Il follow-up degli adenomi nel programma di screening colorettale della Regione Emilia-Romagna: il clinico e l'epidemiologo

Fabio Falcini, Omero Triossi

Elaborazione dati E-R Orietta Giuliani

SERVIZIO SANITARIO REGIONALE
EMILIA-ROMAGNA

10 anni
di screening dei tumori del colon-retto nella Regione Emilia-Romagna

Seminario di studio

Bologna, 9 aprile 2015

SORVEGLIANZA POSTPOLIPECTOMIA

Si considera come esame di follow-up il primo che segue al raggiungimento di un “clean colon”. Le indagini eseguite nel percorso di eradicazione di una lesione (es. un grosso polipo) e di lesioni multiple o per toilette insufficiente non vengono definite quali esami di follow-up.

Il protocollo diagnostico terapeutico dello screening per la diagnosi precoce del tumore del colon-retto - 2012

SORVEGLIANZA POSTPOLIPECTOMIA

- **Area ad elevata inappropriatezza in eccesso**
- **Forte impatto nel programma di screening dei tumori del colon-retto**

SORVEGLIANZA POSTPOLIPECTOMIA

- **Area ad elevata inappropriatezza in eccesso**

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Publications

- GIE Journal
- Practice Guidelines
- Technology Reviews
- PIVIs
- ASGE Connection
- ASGE News
- SCOPE
- ASGE Video Tips
- ASGE Leading Edge
- Endoscopic Learning Library
- GESAP VII Self-Assessment
- Patient Education Brochures
- QR Codes poster
- Anatomical images
- InterLink International News

Standards of Practice

The following ASGE guidelines have been prepared by the ASGE Standards of Practice Committee, chaired by John DeWitt, MD.

Sections

What's New

Quality Indicators for GI Endoscopic Procedures

SCENIC international consensus statement on surveillance and management of dysplasia in inflammatory bowel disease
Gastrointest Endosc 2015;81:489–501.e26

The role of endoscopy in the bariatric surgery patient
Gastrointest Endosc 2015;ePub ahead of print. DOI: http://dx.doi.org/10.1016/j.gie.2014.09.044

Bowel preparation before colonoscopy
Gastrointest Endosc 2015;ePub ahead of print. DOI: http://dx.doi.org/10.1016/j.gie.2014.09.048

The role of ERCP in benign diseases of the biliary tract
Gastrointest Endosc 2015;ePub ahead of print. DOI: http://dx.doi.org/10.1016/j.gie.2014.11.019

Optimizing adequacy of bowel cleansing for colonoscopy: recommendations from the U.S. Multi-Society Task Force on Colorectal Cancer
Gastrointest Endosc 2014;80:543–562

Antibiotic Prophylaxis for GI Endoscopy
Gastrointest Endosc 2015;81:81–89

The role of endoscopy in the management of constipation
Gastrointest Endosc 2014:80;563-565

The role of endoscopy in the management of variceal hemorrhage
Gastrointest Endosc 2014:80:221-227

Routine laboratory testing before endoscopic procedures

TABLE 3. Appropriate indications for colonoscopy[39]

Surveillance of patients with neoplastic polyps

Evidence from surveys indicates that post-polypectomy surveillance colonoscopy in the United States is frequently performed at intervals that are shorter than those recommended in guidelines,[55-60]

INAPPROPRIATEZZA IN ECCESSO

Comitato per la Qualità delle Prestazioni Professionali Mediche

APPROPRIATENESS OF POST-POLYPECTOMY SURVEILLANCE COLONOSCOPY A PROSPECTIVE MULTICENTER STUDY

F. Radaelli[1], S. Paggi[1], O. Triossi, S. Crotta, S. Ierace, A. Lauri, P. Occhipinti, D. Drago, O. Tarantino, E. Tasini, E. Colombo, R. Pometta, L. Ferraris, P. Brosolo, R. De Marco, M. Terpin, R. Franch, S. Peyre, F. Magnolfi, M. Marini, A. Bortoli, A. Solinas, F. Monica, Z. Rossi, A. Merighi, and G. De Pretis[2]

XVII Congresso Nazionale delle Malattie Digestive
Torino, 5-9 marzo 2011

Appropriateness of timing of surveillance:

	All patients (n = 860)	LR patients (n= 438)	p-value
Correct	270 (31.4%)	91 (20.7%)	< 0.001
Anticipated *	462 (53.7%)	294 (67.2%)	< 0.001
Delayed	128 (14.9%)	53 (12.1%)	NS

* Median time of anticipation: 2.1 yr (IQR 1.6 – 2.9)

Appropriateness of surveillance according to referral:

	Endoscopists (n = 561)	Non-endoscopists (n= 273)	p-value
Correct	209 (37.2%)	57 (20.9%)	< 0.001

INAPPROPRIATEZZA IN ECCESSO

Appropriateness of timing of surveillance in NHS screening programs:

	Screening (n = 240)	**No Screening** (n= 620)	**p-value**
Correct	128 (53.3%)	57 (22.9%)	< 0.001
Anticipated	84 (35.1%)	378 (61.1%)	< 0.001
Delayed	28 (11.7%)	100 (16.1%)	NS

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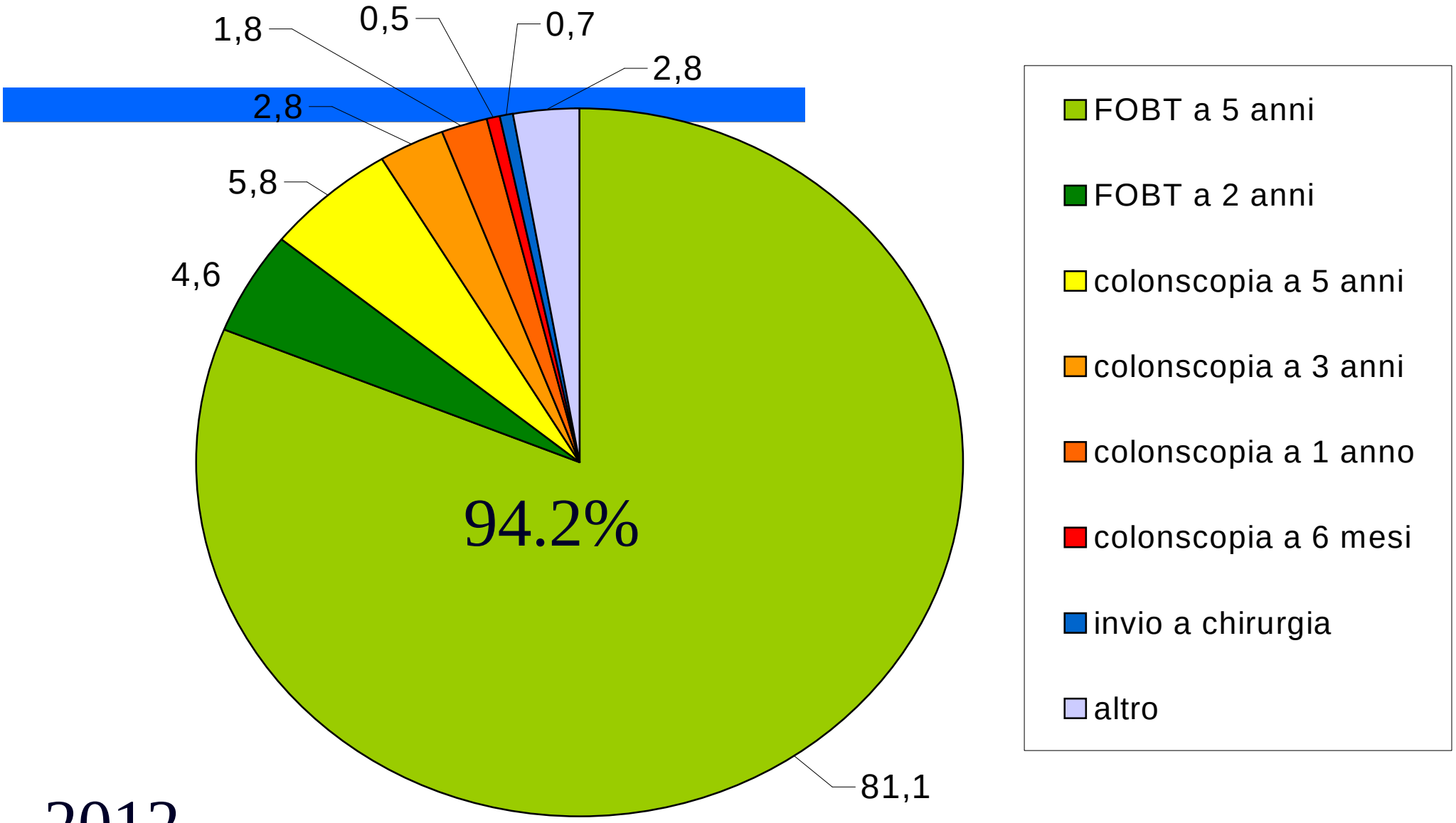
Five Things Physicians and Patients Should Question

3

Do not repeat colonoscopy for at least five years for patients who have one or two small (< 1 cm) adenomatous polyps, without high-grade dysplasia, completely removed via a high-quality colonoscopy.

