Hospital General Universitari d'Alacant

VIGILANCIA POST-POLIPECTOMIA
GUIA AEG-SEMFyC-SEED-SEE

Zaragoza, XX Reunión de la Red Española de Programas de Cribado
18-5-2017

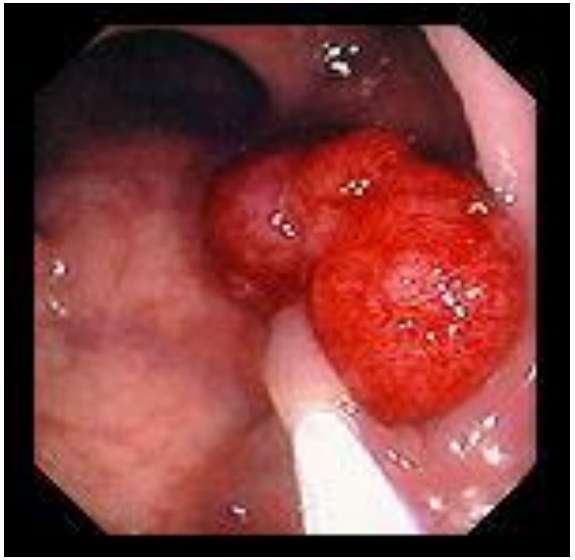
Dr Rodrigo Jover

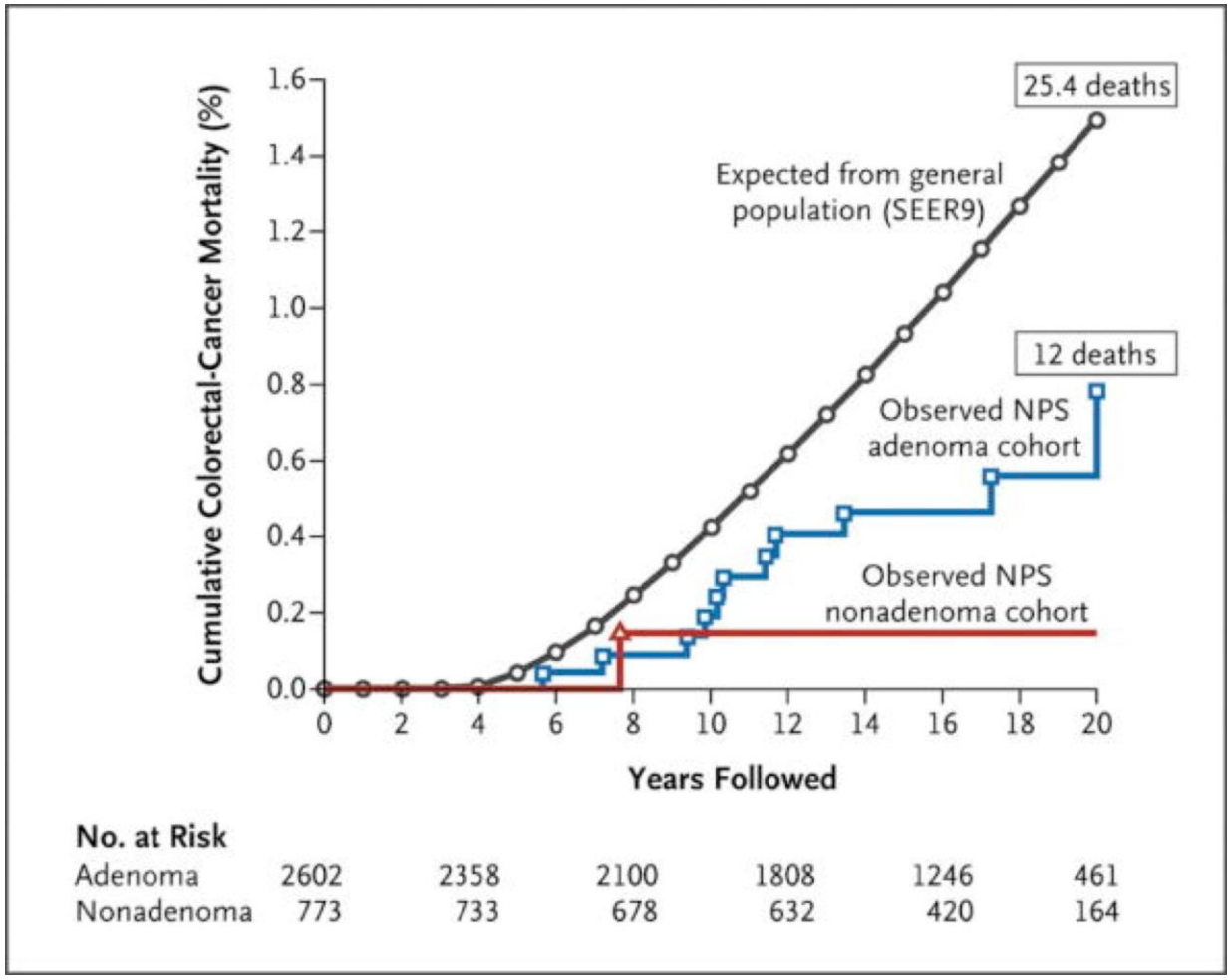
Unidad de Gastroenterología

Hospital General Universitario de Alicante

ASOCIACION ESPAÑOLA DE GASTROENTEROLOGIA
AEG

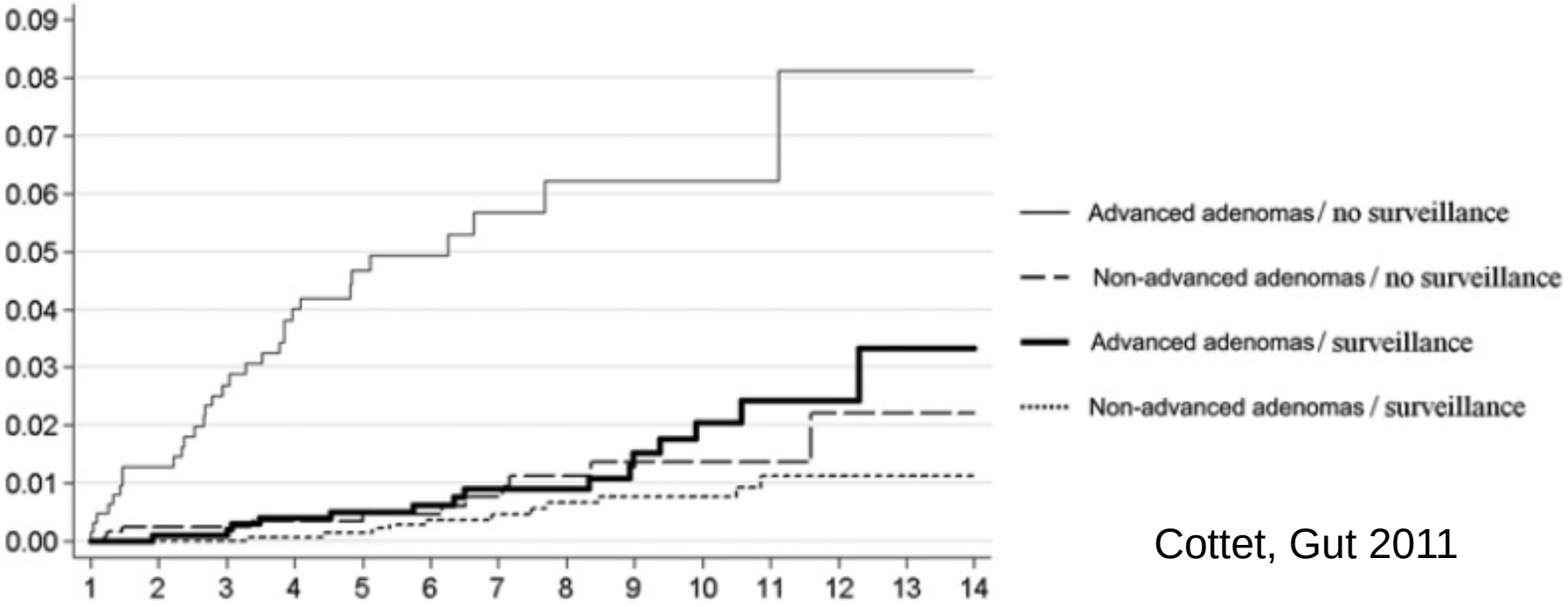
POLIPECTOMIA ENDOSCOPICA





Zauber, NEJM 2012

Los pacientes a los que se extirpa adenomas tienen mayor riesgo de CCR



Cottet, Gut 2011

La vigilancia postpolipectomía reduce el riesgo de CCR

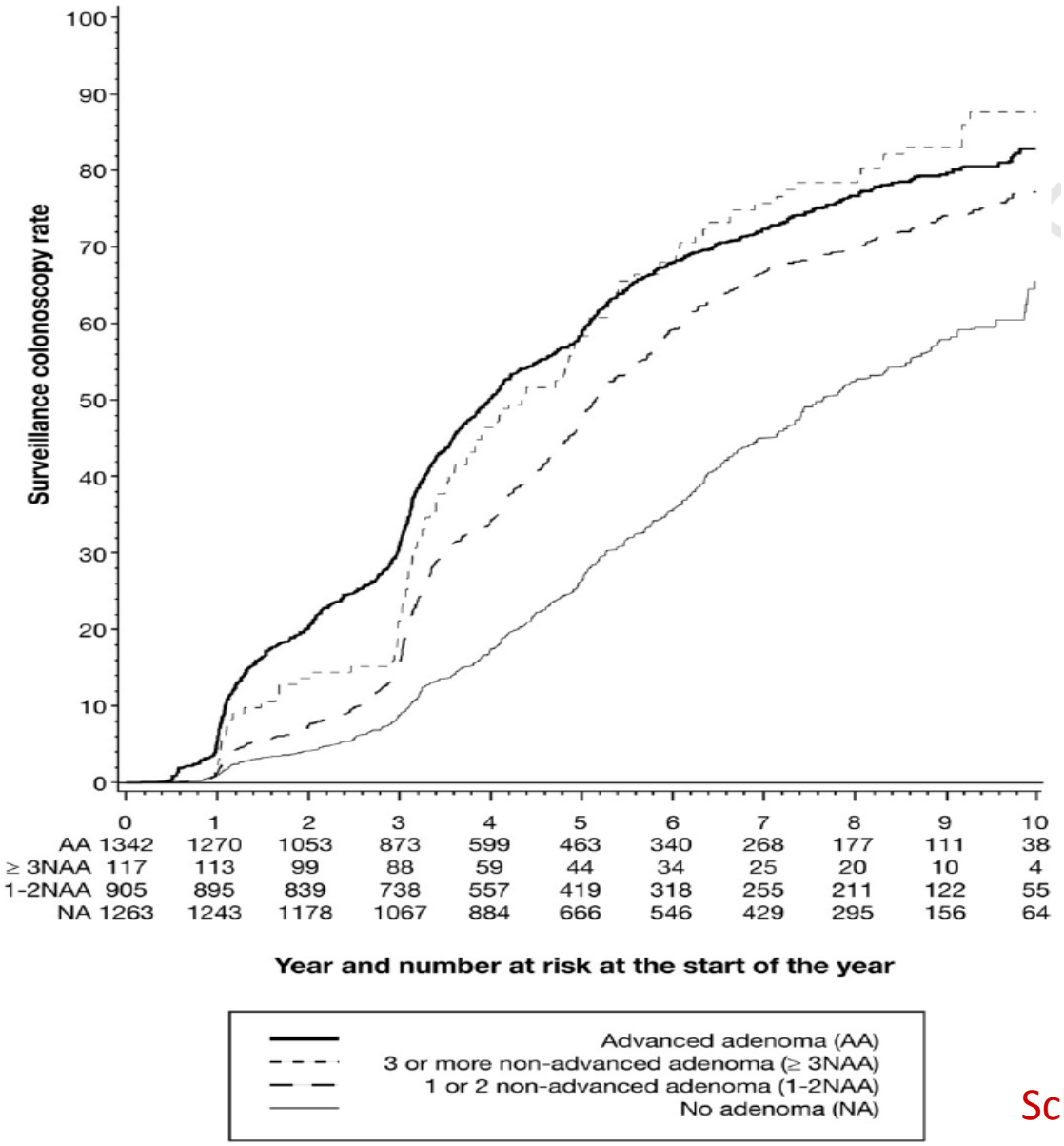
Visits after baseline*	n (%)	CRC cases	Incidence per 10^5 py	Univariable HR (95% CI)	Multivariable HR (95% CI)
0	5 019 (42%)	121	233	1	1
1	3 503 (29%)	51	173	0.54 (0.39-0.77)	0.57 (0.40-0.80)
2	2 085 (18%)	22	174	0.46 (0.28-0.75)	0.51 (0.31-0.84)
≥ 3	1 337 (11%)	16	231	0.49 (0.27-0.88)	0.54 (0.29-0.99)
				p = 0.0004	p = 0.0029

Adenoma surveillance and colorectal cancer incidence: a retrospective, multicentre, cohort study

Wendy Atkin, Kate Wooldrage, Amy Brenner, Jessica Martin, Urvi Shah, Sajith Perera, Fiona Lucas, Jeremy P Brown, Ines Kralj-Hans, Paul Greliak, Kevin Pack, Jill Wood, Ann Thomson, Andrew Veitch, Stephen W Duffy, Amanda J Cross

Lancet Oncology 2017

La colonoscopia de vigilancia se utiliza mal



Schoen, Gastro 2010

Appropriateness of endoscopic surveillance recommendations in organised colorectal cancer screening programmes based on the faecal immunochemical test

Gut 2016

Manuel Zorzi,[1] Carlo Senore,[2] Anna Turrin,[3] Paola Mantellini,[4] Carmen Beatriz Visioli,[4] Carlo Naldoni,[5] Priscilla Sassoli de' Bianchi,[5] Chiara Fedato,[3] Emanuela Anghinoni,[6] Marco Zappa,[4] Cesare Hassan,[7] the Italian colorectal cancer screening survey group

