LA SORVEGLIANZA ENDOSCOPICA NELLO SCREENING - NUOVE CONSIDERAZIONI

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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%

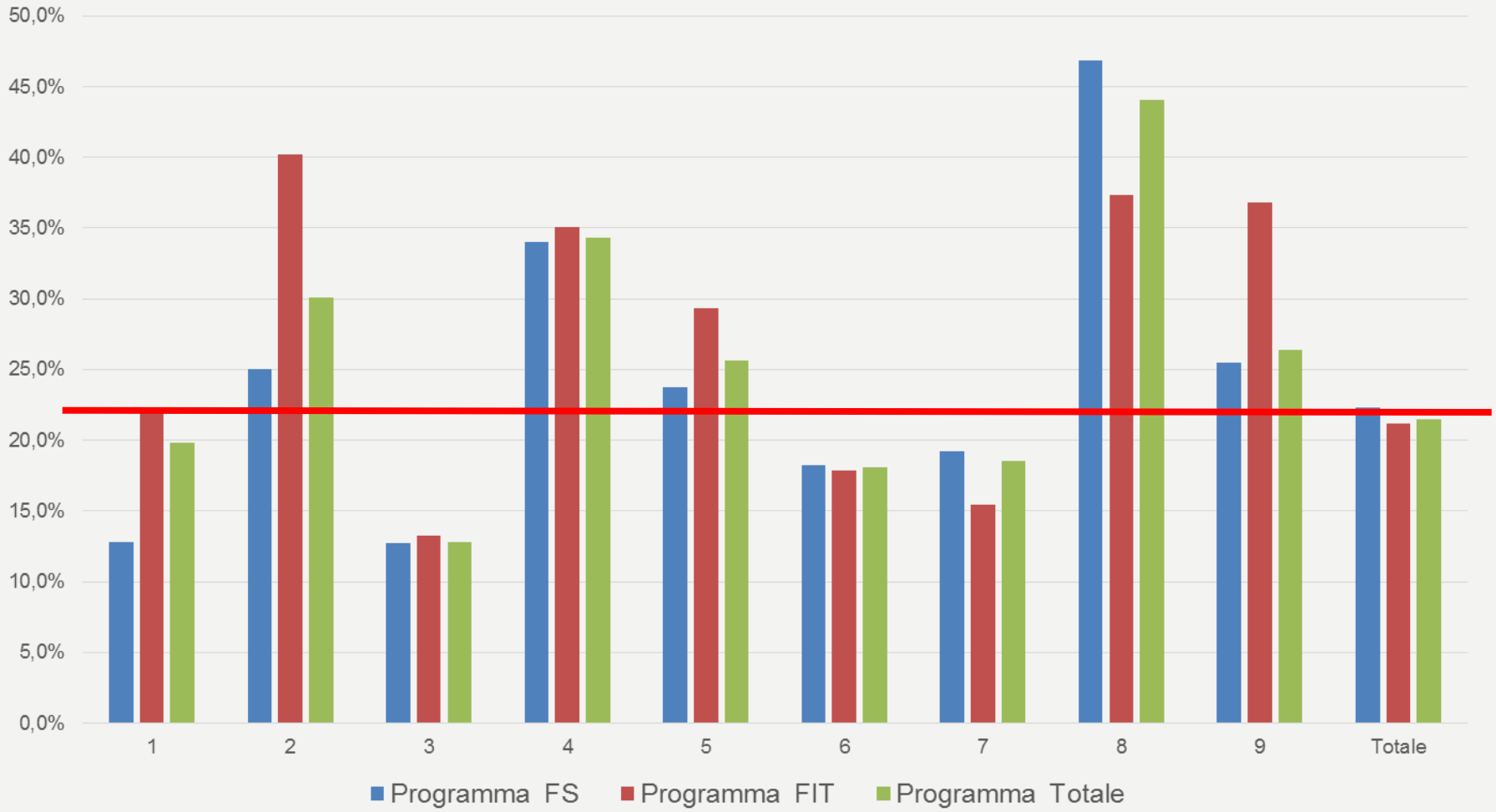
Schoen et al; Gastroenterol 2010; 138: 73–81

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%)

Indicazioni alla sorveglianza non corrispondenti alle raccomandazioni delle linee guida – 2019



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

ABU FREHA N ET AL. INT J COLORECTAL 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)
- Israel → 43% (Abu Freha et al, 2020)

Predictive factors for early recall:

-hyperplastic/HR adenomatous polyps

-comorbidity score

-suboptimal preparation

-family history

-geographic variability

J Clin Gastroenterol. 2009 Jul;43(6):554-8. doi: 10.1097/MCG.0b013e31818242ad.

