WEO
World Endoscopy Organization

Colorectal Cancer Screening Committee Hybrid Meeting: Program and Abstracts

October 7, 2022
Hybrid

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Program and abstracts

WEO Colorectal Cancer (CRC) Screening Committee Meeting

Overview of content

- Program main meeting
- Overview of supporters
- Faculty overview
- Abstracts (in sequence of program)

Program

Colorectal Cancer Screening Committee (CRC SC): Plenary Meeting – Vienna (Hybrid format)

Friday, October 7, 2022 – 12.00 pm – 5.00 pm (CEST)

Corresponding Eastern time: 6.00 am – 11.00 am
Corresponding Singapore time: 6.00 pm – 11.00 pm

The Courtyard by Marriott Prater/Messe
Meeting rooms: Prater 3+4
Trabrennstrasse 4, Vienna, 1020, Austria

Virtual attendance via Zoom Webinars: Registered participants have received a link for the meeting.

Conveners: Evelien Dekker (Netherlands), Global Chair
Michael Kaminski (Poland), Co-Chair Europe

Themes:
CRC screening policy update
Risk stratification
Participation
Screen detection CRC
Early-onset

Goals of the meeting:
To provide updates on recent advances in CRC screening
To seek advice and comments on future initiatives
To reach consensus on controversial areas

Session 1: CRC screening policy update

Chairs: Jaroslaw Regula (Poland), Iris Seriese (Netherlands)
Time: 12.00 pm – 12:45pm

12.00 pm	Welcome by conveners	
12.05 pm	Global CRC incidence and mortality trends	*Linda Rabeneck (Canada)*
12.17 pm	EU Recommendations on Cancer Screening	*Michael Kaminski (Poland)*
12.29 pm	Q+A (16 minutes)	

Session 2: Risk stratification in CRC screening

Chairs: Cesare Hassan (Italy) and Monika Ferlitsch (Austria)
Time: 12.45 pm – 1.20 pm

12.45 pm	Colonoscopy Prioritization	*Revital Kariv (Israel)*
12.57 pm	CRC risk in individuals with positive family history (FH) of Colorectal Cancer (CRC)	*Nastazja Pilonis (Poland)*
1.09 pm	Q+A (11 minutes)	

Session 3: Participation in CRC screening
Chairs: Carlo Senore (Italy), Toni Castells (Spain)
Time: 1.20 pm – 2.00 pm

1.20 pm	The role of Defensive Information Processing in population-based colorectal cancer screening uptake	*Nick Clarke (Ireland)*
1.32 pm	Sustainability within CRC Screening	*Iris Seriese (Netherlands)*
1.44 pm	Q+A (16 minutes)	
2.00 pm	***Coffee Break (30 minutes)***	

Session 4: Early onset CRC
Chairs: Matt Rutter (UK), Anna Forsberg (Sweden), Linda Rabeneck (Canada)
Time: 2.30 pm – 3.07 pm

2.30 pm	Epidemiology trends of early CRC	*Ondrei Majek (Czech Republic)*
2.42 pm	Q+A (25 minutes)	

Session 5: Screen detected CRC
Chairs: Rodrigo Jover (Spain), Evelien Dekker (Netherlands)
Time: 3.07 pm – 3.45 pm

3.07 pm	Screen detected T1 CRC in the Netherlands	*Lisa van der Schee (Netherlands)*
3.19 pm	CRC: Indications for ESD	*Yutaka Saito (Japan)*
3.31 pm	Q+A (14 minutes)	
3.45 pm	***Break (15 minutes)***	

Reports from Expert Working Groups
Chairs: Michael Kaminski (Poland), Evelien Dekker (Netherlands)
Time: 4.00 pm – 5.00 pm

4.00 pm	FIT for Screening	*Sally Benton (UK), Manon Spaander (Netherlands)*
4.10 pm	PCCRC & Quality in Colonoscopy	*Matt Rutter (UK)*
4.20 pm	Inequities in CRC Screening	*Robert Kerrison (UK)*
4.30 pm	Surveillance after Colorectal Neoplasia	*Rodrigo Jover (Spain)*
4.40 pm	New Tests	*Carlo Senore (Italy)*
4.45 pm	Case Studies	*Linda Rabeneck (Canada)*
4.50 pm	Artificial Intelligence	*Yuichi Mori (Norway), Daniel von Renteln (Canada)*
4.55 pm	**Meeting adjourns**	

