ΛΑΪΚΟ
ΓΕΝΙΚΟ ΝΟΣΟΚΟΜΕΙΟ ΑΘΗΝΩΝ
ΠΑΝΕΠΙΣΤΗΜΙΟ ΑΘΗΝΩΝ

11η Εκπαιδευτική Ημερίδα: « ΣΥΓΧΡΟΝΗ ΓΑΣΤΡΕΝΤΕΡΟΛΟΓΙΑ-ΗΠΑΤΟΛΟΓΙΑ: ΑΠΟ ΤΙΣ ΚΑΤΕΥΘΥΝΤΗΡΙΕΣ ΟΔΗΓΙΕΣ ΣΤΗΝ ΚΛΙΝΙΚΗ ΠΡΑΞΗ»

Πανεπιστημιακή Γαστρεντερολογική Κλινική
Διευθυντής: Καθηγητής Παπαθεοδωρίδης Γεώργιος
Αλεξόπουλος Θεόδωρος
Ειδικευόμενος Γαστρεντερολογίας, Διδάκτωρ Ιατρικής Σχολής ΕΚΠΑ

ΕΡΩΤΗΜΑ 1^{Ο}
Μετεωρισμός: θα μπορούσαν οι δίαιτες FODMAPS να είναι η λύση;

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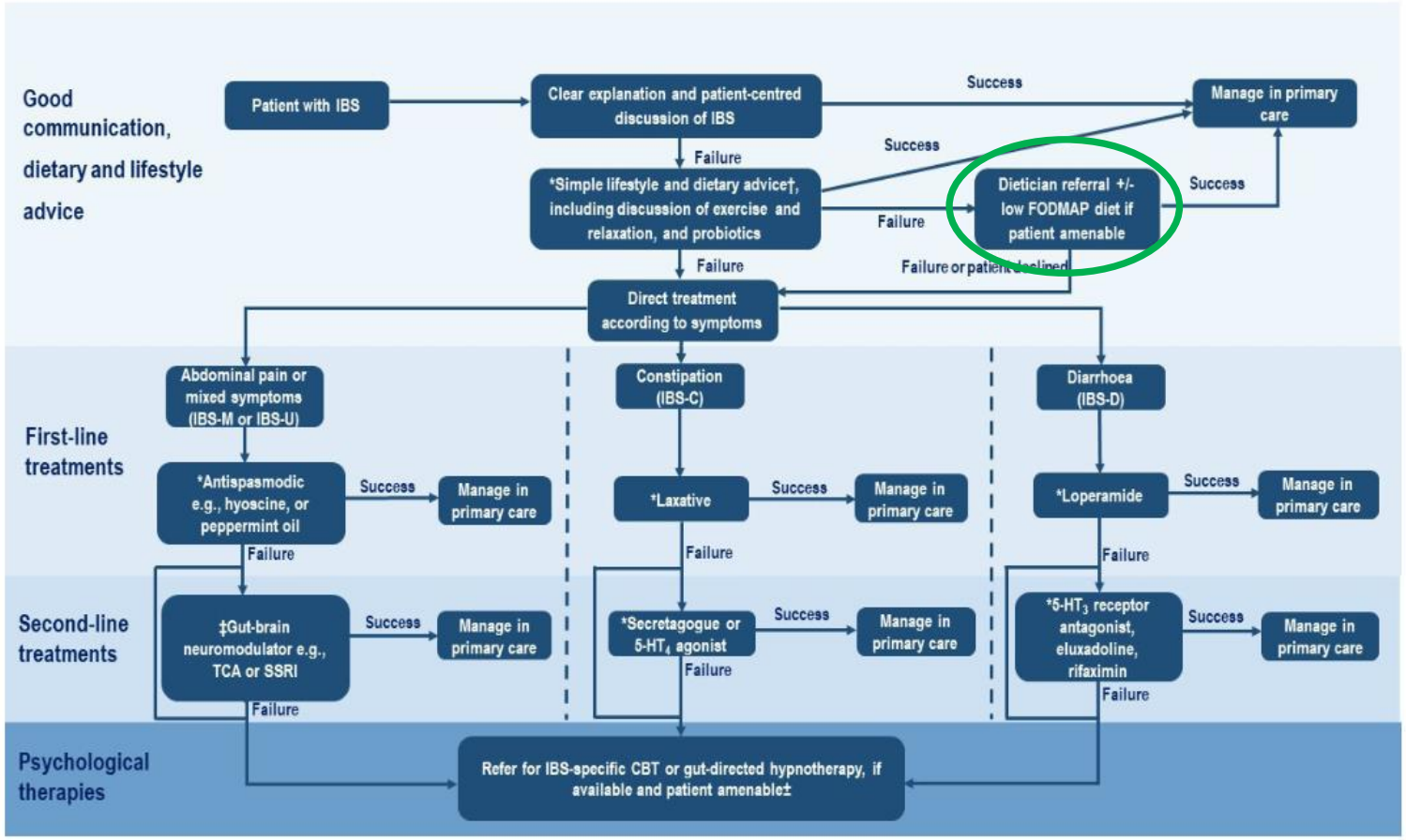