Why don't gastroenterologists follow colon polyp surveillance guidelines?: results of a national survey

Sameer D Saini [1], Rahul S Nayak, Latoya Kuhn, Philip Schoenfeld

Conclusions: Though many gastroenterologists lack knowledge about guideline recommendations for colon polyp surveillance, even those who know the recommendations often ignore them and perform surveillance colonoscopy sooner than recommended.

Future studies should identify factors that lead gastroenterologists to disregard guideline recommendations, including:

- limitations in available data,
- medico-legal concerns,
- suboptimal bowel preparations,
- lack of financial incentives.

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REVIEW ARTICLE

ueg journal WILEY

Post-polypectomy surveillance colonoscopy: Comparison of the updated guidelines

Naim Abu-Freha[1] | Lior H. Katz[2] | Revital Kariv[3] | Elez Vainer[2] | Ido Laish[4] | Nathan Gluck[3] | Elizabeth E. Half[5] | Zohar Levi[6]

TABLE 1 Definitions used in the guidelines

Description/Term	Definition		
	USMSTF[3]	ESGE[4]	BSG/ACPGBI/PHE[5]
1–2 non-advanced adenomas <10 mm in size	Low-risk adenoma	Polyp not requiring surveillance	Premalignant polyp (not requiring surveillance)
Advanced adenoma/advanced adenomatous polyp	1. Adenoma ≥10 mm. 2. Adenoma with high-grade dysplasia. 3. Adenoma with tubulo-villous/villous histology.	Polyp requiring surveillance 1. Adenoma ≥10 mm. 2. Adenoma with high-grade dysplasia.	1. Adenoma ≥10 mm. 2. Adenoma with high-grade dysplasia.
Advanced neoplasia	Advanced adenoma CRC		This term has been used historically to describe the combination of advanced adenomas and colorectal cancers. It is considered outmoded because the serrated pathway is not included.
High-risk adenoma	Advanced neoplasia ≥3 adenomas		
Serrated polyp			Hyperplastic polyps (HPs), sessile serrated lesions (SSLs), SSLs with dysplasia (SSLd), traditional serrated adenomas (TSA) and mixed polyps.
Premalignant polyp			Serrated polyps and adenomatous polyps (excluding diminutive [1–5 mm] and rectal HPs)
Advanced serrated polyp			A serrated polyp ≥10 mm or with any grade of dysplasia.
Advanced colorectal polyp			The term includes both advanced serrated and advanced adenomatous polyps.

Abbreviations: ACPGBI, Association of Coloproctology of Great Britain and Ireland; BSG, British Society of Gastroenterology; CRC, colorectal cancer; ESGE, European Society of Gastrointestinal Endoscopy; PHE, Public Health England; USMSTF, US Multi-Society Task Force.

