

Con il
Patrocinio di:



Johann Gottfried Steffan, Lerici
1900, acquerello

GISCoR

gruppo italiano screening coloretale

XIII CONGRESSO NAZIONALE 2018

25-26 Ottobre 2018

Villa Marigola, Lerici (SP)

CORSO PRE-CONGRESSO

25 Ottobre 2018

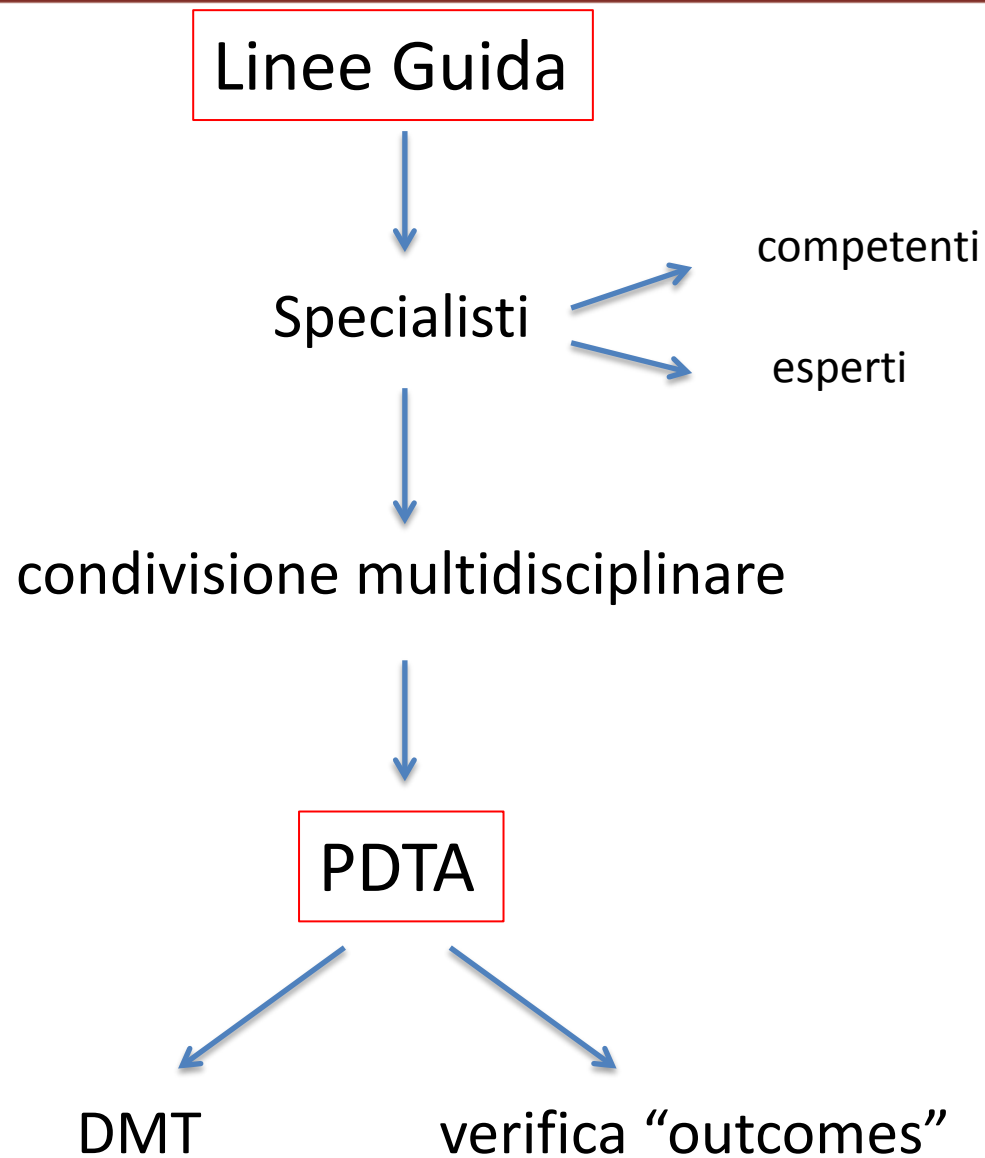


Le neoplasie superficiali del colon retto:
dallo screening al PDTA

GISCoR
gruppo italiano screening coloretale

Dalle linee guida al PDTA

Gian Andrea Binda





Punti controversi

- Definizione
- Valutazione istologica
- Tecnica di Escissione Locale



Punti controversi

- **Definizione**
- Valutazione istologica
- Tecnica di Escissione Locale



Definition

- Superficial CR cancer
- Early CR cancer
- Low risk CR cancer

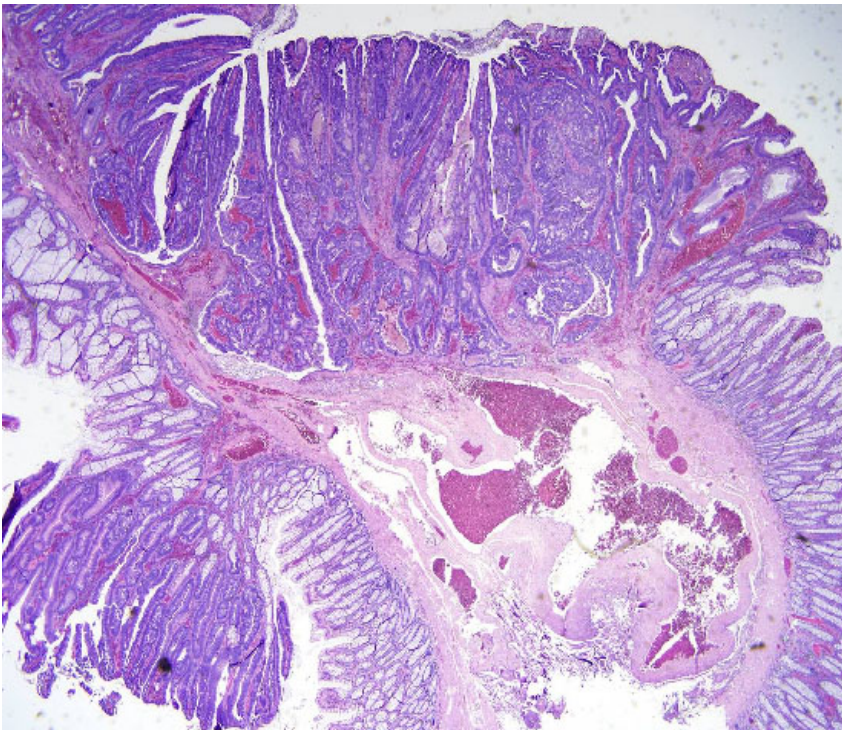


Superficial neoplastic CR lesions

A neoplastic lesion is defined as “superficial” when there is no endoscopic evidence of muscularis propria infiltration, i.e. the depth of penetration in the wall is limited to the submucosa.