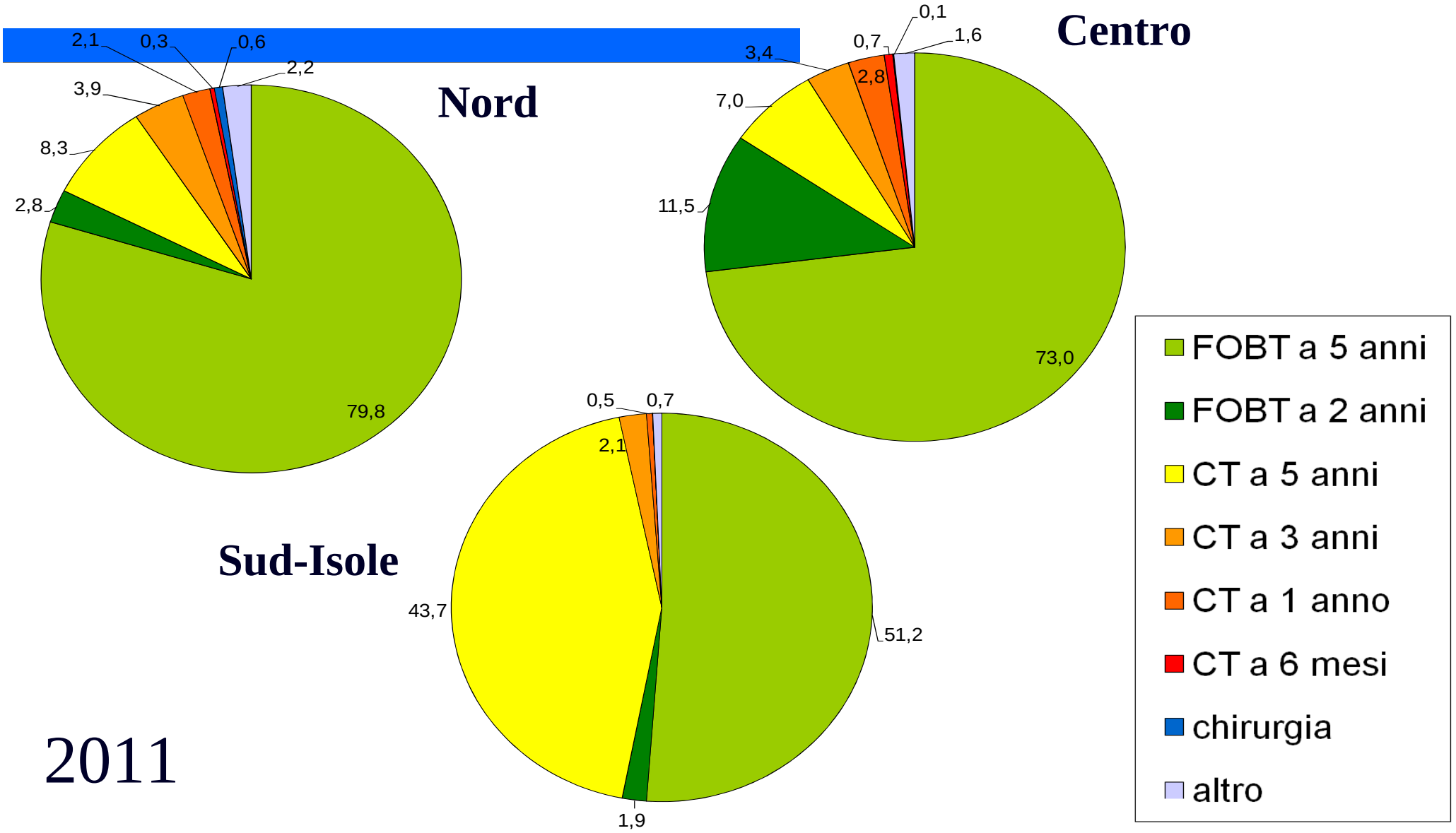
The timing of a follow-up surveillance colonoscopy should be determined based on the results of a previous high-quality colonoscopy. Evidence-based (published) guidelines provide recommendations that patients with one or two small tubular adenomas with low grade dysplasia have surveillance colonoscopy five to 10 years after initial polypectomy. "The precise timing within this interval should be based on other clinical factors (such as prior colonoscopy findings, family history, and the preferences of the patient and judgment of the physician)."

