



VIII CONGRESSO NAZIONALE GISCoR

WORKSHOP SCREENING CCR REGIONE LAZIO



ROMA, 3 E 4 OTTOBRE 2013
Auditorium Antonianum, Viale Manzoni 1

GLI ESITI DELLA CHIRURGIA



Francesco Bianco

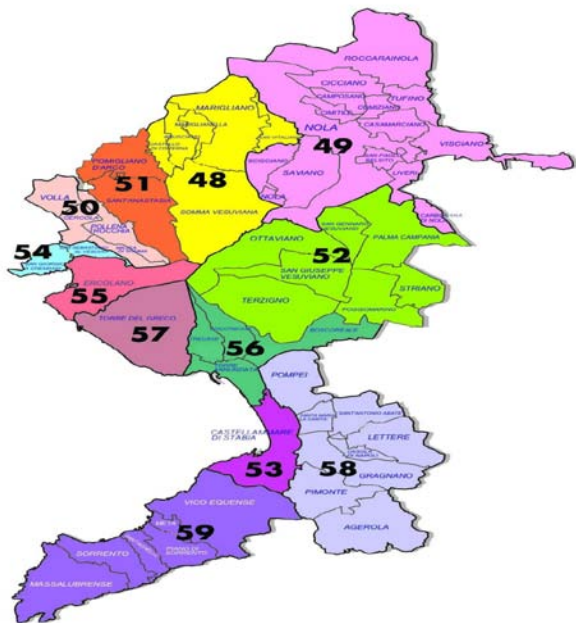


PREVENZIONE DEL CA DEL COLON RETTO

Il territorio della ASL Napoli 3 Sud
conta 56 Comuni (area nord est).

La popolazione ammonta a 1.012.304
abitanti.

La popolazione target (50-74 anni) è
costituita da 282.597 unità con un target
annuale di 141.298 unità.



Risultati 2010-2012

Distretti 48-49-50-51-52-54-59

regione campania
aslnapoli3sud

 Istituto Nazionale Tumori
Fondazione G. Pascale

47.306
Kit consegnati

Soggetti che hanno eseguito il
SOF 35.002 (74%)

SOF Positivi
2348 (6,7%)

Risultati 2010-2012

da SOF

Distretti 48-49-50-51-52-54-59

SOF+ 2348

Colonscopie già effettuate 1666

**Lesioni
precancerose
843**

**Adenomi
avanzati
384**

**Cancri
100**

Pazienti screening 2010-2012

(FOBT IN ETA' TRA 50 E 74 ANNI
POPOLAZIONE GENERALE)

<u>TOTALE CANCRI</u>	100	DR 2,8 ‰
<u>TOTALE ADENOMI AVANZATI</u>	384	DR 11 ‰
<u>Vpp fobt per Ca+Adenoma</u>		29,0 ‰

DEFINIZIONI

DR CANCRI = (n°pers. Con diagnosi di cancro identificati dallo screening/n°pers. Sottoposte a screening)*1000

Val. accettabile > 2 ‰ Val. desiderabile > 2,5 ‰

DR ADENOMI AV. = (n°pers. Con diagnosi di adenoma avanzato identificati dallo screening/n°pers. Sottoposte a screening)*1000

Val. accettabile > 7,5 ‰ Val. desiderabile > 10 ‰

Vpp fobt = (n°pers. Con diagnosi di Ca+Adenoma avanzato/ n°pers. Che hanno eseguito colonscopia di approfondimento)*100

Esame accettabile > 25% desiderabile > 30%

ADENOMA AVANZATO: >10mm /componente villosa > 20%/displasia di alto grado

PROGRAMMA DI SCREENING DEL CA DEL COLON RETTO

Protocollo di convenzione delle attività clinico-scientifiche del centro di terzo livello per lo screening delle neoplasie colo-rettali

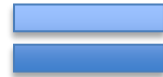
regione campania
aslnapoli3sud

Responsabile: R. Palombino



Istituto Nazionale Tumori
Fondazione G. Pascale

Responsabile: F. Bianco



MODELLO
INTERAZIENDALE

Elective resection of colon cancer by high-volume surgeons is associated with decreased morbidity and mortality.