(Paris Classification, Endoscopy 2005) (Endoscopic Classification Review Group (2005) Update on the Paris classification of superficial neoplastic lesions in the digestive tract. *Endoscopy* 37:570–578)

Early Colorectal Carcinoma



- Definition: adenocarcinoma infiltrating the submucosa (pT1)
- Obsolete terms:
in situ adenocarcinoma
intramucosal adenocarcinoma are not regarded as "malignant" polyps

GISCoR recommendations: "high-grade dysplasia".



Comparison of the guidelines for colorectal cancer in Japan, the USA and Europe (Shinagawa T et al., *Ann Gastroenterol Surg* 2018)

TABLE 1 Comparison of the TNM classification and Japanese classification of colorectal carcinoma

TNM classification ^a	Japanese classification of colorectal carcinoma		
Primary tumors (T)			
Tis	Carcinoma in situ: intraepithelial or invasion of lamina propria	Tis	Within lamina propria
T1	Submucosa	T1a	Submucosa <1000 l m
		T1b	Submucosa ≥1000 l m
T2	Muscularis propria	T2	Muscularis propria
T3	Subserosa/ perirectal tissue	T3	Subserosa or within adventitia
T4a	Perforation into visceral peritoneum	T4a	Exposed to the serosal surface
T4b	Invasion to other organs	T4b	Invasion to other organs



Early rectal cancer

- TNM 7th ed : cT1/cT2, cN0
- EAES 2015, SICCR 2015:
 - **Early:** rectal cancer with good prognostic features that might be safely removed preserving the rectum, and that will have a very limited risk of relapse after local excision
- SEOM 2016:
 - **Early:** cT1/T2, cN0
- ACPGBI 2017:
 - **Early:** cT1-T2 N0 M0, MRF –ve
 - **SPECC lesion:** sessile polyp >20 mm in diameter morphologically aberrant
- ESMO 2017
 - **Very early:** cT1N0, G1/G2
 - **Early:** cT1-cT2;cT3a/b if middle or high, N0, MRF clear, no EMVI

National and international guidelines for rectal cancer

L. B. J. Nielsen and P. Wille-Jørgensen

Faculty of Health Sciences, Digestive Disease Center – K, Bispebjerg Hospital, University of Copenhagen, Copenhagen, Denmark

Received 2 April 2014; accepted 16 April 2014; Accepted Article online 28 May 2014

Colorectal Dis. 2014

Table 2 Staging rectal cancer.

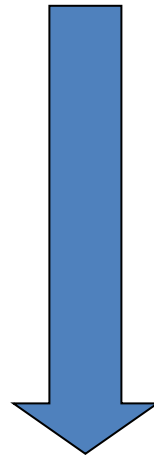
Variable	ESMO	EURECA	SEOM	Ontario	NCCN	ACPGBI	World Congress	JSCCR	DCCG	NGICG	NICE
Classification	<p>Despite much knowledge, there is no international consensus on guidelines for the staging and treatment of rectal cancer.</p>										
T-status											
M-status	T1–T4: MRI	T3: CT-16 slicespiral as alternative		CT		excision being considered MRI	ERUS MRI			T1–T4: MRI	to local excision MRI
	Chest: X-ray/CT Liver/ abdomen: CT/ MRI/US	Chest+abdomen: CT If liver lesions: MRI	Chest: X-ray if suspect CT CT abdomen	CT PET if conventional imaging is equivocal for the presence of metastatic disease	CT chest, abdomen, pelvis	CT chest, abdomen	CT chest, abdomen PET: rule out or confirm metastases		CT chest, abdomen, as an alternative; liver: MRI or US	CT chest, abdomen, pelvis	CT chest abdomen pelvis



Low Risk

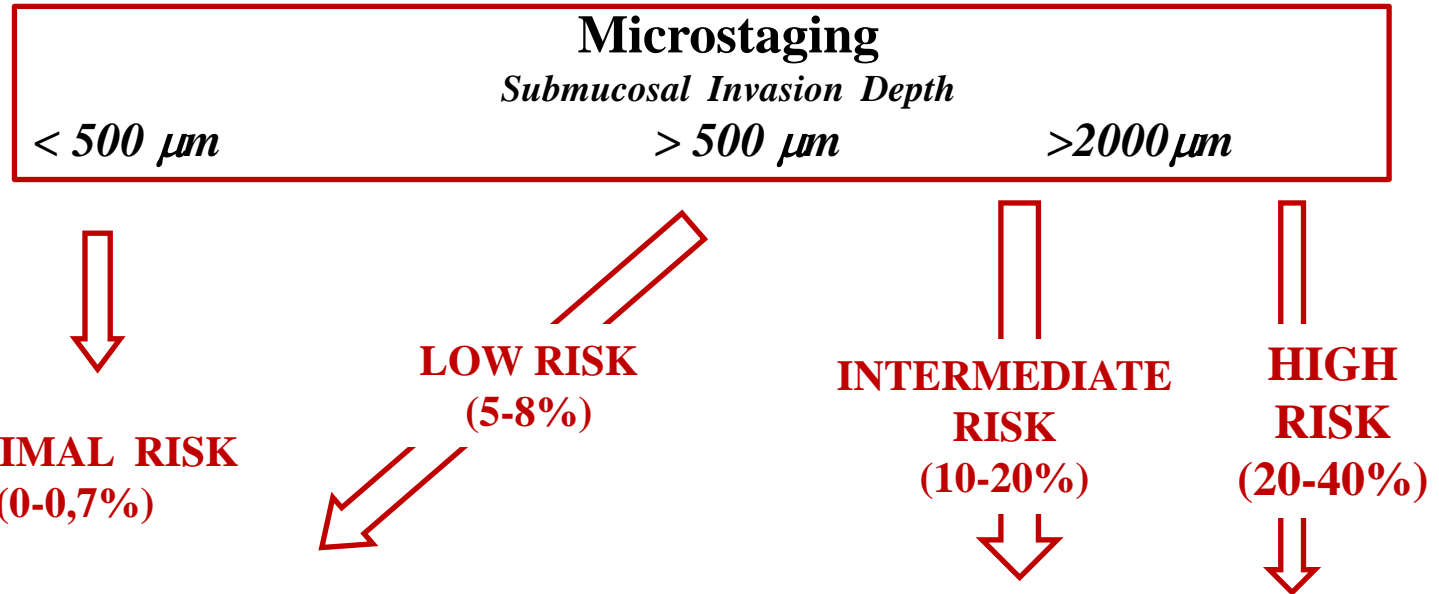
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THE MAIN GOAL OF EARLY CRC ASSESSMENT