Vasant DH, et al. British Society of Gastroenterology guidelines on the management of irritable bowel syndrome Gut 2021;

Ορισμός:FODMAP, **F**ermentable **O**ligosaccharides, **D**isaccharides and **M**onosaccharides and **P**olyols
Ομάδα υδατανθράκων βραχείας αλυσίδας που απορροφώνται ελάχιστα στο λεπτό έντερο και ζυμώνονται γρήγορα από την μικροβιακή χλωρίδα του εντέρου, με αποτέλεσμα να προκαλούνται φούσκωμα, αέρια εντέρου και μετεωρισμός

11 μελέτες σύγκριναν τη low FODMAP δίαιτα με: κανονική διατροφή, δίαιτα πλούσια σε FODMAP και παραδοσιακές διατροφικές οδηγίες. Η δίαιτα χαμηλή σε FODMAP συσχετίστηκε με μειωμένα συμπτώματα (Low Quality of Evidence)

Recommendations

- A diet low in fermentable oligosaccharides, disaccharides and monosaccharides and polyols, as a second-line dietary therapy, is an effective treatment for global symptoms and abdominal pain in IBS, but its implementation should be supervised by a trained dietitian and fermentable oligosaccharides, disaccharides and monosaccharides and polyols should be reintroduced according to tolerance (recommendation: weak, quality of evidence very low).

