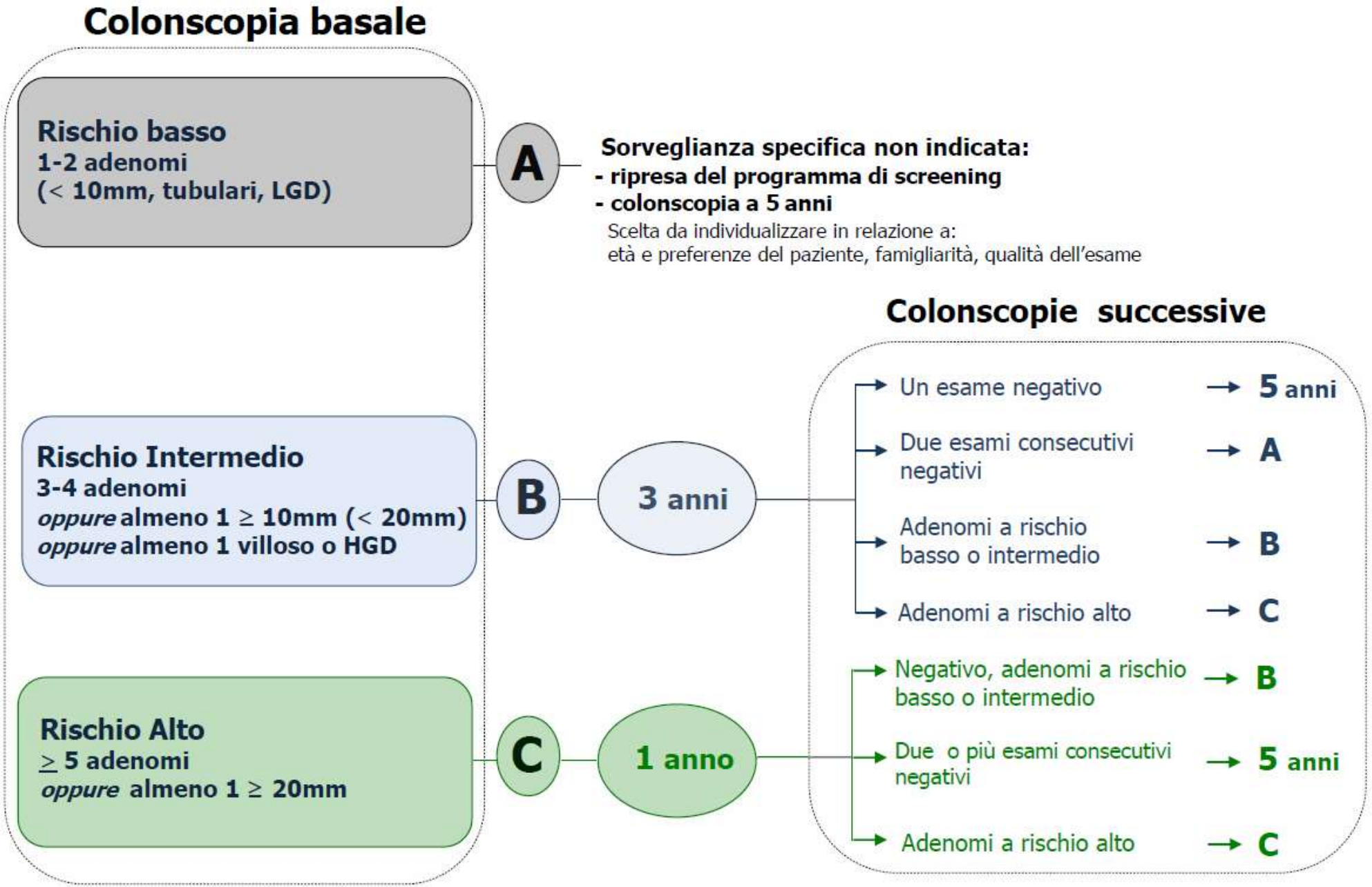
RIUNIONE ANNUALE SCREENING COLORETTALE
PADOVA, 21/11/2017

LA VALUTAZIONE ISTOLOGICA DEI MARGINI NEGLI ADENOMI A "BASSO RISCHIO" NELLO SCREENING DEL CARCINOMA DEL COLON-RETTO: DEFINIZIONE, PROBLEMATICHE, PROSPETTIVE FUTURE

Marcello Lo Mele

U.O.C. ANATOMIA PATOLOGICA
AZIENDA OSPEDALIERA DI PADOVA


Colonscopia basale
Rischio basso
1-2 adenomi
(< 10mm, tubulari, LGD)
A
Sorveglianza specifica non indicata:
- ripresa del programma di screening
- colonscopia a 5 anni
Scelta da individualizzare in relazione a:
età e preferenze del paziente, famigliarità, qualità dell'esame
Rischio Intermedio
3-4 adenomi
oppure almeno 1 ≥ 10mm (< 20mm)
oppure almeno 1 villoso o HGD
B
3 anni
Rischio Alto
≥ 5 adenomi
oppure almeno 1 ≥ 20mm
C
1 anno
Colonscopie successive
Un esame negativo → 5 anni
Due esami consecutivi negativi → A
Adenomi a rischio basso o intermedio → B
Adenomi a rischio alto → C
Negativo, adenomi a rischio basso o intermedio → B
Due o più esami consecutivi negativi → 5 anni
Adenomi a rischio alto → C

Margine:
Valutare sempre il margine se indenne o meno, e se la retrazione della base di impianto, o le caratteristiche del materiale in esame non consentono adeguate precisazioni in merito alla radicalità della exeresi.
Lo stato del margine va riferito in particolar modo per le lesioni adenomatose di alto grado, specificando se il tessuto adenomatoso presente in corrispondenza del margine presenti displasia di basso o alto grado.
Nel caso in cui la lesione sia frammentata, non è possibile pronunciarsi correttamente circa i margini e le dimensioni, se non riportando il frammento con diametro maggiore.

Esempi di refertazione:

1. Adenoma Tubulare/Villoso/Tubulovilloso con displasia epiteliale di basso/alto grado - *con asse maggiore dell'area adenomatosa misurato su vetrino di mm o cm* solo se vi è significativa disparità di dimensioni rispetto a quanto rilevato in macro -
(neoplasia intraepiteliale di ... grado secondo WHO 2010 *o eventualmente* carcinoma intramucoso secondo WHO 2010 *o* neoplasia mucosa di ... grado categoria ... secondo la classificazione di Vienna riadattata dalle linee guida europee).
La lesione adenomatosa è risultata istologicamente compresa nei margini della escissione.
La retrazione della base d'impianto/Le caratteristiche del materiale in esame non consentono adeguate precisazioni in merito alla radicalità della exeresi.
Displasia di ... grado è stata istologicamente documentata in corrispondenza del margine della escissione.
pTis (per la displasia di alto grado e il carcinoma intramucoso).

In caso di lesioni frammentate:
2. Frammenti di Adenoma Tubulare/Villoso/Tubulovilloso con displasia epiteliale di basso/alto grado (opzionale la dizione: margine di escissione non valutabile).
In caso di lesioni adenomatose frammentate in cui sia sospettata, ma non inequivocabilmente documentata, l'invasione della sottomucosa, è consigliabile rimettere alla discussione multidisciplinare le decisioni riguardo al successivo trattamento.

Dig Dis Sci (2012) 57:1786–1791
DOI 10.1007/s10620-012-2115-6

ORIGINAL ARTICLE

Quality of Polyp Resection During Colonoscopy: Are We Achieving Polyp Clearance?

Shanglei Liu · Samuel B. Ho · Mary Lee Krinsky

Received: 31 October 2011 / Accepted: 22 February 2012 / Published online: 30 March 2012

colonoscopy. The primary aim of this study was to determine the incidence of an incomplete polyp resection despite a perceived complete polypectomy.