Table 4 Comparison of the number of observed recommendations for a TC and of expected recommendations according to the EuGL, by type of diagnosis

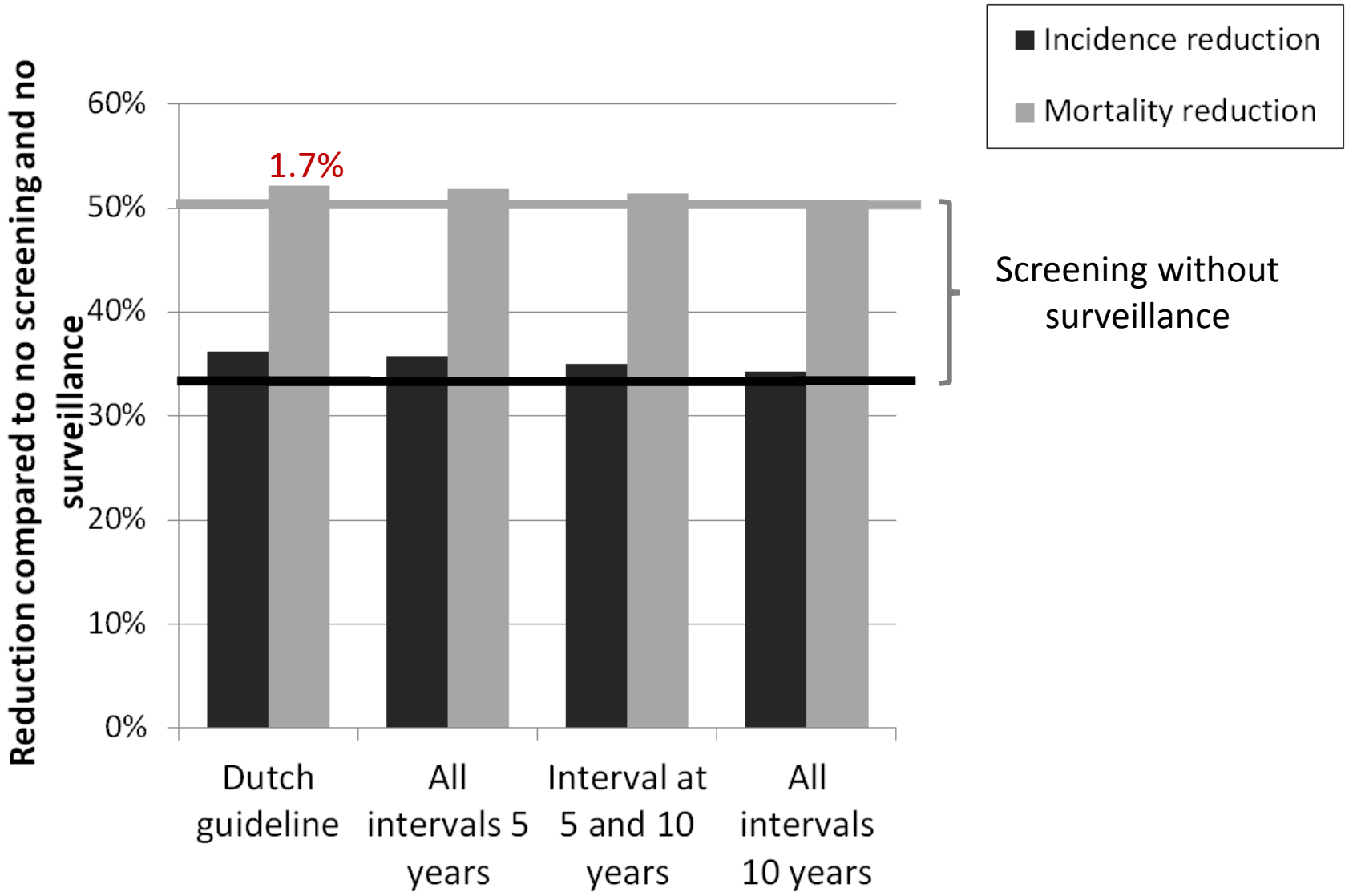
Diagnosis	Recommended TC	Expected TC according to EuGL	Difference
Negative/ non-adenomatous polyp	1818	0	+1818
Low-risk adenoma	5146	0	+5146
Intermediate-risk adenoma	8444	8694	−250
High-risk adenoma	2452	2470	−18
Total	17 860	11 164	+6696

EuGL, European guidelines for quality assurance in colorectal cancer screening and diagnosis; TC, total colonoscopy.

COLONOSCOPIA DE VIGILANCIA PUNTOS DE PARTIDA

- La vigilancia post-polipectomía no ha demostrado su eficacia en la reducción de incidencia/mortalidad de CCR en ensayos clínicos.
- Los intervalos de vigilancia son arbitrarios y no están basados en ensayos clínicos.
- Las evidencias disponibles son escasas y de poca calidad.
- Se utiliza como indicador un marcador secundario, el adenoma avanzado, cuya tasa de progresión a CCR es también incierta
- Indicación sobreutilizada
- La colonoscopia de vigilancia supone alrededor del 25% de las indicaciones de colonoscopia, a menudo con alta tasa de inadecuación

Effectiveness of surveillance



Greuter, Ann Intern Med in press

Post-Polypectomy Surveillance That Would Please Goldilocks—Not Too Much, Not Too Little, but Just Right

Gastroenterology, 2016

WHAT IS RISK?

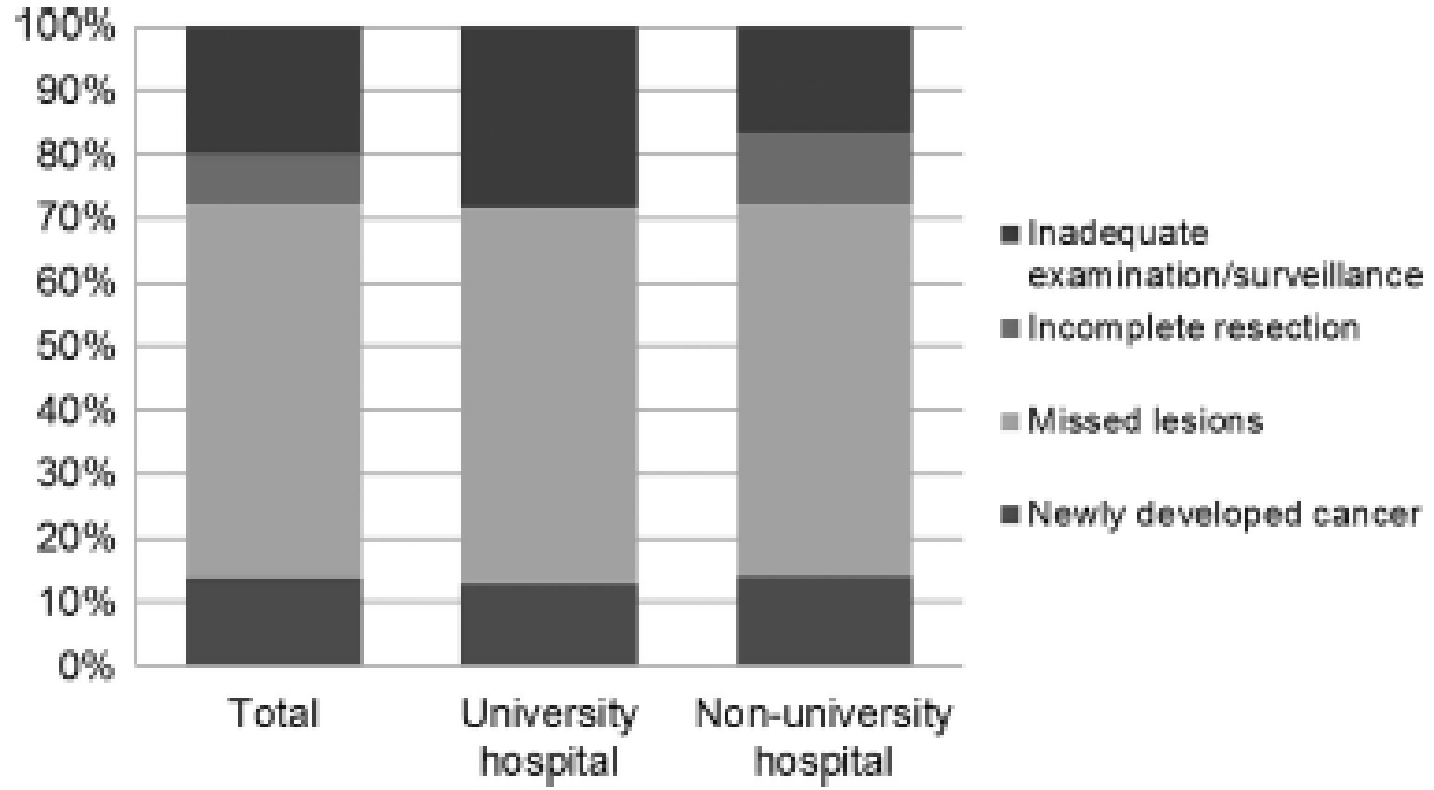
HIGH RISK

LOW RISK

RISK OF METACRONOUS CRC

CANCER DE INTERVALO
causas

CALIDAD



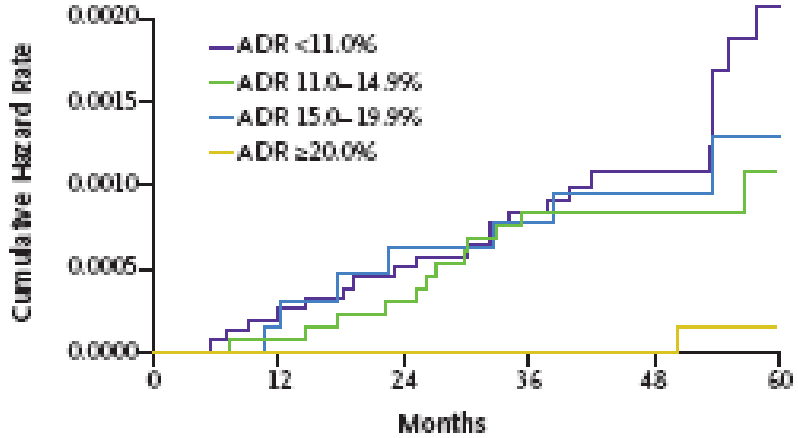
Le Clercq, Gut 2014

FACTORES DE RIESGO
CALIDAD DE LA COLONOSCOPIA

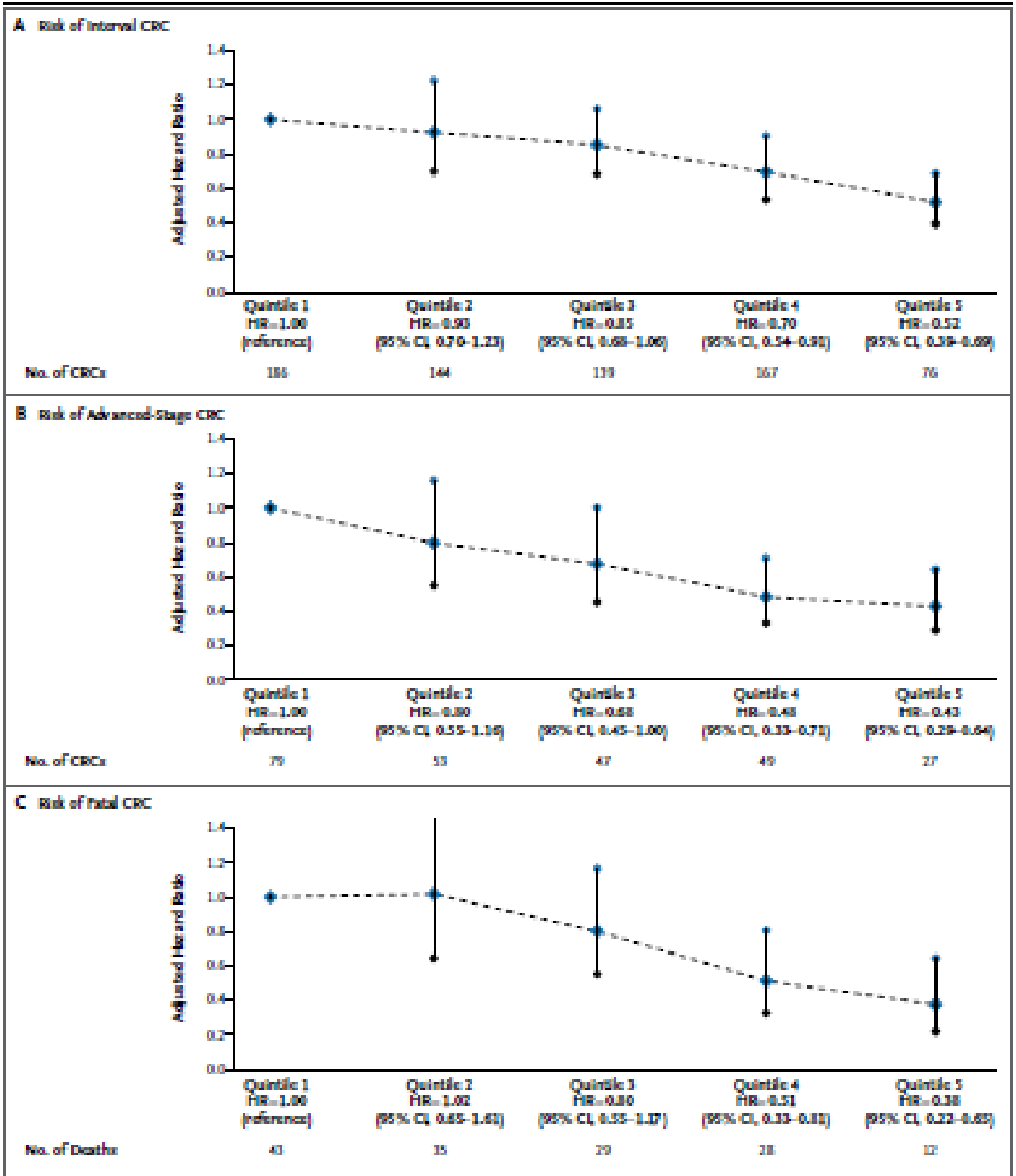
Quality Indicators for Colonoscopy and the Risk of Interval Cancer

Michal F. Kaminski, M.D., Jaroslaw Regula, M.D., Ewa Kraszewska, M.Sc., Marcin Polkowski, M.D., Urszula Wojciechowska, M.D., Joanna Didkowska, M.D., Maria Zwierko, M.D., Maciej Rupinski, M.D., Marek P. Nowacki, M.D., and Eugeniusz Butruk, M.D.

