



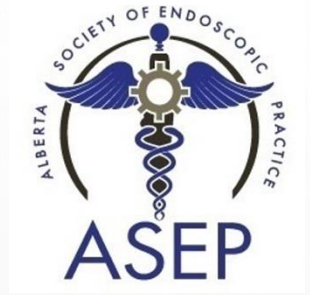
# UPDATES IN POLYP MANAGEMENT

RACHID MOHAMED, MD  
UNIVERSITY OF CALGARY

ASEP 2025

# ENDO SKILLS 2025

## DISCLOSURE OF COMMERCIAL SUPPORT

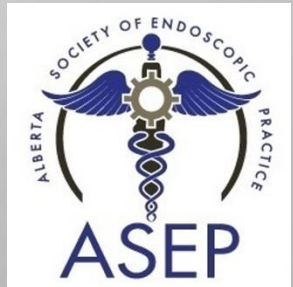


- ▶ ENDO SKILLS IS PRESENTED BY THE ALBERTA SOCIETY FOR ENDOSCOPIC PRACTICE (ASEP)
- ▶ ASEP: NOT FOR PROFIT ORGANIZATION, WHOSE GOAL IS TO PROVIDE EDUCATION, RESOURCES AND COLLABORATION FOR ENDOSCOPISTS AND THEIR TEAMS
- ▶ ENDO SKILLS PLANNING IS INDEPENDENT FROM THE EXHIBITORS
- ▶ ASEP COVERS EXPENSES OF SPEAKERS AND PROVIDES GIFT+/- SMALL HONORARIUM TO SPEAKERS AND PLANNING COMMITTEE

# **ENDO SKILLS 2025**

## **MANAGING SOURCES OF POTENTIAL CONFLICT**

- ▶ **ENDO SKILLS PLANNING COMMITTEE: OVERSEES THE PROGRAM'S CONTENT DEVELOPMENT TO ENSURE ACCURACY AND BALANCE.**
- ▶ **INFORMATION AND RECOMMENDATIONS ARE EVIDENCE AND/OR GUIDELINES-BASED, AND OPINIONS OF THE INDEPENDENT SPEAKERS WILL BE IDENTIFIED AS SUCH.**
- ▶ **PROGRAM DEVELOPED IN ACCORDANCE TO ETHICAL STANDARDS MEETING CERT+ GUIDELINES.**

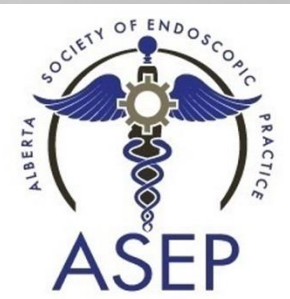


# ENDO SKILLS 2025: PRESENTER DISCLOSURE

▶ PRESENTER: RACHID MOHAMED

▶ RELATIONSHIPS THAT MAY INTRODUCE POTENTIAL CONFLICT OF INTEREST:

**NONE**



# LEARNING OBJECTIVES

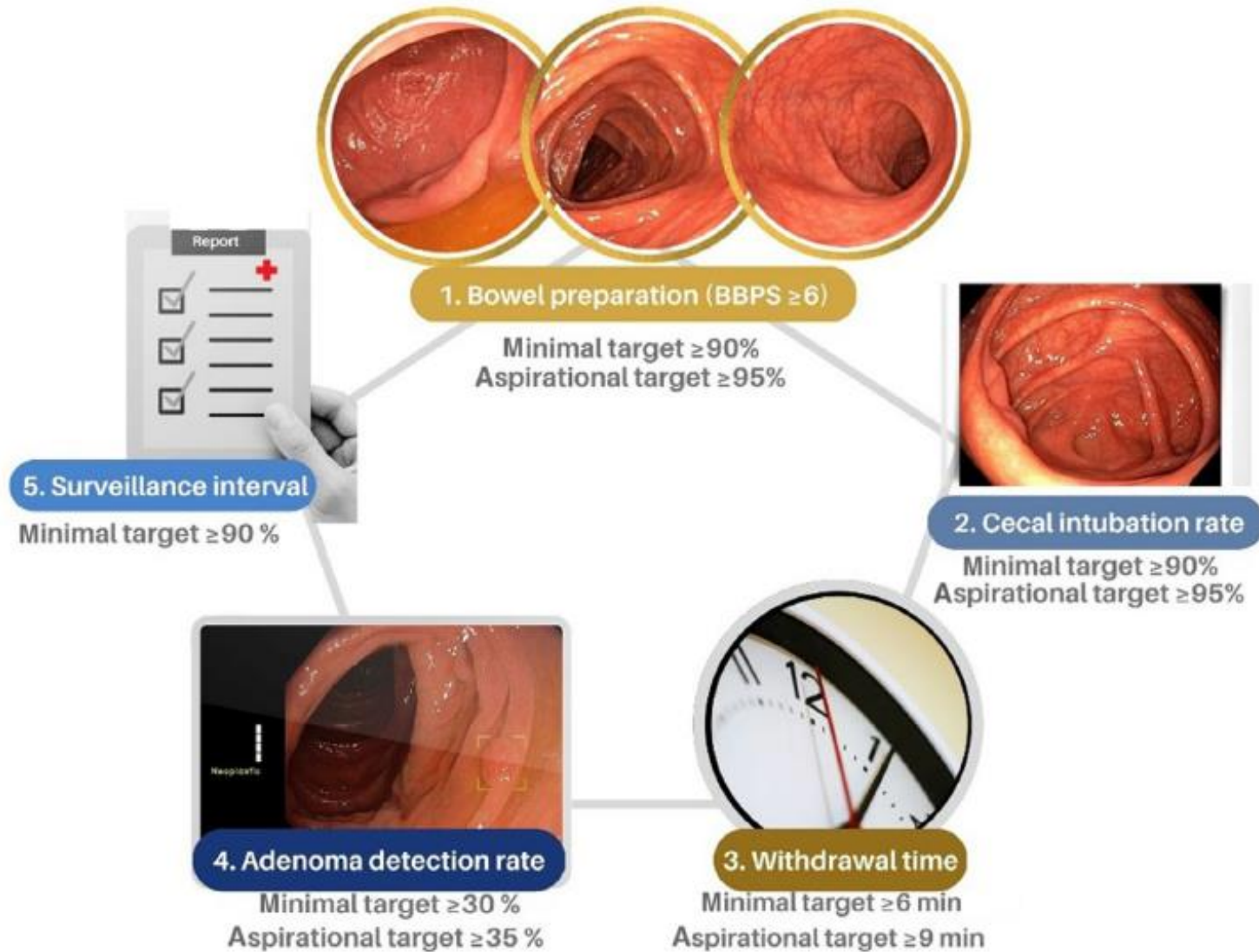
- TRAVEL ALONG THE ‘POLYP JOURNEY’
  - POLYP IDENTIFICATION
  - POLYP CHARACTERIZATION
  - POLYP REMOVAL
  - COMPLICATION MANAGEMENT / PREVENTION
  - POLYP FOLLOW UP



