LA SORVEGLIANZA ENDOSCOPICA NELLO SCREENING - NUOVE CONSIDERAZIONI

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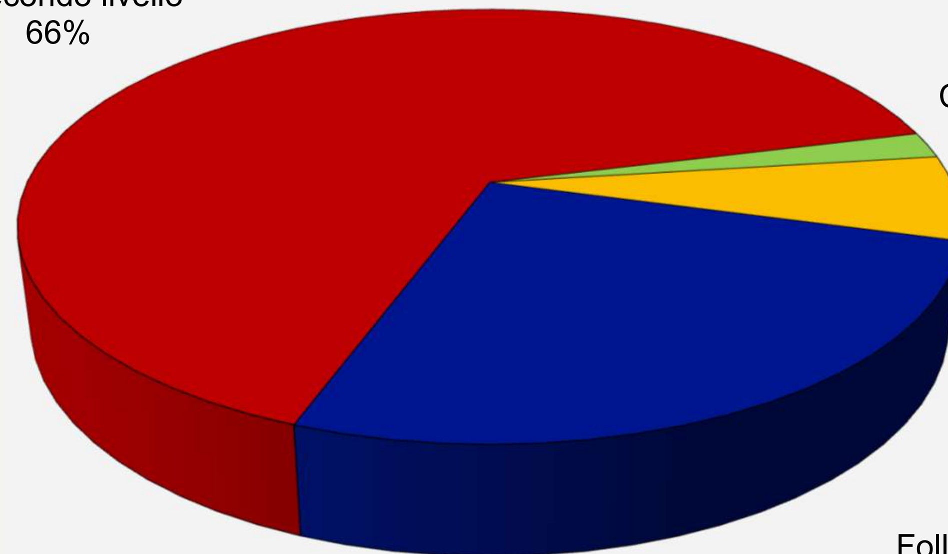
TIPOLOGIA DI ESAME – COLONSCOPIE DI SCREENING – PIEMONTE 2018



Appropriateness of endoscopic surveillance recommendations in organised colorectal cancer screening programmes based on the faecal immunochemical test

Zorzi M, *et al. Gut* 2015;**0**:1–7. doi:10.1136/gutjnl-2015-310139

Diagnosis	Recommended TC	Expected TC according to EU GL	Difference
Negative/non-adenomatous polyp	1,818	0	+1,818
Low-risk adenoma	5,146	0	+5,146
Intermediate-risk adenoma	8,444	8,694	-250
High-risk adenoma	2,452	2,470	-18
Total	17,860	11,164	+6,696 (36%)

Appropriateness of endoscopic surveillance recommendations in organised colorectal cancer screening programmes based on the faecal immunochemical test

Manuel Zorzi [1], Carlo Senore [2], Anna Turrin [3], Paola Mantellini [4], Carmen Beatriz Visioli [4], Carlo Naldoni [5], Priscilla Sassoli de' Bianchi [5], Chiara Fedato [3], Emanuela Anghinoni [6], Marco Zappa [4], Cesare Hassan [7], the Italian colorectal cancer screening survey group

Conclusions In organised screening programmes, a high rate of inappropriate recommendations for patients with low risk or no adenomas occurs, affecting the demand for endoscopic surveillance by a third.

UTILIZATION OF COLONOSCOPY AFTER SCREENING

	Surveillance in 5 yrs	≥2 Surveillance in 7 yrs
Advanced Adenoma (n = 1342)	58.4%	33.2%
≥ 3 non-advanced adenomas (n = 177)	57.5%	26.9%
1-2 non-advanced adenomas (n = 905)	46.7%	18.2%
No adenomas	26.5%	10.4%

Schoen et al; Gastroenterol 2010; 138: 73–81

POST-POLYPECTOMY SURVEILLANCE COLONOSCOPY: ARE WE FOLLOWING THE GUIDELINES?

ABU FREHA N ET AL. INT J COLRECTAL DIS 2020

After carefully examining the collective responses (n = 866), it was noted that

- 37.2% specified a shorter time interval for follow-up colonoscopy,
- 5.4% recommended a longer one,
- in only 57.4% was the time interval for repeat examination compatible with the clinical guidelines.

