Convegno Nazionale
GISCoR 2015

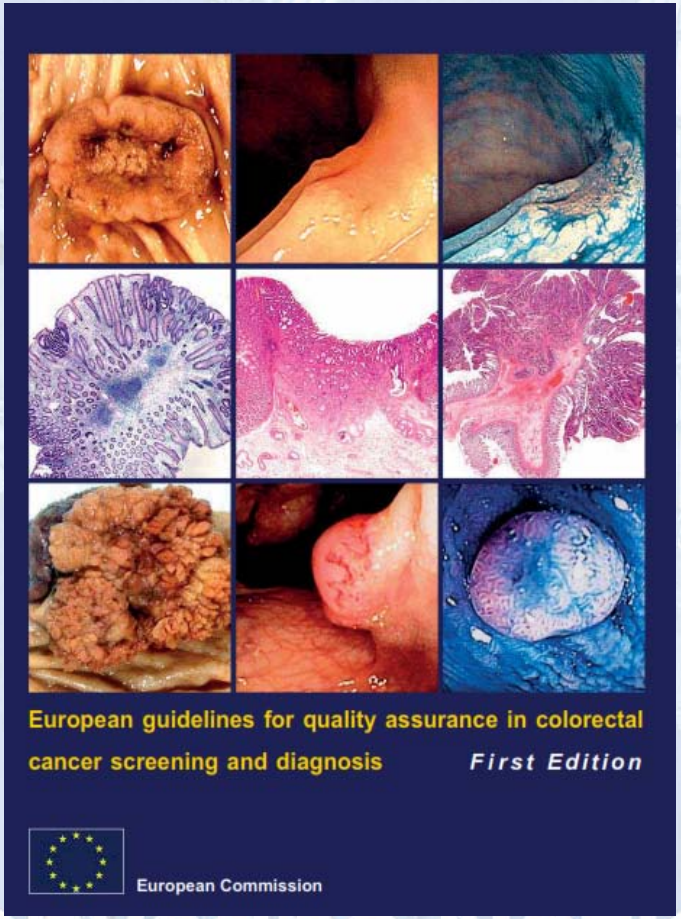
Follow-up e programmi di screening: Raccomandazioni europee e questioni aperte

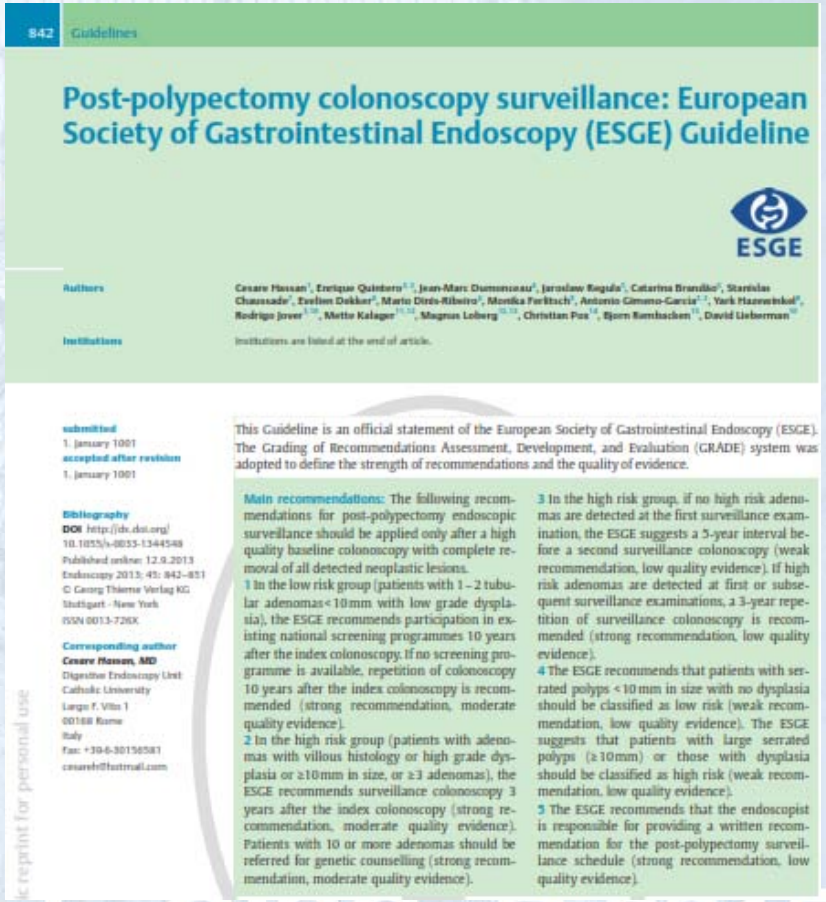
CPO
Centro di Riferimento per l'Epidemiologia e la Prevenzione Oncologica in Piemonte

Carlo Senore

19 -20 NOVEMBRE 2015
NAPOLI | Hotel Royal Continental

Abbiamo un approccio standardizzato e condiviso?





842 Guidelines

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

ESGE

Authors

Cesare Hassan[1], Enrique Quintero[2,3], Jean-Marc Dumonceau[4], Jaroslaw Regula[5], Catarina Brandão[6], Stanislas Chaussade[7], Evelien Dekker[8], Mario Dinis-Ribeiro[9], Monika Fuchs[10], Antonio Gimeno-Garcia[11,12], Yark Hazewinkel[8], Rodrigo Jover[13,14], Metin Kalager[15,16], Magnus Loberg[16,17], Christian Pox[18], Bjorn Rembacken[19], David Lieberman[20]

Institutions

Institutions are listed at the end of article.