to communicate the level of risk

Early Colorectal Carcinoma: Assessment of the Metastatic Risk



- **Carcinoma Grading:**
1 – 2
- **Tumor Budding:**
Absent / Low Grade
- **Vascular Invasion:**
Absent

- **Carcinoma Grading:**
3 – 4
or
- **Tumor Budding:**
Present / High Grade
or
- **Vascular Invasion:**
Present

Courtesy of M. Risio



Punti controversi

- Definizione
- **Valutazione istologica**
- Tecnica di Escissione Locale



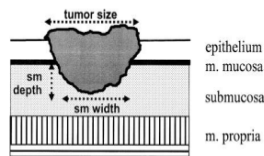
Depth of Submucosal Invasion

Kikuchi classif.

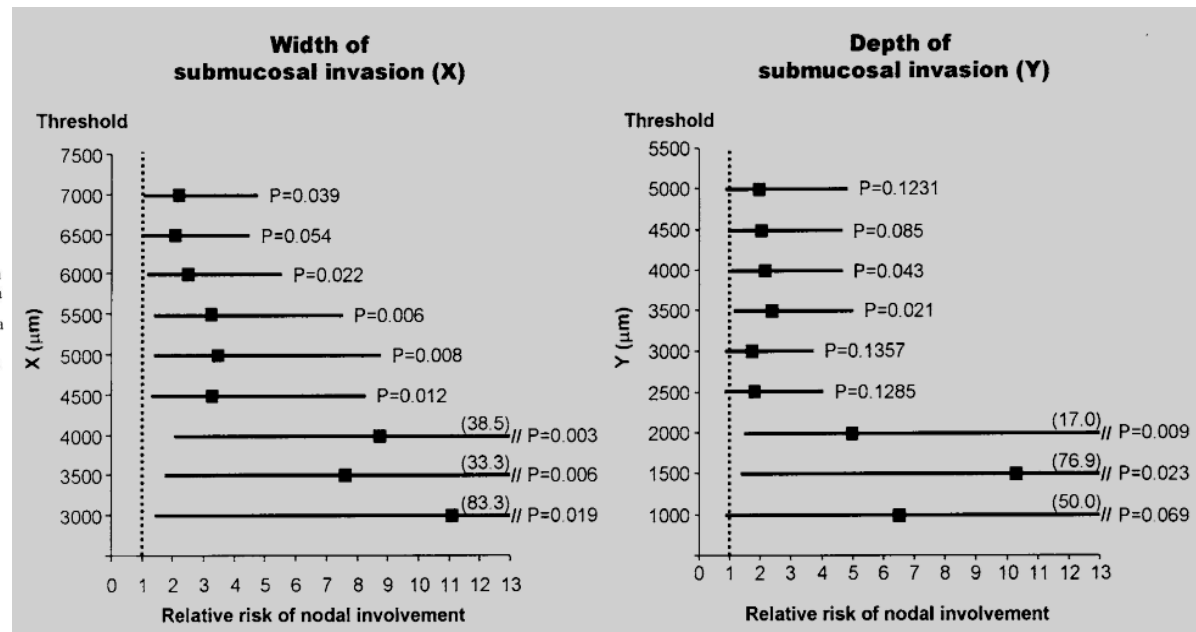
Ueno classif.

LNM in pT1 – depth of submucosal invasion

depth	n	n (%)N+
Sm1	70	2 (3%)
Sm2	120	9 (8%)
Sm3	154	35 (23%)



Nascimbeni R et al. *Dis Colon Rectum* 2002;45, 200-206





Are we accurately measuring the depth of the submucosal invasion in early colorectal cancer by equating the Kikuchi submucosa levels with distances measured in fractions of a millimetre?

Najib Haboubi* and Emil Salmo†

(*Colorectal Dis* 2014)

*University Hospital of South Manchester, Manchester, UK and

†Bolton NHS Foundation Trust, Bolton, UK

Table 1 Percentages of Kikuchi stages in three different series and the associated risk of lymph node metastasis.

Author	Sm level (Kikuchi) (%)	Risk of LNM (%)
Kikuchi <i>et al.</i> [3]	Sm1 68.8	1.2
Nascimbeni <i>et al.</i> [6]	Sm2 28	21.3
Choi <i>et al.</i> [7]	Sm3 15.5	38.5

Table 2 Thickness of submucosa in sections from normal large bowel*.