NEJM 2010

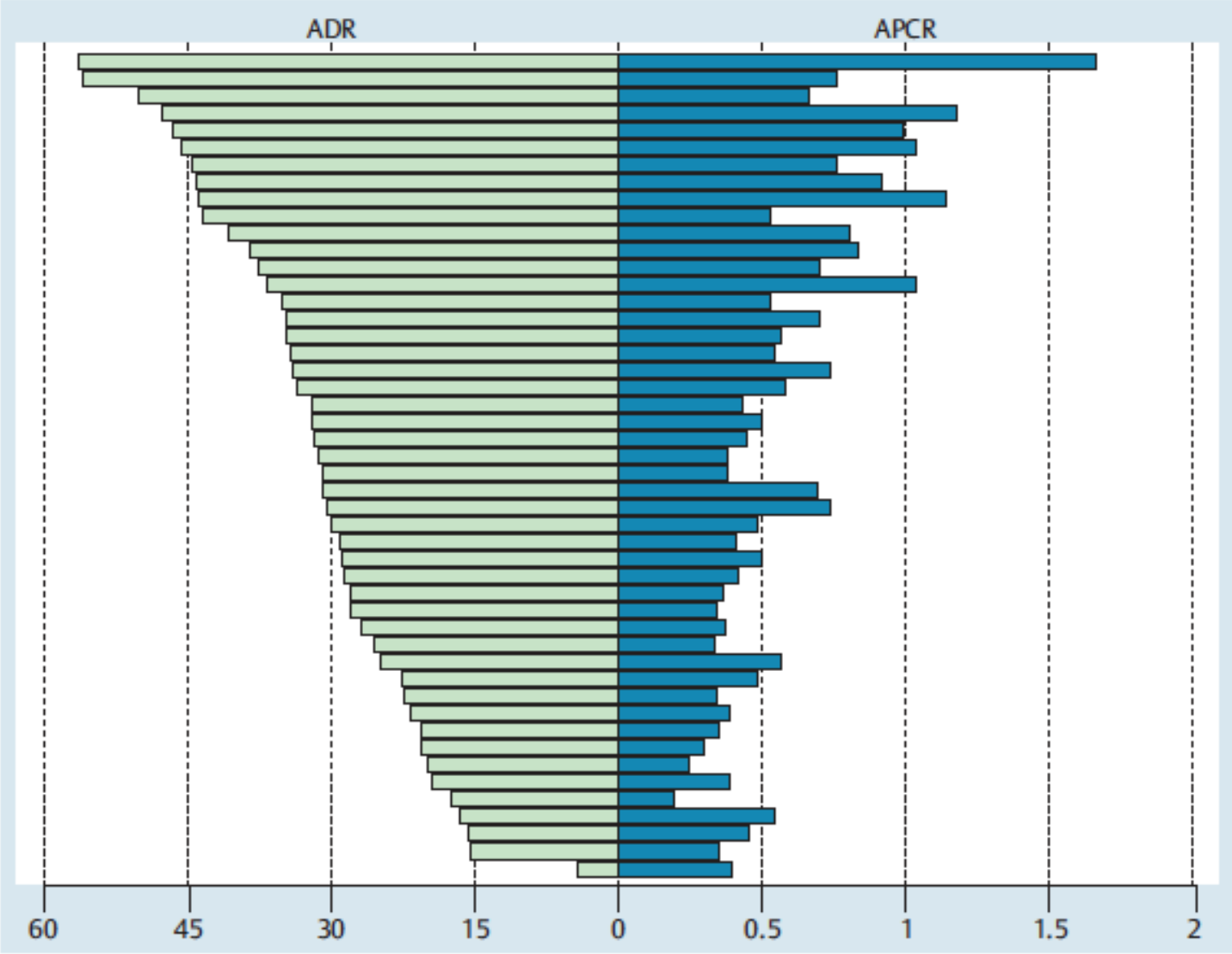


No. at Risk						
ADR <11.0%	15,883	15,805	15,744	15,669	9355	4717
ADR 11.0–14.9%	13,281	13,223	13,182	13,120	7571	4003
ADR 15.0–19.9%	6,607	6,582	6,562	6,539	4022	2529
ADR ≥20.0%	9,255	9,235	9,202	9,166	7155	5548



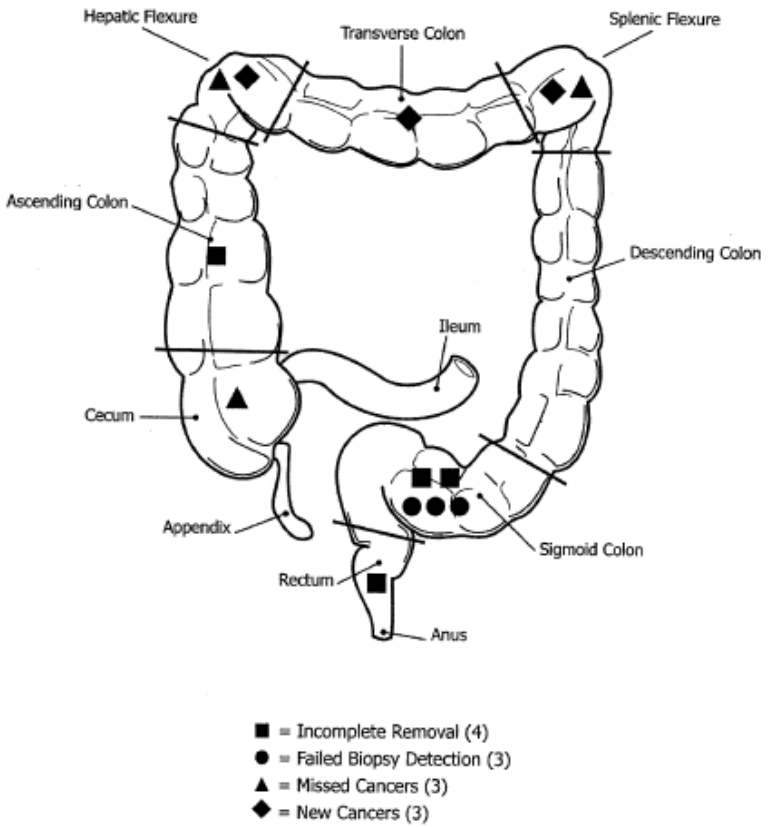
Corley, NEJM 2014

La calidad de los endoscopistas es variable



Jover, Endoscopy 2016

FACTORES DE RIESGO
EXCISION INCOMPLETA ADENOMAS



- Si polipectomía fragmentada: colono de vigilancia en 3-6 meses
- Especialmente en adenomas sesiles y/o mayores de 20 mm

Pabby, GIE 2005

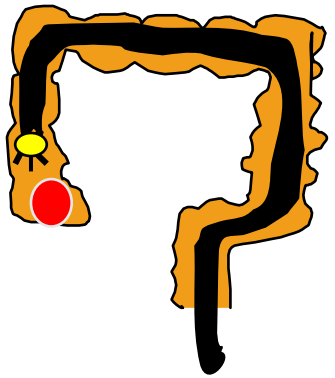
Incomplete Polyp Resection During Colonoscopy—Results of the Complete Adenoma Resection (CARE) Study

HEIKO POHL,[1,2] AMITABH SRIVASTAVA,[3] STEVE P. BENSEN,[2] PETER ANDERSON,[2] RICHARD I. ROTHSTEIN,[2] STUART R. GORDON,[2] L. CAMPBELL LEVY,[2] ARIFA TOOR,[2] TODD A. MACKENZIE,[4] THOMAS ROSCH,[5] and DOUGLAS J. ROBERTSON[1,2]

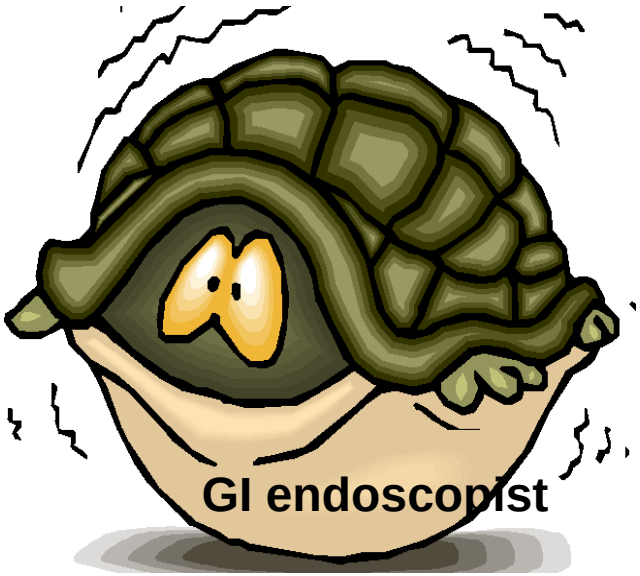
Table 3. Polyp Characteristics Associated With Incomplete Resection of Neoplastic Polyps

	Neoplastic polyps		Relative risk (95% CI)	
Polyp characteristics	All (N = 346), n	Incompletely resected (n = 35) (10.1%), n (%)	Univariate	Multivariate[a]
Size, *mm*				
5–7	172	10 (5.8)	1.00 (reference)	1.00 (reference)
8–9	64	6 (9.4)	1.61 (0.61–4.26)	1.66 (0.62–4.46)
10–14	67	9 (13.4)	2.34 (0.98–5.43)	1.95 (0.87–4.37)
15–20	43	10 (23.3)	4.00 (1.78–9.00)	3.21 (1.41–7.31)
Location in the colon				
Left colon	135	11(8.1)	1.00 (reference)	
Right colon	211	24 (11.4)	1.40 (0.71–2.76)	Not applicable[b]
Location at fold				
Between/on a fold	271	25 (9.2)	1.00 (reference)	
Behind a fold	67	6 (9.0)	0.97 (0.41–2.27)	Not applicable[b]
Morphology				
Nonflat	158	11 (7.0)	1.00 (reference)	1.00 (reference)
Flat	153	19 (12.4)	1.78 (0.88–3.62)	1.45 (0.73–2.91)
Histology				
Adenoma[c]	304	22 (7.2)	1.00 (reference)	1.00 (reference)
SSA/P	42	13 (31.0)	4.28 (2.34–7.83)	3.74 (2.04–6.84)
Resection				
En bloc	286	24 (8.4)	1.00 (reference)	1.00 (reference)
Piecemeal	54	11 (20.4)	2.43 (1.27–4.66)	1.41 (0.66–2.98)
Ease of resection				
Easy	222	17 (7.7)	1.00 (reference)	1.00 (reference)
Moderately difficult	75	10 (13.3)	1.74 (0.83–3.63)	1.56 (0.75–3.24)
Difficult	45	8 (17.8)	2.32 (1.07–5.05)	1.71 (0.67–4.44)

Interval CRC: Reducing the risk
Perform high-quality colonoscopy



- **Monitor quality in practice**
  - Bowel prep
  - Cecal intubation rates
  - ADR – surrogate for interval CRC
  - Adverse events
- **Reduce Inappropriate utilization**
  - Interval < 10 yrs after negative colonoscopy
  - Short surveillance intervals

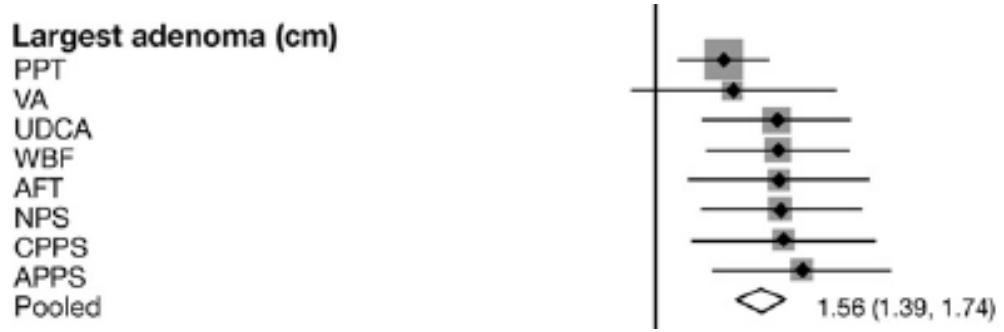


Cedida por D. Lieberman

Factores de riesgo para aparición de nuevos adenomas

NUMERO DE ADENOMAS

TAMAÑO DE LOS ADENOMAS



Martínez, Gastro 2009

Factores de riesgo
Histologia adenomas

Componente velloso

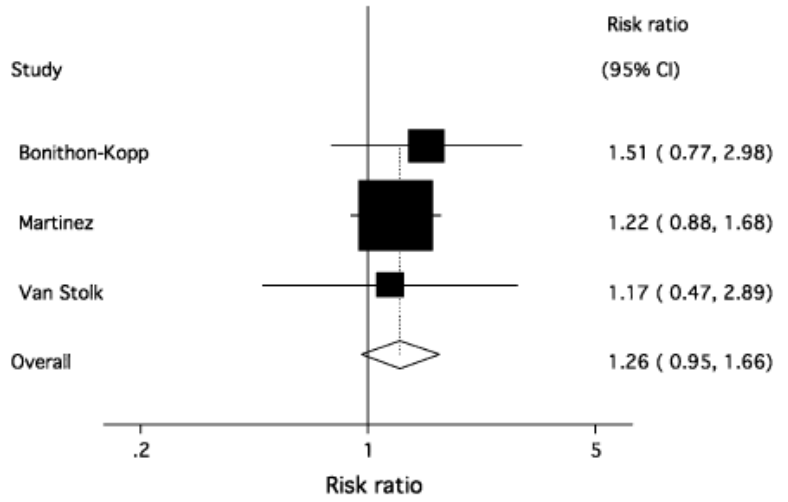


Figure 4. RR of advanced adenoma at 3-year surveillance colonoscopy (van Stolk et al had a 4-year surveillance colonoscopy) in patients with tubulovillous/villous versus tubular adenomas at index colonoscopy. The RRs are 1.51 (95% CI 0.77-2.98) for Bonithon-Kopp et al,[17] 1.22 (95% CI 0.88-1.68) for Martinez et al,[6] and 1.17 (95% CI 0.47-2.89) for van Stolk et al.[8] Data could not be extracted for Winawer et al.[3]

