fluoroscopy.

The third main theme of *Gastroenterological Endoscopy* focuses on various disease states and the impact of endoscopy on the management of such conditions. This is the largest area of the textbook, and it is divided into three sections: upper GI tract diseases, lower GI tract diseases, and hepatobiliary and pancreatic disorders. It is within these sections of the book in which it truly comes to life by using >750 high-definition endoscopic, histologic, and radiographic images supporting its chapters. The chapters themselves are astonishingly comprehensive and robust, and in most cases seem to cover every nook and cranny of the specific topic. For example, in the chapter on endoscopic resection of advanced colorectal polyps, the authors address morphology and classification, endoscopic mucosal resection versus endoscopic submucosal dissection based on location and morphology, post-resection bleeding, and the management of lesion recurrence. Again, all areas are supported by updated and balanced references.

Last, if you thought a textbook in endoscopy would not be fluid enough to address the era of third space endoscopy and the use of novel devices that create new procedures (eg, lumen-appropping metal stents), you were wrong. The history of natural orifice translumenal endoscopic surgery, the indications for peroral endoscopic myotomy, the use of hybrid laparoscopic-endoscopic procedures, and the expansion of submucosal tunneling endoscopic resection, and endoscopic full-thickness resection are all covered, each with its own high-definition endoscopic imagery and supporting data. This is one of the most impressive aspects of the book. There is truly no stone unturned, and it leaves the reader feeling content in his learning (and with his purchase).

**Bottom Line:** I found *Gastroenterological Endoscopy* to be a winner, and a wonderful addition to one’s library of gastroenterological texts. In my opinion, it surpasses previously published endoscopy books because of its unparalleled breath of coverage, and the extent to which it explores each of the individual topics. The endoscopic images, tables, and diagrams within this book are second to none. Unlike most textbooks, this one will not sit on your shelf.

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