IL SECONDO E TERZO LIVELLO DELLO SCREENING DEL CANCRO COLO-RETTALE: PARLIAMONE

9 ottobre 2015

Ferrara

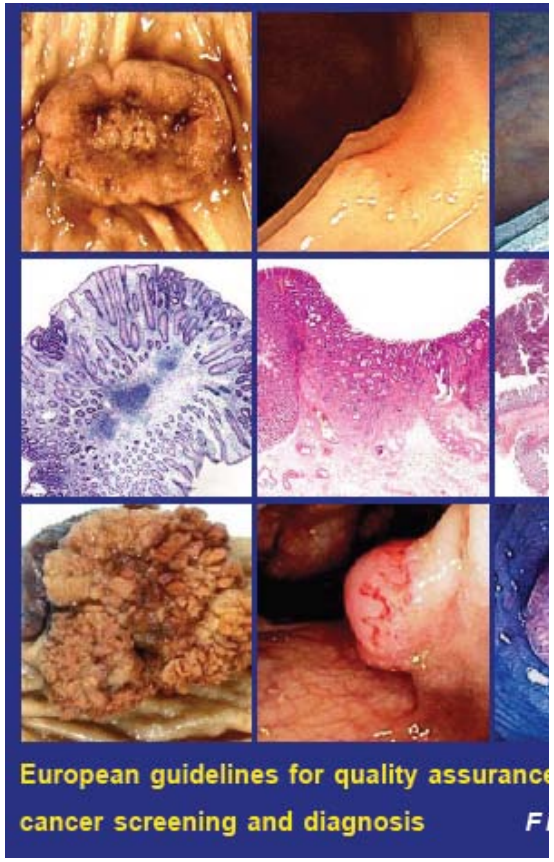
LA NEOPLASIA PRECOCE: QUALE TRATTAMENTO E CON QUALI RISULTATI L'ENDOSCOPISTA

GASTROENTEROLOGIA ED ENDOSCOPIA DIGESTIVA
ARCISPEDALE SANTA MARIA NUOVA-IRCCS
REGGIO EMILIA- Direttore:Dott. Romano Sassatelli

Dott.ssa Veronica Iori

T1 , vecchio polipo cancerizzato : di cosa parliamo

di un cancro con caratteristiche morfologiche per cui si è ritenuta possibile l'asportazione endoscopica con intento radicale



1. NO NEOPLASIA:[2]

Vienna Category 1 (Negative for neoplasia)

2. MUCOSAL LOW GRADE NEOPLASIA:

Vienna Category 3 (Mucosal low-grade neoplasia
Low-grade adenoma
Low-grade dysplasia);
Other common terminology
mild and moderate dysplasia;
WHO: low-grade intra-epithelial neoplasia

3. MUCOSAL HIGH GRADE NEOPLASIA:

Vienna: Category 4.1–4.4 (Mucosal high grade neoplasia
High-grade adenoma/dysplasia
Non-invasive carcinoma (carcinoma *in situ*)
Suspicious for invasive carcinoma
Intramucosal carcinoma);
Other common terminology
severe dysplasia;
high-grade intraepithelial neoplasia;
WHO: high-grade intraepithelial neoplasia
TNM: pTis

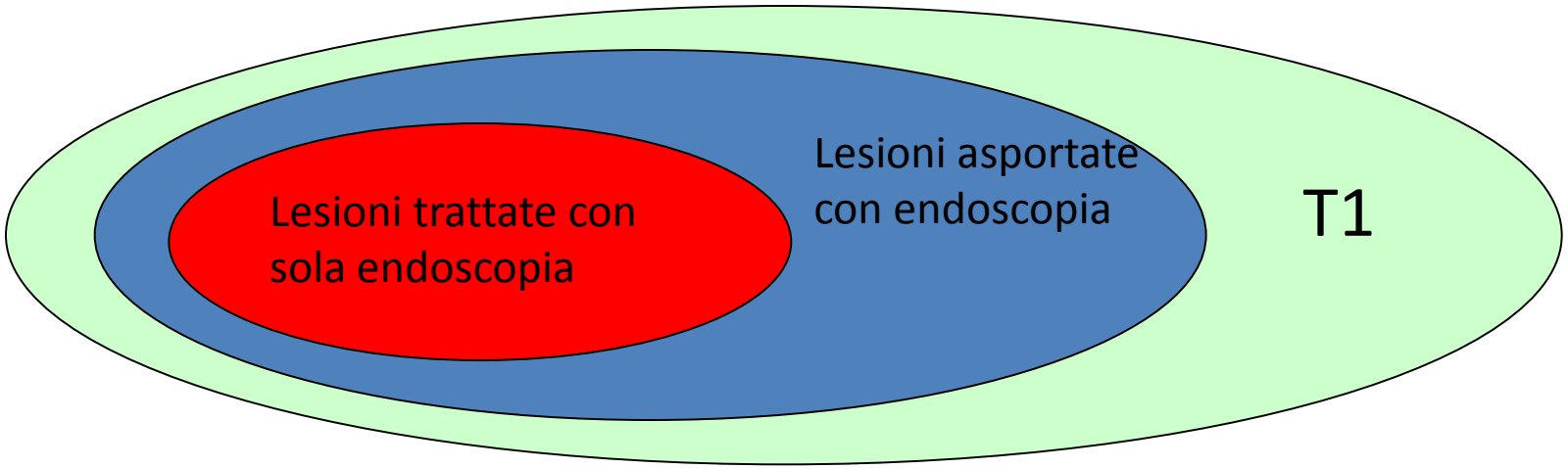
4.4

4. CARCINOMA invading the submucosa or beyond:

4a. Carcinoma confined to submucosa
Vienna: Category 5 (Submucosal invasion by carcinoma);
TNM: pT1
4b. Carcinoma beyond submucosa
TNM: pT2-T4

Pazienti con diagnosi istologica di polipo cancerizzato del colon retto, dopo asportazione giudicata completa dall'endoscopista.

Studio Sec-Giscor (criteri di inclusione)



Cosa succede, di solito

	≤T1	> T1 o T1 AR*
Biopsie e chirurgia	Overtreatment	
Asportazione endoscopica		Inadeguato trattamento

* Invasione linfatici (vascolare), margini, profondità di invasione, Grading, Budding

Management of pT1 colorectal cancer

8.16 If there is clinical suspicion of a pT1 cancer, a site of excision should be marked with submucosal India ink **(VI - C).** Sect 8.4.1

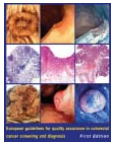
8.17 Where a pT1 cancer is considered high-risk for residual disease consideration should be given to completion colectomy along with radical lymphadenectomy, both for rectal cancer **(II - A)** and colon cancer **(VI - A)**. If surgical resection is recommended, consideration should be given to obtaining an opinion from a second histopathologist as variation exists in evaluating high risk features (see also Ch. 7, Rec. 7.7) **(VI - B).** Sect 8.4.2; 7.5.3

8.18 After excision of a pT1 cancer, a standardised follow-up regime should be instituted **(VI - A).** The surveillance policy employed for high-risk adenomas is appropriate for follow-up after removal of a low-risk pT1 cancer (see Ch. 9, Rec. 9.16) **(III - B).** Sect 8.4.3; 9.5.1

pT1 cancers can be categorised into low-risk and high-risk lesions according to their likelihood of being associated with lymph node metastases:

- Low risk: Well or moderately differentiated and no lymphovascular invasion; rate of lymph node metastases <5%
- High risk: Poorly differentiated and/or lymphovascular invasion; rate of lymph node metastases ~35%

The significance of venous invasion is currently unknown.



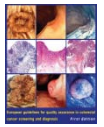
8.4.2 Completion surgery

Patients with a histologically confirmed, completely removed low-risk pT1 cancer do not require additional surgery, due to their low risk of lymph node metastases. In patients with a high-risk polyp cancer with clear margins (R0), the multidisciplinary team should be consulted on whether completion surgery involving removal of the part of the large bowel in which the polyp was situated, along with radical lymphadenectomy, for both rectal cancer **(II - A)** and colon cancer **(VI - A)** is recommended. [Rec 8.17] If surgical resection is recommended, consideration should be given to obtaining an opinion from a second histopathologist, as variation exists in evaluating high risk features (See also Ch. 7, Sect. 7.5.3 and Rec. 7.7) **(VI - B).** [Rec 8.17] The precise nature of the surgery will of course depend on the site of the pT1 cancer. It may be difficult to precisely locate the site of the previous polypectomy and for this reason inking of the site at the time of initial polypectomy is advised when there is any clinical suspicion of polyp cancer (see above).

It should be noted that if a suspected pT1 cancer has been *incompletely* removed, lack of invasion beyond the submucosa cannot be guaranteed, and thus even in the situation where the lesion is well or moderately differentiated with no lymphovascular invasion, further treatment is required. This will usually take the form of completion surgery, although repeat endoscopic excision may be possible and appropriate in some situations.

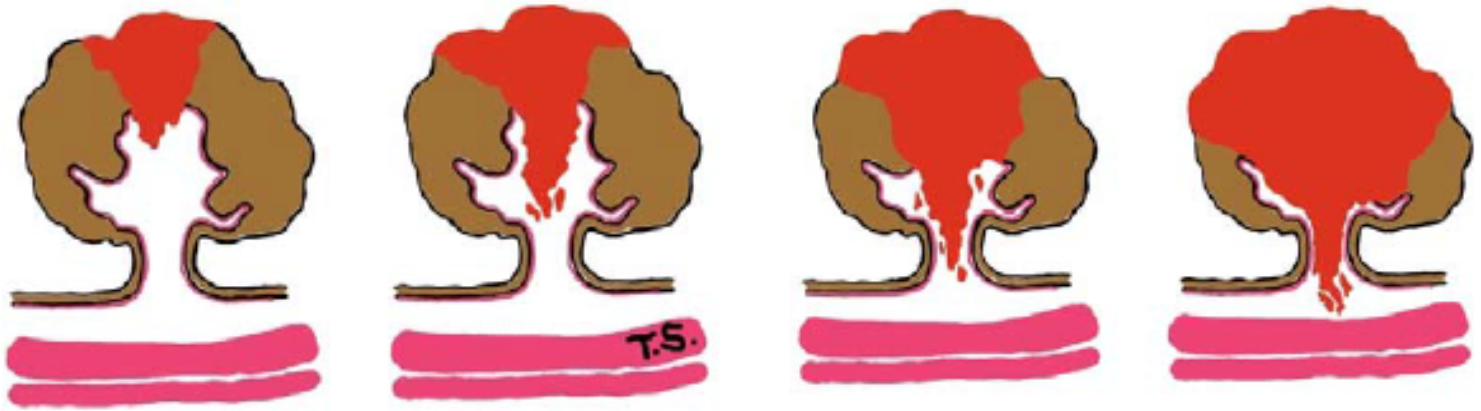
In summary, current consensus would classify a pT1 cancer as high-risk requiring completion surgery in the following circumstances:

- When invasive cancer is seen at or within 1 mm of the resection margin;
- Where the cancer is poorly differentiated; or
- Where there is evidence of lymphovascular invasion within the resected specimen.



Polipi peduncolati

Figure 7.2: Haggitt levels of invasion in polypoid carcinomas



Level 1: invasion of the submucosa but limited to the head of the polyp

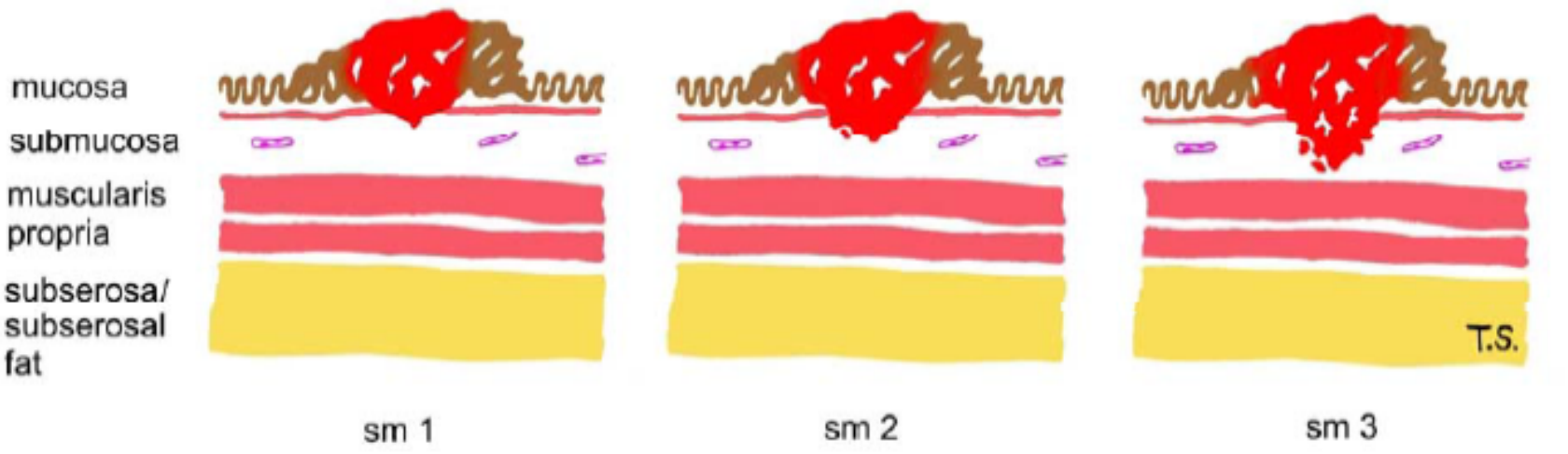
Level 2: invasion extending into the neck of polyp

Level 3: invasion into any part of the stalk

Level 4: invasion beyond the stalk but above the muscularis propria

Polipi sessili

Figure 7.1: Kikuchi levels of submucosal infiltration modified from Nascimbeni et al. (2002)



Kikuchi cannot be used in the absence of muscularis propria

Haggitt is not applicable in non-polypoid lesions, and measurement depends on a recognisable submucosa from which to measure

Profondita' invasione

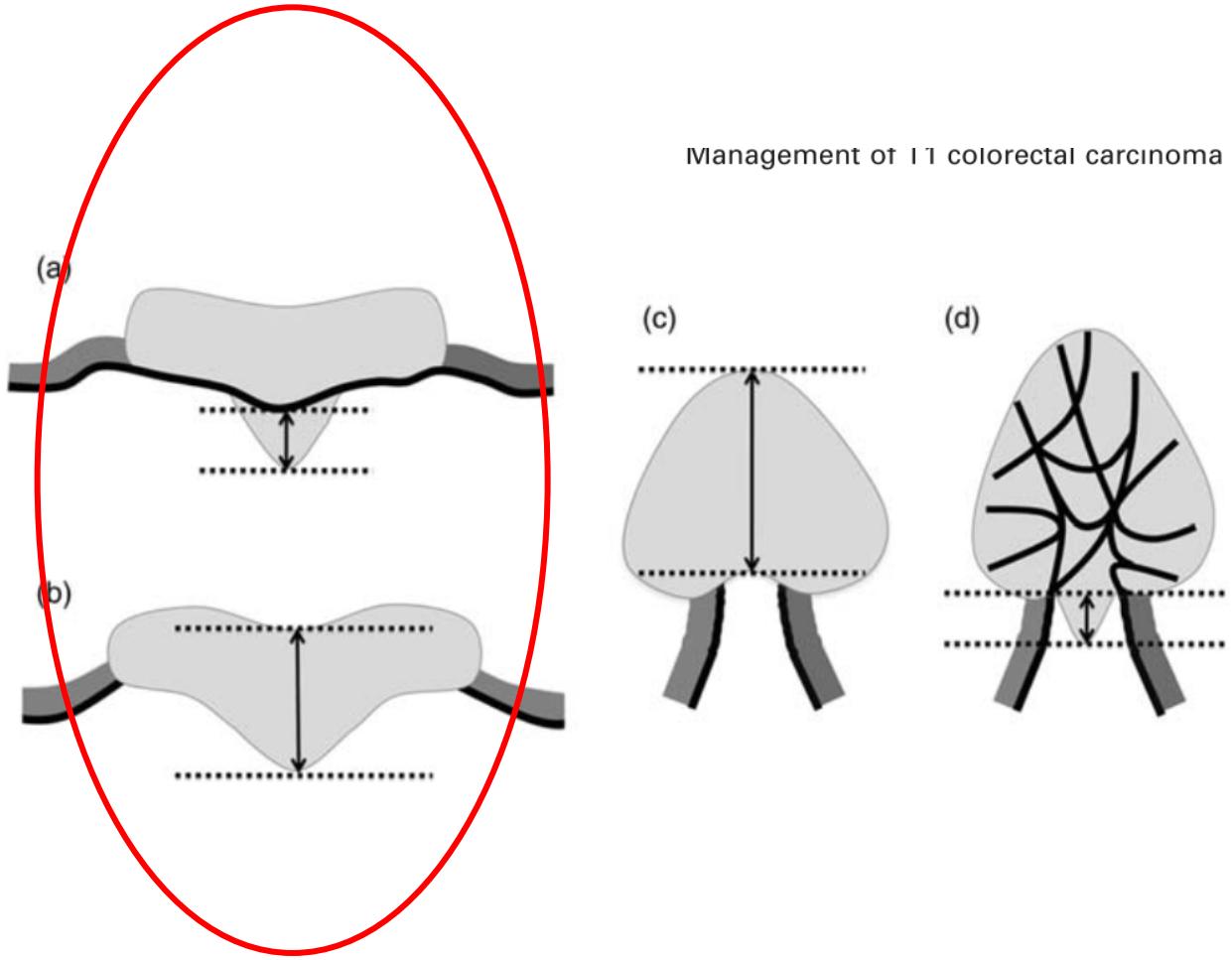
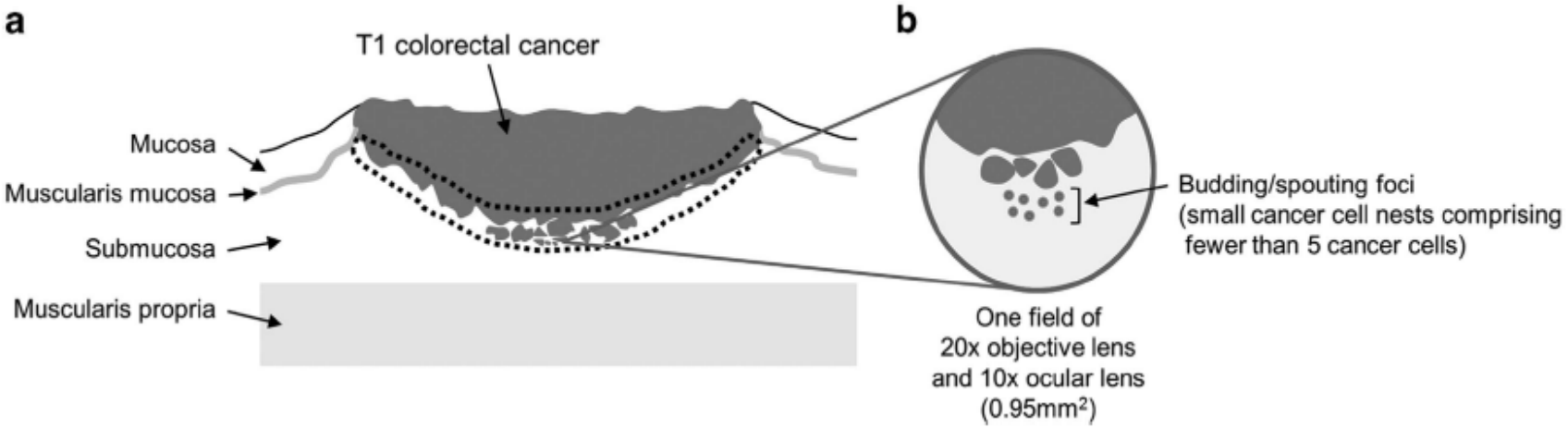


Figure 2 Measurement of the depth of submucosal invasion of colorectal carcinoma. (a) When the level of the muscularis mucosae can be detected or presumed, the distance from the muscularis mucosae to the tumor apex is measured. (b,c) When the level of the muscularis mucosae cannot be detected or presumed, the distance from the tumor surface to the tumor apex is measured. (b, sessile polyp; c, pedunculated polyp). (d) If a pedunculated polyp involves the muscularis mucosae (such as a Peutz-Jeghers polyp), the distance from the neck to the tumor apex is measured (deeper than Haggitt level 2).

