

Endoscopic Mucosal Resection of Non-Polypoid Colorectal Neoplasm

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KEYWORDS

- Non-polypoid colorectal neoplasm
- Endoscopic mucosal resection
- Surveillance colonoscopy • Inject-and-cut technique

Endoscopic mucosal resection (EMR), rather than standard polypectomy, is the preferred resection method of non-polypoid lesions because these lesions can be technically difficult to capture with a snare; furthermore, without submucosal injection the underlying muscularis propria may be excessively coagulated or even inadvertently resected.¹ In addition, because the resection plane of EMR is in the middle or deeper part of the submucosa, EMR allows the precise depth of the lesion to be evaluated. Although the majority of non-polypoid lesions are adenomatous, non-polypoid colorectal neoplasm (NP-CRN) has a high association with advanced pathology, irrespective of size.² Thus, using EMR, a complete pathologic specimen is obtained, the risk of lymph node metastasis can be accurately assessed based on the depth of invasion, and patients can be suitably managed. Used according to its indications, EMR provides curative resection, and obviates the higher morbidity, mortality, and cost associated with surgical treatment.^{3,4}

INDICATIONS FOR COLORECTAL EMR

EMR is indicated for the treatment of non-polypoid colorectal lesions when removal at the submucosal level is required to obtain accurate pathology, and ascertain endoscopic cure. For lesions suspected to have high-grade dysplasia or superficial submucosal invasive cancer, EMR is an appropriate strategy and an attempt should be made to remove the lesion en bloc. On the other hand, if piecemeal EMR is technically necessary to remove such lesions with advanced pathology, then the endoscopist should minimize the number of pieces and consider submucosal dissection technique

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Gastrointest Endoscopy Clin N Am 20 (2010) 503–514

doi:10.1016/j.giec.2010.03.009

1052-5157/10/\$ – see front matter. Published by Elsevier Inc.

giendo.theclinics.com

or surgical management. EMR is not indicated when the endoscopist does not believe that he or she can remove the entire lesion in one session (**Fig. 1**). EMR can be safe and efficacious but requires knowledge, expertise, time, and a team; without them, EMR can in fact be dangerous (**Fig. 2**). Thus, EMR is not indicated when the endoscopist does not have the expertise to perform it or is not willing to follow the principles of safe practice of EMR. The indications of colonoscopic mucosal resection are shown in **Box 1**.

ESTIMATION OF THE DEPTH OF INVASION

Colonoscopic assessment of the most likely pathology and estimation of the depth of invasion is important in planning an EMR of the colon and rectum. Neoplasm limited to the mucosa is the best target lesion. Lesions with minimal or moderate likelihood to contain submucosal invasion can be treated with EMR for diagnostic and therapeutic purposes, provided that the endoscopist believes that the lesion can be safely removed in its entirety, and that the potential benefits of endoscopic treatment outweigh the risks. Patients whose lesions are strongly suggestive of invasion should be referred to surgery after a confirmatory biopsy, as endoscopic resection will expose them to unnecessary risks. For example, colonoscopic resection of neoplasms with massive submucosal invasive cancer is generally difficult to accomplish and has a high risk of bleeding, perforation, recurrence, and metastasis. It is appropriate, after assessment of the lesion, to reschedule the patient for a dedicated resection procedure. This rescheduling allows appropriate discussion of the risks and

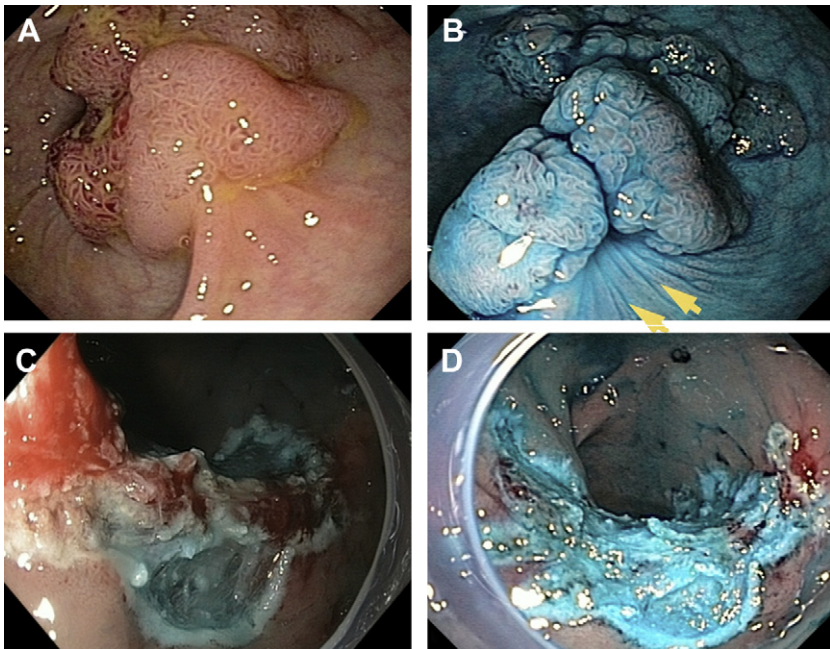


Fig. 1. Repeat EMR of an incomplete prior resection is very difficult. The scar is shown under white light and after indigo carmine spray (A and B, respectively). The resection was piecemeal as the lesion lift partially (C). Such a piecemeal resection produces tissues that are difficult to interpret, thus putting the patient (and physician) at risk. (D) The resected site before application of argon plasma coagulation (not shown).

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