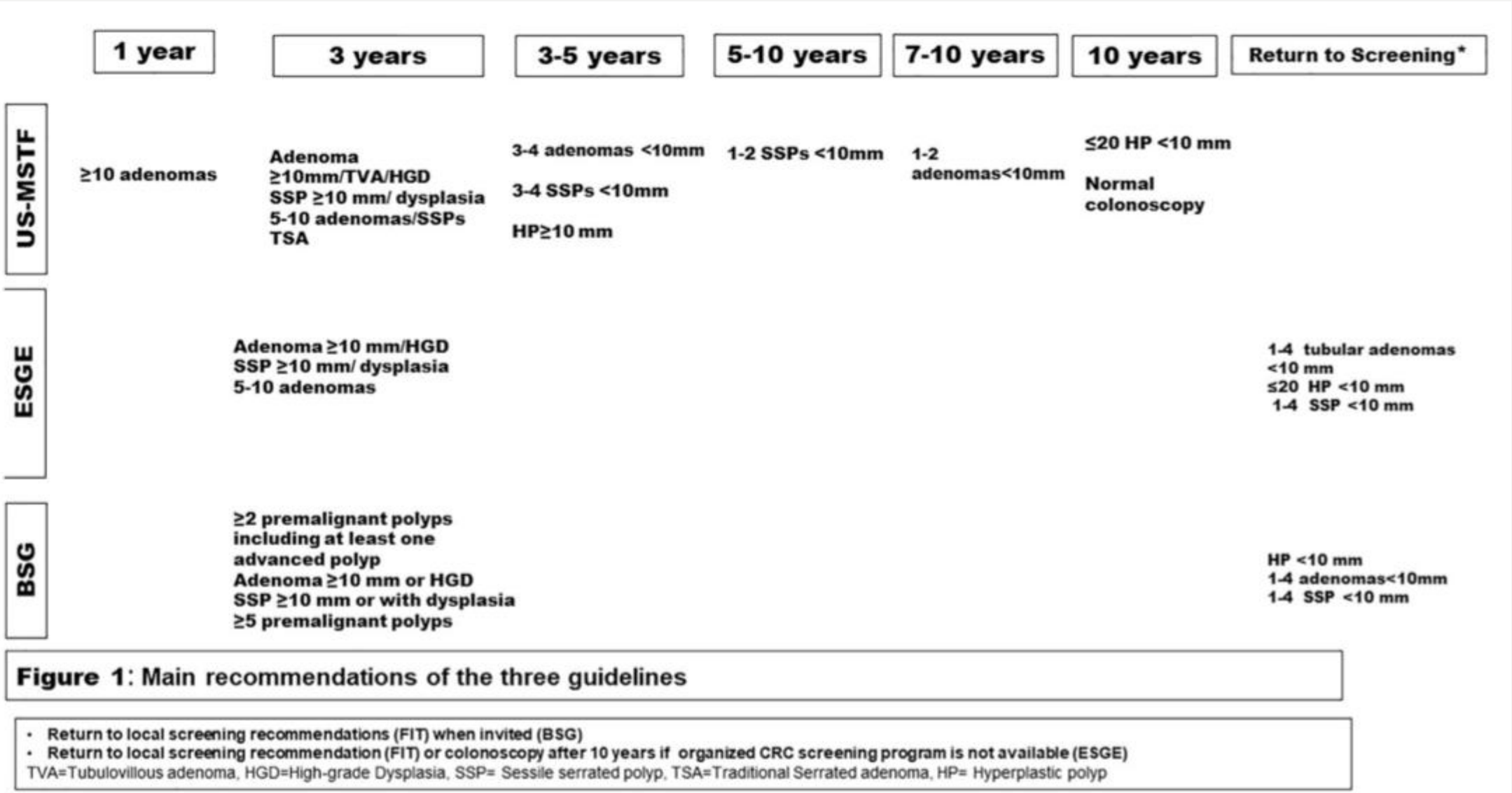
TABLE 2 Comparison of the main recommendations of the three guidelines

	USMSTF[3]	ESGE[4]	BSG/ACPGBI/PHE[5]
1–2 tubular adenomas <10 mm	7–10 years	No surveillance/return to screening	No surveillance/return to screening when invited
3–4 tubular adenomas <10 mm	3–5 years	No surveillance/return to screening	No surveillance/return to screening when invited
5–10 tubular adenomas <10 mm	3 years	3 years	3 years
Adenoma ≥10 mm	3 years	3 years	3 years[b]
Adenoma with tubulovillous or villous histology, <10 mm, low-grade dysplasia	3 years	No surveillance/return to screening	No surveillance/return to screening when invited
Adenoma with high-grade dysplasia	3 years	3 years	3 years[b]
>10 adenomas on single examination	1 year and genetic counseling	Genetic counseling	Referred to BSG hereditary CRC guidelines
Piecemeal resection of adenoma/SSP >20 mm	6 m	3–6 m	2–6 m[a]
≤20 HPs in rectum or sigmoid colon or proximal to sigmoid colon and <10 mm	10 years	No specific recommendation	No specific recommendation
HP > 10 mm	3–5 years	No specific recommendation	No specific recommendation
1–2 SSPs <10 mm	5–10 years	No surveillance/return to screening	No surveillance/return to screening
3–4 SSPs <10 mm	3–5 years	No surveillance/return to screening	No surveillance/return to screening
5–10 SSPs <10 mm	3 years	No specific recommendation	3 years
SSP with dysplasia	3 years	3 years	3 years[b]
SSP ≥ 10 mm	3 years	3 years	3 years[b]
Traditional serrated adenoma (TSA)	3 years	3 years	3 years[b]

Abbreviations: ACPGBI, Association of Coloproctology of Great Britain and Ireland; BSG, British Society of Gastroenterology; CRC, colorectal cancer; ESGE, European Society of Gastrointestinal Endoscopy; PHE, Public Health England; SSP, sessile serrated polyp; USMSTF, US Multi-Society Task Force.

