MICI colique et dysplasie : Comment la surveiller ? Comment la traiter ?

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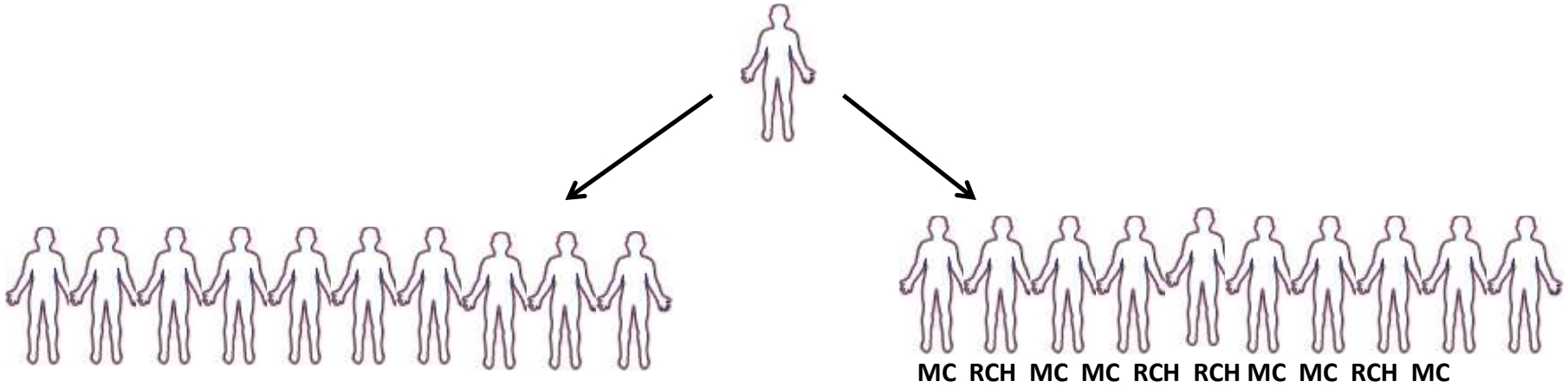
Comment surveiller ?

Cancer colo-rectal et MICI
Dualité du risque

Les personnes vivant avec une MICI



Sont à risque de cancer colo-rectal sporadique comme les autres individus de la population générale

Sont spécifiquement à risque de cancer colo-rectal lié à l'inflammation colique

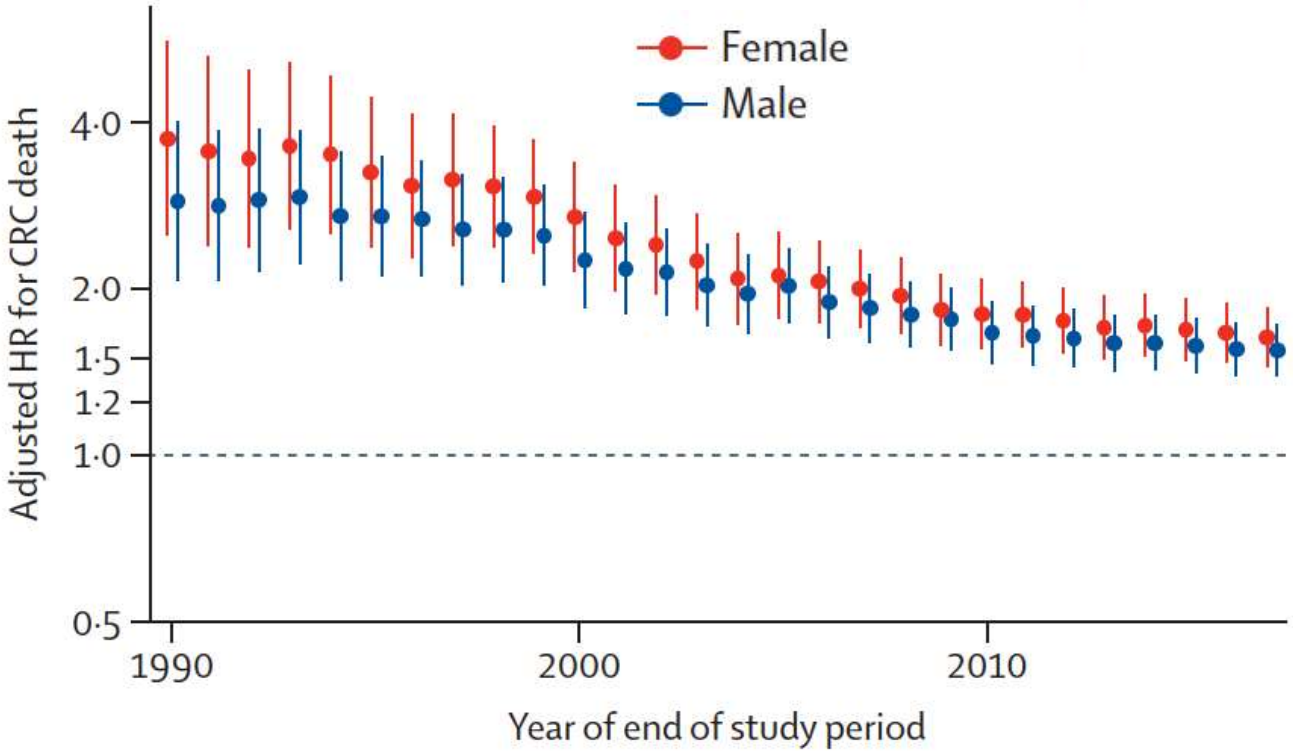
Addition des facteurs de risque de cancer colo-rectal au cours des MICI

