POST-COLONOSCOPY COLORECTAL CANCER (PCCRC)

WEO Consensus

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The story so far…

Definition and taxonomy of interval colorectal cancers: a proposal for standardising nomenclature

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Difference between PCCRCs and interval cancers

• **Interval cancer**
  • A *screening term* – measure of success of screening
  • *Cancer occurring between 2 screening tests*
  • a “colorectal cancer diagnosed after a colorectal screening examination or test in which no cancer is detected, and before the date of the next recommended exam” (Sanduleanu, Gut 2015)

• **Post-colonoscopy CRC (PCCRC)**
  • A *colonoscopy QA term* - measure of accuracy of the colonoscopy
  • A CRC detected after any colonoscopy – *not screening-specific*
  • Within screening, it *includes* CRC detected at next screening exam
Aren’t they the same thing?

- 60 year old
  - FOB POSITIVE
  - COLONOSCOPY NORMAL
  - SCREENING SUCCESS
  - NOT an interval cancer
  - SCREEN DETECTED CANCER
Aren’t they the same thing?

60 year old
- FOB POSITIVE
- COLONOSCOPY NORMAL

2 years later
- FOB POSITIVE
- COLONOSCOPY CANCER

SCREENING SUCCESS
- NOT an interval cancer
SCREEN - DETECTED CANCER
Aren’t they the same thing?

- **60 year old**
  - FOB POSITIVE
  - COLONOSCOPY NORMAL

- **2 years later**
  - FOB POSITIVE
  - COLONOSCOPY CANCER

- **SCREEN-DETECTED CANCER**
  - SCREENING SUCCESS
  - NOT an interval cancer
Aren’t they the same thing?

- **60 year old**: FOB POSITIVE • COLONOSCOPY NORMAL
- **2 years later**: FOB POSITIVE • COLONOSCOPY CANCER
- **PCCRC**: Original colonoscopy failure • Potential QA issue
Aren’t they the same thing?

- So, although a cancer might be a screening success, it can still be a colonoscopy QA failure
- In other words: cancers can be PCCRCs without being interval cancers
They’re not the same thing

• We need BOTH terms:
  • Interval cancer for screening programmes (not a colonoscopy QA term)
  • PCCRC for colonoscopy QA (screening or non-screening)

• Although they’re often very similar, they’re NOT the same & need to be thought of separately, because they’re purpose is different

• They each need their own precise definition

• Risk that if we try to use the same terminology, we will add to the confusion
Project rationale

**PRIMARY:** Colonoscopy QA

- All colonoscopy, not just screening
- *PCCRC rate is the key quality measure in colonoscopy*
- Standardised methodology required
  - Application of published methods & exclusion criteria to the dataset produced significantly different PCCRC rates from 2.5% to 7.7% (*Morris, Gut 2015*)

**SECONDARY:** Better understanding of the aetiology of PCCRCs
Performance measurement – project remit

Process
How to monitor?

Structure
How to report?

Methodology
How to calculate rates?

Checklist
How to review?

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Process Outline

• Set up multidisciplinary project team
• Compile list of key questions
• Literature review
• Divide into 2 Working Groups: *Aetiology* and *Performance*
• Each WG to review/expand evidence and develop statements in their area (AGREE II tool, GRADE methodology)
• Consensus (modified Delphi process)
Core Members

*Project Lead: Matt Rutter*

**PERFORMANCE GROUP**
- Matt Rutter (Lead)
- Roland Valori
- Eva Morris
- Andrew Plumb *(Radiology)*
- Rocky Schoen
- Linda Rabeneck
- Evelien Dekker
- Iosif Beintaris (non-voting member)

**AETIOLOGY GROUP**
- Silvia Sanduleanu (Lead)
- Evelien Dekker
- Gerrit Meijer
- Ulrike Haug *(Epidemiology)*
- Douglas Robertson
- Graeme Young
- Miriam Cuatrecasas Freixas *(Pathology)*
Literature Review

Medline, Cochrane Search terms:
- Colorectal cancer
- Interval cancer
- Healthcare quality assurance

1030 articles

abstract review feedback from members removed duplicates

344 articles*

*as of voting round 1
Aetiology - Key questions

1. What terminology should be used to describe categories?
2. What are risk factors and potential explanations for PCCRC?
3. How to ascribe potential explanations?
4. What should be the minimal histology data set to examine PCCRC?
5. What molecular tests should be performed to examine PCCRC?
6. How to prevent interval CRC in high-risk groups?
Performance - Key questions

1. How should PCCRCs be calculated & reported?
2. How should PCCRC rates be monitored?
3. How should PCCRC papers be peer-reviewed? [Checklist]
4. Radiology – can we/how do we extend to post-imaging CRC?
Modified Delphi Process

• All members have equal vote
• Aiming for 80% agreement (for statement consensus)

• In areas of continuing disagreement
  • A recommendation for or against a particular intervention (compared with a specific alternative) requires both
    • >50% of participants in favour
    • <20% preferring the comparator
  • Failure to meet this criterion results in no recommendation
Milestones
AGREE II tool
Grade methodology
Modified Delphi process

Key-questions Performance group Aetiology group

Systematic review of literature

First draft recommendations

Second draft recommendations

Consensus statements (Voting rounds)

Draft manuscript

May – June 2016
April – May 2016
March - April 2016
Febr - March 2016
First round output

• *Terminology*: 2 statements

• *Aetiology*: 10 statements

• *Performance*: 17 statements

• *High Risk Groups*: 4 statements
WARNING

Voting not yet complete
33 statements
10 minutes...
What next?

• Today – keen to hear views of today’s wider audience
What will the end product look like?

- Clarity of definitions
- Clear guidance on how to review PCCRC cases – minimum dataset
- Clarity on how to categorise PCCRC cases
- Standardised methodology for calculation of PCCRC rate
- Checklist for peer-review of PCCRC papers
What next?

- Capture remaining votes
- Revise
- Revote
  - Head-to-head for terminology
- Develop minimum datasets & checklists
- Aim to complete work in time for UEGW

- Thanks to all of the working party
DISCUSSION