Patients and Methods This was a retrospective quality assurance project conducted at the San Diego Veterans Affair Medical Center and University of California San Diego Medical Center from July 2007 to April 2008. The patients recruited to this study were undergoing surveillance and screening colonoscopy. The resection quality was evaluated in 65 polyps of 47 patients. Twenty-two polyps were removed with standard biopsy forceps, jumbo forceps (18), hot snare (18), and cold snare (7). Biopsies were taken from the post-polypectomy site base and perimeter for histologic examination in order to confirm histologic absence of all polypoid appearing mucosa.

Results The post-polypectomy sites of ten polyps (15 %) were found to have residual polypoid tissue. Six were removed by standard biopsy forceps, jumbo forceps (2), hot snare (1), and cold snare (1). When compared to other polypectomy devices, standard biopsy forceps were more likely to result in an incomplete resection (27 vs. 9 %; $P = 0.076$).

Incomplete Polyp Resection During Colonoscopy—Results of the Complete Adenoma Resection (CARE) Study

HEIKO POHL,[1,2] AMITABH SRIVASTAVA,[3] STEVE P. BENSEN,[2] PETER ANDERSON,[2] RICHARD I. ROTHSTEIN,[2] STUART R. GORDON,[2] L. CAMPBELL LEVY,[2] ARIFA TOOR,[2] TODD A. MACKENZIE,[4] THOMAS ROSCH,[5] and DOUGLAS J. ROBERTSON[1,2]

GASTROENTEROLOGY 2013;144:74–80

tice. **METHODS:** We performed a prospective study on 1427 patients who underwent colonoscopy at 2 medical centers and had at least 1 nonpedunculated polyp (5–20 mm). After polyp removal was considered complete macroscopically, biopsies were obtained from the resection margin. The main outcome was the percentage of incompletely resected neoplastic polyps (incomplete resection rate [IRR]) determined by the presence of neoplastic tissue in post-polypectomy biopsies. Associations between IRR and polyp size, morphology, histology, and endoscopist were assessed by regression analysis. **RESULTS:** Of 346 neoplastic polyps (269 patients; 84.0% men; mean age, 63.4 years) removed by 11 gastroenterologists, 10.1% were incompletely resected. IRR increased with polyp size and was significantly higher for large (10–20 mm) than small (5–9 mm) neoplastic polyps (17.3% vs 6.8%; relative risk = 2.1), and for sessile serrated adenomas/polyps than for conventional adenomas (31.0% vs 7.2%; relative risk = 3.7). The IRR for endoscopists with at least 20 polypectomies ranged from 6.5% to 22.7%; there was a 3.4-fold difference between the highest and lowest IRR after adjusting for size and sessile serrated histology. **CONCLUSIONS: Neoplastic polyps are often incompletely resected, and the rate of incomplete resection varies broadly among endoscopists. Incomplete resection might contribute to the development of colon cancers after colonoscopy (interval cancers). Efforts are needed to ensure complete resection, especially of larger lesions.** ClinicalTrials.gov

Clinical and Experimental Gastroenterology

Open Access Full Text Article

Advances, problems, and complications of polypectomy

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Table 2 Diminutive and small polyps section, key points

- The vast majority of colonic polyps are diminutive (≤5 mm) or small (6–9 mm).
- Polypectomy by cold forceps biopsy is associated with high rates of incomplete removal in this setting. Polypectomy by hot forceps must be avoided, as it is associated with high complication rates.
- Cold snare polypectomy is superior to biopsy forceps in terms of complete polyp removal. It has similar complete removal rates as hot snare polypectomy, but with less complications.
- The "resect and discard" and "leave-in" policies for diminutive polyps are slowly entering clinical practice.

Polypectomy for complete endoscopic resection of small colorectal polyps

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Shanghai, China

: 2017 GASTROINTESTINAL ENDOSCOPY

Background and Aims: Small colorectal polyps are encountered frequently and may be incompletely removed during colonoscopy. The optimal technique for removal of small colorectal polyps is uncertain. The aim of this study was to compare the incomplete resection rate (IRR) by using EMR or cold snare polypectomy (CSP) for the removal of small adenomatous polyps.

Methods: This was a prospective randomized controlled study from a tertiary-care referral center. A total of 358 patients who satisfied the inclusion criteria (polyp sized 6-9 mm) were randomized to the EMR (n = 179) and CSP (n = 179) groups, and their polyps were treated with conventional EMR or CSP, respectively. After polypectomy, an additional 5 forceps biopsies were performed at the base and margins of polypectomy sites to assess the presence of residual polyp tissue. The EMR and CSP samples were compared to assess the IRR.

Results: Among a total of 525 polyps, 415 (79.0%) were adenomatous polyps, and 41 (16.4%) were advanced adenomas. The overall IRR for adenomatous polyps was significantly higher in the CSP group compared with the EMR group (18/212, 8.5% vs 3/203, 1.5%; $P = .001$). Logistic regression analysis revealed that the CSP procedure was a stronger risk factor for the IRR (odds ratio [OR] 6.924; 95% confidence interval [CI], 2.098-24.393; $P = .003$). In addition, piecemeal resection was the most important risk factor for the IRR (OR 28.696; 95% CI, 3.620-227.497; $P = .001$). The mean procedure time for polypectomy was not significantly different between the EMR and CSP groups (5.5 ± 2.7 vs 4.7 ± 3.4 minutes; $P = .410$). None of these patients presented with delayed bleeding. There were no severe adverse events related to the biopsies.

Conclusions: EMR was significantly superior to CSP for achieving complete endoscopic resection of small colorectal polyps. Patients with piecemeal resection of polyps had a higher risk for incomplete resection. (Clinical trial registration number: Hongwei-1102-12.) (Gastrointest Endosc 2017;■:1-8.)

A quantitative assessment of the risks and cost savings of forgoing histologic examination of diminutive polyps

Authors

W. R. Kessler[1], T. F. Imperiale[1,2], R. W. Klein[2], R. C. Wielage[2], D. K. Rex[1]

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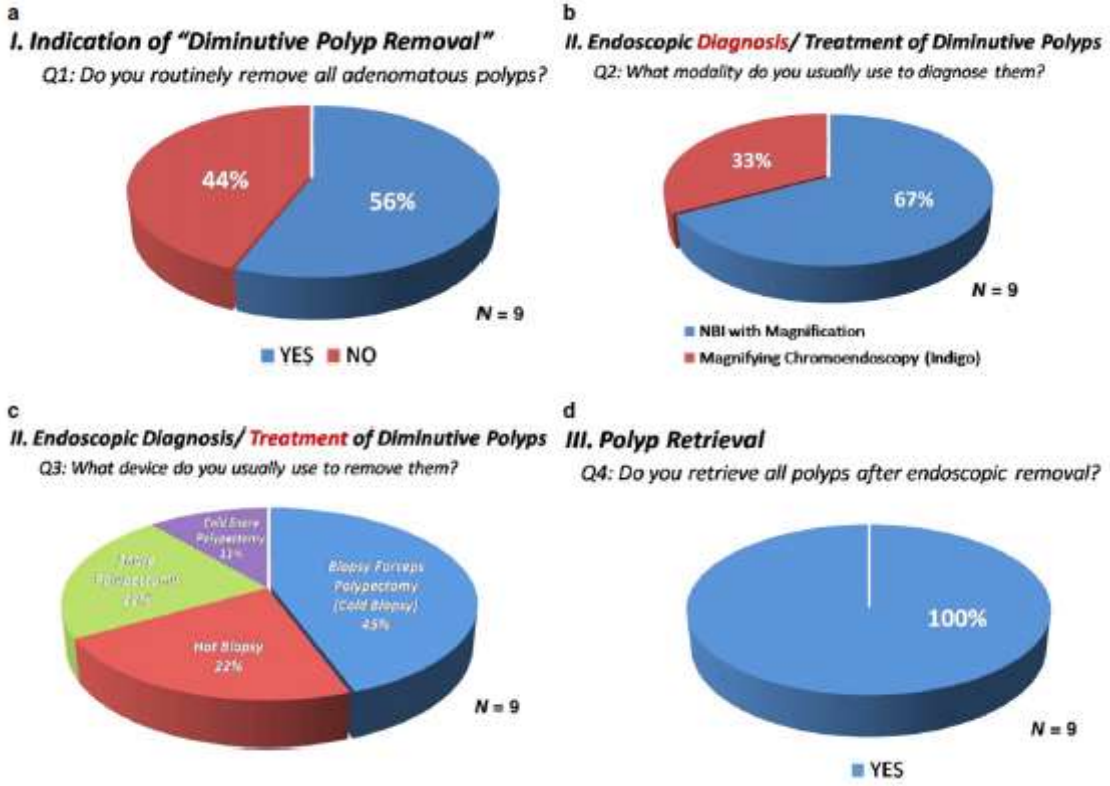
Kessler W R et al. A quantitative assessment of the risks and cost savings of forgoing histological examination of diminutive polyps... Endoscopy 2011; 43: 683–691