Raccomandazione dopo Colonscopia negativa



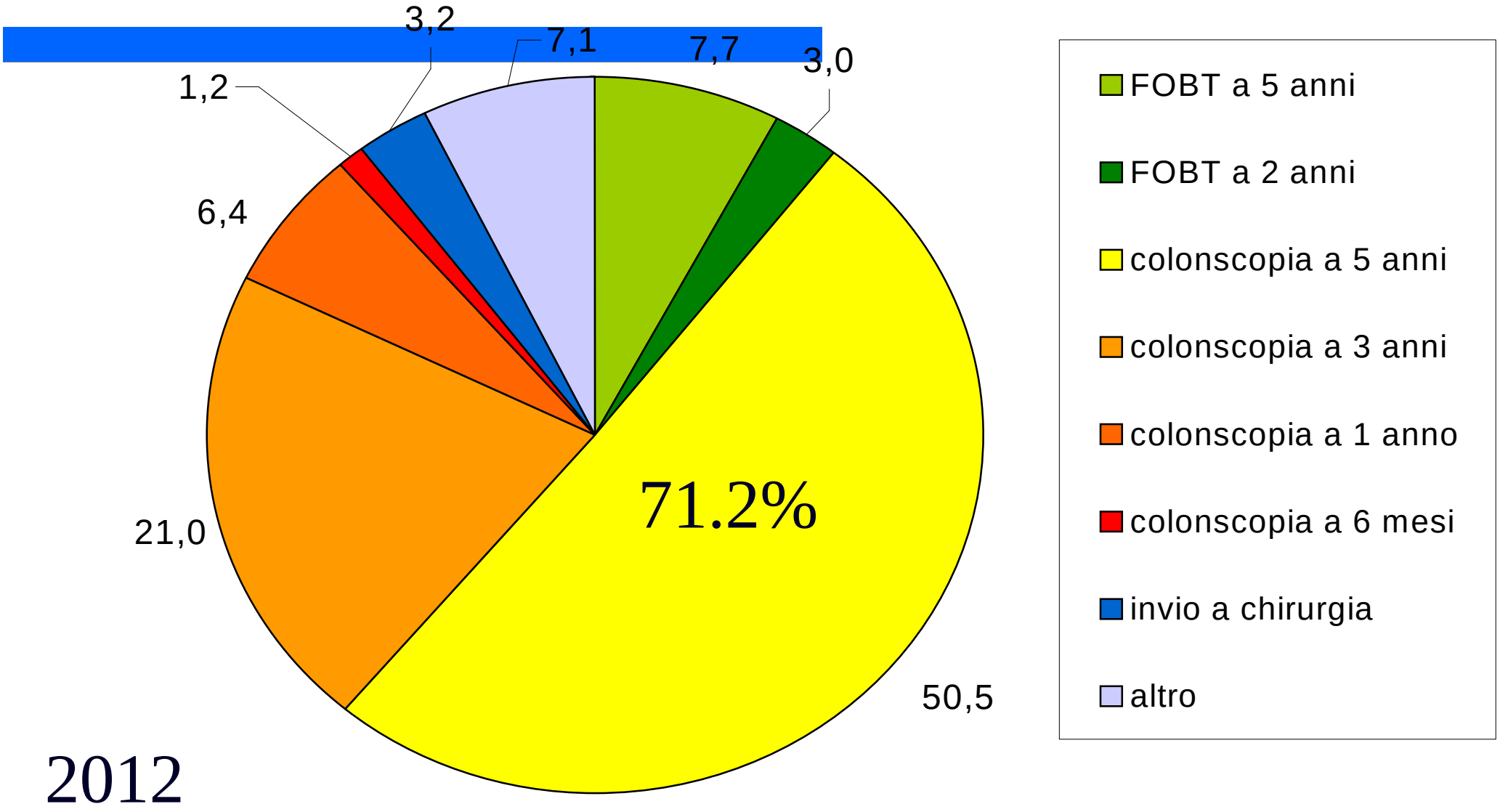
2012

Raccomandazione dopo Colonscopia negativa

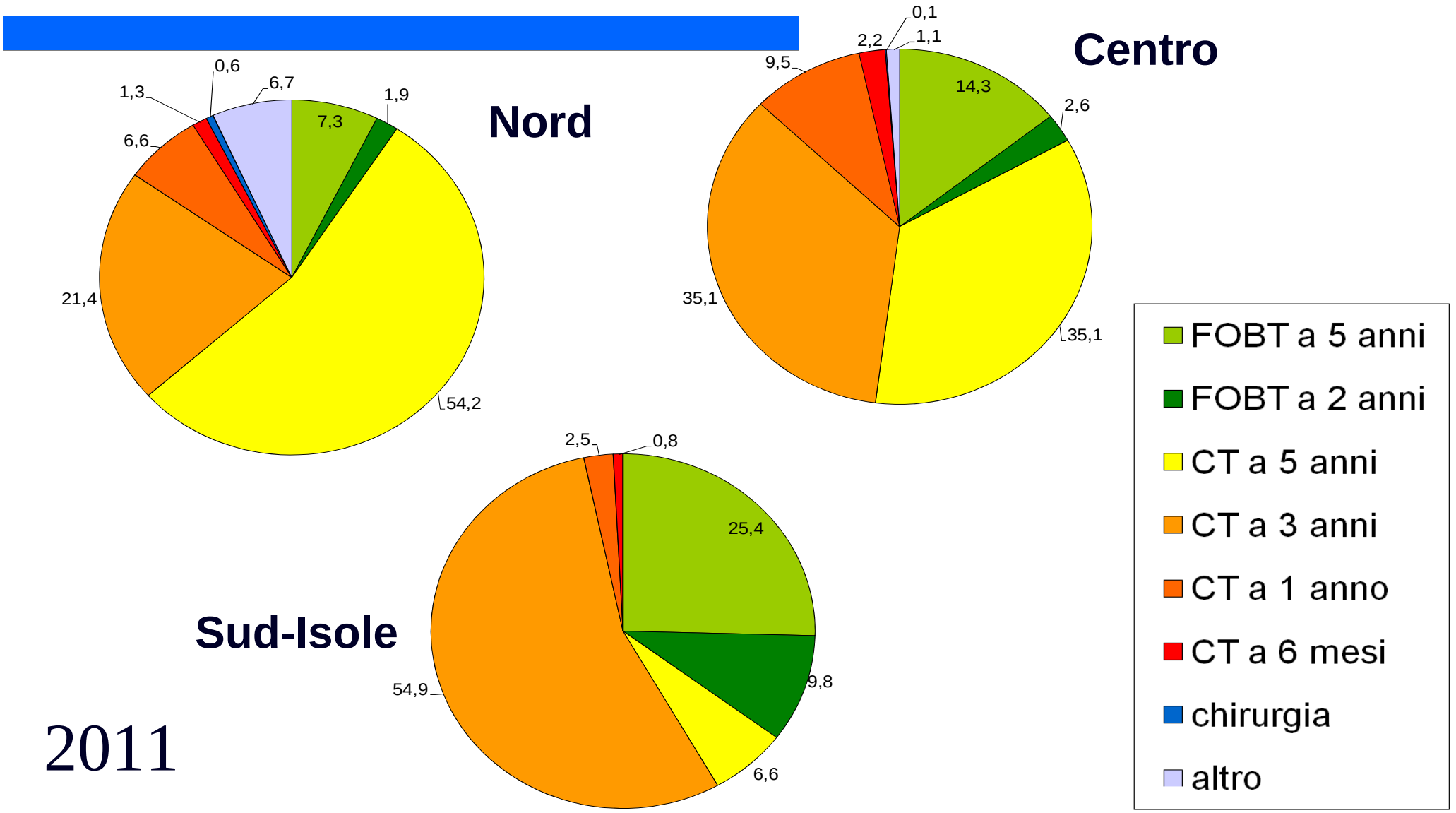


2011

Raccomandazione dopo Adenoma a basso rischio

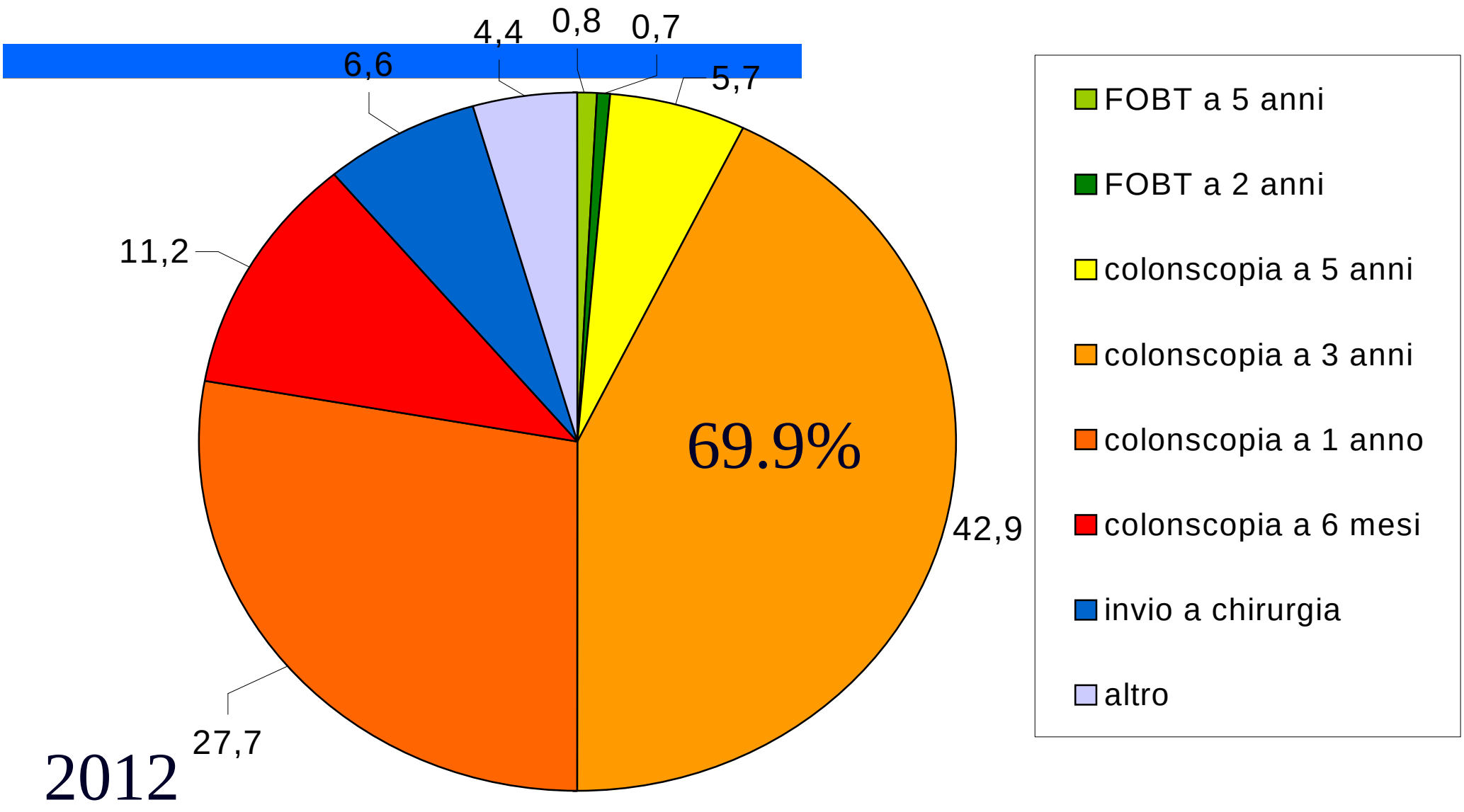


Raccomandazione dopo Adenoma a basso rischio

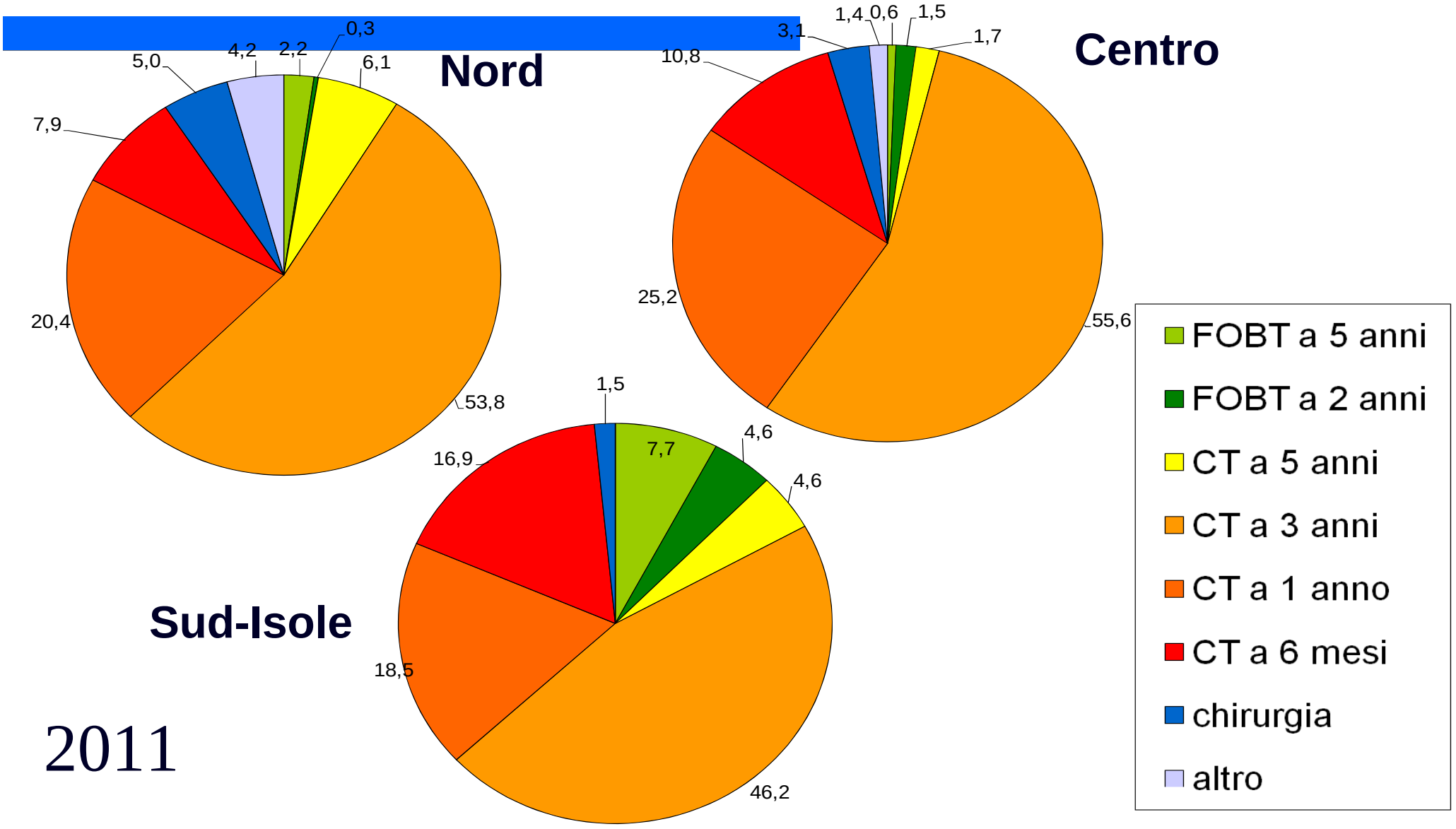


2011

Raccomandazione dopo Adenoma ad alto rischio



Raccomandazione dopo Adenoma ad alto rischio



2011

SORVEGLIANZA POSTPOLIPECTOMIA

- Area ad elevata inappropriatezza in eccesso

- **Forte impatto nel programma di screening dei tumori del colon-retto**

IMPATTO SULLO SCREENING

EPIDEMIOLOGIA & PREVENZIONE

Rivista dell'Associazione italiana di epidemiologia ANNO 31 (6) NOVEMBRE-DICEMBRE 2007 SUPPLEMENTO 1

OSSERVATORIO NAZIONALE SCREENING

Indicatori di qualità per la valutazione dei programmi di screening dei tumori colorettali

Manuale operativo

Quality indicators for the evaluation of colorectal cancer screening programmes

Operative report

A cura di: *Manuel Zorzi, Priscilla Sassoli de' Bianchi, Grazia Grazzini, Carlo Senore e il gruppo di lavoro sugli indicatori del GISCoR*