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Bibliography
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This Guideline is an official statement of the European Society of Gastrointestinal Endoscopy (ESGE). The Grading of Recommendations Assessment, Development, and Evaluation (GRADE) system was adopted to define the strength of recommendations and the quality of evidence.

Main recommendations: The following recommendations for post-polypectomy endoscopic surveillance should be applied only after a high quality baseline colonoscopy with complete removal of all detected neoplastic lesions.

1 In the low risk group (patients with 1–2 tubular adenomas< 10 mm with low grade dysplasia), the ESGE recommends participation in existing national screening programmes 10 years after the index colonoscopy. If no screening programme is available, repetition of colonoscopy 10 years after the index colonoscopy is recommended (strong recommendation, moderate quality evidence).

2 In the high risk group (patients with adenomas with villous histology or high grade dysplasia or ≥ 10 mm in size, or ≥ 3 adenomas), the ESGE recommends surveillance colonoscopy 3 years after the index colonoscopy (strong recommendation, moderate quality evidence). Patients with 10 or more adenomas should be referred for genetic counselling (strong recommendation, moderate quality evidence).

3 In the high risk group, if no high risk adenomas are detected at the first surveillance examination, the ESGE suggests a 5-year interval before a second surveillance colonoscopy (weak recommendation, low quality evidence). If high risk adenomas are detected at first or subsequent surveillance examinations, a 3-year repetition of surveillance colonoscopy is recommended (strong recommendation, low quality evidence).

4 The ESGE recommends that patients with serrated polyps < 10 mm in size with no dysplasia should be classified as low risk (weak recommendation, low quality evidence). The ESGE suggests that patients with large serrated polyps (≥ 10 mm) or those with dysplasia should be classified as high risk (weak recommendation, low quality evidence).

5 The ESGE recommends that the endoscopist is responsible for providing a written recommendation for the post-polypectomy surveillance schedule (strong recommendation, low quality evidence).

NO

	EU Guidelines	ESGE
Adenoma a basso rischio	**Rinvio a screening**	**Rinvio a screening a 10 anni o TC a 10 se no screening**
Adenoma a rischio intermedio	**CT a 3 anni**	**CT a 3 anni**
Adenoma ad alto rischio	**CT entro 1 anno**	

Basso rischio

EU : **Dimensioni e numero e/o istologia**
ESGE : **Dimensioni e numero e istologia**

ORIGINAL RESEARCH | Annals of Internal Medicine

One-Year Risk for Advanced Colorectal Neoplasia: U.S. Versus U.K. Risk-Stratification Guidelines

Maria Elena Martinez, PhD*; Patricia Thompson, PhD; Karen Messer, PhD; Erin L. Ashbeck, MPH; David A. Lieberman, MD; John A. Baron, MD; Dennis J. Ahnen, MD; Douglas J. Robertson, MD; Elizabeth T. Jacobs, PhD; E. Robert Greenberg, MD; Amanda J. Cross, PhD; and Wendy Atkin, PhD*

Table 4. One-Year Risk for Advanced Colorectal Neoplasia, Cross-classified by U.S. and U.K. Risk Category at Baseline

U.S. Guidelines	U.K. Guidelines							
	Low		Intermediate		High		Total	
	Events/At Risk, *n/N*	Absolute Risk (95% CI), %	Events/At Risk, *n/N*	Absolute Risk (95% CI), %	Events/At Risk, *n/N*	Absolute Risk (95% CI), %	Events/At Risk, *n/N*	Absolute Risk (95% CI), %
Lower	45/1194	3.8 (2.7–4.9)	0	–	0	–	45/1194	3.8 (2.7–4.9)
Higher	19/266	7.1 (4.1–10.2)	136/1375	9.9 (8.3–11.5)	72/387	18.6 (14.7–22.5)	227/2028	11.2 (9.8–12.6)
Highest	0	–	0	–	1/4	Not estimated*	1/4	Not estimated*
Total	64/1460	4.4 (3.3–5.4)	136/1375	9.9 (8.3–11.5)	73/391	18.7 (14.8–22.5)	273/3226	8.5 (7.5–9.4)

