Polypectomy of Recurrent Polyps: What’s Your Choice?

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Introduction

Removal of colorectal adenomas during colonoscopy has been shown to reduce the risk for future colorectal cancer (CRC) and advanced adenomas. Nonetheless, CRC remains one of the most common malignancies and leading causes of cancer-related death over the world. Several studies demonstrated a significant incidence rate of CRC in the interval between scheduled surveillance colonoscopies. Several reasons such as inadequate examination, missed polyps, incompletely resected polyps, and rapid progression of newly developed lesion, have been proposed to explain interval CRCs, suggesting that interval CRCs are related in large part, to the quality of baseline colonoscopy. In this presentation, I briefly discuss the optimal treatment strategy for recurrent or residual colorectal polyps after endoscopic resection.

Prevalence and Risk factors for Recurrent or Residual Colorectal Polyps

After endoscopic resection of colorectal tumor, local recurrence is an important issue. Local recurrence rates after endoscopic resection range from 10 to 23%. The local recurrence rate after a piecemeal resection has been reported significantly higher than that after en bloc resection, irrespective of tumor size or macroscopic features. In a recent systematic review and meta-analysis including a total of 33 studies, the mean recurrence risk after endoscopic resection of nonpedunculated colorectal lesions was 15% and recurrence risk was higher piecemeal resection (20%) than after en-bloc resection (3%). In a recent CARE study by Pohl, et al., biopsies from the resection margins after macroscopically complete endoscopic resection showed that 10.1% of all neoplastic polyps were incompletely resected. Incomplete resection was more frequent for large polyps more than 10 mm and for sessile serrated adenomas/polyps (SSA/P). To date, several studies have demonstrated that piecemeal resection, large tumor size, flat lesion, SSA/P, no pre-treatment magnification, and inexperienced operator are risk factors of local recurrence after endoscopic resection of colorectal tumors.

Treatment Strategy for Recurrent or Residual Colorectal Polyps

Local recurrence due to incomplete resection of colorectal tumor remains a problem because concomitant
severe fibrosis makes submucosal dissection difficult. In case of macroscopic residual tissues detected immediately after endoscopic resection of colorectal tumor, an additional endoscopic treatments such as endoscopic mucosal resection (EMR)/snare polypectomy, hot biopsy or argon plasma coagulation (APC) could be performed. The choice of endoscopic treatment methods for recurrent colorectal polyps depends on size and endoscopic features of the recurrent lesion. Hot biopsy are suitable for the excision of adenoma up to 5 mm in size, and snare polypectomy for pedunculated or semi-pedunculated polyps larger than 6 mm. Indications for EMR include flat-type adenomas as well as intramucosal cancers with size less than 20 mm. Candidates for ESD can be large lesion more than 20 mm as well as lesion being technically unsuitable for conventional EMR due to extensive submucosal fibrosis. In the recurrent or residual lesion unsuitable for salvage endoscopic treatment such as index histopathology of submucosal invasion or evidence of nodal metastasis at imaging, surgical treatment should be considered.

Conclusions

There is a significant risk of recurrent or residual polyps after endoscopic resection of large colorectal tumors. To reduce local recurrence after endoscopic resection, it is important to carefully observe the circumferences of the edge and base of the ulcer. An appropriate surveillance colonoscopy should be performed to minimize the risk of interval cancers secondary to local recurrence after endoscopic resection, especially in the high risk patients receiving EPMR for large flat colorectal tumors.

References