LA POLIPECTOMIA A FREDDO: UNA METODICA DI SEMPRE MAGGIOR DIFFUSIONE

Paola Arpe
S.C. Gastroenterologia
Osp. Civ. S. Andrea, La Spezia

GISCoR
gruppo italiano screening colorettale

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START


ELSEVIER
Gastrointestinal Endoscopy
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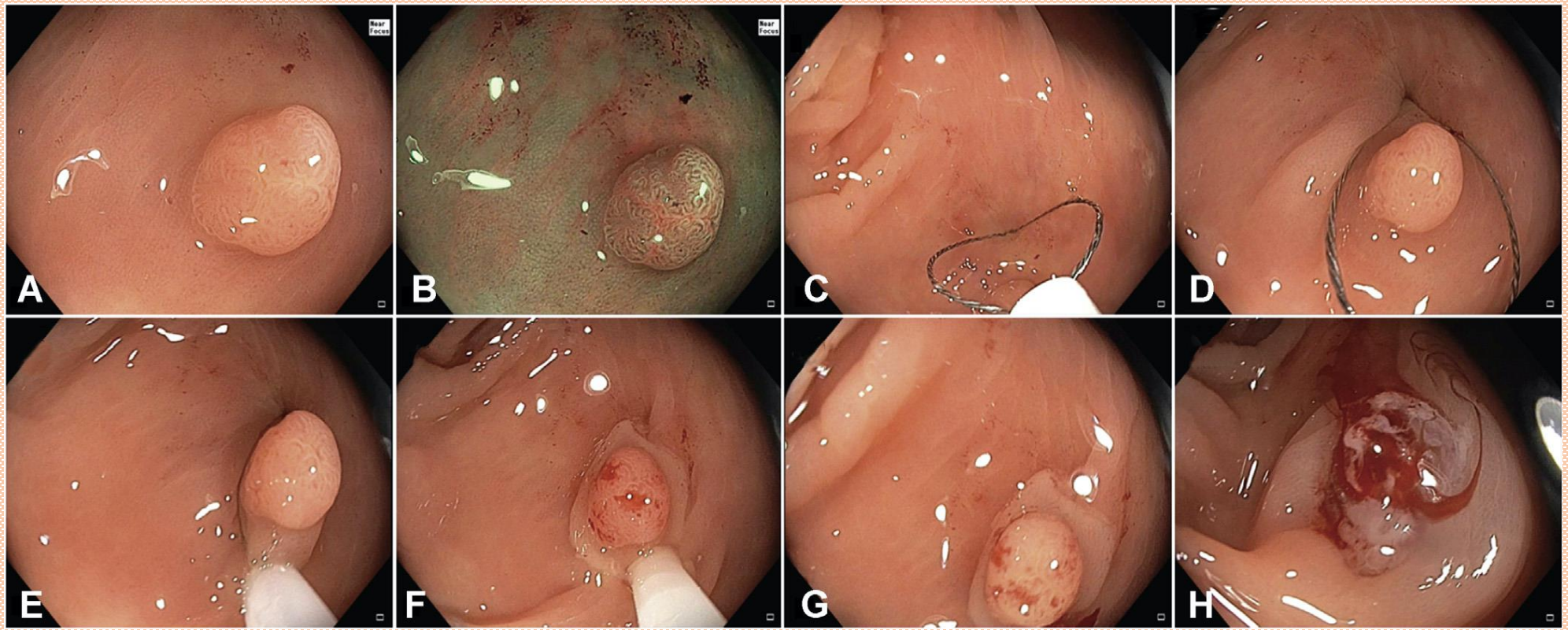
GASTROINTESTINAL ENDOSCOPY
Cold snare excision of small colorectal polyps
Gianfranco Tappero MD, Ezio Gaia MD, Paolo De Giuli MD, Sabina Martini MD, Luciano Gubetta MD, Giorgio Emanuelli MD

COLD Revolution

Cold snare polypectomy



Mucosa

Mucosa

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BREAKING
NEWS

Guideline

Thieme

Colorectal polypectomy and endoscopic mucosal resection: European Society of Gastrointestinal Endoscopy (ESGE) Guideline – Update 2024

ESGE

Ferlitsch M, Endoscopy 2024

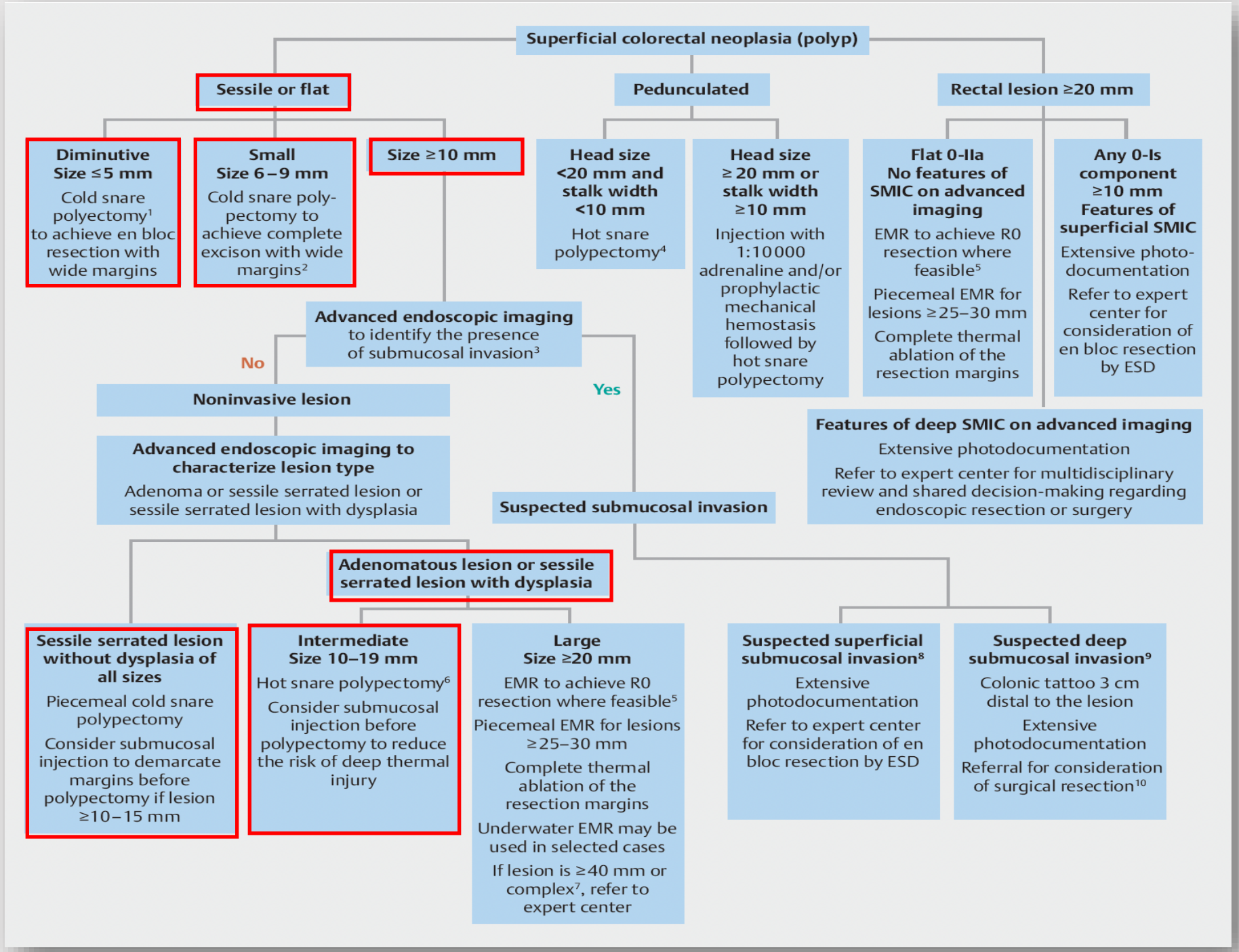
Clinical Gastroenterology and Hepatology 2024;22:470–479

