

Polyp Management Guideline Update

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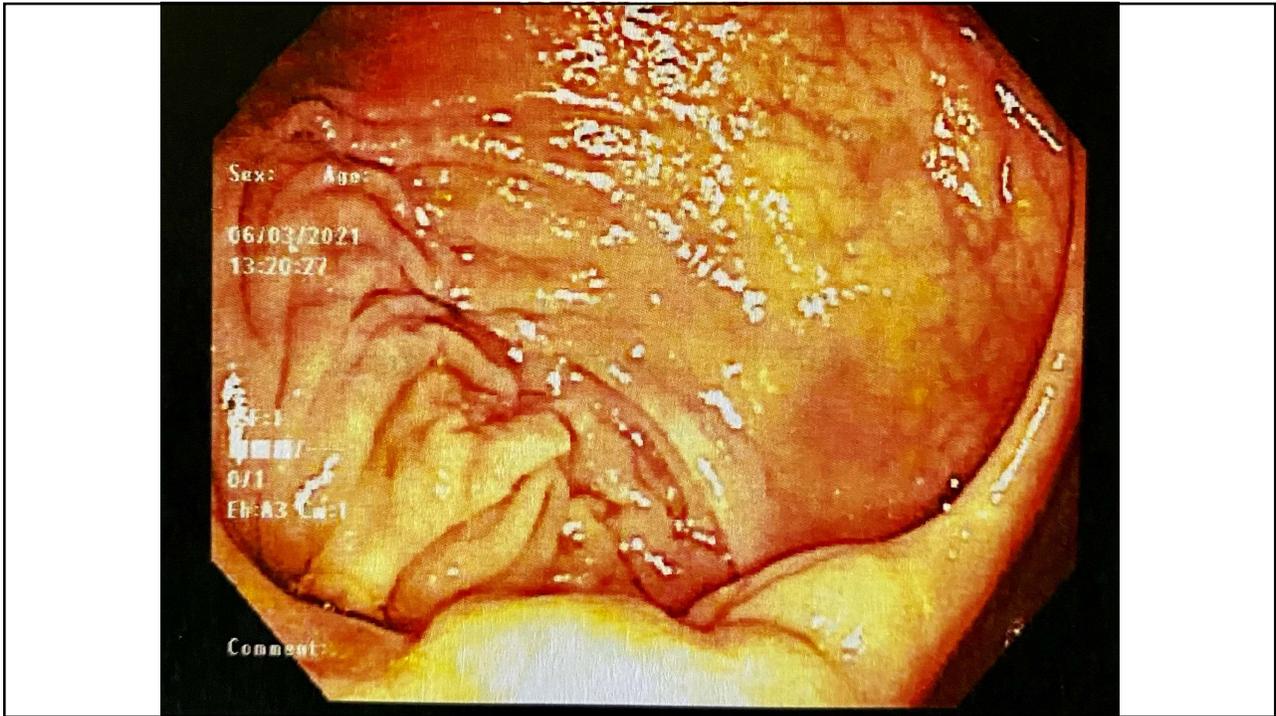
Longmont, CO