Budding



MODERN PATHOLOGY (2015) 00, 1–8

Systematic review and meta-analysis of histopathological factors influencing the risk of lymph node metastasis in early colorectal cancer

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Abstract

Aim Lymph node (LN) metastases are present in up to 17% of early colorectal cancers (pT1). Identification of associated histopathological factors would enable counselling of patients regarding this risk.

Method Pubmed and Embase were employed utilizing the terms 'early colorectal cancer', 'lymph node metastasis', 'submucosal invasion', 'lymphovascular invasion', 'tumour budding' and 'histological differentiation'. Analysis was performed using REVIEW MANAGER 5.1.

Results Twenty-three cohort studies including 4510 patients were analysed. There was a significantly higher risk of LN metastasis with a depth of submucosal invasion > 1 mm than with lesser degrees of penetration (OR 3.87, 95% CI 1.50–10.00, $P = 0.005$). Lymphovascular invasion was significantly associated with LN metastasis (OR 4.81, 95% CI 3.14–7.37, $P < 0.00001$). Poorly differentiated tumours had a higher risk of LN metastasis compared with well or moderately differentiated tumours (OR 5.60, 95% CI 2.90–10.82, $P < 0.00001$). Tumour budding was found to be significantly associated with LN metastasis (OR 7.74, 95% CI 4.47–13.39, $P < 0.001$).

Conclusion Meta-analysis of the current literature demonstrates that in early colorectal cancer a depth of submucosal invasion by the primary tumour of > 1 mm, lymphovascular invasion, poor differentiation and tumour budding are significantly associated with LN metastasis.

Keywords Early colorectal cancer, lymph node metastasis, submucosal invasion, lymphovascular invasion, tumour budding, histological differentiation

Predicting lymph node metastasis in pT1 colorectal cancer: a systematic review of risk factors providing rationale for therapy decisions

Endoscopy 2013; 45: 827–834

Authors Steven L. Bosch[1], Steven Teerenstra[2], Johannes H. W. de Wilt[3], Chris Cunningham[4], Iris D. Nagtegaal[1]

Background and study aim: Population screening for colorectal cancer (CRC) is expected to increase the number of pT1 CRCs. Local excision is an attractive treatment option, but is only oncologically safe in the absence of lymph node metastasis (LNM). A systematic review of the predictive value of pathological risk factors for LNM in pT1 CRC was conducted to provide data for an evidence-based decision regarding follow-up or radical surgery after local excision.

Methods: PubMed was searched for reports on predictors of LNM in pT1 CRC. Published papers written in English and containing at least 50 patients were included. Meta-analyses were performed using Review Manager 5.1.

Results: A total of 17 studies were included involving a total of 3621 patients with available nodal status. The strongest independent predictors of LNM were lymphatic invasion (relative risk [RR] 5.2, 95% confidence interval [CI] 4.0–6.8), submucosal invasion ≥1 mm (RR 5.2, 95%CI 1.8–15.4), budding (RR 5.1, 95%CI 3.6–7.3), and poor histological differentiation (RR 4.8, 95%CI 3.3–6.9). Limitations of the study were: results could not be stratified according to location in the colon or rectum; very early tumors removed by polypectomy without surgical resection were not included in the meta-analysis; and included studies were primarily from Asian countries and results therefore need to be verified in Western populations.

Conclusion: The absence of lymphatic invasion, budding, submucosal invasion ≥1 mm, and poor histological differentiation were each associated with low risk of LNM. Risk stratification models integrating these factors need to be investigated further.

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The Japanese Society of Gastroenterology

REVIEW

Systematic review and meta-analysis of histopathological predictive factors for lymph node metastasis in T1 colorectal cancer

Hiroo Wada · Manabu Shiozawa · Kayoko Katayama · Naoyuki Okamoto · Yohei Miyagi · Yasushi Rino · Munetaka Masuda · Makoto Akaike

Abstract

Background In this study we examined whether histopathological findings, specifically lymphatic vessel invasion identified by an anti-human podoplanin antibody, and several other factors are associated with lymph node metastasis in T1 colorectal cancer.

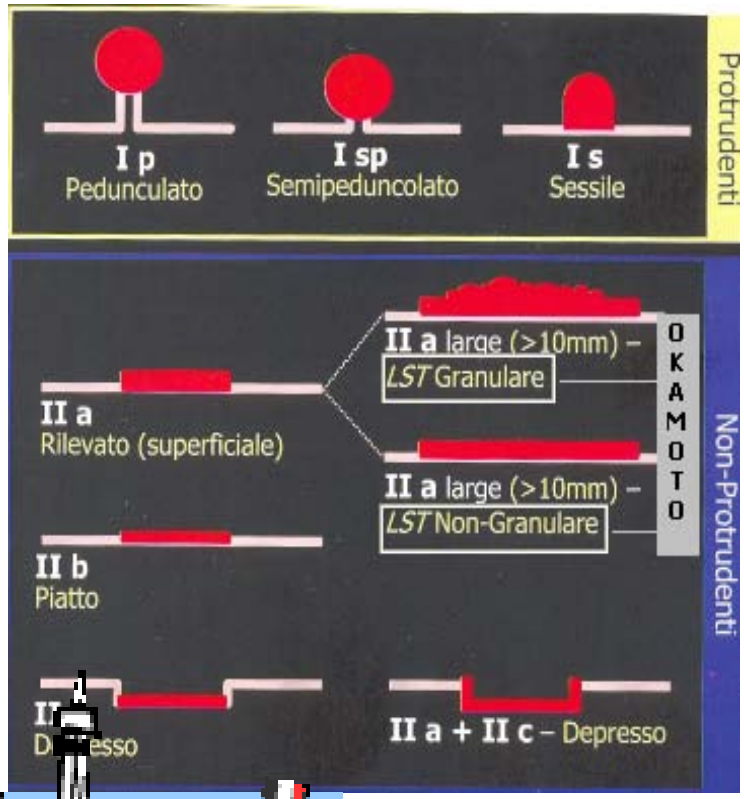
Methods We searched PubMed and Cochrane Library, and also handsearched relevant journals, for reports written in English and published between 1998 and 2012, utilizing combination headings, such as 'colorectal cancer,' 'lymph node metastasis,' and 'risk factors.' For the report to be included in our study, the following criteria had to be met: (1) data on the frequency of lymph node metastasis in T1 colorectal cancer in relation to histopathological factors were reported; (2) patients had undergone bowel resection and had histologically diagnosed T1 colorectal cancer; (3) lymphatic vessel invasion was identified by immunohistochemistry with an anti-human podoplanin antibody rather than by hematoxylin and eosin staining; (4) univariate and multivariate analyses were conducted. Studies investigating molecular markers were excluded. The independent predictive factors were confirmed in at least one study included in the meta-analysis in the present systematic review. Microsoft Excel 2013 for Windows was used for the statistical analysis.

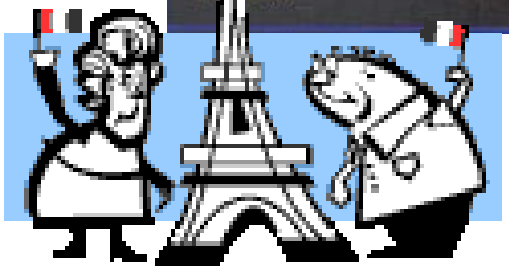
Results Initially, 369 publications were identified in the database searches and handsearches, of which five ultimately met all of the inclusion criteria and selected for this systematic review. The meta-analysis revealed that only two factors were significantly associated with T1 colorectal cancer lymph node metastasis: (1) lymphatic vessel invasion identified by an anti-human podoplanin antibody [Mantel–Haenszel odds ratio (OR) 5.19; (95 % confidence interval (CI) 3.31–8.15; $P = 0.01$]; (2) tumor budding (OR 7.45; 95 % CI 4.27–13.02; $P = 0.0077$).

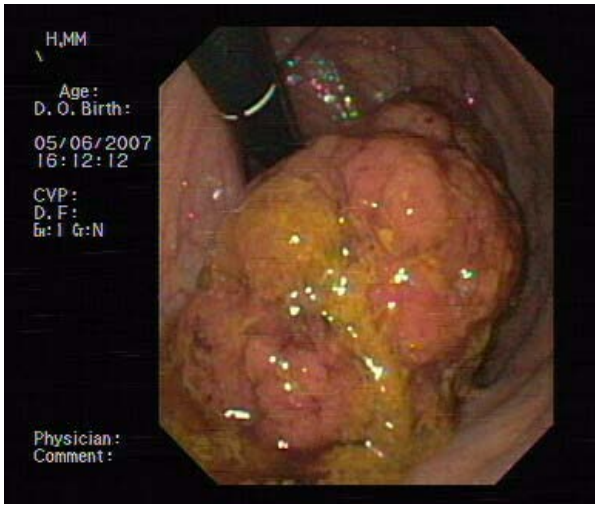
Conclusion Our meta-analysis revealed that lymphatic vessel invasion identified by an anti-human podoplanin antibody and tumor budding were significantly associated with T1 colorectal cancer lymph node metastasis.

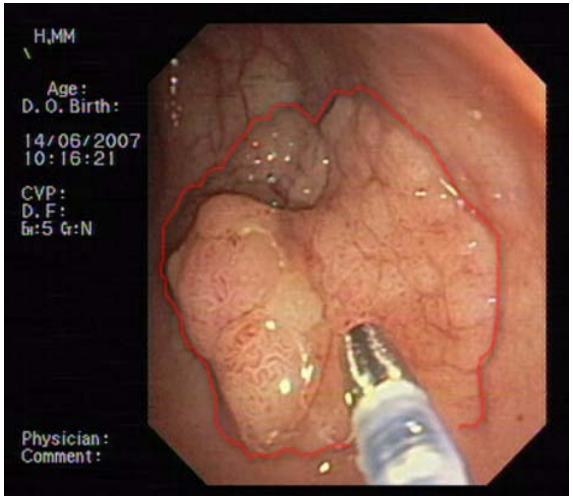
Il problema principale: come sospettare un T1

Dimensioni e forma









19560 lesioni trattate endoscopicamente 1985-2003

Dimensioni e forma

	5 mm or less	6-10 mm	11-15 mm	16-20 mm	21 mm or more
0-I					
Ip + Is	0/5400 (0%)	49/4045 (1.2%)	80/1002 (8%)	58/330 (17%)	56/187 (30%)
0-IIa,b					
IIa + IIb	2/6214 (<0.1%)	2/1015 (0.2%)	9/493 (1.8%)	17/165 (10%)	53/235 (23%)
0-IIc					
All *IIc*	17/236 (7%)	58/132 (44%)	42/63 (67%)	18/20 (90%)	13/15 (87%)
0-III					
III	0	0	0	0	0
Total	19/11,850 (<0.2%)	109/5,192 (2%)	131/1,558 (8%)	93/1,523 (18%)	122/437 (28%)

L'invasione sottomucosa avviene in meno dell'1%, quando la lesione è < 1 cm, ma aumenta con il diametro fino al 30% quando la lesione è > 2 cm.

Nelle lesioni IIa-IIb è inferiore alle lesioni I, tenuto conto del diametro.

Nelle lesioni IIc l'invasione è frequente anche se il diametro è inferiore a 1 cm.

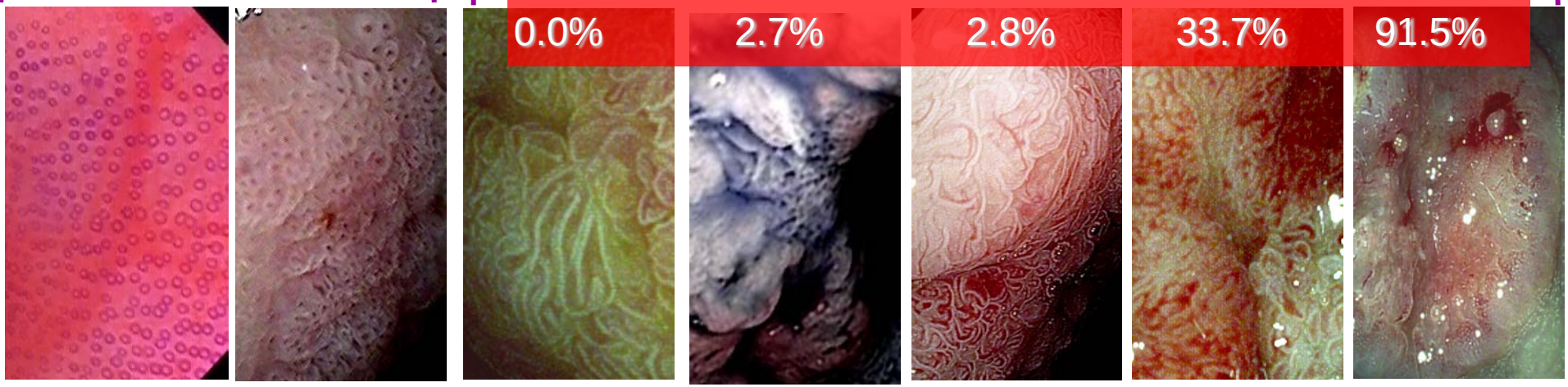
Kudo et al. in Lambert R, Lightdale CJ editors, GIE 2003

