Documento GISCOR-SIED: le raccomandazioni sul II livello

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Disclosure

- Nothing to declare

Adeguate bowel preparation (BBPS ≥2 in each segment)

- Proper peri-procedural sedation
- Correct management of antithrombotic therapy

ADR≥40%

*Adenoma Detection Rate

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Digestive and Liver Disease
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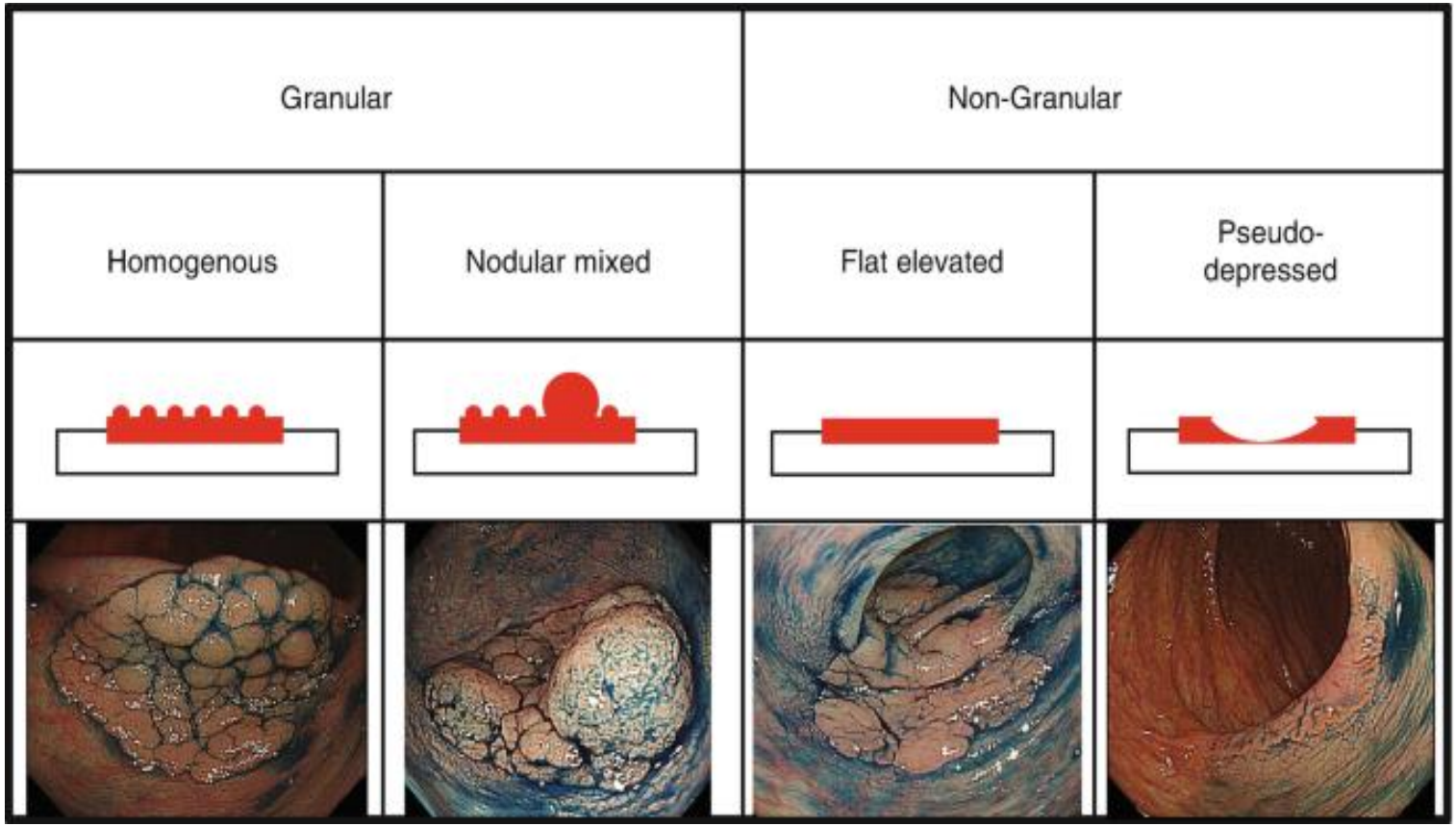
Digestive Endoscopy