Table 1. Risk Factors for Colorectal Cancer in Patients with Inflammatory Bowel Disease.

Risk factors established in the general population	Risk factors specific to patients with inflammatory bowel disease
Increasing age*	Coexisting primary sclerosing cholangitis
Male sex*	Increasing cumulative extent of colonic inflammatory lesions‡
History of colorectal cancer in first-degree relatives*	Increasing duration of inflammatory bowel disease§
Increased body-mass index†	Active chronic endoscopically assessed inflammation
Low level of physical activity†	Active chronic histologically assessed inflammation
Cigarette smoking†	Anatomical abnormalities
High consumption of red meat†	Foreshortened colon
Consumption of alcohol†	Strictures
	Pseudopolyps
	Personal history of flat dysplasia

Beaugerie and Itzkowitz. N Engl J Med 2015

Surrisque persistant comparé à la population générale malgré l'évolution des recommandations et endoscopes



Risque cumulé de cancer colorectal avant 75 ans en cas de pancolite

- Diagnostic de MICI à 65 ans : <10%
- **Diagnostic de MICI à 15 ans: 25%**

Olén et al. Lancet 2020

ECCO Guidelines on Inflammatory Bowel Disease and Malignancies

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Gordon et al. J Crohns Colitis 2022

Screening colonoscopy should be offered to all IBD patients **8 years** after symptom onset*

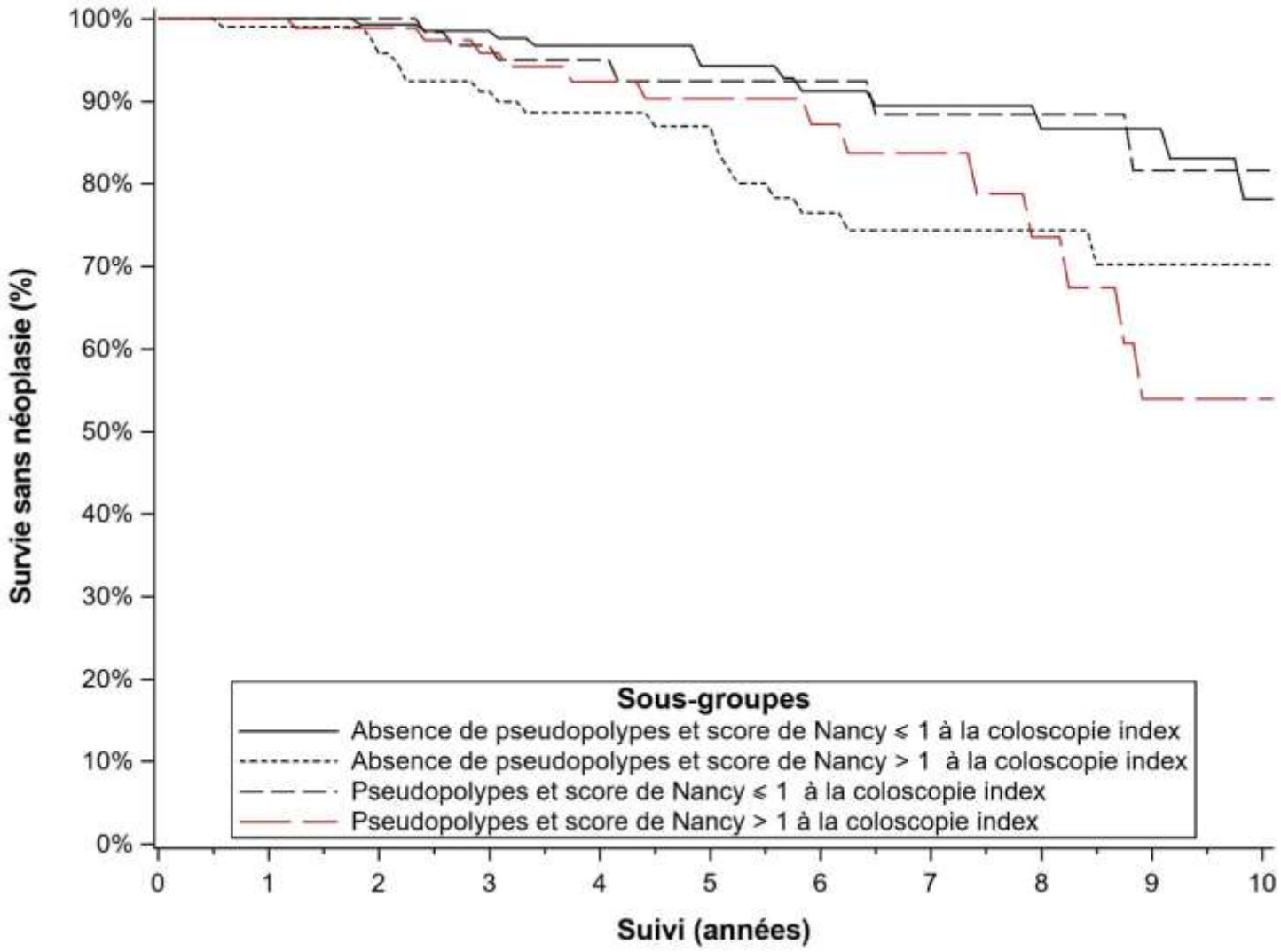
Lower risk	Intermediate risk	High risk
Colitis affecting <50% colon	Extensive colitis with mild to moderate endoscopic and/or histological inflammation	Extensive colitis with severe endoscopic and/or histological inflammation
Extensive colitis with minimal endoscopic or histological inflammation	CRC in first-degree family member >50 years	CRC in first-degree family member ≤50 years
		PSC**
		Stricture in past 5 years
		Dysplasia in past 5 years***