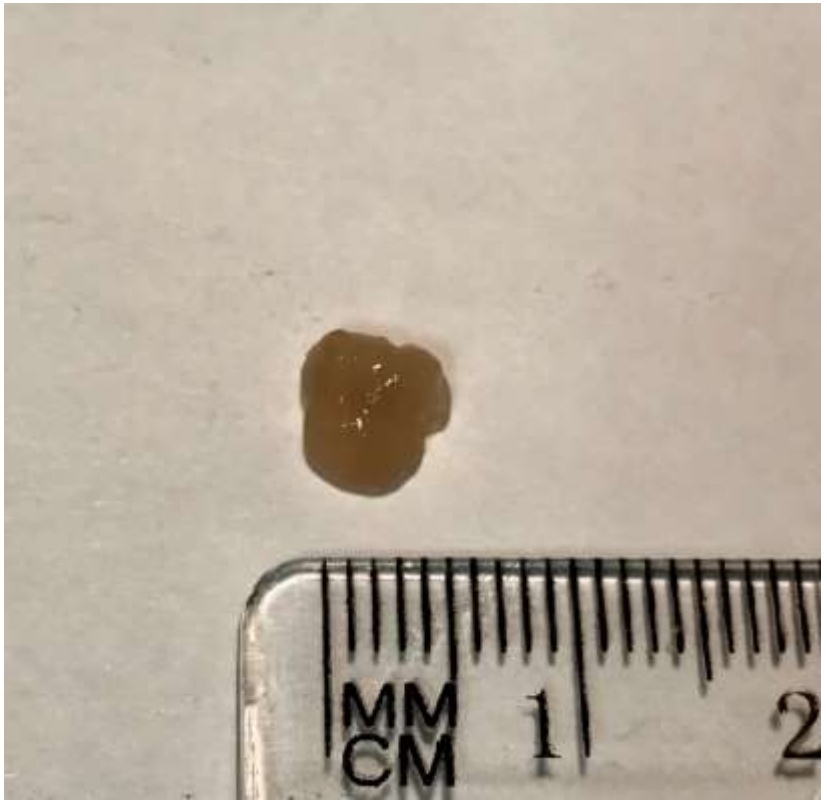
Digestive Endoscopy 2014; **26** (Suppl. 2): 104–108 doi: 10.1111/den.12281

Treatment strategy of diminutive colorectal polyp <5 mm in size – Should it be removed and discarded without pathologic assessment?

Current status and future perspectives of endoscopic diagnosis and treatment of diminutive colorectal polyps

Takahisa Matsuda,[1] Hiroshi Kawano,[4] Takashi Hisabe,[5] Hiroaki Ikematsu,[6] Nozomu Kobayashi,[7] Kenichi Mizuno,[8] Shiro Oka,[9] Yoji Takeuchi,[10] Naoto Tamai,[2] Toshio Uraoka,[3] David Hewett[11] and Han-Mo Chiu[12]