# HIGH QUALITY COLONOSCOPY



# TARGETS FOR THE REAL WORLD



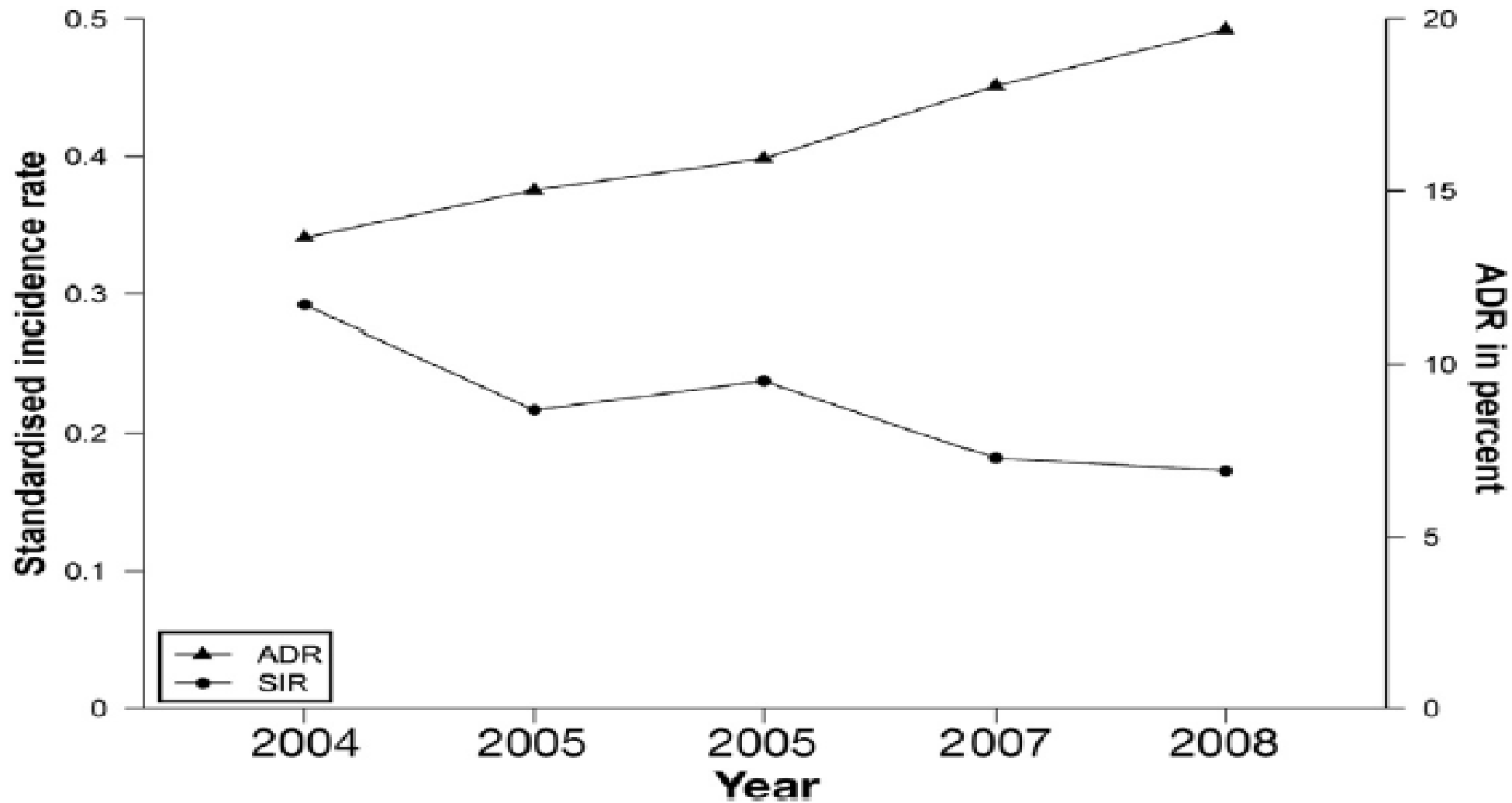
# BOWEL PREPARATION

- TEACHING – VERBAL, WRITTEN – PREDICTS SUCCESS
  - WIDE VARIETY OF BOWEL PREPARATIONS AVAILABLE
- ACCURATE REPORTING OF BOWEL PREPARATION
  - INADEQUATE PREP ASSOCIATED WITH HIGH MISS RATES (15-40%)'
  - ~1/3 OF 'INTERVAL COLON CANCER' HAD SUBOPTIMAL BOWEL PREPARATION
- EARLY INTERVAL REPEAT COLONOSCOPY FOR SUBOPTIMAL PREPARATION
  - INDIVIDUALIZED ACCORDING TO RISK



# TECHNICAL MARKERS

- CECAL INTUBATION
  - TARGET SHOULD BE  $> 95\%$
  - AIDES – WATER IMMERSION, POSITION CHANGE, SCOPE IMAGERS
  - WHAT TO DO IF UNSUCCESSFUL?
- WITHDRAWAL TIME
  - BEST WAY TO INCREASE WITHDRAWAL TIME – IMPROVE INSERTION TIME
  - DYNAMIC POSITION CHANGE, CLEANING



**Figure 2.** Time trend for the standardized interval colorectal cancer rates (per 100,000 patient-years of follow-up evaluation), and adenoma detection rates at the program level. SIR, standardized incidence rate.

**Patient Comfort**

Total Napcoms	139	0	
Avg Score	1.8	NR	2.5
% >4	7%	NR	18%

**Detection Rates****Average Risk****Graph ID: 17**

Procedures	126	206		
PDR	55%	51%	54%	≥35%
ADR <sup>4</sup>	32%	35%	33% <sup>5</sup>	≥25% <sup>***</sup> / ≥32% <sup>*</sup>
APC	0.45	0.61	NR	
SADR	10%	10%	10%	≥8%
SRLDR	41%	43%	40%	
Withdrawal Time <sup>3</sup>	7.4	7.2	8.1	≥ 6 min

**Family History**

Procedures	125	119		
PDR	42%	51%	53%	
ADR	28%	31%	30%	
APC	0.39	0.45	NR	
SADR	14%	16%	12%	
SRLDR	35%	41%	38%	
Withdrawal Time <sup>3</sup>	7.4	7.2	8.1	≥ 6 min



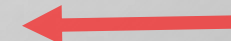
# Impact of a quarterly report card on colonoscopy quality measures

Charles J. Kahi, MD, MSCR,<sup>1,2</sup> Darren Ballard, MD,<sup>1</sup> Anand S. Shah, MD,<sup>3</sup> Raenita Mears, MSN, ACNS-BC, RN,<sup>2</sup> Cynthia S. Johnson, MA<sup>4</sup>

