



QUALITY IN ENDOSCOPY

ESGE / ESDO SYMPOSIUM

COLONOSCOPY &
COLONIC NEOPLASMS

Prague, Czech Republic April 17-18, 2015

THE GREAT DEBATE 5

Managing large lesions & early cancers

– CONTRA endoscopy

Session No.: 6

Name: Prof. Dr. med. Ulrich Güller, MHS, FEBS

Institution: Kantonsspital St. Gallen,

University of Bern

Country: Switzerland



My Task:

CONTRA endoscopic removal of malignant colorectal polyps.



CONTRA Endoscopy

- Father:



CONTRA Endoscopy

- Father: gastroenterologist



CONTRA Endoscopy

- Father: gastroenterologist
- Sister`s husband:



CONTRA Endoscopy

- Father: gastroenterologist
- Sister`s husband: gastroenterologist



CONTRA Endoscopy

- Father: gastroenterologist
- Sister`s husband: gastroenterologist
- Best friend:

CONTRA Endoscopy

- Father: gastroenterologist
- Sister`s husband: gastroenterologist
- Best friend: gastroenterologist

CONTRA Endoscopy

- Father: gastroenterologist
- Sister`s husband: gastroenterologist
- Best friend: gastroenterologist
- Mother:

CONTRA Endoscopy

- Father: gastroenterologist
- Sister`s husband: gastroenterologist
- Best friend: gastroenterologist
- Mother: very upset with me that I did not become a gastroenterologist!

CONTRA Endoscopy

- Father: gastroenterologist
- Sister`s husband: gastroenterologist
- Best friend: gastroenterologist
- Mother: very upset with me that I did not become a gastroenterologist!

=> BIG FAN!!!

Case Report



Case Report

- 65-year old retired engineer, PS 0
- 1.5 cm sessile polyp middle rectum (7cm from anal verge)
- Endoscopically removed (one specimen)
- pT1 adenocarcinoma, G2, LVI 0, no tumor budding, R0
- Submucosal invasion: not determined

Case Report

- No presentation at interdisciplinary tumorboard
- Decision of gastroenterologist against total mesorectal excision
- Follow-up according guidelines of Swiss Association of Gastroenterology

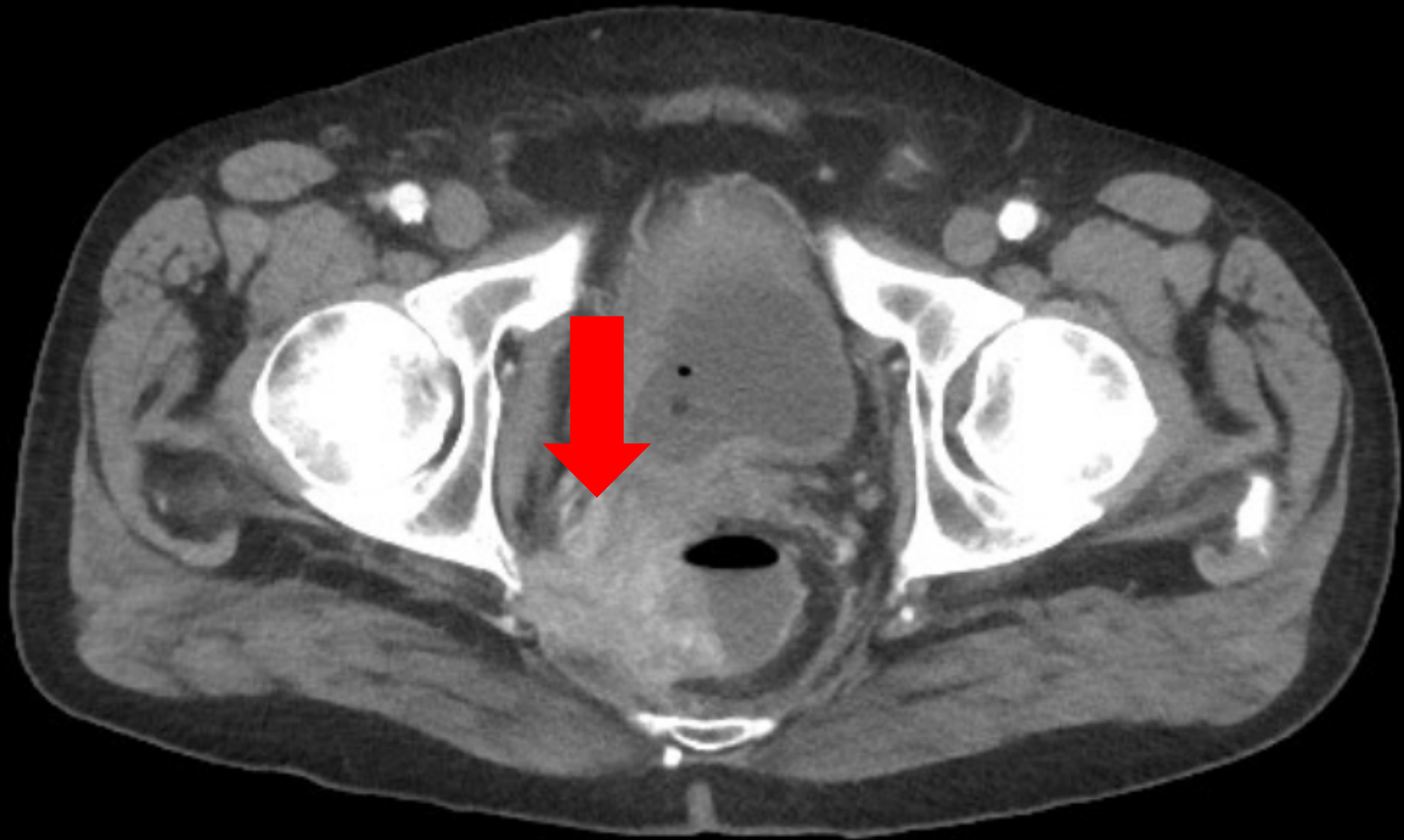
Case Report

- 18 months later
- Burning, neuropathic pain in right leg
- Requiring Pregabalin and opioids
- CT scan