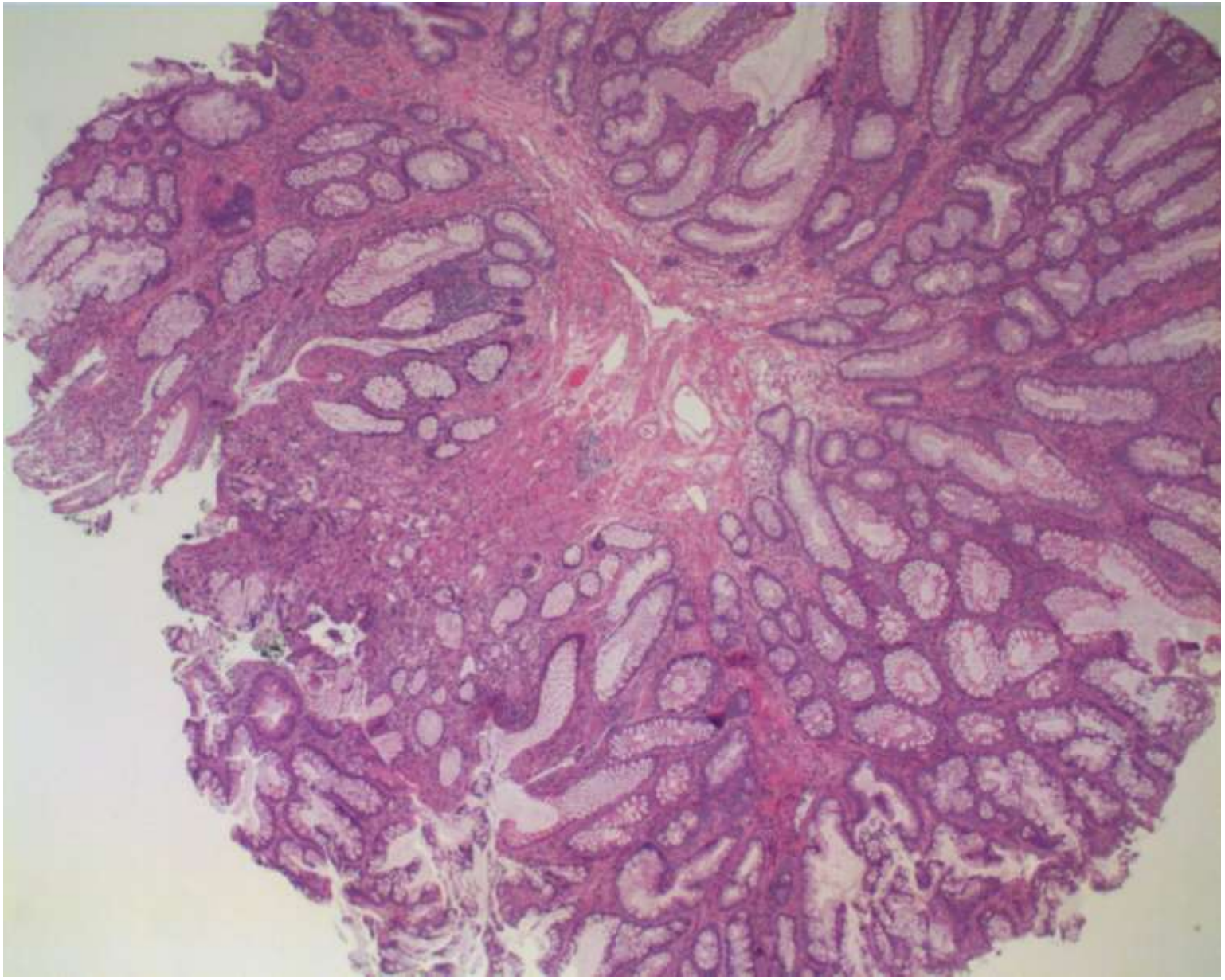




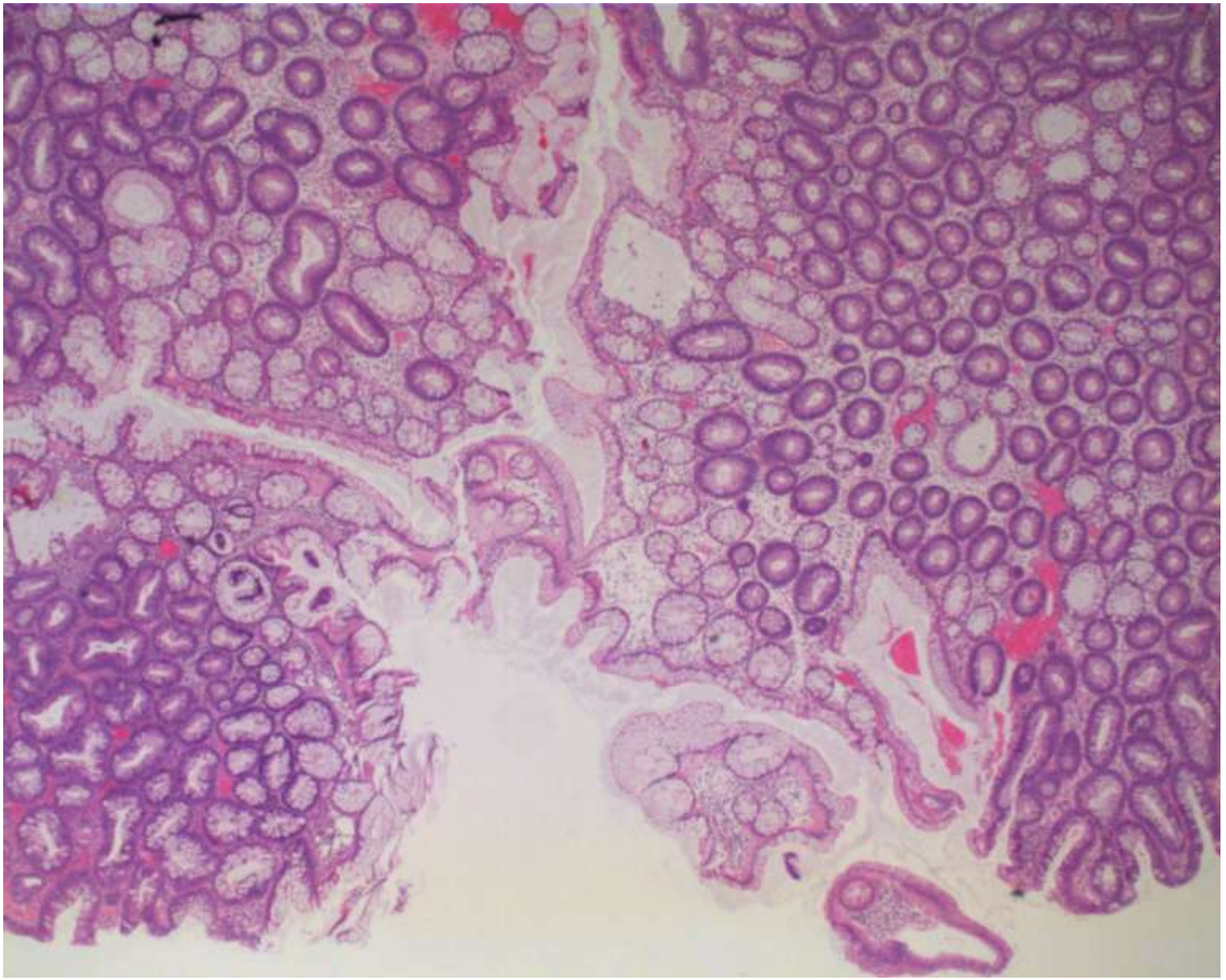
Lesione polipoide
difficilmente orientabile

Lesione polipoide
facilmente orientabile

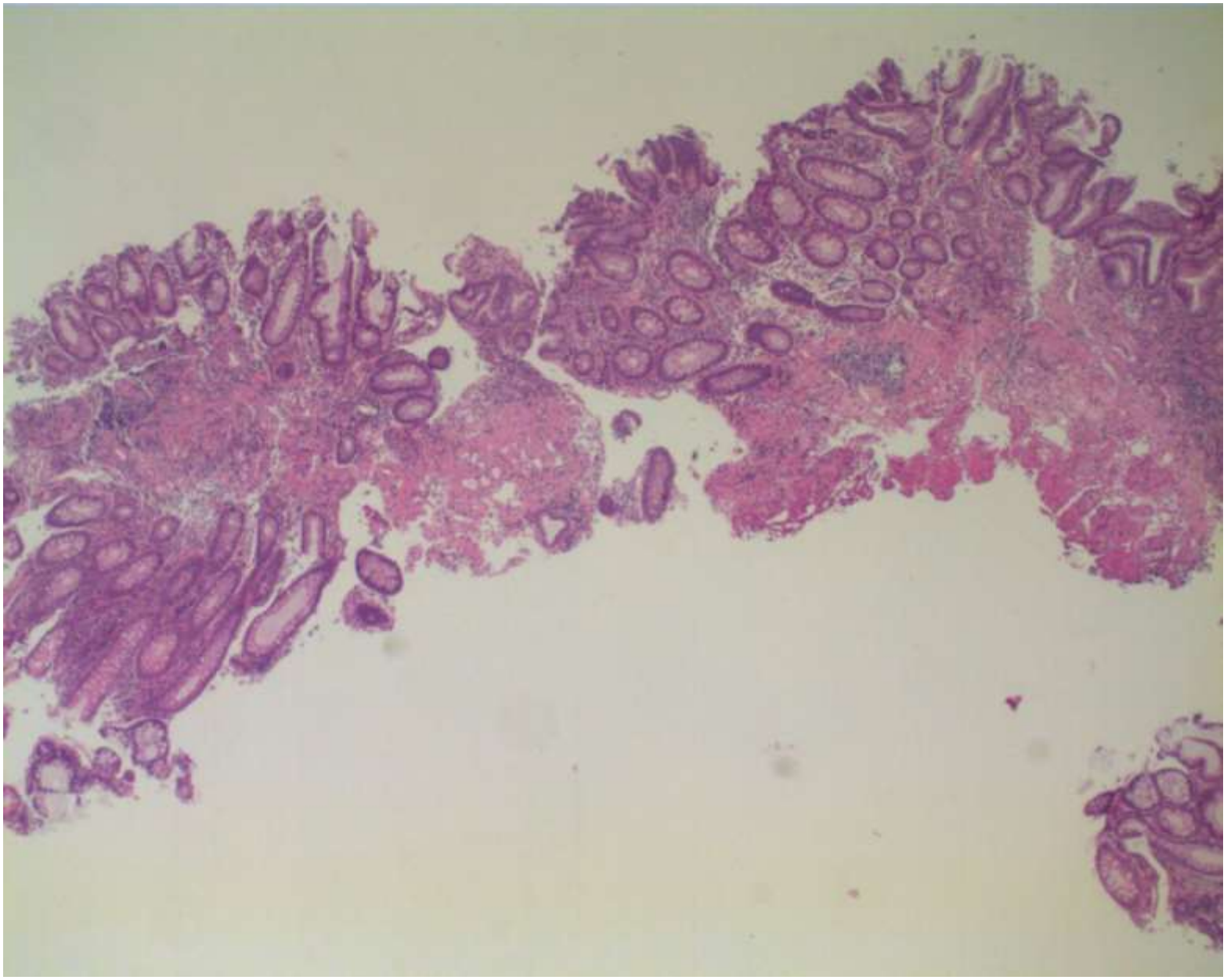
La lesione adenomatosa è risultata istologicamente compresa nei margini della escissione endoscopica