## ► OUTCOME MEASURES DETERMINED BEFORE AND AFTER INTERVENTION OF QUARTERLY REPORT CARDS

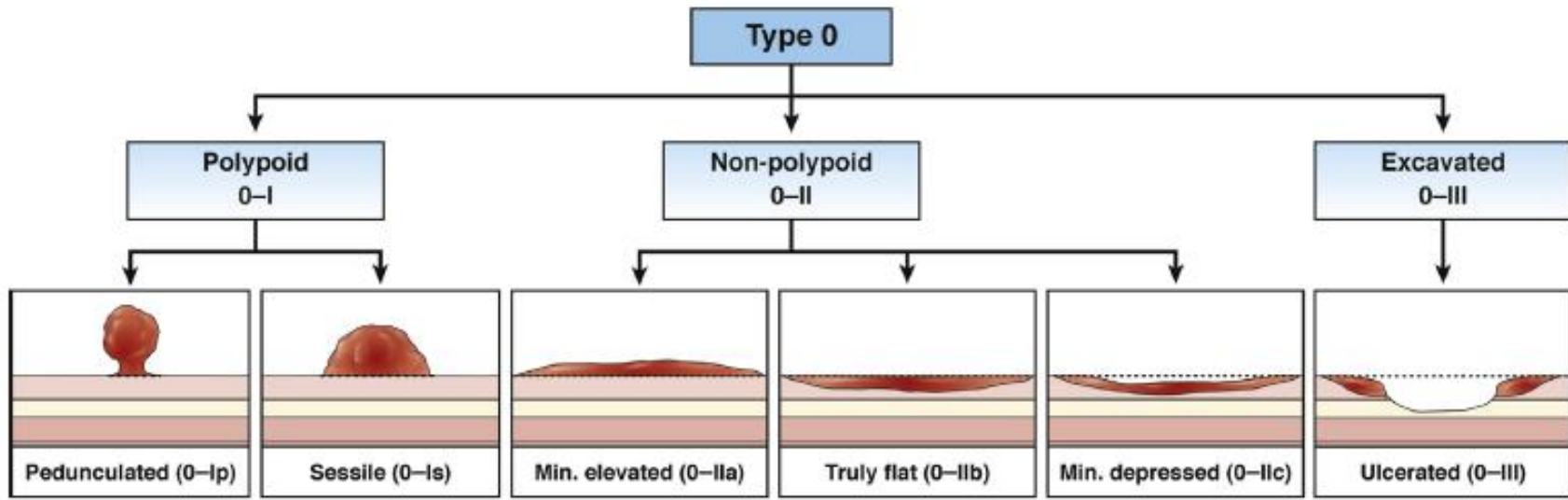
**TABLE 2. Adjusted rates and means by intervention phase**

Variable, rate, % (95% CI, %)	Before intervention	Intervention	P value
Adenoma detection	44.7 (39.1-50.4)	53.9 (49.7-58.1)	.013
Proximal adenoma detection	29.3 (24.4-34.8)	39.8 (35.7-44.0)	.003
Distal adenoma detection	28.4 (23.6-33.7)	27.8 (24.2-31.7)	.840
Advanced neoplasm detection	11.5 (8.4-15.5)	13.3 (10.8-16.4)	.441
Serrated polyp detection	33.8 (28.5-39.5)	32.7 (28.7-36.9)	.741
Cecal intubation	95.6 (92.5-97.5)	98.1 (96.7-99.0)	.027
No. of adenomas per colonoscopy, mean (95% CI)	1.1 (0.7-1.4)	1.2 (0.9-1.5)	.364
Adenoma size per colonoscopy, mean (95% CI), mm	5.6 (4.0-7.1)	5.5 (4.0-7.0)	.956



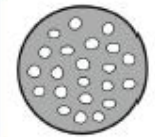
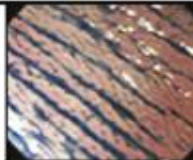


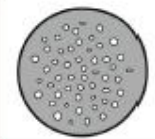


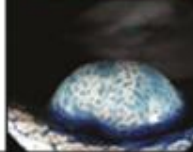






The background of the slide is a light gray gradient. It is decorated with several realistic water droplets of various sizes and shapes, scattered across the top and bottom edges. The droplets have highlights and shadows, giving them a three-dimensional appearance.

# LESION ASSESSMENT



→ Risk of SMI



I		Round pit (normal pit)	
II		Asteroid pit	
III <sub>s</sub>		Tubular or round pit that is smaller than the normal pit (type I)	
III <sub>L</sub>		Tubular or round pit that is larger than the normal pit (type I)	
IV		Dendritic or gyrus-like pit	
V <sub>i</sub>		Irregular arrangement and sizes of III <sub>L</sub> , III <sub>s</sub> , IV type pit pattern	
V <sub>N</sub>		Loss or decrease of pits with an amorphous structure	

~0%

Risk of SMI

~56%

# POLYPECTOMY REPORTING REQUIREMENTS

**1. LOCATION**

**2. SIZE**

**3. BORDER**

**4. SHAPE/MORPHOLOGY (PARIS CLASSIFICATION)**

**5. SURFACE /VASCULAR PATTERN**

# LESION ASSESSMENT

The background features a light gray gradient with several realistic water droplets of various sizes scattered across the surface. The droplets have highlights and shadows, giving them a three-dimensional appearance. The text 'POLYP REMOVAL' is centered in the middle of the image.

