IBD Associated Surveillance Dysplasia Program: New integrated model - Royal Brisbane Hospital
Update Year 1: Audit, summary, future directions and Literature review
Background and Aim:

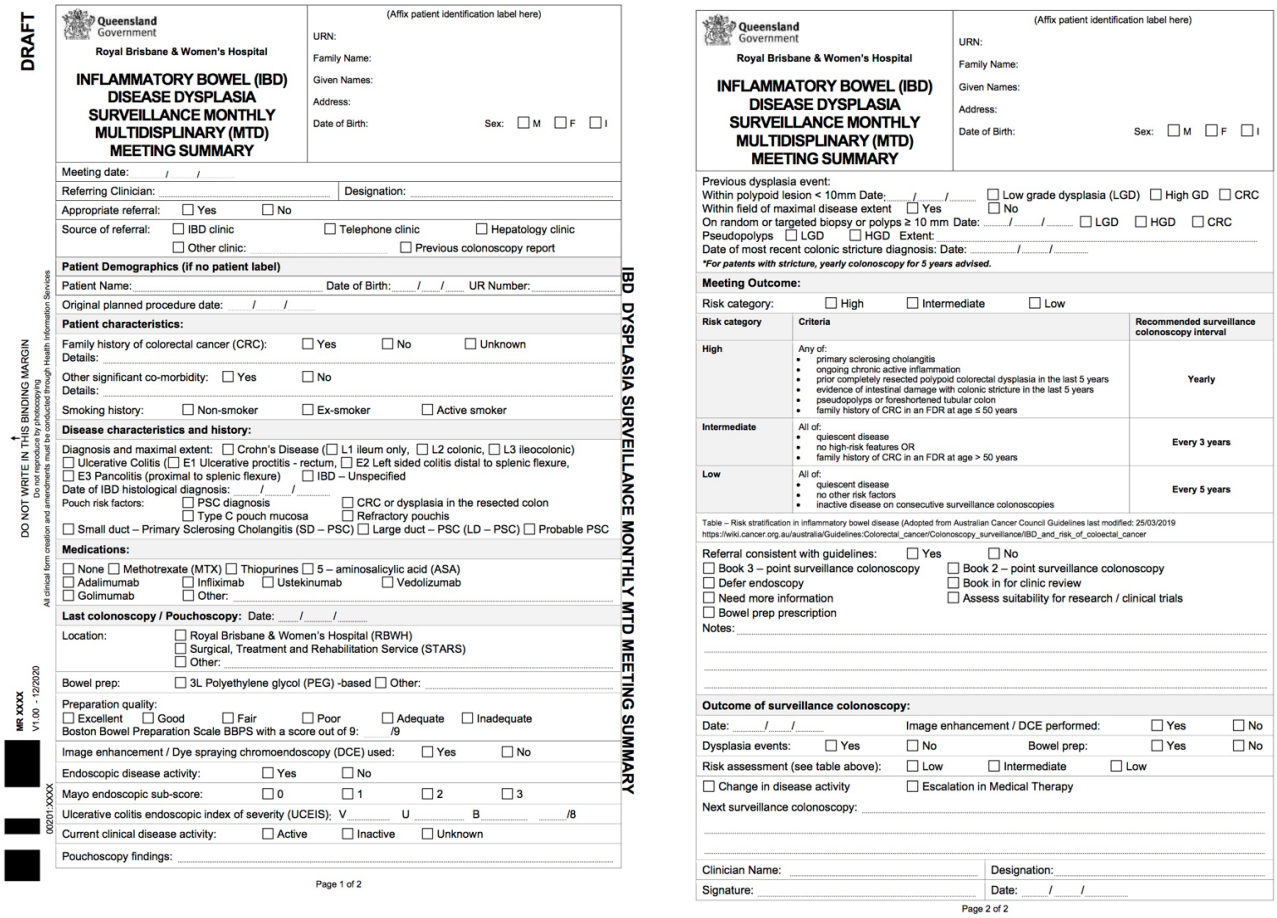
The recommended commencement of screening for dysplasia in IBD cases at 8-year duration of significant colonic inflammatory bowel disease. At this time the risk of colonic IBD patients having colorectal cancer (CRC) approaches 1%. The definition of significant colonic disease is a cumulative Montreal Classification E2 disease, that is proximal to the rectosigmoid junction (~15cm) *or* L2 or L3 Crohn's disease involving at least one-third of the colon. Exceptions: (Early starters) people with a diagnosis of PSC with concurrent IBD suggest surveillance starts annually from the date of PSC diagnosis. Those with a first degree relative (FDR) with CRC should commence screening 10 years prior to the age of diagnosis of the affected relative. Surveillance of the ileoanal pouch following restorative proctectomy is not commented on in the new guidelines. It is usually not recommended in the absence of high-risk features (ASGE, ECCO and BSG Guidelines): PSC diagnosis, CRC or dysplasia in the resected colon, Type C pouch mucosa (defined as pouch mucosa exhibiting permanent persistent atrophy and severe inflammation) or Refractory pouchitis