Utilizzo della sorveglianza

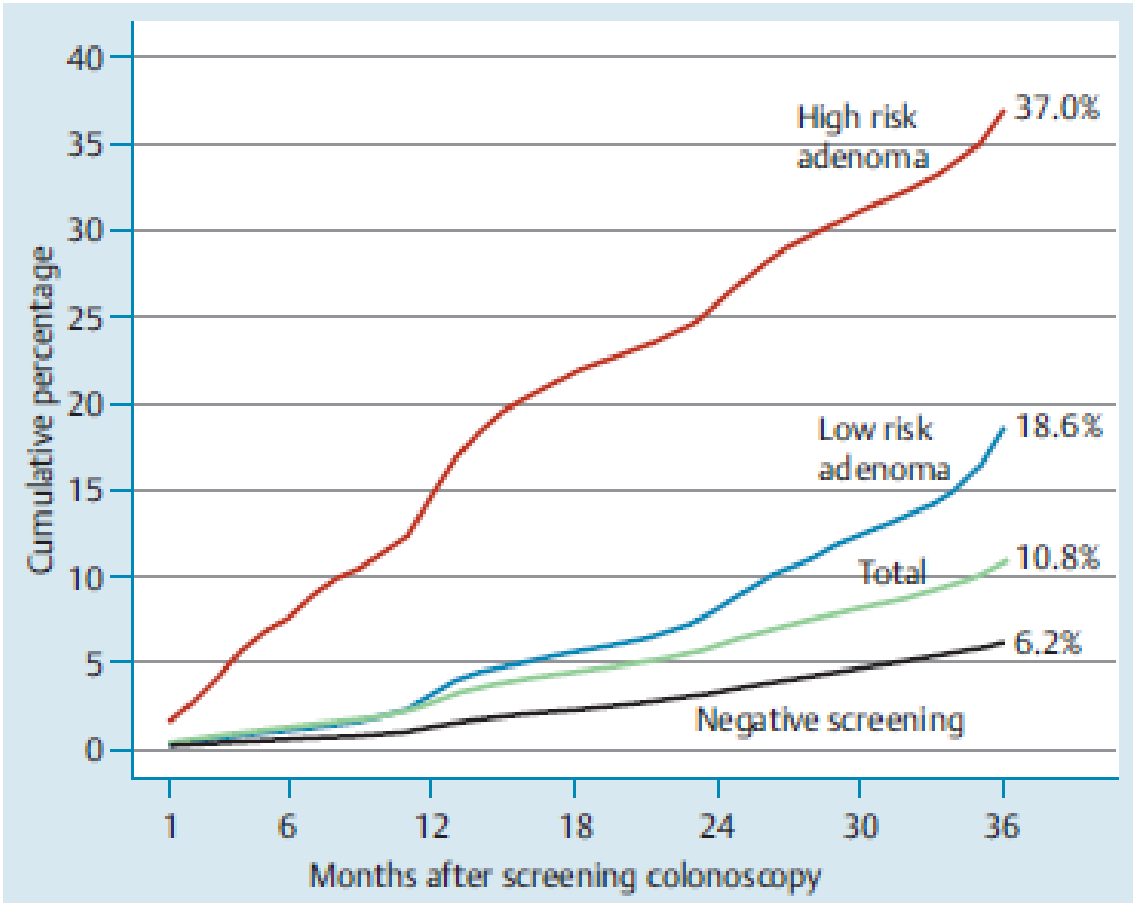


Fig. 2 Utilization of additional colonoscopies, by screening findings.

C. Stock[1], M. Hoffmeister[1], B. Birkner[2,3], H. Brenner[1]

Endoscopy 2013; 45: 537–544

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

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%)

THE NEW ENGLAND JOURNAL OF MEDICINE March 5, 1992

LONG-TERM RISK OF COLORECTAL CANCER AFTER EXCISION OF RECTOSIGMOID ADENOMAS

WENDY S. ATKIN, PH.D., BASIL C. MORSON, D.M., AND JACK CUZICK, PH.D.

Table 5. Relative Risk of Colon Cancer According to Risk Group and Number of Adenomas (Single vs. Multiple).

RISK GROUP/ NO. OF TUMORS *	NO. OF PATIENTS (%)	PERSON-YR AT RISK†	OBSERVED CASES	SIR (95% CI)‡
Low risk				
Single	712 (44)	8968	4	0.6 (0.1–1.4)
Multiple	64 (4)	755	0	0.0 (0.0–6.1)
Total	776 (48)	9723	4	0.5 (0.1–1.3)
High risk				
Single	683 (42)	7922	20	2.9 (1.8–4.5)
Multiple	159 (10)	1581	11	6.6 (3.3–11.8)
Total	842 (52)	9503	31	3.6 (2.4–5.0)

In patients with only a single, small, tubular adenoma, with low-grade dysplasia (43% of the cases), surveillance may not be of value because the risk of cancer is so low

Long-Term Colorectal-Cancer Mortality after Adenoma Removal

Magnus Løberg, M.D., Mette Kalager, M.D., Ph.D., Øyvind Holme, M.D., Geir Hoff, M.D., Ph.D., Hans-Olov Adami, M.D., Ph.D., and Michael Bretthauer, M.D., Ph.D.

