THE NATIONAL SCREENING PROGRAM FOR COLORECTAL CANCER

Interview with Prof. Cristian Gheorghe MD, PhD

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As acting president of the Romanian Society of Coloproctology, what can you tell us about the particularities of this Society?

The Romanian Society of Coloproctology is a multidisciplinary society that has the particularity of the alternative change of its President every two years by successively electing a surgeon and subsequently a gastroenterologist with experience in endoscopy, more precise, in the field of coloproctology. I represent this Society, for this period, until 2024, respectively until the next congress that will be held at Cluj, in April 2024.

What does the Romanian Society of Coloproctology has proposed?

The society aims to discuss coproctological pathology within the National Congresses, in joint sessions attended by gastroenterologists, surgeons, oncologists, radiologists, radiotherapists, anatomo-pathologists, and in separate sessions of surgery and endoscopy, respectively, targeted on surgical and endoscopic technical aspects. Most of the sessions in the National Coloproctology Congresses are common, because both surgeons, as well as gastroenterologists and endoscopists have something to learn from each other's. "Networking" is extremely useful for training and activity in multidisciplinary teams. Under these conditions, the physicians involved in the care of the patients will know the indications and contraindications of the newest treatments for a certain coloproctological pathology and also with whom to collaborate for optimal patient management.

Which is the role of such a Society?

In general, in contemporary medicine, the idea is to sub-specialize, to perfect yourself in a certain technique and to know in detail a certain pathology. Multidisciplinary approach to each patient with a coloprocto-logical pathology is essential. I'll give you some examples. I start with the malignant pathology where rectal cancer represents one theme of the extreme discussions as management approach. "Colorectal cancer" is often mistakenly discussed, but rectal cancer is a different cancer than colon cancer because the epidemiology, course, prognosis, and management is different. The specialization and experience of the surgeon is necessary for this intervention because it is a difficult intervention, with a higher risk of morbi-dity and mortality than resection for colonic cancer. Both in rectal cancer and in colonic cancer, the current standard of surgery is in all specialized clinics, arising in the form of minimally invasive intervention.

What minimally invasive surgery techniques can be used for the two types of cancer?

We discuss laparoscopic colonic surgery and laparoscopic or robotic surgery for the rectum (rectal amputation for lower rectal cancer being the standard technique). For rectal carcinoma,

neoadjuvant therapy (radiotherapy and chemotherapy) precedes surgical intervention. For a selected group of patients, in general, the elderly, with middle rectal cancer and with the best indication, respectively, lower rectal cancer, non-circumferential, without metastases, and without major extension in the depth of the colonic wall; we can discuss about the "watch and wait" intervention. We are talking about a standardized intervention, carried out in specialized centers in which the patient, after the radiation therapy and chemotherapy that lead to the disappearance of the tumor is monitored at regular intervals endoscopically, eco-endoscopically and with pelvic magnetic resonance imaging. Also, although it is not yet in the guidelines, it is being discussed for such type of patients after radiotherapy and chemotherapy, a PET-CT follow-up in order to determine whether the tumor has recurrence criteria or not. If relapse occurs (highlighted by the imaging techniques discussed) then obviously the patient is converted to standard surgical intervention. This is one of the permanent discussions in the working groups of surgery, oncology, gastroenterology and imaging. Regarding colonic cancer, we are discussing minimally invasive laparoscopic intervention in left colonic cancer and also in right colonic cancer. These laparoscopic interventions are operations that require an important degree of expertise from the surgical team and, obviously, adequate equipment.

Which are the approaches in the benign pathology?

From this point of view, I would start with the pathology of the pelvic floor. It is about pelvic floor dyssynergism dysfunctions or about anal incontinence. As a rule, they are elderly or sick patients with history of anal sphincter trauma, for example women after difficult births. Things starts to settle down here too, respectively from this pathology which not long ago was considered without importance for many, at the present moment it benefits from an important exploration such as anorectal manometry, echoendoscopy of the anal sphincter, defecography and magnetic resonance of anal sphincter. Many of these techniques are difficult to be performed or to be learned and that's why we don't have many specialized physicians in our country. A few years ago, however, we started organizing courses and centers of coloproctology for anorectal manometry, and for bio-feedback therapy.

What can you tell us about anal sphincter surgery?

Also, for the surgical intervention at the anal sphincter level, unfortunately, there is a lack of specialists, and we discussed this aspect at The National Congress of Surgery recently held in Eforie-Nord (in the round table dedicated to the benign pathology of coloproctology). Reconstruction of the anal sphincter is a delicate surgical technique, that is difficult to perform, which, although is not a major intervention, as rectal cancer surgery is considered, is important for the patient because it has a major impact on the quality of life.

Are the data clearer in lower GI bleeding?

Here, the diagnostic and treatment algorithm is quite well established lately, with clear recommendations related to what we should do it in the shortest time in patients with multiple comorbidities and hemodynamically unstable. The guidelines, at the moment, recommend, in these patients, angio-CT, to establish the exact source of the bleeding. It is true that CT scan cannot determine the cause of bleeding, but it has a very great therapeutic benefit in the sense that a selective or ultraselective embolization of the vessel involved in haemorrhage with obtaining haemostasis may be performed. This aspect is recently established, respectively, in 2023 in the

American College of Gastroenterology Guidelines. Regarding the inferior GI bleedings, currently, there is a specific endoscopic treatment for each cause of the lower GI haemorrhages. Thus, if it is a diverticular haemorrhage know that endoscopic ligation and/or metal clips must be used. When it comes to post-polypectomy bleeding, we know that the indication is to use the metal clips, and if it is an angio-dysplastic lesions haemorrhage, then the technique is coagulation in argon plasma.