[a]The BSG/ACPGBI/PHE recommend a second site check 18 months after the original resection.

[b]Surveillance at 3 years is recommended if there are two or more premalignant polyps, of which at least one is advanced (surveillance at 3 years would not be recommended if the patient has only one of these adenomas/SSPs).



E 1 Main recommendations of the three guidelines

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.


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

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

View full guideline

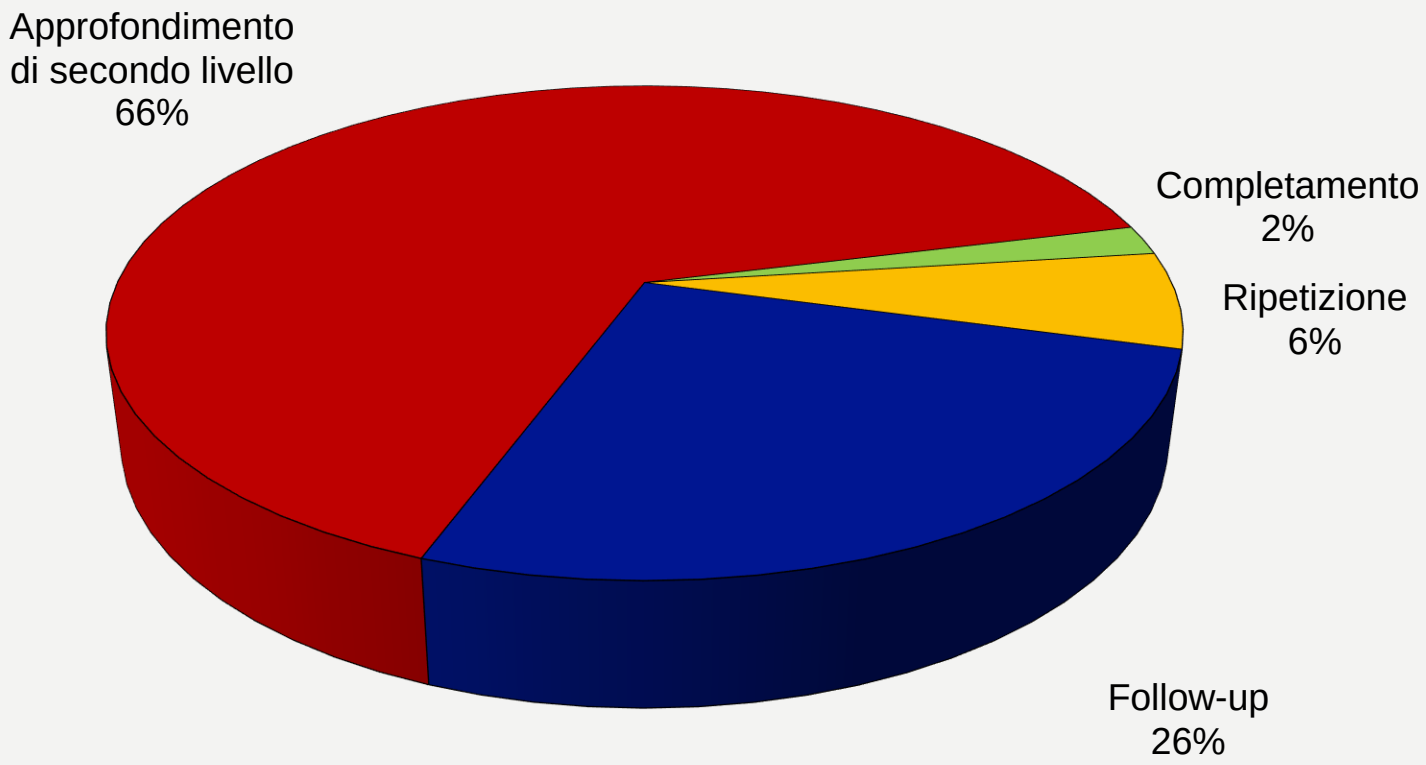
AGE TO STOP SURVEILLANCE

For surveillance, the USMSTF guidelines also discuss age as a contributing factor to their recommendations. They highlight the need for more research to determine whether the benefits of potential cancer prevention and early detection of CRC by way of surveillance outweigh the short-term procedure-related risks for individuals older than age 75 years.