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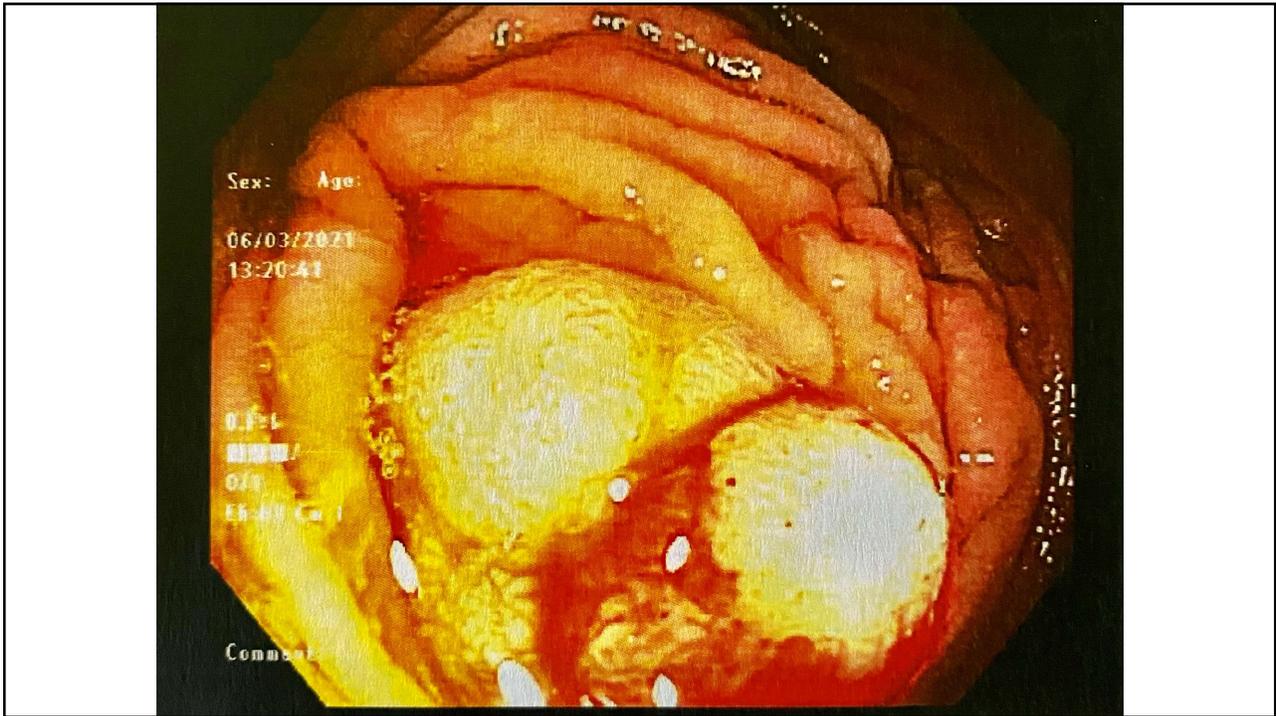
Objectives

- Review colonoscopy quality indicators
- Review risks/benefits of polyp surveillance
- Brief review of polyp histology
- Review changes in surveillance intervals from previous guidelines