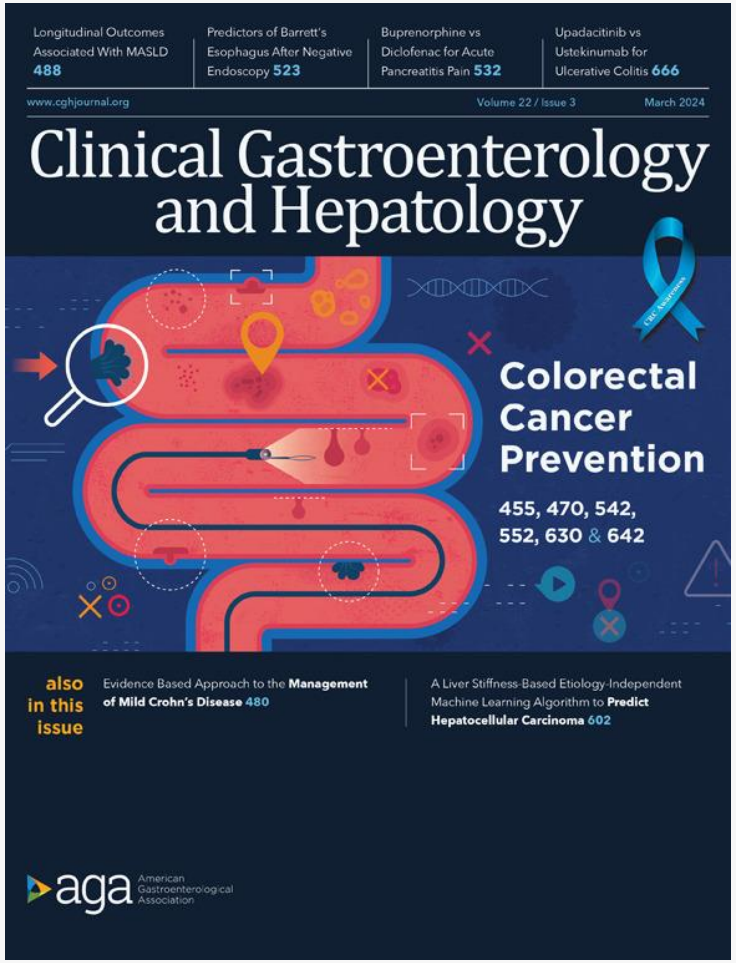
CLINICAL PRACTICE UPDATES

AGA Clinical Practice Update on Appropriate and Tailored Polypectomy: Expert Review

Check for updates

Andrew P. Copland,[1] Charles J. Kahi,[2] Cynthia W. Ko,[3] and Gregory G. Ginsberg[4]


Superficial colorectal neoplasia (polyp)
Sessile or flat
Pedunculated
Rectal lesion ≥20 mm
Diminutive
Size ≤5 mm
Cold snare polyectomy[1] to achieve en bloc resection with wide margins
Small
Size 6–9 mm
Cold snare poly-pectomy to achieve complete excison with wide margins[2]
Size ≥10 mm
Head size <20 mm and stalk width <10 mm
Hot snare polypectomy[4]
Head size ≥ 20 mm or stalk width ≥10 mm
Injection with 1:10000 adrenaline and/or prophylactic mechanical hemostasis followed by hot snare polypectomy
Flat 0-IIa
No features of SMIC on advanced imaging
EMR to achieve R0 resection where feasible[5]
Piecemeal EMR for lesions ≥25–30 mm
Complete thermal ablation of the resection margins
Any 0-Is component ≥10 mm
Features of superficial SMIC
Extensive photo-documentation
Refer to expert center for consideration of en bloc resection by ESD
Advanced endoscopic imaging to identify the presence of submucosal invasion[3]
No
Yes
Noninvasive lesion
Advanced endoscopic imaging to characterize lesion type
Adenoma or sessile serrated lesion or sessile serrated lesion with dysplasia
Features of deep SMIC on advanced imaging
Extensive photodocumentation
Refer to expert center for multidisciplinary review and shared decision-making regarding endoscopic resection or surgery
Suspected submucosal invasion
Adenomatous lesion or sessile serrated lesion with dysplasia
Sessile serrated lesion without dysplasia of all sizes
Piecemeal cold snare polypectomy
Consider submucosal injection to demarcate margins before polypectomy if lesion ≥10–15 mm
Intermediate
Size 10–19 mm
Hot snare polypectomy[6]
Consider submucosal injection before polypectomy to reduce the risk of deep thermal injury
Large
Size ≥20 mm
EMR to achieve R0 resection where feasible[5]
Piecemeal EMR for lesions ≥25–30 mm
Complete thermal ablation of the resection margins
Underwater EMR may be used in selected cases
If lesion is ≥40 mm or complex[7], refer to expert center
Suspected superficial submucosal invasion[8]
Extensive photodocumentation
Refer to expert center for consideration of en bloc resection by ESD
Suspected deep submucosal invasion[9]
Colonic tattoo 3 cm distal to the lesion
Extensive photodocumentation
Referral for consideration of surgical resection[10]



Use cold snare polypectomy for polyps <10 mm in size. Cold forceps polypectomy can alternatively be used for 1- to 3-mm polyps where cold snare polypectomy is technically difficult.

Do not use hot forceps polypectomy.

Clinicians should be familiar with various techniques, such as cold and hot snare polypectomy and endoscopic mucosal resection, to ensure effective, safe, and optimal resection of intermediate-size polyps (10–19 mm).