A total of 54,000 patients underwent resection of colon cancer by 7,313 surgeons in 1,398 hospitals.

CLASSIFICATION:

SURGEON CASE-LOAD	PROCEDURE N°
Low volume	≤4/year
Intermediate volume	5-9/year
High volume	≥10/year

HOSPITAL CASE-LOAD	PROCEDURE N°
Low volume	≤30/year
Intermediate volume	31-60/year
High volume	≥61/year

In patients undergoing elective resection of colon cancer, procedures done by high-volume surgeons are associated with decreased morbidity and mortality.

Hospital volume can serve as a surrogate for surgeon volume for achieving excellent outcomes in colorectal resection.

SURGEON CASE-LOAD	PROCEDURE N°
Low volume	≤5/year
Intermediate volume	5-10/year
High volume	>10/year

HOSPITAL CASE-LOAD	PROCEDURE N°
Low volume	<40/year
Intermediate volume	40-70/year
High volume	≥70/year

Medium-volume surgeons achieved excellent outcomes similar to high-volume surgeons when operating in medium-volume or high-volume hospitals, but not in low-volume hospitals.

The results of low-volume surgeons improved with increasing hospital volume but never equaled those of the high-volume surgeons.

Memorial Sloan-Kettering Cancer Center. New York
Hospital and Surgeon Procedure Volume as

Predictors of **Outcome** Following
Rectal Cancer Resection

420 hospitals 1141 surgeons

SURGEON CASE-LOAD	PROCEDURE N°
Very low vol	1/5 years
Low volume	2/5 years
Intermediate volume	3-5/5 years
High volume	6-26/5 years

HOSPITAL CASE-LOAD	PROCEDURE N°
Very low vol	1-5/5 years
Low volume	6-11/5 years
Intermediate volume	12-20/5 years
High volume	21-57/5 years

Conclusions

Surgeon-specific experience as measured by **procedure volume** can have a significant impact on survival for patients with **rectal cancer**.

Cochrane Database Syst Rev. 2012

- Overall five year survival was significantly improved for patients with colorectal cancer treated in high-volume hospitals , by high-volume surgeons and colorectal specialists .
- The volume-outcome relationship appears somewhat stronger for the individual surgeon than for the hospital.
- There were discrepancies in the definitions of caseload and colorectal specialist
- There were differences between US and non-US data, suggesting provider variability at hospital level between different countries, making it imperative that every country or healthcare system must establish audit systems to guide changes in the service provision based on local data, and facilitate centralisation of services as required.

D. Archampong, D. Borowski, et al. **Workload and surgeon's specialty for outcome after colorectal cancer surgery.** Cochrane Database Syst Rev. 2012 Mar 14;3:CD005391.

CRITERI DI QUALITA'

Organizzativi

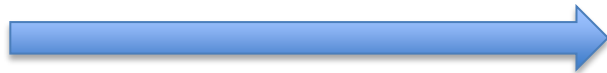
- Lista di attesa trasparente ✓
- Rapporti funzionali con servizi di endoscopia ✓
- *Percorso diagnostico terapeutico integrato* ✓

Indicatori dell'intervento

- *n.ro di linfonodi prelevati (>12)* ✓
- % di reintervento entro 30 giorni ✓
- n.ro di recidive in base allo stadio ✓

Per il retto extraperitoneale

- % dei Pz sottoposti a terapia neoadiuvante ✓
- % di addomino perineali ✓
- numero di pazienti con infiltrazione del margine radiale del meso retto ✓
- *numero di linfonodi prelevati (>12)* ✓
- numero di recidive in base allo stadio ✓



