



QUALITY IN ENDOSCOPY

ESGE / ESPEN SYMPOSIUM

IBD & NUTRITION

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Endoscopic resection of polypoid lesions in IBD

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ESPEN



Older studies confirming the possibility of polypectomy in IBD

1. Engelsgjerd M et al. Gastroenterology 1999
2. Rubin PH et al. Gastroenterology 1999
3. Odze RD et al. Clin Gastr Hepatol 2004
4. Vieth M et al. Gut 2006
5. Quinn AM et al. Inflamm Bowel Dis 2013

Polypoid lesions

- can be treated by polypectomy/EMR providing:
 - completely excised
 - absence of dysplasia in the surrounding area
 - postpolypectomy controls are instituted to ensure completeness
- surveillance is continued (or instituted)

Initial decisions

- 1) Polyp outside of area of colitis – treat as sporadic adenoma

- 2) Borders indistinct even with best help of chromoendoscopy and different manoeuvres –
 - refer to expert centre or for proctocolectomy
(if you are expert)

- 3) Ulceration, depression, non-lifting sign, other features of submucosal invasion
 - refer to expert centre or for proctocolectomy
(if you are expert)

Rules of high quality

- 1) Extent of disease should be defined as greatest extent by endoscopy or histology by any endoscopy
- 2) Lesions need to be described according to Paris classifications
(DALM concept is not valid anymore)

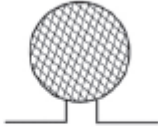




Rules of high quality

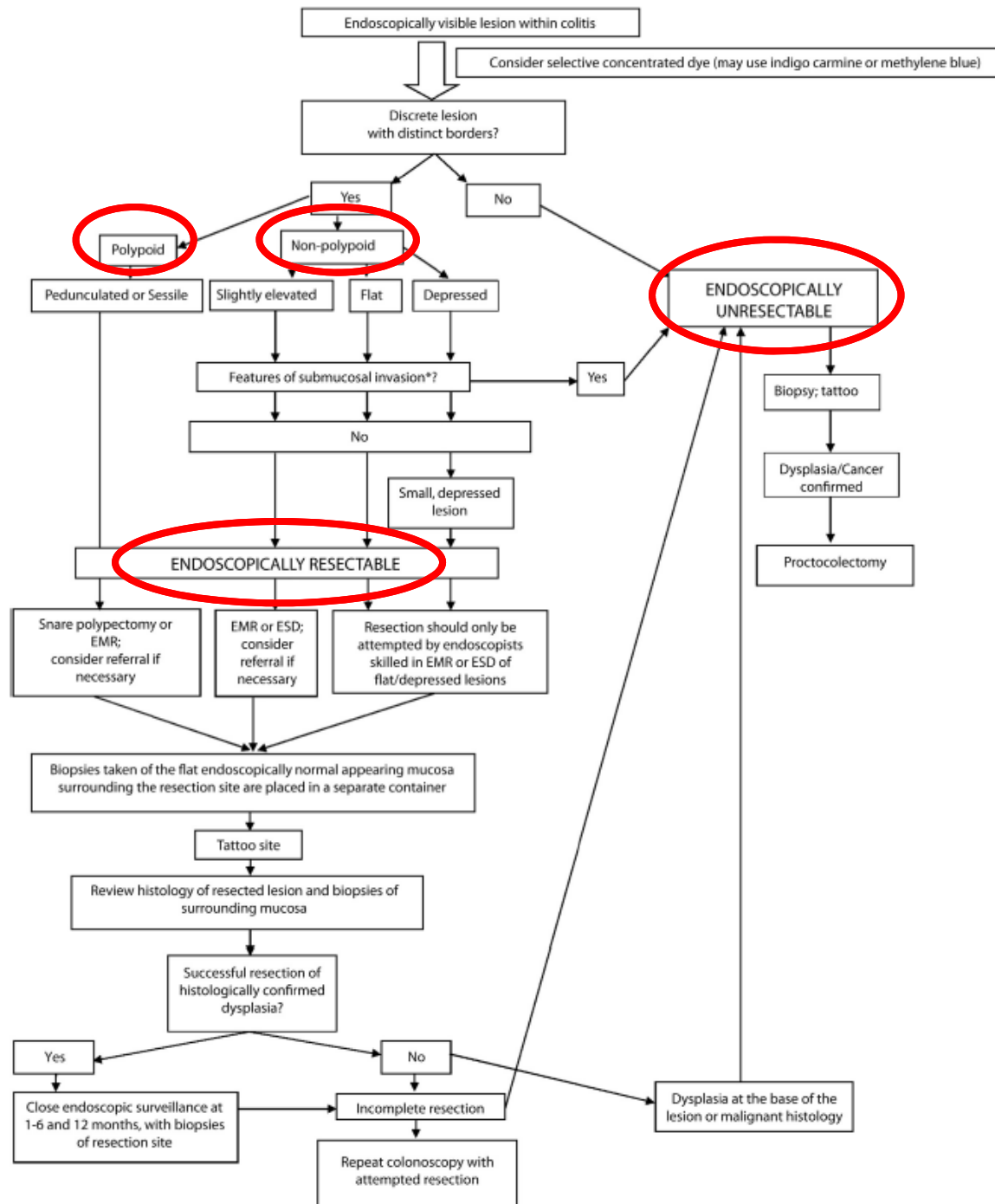
3) Perfect visualisation (bowel prep, good endoscope, chromoendoscopy)