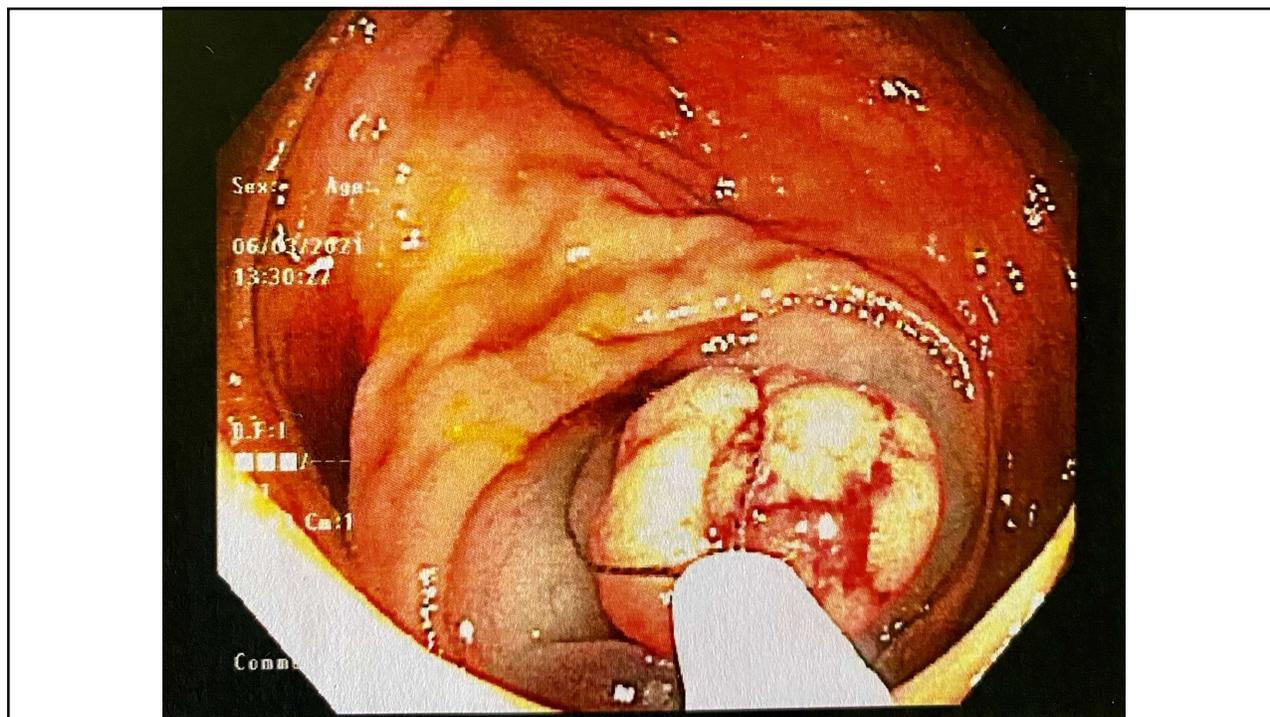
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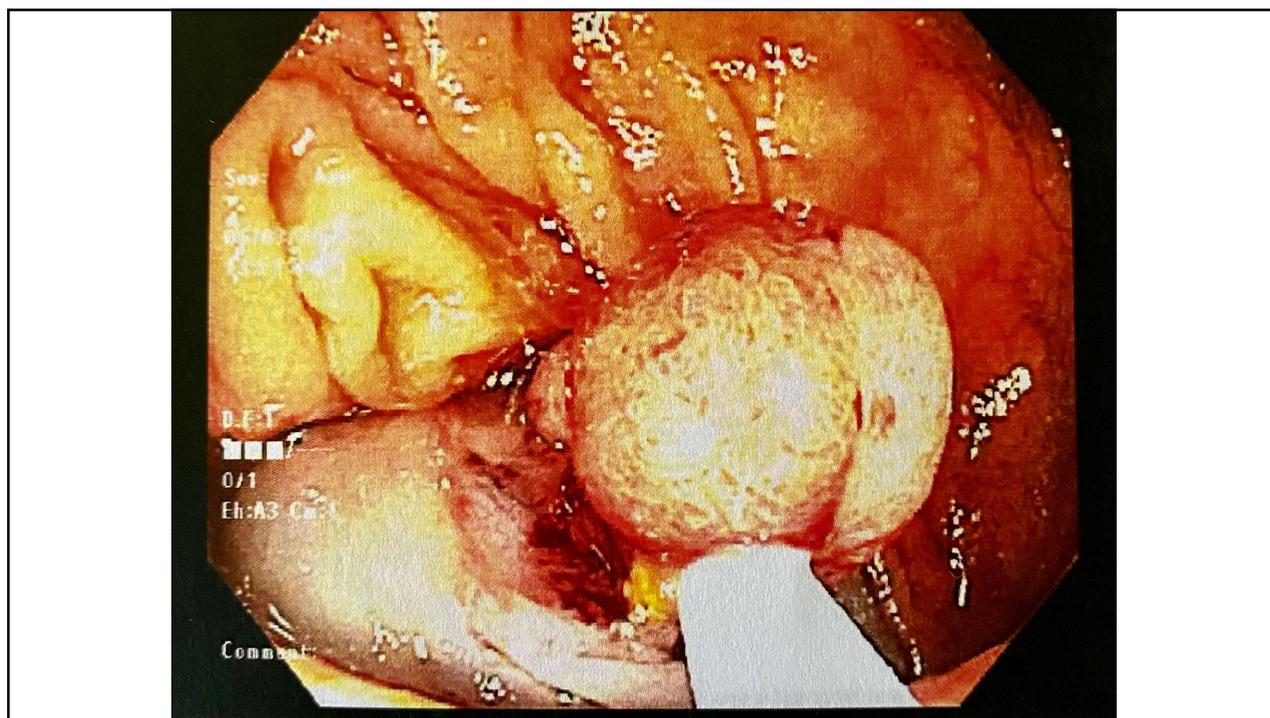
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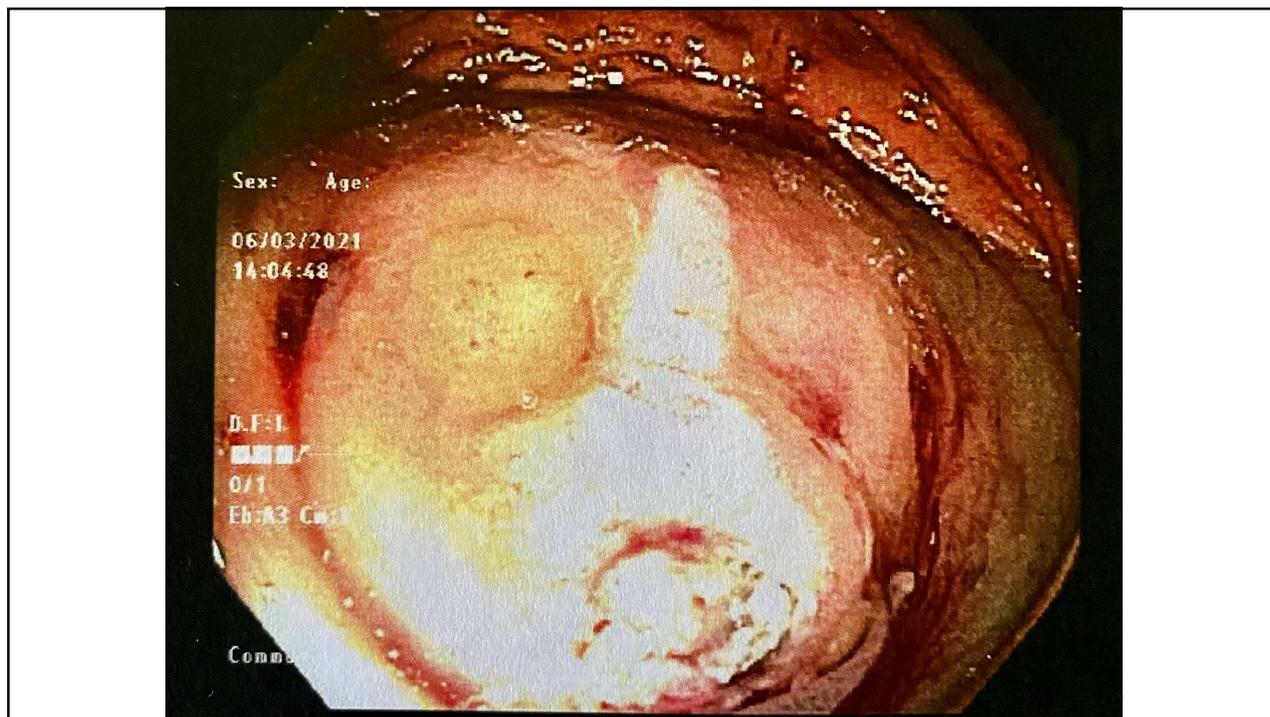
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Colorectal Cancer Importance