Consider additional risk factors, such as age at diagnosis and male gender
When possible, surveillance colonoscopy should be performed during remission
DCE, VCE, or HD-WLE**** should be performed, with targeted biopsies

Surveillance colonoscopy every 5 years	Surveillance colonoscopy every 2-3 years	Surveillance colonoscopy annually

Gordon et al. J Crohns Colitis 2022

Pseudo-polypes à ne plus considérer dans la stratification du risque contrairement à l'activité histologique



Biopsies pour grader l'inflammation histologique dès la 1ère coloscopie de surveillance

Wolf et al. Aliment Pharmacol Ther 2023
Kirchgesner et al. Clin Gastroenterol Hepatol 2020

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Comparison of Endoscopic Dysplasia Detection Techniques in Patients With Ulcerative Colitis: A Systematic Review and Network Meta-analysis

A

Study or Subgroup	Experimental Events	Experimental Total	Control Events	Control Total	Weight	Odds Ratio M-H, Random, 95% CI
1.1.1 Chromoendoscopy vs. SD-WLE						
Kiesslich 2003	32	84	10	81	100.0%	4.37 [1.97, 9.68]
Subtotal (95% CI)		**84**		**81**	**100.0%**	**4.37 [1.97, 9.68]**
Total events	32		10			
Heterogeneity: Not applicable						
Test for overall effect: Z = 3.63 (P = 0.0003)						
1.1.2 NBI vs. SD-WLE						
Dekker 2007	9	20	12	22	100.0%	0.68 [0.20, 2.30]
Subtotal (95% CI)		**20**		**22**	**100.0%**	**0.68 [0.20, 2.30]**
Total events	9		12			
Heterogeneity: Not applicable						
Test for overall effect: Z = 0.62 (P = 0.54)						
1.1.3 Chromoendoscopy vs. HD-WLE						
Mohammad 2015	14	50	6	53	100.0%	3.05 [1.07, 8.71]
Subtotal (95% CI)		**50**		**53**	**100.0%**	**3.05 [1.07, 8.71]**
Total events	14		6			
Heterogeneity: Not applicable						
Test for overall effect: Z = 2.08 (P = 0.04)						
1.1.4 NBI vs. HD-WLE						
Ignjatovic 2012	5	56	7	56	47.2%	0.69 [0.20, 2.31]
van den Broek 2011	13	23	11	25	52.8%	1.65 [0.53, 5.18]
Subtotal (95% CI)		**79**		**81**	**100.0%**	**1.09 [0.46, 2.58]**
Total events	18		18			
Heterogeneity: Tau² = 0.03; Chi² = 1.07, df = 1 (P = 0.30); I² = 7%						
Test for overall effect: Z = 0.20 (P = 0.84)						
1.1.5 Chromoendoscopy vs. NBI						
Bisschops 2017	14	66	14	65	33.2%	0.98 [0.43, 2.26]
Pellise 2011	12	27	10	33	22.2%	1.84 [0.64, 5.32]
Watanabe 2016	16	130	23	133	44.7%	0.67 [0.34, 1.34]
Subtotal (95% CI)		**223**		**231**	**100.0%**	**0.95 [0.56, 1.63]**
Total events	42		47			
Heterogeneity: Tau² = 0.04; Chi² = 2.46, df = 2 (P = 0.29); I² = 19%						
Test for overall effect: Z = 0.18 (P = 0.86)						