GISCoR Gruppo Italiano Screening Colorettale

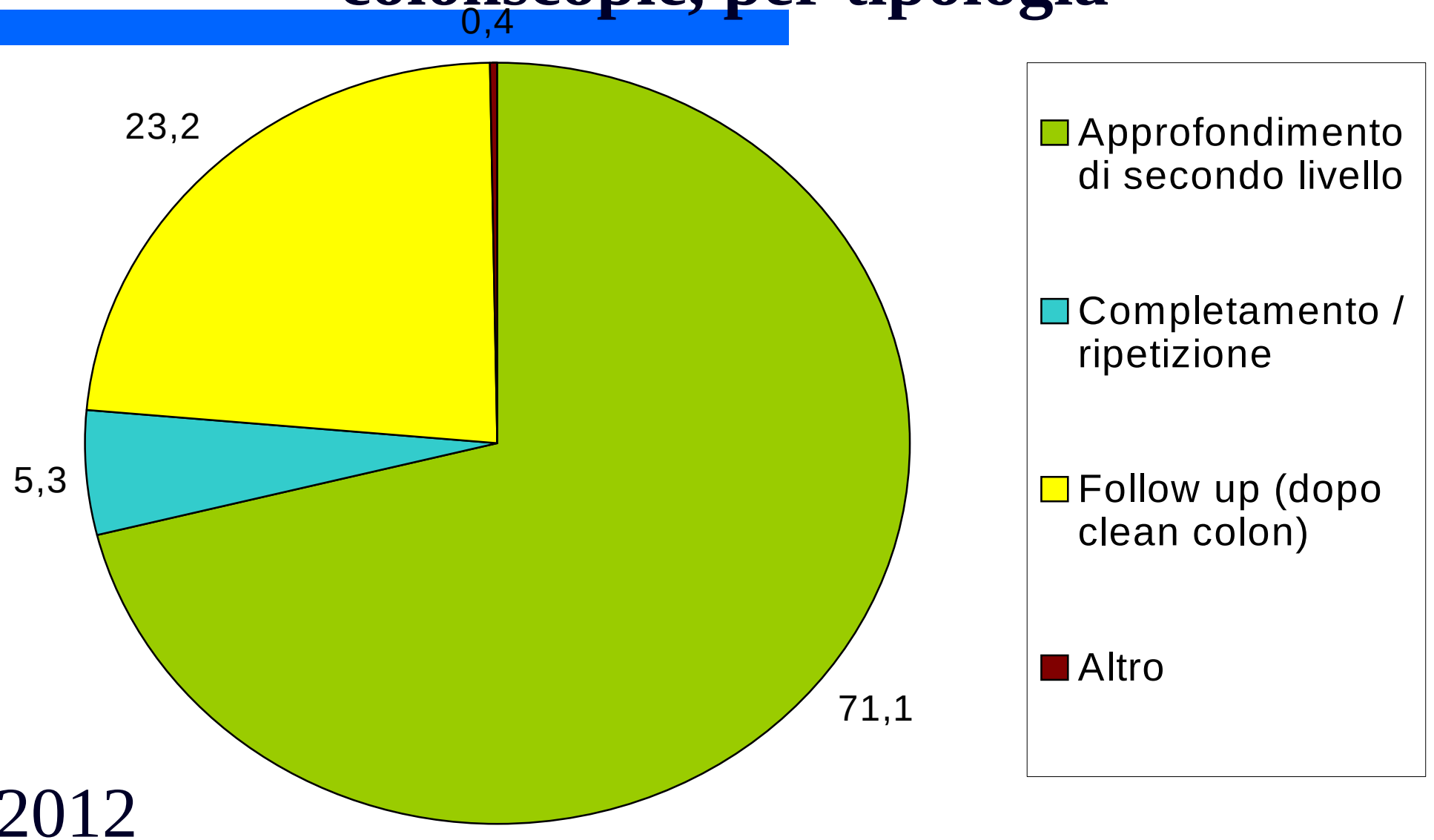
Inferenze

IMPATTO SULLO SCREENING

Il follow up degli adenomi è un argomento cruciale per il controllo dell'appropriatezza delle prestazioni indotte dallo screening del tumore del colon retto.[27]

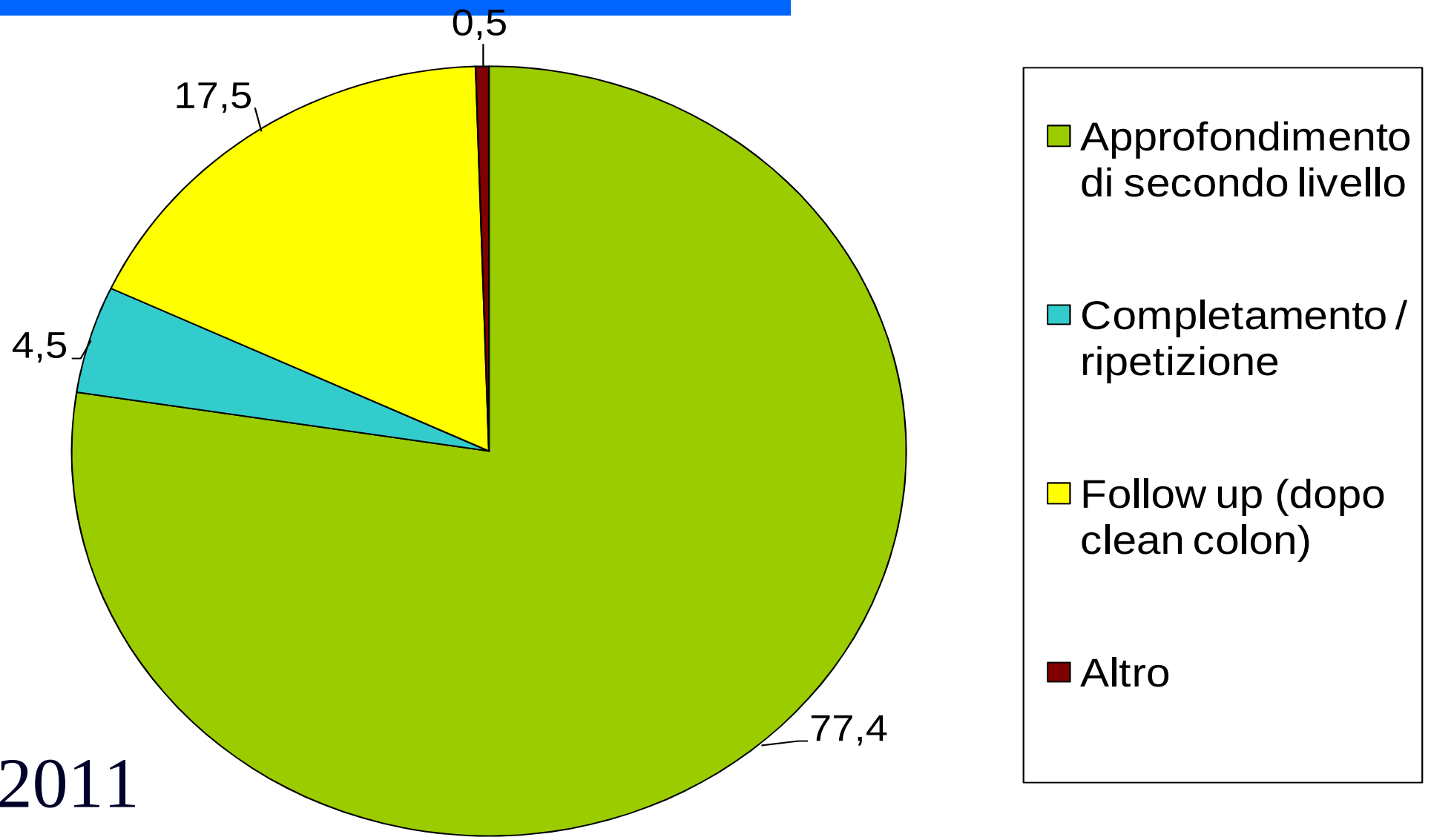
L'attività di follow up può incidere pesantemente sui carichi di lavoro degli ambulatori endoscopici, contribuendo ad allungare i tempi di attesa per l'esecuzione delle colonscopie di secondo livello, che già costituiscono un elemento di fragilità piuttosto diffuso.

Carico endoscopico: distribuzione delle colonscopie, per tipologia



2012

Carico endoscopico: distribuzione delle colonscopie, per tipologia

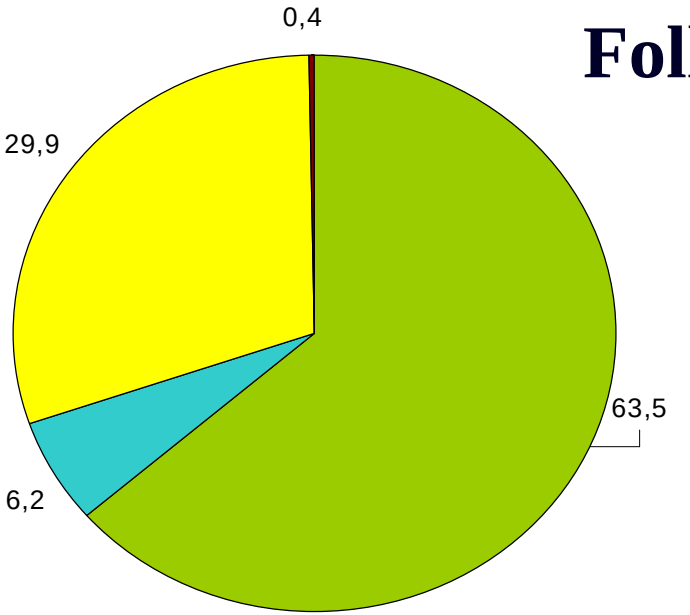


2011

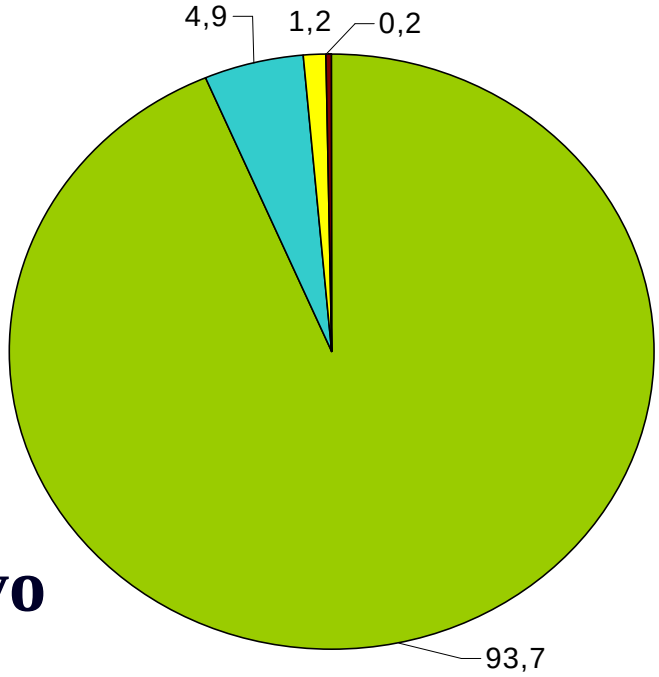
Carico endoscopico per gestione del follow up