Displasia de alto grado

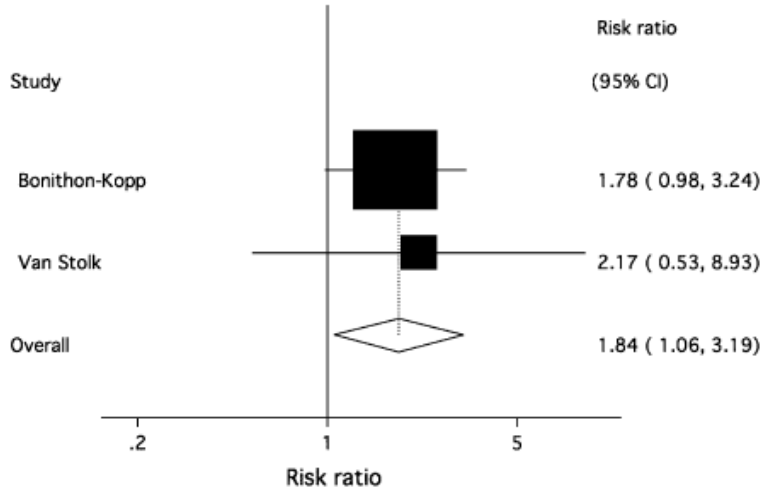


Figure 5. RR of advanced adenoma at 3-year surveillance colonoscopy (van Stolk et al had a 4-year surveillance colonoscopy) in patients with nonmild dysplasia versus mild dysplasia at index colonoscopy. The RRs are 1.78 (95% CI: 0.98-3.24) for Bonithon-Kopp et al[17] and 2.17 (95% CI 0.53-8.93) for van Stolk et al.[8] Data could not be extracted for Martinez et al[6] or Winawer et al.[3]

Saini, GIE 2006

AGA

Guidelines for Colonoscopy Surveillance After Screening and Polypectomy: A Consensus Update by the US Multi-Society Task Force on Colorectal Cancer

DAVID A. LIEBERMAN[*] DOUGLAS K. REX[‡] SIDNEY J. WINAWER[§] FRANCIS M. GIARDIELLO[‖] DAVID A. JOHNSON[¶]
and THEODORE R. LI

*Oregon Health and Science
New York, New York; ¶Johns
Medical Center, Walnut Creek

European guidelines for quality assurance in colorectal cancer screening and diagnosis. First Edition
Colonoscopic surveillance following adenoma removal

Post-polypectomy colonoscopy surveillance: European Society of Gastrointestinal Endoscopy (ESGE) Guideline

R. Lambert[4], C. Pox[5]

ESGE

AGA

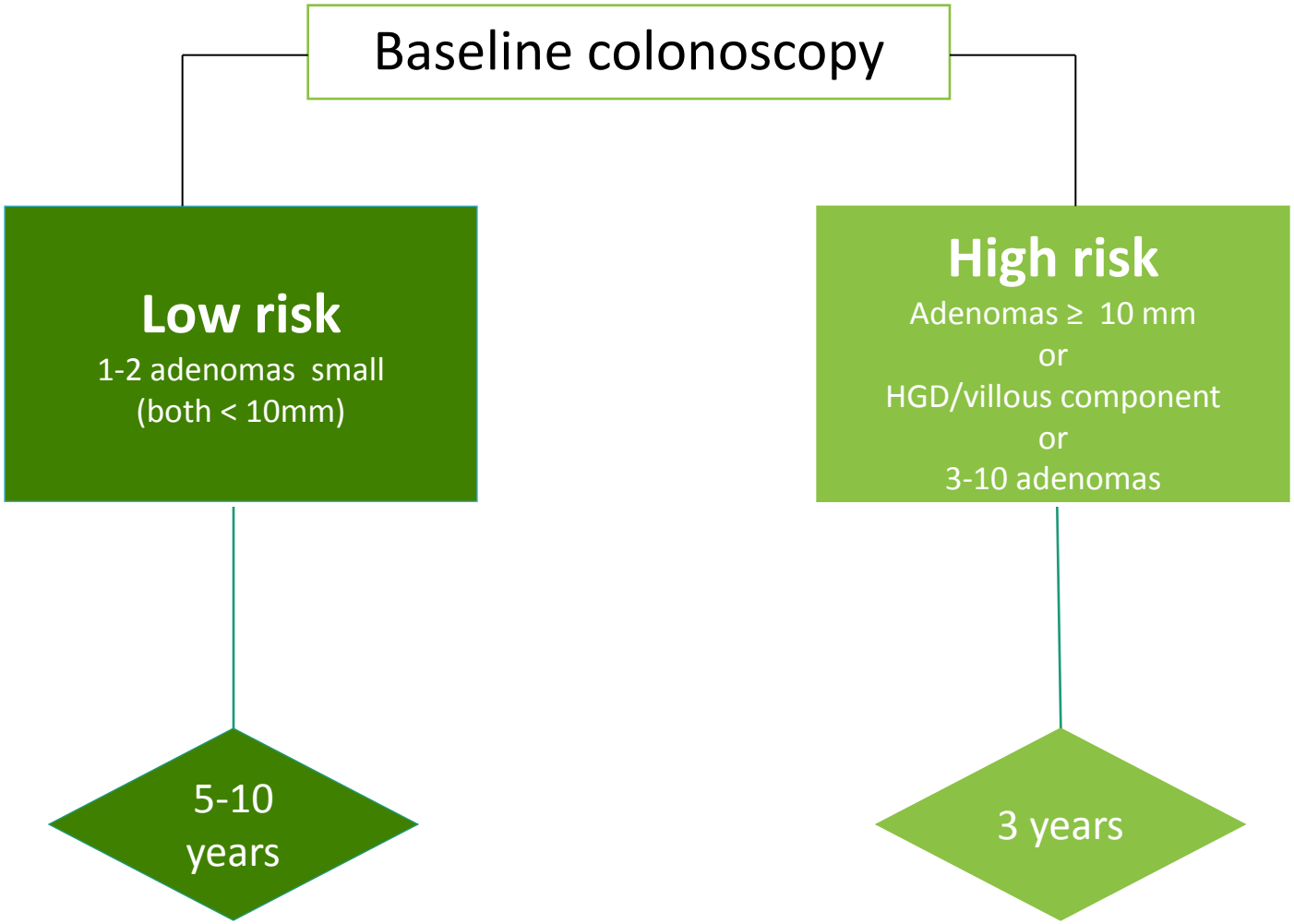
Guidelines for Colonoscopy Surveillance After Screening and Polypectomy: A Consensus Update by the US Multi-Society Task Force on Colorectal Cancer

DAVID A. LIEBERMAN,[*] DOUGLAS K. REX,[‡] SIDNEY J. WINAWER,[§] FRANCIS M. GIARDIELLO,[‖] DAVID A. JOHNSON,[¶] and THEODORE R. LEVIN[#]

Baseline colonoscopy: most advanced finding(s)	Recommended surveillance interval (*y*)	Quality of evidence supporting the recommendation
No polyps	10	Moderate
Small (<10 mm) hyperplastic polyps in rectum or sigmoid	10	Moderate
1–2 small (<10 mm) tubular adenomas	5–10	Moderate
3–10 tubular adenomas	3	Moderate
>10 adenomas	<3	Moderate
One or more tubular adenomas ≥10 mm	3	High
One or more villous adenomas	3	Moderate
Adenoma with HGD	3	Moderate
Serrated lesions		
Sessile serrated polyp(s) <10 mm with no dysplasia	5	Low
Sessile serrated polyp(s) ≥10 mm	3	Low
OR		
Sessile serrated polyp with dysplasia		
OR		
Traditional serrated adenoma		
Serrated polyposis syndrome[a]	1	Moderate