4) Photodocumentation and exact description of procedures

5) Tattooing according to agreed rules

Modified Paris classification

Endoscopic appearance		Description**	Definition	Paris class***
Polypoid lesion protruding from mucosa into the lumen \geq 2.5 mm*		Pedunculated	Lesion attached to mucosa by a stalk	Ip
		Sessile	Lesion not attached to mucosa by a stalk: entire base is contiguous with mucosa	Is
Non-polypoid lesion with little (<2.5mm) or no protrusion above mucosa		Slightly elevated	Lesion with protrusion but < 2.5 mm above mucosa	Ila
		Flat	Lesion without protrusion above mucosa	Ilb
		Depressed	Lesion with at least a portion depressed below the level of mucosa	Ilc



ASGE
Standards of
Practice
Committee.
Gastrointest
Endosc.
2015;81:1101

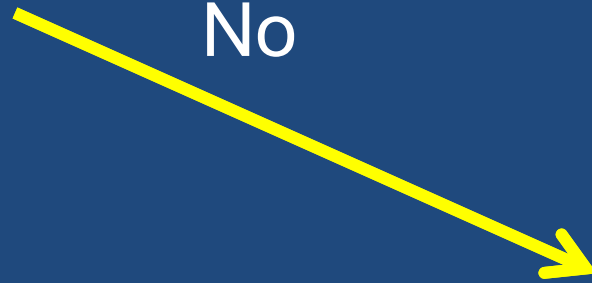
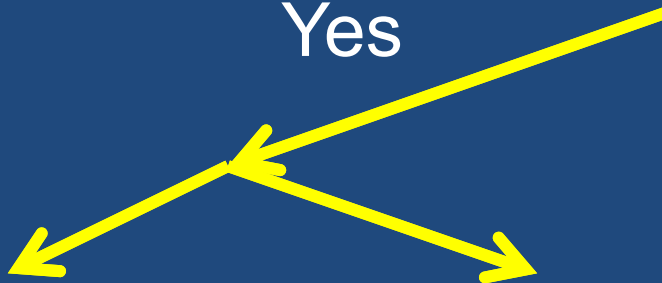
Visible lesion within colitis



Discrete lesion with distinct borders

Yes

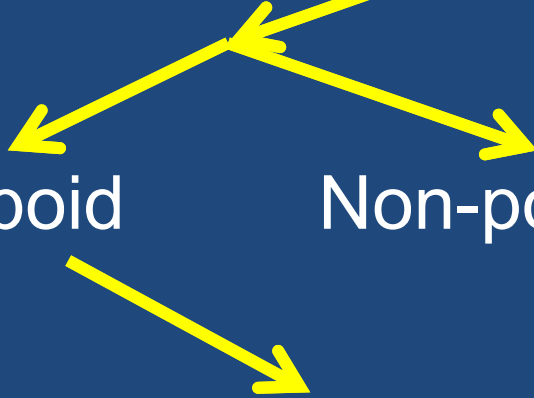
No



Polypoid

Non-polypoid

Endoscopically unresectable



Pedunculated or sessile



Endoscopically resectable?



No



Endoscopically resectable ?

Yes



Polypectomy or EMR

(if necessary in expert centre)



Biopsies from area surrounding resection site



tattoo



Successful resection confirmed by histology ?

Successful resection confirmed by histology?

Yes

Endoscopic surveillance
(1-6, 12 month) with biopsies

Surveillance



Post polypectomy protocol

SUPPLEMENTAL TABLE G. Post-polypectomy surveillance after index resection

Study	Initial surveillance after index resection	Subsequent surveillance recommendation
Rubin ²³⁶	2-6 mo until no dysplastic polyps detected	Yearly
Hurlstone ²²⁶	1, 3, and 6 mo	Biannually
Smith ²²⁷	3 and 6 mo	Biannually

Successful resection confirmed by histology?