Tailored Therapy

Classi di pazienti per problematiche emergenti



Trattamento chirurgico colo-rettale ordinario

HOT TOPIC

Eventuale indicazione a
terapia neoadiuvante

Chirurgia oncologica
radicale con legatura dei
vasi all'origine

Corretta stadiazione

Escissione completa del
mesoretto nei tumori del
retto

Esame anatomopatologico
adeguato



1

Paziente borderline per trattamento endoscopico o chirurgico



- “Second opinion” anatomopatologica
- Valutazione multidisciplinare endoscopica/chirurgica (sincroni)
- Invio a centri dedicati

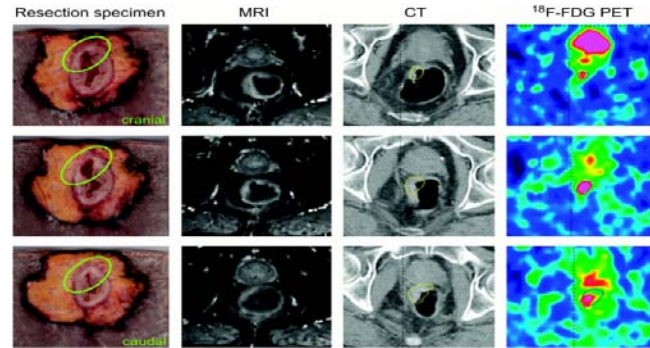
2

Pz borderline per trattamento chirurgico radicale laparotomico o per trattamento chirurgico per via transanale con stretto follow-up



E' necessario un accurato studio preoperatorio e follow-up in centri dove siano presenti esperti del settore di

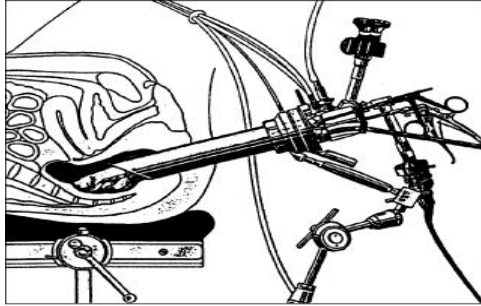
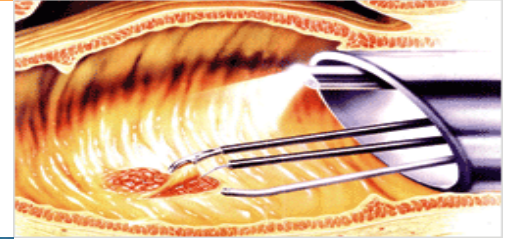
- Anatomia patologica colo-rettale
- RM pelvi
- Ecografia endorettale
- PET TC



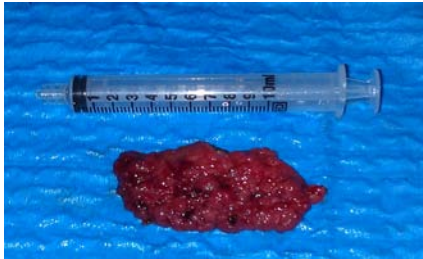
TEM: Transanal Endoscopic Microsurgery



Procedura mini invasiva messa a punto da Gherard Buess nel 1983



Figur 1. Transanal endoskopisk mikrokirurgi (TEM)-apparatet monteret og klar til operation.



Outcome post TEM (local recurrence) SALVAGE SURGERY



The outcome after transanal excision for rectal cancer depends on **close surveillance for early detection of recurrence**. In patients able to undergo surgery, endoluminal or pelvic recurrence should be treated with an immediate radical salvage operation. Overall long-term survival after local excision with **transanal endoscopic microsurgery followed by radical salvage surgery in cases of local recurrence is comparable to overall survival after initial radical surgery.**

Stipa F, Giaccaglia V, Burza A.
Dis Colon Rectum. 2012 Mar;55(3):262-9.