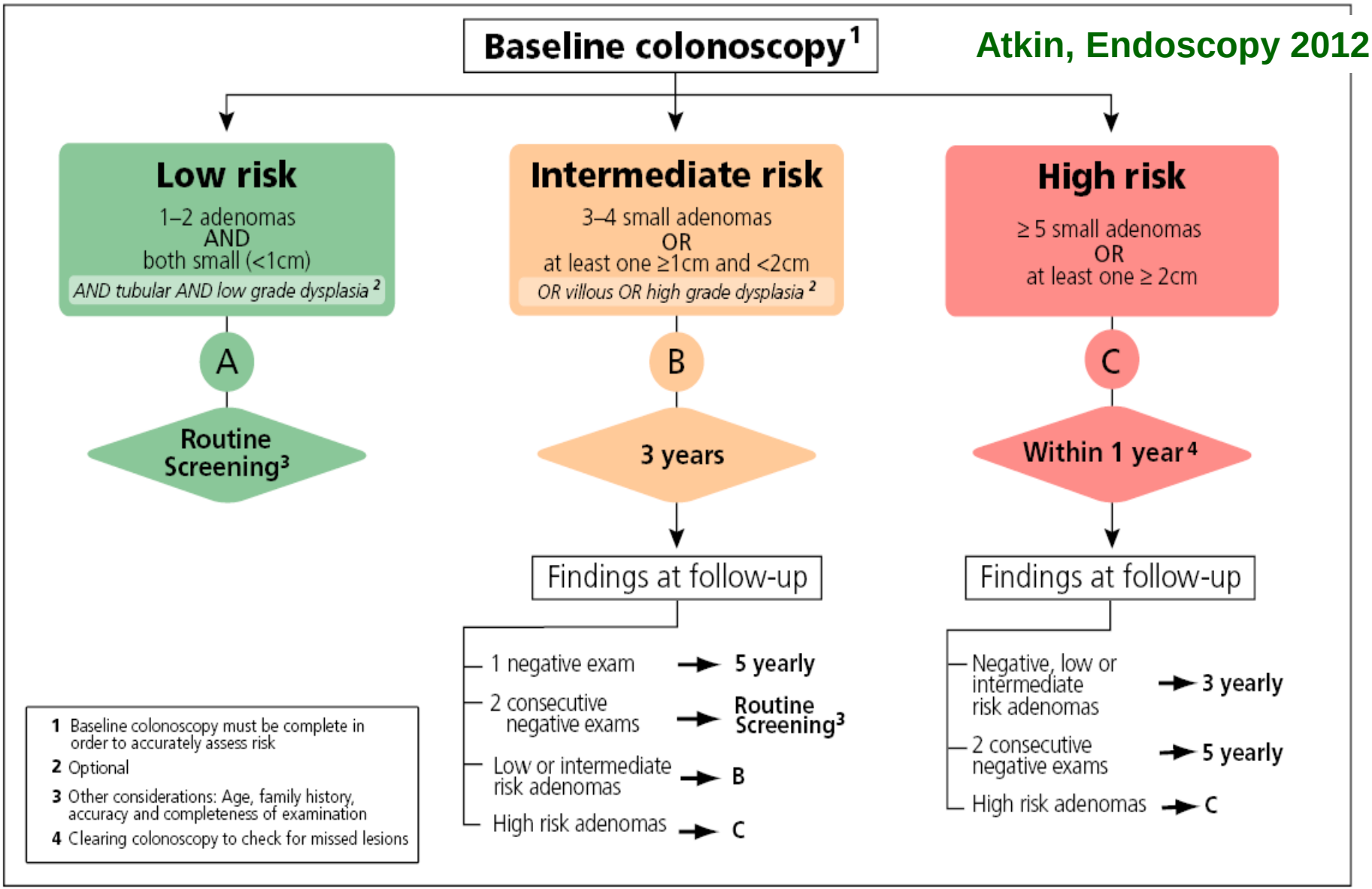
COLONOSCOPIC SURVEILLANCE FOLLOWING ADENOMA REMOVAL

US GUIDELINES

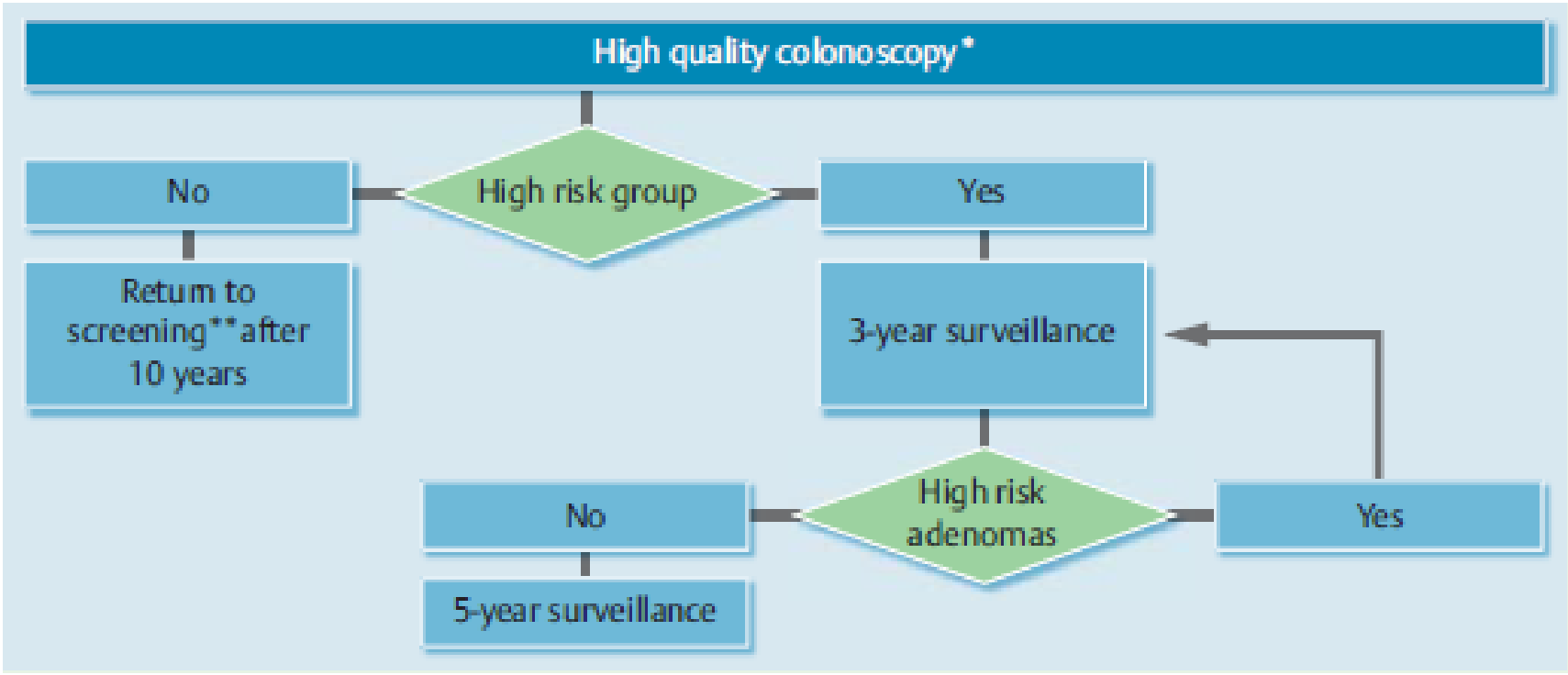


Lieberman, Gastro 2012

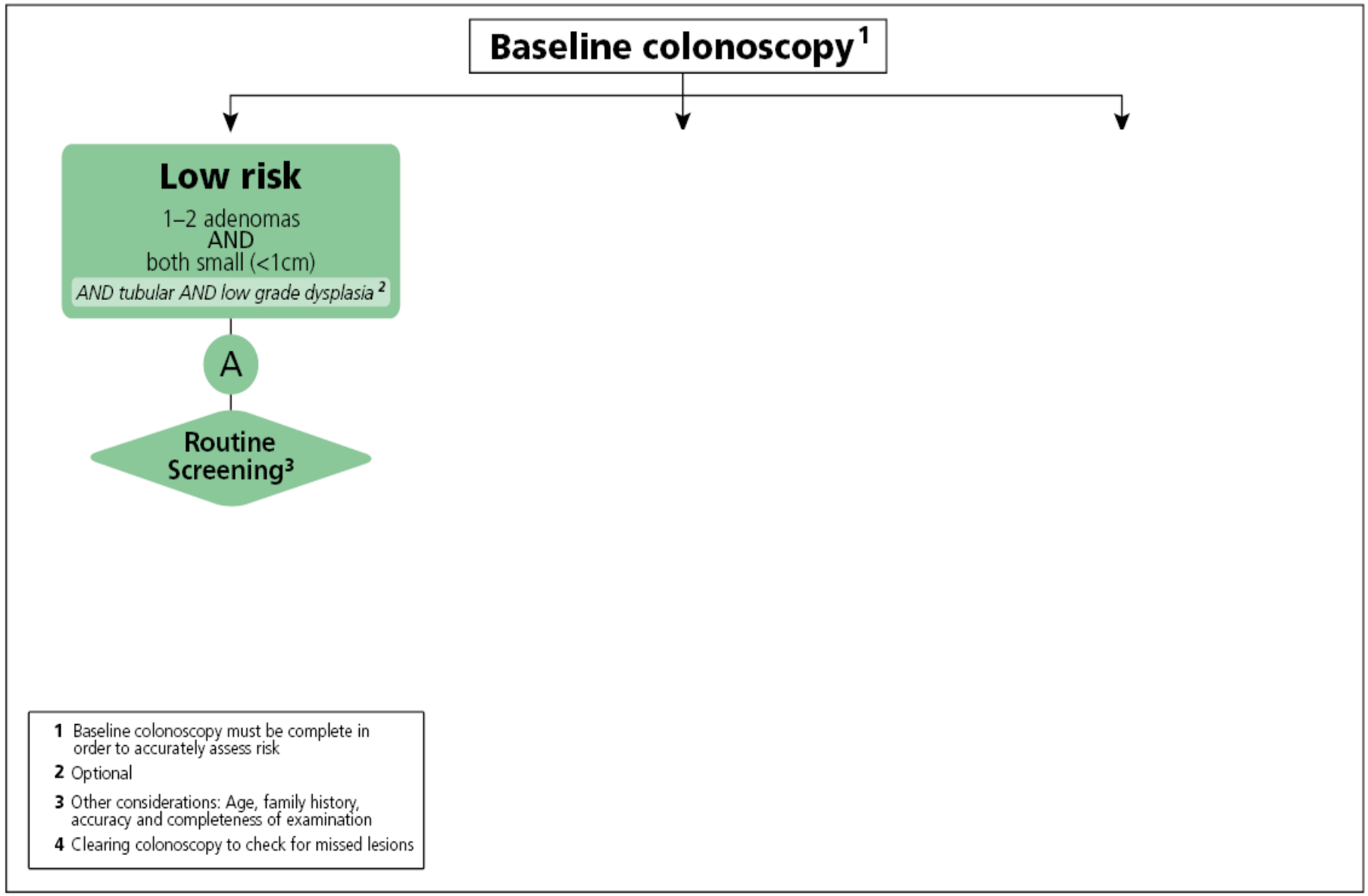
COLONOSCOPIC SURVEILLANCE FOLLOWING ADENOMA REMOVAL (2009)



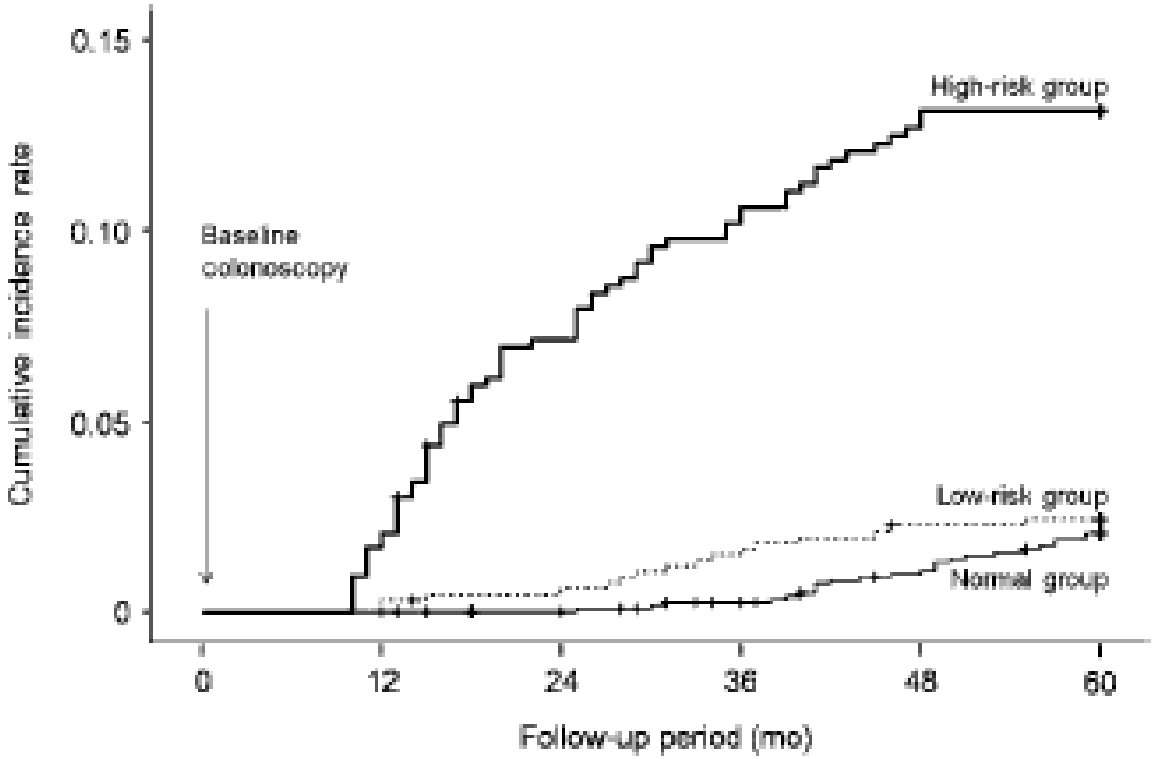
Post-polypectomy colonoscopy surveillance: European Society of Gastrointestinal Endoscopy (ESGE) Guideline



COLONOSCOPIC SURVEILLANCE FOLLOWING ADENOMA REMOVAL (2009)



ADENOMAS DE BAJO RIESGO



HR 1.14 (0.61-2.17)

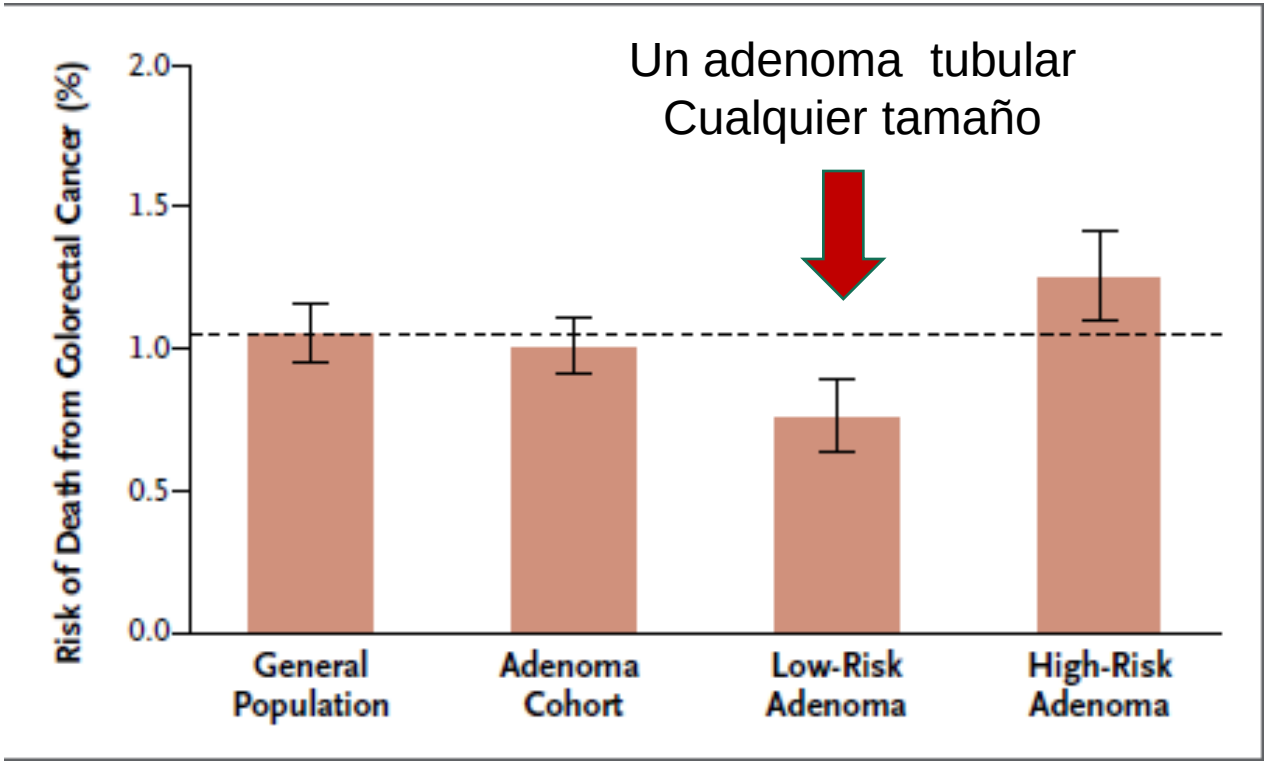
Chung, Gut 2011

The NEW ENGLAND JOURNAL of MEDICINE
ESTABLISHED IN 1812 AUGUST 28, 2014 VOL. 371 NO. 9

Long-Term Colorectal-Cancer Mortality after Adenoma Removal

Magnus Løberg, M.D., Mette Kalager, M.D., Ph.D., Øyvind Holme, M.D., Geir Hoff, M.D., Ph.D., Hans-Olov Adami, M.D., Ph.D., and Michael Bretthauer, M.D., Ph.D.

