



      


Pan London Early Rectal Cancer Meeting

1st November 2018


Avoiding major surgery and improving quality of life in patients with early rectal cancer








How to Set up and Maintain a SPECC MDT



Francesco Di Fabio
Consultant Colorectal Surgeon
Basingstoke North Hampshire Hospital

London Nov 1st 2018

 Andover War Memorial Hospital Basingstoke and North Hampshire Hospital Royal Hampshire County Hospital

SPECC | Significant Polyp & Early Colorectal Cancer

- Programme focused on the treatment of significant polyps and small (T1) tumours
- FREE workshops across UK from 2015 to 2017



SPECC | Significant Polyp & Early Colorectal Cancer

National MDT programme
Designed & delivered by a specialist faculty
Regional workshops



SPECC | Significant Polyp & Early Colorectal Cancer

SPECC | Significant Polyp & Early Colorectal Cancer

For Debate

"SPECC and SPECULATION": Is a significant polyp benign or an early colorectal cancer? How do we know and what do we do?

Brendan Moran, Mit Dattani

First published: 2 August 2016 [Full publication history](#)



View Issue TOC
Volume 18, Issue 8
August 2016
Pages 745-748

Key elements of SPECC programme

1. Definition
2. Recognition & Assessment
3. Documentation
4. Strategic planning
5. Treatment



SPECC | Significant Polyp & Early Colorectal Cancer

SPECC Definition

Non-pedunculated lesion

Large (≥ 20 mm in size)

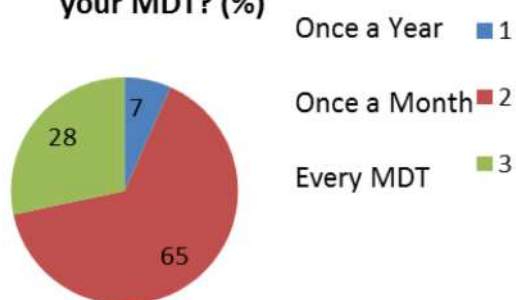
Technically difficult to remove **completely and safely**

Malignancy cannot be excluded **with certainty**



SPECC | Significant Polyp & Early Colorectal Cancer

1. Do early rectal cancers or significant rectal neoplasms pose an uncertainty for your MDT? (%)



Question to 60 delegates

SPECC | Significant Polyp & Early Colorectal Cancer

SPECC MDT

PELICAN
cancer foundation

Does this SPECC look benign or have malignant features?

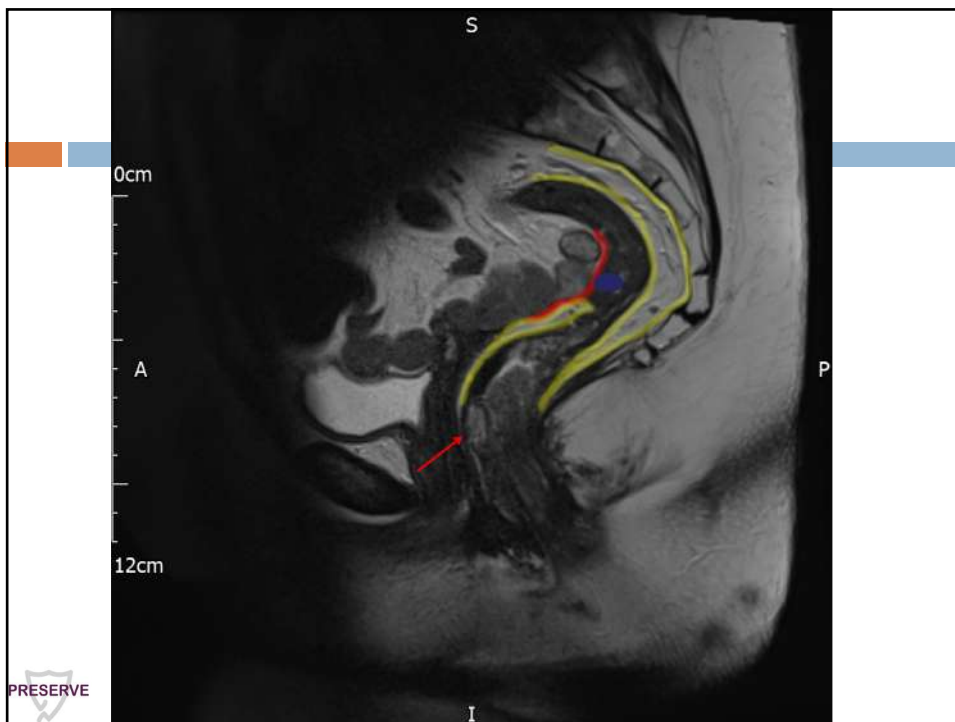
Can this SPECC be removed endoscopically, transanally or does it need resection?