3

Pz eleggibili per chirurgia laparoscopica e/o robotica?



4 Pz con lesioni neoplastiche estese e/o metastatiche

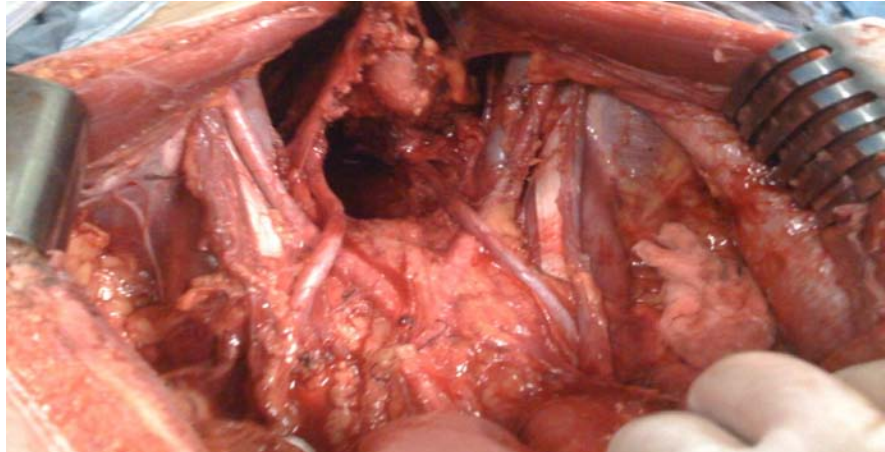


Livello di Evidenza: III

Grado di Raccomandazione: B

RESEZIONE EN BLOC per TUMORI T4 ADERENTI ad
ORGANI ADIACENTI

Il cancro del retto coinvolgente gli organi adiacenti dovrebbe essere trattato con resezione *en bloc*

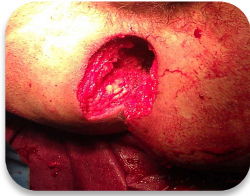


5

Pz con neoplasia del retto ultrabasso

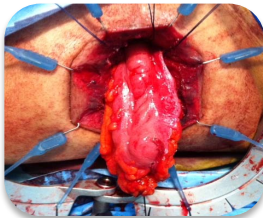
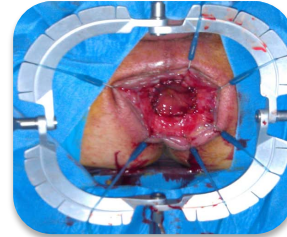


Opzioni terapeutiche:



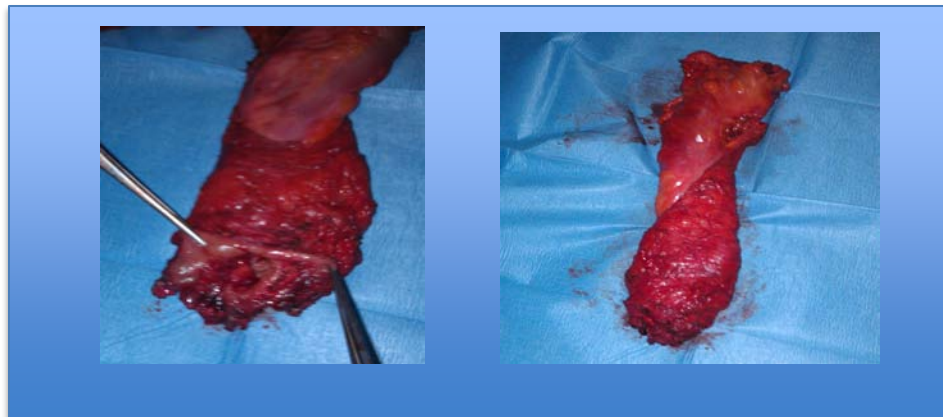
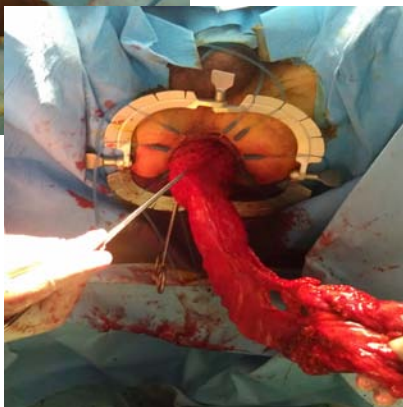
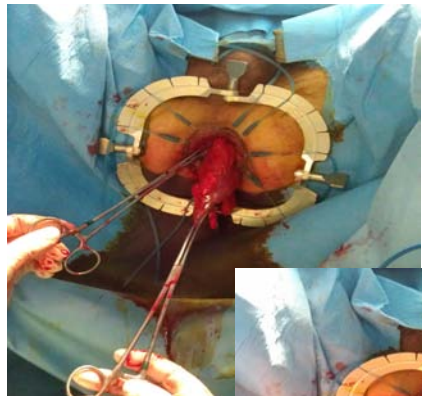
Amputazione addominoperineale secondo Miles con colostomia permanente