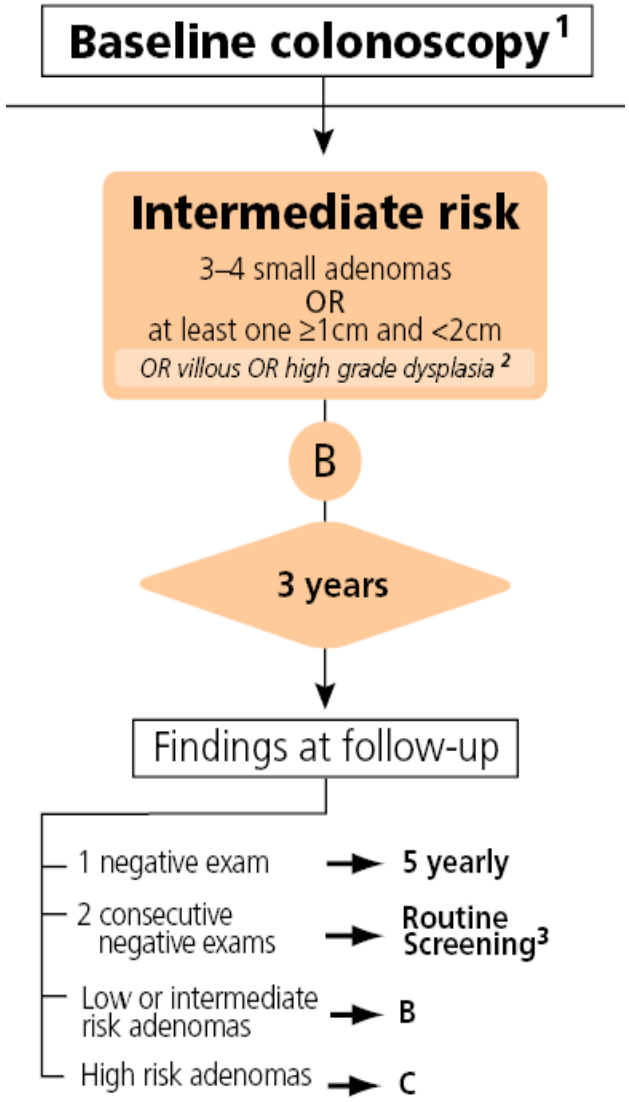
- Estudio noruego: Entorno sin vigilancia
- 40,826 pts con adenomas extirpados
- f/u 7.7 años: Endpoint mortalidad CCR



ADENOMAS DE BAJO RIESGO

- **RECOMENDACION**
  - Cribado habitual
    - Si no cribado: Colonoscopia en 10 años
    - Si cribado: vuelta al programa de cribado
      - Cuándo?
        - 2 años
        - 5 años
        - 10 años

COLONOSCOPIC SURVEILLANCE FOLLOWING ADENOMA REMOVAL (2009)



ADENOMAS AVANZADOS EVIDENCIAS

Table 4. Relative Risk of Advanced Neoplasia Within 5.5 Years Based on Baseline Finding

Baseline finding (n with examination)	No advanced neoplasia, n (%)	Advanced neoplasia, n (%)	RR[a]	95% CI	*P* value	Cancer n (%)	HGD/cancer per 1000 person-yr (95% CI)
No neoplasia (298)	291 (97.6)	7 (2.4)	1.00			1 (0.3)	0.7 (0–2.0)
Tub Ad <10 mm (622)	584 (93.9)	38 (6.1)	2.56	1.16–5.67	.02	4 (0.6)	1.5 (0–2.9)
1 or 2 (496)	473 (95.4)	23 (4.6)	1.92	0.83–4.42	.13	3	1.4 (0–2.9)
>3 (126)	111 (88.1)	15 (11.9)[b]	5.01	2.10–11.96	< .001	1	1.9 (0–5.5)
Tub Ad >10 mm (123)	104 (84.6)	19 (15.5)	6.40	(2.74–14.94)	< .001	1 (0.8)	6.4 (0–13.5)
Villous adenoma (81)	68 (83.9)	13 (16.1)	6.05	(2.48–14.71)	< .001	1 (1.2)	6.2 (0–14.7)
HGD (46)	38 (82.6)	8 (17.4)	6.87	(2.61–18.07)	< .001	2 (4.4)	26.0 (3.2–48.8)
Cancer (23)	15 (65.2)	8 (34.8)	13.56	(5.54–33.18)	< .001	5 (21.7)	74.8 (14.9–134.7)
Number of adenomas[c] at baseline (n)							
1 or 2 (617)	577	40 (6.5)				7 (1.1)	3.3 (1.2–5.5)
3 or 4 (145)	122	23 (15.9)				2 (1.4)	6.6 (0.1–13.0)
5–9 (64)	53	11 (17.2)				3 (4.7)	13.1 (0.0–27.9)
10+ (8)	7	1 (12.5)				0	0.0

Lieberman, Gastro 2007

CRC incidence by baseline risk factors

Baseline risk factor	n	CRC cases	Incidence per 10^5 py	Multivariable HR (95% CI)	p value
Adenoma size (mm)					0.0335
<10	1029	10	120	1	
10-19	6857	116	198	1.97 (1.01-3.81)	
≥20	4058	84	246	2.28 (1.06-4.50)	
Adenoma dysplasia					0.0033
High grade	1994	51	322	1.69 (1.21-2.36)	
Proximal polyps					0.0004
Yes	3649	73	254	1.76 (1.30-2.38)	
Colonoscopy					0.0001
Incomplete or not known	2928	86	299	1.80 (1.34-2.41)	
Bowel prep quality					0.0452
Excellent or good	3956	53	159	1	
Satisfactory	1922	29	213	1.51 (0.95-2.39)	
Poor	671	16	356	2.09 (1.19-3.67)	

Adenoma surveillance and colorectal cancer incidence: a retrospective, multicentre, cohort study

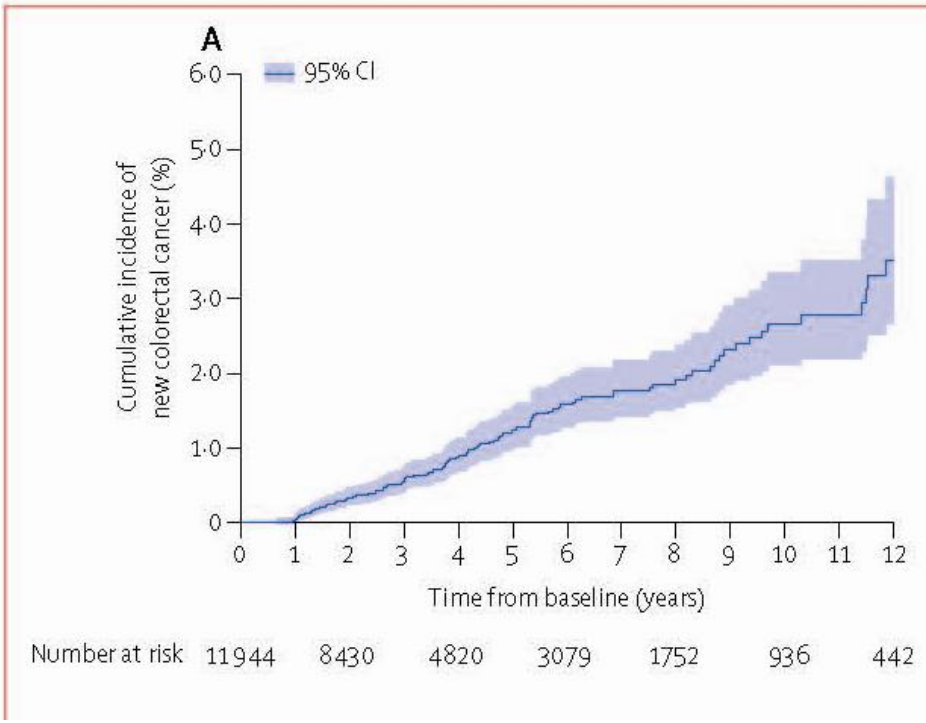
Wendy Atkin, Kate Wooldrage, Amy Brenner, Jessica Martin, Urvi Shah, Sajith Perera, Fiona Lucas, Jeremy P Brown, Ines Kralj-Hans, Paul Greliak, Kevin Pack, Jill Wood, Ann Thomson, Andrew Veitch, Stephen W Duffy, Amanda J Cross

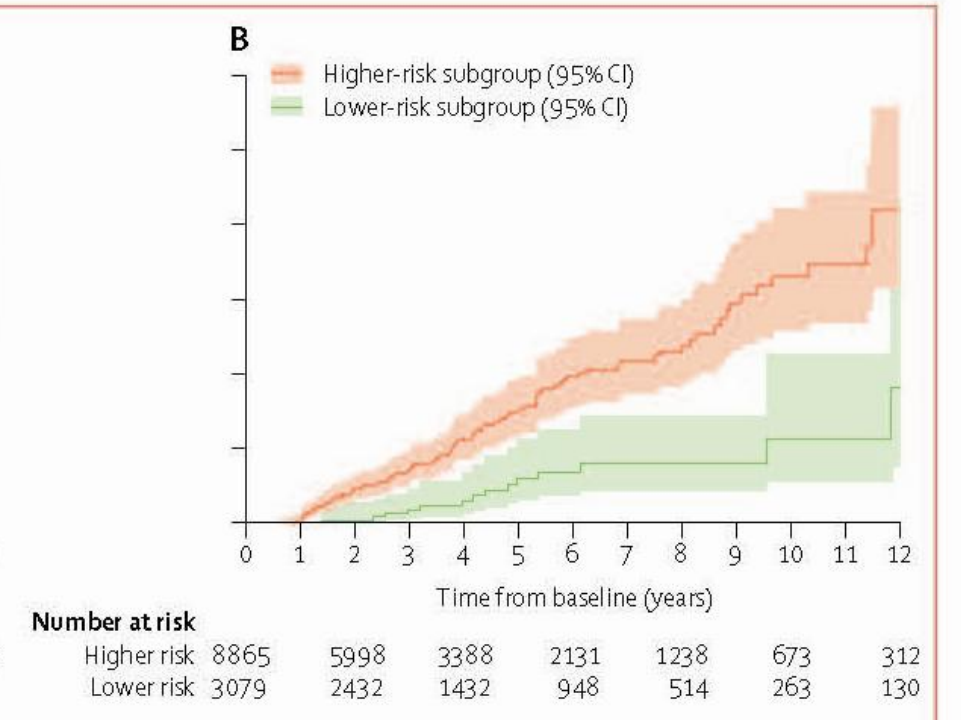
Lancet Oncology Published online April 27,2017

Cumulative CRC incidence after baseline

Whole Intermediate Cohort

Stratified by Subgroup





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Wendy Atkin, Kate Wooldrage, Amy Brenner, Jessica Martin, Urvi Shah, Sajith Perera, Fiona Lucas, Jeremy P Brown, Ines Kralj-Hans, Paul Greliak, Kevin Pack, Jill Wood, Ann Thomson, Andrew Veitch, Stephen W Duffy, Amanda J Cross

Atkin et al., Lancet Oncology Published online April 27,2017

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RANDOMIZED COMPARISON OF SURVEILLANCE INTERVALS AFTER COLONOSCOPIC REMOVAL OF NEWLY DIAGNOSED ADENOMATOUS POLYPS

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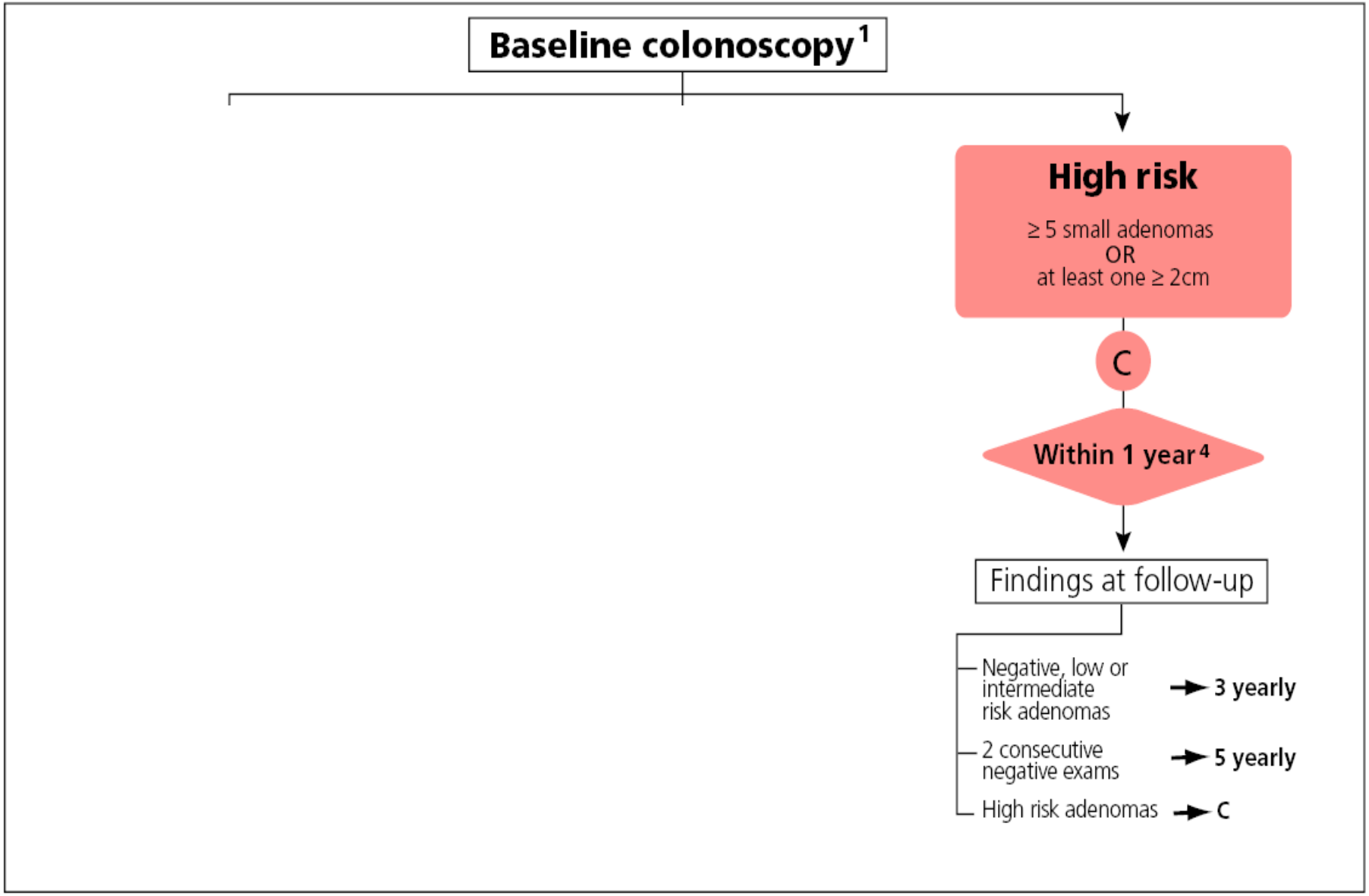
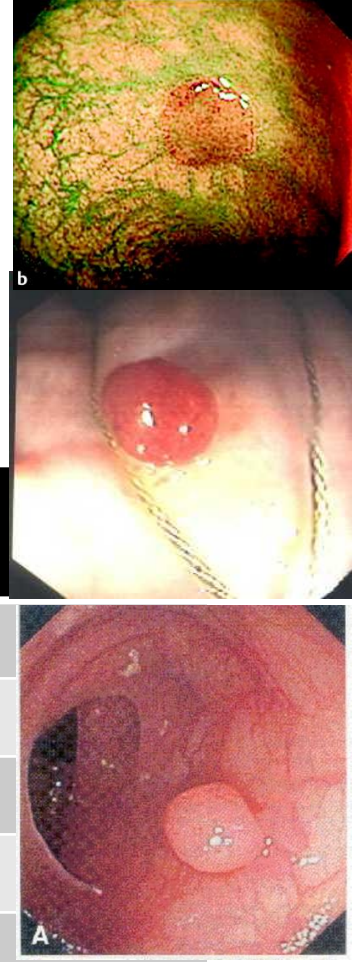
FINDING	2 EXAMINATIONS (N = 338)	1 EXAMINATION* (N = 428)	RELATIVE RISK (95% CI)†	P VALUE
	no. (%) of patients			
Any adenoma detected	141 (41.7)	137 (32.0)	1.3 (1.1–1.6)	0.006
Adenoma with advanced pathological features‡	11 (3.3)§	14 (3.3)	1.0 (0.5–2.2)	0.99