SPECC MDT



Patient's preference
Bowel function, quality of life



Colorectal Disease 


Original article doi:10.1111/codi.14342

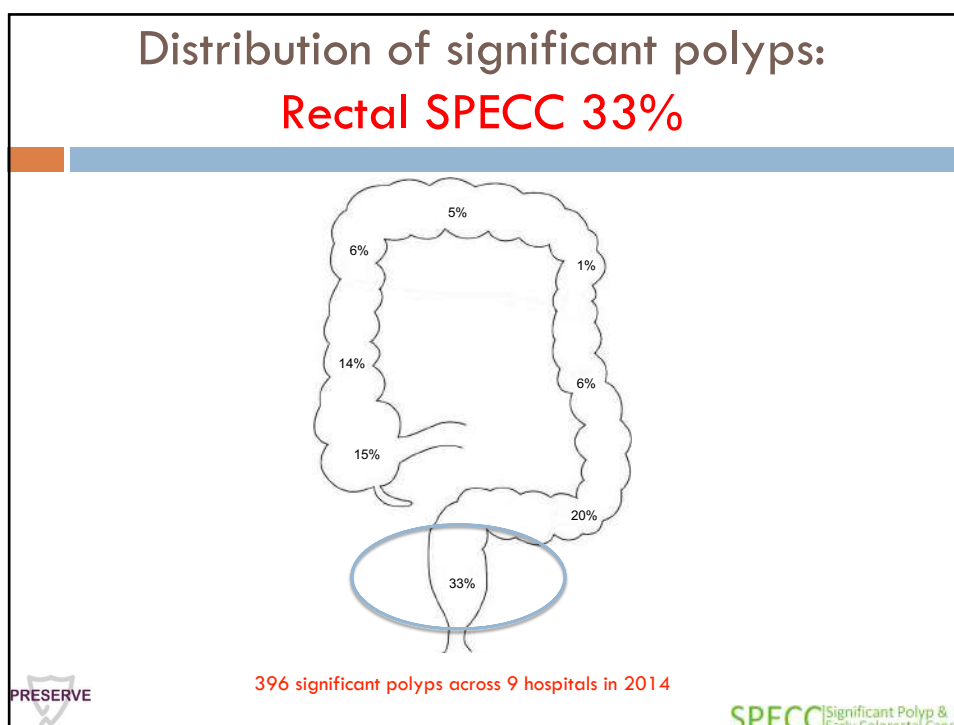
Variations in the management of significant polyps and early colorectal cancer: results from a multicentre observational study of 383 patients

M. Dattani*, S. Crane*, N. J. Battersby†, F. Di Fabio†, B. P. Saunders‡, S. Dolwani§, M. D. Rutter¶, B. J. Moran† and on behalf of the SPECC study group¹

*Pelican Cancer Foundation, Basingstoke, UK, †Basingstoke and North Hampshire Hospital, Basingstoke, UK, ‡St Mark's Hospital and Academic Institute, London, UK, §School of Medicine, Cardiff University, Cardiff, UK, and ¶Department of Gastroenterology, University Hospital of North Tees, Stockton-on-Tees, UK

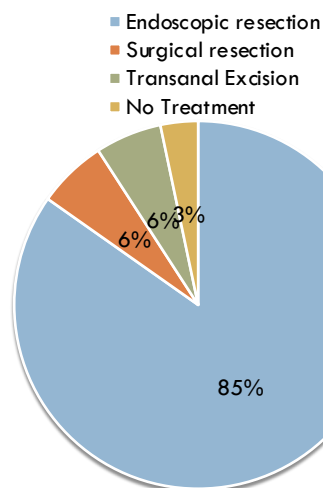
Received 30 April 2018; accepted 11 July 2018; Accepted Article Online 12 July 2018





