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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

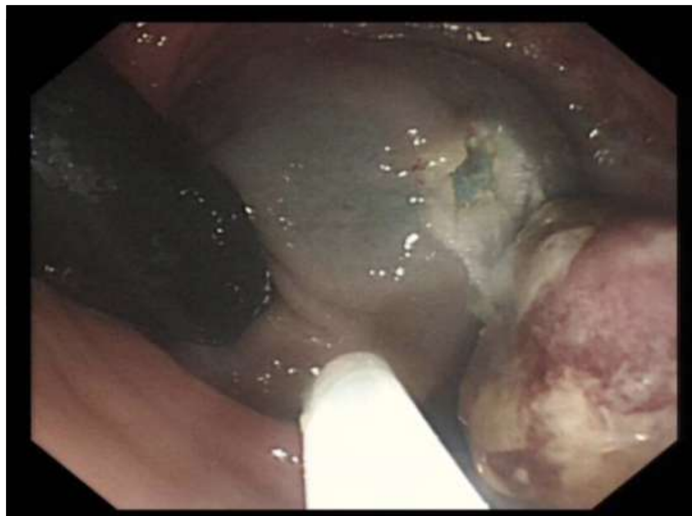
Dr Kevin Monahan FRCP PhD
Consultant Gastroenterologist,
West Middlesex University Hospital,
Chelsea & Westminster Hospitals NHS Trust
& Honorary Senior Clinical Lecturer, Imperial College London

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.

Type	Schematic	Endoscopic	Description	Suggested Pathology	Ideal Treatment
I			Round pits.	Non-neoplastic.	Endoscopic or none.
II			Stellar or papillary pits.	Non-neoplastic.	Endoscopic or none.
III_S			Small tubular or round pits that are smaller than the normal pit	Neoplastic.	Endoscopic.
III_L			Tubular or roundish pits that are larger than the normal pits.	Neoplastic.	Endoscopic.
IV			Branch-like or gyrus-like pits.	Neoplastic.	Endoscopic.
V_I			Irregularly arranged pits with type III_S, III_L, IV type pit patterns.	Neoplastic (invasive).	Endoscopic or surgical.
V_N			Non-structural pits.	Neoplastic (massive submucosal invasive).	Surgical.

Laura J Neilson et al. Frontline Gastroenterol 2015;6:117-126

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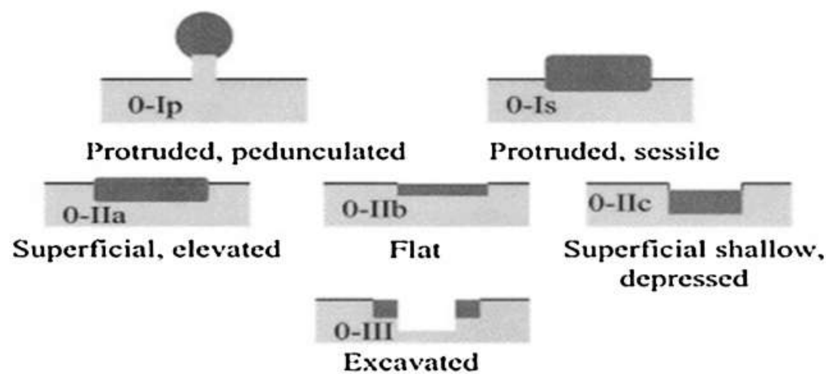
The Paris endoscopic classification of superficial neoplastic lesions.



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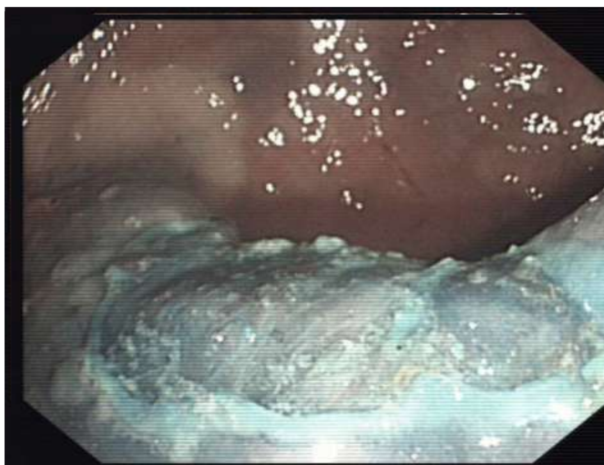
Rectal EMR