SIED-GISCOR recommendations for colonoscopy in screening programs: Part II

~~I – Diagnostic~~ Treatment


Granular
Non-Granular
Homogenous
Nodular mixed
Flat elevated
Pseudo-depressed

Parameter	Range	Score
Size	<1 cm	1
	1–1.9 cm	3
	2–2.9 cm	5
	3–3.9 cm	7
	>4 cm	9
Morphology	Pedunculated	1
	Sessile	2
	Flat	3
Site	Left	1
	Right	2
Access	Easy	1
	Difficult	3

Polyp level	Range of scores
Level I	4–5
Level II	6–8
Level III	9–12
Level IV	>12

SCRLs measuring less than 10mm (<10mm)

- 90% of lesions identified during screening colonoscopy
- Cold Snare Polipectomy (CSP) > Hot Snare Polipectomy (HSP)*

** No significant difference between the two techniques in terms of incomplete resection rate (IRR), but significant increase in procedure time and incidence of adverse events (AEs)* in patients undergoing HSP compared to CSP [14–16]

- SCRLs <3mm: CSP > Cold Biopsy Forceps (CBF)**

*** CBF may be an alternative in cases where CSP is technically challenging* [2,3]

Pedunculated SCRLs

- HSP as standard of care. CSP can be considered in pedunculated SCRLs ≤10mm

- Prophylactic haemostatic techniques (i.e adrenaline injection, endoloop, clips) are recommended for large pedunculated SCRLs with stalk ≥ 10mm or head ≥ 20mm*

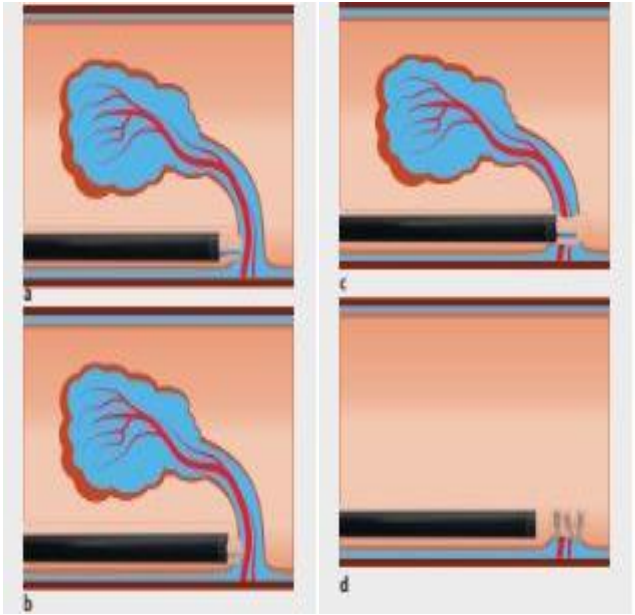
**Potential risk factors for post-polypectomy bleeding (PPB): patient age ≥65 years , presence of cardiovascular and chronic renal disease, use of anticoagulants, size and morphology of the lesion, cutting mode…poor BBPS [22]*