No

Incomplete resection

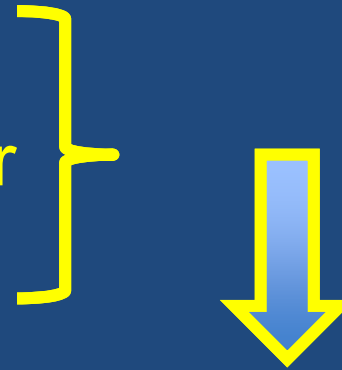
FAILURE

Repeat resection attempt

Dysplasia at resection site or

malignant histology

Incomplete resection or
Dysplasia at resection site or
Malignant histology



Endoscopically unresectable



Tattoo, biopsy

Dysplasia

Cancer confirmed



Procto-colectomy

What is the rate of CRC in pts with longstanding UC who had polypoid lesion resected and underwent surveillance?

Table 1. Outcome Data of Included Articles Including Patient Follow-up and Progression to Dysplasia or CRC

Author	Year	Country	Polypoid dysplasia	Total follow-up (mo)	Surveillance colonoscopies (mean)	CRC progress	CRC/HGD progress	All dysplasia
Blonski ²⁹	2008	USA	6	459	3.6	0	0	0
Goldstone ³⁰	2011	USA	89	3337.5	4	4	7	7
Jess ²⁷	2006	USA	18	2008.8	2	0	0	7
Kisiel ³¹	2012	USA	77	3957.8	1	1	1	33
Medlicott ³²	1997	Canada	6	518.4	8.5	0	0	1
Odze ³³	2004	USA	28	2212	4.4	1	1	19
Pekow ³⁴	2010	USA	12	864	3	1	1	3
Rozen ³⁵	1995	Israel	5	120	1.2	0	0	3
Rubin ²⁸	1999	USA	48	2361.6	2.1	0	0	23
Vieth ³⁶	2006	Germany	87	4611	UK	2	2	4
Total	—	—	376	20,450.1	2.8 (1–8.5)	9	12	100

Mean follow-up time = 54 months

Results

Table 3. Lesion Characteristics Detected During Surveillance Colonoscopy After Resection of Polypoid Dysplasia

Author	Blonski ²⁹	Goldstone ³⁰	Jess ²⁷	Kisiel ³¹	Medlicott ³²	Odze ³³	Pekow ³⁴	Rozen ³⁸	Rubin ²⁸	Vieht ³⁶
Polyp size (cm)	0.54	UK	UK	0.5	0.98	0.79	UK	UK	1.2	UK
Left colon	UK	40	8	42	16	5	UK	UK	UK	UK
Right colon	UK	49	10	43	8	23	UK	UK	UK	UK
Adenoma	UK	UK	4	0	UK	UK	UK	UK	UK	UK
TA	UK	UK	8	75	21	23	UK	7	UK	UK
TVA	UK	UK	4	9	3	4	UK	3	UK	UK
VA	UK	UK	2	1	0	0	UK	0	UK	UK
CRC	0	4	0	1	0	1	1	0	0	2
HGD	UK	3	0	0	0	0	0	0	UK	0
DALM	UK	UK	2	4	0	0	UK	0	UK	0
fLGD	UK	UK	2	28	1	0	2	0	0	0
LGD	UK	UK	3	UK	5	0	0	3	23	2

fLGD, flat low-grade dysplasia; Left colon, number of lesions located distal to splenic flexure; Right colon, number of lesions located proximal to splenic flexure; TA, tubular adenoma; TVA, tubular villous adenoma; UK, unknown; VA, villous adenoma.

Results

Table 4. Pooled Estimates of CRC Rate, CRC/HGD, and All Dysplasia per 1000 Years of Patient Follow-up After Resection of Polypoid Dysplasia