Transverse View



Transverse View



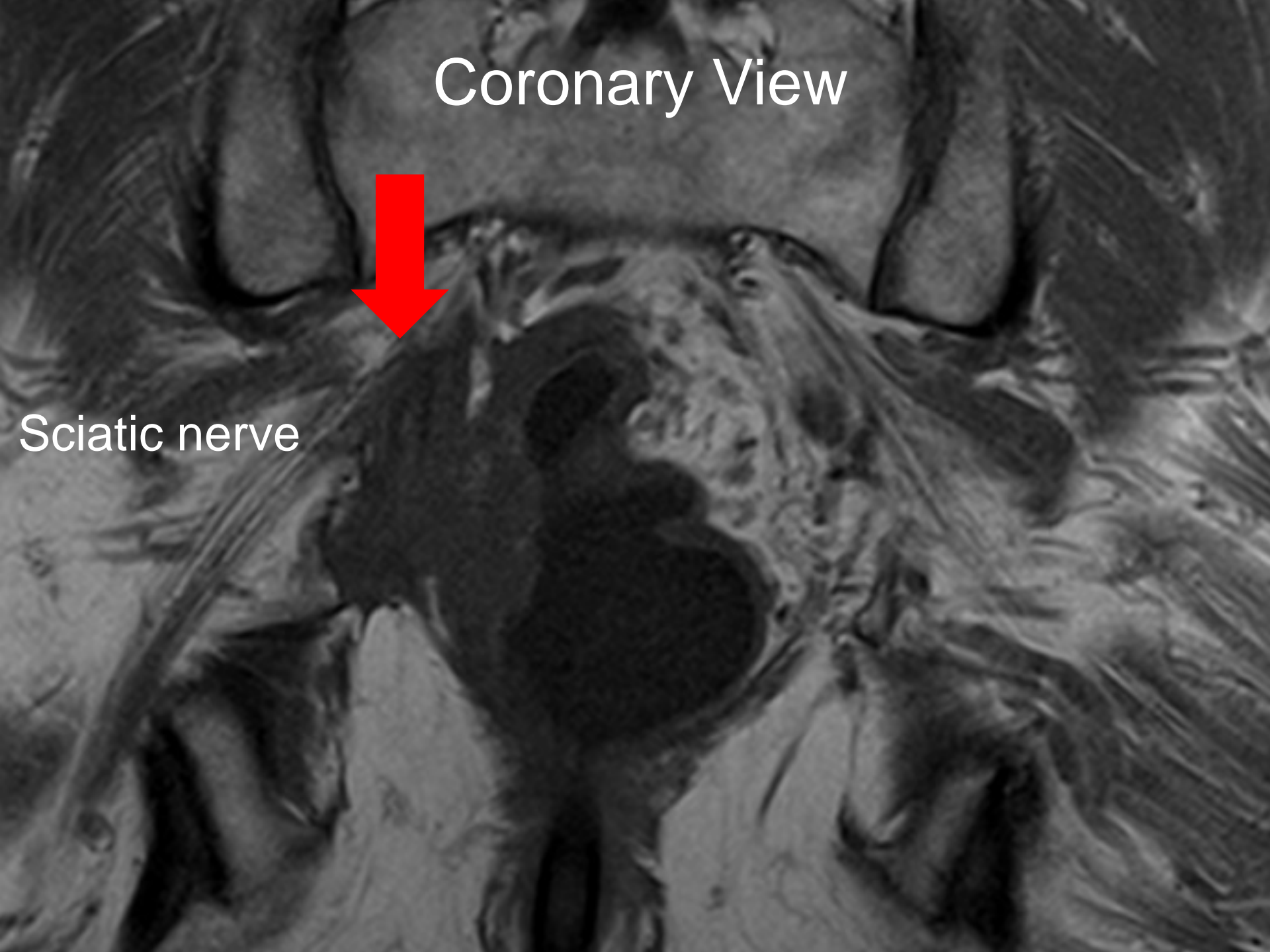
Coronary View



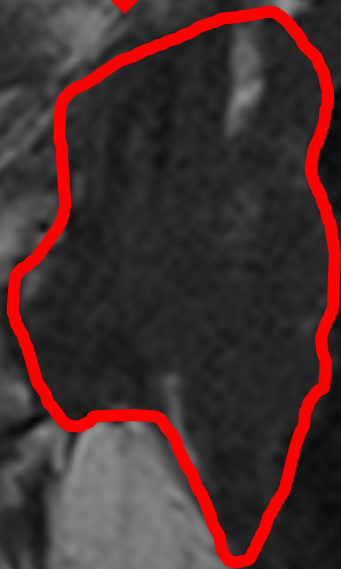
Coronary View



Sciatic nerve



Coronary View



Sciatic nerve

Case Report

- Local recurrence
- Biopsy proven
- Infiltration of right sciatic nerve and pelvis
- Unresectable!!!
- Palliative radiotherapy

Early colon cancer: ESMO Clinical Practice Guidelines for diagnosis, treatment and follow-up[†]

R. Labianca¹, B. Nordlinger², G. D. Beretta³, S. Mosconi¹, M. Mandalà¹, A. Cervantes⁴ & D. Arnold⁵
on behalf of the ESMO Guidelines Working Group^{*}

¹*Ospedale Papa Giovanni XXIII, Bergamo, Italy;* ²*Hospital Ambroise Paré, Paris, France;* ³*Humanitas Gavazzeni Clinic, Bergamo, Italy;* ⁴*Department of Hematology and Medical Oncology, INCLIVA, University of Valencia, Valencia, Spain;* ⁵*Department of Medical Oncology, Tumor Biology Center, Freiburg, Germany*



Malignant Polyp – Unfavorable Features

- G3/G4
- Lymphatic invasion
- Vascular invasion
- Positive resection margins
- Piecemeal resection
- Haggitt level 4 (submucosal invasion of bowel wall below polyp)

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=> Oncologic Resection!

Malignant Polyp – Unfavorable Features

Invasive cancer in sessile polyp => by
definition Haggit level 4

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=> Oncologic Resection!

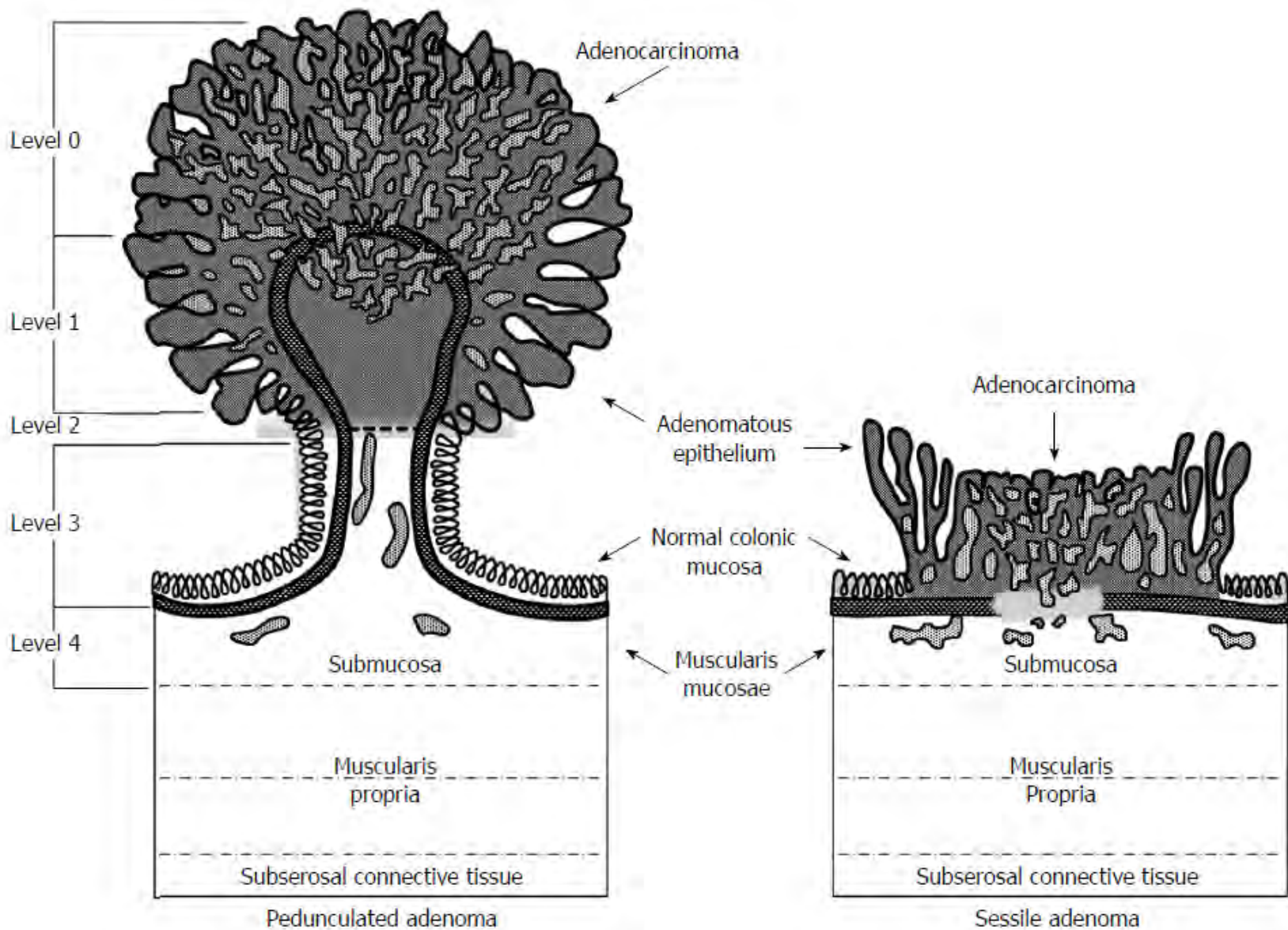


Figure 1 Haggitt classification of pedunculated and sessile polyps. Reprinted permission from [29]