Consider using lifting agents or underwater endoscopic mucosal resection for removal of sessile polyps 10–19 mm in size.

Serrated polyps should be resected using cold resection techniques. Submucosal injection may be helpful for polyps >10 mm if margins cannot be well delineated.

Copland A.P., Clinical Gastroenterology and Hepatology 2024

POLIPI DIMINUTIVI <=5 mm

CFP vs CSP

- Per lesioni <=3 mm stesso tasso di eradicazione completa: 92,1% - 98%
- per lesioni <= 4 mm, CSP dimostra una significativamente più elevata percentuale di resezione en bloc
- In un ampio studio osservazionale si dimostra la sicurezza ed efficacia di entrambe le tecniche di resezione con asportazione completa pari a 99,4 %; ma analisi multivariata dimostra che l'asportazione con pinza di polipi > 3 mm ha un rischio significativamente più elevato di recidiva a 1 anno di follow-up

Huh CW, GIE 2019
Wei MT, AJG 2022
Kuwai T, Endoscopy 2019

PICCOLI POLIPI 6-9 mm

CSP vs HSP

- Elevato tasso di resezione completa tra CSP e HSP: 98.2% vs 97,4% (non inferiority P < .0001).
- Tasso di resezione incompleta: IRR < 2 % (1,8% vs 2,6%)
- Bassa percentuale di sanguinamento post-procedura (0-0,1 %), bassa frequenza di PPS
- Minore tempo per la procedura (18 vs 25 min; P < . 0001)

Kawamura T, Gut 2018
Shinozaki S, Dig. Endosc 2018
Horiuchi, GIE 2014
Chang LC, Ann Intern Med 2023
Belderos T, UEGJ 2017

- ✓ *CSP è equivalente per EFFICACIA a HSP*
- ✓ *CSP è superiore per SICUREZZA a HSP*
- ✓ *IRR rimane il problema principale sia per CSP che per HSP (1,8%-8,5% vs 2.6%-3,7%)*

Dwyer J, Endosc Int Open 2017
Horiuchi A, GIE 2015
Tate DJ, Endoscopy 2018

Fattori che possono contribuire a migliorare IRR dopo CSP:

- *Utilizzo di anse dedicate: sottili monofilamento*
- *Acquisizione di un margine di tessuto normale intorno al polipo resecato (almeno 2 mm)*
- *Valutazione dei margini di resezione dopo asportazione della lesione*

Hewett DG, GIE 2015
Abe Y, Endosc Int Open 2018
Tutticci NJ, Gastrointest Endosc Clin N Am 2019

AJG The American Journal of GASTROENTEROLOGY

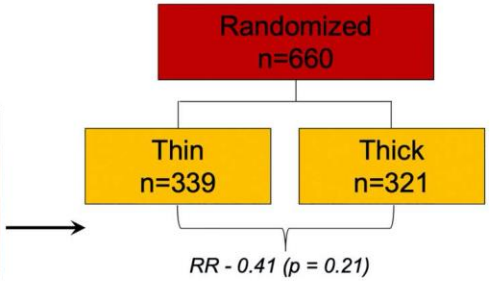
A Randomized Controlled Trial of Cold Snare Polypectomy Technique: Technique Matters More Than Snare Wire Diameter

A randomized trial of cold snar

VOLUME 117 | JANUARY 2022

CSP is recommended for small (≤10mm) colorectal polyps, however rates of incomplete resection (IRR) vary

Snare design has been hypothesized to reduce IRR, but studies to date are contradictory



CSP for small colorectal polyps can achieve very low IRR, independent of snare design

Technique	HSP	CSP
Lesion orientation	6 o'clock	6 o'clock
Extent of tissue capture	Minimized (adapted to the size of the target lesion to minimize the risk of DMI)	Maximized/unlimited (extended beyond the target lesion to ensure margin of normal tissue and achieve complete resection)
Snare pressure on mucosal surface	Minimal (tented away from the mucosa to minimize the risk of DMI and transmural thermal injury)	Maximal (firm downward pressure using the up/down wheel to ensure adequate tissue capture)
Speed of transection	Fast (to minimize unnecessary mural thermal injury)	Not critical, but avoid rapid snare closure to ensure adequate seating of the snare into the surrounding normal mucosa during closure
Primary method of transection	Diathermy/partly mechanical	Mechanical
Depth of excision	Submucosa (6%–20%) (34)	Muscularis mucosa (common, . 60%) Submucosa (uncommon, , 7%)
Defect		
Protrusion	Nil	Yes (common)
Examining for residual adenoma	Challenging, limited due to diathermy-related tissue artefact	Detailed examination by using water pump to expand the defect and evert margins
Extending defect margin	Not recommended	Recommended if any suspected residual adenoma
Method of extending defect margin	EMR	CSP (piecemeal)

	Thin (n 5 339)	Thick (n 5 321)	Total (N 5 660)	P
Complete endoscopic resection, n (%)	339 (100)	321 (100)	660 (100)	—
Complete excision at first attempt, n (%)	316 (93.2)	303 (94.4)	619 (93.8)	0.53
Endoscopic cold snare protrusion, n (%)				
Yes	85 (25.1)	104 (32.4)	189 (28.6)	0.04
Specimen not retrieved, n (%)	0 (0)	1 (0.3)	1 (0.2)	—
Margin biopsy, n (%)	339 (100)	320 (99.8)	659 (99.8)	654 (99.1)
IRR, n (%)[a]	3/339 (0.9)	6/320 (1.9)	9/654 (1.4)	0.28
Histopathology, n(%)[a]				
Hyperplastic	41 (12.1)	45 (14.1)	86 (13.1)	—
TA	210 (61.9)	184 (57.3)	394 (59.7)	—
TVA	7 (2.1)	3 (0.9)	10 (1.5)	0.43
SSL	35 (10.3)	33 (10.3)	68 (10.3)	—
Other	46 (13.6)	55 (17.2)	101 (15.3)	—
Dysplasia, n(%)[a]				
None	127 (37.5)	129 (40.3)	256 (38.8)	—
Low-grade	212 (62.5)	189 (58.9)	401 (60.8)	0.24
High-grade	0 (0)	2 (0.6)	2 (0.3)	—
Adverse events, n (%)				
IPB	1 (0.3)	2 (0.6)	3 (0.5)	0.53
Deep mural injury[b]	0 (0)	0 (0)	0 (0)	—
PPB	0 (0)	0 (0)	0 (0)	0.33
Delayed perforation	0 (0)	0 (0)	0 (0)	—

IRR, incomplete resection rate; IPB, intraprocedural bleeding; PPB, postpolypectomy bleeding; SSL, sessile serrated lesion; TA, tubular adenoma; TVA, tubular villous adenoma.
[a]Percentage calculated from retrieved specimens only.
[b]Sydney DMI Classification.[29]