- Photos could be better
- Could be cleaner

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

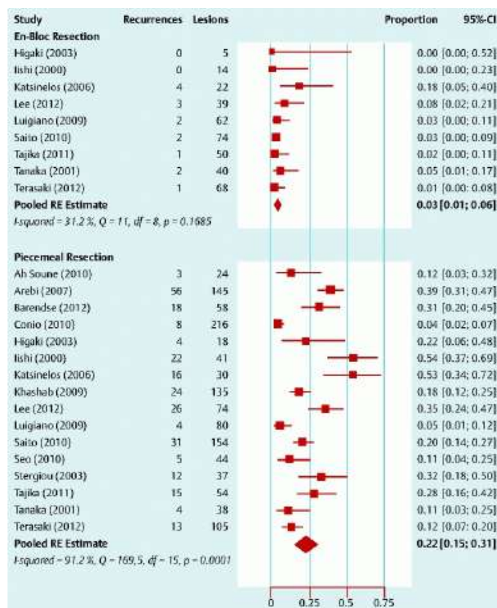


Risk of recurrence LNPCPs

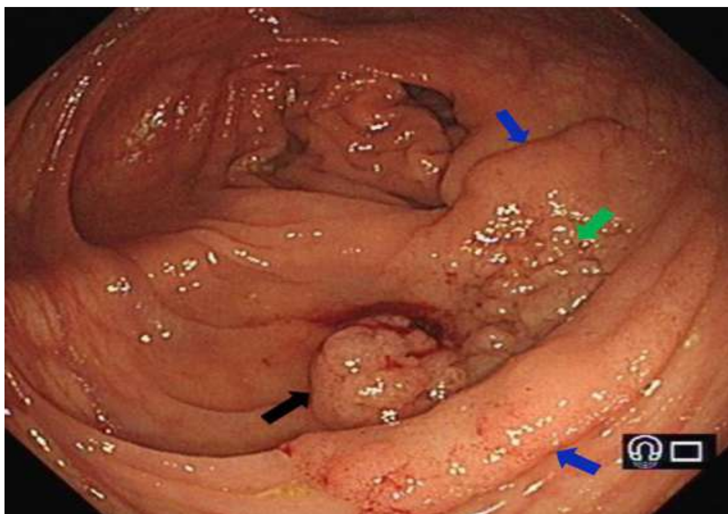
- Large non-pedunculated colorectal polyps (LNPCPs) ≥2cm
  - Piecemeal 22%
  - En-bloc 3%

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).



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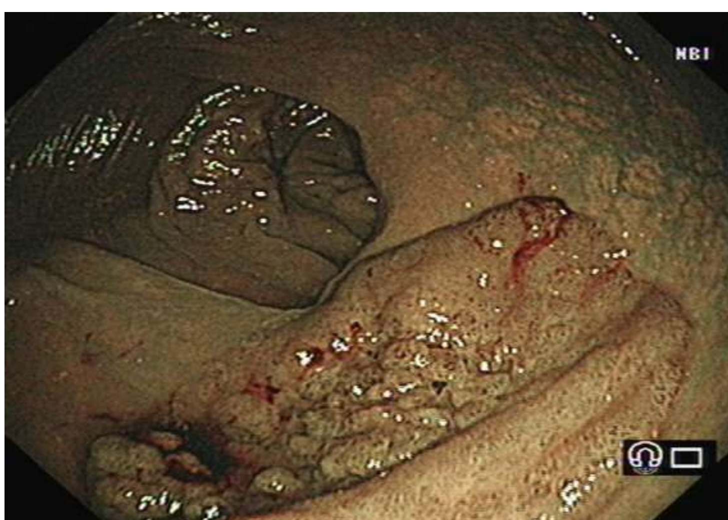
The same mixed LST viewed with NBI