National
Comprehensive
Cancer
Network®

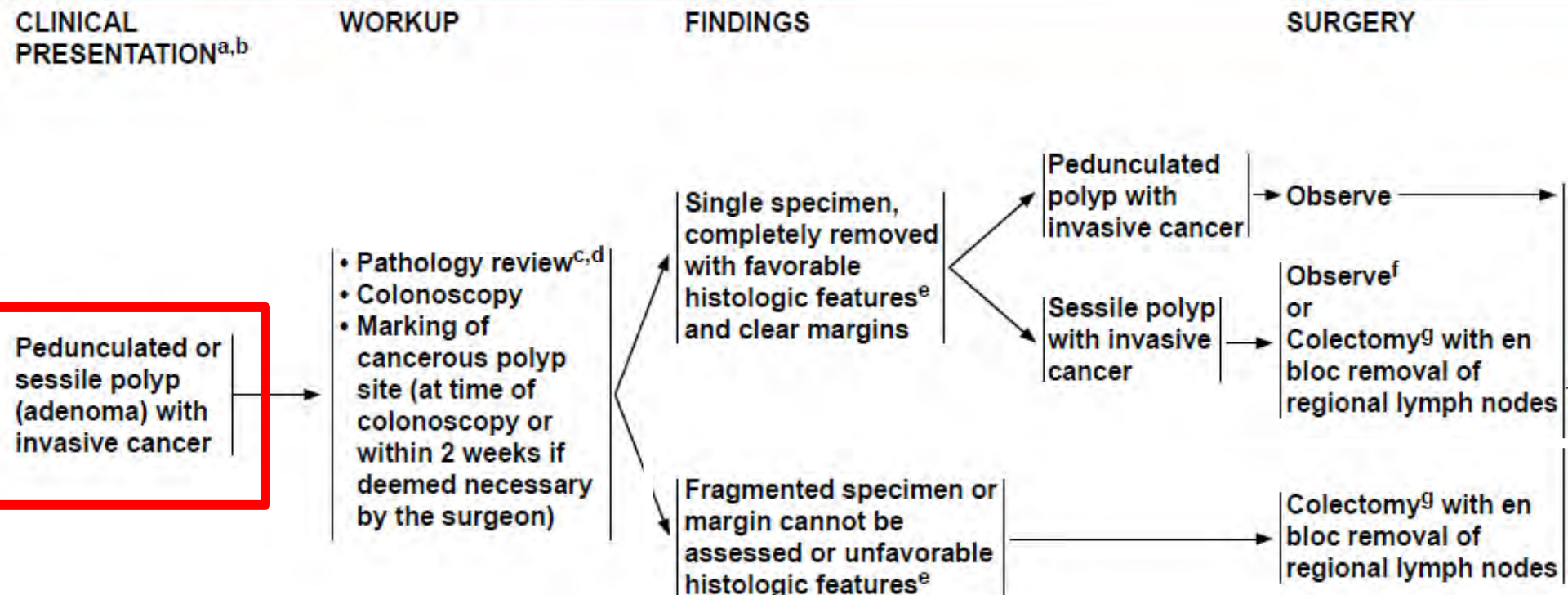
Clinical Practice Guidelines in Oncology (NCCN Guidelines®)