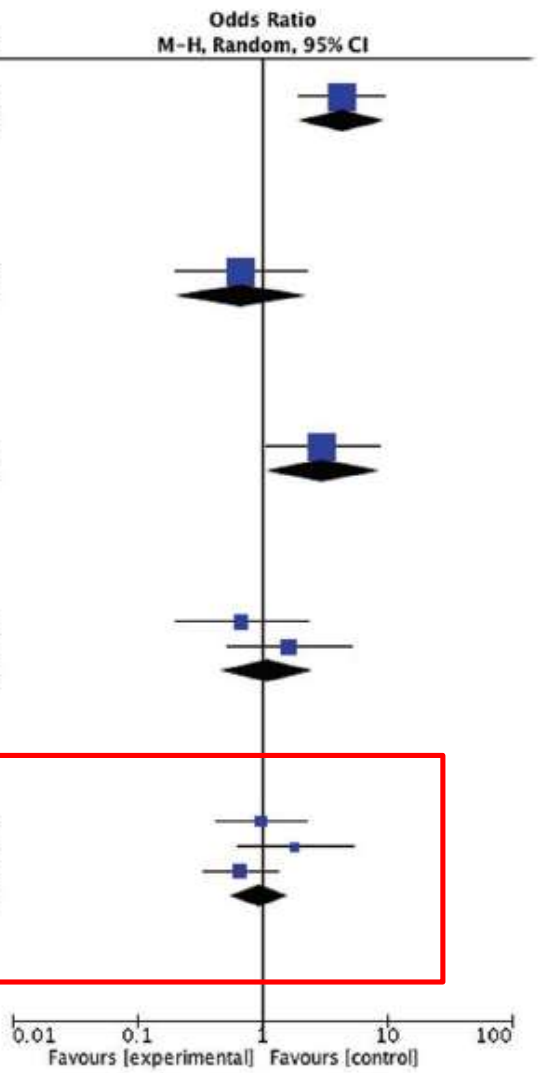

FIGURE 4. Pairwise meta-analysis comparing dysplasia detection techniques for detection of (A) any dysplastic lesion and (B) advanced neoplasia detection.

Détection de toute lésion dysplasique

Bessissow et al. Inflamm Bowel Dis 2018

Place des biopsies non ciblées ?

- **1000 patients atteints de MICI avec coloscopie de surveillance**
  - 94 patients avec dysplasie: 12 sur biopsies aléatoires
  - Rentabilité diagnostique des biopsies aléatoires = 0.2% / biopsies (68/31 865)

- **Facteurs associés à la présence de dysplasie sur biopsies aléatoires (bas ou haut grade)**
  - Antécédents personnels de dysplasie
  - Cholangite sclérosante primitive
  - Colon tubulisé

