A. Prof. Stephen Halloran - 15 Minutes

- **Impact of elapse time and ambient temperature on FIT concentration** – Consider options

- **FIT screening pilot** – participation rate, positivity rate, clinical service provision, mechanism for distribution and return, packaging, literature

- **Population register** – Population register (names, age, sex and address) & cancer registry?

- **Procurement** – FIT system, IT system, lab services, endoscopy services
  - **FIT procurement (analytical system)** - Determine required instrument characteristics, speed, backup equipment, new batch acceptance testing, communication with IT etc.
  - **FIT lab service** – transport, lab site, storage, reporting, QA oversight (calibration, IQC and EQAS)
  - **IT screening system design** - Data for process, monitoring and future development

- **Organisation** –
  - **Population communication systems** – process, package, instructions, collection (elderly & disabled)
  - **Capacity management** – service requirements. referral rate (participation & positivity rates) lab,
  - **Service quality**
    - **Standards** – determine performance standards that can be, monitored, reviewed, enable timely intervention
    - **Scope of standards** - organisation, registers, invitations, laboratories (FIT/Histopath) and endoscopy/CTC, waiting-times, participation, positivity, screen failure rates, influence of temperature
    - **Service audit and review**
    - **Participation**
    - **Potential problems**
A. Prof. Stephen Halloran - Temperature
What is the downside of FIT?

11th May 2009

MEDIA STATEMENT

Self-Test Bowel Cancer Kits – Important Notice For Users

The Department of Health and Ageing will start contacting participants in the National Bowel Cancer Screening Program from this week to invite people to re-take the test, after quality issues were identified during an investigation of the test kits.

The Department has recently observed that the level of positive results in tests performed since 1 December 2008 is lower than expected. The Department has reviewed the reliability of the test kits under certain conditions.

108,000 people have undertaken tests since this time and have returned a negative result and will be asked to repeat the test with a new kit. The Department will write to all 475,000 people who have received the test kits since 1 December 2008, although many have not yet used the test and returned it for assessment.
Stability of FIT (OC Sensor)  
Grazzini, Halloran et al Gut. 2010 Jul 5

Average value of HB in intervals of 5° Celsius

Winter vs. Summer:
- 17% less +ve tests
- 13% less cancers
Seasonal variation in positivity rates in the Netherlands

Range of Temperatures in California

Daily air temperatures in the region during the study period ranged from -6.7 to 43.3°C

Chyke A. Doubeni, MD, MPH
Perelman School of Medicine
University of Pennsylvania
Seasonal Variation in Positivity Rate

Chyke A. Doubeni, MD, MPH
Perelman School of Medicine
University of Pennsylvania

Modified Dickey-Fuller test p-value <0.01
Fig. 11. Changes in remaining Hb with Hb spiked feces (Eiken)
**Interval Cancer Rate - Temperature, FIT positivity and Season**
S Korea National Cancer Screening 2009–2010 - 4,788,104 participants

<table>
<thead>
<tr>
<th></th>
<th>Proximal</th>
<th>Distal</th>
<th>Rectum</th>
<th>Others</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Spring</strong> (3–5)</td>
<td>0.78 (0.58–1.06)</td>
<td><strong>1.21</strong> (0.89–1.65)</td>
<td><strong>1.18</strong> (0.92–1.50)</td>
<td><strong>1.02</strong> (0.67–1.56)</td>
</tr>
<tr>
<td><strong>Summer</strong> (6–8)</td>
<td><strong>1.14</strong> (0.85–1.52)</td>
<td><strong>1.27</strong> (0.93–1.74)</td>
<td><strong>1.47</strong> (1.16–1.86)</td>
<td><strong>1.06</strong> (0.69–1.65)</td>
</tr>
<tr>
<td><strong>Autumn</strong> (9–11)</td>
<td>0.98 (0.72–1.32)</td>
<td><strong>1.42</strong> (1.05–1.93)</td>
<td><strong>1.34</strong> (1.06–1.71)</td>
<td><strong>1.31</strong> (0.86–1.99)</td>
</tr>
</tbody>
</table>

**Risk of Interval Cancer in Fecal Immunochemical Test Screening Significantly Higher During the Summer Months: Results from the National Cancer Screening Program in Korea**
The American Journal of Gastroentontology Jae Myung Cha, VOLUME 113 | APRIL 2018
Home made
Temperature Recording Device

Designed & built by
Dr David Pye
Stop Invitation During Summer?

