

UiO : University of Oslo

Differences between on-going programmes:

POLAND

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Program Badań Przesiewowych

**WCZESNE WYKRYWANIE
RAKA JELITA GRUBEGO**





Facts

- Primary colonoscopy screening
 - Opportunistic (2000-2011)
 - Population-based / invitations (since 2012)
- Priorities
 - Central database
 - Quality control
 - Training
 - Research on optimization



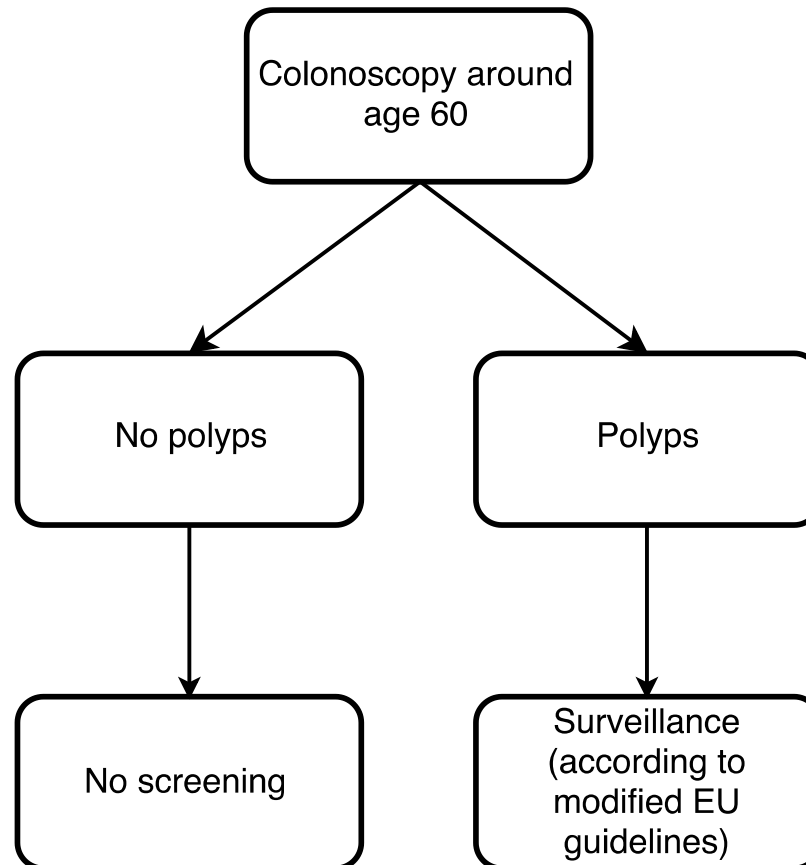
Why primary colonoscopy screening?

- Simplicity: single-stage strategy
- Organization
- Low cost: 100 euro/procedure
- Costs of program – equal to 5 rounds FOBT
- Low acceptance of FOBT (80-ies) - 16%
- Already built colonoscopy capacity

- Challenge: Not proven to be effective (yet?)



Triage screening test





Population-based screening program

- Funded by the Ministry of Health
- High quality invitations
- Colonoscopy appointment on invitation
 - Methodology from the NordICC study
- Once in a lifetime colonoscopy: age 55-64
- Gradually increased coverage of birth cohorts and geographic regions
- Full population coverage from 2021 (assuming 30% compliance)



Central database

- Web-based, national ID (PESEL) for identification
- Modules for all phases
 - Screening invitation and appointments
 - Colonoscopy
 - Histopathology
 - Follow-up
- Reporting, research
- Flexible
 - Integrate new study-specific modules



Quality control

- Selection of screening centers
 - Proven quality standards are a requirement
- Yearly feedback on center and individual level quality measures
 - Database
 - Gastronet (patient experience)
- Train-the-leader course
- Histopathology training session



Platform for clinical effectiveness research

- Effect of program, intervention
- Add-on studies
 - Invitation
 - Bowel prep
 - ...
- Participate in other studies
 - NordICC
 - EPOS
 - ...