Thickness of submucosa (mm)						Mean
Normal large bowel sections						
						1.97
						1.89
						2.43
						1.14
						3.51
						1.07
						2.54
						2.07 (Field)
						1.2
						1.04
Total mean 1.89 mm						
Normal large bowel adjacent to cancer						
Patient 1	1.37	1.75	1.85	1.88	2.0	1.77
Patient 2	0.79	1.1	1.24	1.42	0.8	1.07
Patient 3	0.4	3.32	1.2	3.9	0.4	1.84
Patient 4	0.86	0.51	0.43	1.23	0.47	0.7
Total mean 1.35 mm						

Sm1 with 1 mm or less and Sm2 with 2 mm or more cannot be equated in terms of pathological risk of LNM. It is therefore clear that Kikuchi staging must also be accompanied by an estimation of the measured depth of invasion of the submucosa. **Both systems are needed when reporting early CRC.**



(2016)

ORIGINAL ARTICLE

Interobserver variability amongst gastrointestinal pathologists in assessing prognostic parameters of malignant colorectal polyps: a cause for concern

A. Davenport¹ · J. Morris² · S. A. Pritchard¹ · E. Salmo³ · M. Scott¹ · N. Y. Haboubi⁴

Table 1 Polyp study—new analysis: data on 56 cases unless otherwise indicated

% by observer

% exact

Kappa

Strength of

Significant interobserver variability particularly true for tumour differentiation, Haggitt level and the assessment of lymphovascular invasion

Need to standardise definitions and educate pathologists on the important pathological features which drive management decisions.

The objective measurement of the depth of invasion in polyp cancer is the most reliable tool and the Ueno staging system offers a reasonable way of achieving that.

1 vs 2 vs 3	27/33/40	13/53/34	27/27/46	40/40/20	27	0.36	Fair
2 + 3 vs rest	73	87	73	60	53	0.32	Fair
Ueno							
High risk on width of invasion (4 mm or more)	75	93	66	64	59	0.41	Moderate
Ueno							
High risk on depth of invasion (2 mm or more)	71	88	93	88	75	0.49	Moderate

Is the assessment of submucosal invasion still useful in the management of early rectal cancer? A study of 91 consecutive patients (*Colorectal Dis*, 2016)

Clotilde Debove (MD)¹, Magali Svreck (MD, PhD)², Sylvie Dumont³, Najim Chafai (MD)¹, Emmanuel Tiret (MD, PhD)¹, Yann Parc (MD, PhD)¹, Jérémie H. Lefèvre (MD, PhD)¹

Aim: assess the **histopathological risk factors for LNM** in pT1 rectal cancer and the **cancer specific results** after surgery.

91 pts: 18 LE, 22 LE followed by TME, 51 TME

73 TME	16 LNM (23%)	SM1 15%	p=0.326
		SM2 14%	
		SM3 30%	

Follow up: 56 ± 46 months: 5y OS: 82%, 5y DFS: 75%

No difference in 5y DFS according to:

- surgical management (p=0.87)
- depth of submucosal invasion (p=0.168)



Positive margins after local excision of early rectal cancer: a dedicated multidisciplinary team

R. Zinicola*, **J. Hill†**, **G. A. Binda‡** and
B. Saunders§

Colorectal Disease © 2015 The Association of Coloproctology of Great Britain and Ireland. 17, 735–736

our group suggested two practical matters which may be
The decision for major surgery should depend not only
on the histopathology also on the ‘macro-
scopic operative endorectal excision. This could
avoid unnecessary colectomy.

DMT!!!!!!

completeness of excision and (2) high-quality pictures or
videos from the endoscopic excision should be available.



Punti controversi

- Definizione
- Valutazione istologica
- **Tecnica di Escissione Locale**



Systematic review and Meta-analysis of Endoscopic Submucosal Dissection versus Transanal Endoscopic Microsurgery for non-invasive large rectal lesions.

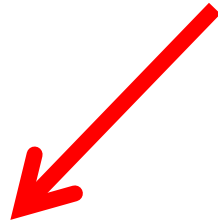
Arezzo A, Passera R, Saito Y et al, Surg Endosc 2014;28:427-38

ESD 11 studi, TEM 10 studi = 2077 pazienti

	ESD	TEM	P
size	35 mm	40 mm	= 0.393
en-block resection	88%	99%	< 0.001
R0 resection	74%	89%	< 0.001
complications	8%	8%	= 0.874
further surgery	1.3%	1.6%	= 0.665
invasive cancers	10%	4%	= 0.189
recurrences	3%	5%	= 0.068
surgery for oncologic reasons	9%	2%	= 0.011
surgery for any reason	9%	3%	< 0.001



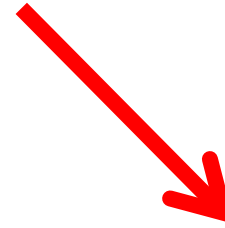
RESEZIONE RETTALE *dopo* Escissione Locale *a tutto spessore*



rischio compromissione
fascia mesorettale



**outcome oncologico
non compromesso**



asportazione del retto
a volte più difficile



risultati funzionali?



APR rate after local excision

Authors	n°	AR	APR	(%)
Sun 2014	7	1	6	86
Hompes 2013	36	31	5	14
Morino 2013	17	10	7	41
Levic 2013	25	14	11	44
Gagliardi 2013	17	9	8	47
Borscitz 2008	41	29	12	31
Beatrup 2008		ns	ns	
Lee 2007	12	5	7	58
Min 2007	7	0	7	100
Hanloser 2005	52	28	24	46
Nakagoe 2004	11	10	1	9
Total	223	137	88	39