- IRR < 2 %
- Stesso IRR sia con uso di anse sottili che spesse
- Resezione istologica completa per singolo endoscopista è > 98%

TECNICA ENDOSCOPICA OTTIMIZZATA

1- LA SISTEMATICA ACQUISIZIONE DI TESSUTO SANO INTORNO ALLE LESIONI (2 mm)

2- LA METICOLOSA ISPEZIONE DEI MARGINI DELLA LESIONE DOPO ASPORTAZIONE CON CSP

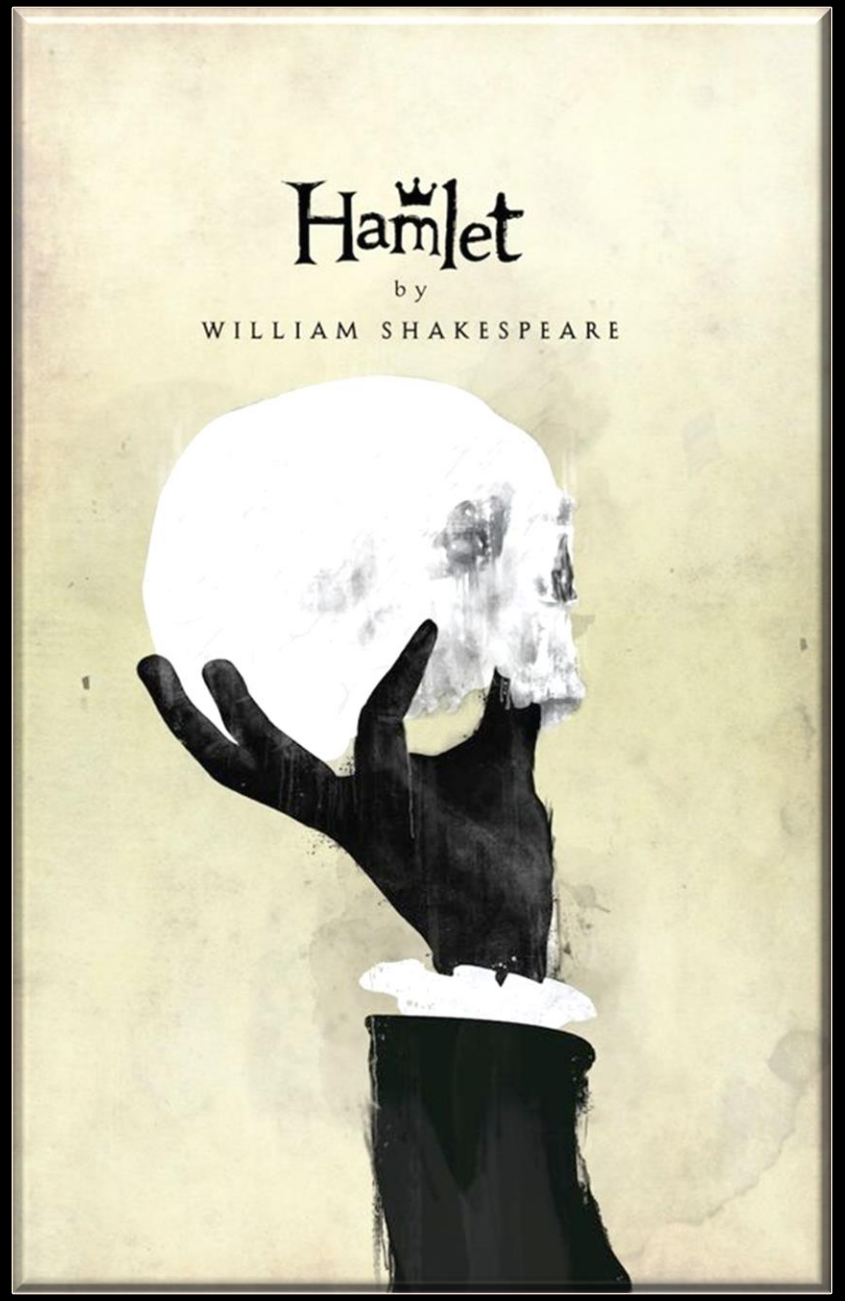
ESGE

RECOMMENDATION

ESGE recommends including a clear margin of normal tissue (1–2 mm) surrounding the polyp.
Strong recommendation, high quality of evidence.

Larger Polyps > 10 mm

To heat or not to heat?



HOT

- Resezione più facile per tessuti di maggiore spessore
- Prevenzione del sanguinamento per rapida coagulazione vascolare
- Ablazione del tessuto ai margini della resezione

Danno termico di parete:

- Sanguinamento ritardato
- perforazione
- sindrome post-polipectomia

IRR = 17,3 %
per polipi sessili 10-20 mm

«CARE study»: Pohl H, Gastroenterol 2013

Endoscopic Mucosal Resection

EMR achieves complete endoscopic resection in 99.5% of the cases

Russo P, Endosc Int Open 2019

New benchmark for adenoma recurrence post EMR: 5,2%

Klein A, Gastroenterology 2019

Intra-procedural bleeding rates after EMR of polyps >10 mm is reported to be as high as 7.7%

Russo P, Endosc Int Open 2019

Perforation is an uncommon but serious event after EMR: 1%–2%.

Russo P, Endosc Int Open 2019

Post-EMR bleeding after resection of polyps ≥20 mm was 6%, of which 55% were managed conservatively

Burgess NG, Clin Gastroenterol Hepatol 2014

The incidence of PPS varies between 0.2% and 7.6%; higher with polyps larger than 20 mm, located in the right colon and non-polypoid lesions

Lee SH, Clin Endosc. 2014

Ferlitsch M, Endoscopy 2024

AGA Clinical practice Update on Appropriate and Tailored Polypectomy: Expert Review

Clinicians should be familiar with various techniques, such as CSP and HSP and EMR, to ensure effective, safe and optimal resection of intermediate-size polyps (10-19 mm)

BEST PRACTICE ADVICE 4:

SSLs should be resected using COLD resection techniques. Submucosal injection may be helpful for polyps > 10 mm if margin cannot be well delineated

BEST PRACTICE ADVICE 6:

Copland A.P., Clinical Gastroenterology and Hepatology 2024

COLD-EMR

EFFICACY

- ✓ Complete resection rate by CSP of 99.3 %
- ✓ Recurrence rate 4.1%
- ✓ Recurrence rates were higher in polyps ≥20 mm (15.4%) and adenomas (11.1% vs 1.0% for SSLs), but are comparable to reported recurrence rates of hot EMR