Methods:
We propose a new IBD Surveillance MDT model (figure 1) that has been integrated into IBD our service. The aim of the MDT is to improve the pathway for surveillance procedures, allocate resources appropriately and identify patients for research and trials. The MDT was conducted by the clinical team (IBD consultant lead of program and IBD fellow) with the assistance of administrative (booking clerks) and data managers. Cases were mainly referred from the prospective months booking database. Each case that is included in the monthly MDT meeting is discussed to ensure appropriate/consistent with guidelines. We collate the case with IBD database and risk calculator, assess and prescribe bowel prep, record outcome and communicate any changes, identify patients for studies and ensure we allocate patients to appropriate endoscopy lists.

Results:
Over a course of 12 meetings conducted monthly a total of 356 cases were screened with 91 cases eligible of which 62 cases considered suitable in meeting inclusion criteria. The majority of these cases were UC (E3/E2) (n=56), Crohns (n=27), colonic IBD (n =7) and IBD-U (n=1). Family history not strongly represented. The majority of cases were deemed in the high risk category for colorectal cancer (43/62). Previous Dysplasia cases limited (n=2 cases with adenoma). There were 17 cases with PSC (of which seven were large duct). Interestingly the MDT meeting found ten new cases of PSC which were being worked up between IBD appointments and yet to have a hepatology referral or critical investigations. There were ten pouchscopy cases. The MDT meeting was particularly useful in identifying challenging allocation cases where evidence from the literature is lacking in best surveillance endoscopy guidelines such as pouchscopy cases pseudopolyps, and those with a stricture. There were a significant number of deferrals, cancellations and reassignments identified and implemented as a result of the MDT IBD surveillance meeting (n =16). Four procedures were cancelled, eight cases reassigned due to extensive pseudo polyps and 17 cases were ensured to be on the annual surveillance list for PSC. We also identified significant bowel prep deficiencies in IBD dysplasia surveillance cases (n=18) and subsequent bowel prescriptions were made. Image Enhancement or chromoendoscopy not utilized in our service and identified as a potential area of improvement. A three-point specified allocation to colonoscopy lists was lacking, possibly mainly due to COVID 19 backlog of cases not allowing for adequate resource allocation. The areas of improvement identified for better implementation of the IBD Surveillance MDT model included attracting referrals from other settings other than the monthly booking file data (i.e increasing awareness of programs such as previously colonoscopy, hepatology clinic, or previous colonoscopy lists), and improving long-term MDT attendance (bookings, nursing and medical staff).

Conclusion:
The IBD surveillance MDT is a clinically useful tool that demonstrates significant improvement in quality and procedure reallocation. The current approach could be streamlined and be potentially used in IBD department across the country. Although resource allocation is required this clinical model can ensure that all IBD dysplasia surveillance cases including those with challenging risk factors or those outside the evidence based guidelines are appropriately monitored.

Figure 1



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INFLAMMATORY BOWEL (IBD) DISEASE DYSPLASIA SURVEILLANCE MONTHLY MULTIDISPLINARY (MTD) MEETING SUMMARY

(Affix patient identification label here)

URN:

Family Name:

Given Names:

Address:

Date of Birth: Sex: ☐ M ☐ F ☐ I

Meeting date: / /

Referring Clinician: Designation:

Appropriate referral: ☐ Yes ☐ No

Source of referral: ☐ IBD clinic ☐ Telephone clinic ☐ Hepatology clinic ☐ Other clinic: ☐ Previous colonoscopy report

Patient Demographics (if no patient label)

Patient Name: Date of Birth: / / UR Number:

Original planned procedure date: / /

Patient characteristics:

Family history of colorectal cancer (CRC): ☐ Yes ☐ No ☐ Unknown
Details:

Other significant co-morbidity: ☐ Yes ☐ No
Details:

Smoking history: ☐ Non-smoker ☐ Ex-smoker ☐ Active smoker

Disease characteristics and history:

Diagnosis and maximal extent: ☐ Crohn's Disease (☐ L1 ileum only, ☐ L2 colonic, ☐ L3 ileocolonic)
☐ Ulcerative Colitis (☐ E1 Ulcerative proctitis - rectum, ☐ E2 Left sided colitis distal to splenic flexure,
☐ E3 Pancolitis (proximal to splenic flexure) ☐ IBD – Unspecified
Date of IBD histological diagnosis: / /
Pouch risk factors: ☐ PSC diagnosis ☐ CRC or dysplasia in the resected colon
☐ Type C pouch mucosa ☐ Refractory pouchis
☐ Small duct – Primary Sclerosing Cholangitis (SD – PSC) ☐ Large duct – PSC (LD – PSC) ☐ Probable PSC

Medications:

☐ None ☐ Methotrexate (MTX) ☐ Thiopurines ☐ 5 – aminosalicylic acid (ASA)
☐ Adalimumab ☐ Infliximab ☐ Ustekinumab ☐ Vedolizumab
☐ Golimumab ☐ Other:

Last colonoscopy / Pouchoscopy: Date: / /

Location: ☐ Royal Brisbane & Women's Hospital (RBWH)
☐ Surgical, Treatment and Rehabilitation Service (STARS)
☐ Other:

Bowel prep: ☐ 3L Polyethylene glycol (PEG) -based ☐ Other:

Preparation quality:
☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Adequate ☐ Inadequate
Boston Bowel Preparation Scale BBPS with a score out of 9: /9

Image enhancement / Dye spraying chromoendoscopy (DCE) used: ☐ Yes ☐ No

Endoscopic disease activity: ☐ Yes ☐ No

Mayo endoscopic sub-score: ☐ 0 ☐ 1 ☐ 2 ☐ 3

Ulcerative colitis endoscopic index of severity (UCEIS): V U B /8

Current clinical disease activity: ☐ Active ☐ Inactive ☐ Unknown

Pouchoscopy findings:

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IBD DYSPLASIA SURVEILLANCE MONTHLY MTD MEETING SUMMARY

Queensland Government

Royal Brisbane & Women's Hospital

INFLAMMATORY BOWEL (IBD) DISEASE DYSPLASIA SURVEILLANCE MONTHLY MULTIDISPLINARY (MTD) MEETING SUMMARY

(Affix patient identification label here)

URN:

Family Name:

Given Names:

Address:

Date of Birth: Sex: ☐ M ☐ F ☐ I

Previous dysplasia event:
Within polypoid lesion < 10mm Date: / / ☐ Low grade dysplasia (LGD) ☐ High GD ☐ CRC
Within field of maximal disease extent ☐ Yes ☐ No
On random or targeted biopsy or polyps ≥ 10 mm Date: / / ☐ LGD ☐ HGD ☐ CRC
Pseudopolyps ☐ LGD ☐ HGD Extent:
Date of most recent colonic stricture diagnosis: Date: / /
For patents with stricture, yearly colonoscopy for 5 years advised.

Meeting Outcome:

Risk category: ☐ High ☐ Intermediate ☐ Low

Risk category	Criteria	Recommended surveillance colonoscopy interval
High	Any of: • primary sclerosing cholangitis • ongoing chronic active inflammation • prior completely resected polypoid colorectal dysplasia in the last 5 years • evidence of intestinal damage with colonic stricture in the last 5 years • pseudopolyps or foreshortened tubular colon • family history of CRC in an FDR at age ≤ 50 years	Yearly
Intermediate	All of: • quiescent disease • no high-risk features OR • family history of CRC in an FDR at age > 50 years	Every 3 years
Low	All of: • quiescent disease • no other risk factors • inactive disease on consecutive surveillance colonoscopies	Every 5 years

Table – Risk stratification in inflammatory bowel disease (Adopted from Australian Cancer Council Guidelines last modified: 25/03/2019
https://wiki.cancer.org.au/australia/Guidelines:Colorectal_cancer/Colonoscopy_surveillance/IBD_and_risk_of_colorectal_cancer

Referral consistent with guidelines: ☐ Yes ☐ No
☐ Book 3 – point surveillance colonoscopy ☐ Book 2 – point surveillance colonoscopy
☐ Defer endoscopy ☐ Book in for clinic review
☐ Need more information ☐ Assess suitability for research / clinical trials
☐ Bowel prep prescription
Notes:

Outcome of surveillance colonoscopy:

Date: / / Image enhancement / DCE performed: ☐ Yes ☐ No

Dysplasia events: ☐ Yes ☐ No Bowel prep: ☐ Yes ☐ No

Risk assessment (see table above): ☐ Low ☐ Intermediate ☐ Low

☐ Change in disease activity ☐ Escalation in Medical Therapy

Next surveillance colonoscopy:

Clinician Name: Designation:

Signature: Date: / /

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