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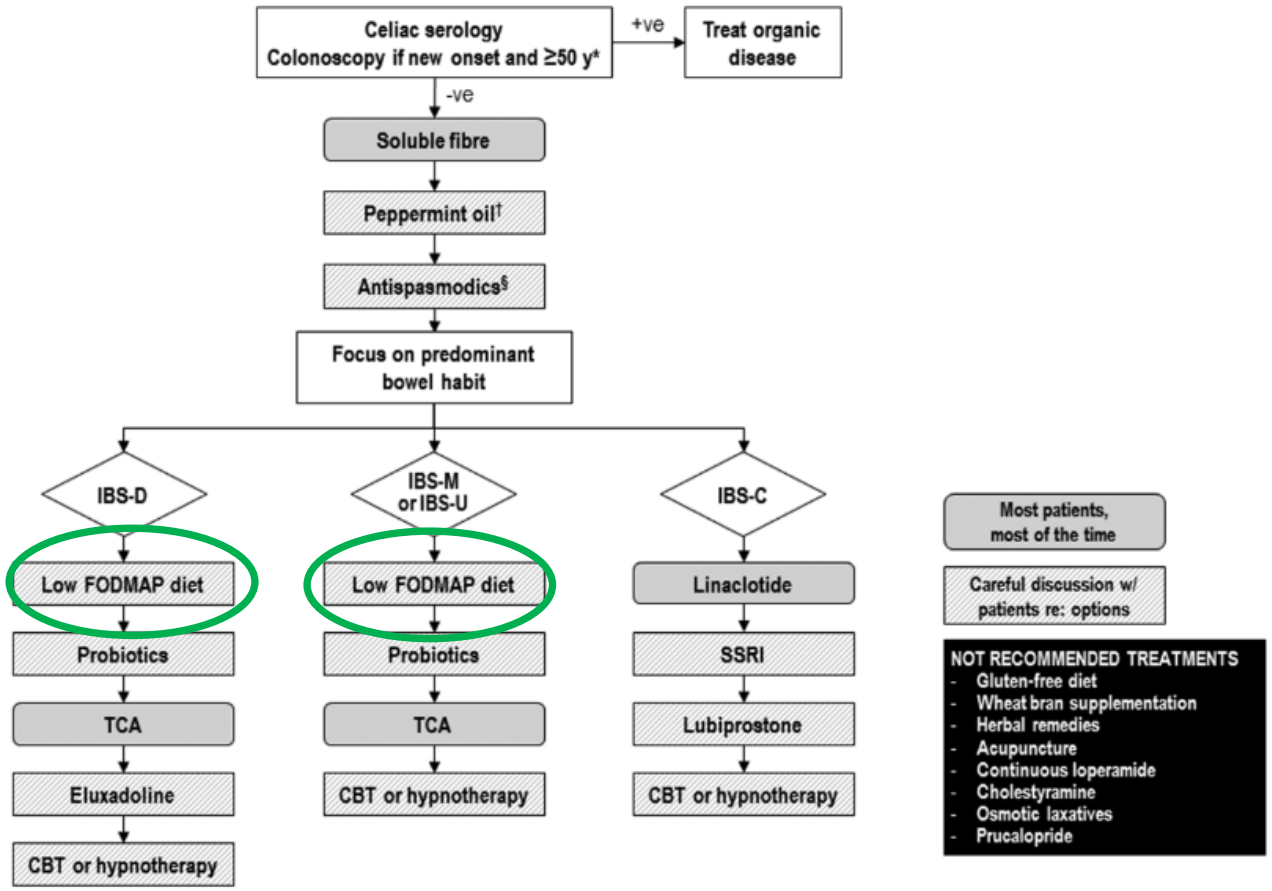

Μειονεκτήματα low FODMAP

1. Επίδραση στο μικροβίωμα του ΠΕ (π.χ Μείωση πληθυσμού Bifidobacteria
2. Οι μελέτες που εξετάσθηκαν είχαν βραχεία διάρκεια (3-4w) χωρίς να συμπεριλάβουν τις φάσεις επανεισαγωγής

Σε περίπτωση που αποφασιστεί η εφαρμογή της απαραίτητη είναι η επίβλεψη από ειδικό διατροφολόγο με όσο το δυνατόν μικρότερη διάρκεια ώστε να αποφευχθούν διατροφικές ελλείψεις

Statement 10: We suggest offering IBS patients a low FODMAP diet to reduce IBS symptoms.

GRADE: Conditional recommendation, very low-quality evidence. Vote: strongly agree, 27%; agree, 64%; neutral, 9%

