WEO
World Endoscopy Organization

EXPERT WORKING GROUP
Surveillance after neoplasia removal

Meeting
Chicago, May 5th 2017
Chair: Rodrigo Jover
Uri Ladabaum

AIM

To improve the quality of the evidences we have regarding post-polypectomy surveillance

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Quality in the Procedural Practice of Colonoscopy with a focus on surveillance after polyp detection: A DELPHI PROCESS.

Rodrigo Jover, Evelien Dekker, Cesare Hassan, Robert Schoen, María Pellisé, Uri Ladabaum on behalf of the WEO Expert Working Group of Surveillance after colonic neoplasm.

Sentences with consensus

DOMAIN	SENTENCE	AGREEMENT SCORE	DEGREE OF CONSENSUS
COMPLETENESS OF THE EXPLORATION			
The extent of the colonoscopy should be considered complete only if:	The whole cecum has been inspected, including the ileocecal valve and the appendiceal orifice.	4.6	82
Regarding documentation of the completeness of the colonoscopy:	Cecal landmarks should always be documented with a photograph.	4.7	89
CLEANLINESS OF THE COLON			
Regarding Bowel Preparation, to provide adequate surveillance recommendations:	a. Quality of the bowel preparation should always be reported.	4.91	94
	A. It is preferable to use a validated scale to describe the bowel preparation.	4.36	82
	B. It is preferable to use a segmental validated scale, such as the Boston scale.	4.15	77
	f. The quality of the bowel preparation should be assessed only after rinsing/washing is complete.	4.24	80
Indication for surveillance	d. If bowel preparation is considered inadequate for providing surveillance recommendations, the colonoscopy should be repeated in less than one year.	4.03	81

COMPLETENESS OF EXCISION			
Evaluation of completeness of polypectomy before giving surveillance recommendations:	In the case of piecemeal polypectomy, evaluation of the completeness of the polypectomy should be assessed by the endoscopist	4.50	85
	B: In the case of en bloc polypectomy (1 piece), evaluation of the completeness of the polypectomy should be assessed by the endoscopist.	4.13	81
Regarding the endoscopy report: the following information should be included in order to provide optimal surveillance recommendations	The total number of polyps	4.61	87
	The total number of polyps removed.	4.73	90
	The total number of polyps retrieved.	4.53	82
	The size of each polyp	4.67	90
	The location of each polyp.	4.34	85
	The morphology of each polyp.	4.36	81
	The use of piecemeal vs "en bloc" resection for each polyp.	4.47	87
	The method of excision of each polyp.	4.36	81
	The assessment of the completeness of excision of each polyp.	4.48	84
Regarding the pathology report, to provide optimal surveillance recommendations:	A histopathological diagnosis for each retrieved polyp is necessary.	4.27	80
	The grade of dysplasia for each retrieved polyp is necessary.	4.19	77
	Presence of villous component of retrieved polyps is necessary.	4.36	81
	In the case of piecemeal polypectomy, the polyp size measured by endoscopists is preferred.	4.41	85
	h. The total number of adenomas must be known.	4.52	87
	i. The total number of adenomas and serrated polyps must be known	4.45	86
After piecemeal polypectomy, early (3-6 months) inspection of the polypectomy site:	Should be performed after piecemeal polypectomy of polyps ≥ 20 mm.	4.50	85
Regarding Tattoos: Tattoing should always be used for:	Large polyps (≥20 mm) resected in a piecemeal fashion.	3.97	76
	D. Polyps with suspicion of invasive carcinoma.	4.84	91

Development of a checklist for fulfillment of minimum quality requisites for post-polypectomy surveillance recommendations

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PROPOSAL OF CHECK-LIST

- ❑The whole cecum has been inspected, including ileoceal valve and appendiceal orifice
- ❑Landmarks of the cecum have been documented by photograph
- ❑The endoscopy report contains information about
  - ❑Total number of polyps, removed polyps and retrieved polyps
  - ❑Size of each polyp
  - ❑Location of each polyp
  - ❑Morphology of each polyp
  - ❑Method of excision of each polyp
  - ❑Assessment of the completeness of excision
  - ❑Use of piecemeal or “en bloc” resection
- ❑The pathology report contains information about
  - ❑The total number of adenomas and serrated polyps
  - ❑The histopathological diagnosis of each polyp
  - ❑The presence of villous component in each polyp
  - ❑The grade of dysplasia of each polyp
- ❑Quality of bowel preparation has been reported using a validated scale and is considered as adequate