Anastomosi coloanale manuale o meccanica con ileostomia temporanea



Anastomosi coloanale con pull-through

Anastomosi coloanale con pull-through



6

Pz con neoplasia del retto ultrabassa estesa alla linea dentata e/o già infiltrante il piano muscolare degli elevatori dell'ano



**Standard
APR**

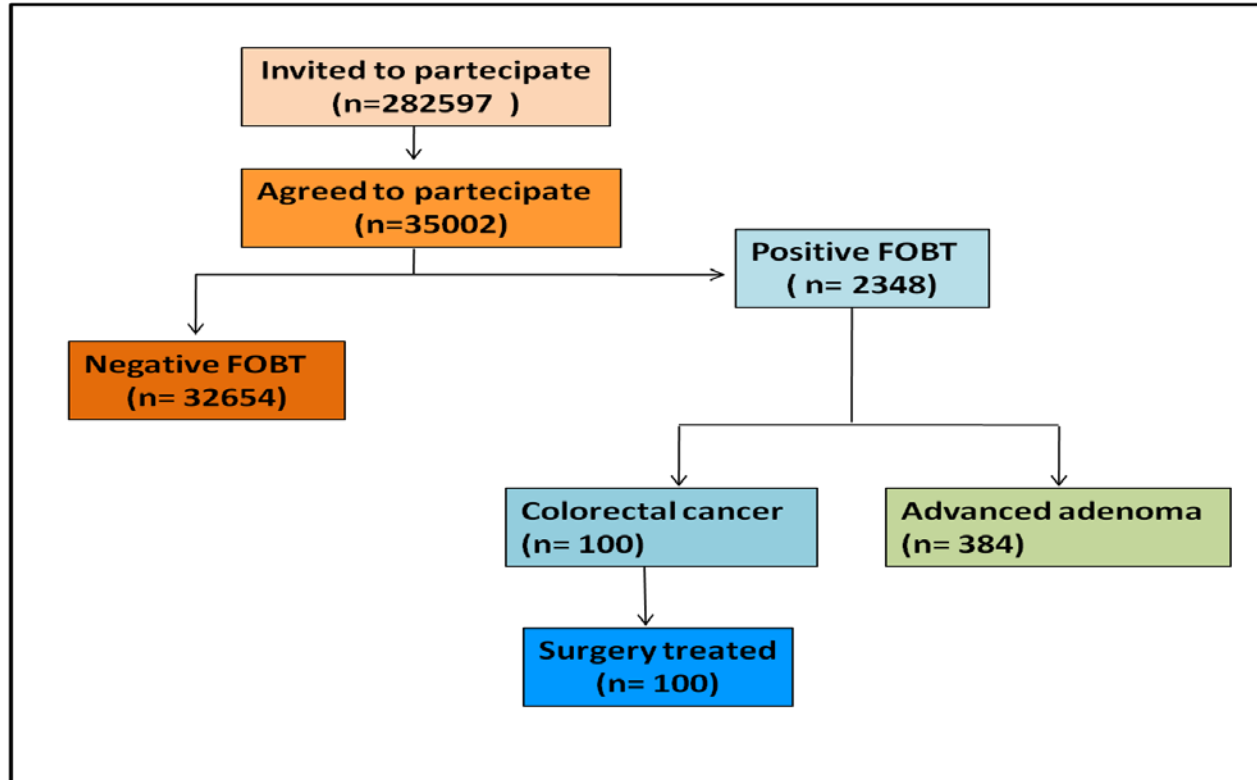


**MULTICENTER RANDOMIZED
CONTROLLED TRIAL,
EXTRALEVATOR VS. STANDARD
ABDOMINOPERINEAL RESECTION
FOR RECTAL ADENOCARCINOMA**



**Cylindrical
APR**

Pazienti screening 2010-2012



PAZIENTI SCREENING SOTTOPOSTI AD INTERVENTO CHIRURGICO

n° 100

➤ **40** operati nell'ambito della convenzione

➤ **37** operati esterni alla convenzione

(istologico comunicato)

➤ **23** operati esterni alla convenzione

(istologico non comunicato)