Results

Management 396 SPECC

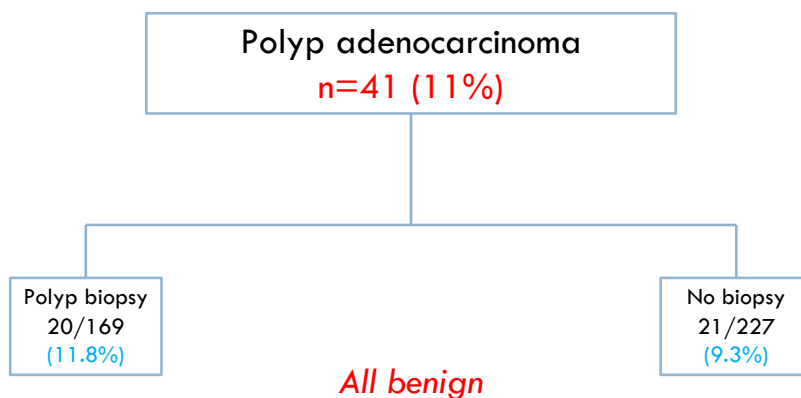


Results – Unexpected cancer

Polyp
adenocarcinoma
n=41 (11%)

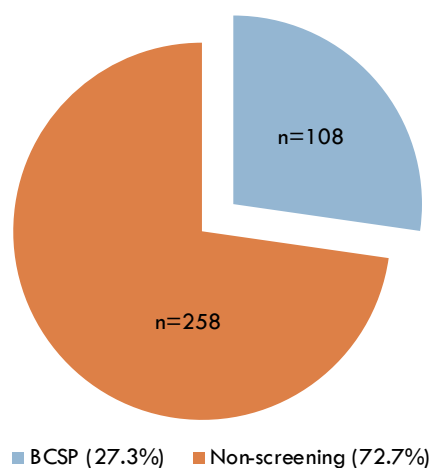


Results – Unexpected cancer



SPECC Significant Polyp & Early Colorectal Cancer

Patient and Polyp characteristics



SPECC Significant Polyp & Early Colorectal Cancer

	BCSP (n=108)	Non-screening (n=275)	p-value
Age (years)*	66.6(5.3)	70.0(11.7)	<0.01 ^β
Sex ratio (M:F)	70:38	154:121	0.12
Polyp Size (mm)*	28.9(9.6)	30.1(13.7)	0.15 ^β
Anatomical location			0.14
Right sided ^c	49(45.4)	102(37.1)	
Left sided	59(54.6)	173(62.9)	
Endoscopic resection at detection	70(64.8)	94(34.2)	<0.01
Polyp biopsy	22(20.4 [†])	134(48.7 [†])	<0.01
Primary surgical resection	7(6.5)	42(15.3)	0.02
Adenocarcinoma	14(13.0)	27(9.8)	0.37
Time to first follow-up endoscopy (months) [‡]	3.5(3.3–5.6)	5.9(3.6–10)	<0.01 ^α

Values in parentheses are percentages unless indicated otherwise; *values are mean(s.d); †values are median (interquartile range). ‡Proximal to the splenic flexure. †Percentages are for proportion of polyps biopsied in the whole group; polyps resected endoscopically at detection, and therefore not liable to a biopsy are accounted for in the text. †X² test, except ‡unpaired Student's t test and †Mann-Whitney U test

...Too much
variability!!!



SPECC programme to address areas of improvement and development

Meticulous assessment + decision making

- Concept of “Think twice, cut once”

Another.....

- Day?
- Clinician?
- Hospital?



SPECC Significant Polyp & Early Colorectal Cancer

Starting a SPECC MDT



MDT core members attended a SPECC workshop

...at the beginning of the colorectal MDT



SPECC Significant Polyp & Early Colorectal Cancer

SPECC MDT - Pros



Still part of colorectal cancer
MDT...pilot phase

Endoscopists feel supported

Expand into regional SPECC MDT in
the future



SPECC MDT - Cons



Complaints about too many MDTs

Over-referrals

Why discuss benign lesions?

Support MDT coordinator




Basingstoke SPECC MDT Reporting Form

Date..... Consultant.....

Patient sticker:

Relevant PMH:

SPECC Location.....