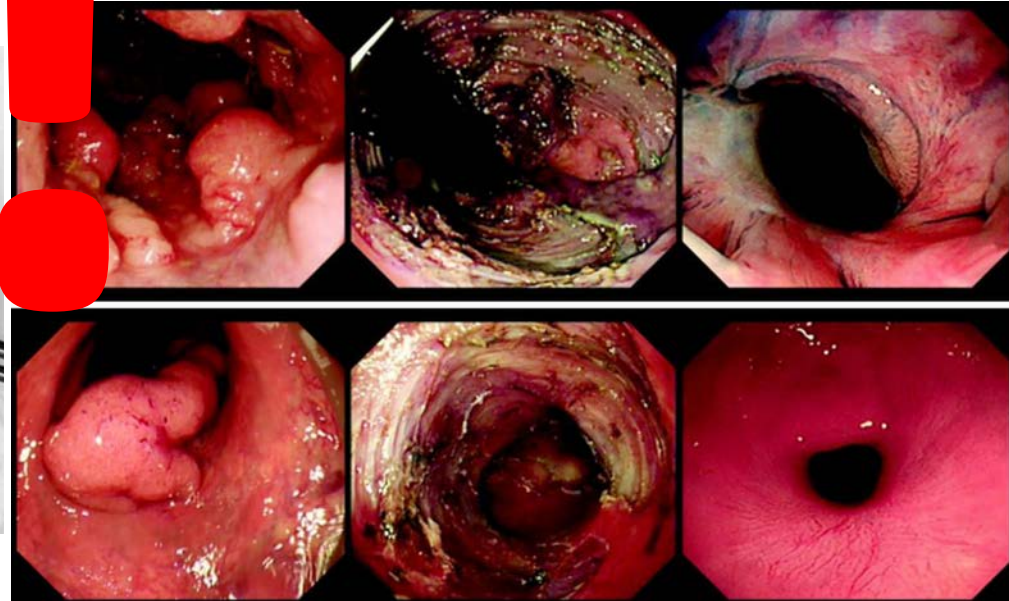


ENDOSCOPY NEWS

Gut 2015

A new instrument for Trans-Anal Submucosal Endoscopic Resection (TASER)

Zacharias P Tsiamoulos,¹ Janindra Warusavithana,² Omar Faiz,²
Andrew Castello-Cortes,³ Timothy Elliott,¹ S. T Peake,¹ Paul Bassett,⁴
Brian P Saunders¹





Finding the right balance ...

E_{SD}

T_{ASCD}

need of prospective trials or international registry
collecting a large number of patients
from experienced centres

T₁



CLINICAL GUIDELINES

**Practice parameters for early colon cancer management:
Italian Society of Colorectal Surgery (Società Italiana di
Chirurgia Colo-Rettale; SICCR) guidelines**

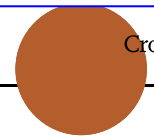
F. Bianco¹ · A. Arezzo² · F. Agresta³ · C. Coco⁴ · R. Faletti⁵ · Z. Krivocapic⁶ ·
G. Rotondano⁷ · G. A. Santoro⁸ · N. Vettoretto⁹ · S. De Francisci¹ ·
A. Belli¹ · G. M. Romano¹

Endoscopic assessment

- Shape
- HD chromoendoscopy

Endoscopic resection

- T1, sm1 or ≤ 1 mm
- Piecemeal EMR in large, no invasive, sessile, laterally spreading adenomas
- Always tattooing



CLINICAL GUIDELINES

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F. Bianco¹ · A. Arezzo² · F. Agresta³ · C. Coco⁴ · R. Faletti⁵ · Z. Krivocapic⁶ ·
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A. Belli¹ · G. M. Romano¹

Resection

- Resection margin < 1 mm
- Submucosal invasion: Hagitt 4, > 1 mm
- G3
- LVI
- Budding

Lfn Harvesting

- ≥ 12



CLINICAL GUIDELINES

Practice parameters for early rectal cancer management: Italian Society of Colorectal Surgery (Società Italiana di Chirurgia Coloretale; SICCR) guidelines

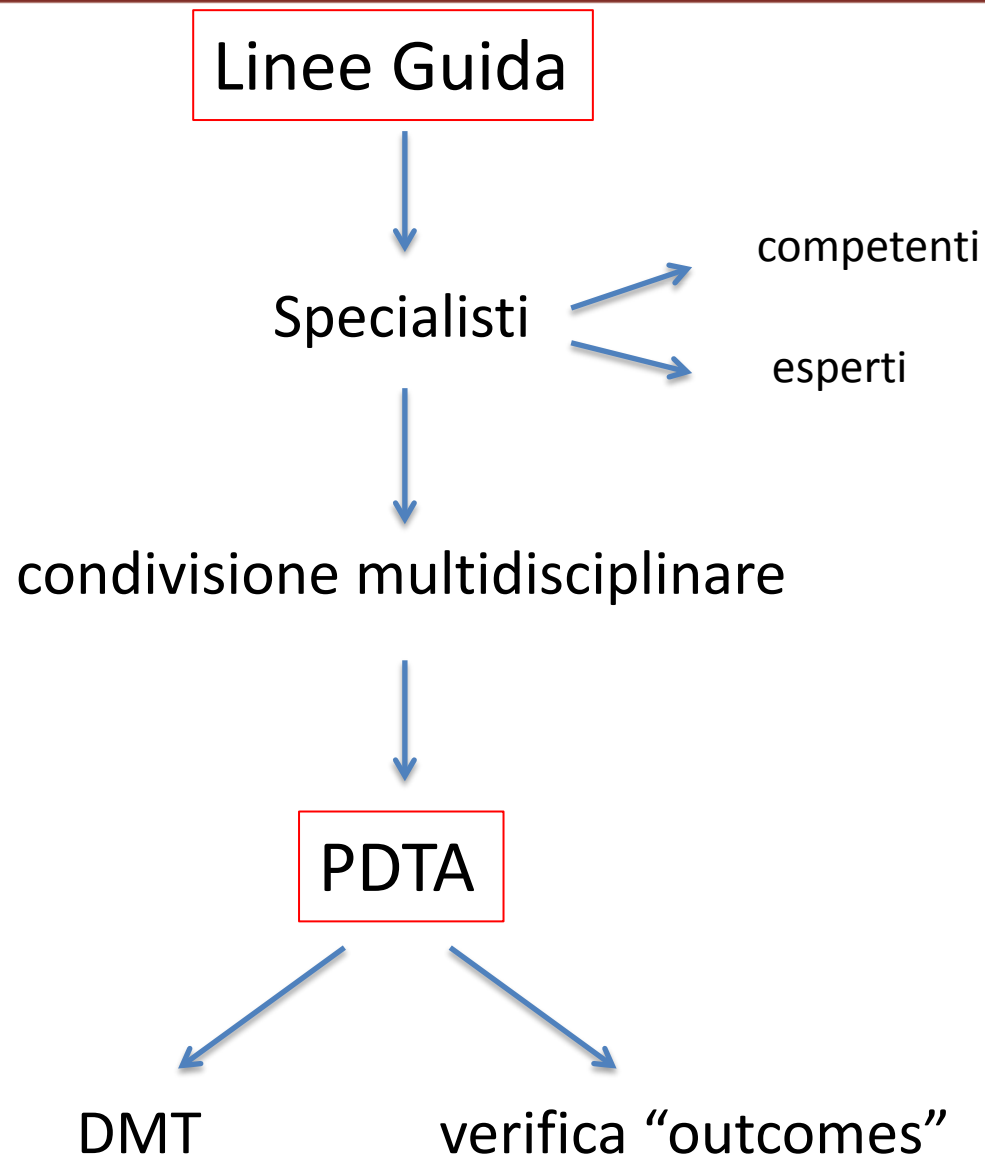
A. Arezzo¹ · F. Bianco² · F. Agresta³ · C. Coco⁴ · R. Faletti⁵ · Z. Krivocapic⁶ ·
G. Rotondano⁷ · G. A. Santoro⁸ · N. Vettoretto⁹ · S. De Franciscis² ·
A. Belli² · G. M. Romano²