Moayyedi et al, Journal of the Canadian Association of Gastroenterology, 2019,

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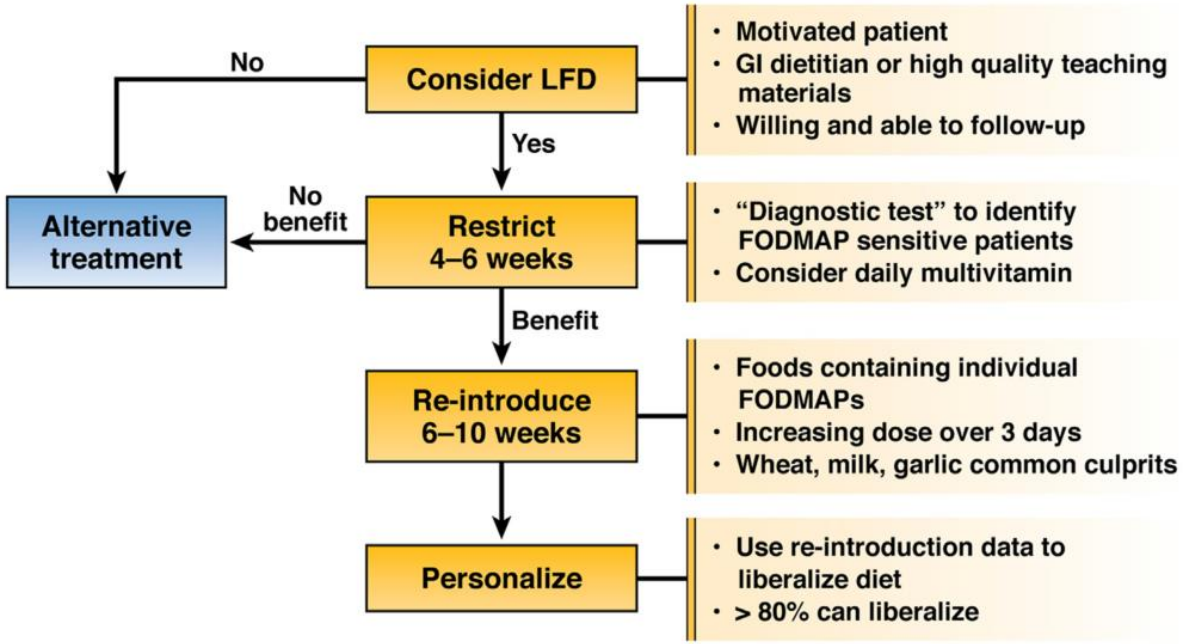
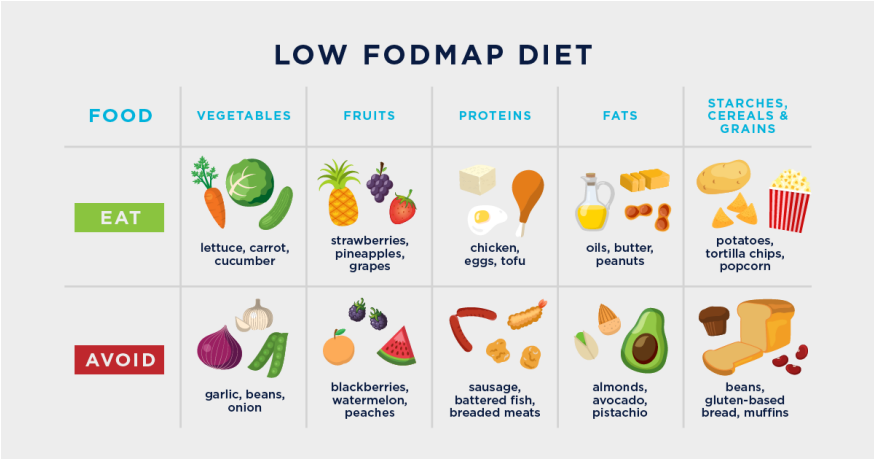


Best Practice Advice 6: The LFD is currently the most evidence-based diet intervention for IBS. Healthy eating advice as described by the National Institute of Health and Care Excellence Guidelines, among others, also offers benefit to a subset of patients with IBS.

Best Practice Advice 7: The LFD consists of 3 phases: 1) restriction (lasting no more than 4–6 weeks), 2) reintroduction of FODMAP foods, and 3) personalization based on results from reintroduction.



13 RCTs έδειξαν αυξημένα ποσοστά ύφεσης συμπτωμάτων όπως ο μετεωρισμός και το κοιλιακό άλγος σε ασθενείς με ΣΕΕ (>50-point reduction in IBS-SSS) σε σύγκριση με άλλες διαιτητικές ή άλλες παρεμβάσεις

Chey et al, Gastrenterology 2022

ΕΡΩΤΗΜΑ 2^{Ο}
Σε ποια άτομα με πολύποδες παχέος εντέρου έχει θέση ο γενετικός έλεγχος;

Published in final edited form as:
Am J Gastroenterol. 2015 February ; 110(2): 223–263. doi:10.1038/ajg.2014.435.