Thoguluva Chandrasekar V,
Gastrointest Endosc 2019

SAFETY

- ✓ Remarkably low adverse event rate
- ✓ Even in larger polyps, most single-arm studies report adverse event rates close to 0%
- ✓ The CSP perforation rate was 0% in all studies due to the lack of thermal wall injury.
- ✓ cold EMR was associated with significantly lower rates of PPB (0% vs. 2.3%, p = 0.03)

Thoguluva Chandrasekar V,
Clin Gastroenterol Hepatol 2020

Original article

Effectiveness and safety of cold snare polypectomy and cold endoscopic mucosal resection for nonpedunculated colorectal polyps of 10-19 mm: a multicenter observational cohort study

Mangira D, Endoscopy 2023

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

EFFICACY

- Residual polyp tissue on biopsies: 7/350
- IRR = 2 %
- Submucosal injection prior to resection and fewer pieces per polyp resection were associated with a reduced risk of incomplete resection
- Completed SC1: 229/350 (65,4%)
- Recurrent Rate = 1,7 %

SAFETY

AEs
- 10/295 = 3,4 %
- 1 intraprocedural event (0.34 %): Bleeding
- 3 immediate post-procedural events (1 %): abdominal pain
- 6 delayed post-procedural events (2 %): PPS, abdominal pain, delayed bleeding

More than two-thirds of the polyps were conventional adenomas

CSP/C-EMR is safe and effective for the removal of nonpeduncolated medium-sized polyps

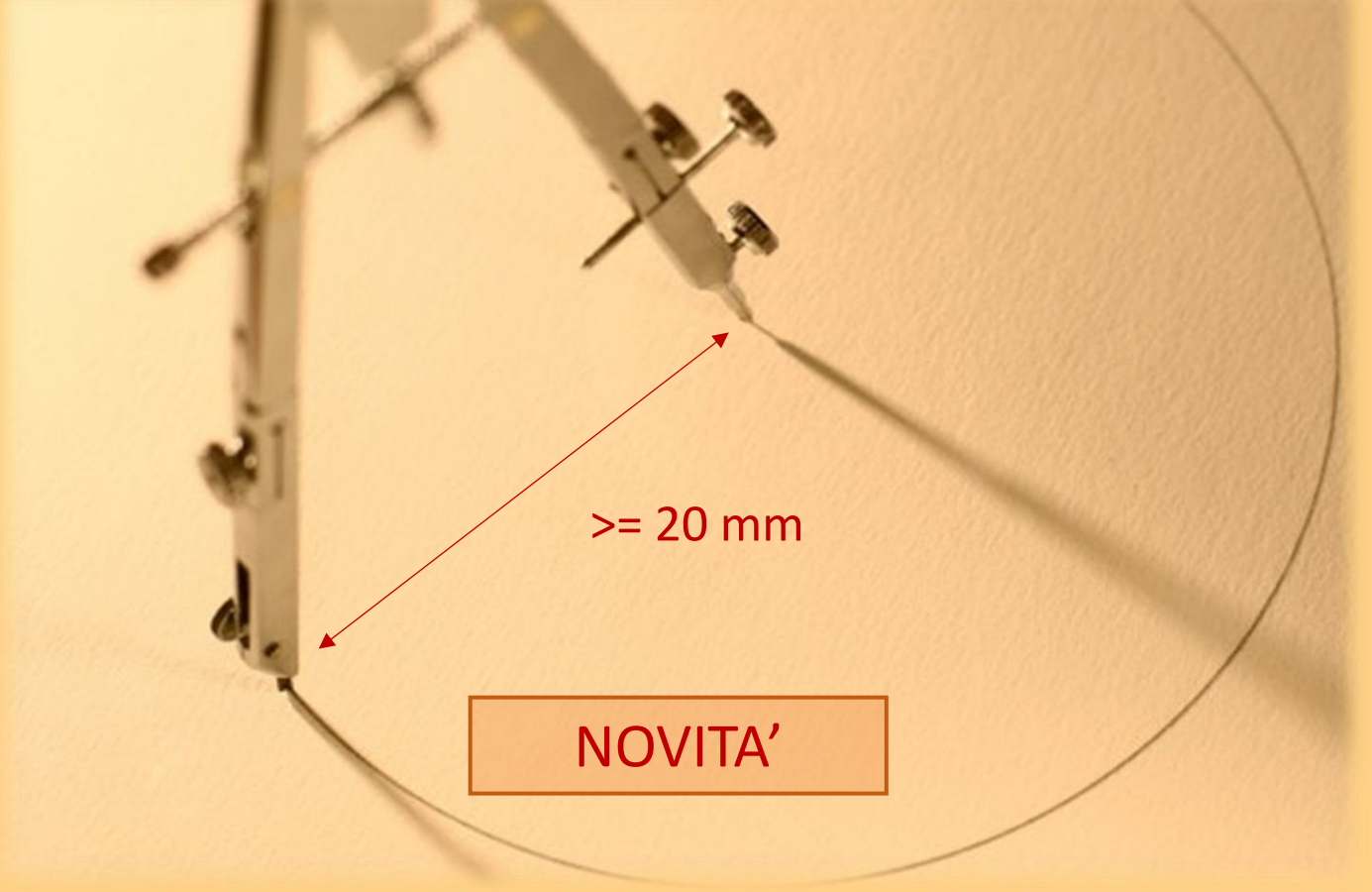
Low IRR, low recurrence rate, high levels of safety

IRR for conventional adenomas (2.1 %) compared with SSLs (0.96 %), non statistically significant (P = 0,72)

Meticolous tecnique, sm injection, dedicated cold snare

CHE COSA SAPPIAMO?

- EMR è lo *standard of care* per lesioni di dimensioni >=10 mm ma presenta un rischio evidente di eventi avversi, incluso un sanguinamento post-procedura e deep mural injury
- In confronto con EMR convenzionale, C-EMR è sicura ed efficace per asportazione di lesioni di medie dimensioni < a 20 mm



RECOMMENDATION

ESGE recommends piecemeal cold EMR for SSLs of ≥20 mm without suspected dysplasia.
Strong recommendation, moderate quality of evidence.

RECOMMENDATION

A suspected area of dysplasia within a large SSL should be resected en bloc by hot EMR.
Strong recommendation, moderate quality of evidence.