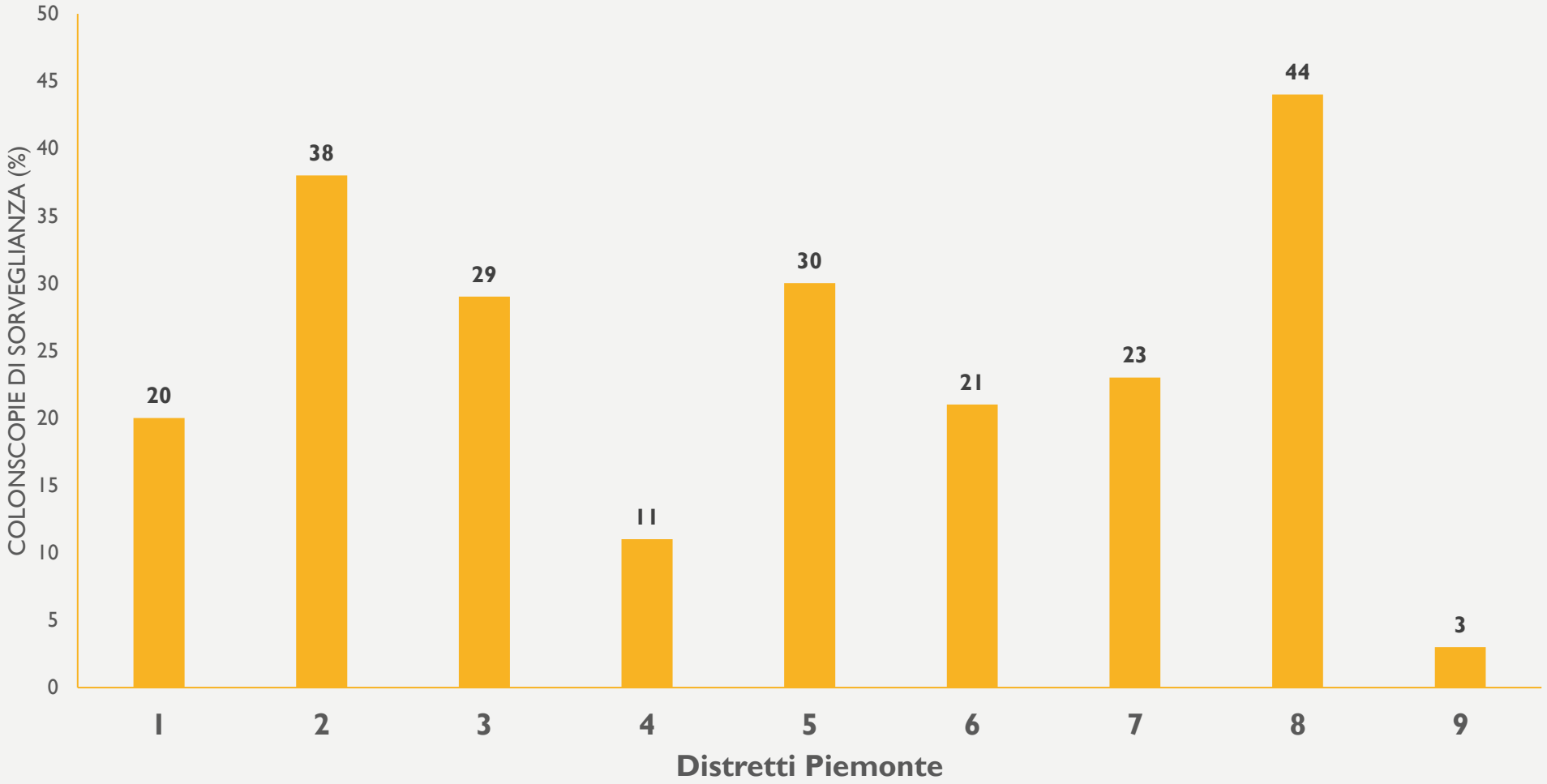
The ESGE recommends discontinuing post-polypectomy surveillance at the age of 80 or earlier if life expectancy is significantly limited by comorbidities. In a similar vein, the BSG/ACPGBI/PHE advise against routine post-polypectomy surveillance on patients older than age 75 years or patients with comorbidities that limit their life expectancy to less than 10 years.