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WEO Colorectal Cancer (CRC) Screening Committee Meeting

Friday, October 7, 2022

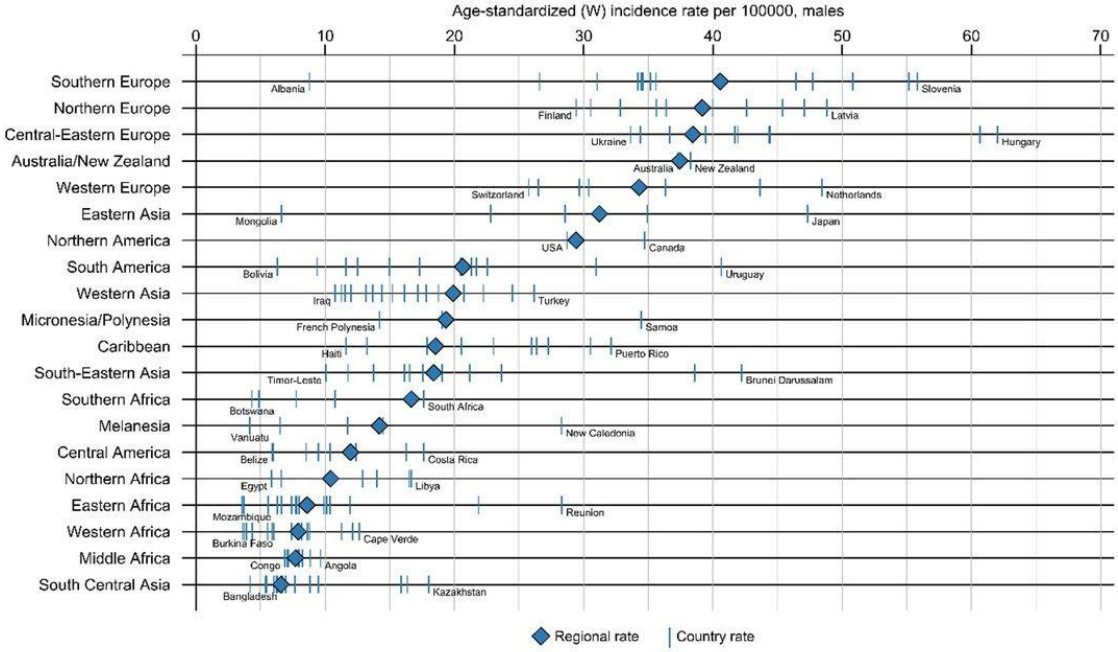
Title: Global Colorectal Cancer Incidence and Mortality Trends

Authors: Linda Rabeneck MD MPH FRCPC

Colorectal cancer (CRC) is a global public health issue. The UN-defined 20 world regions and 4-level Human Development Index (HDI) can be used to assess CRC burden, using data from the GLOBOCAN database.

Overall, there were 1.9 million new CRC cases and 930,000 deaths estimated in 2020. There is variation in incidence and mortality across world regions, and across countries within regions. Incidence rates in men are highest in Southern Europe (40.6 per 100,000), followed by Northern Europe (39.2 per 100,000) and Australia/New Zealand (37.4 per 100,000). Hungarian men had the highest incidence rate (62.0 per 100,000). Incidence rates among women were lower compared with men, but followed a similar pattern, with highest rate in Australia/New Zealand (29.2 per 100,000) followed by Northern Europe (28.8 per 100,000) and Southern Europe (24.5 per 100,000). Norwegian women had the highest incidence rate (38.7 per 100,000). Variations in mortality were less marked, with highest rates in Central-Eastern Europe. Slovakia had the highest mortality rates in both men and women (29.6 and 14.8 per 100,000, respectively).