pit pattern

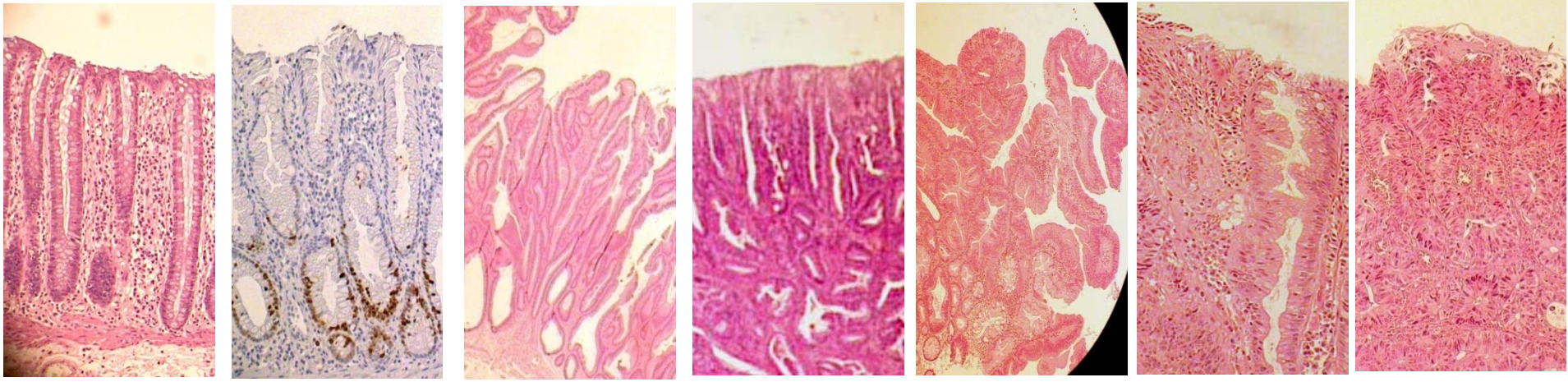
non neoplastic pattern

neoplastic pattern

invasive cancer risk *

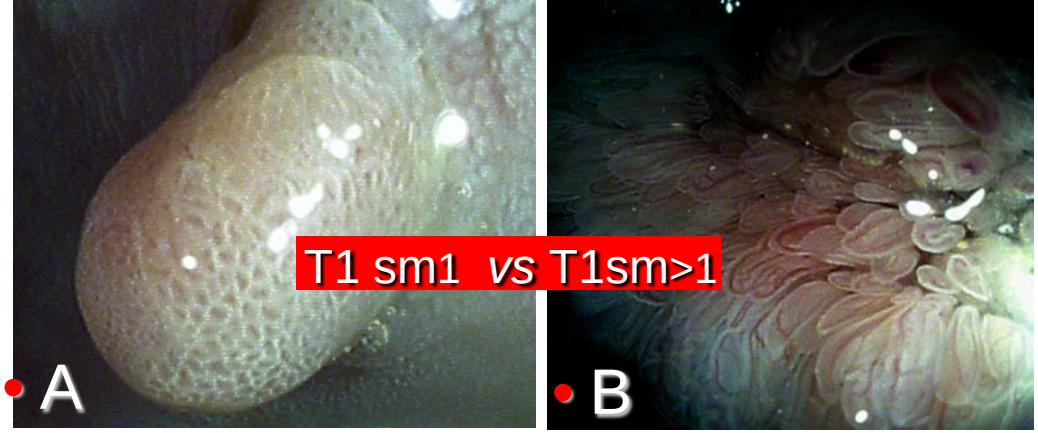


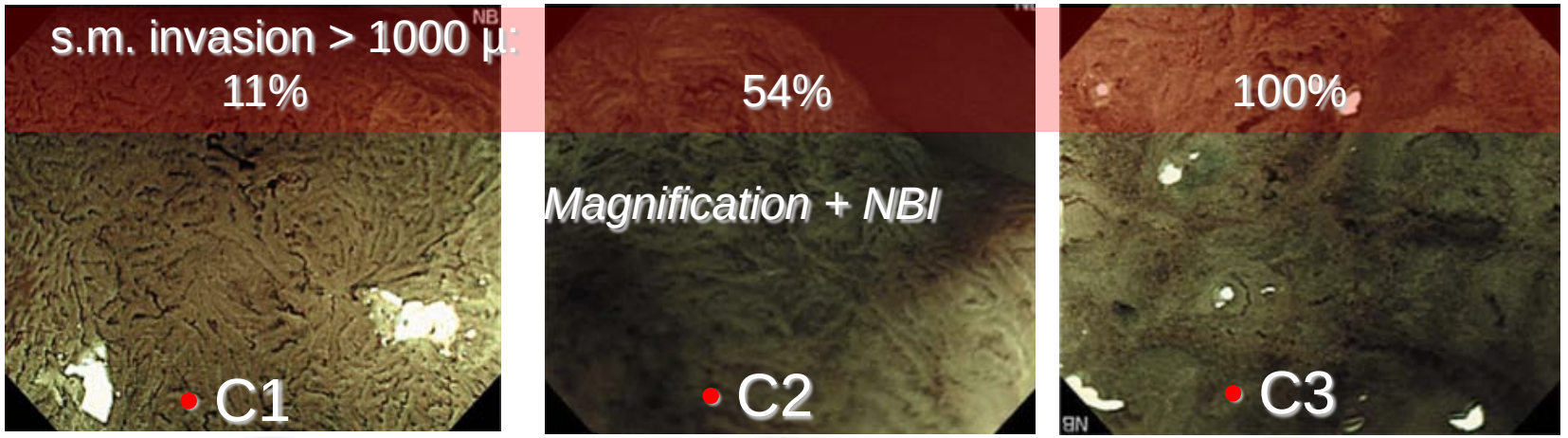
• I • II • III L • III S • IV • V i • V n

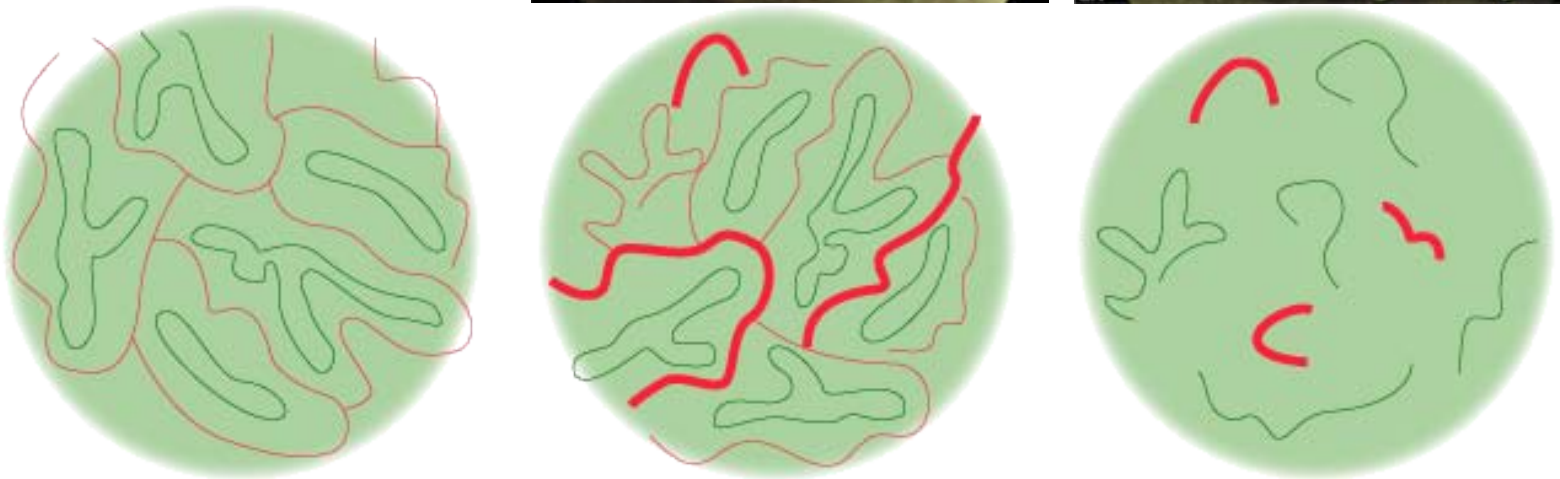


GASTROINTESTINAL ENDOSCOPY Volume 68, No. 4 : 2008 *

vascular pattern



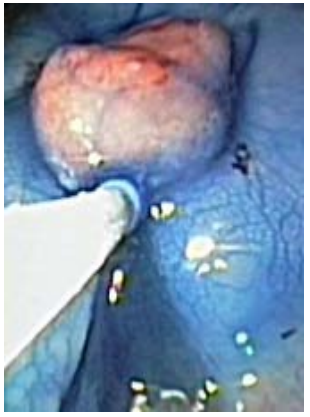


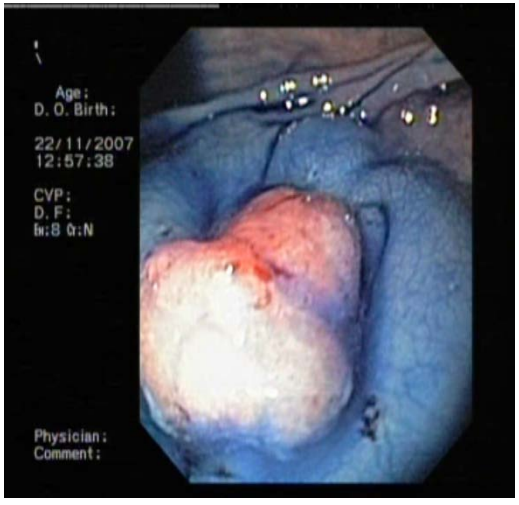


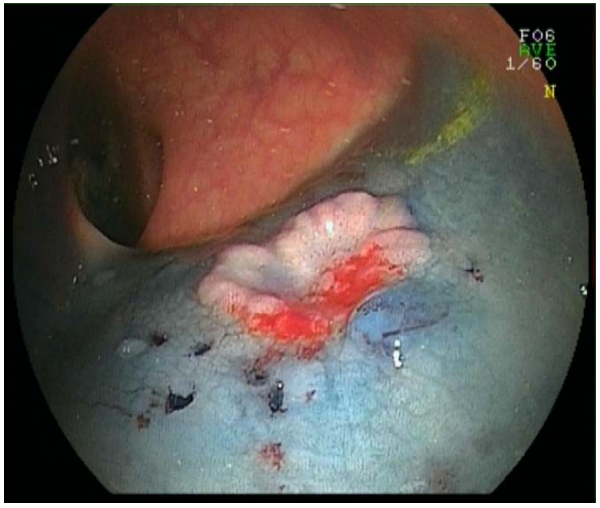
By Hiroyuki Kanao, 2009 (mod. Gizzi)

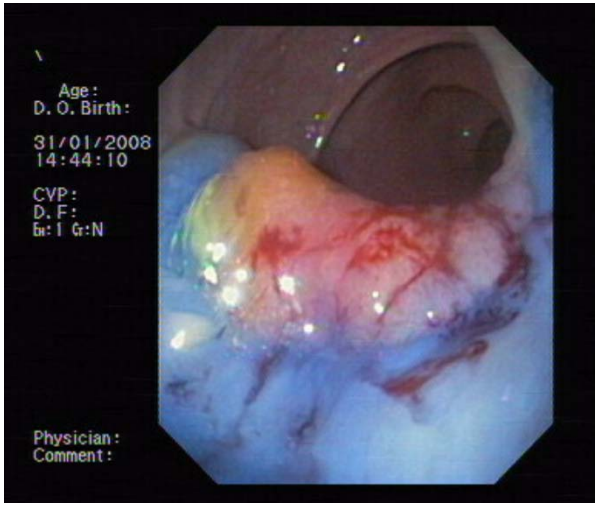
No lift sign

Osservare il comportamento della lesione durante e dopo l'infiltrazione con soluzione salina.
Il "non sollevamento" può dipendere da un'infiltrazione neoplastica della sottomucosa, ma anche da fibrosi es: come conseguenza di precedenti trattamenti endoscopici (polipectomia, biopsie, trattamento termico)