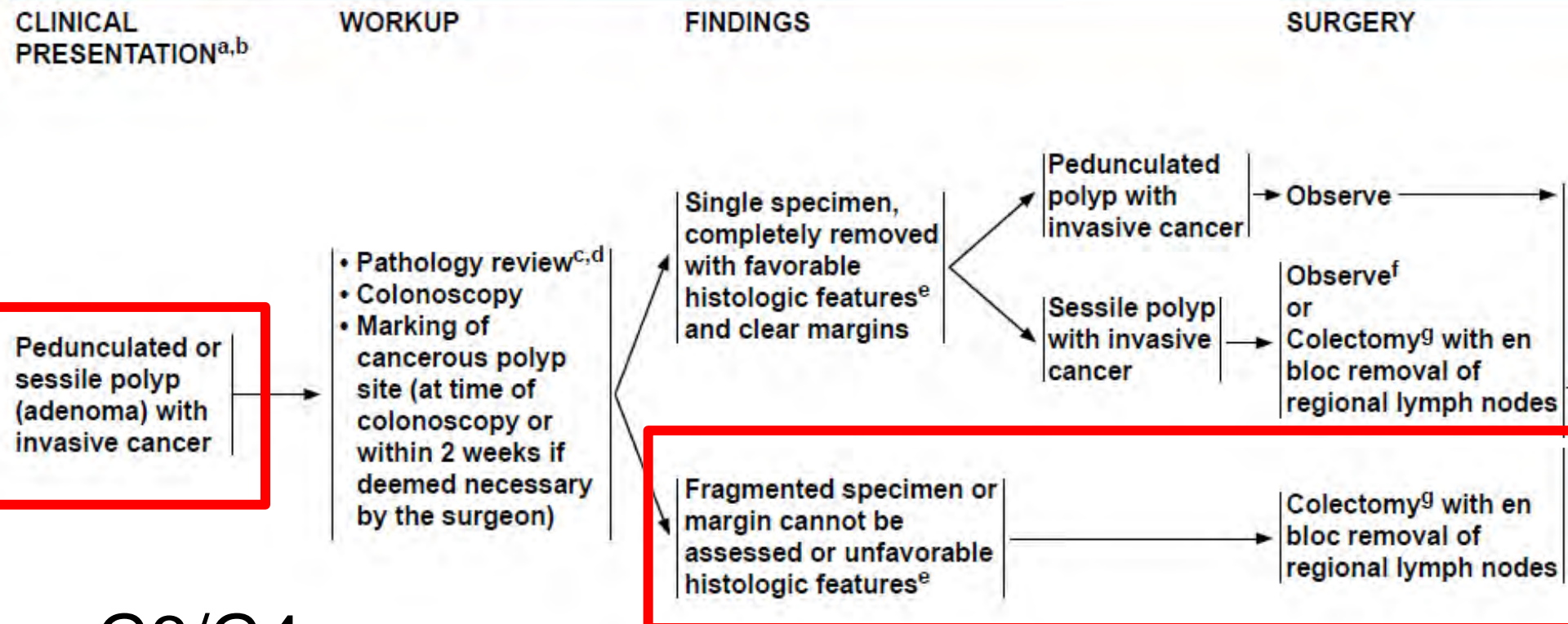
Colon Cancer

Version 2.2015

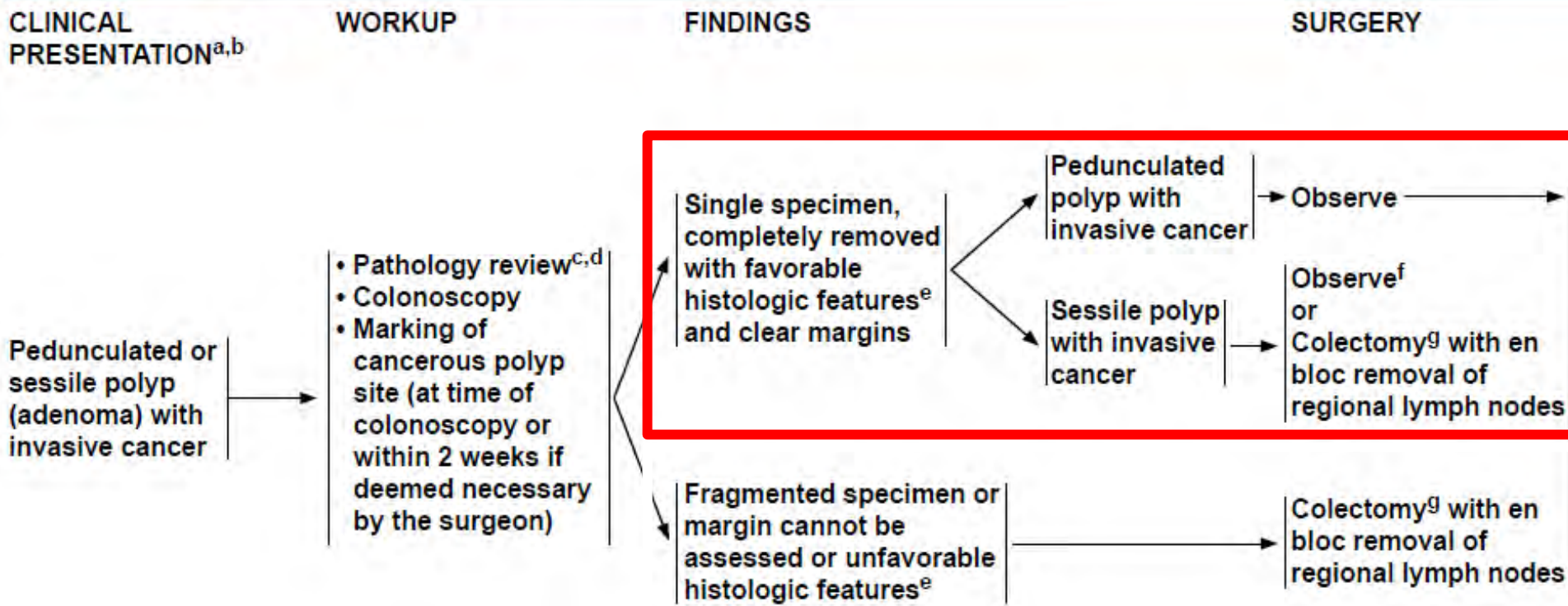
NCCN.org

NCCN Guidelines for Patients® available at www.nccn.org/patients

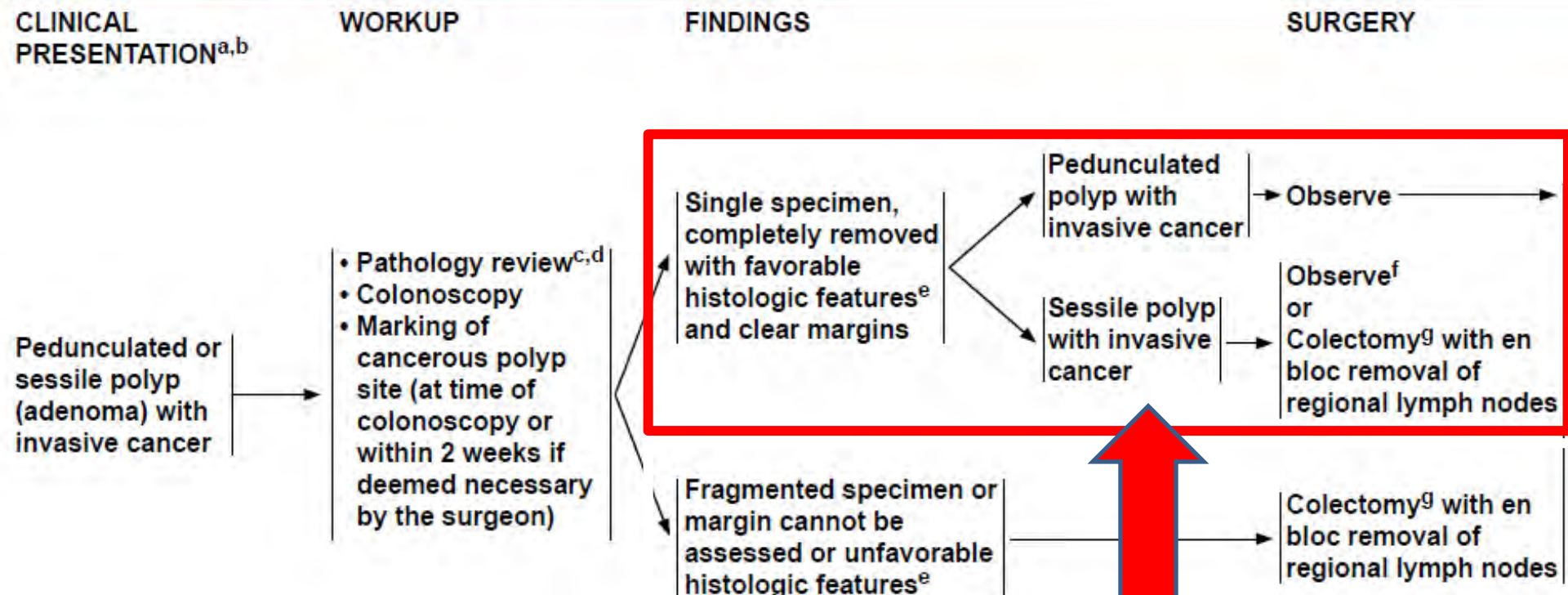




- G3/G4
- Lymphatic invasion
- Vascular invasion
- Positive resection margin



- G1/G2
- No lymphatic invasion
- No vascular invasion



- G1/G2
- No lymphatic invasion
- No vascular invasion

Systematic review and meta-analysis of histopathological factors influencing the risk of lymph node metastasis in early colorectal cancer

C. Beaton*, **C. P. Twine***, **G. L. Williams*** and **A. G. Radcliffe†**

*Department of Colorectal Surgery, Royal Gwent Hospital, Newport, UK and †Screening Division, Public Health Wales, Cardiff, UK

- 23 cohort studies
- 4,510 patients with early colorectal cancer

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Predictors:

- Submucosal invasion >1mm
- Lymphovascular invasion
- G3
- Tumor budding

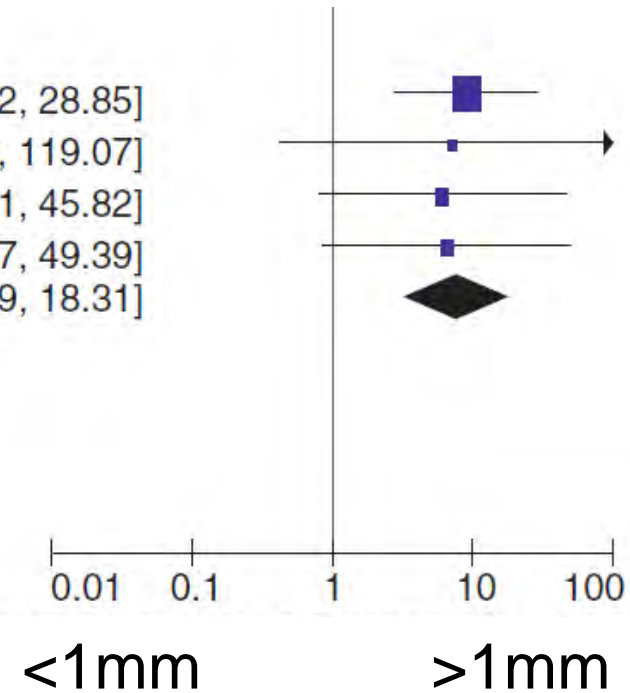
Outcomes:

- Lymph node metastases

Submucosal Invasion and Risk of LN+

1.4.2 studies with > 200 patients

Kitajima 2004 [21]	3	193	84	674	54.5%	9.02 [2.82, 28.85]
Okabe 2004 [26]	0	28	41	372	9.3%	7.14 [0.43, 119.07]
Tateishi 2010 [30]	1	34	45	288	18.2%	6.11 [0.81, 45.82]
Ueno 2004 [6]	1	38	32	213	18.0%	6.54 [0.87, 49.39]
Subtotal (95% CI)		293		1547	100.0%	7.76 [3.29, 18.31]
Total events	5		202			

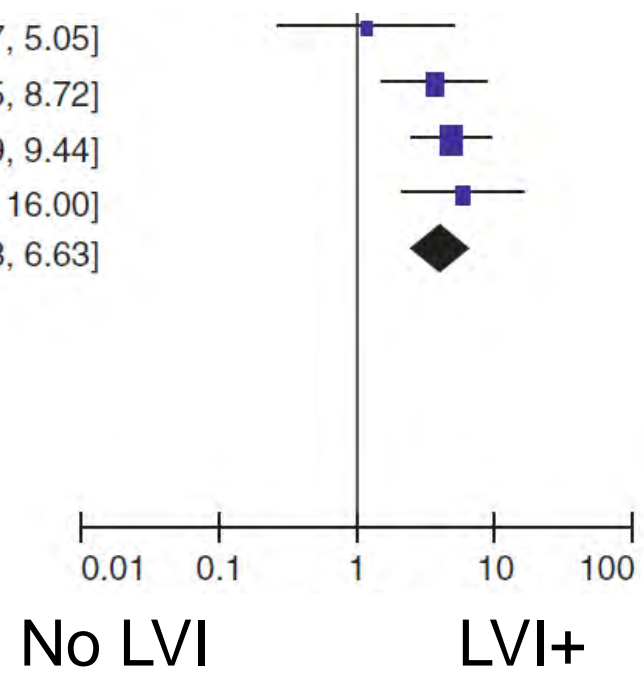


OR: 3.87; 95% CI: 1.50-10.00; p = 0.005

Lymphovascular Invasion and Risk of LN+

Matsuda 2011 [24]	3	8	75	222	10.9%	1.18 [0.27, 5.05]
Nascimbeni 2002 [25]	9	28	37	324	27.2%	3.67 [1.55, 8.72]
Okabe 2004 [26]	28	135	15	293	40.5%	4.85 [2.49, 9.44]
Yamamoto 2004 [3]	13	89	6	212	21.3%	5.87 [2.16, 16.00]
Subtotal (95% CI)		260		1051	100.0%	4.01 [2.43, 6.63]
Total events	53		133			

Heterogeneity: $\tau^2 = 0.05$; $\chi^2 = 3.62$, $df = 3$ ($P = 0.31$); $I^2 = 17\%$
 Test for overall effect: $Z = 5.42$ ($P < 0.00001$)



OR: 4.81; 95% CI: 3.14-7.37; p < 0.00001

Histologic Differentiation and Risk of LN+

3.3.2 studies with > 200 patients

Kitajima 2004 [21]	82	845	5	20	40.5%	3.10 [1.10, 8.75]
Matsuda 2011 [24]	38	222	1	8	13.8%	0.69 [0.08, 5.79]
Okabe 2004 [26]	38	416	5	12	33.8%	7.11 [2.15, 23.48]
Yamamoto 2004 [3]	18	297	1	4	11.9%	5.17 [0.51, 52.20]
Subtotal (95% CI)		1780		44	100.0%	3.55 [1.52, 8.28]

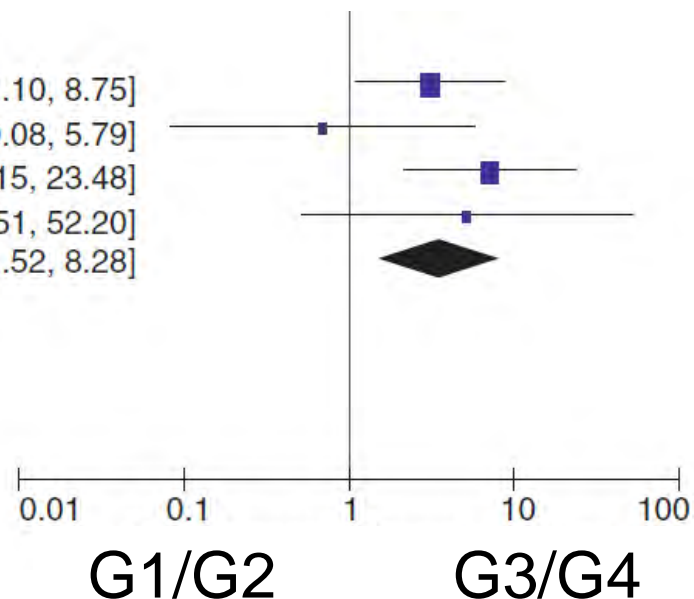
Total events

176

12

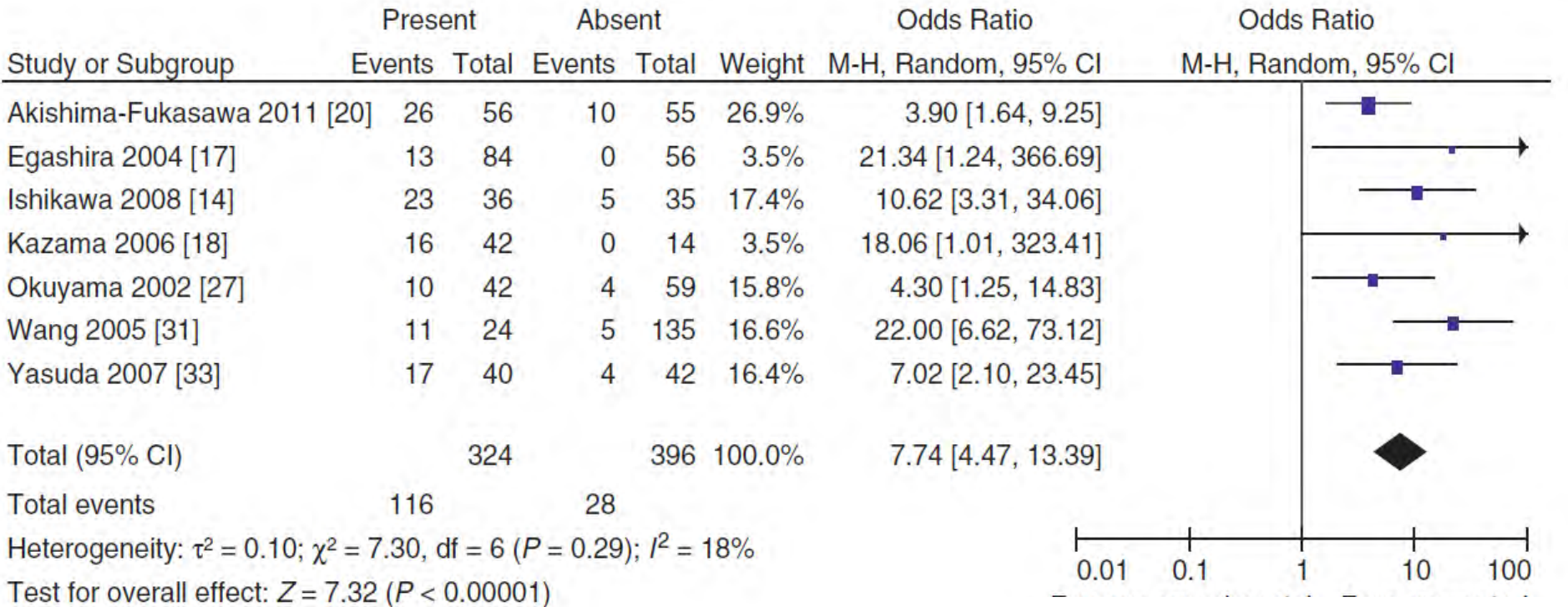
Heterogeneity: $\tau^2 = 0.18$; $\chi^2 = 3.93$, $df = 3$ ($P = 0.27$); $I^2 = 24\%$