RECOMMENDATION

ESGE suggests cold snare piecemeal EMR for carefully selected large (≥20 mm) flat adenomas (granular homogeneous LSLs), mostly in the right colon, and particularly when co-morbidity levels are high to reduce the risks of deep mural injury and delayed post-EMR bleeding.
Weak recommendation, low quality of evidence.

p-CSP vs p-EMR

Successo tecnico: 100% vs 99%

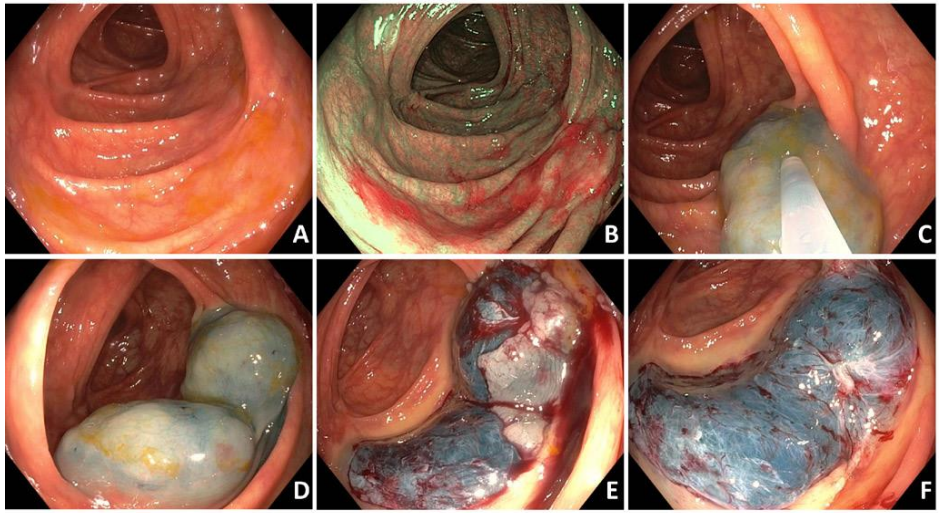
Nessun evento avverso in p-CSP

Per p-EMR: sang. ritardato 5,1%

DMI 3,4%

Per patient resection outcomes (n, %)	p-CSP 121 (25.5)	EMR 353 (74.5)	P value
CSPEB (n, %)	0 (0.0)	18 (5.1)	0.010
CSIPB (n, %)	0 (0.0)	5 (1.4)	0.336
DMI total (n, %)	0 (0.0)	10 (2.8)	0.071
Type 3 ('target sign')		9 (2.5)	
Type 4/5 (transmural perforation)		1 (0.3)	
Delayed perforation (n, %)	0 (0.0)	2 (0.6)	1.000

RISULTATI



SAFETY

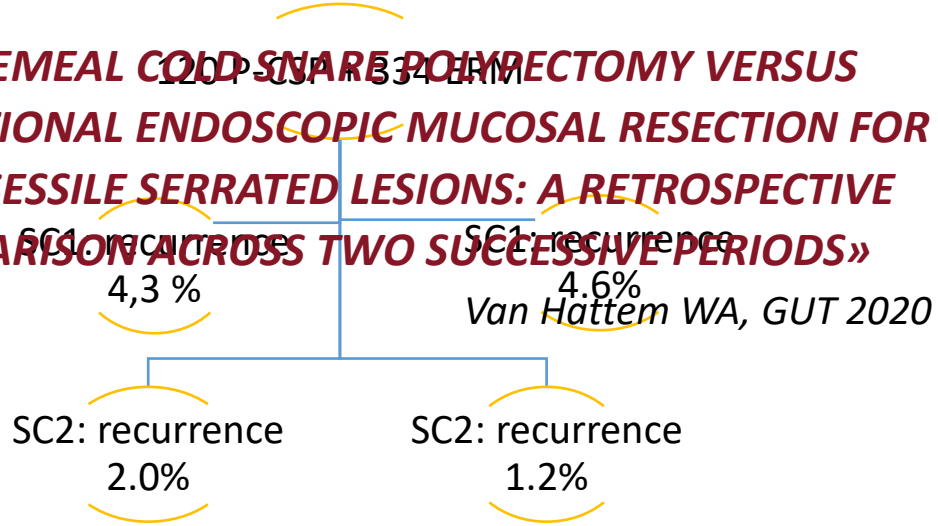
EVENTI AVVERSI TOT 5,4%

- Sang. intraprocedurale 2.2%
- Sang. post-EMR 3,8%
- Dolore addominale non specifico 0.5%

EFFICACY

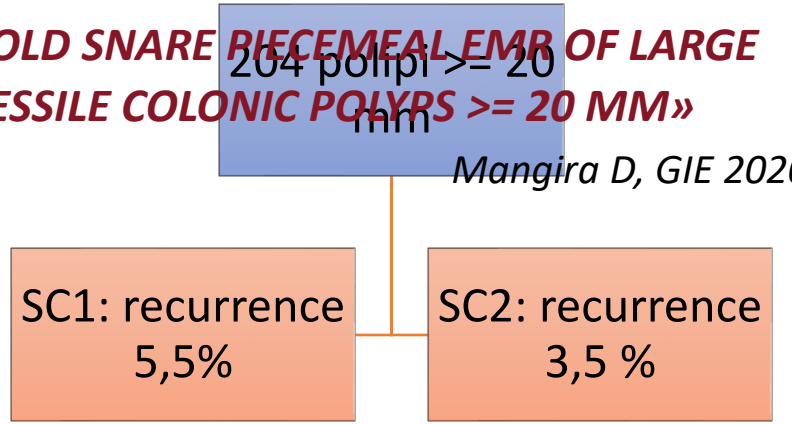
«PIECEMEAL COLD SNARE POLYPECTOMY VERSUS CONVENTIONAL ENDOSCOPIC MUCOSAL RESECTION FOR LARGE SESSILE SERRATED LESIONS: A RETROSPECTIVE COMPARISON ACROSS TWO SUCCESSIVE PERIODS»

Van Hattem WA, GUT 2020



«COLD SNARE PIECEMEAL EMR OF LARGE SESSILE COLONIC POLYPS >= 20 MM»