<p>Morphology</p> <ul style="list-style-type: none"> • Size..... • Paris..... • Pictures / Video • Biopsy Y N • Malignant appearance: Y N • Excision complete Y N <p>Further management</p> <ul style="list-style-type: none"> • Snare / EMR / ESD • TEMS - TAMIS • Surgical resection • Radiotherapy; External / Contact • Surveillance 	<p>Investigations</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left;"></th> <th style="text-align: center;">done</th> <th style="text-align: center;">needed</th> </tr> </thead> <tbody> <tr> <td>• Colonoscopy</td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td>• CT</td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td>• MRI rectum</td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td>• ERUS</td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> </tbody> </table> <p>Histology</p> <ul style="list-style-type: none"> • Hyperplastic / Low - / High- Grade Dysplasia • Adenocarcinoma <ul style="list-style-type: none"> • T1- Haggitt 1 2 3 4 • T1- Kikuchi 1 2 3 • N/A • Differentiation Well Mod Poor • Lympho-vascular invasion Y N • Resection margin <1mm clear 		done	needed	• Colonoscopy	<input type="radio"/>	<input type="radio"/>	• CT	<input type="radio"/>	<input type="radio"/>	• MRI rectum	<input type="radio"/>	<input type="radio"/>	• ERUS	<input type="radio"/>	<input type="radio"/>
	done	needed														
• Colonoscopy	<input type="radio"/>	<input type="radio"/>														
• CT	<input type="radio"/>	<input type="radio"/>														
• MRI rectum	<input type="radio"/>	<input type="radio"/>														
• ERUS	<input type="radio"/>	<input type="radio"/>														

Plan	Upgrade Y N	Consultant	Signature
------	-------------	------------	-----------



Basingstoke SPECC MDT

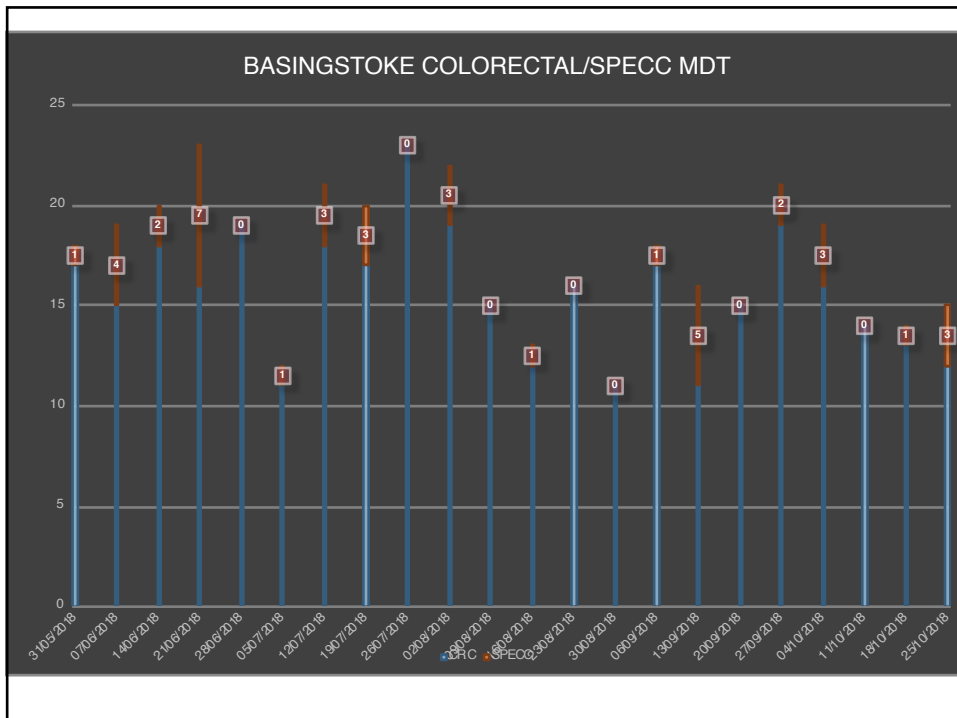
5 months' period (31/05 - 25/10)