FREQUENCY OF ANTICIPATED OR UNNECESSARY RECALLS AFTER SCREENING COLONOSCOPY

- Italy → around 30% (Zorzi et al. 2016)
- Canada → 46% (Schreuders et al, 2013)
- Usa → 34% (Johnson et al, 2013)

Predictive factors for early recall (Usa):

-hyperplastic/HR adenomatous polyps

-comorbidity score

-suboptimal preparation

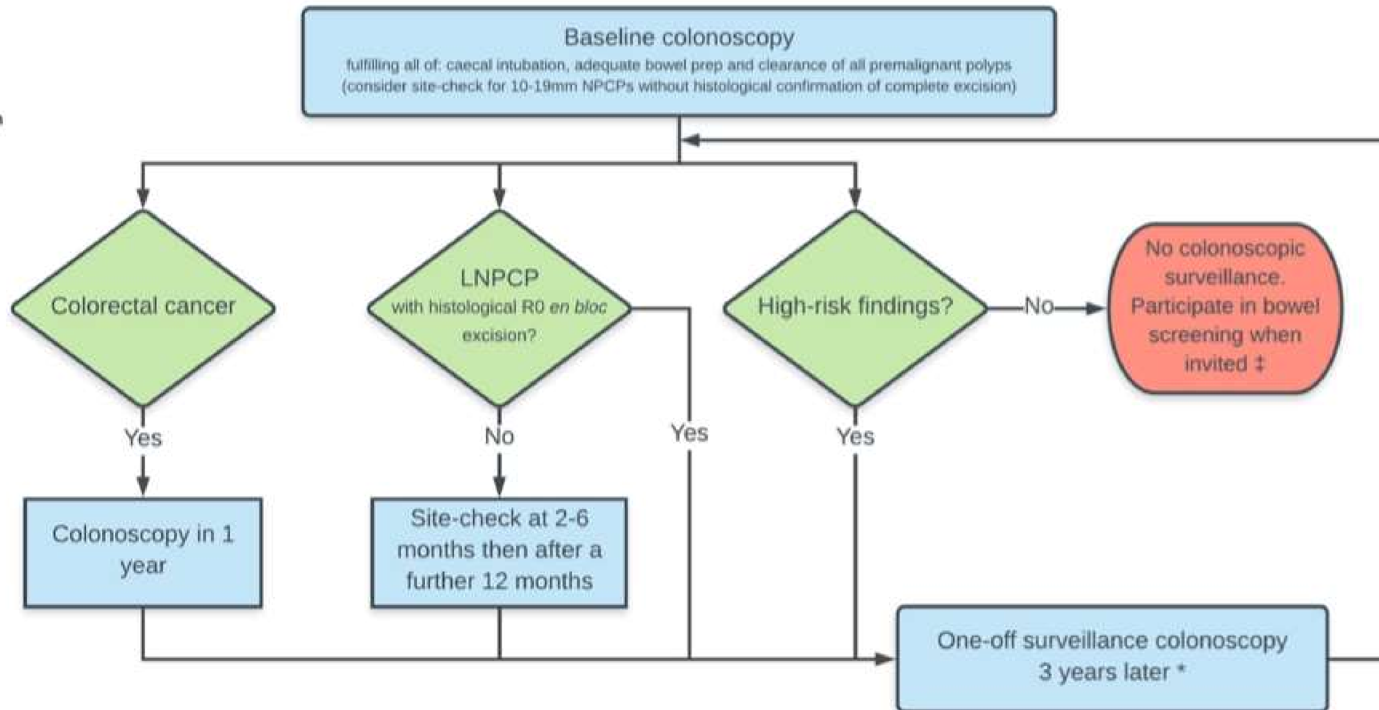
-family history

-geographic variability

CRITICITÀ PIÙ FREQUENTI NELLE RACCOMANDAZIONI DI SORVEGLIANZA (WORKSHOP REGIONE PIEMONTE 2019)

- Alto rischio (Biella-Vercelli; Torino 3; Cuneo; Novara (intervalli troppo allungati) (piccoli numeri)
- Rischio intermedio (Alessandria; Ivrea) (intervalli troppo ravvicinati)
- Normali/Basso rischio (Asti; Torino 2 (Moncalieri); Torino città) (troppi invii a colonscopia a diversi intervalli di tempo)
- Gli invii a chirurgia per lesioni non maligne meritano una riflessione (errori di compilazione?)