Incidence rates increase with HDI category (low, medium, high, very high). As countries undergo economic transition (with changes in lifestyle and diet), moving from low to high HDI, CRC incidence increases. This accounts for temporal trends seen in many transitioning countries in Eastern Europe, Asia and Latin America. Trends are stabilizing or decreasing in very high HDI countries such as Canada and the US. Incidence rates are also rising in adults < 50 years.



Morgan E et al. Gut 2022; in press.

WEO Colorectal Cancer (CRC) Screening Committee Meeting

Friday, October 7, 2022

Title: Colonoscopy prioritization

Author: Revital Kariv

The concept of colonoscopy prioritization is wide and relevant for health systems with limited resources, as well as under special circumstances, such as the COVID-19 pandemic.
As colonoscopy performance is on the rise and requires substantial resources, it may become a worldwide burden due to increased awareness and earlier screening onset. As a result - prioritisation may become widely relevant and adopted by various health systems and colorectal cancer (CRC) screening programs.

The existing literature review shows only few reports of colonoscopy prioritisation, mostly from the UK during the pandemic, using CBC based algorithms and Fecal Immunochemical Test (FIT). Additional investigational risk prediction tools based on polygenic risk scores, clinical and demographic parameters are currently being studied.
Efforts to limit colonoscopy burdens include FIT threshold adjustment.
Incorporation of prioritisation tools in CRC screening programs require threshold definition and management, as well as structured clinical application [systematic or through general practitioners (GP)/gastroenterologists].

The Israeli CRC program allows both FIT and colonoscopy for CRC screening among the average risk population, with a recent substantial increase in the use of colonoscopies and waiting time. Symptomatic and high risk populations are not prioritized over the average-risk screening population.

At Maccabi Health Care Services (MHS), the second largest HMO in Israel with a client base of around 2.5 million, there is an ongoing use of FIT and colonoscopy for screening, as well as a blood CBC based CRC-prediction-algorithm (ColonFlag) for the unscreened population that underwent a recent CBC. Due to the increased waiting time and shortage of colonoscopies, we have established a polyp prediction bio-informatic tool, based on MHS's general database and a free text search of colonoscopies and histological reports- to be presented with ColonFlag, along with various implementation strategies for the target population.
Because age is a major CRC and a colorectal polyp risk predictor, yet, the overall screening benefit is greater among the younger and healthier population, prioritisation tools should address this issue. An appropriate educational program for GPs and gastroenterologists should accompany this process.

Conclusion: This talk will present the topic of colonosopy prioritisation, its relevance and importance, literature review, various potential tools and specific implementation efforts at MHS.

WEO Colorectal Cancer (CRC) Screening Committee Meeting

Friday, October 7, 2022

Title: The role of Defensive Information Processing in population-based colorectal cancer screening uptake

Authors: Nicholas Clarke PhD 1, Louise Hayes PhDa2, Amy McQueen PhD3, Pamela Gallagher PhD1, Patricia M. Kearney, MD4, Deirdre McNamara MD5, Colm A. O'Morain MD6, Christian von Wagner PhD7, Therese Mooney PhD8, Linda Sharp PhD2

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Background: Internationally, colorectal cancer screening participation remains low, despite the availability of home-based testing and numerous interventions to increase uptake. To be effective, interventions should be based on an understanding of what influences individuals' decisions about screening participation. This study investigates the association of defensive information processing (DIP) in Faecal Immunochemical Test (FIT)-based colorectal cancer screening uptake.

Methods: Regression modelling of data from a cross-sectional survey within a population-based FIT screening programme was conducted. The survey included the 7 sub-domains of the McQueen DIP measure. The primary outcome variable was uptake status (screening User or Non-user). Multivariable logistic regression was used to estimate the odds ratio (OR) for screening non-use by DIP (sub)domain score, with adjustment for socio-demographic and behavioural factors associated with uptake.

Results: Higher scores (equating to greater defensiveness) on all DIP domains were significantly associated with lower uptake in model adjusted for sociodemographic factors. In model with additional adjustment for behavioural factors, the suppression sub-domains of "deny immediacy to be tested" (OR: 0.53, 95% CI 0.43, 0.65: P<0.001) and "self-exemption" (OR: 0.80; 95% CI 0.68, 0.96: P: <0.001) independently predicted non-use of FIT-based screening.