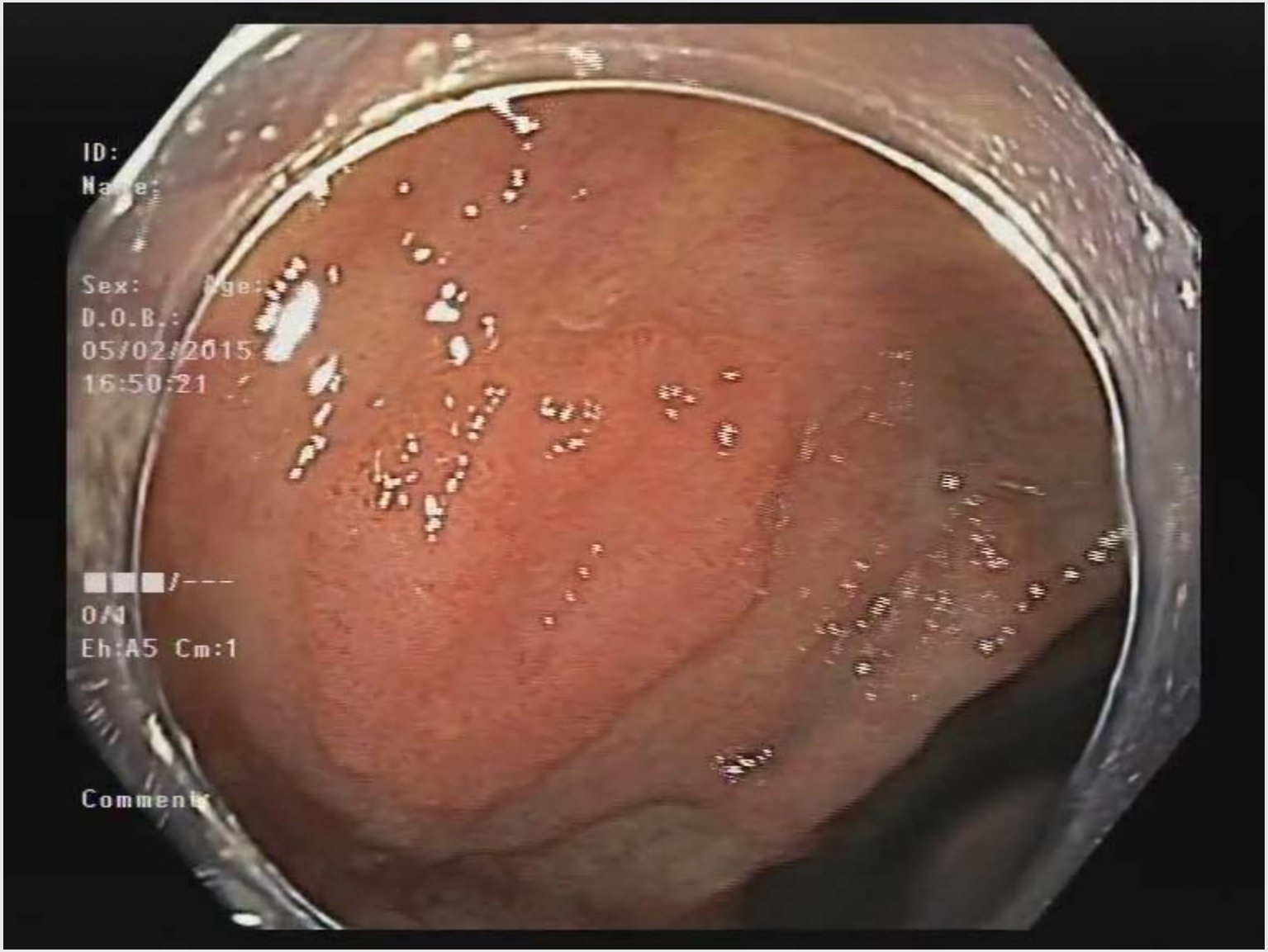




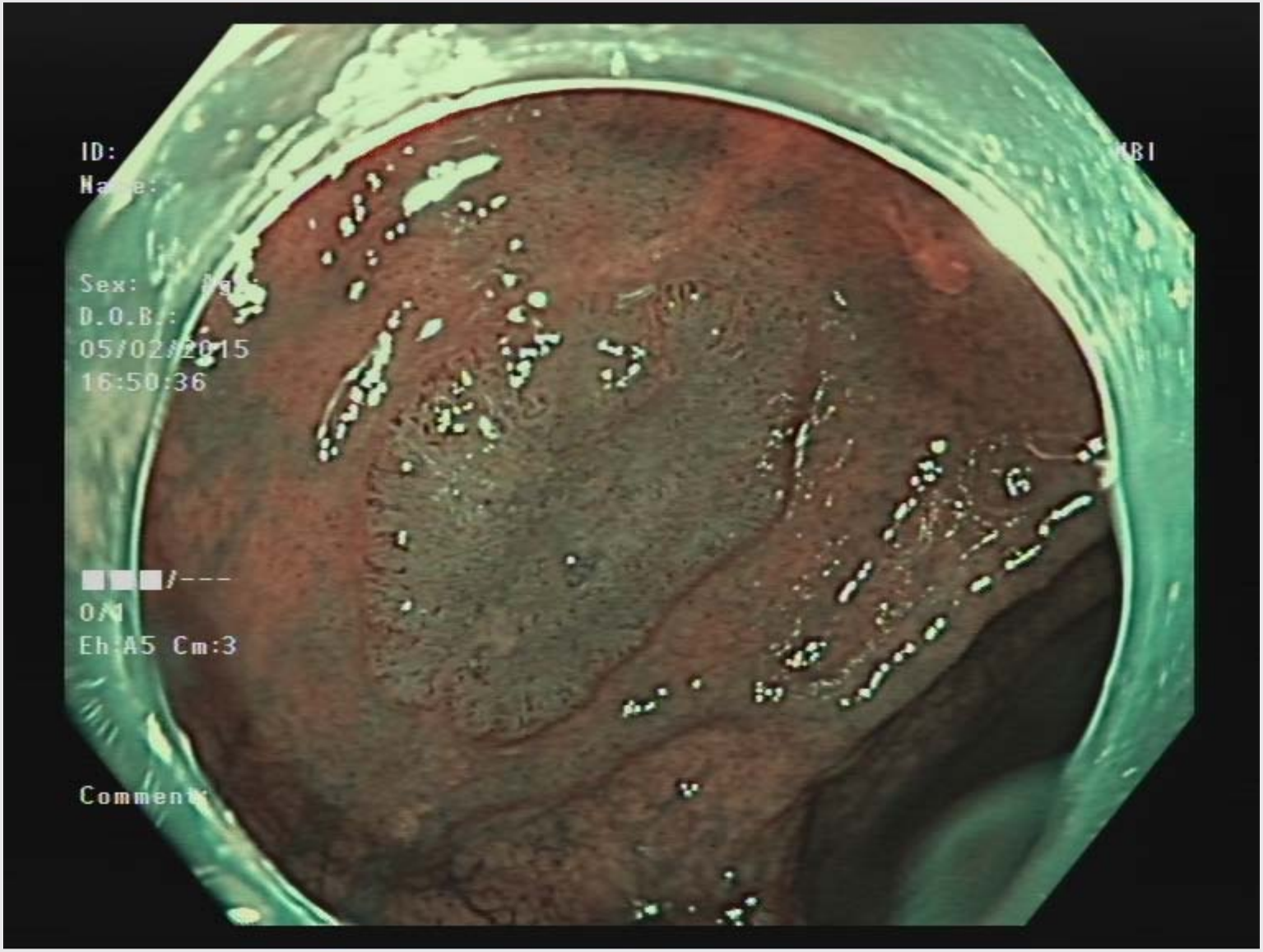




Il problema principale: come sospettare un T1



M, 77°, hep flex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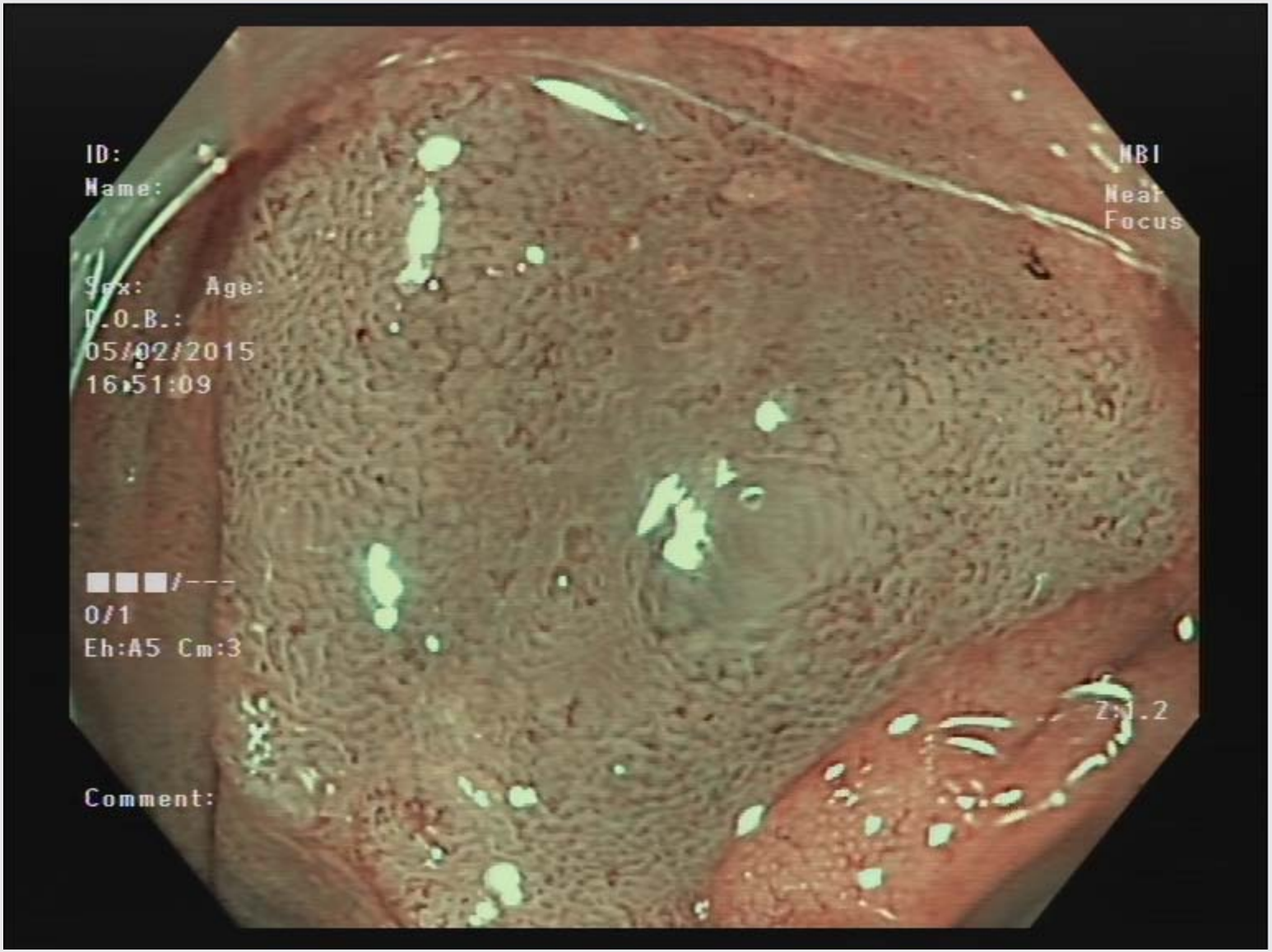

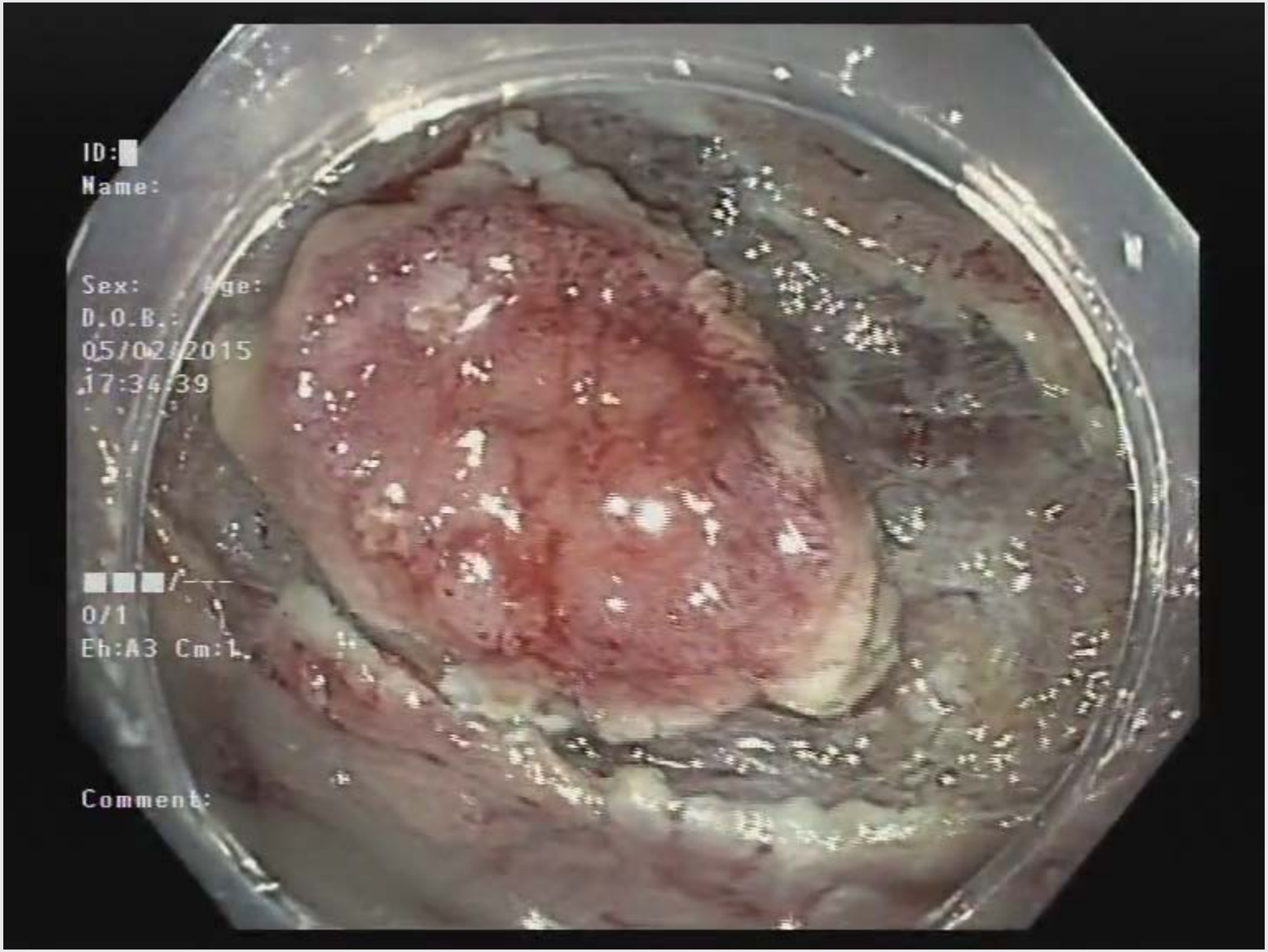
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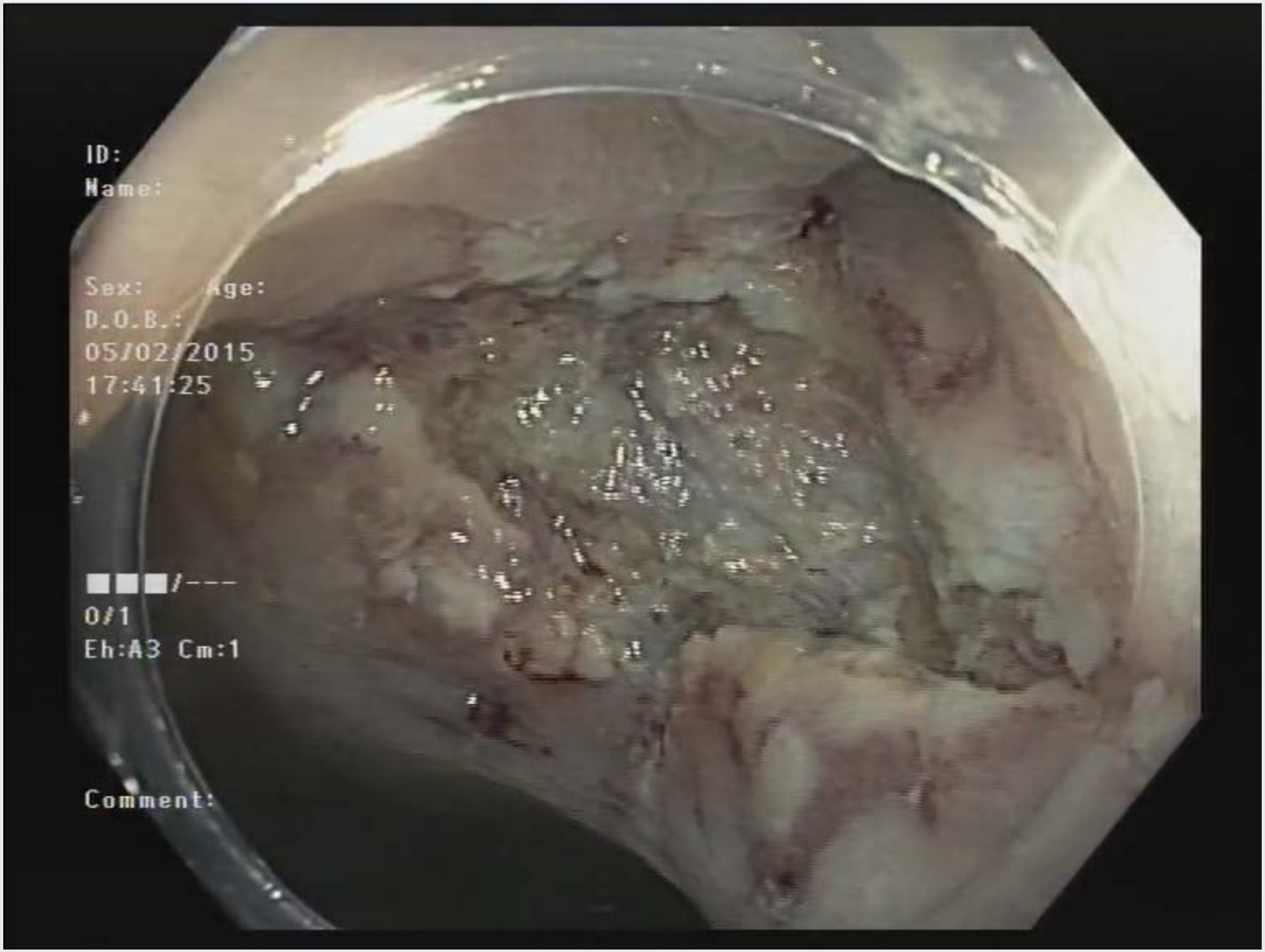
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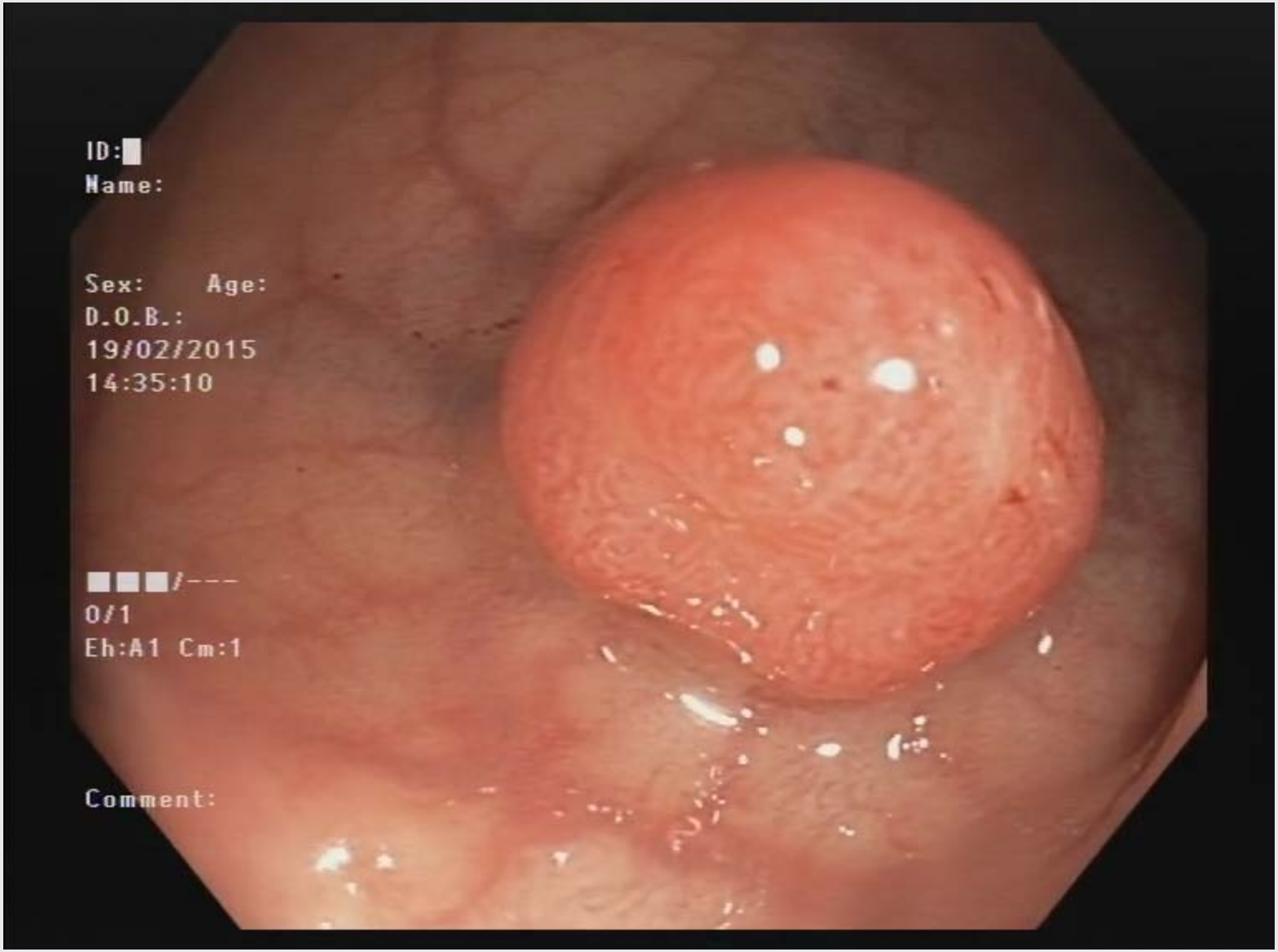
Perviene in formalina orientato in apposita macrocassetta polipo sessile di cm 1,5 x 1.
I margini di resezione vengono inchiostrati. Il materiale viene prelevato in toto in 1 inclusione.

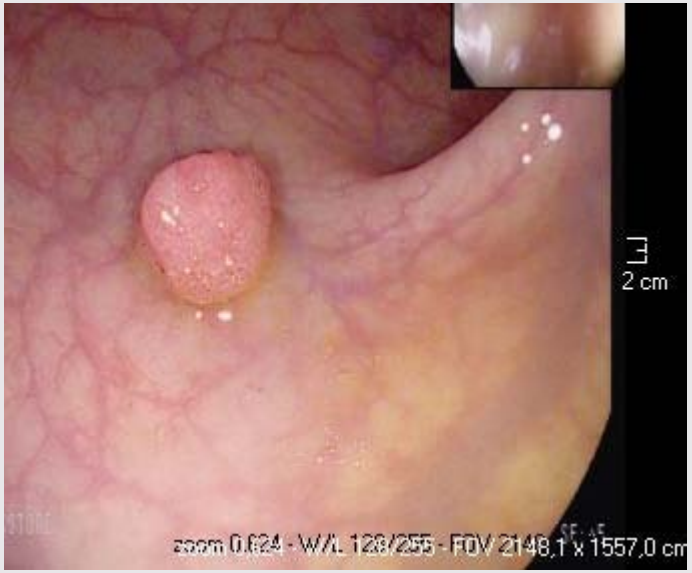
DIAGNOSI ISTOLOGICA

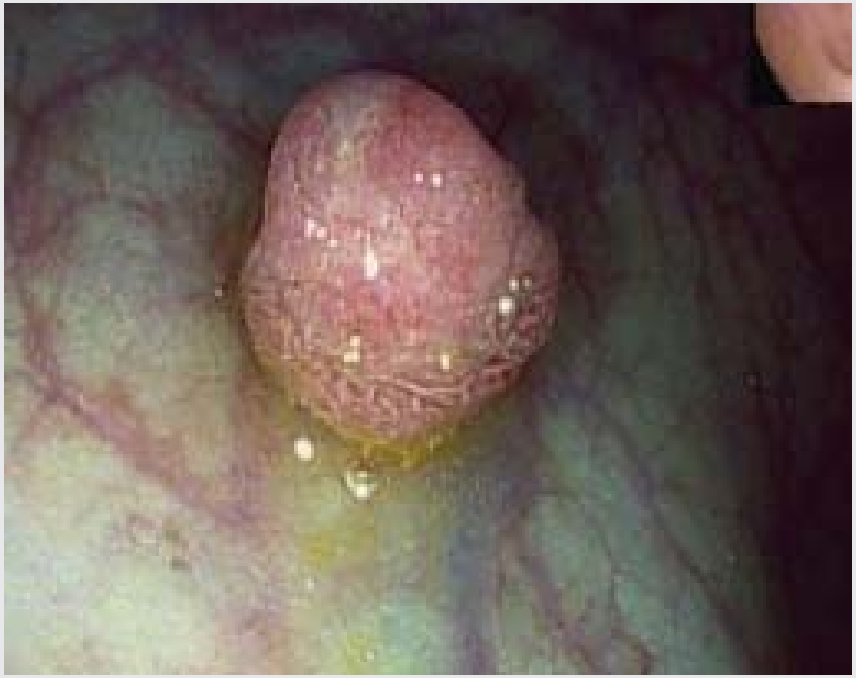
Adenocarcinoma con aspetti di scarsa differenziazione, infiltrante la sottomucosa. La neoplasia giunge a 0,5 mm dal margine di resezione.
Grading Adenocarcinoma: alto grado.
Embolizzazione neoplastica: assente.
"Budding" tumorale: presente.
Percentuale tessuto adenomatoso/adenocarcinoma: 0/100.
Ampiezza e profondità di infiltrazione dello stroma sottomucoso:
l'ampiezza di infiltrazione è di 11 mm, la profondità di infiltrazione è di 0,6 mm.
CONCLUSIONE: la neoplasia è ad alto rischio di progressione neoplastica.

