LOng-term onCologicAL outcomes of endoscopic full-thickness resection after previous incomplete resection of low-risk T1 CRC

No registrations found.

Ethical review	Positive opinion
Status	Recruiting
Health condition type	-
Study type	Observational non invasive

Summary

ID

NL-OMON22704

Source
Nationaal Trial Register

Brief title
LOCAL study

Health condition

endoscopic full thickness resection
colorectal polyp
T1 colorectal cancer
colonoscopy

Sponsors and support

Primary sponsor: Amsterdam University Medical Center, location AMC
Source(s) of monetary or material Support: Investigator initiated, so no funding by commercial parties

Intervention

Outcome measures

Primary outcome

To assess the 2- and 5- year local luminal tumor recurrence rate after scar resection by eFTR following a previous potentially incomplete resection of low-risk T1 CRC

Secondary outcome

1. To assess the feasibility of completion eFTR, defined as a macroscopic complete en bloc scar excision in >80% of cases.
2. To assess the percentage of curative eFTR resections, defined as no residual cancer in the scar or in case any residual cancer a R0 resection for T1 CRC without high-risk features (poor differentiation, lymphovasular invasion and/or high-grade tumor budding (grade 2 or 3)).
3. To assess the presence of scar tissue and/or complete scar excision at histopathology 4. To assess the procedure-related adverse event rate and safety of eFTR compared to oncologic surgery in a historical patient-cohort for T1 CRC
5. To assess the 2- and 5- year locoregional nodal and/or distant tumor recurrence rate
6. To assess the 5-year disease-specific survival rate and overall survival rate
7. To assess the 2- and 5-year luminal, nodal and distant tumor recurrence rate in patients not meeting our inclusion criteria, but who did undergo eFTR completion treatment followed by strict surveillance

Study description

Background summary

Rationale: Endoscopic resection is an attractive treatment for early colorectal cancer (CRC) due to substantially lower morbidity and mortality rates as compared to radical surgery. Complete endoscopic polypectomy in one piece (en bloc) can be considered a curative treatment for T1 CRC without histological high-risk features for lymphatic spread. In contrast, incomplete excision with unclear resection margins (R1 resection) or with margins that are indeterminate (Rx resection) is considered a high-risk factor for residual disease and local recurrence. Therefore international guidelines recommend additional oncologic resection in case of R1/Rx resections, even in the absence of histological high-risk features. Recent introduction of minimally invasive local treatment options, as endoscopic full-thickness resection (eFTR), can serve as a valid alternative treatment option to perform a second attempt for radical en bloc resection of low-risk T1 CRC or to confirm local radicality of the previous resection. At present completion treatment with eFTR after previous incomplete resection of low-risk T1 CRC has already been adopted in some practices in the Netherlands. However, oncologic safety of this strategy has not been established and long-term data are lacking. Besides, at present surveillance following completing eFTR varies widely in practice and require standardization.

Objective: This project aims to investigate the feasibility and oncological safety of eFTR as minimal invasive completion treatment after previous incomplete endoscopic resection of low-risk T1 CRCs.

Study design: a nationwide, multicenter, prospective cohort study.

Study population: Patients scheduled to undergo additional scar resection by eFTR following a previous incomplete resection of T1 CRC in the Netherlands.

Main study parameters/endpoints: Primary endpoint is to assess the 2 and 5 year local luminal tumor recurrence rate after eFTR completion treatment following incomplete excised low-risk T1 CRC. Secondary study endpoints are to assess the feasibility of completion eFTR, defined as a macroscopic complete en bloc scar resection in > 80% of cases, the percentage of curative eFTR resections, defined as no residual cancer in the scar or in case of any residual cancer a histological R0 resection of T1 CRC without one or more high-risk features (poor differentiation, lymphatic or vascular invasion, tumor budding), the presence of scar tissue and complete scar excision at histopathology, the procedure-related adverse event rate and safety of eFTR compared to oncological surgical resection, the 2 and 5 year nodal and/or distant tumor recurrence rate and the 5-year disease-specific survival rate and overall survival rate.