Yes (3)
- **Australia** - Selected if Temp >30°
- **Italy (E-R)** - Reduced July /August
- **Japan** (most municipalities)

No (14)
- England
- Canada - Saskatchewan, PEI, Alberta, L&N
- Czech Republic
- Denmark
- Ireland
- Italy - Veneto, Piedmont
- Malta
- The Netherlands (but stop for Christmas!)
- New Zealand
- Singapore
- Slovenia
- Spain - Basque
- Taiwan
- Uruguay
FIT Kit Modes of Delivery

- Mail: 10
- Hospital: 1
- Public Health: 1
- Pharmacy: 1
- GP: 4
FIT Return Instructions?

- None: 4
- <7 days: 2
- <2 - 3 days: 1
- Return <2 days: 2
- Post <24 hours: 2
- Post immediately: 1
- Post Office not street box: 2
- Not if hot weather: 1
- Not at weekend: 7

Programmes

KEEP CALM ITS THE WEEKEND
FIT Kit
Return
Methods

- Pharmacy: 5
- Hospital: 1
- Mail: 9
- GP: 1
Individual Stool Samples
Spiked to 150 ng/mL
Old and New Eiken Buffers at 4°C
Individual Stool Samples
Spiked to 150 ng/mL
Old and New Eiken Buffers at 25°C
Individual Stool Samples
Spiked to 150 ng/mL
Old and New Eiken Buffers at 37°C

Spiked Stool Concentration (ng/mL)
Positivity by Southern Hub
60 – 74 year old incident episodes 2013/14
\[ y = 0.90x - 1.06 \]
\[ R^2 = 0.99 \]
Eiken - New and Old Buffer Comparison
(Buffer 2012/ Buffer 2006)
310 Stool Samples

Correlation Statistics
\[ y = 0.92x - 1.89 \]
\[ R^2 = 0.98 \]
Period in days – kit sent to final result

(subjects with +ve result)
Period in days – kit sent to final result

*(subjects with +ve result)*

% Returned with +ve results

Period Sent to result (days)

- BCS01
- BCS02
A. Prof. Stephen Halloran - 10 Minutes

Example of an Annual Report – Southern Hub

Example of Quality Standards
These revised national standards for the NHS bowel cancer screening programme (BCSP) replace previous measurable standards documented in quality assurance guidelines as from 1 April 2018 unless stated within the document.

Screening standards ensure that stakeholders have access to:

- reliable and timely information about the quality of the screening programme
- data at local, regional and national level
- quality measures across the screening pathway without gaps or duplications

They will also ensure a consistent approach across screening programmes and data collection is beneficial.

NHS BCSP supports health professionals and commissioners in providing a high quality screening programme. This involves developing and reviewing the screening standards against which data is collected and reported annually. The standards provide a defined set of measures that providers have to meet to ensure local programmes are safe and effective.
Bowel cancer screening: colonoscopy quality assurance

Quality assurance guidelines for colonoscopy.

Ref: NHS BCSP Publication No 6
PDF, 305KB, 28 pages

This file may not be suitable for users of assistive technology. Request an accessible format.

Details

This publication explains quality assurance guidelines for colonoscopy in bowel cancer screening.

It includes full reporting criteria and information about:

- quality indicators
- standards
- harm reduction
- interval cancers
- failure to meet agreed quality standards
Appendix 3: Professional Best Practice Guidance

NHSBCSP 1: *Reporting Lesions in the NHS Bowel Cancer Screening Programme*
Published September 2007

NHSBCSP 2: *Bowel Cancer Screening Programme Ceasing Guidelines*
Published October 2007

NHSBCSP 3: *Guidance for public health and commissioners*
Published January 2008

NHSBCSP 4: *Evidence summary: patient information for the NHS Bowel Cancer Screening Programme*
Published November 2008

NHSBCSP 5: *Guidelines for the use of imaging in the NHS Bowel Cancer Screening Programme. Second edition*
Published November 2012

NHSBCSP 6: *Quality assurance guidelines for colonoscopy*
Published February 2011
## Appendix 1: Key Performance Indicators