Conclusion: This is the first study outside of the USA which has identified DIP as a barrier to colorectal cancer screening uptake, and the first focussed specifically on FIT-based screening. The findings suggest the two suppression barriers, namely denying the immediacy to be tested and self-exempting oneself from screening, may be promising targets for future interventions to improve uptake.

[1] Nicholas Clarke and Louise Hayes are joint first authors

WEO Colorectal Cancer (CRC) Screening Committee Meeting

Friday, October 7, 2022

Title: Reducing the footprint of CRC screening

Author: Iris Seriese, Programme Manager Dutch CRC Screening

Worldwide the climate is changing, reflected in extreme weather phenomena and changes in temperature. This is more than ever affecting our health. We suffer more from UV radiation, heat stress, allergies, infectious diseases and air pollution. An increase in health problems results in increasing health care consumption, but we are in a paradox as the health care sector's carbon footprint is sizeable. In the Netherlands, the health care sector is responsible for 7% of our national greenhouse gas emissions. Furthermore, in hospitals, the colonoscopy department is the third largest contributor. The Dutch CRC screening organisation feels responsible to evaluate their carbon footprint.

Is it possible to minimize the CRC screening footprint? Recently, a Life Cycle Assessment (LCA) was conducted on the Dutch CRC screening programme. They took an in-depth look in the (logistic) programme to see where the largest amounts of emissions are, the so called 'hot spots'. Knowing these hot spots, we figured out how we can reduce pollution by substituting elements for a less polluting solution. In some cases, the solution seemed relatively easy. For instance, by changing the materials of the invitation package into recyclable materials. Some elements were more difficult to approach. For example, how we can reduce the occurrence of wasting the FIT-test because it is not used properly? We conducted research on why some people do not use the FIT-test correctly. By simply changing the manual, we try to reduce the number of unusable FIT-tests.

We learned that sending out less material is always more effective then replacing materials for more eco-friendly variants. For that reason, we have looked into minimizing the materials in our invitation package as well. We changed the response envelop by a smaller format, and we are investigating whether people who participated in the previous round of the screening programme are able to make the decision to join again based on less information. The bigger projects to reduce our footprint made us aware of an underlying discussion point: Since January 2021 we are conducting a so called 'non-responder project'. Screening invitees who did not respond to their invitation twice now only receive an invitational letter. This adds an extra step for invitees, having to reach out to the screening organisation to get the full package if they do decide to join this round. We are currently evaluating how this impacts the response rate and yield. First results indicate that more people seem to consider this extra step a barrier to participate. Whether to implement this pilot into practice is a complicated decision.

Does sustainability outweigh accessibility? To answer this question, we try to investigate the impact of missing these extra non-participants further down the healthcare-chain, as we assume that they are more likely to return into health care with a more advanced CRC. Needing more intensive care with an even larger footprint as a result.

WEO Colorectal Cancer (CRC) Screening Committee Meeting

Friday, October 7, 2022

Title: : Indications for ESD/proposal for a white paper/guideline from WEO's CRC Screening committee

Authors: Yutaka Saito

Colorectal ESD is a technique that allows en bloc resection of tumors larger than 2 cm, especially early-stage cancer, and can reduce local recurrence to almost zero.
In addition, as the diameter of colorectal tumors increases, the cancer-carrying rate also increases, and since there is pSM invasion that cannot be diagnosed preoperatively, accurate pathological diagnosis is essential for the selection of appropriate subsequent treatment including surgery.
On the other hand, since intramucosal carcinoma is not defined in the colon in the Western countries, therefore, pEMR is considered sufficient for LSTs larger than 2 cm.
In addition, ablation of the surrounding area with snare-tips have been reported to reduce local recurrence. In reality, however, recent meta-analyses have reported local recurrence of 6% or more, and surgery is often the treatment of choice due to the difficulty of additional EMR.