Mangira D, GIE 2020

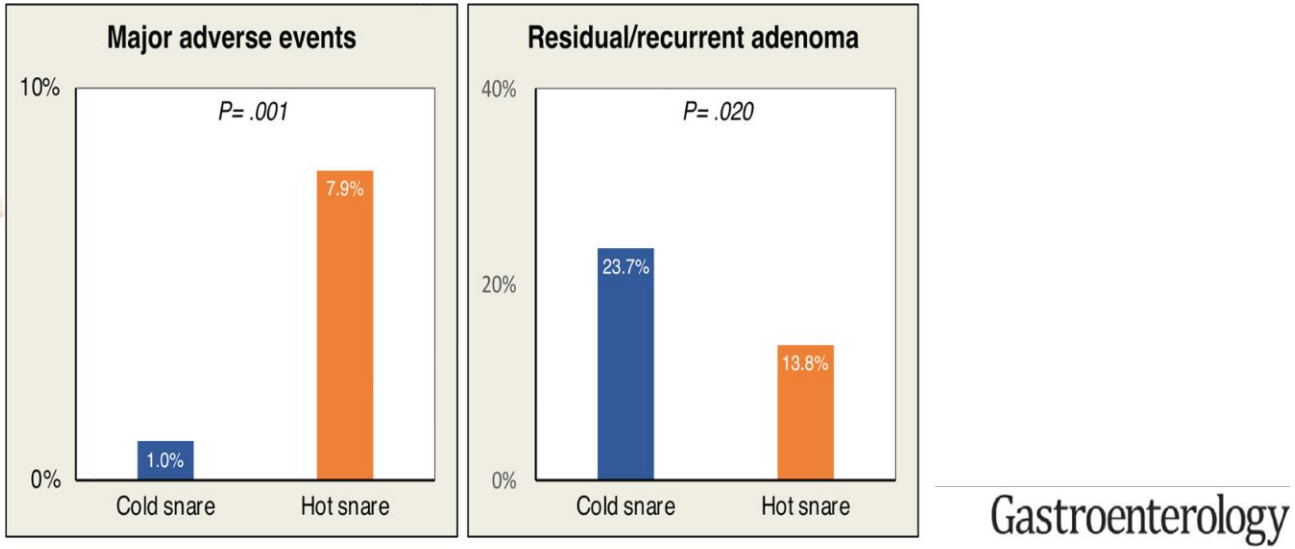


Van Hattem WA, GUT 2020

Mangira D, GIE 2020

Cold versus Hot Snare Endoscopic Resection of Large Non-Pedunculated Colorectal Polyps (Randomized-controlled German CHRONICLE-trial)

Major adverse events are a relevant problem of hot snare-EMR of non-pedunculated colorectal polyps ≥ 2cm.



Gastroenterology

Steinbruck I, Gastroenterology 2024

BACKGROUND AND CONTEXT

H-EMR is the standard therapy for the resection oh nonpeduncolated polyps >=20 mm, but major adverse events are clinically relevant problem

NEW FINDINGS

In this RCT, C-EMR appeared to be safer than H-EMR, with almost complete elimination of maior adverse events, but resulted in a higher rate of residual neoplasia.
However, in selected lesions, this drawback appears to be only minor

The higher rate of residual adenoma/neoplasia after cold EMR of flat colorectal polyps >2 cm was confirmed by this RCT, with an increase of 10% compared with hot resection.

In SSL, rates of residual neoplasia were not different between cold and hot resection.

The rate of residual adenoma of 14% in the hot EMR group is similar to a recent review.

One limitation of the study is the not sistematically performed margin coagulation

Outcomes in the Intention-to-Treat and Per-Protocol Analysis

	ITT					
	Cold snare EMR (n = 193)		Hot snare EMR (n = 203)			
Variable	n (%)	95% CI	n (%)	95% CI	*P* value	Odds ratio (95% CI)
Major AE	2 (1.0)	0.2–3.7	16 (7.9)	4.9–12.4	**.001**[a]	**0.12** (0.03–0.54)
Perforation	0 (0)	0.0–1.8	8 (3.9)	2.0–7.6	**.007**[b]	**0.06** (0.003–1.04)
Postprocedural bleeding	2 (1.0)	0.2–3.7	9 (4.4)	2.3–8.2	**.040**[a]	**0.23** (0.05–1.06)
Intraprocedural bleeding	27 (14.0)	9.8–19.5	46 (22.7)	17.4–28.8	**.026**[a]	**0.56** (0.33–0.94)
Postpolypectomy syndrome	6 (3.1)	1.4–6.6	9 (4.4)	2.3–8.2	.490[a]	0.69 (0.24–1.98)
Residual/recurrent adenoma (first FU)	42/177 (23.7)	18.1–30.5	24/174 (13.8)	9.4–19.7	**.020**[b]	**1.94** (1.12–3.38)

	PP					
	Cold snare EMR (n = 173)		Hot snare EMR (n = 197)			
Variable	n (%)	95% CI	n (%)	95% CI	*P* value	Odds ratio (95% CI)
Major AE	2 (1.2)	0.3–4.1	15 (7.6)	4.6–12.1	**.003**[a]	**0.14** (0.03–0.63)
Perforation	0 (0)	0.0–2.1	8 (4.1)	2.1–7.8	**.008**[b]	**0.06** (0.004–1.12)
Postprocedural bleeding	2 (1.2)	0.3–4.1	8 (4.1)	2.1–7.8	.112[a]	0.28 (0.06–1.32)
Intraprocedural bleeding	18 (10.4)	6.7–15.8	44 (22.3)	17.1–28.6	**.002**[a]	**0.40** (0.22–0.73)
Postpolypectomy syndrome	6 (3.5)	1.6–7.4	9 (4.6)	2.4–8.5	.592[a]	0.75 (0.26–2.15)
Residual/recurrent adenoma (first FU)	38/160 (23.8)	17.8–31.0	20/168 (11.9)	7.8–17.7	**.006**[b]	**2.30** (1.28–4.17)

Subgroup Analysis for Residual/Recurrent Adenoma/Neoplasia at the First Follow-up Examination (Intention-to-Treat and Per-Protocol Datasets)

Variable	Cold snare EMR n (%)	Cold snare EMR 95% CI	Hot snare EMR n (%)	Hot snare EMR 95% CI	*P* value	Odds ratio (95% CI)
ITT dataset						
Suspected SSL	4/48 (8.3)	3.3–19.5	2/42 (4.8)	1.3–15.8	.681[b]	1.75 (0.30–14.75)
LST granular-type homogeneous	17/57 (29.8)	19.55–42.6	12/57 (21.1)	12.5–33.3	.116[a]	1.58 (0.67–3.81)
LST nodular mixed-type	15/37 (40.5)	26.3–56.5	6/42 (14.3)	6.7–27.8	**.011**[a]	**3.97** (1.38–12.80)
LST nongranular-type	6/35 (17.1)	8.1–32.7	4/33 (12.1)	4.8–27.3	.735[b]	1.48 (0.37–6.56)
PP dataset						
Suspected SSL	4/44 (9.1)	3.6–21.2	2/41 (4.9)	1.3–16.1	.677[b]	1.87 (0.33–15.84)
LST granular-type homogeneous	15/51 (29.4)	19.1–43.7	11/56 (19.6)	11.3–31.8	.261[a]	1.69 (0.69–4.25)
LST nodular mixed-type	13/32 (40.6)	25.5–57.7	5/41 (12.2)	5.3–25.5	**.007**[a]	**4.74** (1.52–17.09)
LST nongranular-type	6/33 (18.2)	8.6–34.4	2/30 (6.7)	1.8–21.3	.261[b]	2.93 (0.59–23.67)