<table>
<thead>
<tr>
<th>KPIs for FOBT Bowel Cancer Screening to be produced at hub and screening centre level</th>
<th>Source of report (provided by QA service)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>KPI</strong></td>
<td><strong>Definition</strong></td>
</tr>
<tr>
<td>1. Invitations sent</td>
<td>The total number of invitations sent (including over-age self-referrers)</td>
</tr>
<tr>
<td>2. Kits sent</td>
<td>The total number of kits sent, including self refer, retest kits and new kits requested</td>
</tr>
<tr>
<td>3. Kits returned</td>
<td>The total number of kits returned, including self-refer, retest kits and new kits requested</td>
</tr>
<tr>
<td>4. Uptake</td>
<td>Percentage of people adequately screened out of those invited for FOBT screening</td>
</tr>
<tr>
<td>5. Positivity</td>
<td>Percentage of people with a definitive FOBT outcome of “abnormal” out of those who were adequately screened (via FOBT)</td>
</tr>
<tr>
<td>6. Coverage</td>
<td>Percentage of people adequately screened in the last 2.5 years out of those who are eligible for FOBT screening</td>
</tr>
<tr>
<td>7. SSP waiting times</td>
<td>Percentage of people where the elapsed time between the “definitive abnormal FOBT date” (booked date) and the first offered “SSP colonoscopy assessment date” falls within the 14 day specified time limit, out of those given an “SSP colonoscopy assessment date”</td>
</tr>
<tr>
<td>8. Diagnostic test waiting times</td>
<td>Percentage of people where the elapsed time between the “SSP colonoscopy assessment date” falls within the 14 day specified time limit, out of those given a “SSP colonoscopy assessment date”</td>
</tr>
</tbody>
</table>
## Appendix 2: Part 1/2 Performance Indicators (screening centres only)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Definition</th>
<th>Minimum standard</th>
<th>Reporting period</th>
<th>Source of report (provided by QA service)</th>
</tr>
</thead>
<tbody>
<tr>
<td>9. Colonoscopy uptake</td>
<td>Percentage of people who attend at least 1 screening colonoscopy out of those with a definitive abnormal FOBT result (within the same episode)</td>
<td>81%</td>
<td>Quarterly (3 months in arrears)</td>
<td>OBIEE reports &gt;&gt; endoscopy QA standards &gt;&gt; Colonoscopy uptake tab Report the % uptake and actual count</td>
</tr>
<tr>
<td>10. Adenoma detection</td>
<td>Percentage of colonoscopies where at least one histologically confirmed adenoma was detected, out of all the “index screening colonoscopies” performed. Expected value ≥ 44%</td>
<td>40%</td>
<td>Quarterly</td>
<td>OBIEE reports &gt;&gt; endoscopy QA standards &gt;&gt; Adenoma detection tab Report the ADR % and actual count</td>
</tr>
<tr>
<td>11. Colonoscopies performed</td>
<td>Count of the total number of screening programme colonoscopies performed per year, per colonoscopist</td>
<td>&gt;150 per year (pro rata)</td>
<td>Quarterly</td>
<td>OBIEE reports &gt;&gt; endoscopy QA standards &gt;&gt; Colonoscopies performed tab Report colonoscopies performed /endoscopist</td>
</tr>
<tr>
<td>12. Cancers found*</td>
<td>Percentage of confirmed cancers, out of the total number of people who had at least one diagnostic test</td>
<td>8%</td>
<td>Quarterly (annually in arrears)</td>
<td>OBIEE reports &gt;&gt; Pathology dashboard &gt;&gt; Cancer found tab Report the % cancer found and actual count</td>
</tr>
<tr>
<td>13. Cancer staging (TNM)*</td>
<td>Percentage of TNM staged cancers out of the total number of confirmed cancers found</td>
<td>100% within 12 months</td>
<td>Quarterly (annually in arrears)</td>
<td>OBIEE reports &gt;&gt; Pathology dashboard &gt;&gt; Cancer staging: TNM (final pre-treat TNM) Report the % TNM staged and actual count</td>
</tr>
<tr>
<td>14. Pathologist reporting</td>
<td>Percentage of NHSBCSP pathology samples (polyps and cancers) reported within the target time, out of all the NHSBCSP pathology samples reported</td>
<td>100% ≤ 7 days</td>
<td>Quarterly</td>
<td>OBIEE reports &gt;&gt; Pathology dashboard &gt;&gt; Pathologist tabs: “polyps” and “cancers” Report the % within target and actual count</td>
</tr>
<tr>
<td>Data requirement</td>
<td>Frequency</td>
<td>Source of information (provided by QA service)</td>
<td>Definition</td>
<td></td>
</tr>
<tr>
<td>----------------------------------------------------------------------------------</td>
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<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
</tbody>
</table>
| 15. Number of individuals attending first SSP clinic appointment                   | Quarterly | OBIEE reports >> Screening Centre Dashboard >> SSP appointments tab  
Appointment type = “positive assessment”  
Report the count given in the “Attended count” column for each appropriate month | Number of attendances at FOBt positive colonoscopy fitness assessment  
- Where the appointment type is positive assessment |
| 16. Number of individuals who DNA SSP clinic                                       | Quarterly | OBIEE reports >> Screening Centre Dashboard >> SSP appointments tab  
Report the count given in the “DNA count” column for each appropriate month | Number of SSP clinics that were DNA’ed  
- Include all SSP clinic types: FOBt positive assessment, surveillance, post investigation |
| 17. Number of screening colonoscopies undertaken                                   | Quarterly | OBIEE reports >> Screening Centre Dashboard >> Diagnostic test carried out tab  
Episode type = “screening”  
Report the count given in the “colonoscopy” column for each appropriate month | Number of screening colonoscopies undertaken.  
- Where the episode type is screening |
| 18. Number of individuals DNA at screening colonoscopy                              | Quarterly | OBIEE reports >> Screening Centre Dashboard >> Diagnostic test attendance tab  
Episode type = “screening”  
Report the count given in the “did not attend count” column for each appropriate month | Number of diagnostic test procedures that were DNA’ed  
- Where the episode type is screening  
- Include all diagnostic test procedure types |
| 19. Number of other tests undertaken                                               | Quarterly | OBIEE reports >> Screening Centre Dashboard >> Diagnostic test carried out tab  
Episode type = “screening”  
Sum the counts for all procedures not in “colonoscopy” column for each appropriate month | Number of screening “other tests” undertaken  
- Where the episode type is screening |
A.  Prof. Stephen Halloran - Participation
Uptake and Demographics - Sept’ 2013

