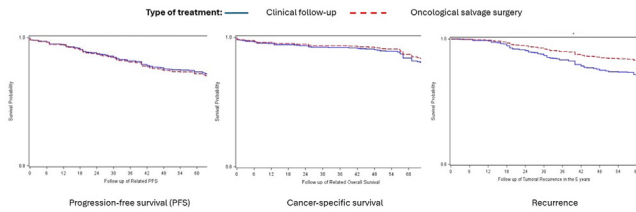


Figure 1. Primary outcomes: progression-free survival (PFS), cancer-specific survival, and recurrence.



	Clinical follow-up	Oncological salvage surgery	HR (95%CI)	p
PFS	11 (8,15%)	9 (3,73%)	0.68 (0.42; 1.09)	0,107
Cancer-specific survival	6 (4,44%)	4 (1,66%)	0.72 (0.39; 1.33)	0,296
Recurrence	9 (6,67%)	7 (2,90%)	0.59 (0.34; 1.02)	0,058
Endoluminal recurrence	8 (1,93%)	5 (8,1%)	0.30 (0.10; 0.94)	0,040

Figure 2. Stratified analysis by histological risk: Results in High risk patients

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COST-EFFECTIVENESS COMPARISON OF TEM & ESD IN EARLY RECTAL TUMOURS: THE MUCEM - GRECCAR 13 - FRENCH04 TRIAL

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Abstract Body: BACKGROUND: Only retrospective single-centre studies have compared Transanal Endoscopic Microsurgery (TEM) and Endoscopic Submucosal Dissection (ESD) for the local excision of early rectal tumours (ERT). OBJECTIVE: A cost-effectiveness analysis was conducted, with effectiveness defined by the rate of complete resection. DESIGN: This was a two-arm non-randomised, multicentre controlled trial, following a "here vs. elsewhere" approach. The inclusion criteria were early rectal tumours (i.e., adenoma, in situ, and uT1N0 carcinoma) eligible for treatment with either TEM or ESD. Preoperative chemoradiotherapy was an exclusion criterion. RESULTS: A total of 213 ESD and 117 TEM procedures were included. The tumours did not differ regarding their circumferential involvement (ESD 3.0% vs. TEM 5.7%, $p=0.50$), although the tumours in the ESD group were larger (ESD 39.2 ± 19 mm vs. TEM 30.5 ± 17 , $p<0.01$). There were more carcinomas in the TEM group (14% vs. 25%, $p=0.01$). Cost-effectiveness analysis favoured ESD, with a differential cost of €1500 ($p=0.06$), even after adjustment for histopathology by sensitivity analysis ($p=0.05$). The rate of complete resection did not differ (ESD 84.5% vs. TEM 76.9%, $p=0.10$). In terms of secondary outcomes, en-bloc excision favoured ESD (99% vs. 92.5%, $p<0.01$), even after adjustment for histopathology. Overall and major morbidity did not differ ($p=0.55$ and $p=0.23$). At 3 years, cost-utility analysis showed no differences in terms of QALY, and overall survival did not differ ($p=0.81$), while disease-free survival was better after ESD (94.3% vs. 84.6%, $p<0.01$). CONCLUSION: The findings of this study favour ESD over TEM for ERT in terms of cost-effectiveness, excision quality, and recurrence.

ID: 4256422

TECHNICAL AND ONCOLOGICAL OUTCOMES OF ENDOSCOPICALLY RESECTED T1 COLORECTAL CANCER ACCORDING TO OPTICAL DIAGNOSIS CLASSIFICATION

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Abstract Body: Aims: Optical diagnosis attempts to guide the endoscopist in making a treatment choice, however, selecting lesions with possible covert cancer (CON-ECCT IIA lesions: JNET IIA, no macronodule, no depressed area), high-risk lesions (CONECCT IIC lesions: JNET IIB or macronodule or depressed area) or overt sub-mucosal invasive carcinoma (SMIC) (CONECCT III lesions: JNET III area) remains challenging. We aim to describe the endoscopic and oncologic outcomes of endoscopically removed T1-colorectal cancers (T1-CRC), according to their pre-resection classification by optical diagnosis. Methods: Multicenter prospective cohort study in 13 centers. Procedural and oncological outcomes were analyzed using univariate analysis. Results: 7495 colorectal ESDs were included from 09/2019 to 09/2024, with a median lesion size of 50mm [35-65], rectal location in 35.3% and right colon in 37.9%. Lesions were classified as CONECCT IIA in 30.2%, CONECCT IIC in 64.2% and CONECCT III in 5.6%. En-bloc, R0 and curative resection rates were 96.3%, 88.1% and 81.4%, with significant decreasing trends as the CONECCT classification advanced (97.3%; 91.9%; 90.7% in IIA, 96.3%; 87.6%; 80.6% in IIC and 93.2%; 74.2%; 32.0% in III, respectively; $p<0.001$). T1-CRC occurred in 10.4% with prevalence significantly differing according to the optical diagnosis: 2.3% in CONECCT IIA, 10.8% in CONECCT IIC and 49.6% in CONECCT III. En-bloc, R0 and curative resection rates were 96.7%, 74.9% and 23.6% respectively, with a significant decreasing trend in curative resection rates as the CONECCT classification increased (25.5% in IIA, 26.5% in IIC and 13.9% in III; $p=0.002$). Vertical margins were free in 80.3%. The median depth of SMIC was 1500µm [750-2560], measuring 1426µm in CONECCT IIA, 1840µm in CONECCT IIC and 2744µm in CONECCT III ($p<0.001$), corresponding to deep SMIC in 46.8%, 62.2% and 77.1% of CONECCT IIA, IIC and III ($p<0.001$). Lympho-vascular invasion and tumor budding were more frequently observed in CONECCT III at 30.0% and 34.3% respectively (vs 23.9%; 23.9% in IIA and 16.4%; 20.6% in IIC; $p=0.002$). Poor differentiation was reported in 5.3% with no significant difference between categories. Finally a trend was noted in the number of prognostic risk factors per lesion: no high-risk factors in 34.0% of CONECCT IIA, 29.5% in CONECCT IIC and 18.6% in CONECCT III, versus 3 high-risk factors in 4.3% in CONECCT IIA, 7.0% in CONECCT IIC and 11.2% in CONECCT III ($p=0.049$). Conclusion: Endoscopic resection of T1-CRC demonstrates high en-bloc and R0 resection rates. However, curative outcomes and oncologic features worsen significantly with the presence of risky optical diagnostic criteria, highlighting the importance of adequate optical diagnosis and considering intramuscular resection techniques for advanced lesions, balancing over- and undertreatment as nearly 50% of CONECCT III lesions were T1-CRC.

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DECLINING RATES OF SURGERY FOR NON-MALIGNANT COLORECTAL POLYPS IN THE UNITED STATES OVER THE LAST DECADE: A REAL-WORLD ANALYSIS OF OVER 1 MILLION PATIENTS

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