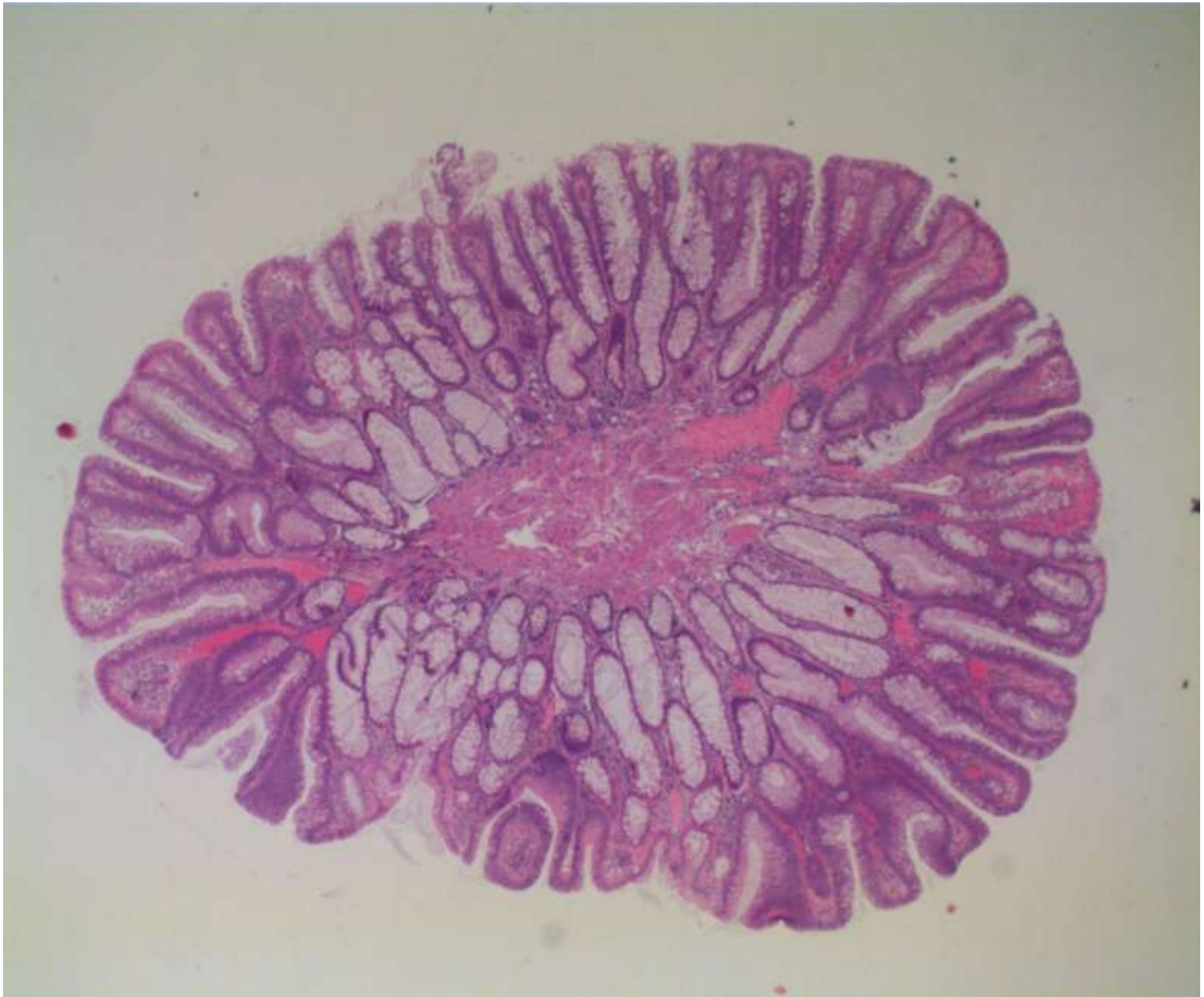
La lesione adenomatosa è risultata istologicamente compresa nei margini della escissione endoscopica



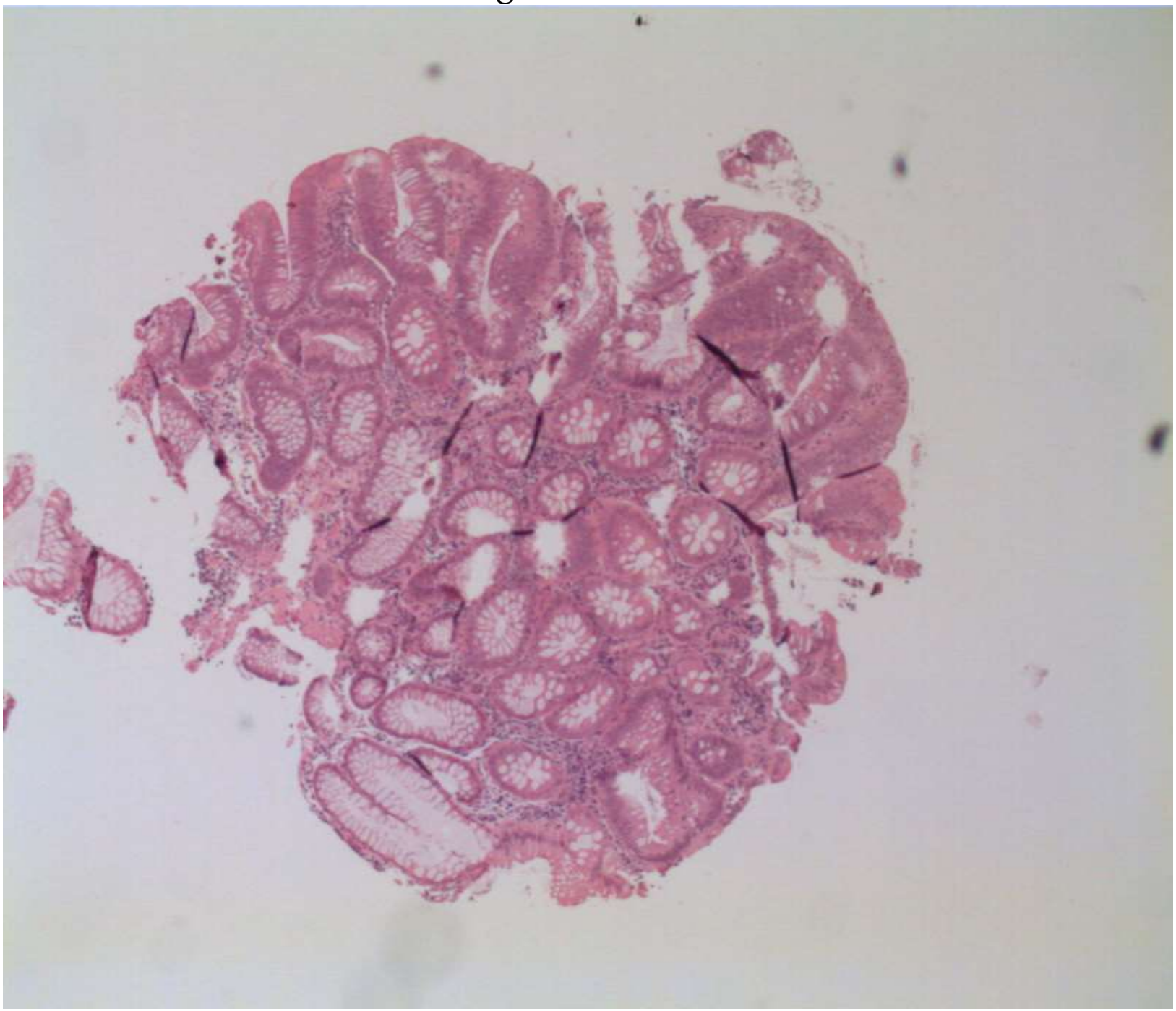
La retrazione della base di impianto della lesione adenomatosa non consente attendibili precisazioni in merito alla radicalità della exeresi