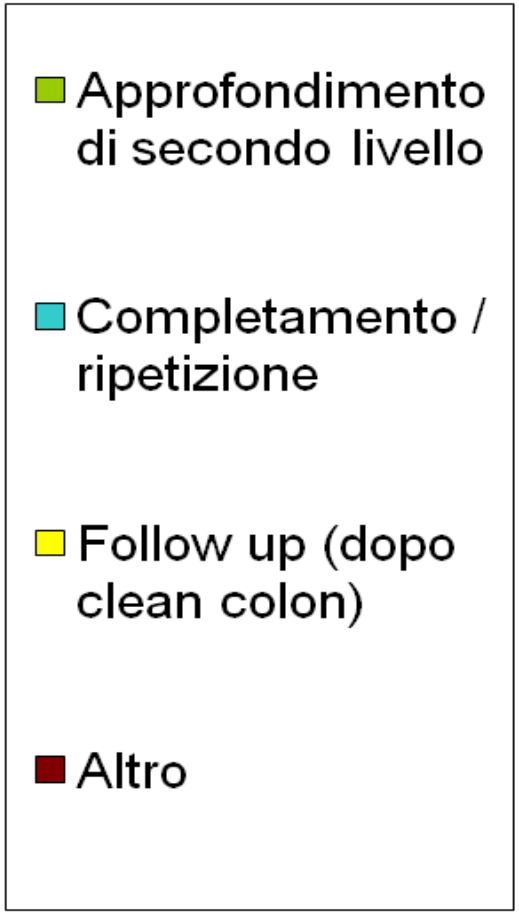
Distribuzione delle colonscopie, per tipologia

Follow up attivo



Follow up passivo

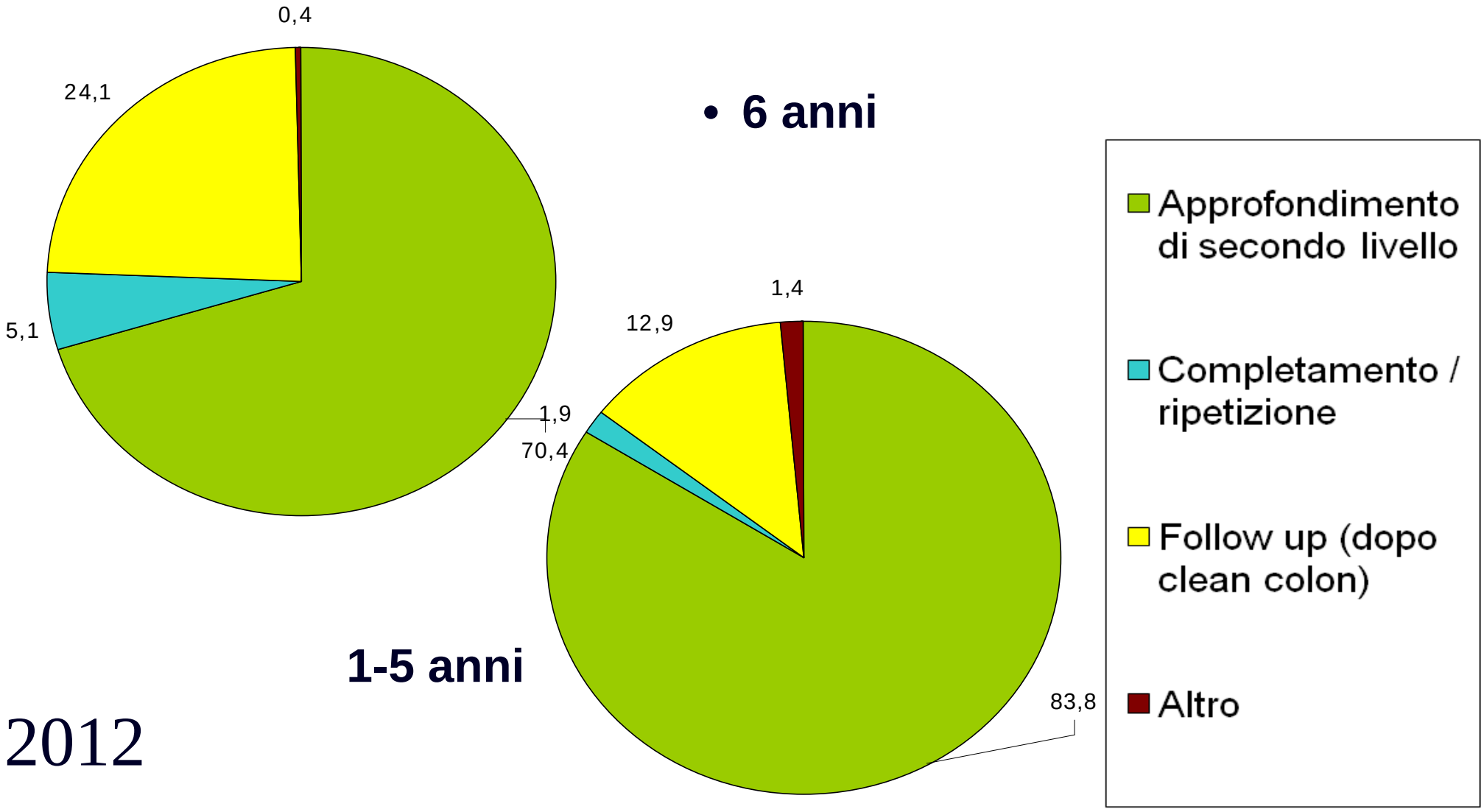




2012

Carico endoscopico per anni di attività

Programmi con follow up attivo



2012

Regione Emilia-Romagna

- **Analisi effettuata sulle colonscopie eseguite dopo la prima colonscopia per FIT positivo**

- **Considerati tre intervalli temporali:**
  - **12 mesi ± 3 (9-15 mesi)**
  - **36 mesi ± 3 (33-39 mesi)**
  - **60 mesi ± 3 (57-63 mesi)**

- **Per il biennio 2013-14 dati fino al 30/11/14**

Colonscopie di sorveglianza E-R

ROUND	12 mesi	36 mesi	60 mesi	RCS FIT +	Totale	% FU
2005-06	175	0	0	15745	15920	1,1%
2007-08	1966	642	0	22558	25166	10.4%
2009-10	1547	4348	285	19629	25809	23.9%
2011-12	1224	3245	2463	18743	25675	27,0%
2013-14	884	2490	1777	17365	22516	22.9%

Regione Emilia-Romagna

- Analisi effettuata sulle colonscopie eseguite dopo la prima colonscopia per FIT positivo

- Considerati tutti gli intervalli temporali:
  - < 8 mesi 9-15 mesi 16-32 mesi
  - 33-39 mesi 40-56 mesi 57-63 mesi