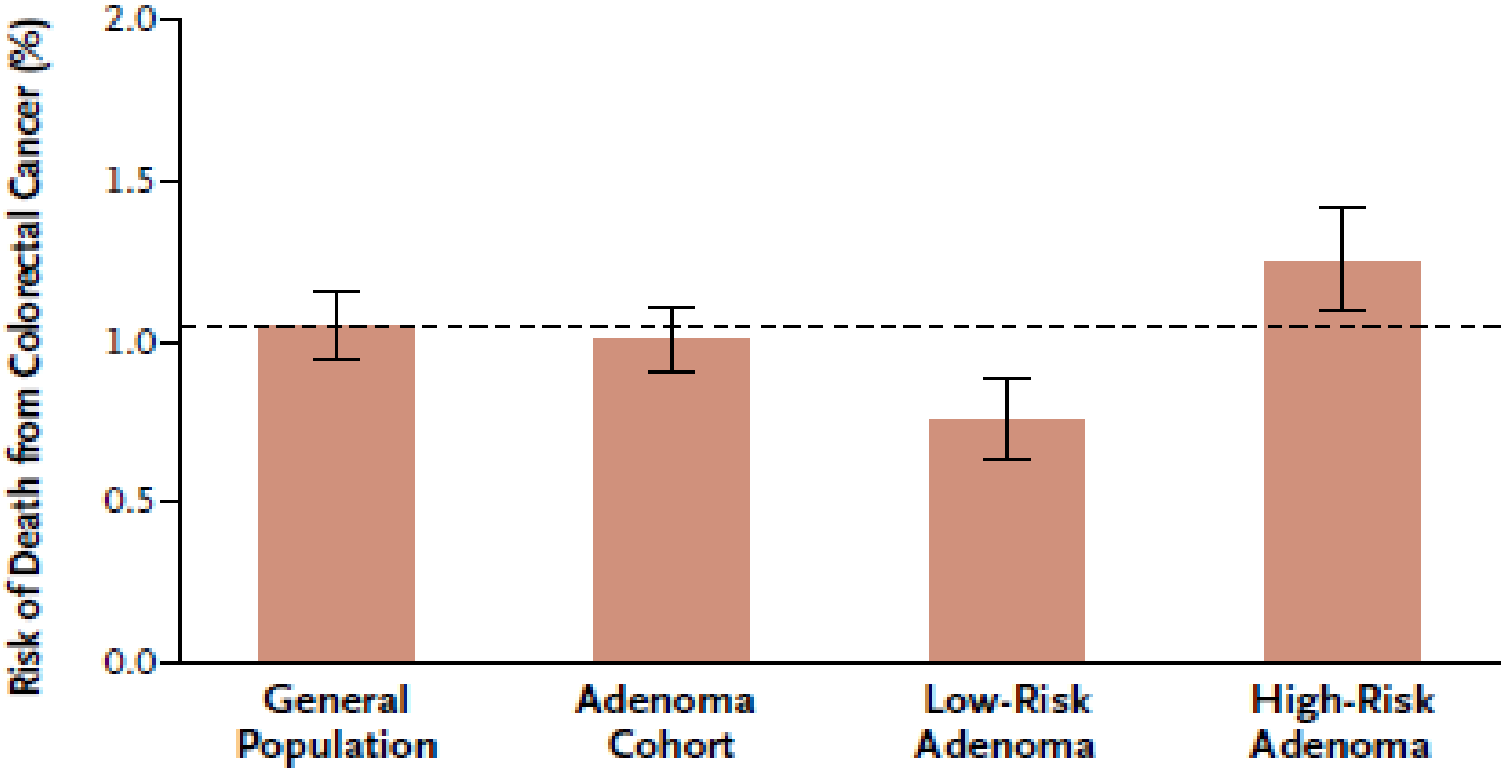
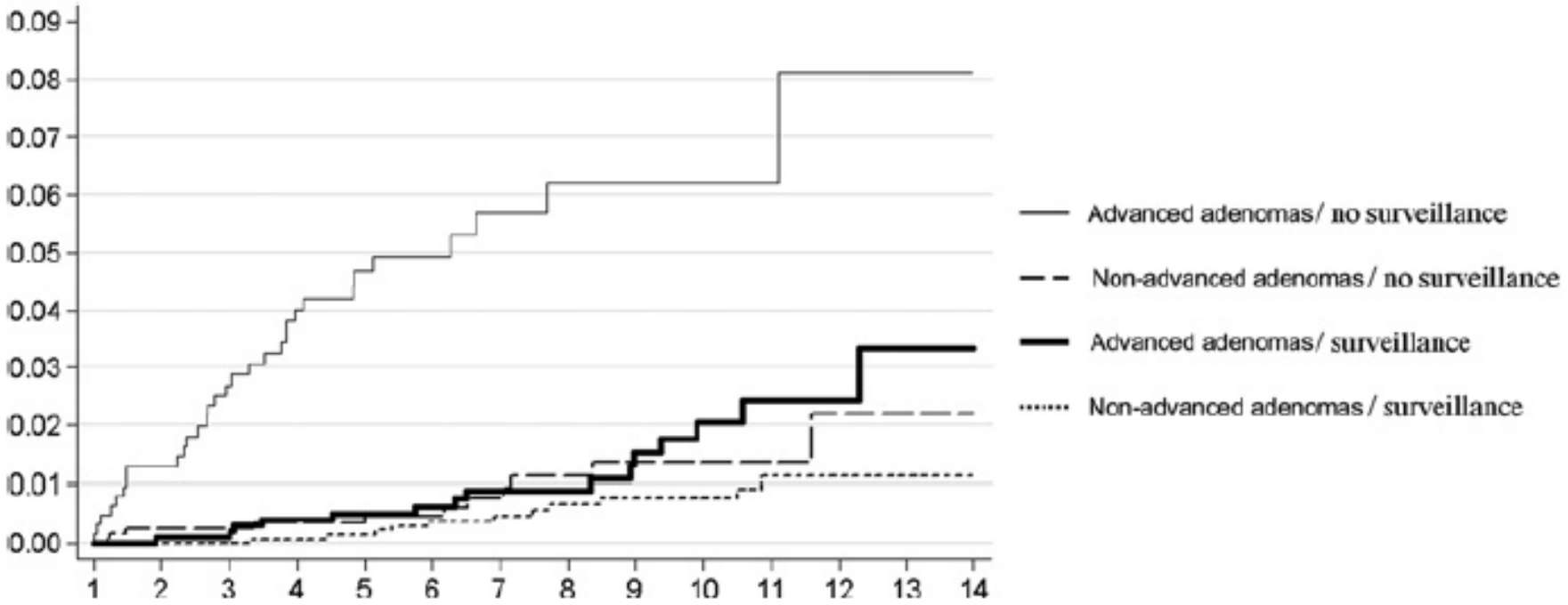


Figure 1. Colorectal-Cancer Mortality in a Cohort of Patients Who Underwent Removal of Adenomas and in the General Population.