Target Population 2.5 million

Response
No Response
Uptake in Portsmouth

Response: 66.4%
No Response: 33.9%
Uptake in Taunton – Bristol 2013/4
Uptake in Taunton – Bristol 2013/4
Uptake in Bristol 2013/4
Poor Uptake in Slough
Better Uptake in Reading

%Uptake

29%
63%
24%
Bowel Cancer Screening Programme – S. Hub

Positivity & Uptake
At street level!!!

Sept’ 2013
% Uptake – *Relationship to Socioeconomic Status*

First 2.6 million Invitation
*(BCSP - UCL Study)*

von Wagner C, Baio G, Raine R *et al.*
Uptake of faecal occult blood test colorectal cancer screening by different ethnic groups in the Netherlands

M. Deutekom *E J of Public Health* 2009 Vol. 19, No. 4, 400–402
% Uptake - gFOBT Screening
(Southern Hub - Population 60 – 74 year)

61% Uptake
% Uptake - gFOBT Screening
(Southern Hub - Population 60 – 74 year)

% Uptake following previous acceptance

% Uptake in all invited

61% Uptake

% Uptake following previous refusal

Date Sept 2006 – April 2013
% Uptake - Flexible Sigmoidoscopy

(N = 24,268 invitations since March 2013)
<table>
<thead>
<tr>
<th>% Uptake FOBT kits</th>
<th>First 2.6 million invitations in England</th>
</tr>
</thead>
</table>

![Chart showing % Uptake FOBT kits by Gender, Age, Area ethnic diversity, and Area deprivation.](chart.png)

% Uptake FOBT kits
First 2.6 million invitations in England

% Uptake FOBT kits
First 2.6 million invitations in England

%Uptake - Geodemographic Profile

GP Surgeries within Centres

Cheltenham & Gloucester
%Uptake - Geodemographic Profile

GP Surgeries within Centres

Cheltenham & Gloucester

Berkshire

GP Practice Code

GP Practice Code
%Uptake - by Postcode Sector
(Southern Hub)
A. Prof. Stephen Halloran - Timeline
A. Prof. Stephen Halloran - FIT screening pilot
1 FIT in every 28 gFOBT

