UK SPECC program – optimising management of the early lesion

Neil Borley
Cheltenham General Hospital
on behalf of the SPECC programme team
What is SPECC?

“SPECC is a national development programme, focussed on the treatment of small (T1) tumours and significant polyps”

• Multidisciplinary – surgeons, gastroenterologists, radiologists, pathologists, oncologists, nurse specialists, MDT co-ordinators
Why the need? Why are we here?

• Early Rectal Cancer MDTs
Why the need? Why are we here?

Assessment Protocol for Early Rectal Cancer

10-1C-119d The NSSG, in consultation with the MDTs, should agree network-wide guidelines for the assessment of patients with early rectal cancer. It should specify at least the following:

- an investigation protocol specifying the imaging techniques and selection criteria for identifying patients with T1 rectal cancer which are suitable for local resection. The protocol should specify the role of MRI scanning;
- that rectal endosonography should be used in that part of the protocol which deals with selection for suitability for trans-anal endoscopic microsurgery (TEMS), if patients are referred for this procedure.

Notes:

- The term 'local resection' is defined here, for the purposes of peer review, as a resection procedure intended to achieve complete local removal of malignant disease from the primary site, but which does not involve the resection of the full circumference of the bowel and removal of a complete segment.
- Specific surgical techniques as agreed in the network, may be named in the protocol such as 'endo anal resection', 'endoscopic mucosal resection', etc. The details of procedures are not subject to review except for the requirement for rectal endosonography prior to the procedure referred to as TEMS.

Compliance: The protocol agreed by the Chair of the NSSG.
Why the need? Why are we here?

- Early Rectal Cancer MDTs
- NBCSP
# Colorectal Polyp Cancers in the NHS Bowel Cancer Screening Programme

**T.J.W. Lee**\(^1,2\), C. Nickerson\(^3\), R.Q. McNally\(^2\), M.D. Rutter\(^4\)

\(^1\) Endoscopy, University Hospital of North Tees, Stockton on Tees, \(^2\) Institute of Health and Society, Newcastle University, Newcastle, \(^3\) NHS Cancer Screening, Sheffield, \(^4\) Tees Bowel Cancer Screening Centre, University Hospital of North Tees, Stockton on Tees, United Kingdom

<table>
<thead>
<tr>
<th>Size</th>
<th>Number of polyp cancers</th>
<th>Total number of polyps</th>
<th>Percentage of all polyps which were polyp cancers by size group</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-9 mm</td>
<td>103</td>
<td>34959</td>
<td>0.29%</td>
</tr>
<tr>
<td>10-19 mm</td>
<td>370</td>
<td>8425</td>
<td>4.39%</td>
</tr>
<tr>
<td>20-29 mm</td>
<td>240</td>
<td>3008</td>
<td>7.98%</td>
</tr>
<tr>
<td>≥30 mm</td>
<td>174</td>
<td>1705</td>
<td>10.2%</td>
</tr>
<tr>
<td>Size not recorded</td>
<td>34</td>
<td>957</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>921</td>
<td>49054</td>
<td><strong>1.88%</strong></td>
</tr>
</tbody>
</table>

18th UEGW 2010
Why the need? Why are we here?

- Early Rectal Cancer MDTs
- NBCSP
- ‘Significant Rectal Neoplasm’
Lesion morphology and unexpected malignancy in Significant Rectal Neoplasms

Scandinavian TEMS

Neil Borley

Cheltenham Colorectal


The significant rectal neoplasm and mucosectomy by transanal endoscopic microsurgery.

Borley NR¹, Wheeler JM.
Why the need? Why are we here?

- Early Rectal Cancer MDTs
- NBCSP
- ‘Significant Rectal Neoplasm’
- BSG/ACPGBI guidelines
Management of the malignant colorectal polyp: ACPGBI position statement


*Royal Wolverhampton Hospitals, Royal Infirmary, Wolverhampton, UK
††Imperial College Healthcare NHS Trust, London, UK
‡‡University Hospital of South Manchester, Manchester, UK
¶¶Salisbury NHS Trust, Salisbury, UK

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 Dolwani12

Gut 2015
Significant Polyp (Neoplasm)
What are the challenges for ‘Good’ management?
What are the challenges for ‘Good’ management?

• Quarry identification
Yes  

Yes  

Yes yes yes!  

NO!!
What are the challenges for ‘Good’ management?

• Quarry identification
• Range of weapons
What are the challenges for ‘Good’ management?

• Quarry identification
• Range of weapons
• Teams not players
BIG SHOT
Cheney wounds hunting buddy in accident

FULL STORY: PAGE 7
What are the challenges for ‘Good’ management?

• Quarry identification
• Range of weapons
• Teams not players
• Who’s in the team?
4 ESGE states that the majority of sessile polyps can be effectively removed in a curative way by standard polypectomy (Level A, moderate quality evidence).