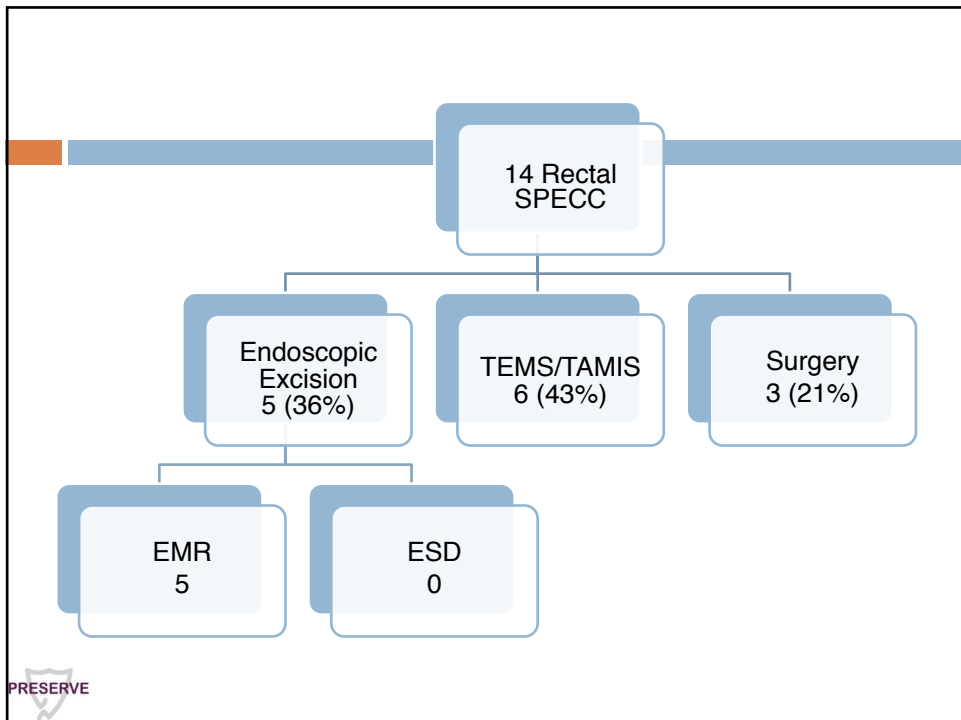
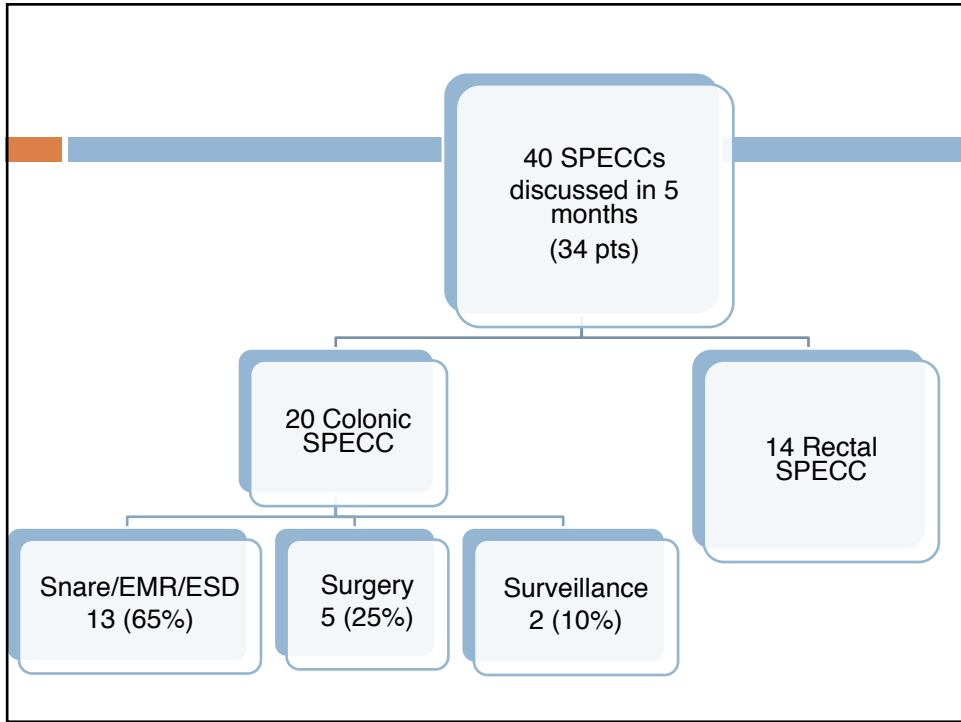
22 MDTs

384 pts discussed

40 SPECCs

15/22 MDTs included 1 to 7 SPECCs





Histology Rectal SPECC (n=14)

LGD=4

HGD=3

Adenoca T1=3

Adenoca T2 =1

Neuroendocrine=1



Awaiting surgery =2



Conclusion

SPECC MDTs

- Decision making
- Imaging
- Pathology

Includes patient's preference in the discussion

Platform to recruit patients for the PRESERVE UK trial