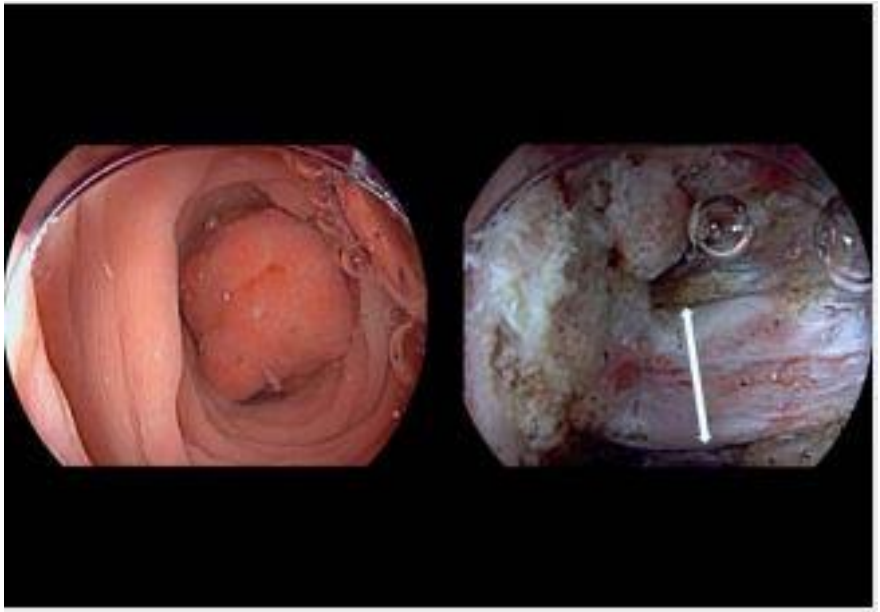
- Tattoo close to the stalk is suggested in pedunculated SCRLs where malignancy is suspected (i.e ≥ 20mm, irregular pit and vascular pattern)

E-Videos
Thieme

Targeted coagulation of large stalk vessels in giant pedunculated colorectal polyp: is endoscopic submucosal dissection the new way to go?