Diagnosis

- ERUS T1/T2
- MRI - \geq T2, N
 - restaging after CT/RT

Local excision

- mobile, exophytic, not ulcerated
- Low risk tumors
- Frail pts
- TEM or TAMIS (> en block and R0 vs LE or ESD, < morbidity vs TME)





GL ----- PDTA ----- Pts



“The only thing we learned from our experience is that the patient is very happy to save its rectum; so, clearly it is time to think doing less in treatment of rectal cancer.”

Eric Rullier, GRECCAR group, ESCP Meeting 2014



The patient's view!

Colorectal Disease

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VOLUME 17
SUPPLEMENT 1
JANUARY 2015



COLORECTAL POLYPS: RECENT
ADVANCES FROM GENETIC
MANAGEMENT

2ND GENOA MEETING
14 APRIL 2014

GUEST EDITORS GIAN ANDREA BINDA
AND NAJB HABOUBI

WILEY
Blackwell

View this journal online at wileyonlinelibrary.com/journal/codi

GISCoR

gruppo italiano screening colrettale

We have the pleasure to invite
you to watch the outlines of the
meeting presentations

RECENT ADVANCES IN COLORECTAL POLYPS

The videos and presentations are available on
www.colorectalpolyps.net



This is a new edition of the Conference on Colorectal Polyps that was held in Genoa in 2004. The workshop provides a high level and up-to-date information on this

Grazie per l'attenzione!

diagnosis and treatment of colorectal polyps; the entire meeting has been video recorded and is available online. All the presentation are published as a supplement in the Colorectal Disease journal.



Project support by Rosa Gallo Foundation/Association
Supervisor: Gian Andrea Binda





Low risk

- T1
- sm 1 or $< 1000 \mu m$
- *G1 – G2*
- *no LVI*
- *no or low Budding*



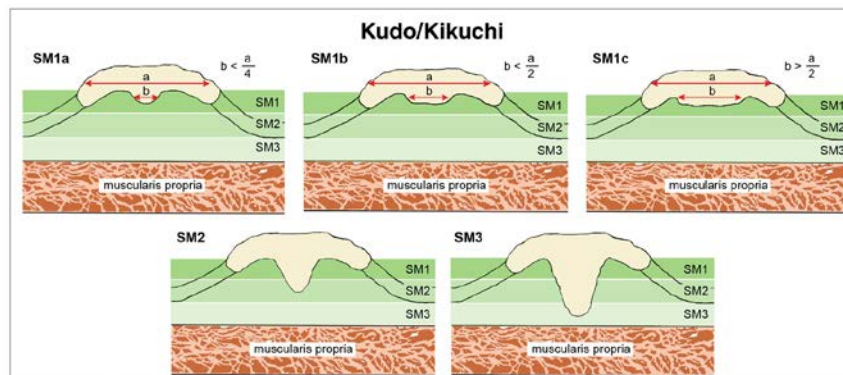
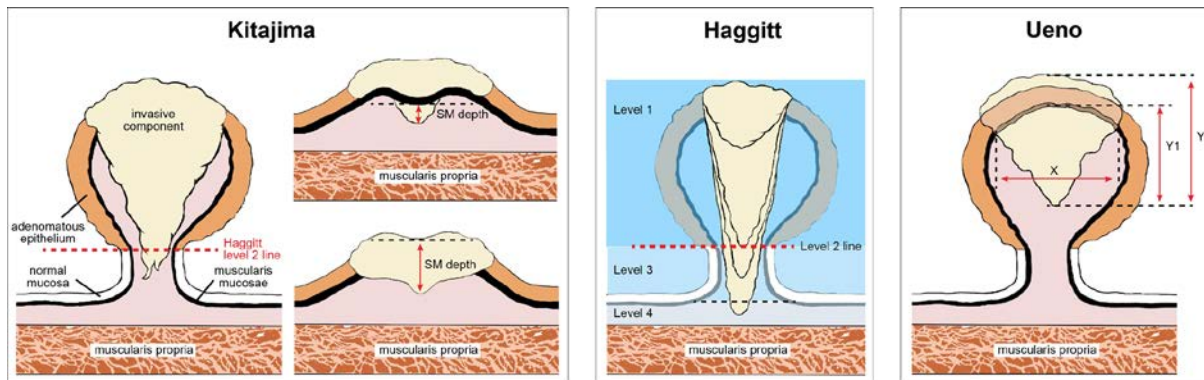
Early Colorectal Carcinoma

- The overall risk of lymph node metastases is 8-16% of cases
- Two groups can be distinguished on the basis of histological features :
 - **Low risk**
 - **High risk**
- In the case of endoscopic removal of the polyp, the presence of infiltration at the resection margin or of parameters associated with high risk is an indication for surgical resection.