Moussata et al. Gut 2018

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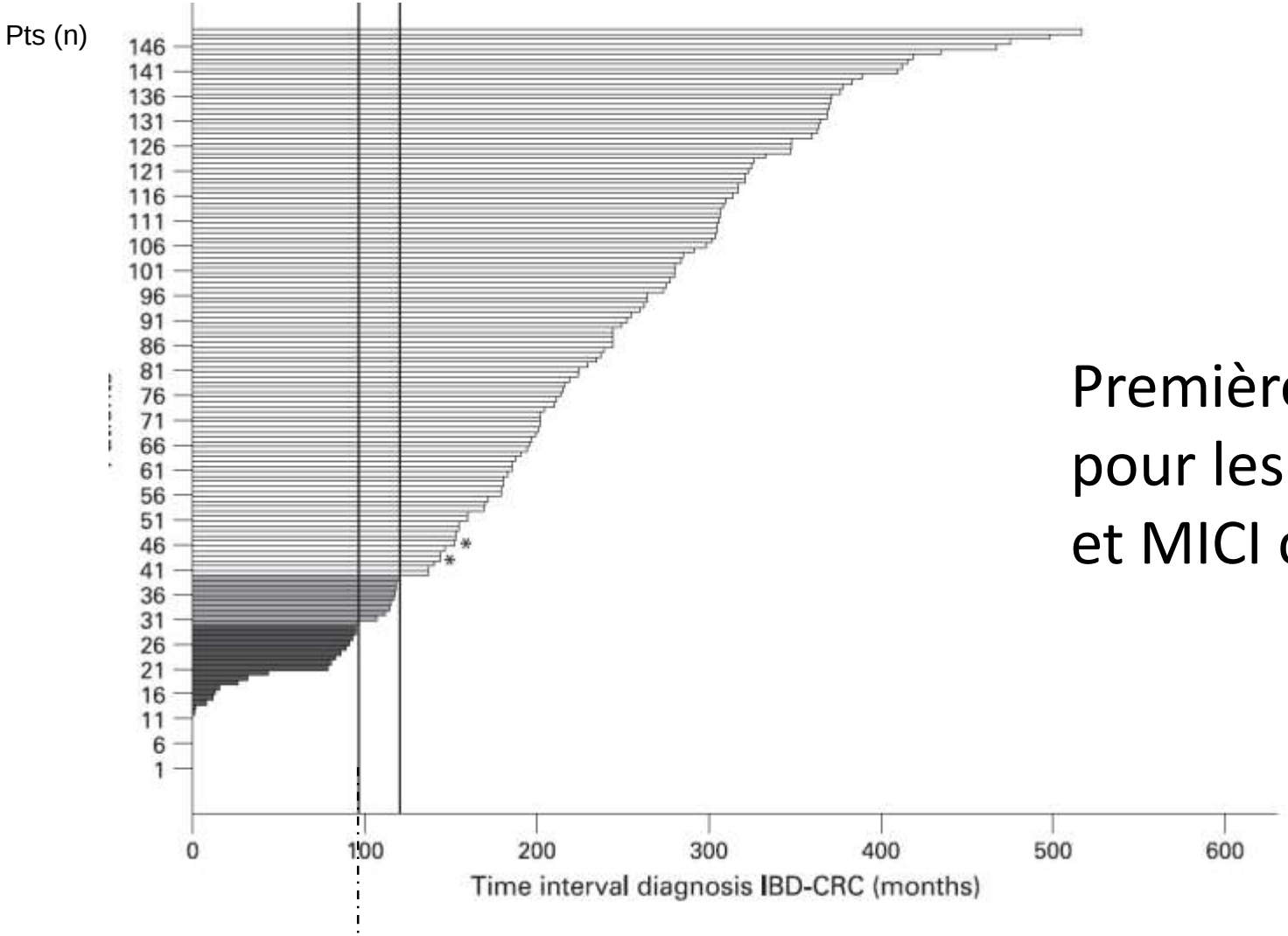