Test for overall effect: $Z = 2.92$ ($P = 0.003$)



OR: 5.60; 95% CI: 2.90 -10.82; $p < 0.0001$

Tumor Budding and Risk of LN+



No tumor budding Tumor budding

OR: 7.74; 95% CI: 4.47-13.39; p = 0.005

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Increased risk of LN metastases:

- Submucosal invasion >1mm
- Presence of LVI
- G3/G4
- Tumor budding

Risk of Surgery



Risk of Surgery

Surgical-related mortality 0.8%!!!

Advantages of laparoscopic surgery:

- Less adhesions
- Less incisional hernias
- Less postoperative pain
- Shorter hospital stay
- Equivalent (trend to better) oncologic outcomes



Management of malignant colon polyps: Current status and controversies

Cary B Aarons, Skandan Shanmugan, Joshua IS Bleier

Aarons CB *et al.* Management of malignant colon polyps

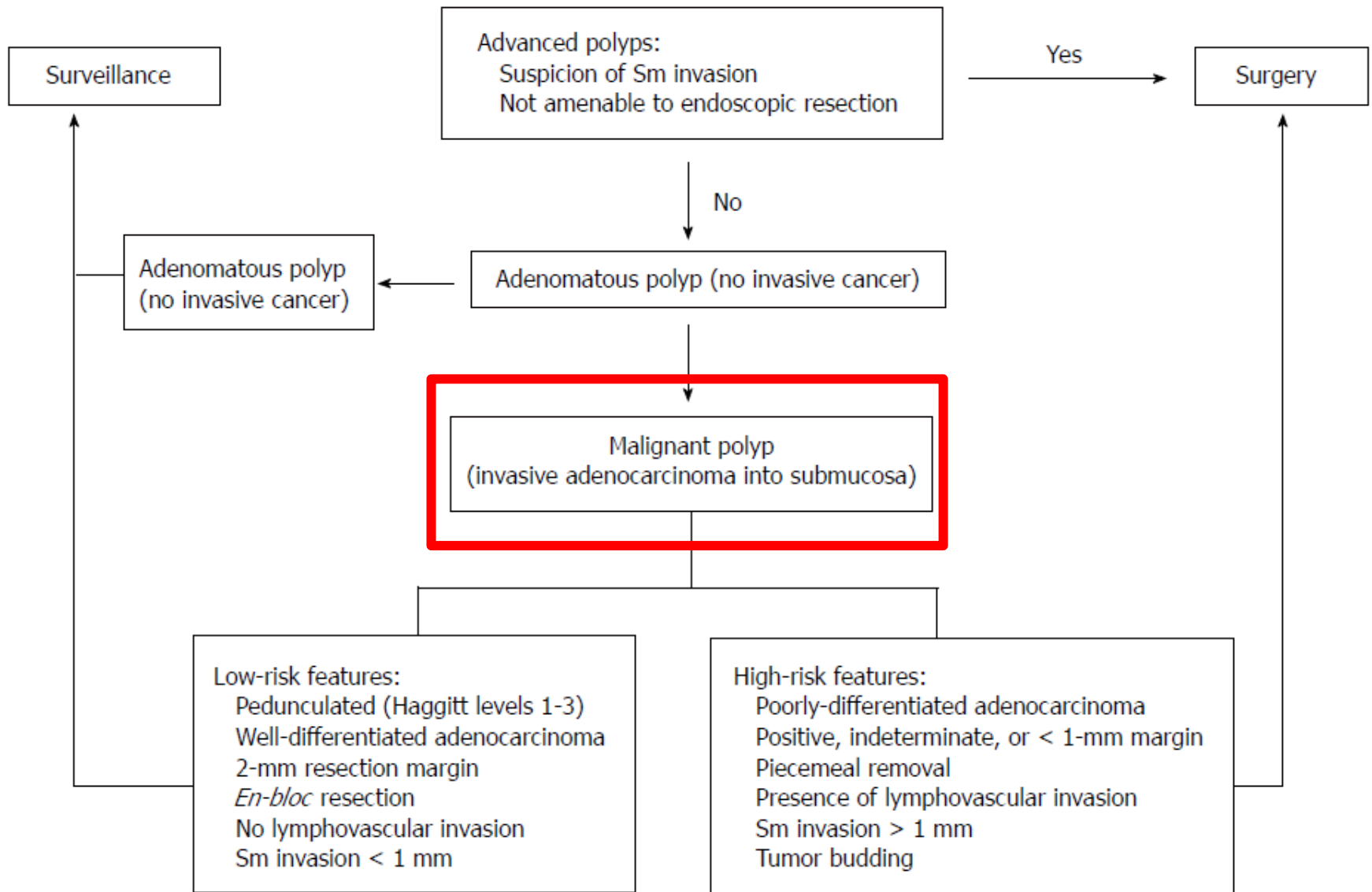


Figure 3 Algorithm for the management of malignant colon polyps. Sm: Submucosal; EMR: Endoscopic submucosal resection.