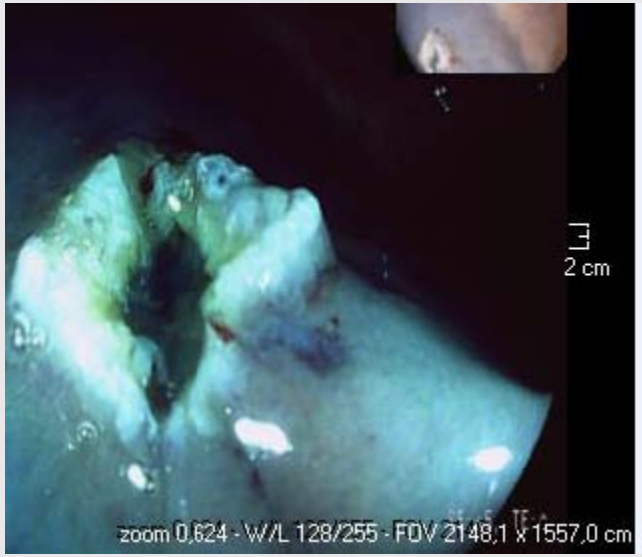
Come ausilio diagnostico il materiale è stato subseriato ed è stata eseguita una colorazione immunoistochimica per pancitocheratina.



F, 61 a, sigma


2 cm
zoom 0,624 - W/L 128/255 - FOV 2148,1 x 1557,0 cm




2 cm
zoom 0,624 - W/L 128/255 - FOV 2148,1 x 1557,0 cm

Pervengono in formalina in contenitori distinti:

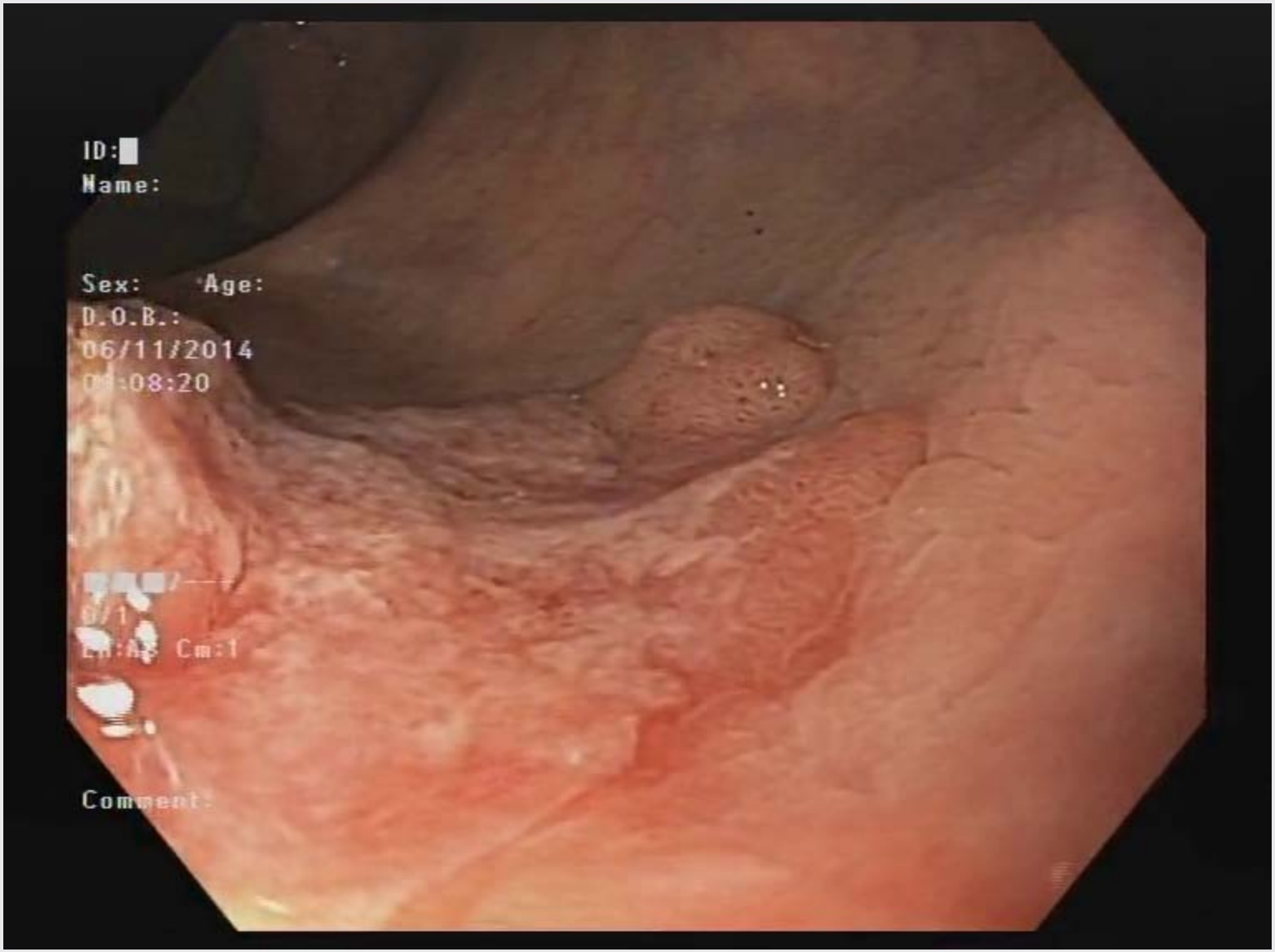
1) Frustoli grigiastri. Il materiale viene prelevato in toto in 1 inclusione (prelievo A).
2) Formazione polipoide sessile di cm 1.3 di asse maggiore. Il materiale viene prelevato in toto in 1 inclusione (prelievo B).

DIAGNOSI ISTOLOGICA

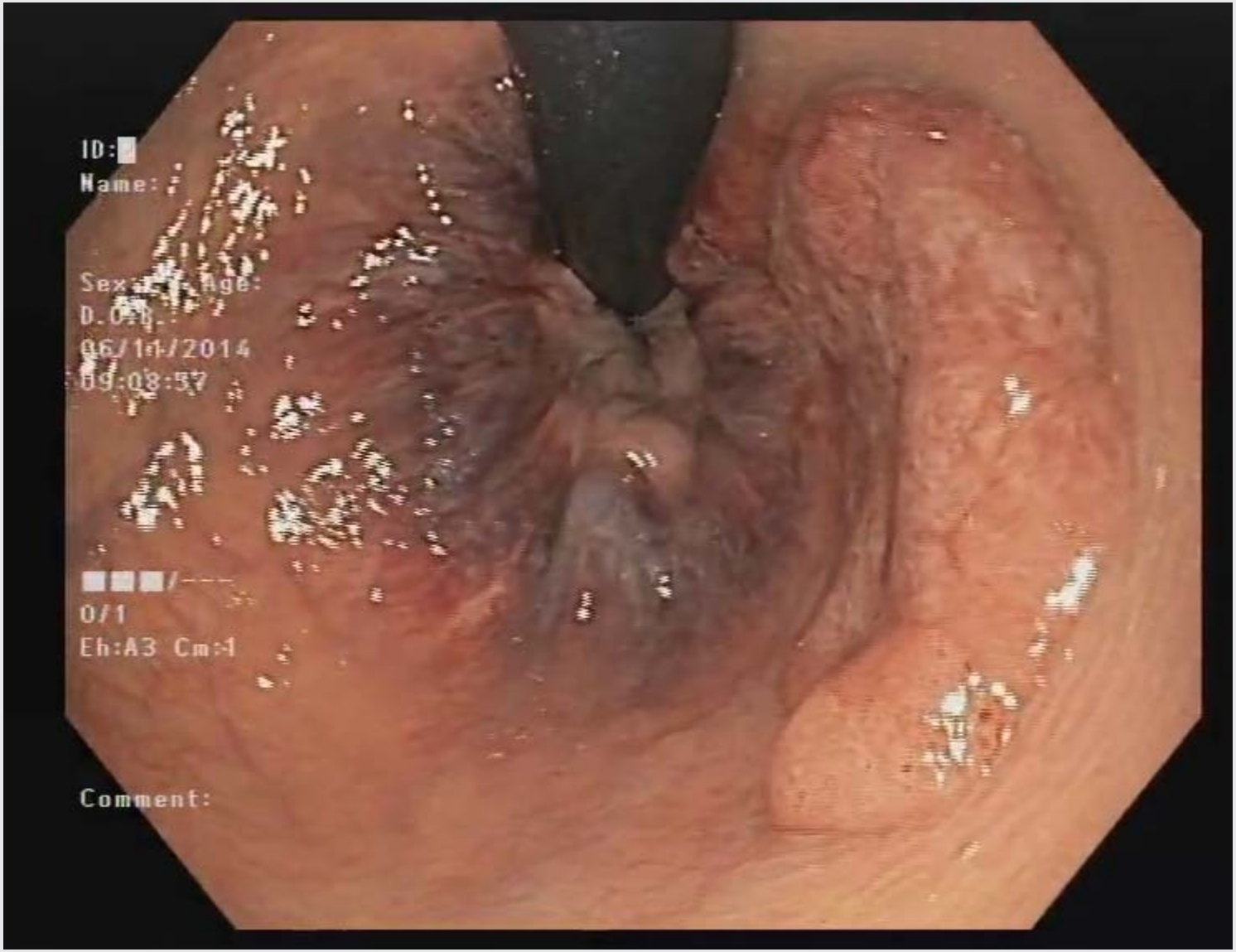
1) Adenoma serrato sessile e adenoma tubulare con displasia di basso grado.

2) Adenocarcinoma con aspetti di scarsa differenziazione, infiltrante la sottomucosa, insorto in adenoma tubulo-villoso con displasia di alto grado dell'epitelio. La neoplasia raggiunge il margine di resezione.

Grading Adenocarcinoma: alto grado.
Embolizzazione neoplastica: presente.
"Budding" tumorale: alto grado.
Margine di exeresi: interessato.
Percentuale tessuto adenomatoso/adenocarcinoma: 10/90
Ampiezza e profondità di infiltrazione dello stroma sottomucoso:
La profondità di infiltrazione è di 7 mm, l'ampiezza di infiltrazione di 8 mm.