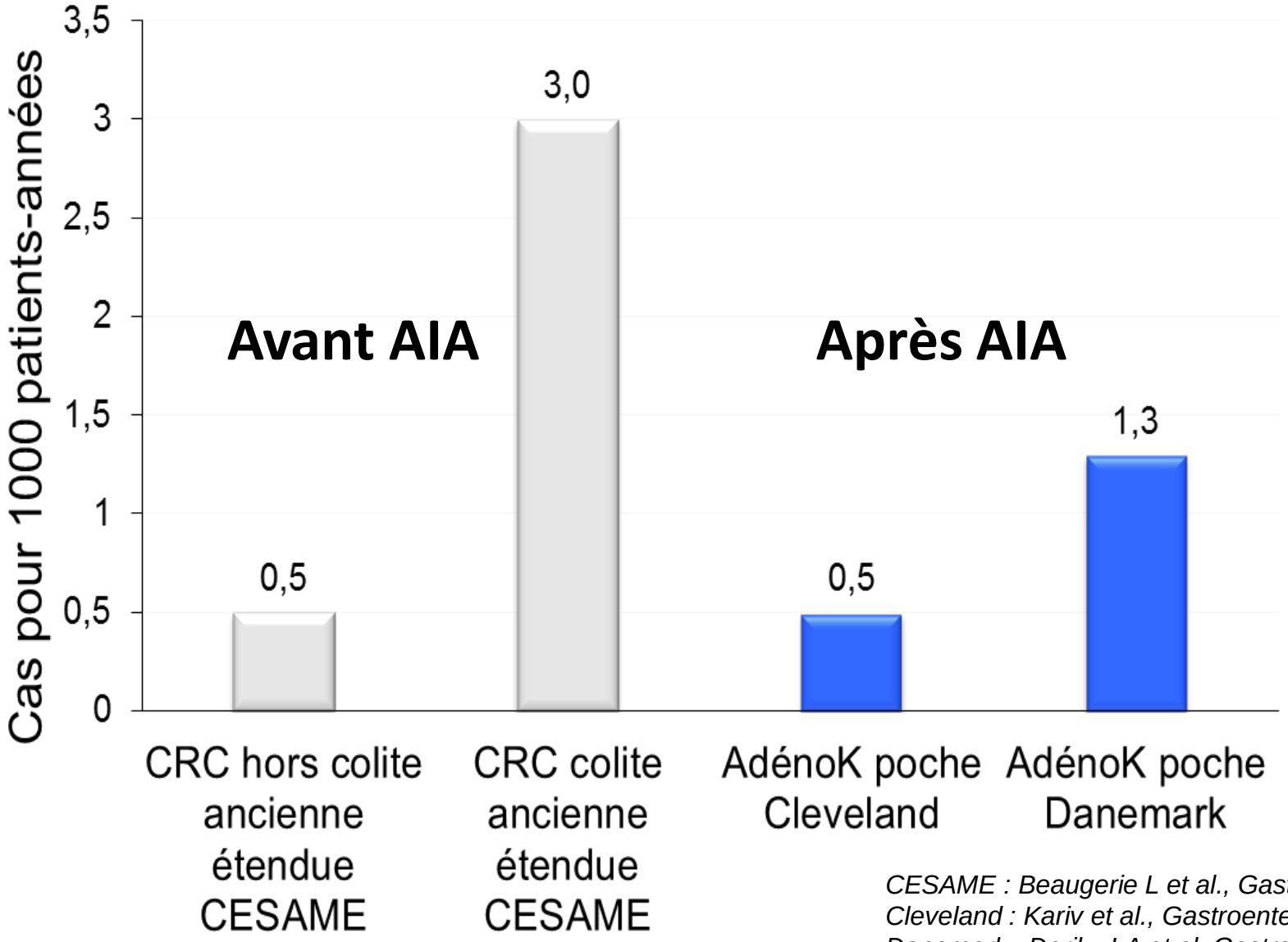
Limites de la première coloscopie à 8 ans