BSG/PHE/ACPGBI Guidelines for Post-polypectomy and Post-cancer-resection Surveillance



High-risk findings

- **≥2 premalignant polyps including ≥1 advanced colorectal polyp; or**
- **≥5 premalignant polyps**

Definitions:

- *Serrated polyps: umbrella term for hyperplastic polyps, sessile serrated lesions, traditional serrated adenomas and mixed polyps*
- *Premalignant polyps: serrated polyps (excluding diminutive [1-5mm] rectal hyperplastic polyps) and adenomatous polyps*
- *Advanced colorectal polyps: serrated polyp ≥10mm, serrated polyp with dysplasia, adenoma ≥10mm, adenoma with high-grade dysplasia*
- *(L)NPCP: (Large; ≥20mm) non-pedunculated colorectal polyp*

Exceptions

* In general, we recommend no surveillance if life-expectancy <10y or if older than about 75y

‡ If patient is >10y younger than lower screening age and has polyps but no high-risk findings, consider colonoscopy at 5 or 10y

Refer to BSG hereditary CRC guidelines if:

Family history (FH) of colorectal cancer (CRC):
- 1 first-degree relative (FDR) diagnosed with CRC <50y, or
- 2 FDRs diagnosed with CRC at any age

Personal history of CRC
- <50y
- any age, who also has FDR with CRC at any age

Personal history of multiple adenomas:
- <60y with lifetime total ≥10 adenomas; or
- ≥60y with lifetime total ≥20 adenomas, or ≥10 + FH CRC/polyposis

Known/suspected inherited CRC predisposition syndromes including
- Lynch Syndrome or other polyposis syndrome
- Serrated Polyposis Syndrome:
  - ≥5 serrated polyps ≥5mm prox to rectum, with ≥2 of ≥10mm; or
  - ≥20 serrated polyps (any size) including ≥5 prox to rectum

Rutter et al., Gut 2020

HIGH-RISK FINDINGS

- >/= 2 premalignants polyps including >/= 1 advanced CR polyp

OR

- >/= 5 premalignant polyps

DEFINITIONS

- Serrated polyps → umbrella term for: hyperplastic polyps; sessile serrated lesions; traditional serrated adenomas; mixed polyps
- Premalignant polyps → serrated polyps (excluding diminutive [1-5 mm] rectal hyperplastic polyps); adenomatous polyps
- Advanced CR polyps → serrated polyps >/= 10 mm; serrated polyps with dysplasia; adenoma >/= 10 mm; adenomas with HGD
- LNPCP → Large (>/= 20 mm) non pedunculated <CR polyps

Gastroenterology 2020;158:1131–1153

Recommendations for Follow-Up After Colonoscopy and Polypectomy: A Consensus Update by the US Multi-Society Task Force on Colorectal Cancer

Samir Gupta,[1,2,3] David Lieberman,[4] Joseph C. Anderson,[5,6,7] Carol A. Burke,[8] Jason A. Dominitz,[9,10] Tonya Kaltenbach,[11,12] Douglas J. Robertson,[5,6] Aasma Shaukat,[13,14] Sapna Syngal,[15,16] and Douglas K. Rex[17]