F, 53 a, retto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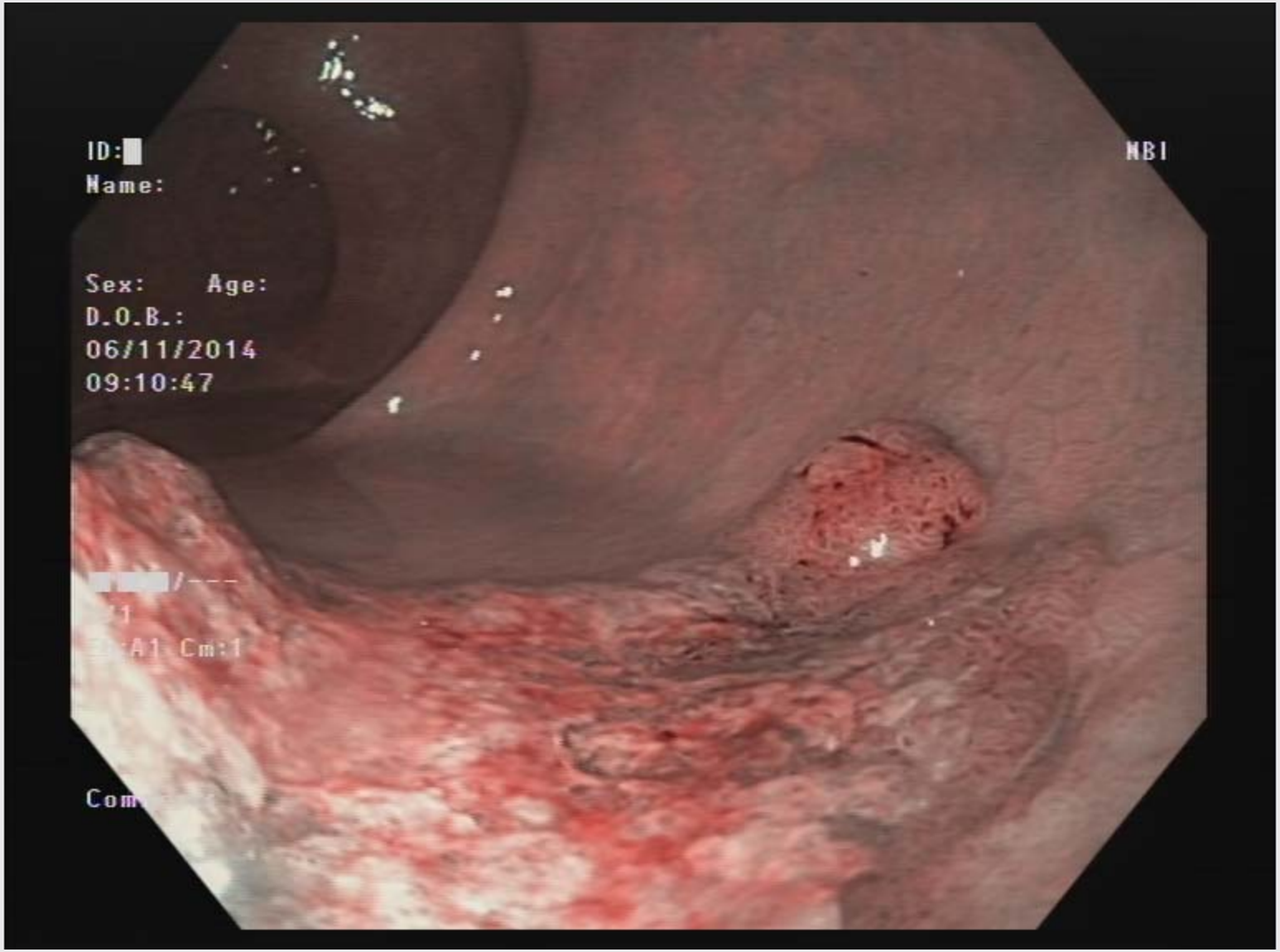
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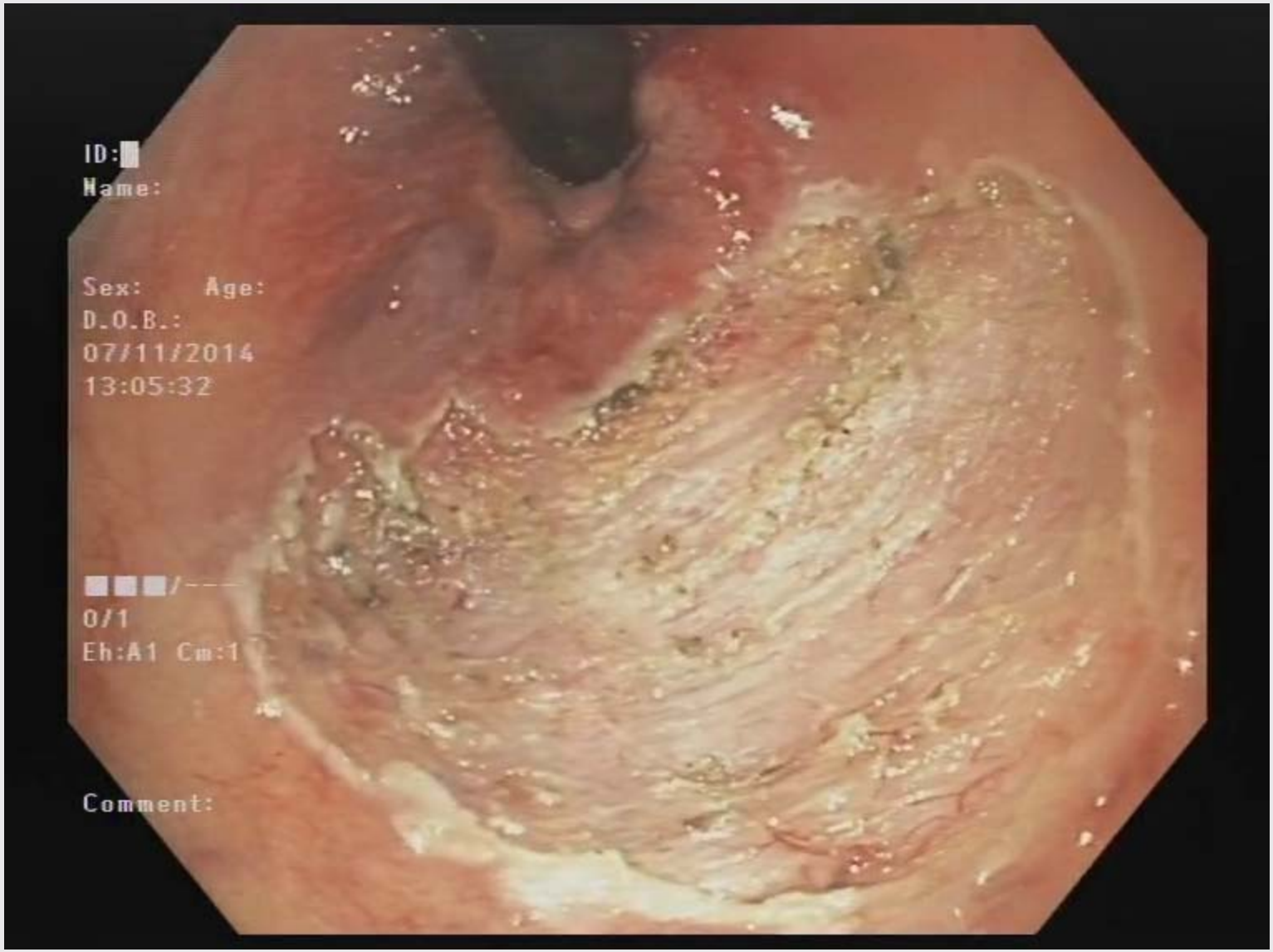
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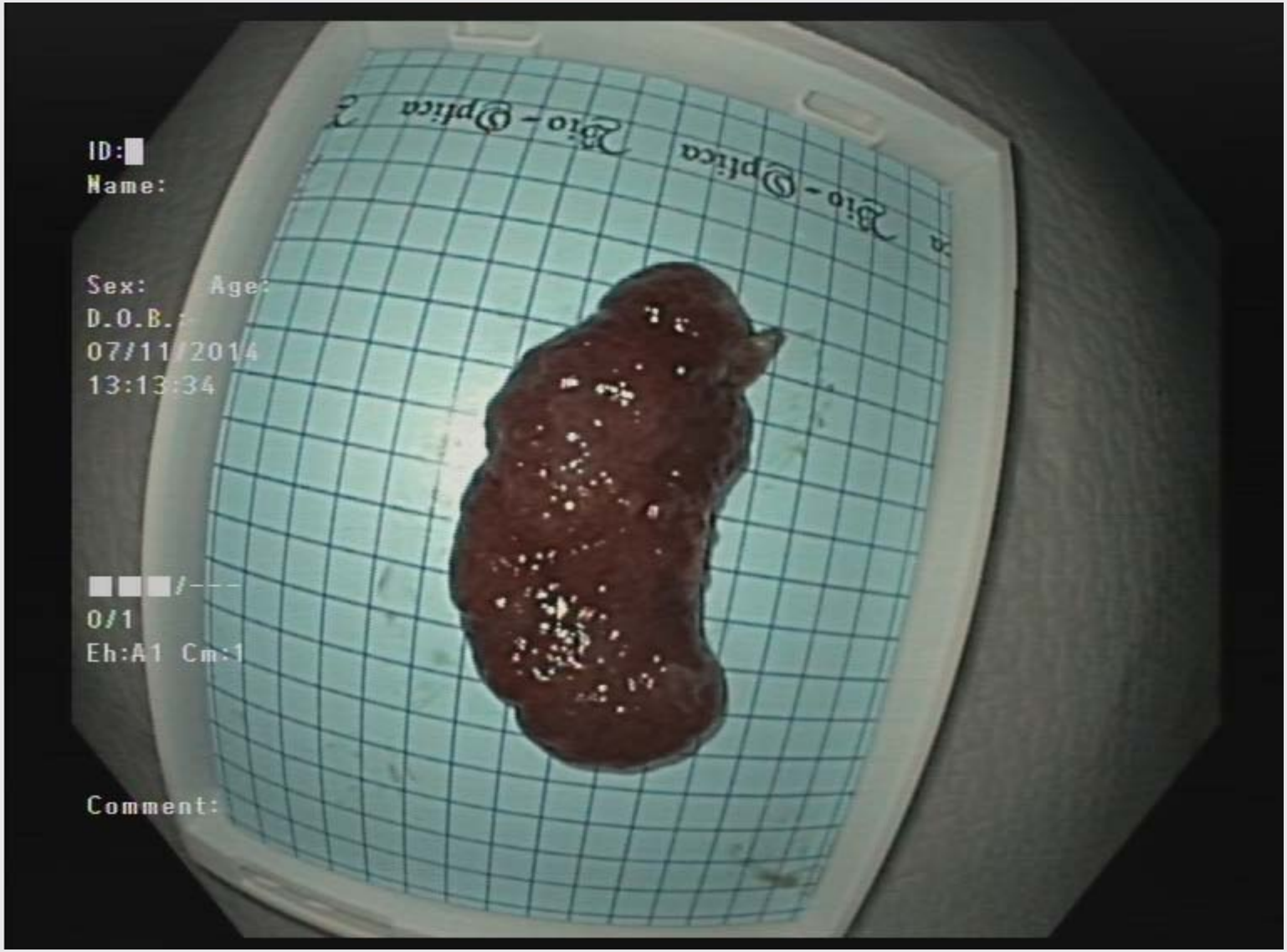
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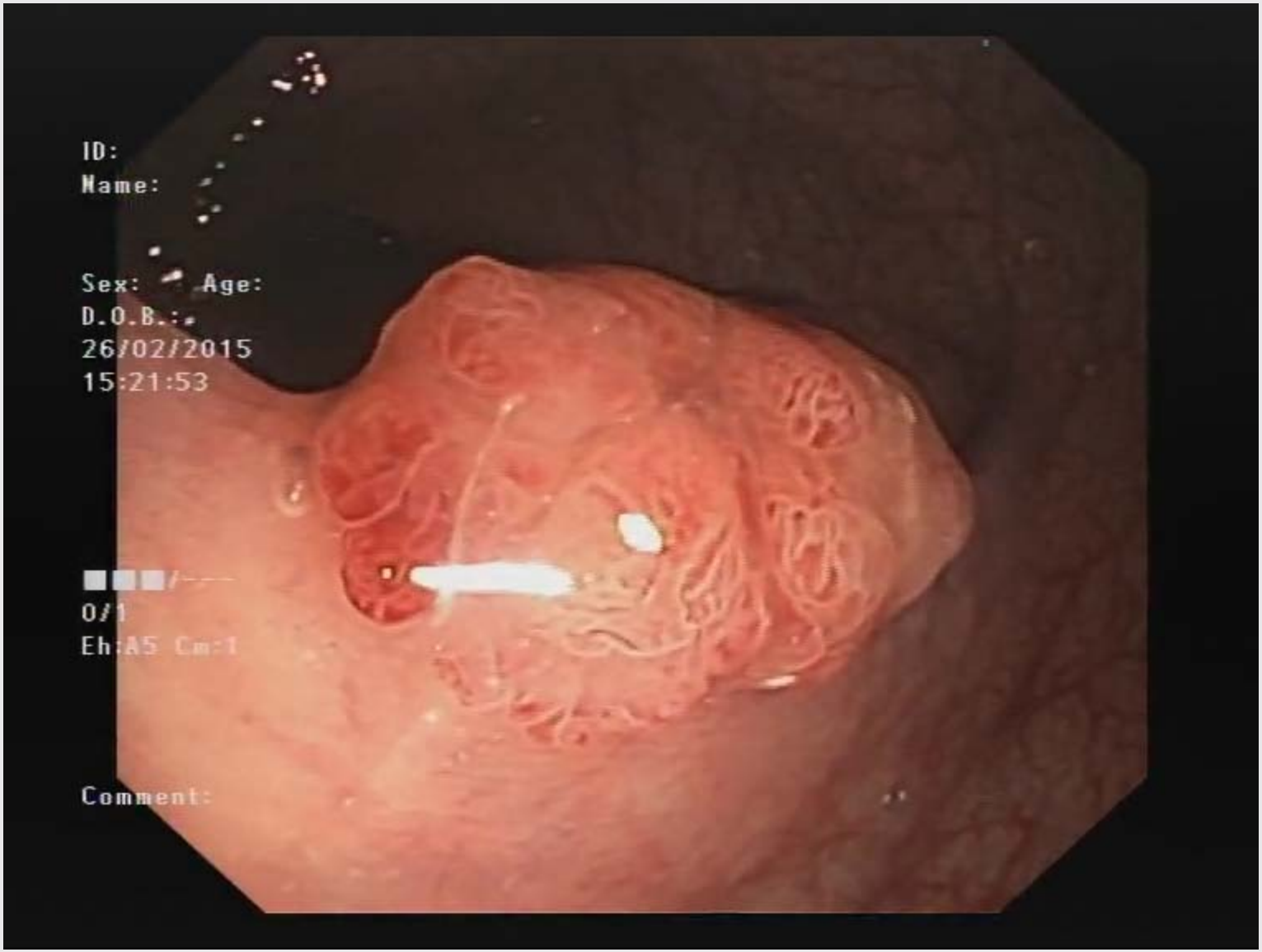
DESCRIZIONE MACROSCOPICA

Perviene in formalina, in macrobiocassetta, formazione polipoide sessile cm 3,2 x 1,5 orientata su carta millipore che si preleva con sezioni parallele e consecutive. I margini di resezione vengono inchiostrati. Il materiale viene prelevato in toto in 5 inclusioni.

DIAGNOSI ISTOLOGICA

Adenoma tubulovilloso con displasia di alto grado degli epiteli. Non si osservano aspetti di infiltrazione della sottomucosa. La base di impianto appare indenne e rivestita da epitelio iperplastico.



F , 71 a, retto

DESCRIZIONE MACROSCOPICA

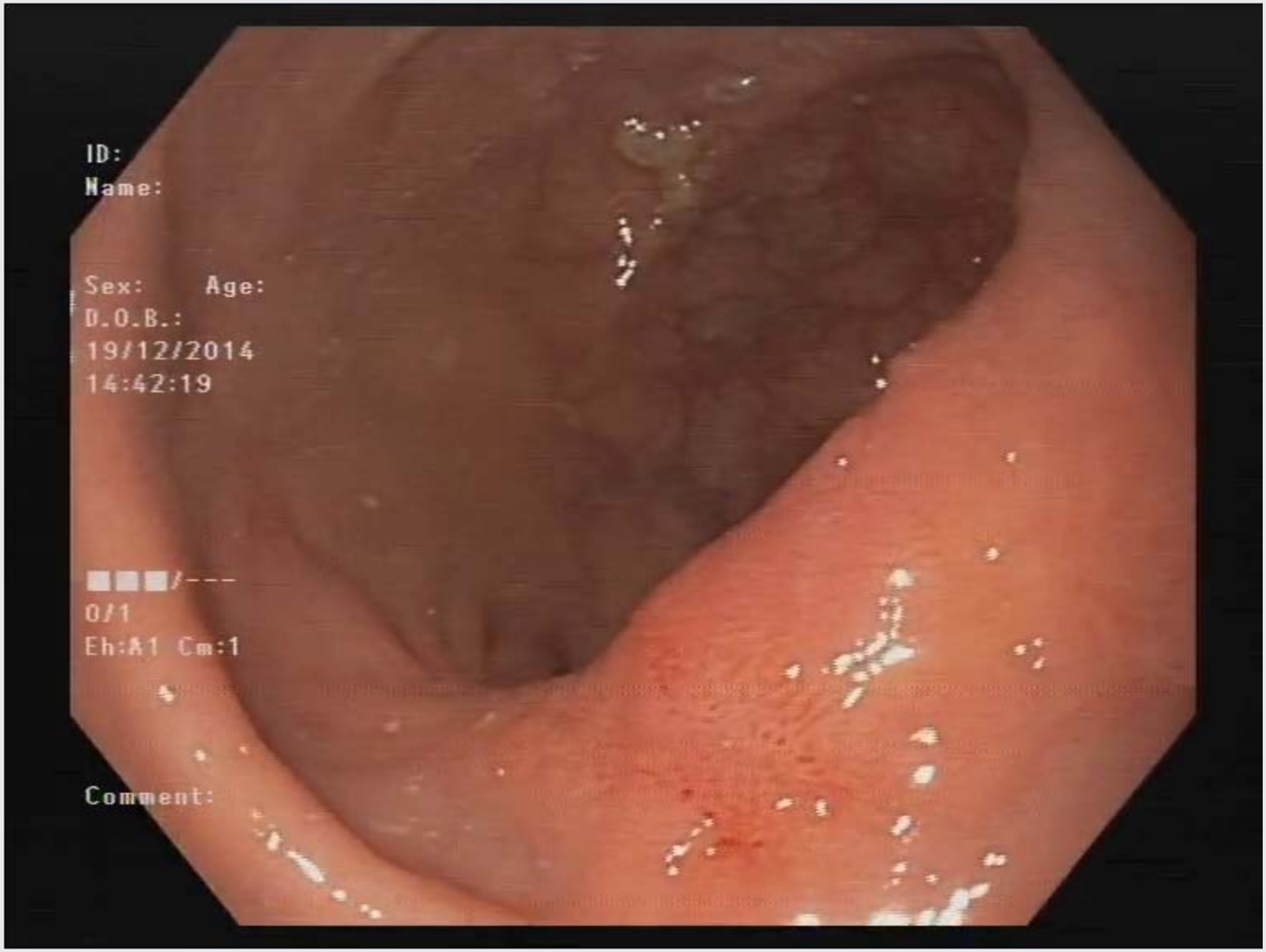
Pervengono in formalina in contenitori distinti:

1) Microfrustoli.
   Il materiale viene prelevato in toto in 1 inclusione (prelievo A).
2) Alcuni frammenti grigiastri e due frammenti polipodi di cm 2 e cm 1 di asse maggiore.
   Si preleva in toto come segue:
   B: frammenti minori; C: frammento polipoide di cm 1; D,E,F: frammento polipoide di cm 2.

DIAGNOSI ISTOLOGICA

1) Frammenti di adenoma tubulare con displasia di basso grado.
2) Adenocarcinoma mediamente differenziato, infiltrante la sottomucosa, insorto in adenoma tubulovilloso con displasia di alto grado dell'epitelio.
La neoplasia raggiunge il margine di resezione.
Grading Adenocarcinoma: basso grado.
Embolizzazione neoplastica: non evidente.
"Budding" tumorale: alto grado.
Margine di exeresi: interessato.
Percentuale tessuto adenomatoso/adenocarcinoma: 30/70
Ampiezza e profondità di infiltrazione dello stroma sottomucoso:
la profondità di infiltrazione è di 5 mm, l'ampiezza di infiltrazione di 7 mm.

CONCLUSIONE: la neoplasia è ad alto rischio di progressione neoplastica.



M , 76 a , retto , pregresse asportazioni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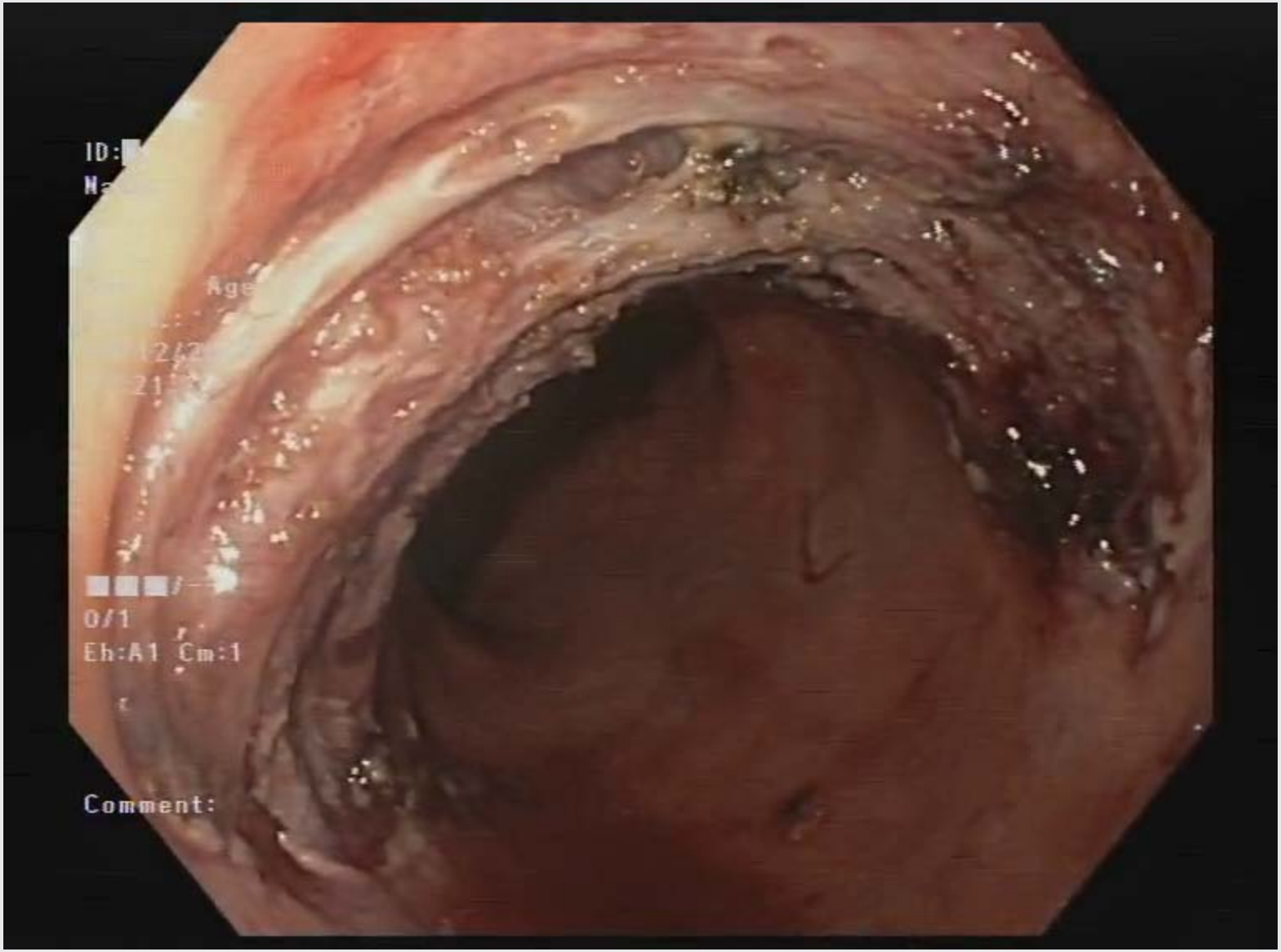
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DESCRIZIONE MACROSCOPICA

Perviene in formalina, appoggiato su carta millipore, lembo mucoso di cm 3.5x2.5. I margini di resezione vengono inchiostrati. Il materiale viene prelevato in toto in 8 inclusioni eseguendo sezioni seriate da una estremità verso quella opposta.