# POLYP REMOVAL

# POLYP REMOVAL

- 3 LARGE GROUPS TO CONSIDER
  - SMALL (<10MM) LESIONS
  - SESSILE / FLAT LESIONS > 10MM
  - PEDUNCULATED LESIONS

# LESIONS < 10MM

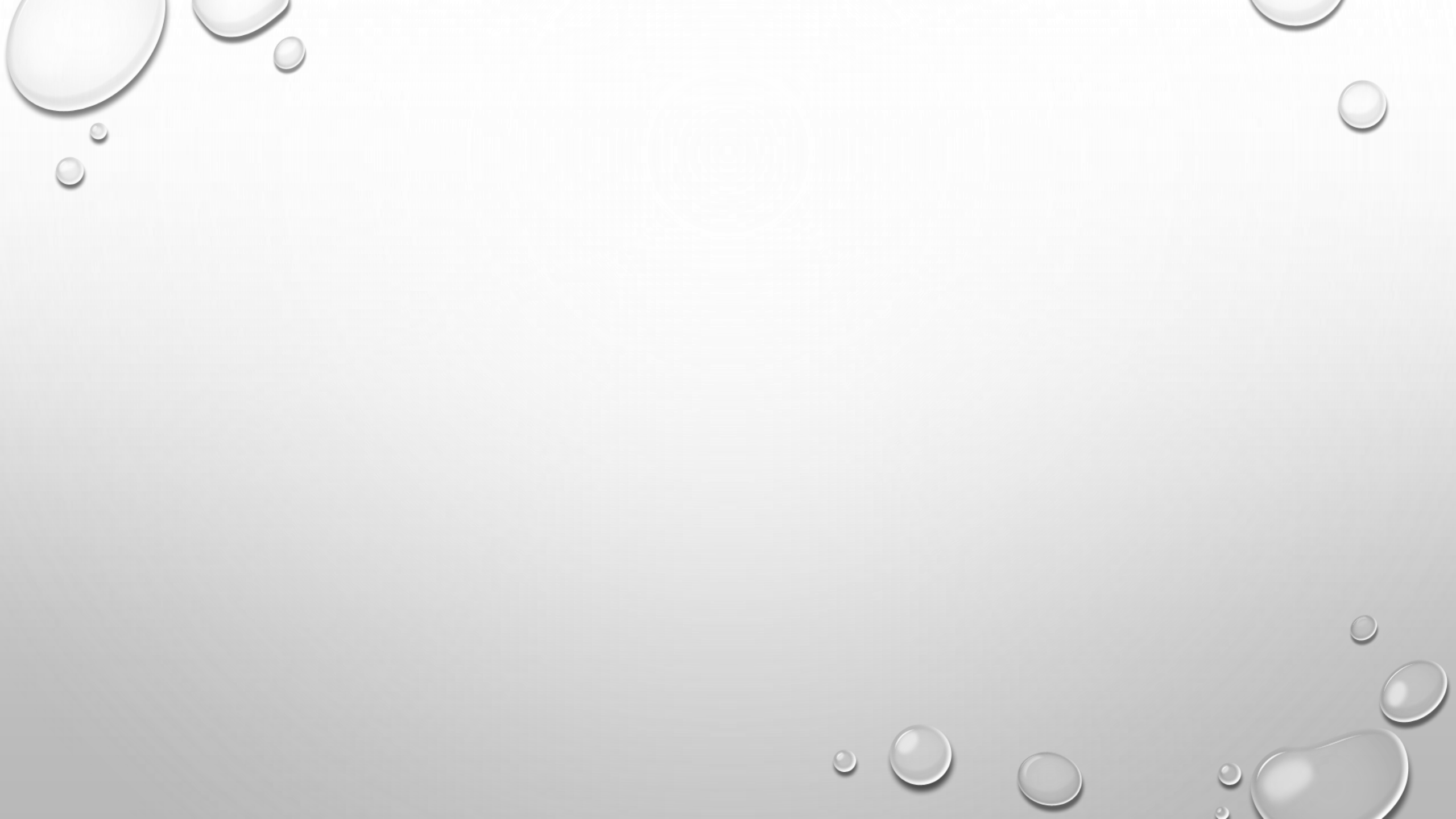
- “COLD SNARE POLYPECTOMY IS THE FIRST-LINE TREATMENT FOR COLORECTAL POLYPS LESS THAN 10MM”
  - US MULTI-SOCIETY TASK FORCE 2020
  - EUROPEAN SOCIETY OF GASTROINTESTINAL ENDOSCOPY 2018
  - JAPANESE GASTROENTEROLOGICAL ENDOSCOPY SOCIETY 2022



# COLD SNARE POLYPECTOMY

# NOT TO BE TAKEN FOR GRANTED

- COLD SNARE RESECTION USED (SHOULD BE) IN >95% OF POLYPS
- TECHNIQUE ENHANCES COMPLETE RESECTION
  - THIN WIRE (0.3MM) SUPERIOR FOR COMPLETE RESECTION
- DEFECT INSPECTION POST RESECTION





**IS THIS AN  
ISSUE?**

BUT WE NEED TO BE BETTER.....

## **Rates of Incomplete Resection of 1- to 20-mm Colorectal Polyps: A Systematic Review and Meta-Analysis**

Roupen Djinbachian,<sup>1,2</sup> Ryma Iratni,<sup>2,3</sup> Madeleine Durand,<sup>1,2</sup> Paola Marques,<sup>2,4</sup> and Daniel von Renteln<sup>2,5</sup>

- COLD SNARE IRR 17.3% VS 14.2% FOR HOT SNARE (NOT STATISTICALLY DIFFERENT)
- COLD SNARE IRR HIGHER FOR POLYPS >10MM COMPARED TO <10MM (20.8% VS 15.9%)


# WHY IS INCOMPLETE RESECTION SO HIGH?

- IDENTIFICATION
  - INCOMPLETE DELINEATION OF POLYP MARGINS
- TECHNIQUE
  - INCOMPLETE TISSUE CAPTURE AND REMOVAL
- INSPECTION POST RESECTION
  - LIMITED BY IMMEDIATE BLEEDING





# NEW METHODS TO IMPROVE CSP

- COLD SNARE EMR
    - PREMISE: INJECTION OF SUBMUCOSA MAY IMPROVE LESION IDENTIFICATION AND COMPLETE RESECTION
- 

## COLD EMR FOR POLYPS < 10MM

# Is Submucosal Injection Helpful in Cold Snare Polypectomy for Small Colorectal Polyps?

Ji Hyun Song<sup>1</sup> and Shai Friedland<sup>2,3</sup>

- 100 PATIENTS, RANDOMIZED TO CSP VS CS-EMR
- COMPLETE RESECTION (CR) DEFINED AS 'CLEAR MARGIN VISUALIZED AFTER RESECTION'
- CR NOT DIFFERENT IN THE TWO GROUPS (92% VS 96%)
- TIME SLIGHTLY LONGER IN CS-EMR (78 SEC VS. 23 SEC)

# Impact of submucosal saline solution injection for cold snare polypectomy of small colorectal polyps: a randomized controlled study 📺

- N – 214, POLYPS 3-10MM
- RANDOMIZED TO SUBMUCOSAL INJECTION VS STANDARD CSP
- OUTCOMES – 'COMPLETE MM RESECTION', NEGATIVE LATERAL/VERTICAL MARGINS
- RESULTS
  - COMPLETE MM RESECTION 43.9% WITH EMR VS. 53.3% (P-NS) - ??RELEVANCE
  - EMR RESULTED IN LESS NEGATIVE VERTICAL AND LATERAL MARGINS (BOTH P <0.5)

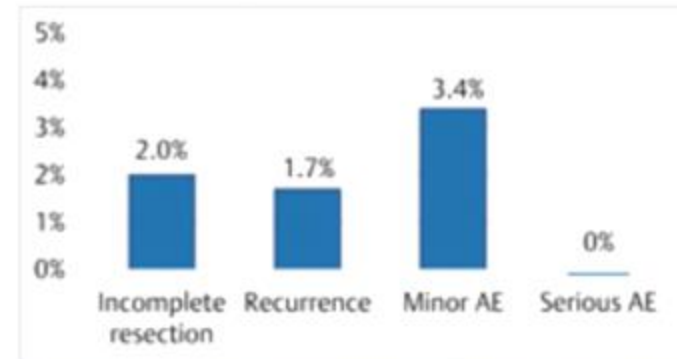
# UNDERWATER CSP

- EFFICACY/SAFETY ESTABLISHED IN RESECTION OF ADVANCED ADENOMAS
- U-CSP FOR POLYPS <10MM
  - 214 PATIENTS, POLYPS REMOVED UNDERWATER.
  - REPEAT COLONOSCOPY 3 WEEKS LATER TO BIOPSY SITE FOR RESIDUAL ADENOMA
  - CRR 80.2% VS 32.7% (P <0.001)