➤ 22 Centri
➤ 2 pz trattati fuori regione

PAZIENTI SINTOMATICI SOTTOPOSTI AD INTERVENTO CHIRURGICO
PRESSO LA STRUTTURA DI RIFERIMENTO

n° 109

Pazienti screening operati nell'ambito della convenzione

40 pz

T0N0	2	T0N+	1
T1N0	7	T1N+	-
T2N0	7	T2N+	9
T3N0	6	T3N+	6
T4N0	-	T4N+	2
TOTALE N0	22	TOTALE N+	18

N0 55%

N+ 45 %

Pazienti screening operati al di fuori della convenzione

37 pz

T0N0	5	T0N+	-
T1N0	10	T1N+	-
T2N0	6	T2N+	2
T3N0	8	T3N+	3
T4N0	1	T4N+	1
N0 M+	-	N+M+	2
TOTALE N0	30	TOTALE N+	7

N0 76,7%

N+ 23,3%

Pazienti screening operati nell'ambito della convenzione

40 pz

T0N0	2	T0N+	1
T1N0	7	T1N+	-
T2N0	7	T2N+	9
T3N0	6	T3N+	6
T4N0	-	T4N+	2
TOTALE N0	22	TOTALE N+	18

N0 55%

N+ 45 %

Pazienti non screening **109 pz**

T0N0	6	T0N+	1
Tis N0	9	Tis N+	-
T1N0	6	T1N+	1
T2N0	16	T2N+	15
T3N0	24	T3N+	31
T4N0	-	T4N+	-
TOTALE N0	61	TOTALE N+	48

N0 55 %

N+ 45 %