PANDEMIA E SORVEGLIANZA ENDOSCOPICA

TIPOLOGIA DI ESAME – COLONSCOPIE DI SCREENING – PIEMONTE 2018



QUOTA DELLE COLONSCOPIE DI FOLLOW UP SUL TOTALE DELLE RISORSE ALLOCATE - 2019



Observational Study > Dig Dis Sci. 2021 Aug;66(8):2578-2584.
doi: 10.1007/s10620-020-06539-1. Epub 2020 Aug 16.

Adoption of Multi-society Guidelines Facilitates Value-Based Reduction in Screening and Surveillance Colonoscopy Volume During COVID-19 Pandemic

Alexander Hua Xiao [1], Stephen Y Chang [1 2], Christian G Stevoff [1 2], Srinadh Komanduri [1 2], John E Pandolfino [1 2], Rajesh N Keswani [3 4]

Conclusion: Up to one-fifth of patients scheduled for "open-access" colonoscopy can be rescheduled into a future year based on USMSTF guidelines. Rigorously applying guidelines could judiciously allocate colonoscopy resources as we recover from the COVID-19 pandemic.

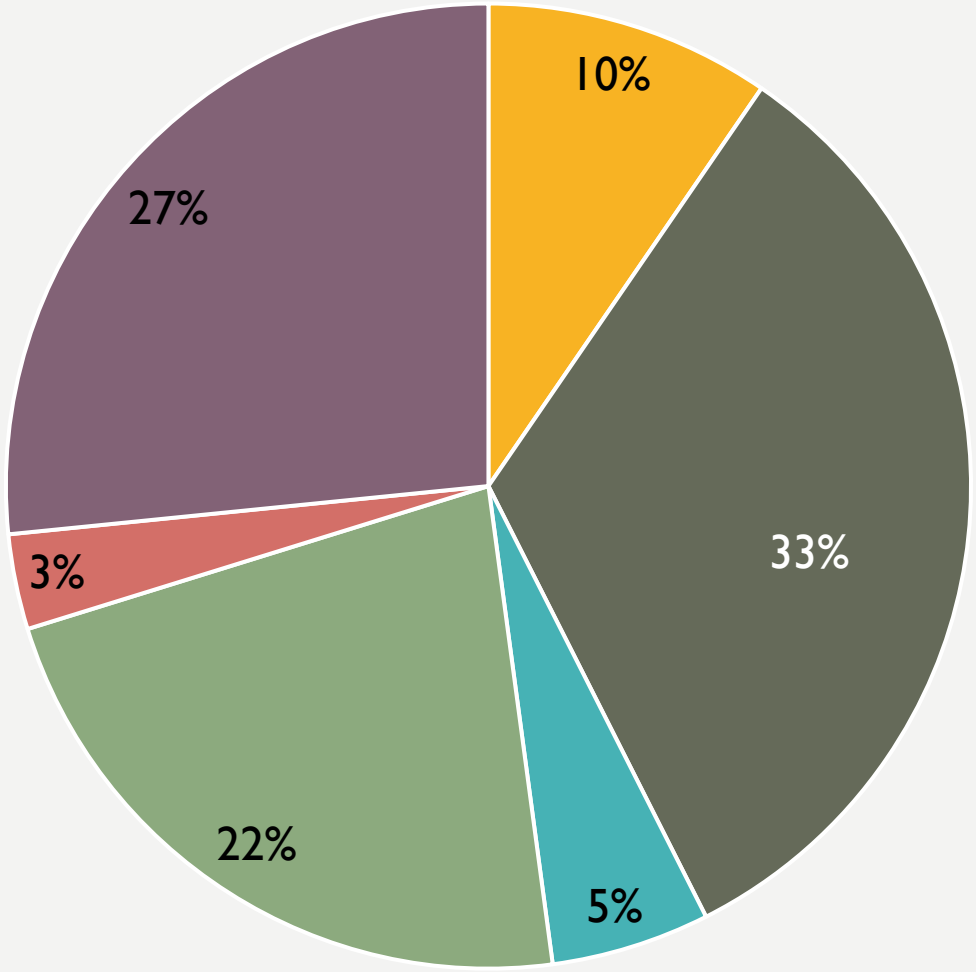
ALLOCAZIONE RISORSE ENDOSCOPICHE SCREENING- PIEMONTE 2020

	Programma FIT				Programma FS		
	FIT+		Sorveglianza		Esami 2019	Esami 2020	% 2020 su 2019
	Gen-Sett	Gen-Dic	Gen-Sett	Gen-Dic			
1	50%	47,8%	67%	51,3%	3775	1176	31,2%
2	75%	67,5%	87%	86,1%	1138	529	46,5%
3	46%	37,7%	48%	35,7%	2074	703	33,9%
4	50%	48,4%	127%	144,8%	2219	394	17,8%
5	40%	36,2%	54%	32,9%	1250	483	38,6%
6	42%	36,0%	39%	33,3%	2009	516	25,7%
7	58%	55,7%	66%	89,2%	2884	913	31,7%
8	22%	22,0%	77%	96,9%	912	198	21,7%
9	33%	28,2%	178%	138,5%	587	105	17,9%

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
- Data priorità assoluta ai casi di controllo a 2-6 mesi post-EMR con tecnica piece-meal

NUOVA ATTRIBUZIONE DEGLI INTERVALLI DI SORVEGLIANZA



I semestre 2021

