MANAGEMENT OF INCIDENTAL POLYPS DURING COLONOSCOPY.

Mpho Kgomo

BACKROUND.

- CLASSIFIED AS NEOPLASTIC OR NON NEOPLASTIC.
- ADENOMATOUS/NON ADENOMATOUS.
- MOST COLORECTAL CANCERS ARISE FROM NEOPLASTIC ADENOMAS. ajg 2000;95:3053-63
- SIMPLE ADENOMAS (<1cm) and TUBULAR COMMON < MALIGNAT POTENTIAL. ajg2000;95:3053-63
- ADVANCED ADENOMAS (>1cm) VILLOUS TISSUE > MALIGNANT POTENTIAL. ajg2000;95:3053-63

EPIDEMIOLOGY.

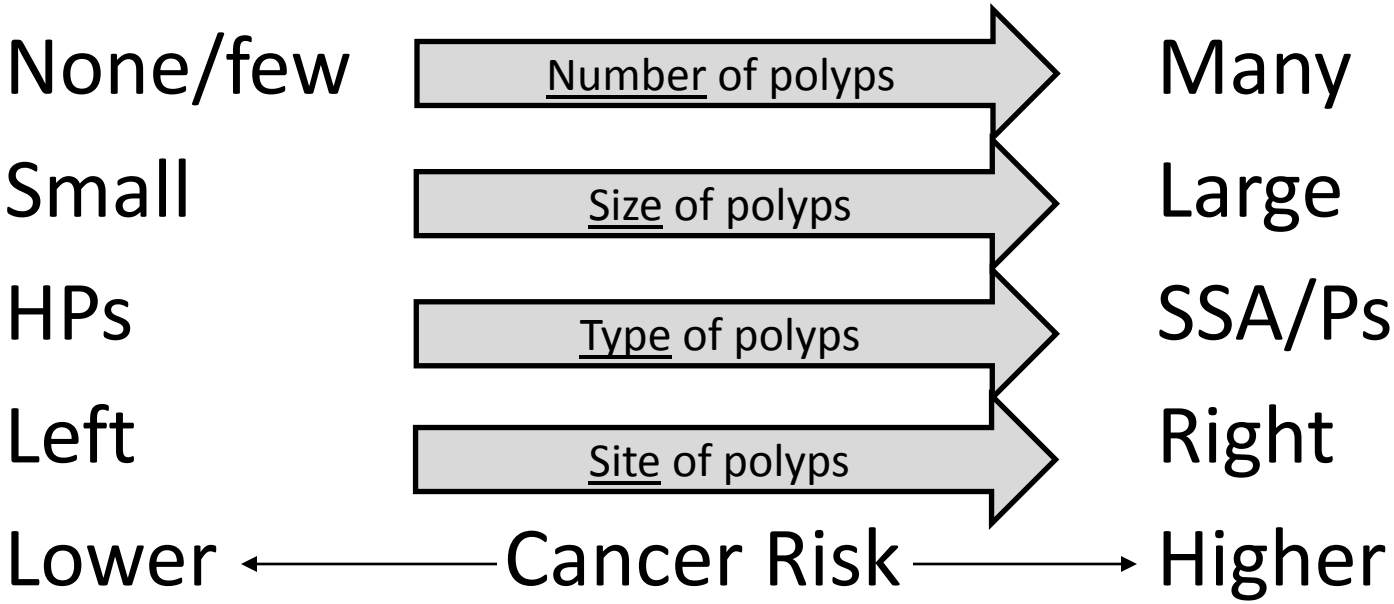
- >95% OF CRC ARISES FROM BENIGN ADENOMAS.ajg2000;95;3053-63.
- CRP ARE FOUND IN >30% OF AUTOPSIES OF PEOPLE >60YRS IN WESTERN COUNTRIES.gastroenterol1979;77:1245-51. gut1982;23:835-42.
- W.H.O CLASSIFICATION TUBULAR, TUBULOVILLOUS,OR VILLOUS ADENOMAS.
- ADENOMATOUS POLYPS 70% OF ALL POLYPS AT COLONOSCOPY. j clin pathol1982;35:830-41.

EPIDEMIOLOGY.

- 70-85% ARE TUBULAR.
- 10-25% TUBULOVILLOUS.
- < 5% VILLOUS.
- MOST < 1cm ARE TUBULAR ON HISTOLOGY.

ajg2000;95:3053-63.

Serrated polyps.



Ajg2012;107:1315-29

DIAGNOSIS AND TREATMENT.

- MOST POLYPS CAN BE SAFELY AND COMPLETELY RESECTED.
- RESECTING ADENOMATOUS POLYPS PREVENTS CRC.
- PERFORATION AFTER COLONOSCOPIC POLYPECTOMY IS 0,2%.
- SIGNIFICANT BLEEDING RATE IS 1%.

gastrointestinal endoscopy 1987:873-8

INITIAL MANAGEMENT OF POLYPS.

- SMALL POLYP(<1cm) at sigmoidoscopy.
- INDIVIDUALISE, AGE, COMORBIDITY &HISTORY.

  biopsy to determine histology.

  if adenoma follow full colonoscopy.

  if more than two, colonoscopy.
- SYNCHRONOUS ADENOMAS IN 30-50%.
- MALIGNANT RATE IS < 1%.

ajg1988;83:120-2. gastrointest endosc 1982;28:1-5.

MANAGEMENT OF LARGE SESSILE POLYPS.

- IF successful colonoscopic excision of large sessile (2cm)
- Follow up colonoscopy in 3-6 months to confirm complete excision.
- If there is residual polyp, remove and check in 3-6 months.
- Failure of second attempt, refer for surgical therapy.
- Ajg2000;95:3053-63

MALIGNANT POLYPS.

- Neoplasm that contains cancer cells not penetrating through muscularis mucosae layer into the submucosa.
- Simple polypectomy is adequate if no high grade malignancy or incomplete excision.

Cancer 1988;61:2552-7.

RECOMMENDATION FOR PATIENTS WITH MALIGNANT POLYP.

- NO NEED FOR SURGERY IF:

  If completely excised.

  Specimen confirms depth of invasion, grade of differentiation and completeness of excision.

  Cancer not poorly differentiated.

  No vascular or lymphatic invasion.

  Margins not involved.gastroenterol1973;64. cancer1988;61. gut1989;25.

Follow up.

- Colonoscopy in 3 months
- Standard surveillance as adenoma.

Ajg2000;95:3053-63

POST POLYPECTOMY SURVEILLANCE.

- Colonoscopy in 3 yrs for

  Multiple adenomas(>2)

  Large adenoma (>1cm).

  Villous adenoma.

  High grade dysplasia.

  FH of CRC.

If negative increase interval to 5 yrs.gastroenterol clin north Am1997;26. gastrointest endosc1999;49:563-6. gastroenterol1998;115:13-8

SURVEILLANCE OF FAMILIES.

- Colonoscopy for 1st degree relatives of adenoma patients esp:

  Advanced adenoma.

  Diagnosis before age 60 yrs.

  Siblings if parent diagnosed at any age.

Initiate 5 yr younger than age of diagnosis or age 40yrs.

Interval 3-5 yrs.

Ajg2000;95:3053-63

CONCLUSION.

- Management of incidental polyp at colonoscopy depends on:

  The patient.

  Polyp size and number.

  Polyp histology.
- Follow up of patients and family members may be necessary.

LOW RISK PATIENTS.

- Colonoscopy in 5 yrs.

  1-2 small tubular adenomas.

  No FH of CRC.

If negative no need for further colonoscopy