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Effect of adenoma surveillance on colorectal cancer incidence: a multicentre cohort study

Wendy Atkin FMedSci OBE

Cancer Screening and Prevention Research Group
Department of Surgery and Cancer
Imperial College London

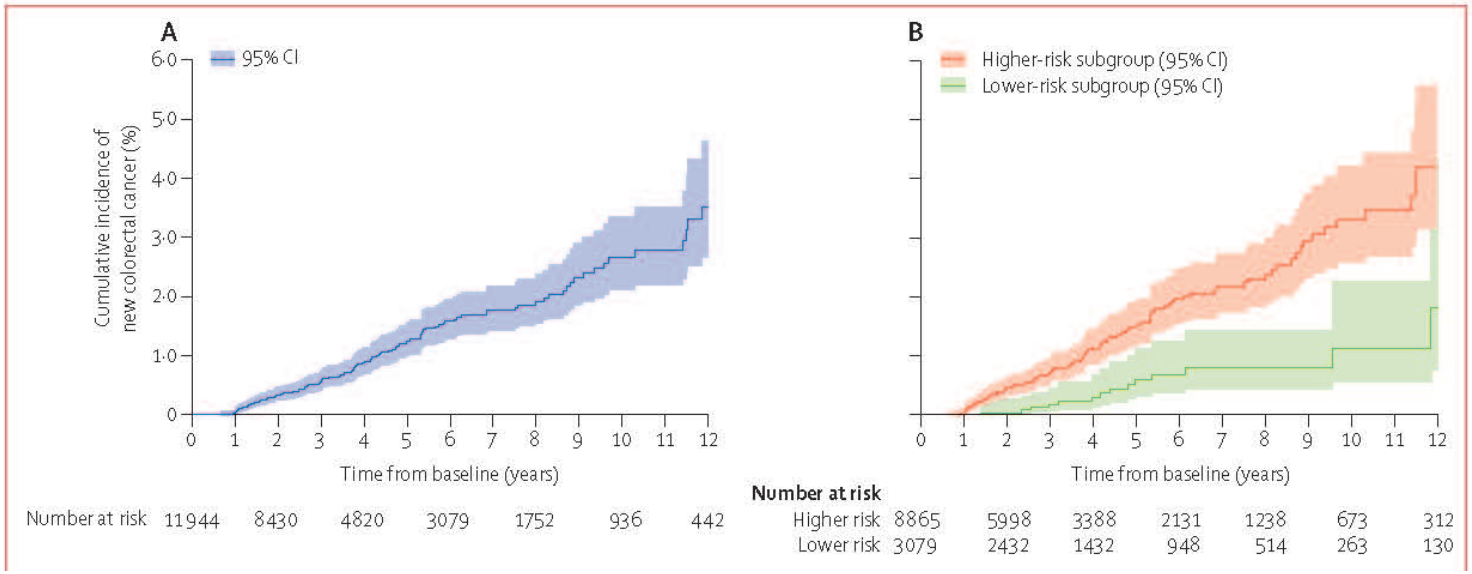
CRC incidence by baseline risk factors

Baseline risk factor	n	CRC cases	Incidence per 10^5 py	Multivariable HR (95% CI)	p value
Adenoma size (mm)					0.0335
<10	1029	10	120	1	
10-19	6857	116	198	1.97 (1.01-3.81)	
≥20	4058	84	246	2.28 (1.06-4.50)	
Adenoma dysplasia					0.0033
High grade	1994	51	322	1.69 (1.21-2.36)	
Proximal polyps					0.0004
Yes	3649	73	254	1.76 (1.30-2.38)	
Colonoscopy					0.0001
Incomplete or not known	2928	86	299	1.80 (1.34-2.41)	
Bowel prep quality					0.0452
Excellent or good	3956	53	159	1	
Satisfactory	1922	29	213	1.51 (0.95-2.39)	
Poor	671	16	356	2.09 (1.19-3.67)	

Atkin et al., Lancet Oncology Published online April 27,2017

Cumulative CRC incidence after baseline

Whole Intermediate Cohort **Stratified by Subgroup**



Atkin et al., Lancet Oncology Published online April 27,2017

Differences between guidelines for post-polypectomy surveillance: is that justified?