COLONOSCOPIC SURVEILLANCE FOLLOWING ADENOMA REMOVAL (2009)



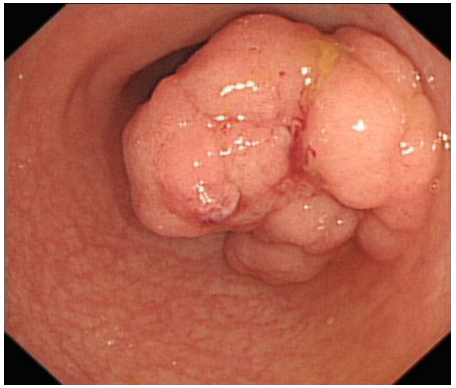
Multiplicidad



Baseline adenoma #	% with Advanced Adenoma at f/u (95% CI)	Adjusted OR
1	8.6 (7.8-9.3)	1.00
2	12.7 (11.3-14.1)	1.39 (1.17-1.66)
3	15.3 (12.9-17.6)	1.85(1.46-2.34)
4	19.6 (15.3-19.3)	2.23 (1.71-3.40)
5+	24.1 (19.8-28.5)	3.87 (2.76-5.42)
P-trend		<0.0001

Martínez, Gastroenterology 2009

Tamaño

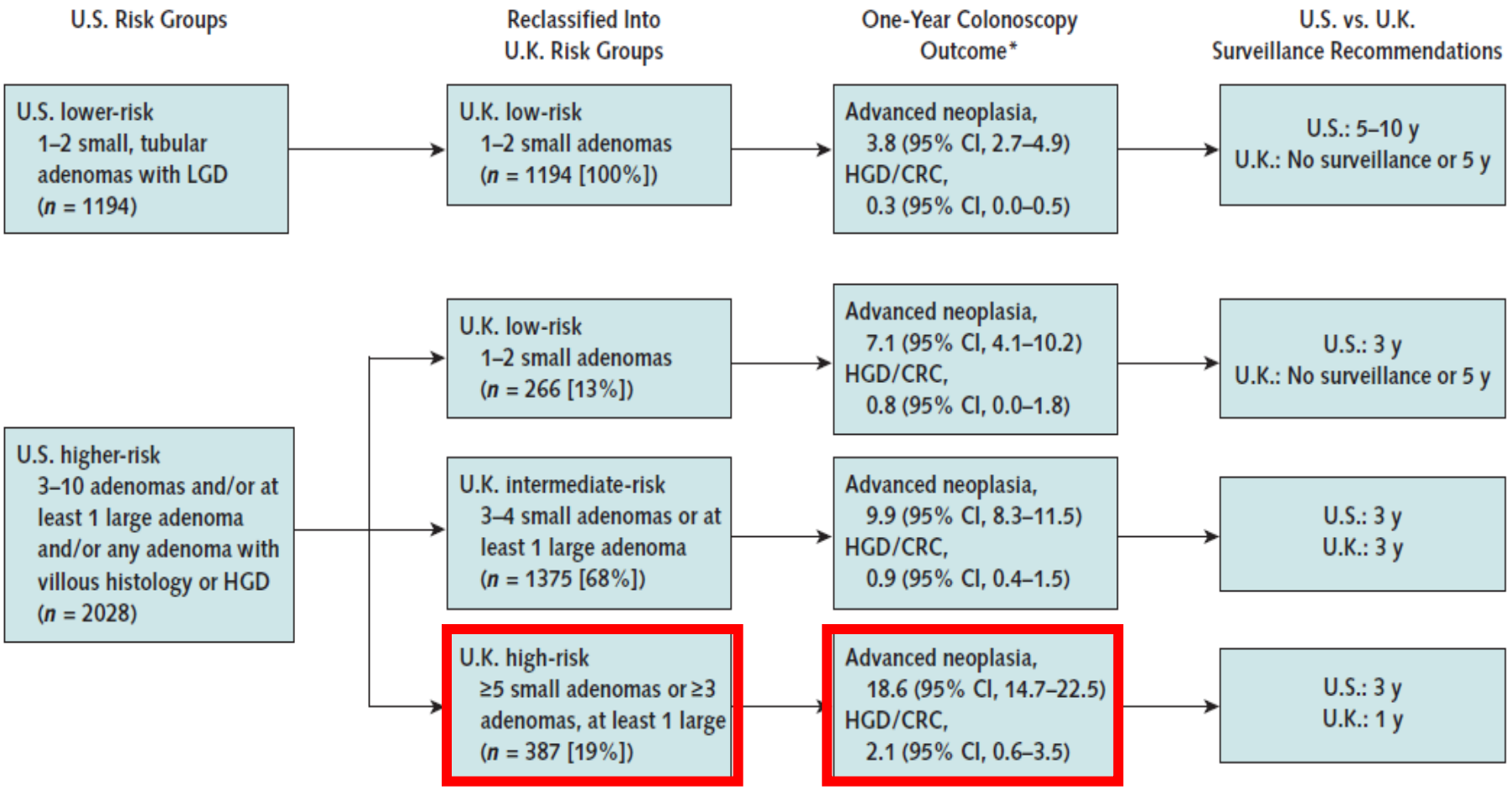


Baseline adenoma size	% with Advanced Adenoma at f/u (95% CI)	Adjusted OR
< 5 mm	7.7 (6.6-8.7)	1.00
5-9	8.7 (7.7-9.7)	1.17 (0.95-1.42)
10-19	15.9 (14.5-17.4)	2.27 (1.84-2.78)
20+	19.3 (16.4-22.3)	2.99 (2.24-4.00)
P-trend		<0.0001

Martínez, Gastroenterology 2009

One-Year Risk for Advanced Colorectal Neoplasia: U.S. Versus U.K. Risk-Stratification Guidelines

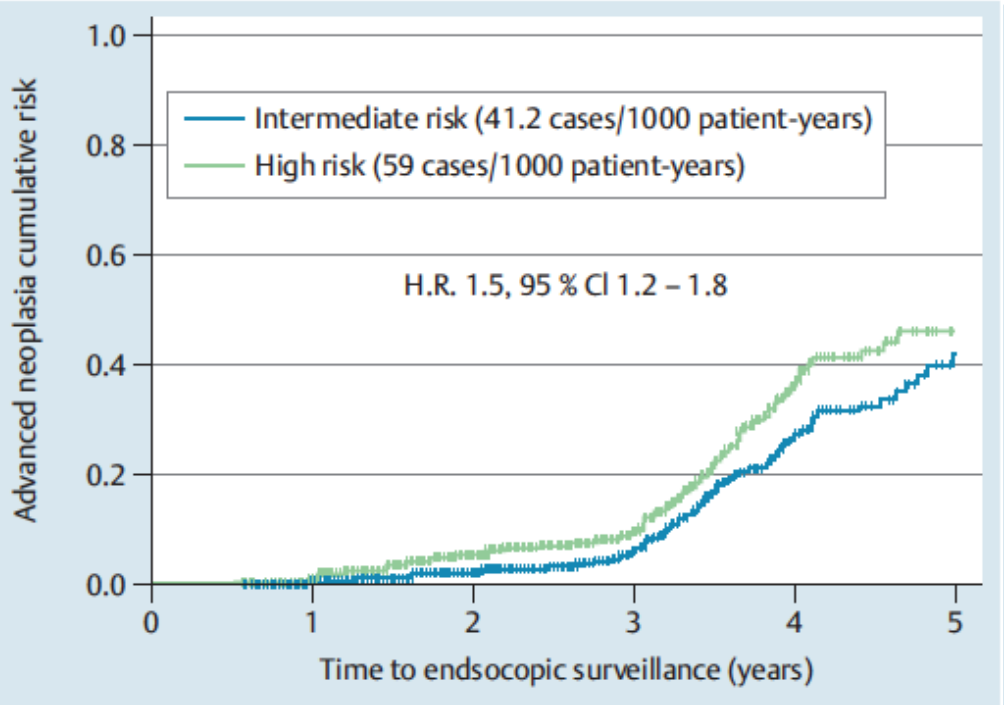
María Elena Martínez, PhD*; Patricia Thompson, PhD; Karen Messer, PhD; Erin L. Ashbeck, MPH; David A. Lieberman, MD; John A. Baron, MD; Dennis J. Ahnen, MD; Douglas J. Robertson, MD; Elizabeth T. Jacobs, PhD; E. Robert Greenberg, MD; Amanda J. Cross, PhD; and Wendy Atkin, PhD*



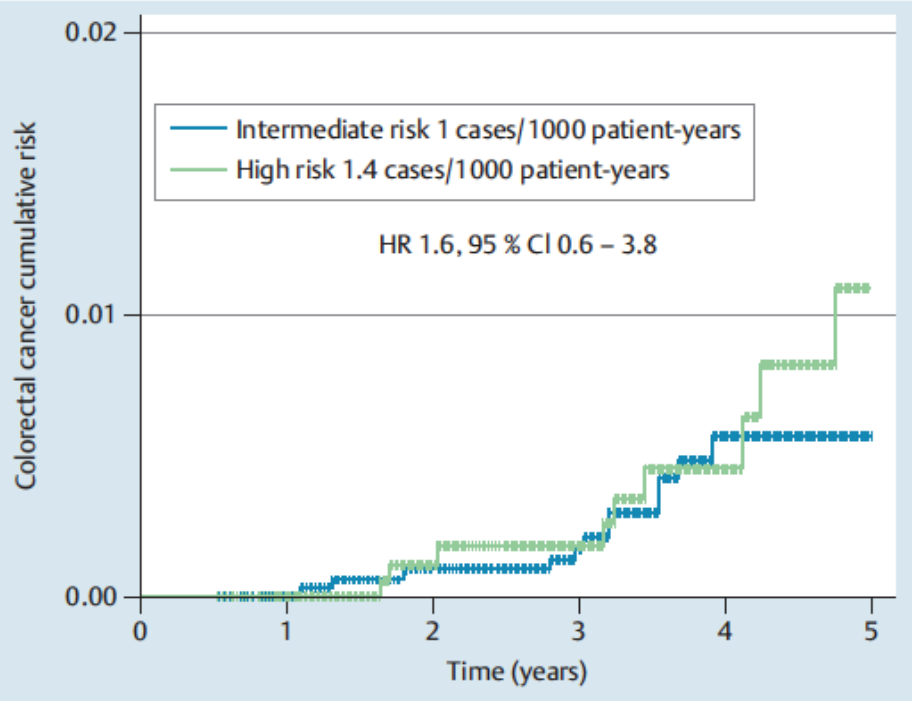
Incidence of advanced neoplasia during surveillance in high- and intermediate-risk groups of the European colorectal cancer screening guidelines

Endoscopy 2016

Authors Joaquín Cubiella[1], Fernando Carballo[2], Isabel Portillo[3], José Cruzado Quevedo[4], Dolores Salas[5], Gemma Binefa[6], Núria Milà[6], Cristina Hernández[7], Montse Andreu[8], Álvaro Terán[9], Eunate Arana-Arri[10], Akiko Ono[2], María José Valverde[4], Luis Bujanda[11], Vicent Hernández[12], Juan Diego Morillas[13], Rodrigo Jover[14], Antoni Castells[15]



Adenoma avanzado



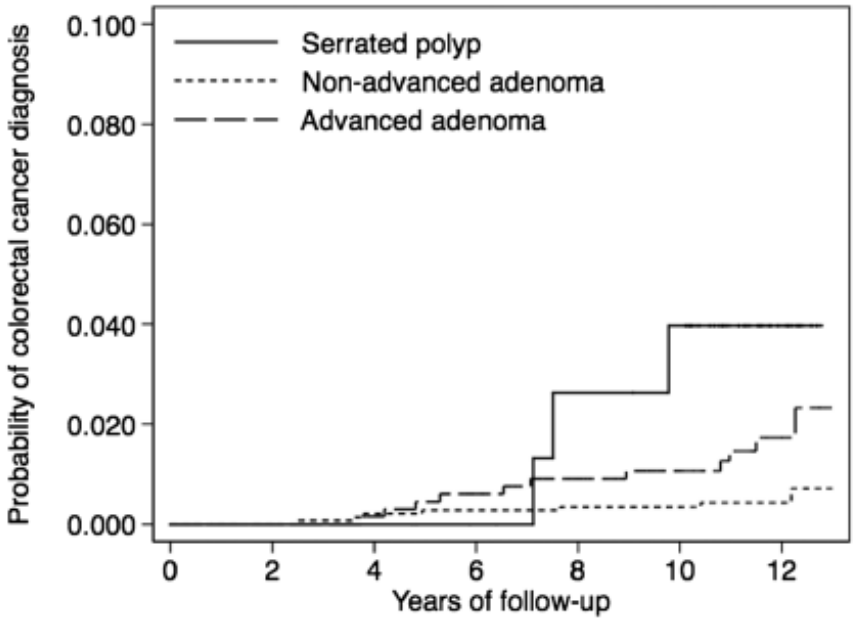
Cáncer

POLIPOS SERRADOS

Table 4. Estimated 10-Year Risk of Colorectal Cancer for Each Polyp Type

	Cases/controls	Adjusted OR (95% CI)	Estimated 10-year risk[a]
SSA/P with synchronous conventional adenomas	30/61	2.66 (1.70–4.16)	2.47%
SSA/P without synchronous conventional adenomas	49/81	3.40 (2.35–4.91)	3.16%
SSA/P with cytologic dysplasia	20/25	4.76 (2.59–8.73)	4.43%
SSA/P without cytologic dysplasia	59/117	2.75 (1.99–3.80)	2.56%
Conventional adenomas without SSA/P	727/1631	2.50 (2.24–2.80)	2.33%
Traditional serrated adenomas overall	14/17	4.84 (2.36–9.93)	4.50%
Hyperplastic polyps only	55/235	1.30 (0.96–1.77)	1.21%

Erichsen, Gastroenterology 2016



Holme, Gut 2015

What to do after 1st surveillance?