ACG Clinical Guideline: Genetic Testing and Management of Hereditary Gastrointestinal Cancer Syndromes

Sapna Syngal, MD, MPH, FACG[1,2,3], **Randall E. Brand, MD, FACG**[4], **James M. Church, MD, FACG**[5,6,7], **Francis M. Giardiello, MD**[8], **Heather L. Hampel, MS, CGC**[9], and **Randall W. Burt, MD, FACG**[10]

ΕΡΩΤΗΜΑ 2^{Ο}
Σε ποια άτομα με πολύποδες παχέος εντέρου έχει θέση ο γενετικός έλεγχος;

Σύνδρομο Lynch

3. Individuals who have a personal history of a tumor showing evidence of mismatch repair deficiency (and no demonstrated BRAF mutation or hypermethylation of *MLH1)*, a known family mutation associated with LS, or a risk of ≥5% chance of LS based on risk prediction models should undergo genetic evaluation for LS.

Summary statement

- Genetic testing of patients with suspected LS should include germline mutation genetic testing for the *MLH1*, *MSH2*, *MSH6*, *PMS2*, and/or *EPCAM* genes (13–23), or the altered gene(s) indicated by IHC testing.

Amsterdam criteria II (24)

At least three relatives must have a cancer associated with Lynch syndrome (colorectal, cancer of the endometrium, small bowel, ureter, or renal–pelvis); all of the following criteria should be present:

One must be a first-degree relative of the other two;

At least two successive generations must be affected;

At least one relative with cancer associated with Lynch syndrome (LS) should be diagnosed before age 50;

Familial adenomatous polyposis should be excluded in the CRC case(s) (if any);

Tumors should be verified whenever possible.

Revised Bethesda guidelines (24)

Tumors from individuals should be tested for microsatellite instability (MSI) in the following situations:

CRC diagnosed in a patient who is younger than 50 years of age

Presence of synchronous, or metachronous, colorectal or other LS-related tumors[a], regardless of age

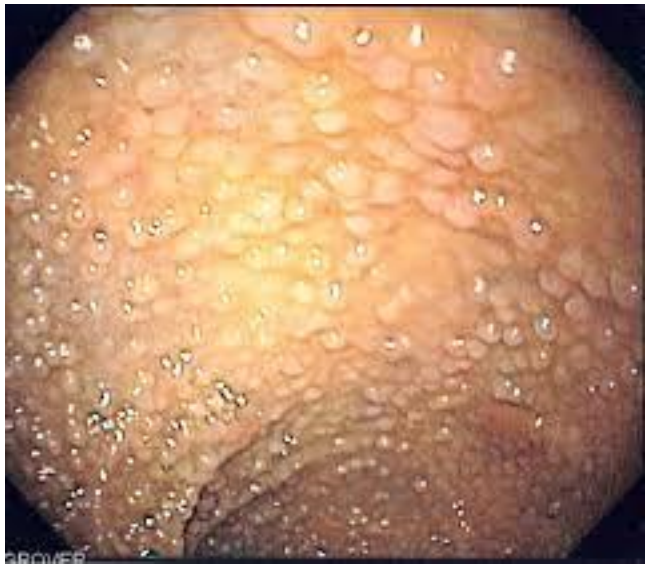
CRC with MSI-high histology[b] diagnosed in a patient who is younger than 60 years of age

CRC diagnosed in a patient with one or more first-degree relatives with an LS-related cancer, with one of the cancers being diagnosed under age 50 years

CRC diagnosed in a patient with two or more first- or second-degree relatives with LS-related cancer regardless of age

FAP-AFAP-MAP

Individuals who have a personal history of >10 cumulative colorectal adenomas, a family history of one of the adenomatous polyposis syndromes, or a history of adenomas and FAP-type extracolonic manifestations (duodenal/ampullary adenomas, desmoid tumors (abdominal>peripheral), papillary thyroid cancer, congenital hypertrophy of the retinal pigment epithelium, epidermal cysts, osteomas) should undergo assessment for the adenomatous polyposis syndromes.