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May 5, 2017

David Lieberman MD
Chief, Division of Gastroenterology and Hepatology
Oregon Health and Science University

- WEO proposal for worldwide surveillance recommendations based on literature analysis
- Stratification of risk
- Polyps that need or do not need surveillance: adenomas and serrated polyps

FORTE: Five or Ten Year Colonoscopy for 1-2 Non-Advanced Adenomas

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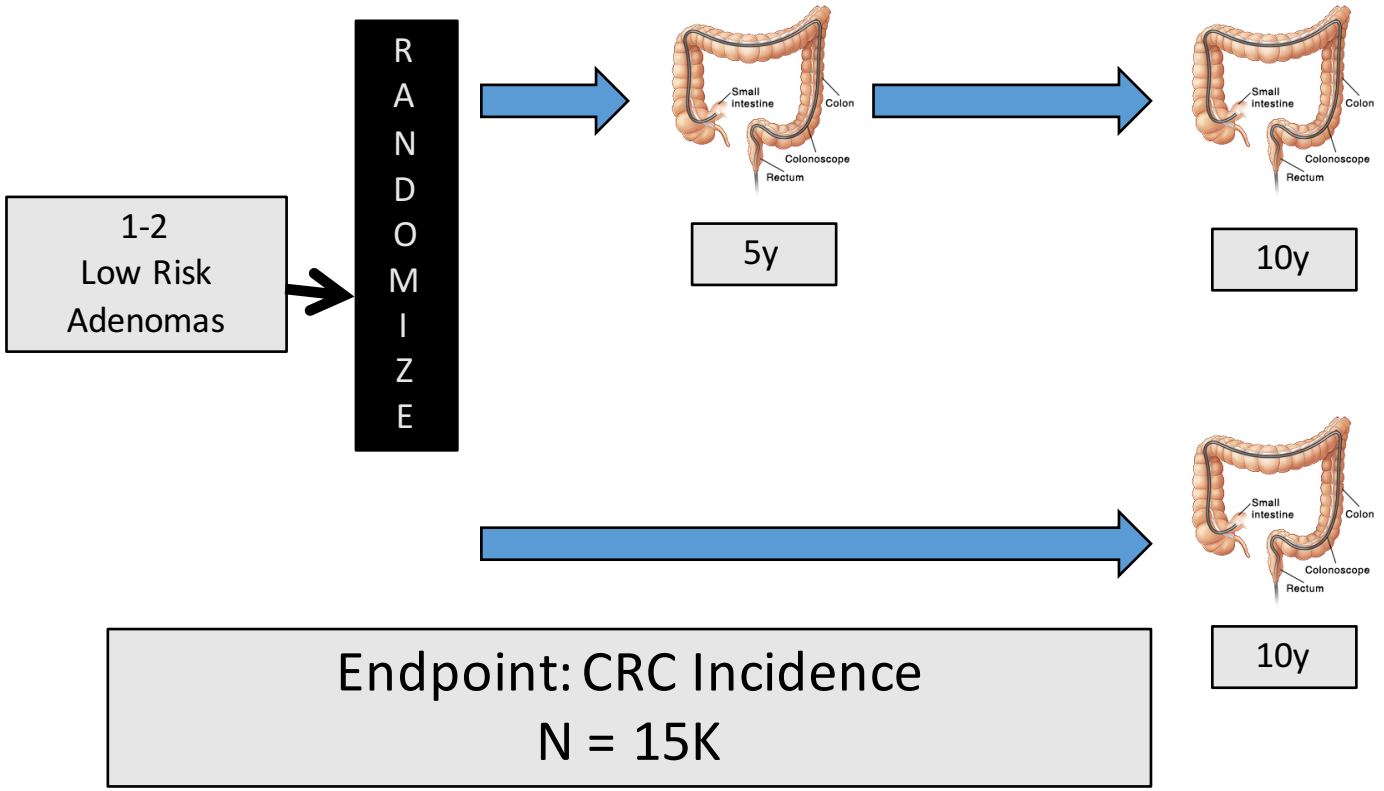
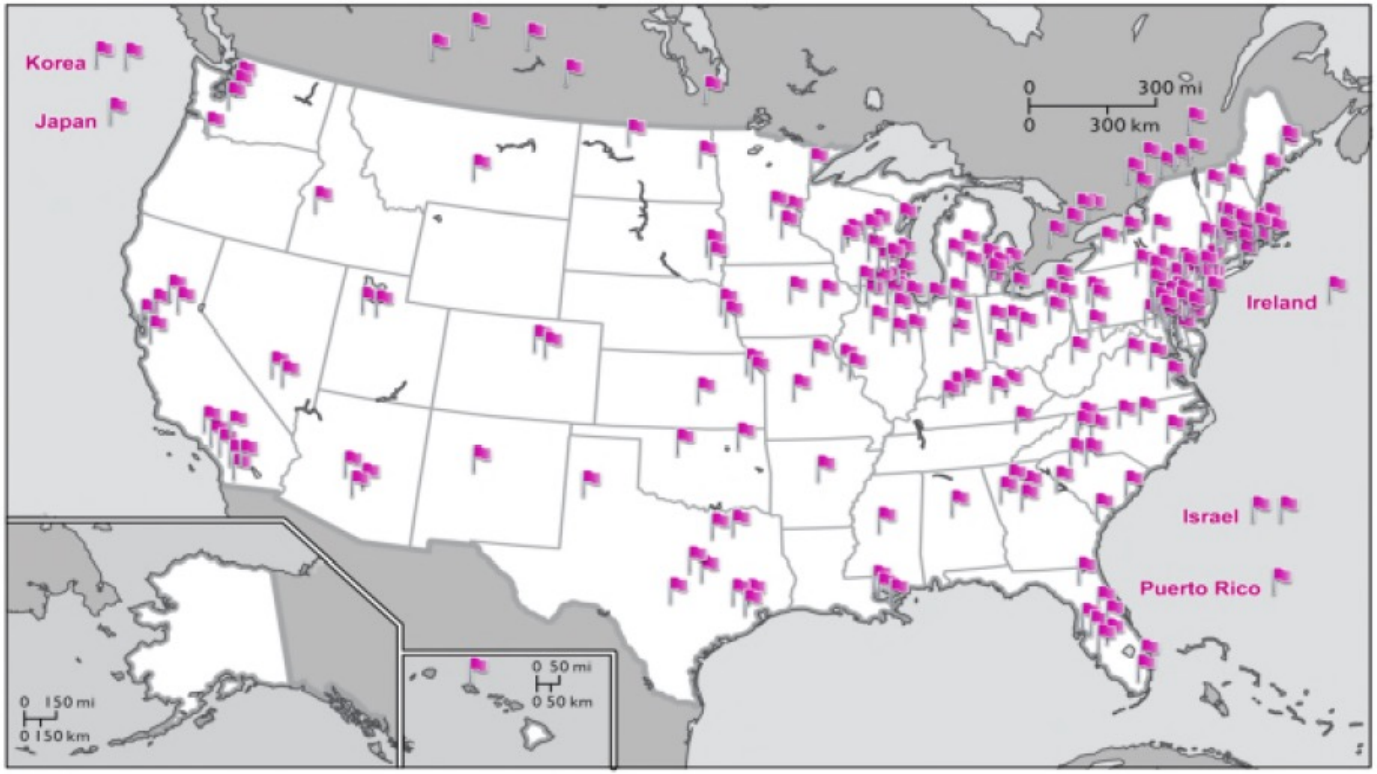
FORTE Proposed Schema



NRG ONCOLOGY MAIN MEMBERS, LAPS, & NCORP INSTITUTIONS JUNE 2016



N=218 Institutions

N=30 Lead Academic Performance Sites

N=32 NCORP Sites – 10 minority Underserved