DIAGNOSI ISTOLOGICA

Adenocarcinoma mediamente differenziato, infiltrante la sottomucosa, insorto in adenoma tubulovilloso con displasia di alto grado dell'epitelio.
Non è presente budding tumorale, né aspetti di invasione vascolare.
La neoplasia è focale ed è presente in una sola sezione del prelievo "D" e giunge a 0,5 mm dalla banda di diatermocoagulazione.
La colorazione immunoistochimica per cheratina non ha fornito risultati significativi. Il materiale è stato subseriato.
Grading Adenocarcinoma: basso grado.
Embolizzazione neoplastica: non evidente.
"Budding" tumorale: assente.
Percentuale tessuto adenomatoso/adenocarcinoma: 95/5
Ampiezza e profondità di infiltrazione dello stroma sottomucoso:
La profondità di infiltrazione è di 0,8 mm, l'ampiezza di infiltrazione di 0,5 mm.

REFERTO BIS 2-2-15
Le immagini del caso sono state inviate al Dr. M R per un parere sul margine di resezione, che considera completamente indenne, libero da neoplasia per cui la lesione va considerata a basso rischio e quindi non è richiesto ulteriore trattamento.


ID:
Name:
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Near
Focus
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0/1
Eh:A1 Cm:1
Z:1.5
Comment:

E se anche lo riconosco, come lo tratto il T1

TECHNIQUES FOR COLONIC LESIONS

Polypectomy

Endoscopic Mucosal Resection (EMR)

Endoscopic Submucosal dissection (ESD)

La EMR nel trattamento dei polipi cancerizzati

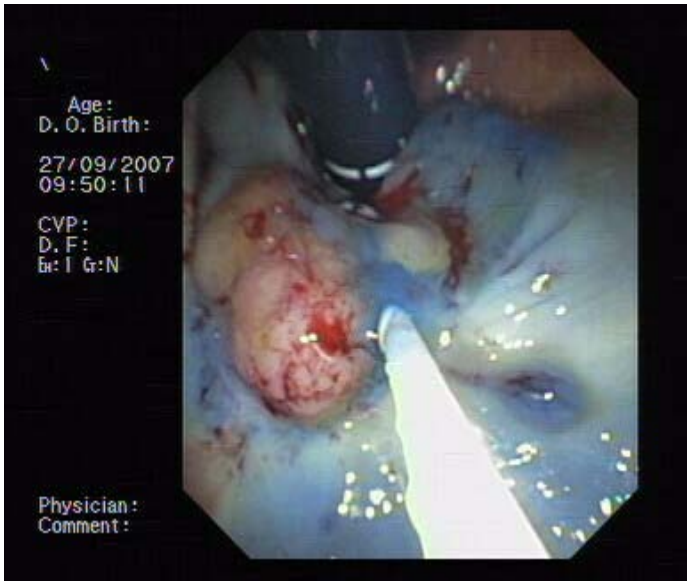
L’asportazione è a frammenti, se diametro > 2 cm per i limiti delle dimensioni del blocco di mucosa afferrabile con l’ansa

Le recidive sono frequenti (anche 20%) in caso di resezione peacemeal

In caso di polipo cancerizzato spesso è impossibile determinare lo stato dei margini e la profondità di invasione della sottomucosa→ indicazioni chirurgiche per istologia inadeguata

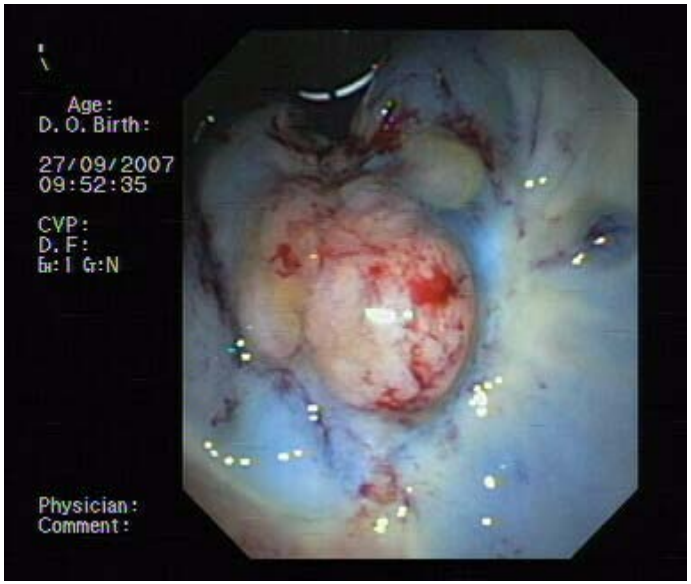
La EMR nel trattamento dei polipi cancerizzati: problematiche aperte

Il sollevamento delle lesioni può essere difficile, in particolare in conseguenza della fibrosi in esito a precedenti trattamenti o per interessamento della sottomucosa. In questi casi la EMR non è praticabile.



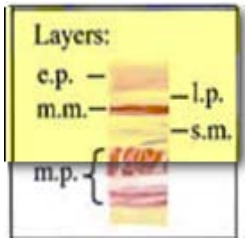
iniezione di 40 cc

di fisiologica

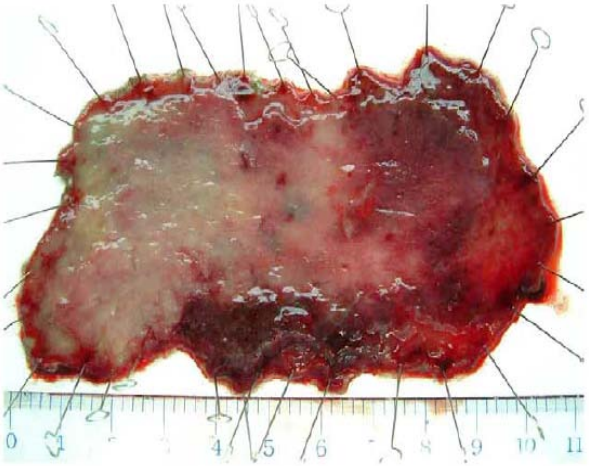


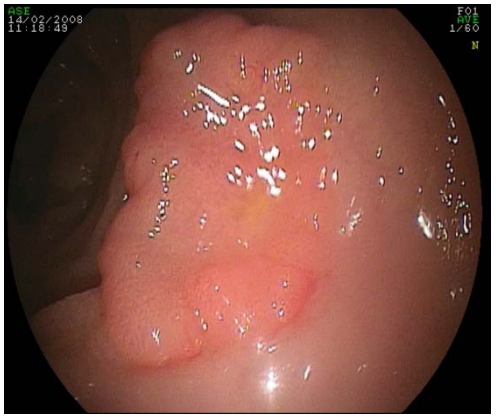
ESD (dissezione endoscopica sottomucosa)

Permette di rimuovere la mucosa affetta resecando in profondità fino a raggiungere,in alcuni casi, la tonaca muscolare.



E’ possibile asportare in blocco anche lesioni voluminose




ASE
14/02/2008
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F01
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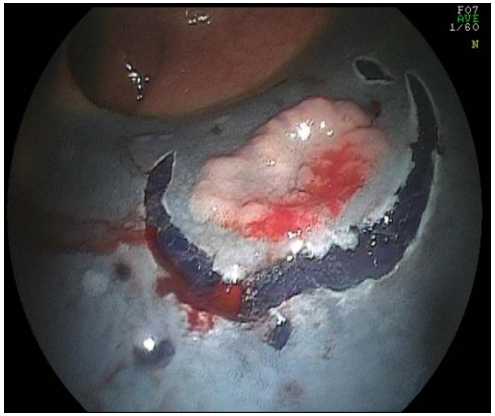
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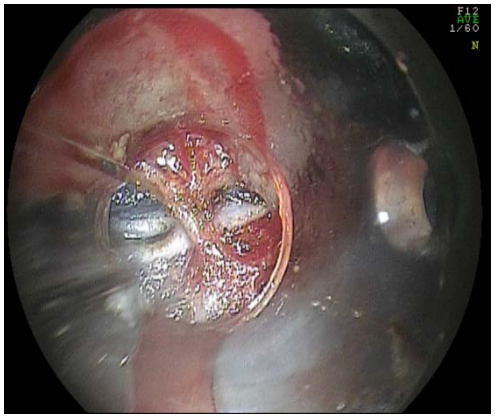
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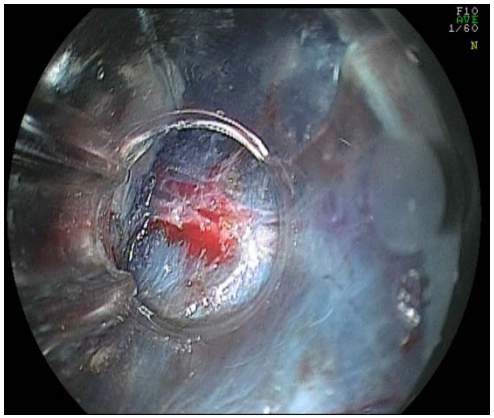
F10
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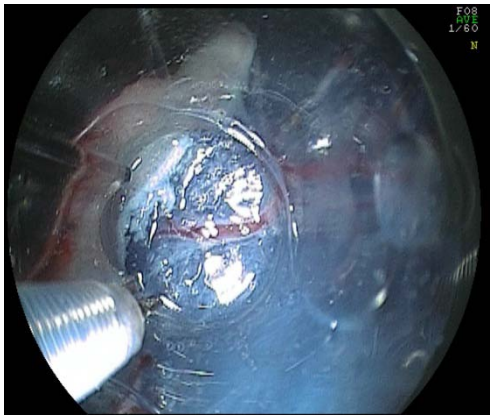
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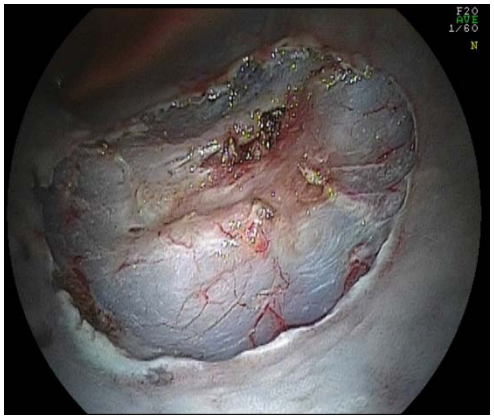
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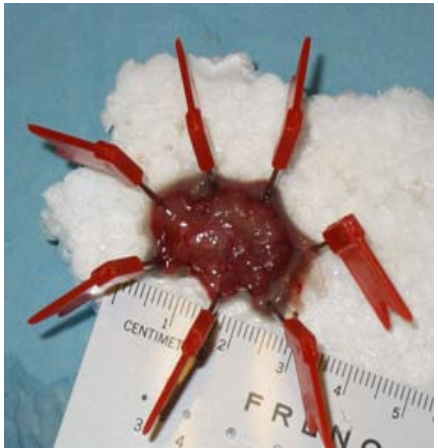


VANTAGGI DELLA ESD

controllo della forma e del profilo dei margini del frammento asportato;

asportazione in un unico frammento anche di lesioni di grosse dimensioni: istologia accurata e recidive/residui praticamente assenti

asportazione anche di lesioni di difficile sollevamento, quali quelle ulcerate o le recidive di pregressi trattamenti;

SVANTAGGI DELLA ESD

ampia esperienza nello stomaco in Giappone; progressiva, lentissima diffusione altrove

Procedura “time consuming” con durata difficimente prevedibile con conseguenti difficoltà anche organizzative

Richiede estrema pazienza

curva di apprendimento lunga

E’ tecnicamente difficile

Stressante per l’operatore (concentrazione costante, assenza di fasi facili)

E’ necessario dedicare maggiore attenzione ad informare adeguatamente il paziente

Endoscopic submucosal dissection: European Society of Gastrointestinal Endoscopy (ESGE) Guideline

Authors

Pedro Pimentel-Nunes[1], Mário Dinis-Ribeiro[1], Thierry Ponchon[2], Alessandro Repici[3], Michael Vieth[4], Antonella De Ceglie[5], Arnaldo Amato[6], Frieder Berr[7], Pradeep Bhandari[8], Andrzej Bialek[9], Massimo Conio[10], Jelle Haringsma[11], Cord Langner[12], Søren Meisner[13], Helmut Messmann[14], Mario Morino[15], Horst Neuhaus[16], Hubert Piessevaux[17], Massimo Rugge[18], Brian P. Saunders[19], Michel Robaszkiewicz[20], Stefan Seewald[21], Sergey Kashin[22], Jean-Marc Dumonceau[23], Cesare Hassan[24], Pierre H. Deprez[17]

Table 3 Outcomes of endoscopic submucosal dissection (ESD) for colorectal superficial lesions.

Study First author, year	Lesions included, n	Location (colon or rectum)	En bloc resection rate, n/N (%)	Complete R0 resection rate R0 n/N (%)	Local recurrence rate, n/N (%)	Mortality, ESD-related	Procedure-related bleeding, n/N (%)	Procedure-related perforation, n/N (%)	Mean operation time, min
Repici 2012 [190] (systematic review)	2841	Both	2727/2841 (96)	2500/2841 (88%)	1/1397 (<0.1%)	0	47/2841 (2%)	135/2841 (4%)	
Hisabe 2012 [192]	200	Both	172/200 (86%)	–	–	–	2/200 (1%)	14/200 (7%)	109
Takeuchi 2012 [193]	185	Both	172/185 (93%)	140/185 (76%)	6/185 (3%)	–	4/185 (2%)	3/185 (<2%)	–
Lee 2013 [194]	1000	Both	973/1000 (97%)	911/1000 (91%)	3/722 (<1%)	–	4/1000 (<1%)	53/1000 (5%)	–
Repici 2013 [195]	40	Rectum	36/40 (90%)	32/40 (80%)	1/40 (2%)	–	2/40 (5%)	1/40 (2%)	86
Rahmi 2014 [196]	45	Rectum	29/45 (64%)	24/45 (53%)	3/45 (7%)	–	6/45 (13%)	8/45 (18%)	110

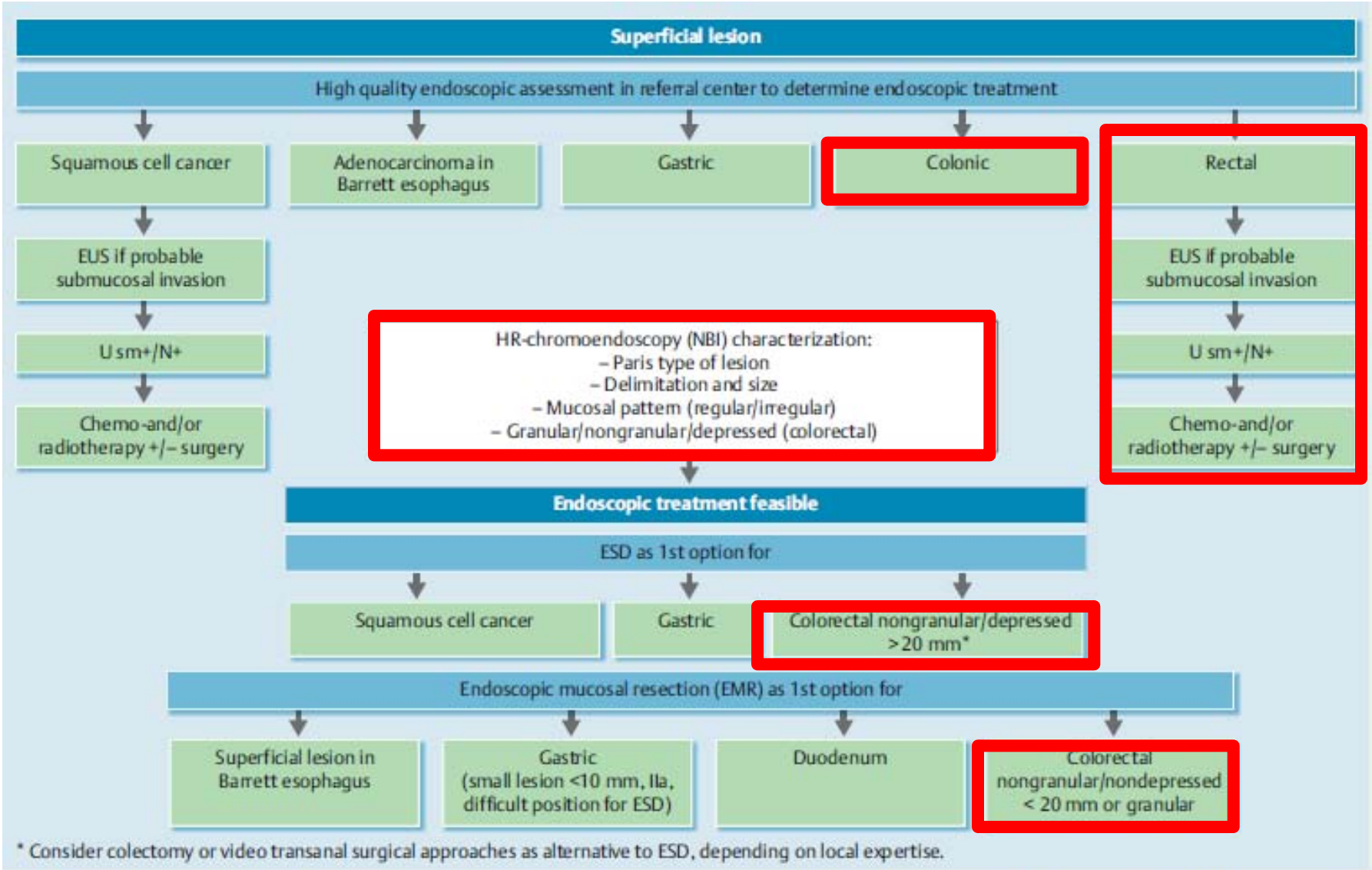


Fig. 1 Endoscopic submucosal dissection (ESD) for superficial lesions: a decision-making algorithm. EUS, endoscopic ultrasound; U sm+N/+, ultrasound suggestive of submucosal invasion or positive lymph nodes.