## Cold snare polypectomy for colorectal polyps of 10–19 mm

### Prospective multicenter cohort study

- 350 nonpedunculated polyps of 10–19 mm removed with a cold snare (with or without submucosal injection)
- 69% adenomas, 30% sessile serrated lesions



Cold snare polypectomy is effective and safe for medium-sized nonpedunculated colorectal polyps

AE, adverse event

Endoscopy

# EXPANSION OF COLD SNARE

INCREASING LITERATURE SHOWING SAFETY AND EFFICACY IN SESSILE LESIONS 10-19MM

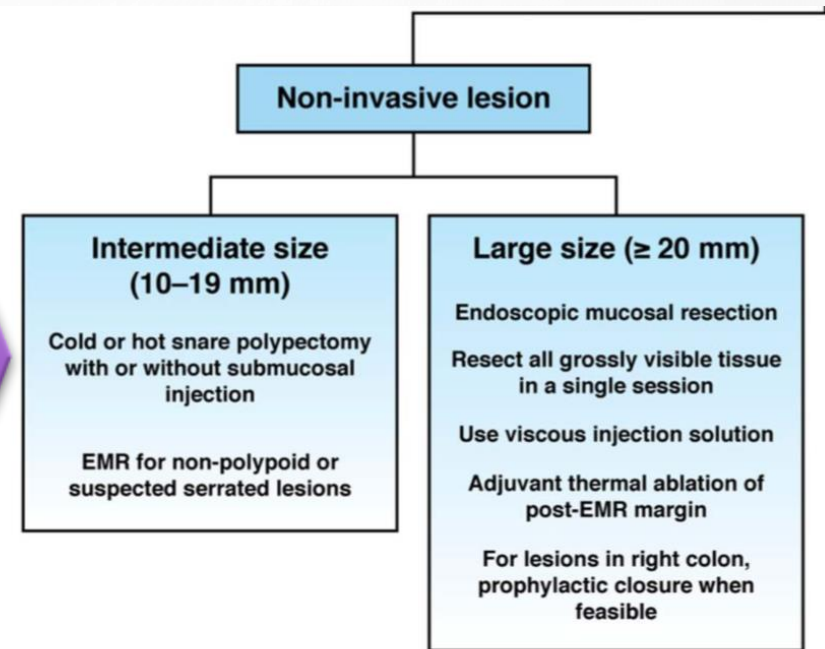
# Endoscopic Removal of Colorectal Lesions: Recommendations by the US Multi-Society Task Force on Colorectal Cancer

Tonya Kaltenbach<sup>1</sup>, Joseph C. Anderson<sup>2-3,4</sup>, Carol A. Burke<sup>5</sup>, Jason A. Dominitz<sup>6-7</sup>, Samir Gupta<sup>8,9</sup>, David Lieberman<sup>10</sup>, Douglas J. Robertson<sup>2-3</sup>, Aasma Shaukat<sup>11-12</sup>, Sapna Syngal<sup>13</sup> and Douglas K. Rex<sup>14</sup>

**SUPPLEMENTARY MATERIAL** accompanies this paper at <http://links.lww.com/AJG/B415>, <http://links.lww.com/AJG/B416>, <http://links.lww.com/AJG/B420>, <http://links.lww.com/AJG/B421>, <http://links.lww.com/AJG/B431>, <http://links.lww.com/AJG/B432>, <http://links.lww.com/AJG/B422>, <http://links.lww.com/AJG/B423>, <http://links.lww.com/AJG/B424>, <http://links.lww.com/AJG/B425>, <http://links.lww.com/AJG/B417>, <http://links.lww.com/AJG/B426>, <http://links.lww.com/AJG/B427>, <http://links.lww.com/AJG/B428>, <http://links.lww.com/AJG/B429>, <http://links.lww.com/AJG/B418>, <http://links.lww.com/AJG/B433>

*Am J Gastroenterol* 2020;00:1–30. <https://doi.org/10.14309/ajg.0000000000000555>

1. LESION ASSESSMENT
2. LESION REMOVAL
3. LESION MARKING
4. SURVEILLANCE POST POLYPECTOMY
5. EQUIPMENT
6. QUALITY



**Figure 5.** Algorithm for the management of colorectal lesions.

2020



# WHY INJECT AND WHAT TO USE?

- PURPOSE OF INJECTION
  - LESION CHARACTERIZATION – BORDERS, SIZE
  - RESECTION PLANNING
  - SAFETY

# WHAT AGENT TO INJECT

## CRYSTALLOID (SALINE)

- CHEAP, ACCESSIBLE
- FAST, CAN MIX WITH DYE
- RAPID EXIT FROM TISSUE

## COLLOID (VOLUVEN, OTHER)

- ACCESSIBLE,
- CAN INCLUDE STEPS FOR SET UP
- MAINTAINS CUSHION LIFT
- PROVIDES SUFFICIENT CUSHION HEIGHT

# WHAT TO USE FOR POLYPECTOMY?

- EUROPEAN SOCIETY OF GASTROINTESTINAL ENDOSCOPY  
2017 GUIDELINES
  - ESGE SUGGEST USE OF MICROPROCESSOR-  
CONTROLLED ELECTROCAUTERY UNIT FOR  
POLYPECTOMY
  - AVOID PURE COAGULATION USE
    - HIGHER RISK OF DEEP MURAL INJURY, PERFORATION AND DELAYED  
BLEEDING
    - OR 2 FOR POST-POLYPECTOMY BLEEDING WHEN USING AN NON-  
AUTOMATED ELECTROSURGICAL CURRENT

# ELECTROCAUTERY

- PEARLS

- BLENDED CURRENT FOR SESSILE

FOR MOST STANDARD POLYPECTOMY, CAN USE BLENDED CURRENT WITH MODERATE EFFECT”