		Advanced Neoplasia at 2nd Surveillance		
Baseline CSP	**1st Surv.**	**Pinsky 2009 PLCO**	**Laiyema, 2009; PPT**	**Robertson 2009**
HRA*	**HRA**	19.3%	30.6%	18.2%
	LRA	6.7%	8.9%	13.6%
	No adenoma	5.9%	4.8%	12.3%
LRA	**HRA**	15.6%	6.9%	20.0%
	LRA	5.7%	4.7%	9.5%
	No adenoma	3.9%	2.8%	4.9%
No Adenoma	**HRA**	11.5%		
	LRA	4.7%		
`	No adenoma	3.1%		

Cedida por D. Lieberman

Cuestiones sin resolver

1. ¿Deberíamos vigilar a los adenomas de bajo riesgo?
2. ¿Son los intervalos de vigilancia apropiados?
3. ¿Cuáles son las razones para la falta de adherencia a las guías?
4. ¿Merece la pena diferenciar entre adenomas de riesgo intermedio y alto?
5. ¿Debemos vigilar a los pólipos serrados? ¿cómo?
6. ¿Cuáles deben ser los intervalos de vigilancia tras la primera colonoscopia de seguimiento?
7. ¿Cuál es la relación entre la calidad de la colonoscopia basal y la vigilancia?
8. ¿Sabemos suficiente sobre la historia natural de secuencia adenoma carcinoma? ¿Hay algo más allá del tamaño y el número?
9. ¿Podemos utilizar TSOH en vigilancia?
10. ¿Tiene importancia la historia familiar o la localización de los adenomas?

Quality in the Procedural Practice of Colonoscopy with a focus on surveillance after polyp detection: A DELPHI PROCESS.

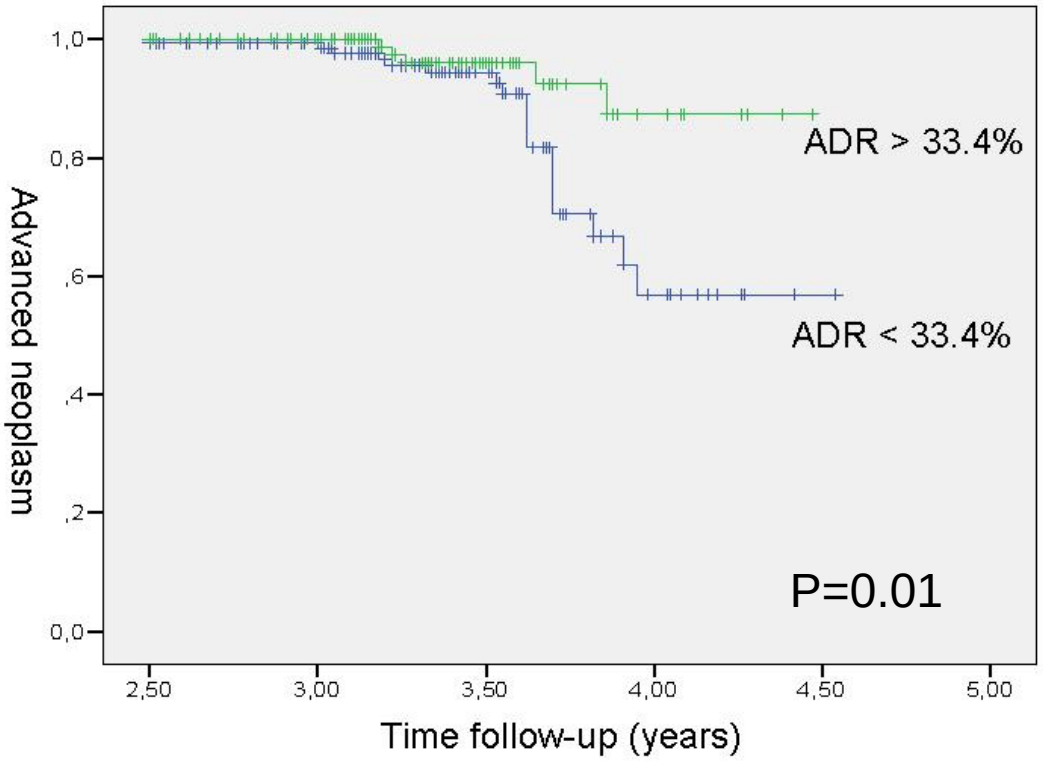
Rodrigo Jover, Evelien Dekker, Cesare Hassan, Robert Schoen, María Pellisé, Uri Ladabaum on behalf of the WEO Expert Working Group of Surveillance after colonic neoplasm.

PROPOSAL OF CHECK-LIST

- ❑ The whole cecum has been inspected, including ileoceal valve and appendiceal orifice
- ❑ Landmarks of the cecum have been documented by photograph
- ❑ The endoscopy report contains information about
  - ❑ Total number of polyps, removed polyps and retrieved polyps
  - ❑ Size of each polyp
  - ❑ Location of each polyp
  - ❑ Morphology of each polyp
  - ❑ Method of excision of each polyp
  - ❑ Assessment of the completeness of excision
  - ❑ Use of piecemeal or “en bloc” resection
- ❑ The pathology report contains information about
  - ❑ The total number of adenomas and serrated polyps
  - ❑ The histopathological diagnosis of each polyp
  - ❑ The presence of villous component in each polyp
  - ❑ The grade of dysplasia of each polyp
- ❑ Quality of bowel preparation has been reported using a validated scale and is considered as adequate

WEO
World Endoscopy Organization

La paradoja de la detección y la vigilancia



Mangas, GIE submitted

El riesgo de neoplasia avanzada en colonoscopia de vigilancia depende de la calidad del endoscopista que hace la colonoscopia basal

EPoS trials
European Polyp Surveillance

European Polyp Surveillance Trial

Baseline colonoscopy (all polyps removed)

EPoS I
Low risk adenomas
13,746 patients

EPoS II
High risk adenomas
13,704 patients

EPoS III
Serrated polyps

0 — 1:1 randomization

3 — Surveillance colonoscopy

5 — Surveillance colonoscopy

End point acquisition:. Advanced neoplasia

10 — Surveillance colonoscopy

OBSERVATION

End point acquisition: Colorectal cancer incidence

Jover
Endoscopy 2016

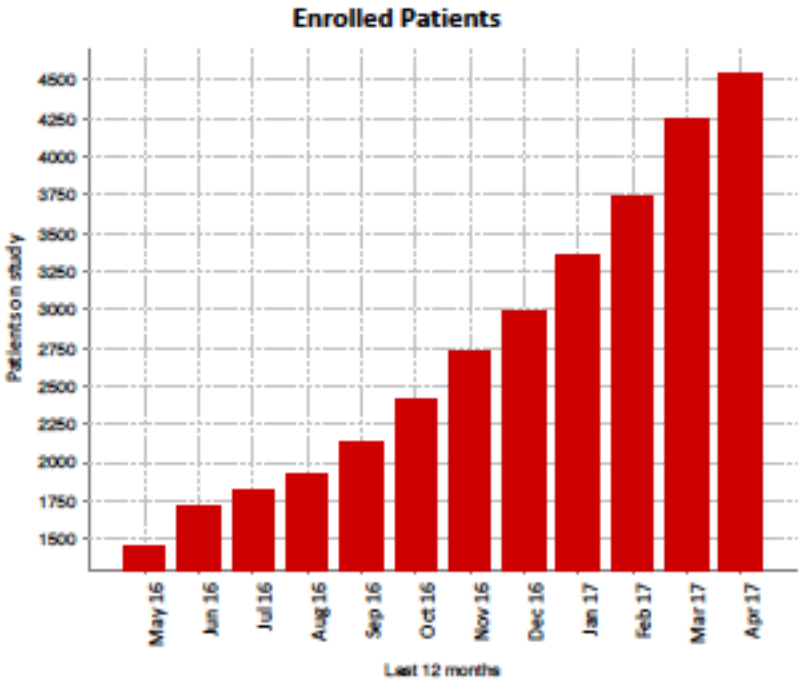
worldatlasbook.com

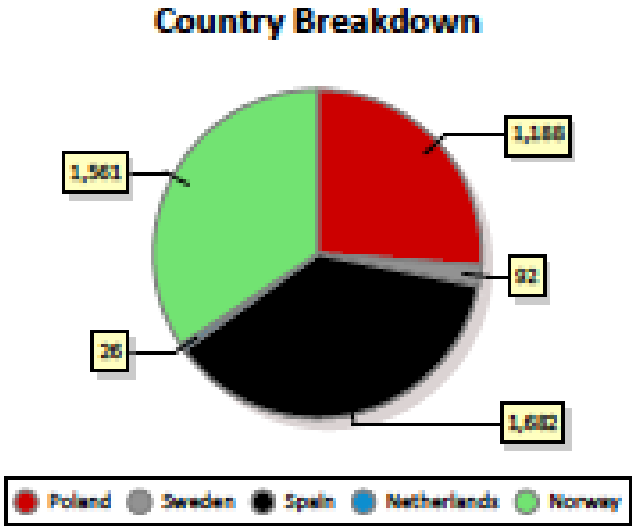
Europe

Map not to scale


La Coruña
Santiago de Compostela
Lugo
Ponte
Santander
Bilbao
Vitoria-Gasteiz
Pamplona
León
Logroño
Burgos
Huesca
Gerona
Zamora
Soria
Zaragoza
Lérida
Salamanca
Segovia
Guadalajara
Avila
Teruel
Cuenca
Castellón de la Plana
Palma de Mallorca
Cáceres
Toledo
Valencia
Badajoz
Mérida
Ciudad Real
Albacete
Córdoba
Jaén
Huelva
Granada
Málaga
Almería
Cádiz
Ceuta
Melilla
Las Palmas de Gran Canaria
GALICIA
CANTABRIA
NAVARRA
LA RIOJA
CASTILLA Y LEÓN
COMUNIDAD VALENCIANA
EXTREMADURA
CASTILLA - LA MANCHA
ANDALUCÍA
ISLAS BALEARES
ISLAS CANARIAS
EPoS

European Polyp Surveillance Trial





WHAT IS RISK?

HIGH RISK

LOW RISK

RISK OF METACRONOUS CRC

GUIA AEG-SEMFyC-SEED-SEE

- **POLIPOS QUE NO REQUIEREN VIGILANCIA**
  - Pólipos hiperplásicos <10mm en recto-sigma
  - 1-2 adenomas tubulares con DBG
  - Pólipos serrados sin displasia < 10 mm
- **POLIPOS QUE REQUIEREN VIGILANCIA**
  - Adenomas ≥10mm
  - Componente velloso o DAG
  - ≥ 3 adenomas
  - P. serrados ≥10mm o con displasia

GUIA AEG-SEMFyC-SEED-SEE

POLIPOS QUE NO REQUIEREN SEGUIMIENTO

SOH a los 5 años o CS a los 10 años

CS seguimiento

Recomendación según las lesiones identificadas

POLIPOS QUE REQUIEREN SEGUIMIENTO

CS a los 3 años

Si normal o lesiones que no requieren vigilancia CS a los 5 años

Si lesiones que requieren vigilancia CS a los 3 años

Si 2 CSs consecutivas normales retorno al cribado o CS a los 10 años

ASOCIACIÓN ESPAÑOLA DE GASTROENTEROLOGÍA

semFYC Sociedad Española de Medicina de Familia y Comunitaria

SOCIEDAD ESPAÑOLA DE ENDOSCOPIA DIGESTIVA

SOCIEDAD ESPAÑOLA DE EPIDEMIOLOGÍA

GUIA AEG-SEMFyC-SEED-SEE

SITUACIONES ESPECIALES

Indicación en Unidad de endoscopias

Resección fragmentada de lesión >20mm
Dudas sobre resección incompleta
Mucosectomía "LST" >40mm

↓

Revisión a 4-6m

↓

CS a los 3 años

Síndrome de Poliposis Serrada
≥10 pólipos y 50% serrados
≥ 10 adenomas

↓

Consultas de Alto Riesgo
Consejo genético

RESUMEN

- La colonoscopia de vigilancia debe ser usada con prudencia: evitar sobreutilización
- Escasa evidencia para mucha carga de trabajo
- Imprescindible colonoscopia de calidad: colono completa, polipectomía completa, limpieza completa
- Necesario generar evidencias
- Propuesta de nueva guía española para estudio y discusión con programas de cribado