Selected a low FIT threshold (20ug/g)
- High positivity
- High colonoscopy rate
- High detection rate

- Target pop’n - 50% of England
- 40,000 FIT invitations
- Complete in 6 months
Make FIT Packaging

- Attractive
- Simple to use
- Safe for mailing
- Informative
- Reliable
FIT Pilot
(England)

Midlands & North West Hub
More Deprivation
• Population 13.1 m
• gFOBT Kits = 537,770
• FIT Kits = 19,289

Both Hubs
• Population 27.8 m
• gFOBT Kits = 1,126,087
• FIT Kits = 40,930

Southern Hub
Less Deprivation
• Population 14.7 m
• gFOBT Kits = 588,317
• FIT Kits = 21,641
**FIT Pilot (England)**

**Uncertainty - Pilots**
- Population 13.1 m
- gFOBT Kits = 537,770
- FIT Kits = 19,289

**Both Hubs**
- Population 27.8 m
- gFOBT Kits = 1,126,087
- FIT Kits = 40,930

**Southern Hub**
- Less Deprivation
  - Population 14.7 m
  - gFOBT Kits = 588,317
  - FIT Kits = 21,641

**Midlands & North West Hub**
- More Deprivation
  - Population 13.1 m
  - gFOBT Kits = 537,770
  - FIT Kits = 19,289

**Observations**
- 50% of BCSP area
- Excludes East & London
- OC-Sensor FIT
- 73 ‘FIT’ cancers (20 ug/g)
- 37 ‘FIT’ cancers (160 ug/g)

**Outcomes for FIT (20ug/g)**
- Attend Colonoscopy: 1,824
- Diagnostic Outcomes:
  - Cancer: 73
  - High-risk Adenoma: 212
  - Int-risk Adenoma: 259
  - Low-risk Adenoma: 471
  - Abnormal: 542
  - Normal: 267
A. Prof. Stephen Halloran - 15 Minutes

• Developing a FIT Pilot – participation rate, positivity rate, clinical service provision
• Develop standards for all aspects of service quality (organisational, laboratory and clinical)
• Determine required instrument characteristics, speed, backup, communication with IT etc.
• FIT Procurement – currently 4 suitable products
• Determine colonoscopy screening capacity for expected participation rate & FIT positivity (test threshold)
• Identify and pilot mechanism for distribution and return
• Assess effect of seasonal ambient temperatures on FIT positivity
• Packaging – trial FIT transport arrangements and easy to use for elderly and disabled users
• Develop and trial use of participant identification for returned FIT devices
• Centralized lab analysis agree quality monitoring arrangements (calibration, IQC and EQAS)
• Performance monitoring – positivity, failure rate, influence of temperature and IQC
• Established arrangements with manufacturer for checking performance of new batched
• Begin to gather data for prospective intelligent use of FIT
Lesson learnt...
Need ‘tight’ QA of screening colonoscopy
• ‘Driving test’ prior to screening
• Monitored ADR etc
• Regular reviews
France
Public Health France

Participation RATE - 2015-2016
*1st 4.8m FIT invitations*

Men 28%
Women 31%

Regions - 9% to 46%

Lesson learnt...
- Design for good uptake
- Redesign if not achieved!

Italy
Public Health Piedmont

Participation Rate
*Flexi Sigmoidoscopy (FS) or FIT*

1*st FS - 25%
2*nd FIT (no FS at 6m) - 19%

After 2 years of invites...
...uptake 40% - 42%

Overall Participation Rates

Less than 40%

Women
Men
British Columbia’s four-year-old CRC screening program… grossly impair patients’ access to timely colonoscopies.

80% wait >30 days for colonoscopy

Changed FIT threshold – from 20 to 47ug/g

FIT threshold 15ug/g - some wait >6 months

Lesson learnt...
Avoid long waiting times!
Make timely adjustment to FIT threshold.
Colon cancer screening test suspended in B.C. due to manufacturing defect

Testing suspended... manufacturing problem... with fecal immunochemical tests (FIT)

Lesson learnt...
Very ‘tight’ QA of Labs and screening programmes is essential

B.C. health authorities identify problem with early colon cancer test
Health Minister David Clark revealed... 2500 people had not received screening invitations.
Three people... developed cancer... one died.