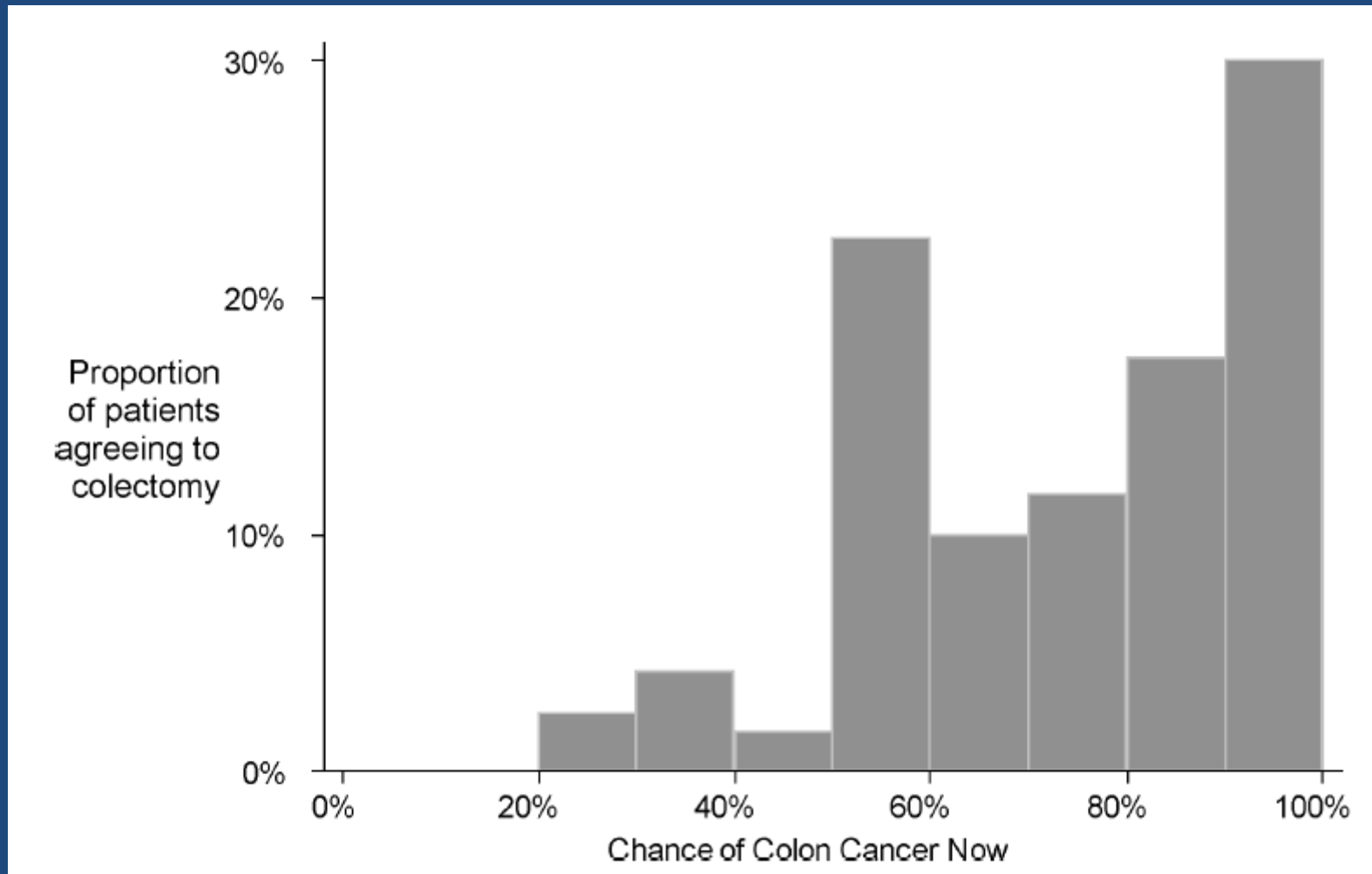
Study	CRC rate, estimate (95% CI)	CRC/HGD, estimate (95% CI)	All dysplasia, estimate (95% CI)
Blonski ²⁹ (2008)	0.0 (0.0–96.4)	0.0 (0.0–96.4)	157 (58–341)
Goldstone ³⁰ (2011)	14.4 (3.9–36.8)	25.2 (10.1–51.9)	25 (10–52)
Jess ²⁷ (2006)	0.0 (0.0–22.0)	0.0 (0.1–22.0)	42 (17–86)
Kisiel ³¹ (2012)	3.0 (0.1–16.9)	3.0 (0.1–16.9)	100 (69–141)
Medlicott ³² (1997)	0.0 (0.0–85.4)	0.0 (0.0–85.4)	139 (51–302)
Odze ³³ (2004)	5.4 (0.1–30.4)	5.4 (0.1–30.4)	103 (62–161)
Pekow ³⁴ (2010)	13.9 (0.4–77.4)	13.9 (0.4–77.4)	42 (9–122)
Rozen ³⁵ (1995)	0.0 (0.0–368.9)	0.0 (0.0–368.9)	300 (62–876)
Rubin ²⁸ (1999)	0.0 (0.0–18.7)	0.0 (0.0–18.7)	117 (74–176)
Vieth ³⁶ (2006)	5.2 (0.6–18.8)	5.2 (0.6–18.8)	10 (4–28)
Pooled value	5.3 (2.7–10.1)	7.0 (4.0–12.4)	65 (54–78)

Acceptability of colectomy depends on the perceived risk of CRC

Questionnaire study in US

199 patients, mean age 49, 52% female,

Patients would agree to colectomy only after their risk of getting CRC right now was at least 73% (SD 21.6)



Conclusions

- 1) Polypoid lesions in patients with IBD can safely be treated endoscopically
- 2) High quality at every step of management is necessary
- 3) Postpolypectomy surveillance – needs to be frequent