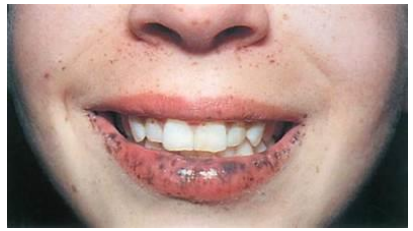
Syngal et al, Am J Gastroenterol. 2015

ΕΡΩΤΗΜΑ 2^{Ο}
Σε ποια άτομα με πολύποδες παχέος εντέρου έχει θέση ο γενετικός έλεγχος;

Σύνδρομο Peutz Jeghers

Indications for genetic testing: ***Summary statement***

- Individuals with perioral or buccal pigmentation and/or two or more histologically characteristic GI hamartomatous polyp(s) or a family history of PJS should be evaluated for PJS.



Summary statement

- Genetic evaluation of a patient with possible PJS should include testing for *STK11* mutations.

Σύνδρομο Οδοντωτής Πολυποδίασης

Summary statement

- Indications for genetic testing. A clear genetic etiology has not yet been defined for SPS, and therefore genetic testing is currently not routinely recommended for SPS patients; testing for *MUTYH* mutations may be considered for SPS patients with concurrent adenomas and/or a family history of adenomas.

Σύνδρομο Νεανικής Πολυποδίασης

Indications for genetic testing—*Summary statement*

- Individuals with five or more juvenile polyps in the colorectum or any juvenile polyps in other parts of the GI tract should undergo evaluation for JPS.

Summary statement

- Genetic evaluation of a patient with possible JPS should include testing for *SMAD4* and *BMPR1A* mutations.

Σύνδρομο Cowden

Summary statement

- Individuals with multiple GI hamartomas or ganglioneuromas should be evaluated for CS and related conditions.

Summary statement

- Genetic evaluation of a patient with possible CS should include testing for *PTEN* mutations.

Syngal et al, Am J Gastroenterol. 2015

ΕΡΩΤΗΜΑ 2^{Ο}
Σε ποια άτομα με πολύποδες παχέος εντέρου έχει θέση ο γενετικός έλεγχος;

Features that warrant evaluation and possible testing for HCCS

CRC in patients younger than 50 yr
Personal history of multiple cancers (e.g., CRC and endometrial cancer, colonic polyposis, and thyroid cancer)
Personal and family history suspicious for LS[a]
Tumor testing with deficient mismatch repair[b]
More than 10–20 cumulative colonic adenomas
More than 3 colonic hamartomas or 2 small bowel hamartomas[c]
Family members with known genetic diagnosis of HCCS

CRC, colorectal cancer; HCCS, hereditary colorectal cancer syndromes; LS, Lynch syndrome.

[a]Assessed using tools such as Amsterdam II, revised Bethesda criteria, PREMM5 or a 3-question survey, see Table 3.

[b]Caveats are when loss of MLH1/PMS2 or microsatellite instability is due to somatic methylation or double somatic mutations rather than germline mutation.

[c]In addition to other clinical criteria for juvenile polyposis syndrome, Peutz-Jeghers syndrome and Cowden syndrome.

Πώς και πότε γίνεται ο γενετικός έλεγχος;

- Multipannel testing μετά από εκτίμηση από ειδικό γενετιστή
- Για σύνδρομα που εκδηλώνονται σε παιδική ηλικία (FAP, Peutz Jeghers, Νεανική Πολυποδίαση) ο έλεγχος σε παιδική ηλικία
- Για οικογενειακό ιστορικό LS έλεγχος 18-20 ετών
- Σε νεοδιαγνωσθέντα ΚΠΕ με χαρακτηριστικά HCCS έλεγχος προ του χειρουργείου