Long-term risk of colorectal cancer after adenoma removal: a population-based cohort study

Vanessa Cottet,[1,2,3] Valérie Jooste,[1,2] Isabelle Fournel,[1,2] Anne-Marie Bouvier,[1,2,3,4,5] Jean Faivre,[1,2,3] Claire Bonithon-Kopp[1,2,4,5]



Cumulative CRC risk over 10 years among subjects with LR adenomas with no TC surveillance : 1.4%

20% reduction compared to average risk population

No difference as compared to those undergoing surveillance

AP&T Alimentary Pharmacology and Therapeutics

Systematic review with meta-analysis: the incidence of advanced neoplasia after polypectomy in patients with and without low-risk adenomas

C. Hassan*, A. Gimeno-García[†,‡], M. Kalager[§,¶], C. Spada*, A. Zullo*, G. Costamagna*, C. Senore**, D. K. Rex[††] & E. Quintero[†,‡]

	Low-risk adenoma		No neoplasia			Risk Ratio
Study or Subgroup	Events	Total	Events	Total	Weight	M-H, Random, 95% CI
Chung	16	671	25	1242	17.2%	1.18 [0.64, 2.20]
Huang	4	90	5	301	5.8%	2.68 [0.73,9.75]
Leung	4	81	6	401	6.2%	3.30 [0.95, 11.43]
Lieberman	23	496	7	298	11.6%	1.97 [0.86, 4.54]
Miller	9	158	10	197	10.8%	1.12 [0.47, 2.69]
Pinsky	52	765	36	785	25.5%	1.48 [0.98, 2.24]
Yamaji	40	1818	30	4084	22.9%	3.00 [1.87, 4.79]
Total (95% CI)		4079		7308	100.0%	1.83 [1.31, 2.56]
Total events	148		119			

Heterogeneity: $Tau^2 = 0.07$; $Chi^2 = 9.54$, df = 6 (P = 0.15); $I^2 = 37\%$

Test for overall effect: Z = 3.52 (P = 0.0004)

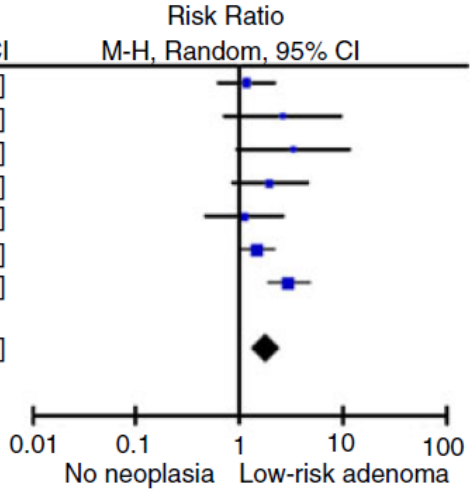


Figure 2 | Forest plot of the included studies comparing the incidence of metachronous advanced neoplasia between patients with low-risk adenomas and those without neoplasia at index examination.

The individuals who underwent additional colonoscopy may not be a representative sample of all screening colonoscopy participants but they are (self-)selected.

For the evaluation of the adequacy of surveillance intervals, a study design that aims at subsequent colonoscopy in all subjects in the risk groups of interest after a pre-specified interval (or at different pre-specified time points) is needed.

C. Stock[1], M. Hoffmeister[1], B. Birkner[2,3], H. Brenner[1] Endoscopy 2013; 45: 537–544

Performance of additional colonoscopies and yield of neoplasms within 3 years after screening colonoscopy: a historical cohort study

C. Stock[1], M. Hoffmeister[1], B. Birkner[2,3], H. Brenner[1]

Endoscopy 2013; 45: 537–544

Table 6 Findings of additional colonoscopies, by findings at screening.

Findings of screening colonoscopy		Within 6 months		After 6–36 months		Total	
		N	% [95%CI]	N	% [95%CI]	N	% [95%CI]
Negative	Negative	168	76.0 [70.4–81.7]	1799	82.2 [80.6–83.8]	1923	81.4 [79.9–83.0]
	Low risk adenoma	32	14.4 [9.8–19.1]	296	13.5 [12.1–15.0]	325	13.8 [12.4–15.2]
	Advanced neoplasm	21	9.5 [5.6–13.4]	94	4.3 [3.4–5.1]	113	4.8 [3.9–5.6]
	High risk adenoma	21	9.5 [5.6–13.4]	77	3.5 [2.7–4.3]	96	4.1 [3.3–4.9]
	Carcinoma	0		17	0.8 [0.4–1.1]	17	0.7 [0.4–1.1]
Low risk adenoma	Negative	44	48.4 [38.1–58.6]	992	63.4 [61.0–65.8]	1009	62.4 [60.1–64.8]
	Low risk adenoma	24	26.4 [17.3–35.5]	491	31.4 [29.1–33.7]	507	31.4 [29.1–33.6]
	Advanced neoplasm	23	25.3 [16.3–34.2]	81	5.2 [4.1–6.3]	100	6.2 [5.0–7.4]
	High risk adenoma	20	22.0 [13.4–30.5]	76	4.9 [3.8–5.9]	92	5.7 [4.6–6.8]
	Carcinoma	3	3.3 [0.0–7.0]	5	0.3 [0.0–0.6]	8	0.5 [0.2–0.8]
High risk adenoma	Negative	107	33.0 [27.9–38.2]	757	53.2 [50.6–55.8]	769	48.5 [46.1–51.0]
	Low risk adenoma	78	24.1 [19.4–28.7]	463	32.6 [30.1–35.0]	492	31.1 [28.8–33.3]
	Advanced neoplasm	139	42.9 [37.5–48.3]	202	14.2 [12.4–16.0]	323	20.4 [18.4–22.4]
	High risk adenoma	136	42.0 [36.6–47.4]	194	13.6 [11.9–15.4]	312	19.7 [17.7–21.7]
	Carcinoma	3	0.9 [0.0–2.0]	8	0.6 [0.2–1.0]	11	0.7 [0.3–1.1]