- Per il biennio 2013-14 dati fino al 30/11/14

Colonscopie di sorveglianza E-R

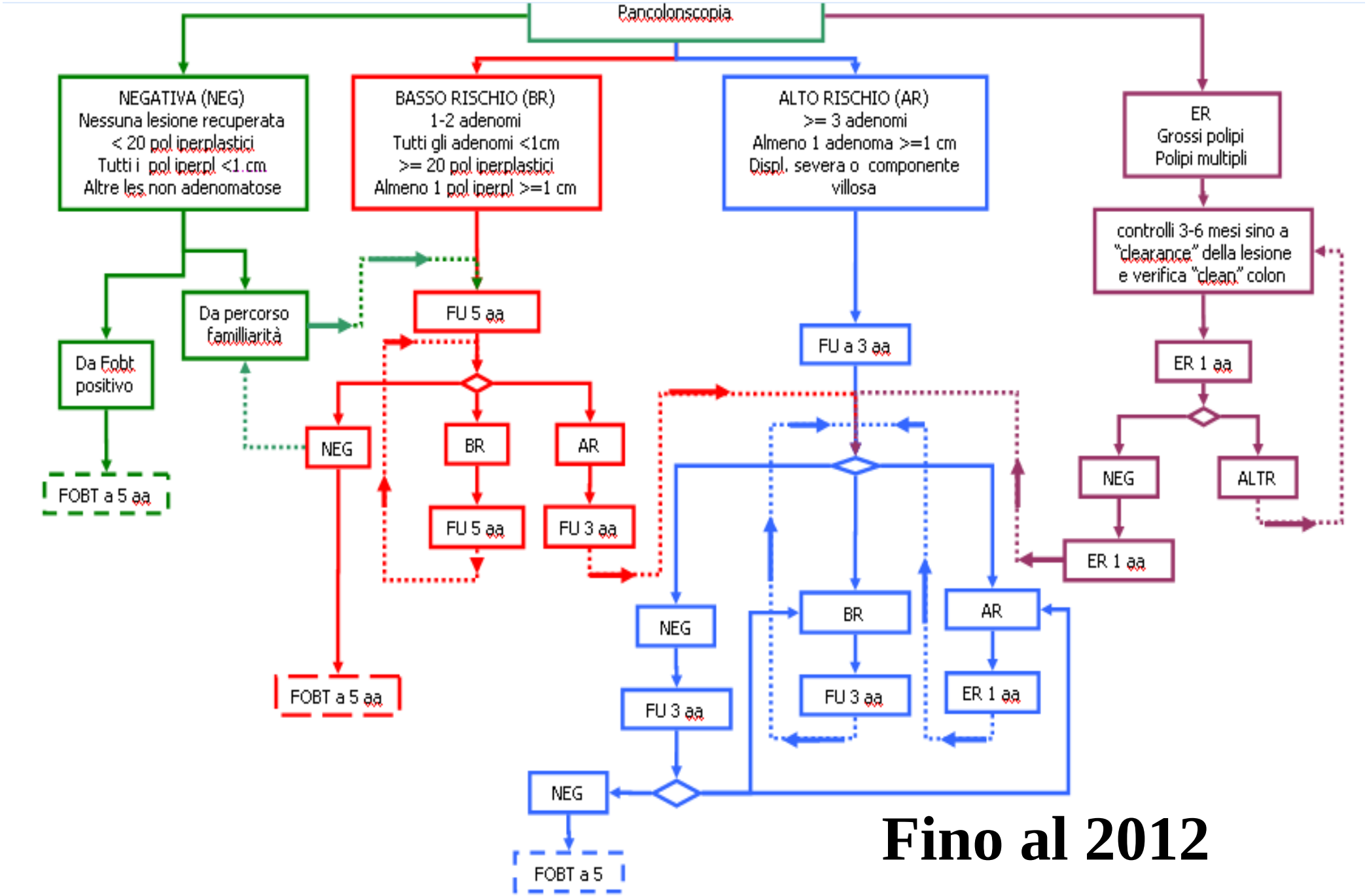
Round	≤ 8	9-15	16-32	33-39	40-56	57-63	FIT +	Tot	% FU
05-06	1821	175	17	0	0	0	15745	15937	1,2%
07-08	3155	1966	1371	642	17	0	22558	26554	15.0%
09-10	2545	1547	1595	4348	1864	285	19629	29268	32.9%
11-12	2298	1224	1090	3245	4754	2463	18743	31519	40.5%
13-14	1598	884	673	2490	6084	1777	17365	29273	40.1%

Colonscopie di sorveglianza E-R

10 anni di attività			
Follow-up	**FIT +**	**Totale**	**% FU**
38511	**94040**	**132551**	**29%**

Colonscopie di sorveglianza E-R

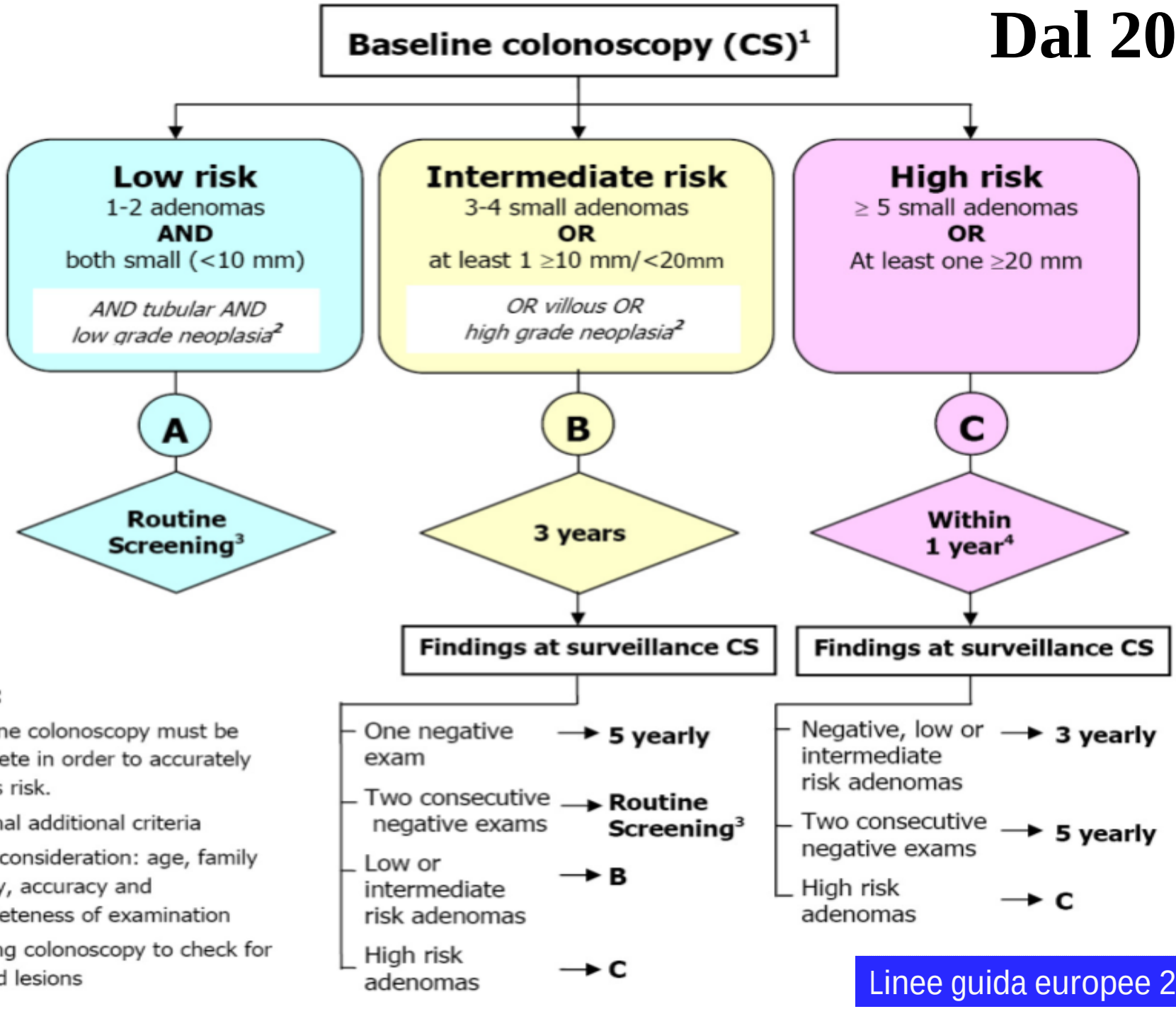
10 anni di attività				
AUSL	**Follow-up**	**FIT +**	**Totale**	**FU%**
PC	**1323**	**5613**	**6936**	**19.1%**
PR	**1236**	**8660**	**9896**	**12.4%**
RE	**8749**	**14239**	**22988**	**38.6%**
MO	**7214**	**14371**	**21585**	**33.4%**
BO	**7718**	**16584**	**24302**	**31.7%**
IM	**943**	**2493**	**3436**	**27.4%**
FE	**3106**	**8588**	**11694**	**26.6%**
RA	**4260**	**9569**	**13829**	**31.0%**
FO	**676**	**2378**	**3054**	**22.1%**
CE	**1357**	**4458**	**5815**	**23.3%**
RN	**1929**	**7087**	**9016**	**27,2%**



Fino al 2012

Da Atkin e Saunders, Gut, 2002;51 (Suppl5),

Dal 2013



Notes:

[1] Baseline colonoscopy must be complete in order to accurately assess risk.