Recently from Japan, a multicenter prospective cohort study by the CREATE-J group showed in Gastroenterology that the bowel preservation rate and long-term prognosis are favorable in cases of curative resection. 1The 1814 lesions included 40% adenoma, 39% M carcinoma, 7% SM1, and 8% SM2 or deeper.
On the other hand, 9% were diagnosed with non-curative resection, of which metastatic recurrence, although infrequent, was observed after 13-25 months, and after 8-69 months as reported by Ikematsu et al. Therefore, surveillance of T1 cancers after endoscopic resection is necessary for a minimum of 5 years.

The ESGE guidelines limit the indication for ESD to cSM1 only.
Although the ESGE guidelines suggest SM1 as a suggestive finding, a well-defined depression or Type V Pit is usually associated with SM2.

Cost analysis results suggest that selective ESD of SM1 only is the most economical.
However, in our analysis, ESD is economical when surveillance is included, 2 and it is not possible to choose only SM1 even with magnifying endoscopy or AI, so we consider SM1 cancer including M cancer (high-grade dysplasia) to be an indication.
The WEO is a globally influential society, and we hope that the WEO will publish evidence-based guidelines for the indidation of colorectal ESD/EMR.

References

1. Ohata K, Kobayashi N, Sakai E, et al. Long-Term Outcomes After Endoscopic Submucosal Dissection for Large Colorectal Epithelial Neoplasms: A Prospective, Multicenter, Cohort Trial from Japan. Gastroenterology 2022.
2. Sekiguchi M, Igarashi A, Mizuguchi Y, et al. Cost-effectiveness analysis of endoscopic resection for colorectal laterally spreading tumors: Endoscopic submucosal dissection versus piecemeal endoscopic mucosal resection. Dig Endosc 2022;34:553-568.

WEO Colorectal Cancer (CRC) Screening Committee Meeting

Friday, October 7, 2022

Title: Short and long-term oncological outcomes in screen-detected T1 colorectal cancer: a multicentre cohort study

Author: **Lisa van der Schee**[1,14], Krijn J.C. Haasnoot[1], Sjoerd G. Elias[2], Kim M. Gijsbers[1,3], Frank ter Borg[3], Ruud W.M. Schrauwen[4], Anne-Marie van Berkel[5], Wouter H. de Vos tot Nederveen Cappel[6], Koen Kessels[7], Jochim S. Terhaar Sive Droste[8], Marcel B.W.M. Spanier[9], Femke Boersma[10], Yasser A. Alderlieste[11], Ramon-Michel Schreuder[12], Tom C.J. Seerden[13], Gertjan Rasschaert[14], Yara Backes[1], Frank P. Vleggaar[1], Miangela M. Laclé[14], Leon M. G. Moons[1]

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Background

The detection and local excision of T1 colorectal cancers (T1CRC) have increased with the implementation of CRC screening programs. It is however unknown whether screen-detected (sd) and non-screen-detected (non-sd) T1CRCs have similar oncological risk profiles, or if they should be considered as two distinct entities.

Methods

We analysed data from consecutive patients diagnosed with T1CRC between 2014-2017 in 12 participating hospitals. Sd and non-sd patients were compared on the presence of lymph node metastasis (LNM) at baseline and on overall survival (OS), recurrence-free survival (RFS), and metastasis-free survival (MFS) during follow-up. The association between method of detection (sd vs. non-sd) and LNM was analysed in all surgically treated patients using multivariable logistic regression. We adjusted for clinical and histological confounding factors (i.e., age, gender, tumour location, morphology, lymphovascular invasion, and grade of differentiation). We used Cox proportional hazard regression to study the association between the method of detection and OS, RFS and MFS, adjusting for covariates (age at diagnosis and ASA classification for OS; location of primary T1 CRC and treatment strategy for RFS and MFS).