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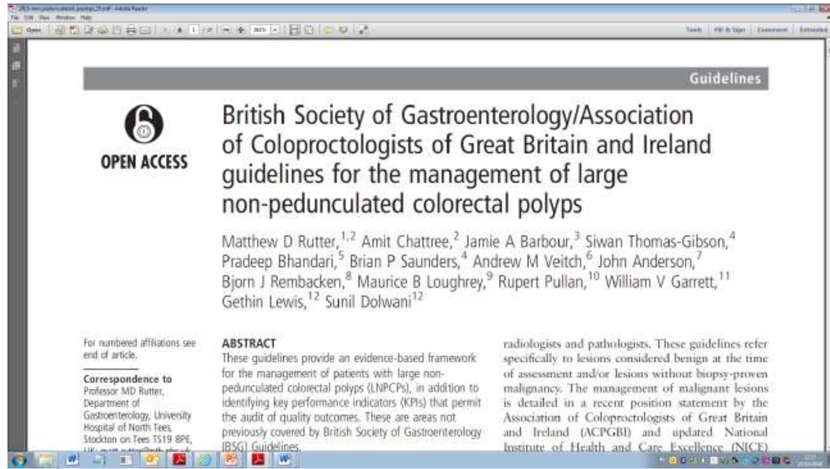
Endoscopic Guidelines LNPCPs



Guidelines

OPEN ACCESS

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

Matthew D Rutter,[1,2] Amit Chattree,[2] Jamie A Barbour,[3] Siwan Thomas-Gibson,[4] Pradeep Bhandari,[5] Brian P Saunders,[4] Andrew M Veitch,[6] John Anderson,[7] Bjorn J Rembacken,[8] Maurice B Loughrey,[9] Rupert Pullan,[10] William V Garrett,[11] Gethin Lewis,[12] Sunil Dolwani[12]

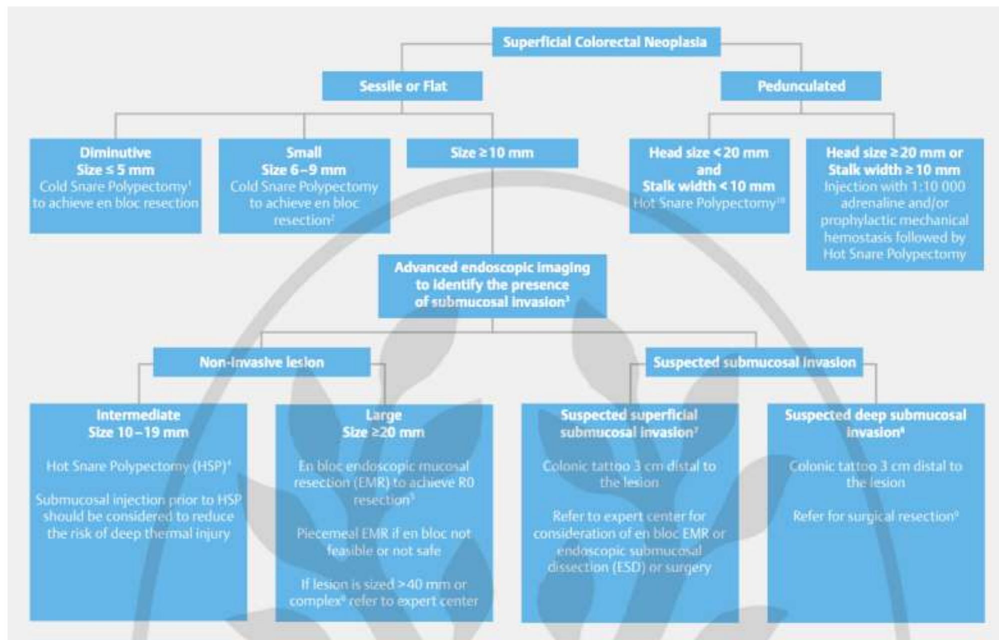
For numbered affiliations see end of article.

Correspondence to Professor MD Rutter, Department of Gastroenterology, University Hospital of North Tees, Stockton on Tees TS19 8PE,