Aarons CB *et al.* Management of malignant colon polyps

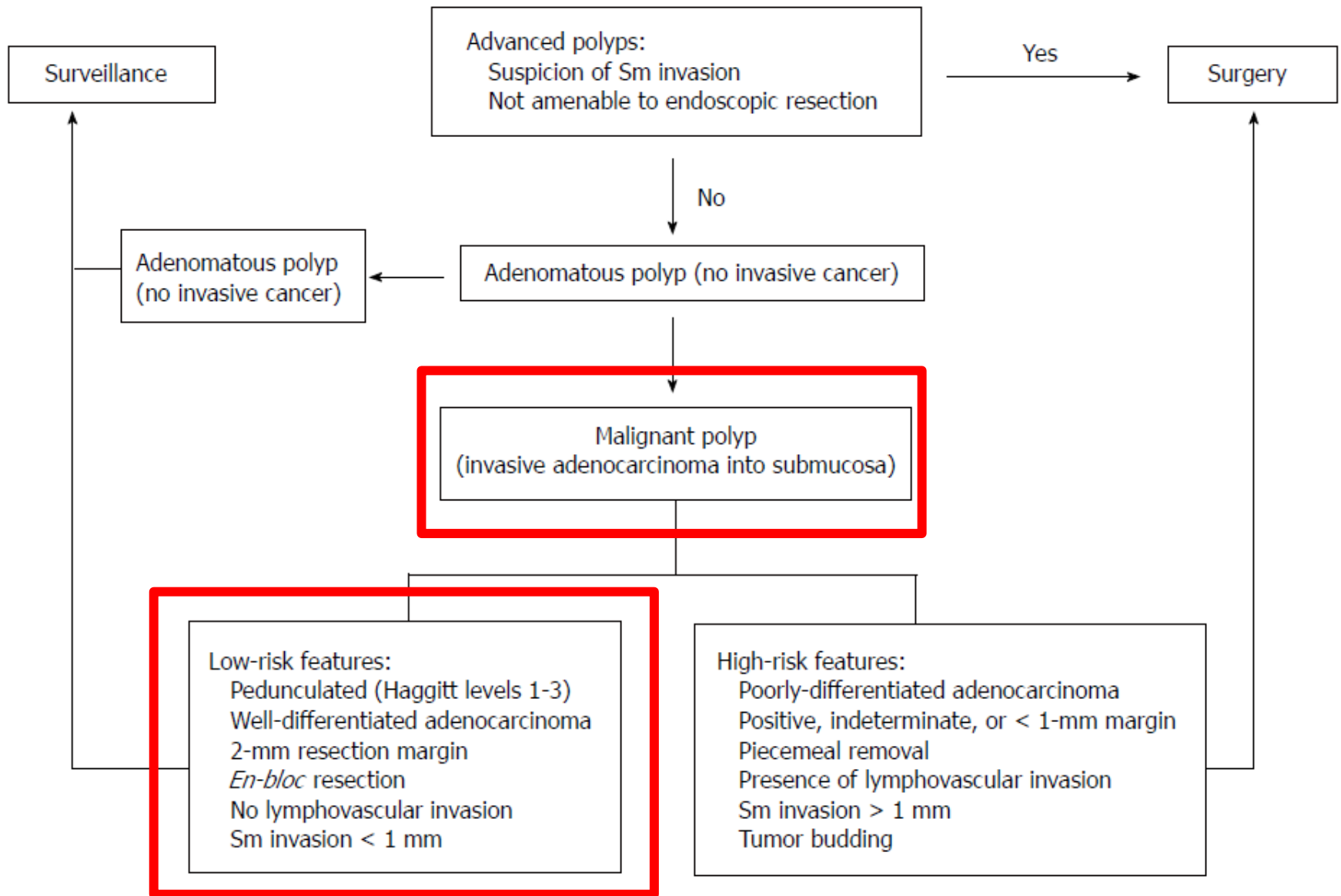


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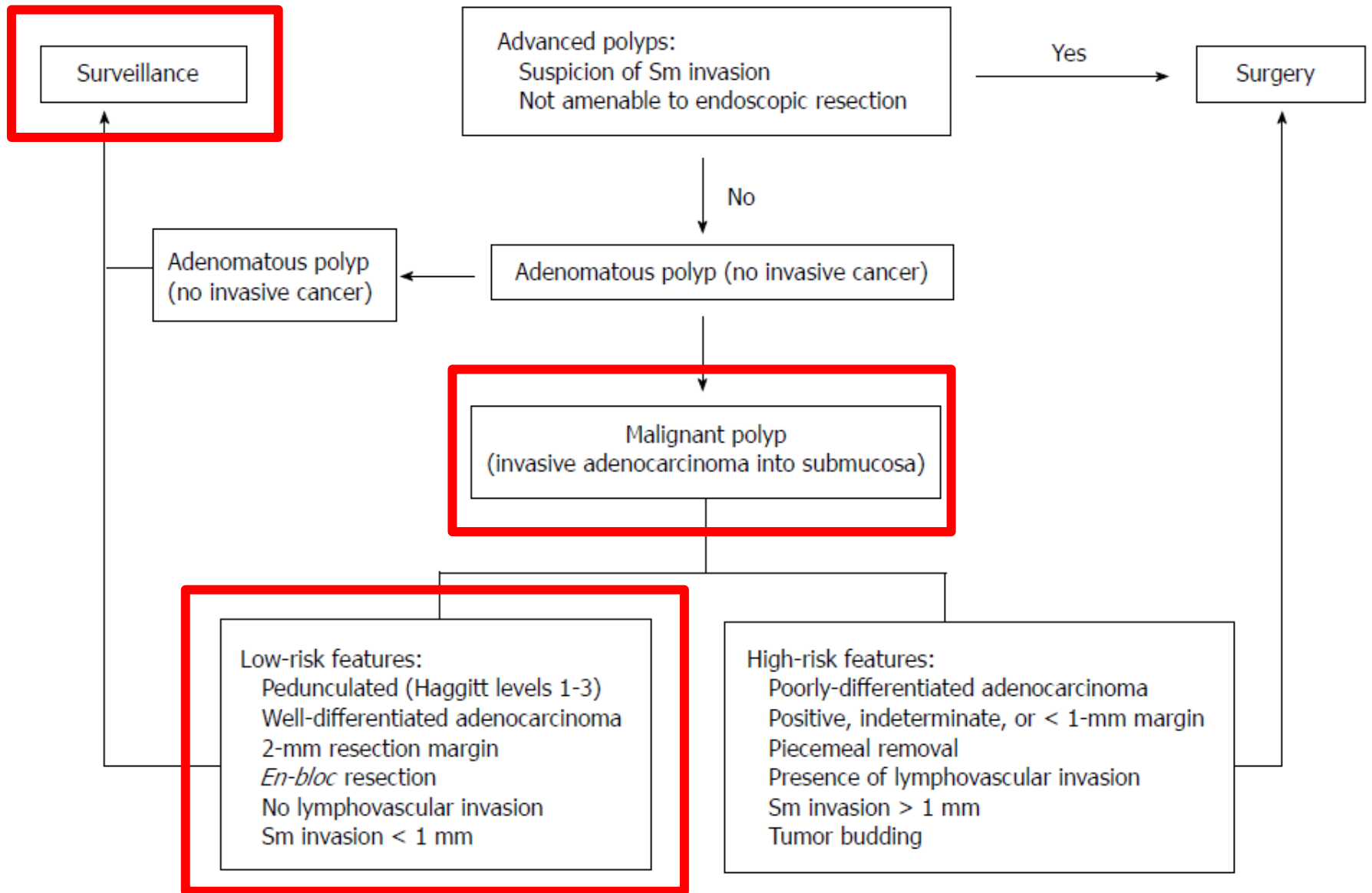