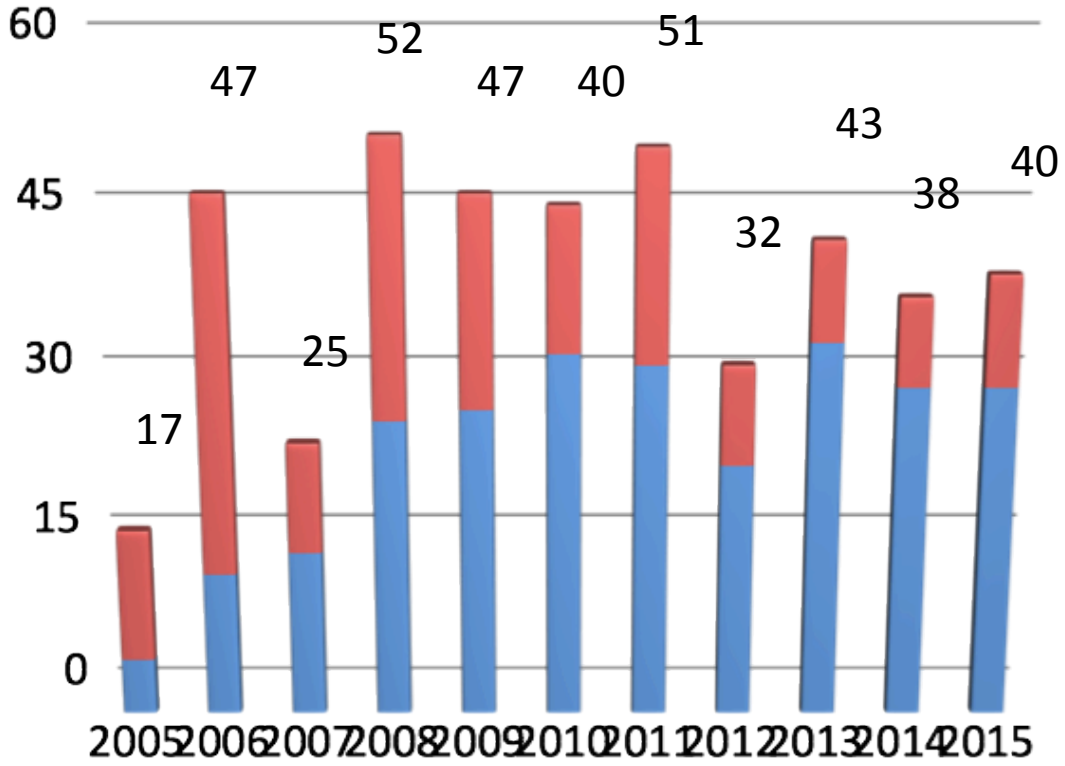
<table>
<tr><td></td><td colspan="3">VM0</td><td>VM1</td></tr>
<tr><td rowspan="2">En bloc HM0</td><td colspan="3">R0</td><td rowspan="2">R1</td></tr>
<tr><td>No submucosal invasion</td><td>< Cutoff*,
L0 & V0,
Well moderately differentiated</td><td>> Cutoff*, or
L1 or V1, or
Poorly differentiated</td></tr>
<tr><td colspan="2">Low-risk resection
(endoscopic follow-up is enough)</td><td>High risk resection
(i.e. surgery +/− adjuvant treatment recommended)</td><td>High risk resection
(i.e. surgery +/− adjuvant treatment recommended)</td></tr>
<tr><td rowspan="2">En bloc HM1c
En bloc HM1d
Piecemeal</td><td colspan="3">RX</td><td>R1</td></tr>
<tr><td colspan="2">Local-risk resection
(endoscopic follow-up and putative therapy may be possible)</td><td>High risk resection
(i.e. surgery +/− adjuvant treatment recommended)</td><td>High risk resection
(i.e. surgery +/− adjuvant treatment recommended)</td></tr>
</table>

Notation: VM, vertical margin; HM, horizontal margin; R, resection; L, lymphatic invasion; V, vascular invasion; c, carcinoma; d, dysplasia

Fig. 2 Pathological criteria for determining whether to consider the resection as low risk, local risk (risk of local recurrence), or high risk (to be adjusted according to organ and size if required). * Cutoff will differ: SCC ≤ 200 µm, Barrett's or gastric adenocarcinoma ≤ 500 µm and colorectal adenocarcinoma ≤ 1000 µm

Ma di quanti T1 discutiamo in questo gruppo multi disciplinare?

T1 osservati 2005-2015 endoscopie ASMN e AUSL Reggio Emilia



Tot.432

Screening

Routine

RCS
ADVANCING SURGICAL STANDARDS

COLORECTAL

Ann R Coll Surg Engl 2013; **95**: 477–480
doi 10.1308/003588413X13629960048271

Variability in management of T1 colorectal cancer in Wales

U Khalid, MD Evans, GL Williams, J Hanson, M Davies

on behalf of the Colorectal Cancer Subgroup of the National Specialist Advisory Group for Cancer, Wales, UK

ABSTRACT

INTRODUCTION The management of T1 colorectal cancer is controversial. Surgical resection should offer cure in the majority of patients and can stage lymph nodes accurately. Nevertheless, there can be significant associated morbidity and it potentially risks overtreating the patient. Endoscopic/local excision has significantly reduced morbidity but risks undertreating undetected metastatic lymph nodes, thereby compromising oncological outcomes. The aim of this study was to review the practice across Wales over a two-year period.

METHODS Data on T1 tumours for the period of 2009–2011 were collected from the Cancer Network Information System Cymru.

RESULTS A total of 161 patients were diagnosed as having T1 colorectal cancer (without prior neoadjuvant treatment). The median age was 68 years (range: 14–91 years) and 66% of the patients were male. Forty-eight (30%) of these tumours were screen detected. There were 112 colonic and 49 rectal tumours. Ninety-five patients with colonic tumours (85%) underwent major surgical resections, 51% of which were laparoscopic. Forty patients with rectal cancers (82%) underwent major surgical resection and 45% of these procedures were laparoscopic. The rest of the patients underwent local excision in the form of endoscopic polypectomy or transanal resection.

CONCLUSIONS This study demonstrates that there is no consensus in the management of T1 disease across Wales. With the advent of screening and the development of more sophisticated endoscopic techniques, the decision of how to treat T1 colorectal cancer will become a more regular challenge for the colorectal multidisciplinary team. The treatment needs standardisation. For now, however, this balance of risk will need to be made on an individual patient basis.

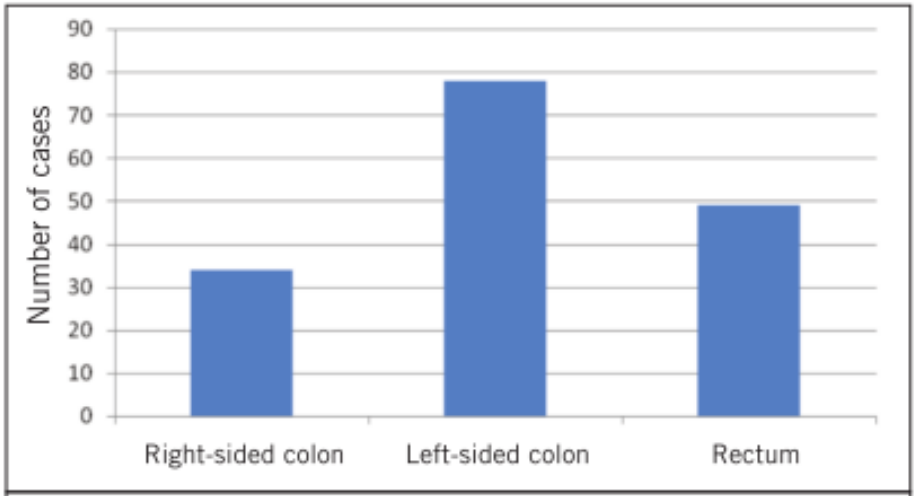


Figure 1 Distribution of T1 tumours according to tumour site

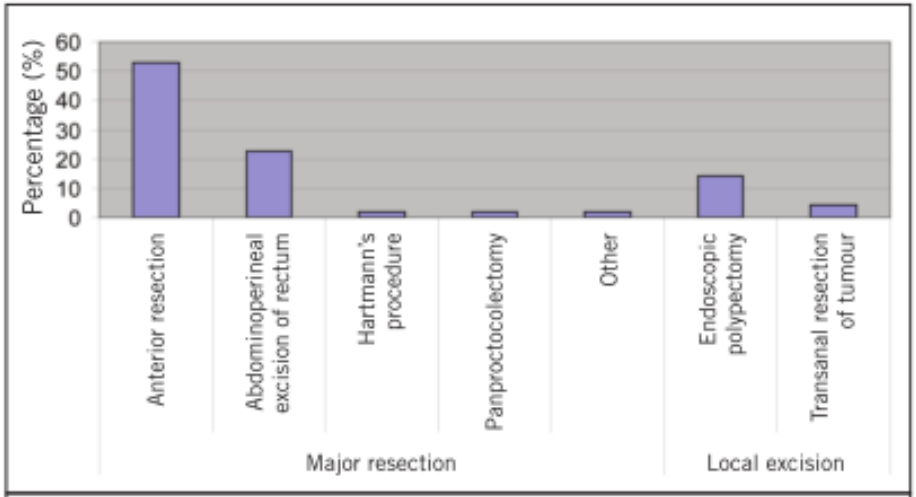


Figure 3 Treatment for T1 cancers originating in the rectum

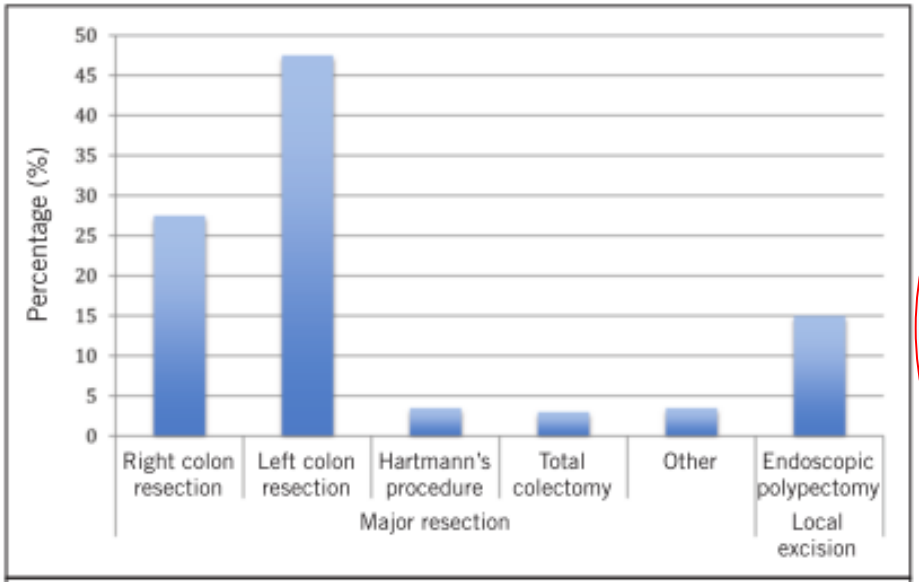


Figure 2 Treatment for T1 cancers originating in the colon

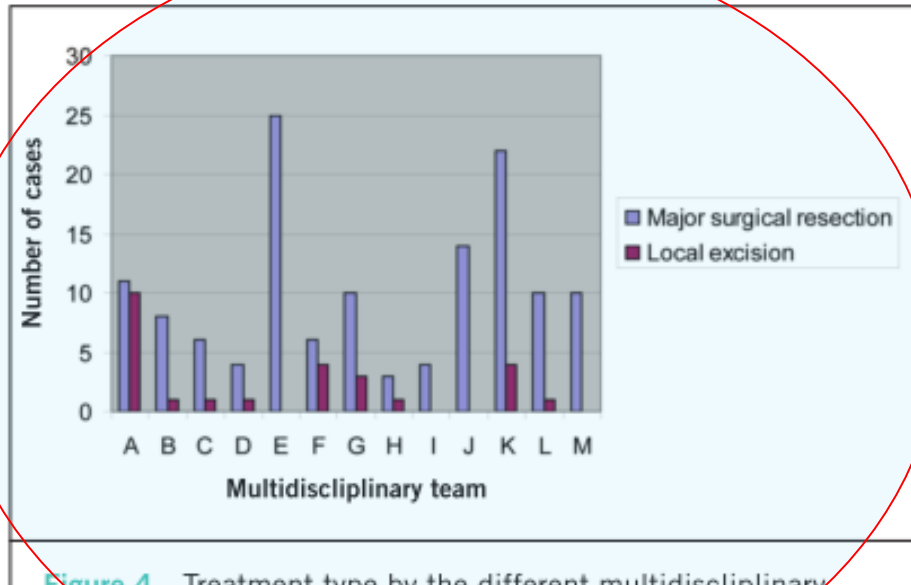
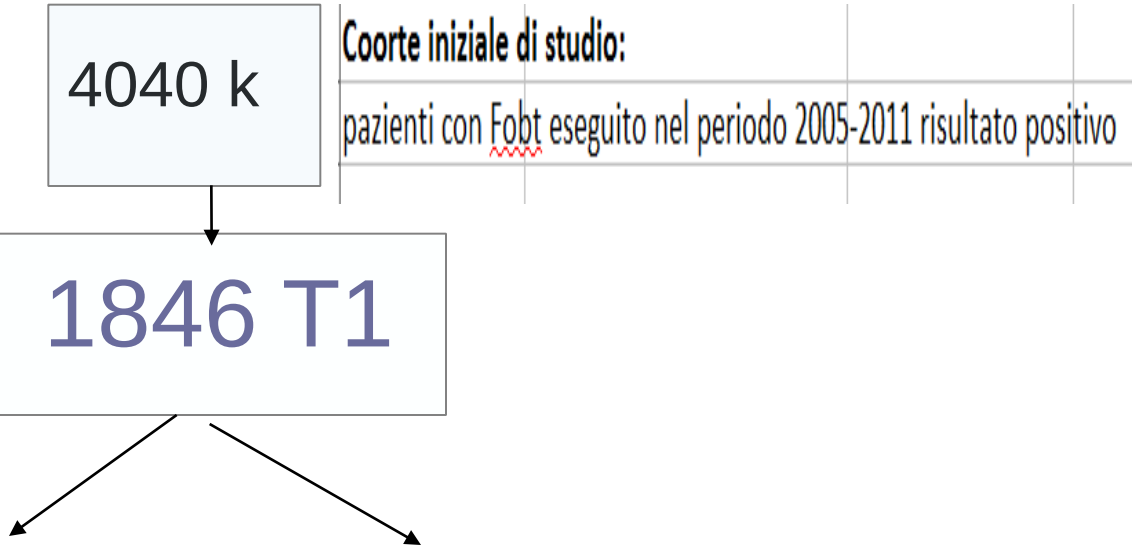


Figure 4 Treatment type by the different multidiscliplinary teams in Wales

Adenocarcinomi T1 nel programma di screening dei tumori colorettali dell'Emilia-Romagna: frequenza, trattamento...

Cinzia Campari, Romano Sassatelli



1297 (70.2%)
curati con chirurgia

609 dopo istologia
688 dopo polipectomia

1181 dopo prima endoscopia,
192 senza istologia,
87 dopo più di una endoscopia,
29 colon non agganciate

549 (29.8%)
curati con polipectomia

Su 1206 trattati con polipectomia
688 (57%) a chirurgia successiva

1198 direttamente alla prima endoscopia,
8 a seconda o terza endoscopia

Indicatori per azienda

AUSL	% lesioni T1 inviate a ch	% lesioni T1 con tentativo asport. endoscopica	% lesioni T1 inviate a ch dopo tentativo asport. endoscopica
Piacenza	72%	37%	38%
Parma	71%	48%	59%
Reggio Emilia	77%	78%	70%
Modena	72%	71%	61%
Bologna	68%	71%	55%
Imola	84%	38%	63%
Ferrara	76%	53%	59%
Romagna	64%	72%	51%
TOT.	70%	65%	57%

Emilia-Romagna	colon destro	colon sinistro	retto	totale
numero lesioni	359	1215	272	1846
% lesione	19%	66%	15%	100%
% lesioni T1 inviate a ch	88%	63%	81%	70%
% lesioni T1 con tentativo asport. endoscopica	43%	75%	53%	65%
% lesioni T1 inviate a ch dopo tentativo asport. endoscopica	73%	53%	64%	57%

Grazie per l’attenzione