SORVEGLIANZA PER ADENOMI A BASSO RISCHIO

VALUTAZIONE PROSPETTICA NELL'AMBITO DEI PROGRAMMI DI POPOLAZIONE CON PROTOCOLLI DI SORVEGLIANZA ATTIVA

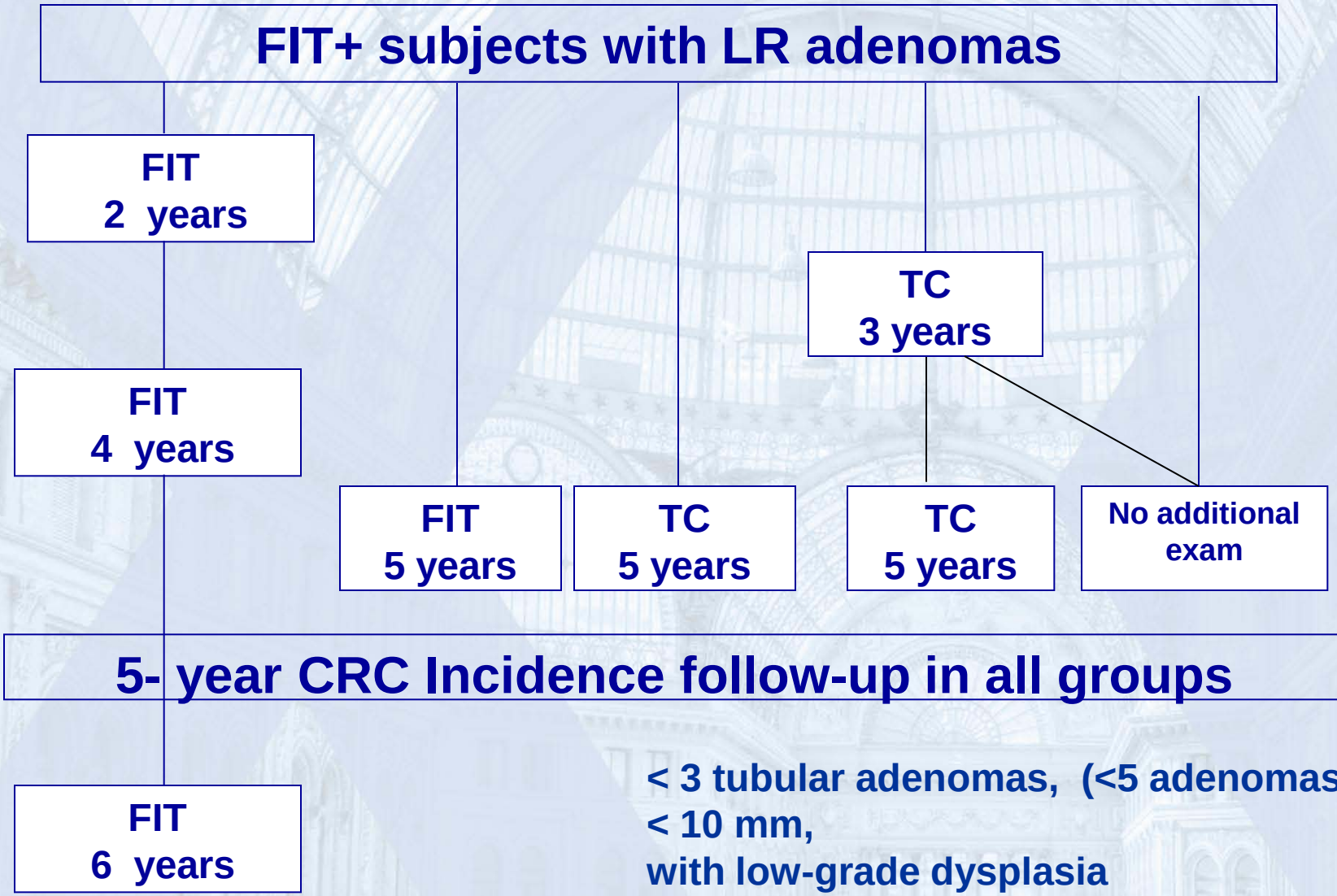
COORTI DI INTERESSE:

- **PERSONE CON UNA COLONSCOPIA NEGATIVA DOPO UN FIT/FS POSITIVI**

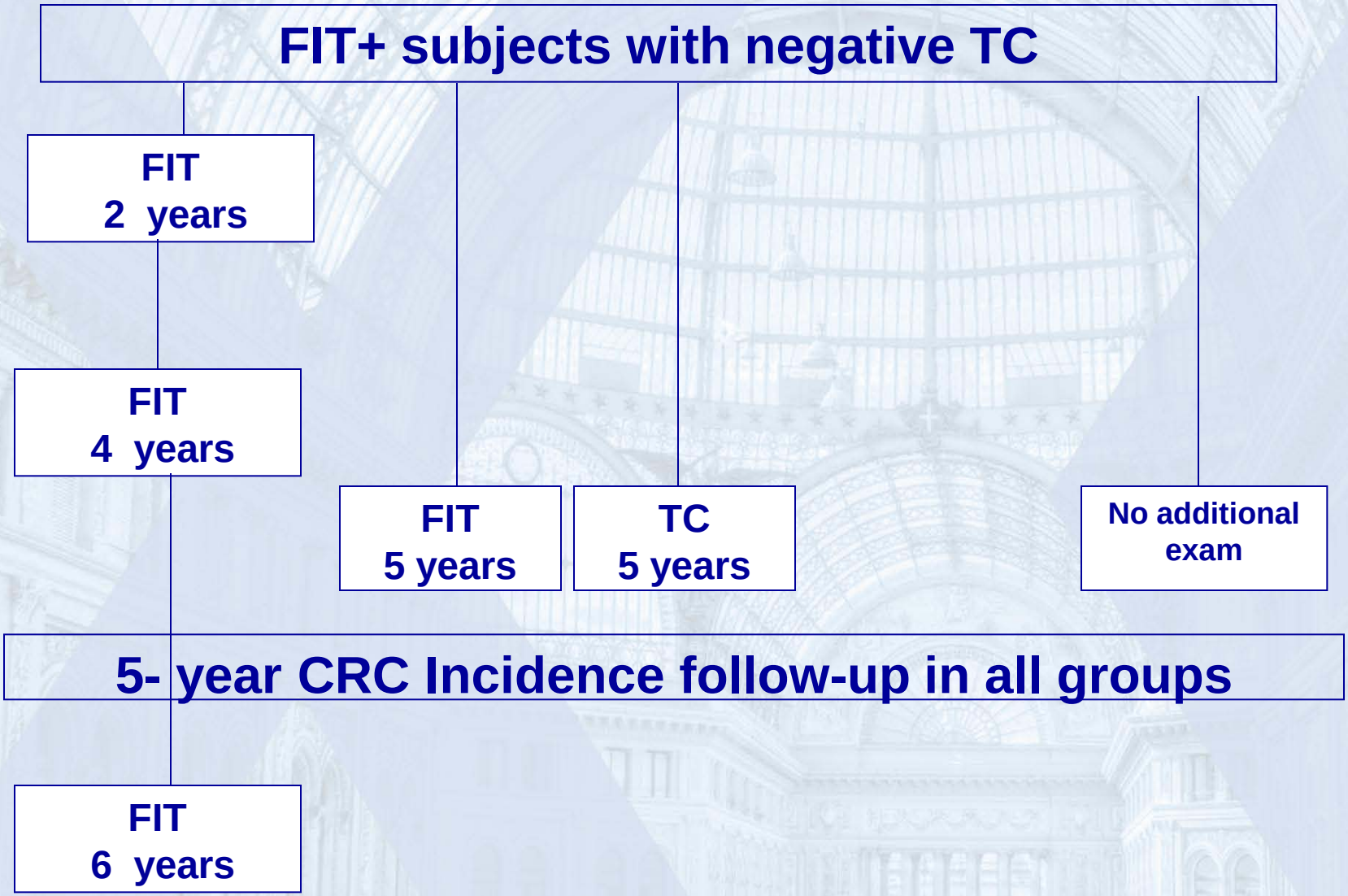
- **PERSONE CON ADENOMI A BASSO RISCHIO (DIMENSIONI, NUMER E ISTOLOGIA) DOPO FIT / FS POSITIVI**

OBIETTIVI

VALUTARE L'IMPATTO DEI PROTOCOLLI DI SORVEGLIANZA IN USO IN TERMINI DI DR CUMULATIVA DI CANCRO E ADENOMA AVANZATO, L'ACCETABILITA' PER I PAZIENTI E L'IMPEGNO ORGANIZZATIVO



< 3 tubular adenomas, (<5 adenomas?)
< 10 mm,
with low-grade dysplasia
1 SSA/SSP without dysplasia


FIT+ subjects with negative TC
FIT
2 years
FIT
4 years
FIT
5 years
TC
5 years
No additional exam
5- year CRC Incidence follow-up in all groups
FIT
6 years

Confronti di interesse

A) screening biennale con FIT/gFOBT (2 round)
versus
screening a 5 anni con FIT/gFOBT o
colonscopia a 3-5 anni

outcome:
DR cumulativa di adenomi avanzati/ incidenza cumulativa di CCR

B) Persone con precedente FIT/gFOBT positivo
versus
persone con precedente FIT/gFOBT negativo
che eseguono il test successivo allo stesso intervallo
outcome:
DR di adenoma avanzato / CCR

Confronti di interesse

C) screening biennale con FIT/gFOBT (2 round)
screening a 5 anni con FIT/gFOBT o colonscopia a 3-5 anni
versus
persone con CT indice negativa

outcome:
DR cumulativa di adenomi avanzati/ incidenza cumulativa di CCR

Metodi

Dimensioni del campione

6,700 - 7,800 persone per braccio

1% differenza assoluta nella DR di adenomi avanzati

0.5% differenza assoluta nella incidenza cumulativa di CRC

Record inviduale anonimizzato

- **risultato del test indice (inclusa quantita' di emoglobina)**
- **risultato della colonscopia indice**
- **utilizzo di CT nell'intervallo tra la CT indice e il successivo esame (screening o sorveglianza)**
- **risultato dei test di screening successivi e della eventuale TC indotta**
- **Incidenza di CRC**