NUMERO MEDIO DI LINFONODI ASPORTATI

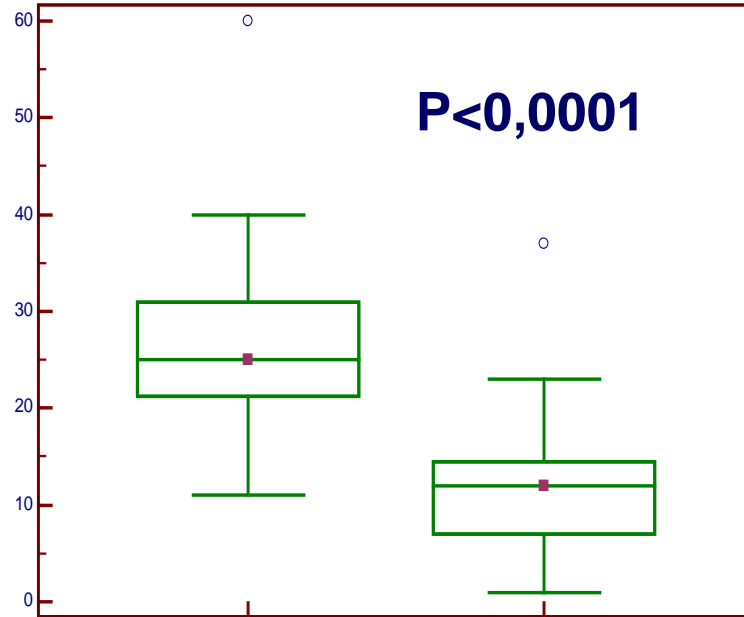
	SCREENING CENTRO DI RIFERIMENTO	SCREENING ALTRE STRUTTURE	NON SCREENING CENTRO DI RIFERIMENTO
COLON	30.2	10.7	27.7
RETTI	18.2	11	24.4

STATISTICAL ANALYSIS

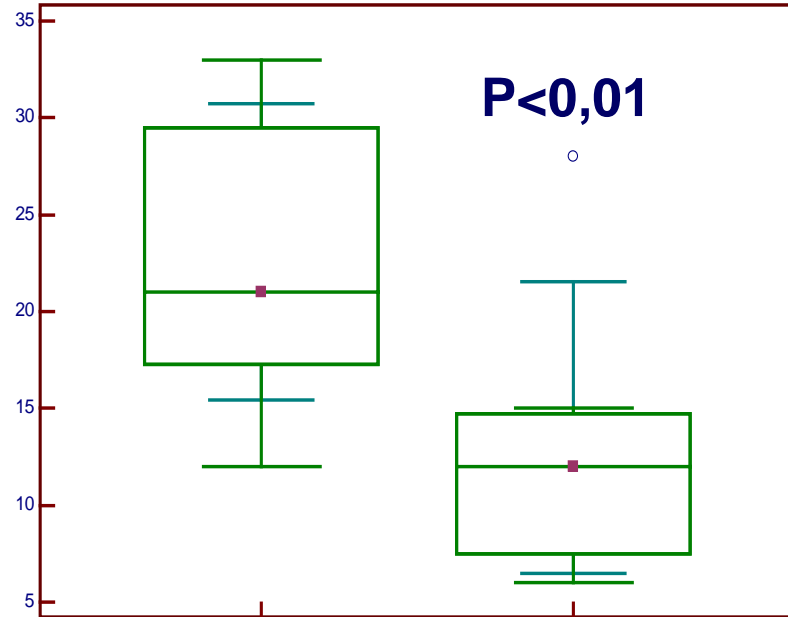
The analysis was differentiated for colon cancer and rectal cancers and the two groups were matched for sex and age (colon cancer: $P= 0.58$ for sex and $P= 0.22$ for age , rectal cancer: $P= 0.77$ for sex and $P= 0.76$ for age).

An higher number of removed lymph-nodes was found both in patients with colon and rectal cancer operated on in the referral center compared to district hospital (colon cancer: median **27**, 95% CI 22 - 28.8 vs **12**, 95% CI 8.4 – 14, respectively, $P<0,0001$; rectal cancer: median **21**, 95% CI 15.4 – 30.7 vs **12**, 95% CI 6.4 – 21.5, respectively, $P=0,01$).