- EFFECT
    - CUT DURATION
    - CUT INTERVAL

- AVOID BLUE PEDAL ONLY FOR TISSUE RESECTION

- LESS IS MORE

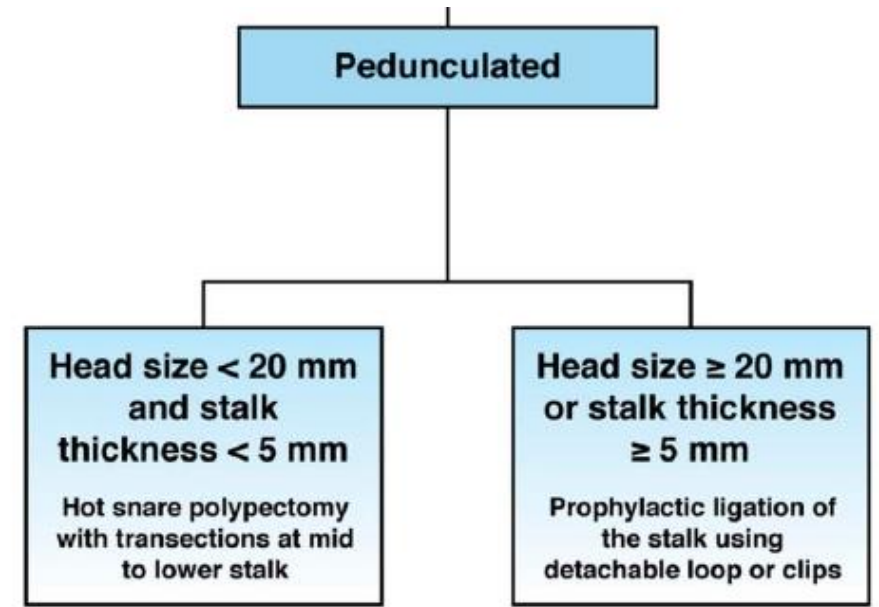
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1. LESION ASSESSMENT
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4. SURVEILLANCE POST POLYPECTOMY
5. EQUIPMENT
6. QUALITY





# QUICK WORD ABOUT COMPLEX POLYPS

- QUESTIONS TO ASK/CONSIDER:
    - IS THIS THE RIGHT TIME?
    - IS THIS THE RIGHT PATIENT?
    - IF I START, CAN I FINISH?
- 

## ▶ TWO IMPORTANT CONSIDERATIONS

### ▶ COMPLETE RESECTION OF ADENOMATOUS PORTION

- ▶ INSPECTION OF LESION FOR DEMARCATION OF POLYP PORTION

### ▶ MITIGATION OF RISK, NAMELY BLEEDING

- ▶ STALK HOUSES VASCULAR SUPPLY TO POLYP HEAD
- ▶ RISK IS LARGELY THAT OF IMMEDIATE BLEEDING BUT DELAYED BLEEDING SHOULD BE NOTED

# PEDUNCULATED LESIONS



POLYP / STALK ASSESSMENT



**SIMPLE PEDUNCULATED LESION**

▶ WHICH STALKS WARRANT PRE-TREATMENT CONSIDERATION?

- ▶ STALK DIAMETER > 5MM
- ▶ POLYP HEAD > 20MM
- ▶ DIFFICULT POSITIONING
- ▶ PATIENT FACTORS FOR INCREASED BLEEDING – ASA, NSAIDS, RENAL DISEASE, ETC

## COMPLEX PEDUNCULATED LESIONS

▶ GOAL IS TO REDUCE (ELIMINATE) IMMEDIATE BLEEDING AND PREVENT DELAYED BLEEDING

▶ PHARMACEUTICAL

▶ EPINEPHRINE FOR VASOCONSTRICTION

▶ MECHANICAL

▶ CLIPS

▶ LIGATURE/LOOPS

▶ ELECTROCAUTERY

## PRE-TREATMENT OPTIONS

# EPINEPHRINE PRETREATMENT

- ▶ LIMITED DATA
- ▶ SMALL CASE SERIES (N – 3) SUGGESTED REDUCED SIZE OF HEAD AND INCREASED EN BLOC REMOVAL WITH 4-8CC OF 1:10000 INJECTION
- ▶ COMPARISON TO MECHANICAL LIGATION SHOWS RELATIVE INFERIORITY FOR IMMEDIATE AND DELAYED BLEEDING

Hogan RB GIE 2007

Kouklakis G Surg Endosc 2009

# EPINEPHRINE

▶ CLIPS

- ▶ BENEFITS INCLUDE FAMILIARITY, ROTATABILITY, EASE OF APPLICATION
- ▶ DOWNSIDE COULD BE POTENTIATION OF CAUTERY LEADING TO WALL INJURY

▶ LOOPS

- ▶ ALLOW FOR SECURE, RELIABLE CONTROL OF STALK
- ▶ HIGHLY USER DEPENDENT

## MECHANICAL LIGATION



- ▶ REQUIRES UNDERSTANDING AND COMMUNICATION BETWEEN MD AND RN
- ▶ INCORRECT DEPLOYMENT CAN RESULT IN SIGNIFICANT INCREASED DIFFICULTY AND RISK OF INCOMPLETE RESECTION
- ▶ HEAD TO HEAD (CLIPS VS. LOOPS) HAVE SHOWN SIMILAR BLEEDING RISK (~5%)

Ji JS Endoscopy 2014

# ENDOLOOP

The background of the slide is a light gray gradient with several realistic water droplets of various sizes scattered across it. The droplets have highlights and shadows, giving them a three-dimensional appearance. The text is centered in the middle of the slide.