Another important issue related to non-malignant pathology is diverticular disease. How are the things in this situation?

Colonic diverticulosis is increasing in frequency, because increasing age of patients and due to unhealthy diet. Obviously, there are genetic factors and correlated with the age of the patients, but the diet without vegetable fibres, with overprocessed foods, favour diverticular disease. For example, we know that at the age of 80 approximately 80% of patients have diverticula. What's new in the treatment of complicated diverticulosis represent the principle of non-invasive therapy. Surgical intervention is indicated only in complications that cannot be resolved by minimally invasive radiology. In diverticulitis complicated with abscess without peritonitis, the abscess drainage is performed by a specialized radiologist specialized in interventional radiology, through radiological intervention. If the size of the abscess is not big, it can be treated conservatively with antibiotics, rest, hydration under strict supervision in order to evaluate the evolution and to intervene surgically or radiologically when is required. If surgery is indicated, then it should be performed by a surgeon specialized in laparoscopic colonic surgery; this type of minimally invasive intervention should be chosen whenever it is possible, although it is a difficult intervention in patients with repeated episodes of diverticulitis in historic.

How important are prevention and early diagnosis in colorectal cancer? As the national coordinator, what can you tell us about the screening program?

Related to prevention and early detection in colorectal cancer, it is obvious that a healthy diet is important, respectively, rich in vegetable fibres, without excess of processed foods and without excess of red meat (including here not only pork and beef, but also highly processed meet). For example, we frequently recommend the Mediterranean diet both to the healthy population and, also, to our patients. Alongside with smoking cessation. Obesity and sedentarism are risk factors for many coloproctological types of diseases. As regards early diagnosis, this year we are at the end of a pilot project financed by the European Union for the early detection of premalignant and malignant colorectal lesions. It's the ROCCAS project, which started in December 2019 through a program of populational education, alongside with general practitioners and gastroenterologists/ endoscopists. In parallel with the educational program, from January 2022 the detection program actually started with early detection of pre-malignant and malignant lesions, by the two methods, detection of occult bleeding in the stool by immunological tests, (FIT test) and for FIT positive patients by colonoscopy in centres dedicated for colonoscopic screening.

What is the target population for this program?

The project financed by the European Union targets the population of 50-74 years old with standard and high risk and, also, the symptomatic population from the South of the country. There are four centers: Craiova, Bucharest (Fundeni Clinical Institute and Central Military Hospital) and Constanța, with the counties surrounding the aforementioned screening centers. For example, for Fundeni Clinical Institute we have seven counties from the South-Muntenia region. Each screening

and colonoscopy center has a target of 50,000 people who will benefit from the pilot program through the input of general practitioners from these districts. The general practitioners have an extremely important role in the screening program by educating the population to participate in the screening, followed by handing out the FIT test and, after testing, returning to the office with the FIT test for storage and, later, sending it to the laboratory; patients with a positive FIT test are recalled by their general practitioners and referred to colonoscopy centers. So, a population of 200 thousand people is the targeted by the testing. According to the indications of the European Union, it must be a disadvantaged population in over 60% of cases. We are at the end of this project and we hope that it will continue and expand throughout the country, in the other geographical areas starting from 2024. The education project, which started in 2019, is coordinated by the Fundeni Clinical Institute, which has held countless courses for general practitioners and gastro-enterologists /endoscopists. A peculiarity of the screening program in Romania is that it addresses not only the population with increased risk due to age, the so-called standard population. The general practitioners' registers in the electronic data system and advises, also, symptomatic patients, those who have haemorrhage, anaemia and weight loss. They are sent directly to colonoscopy in the same screening program for early detection of (pre)malignant lesions. In the Colonoscopy Screening Center, if colonic polyps are detected, they are resected in the same session (polyps up to 2 cm), and the patient returns home the same day. Another group of patients is the one with increased risk due to family or personal history and genetic diseases (a significant group is represented by Lynch syndrome patients). For familial cancers, including colonic cancer, the general practitioners have the role of performing the pedigree and determining who requires colonoscopic exploration. The screening program for (pre)malignant colorectal diseases is considered the most difficult screening program due to its complexity and the large number of specialists involved.

How important is education in prevention and early diagnosis?

From our point of view, education is essential. We're talking about the education of the population, the education of general practitioners: how to detect patients, what to do and how to talk with them, how to convince them to do the tests, and how to convince the positive ones to go to colonoscopy. For the Colonoscopy Centers it is about education of colonoscopists how to perform a colonoscopy in safe and efficacious conditions for the patient. The time allotted for a colonoscopy is one hour, the patient is sedated, and, normally, over 80% of patients who come with positive tests and polyps, are resolved in the same session. The rest i.e. 20% of patients either have large polyps or cancers discovered in screening and are referred for hospitalization following the standard circuit.