OPEN ACCESS

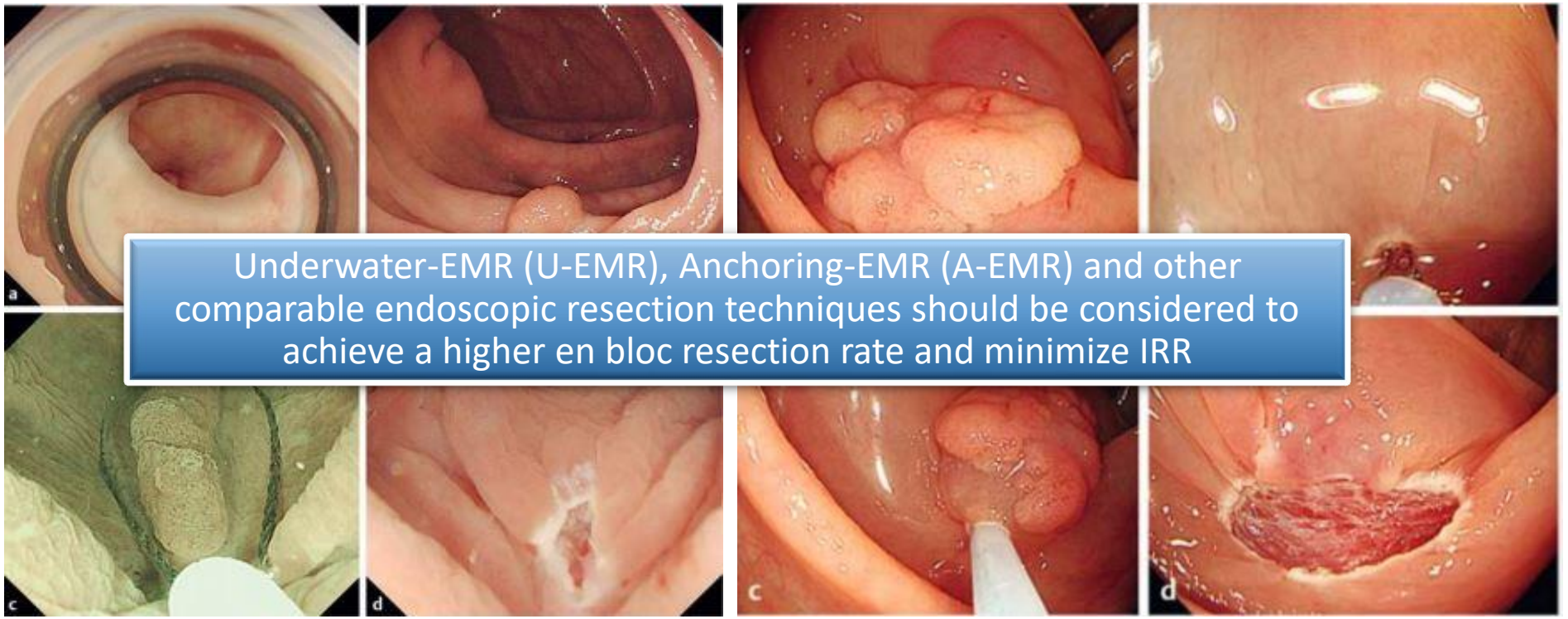




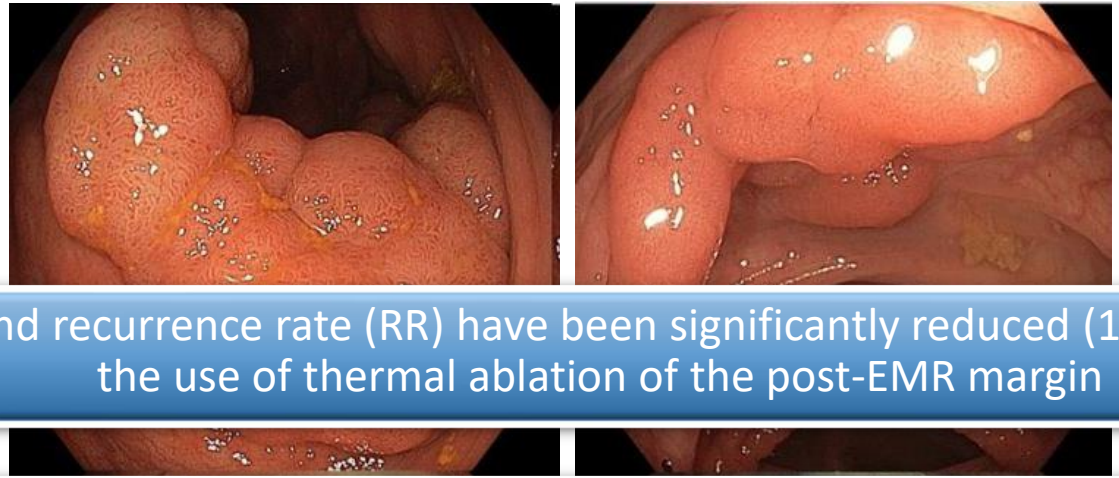
Non-pedunculated SCRLs measuring between 10-19mm (10-19mm)

- SCRLs measuring less than 20mm (<20mm) should be resected during the index screening colonoscopy
- Piecemeal CSR (pCSR) could be preferred against HSR in Sessile Serrated Lesions (SSLs) without dysplasia
- Hot Snare Resection (HSR) as standard of care in cases of conventional adenomas or when there is a notable suspicion of dysplasia*

* pCSR should be considered as an alternative for carefully selected non-pedunculated adenomas measuring between 10-19mm in the right colon and/or in unfit patients to reduce the risk of peri-procedural and late complications