ORIGINAL ARTICLE

Interobserver variability amongst gastrointestinal pathologists in assessing prognostic parameters of malignant colorectal polyps: a cause for concern

A. Davenport¹ · J. Morris² · S. A. Pritchard¹ · E. Salmo³ · M. Scott¹ · N. Y. Haboubi⁴





In situ adenocarcinoma and Intramucosal adenocarcinoma

- Both lesions have virtually no risk of metastasis. The colon-rectum is probably the only organ in which the invasion of the lamina propria is not associated with metastatic risk.
- In the TNM classification both lesions are designated as pTis.
- GISCoR recommendations: "not to use those designations in screening reporting and include both lesions under the term high-grade dysplasia."

National and international guidelines for rectal cancer

L. B. J. Nielsen and P. Wille-Jørgensen

Faculty of Health Sciences, Digestive Disease Center – K, Bispebjerg Hospital, University of Copenhagen, Copenhagen, Denmark

Received 2 April 2014; accepted 16 April 2014; Accepted Article online 28 May 2014

Colorectal Dis. 2014

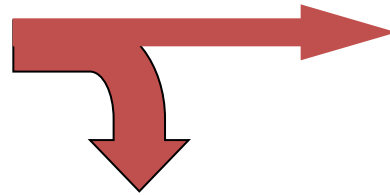
Table 1 Overview of the guidelines and the definition of rectal cancer.

	EURECA- CC2 2nd European Rectal Cancer Consensus Conference (EURECA- CC2) 2009[3]	SEOM Spanish Society of Medical Oncology 2010 [1]	Ontario Cancer care Ontario 2008– 2012 [14]	NCCN National Comprehensive Cancer Network 2012 [15]	ACPGBI The Association of Coloproctol- ogy of Great Britain and Ireland Guidelines 2007 [16]	World Congress on GI Cancer 2007 [2]	JSCCR Japanese Society for Cancer of the Colon and Rectum 2012[17]	DCCG Danish Colorectal Cancer Group 2010–13 [18]	NGICG Norwegian Gastrointestinal Cancer Group. 2012 [20]	NICE – UK National Institute f or Health and Care Excellence 2011 [21]
Rigid sigmoidoscopy with biopsy Tumour < 15 cm from the anal verge	Rigid proctosc opy MRI	Below peritoneal refluction, tumour 12 cm from the anal verge	Tumour between the termination of the sigmoid colon, usually at the level of the sacral promontory, and the dentate line	Tumour within 12 cm of the anal verge on rigid proctoscopy	Tumour within 15 cm of the anal verge on rigid proctoscopy Always biopsy	CT or MRI: rectum defined as below the first or second sacral vertebra	NA	Tumour within 15 cm of the anal verge on rigid proctoscopy	Tumour within 15 cm of the anal verge on rigid proctoscopy	NA



Communicating the level of risk

Early CRC



Margin involvement:
Residual/recurrent
tumor 14,3%

2

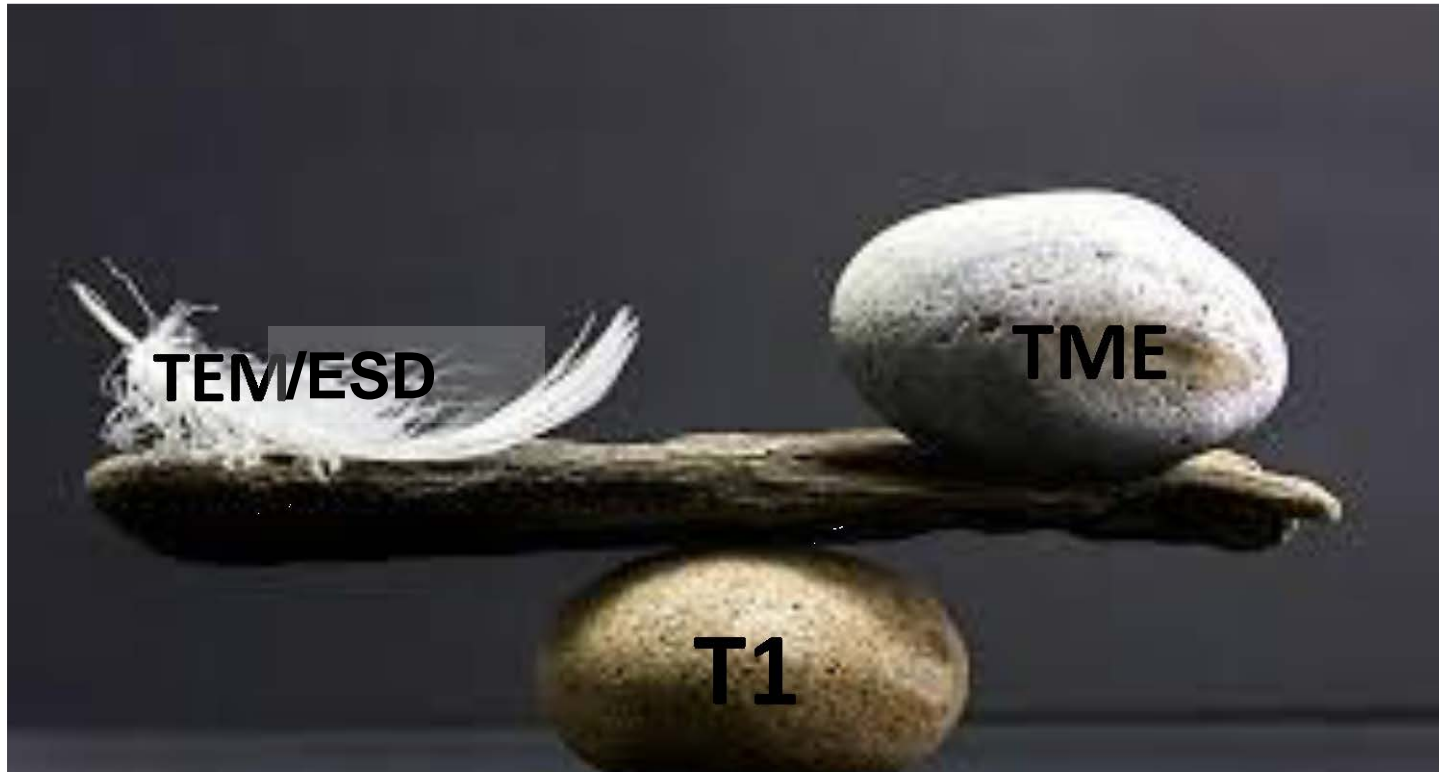
Vascular invasion

Tumor grade

Budding

} ~1%

Finding the right balance...