Protocollo sottomesso entro il mese di Novembre al comitato etico a Torino

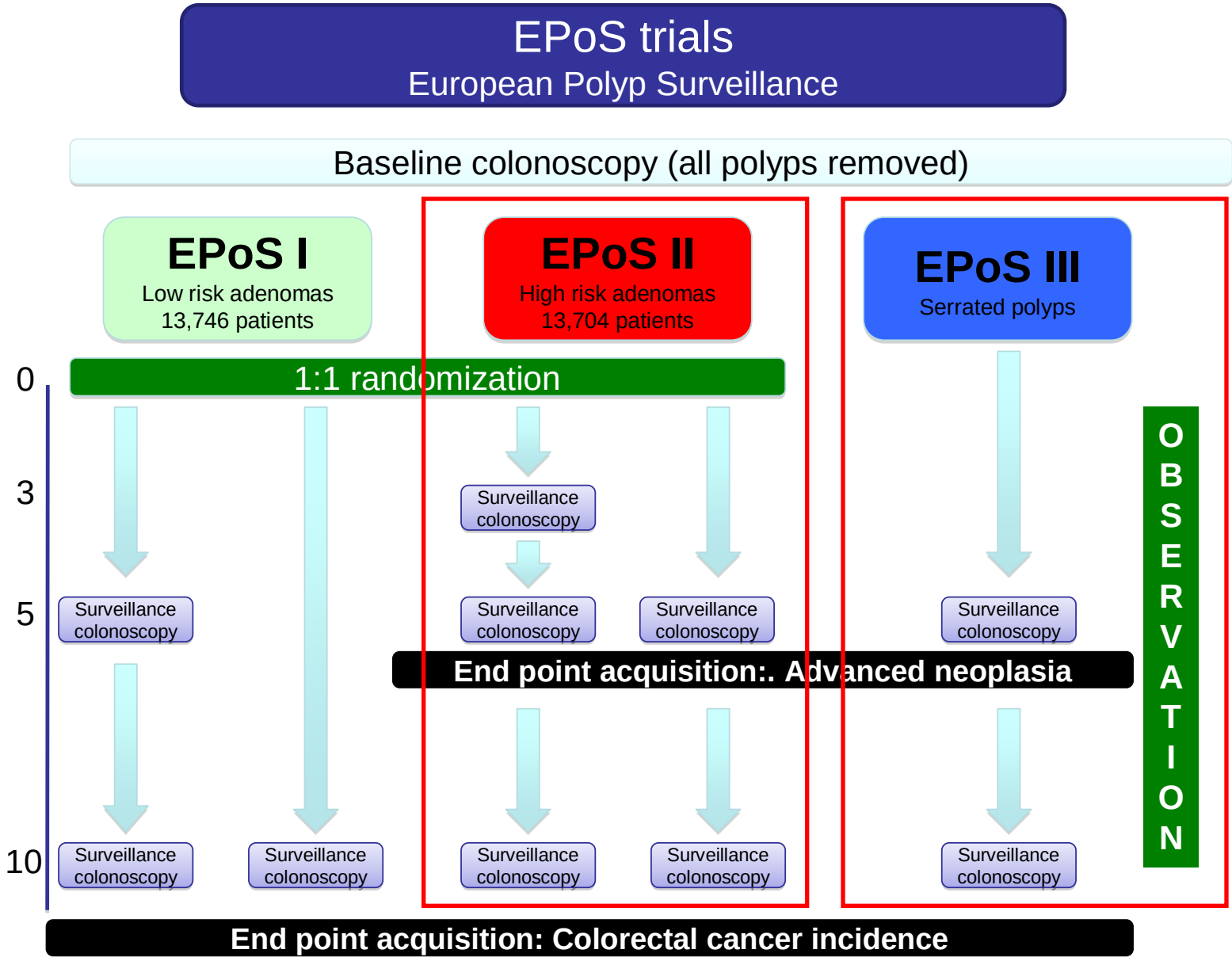
Centri partecipanti:

Regione Piemonte
Regione Veneto
Trento
Reggio Emilia
Firenze?
Roma?

SORVEGLIANZA PER ADENOMI A RISCHIO INTERMEDIO

- **I MIGLIORAMENTI DELLE CARATTERISTICHE TECNICHE DELLA STRUMENTAZIONE**
- **GLI EFFETTI DEI PROGRAMMI DI RETRAINING E MONITORAGGIO DELLA QUALITA' DELLE PRESTAZIONI ENDOSCOPICHE**

hanno favorito miglioramenti della pratica endoscopica, tali da determinare un riduzione del rischio di ricorrenza post-polipectomia, rispetto a quanto osservato finora,grazie alla riduzione della quota di casi attribuibile a carenze della tecnica di esecuzione dell'esame


EPoS trials
European Polyp Surveillance
Baseline colonoscopy (all polyps removed)
EPoS I
Low risk adenomas
13,746 patients
EPoS II
High risk adenomas
13,704 patients
EPoS III
Serrated polyps
0
1:1 randomization
3
Surveillance colonoscopy
5
Surveillance colonoscopy
Surveillance colonoscopy
Surveillance colonoscopy
Surveillance colonoscopy
End point acquisition:. Advanced neoplasia
10
Surveillance colonoscopy
Surveillance colonoscopy
Surveillance colonoscopy
Surveillance colonoscopy
Surveillance colonoscopy
OBSERVATION
End point acquisition: Colorectal cancer incidence

GISCoR
gruppo italiano screening colorettale

GRAZIE PER L'ATTENZIONE