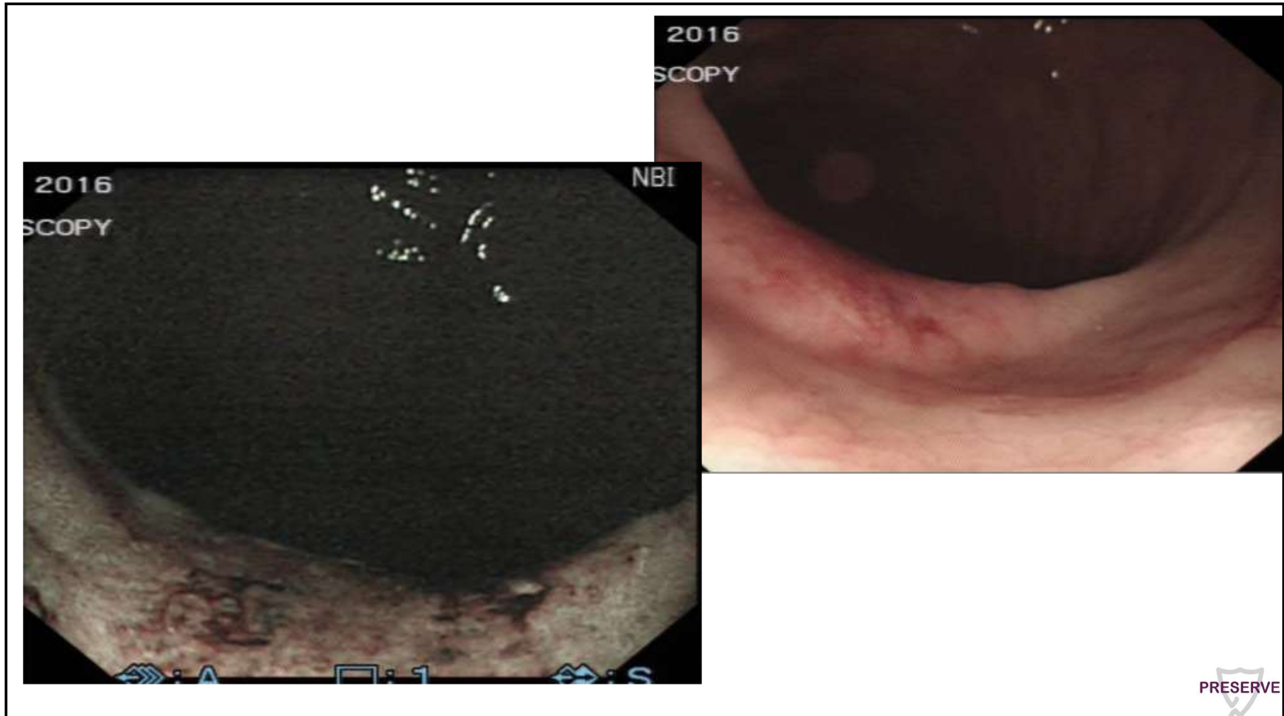
ABSTRACT

These guidelines provide an evidence-based framework for the management of patients with large non-pedunculated colorectal polyps (LNPCPs), in addition to identifying key performance indicators (KPIs) that permit the audit of quality outcomes. These are areas not previously covered by British Society of Gastroenterology (BSG) Guidelines.

radiologists and pathologists. These guidelines refer specifically to lesions considered benign at the time of assessment and/or lesions without biopsy-proven malignancy. The management of malignant lesions is detailed in a recent position statement by the Association of Coloproctologists of Great Britain and Ireland (ACPGBI) and updated National Institute of Health and Care Excellence (NICE)



ESGE Guidelines 2017 Ferlitsch et al Endoscopy



Endoscopic VS Trans-Anal Excision

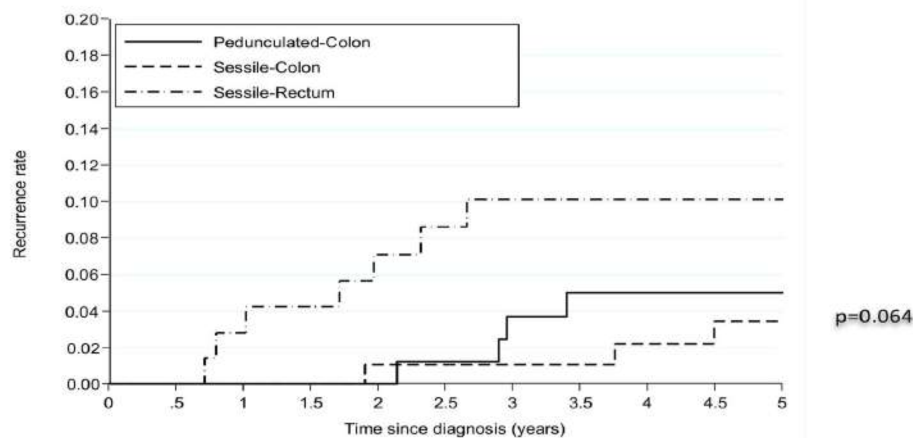
- In absence of adverse histology

▪ 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)

PRESERVE

Cummulative recurrence curve after complete resection for malignant polyps (MPs) by location and gross morphology.