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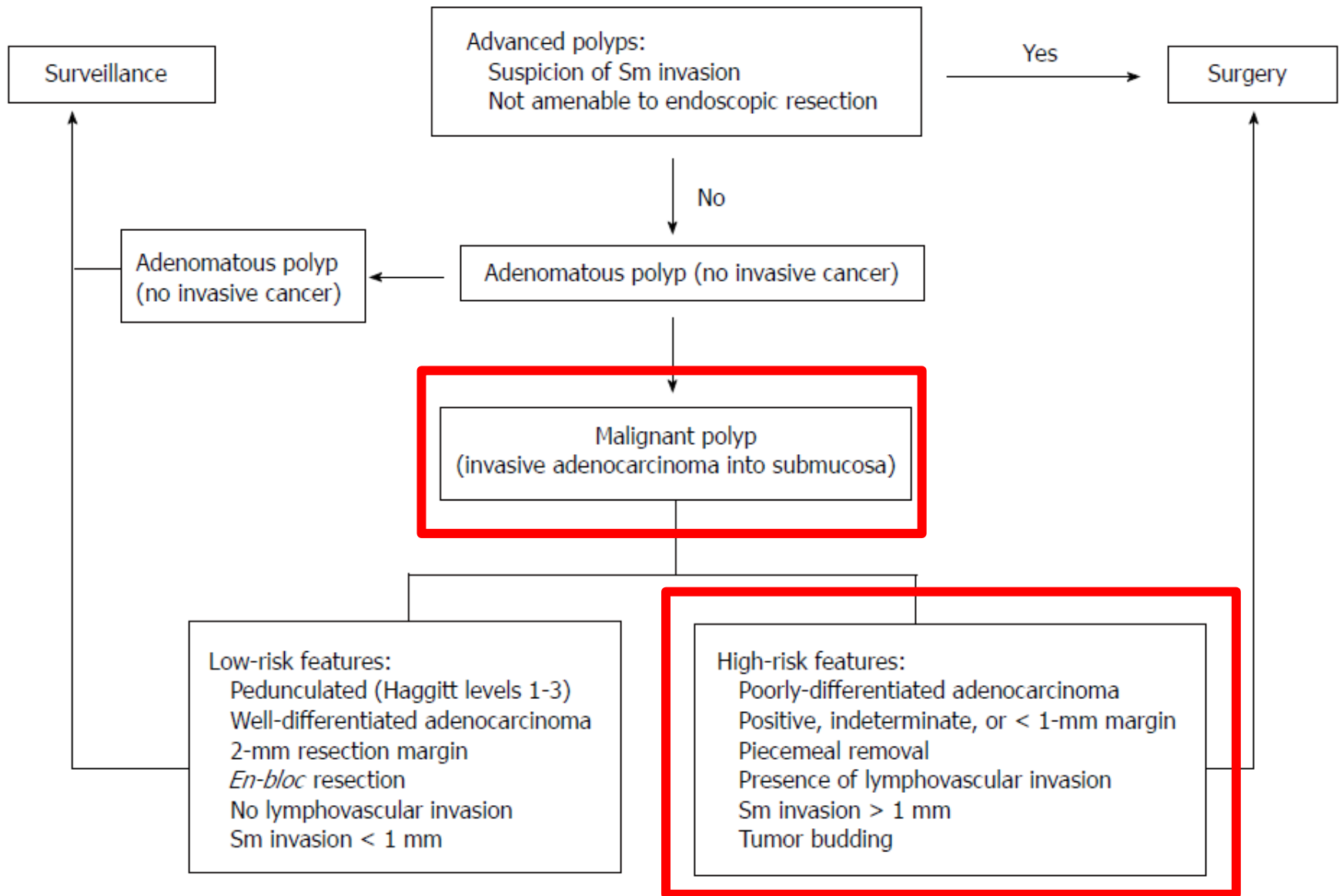


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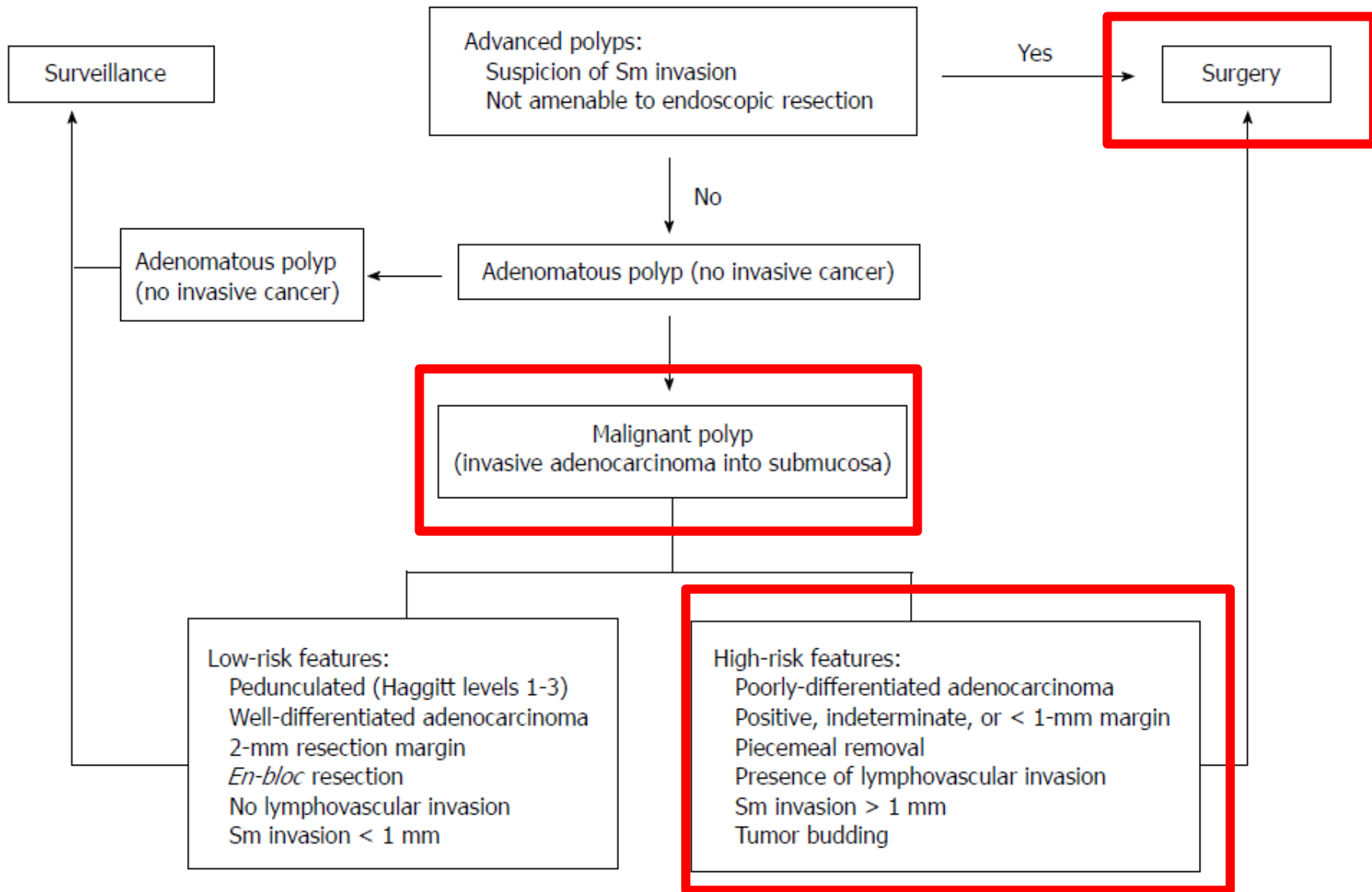


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- Local recurrence
- Infiltration of right sciatic nerve and pelvis
- Unresectable!!!
- Palliative radiotherapy

Case Report

- Local recurrence
- Infiltration of right sciatic nerve and pelvis
- Unresectable!!!
- Palliative radiotherapy

= > could have been cured with
oncologic resection!!!!

Take Home Messages

Local recurrence after endoscopic removal of malignant polyp:

- Terrible complication!
- Often not amenable to curative surgery
- Relevant symptoms (pain, odor, bleeding, obstruction)
- Difficult to manage

Take Home Messages

Elective surgical oncologic resection:

- Low morbidity and mortality (<1%)
- Laparoscopic surgery preferred!

Take Home Messages

Each patient with malignant polyp MUST be discussed at interdisciplinary tumorboard.

Input of gastroenterologist, surgeon, medical oncologist, pathologist, radiologist is key!!

Take Home Messages

If in doubt...

Take it out – with a surgical, oncologic (ideally laparoscopic) resection!!!



And remember...

Always treat your patient`s colon....

And remember...

Always treat your patient`s colon

as if it were your own!!!



THANK YOU!!!