II semestre 2021

ripetizioni per scarsa preparazione

no FU

record inadeguati

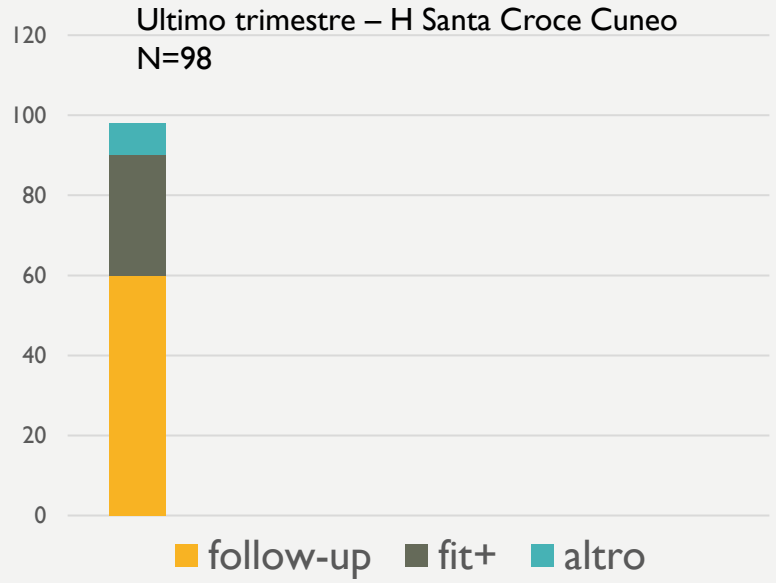
2022-2025

N=185

COLONSCOPIE DI SORVEGLIANZA - OSPEDALE SANTA CROCE CUNEO -2020-2022

- Semestre 2020/2021 sospensione delle endoscopie di sorveglianza –
- Programmati solo Fit-positivi, sigmoidoscopie e colonscopie post-sigmoidoscopia

- Successivo inserimento di 2 follow-up alla settimana
- Attualmente sbilanciamento a favore degli esami di follow-up



CONSIDERAZIONI CONCLUSIVE I

- C'è ancora molto da lavorare per ottimizzare gli intervalli di sorveglianza post-colonscopia di screening, alla luce delle innovazioni e della variabilità nelle linee-guida
- Non e' facile identificare una categoria di pazienti a maggior rischio di «errore» nelle raccomandazioni per i successivi controlli
- La pandemia e il post-pandemia ha creato ampia variabilità nell'allocazione degli esami endoscopici di sorveglianza

CONSIDERAZIONI CONCLUSIVE II

- I punti cruciali su cui vigilare maggiormente:

- I bassi rischi (no endoscopia!)
- Gli ex-rischi intermedi (maggior lassità nella sorveglianza),
- Gli adenomi tubulo-villosi (maggior lassità nella sorveglianza)
- T1 da sorvegliare a un anno
- Il rispetto del timing del FU a breve termine nelle lesioni asportate piece-meal
- Il follow-up dei polipi persi o «discarded»
- Il follow-up del follow-up
- Rispetto e omogeneità nella scelta dell'età di sospensione della sorveglianza
- Gestione dei pazienti con > 10 lesioni asportate –
- Gestione polipi > 2 cm resecati en-bloc
- La gestione della familiarità associata
- Counseling genetico

Grazie dell'attenzione