Anthony Lopez et al. Gut doi:10.1136/gutjnl-2016-312093

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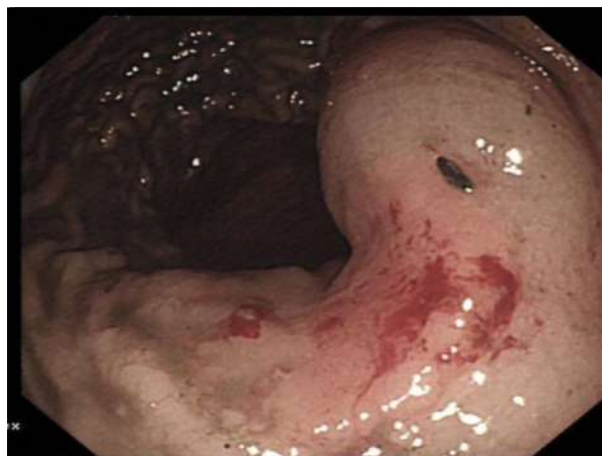
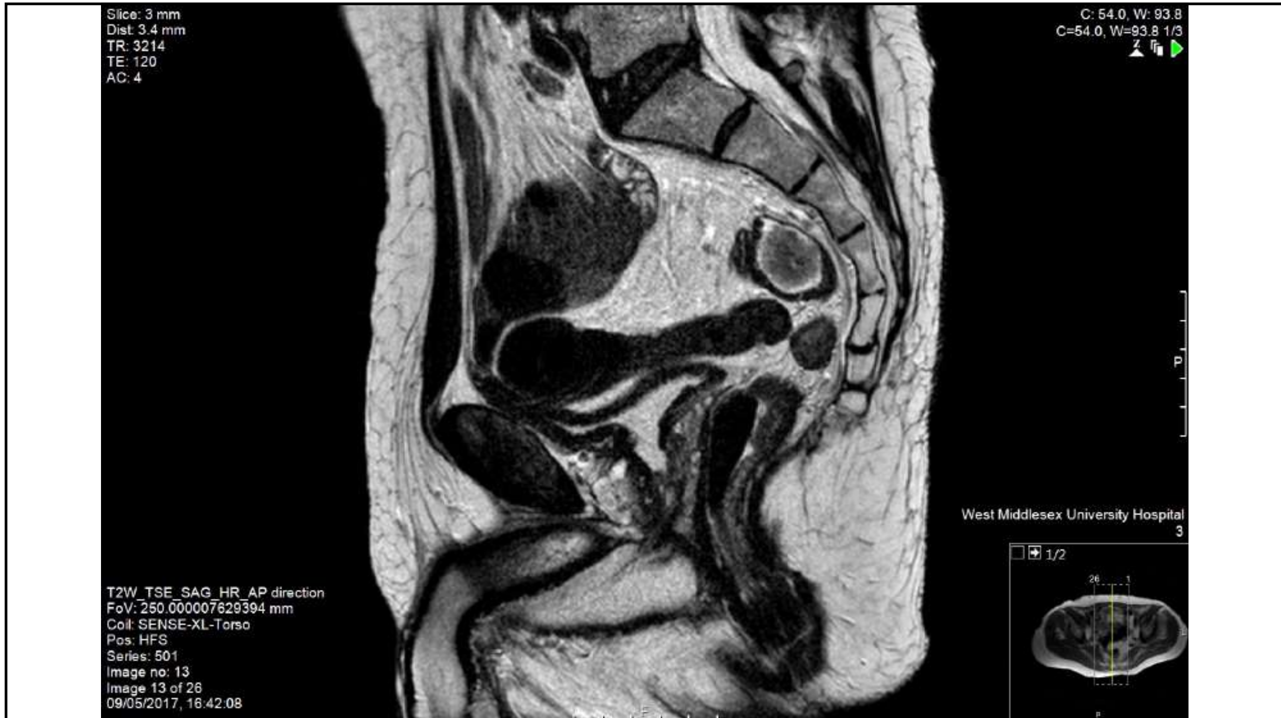
GUT

Which method of excision: EMR? ESD? Transanal? TME?

- 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

PRESERVE