Pan London Early Rectal Cancer Meeting

1st November 2018

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

Identification and pathway of lesions for organ-preserving local excision approach

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**ERC: Rationale for local excision**

- **Improvements in early detection**
  - BCSP: 10% Polyp cancers & 32% Dukes’ A,
  - Other diagnostic advances e.g. endoscopy training & advanced imaging
- **Approach to resection**
  - Increasing range of options for organ preservation
    - Consider all option at ERC/Polyp MDM
  - Many patients still having TME for ERC (NBOCAP data)
    - Impact on patient QOL
- **Imaging & staging**
  - Quality endoscopic images
  - UK TEM database: 30% ERC under-staged
  - ERUS not effective at staging ERC?

**How do we excise: EMR? ESD? Transanal? TME?**

- 22 year old man
- No family history cancer
- **PC: Prolapsing neoplasm**
- First endoscopy: “not endoscopically resectable”
  - Biopsies: TVA HGD
- **Polypectomy: Adenocarcinoma**
  - Moderately differentiated
  - pMMR
  - 7mm clearance
  - Haggitt 1
Kudo classification of pit patterns with photographic correlation of lesions.


The Paris endoscopic classification of superficial neoplastic lesions.

Rectal EMR

• Photos could be better
• Could be cleaner

• But... Easily lifts
• Removed piecemeal
• For benign lesions only
• What is the correct approach for malignant lesions?

Risk of recurrence LNPCPs

• Large non-pedunculated colorectal polyps (LNPCPs) ≥2cm
  • Piecemeal 22%
  • En-bloc 3%

Avoid piecemeal resection if malignancy is suspected

Belderbos 2014 Endoscopy
A mixed laterally spreading tumour (LST) that demonstrates both granular (green arrow) and non-granular aspects (blue arrow).

The same mixed LST viewed with NBI

Endoscopic Guidelines LNPCPs

Guidelines

British Society of Gastroenterology/Association of Coloproctologists of Great Britain and Ireland guidelines for the management of large non-pedunculated colorectal polyps

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ABSTRACT

These guidelines provide an evidence-based framework to the management of patients with large non-pedunculated colorectal polyps (LNPCPs) in addition to developing key performance indicators (KPIs) that permit the evaluation of quality outcomes. These are also not previously published by British Society of Gastroenterology (BSG) guidelines.

ESGE Guidelines 2017 Ferlitsch et al Endoscopy
Endoscopic VS Trans-Anal Excision

• In absence of adverse histology
  - Positive (<1mm)/Indeterminate resection margins
  - Deep submucosal invasion (>1000μm)
  - Poorly differentiated
  - Lymphovascular invasion

• No significant differences overall (Rutter Gut 2015)
  - Survival
  - Recurrence

• Salvage Surgery?

• Risk recurrence may be higher in rectal vs colonic submucosal cancer
  (Lopez Gut 2017; Ikematsu Gastroenterology 2013)
Cummulative recurrence curve after complete resection for malignant polyps (MPs) by location and gross morphology.


- Paris 0-IIa
- Kudo type 5
- Non-lift sign
- Avoid biopsies
- Depth of invasion?
EMR/ESD

- To avoid fibrosis
  - Avoid biopsies
  - Tattoo: >3cm away in colon, not in rectum at all
  - Avoid lift unless can easily be excised

- Lesion description
  - Quality photography/video
  - Paris/Kudo/NICE
  - Distance, anterior/posterior etc

- Piecemeal EMR – site check at 3-6 months
- Aim for en-bloc and the best possible staging