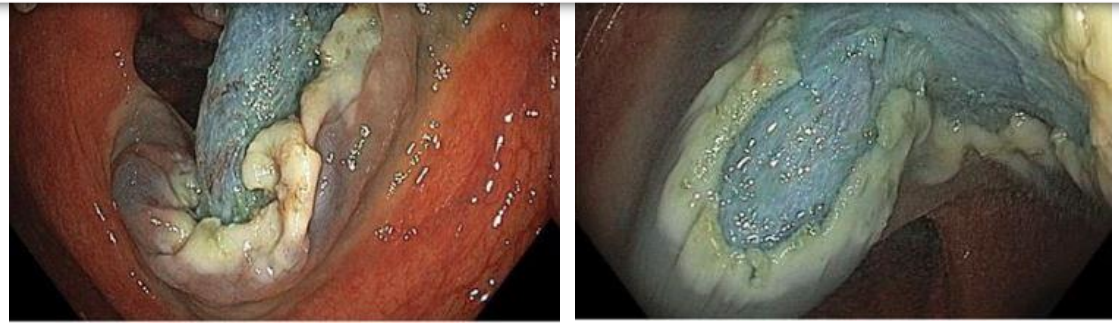


Underwater-EMR (U-EMR), Anchoring-EMR (A-EMR) and other comparable endoscopic resection techniques should be considered to achieve a higher en bloc resection rate and minimize IRR



IRR and recurrence rate (RR) have been significantly reduced (1-5%) with the use of thermal ablation of the post-EMR margin

Snare Tip Soft Coagulation (STSC) > Argon Plasma Coagulation (APC)



Non-pedunculated SCRLs measuring 20 mm and above (≥20mm) without features of SMIC

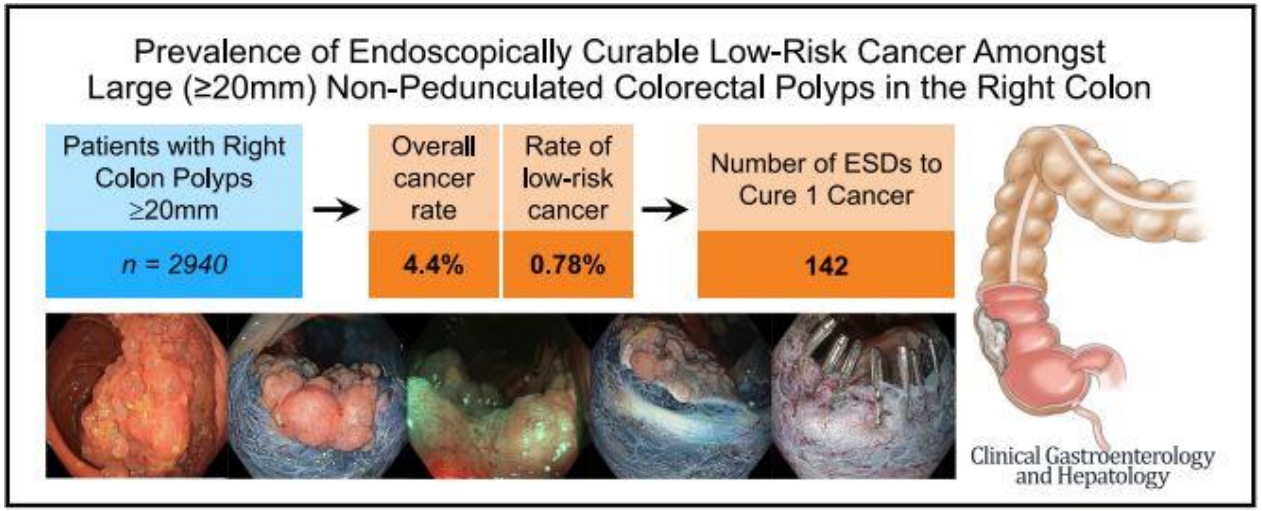
- Adequate characterization according to internationally validated classifications using high-resolution white light and chromoendoscopy should be recommended
- For SCRLs proximal to the rectum and at low risk of SMIC (i.e JNET2a), either en bloc or piecemeal resection may be performed*,**