- 3rd Leading cause of cancer death for both men and women, #2 overall
- Leading cause of cancer death for non-smokers
- Lifetime risk of colon cancer - approximately 1 in 35
- Lifetime risk of dying from colon cancer - approximately 1 in 55
- Over 50,000 projected deaths from colon cancer for 2021

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Colon Polyp Surveillance Update-2020

- US Multi-Society Task Force on Colorectal Cancer
- Comprised of representatives of the American College of Gastroenterology, the American Gastroenterology Association, and the American Society for Gastrointestinal Endoscopy
- Published March 2020 (in Gastrointestinal Endoscopy, Gastroenterology, and The American Journal of Gastroenterology)/Updated guideline from 2012
- Full text article <https://10.1016/j.gie.2020.01.014>

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Colon- Polyp Surveillance Update- 2020 Cont.

- Based on prior findings and current literature review (last search done in September 2018)
- Recommendations developed by 2 authors and then consensus discussion with 8 additional authors
- Does not apply to individuals with hereditary colorectal cancer syndromes, inflammatory bowel disease, a personal history of colon cancer, or serrated polyposis syndrome
- UpToDate Pathway- Colon polyps:Surveillance after colon polyp resection

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Quality of Colonoscopy Assumptions

- Adenoma Detection Rate (ADR) - >30% men, >20% women
- Adequate Bowel Prep - > 85% (adequate for visualization of polyps >5mm)
- Reach the Cecum Rate - >95%
- Documentation of polyp size using open snare or biopsy forceps
- Attention to Complete Polyp Excision (removal of all visually detected polypoid tissue)

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What does a normal colonoscopy mean? Why a 10 year follow-up?

- In a study of >1.2 million in the US a normal colonoscopy decreased the risk of colon cancer for 10 years by nearly 50% and decreased the risk of dying from colon cancer by nearly 90%
- Risk reduction persisted for at least 12 years
- Modeling study of 4.2 million, normal colonoscopy=<0.5% chance of colon cancer in 10 years
- 2nd colonoscopy further decreased risk by >75% (modeling study only)
- but first colonoscopy is still the most important and most effective

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Are Polyps Important?