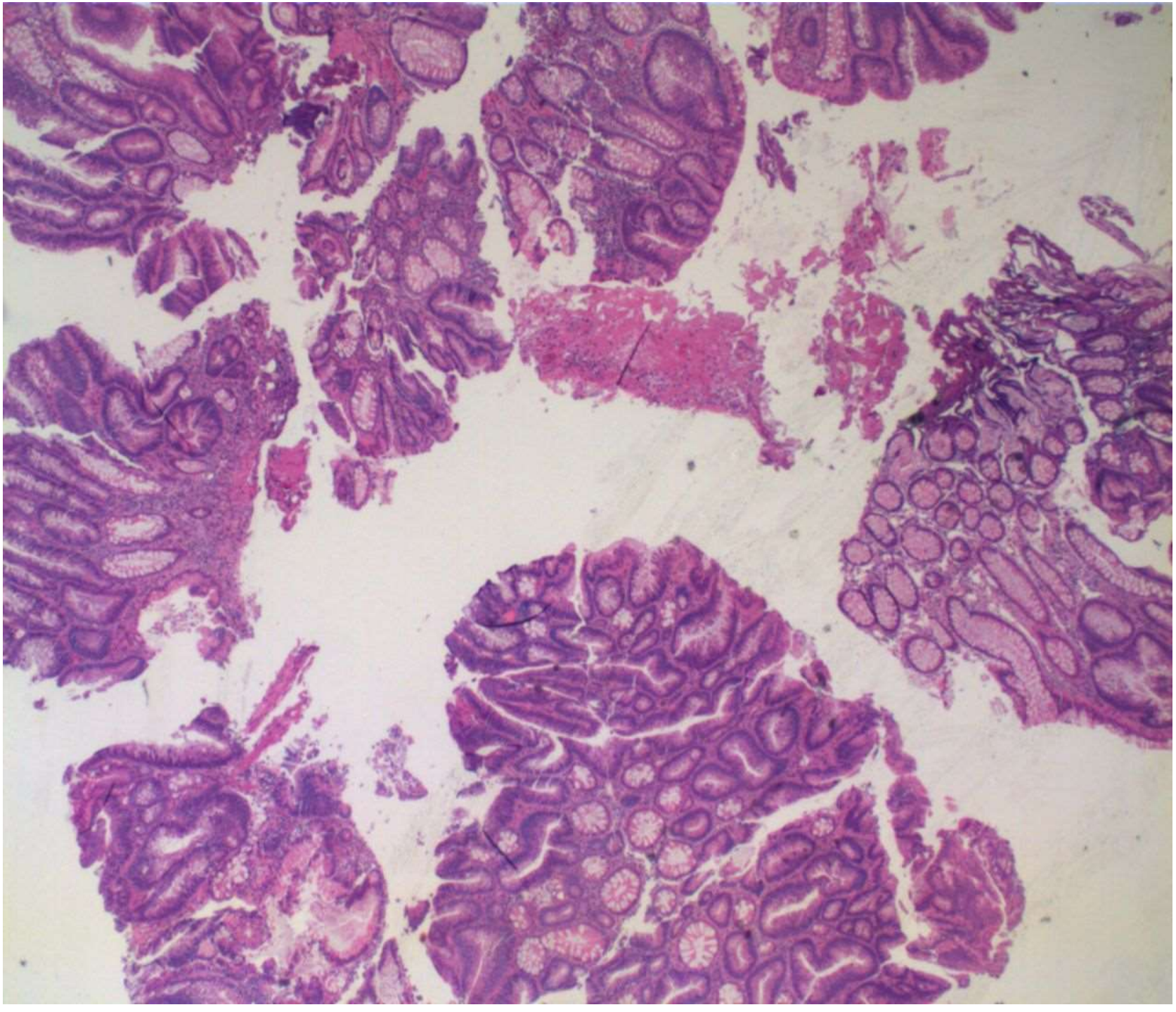
Le caratteristiche del materiale in esame non consentono attendibili precisazioni in merito alla radicalità della exeresi della lesione adenomatosa



Margini non valutabili

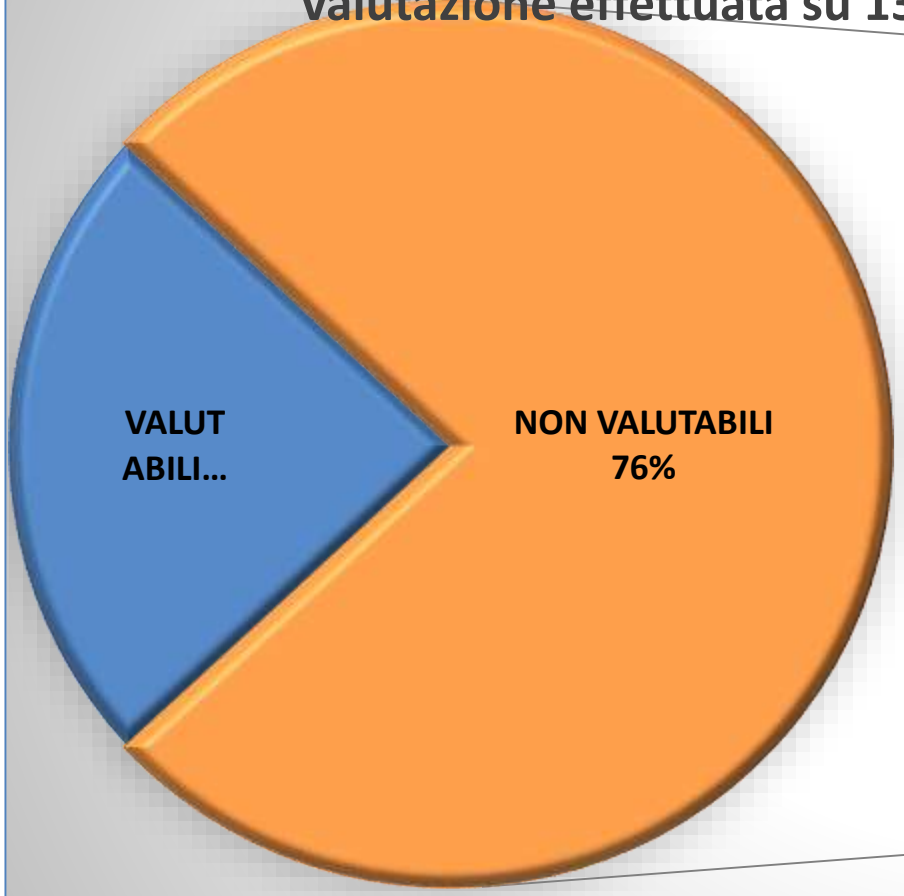


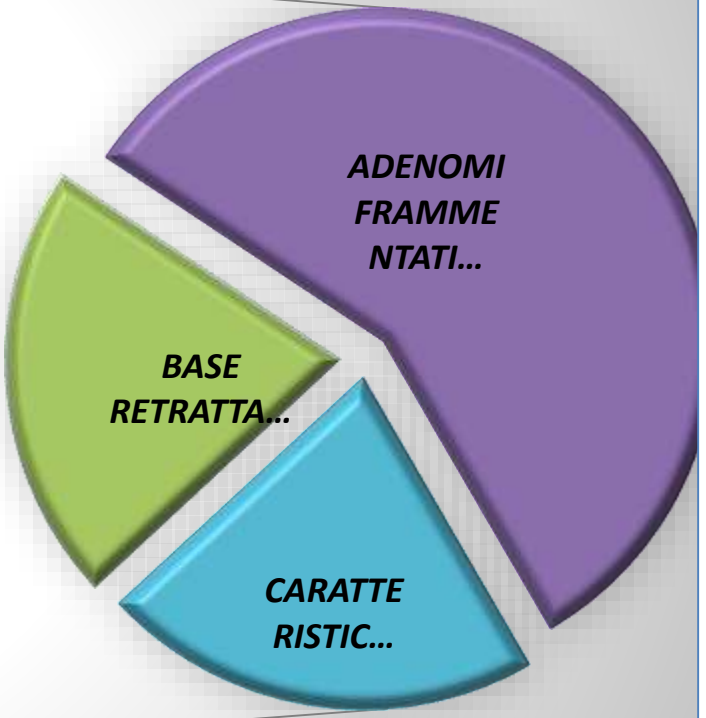
Adenoma frammentato



LESIONI POLIPOIDI DEL GROSSO INTESTINO: VALUTABILITA' DEI MARGINI DI EXERESI

valutazione effettuata su 1367 pazienti (dal 30/11/2015 al 30/11/2016)