Randomized health service study

- Each year 20% of each birth cohort 1:1
- Screening group:
 - Invited to colonoscopy in the year of randomization
- Control group:
 - Invited to colonoscopy 5 years later (not informed about the status of controls)



Randomized health service study





Short term analyses

- Sensitivity of the screening episode and program for clinically detectable CRC within 2 (5) years
- Cost-effectiveness of the program
- Compliance in response to different invitation schemes, bowel preps etc.

- Screening versus control groups
 - Incidence of advanced CRC within 2 (5) years after randomization
 - 30-day mortality and hospitalization rates



Long term analyses

- Different designs:
 - Immediate versus delayed or no screening groups
 - Different areas (implementation phase and historical phase)
 - Population-based screening
 - Opportunistic screening
 - No screening
- Endpoints:
 - Reduction in CRC incidence after 10-25 years of follow-up
 - Reduction in CRC mortality after 10-25 years of follow-up



Ethical considerations

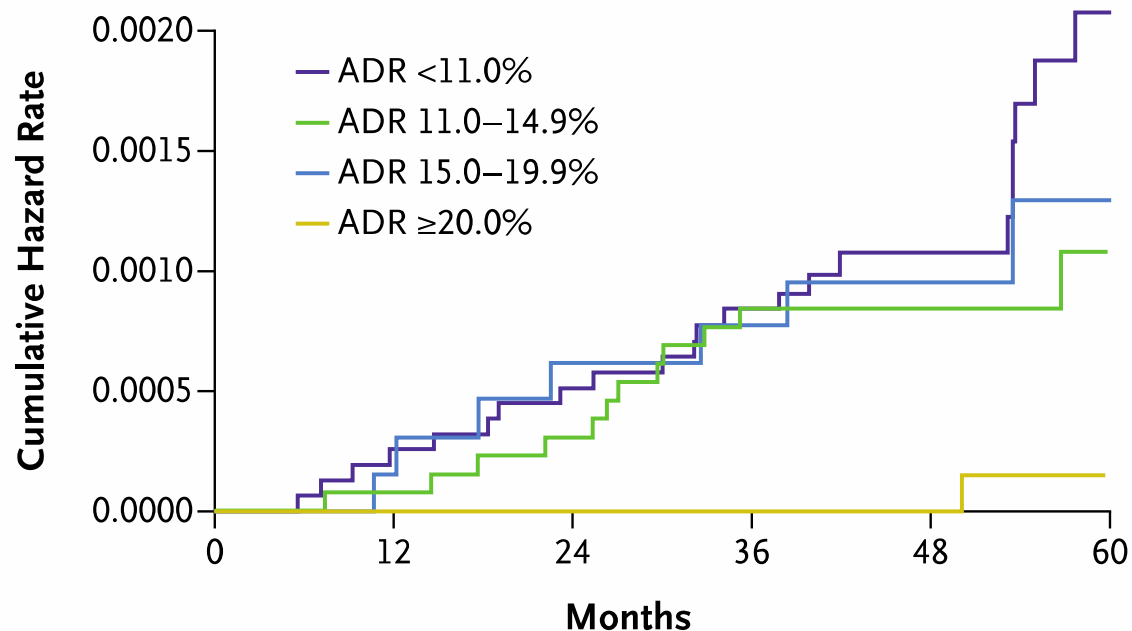
- Randomization
 - Capacity
 - Colonoscopy not tested for long-term effect on CRC incidence and mortality



ORIGINAL ARTICLE

Quality Indicators for Colonoscopy and the Risk of Interval Cancer

Michał F. Kamiński, M.D., Jarosław Reguła, M.D., Ewa Kraszewska, M.Sc.,
Marcin Polkowski, M.D., Urszula Wojciechowska, M.D., Joanna Didkowska, M.D.,
Maria Zwierko, M.D., Maciej Rupinski, M.D., Marek P. Nowacki, M.D.,
and Eugeniusz Butruk, M.D.