- “Not all polyps become colon cancer, but basically all colon cancers come from polyps” (polyp surveillance accounts for 25% of colonoscopies in US)
- Individuals who have had adenomatous polyps have an increased risk of colorectal cancer (up to 2-3x higher)
- Limited studies have shown 40-50% decrease in risk of incident colorectal cancer in those receiving surveillance versus those without
- In patients with advanced adenoma (adenoma \geq 10mm or any size adenoma with tubulovillous/villous histology or high-grade dysplasia) who had at least 1 follow-up colonoscopy, risk of subsequent colorectal cancer fell to that of general population versus a 4x higher risk in those without follow-up colonoscopy

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Small Polyps May Not Increase Risk

- Patients with only 1-2 tubular adenomas <1cm did not have an increased risk of subsequent colorectal cancer in 2 recent studies and only a 2% increased risk of advanced neoplasia on subsequent colonoscopy
- It is less clear that these patients benefit from surveillance colonoscopies
- Histology seems to matter - serrated adenomas, even if <1cm in size, may still have a 2x increase in risk for subsequent colorectal cancer

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Normal Colonoscopy

- No polyps
- ≤ 20 hyperplastic polyps <10mm (>10mm hyperplastic polyps are treated like adenomatous polyps)(Are you removing hyperplastic polyps from the rectum & sigmoid? Are you using NBI?)(Proximal hyperplastic polyps vs ssa's?)
- Repeat colonoscopy in 10 years

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1-2 Adenomas <10mm - 7-10 year follow-up

- Previous recommendations of 5-10 years
- What to do with 5 year follow-up recommendations?

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3-4 Tubular Adenomas <10mm - 3-5 yrs

5-10 Tubular Adenomas <10mm - 3 yrs

- Favors 5 year follow-up for 3-4 tubular adenomas over 3 year follow-up (limited evidence)
- Consider total number of lifetime adenomas when making decision (>10 is significant, consider genetic testing)
- Additional new recommendation - 3-4 tubular adenomas on first colonoscopy, normal colonoscopy on 2nd colonoscopy -10 year follow-up recommended

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1 or more adenomas ≥ 10 mm, or any polyp containing villous histology or high-grade dysplasia or traditional serrated adenoma - 3 year follow-up

- > 5x increased risk of colorectal cancer at follow-up
- Must be completely excised
- Are you following this for hgd? Did the term intramucosal adenocarcinoma scare you?

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>10 adenomas - Repeat in 1 year

- Consider genetic testing
- Increased possibility of hereditary cancer syndromes

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1-2 Sessile Serrated Adenomas <10mm- Repeat 5-10 years

- Limited small studies
- Variability in groups
- Increased risk of other large serrated adenomas at follow-up (23 large serrated adenomas followed for median 11 years in situ-no CRC)
- Unclear if have increased risk of other advanced lesions, except if have both sessile serrated adenoma and tubular or tubulovillous adenoma during same procedure
- Is more aggressive than similar recs for tubular adenomas due to less evidence and complete excision of sessile serrated adenomas is more difficult (? nearly 50% incompletely excised if >10mm)
- Same recommendations for 3-4 SSP's- 3-5 years and 5-10 SSP's- 3 year follow-up, as for tubular adenomas

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Sessile Serrated Polyp \geq 10mm

- 3 year follow-up
- Hyperplastic polyp \geq 10mm = 3-5 year follow-up (timing is based on path reliability, prep, complete excision etc)
- 3 year follow-up for all ssp's with dysplasia (sooner if complete excision is unclear)

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Large polyps ($\geq 20\text{mm}$)

- En bloc vs Piecemeal resection
- Endoscopic Mucosal Resection (EMR)
- Fulguration of Resection Margin
- Cold versus Hot Snare
- Clips
- ? Advanced histology should be treated the same
- Varying recommendations but $\geq 20\text{mm}$, piecemeal resection- repeat at 6 months, then 1 year, then 3 years

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Risk Factors for Metachronous Neoplasia

- Increased risk - Smoking, Obesity, Rural, Sedentary
- Not increased – Race (black patients have higher age-adjusted incidence and mortality from CRC and develop CRC at a younger age than other racial and ethnic groups), Proinflammatory Diet
- Not decreased - Increased fruits and vegetables, Calcium, Vitamin D
- Aspirin - still controversial
- Metformin may be beneficial

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Challenges and Opportunities

- Over 20 million in US between 45-49
- Screening the 45-49 age group may have less benefit than >50
- New surveillance guidelines may better utilize limited resources
- In general we under screen and overdo surveillance
- Updating colon polyp surveillance systems not necessarily easy
- Targeting underserved populations- surveillance programs may be more challenging
- What to do for the >75 y.o. or even >85 y.o. (modeling study suggests FIT may be effective strategy)

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Thank You!

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