Results

1803 patients were included (median age 69 years, 62% male, 14% ASAIII/IV, 34% pedunculated T1CRCs), of which 1114 (62%) were detected by screening. Sd patients were younger (67 vs 71 years, P<0.001), more frequently male (65% vs 58%, P<0.01), had fewer comorbidities (ASA III/IV 9% vs 21%, P<0.001), and had more left-sided tumours (63% vs 52%, P<0.001) than non-sd patients. The proportions of pedunculated T1CRCs (34% vs 34%), frequency of the histological risk factors for LNM, and proportion of surgery (primary and completion) (53% vs 54%) were comparable. LNM was more often observed in sd patients (12.6%; 95%CI 9.9-15.9%) than in non-sd patients (8.9%, 95%CI 6.1-12.5%). However, when adjusted for potential confounders, the risk was not significantly different (1.42; 95% CI 0.90-2.24; P=0.11). In 62 patients (3.4%) recurrences were observed (median FU 51 months [IQR 30 months]), with similar recurrence rates in the sd and non-sd population (3.4% vs 3.5%; univariate HR 1.02; 95%CI 0.60-1.73; P=0.95). No significant differences were found in RFS (96.3% vs 95.5%; adjusted HR 0.88; 95%CI 0.54-1.44; P=0.62) and MFS (96.9% vs 97.0%; adjusted HR 1.07; 95%CI 0.61-1.84; P=0.82) between sd and non-sd T1 CRC patients. Overall survival was significantly better in the sd population (92.1% vs 78.5%; adjusted HR 0.52; 95%CI 0.39-0.69; P < 0.001).

Conclusion

Our data show similar short- and long-term oncological outcomes for sd patients and non-sd patients with T1CRC. This supports that risk stratification, primarily based on non-sdT1CRCs, can be safely applied to sdT1CRCs as well. Remarkably, non-CRC-related mortality was significantly higher in non-sdT1CRC patients, which could not be completely explained by differences in age at diagnosis and comorbidities.

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Title: Epidemiological trends of early-onset colorectal cancer and the situation in the Czech Republic

Authors: Ondřej Májek, Ondřej Ngo, Kateřina Hejcmanová, Monika Ambrožová, Renata Chloupková, Štěpán Suchánek, Miroslav Zavoral, Bohumil Seifert, Ladislav Dušek

Whereas recent studies show decline or stabilisation in overall colorectal cancer (CRC) burden in some high-income countries, increasing incidence in young adults was also recently reported in many populations. The CRC occurring in patients aged under 50 is often referred as early-onset CRC. Although the concrete reasons for the increase remain unclear, theories for explanation include effects of western lifestyle and obesity, changes in gut microbiota, etc.

Recent European study including data from 20 countries reported 7.9% increase of CRC incidence per year in individuals aged 20-29, 4.9% increase in individuals aged 30-39, and 1.6% increase in individuals aged 40-49. Notable exception among participating countries, with significant decrease in CRC incidence among individuals aged 40-49, was the Czech Republic.
We aimed to investigate recent trends in CRC incidence and accompanying trends in utilisation of early detection examinations. We used data from the Czech National Cancer Registry and the National Registry of Reimbursed Health Services.

The recent cancer registry data confirm substantial decrease of CRC incidence in individuals over 50 (APC -4.8, 95% CI -5.6 to -4.0). Whereas the decrease is extended to the younger age groups, with decreasing incidence in those aged 45-49 (APC -1.5, 95% CI -1.8 to -1.1) and 40-44 years (APC -0.3 95% CI -0.5 to 0.0), the incidence has been rather increasing recently for those aged 30-39 (APC 2.7, 95% CI -0.1 to 5.4) and namely 20-29 (APC 6.7, 95% CI 3.4 to 10.0). Recent data suggest that potential increase in incidence might be expected for cohorts born approximately after 1980.
Furthermore, utilisation of early detection examinations might be contributing to slower increase of incidence in individuals aged 30-49. Cumulative 5-year coverage of the population by colonoscopy or faecal occult blood test increases with age and reaches 8.6% in those aged 45-49 in 2021. Over 20% of individuals aged 45-49 are undergoing endoscopic therapy (EPE, EMR, or ECD) following colonoscopy (from all indications) examination. This results in 6-7 thousand patients aged 30-49 undergoing endoscopic therapy annually and could potentially translate to decrease in CRC incidence to some extent.

Our study confirms cautionary CRC incidence trends in younger adults. Efforts should be made to strengthen primary prevention strategies, appropriately identify and care for younger individuals at higher risk, and to investigate possibilities for future extension of population-based screening programmes to younger ages.

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