# **MANAGEMENT OF COMPLICATIONS**

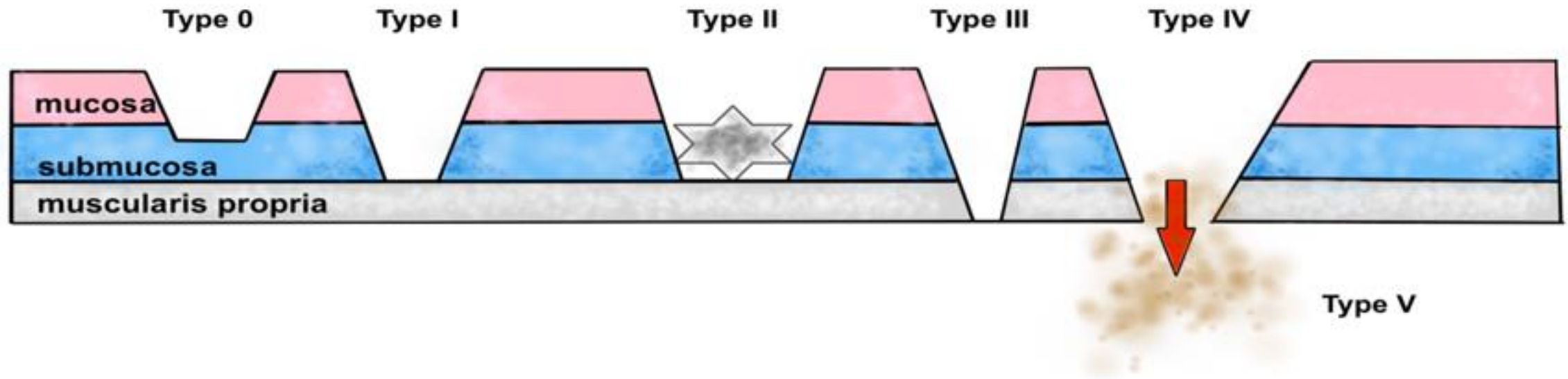
# POLYPECTOMY COMPLICATIONS

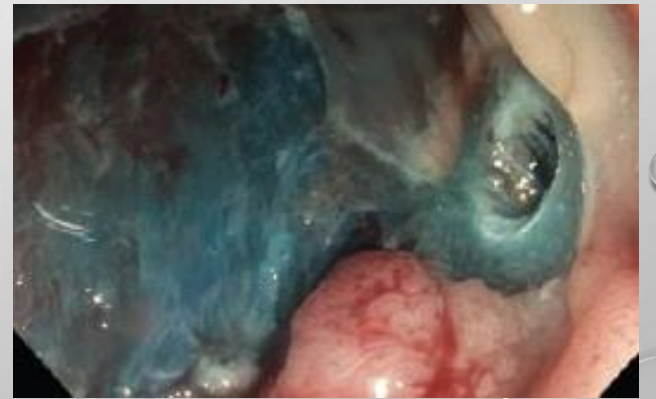
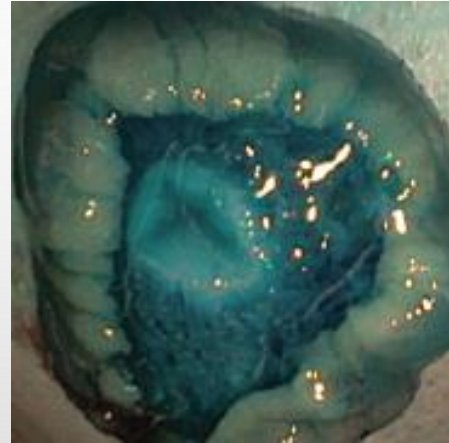
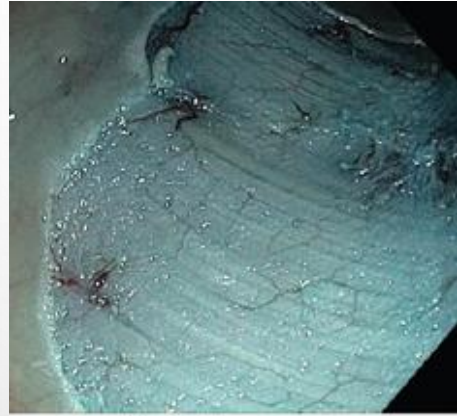
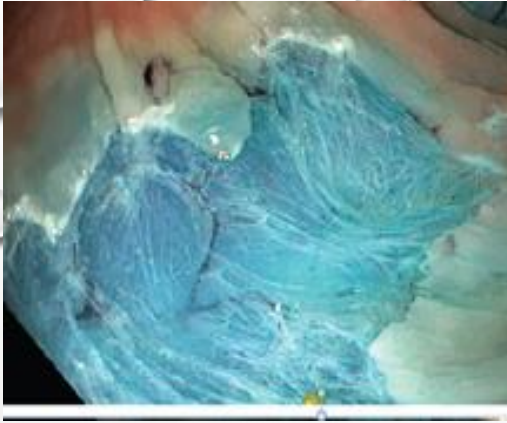
- PAIN
  - IMPORTANT TO RULE OUT PERFORATION
  - OTHER CAUSES – DISTENTION, EPINEPHRINE, POST POLYPECTOMY SYNDROME
- BLEEDING
  - GENERALLY LOW RISK OVERALL
  - RISK FACTORS – PROXIMAL LOCATION, SIZE INCREASE
- DEEP MURAL INJURY

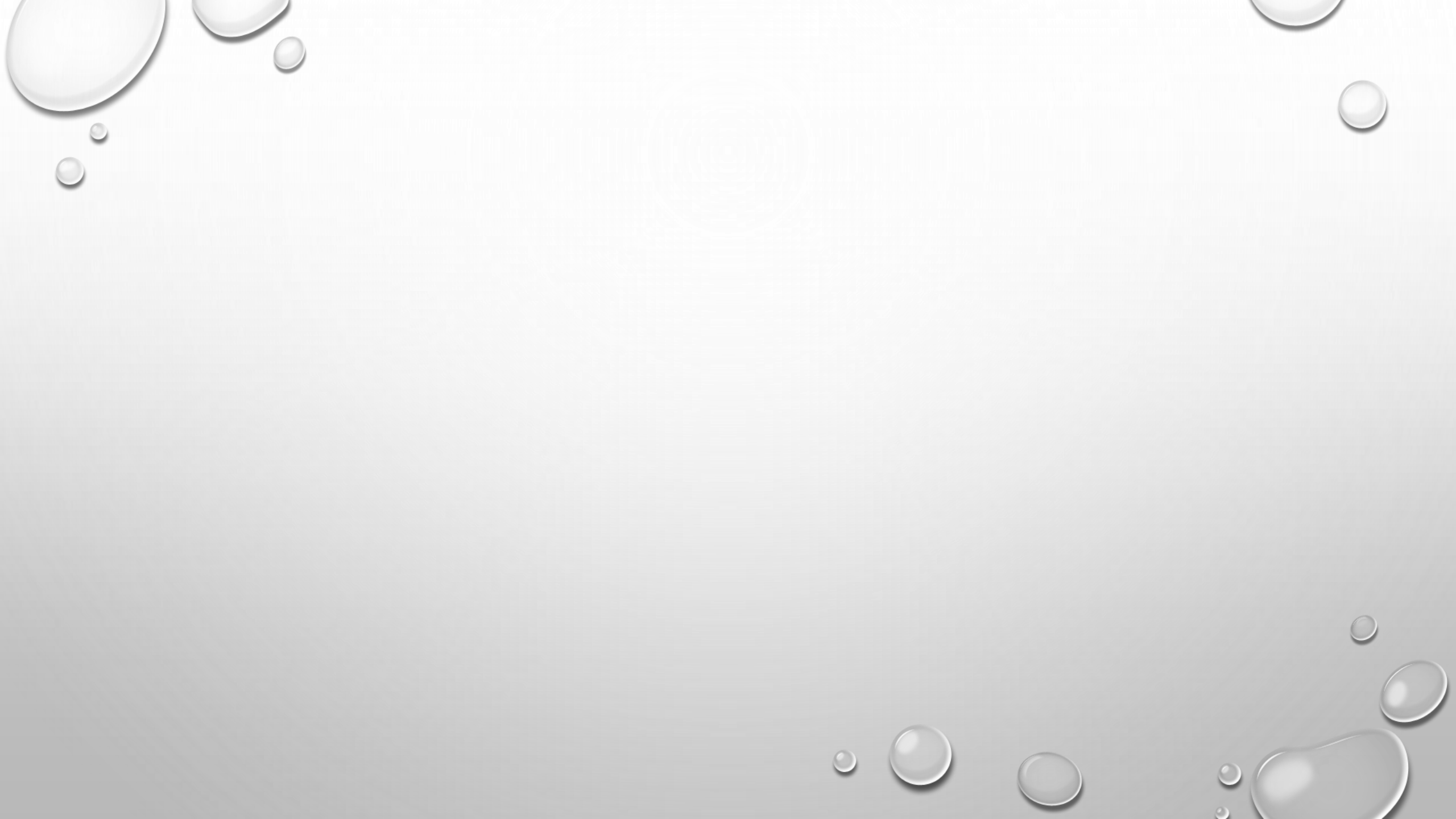
# BLEEDING

- MOST WILL SLOW/STOP WITH IRRIGATION AND TIME
- LOCAL THERAPY – SNARE TIP SOFT COAGULATION
  - EFFECT 4, 80W – BLUE PEDAL
- CLIPPING
- OTHER