Première coloscopie à 3-4 ans pour les patients avec pancolites et MICI chroniques actives ?

Lutgens et al. Gut 2008

Anastomose iléoanale et adénocarcinome



CESAME : Beaugerie L et al., Gastroenterology 2013;145:166-75
Cleveland : Kariv et al., Gastroenterology 2010;139:806-12
Danemark : Derikx LA et al.,Gastroenetrology 2014;146:119-28

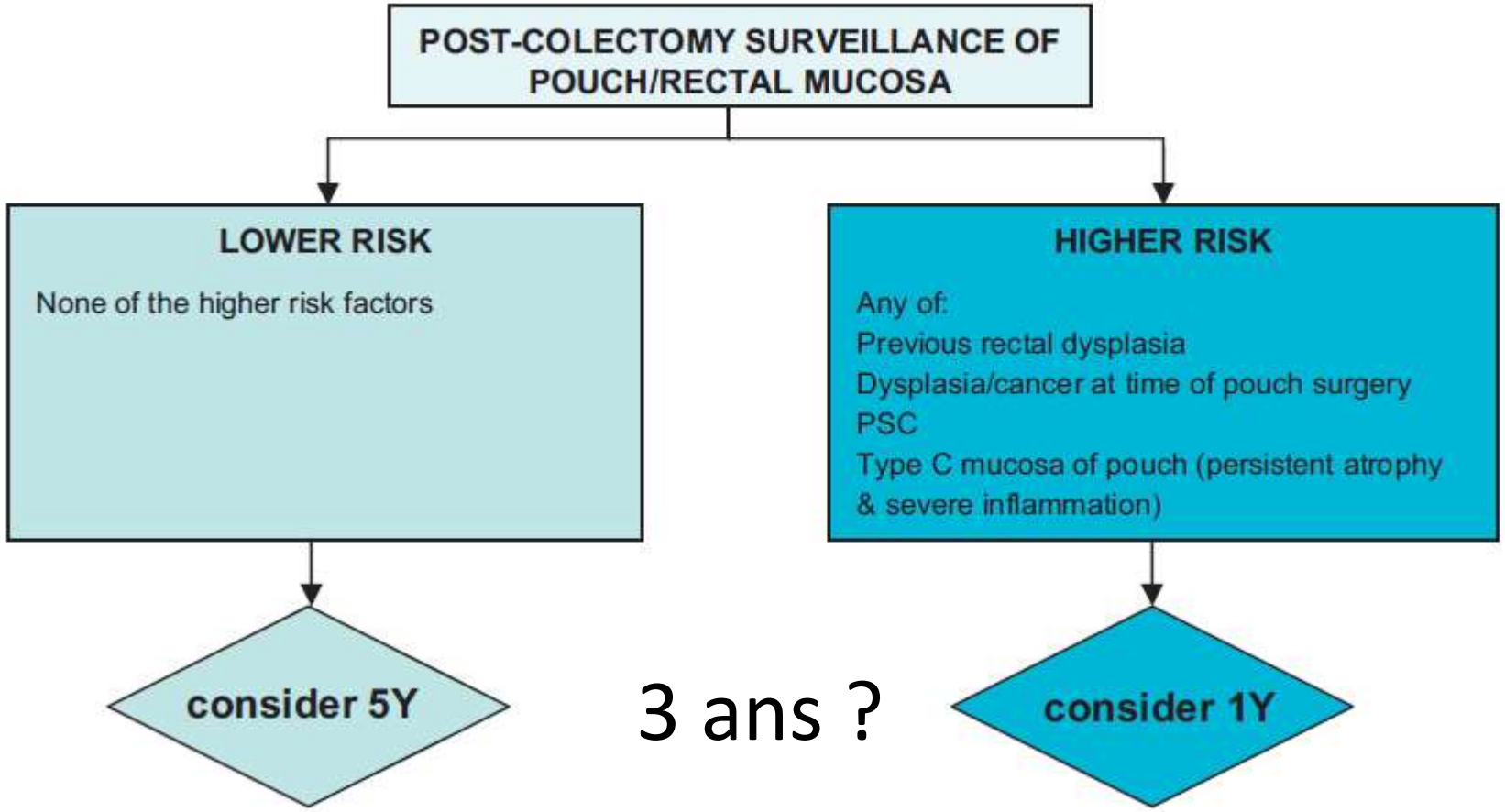
Statement 5

In patients with IBD and IPAA, a preoperative diagnosis of dysplasia or cancer of the colon or rectum is a risk factor for pouch dysplasia or adenocarcinoma. [EL 1] In these patients and in patients with PSC, annual pouch surveillance should be performed. [EL3]

Consensus: 100%

Gordon et al. J Crohns Colitis 2022

Quel protocole ?



3 ans ?

Zone transitionnelle anale (2-3 biopsies)
Poche (3 biopsies)
(Muqueuse glandulaire rectale résiduelle) (2-3 biopsies)

Cairns et al. Gut 2010

Surveillance endoscopique des patients ne rentrant pas dans le protocole de surveillance spécifique des MICI

- FIT non adaptés

- Proposition: coloscopie tous les 10 ans en l'absence de polypes à partir de 50 ans

Ce que nous faisons à Saint-Antoine

Coloscopie HD avec chromoendoscopie à l'indigo carmin OU chromoendoscopie virtuelle (NBI/BLI) + biopsies ciblées.

Biopsies non ciblées en fonction du « niveau de risque ».

Patients à risque très élevé

4 biopsies en cadrans sur 8 segments coliques ≥ 32

- Cholangite sclérosante primitive
- Antécédent personnel de dysplasie
- Colon tubulé
- Sténose
- Défaut de préparation empêchant une coloration de qualité (?)

Patients à risque élevé

2 biopsies en cadrans sur 4 segments coliques ≥ 8

Tous les autres patients…

Comment traiter ?

Bien décrire la lésion

Site	
Size	<2 cm favours endoscopic resection EMR or ESD can be considered for larger lesions
Shape	Polypoid (Modified Paris 1p or 1s) vs Non Polypoid (IIa, IIb, IIIc) Borders (distinct vs indistinct)
Surface	Kudo or FACILE (Frankfurt Advanced Chromoendoscopic IBD lesions)
Surroundings	Mucosal activity, other lesions in surrounding area, submucosal fibrosis