[2] Optional additional criteria

[3] Other consideration: age, family history, accuracy and completeness of examination

[4] Clearing colonoscopy to check for missed lesions

Linee guida europee 2011

Table 1. 2012 Recommendations for Surveillance and Screening Intervals in Individuals With Baseline Average Risk

Baseline colonoscopy: most advanced finding(s)	Recommended surveillance interval (*y*)	Quality of evidence supporting the recommendation	New evidence stronger than 2006
No polyps	10	Moderate	Yes
Small (<10 mm) hyperplastic polyps in rectum or sigmoid	10	Moderate	No
1–2 small (<10 mm) tubular adenomas	5–10	Moderate	Yes
3–10 tubular adenomas	3	Moderate	Yes
>10 adenomas	<3	Moderate	No
One or more tubular adenomas ≥10 mm	3	High	Yes
One or more villous adenomas	3	Moderate	Yes
Adenoma with HGD	3	Moderate	No
Serrated lesions			
Sessile serrated polyp(s) <10 mm with no dysplasia	5	Low	NA
Sessile serrated polyp(s) ≥10 mm	3	Low	NA
OR			
Sessile serrated polyp with dysplasia			
OR			
Traditional serrated adenoma			
Serrated polyposis syndrome[a]	1	Moderate	NA

NOTE. The recommendations assume that the baseline colonoscopy was complete and adequate and that all visible polyps were completely removed.

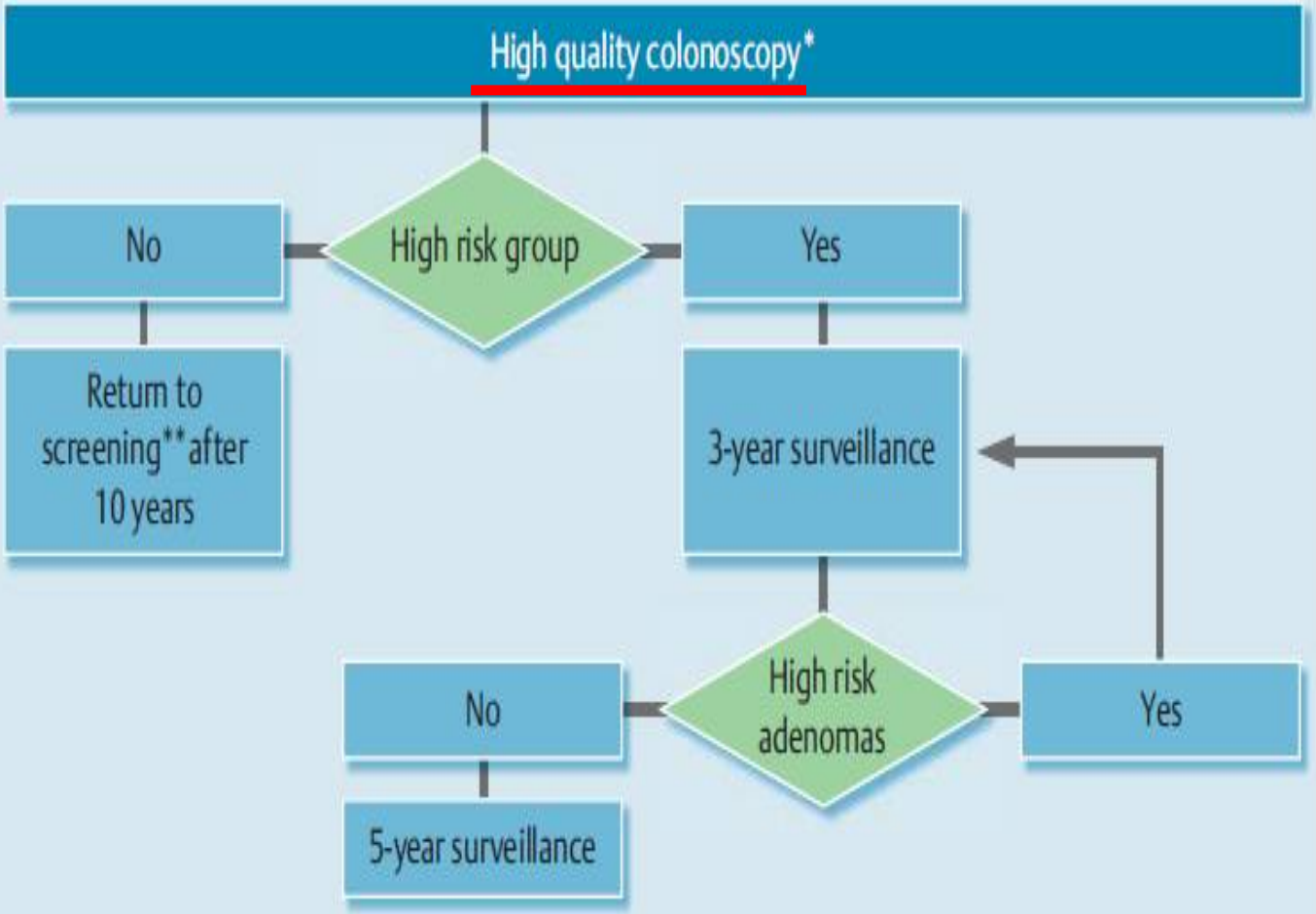


Fig. 1 Dichotomization of patients following a high quality colonoscopy in which high risk lesions have or have not been detected. High risk group: patients with an adenoma ≥10 mm; or with high grade dysplasia; or a villous component or ≥3 adenomas; serrated polyp ≥10 mm or with dysplasia. * Excluding those in whom cancer has already developed. ** To a screening programme if available, otherwise to repetition of colonoscopy.

2013

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Five Things Physicians and Patients Should Question

2

Do not repeat colorectal cancer screening (by any method) for 10 years after a high-quality colonoscopy is negative in average-risk individuals.

A screening colonoscopy every 10 years is the recommended interval for adults without increased risk for colorectal cancer, beginning at age 50 years. Published studies indicate the risk of cancer is low for 10 years after a high-quality colonoscopy fails to detect neoplasia in this population. Therefore, following a high-quality colonoscopy with normal results the next interval for any colorectal screening should be 10 years following that normal colonoscopy.

Conclusioni

- **La sorveglianza postpolipectomia è un’area ad elevata inappropriatezza in eccesso**

- **La sorveglianza rappresenta una quota rilevante del carico endoscopico indotto dai programmi di screening**

- **Si potrebbe cominciare a valutare la possibilità di sospensione per 10 anni dopo colonscopia negativa di alta qualità?**

SERVIZIO SANITARIO REGIONALE
EMILIA-ROMAGNA

10 anni
di screening dei tumori del colon-retto nella Regione Emilia-Romagna

Seminario di studio

Bologna, 9 aprile 2015

INAPPROPRIATEZZA IN ECCESSO

Surveillance recommendation according to US Multi-Society task Force on Colorectal cancer and the American Cancer Society [5,6].

Risk groups based on colonoscopy findings	Surveillance recommendations
Patients with only one or two small (<1 cm) tubular adenomas with only low-grade dysplasia (low-risk subjects)	5–10 years
Patients with 3 to 10 adenomas, or any adenoma >1 cm, or any adenoma with villous features, or high-grade dysplasia (high-risk subjects)	3 years
High risk subjects with follow-up endoscopy showing normal findings or presence of only one or two small (<1 cm) tubular adenomas with only low-grade dysplasia	5 years
Patients who have more than 10 adenomas at one examination	<3 years[a]
Patients with sessile adenomas that are removed piecemeal	2–6 months
Patients with small rectal hyperplastic polyps	No follow-up indication

[a] Clinician should consider the possibility of an underlying familial syndrome.