An higher number of removed lymph-nodes was found both in patients with colon and rectal cancer operated on in the referral center compared to district hospital

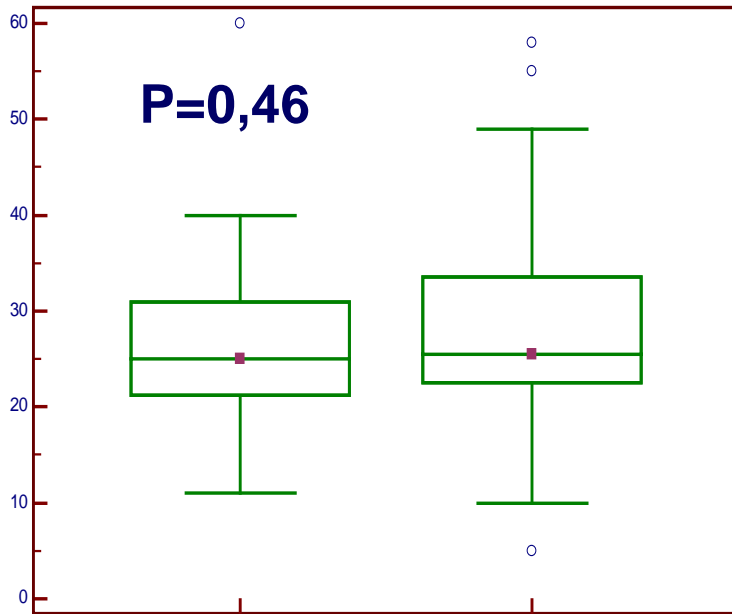


Screened colon RC vs Screened colon DH

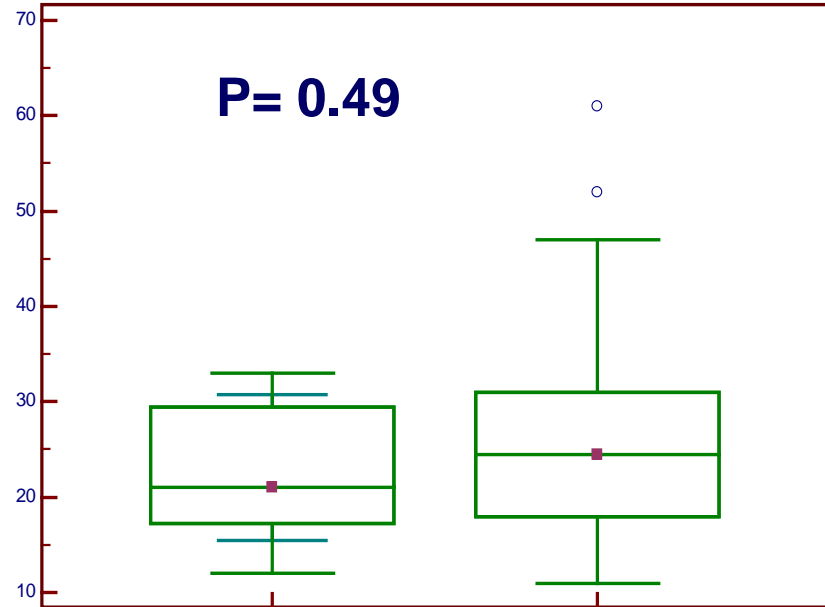


Screened rectum RC vs Screened rectum DH

In the same period 109 symptomatic CRC patients were treated in our RC, and these data were used as a control group, to identify the quality of the surgical outcome in our center.



**Screened colon RC vs
Unscreened colon**



**Screened rectum RC vs
Unscreened rectum**

MORBILITA' e MORTALITA'

Pazienti screening

trattati nell'ambito della
convenzione

0

Pazienti non screening

- **3 reinterventi**
2 per fistola
(1 colon dx-1 ch. ileostomia)
1 per aderenze
- **2 fistole del retto** (trattamento
conservativo)

Mortalità 0

CONCLUSION

Differences between referral center and district hospitals in lymph nodes retrieval are more evident for colon cancer than rectal cancer.

Does it imply that not only rectal cancer but also colon cancer patients should be referred to high volume centers ?

MODELLO di COORDINAMENTO REGIONALE