*In the case of piecemeal resection, it is recommended to resect the lesion in as few pieces as possible and to complete the procedure with thermal ablation of the margin, ** pCSR could be considered *for SSLs ≥20mm without dysplasia and* carefully selected non-pedunculated adenomas measuring between 10-19mm in the right colon and/or in unfit patients to reduce the risk of peri-procedural and late complications

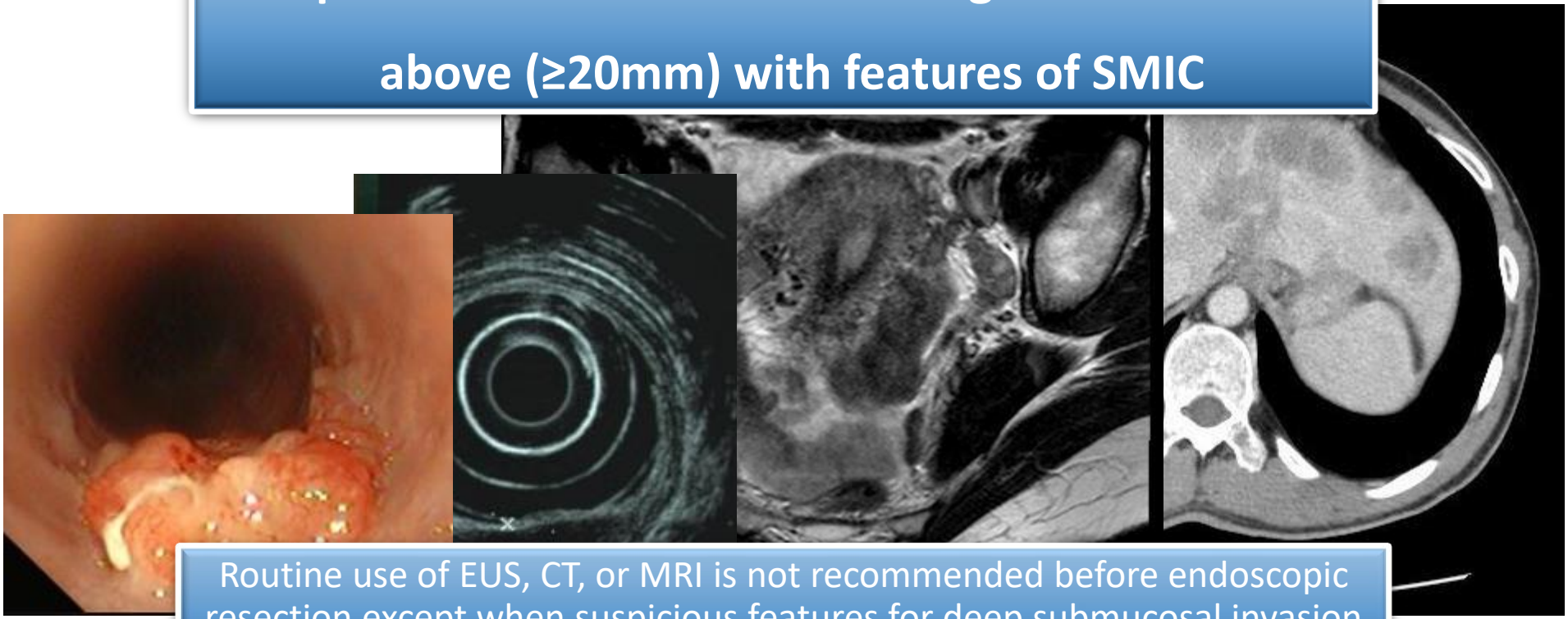
- For SCRLs in the rectum with a low risk of SMIC (JNET2a), en bloc resection should be preferred if feasible (i.e en bloc EMR or ESD)

Prevalence of Endoscopically Curable Low-Risk Cancer Among Large (≥20 mm) Nonpedunculated Polyps in the Right Colon