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UNITA' OPERATIVA DI ANATOMIA PATOLOGICA

Dai dati provenienti dall'archivio dell'Anatomia Patologica dell'Azienda Ospedaliera-Universitaria di Padova:

SCREENING COLON RETTO (30/11/2015-30/11/2016)

Totale Adenomi <1cm = 768

- ***214 margini non valutabili (per caratteristiche del campione – 117, cioè il 12%- o per retrazione della base di impianto-97, cioè il 10%)***
- ***554 (78%) comprendono lesioni completamente escisse e lesioni frammentate***

Displasia di Alto grado (con margini non valutabili): 15, cioè 1% dei 768, quindi il 7% dei 214

ADENOMI A "BASSO RISCHIO" NELLO SCREENING DEL CARCINOMA DEL COLON-RETTO

2013-2014

Dai dati provenienti dall'archivio dell'Anatomia Patologica dell'Azienda Ospedaliera-Universitaria di Padova:

2433 casi, di cui 640 con diametro non superiore a cm 0,9.

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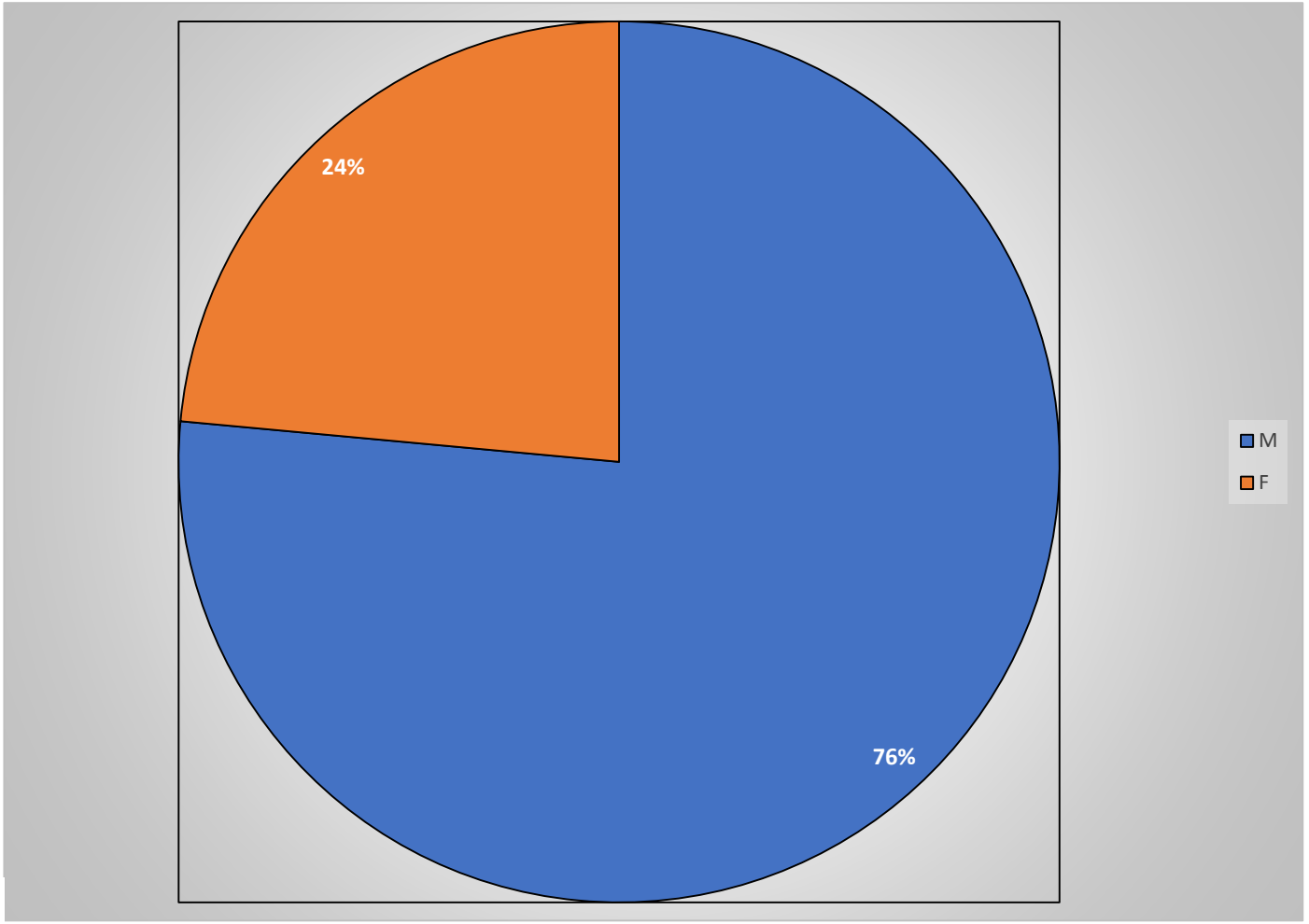
ADENOMI A "BASSO RISCHIO" NELLO SCREENING DEL CARCINOMA DEL COLON-RETTO