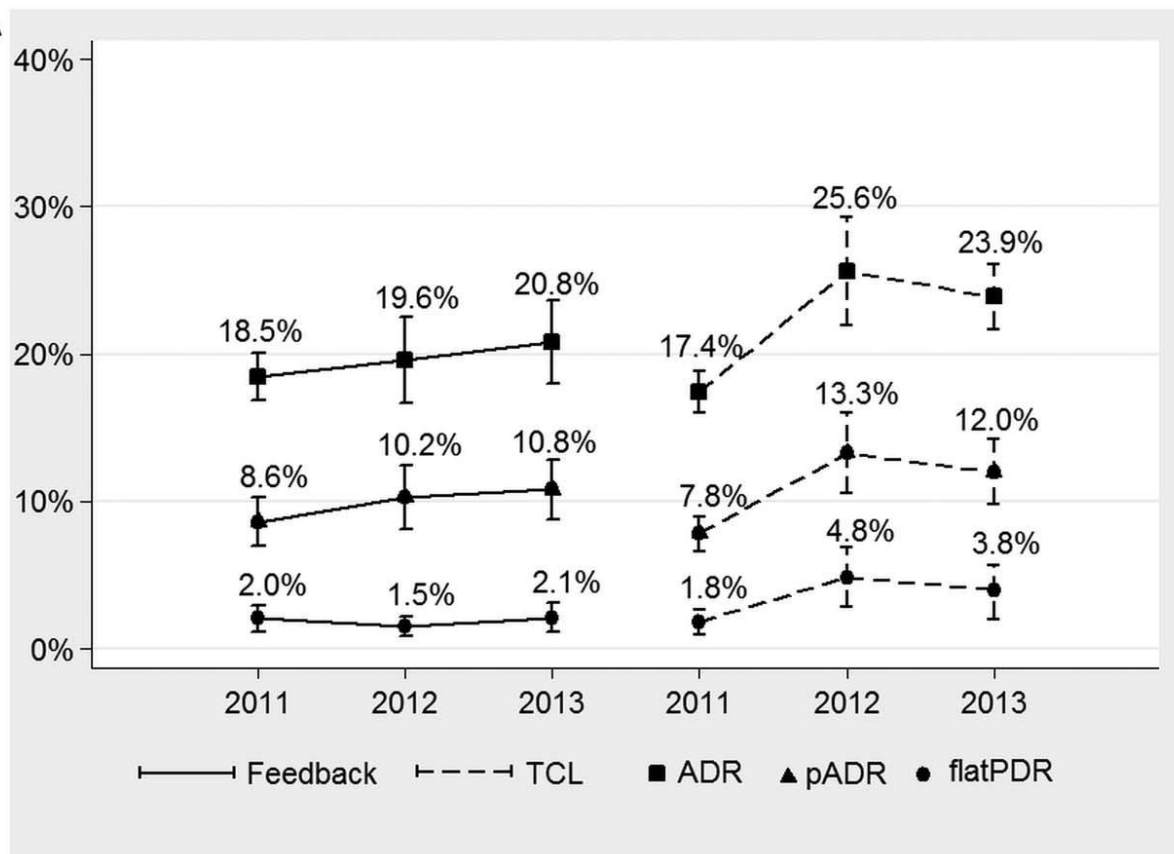




ORIGINAL ARTICLE

Leadership training to improve adenoma detection rate in screening colonoscopy: a randomised trial

