別紙1－1

論文審査の結果の要旨および担当者

報告番号	※　甲　第　　　　　号

氏　　　　　名　　Leonardo Zorron Cheng Tao Pu

論　文　題　目

Endoscopy-focused primary, secondary and tertiary prevention of colorectal cancer

(内視鏡による大腸癌の一次、二次、三次予防)

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論 文 審 査 の 結 果 の 要 旨

BACKGROUND: Colorectal cancer (CRC) is among the commonest and deadliest types of cancer. Research that can improve the prevention and treatment of this cancer is of the utmost importance. METHODS, RESULTS AND DISCUSSION: In primary prevention, I studied the factors associated with colorectal lesions (e.g. colorectal adenomas and sessile serrated adenomas/polyps), the effect of scheduling and simplification of methods for assessing quality measures in colonoscopy. With respect to secondary prevention, I undertook studies looking at characterisation and endoscopic resection of colorectal lesions. Lastly, considering tertiary prevention, I evaluated the necessity of routine biopsies for the follow up of previous endoscopic resection of colorectal lesions. CONCLUSION: The evidence produced during this thesis has the potential to immediately influence not only research but also clinical practice related to primary, secondary and tertiary prevention of CRC.

Answer to examiners:

A1) ADR based on specialty has been studies in other countries and not always shows a difference between surgeons and gastroenterologists. ADR is dependent on training, and in Australia I feel that most surgeons have less training in GI endoscopy than gastroenterologists. In addition, the study did not involve only surgeons specialised in the GI tract (e.g. also included breast endocrine surgeons). An interesting follow-up study would be to look at specialised "surgical endoscopists" (i.e. surgeons with endoscopy focus as myself).

A2) Although they did know the classic Sano classification, they did not know the MS. Our contact with NU came with the joint degree and NUH did not know of the research carried out by Prof Singh (i.e. MS classification) before I got there.

A3) Indeed, only crisp clear images were used which is not what we find for every day endoscopists. Further research on integrating "bad images" to the training set, to be able to accurately predict both good and bad images, is warranted.

A4) Although classic Sano did not use the mucosal pattern, the MS uses it. In addition, the differentiation of high-grade lesions favours the correct diagnosis with MS (e.g. both TVA LGD and HGD would be IIIa), while they could be potentially wrongly classified by JNET (e.g. TVA LGD – JNET 2A and TVA HGD - JNET 2B).

以上の理由により、本研究は博士（医学）の学位を授与するに相応しい価値を有するものと評価した。

試験の結果の要旨および担当者

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（試験の結果の要旨）

　　主論文についてその内容を詳細に検討し、次の問題について試験を
実施した。

1．Regarding the study described in Chapter 4, what are your thoughts about the differences in ADR between surgeons and gastroenterologists?

2．Regarding the study described in Chapter 7, did the endoscopists involved in the validation phase had no previous knowledge of the modified Sano's classification?

3．Regarding the study described in Chapter 8, I understand it was trained and tested only using crisp clear photos. However, in real life, few endoscopists can get good photos. How do you suppose the software would deal with "bad images"?

4．Regarding the study described in Chapter 7, how do you explain the differences between the MS and JNET classifications?

　　以上の試験の結果、本人は深い学識と判断力ならびに考察力を
有するとともに、消化器内科学一般における知識も十分具備している
ことを認め、学位審査委員合議の上、合格と判断した。