A prospective analysis of extended endoscopic submucosal dissection for patients with tumours exceeding 100 mm in diameter. Hurststone DP, Sanders DS, Cross SS, George R, Shorthose T. Gastroenterology and Liver Unit at the Royal Hallamshire Hospital, Sheffield.
SPECC programme
SPECC programme
# SPECC programme

<table>
<thead>
<tr>
<th>Network</th>
<th>Date</th>
<th>Delegates</th>
<th>MDTs</th>
</tr>
</thead>
<tbody>
<tr>
<td>London Cancer</td>
<td>Nov 15</td>
<td>82</td>
<td>11</td>
</tr>
<tr>
<td>York &amp; Humber</td>
<td>Jan 16</td>
<td>103</td>
<td>15</td>
</tr>
<tr>
<td>London Alliance</td>
<td>Mar 16</td>
<td>40</td>
<td>11</td>
</tr>
</tbody>
</table>
SPECC messages

• Evaluation
• Treatment
• Surveillance (rectum)
• Value of the SPECC MDT
‘The Mk I standard eyeball’
‘The Mk I standard eyeball’
Look plenty, touch little, do even less

• Target biopsies only where a positive result would change a treatment strategy
• Avoid all ‘snare biopsies’
• Don’t trial a lift
• Primary definitive intervention is always the best
• If in doubt a second view is best (second scope, second person, second opinion)
TRUS – an old friend revisited

1° uTVAd → uT0 (226) → pT0 (198) (88%) (96%)

uTx →

Rec uTVad → uTx/0 (51) → pT0 (48) (94%) (96%)

pT1 (26) (12%)
pT2 (2) (1%)

pT0 (7) (17%)
pT1 (26) (62%)
pT2 (9) (21%)

pT1 (1) (2%)
pT2 (2) (4%)

NERC May 2013

ERCa* → uT1 (42) →

*for cure

SPECC | Significant Polyp & Early Colorectal Cancer
MRI – a familiar companion

• Setup and planning are critical to achieve optimal images
MRI – a familiar companion
MRI – a familiar companion

• Setup and planning are critical to achieve optimal images
• Structured reporting to allow best MRI input to decision making
MRI – a familiar companion

MRI date: [ ] Hospital: [ ] Radiologist initials: [ ]

MORPHOLOGY: [ ] sessile/flat [ ] pedunculated [ ] mucinous [ ] non-mucinous

TUMOUR HEIGHT: [ ] mm to anal verge and [ ] mm to the top of the puborectalis sling

- [ ] tumour above peritoneal reflection
- [ ] tumour not above peritoneal reflection

SIZE: [ ] maximum diameter (mm) [ ] thickness (mm)

Lesion in the [ ] 12 to 3 o’clock [ ] 3 to 6 o’clock [ ] 6 to 9 o’clock [ ] 9 to 12 o’clock position

Central depressed portion in the [ ] 12 to 3 o’clock [ ] 3 to 6 o’clock [ ] 6 to 9 o’clock [ ] 9 to 12 o’clock

EXCISION OPTIONS FOR TUMOUR FREE DEEP MARGIN (SURGICAL PLANE):

A) [ ] Tis/T1m1: No definite evidence for invasion into submucosa (Eligible for EMR)
B) [ ] T1m2: <1mm submucosa preserved (Eligible for EMR or partial thickness TEMS)
C) [ ] T1m3/HaryT2: <1mm submucosa visible but >1mm muscles preserved (Eligible for full thickness TEMS)
D) [ ] T2/T3a: <1mm of preserved muscles (Major oncological resection indicated)

Lymph node status:
- [ ] no nodes visible
- [ ] normal nodes
- [ ] vascular deposits N1c

Evaluation for discontinuous spread:
- [ ] EMVI present (tumour expansion of vessels)
- [ ] No EMVI

Circumferential Resection Margin:
- [ ] Clear mCRM
- [ ] Closest CRM encroachment is at [ ] o’clock and is [ ] mm from the mesorectal fascia

Pelvic side wall lymph nodes:
- [ ] no nodes visible
- [ ] normal nodes
- [ ] PSW malignant
ESD

- Drive for single piece resection – especially in uncertain lesions
TEMS

• Excellent treatment for suitable T1 disease
TEMMS

- Local recurrence-free survival
- Time after surgery (months)

Graph showing local recurrence-free survival over time for different groups: pT1 G1–2 R0 LyV0 and remainder.
TEMS

• Excellent treatment for suitable T1 disease
• Potential to extend with adjuvant therapy
## TEMS

Local recurrence according to post TEM treatment

<table>
<thead>
<tr>
<th>Stage</th>
<th>LE then CRT</th>
<th>LE then TME</th>
<th>LE alone</th>
</tr>
</thead>
<tbody>
<tr>
<td>T1</td>
<td>10%</td>
<td>6%</td>
<td>15-20%</td>
</tr>
<tr>
<td>T2</td>
<td>16%</td>
<td>10%</td>
<td>30-40%</td>
</tr>
</tbody>
</table>
TEMS

• Excellent treatment for suitable T1 disease
• Potential to extend with adjuvant therapy
• Option to use after neoadjuvant therapy
Contact Brachytherapy ‘Papillon’

- A clear role in key groups as an alternative to LE

- Low risk early rectal cancer (<6cm) ct1/ct2/ct3a
- Small mobile cancers (<3cm)
- Elderly patients (80+ years)
- Younger patients with high surgical risk (CPX)
- No suspicious Lymph nodes
- Discuss at early rectal cancer MDT
- Offer patient treatment options after MDT
Surveillance after local excision for cure
The impact of a dedicated MDT

- SRN MDT discussion 89% vs 100%
- Pre-procedure MRI 63% vs 75%
- Pre-procedure TRUS 21% vs 83%
- Local Excision as definitive Rx 11% vs 67%

*Vaughn-Shaw, Wheeler, Borley Colorectal Dis 2015;17(8):704-09*
Challenges

• Do we have the time?
• Do we have the resources? (video conferencing, getting the right people there)
• Is it really worthwhile to do second look?
• Old practice and self interest: GE vs GI surgeon
Summary

• Consolidation and dissemination of parallel developments
• Inclusive facilitative process with real progress to help build SPECC teams
• A genuinely world leading approach to a major challenge of the 21st C
• Thanks