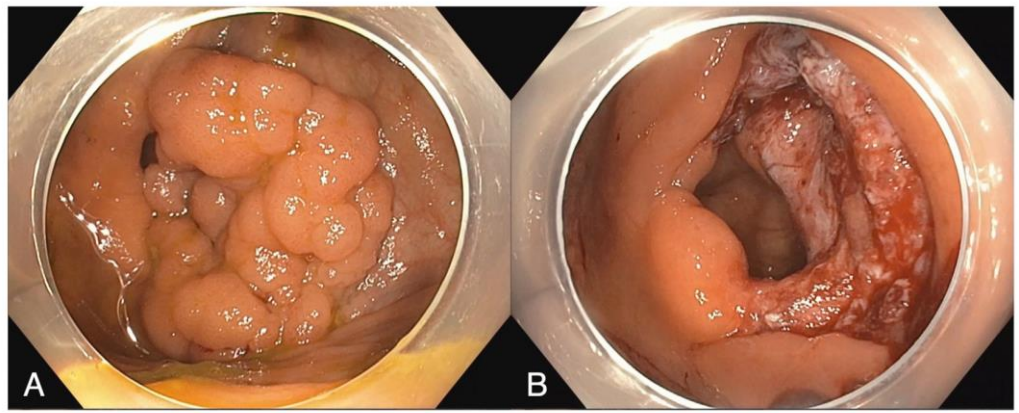


Figure 1. LST nodular-mixed type in the ascending colon before (*A*) and after (*B*) cold snare piecemeal EMR.

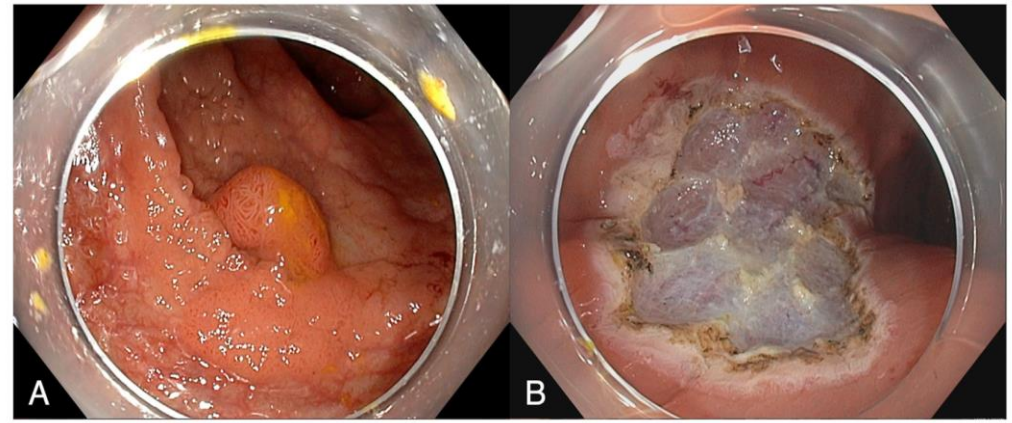


Figure 2. LST nodular-mixed type in the ascending colon before (*A*) and after (*B*) hot snare piecemeal EMR with margin coagulation.

The lower technical success rate of the cold snare and also data of our post-hoc subgroup analysis suggest that not every lesion is equally suitable for cold snare EMR

Suspected SSLs seem to be best suited for cold snare resection because recurrence rates were similar in both groups. This is in concordance with previous retrospective series

Very flat and homogenous adenomatous lesions, such as granular-type LST, may also be suitable for the cold snare.

The largest difference in favour of hot resection was seen in the mixed-type LST

Histology of advanced adenoma or carcinoma and polyp diameter > 4 cm were independent predictors for residual neoplasia

Lesions of a larger size and those with a complex morphology should be treated further by hot snare EMR


RISK
SAFETY

17 studi di cui 5 RCTs
96% dei polipi < = 10 mm

Rischio tromboembolico è simile tra pz che usano e non usano farmaci antitrombotici

PIU' ELEVATO RISCHIO DI SANGUINAMENTO RITARDATO IN PZ CHE ASSUMONO UN TRATTAMENTO ANTITROMBOTICO

POOLED DELAYED BLEEDING RATE AFTER CSP

1.6 %

PIU' ELEVATO RISCHIO DI SANGUINAMENTO IMMEDIATO IN PZ CHE ASSUMONO UN TRATTAMENTO ANTITROMBOTICO, > CON ANTIAGGREGANTI (p<0,001) E DOACs

POOLED IMMEDIATE BLEEDING RATE AFTER CSP

10,5 %

CON WARFARIN	0,3 %
CON DOACs	2,5 %
CON AG. MULTIPLI	3,9 %

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L’ USO DI AGENTI ANTITROMBOTICI AUMENTA IL RISCHIO DI SANGUINAMENTO

TALE RISCHIO E’ COMUNQUE < PER CSP vs HSP

RISCHIO DI SANGUINAMENTO IMMEDIATO COMPLESSIVO E’ 10,5 %, PERCENTUALE NON MAGGIORE DI QUELLA PER HSP

SEBBENE NON SIANO STATI PARAGONATI DIRETTAMENTE I DIVERSI ANTIGOAGULANTI, CON WARFARIN IL RISCHIO COMPLESSIVO DI SANGUINAMENTO RITARDATO E’ MOLTO PIU’ BASSO RISPETTO AI DATI PRECEDENTI (0,3%)

PER IL LIMITATO RISCHIO DI SANGUINAMENTO RITARDATO (<1%) DOPO CSP, SOPRATTUTTO IN PZ CHE USANO ANTIAGGREGANTI E WARFARIN, CSP POTREBBE ESSERE CONSIDERATA UNA PROCEDURA A BASSO RISCHIO

CONSIDERANDO CHE AGENTI ANTIAGGREGANTI PIASTRINICI E WARFARIN PRESENTANO UN RISCHIO DI SANGUINAMENTO MODESTO, LA LORO CONTINUAZIONE SOPRATTUTTO PER CSP DI POLIPI DIMINUTIVI PUO’ ESSERE RITENUTA ACCETTABILE

- *NEGLI ULTIMI ANNI STIAMO ASSISTENDO AD UNA VERA E PROPRIA «COLD REVOLUTION» PER LA RESEZIONE DI LESIONI DEL TRATTO DIGESTIVO INFERIORE*
- *LE TECNICHE DI RESEZIONE A «FREDDO» PRESENTANO LA STESSA EFFICACIA DI QUELLE A «CALDO» MA MOSTRANO UN PROFILO DI SICUREZZA SUPERIORE*
- *LA RESEZIONE A FREDDO «OTTIMIZZATA» RISULTA ESSERE LO «STANDARD BEST PRACTICE» ED E' STATA INCORPORATA NELLE LINEE GUIDA INTERNAZIONALI PER L'ASPORTAZIONE DI LESIONI DEL COLORETTO*


The End?