Julia L. Gauci,[1,*] Anthony Whitfield,[1,2,*] Renato Medas,[3,4] Clarence Kerrison,[1,2] Francesco Vito Mandarino,[1] David Gibson,[5,6] Timothy O'Sullivan,[1,2] Oliver Cronin,[1,2] Sunil Gupta,[1,2] Brian Lam,[1] Varan Perananthan,[1] Luke Hourigan,[7] Simon Zanati,[5,6] Rajvinder Singh,[8] Spiro Raftopoulos,[9] Alan Moss,[5,6] Gregor Brown,[5,6] Amir Klein,[10,11] Lobke Desomer,[12] David J. Tate,[13,14] Steven J. Williams,[1] Eric Y. Lee,[1,2] Nicholas Burgess,[1,2] and Michael J. Bourke[1,2]



Non-pedunculated SCRLs measuring 20 mm and above (≥20mm) with features of SMIC



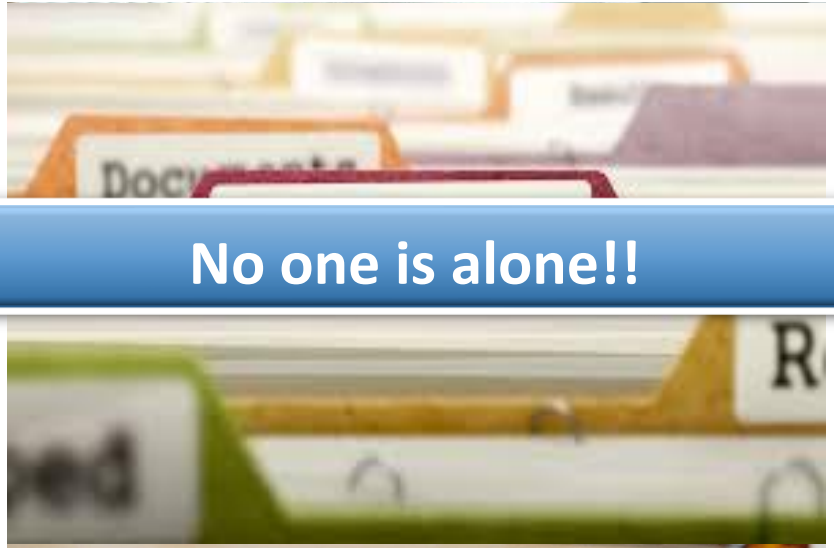
Routine use of EUS, CT, or MRI is not recommended before endoscopic resection except when suspicious features for deep submucosal invasion are present

Non-pedunculated SCRLs measuring 20 mm and above (≥20mm) with features of SMIC

- Multidisciplinary (MD) discussions should be held for SCRLs with features of SMIC particularly in cases where high-risk pathological factors (i.e lymphovascular invasion, tumour budding or poor differentiation) are present
- Treatment decisions should be individualised. Surveillance or non-surgical therapies should be considered as an alternative for selected patients in cases where en bloc-R0 resection of a SCRLs with the single high-risk factor of deep submucosal invasion (i.e sm2-sm3) has been achieved

Goals for future

- Need to create a *common and standardized iter* among the hospitals to facilitate the most appropriate treatment for the patient



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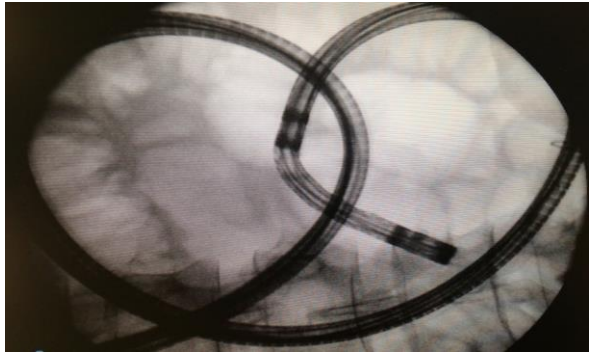


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XVII CONGRESSO NAZIONALE 2024

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