# POST POLYPECTOMY DEFECT ASSESSMENT









# DEFECT MANAGEMENT

- CLOSURE OF LARGER DEFECTS HAS BEEN SHOWN TO REDUCE DELAYED BLEEDING
  - ODDS RATIO 0.31

Forbes et al. GIE 2022

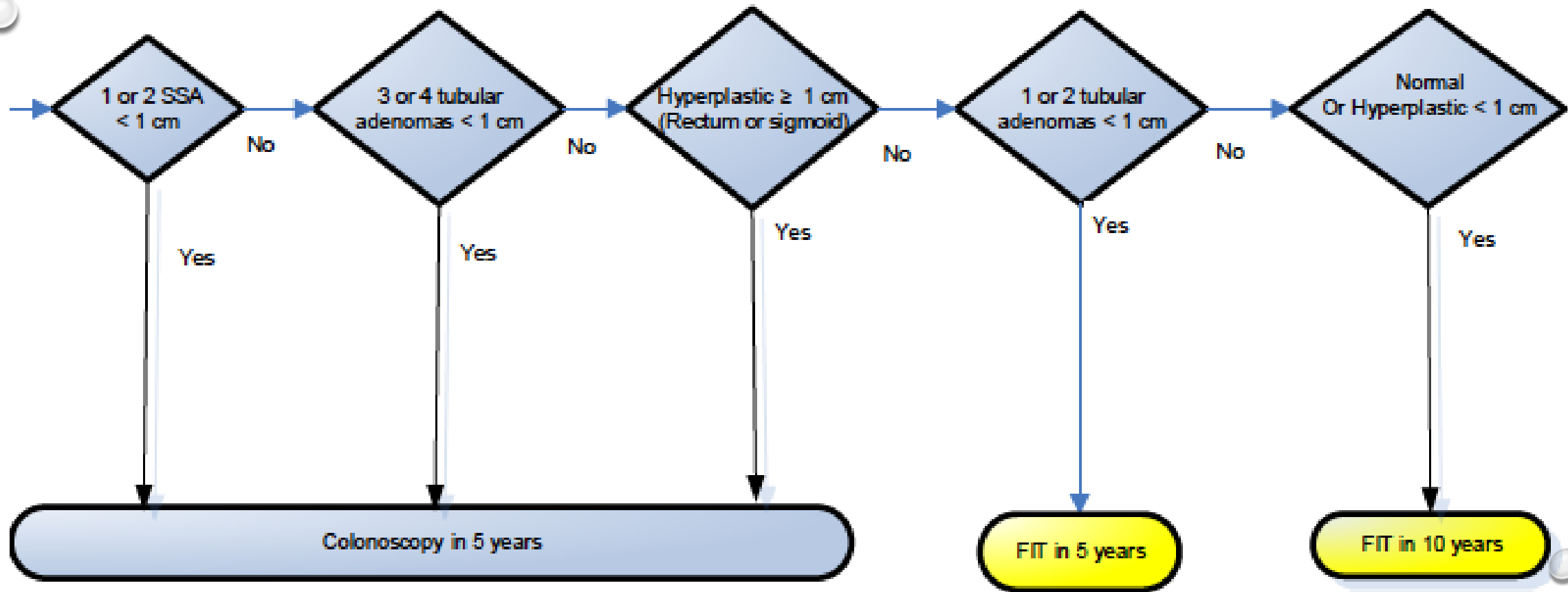
- IF ANY CONCERNS ABOUT DEEP MURAL INJURY, CLOSURE IS RECOMMENDED

The background features a light gray gradient with several realistic water droplets of various sizes scattered across the surface. The droplets have highlights and shadows, giving them a three-dimensional appearance. The text is centered in the middle of the frame.

# POLYP FOLLOW UP

# POST POLYPECTOMY SURVEILLANCE

- CONSTANT BALANCE BETWEEN REFERRAL VOLUME AND RESOURCE CAPACITY
- HISTORICAL SURVEILLANCE (AVERAGE RISK)
  - NORMAL – FIT / COLONOSCOPY IN 10 YEARS
  - 1-2 ADENOMAS – COLONOSCOPY IN 5 YEARS
  - >2 ADENOMAS – COLONOSCOPY IN 3 YEARS
  - ADVANCED ADENOMA – COLONOSCOPY IN 3 YEARS
- NEW RECOMMENDATIONS INCORPORATE INCREASED FIT SURVEILLANCE



## Surveillance Interval Guidelines for High Risk Polyps

### Condition

### Interval

#### Conventional Adenomas

5 – 10 tubular adenomas < 1 cm

3 years

Any adenoma  $\geq$  1 cm

3 years

Any adenoma with high-grade dysplasia

3 years

(review with MD re repeat within 6 months)

Any adenoma with villous histology

3 years

> 10 adenomas

1 year + ?genetics

#### Serrated Lesions

Traditional Serrated Adenoma

3 years

Sessile Serrated Lesion (SSL) with cytological dysplasia

3 years

SSL  $\geq$  1 cm

3 years

3 – 10 SSL < 1 cm

3 years\*

### Recommendations Following Subsequent Colonoscopies

First Colonoscopy Findings	Recommendation if 2 <sup>nd</sup> Colonoscopy Normal	Recommendation if 3 <sup>rd</sup> Colonoscopy Normal
<b>Adenomas Only</b>		
1 – 2 TAs < 10 mm	FIT in 5 years <sup>1</sup>	----
3 -4 TAs < 10 mm	FIT in 5 years <sup>1</sup>	----
Hyperplastic polyps < 1 cm	FIT in 5 years <sup>1</sup>	----
5 – 10 TAs < 10 mm	colonoscopy in five years	FIT in 5 years <sup>1</sup>
≥ 10 mm adenoma	colonoscopy in five years	FIT in 5 years <sup>1</sup>
Villous histology or HGD	colonoscopy in five years	FIT in 5 years <sup>1</sup>
> 10 TAs	At endoscopist discretion	At endoscopist discretion
<b>Serrated Lesions Only</b>		
1 – 2 SSLs < 10 mm	FIT in 5 years <sup>1</sup>	-----
3 - 10 10 SSLs < 10 mm	colonoscopy in five years	FIT in 5 years <sup>1</sup>
≥ 10 mm SSL	colonoscopy in five years	FIT in 5 years <sup>1</sup>

# SUMMARY

- COLONOSCOPY WITH POLYP REMOVAL REMAINS THE MOST IMPACTFUL INTERVENTION IN ENDOSCOPY PRACTICE
- CONTINUED FOCUS ON:
  - QUALITY SCREENING
  - APPROPRIATE POLYP REMOVAL TECHNIQUE
  - EVIDENCE BASED SURVEILLANCE RECOMMENDATIONS





Thank You