2013-2014



MASCHI: 50
FEMMINE: 22

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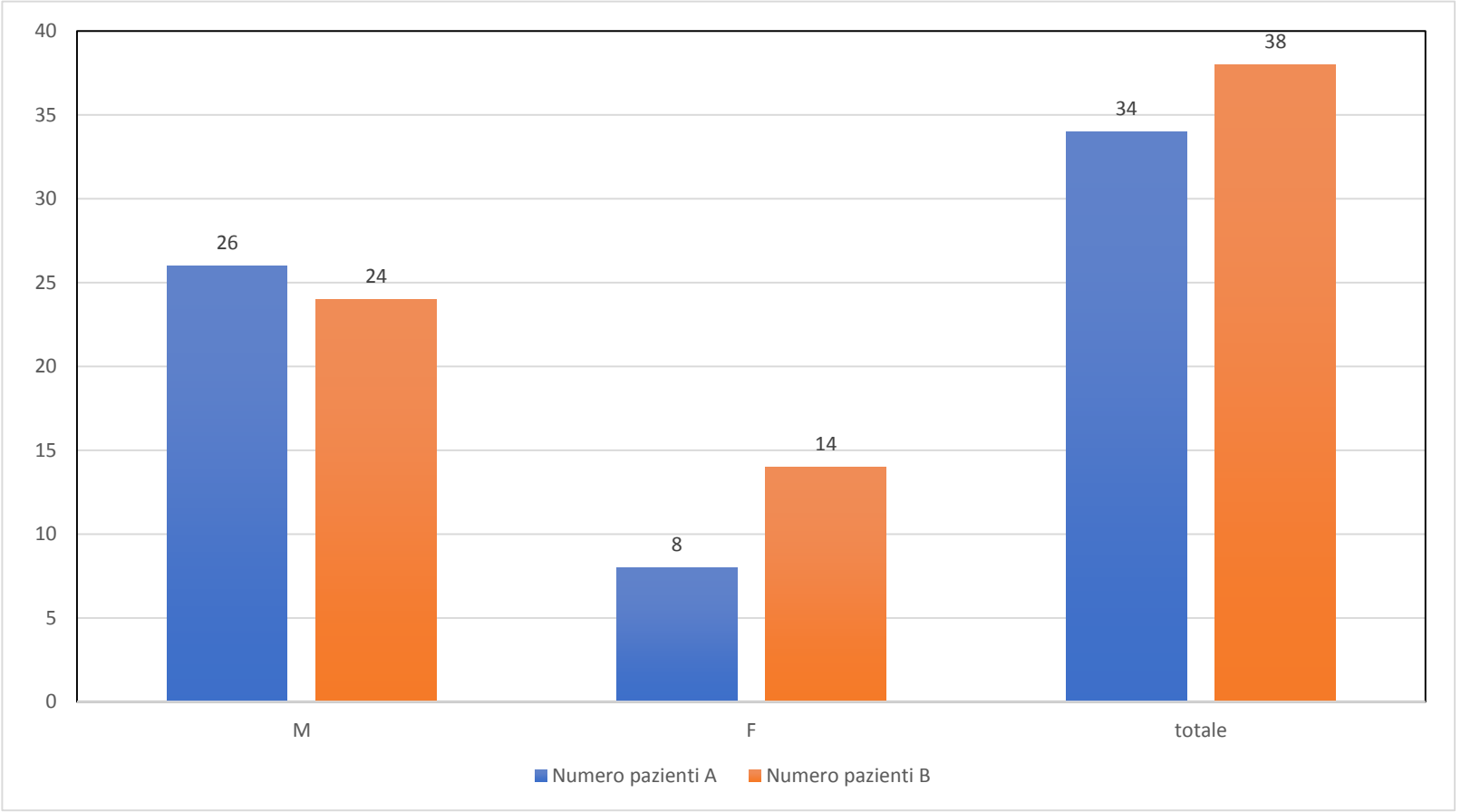
ADENOMI A "BASSO RISCHIO" NELLO SCREENING DEL CARCINOMA DEL COLON-RETTO

2013-2014



A= MARGINI INDENNI
B= MARGINI NON DEFINIBILI

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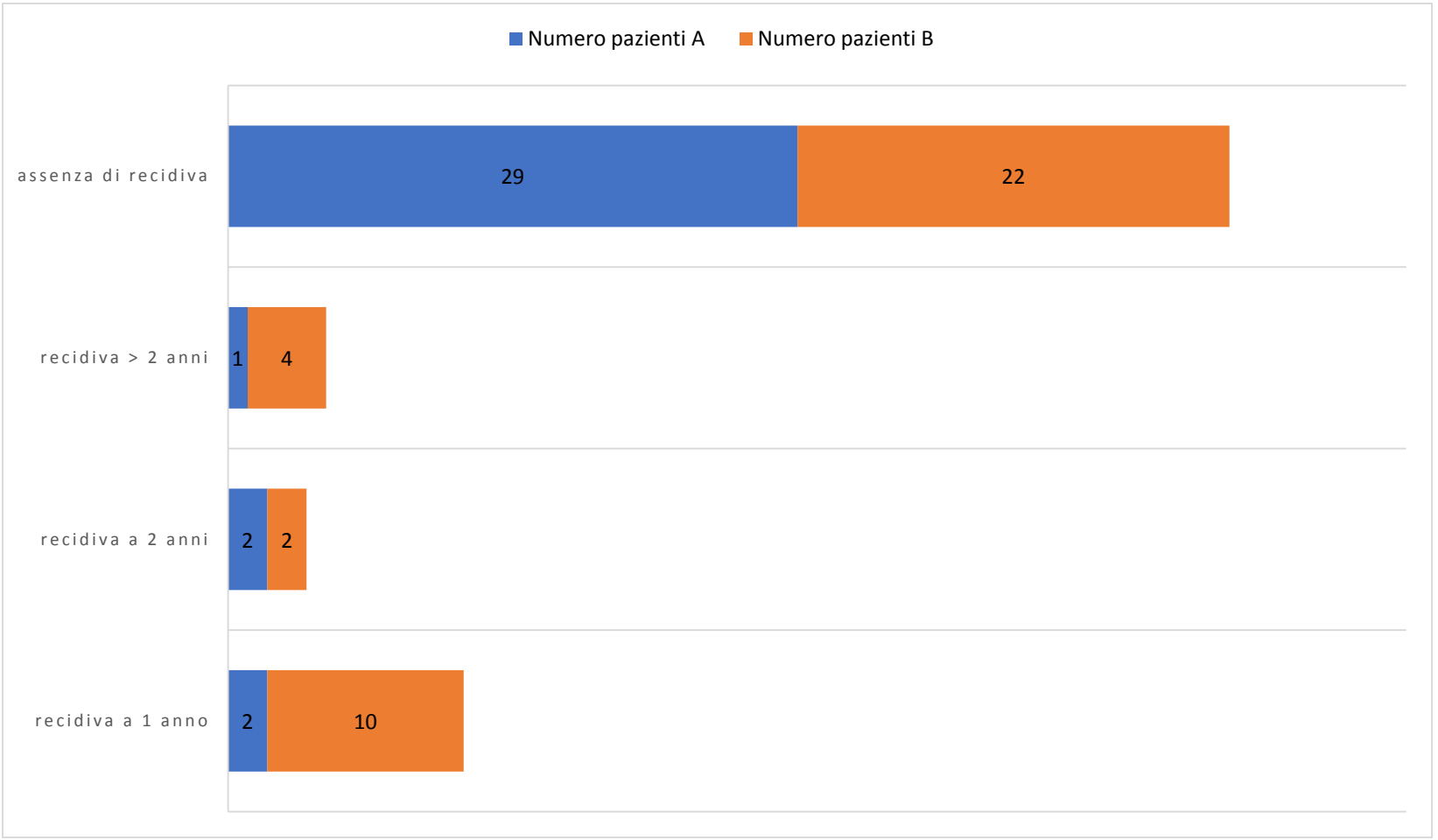
ADENOMI A "BASSO RISCHIO" NELLO SCREENING DEL CARCINOMA DEL COLON-RETTO

2013-2014



A= MARGINI INDENNI
B= MARGINI NON DEFINIBILI

UNITA' OPERATIVA DI ANATOMIA PATOLOGICA

<u>PROBLEMATICHE e PROSPETTIVE FUTURE</u>:
per l'Anatomo Patologo:
è per definizione importante definire il margine di una neoplasia che può dare recidiva e quindi
-Il corretto orientamento dall'Endoscopista
-La corretta chinatura del margine quando è possibile
-Nuove metodiche di inclusione e di processazione

per l'Endoscopista:
non è possibile con certezza definire quanto la definizione del margine possa influire sul follow-up e sul rischio di una possibile recidiva:
-Numero dei polipi
-Grado della displasia
-Dimensioni
-Differenti strategie delle varie Unità Operative

Non si può definire una recidiva dalla sede inviata (ad es. colon trasverso), ma solo dalla esatta distanza riscontrata dal margine anale.

<u>CONCLUSIONE:</u>

NON E' POSSIBILE DEFINIRE CON CERTEZZA QUANTO LA DEFINIZIONE DEL MARGINE POSSA INFLUENZARE IL FOLLOW-UP DEGLI ADENOMI A "BASSO RISCHIO".

RINGRAZIAMENTI:

PROF. MASSIMO RUGGE

DOTT. ROCCO CAPPELLESSO

DOTT. NICOLO' FANELLI
DOTT.SSA DIANA SACCHI