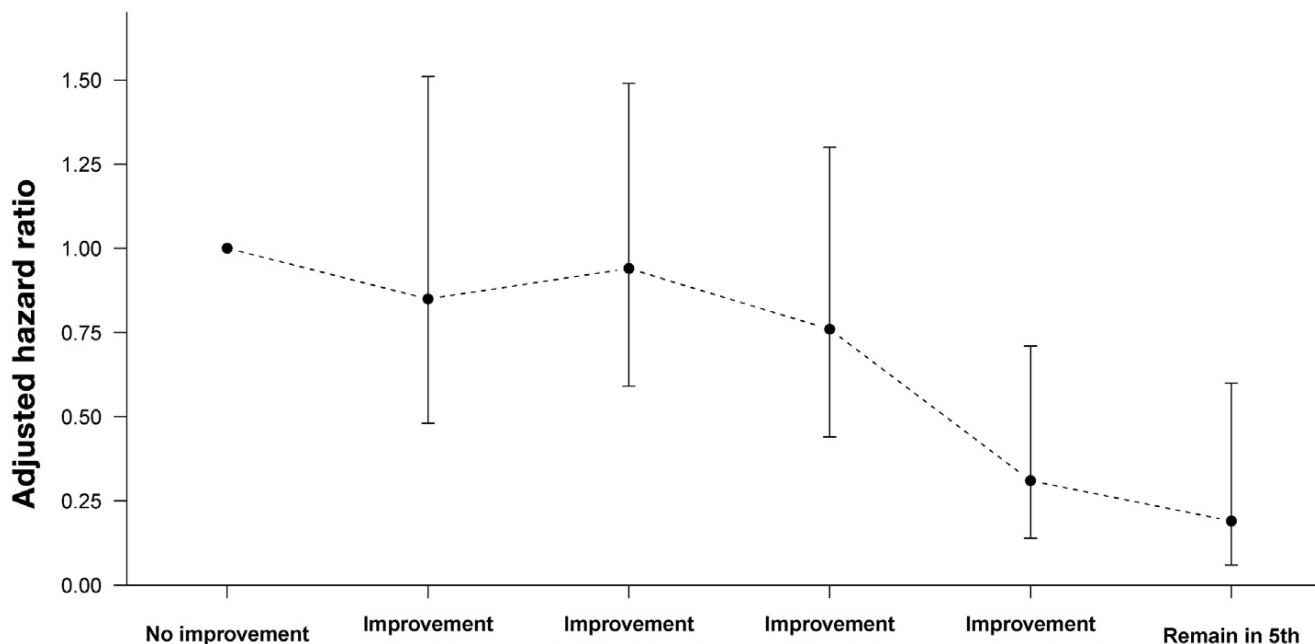
Michal F Kaminski,¹ John Anderson,² Roland Valori,³ Ewa Kraszewska,¹ Maciej Rupinski,¹ Jacek Pachlewski,¹ Ewa Wronska,¹ Michael Bretthauer,^{4,5} Siwan Thomas-Gibson,⁶ Ernst J Kuipers,⁷ Jaroslaw Regula¹





Increased Rate of Adenoma Detection Associates With Reduced Risk of Colorectal Cancer and Death

Michal F. Kaminski,^{1,2,3,4,*} Paulina Wieszczy,^{1,2,4,*} Maciej Rupinski,^{1,2}
 Urszula Wojciechowska,⁵ Joanna Didkowska,⁴ Ewa Kraszewska,² Jaroslaw Kobiela,^{2,6}
 Robert Franczyk,^{1,2} Maria Rupinska,^{1,2} Bartlomiej Kocot,² Anna Chaber-Ciopinska,^{1,2}
 Jacek Pachlewski,¹ Marcin Polkowski,^{1,2} and Jaroslaw Regula^{1,2}



	No improvement	Improvement from 1 to 2	Improvement from 1 or 2 to 3	Improvement from 1-3 to 4	Improvement from 1-4 to 5	Remain in 5th
HR	1.00	0.90	0.74	0.64	0.27	0.18
95% CI		(0.61, 1.34)	(0.47, 1.16)	(0.41, 1.01)	(0.12, 0.63)	(0.06, 0.56)
No. of cancers/ 100,000 p-yrs	25.34	22.67	18.86	16.25	7.09	4.49