Kupfer et al, Am J Gastroenterol. 2020

ΕΡΩΤΗΜΑ 3^{Ο}
Μέθοδοι βελτίωσης του ποσοστού ανίχνευσης αδενωμάτων παχέος εντέρου (ADR)

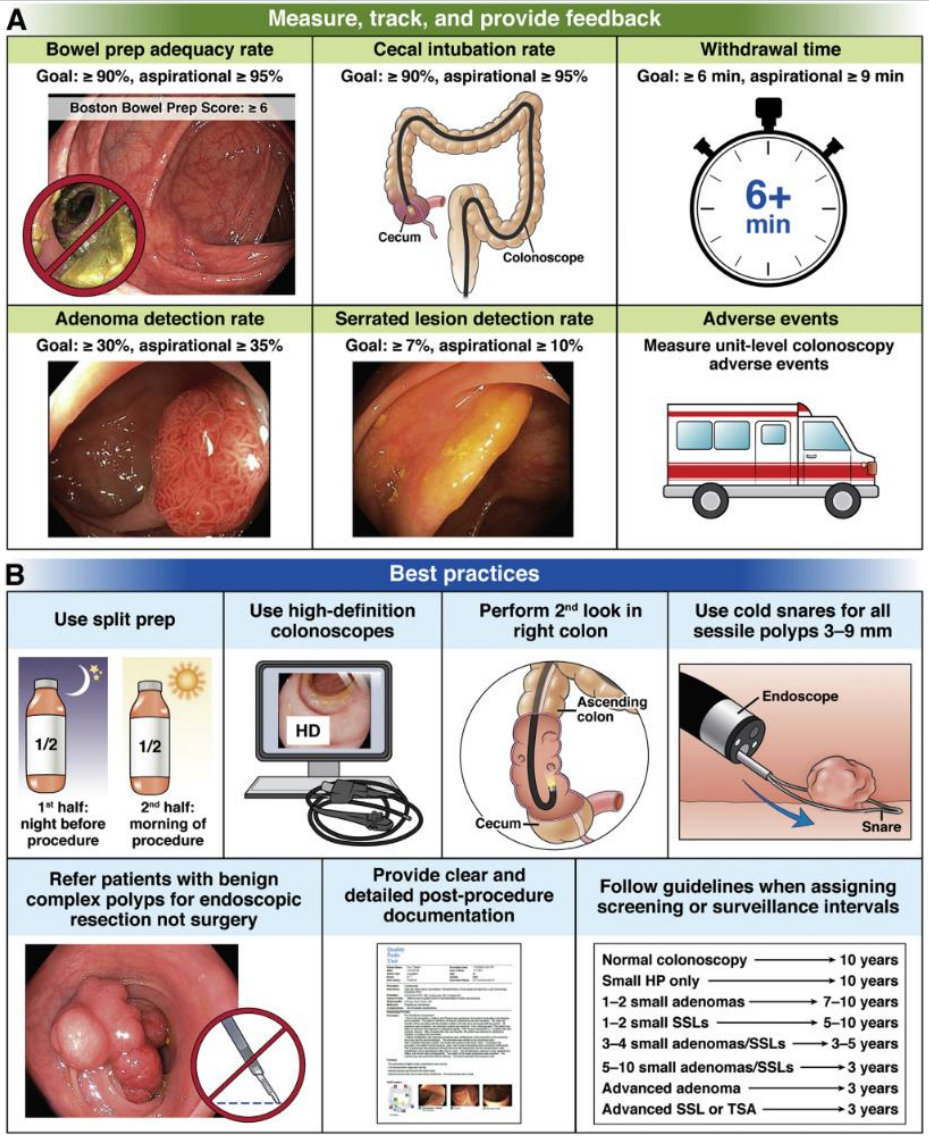
ΕΡΩΤΗΜΑ 3Ο
Μέθοδοι βελτίωσης του ποσοστού ανίχνευσης αδενωμάτων παχέος εντέρου (ADR)