need of prospective trials or international registry
collecting a large number of patients
from experienced centres



Assessment of the Metastatic Risk

	<u>Risk of Lymph. Mets</u>
Early CRC (all)	13.1%
E-CRC with 1 risk factor	20.7%
E-CRC with >1 risk factor	36.4%
E-CRC with no risk factors	0,7%

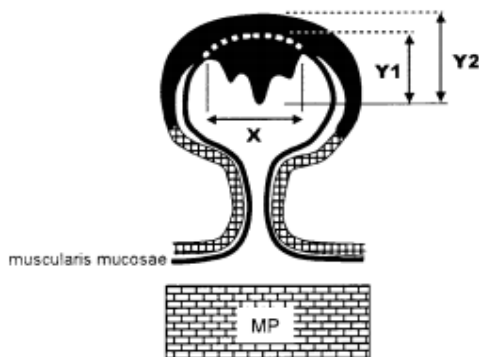
Risk Factors for an Adverse Outcome in Early Invasive Colorectal Carcinoma

GASTROENTEROLOGY 2004;127:385-394

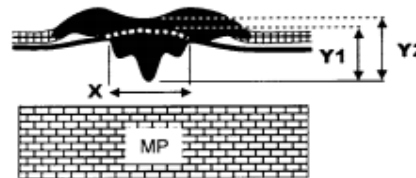
HIDEKI UENO,* HIDETAKA MOCHIZUKI,* YOJIRO HASHIGUCHI,* HIDEYUKI SHIMAZAKI,† SHINSUKE AIDA,† KAZUO HASE,§ SUSUMU MATSUKUMA,|| TADAO KANAI,¶ HIROYUKI KURIHARA,¶ KOTARO OZAWA,¶ KAZUYOSHI YOSHIMURA,# AND SHINYA BEKKU#

Depth and Width of Submucosal Invasion

Width
> 4000 μm

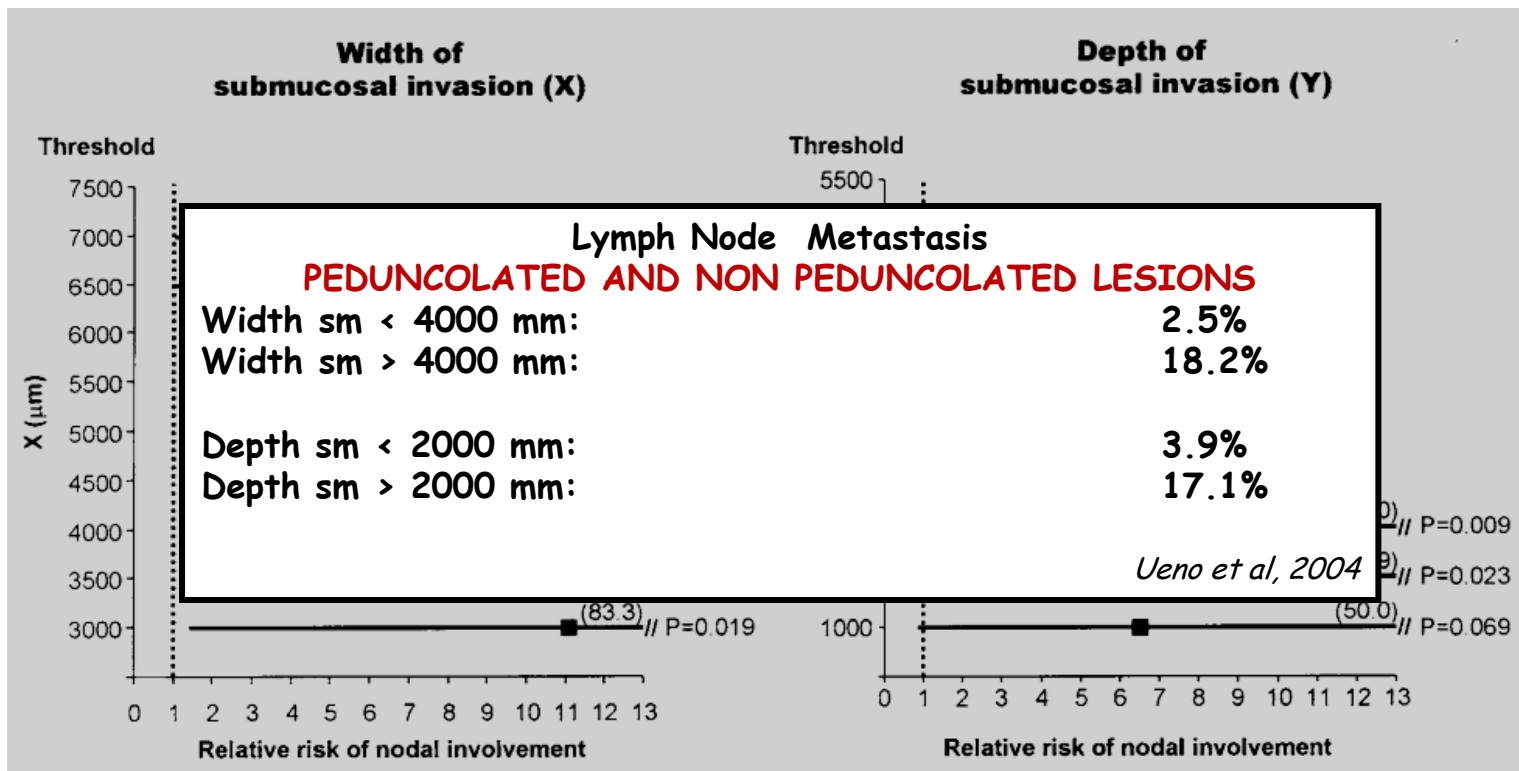


Pedunculated



Sessile

Depth
> 2000 μm





EARLY COLORECTAL CANCER

- Nowadays we speak a common language