Nature and extent of the burden and risks associated with participation, benefit and group relatedness: Positive polypectomy margin status is associated with residual disease in the colon wall, but not with LNM. Current guidelines advise therefore secondary radical surgical resection for T1 CRCs with incomplete resection margins, even in the absence of other unfavourable histological factors. A segmental resection serves to clear the patient of the risk of residual tumor but carries significant inherent morbidity and mortality. The fact that the majority of patients (> 80%) has no evidence of residual disease on histological evaluation of their surgical specimens suggests a substantial overtreatment, especially for those without histological high-risk features for lymphatic spread. eFTR is a relatively new technique that allows complete en bloc resection of the previous resection site/scar to determine the local completeness of the previous resection, potentially avoiding unnecessary surgical risks.
At present completion treatment with eFTR after previous incomplete resection of low-risk T1 CRC has been already adopted in some practices in the Netherlands. However, the oncologic safety of this strategy has not been established and long-term data are lacking. Besides, at present no standard surveillance protocol exists following completion eFTR and surveillance varies widely in practice.

Study objective

This project aims to investigate the feasibility and oncological safety of eFTR as minimal invasive completion treatment following previous incomplete endoscopic resection of low-risk T1 CRC.

Study design

Evaluation of local luminal tumor recurrence 2- and 5- year after scar resection by eFTR

following a previous potentially incomplete resection of low-risk T1 CRC

Contacts

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Eligibility criteria

Inclusion criteria

Patients meeting all of the following criteria will be invited for participation in the study:
- Recent polypectomy/(p)EMR/ESD of T1 CRC without the following histological high-risk features*:
o Poor differentiation
o Lymphovascular invasion (NB if lymphovascular invasion cannot be assessed, patients are NOT eligible for inclusion)
o Tumor budding grade 2/3 (NB if tumor budding cannot be assessed at histopathology, patients are NOT eligible for inclusion)
- This recent polypectomy/(p)EMR/ESD for T1 CRC resulted in positive resection margins < 0.1mm (R1) or indeterminate resection margins (Rx)
- The resection scar after polypectomy/EMR/ESD is clearly recognized at endoscopy, either by a tattoo or by detecting a scar in the colonic segment where no other polypectomies were performed
- The diameter of the original lesion was ≤ 30 mm
- The diameter of the scar and/or residual lesion ≤ 15 mm
- The interval between index polypectomy/EMR and additional eFTR is at most 12 weeks
- Staging computed tomography (CT) of thorax and abdomen is performed and no local lymph node or distant metastases are detected. In case of rectal location an additional magnetic resonance imaging (MRI) of the pelvis is performed and no local suspicious lymph node(s) detected. If the target lesion is visible on MRI, rectal location is defined as location distal from the sigmoid take off. If not visible on MRI, rectal location is defined as < 15 cm from anal verge on endoscopy.

- Written informed consent is provided

*Before inclusion in this study, eligible histology needs to be centrally revised by an expert gastrointestinal pathologist (either Dr. M. Lacle University Medical Center Utrecht or Dr. A. Farina Sarasqueta Amsterdam UMC). In case of any doubt on the presence of high-risk features, both expert pathologist will have a case discussion in order to make a statement on either the presence of these risk features or the indetermination of those.

Exclusion criteria

Patients meeting any of the following criteria will be excluded from participation in this study:
- If lymphovascular invasion and/or tumor budding grade 2/3 cannot be assessed after prior polypectomy/(p)EMR, patients are NOT eligible for inclusion
- The patient is known with at least one of the following conditions:
o Active inflammatory bowel disease (IBD) in the colon
o Synchronous advanced CRC (defined as CRC in the 5 years before detection of T1 CRC, or elsewhere in the colorectum at the time of detection of T1 CRC)
- Index lesion located < 5 cm of the anal verge or with involvement of the valvula Bauhini or appendiceal orifice
- Age < 18 years
- Pregnancy

Study design

Design

Study type:	Observational non invasive
Intervention model:	Other
Allocation:	Non controlled trial
Masking:	Open (masking not used)
Control:	N/A , unknown

Recruitment

NL

Recruitment status:	Recruiting
Start date (anticipated):	16-07-2019
Enrollment:	153
Type:	Anticipated

IPD sharing statement

Plan to share IPD: Undecided

Ethics review

Positive opinion

Date:	16-07-2019
Application type:	First submission

Study registrations

Followed up by the following (possibly more current) registration

No registrations found.

Other (possibly less up-to-date) registrations in this register

No registrations found.

In other registers

Register	ID
NTR-new	NL7879
Other	METC AMC : W19_275

Study results