Προετοιμασία

Τεχνική

Καταγραφή

BPA	Statement
1	Endoscopy units should measure bowel preparation quality routinely, at a minimum annually, on a unit level. Adequate bowel preparation (defined as a BBPS score ≥6, with each segment score ≥2) should be achieved in ≥90% (≥95% aspirational target) of screening and surveillance colonoscopies.
2	Endoscopy units should use a split-dose bowel preparation as the standard preparation strategy in patients undergoing colonoscopy.
3	Bowel preparation instructions should be clearly written at a sixth-grade reading level in the patient's native language. Units with suboptimal bowel preparation quality should augment preprocedure instructions with additional patient education and support.
4	Endoscopy units should use high-definition colonoscopes for screening and surveillance colonoscopy.
5	Endoscopy units should measure cecal intubation rates on an endoscopist level. Cecal intubation rates should be ≥90% (aspirational ≥95%). The cecal landmarks (appendiceal orifice and ileocecal valve) should be photodocumented in colonoscopy reports.
6	Endoscopy units should measure withdrawal times on an endoscopist level. Mean withdrawal times among normal colonoscopies should be ≥6 minutes (aspirational target ≥9 minutes).
7	Endoscopists should perform a second look of the right colon, either in retroflexed or forward view, to improve the detection of polyps.
8	Endoscopy units should measure and provide feedback on adenoma detection rate at both the endoscopist and unit level on a routine basis, at a minimum annually or when endoscopists have accrued 250 screening colonoscopies.
9	The goal adenoma detection rate for an individual endoscopist should be ≥30% (aspirational target ≥35%). Endoscopists not meeting these thresholds may consider extending withdrawal times, self-learning regarding mucosal inspection and polyp identification, peer feedback, and other educational interventions.
10	Endoscopy units should measure and provide feedback on serrated lesion detection rates on an endoscopist- and unit- level. The goal serrated lesion detection rate for an individual endoscopist should be ≥7% (aspirational target ≥10%). If rates are low, improvement efforts should be oriented toward both colonoscopists and pathologists.



Keswani et al,Gastroenterology. 2021

ΕΡΩΤΗΜΑ 3Ο
Μέθοδοι βελτίωσης του ποσοστού ανίχνευσης αδενωμάτων παχέος εντέρου (ADR)

Technique		
Water assistance	CO_2/air insufflation	6% water immersion 10% for water exchange
Lengthening withdrawal time	<6 min	9% for 9-min WT compared with 6 min
Retroflexion in cecum	No retroflexion	17% for right-sided adenomas
Second look, either retroflexion in the cecum or second forward look in the proximal colon	Single forward look	10% for all adenomas, 5% for right-sided adenomas
Dynamic change in patient position	No change in position	7%
Technology		
Distal attachment devices	Standard colonoscopy	5%-11%
Enhanced imaging technology (narrow-band imaging, i-SCAN, linked-color imaging, blue-laser imaging, chromoendoscopy, and Methylene Blue-MMX (Cosmo Pharmaceuticals, Dublin, Ireland))	Standard or high definition white-light colonoscopy	5% to 18% absolute improvement in adenoma detection
Computer aided detection technologies	Standard colonoscopy	10%-12% in adenoma, .2 in adenoma per colonoscopy
Systematic interventions		
Split-dose bowel preparation	Day-before bowel preparation	26%
Same-day bowel preparation	Split-dose bowel preparation	No improvement
Video recording of colonoscopy	No recording	No improvement
Nurse assigned to observe colonoscopy monitor	No observation	19%
Education and feedback		
Physician report cards	No report cards	10%-15%
Focused educational interventions	No education	29% for ADR, 39% for proximal ADR
Financial incentives	No financial incentives	0%-3%
Public reporting of ADR	No public reporting	45% increase in ADR, 25% in advanced ADR

Shaukat et al,GI Endoscopy 2022

ΣΑΣ ΕΥΧΑΡΙΣΤΩ ΠΟΛΥ ΓΙΑ ΤΗΝ ΠΡΟΣΟΧΗ ΣΑΣ