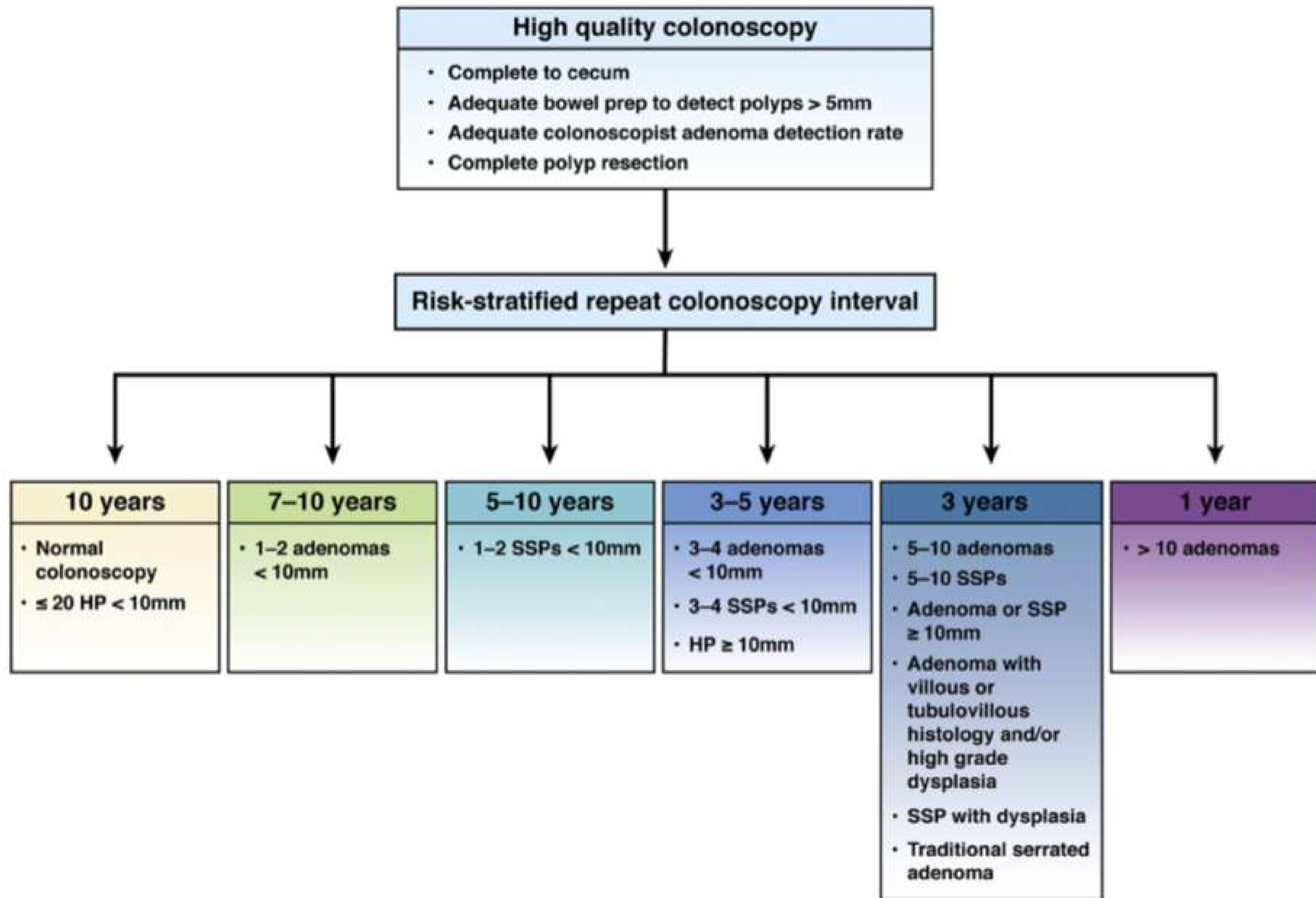

High quality colonoscopy
• Complete to cecum
• Adequate bowel prep to detect polyps > 5mm
• Adequate colonoscopist adenoma detection rate
• Complete polyp resection
Risk-stratified repeat colonoscopy interval
10 years
• Normal colonoscopy
• ≤ 20 HP < 10mm
7–10 years
• 1–2 adenomas < 10mm
5–10 years
• 1–2 SSPs < 10mm
3–5 years
• 3–4 adenomas < 10mm
• 3–4 SSPs < 10mm
• HP ≥ 10mm
3 years
• 5–10 adenomas
• 5–10 SSPs
• Adenoma or SSP ≥ 10mm
• Adenoma with villous or tubulovillous histology and/or high grade dysplasia
• SSP with dysplasia
• Traditional serrated adenoma
1 year
• > 10 adenomas

Table 9. Key Updates Since 2012 Recommendations Provided in the 2019 US Multi-Society Task Force Recommendations for Follow-Up After Colonoscopy and Polypectomy