Lesson learnt...
Essential - Close monitoring and verification of every step in the screening process.

Lesson learnt...
IT screening system development before implementation.
Understanding... ‘Formal (Organised) Population-based Screening Programmes’

Definitions - 2017

To qualify as an Organized Programmes...

Must have management!

• Policies and protocols to specify management procedures...
  …based on evidence of effectiveness with a balance between benefit and harm

• Team to implement every aspect of the policy - national or regional
  1. Coordinate service delivery
  2. Maintaining specified quality
  4. Supervision and monitoring of screening process
  5. Comprehensive guidelines and rules defining standard operating procedures
  6. Quality assurance structure
  7. Measure population burden of the disease
Understanding... ‘Formal (Organised) Population-based Screening Programmes’

Definitions - 2017

To qualify as Population-based Programme...

• all people in the eligible target population, in the area served by a programme, are individually identified and personally invited

• a high degree of organisation to assure that invitations are reliable and coordinated with subsequent screening processed.
• FIT Screening – Challenges and Opportunities
• Prof. Stephen P. Halloran

The presentation will describe the analytical differences between FIT (Faecal Immunochemical Test) and gFOBT (guaiac Faecal Occult Blood Test) and progress to examine the strengths and weaknesses of the two tests with international studies that have explored the use FIT in population-based screening programmes.

The details of the UK pilot of FIT will be shared with the audience with a focus on participation rate, positivity and timely colonoscopy. The impact of FIT screening on different population cohorts will be discussed. The presentation will then explore how the risk of CRC in different subgroups can be exploited and a multivariate risk score developed to enable better targeted screening and referral to colonoscopy.

The presentation will highlight critical elements in the implementation of a FIT-based screening programme for both the current and future success of colorectal cancer screening.
# The First CRC Screening & Quality in Colonoscopy Symposium

**Saturday, 28 April, 2018**

**8:30 AM - 9:10 AM**
- Welcome and Introduction
  - Antoine Abou Rached

**9:10 AM - 11:00 AM**
- **CRC Screening: the Roadmap to Success**
  - CRC Global Epidemiology & Burden
    - Linda Rabeneck
  - Molecular Pathways and the Serrated Polyp
    - Charles Kahi
  - Strengths and Weaknesses of Opportunistic and Program-based CRC Screening
    - Roland Valori
  - FIT Screening - Challenges and Opportunities
    - Stephen Halloran

**11:00 AM - 11:15 AM**
- Coffee break

**11:15 AM - 12:00 PM**
- FIT Workshop by Stephen Halloran, Ala Sharara, Georges Cortas & Hana Nimer
  - Supported by Fujifilm

**12:00 PM - 1:00 PM**
- Lunch Break

**1:00 PM - 5:00 PM**
- **Quality in Colonoscopy: Excellence is a Habit, Not an Act!**
  - WEO & LSGE Commitment to Quality
    - Linda Rabeneck
    - Ala Sharara
    - Georges Cortas
  - Setting up a National Quality Program
    - Roland Valori
    - Georges Cortas
  - Quality Metrics in Colonoscopy
    - Charles Kahi
  - The Optimal Bowel Prep
    - Ala Sharara

**4:00 PM - 4:15 PM**
- Coffee break

**4:15 PM - 5:00 PM**
- Polypectomy Competencies: How to Achieve High Quality and Safe Polypectomy
  - Roland Valori
- The Difficult Polyp: Pearls and Pitfalls
  - Pradeep Bhandari

**5:00 PM - 5:15 PM**
- Polyp Differentiation Using Virtual Chromoendoscopy vs. White Light Endoscopy: FICE, NICE or Plain White?
  - Supported by Fujifilm
  - Pradeep Bhandari
  - Charles Kahi

**5:15 PM - 5:30 PM**
- **Debate:** The Diminutive Colon Polyp
  - Resect & Discard
  - My “Best Friend Forever” the Pathologist
  - Pradeep Bhandari
  - Charles Kahi

**5:30 PM - 5:45 PM**
- Closing Remarks by Antoine Abou Rached, Ala Sharara & Georges Cortas