Gordon et al. J Crohns Colitis 2022

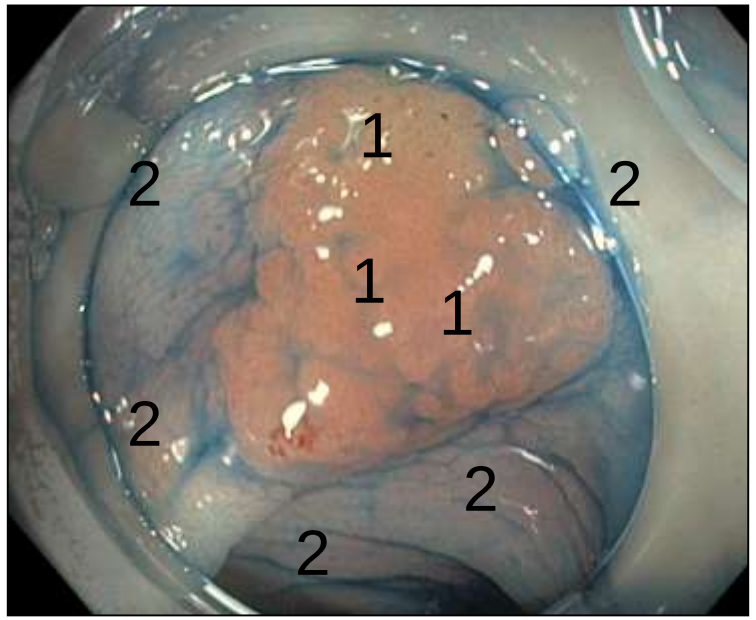
Critères de résection complète

1. Marges lésionnelles bien définies en endoscopie
2. Résection endoscopiquement complète
3. Résection complète confirmée histologiquement
4. Biopsies réalisées sur la muqueuse adjacente à la lésion indemnes de dysplasie

Yang et al. J Gastroenterol Hepatol 2019

Biopsies ciblées

- De la lésion (1)
- Du pourtour de la lésion (2)



POST'U Xavier Dray 2017

Techniques de résection

- Mucosectomie standard (EMR), dissection sous-muqueuse (ESD)
- De réalisation souvent plus difficile du fait de la fibrose sous-muqueuse
- Le soulèvement est parfois difficile et ne doit pas systématiquement être interprété comme un « non-lifting sign »

Yang et al. J Gastroenterol Hepatol 2019

Privilégier la résection endoscopique en cas de lésion résécable

Endoscopic features	Therapeutic management	Follow up
Polypoid lesion OR Non-polypoid lesion ≤2 cm without stigmata of invasive cancer or fibrosis and distinctive border	Endoscopic en-bloc resection (EMR, ESD, Hybrid ESD) Undertaken by expert endoscopist	Close surveillance with DCE or VCE + targeted biospies HGD: 3 months for the first year then annually Non-polypoid LGD: 6 months for the first year then annually Polypoid <1 cm or pedunculated LGD: 12 months
Non-polypoid large lesion >2 cm without stigmata of invasive cancer or fibrosis and distinctive border	Endoscopic en-bloc resection (ESD) by expert endoscopist Surgery as an alternative to endoscopic resection	Intense surveillance with DCE or VCE + targeted and random biopsies Every 3-6 months for the first year and then annually

Gordon et al. J Crohns Colitis 2022

Indication chirurgicale

Endoscopic features	Therapeutic management	Follow up
Unresectable large lesion (indistinctive borders), invasive cancer	Surgery	
Multifocal dysplasia LGD or HGD	Surgery In select cases of colonic lesions with discrete borders, en-block endoscopic resection can be considered following MDT discussion	Surgery should be performed in the majority of patients with multifocal LGD or HGD If endoscopic resection is undertaken, surveillance should be performed every 3 months for the first year then annually

Gordon et al. J Crohns Colitis 2022

Nouvelle coloscopie rapprochée et relecture anapath

Endoscopic features	Therapeutic management	Follow up
Invisible dysplasia on random biopsies	Confirmation by second pathologist Repeat surveillance colonoscopy with DCE +random and targeted biopsies by an expert endoscopist	Unmasked visible dysplasia: as above Persistent unifocal invisible LGD: consider intensive DCE surveillance follow up Persistent unifocal invisible HGD: consider colectomy
Indefinite dysplasia	Confirmation by second pathologist Optimise therapy and control inflammation Repeat surveillance colonoscopy with DCE or VCE +random and targeted biopsies in quiescent disease	Annual surveillance colonoscopy

Gordon et al. J Crohns Colitis 2022

Prise en charge non spécifique des adénomes sporadiques

Endoscopic features	Therapeutic management	Follow up
Sporadic adenoma in IBD	Endoscopic en-bloc resection	Surveillance colonoscopy as per post-polypectomy guidelines

Discussion en staff pluridisciplinaire MICI
Relecture par anapath expert

Gordon et al. J Crohns Colitis 2022

Take home messages

- Biopsies étagées pour grader l'inflammation histologique et stratifier le risque
- Envisager coloscopie de surveillance précoce chez les patients avec maladie chronique active et pancolite
- Surveillance endoscopique pour le risque d'adénome sporadique chez les patients sans surrisque lié à la MICI
- Discussion en staff pluridisciplinaire MICI et relecture anapath par un centre expert

Merci de votre attention

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