- New evidence based on risk of colorectal cancer outcomes, rather than based only on risk of advanced adenoma during surveillance, is provided to strengthen polyp surveillance recommendations
- 7- to 10-y rather than 5- to 10-y follow-up is recommended after removal of 1–2 tubular adenomas <10 mm in size (Table 4)
- More detailed recommendations for follow-up after removal of serrated polyps have been provided (Table 5)
- Importance of high-quality baseline examination has been emphasized
- 1 y rather than <3-y follow-up is recommended after removal of >10 adenomas
- Option to recommend 3–5 y instead of 3-y follow-up after removal of 3–4 adenomas <10 mm in size

Post-polypectomy colonoscopy surveillance: European Society of Gastrointestinal Endoscopy (ESGE) Guideline - Update 2020

Authors: Cesare Hassan, Giulio Antonelli, Jean-Marc Dumonceau, Jaroslaw Regula, Michael Bretthauer, Stanislas Chaussade, Evelien Dekker, Monika Ferlitsch, Antonio Gimeno-Garcia, Rodrigo Jover, Mette Kalager, Maria Pellisé, Christian Pox, Luigi Ricciardiello, Matthew Rutter, Lise Mørkved Helsingen, Arne Bleijenberg, Carlo Senore, Jeanin E. van Hooft, Mario Dinis-Ribeiro, Enrique Quintero

MAIN RECOMMENDATIONS

The following recommendations for post-polypectomy colonoscopic surveillance apply to all patients who had one or more polyps that were completely removed during a high quality baseline colonoscopy.

1 ESGE recommends that patients with complete removal of 1 – 4 < 10 mm adenomas with low grade dysplasia, irrespective of villous components, or any serrated polyp < 10mm without dysplasia do not require endoscopic surveillance and should be returned to screening.
Strong recommendation, moderate quality evidence.

If organized screening is not available, repetition of colonoscopy 10 years after the index procedure is recommended.
Strong recommendation, moderate quality evidence.

2 ESGE recommends surveillance colonoscopy after 3 years for patients with complete removal of at least 1 adenoma ≥ 10mm or with high grade dysplasia, or ≥5 adenomas, or any serrated polyp ≥ 10mm or with dysplasia.
Strong recommendation, moderate quality evidence.

3 ESGE recommends a 3 – 6-month early repeat colonoscopy following piecemeal endoscopic resection of polyps ≥ 20mm.
Strong recommendation, moderate quality evidence.

A first surveillance colonoscopy 12 months after the repeat colonoscopy is recommended to detect late recurrence. Strong recommendation, high quality evidence.

4 If no polyps requiring surveillance are detected at the first surveillance colonoscopy, ESGE suggests to perform a second surveillance colonoscopy after 5 years. Weak recommendation, low quality evidence. After that, if no polyps requiring surveillance are detected, patients can be returned to screening.

5 ESGE suggests that, if polyps requiring surveillance are detected at first or subsequent surveillance examinations, surveillance colonoscopy may be performed at 3 years.
Weak recommendation, low quality evidence.

DOI https://doi.org/10.1055/a-1185-3109
Published online: 22.6.2020 | Endoscopy 2020; 52
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View full guideline

Clinical Gastroenterology and Hepatology 2021;19:1410–1417

Impact of SARS-CoV-2 Pandemic on Colorectal Cancer Screening Delay: Effect on Stage Shift and Increased Mortality

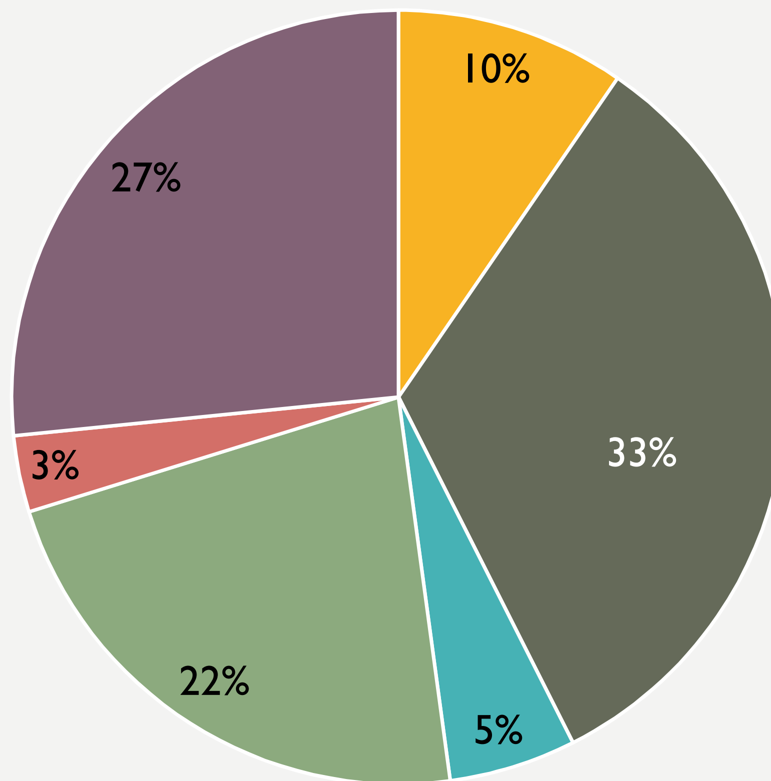
Luigi Ricciardiello,[*,**,a,b] Clarissa Ferrari,[‡,a] Michela Cameletti,[§,a] Federica Gaianill,[‡‡] Francesco Buttitta,[*,**] Franco Bazzoli,[*,**] Gian Luigi de'Angelis,[||,‡‡] Alberto Malesci,[¶] and Luigi Laghi[||,#,a,b]

CONCLUSIONS: Screening delays beyond 4-6 months would significantly increase advanced CRC cases, and also mortality if lasting beyond 12 months. Our data highlight the need to reorganize efforts against high-impact diseases such as CRC, considering possible future waves of SARS-CoV-2 or other pandemics.

PROGRAMMA DI REVISIONE DEI FOLLOW-UP OSPEDALE SANTA CROCE - CUNEO

- Invio da parte del centro screening dei casi programmati durante l'anno 2021
- Controllo delle schede endoscopiche e istologiche sia sul gestionale dello screening che sul programma ospedaliero di refertazione endoscopica
- Attribuzione del nuovo intervallo di sorveglianza sulla base delle più recenti linee-guida
- Comunicazione al centro screening delle modifiche, con le relative priorità
- Durante i mesi dell'inverno 2020/2021 sospese le endoscopie di sorveglianza; successivamente inserimento di 2 follow-up alla settimana
- Data priorità assoluta ai casi di controllo a 2-6 mesi post-EMR con tecnica piece-meal

NUOVA ATTRIBUZIONE DEGLI INTERVALLI DI SORVEGLIANZA



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I semestre 2021 · II semestre 2021 · ripetizioni per scarsa preparazione · no FU · record inadeguati · 2022-2025

PROGRAMMA DI REVISIONE DEI FOLLOW-UP OSPEDALE SANTA CROCE – CUNEO - CRITICITA'

- Difficoltà nel far coincidere la nuova prescrizione con quella indicata nella lettera di invito, soprattutto nei primi tempi (grande numero di persone su tempi relativamente stretti) (problemi di immagine del programma di screening)
- Problemi nel gestire le telefonate a scopo di chiarimento
- Necessità di giocare d'anticipo nella gestione delle liste
- Difficoltà nel creare «proselitismo» negli altri centri

CONSIDERAZIONI CONCLUSIVE (WORKSHOP REGIONE PIEMONTE 2019-2020-2021)

- C'è ancora molto da lavorare per ottimizzare gli intervalli di sorveglianza post-colonscopia di screening
- Non vi è una categoria di pazienti a maggior rischio di «errore» nelle raccomandazioni per i successivi controlli
- I punti cruciali su cui ragionare nel prossimo futuro sono:

  * i bassi rischi (no endoscopia!)

  * i rischi intermedi (maggior lassità nella sorveglianza),

  * gli adenomi tubulo-villosi (maggior lassità nella sorveglianza)

  * La gestione del follow-up nei casi con polipi voluminosi (20 mm)

  * i T1 da sorvegliare a un anno

  - il grado di rischio delle lesioni rimosse in sigmoidoscopia da tener presente nel consigliare il F/U post-colonscopia totale
  - Il follow-up dei polipi persi
  - Il follow-up del follow-up

Grazie dell'attenzione